



Age and Youth in Action

February 3, 2015

Hon. Thomas DiNapoli
Office of State Comptroller
Alfred E Smith Bldg, 5th Fl
Albany, NY 12236-0001

RE: Need for audit or policy analysis of the New York State Department of Health's responses to complaints about the quality of care and safety in nursing homes

Dear Comptroller DiNapoli:

The Gray Panthers, New York City Network, urges that you use the powers of your office to conduct an inquiry into the effectiveness of the New York State Department of Health's (NYSDOH's) responses to complaints about safety and healthcare quality in nursing homes in New York. We ask that you re-examine compliance with the recommendations of your office's 2002 audit. We also urge you to expand your inquiry to address safety provisions set out in Part 415, several provisions of which are described below, and the strength of NYSDOH's existing enforcement and penalty powers.

The NYSDOH has authority to investigate reported complaints of physical abuse, mistreatment and neglect of persons in residential health care facilities, as related to applicable State and federal regulations. A 2002 Comptroller's audit of the NYSDOH's responses to complaints concluded that improvements were urgently needed, especially in the New York City area. This audit found that:

- Many actions of investigators were not documented properly;
- DOH neglected to conduct some investigations, relying instead on nursing homes' internal investigations even though DOH procedures required on-side investigation;
- In several instances, allegations were either not recorded or were misclassified; and
- DOH had failed, since 1998, to provide the required annual reports on incidents to the Governor and the NYS Legislature.

The Comptroller's Audit recommended specific corrective actions, but its 2004 follow-up review found that the NYSDOH had not implemented several of these recommendations, including:

1. Take steps to ensure that complaint investigations are initiated in a timely manner and are thorough, with documentation of investigations maintained in the case files;
2. Monitor how well regional offices meet time standards for closing cases;
3. Identify and assign all open cases to investigators and reassign to active investigators any cases that have been assigned to non-active investigators;
4. Ensure that all complaint investigators are properly certified;
5. Ensure that all complaints are sent to the proper regional office for investigation;
6. Prepare annual reports by March 15 of each year on nursing home incidents as required by the Public Health Law.

We would like to know if these problems have been solved.

We would also like to know whether or not the NYSDOH is ensuring that facilities comply with key patient safety regulations, including the requirements to:

- Conduct a comprehensive assessment of a resident promptly after a significant improvement or decline in the resident's physical status. 10 NYCRR § 415.11(a)(3). In what percentage of cases in which a facility failed to address a resident's condition after an injury did DOH fail to assess a penalty against the facility?
- Ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable despite every reasonable effort to prevent them. 10 NYCRR § 415.12(c). In what percentage of cases in which DOH was informed of a failure to prevent pressure sores did DOH assess a penalty against the facility?
- Ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents. 10 NYCRR §415.12(h). Ms. Laura Kash sent your office information about the case of her mother, who died due to complications from a fall that apparently occurred because she was not given assistance in getting to the bathroom, had an accident and slipped on the wet floor. Other issues can also result from failure to tend to nursing home residents' physical needs. In what percentage of cases in which DOH was informed of a failure to tend to a patient's physical needs did DOH assess a penalty against the facility?

Finally, we urge that you examine the issue of the effectiveness of fines levied against nursing homes. A 2011 report by the Long Term Care Community Coalition entitled "Care and Oversight of Assisted Living in New York State" expressed concern about the low fines allowed under the law and the ease with which facilities can avoid paying most fines by making a correction within 30 days.

Thank you for your time and attention to this request.

Sincerely,

A handwritten signature in black ink that reads "Jack Kupferman". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Jack Kupferman
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