U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

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A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011–2015

Key Takeaways:

- Overall, States received one-third more nursing home complaints in 2015 than in 2011
- States prioritized more than half of nursing home complaints into the most serious categories—"immediate jeopardy" and "high priority"—which require onsite investigations within 2 or 10 working days, respectively
- States conducted nearly all of the required onsite investigations for the most serious nursing home complaints
- Although almost all States conducted most of their onsite investigations within required timeframes, a few States fell short
- Two States accounted for most of the late investigations of immediate jeopardy complaints
- Four States accounted for almost half of the late investigations of high priority complaints
- Almost one-quarter of States did not meet CMS's performance threshold for timely onsite investigations of high priority complaints in all 5 years
- States substantiated almost one-third of the most serious nursing home complaints each year

This Data Brief

In this data brief, the Office of Inspector General (OIG) highlights the extent to which State survey agencies (hereinafter, States) met onsite investigation timeframes for the most serious nursing home complaints from 2011 through 2015. It updates our 2006 report and offers the Centers for Medicare & Medicaid Services (CMS) some insights into the States that have room to improve in prioritizing and responding to nursing home complaints.

Introduction

The nursing home complaint process is a critical safeguard to protect vulnerable residents of nursing homes. CMS relies on the States' respective survey agencies to serve as the front-line responders to address health and safety concerns raised by residents, their families, and nursing home staff.[1] Examples of concerns that might result in a complaint are residents being left sitting in their urine and feces for hours, residents being admitted to the hospital because of preventable infections, and inappropriate social media posts by nursing home employees.

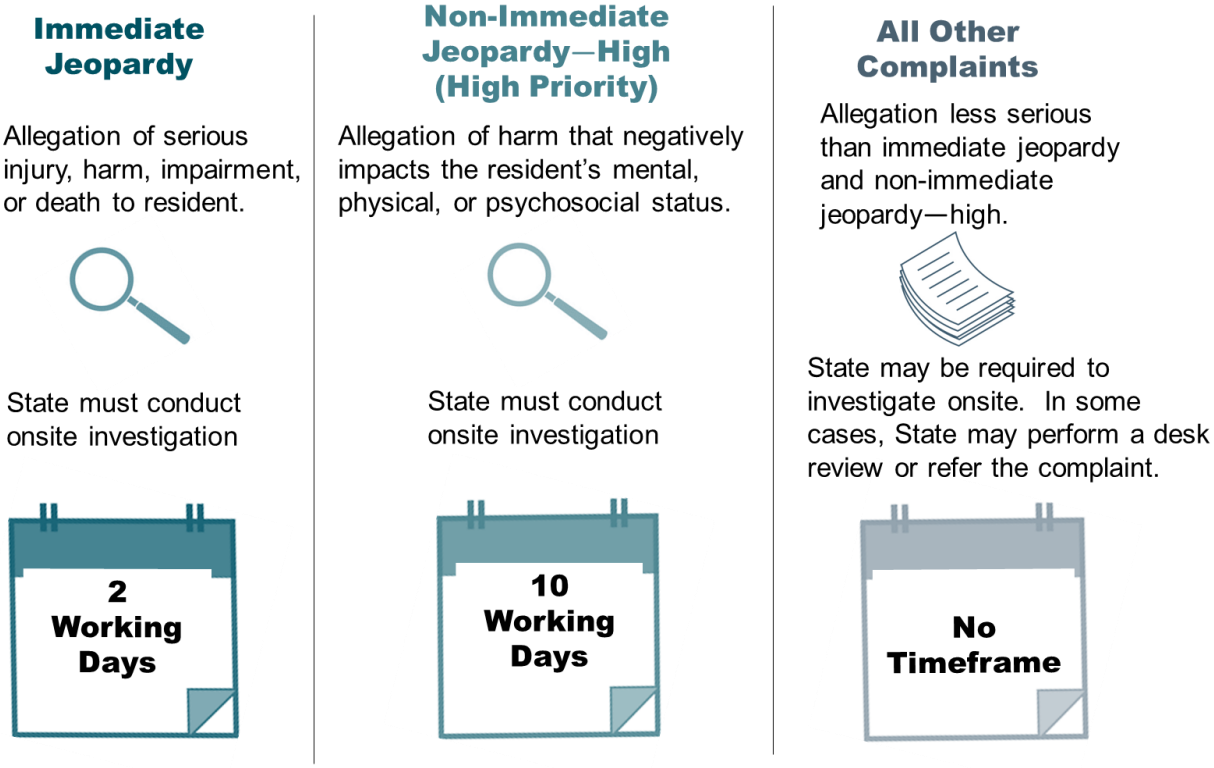
States must conduct onsite investigations within certain timeframes for the two most serious levels of complaints—those that allege serious injury or harm to a nursing home resident and require a rapid response to address the complaint and ensure residents' safety. However,

previous reports by the OIG and the Government Accountability Office (GAO) found that States did not conduct onsite investigations within the required timeframes for some of these complaints.[2,3]

CMS provides States with procedural guidelines for investigating complaints for Medicare/Medicaid-certified nursing homes.[4] CMS provides a detailed protocol for States on the process that includes complaint intake, prioritization, and investigation.

CMS requires that each complaint be prioritized by a qualified professional who has knowledge of current clinical standards and Federal requirements. The priority level that the State assigns to a complaint is critical because it determines the State's required action and timeframe for investigating. The two highest priority levels are immediate jeopardy and non-immediate jeopardy—high (high priority), which States must investigate onsite within 2 and 10 working days, respectively. See Exhibit 1 for complaint priority levels and definitions.

Exhibit 1: Nursing Home Complaint Priority Levels



Source: CMS *State Operations Manual*, ch. 5, "Complaint Procedures," (Revised 120, 09-19-14).

In addition to assigning a priority level to complaints, States categorize each allegation within a complaint by type. (A complaint can consist of more than one allegation.) Some examples of allegation categories are quality of care, resident neglect, and violation of resident rights.

During its investigation, the State determines whether to substantiate the complaint and may cite the nursing home for deficiencies related or unrelated to the complaint. The State cites the nursing home for a deficiency when the facility is not compliant with specific Federal requirements. CMS instructs surveyors to substantiate an allegation when the State verifies it with evidence, even if the noncompliance has been corrected.

Every year, CMS evaluates each State's performance in carrying out all its survey and certification responsibilities including, but not limited to, responding to complaints at nursing homes. CMS uses its State Performance Standards System to ensure that the States meet Federal requirements and to identify areas for improvement. As part of this evaluation, CMS reviews the timeliness of States' complaint investigations for nursing homes and other facilities.

For additional background, see Appendix A.

Our primary source of data for this data brief was complaints regarding Medicare/Medicaid-certified nursing homes and associated investigation information entered into CMS's Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS) from 2011 through 2015. For a detailed methodology, see Appendix B.

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.

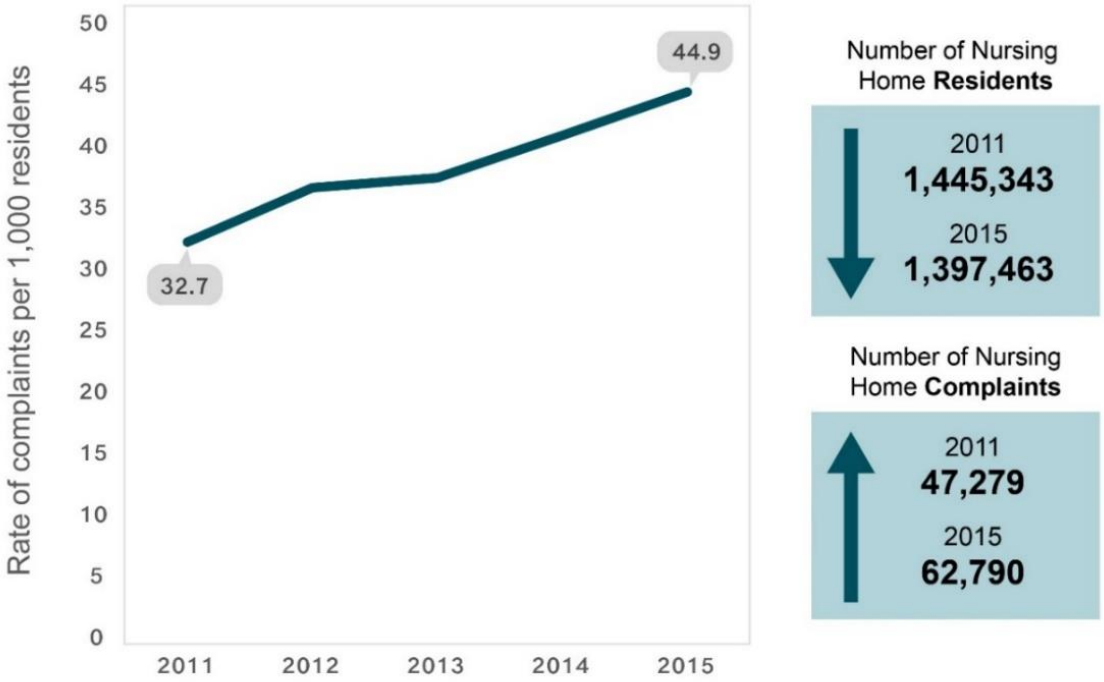
To complement this data brief, OIG has published an interactive map illustrating State-by-State trends in nursing home complaints. The interactive map is available at https://oig.hhs.gov/oei/maps/nursing-home/.

RESULTS

Overall, States received one-third more nursing home complaints in 2015 than in 2011

While the number of nursing home residents decreased slightly between 2011 and 2015, the number of nursing home complaints States received increased 33 percent, from 47,279 to 62,790. Over this 5-year period, the number of complaints that States received per 1,000 nursing home residents increased from 32.7 to 44.9 complaints per year (see Exhibit 2).

Exhibit 2: Rate of Complaints per 1,000 Nursing Home Residents, 2011–2015

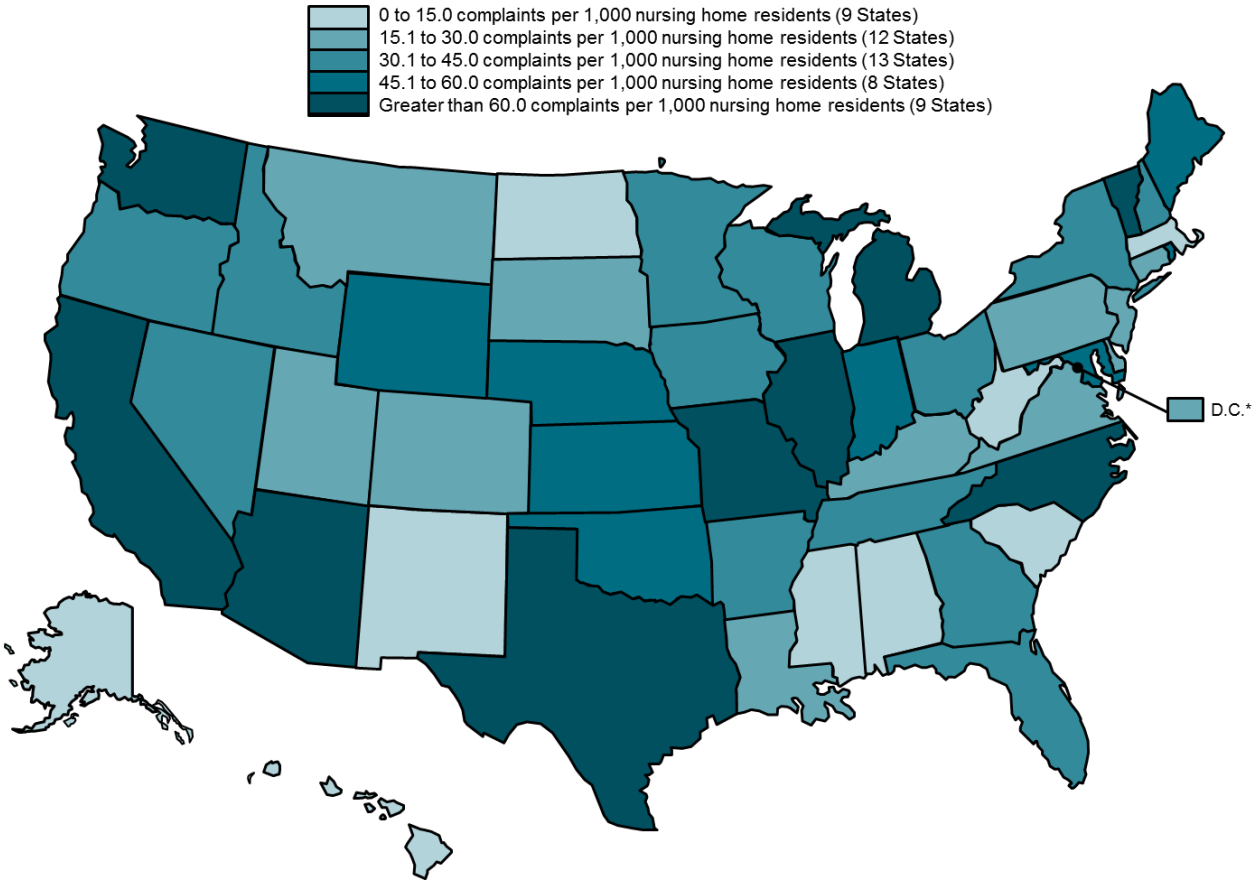


Source: OIG analysis of ACTS data and CMS Minimum Data Set (MDS) 3.0 Frequency Report, 2017.

State trends in nursing home complaints varied between 2011 and 2015. Thirty-five States had increases in the number of complaints during this time, with increases of 50 percent or more in 11 of those States. In contrast, 16 States had decreases in the number of complaints, with decreases of 50 percent or more in 5 of those States.

In addition, the number of nursing home complaints received varied from one State to another. For example, in 2015 the number of complaints that States received ranged from 2.1 per 1,000 nursing home residents to 109 per 1,000 residents (see Exhibit 3). Across all 5 years, Hawaii generally had few complaints—an average of 3.3 per 1,000 residents—while Washington consistently had the highest number of complaints, with an average of 108.7 complaints per 1,000 residents. Exhibit C-1 in Appendix C provides details on the number of nursing home complaints that each State received.

Exhibit 3: Rate of Complaints per 1,000 Nursing Home Residents by State in 2015



Source: OIG analysis of ACTS data, 2017.
*In this report, we refer to the District of Columbia as a State.
Note: See https://oig.hhs.gov/oei/maps/nursing-home/ for rates of complaints for years 2011–2015 by State.

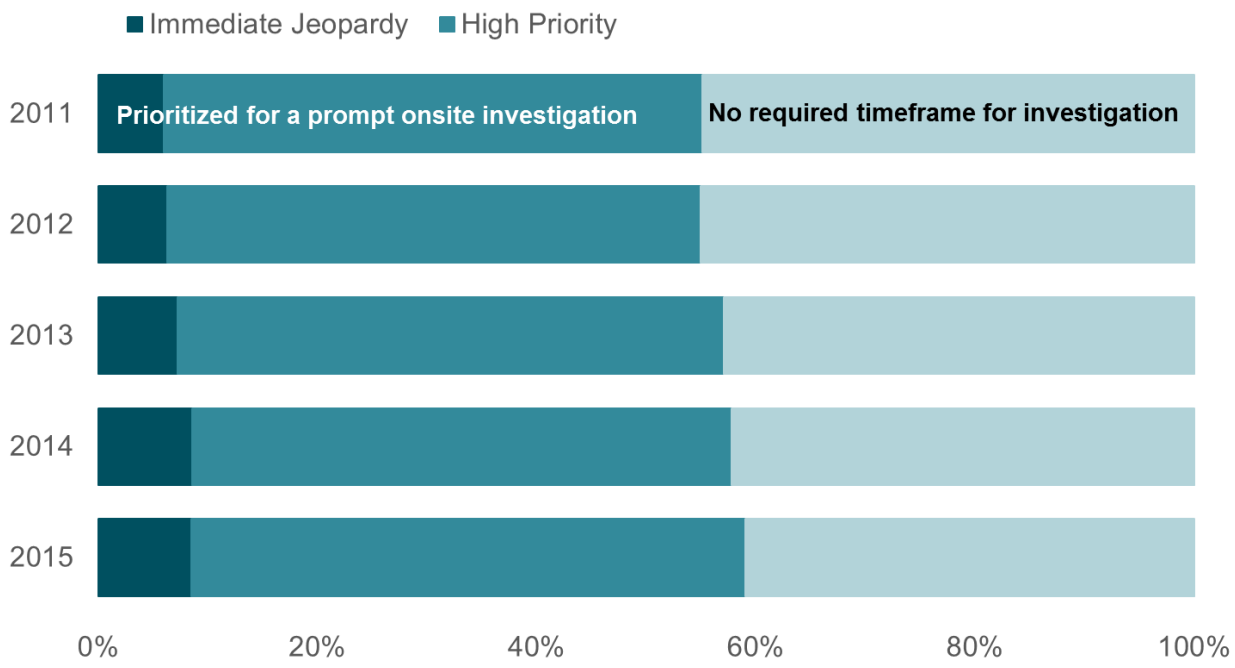
Each year, half of all nursing home complaints required prompt onsite investigation

The priority level that the State assigns to each nursing home complaint determines the State's required action and timeframe for addressing the complaint. The two most serious priority levels of complaints—immediate jeopardy and high priority—require the State to conduct an onsite investigation within 2 working days or 10 working days, respectively, to address the complaint and ensure the resident's safety.

In 2015, States prioritized 59 percent of complaints as either immediate jeopardy or high priority, compared to 55 percent in 2011

Each year, States prioritized about 7 percent of complaints as immediate jeopardy, a level that requires a State to conduct an onsite investigation within 2 working days. Although the proportion of total complaints remained about 7 percent, the number of immediate jeopardy complaints almost doubled during this time, from 2,844 to 5,341. In addition, States prioritized about 50 percent of complaints each year as high priority, a level that requires a State to investigate onsite within 10 working days (see Exhibit 4).

Exhibit 4: Percentage of Nursing Home Complaints That States Prioritized for Prompt Onsite Investigation: 2011–2015



Source: OIG analysis of ACTS data, 2017.

The percentage of complaints that States prioritized as immediate jeopardy and high priority varied from one State to another. For example, in 2015, eight States did not prioritize any complaints as immediate jeopardy while three States (Georgia, Kentucky, and Tennessee) prioritized over 40 percent of their complaints as immediate jeopardy. Of the eight States that prioritized no complaints as immediate jeopardy in 2015, three States—New Hampshire, Oregon, and Rhode Island—prioritized no complaints as immediate jeopardy during the entire 5-year period we analyzed.

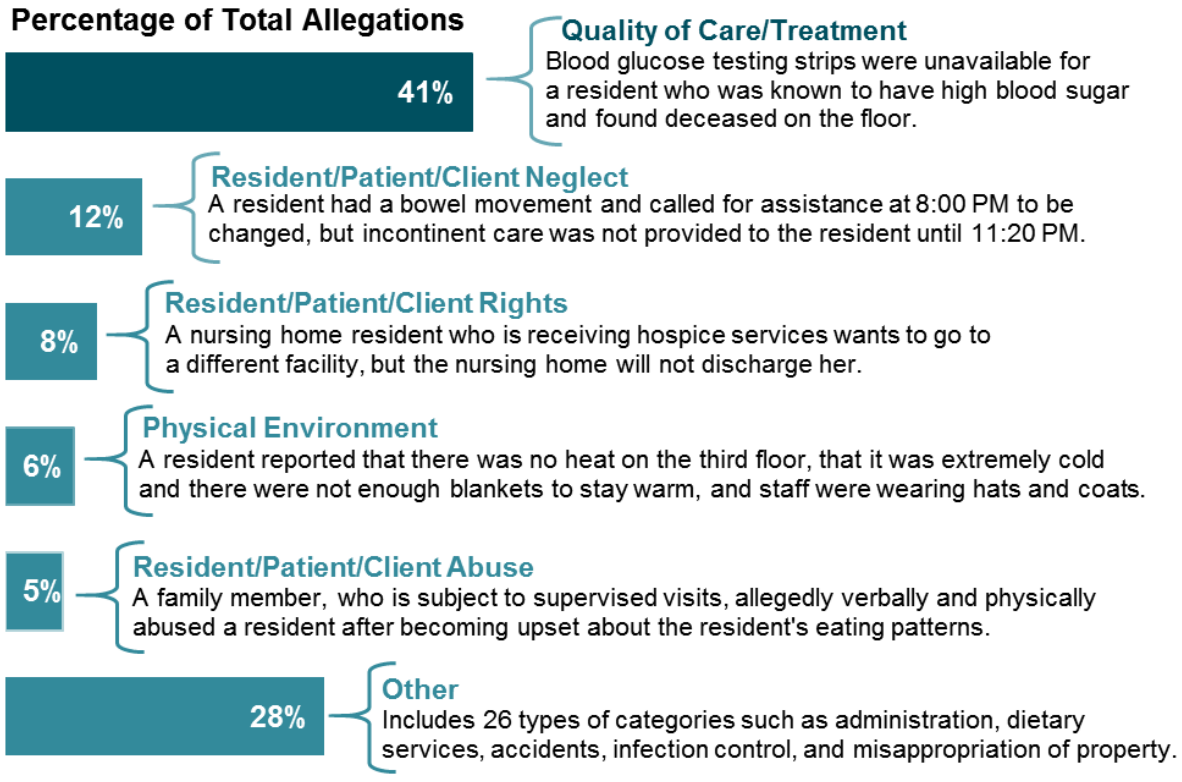
We also found variation from one State to another in the percentages of complaints that they prioritized as high priority. For example, in 2015, Hawaii and North Dakota

prioritized no complaints as high priority while 18 States prioritized more than 50 percent of complaints as high priority. Furthermore, North Dakota prioritized no complaints as high priority in 4 of the 5 years we analyzed. Exhibit C-1 in Appendix C provides details on the percentages of nursing home complaints that each State prioritized as immediate jeopardy and high priority.

Among the most serious complaints, the most common allegations related to quality of care or treatment

Between 2011 and 2015, for complaints prioritized as immediate jeopardy or high priority, States categorized an average of 42 percent of the allegations as relating to quality of care or treatment. In 2015, allegations regarding quality of care or treatment were the most common (41 percent), followed by allegations regarding resident neglect (12 percent) and resident rights (8 percent). See Exhibit 5 for examples of allegations in each category and the percentages of total allegations for these categories in 2015.

Exhibit 5: Percentages of the Types of Allegations Associated With the Most Serious Nursing Home Complaints in 2015, with Examples



Source: OIG analysis of ACTS data and examples provided by CMS, 2017.

States conducted nearly all required onsite investigations for the most serious nursing home complaints each year

Over this 5-year period, States did not investigate 9 immediate jeopardy and 166 high priority nursing home complaints onsite, representing less than 1 percent of these complaints collectively. States received about half of these complaints in 2015 (see Exhibit 6). For immediate jeopardy complaints, no State missed more than two required onsite investigations in any year. For high priority complaints, however, 4 States—Arizona, California, Delaware, and New Jersey—missed onsite investigations for more than 10 high priority complaints in at least 1 of the 5 years. Being onsite allows surveyors to directly observe the conditions and care practices at a nursing home.

Exhibit 6: Number of Immediate Jeopardy and High Priority Complaints Without Onsite Investigations, 2011–2015

	Number of nursing home complaints without onsite investigations	
Year	Immediate Jeopardy Complaints	High Priority Complaints
2011	0 of 2,844 total complaints	9 of 23,221 total complaints
2012	0 of 3,329	21 of 25,715
2013	3 of 3,905	16 of 26,681
2014	2 of 5,009	37 of 28,810
2015	4 of 5,341	83 of 31,748
Total	9 of 20,428	166 of 136,175

Source: OIG analysis of ACTS data, 2017.

Although almost all States conducted most of their onsite investigations within required timeframes, a few States fell short

The potential for further harm to nursing home residents makes it essential that States conduct prompt onsite investigations of immediate jeopardy and high priority complaints.

Two States accounted for most of the late investigations of immediate jeopardy complaints

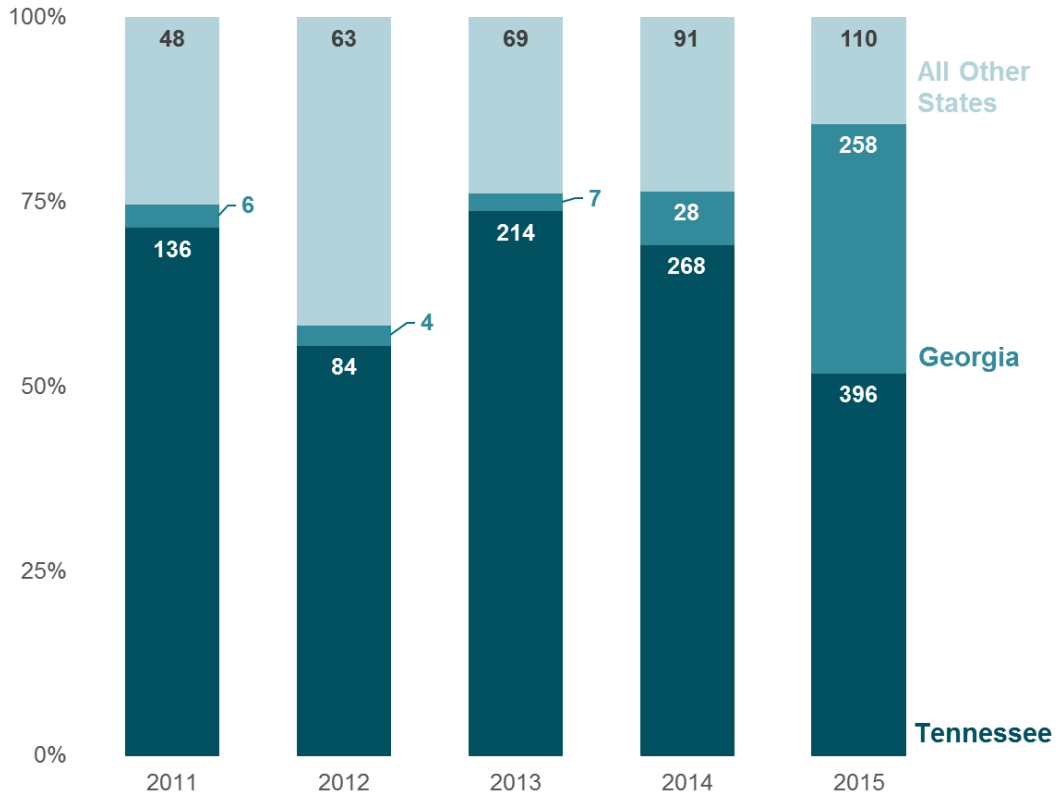
Each year, Tennessee and Georgia accounted for over half of the immediate jeopardy complaints that were not investigated within 2 working days. Across the 5-year period, Tennessee accounted for most of the immediate jeopardy complaints that were

investigated within 2 working days, whereas until 2015 Georgia had accounted for only a few of the late investigations.

In 2015, Tennessee and Georgia received a total of 912 immediate jeopardy complaints (17 percent of all immediate jeopardy complaints). Of these 912 complaints, they investigated 654 complaints late. These 654 complaints constituted 86 percent of the 764 immediate jeopardy complaints nationwide that were investigated late (see Exhibit 7).

Nationwide, the percentage of immediate jeopardy complaints that States did not investigate within 2 working days was 14 percent in 2015, compared to 7 percent in 2011. For the 49 States other than Tennessee and Georgia, the overall percentage of immediate jeopardy complaints not investigated within 2 working days was about 2 percent each year.

Exhibit 7: Number of Immediate Jeopardy Complaints Not Investigated Onsite Within 2 Working Days: 2011–2015



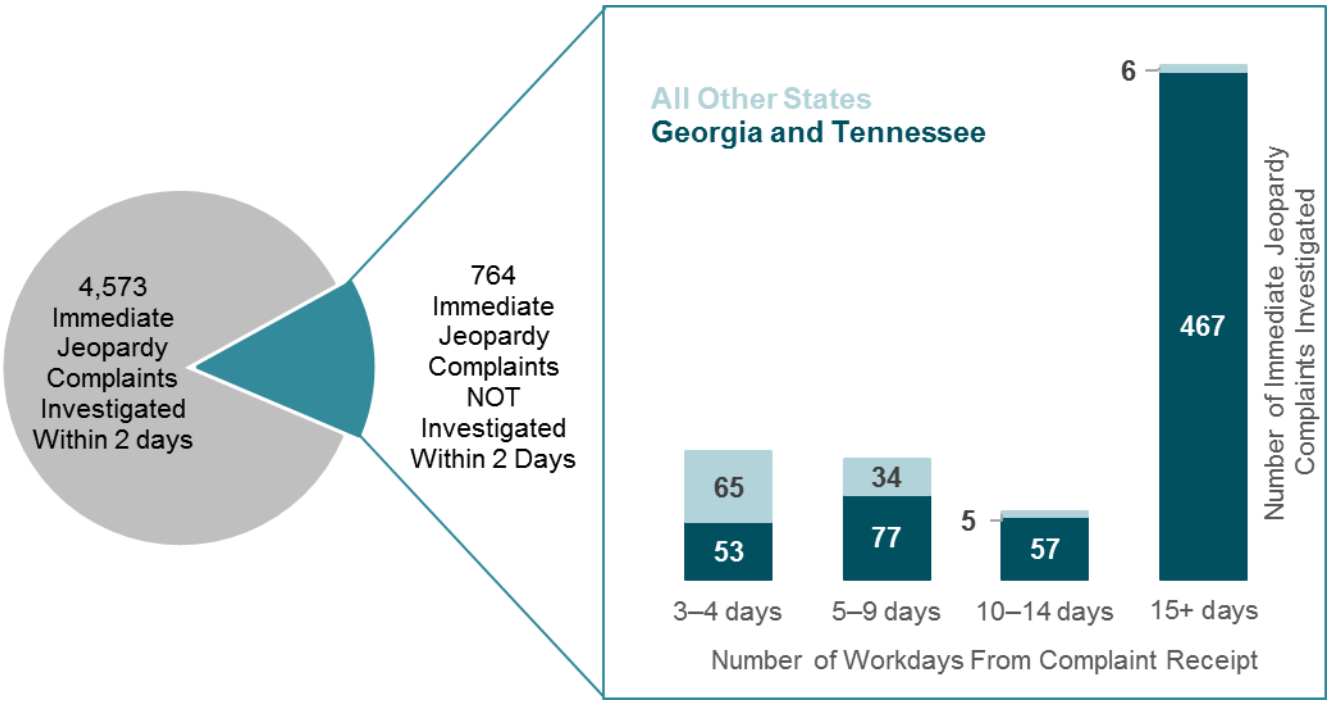
Source: OIG analysis of ACTS data, 2017.

CMS states that it is working with Tennessee to address a backlog of complaints, which the State attributed to insufficient staff and loss of institutional knowledge as a result of staff turnover. CMS stated that vacancies contributed in a similar fashion to Georgia's late complaint investigations, and that the State is working to hire additional surveyors.

CMS noted that both States have hired contractors to help conduct surveys. Exhibit C-2 in Appendix C provides details on each State's number of immediate jeopardy nursing home complaints not investigated within required timeframes.

Furthermore, these two States investigated many immediate jeopardy complaints weeks late. For example, in 2015, Tennessee and Georgia accounted for almost all of the immediate jeopardy complaints (467 of 473) that States investigated onsite 15 or more days after complaint receipt (see Exhibit 8).

Exhibit 8: Number of Immediate Jeopardy Complaints Investigated by Number of Workdays From Complaint Receipt, 2015



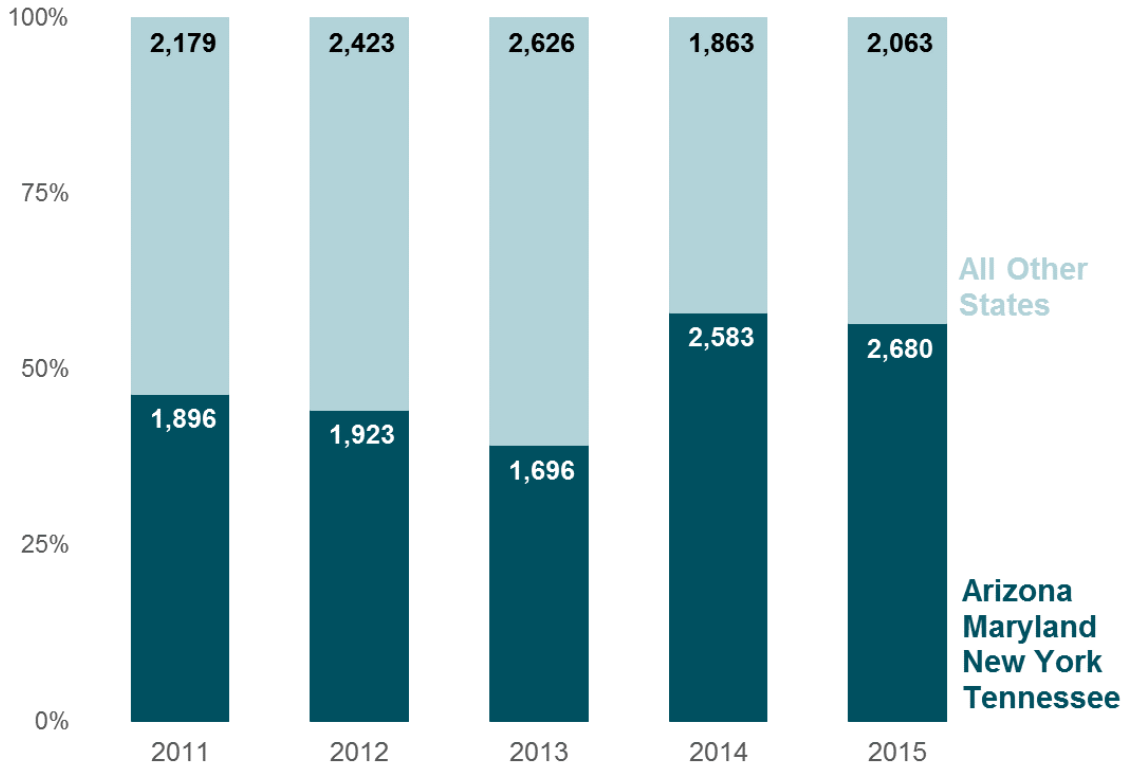
Source: OIG analysis of ACTS data, 2017.
Note: See Appendix D for national data on the number of immediate jeopardy complaints investigated by the number of workdays from complaint receipt for 2011 through 2015.

Four States accounted for almost half of the late investigations of high priority complaints

As was the case with immediate jeopardy complaints, some States accounted for a higher number of late onsite investigations of high priority complaints than did others. Across all 5 years, Arizona, Maryland, New York, and Tennessee accounted for almost half of the high priority complaints not investigated onsite within 10 working days. For example, in 2015, these four States did not investigate 2,680 of 4,743 high priority complaints (57 percent) within the required timeframes (see Exhibit 9). In 2015, these four States accounted for 13 percent of all high priority complaints. The national

percentage of high priority complaints not investigated within 10 working days was 15 percent in 2015, compared to 18 percent in 2011. For the 47 States other than these 4, the overall percentage of high priority complaints not investigated within 10 working days was 7 percent in 2015, compared to 11 percent in 2011.

Exhibit 9: Number of High Priority Complaints Not Investigated Onsite Within 10 Working Days: 2011–2015

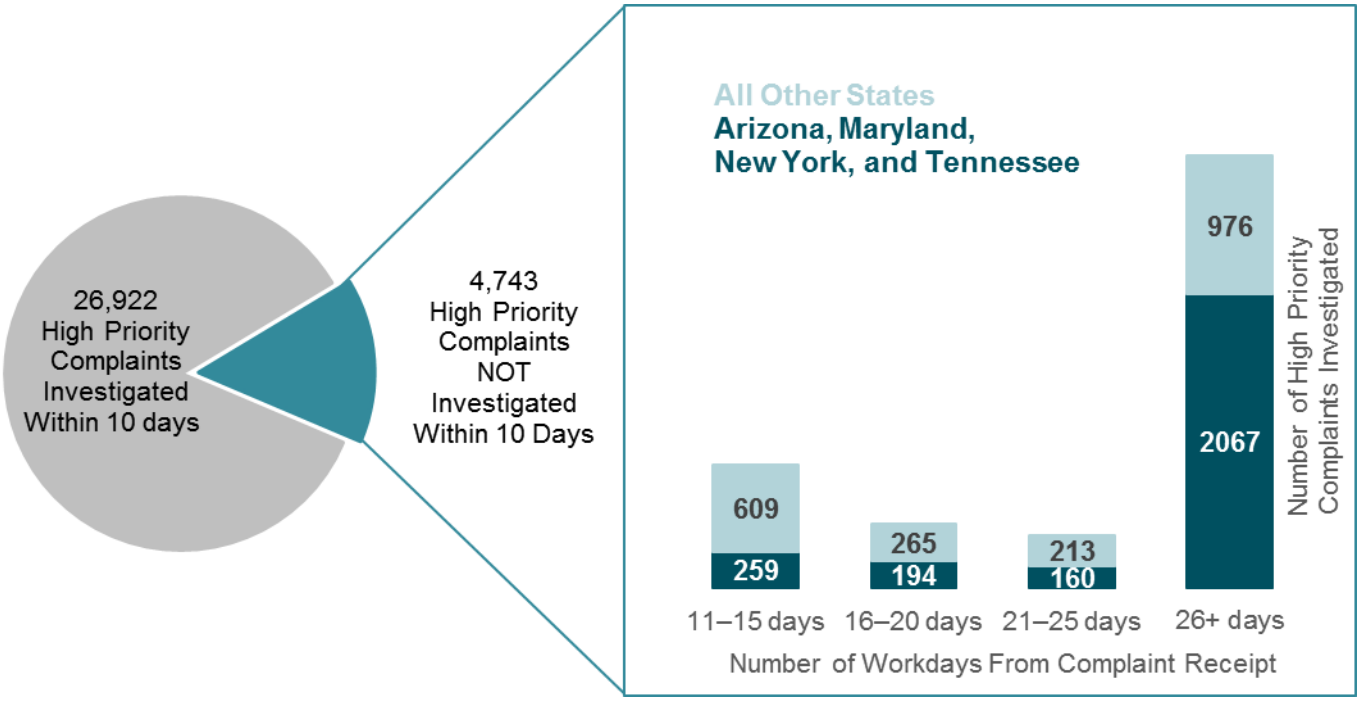


Source: OIG analysis of ACTS data, 2017.

Furthermore, these four States investigated many high priority complaints weeks late. For example, in 2015, these States accounted for two-thirds (2,067 of 3,043) of high priority complaints that States investigated onsite 26 days or more after complaint receipt (see Exhibit 10).

According to CMS, these States generally faced challenges related to staff shortages and are working to improve response times for complaint investigations. Exhibit C-2 in Appendix C provides details on the each State's number of high priority nursing home complaints not investigated within required timeframes.

Exhibit 10: Number of High Priority Complaints Investigated by Number of Workdays From Complaint Receipt, 2015



Source: OIG analysis of ACTS data, 2017.
Note: See Appendix D for national data on the number of high priority complaints investigated by the number of workdays from complaint receipt for years 2011 through 2015.

Almost one-quarter of States did not meet CMS's performance threshold for timely onsite investigations of high priority complaints in all 5 years

Although CMS requires that States investigate all high priority nursing home complaints onsite within 10 working days, it will impose a sanction or remedy when a State does not investigate 95 percent of these complaints within that timeframe.[5] Eleven States (22 percent) did not meet CMS's performance threshold for timely onsite investigations of high priority nursing home complaints every year between 2011 and 2015 (see Exhibit 11). In addition, Colorado, Connecticut, Iowa, and Maine did not meet CMS's threshold for 4 of these 5 years.

Furthermore, Mississippi, and Tennessee did not conduct onsite investigations for 95 percent of the immediate jeopardy nursing home complaints they received each year. We cannot determine whether these States met CMS's annual performance threshold for timely investigation of immediate jeopardy

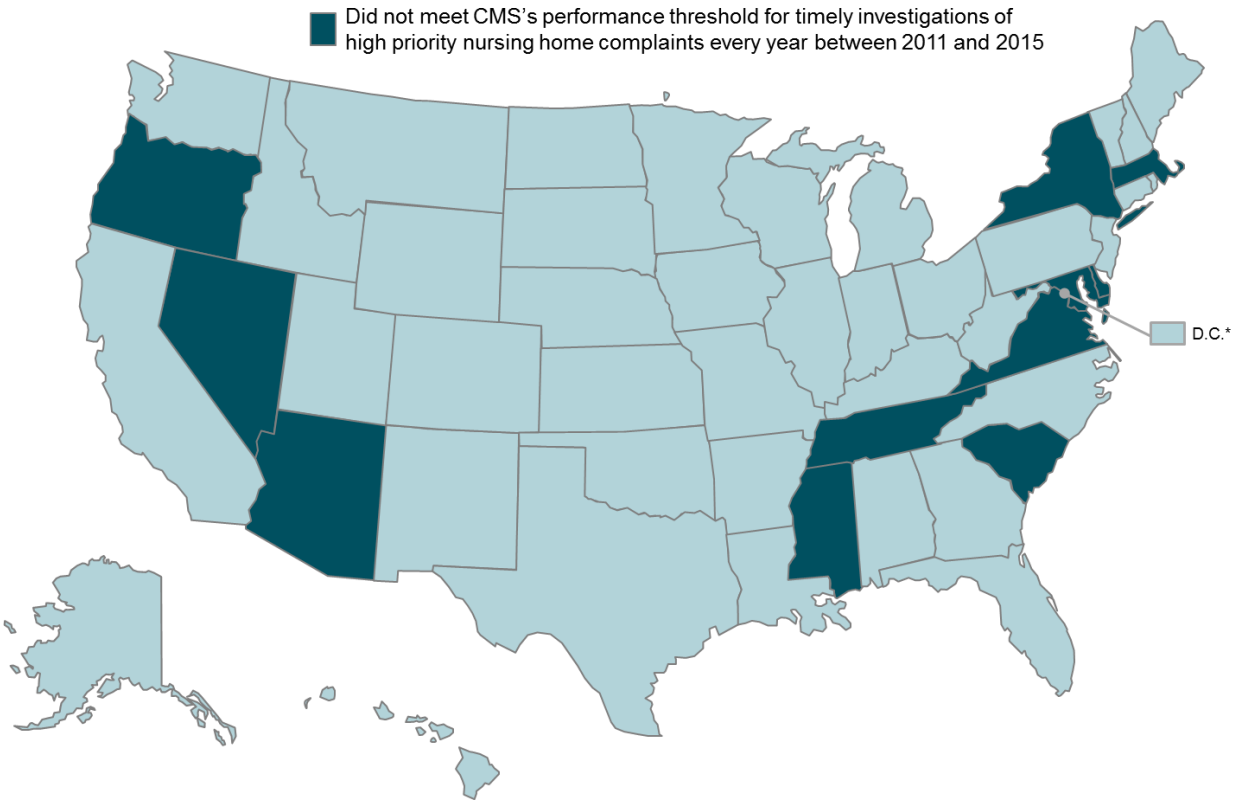
States must investigate:

Within 2 working days: 95% of immediate jeopardy complaints received for nursing homes and other facilities.

Within 10 working days: 95% of high priority complaints received for nursing homes.

complaints because CMS includes other facilities with nursing homes in its calculations for this performance threshold. However, these 2 States are included among the 11 States that did not meet CMS's performance threshold for timely investigations of high priority complaints each year.

Exhibit 11: States That Did Not Meet CMS's Performance Threshold for Timely Investigations of High Priority Nursing Home Complaints Every Year Between 2011 and 2015



Source: OIG analysis of ACTS data, 2017.
*In this report, we refer to the District of Columbia as a State.

States substantiated almost one-third of the most serious nursing home complaints

Between 2011 and 2015, States substantiated 31 percent, on average, of the immediate jeopardy and high priority nursing home complaints that they investigated (see Exhibit 12).[6] When we analyzed the two priority levels of complaints separately, we found little difference between the average percentages substantiated for each priority level—on average, States substantiated 34 percent of immediate jeopardy complaints and 30 percent of high priority complaints.

Exhibit 12: Average Percentage of the Most Serious Nursing Home Complaints That States Substantiated, 2011–2015

Source: OIG analysis of ACTS data, 2017.

States varied in the percentage of complaints they substantiated. According to CMS, how States apply CMS's definition of substantiation may not be consistent from one State to another. For example, following an investigation, a State confirmed that a resident fell and dislocated a shoulder as alleged in the resident's complaint, but the State had insufficient evidence to support a Federal deficiency. In this example, some States would consider the complaint substantiated because the resident did fall and did dislocate a shoulder; however, other States would consider the complaint unsubstantiated because the State did not cite a Federal deficiency.

CMS instructs surveyors to substantiate an allegation when the State verifies it with evidence, even if the noncompliance has been corrected.

For States that in 2015 investigated most than 20 of the most serious complaints (i.e., immediate jeopardy and high priority complaints), the percentages of the complaints that they substantiated ranged from 4 percent to 82 percent. Six States substantiated more than 50 percent of their most serious complaints, whereas only Rhode Island substantiated less than 10 percent of its most serious complaints. Exhibit C-3 in Appendix C provides details on the percentages of immediate jeopardy and high priority nursing home complaints that each State substantiated.

CONCLUSION

Overall, nursing home complaints rose by one-third across States from 2011 to 2015, while the number of nursing home residents decreased about 3 percent. However, we do not know whether an increase in complaints represents a decrease in quality of care. Other factors may contribute to an increase in complaints, such as more accessible and user-friendly options to file complaints, better tracking of complaints, or possibly an increased willingness among consumers to report on their nursing home experiences.

This data brief raises questions about how some States respond to complaints, as these responses could have serious consequences for nursing home residents in those States. Residents and their families rely on a functioning complaint system to take their complaints seriously and to investigate them appropriately. A functioning complaint system also complements other oversight efforts, such as routine surveys. However, a handful of States accounted for about half of the late investigations of the most serious nursing home complaints, with most such investigations being weeks late. Further, some States never prioritized any complaints as immediate jeopardy.

This data brief offers CMS some insights into the States that have room to improve in prioritizing and responding to nursing home complaints. Nursing home residents are a vulnerable population, and States serve as the front-line responders in addressing concerns raised by residents, their families, and nursing home staff. To ensure the health and safety of nursing home residents, CMS must remain vigilant and assist the States that are falling short in meeting timeframes for investigations of complaints. OIG will continue to monitor the oversight of nursing homes and will initiate additional reviews as necessary**.**

APPENDIX A: DETAILED BACKGROUND

Nursing Home Oversight

CMS, in conjunction with States, oversees nursing homes to ensure that they meet Federal standards. States conduct certification surveys on behalf of CMS on average every 12 months but no less frequently than every 15 months.[7] These surveys evaluate the safety and quality of care that nursing homes provide.[8] 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 and incidents 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 working 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 working 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.

Complaint Investigation and Substantiation

The State will determine during its investigation whether to substantiate the complaint and may cite the nursing home for Federal deficiencies related or unrelated to the

complaint. CMS also requires that the State follow up with the nursing home after its investigation and provide information to the complainant.

When a State investigation cites a Federal deficiency at the level of immediate jeopardy, CMS requires the State to revisit the facility and confirm removal of the immediate jeopardy. The facility must remove the immediate jeopardy no later than 23 days from the last day of the State's investigation.[9] The State should also impose other remedies such as monetary fines or State monitoring and require a corrective action plan to address any underlying deficiencies. When a State investigation cites a deficiency but immediate jeopardy does not exist, the State may (1) require a corrective action plan to address deficiencies, (2) impose monetary penalties or other remedies, and/or (3) revisit the nursing home. The facility must resolve any noncompliance no later than 6 months from the last day of the State's investigation.

State Performance Standards System

Every year, CMS evaluates each State's performance in carrying out all its survey and certification responsibilities. The State Performance Standards System consists of 19 measures across 3 categories of performance standards: frequency; quality; and enforcement and remedy. Under the quality standard, CMS reviews the timeliness of States' investigations of complaints and facility-reported incidents for nursing homes and other facilities.[10]

Although CMS requires States to investigate all immediate jeopardy and high priority nursing home complaints onsite within certain timeframes, the threshold by which it measures States' performance is lower. For purposes of the State Performance Standards System, States must conduct onsite investigations within 2 working days for 95 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 is for States to conduct onsite investigations within 10 working days for 95 percent of the high priority complaints they receive. If a State does not meet one of these performance thresholds, CMS provides the State with a corrective action plan and follows up on the State's implementation of the plan.[11]

APPENDIX B: DETAILED METHODOLOGY

Our primary data source for this data brief was all nursing home complaints and associated investigation information entered in ACTS from 2011 through 2015. We also interviewed CMS staff.

ACTS Data

CMS provided us with data on all Medicare/Medicaid-certified nursing home complaints and facility-reported incidents and associated investigation information entered into ACTS from 2011 through 2015. We removed records in which the State entered a start date for the onsite investigation that was prior to the complaint receipt date (42,869 records). Our final dataset included 874,972 records from all 50 States and the District of Columbia. Complaints and incidents can include multiple allegations; each record represents one allegation.

We analyzed these data using SAS to determine national and State trends for nursing home complaints between 2011 and 2015. 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; (3) the percentage of immediate jeopardy and high priority complaints that States investigated onsite within required timeframes; and (4) the percentage of immediate jeopardy and high priority complaints that States substantiated. To compare across States, we obtained the number of nursing home residents for each State from the nursing home resident Minimum Data Set 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.

CMS Interviews

We conducted interviews with CMS staff to learn about ACTS data and how States use ACTS.

Nursing Home Incidents

In addition to receiving complaints, States also receive reports of and respond to nursing home incidents. Incidents are self-reported by the nursing home, whereas complaints come from all other sources, including residents, family members, and nursing home staff. Nursing homes must self-report incidents that involve any suspected mistreatment, abuse, neglect, or misappropriation of resident property. States triage and prioritize incidents in the same manner as complaints. In addition, CMS holds States to the same timeframe requirements for onsite investigation of incidents prioritized as immediate jeopardy or high priority. We analyzed data on incidents in addition to complaints, but for the purposes of this data brief, we reported

results only on complaints. We did this because CMS told us that complaints and incidents could be redundant—i.e., a State might record a single situation in ACTS as an incident as well as a complaint. In addition, our analysis of incidents revealed similar patterns as our analysis of complaints (See Appendix E).

Limitations

Our analysis had some limitations. We did not assess the extent to which the data in ACTS are complete or the appropriateness of State responses to complaints or of 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 information collected directly from States.

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%
Ohio	3,111	38.7	7%	52%	2,817	36.5	16%	73%

	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
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 Prority 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
North Carolina	7	17	6	108
North Dakota	N/A	0	0	N/A
Ohio	1	16	1	2

	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
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.

Exhibit C-3: Number of Immediate Jeopardy and High Priority Complaints Investigated Onsite and Substantiatated by State, 2011 and 2015

	2011			2015		
	Number of Immediate Jeopardy and High Priority Complaints Investigated Onsite	Number (and Percentage) of Immediate Jeopardy and High Priority Complaints Substantiated		Number of Immediate Jeopardy and High Priority Complaints Investigated Onsite	Number (and Percentage) of Immediate Jeopardy and High Priority Complaints Substantiated	
Alabama	148	59	(40%)	72	21	(29%)
Alaska	3	1	(33%)	3	1	(33%)
Arizona	395	136	(34%)	786	132	(17%)
Arkansas	525	230	(44%)	497	205	(41%)
California	147	103	(70%)	5,148	1,900	(37%)
Colorado	186	135	(73%)	217	116	(53%)
Connecticut	20	13	(65%)	31	22	(71%)
Delaware	44	28	(64%)	54	16	(30%)
District of Columbia	4	1	(25%)	2	1	(50%)
Florida	1,026	350	(34%)	694	241	(35%)
Georgia	779	207	(27%)	853	140	(16%)
Hawaii	2	1	(50%)	N/A	N/A	N/A
Idaho	29	16	(55%)	21	15	(71%)
Illinois	1,146	587	(51%)	3,370	1,532	(45%)
Indiana	672	468	(70%)	671	552	(82%)
Iowa	446	192	(43%)	451	188	(42%)
Kansas	110	53	(48%)	211	87	(41%)
Kentucky	601	254	(42%)	665	158	(24%)
Louisiana	393	211	(54%)	356	119	(33%)
Maine	224	34	(15%)	72	15	(21%)
Maryland	951	354	(37%)	881	327	(37%)
Massachusetts	478	117	(24%)	288	69	(24%)
Michigan	1,271	646	(51%)	2,351	1,009	(43%)
Minnesota	277	33	(12%)	273	49	(18%)
Mississippi	198	89	(45%)	204	53	(26%)
Missouri	1,565	273	(17%)	2,458	342	(14%)
Montana	11	6	(55%)	9	5	(56%)
Nebraska	67	33	(49%)	117	44	(38%)
Nevada	45	21	(47%)	25	7	(28%)
New Hampshire	4	1	(25%)	1	0	N/A

	2011			2015		
	Number of Immediate Jeopardy and High Priority Complaints Investigated Onsite	Number (and Percentage) of Immediate Jeopardy and High Priority Complaints Substantiated		Number of Immediate Jeopardy and High Priority Complaints Investigated Onsite	Number (and Percentage) of Immediate Jeopardy and High Priority Complaints Substantiated	
New Jersey	54	11	(20%)	354	109	(31%)
New Mexico	29	11	(38%)	21	8	(38%)
New York	1,608	172	(11%)	1,961	218	(11%)
North Carolina	764	146	(19%)	981	207	(21%)
North Dakota	1	1	(100%)	1	1	(100%)
Ohio	1,844	667	(36%)	2,486	626	(25%)
Oklahoma	515	194	(38%)	372	130	(35%)
Oregon	232	80	(34%)	276	112	(41%)
Pennsylvania	1,858	454	(24%)	1,417	506	(36%)
Rhode Island	11	3	(27%)	47	2	(4%)
South Carolina	108	38	(35%)	201	54	(27%)
South Dakota	3	3	(100%)	14	10	(71%)
Tennessee	616	174	(28%)	873	217	(25%)
Texas	4,601	965	(21%)	5,609	947	(17%)
Utah	25	10	(40%)	34	14	(41%)
Vermont	37	13	(35%)	38	10	(26%)
Virginia	81	52	(64%)	87	59	(68%)
Washington	1,538	294	(19%)	1,089	224	(21%)
West Virginia	136	61	(45%)	35	16	(46%)
Wisconsin	214	119	(56%)	294	130	(44%)
Wyoming	14	11	(79%)	31	20	(65%)
National Total	26,056	8,131	(31%)	37,002	10,986	(30%)

Source: OIG analysis of ACTS data, 2017.
Not Applicable (N/A) - States had none of these complaints to investigate.

APPENDIX D: Number of Immediate Jeopardy and High Priority Complaints Investigated by Number of Workdays From Complaint Receipt, 2011–2015

Exhibit D-1: Number of Immediate Jeopardy Complaints Investigated by Number of Workdays From Complaint Receipt, 2011–2015

Number of Days from Receipt of Complaint to Onsite Investigation	2011	2012	2013	2014	2015
2 days or less	2,654	3,178	3,612	4,620	4,573
3-4 days	47	53	46	81	118
5-9 days	28	15	36	35	111
10-14 days	13	12	19	25	62
15+ days	102	71	189	246	473
Not Investigated	0	0	3	2	4
Total Investigated	2,844	3,329	3,902	5,007	5,337

Source: OIG analysis of ACTS data, 2017.

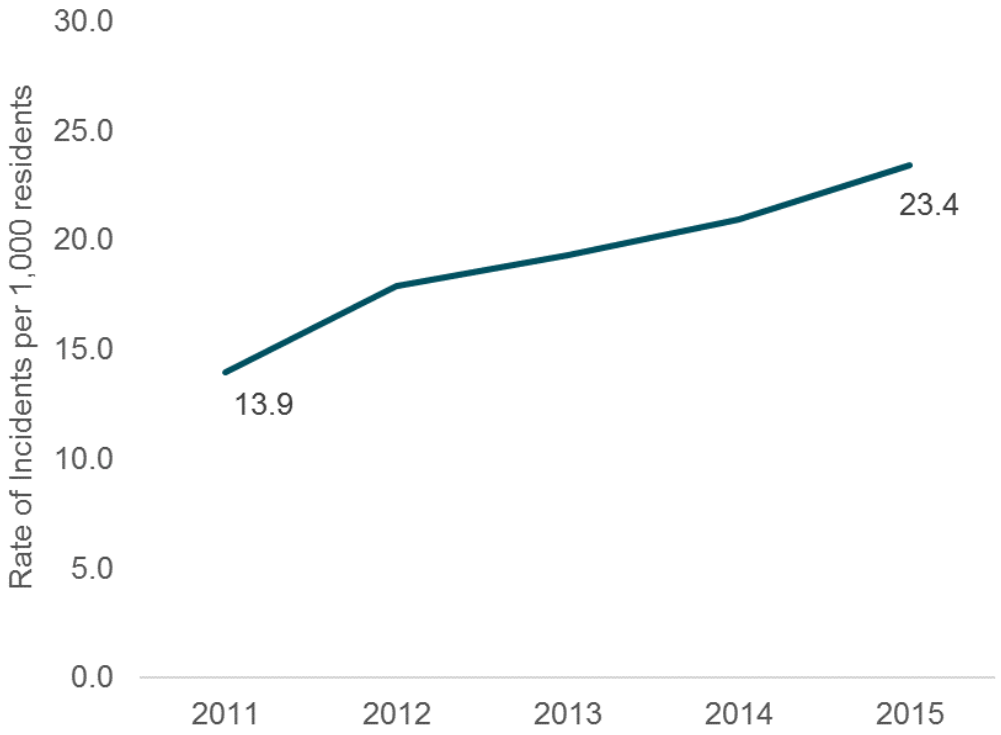
Exhibit D-2: Number of High Priority Complaints Investigated by Number of Workdays From Complaint Receipt, 2011–2015

Number of Days from Receipt of Complaint to Onsite Investigation	2011	2012	2013	2014	2015
10 days or less	19,137	21,348	22,343	24,327	26,922
11-15 days	918	872	933	887	868
16-20 days	497	458	523	428	459
21-25 days	335	394	379	361	373
26+ days	2,325	2,622	2,487	2,770	3,043
Not Investigated	9	21	16	37	83
Total Investigated	23,212	25,694	26,665	28,773	31,665

Source: OIG analysis of ACTS data, 2017.

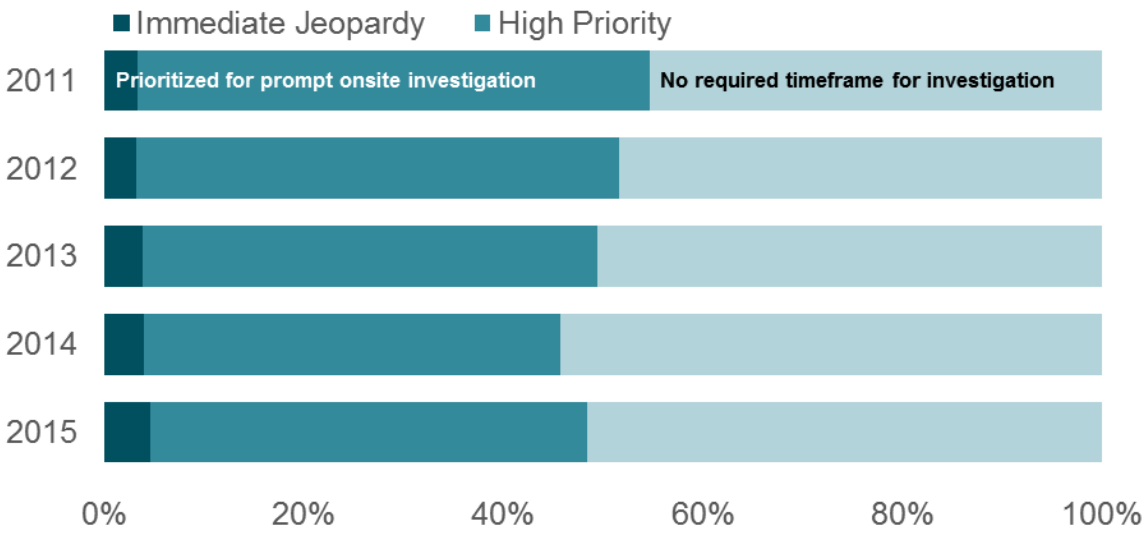
APPENDIX E: Trends in Nursing Home Incidents, 2011–2015

Exhibit E-1: Rate of Incidents per 1,000 Nursing Home Residents, 2011–2015



Source: OIG analysis of ACTS data, 2017.

Exhibit E-2: Percentage of Nursing Home Incidents That States Prioritized for Prompt Onsite Investigations, 2011–2015



Source: OIG analysis of ACTS data, 2017.

Exhibit E-3: Number of Immediate Jeopardy and High Priority Incidents Without Onsite Investigations, 2011–2015

	Number of nursing home incidents without onsite investigations	
Year	Immediate Jeopardy Incidents	High Priority Incidents
2011	2 of 678 total incidents	17 of 10,328 total incidents
2012	1 of 827	1 of 12,296
2013	0 of 1,032	1 of 12,423
2014	0 of 1,178	4 of 12,330
2015	1 of 1,507	19 of 14,323
Total	**4 of 5,222**	**42 of 61,700**

Source: OIG analysis of ACTS data, 2017.

Exhibit E-4: Number of Immediate Jeopardy Incidents Investigated by Number of Workdays From Incident Receipt, 2011–2015

Number of Days from Receipt of Incident to Onsite Investigation	2011	2012	2013	2014	2015
2 days or less	641	792	863	1,023	1,187
3-4 days	13	14	23	14	24
5-9 days	9	4	16	15	35
10-14 days	2	3	17	11	26
15+ days	11	13	113	115	234
Not Investigated	2	1	0	0	1
Total Investigated	676	826	1,032	1,178	1,506

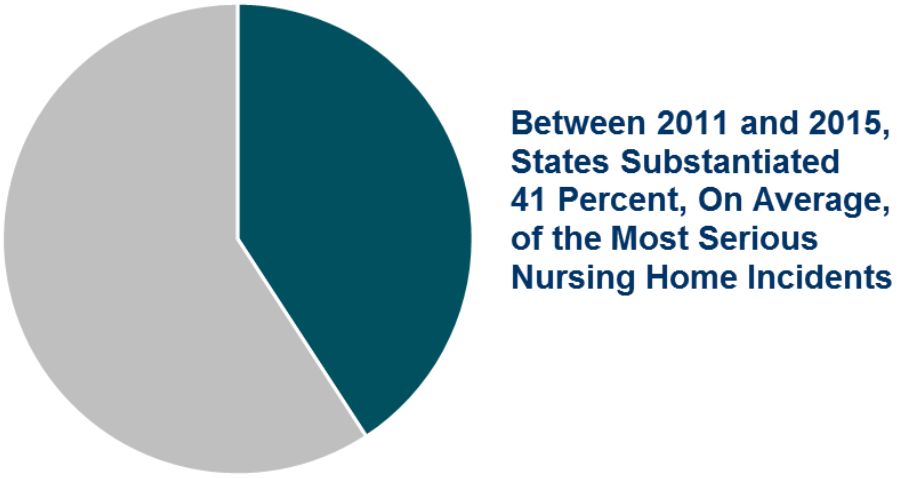
Source: OIG analysis of ACTS data, 2017.

Exhibit E-5: Number of High Priority Incidents Investigated by Number of Workdays From Incident Receipt, 2011–2015

Number of Days from Receipt of Incident to Onsite Investigation	2011	2012	2013	2014	2015
10 days or less	8,163	9,732	10,281	10,732	12,337
11-15 days	538	663	537	433	522
16-20 days	284	375	306	190	233
21-25 days	205	265	181	137	184
26+ days	1,121	1,260	1,117	834	1,028
Not Investigated	17	1	1	4	19
Total Investigated	10,311	12,295	12,422	12,326	14,304

Source: OIG analysis of ACTS data, 2017.

Exhibit E-6: Average Percentage of the Most Serious Nursing Home Incidents That States Substantiated, 2011–2015



Source: OIG analysis of ACTS data, 2017.

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To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

ENDNOTES

[1] Section 1819(g)(4)(A) of the Social Security Act
[2] OIG, *Nursing Home Complaint Investigations*, OEI-01-04-00340, July 2006.
[3] GAO, *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations*, GAO-11-280, April 2011.
[4] *State Operations Manual*, Pub. No. 100-07, ch. 5, "Complaint Procedures."
[5] *State Operations Manual*, Pub. No. 100-07, ch. 8, "Standards and Certification."
[6] States did not investigate some of the most serious nursing home complaints and therefore did not make a determination regarding substantiation in those complaints.
[7] Sections 1819(g)(1)(A) and 1819(g)(2)(A)(iii) of the Social Security Act.
[8] Sections 1819(g)(1)-(2) of the Social Security Act.
[9] *State Operations Manual*, Pub. No. 100-07, ch. 7, "Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities."
[10] CMS's Fiscal Year 2016 State Performance Standards System Guidance (CMS internal guidance sent to State survey agencies each year and provided to OIG for the purposes of this report).
[11] *Ibid.*