U.S. Department of Health and Human Services

Office of Inspector General

Data Brief

September 2020, OEI-01-19-00421

Key Results

- ✓ The rate of nursing home complaints per 1,000 nursing home residents increased from 45 in 2015 to 52 in 2018.
- ✓ Twenty-one States failed to meet CMS's timeliness threshold for the second-most serious level of complaints in all 3 years from 2016 through 2018, and 10 of these States did not meet the threshold for 8 consecutive years, from 2011 through 2018.
- ✓ Of the five States that fell short in timely investigation of the most serious nursing home complaints from 2011 through 2015, Georgia had limited improvement, while Arizona, Maryland, New York, and Tennessee continued to fall short through 2018.
- ✓ Trends in late investigations of complaints from 2016 through 2018 raise concerns in New Jersey, Illinois, and Texas.
- ✓ Because States we communicated with face challenges in triaging complaints, we recommend that CMS should ensure that all States receive training on updated triage guidance.
- ✓ We also recommend that CMS should identify new approaches to address States that are consistently failing to meet required timeframes for investigating the most serious nursing home complaints.
- ✓ CMS concurred with both recommendations.

States Continued To Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016-2018

In this data brief, we examine the extent to which State survey agencies (hereinafter, States) met required timeframes for investigating the most serious nursing home complaints from 2016 through 2018 (preceding the COVID-19 public health emergency).[1] We highlight trends for this 3-year period that raise questions about many States' timeliness in responding to such complaints. We also determined whether five States—Arizona, Georgia, Maryland, New York, and Tennessee—that fell short between 2011 and 2015 made progress during 2016 through 2018, as compared to 2015.[2]

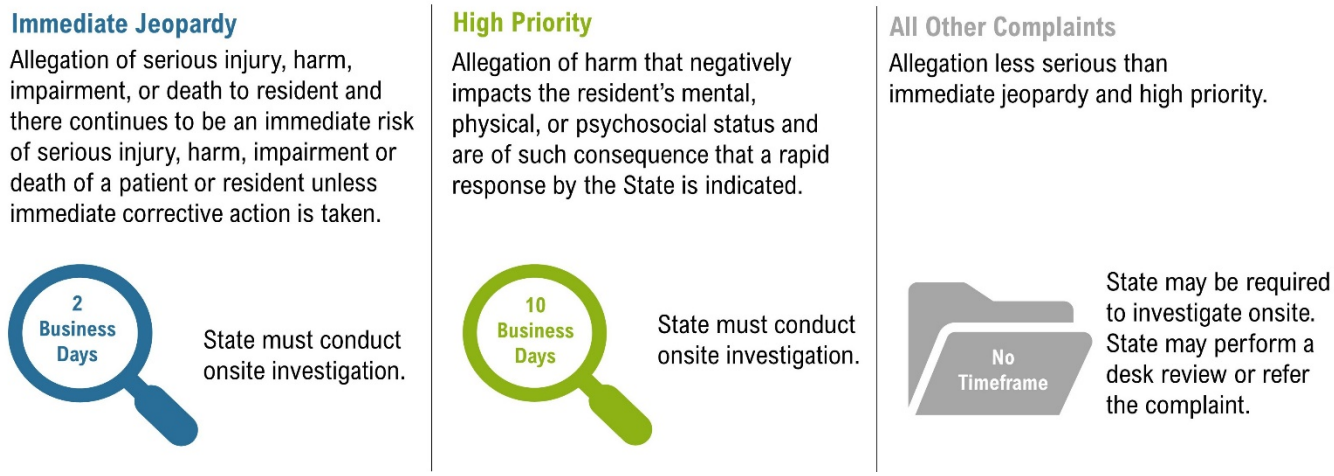
Introduction

The nursing home complaint process is a critical safeguard to protect vulnerable residents of nursing homes. The Centers for Medicare & Medicaid Services (CMS) relies on each State to serve as the front-line responder to address health and safety concerns raised by residents, their families, and nursing home staff.[3] Examples of concerns that might result in a complaint are delays in residents being fed, inadequate staffing that result in insufficient care, and inappropriate social media posts by nursing home employees.

CMS provides States with procedural guidelines for how to intake, prioritize, and investigate complaints for Medicare/Medicaid-certified nursing homes.[4] CMS requires that a qualified professional with knowledge of clinical standards and Federal requirements triage each complaint by assigning it a priority level. A complaint's priority level determines the State's required timeframe for investigating. The two most serious priority levels are immediate jeopardy and non-immediate jeopardy–high. (In this data brief, we refer to non-immediate jeopardy–high complaints as high priority complaints.) These complaints allege serious

injury or harm and require a rapid response to address the complaint and ensure residents' safety. States must investigate immediate jeopardy complaints within 2 business days of receipt and high priority complaints within 10 business days of prioritization.[5] See Exhibit 1 for complaint priority levels and definitions.

Exhibit 1: Complaints prioritized as immediate jeopardy or high priority require States to conduct a prompt onsite investigation.[6]



Source: CMS *State Operations Manual* (SOM), Pub. No. 100-07, ch. 5, "Complaint Procedures" (Revised 155, 06-10-16).

This evaluation focuses on nursing home complaint investigations from 2018 and earlier; it does not include complaints or investigations during the COVID-19 public health emergency of 2020. We note that in response to the COVID-19 public health emergency, CMS modified its priorities for States' survey activities. On March 23, 2020, CMS temporarily suspended State investigations for complaints less severe than immediate jeopardy.[7]

Every year, CMS evaluates each State's performance in carrying out all its survey and certification responsibilities, which include conducting surveys that evaluate the safety and quality of care that nursing homes provide and complaint investigations. CMS uses its State Performance Standards System (SPSS) to ensure that States meet Federal requirements and to identify areas for improvement. As part of this yearly evaluation, CMS reviews the timeliness of each State's investigations of complaints regarding nursing homes and other facilities.[8]

Although CMS requires States to investigate all immediate jeopardy and high priority nursing home complaints onsite within certain timeframes, the standards by which it measures States' performance is less stringent. For purposes of the SPSS, States must conduct onsite investigations within 2 business days for 95 percent, rather than 100 percent, of all immediate jeopardy complaints that they receive. This performance threshold includes all immediate jeopardy complaints, whether for nursing homes or for other facilities, such as hospitals and ambulatory surgery centers. Similarly, CMS's performance threshold regarding high priority complaints requires States to conduct onsite investigations within 10 business days for 95 percent

of the high priority nursing home complaints they receive, even though CMS requires States to investigate 100 percent within 10 business days of prioritization.

If a State does not meet one of these performance thresholds, CMS requires the State to develop a corrective action plan and follows up on the State's implementation of the plan.[9] CMS reported that it may also take further action to help States meet performance thresholds, such as conducting site visits to evaluate a State's processes for intake and triage of complaints. In addition, CMS may hire a contractor to work with a State onsite. Finally, CMS may take enforcement action by withholding funds from a State.

Related Office of Inspector General (OIG) Work

This study is part of a larger body of work from OIG examining nursing home oversight. Specifically, this study updates OIG's 2017 data brief that found a few States fell short in timely investigation of the most serious nursing home complaints.[10] In addition, OIG has a forthcoming report examining oversight of nursing homes during the COVID-19 public health emergency, including the extent to which States conducted onsite surveys during that period and challenges they faced in doing so.[11] Another forthcoming OIG report is examining CMS oversight of State performance specific to nursing homes and may identify additional opportunities or recommendations for CMS to improve State performance.[12]

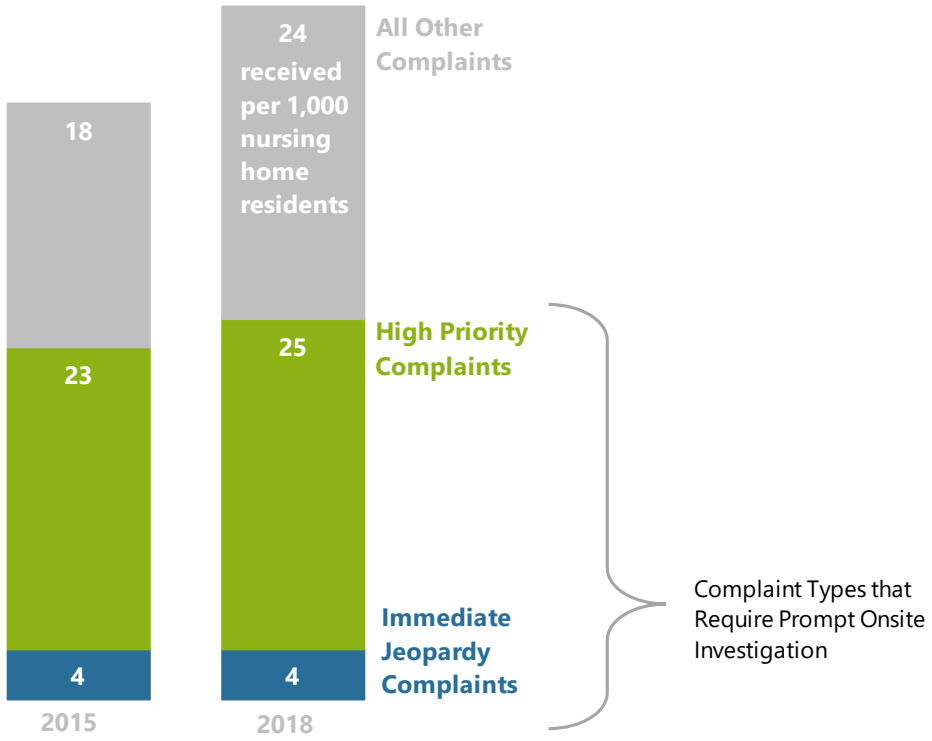
To complement this data brief, OIG published an updated interactive map illustrating State-by-State trends in nursing home complaints for 2016 through 2018. The interactive map is available at https://oig.hhs.gov/oei/maps/2019-nursing-home/index.asp.

For additional background on the complaint investigation process, see Appendix A.

NATIONAL TRENDS

The rate of complaints that States received increased slightly from 2015 to 2018, going from 45 complaints per 1,000 nursing home residents to 52 per 1,000. This included a slight increase in the rate of high priority complaints and a larger increase in the rate of less serious complaints. The most serious nursing home complaints (i.e., immediate jeopardy and high priority complaints), which require prompt onsite investigation, accounted for about half of all nursing home complaints.

Exhibit 2: In both 2015 and 2018, About half of all nursing home complaints require prompt onsite investigation.



Source: OIG analysis of data from the Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS), 2019.

The percentage of complaints that States investigated late increased slightly for high priority complaints but not for immediate jeopardy complaints. The percentage of high priority complaints that States investigated late increased from 15 percent in 2015 to 19 percent in 2018, while the percentage of immediate jeopardy complaints States investigated late remained about the same (14 percent in 2015 and 13 percent in 2018).

States investigated

19%

of high priority complaints late in 2018.

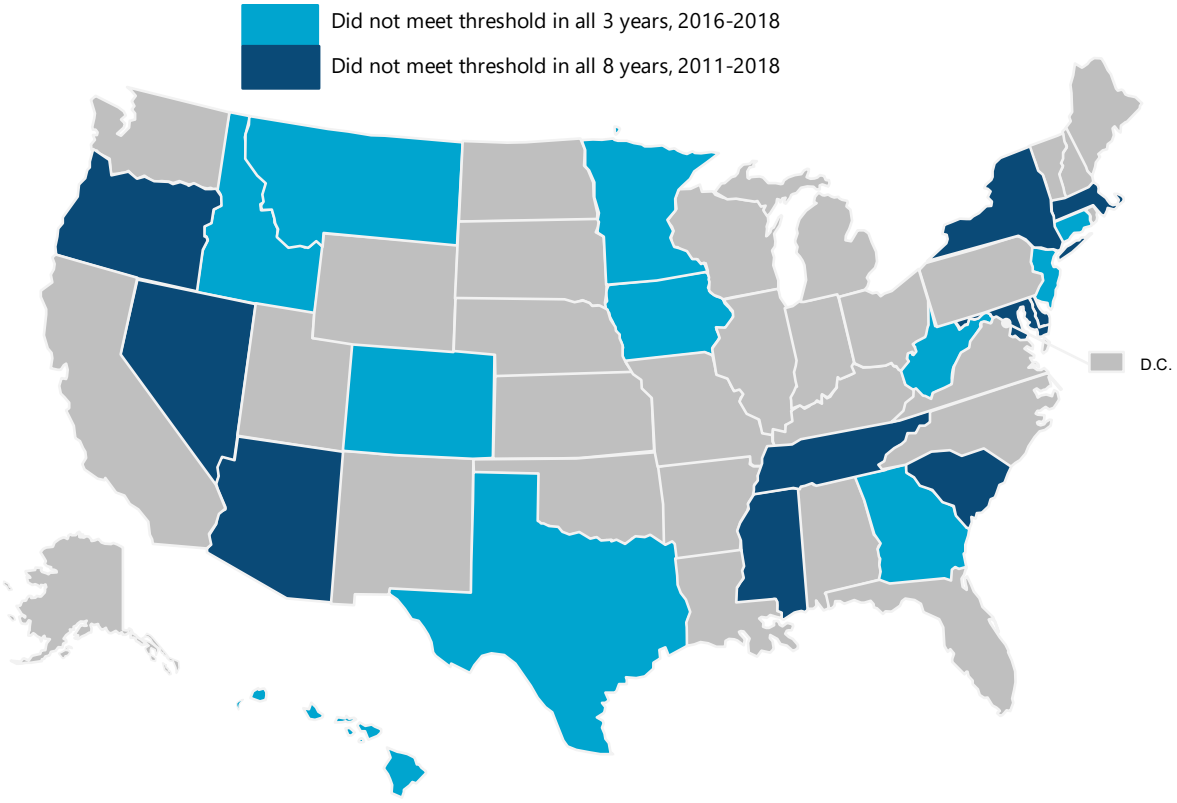
See Appendices B and C for the number of nursing home complaints and the number of late investigations for immediate jeopardy and high priority complaints by State for 2016 and 2018 (Appendix B) and for 2011 and 2015 (Appendix C).

RESULTS

Twenty-one States failed to meet CMS's timeliness threshold for high priority complaints in all 3 years from 2016 through 2018

Many States are consistently failing to meet CMS's performance threshold for timeliness for high priority complaint investigations. We identified 21 States that did not meet this threshold in every year from 2016 through 2018. Our prior data brief identified 10 of these States as not meeting CMS's threshold in every year from 2011 through 2015. This means that these 10 States—Arizona, Delaware, Massachusetts, Maryland, Mississippi, Nevada, New York, Oregon, South Carolina, and Tennessee—have failed to meet CMS's performance threshold for timely investigation of high priority complaints for 8 consecutive years, from 2011 through 2018 (see Exhibit 3).

Exhibit 3: Twenty-one States failed to meet CMS's performance threshold for timeliness in all 3 years from 2016 through 2018, and 10 of these States did not meet it for 8 consecutive years, from 2011 through 2018.



Source: OIG analysis of ACTS data, 2019.

We reviewed a sample of 12 corrective action plans from 2016 through 2018 and found that these plans most often cited staff support and data monitoring as ways to address States' failure to meet timeliness requirements. For example, 11 of the 12 corrective action plans we reviewed said that the States would hire and/or train staff to increase timeliness. According to one plan, the State would attempt to fill eight vacancies to address staffing shortages that affect timely investigations. Another plan said that the State would train all its surveyors to investigate complaints. In addition, eight of the corrective action plans said that the States would increase or continue to monitor complaint data to ensure timeliness. One plan noted that the State's survey staff would complete biweekly reviews of immediate jeopardy and high priority complaints to ensure that the State investigates on time.

To address States that consistently fail to meet CMS's performance threshold, CMS may take additional actions beyond corrective action plans, but it faces challenges in doing so. For example, CMS told us that it may conduct site visits to evaluate a State's processes or have a contractor work with a State onsite, among other actions. But according to CMS, it cannot use just one approach to help various States because they face different challenges with timeliness, requiring different approaches from CMS. Furthermore, CMS told us that the increase in nursing home complaints each year has been a challenge for CMS and States because resources to investigate these complaints have remained flat. Specifically, complaints have increased by 20 percent since 2013, but CMS's funds for survey and certification have remained the same since 2015 at about $390 million. Although CMS can work with States to improve investigation timeliness, CMS told us that it is limited in the enforcement actions it can take against States that consistently perform poorly. CMS told us it is limited to only taking punitive actions which could undermine a State's ability to respond to complaints, such as withholding funds.

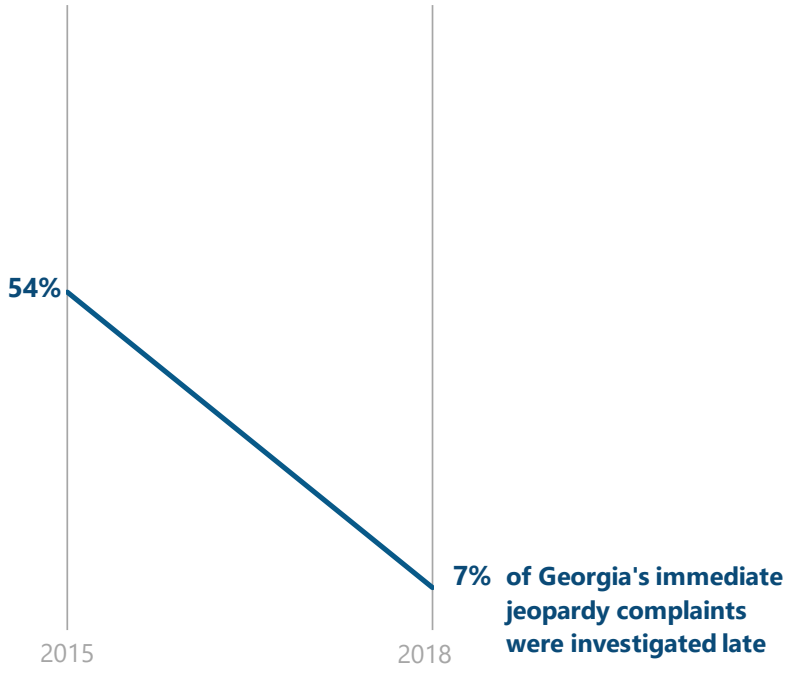
Of the five States that fell short in timely investigations from 2011 through 2015, one had limited improvement, and four continued to fall short through 2018

In our previous data brief, we identified five States—Arizona, Georgia, Maryland, New York, and Tennessee—that fell short in investigating immediate jeopardy and high priority complaints on time from 2011 through 2015. Our prior data brief highlighted how these States were working to improve their investigation response times to serious nursing home complaints. However, we found that only Georgia improved its timeliness for investigations of immediate jeopardy complaints, while the other four States continued to fall short through 2018 in investigating complaints on time.

Georgia improved in meeting required timeframes for investigating immediate jeopardy complaints but not for high priority complaints.

From 2015 to 2018, Georgia improved the timeliness of its investigations of immediate jeopardy complaints. In 2018, Georgia investigated 7 percent of its immediate jeopardy complaints late, a decrease from 54 percent in 2015 (see Exhibit 4). During this time period, Georgia investigated complaints during the weekends and advocated for additional resources to address its complaint workload.

Exhibit 4: Georgia investigated a much smaller percentage of its immediate jeopardy complaints late in 2018 than in 2015.



Source: OIG analysis of ACTS data, 2019.

Notably, Georgia also prioritized fewer complaints as immediate jeopardy in 2018 than in 2015. The number of complaints Georgia prioritized as immediate jeopardy decreased from 478 in 2015 to 133 in 2018. According to Georgia, prior to 2018, the State prioritized a disproportionately high percentage of complaints as immediate jeopardy that did not warrant an immediate jeopardy prioritization. In response, CMS worked with Georgia to improve the State's triage process for complaints.

However, Georgia did not notably improve the timeliness of its investigations of high priority complaints. In 2018, Georgia investigated 46 percent of its high priority complaints late, about the same percentage as in 2015 (49 percent).

Tennessee continued to investigate many of its most serious nursing home complaints late.

Tennessee accounted for

55%

of late investigations of immediate jeopardy complaints nationally in 2018.

Although Tennessee improved the timeliness of its most serious complaint investigations from 2015 to 2018, it continued to fall short. In 2018, Tennessee investigated 61 percent of its immediate jeopardy complaints and 40 percent of its high priority complaints late. In fact, Tennessee accounted for more than half of the national total of immediate jeopardy investigations that were late in 2018. Tennessee conducted over half of its late investigations of immediate jeopardy complaints more than 2 weeks late in each year from 2016 through 2018. According to Tennessee, changes of ownership, bankruptcies, and nursing home terminations increased during this period, which contributed to an increase in immediate jeopardy and high priority complaints, while State agency staffing remained the same.

From 2016 through 2018, Tennessee attempted to address late complaint investigations. For example, it hired contractors to allow its surveyors to address late complaints. Tennessee also improved the efficiency of complaint investigations by allowing surveyors to send investigation findings electronically, among other efforts. During this time, CMS withheld a portion of funds from Tennessee because the State failed to meet established performance benchmarks for investigation timeliness.

Arizona, New York, and Maryland continued to fall short in meeting required timeframes for investigations of high priority complaints.

Both Arizona and New York investigated their high priority complaints late more often in 2018 than in 2015. In 2018, Arizona investigated 93 percent of its high priority complaints late, an increase from 87 percent in 2015. Similarly, New York increased its late investigations of high priority complaints from 53 percent in 2015 to 78 percent in 2018 (see Exhibit 5). In addition, both States conducted over 80 percent of their late investigations more than 2 weeks late in 2018. However, Arizona and New York conducted most investigations of their immediate jeopardy complaints on time from 2015 through 2018.

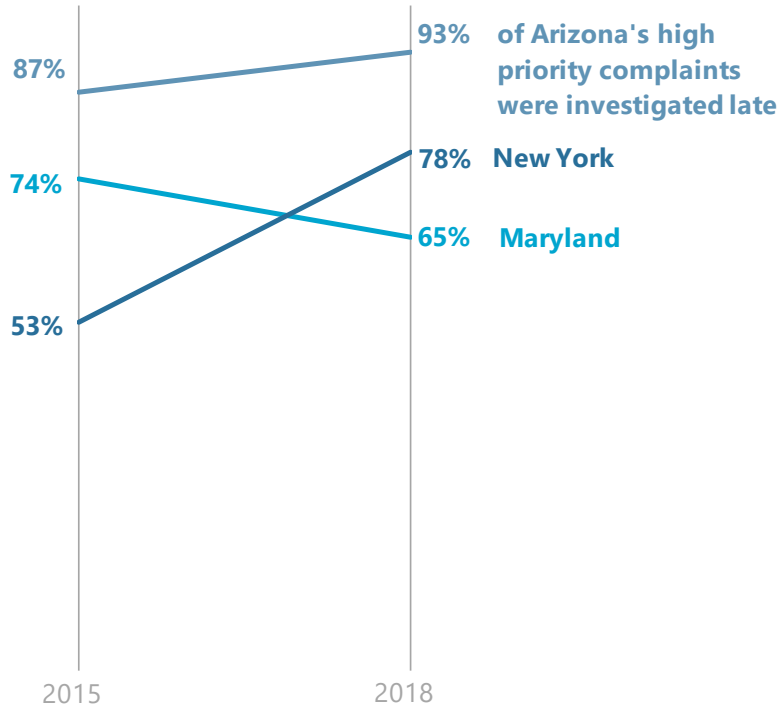
Arizona told us that it is working to investigate its complaints within required timeframes. For example, Arizona is currently conducting a comprehensive assessment of its intake process for complaints regarding long-term care facilities and plans to improve its complaint triage process, among other improvements. Arizona has also initiated discussions with lawmakers regarding funding to help the State

investigate complaints within required timeframes. New York did not provide us information on any efforts to address late complaint investigations.

Despite some progress since 2015, Maryland continued to investigate many of its high priority complaints late. In 2018, Maryland investigated 65 percent of its high priority complaints late (see Exhibit 5). Furthermore, Maryland conducted 65 percent of these late investigations more than 2 weeks late in 2018. However, like Arizona and New York, Maryland conducted most investigations of its immediate jeopardy complaints on time from 2015 through 2018.

To improve its investigation timeliness for high priority complaints, Maryland developed a 7-year plan to increase its number of surveyors and is working to improve staff recruitment and retention through a variety of efforts, including training and career development. In addition, Maryland improved the efficiency of its complaint investigation process by shifting from paper-based to cloud-based systems.

Exhibit 5: Arizona, New York, and Maryland continued to investigate many of their high priority complaints late in 2018.



Source: OIG analysis of ACTS data, 2019.

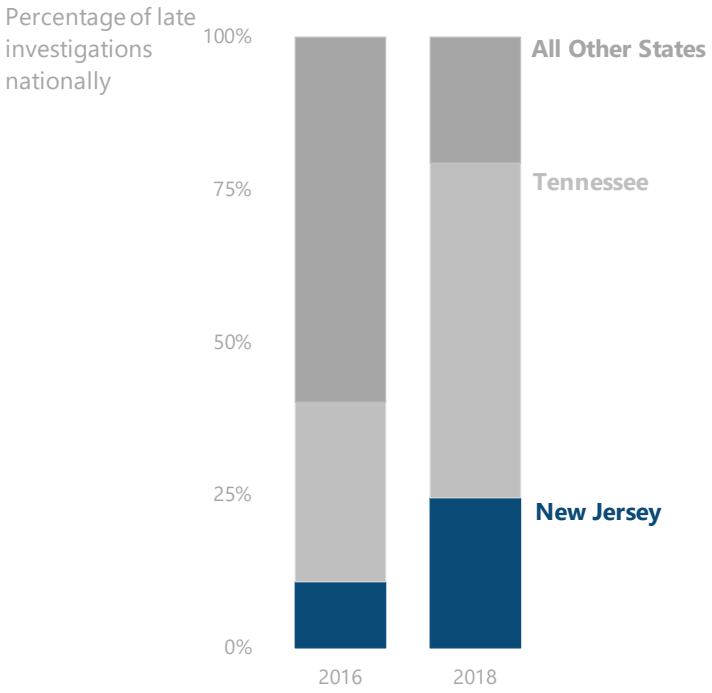
Trends in late complaint investigations from 2016 through 2018 in three additional States raise concerns

New Jersey, Illinois, and Texas also fell short in investigating the most serious nursing home complaints on time since 2015. The trends in complaint investigations from 2016 through 2018 in these States raise questions about how the States are responding to serious nursing home complaints. These findings emphasize the importance of CMS's continued oversight of States' timeliness in nursing home complaint investigations, as States that meet required timeframes in one year may fall short the next year.

New Jersey investigated over 70 percent of its most serious nursing home complaints late from 2016 through 2018.

New Jersey investigated most of its immediate jeopardy and high priority nursing home complaints late. From 2016 through 2018, New Jersey investigated between 72 and 89 percent of both its immediate jeopardy and high priority complaints late each year. In addition, New Jersey accounted for 25 percent of late investigations of immediate jeopardy complaints nationally in 2018, an increase from 11 percent in 2016 (see Exhibit 6). New Jersey's proportion of late investigations of immediate jeopardy complaints nationally in 2018 was higher than all other States except Tennessee.

Exhibit 6: New Jersey accounted for a greater percentage of late investigations of immediate jeopardy complaints nationally in 2018 than in 2016.



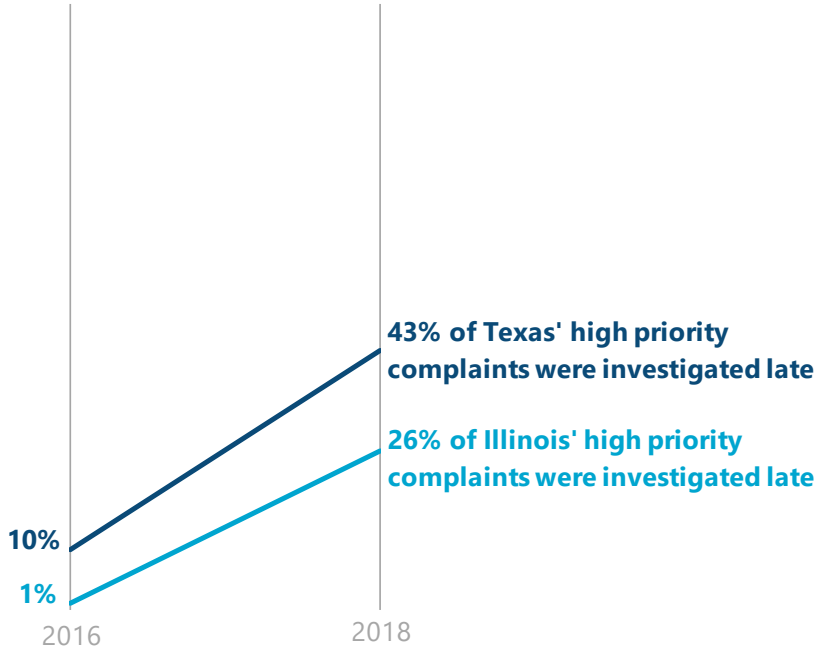
Source: OIG analysis of ACTS data, 2019.

New Jersey pointed to its triage practices and staff shortages as reasons for late investigations. According to New Jersey, from 2016 through 2018, its staff not only prioritized complaints at a higher severity level than appropriate, but the State also lacked the staff resources to investigate complaints within required timeframes. CMS trained staff on complaint triage during this same time period, and the State implemented supervisory review of complaint triage. The State is also trying to hire additional survey staff.

Illinois and Texas investigated many more of their high priority complaints late in 2018 than in 2016.

From 2016 to 2018, Illinois and Texas had large increases in their late investigations of high priority complaints. In 2016, Illinois investigated only 1 percent of its high priority complaints late, but in 2018, it investigated 26 percent of these complaints late. In Texas, 10 percent of these investigations were late in 2016, which increased to 43 percent in 2018 (see Exhibit 7). Furthermore, Illinois and Texas accounted for 38 percent of all late investigations of high priority complaints nationally in 2018, an increase from 9 percent in 2016.

Exhibit 7: Illinois and Texas investigated a greater percentage of their high priority complaints late in 2018 than in 2016.



Source: OIG analysis of ACTS data, 2019.

Texas and Illinois pointed to insufficient staffing to explain their increase in late investigations. For example, Texas experienced high staff turnover and difficulty filling

positions. In Illinois, the number of surveyors remained constant while the number of complaints increased. Both States are addressing late investigations by reallocating surveyors to assist in areas with more complaints. Specifically, Texas divided the workload more uniformly among survey staff. In addition, Texas implemented an abbreviated template for investigation reports to reduce the time for surveyors to complete complaint investigations.

CONCLUSION AND RECOMMENDATIONS

Our analysis raises questions about some States' ability to address serious nursing home complaints and also about the effectiveness of CMS's oversight of States. Many States are consistently failing to meet required timeframes for investigating the most serious nursing home complaints. Generally, we found that the States we communicated with face challenges with receiving high volume of complaints, triaging complaints, and having adequate human resources to investigate complaints. CMS has worked with States to address these challenges, yet few States have made progress. Moreover, CMS's survey and certification funding has not increased along with the volume of complaints. Complaints have increased by 20 percent since 2013, while survey and certification funding has remained flat since 2015. Furthermore, CMS told us that it is limited in the enforcement actions it can take against States that consistently perform poorly (i.e., withholding funds from States) without further undermining a State's ability to respond to complaints.

It is imperative that CMS ensure that States improve their timeliness, as late responses to complaints could have serious consequences for nursing home residents in those States. This is especially important for those States that have consistently investigated complaints late over several years. According to CMS, the agency is revising guidance on complaint triage processes in the State Operations Manual and plans to train States on this guidance.

In light of our findings we recommend that:

CMS should ensure that all States receive training on CMS's updated triage guidance.

Assigning the appropriate priority level to complaints ensures that States conduct prompt onsite investigations for complaints when warranted. CMS already has plans to update its triage guidance. Ensuring that all States receive training on that updated guidance could improve States' timeliness of complaint investigations.

CMS should identify new approaches to address those States that are consistently failing to meet the required timeframes for investigating the most serious nursing home complaints.

States face challenges to conducting timely investigations of serious nursing home complaints that extend beyond appropriate triage. Despite CMS tailoring its efforts to address each State's unique challenges with investigating complaints on time, we

found that few States made progress, and some States worsened over time. CMS should identify new approaches to help these States improve. CMS could identify new approaches through a review of best practices implemented in corrective action plans or used by States that consistently investigate complaints within required timeframes. Such practices may include those that increase investigation efficiency, improve State intake and triage processes, and increase performance monitoring. CMS could also identify additional nonpunitive actions it can take that would support States' ability to respond and may create incentives for States to improve.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with our recommendation to ensure that all States receive training on CMS's updated triage guidance. CMS stated that it plans to issue guidance on prioritizing complaints and will ensure that States receive appropriate training. CMS also noted that it already provides a comprehensive national training program. We appreciate CMS's commitment to training and look forward to the updates on the status of its guidance and an accounting of States that have received the training in its Final Management Decision.

CMS also concurred with our recommendation to identify new approaches to address those States that are consistently failing to meet required timeframes for investigating the most serious nursing home complaints. CMS stated that in April 2018, it launched an initiative to evaluate and improve how CMS monitors State performance. CMS said that it will assess whether new approaches would help States that are consistently failing to meet required timeframes for investigating the most serious nursing home complaints. We look forward to receiving CMS's Final Management Decision, including any outcomes from its initiative.

For the full text of CMS's comments, see Appendix D.

METHODOLOGY

Our primary source of data for this data brief was Medicare/Medicaid-certified nursing home complaints and associated investigation information entered into CMS's Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS) from 2015 through 2018. In addition, we corresponded with State survey agency and CMS staff.

ACTS Data

CMS provided us with data on all Medicare/Medicaid-certified nursing home complaints and associated investigation information States entered into ACTS from 2016 through 2018. We removed 32,921 records in which the State entered a start date for the onsite investigation that was prior to the complaint receipt date. Our final dataset included 652,335 records from all 50 States and the District of Columbia. Complaints can include multiple allegations; each record represents one allegation. We did not review facility-reported incidents from nursing homes.

We determined the national and State trends for nursing home complaints between 2016 and 2018. We analyzed these data to determine: (1) the number of nursing home complaints that States received; (2) the percentage of complaints that States prioritized as immediate jeopardy and high priority; and (3) the percentage of immediate jeopardy and high priority complaints that States investigated onsite within required timeframes. To compare across States, we obtained the number of nursing home residents for each State from the nursing home resident Minimum Data Set 3.0 Public Reports on the CMS website. To determine whether States investigated complaints within required timeframes, we excluded weekends and Federal holidays and calculated the number of days that elapsed between the complaint receipt date and onsite investigation date. We did not exclude State-only holidays from our analysis.

We also determined whether States met CMS's performance threshold for timely onsite investigations of high priority nursing home complaints each calendar year. To do this, we calculated the percentage of a State's high priority complaints that it investigated within 10 working days each calendar year. We considered the performance threshold not met if we calculated the percentage to be under 95 percent.

We used data from our previous data brief to determine whether States that previously fell short in investigating immediate jeopardy and high priority complaints on time have made progress since 2015. For those States, we compared nursing home complaint and investigation data from 2015 to nursing home complaint and investigation data from 2016 through 2018. Specifically, we compared the number of

complaints received, the prioritization of these complaints, and the timeliness of complaint investigations.

Questions to States and CMS Interview

We sent questions through email to the States identified in this report: Arizona, Georgia, Illinois, Maryland, New Jersey, New York, Tennessee, and Texas. We asked each of these States about their respective trends in nursing home complaints and investigations from 2016 through 2018. In addition, we asked each State about how it works with CMS to address late investigations. We also interviewed CMS about CMS's efforts to address late nursing home complaint investigations.

Review of State Corrective Action Plans

OIG requested States' corrective action plans for fiscal years 2015 through 2018 from each of the 10 CMS Regional Offices. We identified a purposive sample—based on CMS Region, State, and year—of 12 corrective action plans from 12 different States that addressed CMS's performance measure for timely investigation of high priority complaints. We reviewed the sections in these corrective action plans relevant to this performance measure and categorized the information based on theme. Finally, we used the data from these corrective action plans to provide examples and context but did not use them to generalize to all corrective action plans addressing timely investigation of high priority complaints.

Limitations

We did not assess the extent to which the data in ACTS are complete or the appropriateness of State responses to complaints or State investigation results. We also did not independently verify the accuracy of the ACTS records. Our analysis is based only on ACTS data and not on data collected directly from States or SPSS result data from CMS. We acknowledge a discrepancy between the States we identify as not meeting CMS's performance threshold and those that CMS identified. This may be because our analysis did not exclude State holidays and was based on the calendar year and not the fiscal year.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

APPENDIX A

Detailed Background

CMS, in conjunction with States, oversees nursing homes to ensure that they meet Federal standards. States conduct certification surveys on behalf of CMS every 12 months on average, but no less frequently than every 15 months.[13] These surveys evaluate the safety and quality of care that nursing homes provide.[14] In addition, States conduct complaint investigations as needed between certification surveys.

Complaint Investigations

Complaint Intake

CMS instructs States to collect comprehensive information from complainants. This information includes, but is not limited to, information about the complainant; the nursing home; the individuals involved; a narrative of the allegation; how and why the complainant believes the problem leading to the allegation occurred; and the complainant's expectation of the resolution. CMS requires States to enter all data regarding complaints into ACTS.

Complaint Priority Levels

Complaints that States prioritize as immediate jeopardy allege a situation in which the provider's noncompliance with Federal requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. States must prioritize and investigate these complaints onsite within 2 business days of receiving the complaint. To help States identify immediate jeopardy complaints, CMS provides examples of circumstances that may indicate immediate jeopardy situations. For example, serious injuries such as head trauma or fractures may indicate that the nursing home has failed to protect the resident from abuse.

Complaints that States prioritize as high priority allege a situation in which the provider's noncompliance with Federal requirements may have caused harm that negatively affects the resident's mental, physical, and/or psychosocial status. A high priority situation is one that requires a rapid response because of its potential consequences to a resident's well-being. States must investigate high priority complaints onsite within 10 business days of prioritization.

For a complaint considered less serious than immediate jeopardy or high priority, a State may be required to schedule an onsite survey or to investigate the complaint during its next onsite survey at the nursing home. In some cases, a State may perform a desk review of the complaint or refer the complaint to a more appropriate agency.[15]

APPENDIX B

Trends in Nursing Home Complaints by State, 2016 and 2018

Exhibit B-1: Number and Prioritization of Nursing Home Complaints by State, 2016 and 2018

	2016				2018			
	Total Number of Complaints Received	Rate of Complaints per 1,000 Residents	Percentage Immediate Jeopardy	Percentage High Priority	Total Number of Complaints Received	Rate of Complaints per 1,000 Residents	Percentage Immediate Jeopardy	Percentage High Priority
Alabama	199	8.6	31%	26%	127	5.4	14%	31%
Alaska	8	12.9	0%	13%	13	20.5	0%	15%
Arizona	760	61.0	1%	68%	280	22.3	<1%	72%
Arkansas	457	25.2	6%	74%	1,034	58.7	9%	74%
California	7,283	67.3	9%	76%	8,656	80.9	14%	79%
Colorado	419	24.4	6%	64%	533	31.2	8%	56%
Connecticut	441	18.5	<1%	3%	533	23.1	1%	7%
Delaware	72	16.4	3%	81%	188	44.4	2%	90%
District of Columbia	50	20.0	2%	26%	41	17.1	0%	0%
Florida	2,539	33.0	1%	13%	2,607	33.8	2%	6%
Georgia	1,155	33.6	72%	24%	1,239	36.1	11%	80%
Hawaii	21	5.5	5%	10%	33	8.7	24%	12%
Idaho	103	25.3	3%	16%	127	30.7	2%	69%
Illinois	4,985	70.7	5%	72%	5,749	84.8	2%	79%
Indiana	2,139	53.2	1%	34%	2,393	59.8	3%	41%
Iowa	856	35.2	5%	65%	916	39.1	3%	65%
Kansas	1,167	64.8	14%	18%	1,325	76.9	12%	33%
Kentucky	666	28.2	44%	55%	746	32.1	32%	67%
Louisiana	537	20.2	13%	50%	583	22.0	14%	45%
Maine	400	64.8	1%	11%	316	53.1	2%	9%
Maryland	1,432	55.8	<1%	78%	1,196	47.8	1%	35%
Massachusetts	358	8.7	<1%	89%	494	12.5	0%	82%
Michigan	3,002	73.4	3%	48%	3,243	80.7	2%	23%
Minnesota	444	17.4	13%	34%	1,224	49.3	5%	16%
Mississippi	240	15.0	15%	76%	223	13.8	24%	75%
Missouri	4,191	108.0	6%	53%	4,284	111.9	9%	67%
Montana	99	22.4	1%	11%	113	26.9	1%	10%
Nebraska	688	58.8	9%	22%	653	57.3	6%	18%
Nevada	202	36.7	1%	9%	309	51.6	1%	45%
New Hampshire	139	20.7	1%	1%	92	14.1	0%	2%
New Jersey	829	18.0	26%	18%	709	15.6	29%	14%
New Mexico	106	17.7	2%	36%	85	14.6	8%	34%
New York	4,333	39.6	2%	35%	2,971	27.6	3%	35%
North Carolina	2,612	68.9	8%	35%	2,883	77.1	7%	27%
North Dakota	32	5.7	0%	3%	31	5.7	3%	3%
Ohio	4,202	54.7	18%	72%	4,465	59.8	8%	83%

	2016				2018			
	Total Number of Complaints Received	Rate of Complaints per 1,000 Residents	Percentage Immediate Jeopardy	Percentage High Priority	Total Number of Complaints Received	Rate of Complaints per 1,000 Residents	Percentage Immediate Jeopardy	Percentage High Priority
Oklahoma	854	45.3	5%	22%	930	50.1	2%	17%
Oregon	326	39.8	<1%	97%	571	72.6	2%	60%
Pennsylvania	3,143	39.6	2%	58%	3,619	46.4	4%	23%
Rhode Island	354	43.5	0%	1%	327	40.8	1%	5%
South Carolina	164	9.4	4%	92%	148	8.5	5%	89%
South Dakota	89	14.4	8%	33%	27	4.6	15%	59%
Tennessee	917	32.3	56%	43%	1,017	36.1	60%	38%
Texas	9,042	91.9	12%	47%	9,817	102.3	7%	31%
Utah	135	22.9	5%	25%	154	26.6	3%	24%
Vermont	126	47.4	5%	25%	144	58.3	3%	24%
Virginia	484	16.6	1%	10%	512	17.8	1%	11%
Washington	1,920	111.6	2%	45%	2,350	141.4	3%	42%
West Virginia	127	13.2	2%	16%	130	13.6	0%	9%
Wisconsin	1,108	43.1	3%	22%	1,323	56.3	2%	25%
Wyoming	122	49.9	6%	20%	119	50.8	13%	32%
National Total	66,077	47.3	9%	50%	71,602	52.3	7%	47%

Source: OIG analysis of ACTS data, 2019.

Exhibit B-2: Number of Immediate Jeopardy and High Priority Complaints Not Investigated Onsite Within Required Timeframes by State, 2016 and 2018

	2016		2018	
	Number of Immediate Jeopardy Complaints Not Investigated Within 2 Business Days	Number of High Priority Complaints Not Investigated Within 10 Business Days	Number of Immediate Jeopardy Complaints Not Investigated Within 2 Business Days	Number of High Priority Complaints Not Investigated Within 10 Business Days
Alabama	3	1	3	0
Alaska	N/A	0	N/A	0
Arizona	1	413	0	179
Arkansas	0	10	2	11
California	4	148	16	131
Colorado	3	52	3	55
Connecticut	0	2	0	4
Delaware	0	50	1	135
District of Columbia	0	0	N/A	N/A
Florida	3	4	2	10
Georgia	783	246	9	453
Hawaii	0	1	3	1
Idaho	1	13	1	71
Illinois	3	36	2	1,189
Indiana	0	13	0	8
Iowa	0	115	2	372
Kansas	2	10	6	75
Kentucky	11	18	6	68
Louisiana	1	5	1	7
Maine	0	0	0	0
Maryland	1	915	0	269
Massachusetts	1	248	N/A	298
Michigan	3	50	6	91
Minnesota	20	96	37	117
Mississippi	5	13	12	14
Missouri	1	123	0	120
Montana	0	2	1	6
Nebraska	2	3	1	0
Nevada	0	9	0	78
New Hampshire	0	0	N/A	0
New Jersey	156	119	164	77
New Mexico	1	1	0	0
New York	0	1150	0	773
North Carolina	6	19	9	25
North Dakota	N/A	0	0	0

	2016		2018	
	Number of Immediate Jeopardy Complaints Not Investigated Within 2 Business Days	Number of High Priority Complaints Not Investigated Within 10 Business Days	Number of Immediate Jeopardy Complaints Not Investigated Within 2 Business Days	Number of High Priority Complaints Not Investigated Within 10 Business Days
Ohio	0	6	1	0
Oklahoma	1	3	0	1
Oregon	0	259	0	230
Pennsylvania	1	4	1	115
Rhode Island	N/A	2	0	2
South Carolina	1	122	1	50
South Dakota	0	0	0	0
Tennessee	426	290	367	152
Texas	11	420	10	1,304
Utah	0	0	1	4
Vermont	0	0	0	1
Virginia	0	2	0	7
Washington	1	57	0	10
West Virginia	0	2	N/A	3
Wisconsin	0	9	2	24
Wyoming	0	0	0	0
National Total	1,452	5,061	670	6,540

Source: OIG analysis of ACTS data, 2019.

Not Applicable (N/A) - States had none of these complaints to investigate.

APPENDIX C

Trends in Nursing Home Complaints by State, 2011 and 2015

Exhibit C-1: Number and Prioritization of Nursing Home Complaints By State, 2011 and 2015

	2011				2015			
	Total Number of Complaints Received	Rate of Complaints per 1,000 Residents	Percentage of Complaints Prioritized as Immediate Jeopardy	Percentage of Complaints Prioritized as High Priority	Total Number of Complaints Received	Rate of Complaints per 1,000 Residents	Percentage of Complaints Prioritized as Immediate Jeopardy	Percentage of Complaints Prioritized as High Priority
Alabama	218	9.3	39%	29%	143	6.2	22%	29%
Alaska	19	31.3	0%	16%	9	14.6	0%	33%
Arizona	612	47.5	1%	64%	1,108	89.5	0%	73%
Arkansas	736	39.7	7%	64%	653	36.5	12%	65%
California	227	2.1	3%	62%	6,521	60.5	6%	73%
Colorado	282	17.0	5%	61%	356	21.1	3%	58%
Connecticut	336	12.9	1%	5%	457	18.9	1%	6%
Delaware	238	55.8	0%	19%	79	18.2	0%	87%
District of Columbia	26	9.9	4%	12%	63	24.1	0%	3%
Florida	2,135	27.6	4%	44%	2,433	32.0	2%	26%
Georgia	908	26.0	6%	80%	1,081	31.8	44%	35%
Hawaii	16	4.1	6%	13%	8	2.1	0%	0%
Idaho	106	24.8	4%	24%	144	35.4	3%	11%
Illinois	2,687	35.1	1%	41%	4,792	65.6	6%	64%
Indiana	1,442	36.1	4%	42%	1,851	46.2	1%	35%
Iowa	652	25.7	3%	65%	765	31.3	3%	56%
Kansas	797	42.0	3%	11%	972	53.3	8%	14%
Kentucky	667	28.5	24%	66%	685	28.7	46%	51%
Louisiana	447	17.3	24%	64%	553	21.1	27%	37%
Maine	316	49.2	2%	69%	318	51.0	1%	22%
Maryland	1,083	41.8	1%	87%	1,164	45.5	<1%	75%
Massachusetts	525	11.9	0%	91%	442	10.6	1%	65%
Michigan	1,331	31.5	7%	89%	2,977	73.7	4%	75%
Minnesota	362	12.7	19%	58%	877	33.9	7%	24%
Mississippi	269	16.6	6%	68%	213	13.2	22%	74%
Missouri	2,733	69.9	8%	49%	4,070	105.0	9%	52%
Montana	69	14.3	3%	13%	83	18.8	1%	10%
Nebraska	392	30.9	2%	16%	658	54.9	3%	15%
Nevada	221	38.2	1%	19%	211	40.2	<1%	11%
New Hampshire	45	6.3	0%	9%	209	30.7	0%	<1%
New Jersey	1,971	41.1	1%	2%	975	21.3	19%	19%
New Mexico	146	23.0	2%	18%	77	12.9	8%	20%
New York	4,569	40.0	2%	33%	4,338	40.0	2%	43%
North Carolina	1,986	51.5	9%	29%	2,391	63.1	8%	34%
North Dakota	29	5.1	0%	3%	37	6.6	3%	0%

	2011				2015			
	Total Number of Complaints Received	Rate of Complaints per 1,000 Residents	Percentage of Complaints Prioritized as Immediate Jeopardy	Percentage of Complaints Prioritized as High Priority	Total Number of Complaints Received	Rate of Complaints per 1,000 Residents	Percentage of Complaints Prioritized as Immediate Jeopardy	Percentage of Complaints Prioritized as High Priority
Ohio	3,111	38.7	7%	52%	2,817	36.5	16%	73%
Oklahoma	1,050	53.3	13%	37%	1,036	54.4	7%	29%
Oregon	262	32.2	0%	89%	310	38.7	0%	89%
Pennsylvania	1,955	24.0	<1%	95%	2,287	28.7	<1%	62%
Rhode Island	324	38.4	0%	3%	436	54.1	0%	11%
South Carolina	114	6.5	8%	87%	207	12.2	4%	93%
South Dakota	10	1.6	0%	30%	101	16.0	1%	13%
Tennessee	698	21.8	25%	64%	892	31.1	49%	49%
Texas	6,975	67.9	10%	56%	8,939	90.0	14%	49%
Utah	128	21.1	5%	15%	152	25.9	5%	18%
Vermont	139	48.5	6%	21%	170	63.9	3%	19%
Virginia	544	18.3	<1%	15%	530	18.4	<1%	16%
Washington	2,127	118.5	4%	69%	1,915	109.0	2%	55%
West Virginia	294	30.2	1%	45%	113	11.7	2%	29%
Wisconsin	874	28.9	5%	19%	1,052	39.8	3%	25%
Wyoming	76	30.9	5%	13%	120	50.3	7%	19%
National Total	47,279	32.7	6%	49.1%	62,790	44.9	8.5%	50.6%

Source: OIG analysis of ACTS data, 2017.

Exhibit C-2: Number of Immediate Jeopardy and High Priority Complaints Not Investigated Onsite Within Required Timeframes By State, 2011 and 2015

	2011		2015	
	Number of Immediate Jeopardy Complaints Not Investigated Within 2 Working Days	Number of High Priority Complaints Not Investigated Within 10 Working Days	Number of Immediate Jeopardy Complaints Not Investigated Within 2 Working Days	Number of High Priority Complaints Not Investigated Within 10 Working Days
Alabama	2	1	0	2
Alaska	N/A	0	N/A	0
Arizona	0	344	N/A	682
Arkansas	0	7	1	3
California	0	5	6	104
Colorado	3	27	1	25
Connecticut	0	3	1	4
Delaware	N/A	34	N/A	44
District of Columbia	0	0	N/A	0
Florida	0	12	0	10
Georgia	6	31	258	185
Hawaii	0	1	N/A	N/A
Idaho	0	0	0	9
Illinois	3	390	1	33
Indiana	0	14	0	6
Iowa	0	13	0	49
Kansas	1	5	1	5
Kentucky	4	296	5	10
Louisiana	6	11	4	6
Maine	0	102	0	0
Maryland	0	742	0	648
Massachusetts	N/A	183	0	232
Michigan	3	320	2	70
Minnesota	6	18	4	10
Mississippi	2	62	5	22
Missouri	0	64	0	76
Montana	0	1	0	1
Nebraska	0	2	0	3
Nevada	0	13	0	5
New Hampshire	N/A	0	N/A	0
New Jersey	0	0	50	138
New Mexico	0	1	0	0
New York	0	448	2	976

	2011		2015	
	Number of Immediate Jeopardy Complaints Not Investigated Within 2 Working Days	Number of High Priority Complaints Not Investigated Within 10 Working Days	Number of Immediate Jeopardy Complaints Not Investigated Within 2 Working Days	Number of High Priority Complaints Not Investigated Within 10 Working Days
North Carolina	7	17	6	108
North Dakota	N/A	0	0	N/A
Ohio	1	16	1	2
Oklahoma	1	274	1	2
Oregon	N/A	105	N/A	233
Pennsylvania	0	2	0	2
Rhode Island	N/A	0	N/A	27
South Carolina	0	59	0	147
South Dakota	N/A	0	1	0
Tennessee	136	362	396	374
Texas	6	25	18	400
Utah	0	3	0	1
Vermont	0	6	0	0
Virginia	1	16	0	19
Washington	0	3	0	62
West Virginia	1	30	0	1
Wisconsin	1	7	0	7
Wyoming	0	0	0	0
National Total	190	4,075	764	4,743

Source: OIG analysis of ACTS data, 2017.

Not Applicable (N/A) - States had none of these complaints to investigate.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: September 15, 2020

TO: Suzanne Murrin
Deputy Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General Draft Report: States Continue to Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016-2018

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is charged with developing and enforcing quality and safety standards across the nation's health care system, a responsibility the Agency takes seriously. This duty is especially important when it comes to the care provided for some of the most vulnerable in our society, beneficiaries residing in nursing homes, and is especially critical now as we respond to the coronavirus disease 2019 (COVID-19) pandemic.

CMS's approach to oversight of nursing homes is constantly evolving, and CMS is continuously looking for ways to improve our oversight approach to nursing home safety and quality. Over the past two years, CMS has undertaken a comprehensive review of its regulations, guidelines, internal structure, and processes related to safety and quality in nursing homes. To ensure that the care provided in nursing homes is of the highest possible quality, CMS has developed a five-part plan that focuses on strengthening oversight, enhancing enforcement, increasing transparency, improving quality, and putting patients over paperwork. This includes ensuring timely investigations by State Survey Agencies (SSA) of complaints received.

As OIG recognizes, the nursing home complaint process is a critical safeguard to protect vulnerable residents of nursing homes. CMS works in partnership with SSAs to oversee nursing homes. SSAs serve as the front-line responders to address health and safety concerns raised by residents, their families, and nursing home staff. As part of CMS's commitment to strengthen oversight of SSAs, CMS revised and streamlined the guidelines for determining the severity of a complaint. In November 2017, CMS moved to a single, computer-based survey process, pairing it with updated guidance as we implemented revised requirements for participation for all nursing homes. This new process allows for streamlined, clear direction to SSAs as they evaluate nursing home safety and provides CMS with standardized data to evaluate trends and outcomes. The updated guidance includes, for example, streamlined guidelines for determining Immediate Jeopardy during a survey, and such guidelines would also help SSA staff to appropriately categorize and triage complaints.

In addition, CMS conducts a formal assessment of each SSA's performance relative to measures included in the State Performance Standard System (SPSS) program. CMS works with the SSAs to strengthen oversight so that the care provided in nursing homes is of the highest quality. In

April 2018, CMS launched an initiative to evaluate the SPSS process and identify ways to improve how we monitor SSA performance. CMS released revisions to the SPSS process in October 2019. The resulting updates to the SPSS process are aimed at enabling CMS and SSAs to address areas of concern more effectively and ultimately improve resident safety and the quality of their care. Specific changes include increased CMS monitoring of SSAs, using new metrics that are reviewed more frequently to ensure SSAs are conducting surveys, including complaint investigations, in a timely manner. Additional changes include establishing state performance indicators to identify underlying causes for inadequate performance and the ability to include additional measures to address state-specific issues. These actions are the latest examples of CMS delivering on its five-part plan to ensure **safety and quality in the nation's** nursing homes – specifically strengthening oversight.[1]

However, it is important to recognize the resource constraints CMS and states face, which hinder efforts to strengthen enforcement against health care facilities. As OIG notes in the draft report, complaint-based surveys have increased by 20 percent since 2013, but the survey and certification budget has remained flat since 2015 with the exception of a pandemic-related, one-time addition of funds in the Coronavirus Aid, Relief and Economic Security (CARES) Act. The **President's FY 2020 Budget requests $442 million for** survey and certification, a $45 million increase from the previous year. Increased funding would enable CMS to continue to meet statutory survey requirements while dealing with the increase in volume and severity of complaints and rising survey costs. T**hrough the President's Budget, CMS has** asked Congress to provide the Agency with statutory authority to adjust the frequency of mandatory nursing home surveys so that more time and resources can be focused on nursing homes with records of poor performance while continuing efforts to respond to complaints.

CMS thanks OIG for its efforts on this issue and looks forward to working with OIG on this and other issues in the future. **OIG's recommendations and CMS'**s responses are below.

OIG Recommendation

CMS should ensure that all States receive training on CMS's updated triage guidance.

CMS Response

CMS concurs with OIG's recommendation. CMS already provides a comprehensive national training program, which includes prerequisite training, basic training, and post basic training in the forms of advanced courses, refreshers, and competency tests. CMS plans to issue guidance on the prioritization of complaints, and will ensure that states have appropriate training.

OIG Recommendation

CMS should identify new approaches to address those States that are consistently failing to meet required timeframes for investigating the most serious nursing home complaints.

CMS Response

[1] CMS Blog, ***Ensuring Safety and Quality in America's*** *Nursing Homes* (April 15, 2019), https://www.cms.gov/blog/ensuring-safety-and-quality-americas-nursing-homes.

CMS concurs with OIG's recommendation. In April 2018, CMS launched an initiative to evaluate the SPSS process and identify ways to improve how we monitor SSA performance. CMS released revisions to the SPSS process in October 2019. [2] The resulting updates to the SPSS process are aimed at enabling CMS and SSAs to address areas of concern more effectively, and ultimately improve resident safety and the quality of their care. CMS will assess whether new approaches would help to address issues with states that are consistently failing to meet required timeframes for investigating the most serious nursing home complaints.

[2] Fiscal Year (FY) 2020 State Performance Standards System (SPSS) Guidance

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Acknowledgments

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This report was prepared under the direction of Joyce Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston regional office, and Danielle Fletcher and Ken Price, Deputy Regional Inspectors General.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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ENDNOTES

[1] For this report, we examined only nursing home complaints and not facility-reported incidents. Facility-reported incidents are reports made by the nursing home itself in accordance with reporting requirements in 42 CFR § 483.12(c). Complaints are reports alleging noncompliance with Federal and/or State requirements made by anyone other than the nursing home (see CMS State Operations Manual, Chapter 5, Section 5010).
[2] OIG, "A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015," OEI-01-16-00330, September 2017.
[3] Sections 1819(g)(4)(A) and 1919(g)(4)(A) of the Social Security Act
[4] CMS State Operations Manual (SOM), Pub. No. 100-07, Ch. 5 – Complaint Procedures (Revised 155, 06-10-16).
[5] During the period of our review (2016 – 2018), this provision of the State Operations Manual used "working days" in place of "business days." Effective July 19, 2019, CMS revised Chapter 5 under Rev. 191 and replaced "working days" with "business days."
[6] For complaints prioritized as non-immediate jeopardy medium, States must schedule an onsite survey but do not need to conduct the survey within a required timeframe. For complaints prioritized as non-immediate jeopardy low, States must investigate the complaint during the next onsite survey (see CMS State Operations Manual Chapter 5, 5075.9). States may also assign complaints the priority of "administrative review/offsite investigation" if an onsite investigation is not necessary. In this case, the State may confirm the findings of the administrative review/offsite investigation at the next onsite survey (see CMS State Operations Manual Chapter 5, 5075.5).
[7] CMS, "Prioritization of Survey Activities," Admin Info: QSO-20-20-All, March 23, 2020.
[8] CMS, "FY 2020 State Performance Standards System Guidance," Admin Info: 20-02-ALL, October 17, 2019; "FY 2018 State Performance Standards System Guidance," Admin Info: 18-02-ALL, October 17, 2017.
[9] Ibid.
[10] OIG, "A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015," OEI-01-16-00330, September 2017.
[11] OIG Work Plan, "Nursing Home Oversight During the COVID-19 Public Health Emergency," OEI-01-20-00430.
[12] OIG Work Plan, "Nursing Homes: CMS Oversight of State Survey Agencies," OEI-06-19-00460.
[13] Sections 1819(g)(1)(A) and(g)(2)(A)(iii) and 1919(g)(1)(A) and (g)(2)(A)(iii) of the Social Security Act.
[14] Sections 1819(g)(1)-(2) and 1919(g)(1)-(2) of the Social Security Act.
[15] CMS State Operations Manual (SOM), Pub. No. 100-07, Ch. 5 – Complaint Procedures (Revised 155, 06-10-16).