Department of Health

Nursing Home Resident Abuse and Complaint Investigation Report

January 1, 2024 – December 31, 2024

Table of Contents

INTRODUCTION

The New York State Department of Health ("Department") protects and promotes the health of all New Yorkers through prevention, science, and the assurance of quality health care delivery. Assuring high quality care and quality of life for all nursing home residents in New York State is an agency priority. Whether they are the elderly, young adults or children, nursing home residents are among the most vulnerable to abuse, mistreatment, or neglect. They are often less able to defend themselves against harm.

To protect the health and safety of these residents, the Department aggressively and thoroughly investigates allegations of abuse, mistreatment or neglect and other negligent practices within our state's nursing homes and takes appropriate action when these allegations are sustained by evidence.

The Patient Abuse Reporting Law, Public Health Law Section 2803-d, was enacted in 1977 to protect persons living in nursing homes from abuse, mistreatment, or neglect. The law requires every nursing home employee -- including administrators and operators -- and all licensed professionals, whether or not employed by the nursing home, to report instances of alleged abuse, mistreatment, or neglect to the Department. The statute requires the Department to investigate all such allegations and provides sanctions against individuals who are found guilty of these acts and against anyone required to report but fails to do so.

Public Health Law Section 2803-d also requires the Department to issue an annual report on incidents of abuse, mistreatment, and neglect of persons receiving care in residential health care facilities. This report provides statistics and information about the Department's investigation of allegations of abuse, mistreatment, or neglect from January 1, 2020 to December 31, 2024. The Department remains committed to aggressively investigating all allegations of nursing home residents being harmed or in danger of harm.

EXECUTIVE SUMMARY

In calendar year 2024, the Department surveyed 545 nursing homes, received 14,726 complaints and incidents and closed 17,513 complaints and incidents. Of the 14,726 complaints received in 2024, a total of 3,947 (27%) involved allegations of resident abuse, mistreatment, or neglect.

Of the 17,513 complaints and incidents closed in 2024, 1,237 required no action, and of the remaining 16,276 cases closed, 5,127 (32%) involved allegations of resident abuse, mistreatment, or neglect. The Department substantiated 129 (2.5%) of the closed cases which involved allegations of resident abuse, mistreatment, or neglect. Not all the cases closed in 2024 were received in 2024.

NEW YORK STATE NURSING HOME SURVEILLANCE PROGRAM

The Department is responsible for inspecting and investigating complaints against health care providers licensed under Article 28 of the Public Health Law. As the designated Single State Survey Agency for New York, the Department conducts inspections (or "surveys") and investigates complaints on behalf of the Federal Centers for Medicare and Medicaid Services to

ensure provider compliance with Federal regulations. Through its surveys and investigations, the Department also ensures compliance with New York State regulatory requirements.

The Department's Nursing Home Surveillance Program, within the Office of Aging and Long-Term Care, Center for Residential Surveillance, has surveillance responsibilities for long-term care facilities throughout New York State. The Nursing Home Surveillance Program conducts complaint investigations through the Central Office in Albany and four Regional Offices:

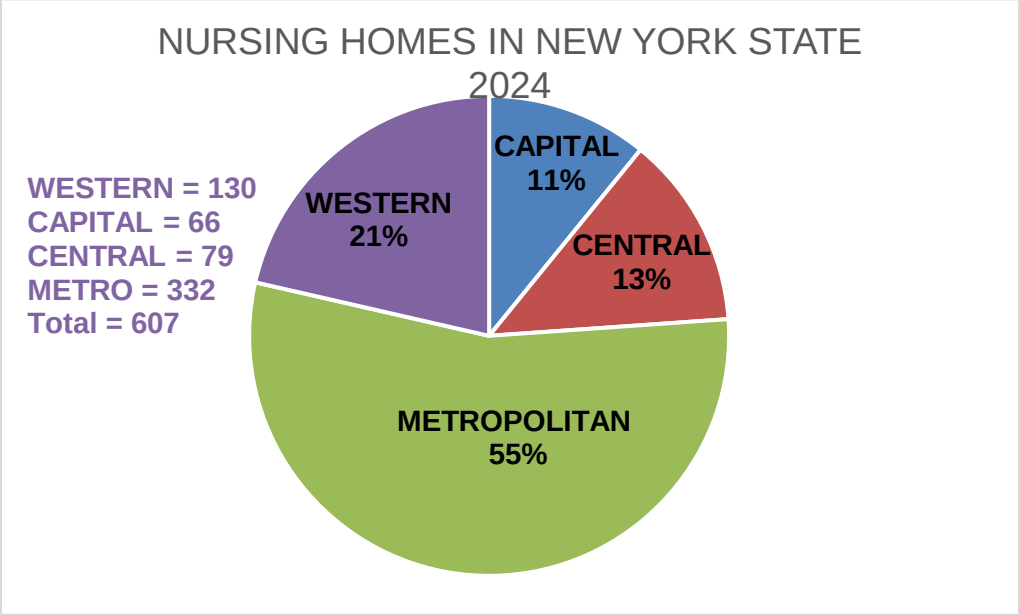
- Capital District Regional Office in Albany;
- Central New York Regional Office in Syracuse;
- Metropolitan Area Regional Office with offices in New York City, New Rochelle, and Central Islip; and
- Western Regional Office with offices in Buffalo and Rochester.

Each Regional Office is responsible for nursing home surveillance activities in specific counties (See Figure 1). In calendar year 2024, the Department surveyed 545 nursing homes (See Figure 2), conducted 10,761 onsite investigations and 6,752 offsite investigations. Through their ongoing contact with providers, Regional Office investigators acquire in-depth knowledge of the local long-term care system and the operations of its nursing homes and can quickly respond to reports of nursing home deficient practices in their geographic area.

Figure 1 – Regional Office Counties Served

REGIONAL OFFICE	COUNTIES SERVED
Capital District	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
Central New York	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins
Metropolitan Area	Bronx, Kings, New York, Queens, Richmond, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester, Nassau, Suffolk
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates

Figure 2 – Nursing Homes by Regional Office



THE COMPLAINT INVESTIGATION PROCESS

When the Department receives an allegation of an actual or potential adverse resident outcome, the submission is categorized by Nursing Home Complaint Intake staff as an allegation of abuse, mistreatment, or neglect against an individual, or as a general complaint against the provider that alleges a violation of Federal or State regulation. The allegation is opened as an investigation or "case." A case may include more than one allegation. The case is then investigated by the appropriate Regional Office to determine whether the allegation occurred and if Public Health Law Section 2803-d and/or Federal or State regulation has been violated. Each complaint is assigned to the Regional Office or Central Office for investigation and a projected completion date is established during a federally established triage process, which determines the immediacy of the case. The assignment of a completion date and the determination that an onsite investigation is required are based on the seriousness of the complaint, evaluation of safety measures in place, current level of risk to all residents in the home and existing survey schedule. Abuse complaints fall into two categories:

1. Those that allege a violation of Public Health Law Section 2803-d related to resident abuse, mistreatment, or neglect that were required to be reported and
2. Those that allege a violation by the provider of Federal or State regulation that may constitute abuse or neglect.

Complaints that are outside the Department's jurisdiction are promptly referred to the appropriate Federal or State agency.

Between January 1, 2024, and December 31, 2024, the Department closed 17,513 complaint cases, approximately 14% higher than in calendar year 2023. Of the cases closed in 2024, 16,256 (93%) were related to allegations of violations of Federal or State regulation by the provider, and 1,257 (7%) were allegations of resident abuse, mistreatment, or neglect by an

individual. In each case, the Department commenced its standard investigation, which thoroughly reviews the facts surrounding each allegation.

Third-party reported complaints are those from residents, family, friends, etc. via standard mail or fax (5%), by calling the Department's toll-free Nursing Home Complaint Hotline (46%), or by submitting an online Nursing Home Complaint Form (49%).

Of all the cases received in 2024, about 60% are incidents self-reported by nursing homes through an online Incident Reporting Form. Public Health Law Section 2803-d requires designated persons in nursing homes to report any instance in which the facility has determined there is reasonable cause to suspect that a resident has suffered abuse, mistreatment, or neglect. All provider incidents received within the Department's jurisdiction and authority are investigated.

Public Health Law Section 2803-d Complaints of Abuse, Mistreatment, or Neglect

Public Health Law Section 2803-d governs the reporting of suspected abuse, mistreatment, or neglect of a nursing home resident. It identifies mandated reporters, establishes the process that the Department must follow in investigating complaints, and identifies potential penalties the Department may impose. The Department investigates every allegation of abuse, mistreatment, or neglect that it receives. The purpose of an investigation subject to Public Health Law Section 2803-d is to determine if the allegation is true, and if so, who is responsible. Department investigators also examine whether any systemic, regulatorily non-compliant issues exist within the nursing home by conducting a concurrent Federal investigation, as defined in the next section of this report.

The Public Health Law Section 2803-d investigation conducted by Regional Office investigators includes observation of care and services provided in the facility, review of records and interviews (when possible) with all individuals potentially related to the case, including the resident, regarding the circumstances associated with the allegation. After completion of the investigation, the Regional Office issues a recommendation for the disposition of the case.

All completed Public Health Law Section 2803-d investigations are reviewed by a Commissioner of Health's designee in each Regional Office. Complaints are closed with one of the following three outcomes:

1. **Resident Rights Violation:** There is sufficient evidence that a violation of Public Health Law Section 2803-d occurred, and individual culpability is established. Fines are assessed.

2. **Substantiated Abuse, Mistreatment or Neglect Violation:** There is sufficient evidence that the incident or event of abuse occurred, that it constitutes a violation of the regulation and individual culpability is established. Fines are assessed.

3. **Unsubstantiated Abuse, Mistreatment or Neglect Violation:** There is insufficient evidence that the event or incident occurred, or there is insufficient evidence that the incident or event of abuse constitutes a violation of the Public Health Law Section 2803-d. No fines are assessed.

In all cases where it is determined that there is evidence that an abuse violation exists, each accused individual and the facility administrator are concurrently notified of the violation and their individual due process rights via letter from the Department's Division of Legal Affairs. A request for an administrative hearing may be made in writing within 30 days of receipt of the Department's letter. All hearings are scheduled and conducted by the Division of Legal Affairs. The purpose of the hearing is to determine whether the record should be amended or sealed on the grounds that the record is inaccurate, or the evidence does not support the determination. The hearing can determine whether a fine is warranted.

Once all due process requirements have been satisfied, the accused individual and complainant are advised in writing of the final outcome of the case and if the determination will include a civil fine and be referred to a licensure board or Certified Nurse Aide registrar for further action.

In cases where there is insufficient evidence that an abuse violation exists, the accused individual and the complainant are notified that the complaint is unsustained. All records related to the report are expunged in accordance with the statute.

Complaints about the Provider

Federal and State regulations require nursing homes to establish policies and procedures to ensure that each resident attains and maintains their highest practicable level of physical, mental, and psychosocial well-being. When these policies and procedures are not followed and a breakdown occurs in the system, residents can be affected. In many cases, negative outcomes do occur.

General provider complaints are defined as alleged incidents or events that result from breakdowns of the policies and procedures instituted by the provider for the provision of care, services, treatments, medications, food, physical plant, and maintenance. Unlike patient abuse allegations under Public Health Law Section 2803-d, where the ultimate culpability rests with an individual(s) in an isolated situation or incident, the ultimate culpability in general provider complaints, including abuse or neglect, rests with the nursing home operator.

When a complaint alleges resident harm, Federal guidelines require an unannounced onsite investigation at the nursing home. The Department's Regional Office investigators are responsible for conducting onsite investigations for this type of complaint. All investigations focus on the regulatory areas which are related to the allegations. An alleged deficient practice is examined against the nursing home regulatory requirements to determine whether a regulatory violation has occurred. If the Department investigation determines that a regulatory violation has occurred, a Statement of Deficiencies is issued to the nursing home describing the violation and requiring that a Plan of Correction be developed and implemented by the nursing home.

The Plan of Correction submitted for Department approval must address the identified issues and preventive or proactive measures that will detect and monitor ongoing practices in the nursing home to minimize reoccurrence. Progressive sanctions such as required staff training, directed corrective action plans, financial penalties, and limitations on resident admissions are also imposed as warranted by individual circumstances.

Complaints against providers are closed, per Federal guidelines, with one of the following two outcomes:

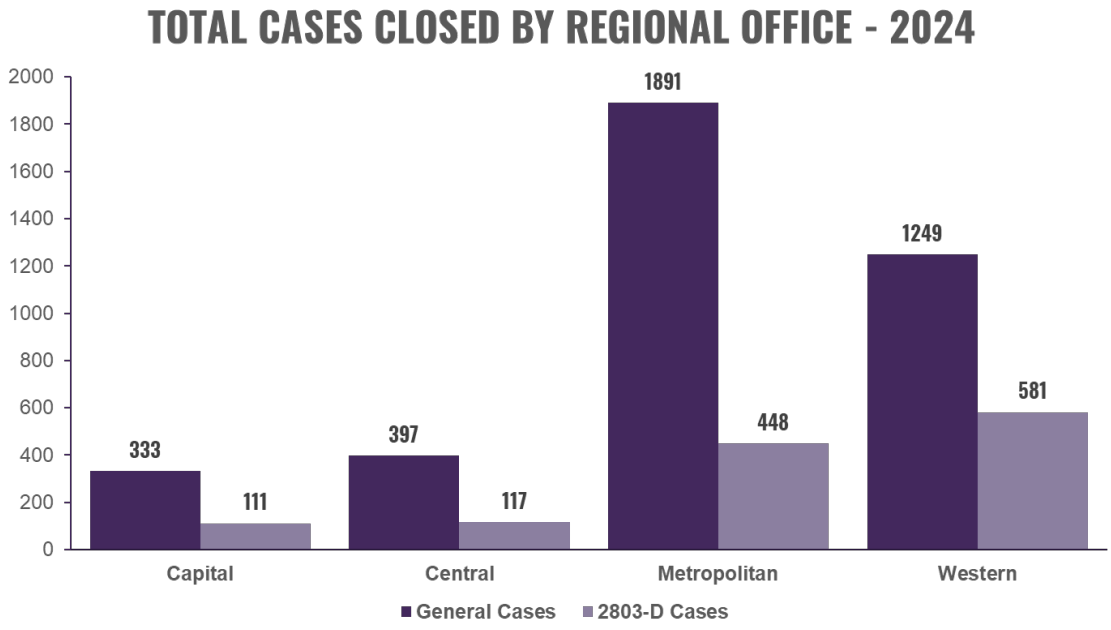
1. **Substantiated:** Deficient practices identified during a survey are operational violations of Federal and/or State regulations, and a Statement of Deficiency is issued to the provider as a result of the complaint.

2. **Unsubstantiated:** Based on interviews, documents and record review, the care provided by the facility was found to be appropriate and timely and all relevant facility policies and procedures were compliant with State and Federal requirements. As such, it was determined that there was insufficient credible evidence to sustain the allegations contained in the complaint.

Cases Closed by the Department

Between January 1, 2024 and December 31, 2024, the Department closed 17,513 cases. Of these cases, 3,870 (22%) were related to general allegations of abuse, mistreatment or neglect and 1,257 (7%) were related to allegations of violations of Public Health Law Section 2803-d. The distribution of abuse cases received by Regional Office is displayed in Figure 3.

Figure 3 – Total Cases Closed by Regional Office 2024



Regional Office investigators commence investigations immediately upon receipt of allegations of abuse, mistreatment or neglect of residents, and the agency takes swift and aggressive action against those who are found to have committed such acts. Any case reported to the Department that alleges abuse, mistreatment or neglect is referred to the Regional Attorney General's Office. An average of 907 PHL Section 2803-d cases were investigated annually by the Department over the last five years (See Figure 4).

Figure 4 – Total Cases Closed by Year 2020-2024

Year	Total Cases Closed	General Cases	2803-d Cases	% of 2803-d Cases
2020	13,465	12,721	744	6%
2021	12,844	12,154	690	5%
2022	13,862	12,985	692	5%
2023	16,252	15,491	1154	7%
2024	17,513	16,256	1257	7%

The Elder Justice Act requires reporting of any reasonable suspicion of a crime under Section 1150B of the Social Security Act, as established by the Patient Protection and Affordable Care Act, Section 6703(b)(3). This requires certain individuals in long-term care facilities to report a reasonable suspicion of a crime committed against a resident. Those reports must be submitted to one law enforcement agency of jurisdiction, as well as the Department. Individuals who are required to report include the owner, operator, employee, manager, agent, or contractor. The New York Attorney General's Office, Medicaid Fraud Control Unit, which has jurisdiction to investigate and prosecute instances of abuse, mistreatment, neglect, and misappropriation of resident funds, qualifies as a local law enforcement agency for these purposes. A serious bodily injury must be reported within two hours, whereas all other reports must be made within 24 hours. Individuals and nursing homes that fail to report may have a Civil Money Penalty imposed. Nursing homes must notify covered individuals annually of their need to report and may not retaliate against an employee for reporting.

Public Health Law Section 2803-d Cases Closed by the Department

The Department closed 17,513 cases during calendar year 2024. Of those, 6,751 cases were closed through an offsite review or investigation as they neither alleged abuse, mistreatment, or neglect, nor contained a violation of Federal or State regulations. Of the remaining 10,761 closed complaint cases, 5,127 cases were related to allegations of abuse, mistreatment, or neglect. Regional Office investigators closed 1,257 cases in calendar year 2024 that include alleged violations of Public Health Law Section 2803-d. The Department sustained 1.4% of the cases against an individual in violation of Public Health Law Section 2803-d, which involved abuse against a resident, or a responsible individual not reporting an incident of abuse. The reason for the low percentage of substantiated cases is likely due to the high turnover of nursing home staff which makes it difficult to locate alleged perpetrators and witnesses of alleged incidents as needed to substantiate the allegations. Figures 5 and 6 present information about the final disposition of cases by region related to alleged violations of Public Health Law Section 2803-d.

Figure 5 – Total 2803-d Cases Closed by Regional Office 2024

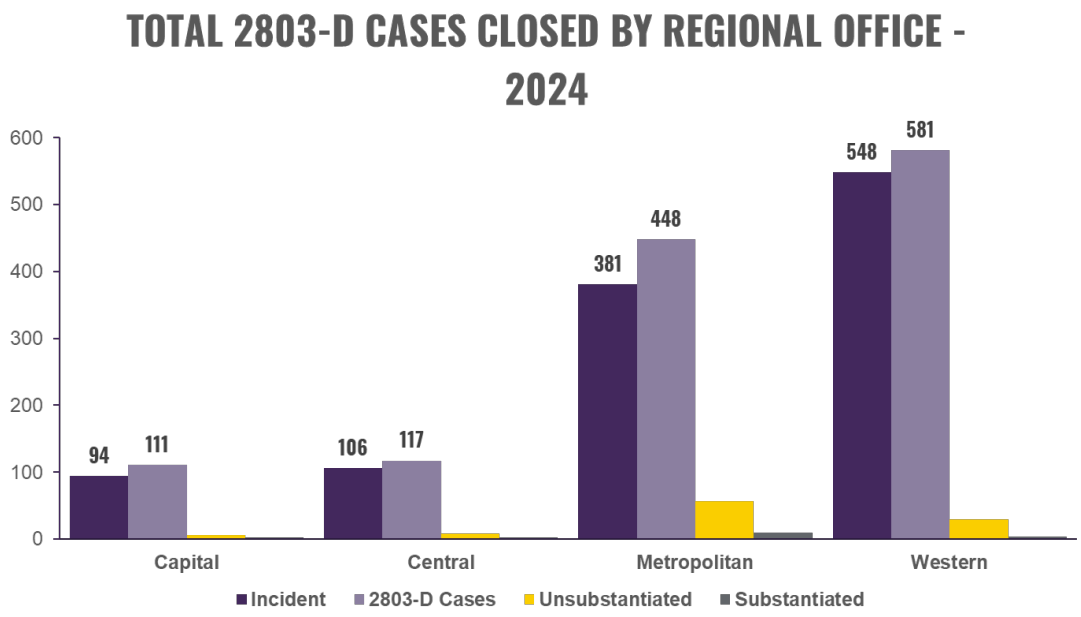


Figure 6 – Total 2803-d Cases Closed by Year 2020-2024

Year	2803-d Cases Closed	2803-d Cases Substantiated	% Of Cases Substantiated
2020	503	71	14.1%
2021	908	101	11.1%
2022	691	14	2.0%
2023	1154	21	2.0%
2024	1257	17	1.4%

CONCLUSION

The Department is committed to ensuring the health and safety of individuals residing in New York State's nursing homes.

Despite challenges that make sustaining cases difficult due to insufficient evidence caused by staff turnover, lack of witnesses, residents no longer at the facility, and few findings upon interview of staff and review of medical records, the Department continues to ensure that all allegations of resident abuse, neglect, or mistreatment are aggressively and thoroughly investigated and that those who commit abuse, mistreatment, or neglect are held responsible through appropriate penalties.

The Department's efforts will continue. Those who call New York's skilled nursing facilities their homes deserve high quality, appropriate and timely health care, and other services appropriate to their individual needs to maximize their highest practicable level of physical, mental, and psychosocial well-being. They deserve to receive services in a manner that recognizes their dignity and ensures a high quality of life. The Department will continue to seek and implement innovative quality improvement practices that ensure that residents of New York State's nursing homes receive the care and services they deserve.