New York's Nursing Home Enforcement Has Been Inadequate

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EXECUTIVE SUMMARY

This report was prepared at the request of Representatives Louise Slaughter and Carolyn Maloney. It examines the enforcement of federal health and safety standards in New York nursing homes. The report finds that the state has not adequately protected the residents of New York nursing homes.

There are over 100,000 nursing home residents living in over 600 nursing homes in New York State. These nursing home residents are often frail, elderly, and unable to take care of their basic needs. Sometimes, they cannot even speak out when they are neglected or abused. Their health and well-being depends on the quality of care they receive from the nursing home.

To protect these vulnerable residents, Congress enacted federal health and safety standards in 1987. This law and its implementing regulations require nursing homes to provide clean living conditions, adequate nutrition, and proper medical care to residents. The primary responsibility for ensuring compliance with these health and safety standards belongs to the states. In New York, this enforcement responsibility has been delegated to the New York State Department of Health.

This report investigates New York's enforcement of the federal nursing home standards. It examines four separate barometers of enforcement effectiveness. In each area, New York's record has been poor. Specifically, the report finds:

- **New York inspectors missed many serious violations.** When federal nursing home inspectors visited a nursing home after New York inspectors conducted an inspection, the federal inspectors consistently found many violations missed by the state inspectors. On average, the federal inspectors found over twice as many violations -- and over three times as many serious violations -- as the state inspectors. The violations missed by the state inspectors include violations involving the abuse of residents, the improper use of restraints, and inadequate medical care.

- **New York inspectors conducted inadequate investigations.** When federal nursing home inspectors accompanied New York inspectors on nursing home inspections, federal inspectors often found that the New York inspectors did a poor job of enforcing federal nursing home standards. Federal inspectors found that New York inspectors committed "egregious omissions" and missed "overwhelming evidence of widespread quality of care problems."

- **New York inspectors found fewer violations than inspectors in other states.** Each state conducts annual inspections of nursing homes to determine their compliance with federal health and safety standards. Compared to other states, New York inspectors found fewer violations of these standards. In 2000, inspectors in other states found 30% more violations per nursing home than New York inspectors. The low number of violations do not appear to be the result of better conditions in New York nursing homes.

- **New York inspectors dismissed most nursing home complaints.** New York has done a poor job responding to complaints of nursing home neglect and abuse. On average, New York inspectors dismissed 84% of nursing home complaints in 1999 without initiating enforcement action based on the complaint. New York inspectors initiated enforcement proceedings based on a complaint only 16% of the time, which was only half of the national average.

There is evidence that New York has recently begun to improve its enforcement of federal health and safety standards in nursing homes. According to federal inspectors, the state is trying to address concerns raised in this report. For example, New York has recently begun to hire new nursing home inspectors to reverse extensive staff reductions that occurred during the first six years of the Pataki Administration. Nursing home advocates have testified that this increased staffing will improve New York's enforcement efforts.

I. NEW YORK'S ENFORCEMENT RESPONSIBILITIES

New York State has 667 nursing homes with 113,780 residents. The Medicaid program pays for the care of 84,353 of these residents. The Medicare program pays for the care of 12,079 of these residents.

Under a 1987 federal law, nursing homes that receive Medicaid or Medicare funds must comply with federal health and safety standards.[1] The protections offered by this law are broad and important. They require nursing homes to ensure that residents receive proper medical care and nutrition, that residents are properly cleaned and bathed, and that residents live in a safe and sanitary environment free of hazards that could cause accidents.[2]

Enforcement of these standards is primarily a state responsibility. The U.S. Department of Health and Human Services (HHS) provides funds to the states to conduct inspections of homes and certify to the federal government that each home is in compliance with federal nursing home standards. In New York State, enforcement of federal nursing home regulations is the responsibility of the New York State Department of Health.

The New York State Department of Health carries out this responsibility by inspecting each nursing home, on average, annually. Federal law requires New York to inspect every nursing home in New York at least once every 15 months.[3] During these annual inspections, state inspectors spend several days at a facility interviewing residents, reviewing medical records, and observing conditions in the home. The inspectors cite any violations that they discover during this inspection. These citations are categorized by severity (degree of actual harm or risk to residents) and scope (number of residents affected). HHS has established a letter ranking system from A to L to capture these categories. The least serious violation is A (an isolated violation that poses minimal risks to residents) and the most serious is L (a widespread violation that causes or has the potential to cause death or serious injury).

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[1]Omnibus Budget and Reconciliation Act of 1987, Pub. L. 100-203,101 Stat. 1330 (codified at 42 U.S.C. §§ 1395-1396).

[2]*See* 42 C.F.R. § 483.25 (requiring the facility to maintain good grooming and hygiene of residents and also requiring the facility to ensure that the environment is free of hazards); *id.* § 483.35 (requiring the facility to provide each resident a well-balanced diet that meets the nutritional and special dietary needs of each resident); *id.* § 483.40 (requiring that each resident's medical care be supervised by a physician); *id.* § 483.60 (requiring the facility to review a resident's drug regimen at least once a month and also requiring the facility to provide pharmaceutical services that meet the needs of each resident). These and other regulations were promulgated by the Department of Health and Human Services in 1990 and 1995. 42 C.F.R. Part 483.

[3]42 U.S.C. § 1395i-3(g)(2)(A)(iii)(I).

The inspectors provide the nursing home with the results of the investigation and can impose fines or other sanctions depending on the violations found. Nursing homes with violations are required to submit a plan of correction detailing how the violations will be corrected. Violations that are not detected by the state inspectors can go uncorrected.

In addition to the annual inspections, the New York Department of Health also investigates complaints about nursing homes from residents, family members, and staff. When a nursing home resident has been abused or mistreated or has otherwise received poor care, a complaint can be filed with the state.[4] The Department then investigates the complaint to determine whether the allegation can be validated. If it is, the state can fine or sanction the home and require it to correct the problem. Like the annual inspections, complaint investigations are a vital tool in ensuring that nursing homes are meeting federal health and safety standards and providing the level of care that residents deserve.

II. OBJECTIVE OF THE REPORT

Representatives Louise Slaughter and Carolyn Maloney asked the minority staff of the Government Reform Committee to investigate the effectiveness of nursing home enforcement in New York. Representative Slaughter represents the 28th Congressional District of New York, which includes the City of Rochester and part of Monroe County. Representative Maloney represents the 14th Congressional District of New York, which includes the East Side of Manhattan and parts of Queens.

This report provides the results of that investigation. It evaluates how well the state fulfills its responsibility to enforce federal health and safety standards in nursing homes in New York. The report examines four primary measures of New York's enforcement effectiveness: (1) it analyzes the results of federal "comparative surveys" in which federal inspectors visit nursing homes after New York inspectors have left to assess the performance of the state inspectors; (2) it reviews the results of federal "observational surveys" in which federal inspectors accompany state inspectors on nursing home inspections to observe their performance; (3) it compares the number of health and safety violations found by New York inspectors with the number of violations found by inspectors in other states; and (4) it compares the response of New York inspectors to nursing home complaints with the response of inspectors in other states.

In addition, the report also examines staffing levels in the Department of Health to assess New York's commitment to nursing home enforcement.

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[4]New York law requires nursing home employees to immediately report any instances of abuse, mistreatment or neglect. N.Y. Public Health Law § 2803-d.

III. FINDINGS

The report finds that New York has a poor record of enforcing nursing home standards. On each of the four measures of enforcement effectiveness, the report finds significant deficiencies in the state's performance. According to federal inspectors who have accompanied state inspectors on nursing home inspections, state inspectors have committed "egregious omissions" and missed "overwhelming evidence of widespread quality of care problems."

A. New York Inspectors Missed Many Serious Violations

The Health Care Financing Administration (HCFA) is the branch of HHS responsible for nursing home conditions. As part of its effort to ensure that states adequately perform their enforcement responsibilities, HCFA conducts what are known as "comparative surveys." During comparative surveys, federal inspectors conduct independent inspections of nursing homes recently inspected by state inspectors. According to the U.S. General Accounting Office (GAO), comparative surveys are HCFA's "most effective technique . . . for assessing state agencies' abilities to identify serious deficiencies in nursing homes."[5]

Comparative surveys are effective because they allow HCFA, through its independent inspection, to evaluate what violations state inspectors have overlooked. The federal inspection is designed to replicate the state inspection. The federal inspectors attempt to evaluate the same residents as the state inspectors,[6] and they attempt to conduct their inspection soon after the state conducts its inspection.[7] The results of the two inspections are then compared. Federal and state inspectors are expected to find similar violations, although they are not expected to find the exact same violation in every case. Most violations cited by federal inspectors reflect quality of care problems in the facility that state inspectors are expected to cite.

The minority staff reviewed the six comparative surveys conducted in New York between

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[5]GAO, *Nursing Homes Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, 3 (Nov. 1999).

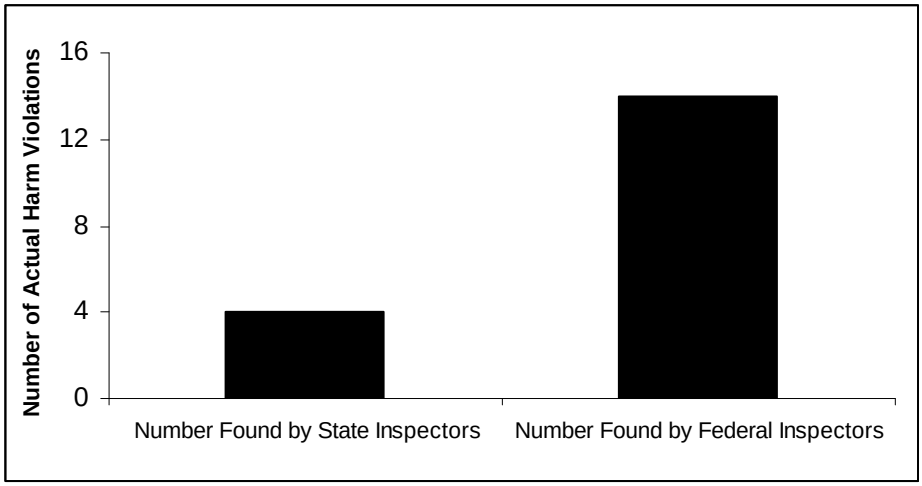
[6]Although the federal survey team attempts to evaluate the same resident sample as the state team, sometimes residents move or die, and it is not possible to evaluate all of the residents in the state sample. When a resident in the state sample is unavailable for the federal inspection, the federal team chooses another resident, who was not interviewed by the state team, to complete the sample. *See* HCFA State Operations Manual, *Procedures for Conducting the Federal Comparative Survey*.

[7]HCFA guidelines suggest that comparative surveys be completed within 30 days of the state survey, and federal law requires that the survey be conducted within two months of the state survey. 42 U.S.C. 1395i-3(g)(3)(A). Every comparative survey examined in this study was conducted within this time frame except one, which was conducted 77 days after the state survey.

January 1999 and August 2000. An analysis of these surveys indicates that state inspectors have missed many violations of federal health and safety standards. During the state inspections of the six nursing homes, the state inspectors found only 24 violations of federal health and safety standards. In comparison, when the federal inspectors visited the same nursing homes, they found 61 violations of the standards, over 150% more than the state inspectors.

The most serious violations in nursing homes are those that cause actual harm to residents or have the potential to cause death or serious injury. The state inspectors did an especially poor job detecting these violations. During the state inspections of the six nursing homes, the state inspectors found only four actual harm violations. In comparison, when the federal inspectors visited the same nursing homes, they found 14 violations that caused actual harm to residents. The federal inspectors thus found more than three times as many serious violations in these nursing homes as the state inspectors (Figure 1).

Figure 1: Federal Inspectors Found Over Three Times as Many Actual Harm Violations as State Inspectors



An examination of the actual inspection reports reveals that the state inspectors missed many disturbing violations. In two of the six comparative surveys, federal inspectors filled out a form that asked whether the state inspectors should have found the violations found by the federal team.[8] Federal inspectors determined that state inspectors should have found 18 of the 21 violations found by the federal teams.[9] However, state inspectors found only one of these

[8]Federal inspectors in New York did not fill out this form prior to January 1, 2000. Only two comparative surveys were conducted after January 1, 2000.

[9]Checksheet for Federal Comparative Survey for Nursing Home in Forest Hills (April 18, 2000); Checksheet for Federal Comparative Survey for Nursing Home in New Berlin (Aug. 24,

violations.[10] Many of the violations missed by state inspectors represent troubling quality of care problems. For example, the federal inspectors found:

- State inspectors failed to cite one of these facilities for leaving residents in more pain than necessary. One resident was subject to episodes of screaming behavior. Nurses explained that pain medication reduced the screaming behavior, yet the facility had discontinued it. Another resident grimaced and told the nurse that "it hurts" when her dressings were changed, yet the facility failed to address the resident's pain. Federal inspectors found that this violation caused actual harm to residents.[11]

- State inspectors failed to cite the same facility for not providing proper nutrition to its residents. This poor care caused one resident to lose over 20% of her body weight, falling to as low as 85 lbs. and eventually requiring hospitalization. Federal inspectors found that this violation caused actual harm to residents.[12]

- State inspectors also failed to cite this facility for its improper use of physical restraints, such as vest restraints. Federal inspectors noted that the facility had "failed to demonstrate that [the] restraints were not used for staff convenience." Federal inspectors found that this violation had the potential to cause more than minimal harm to residents.[13]

- State inspectors failed to cite the other facility for failing to notify the Department of Health about allegations of staff abuse of a resident[14] and for failing to screen five of seven new employees for a history of abuse, neglect, or mistreatment of residents.[15] Federal inspectors found that these violations had the potential to cause more than minimal harm to residents.

2000).

[10]HCFA Form 2567 for Nursing Home in Forest Hills (April 3, 2000).

[11]HCFA Form 2567 for Nursing Home in Forest Hills (G-level violation) (Apr. 18, 2000); Checksheet for Federal Comparative Survey for Nursing Home in Forest Hills (April 18, 2000).

[12]HCFA Form 2567 for Nursing Home in Forest Hills (G-level violation) (Apr. 18, 2000); Checksheet for Federal Comparative Survey for Nursing Home in Forest Hills (April 18, 2000).

[13]HCFA Form 2567 for Nursing Home in Forest Hills (E-level violation) (Apr. 18, 2000); Checksheet for Federal Comparative Survey for Nursing Home in Forest Hills (April 18, 2000).

[14]HCFA Form 2567 for Nursing Home in New Berlin (D-level violation) (Aug. 24, 2000); Checksheet for Federal Comparative Survey for Nursing Home in New Berlin (Aug. 24, 2000).

[15]HCFA Form 2567 for Nursing Home in New Berlin (E-level violation) (Aug. 24, 2000); Checksheet for Federal Comparative Survey for Nursing Home in New Berlin (Aug. 24, 2000).

In the other comparative surveys, federal inspectors found numerous serious violations that the state did not find. For example, federal inspectors found that one facility was providing improper nutrition to all eight residents in their survey, thereby causing them actual harm.[16] Although federal inspectors found a clear pattern of this violation, it was not reported by the state inspectors.

At this same nursing home, the federal inspectors reviewed the efforts of the facility to protect residents from the spread of infection or contamination. The federal inspectors reviewed the care provided to 15 infected residents and, in each case, found that nurses and aides failed to ensure that the infections would not spread to other residents.[17] Although federal inspectors found that this pattern of poor care caused actual harm to residents, state inspectors did not cite the home for any infection control problems.

One of the goals of the 1987 nursing home law was to reduce the improper use of chemical and physical restraints. Federal inspectors, however, questioned the "ability of the state survey team to identify inappropriate use of resident restraints."[18] Federal inspectors found two facilities that used improper restraints, yet the state did not cite any homes for this violation.[19] For example, federal inspectors found that a resident was improperly given anti-psychotic drugs.[20] Even though much of the evidence for this violation was in the resident's files, state inspectors missed the violation entirely.

At yet another nursing home, state inspectors failed to report instances where residents were physically abused by other residents, despite the fact that these aggressive behaviors were documented in the residents' files. Federal inspectors reviewing these files found numerous instances of resident abuse, such as one resident swinging his cane at another resident and a second resident slapping another resident. Federal inspectors determined that the nursing home did not adequately respond to these aggressive behaviors.[21] State inspectors did not cite this nursing home for abuse violations.

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[16]HCFA Form 2567 for Nursing Home in Woodbury (H-level violation) (Feb. 17, 1999).

[17]HCFA Form 2567 for Nursing Home in Woodbury (H-level violation) (Feb. 17, 1999).

[18]Letter from Kathleen Gormaley, Branch Chief, Division of Medicaid & State Operations, to Laura Leeds, Deputy Director, New York State Department of Health, Office of Continuing Care (Mar. 2, 2000) (hereinafter "HCFA Letter").

[19]HCFA Form 2567 for Nursing Home in Forest Hills (E-level violation) (Apr. 18, 2000); HCFA Form 2567 for Nursing Home in Woodbury (D-level violation) (Feb. 17, 1999).

[20]HCFA Form 2567 for Nursing Home in Woodbury (D-level violation) (Feb. 17, 1999).

[21]HCFA Form 2567 for Nursing Home in Brooklyn (H-level violation) (Mar. 31, 1999).

Many other serious violations detected by federal inspectors were also missed by state inspectors, including failing to maintain an alternate power supply in the event of a power interruption, even though eight residents depended on electricity for their life sustaining machines.[22] Other violations cited by federal inspectors but not by state inspectors include the improper administration of medicines[23] and the failure to keep the home free of hazards.[24]

B. New York Inspectors Conducted Inadequate Inspections

In addition to conducting comparative surveys, HCFA also conducts observational surveys, also known as "federal oversight and support surveys." During an observational survey, federal inspectors accompany state inspectors on a nursing home inspection, watch the state inspectors perform a variety of tasks, and provide verbal feedback. The federal inspectors then rate the state inspectors' performance on the eight tasks and sometimes provide narrative descriptions of their observations. The nursing homes selected for observational surveys are often facilities where federal officials expect to encounter quality of care problems.

These observational surveys are more common than the comparative surveys. In fiscal year 2000, 31 observational surveys in New York were conducted. Although some state inspectors received high marks from federal inspectors, a review of the results of these surveys again shows New York's enforcement efforts were often deficient.

The observational surveys conducted in fiscal year 2000 indicate that even when federal inspectors were present, state inspectors made many serious errors. For example, in one nursing home, state inspectors did not identify violations that put residents in immediate jeopardy "despite overwhelming evidence of widespread quality of care problems."[25]

In another nursing home, federal inspectors reported "several egregious omissions" by the inspectors.[26] Among the violations missed by state inspectors was an immediate jeopardy incident involving the abuse of a resident by another resident.

Federal inspectors reported that state inspectors consistently failed to properly investigate

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[22]HCFA Form 2567 for Nursing Home in Brooklyn (H-level violation) (Mar. 31, 1999).

[23]HCFA Form 2567 for Nursing Home in Brooklyn (E-level violation) (Mar. 31, 1999).

[24]HCFA Form 2567 for Nursing Home in Woodbury (F-level violation) (Feb. 17, 1999).

[25]HCFA Letter, *supra* note 18, at 6.

[26]Federal Monitoring Survey of Nursing Home in Brooklyn (Feb. 17, 2000).

the improper use of restraints on residents.[27] Federal inspectors at one nursing home said that the "problem is more systemic than just within this team."[28] At another nursing home, state inspectors were reluctant to cite a facility for inappropriate use of restraints even though 70 of 105 residents were subject to restraints and the home had reported that no restraints were in use.[29] At yet another nursing home, state inspectors failed to check for violations involving physical restraints, even though this was highlighted as a concern prior to the inspection.[30]

In other instances, federal inspectors reported that the state inspectors simply did not cite violations that they observed. In one nursing home, a state inspector noticed the improper treatment of pressure sores, but did not cite the violation.[31] In another home, a biohazard violation was noted but not cited.[32]

State inspectors even ignored issues that they themselves identified as concerns. Prior to starting one inspection, state inspectors were aware that fecal impaction was a concern in the nursing home. Yet when the inspection was conducted, no residents with fecal impaction were included in the review of medical records.[33]

At other times, state inspectors failed to follow through on problems that were observed or raised during the inspection. One nursing home had an inordinate number of falls involving residents, yet federal inspectors reported that state inspectors did not investigate to determine why these falls were occurring.[34] In another nursing home, state inspectors failed to investigate a bruise that was observed around a resident's eye.[35] In two other facilities, state inspectors failed

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[27]Federal Monitoring Survey of Nursing Home in Bronx (Feb. 15, 2000); Federal Monitoring Survey of Nursing Home in New York (Mar. 21, 2000); Federal Monitoring Survey of Nursing Home in Brooklyn (Dec. 6, 1999).

[28]Federal Monitoring Survey of Nursing Home in Bronx (Feb. 15, 2000).

[29]HCFA Letter, *supra* note 18, at 4.

[30]Federal Monitoring Survey of Nursing Home in Hollis (Oct. 19, 1999).

[31]Federal Monitoring Survey of Nursing Home in Jamaica (Mar. 9, 2000).

[32]Federal Monitoring Survey of Nursing Home in Brooklyn (Jan. 27, 2000).

[33]Federal Monitoring Survey of Nursing Home in Brooklyn (Jan. 27, 2000).

[34]Federal Monitoring Survey of Nursing Home in Brooklyn (Jan. 27, 2000).

[35]Federal Monitoring Survey of Nursing Home in Lake Katrine (Sept. 28, 2000).

to explore why many of the residents in the facilities had developed pressure sores.[36]

According to federal inspectors, state inspectors frequently conducted the inspection improperly, detracting from the survey results. One state inspector was not qualified to conduct the review assigned to her. She admitted to federal observers that she was uncomfortable doing the task and she missed some important observations.[37] At another facility, the state inspectors' failure to use the all the methods available to them resulted in a "superficial review that did not identify potential quality of care issues."[38] State inspectors in another home did not reconcile medical records with their personal observations, which could cause medical errors to be missed.[39] In another instance, federal inspectors stated that state inspectors lacked focus and were not adequately prepared for the visit. Federal inspectors had to remind state inspectors that the nursing home faced termination depending on the results of this inspection.[40]

Sometimes, federal inspectors had to step in to ensure that state inspectors conducted a complete inspection. In one facility, state inspectors intended to tour only two of the facility's units. Federal inspectors had to remind the state inspectors that the entire nursing home needed to be inspected. State inspectors toured the entire facility, reviewing five units, containing 203 residents, in a little over an hour. In this rushed tour, state inspectors failed to elicit important information about residents such as behavior problems.[41]

C. New York Inspectors Found Fewer Violations than Inspectors in Other States

HCFA maintains a database of nursing home violations cited by state inspectors. This database is called the On-Line Survey, Certification, and Reporting (OSCAR) database. The OSCAR database contains the results of annual surveys conducted by state inspectors, including the number and severity of the violations found.

The OSCAR database was reviewed in this report to compare the number of violations cited by New York inspectors with the number of violations cited by inspectors in other states.

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[36]Federal Monitoring Survey of Nursing Home in Woodbury (Nov. 15, 1999); Federal Monitoring Survey of Nursing Home in Hollis (Oct. 19, 1999).

[37]Federal Monitoring Survey of Nursing Home in New York (Mar. 21, 2000).

[38]Federal Monitoring Survey of Nursing Home in Brooklyn (Oct. 28, 1999).

[39]Federal Monitoring Survey of Nursing Home in Ossining (Jan. 11, 2000); HCFA Letter, *supra* note 18, at 2.

[40]Federal Monitoring Survey of Nursing Home in Bronx (Aug. 7, 2000).

[41]Federal Monitoring Survey of Nursing Home in Lake Katrine (Sept. 28, 2000).

This analysis showed that New York inspectors found a low number of violations. In 1999, New York inspectors found on average only 3.6 violations of federal health and safety standards per nursing home. The national average was 5.8 violations per nursing home, 61% more violations per nursing home inspected than New York inspectors found.

The number of violations cited by New York increased in 2000, but remained below the national average. As of December 1, 2000, New York inspectors cited an average of 4.6 violations per home. The national average was 6.0, 30% more violations per nursing home than New York inspectors found.

New York officials point out that their enforcement efforts are improving. In a recent press release, the state noted that it doubled the number of immediate jeopardy citations – the most serious citation that can be imposed – from 13 homes in 1999 to 28 in 2000. It also noted that the number of facilities fined also doubled from 21 in 1999 to 45 in 2000.[42]

The low numbers of violations cited by New York inspectors do not appear to be the result of better conditions in New York nursing homes. According to the Department of Health, New York's low number of violations in comparison to other states may be caused by "less depth to the survey process and the identification of fewer important deficiencies per visit."[43] A report by the New York City Public Advocate and a state assemblyman reached a similar conclusion, finding that the decline in nursing home citations in New York is "a product of poorer enforcement."[44]

D. New York Inspectors Dismissed Most Nursing Home Complaints

In addition to conducting annual inspections of nursing homes, New York is also responsible for responding to complaints of poor conditions in nursing homes. When a complaint is filed against a nursing home, the state investigates it and determines whether the complaint can be validated and enforcement action is warranted. New York's record in responding to these complaints is poor. In New York, more than four out of every five

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[42]Press Release, Office of the Governor, *Governor: Strongest Nursing Home Protections in State History* (Jan. 14, 2001).

[43]New York State Department of Health Surveillance Workgroup, *Quality Assurance and Quality Improvement Through Facility Surveillance: Issues and Opportunities*, 12 (June 25, 1999) (noting that the comparison of New York State's violation citation rate with those in other states supports the finding that New York inspectors are not adequately conducting their inspections). This report is discussed more extensively in Section IV.

[44]Mark Green, Public Advocate for the City of New York and Richard N. Gottfried, Chair New York State Assembly Health Committee, *Residents at Risk: The Collapse of Nursing Home Enforcement in New York City*, i (Aug. 1998).

complaints have been dismissed by state inspectors.

To analyze New York's response to complaints, the minority staff obtained a national complaint database maintained by HCFA. The database contains information about the subject of the complaint and whether the state found the complaint to be valid. The staff reviewed data on the number of complaints investigated in New York and across the nation in 1999 and 2000.[45]

This review found that New York dismissed more complaints than most of the rest of the nation. In 1999, nationally, 32% of complaints involving nursing homes resulted in enforcement actions that cite the nursing home for health and safety violations relating to the complaint. But in New York in 1999, only 16% of complaints -- half of the national average -- resulted in enforcement actions based on the complaint. New York inspectors dismissed 84% of complaints filed without initiating enforcement action based on the complaint.

Preliminary data from 2000 suggests that New York did not improve in 2000. The partial data that is available shows that in 2000, 29% of complaints resulted in enforcement action nationally. In New York in 2000, only 16% of the complaints resulted in enforcement action, no more than in 1999.

The minority staff interviewed several family members who had filed complaints involving New York nursing homes in 1999. The family members interviewed by the staff were identified by advocacy organizations in New York, so they were not a random sample. Nevertheless, their experiences suggest that New York loses complaints, does not respond promptly, and fails to conduct thorough investigations.

Tom Deluca, a family member from Bronx, New York, had one typical experience. His mother is a resident of a nursing home in Bronx, New York. One day in 1999, he noticed that her leg was swollen and sore. Although Mr. Deluca's mother complained of pain and could not walk, a doctor in the home told Mr. Deluca that his mother needed to get up and move around more. It took five and a half weeks before the nursing home finally had x-rays taken of the lower part of his mother's leg and discovered that it was fractured.

Mr. Deluca filed a complaint about his mother's treatment with the New York Department of Health. An inspector did a preliminary investigation and told Mr. Deluca that she did not believe that there was reason for concern. Mr. Deluca asked her if she had looked at the x-rays of his mother's leg. She responded: "I am not a radiologist, I don't look at x-rays." Mr. Deluca appealed to a supervisor who was more sympathetic and told Mr. Deluca that the case would be forwarded to an independent contractor who would look into it. Over four months later, Mr. Deluca received a call from the Department of Health telling him that the Department had lost track of his complaint and that it had never been forwarded. After another three weeks, the complaint was finally forwarded to the contractor. "Dealing with the Department of Health,"

[45]Data for Alaska and Alabama was not included in the HCFA database.

Mr. Deluca says, "is an exercise in futility."[46]

Theresa LaMacchia, a family member from Brooklyn, New York, had a similar experience. Her mother was a resident of a nursing home in Brooklyn, New York. In 1999, her mother was placed on a feeding tube and became so dehydrated that she was sent to a hospital. The doctor at the hospital told Ms. LaMacchia to get her mother out of that nursing home because the home almost caused her death. Ms. LaMacchia called the Department of Health on July 14, 1999, to complain about the treatment. After not hearing any news for a few weeks, she called again on July 30. She was told that her complaint had been "misplaced" and that they had no record of it. She filed it again. In November, she was told that the state inspectors were not able to validate her complaint.[47]

IV. STAFFING LEVELS AT THE DEPARTMENT OF HEALTH

One of the causes of New York's inadequate enforcement record appears to be staff shortages at the Department of Health. Since the early 1990s, New York has experienced a precipitous decline in the number of staff engaged in nursing home enforcement. Although the measurement of the staff reduction may vary depending on how the data is calculated, staffing in the office responsible for nursing home inspections has gone down substantially since 1993.

An internal report from the Department of Health reports that the number of employees in the Office of Continuing Care dropped 28% between 1993 and 1999, from 275 in 1993 to 198 in 1999. This office was responsible for the oversight of nursing homes as well as the oversight of certified home health agencies, licensed home care service agencies, and intermediate care facilities for the developmentally disabled.[48]

The Department of Health's internal report found that reduced staffing has an adverse impact on the quality of its enforcement responsibilities:

> As staffing levels have declined and workload has increased, . . . the interval between routine surveys has increased as have delays in conducting follow-up surveys and in issuing reports of surveys and investigations. There is widespread concern that surveillance quality has suffered as well.[49]

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[46]Interview with Tom Deluca on September 27, 2000.

[47]Interview with Teresa La Macchia on September 7, 2000.

[48]The Department of Health recently reorganized the Office of Continuing Care.

[49]New York State Department of Health Surveillance Workgroup Report, *supra* note 43, at 2.

Other data from the New York State Department of Health suggests that the staff responsible for nursing home inspections and enforcement may have borne a disproportionate share of the staff reductions. According to the Department of Health, there has been a 37% reduction in staff in the Office for Long-Term Care Survey and Certification between 1995 and 1999.[50]

One surveyor recently testified that she has seen a "steady decline in the staffing and support" over the past three to four years. "The quality and integrity of the survey process are suffering," she stated. She further testified that management tells inspectors that they "don't have time to delve into all findings that we have to 'let things go.'"[51] Another surveyor testified that the staff was "severely depleted" causing "[m]any issues [to be] left on the back burner" because staff was "told to report only the obvious."[52]

Part of the reason for the decline in the number of nursing home inspectors in New York is that New York refused to use all of the federal money available to it for hiring nursing home inspectors. For example, HCFA's records indicate that between fiscal years 1996 and 1998, New York turned back almost $2.5 million in federal funding for hiring nursing home inspectors.[53]

The Department of Health has recently begun to reverse some of these practices. In fiscal year 2000, the Department actually exceeded its federal allocation of funds. In addition, the Department has committed to hiring 72 new inspectors for the nursing home surveillance program.[54] There is evidence that this increased staffing is producing results. According to HCFA's regional office, New York is making progress in addressing problems identified in this

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[50]According to the Department of Health, staff in the Office for Long-Term Care Survey and Certification, the office responsible for nursing home inspections and enforcement, dropped from 115.54 full-time equivalents (FTEs) in 1995 to 72.95 FTEs in 1999.

[51]Testimony of Mary Ann Vincent, RN, Long Term Care Surveyor, NYS Department of Health, before a Joint Public Hearing of the New York State Assembly Committees on Aging and Health, "Nursing Home Quality of Care, Staffing and Regulation Hearing" (Dec. 12, 2000).

[52]Testimony of August Cardinale, on behalf of the New York State Public Employees Federation, before a Joint Public Hearing of the New York State Assembly Committees on Aging and Health, "Nursing Home Quality of Care, Staffing and Regulation Hearing" (Dec. 12, 2000).

[53]According to data from HCFA, New York did not expend $654,775 of the federal funds approved in fiscal year 1998, $676,543 of the funds approved in fiscal year 1997, and $1,157,791 of the funds approved in fiscal year 1996.

[54]Testimony of Wayne Osten, Director of the Office of Health Systems Management for the New York State Department of Health, before a Joint Public Hearing of the New York State Assembly Committees on Aging and Health, "Nursing Home Quality of Care, Staffing and Regulation Hearing" (Dec. 12, 2000).

report. In addition, nursing home advocates acknowledge that New York's enforcement efforts are improving.[55]

V. CONCLUSION

Enforcement of the protections afforded to nursing home residents is an important responsibility. Because many nursing home residents are elderly and frail, they must depend on the enforcement system to ensure that they receive quality care. Unfortunately, the findings in this report indicate that New York has had a poor enforcement record, frequently missing serious health and safety violations during nursing homes inspections.

[55]Testimony of Cynthia Rudder, Director of the Nursing Home Community Coalition of New York State, before a Joint Public Hearing of the New York State Assembly Committees on Aging and Health, "Nursing Home Quality of Care, Staffing and Regulation Hearing" (Dec. 12, 2000).