ARIZONA Auditor General
Making a Positive Difference

Arizona Department of Health Services Performance Audit and Sunset Review—Long-Term Care Complaints and Self-Reports
36-Month Follow-Up Report

The September 2019 Arizona Department of Health Services performance audit and sunset review found that the Department failed to investigate or timely investigate some long-term care facility complaints and self-reports. We made 5 recommendations to the Department in that report. The May 2022 30-month followup found that the Department had not implemented any of the 5 recommendations and identified additional significant complaint-prioritization and investigation failures, including inappropriately closing most High-Priority complaints and self-reports without a required on-site investigation and failing to timely initiate investigations. We made 4 additional recommendations in our 30-month follow-up report. The Department's status in implementing the 9 recommendations is as follows:[1,2]

Status of 9 recommendations

In process	6
Not implemented	**3**

This report continued to analyze Department data to assess its long-term care facility complaint and self-report prioritization and investigation processes.[3] Specifically, we analyzed Department data for complaints and self-reports that were still open as of April 22, 2021, and received on and after that date through October 20, 2022.[4] We also assessed the Department's efforts to implement our recommendations since we issued the 30-month follow-up report in May 2022. Although we found that the Department began to implement 6 of the 9 recommendations after we issued our 30-month followup, we continued to see some problems with its long-term care facility complaint and self-report prioritization and resolution processes that may put long-term care facility residents' health, safety, and welfare at risk.

We will continue to follow up with the Department on the status of the recommendations that have not been fully implemented.

[1] Our September 2019 Arizona Department of Health Services performance audit and sunset review also contained a recommendation for the Legislature to consider forming a task force to study and propose policy options for addressing the Department's timely investigation and processing of long-term care facility complaints and self-reports. During the 2020 regular legislative session, Senate Bill 1199, which included establishing a long-term care facility task force, was introduced but not enacted.

[2] For the implementation status of the 12 other recommendations from our September 2019 Arizona Department of Health Services performance audit and sunset review, see our 30-Month Follow-up Report on Conflict-of-Interest, IT Security, and Other Recommendations.

[3] Our 30-month follow-up report analyzed Department complaint and self-report data from July 1, 2019, through April 21, 2021.

[4] Our work focused on complaints and self-reports the Department had categorized as federal, meaning there were potential violations of federal requirements.

Although Department has started to implement some recommendations, its continued complaint prioritization and resolution issues may put long-term care facility residents' health, safety, and welfare at risk

Department inaccurately classified some complaints and self-reports and continued to prioritize most as lower priority, and through June 2022, inappropriately closed most self-reports without an on-site investigation

The federal Centers for Medicare & Medicaid Services (CMS) views state long-term care facility regulatory agencies, including the Department, as the front-line responders to address concerns, including complaints, raised by long-term care facility residents, their families, and facility staff to help protect vulnerable residents from abuse, neglect, exploitation, or inadequate care.[5,6] Accordingly, CMS' operation manual for states outlines a detailed process for handling complaints and self-reports that includes specific requirements for intake, prioritization, and investigation (see textbox for priority levels requiring an on-site investigation).

Complaint and self-report priority levels that require an on-site investigation[1,2]

Immediate Jeopardy—Alleged noncompliance has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Specifically, adverse outcomes which result in or are likely to result in death, a significant decline in physical, mental or psychosocial functioning, loss of limb or disfigurement, excruciating pain, or life-threatening complications. Department must start its on-site investigation within 2 working days of receipt of the initial report.[3]

High Priority—Alleged noncompliance may have caused harm that negatively impacts a resident's mental, physical, and/or psychosocial status and are of such consequence to the person's well-being that a rapid response is indicated. Usually specific rather than general information, such as names, date/time/location, description of harm, factors into the assignment of this level. Department must start its on-site investigation within 10 working days of establishing this priority.[3]

Medium Priority—Alleged noncompliance may have caused no actual physical and/or psychosocial harm but there is the potential for more than minimal harm to the residents. The Department must start its investigation in 45 calendar days or no later than the next on-site inspection.[3]

1 A self-report is an incident that a long-term care facility must report to the Department, such as incidents that involve potential regulatory violations, including resident injuries of an unknown origin, allegations of resident neglect and/or abuse, and misappropriation of resident property.

2 Federal standards also establish 1 priority (Low) for use when alleged noncompliance may have caused no actual harm. The Department is not required to conduct an on-site investigation but must track and trend allegations for potential followup during its next on-site survey; and 4 other priorities that do not require an on-site investigation, such as when the Department is required to refer the intake to another agency or if the allegations are outside of the Department's regulatory authority.

3 Effective October 2022, CMS changed the investigation initiation time frame for Immediate Jeopardy complaints and self-reports from 2 working days after receipt to 3 working days from receipt of the initial report. In October 2022, CMS also changed the investigation initiation time frame for High Priority complaints and self-reports from 10 days after prioritization to an annual average of 15 working days from receipt of the initial report, not to exceed 18 working days; and for Medium Priority to 45 working days from receipt, but it is allowing states until October 2023 to implement these changes.

Source: Auditor General staff review of CMS' State Operations Manual Chapter 5, and Appendix Q.

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5 Office of Inspector General. (2020). Data brief: States continued to fall short in meeting required timeframes for investigating nursing home complaints, 2016-2018. Washington, DC: U.S. Department of Health and Human Services. Retrieved 5/1/2023 from https://oig.hhs.gov/oei/reports/OEI-01-19-00421.pdf; and U.S. Centers for Medicare & Medicaid Services (CMS). (2023). State Operations Manual, Chapter 5 – Complaint Procedures (Rev.212, 02-10-23). Washington, DC. Retrieved 4/13/2023 from https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c05pdf.pdf.

6 The Department operates as the State agency responsible for ensuring healthcare entities meet all applicable federal health standards for Medicaid participation. This responsibility includes conducting initial certification surveys and complaint investigations.

Department incorrectly used Medium Priority for some Immediate Jeopardy and High-Priority complaints/self-reports—Our review of a sample of 119 complaints and self-reports the Department prioritized as Medium Priority identified 41 complaints/self-reports that contained allegations of abuse, sexual assault, and neglect, and thus could have been prioritized higher than a Medium Priority according to CMS' requirements.[7] For example, 1 complaint had allegations of neglect, and another complaint had an allegation of sexual assault, both of which could have negatively impacted the residents' mental, physical, and/or psychosocial status.[8]

We provided the Department these 41 complaints and self-reports for review and according to the Department, it should have given 16 of the 41 complaints and self-reports a higher priority level (see Figure 1, page 4), including 3 complaints the Department received after July 2022 when it indicated it had started making changes to its prioritization process. The Department indicated that it should have prioritized 3 of 16 complaints as Immediate Jeopardy, which would have required it to initiate an on-site investigation within 2 working days of receipt. Instead, it initiated an on-site investigation between 116 and 283 working days for these 3 Immediate Jeopardy complaints/self-reports. The Department had completed its investigations of all 3 by November 2022 but did not substantiate any of them due to lack of sufficient evidence. For example:

> In July 2021, the Department received a complaint about a long-term care resident, who was wheelchair bound and required 24-hour care, and who was left outside in the heat for an unknown amount of time. According to the complaint record the resident was later found on the pavement, face down, with a cracked skull, and there was blood everywhere. Upon receipt of the complaint, Department staff categorized the allegations as resident/patient/client neglect and assigned the complaint a Medium Priority. The Department did not conduct an on-site investigation until late August 2022, more than a year after it had received the complaint. According to the complaint record, the Department was unable to substantiate the allegations due to a lack of sufficient evidence.

The Department also indicated that it should have prioritized 13 complaints and self-reports as High Priority, which would have required it to initiate an on-site investigation within 10 working days after prioritization. Instead, it initiated an on-site investigation between 18 and 577 working days for these 13 High-Priority complaints. As of March 2023, it had completed its investigation of these complaints and was unable to substantiate 12 of the 13 complaints due to lack of sufficient evidence. For example:

> In October 2021, the Department received a complaint from a former employee of a long-term care facility who indicated that the facility was understaffed, call lights were not answered, wound care was not done, and residents were left wet for long periods. The complainant indicated that when she was cleaning a resident after he had passed away, he had maggots in his wound. Upon receipt of the complaint, Department staff categorized the allegations as quality of care/treatment and resident/patient/client neglect and assigned the complaint a Medium Priority. The Department did not conduct an on-site investigation until August 2022, about 10 months after it had received the complaint. According to the complaint record, the Department was unable to substantiate the allegations due to a lack of sufficient evidence.

The Department indicated that it appropriately prioritized the remaining 25 complaints and self-reports as Medium Priority for various reasons. However, we identified some concerns with the Department's explanations. For example, in 1 case, the complaint record indicated that a facility resident reported he was raped but did not see anyone come into his room. Although the complaint record indicated that the client was assessed medically and there were no

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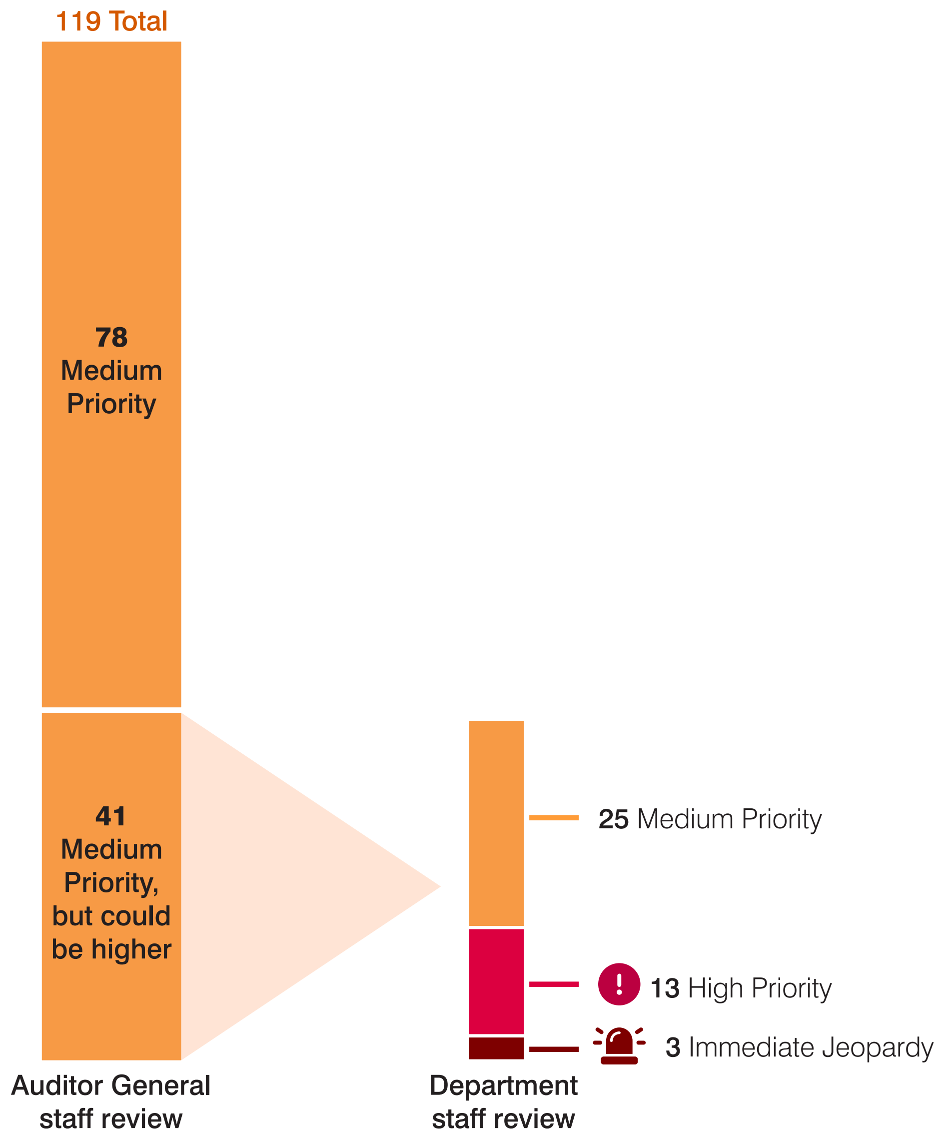
[7] The 119 complaint and self-report files we reviewed comprised 2 separate samples. The first sample consisted of a random sample of 59 of 213 federal complaints and self-reports the Department received prior to July 1, 2022, and investigated in August 2022.The second sample consisted of 60 of 906 federal complaints and self-reports the Department received between August 1, 2022 and October 20, 2022, and prioritized as Medium Priority. Of the 41 complaints and self-reports we identified that could have been prioritized as higher than a Medium Priority, 27 were received before July 1, 2022, and 14 were received after August 1, 2022.

[8] The Department indicated that the complaint with an allegation of sexual abuse was appropriately prioritized as Medium Priority because based on information available, there was no indication of harm that negatively impacted the resident (see page 6, for more information on this complaint). The Department indicated that complaint with the neglect allegation should have been prioritized as High Priority.

signs of trauma, the record also indicated that the resident wanted to go to the hospital to get checked out and did not want to stay at the facility. The Department indicated that the facility self-reported the incident and that the facility responded by acquiring medical attention, investigating, and ensuring the safety of the resident immediately. However, the Department's explanation does not indicate what efforts the facility took to ensure the safety of other residents. Additionally, the Department did not conduct its own on-site investigation until August 2022, approximately 18 months after it had received the complaint, and did not substantiate the complaint due to lack of evidence.

Figure 1
Department determined 16 of 41 complaints and self-reports it prioritized as lower, Medium Priority should have been prioritized as High Priority or Immediate Jeopardy
(Unaudited)



Source: Auditor General staff review of a sample of 119 complaints and self-reports that the Department prioritized as Medium Priority (see footnote 7, page 3, for more information on the sample) from which we identified 41 that could have been prioritized higher given the allegations, and Department review of the 41 complaints and self-reports.

In addition, the Department reported that several complaint records lacked a specific description of harm and/or did not indicate an outcome of harm for the resident. For example, the intake notes for 1 self-report alleging abuse of a long-term care facility resident stated only, "Case manager sent an email stating that [resident] is being abused. No other

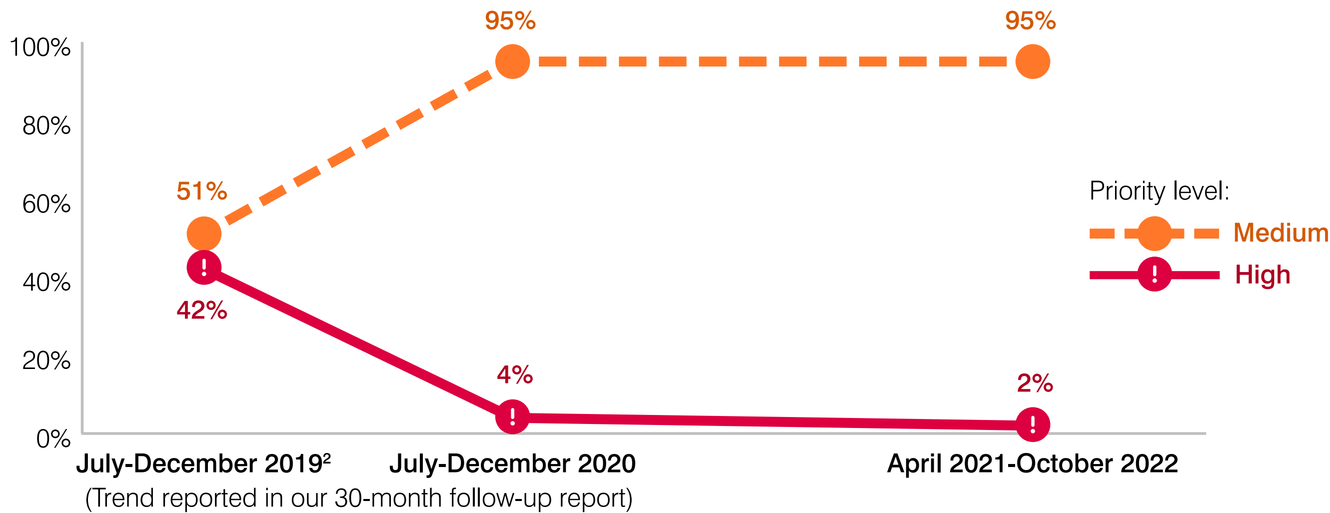
details mentioned." However, CMS requirements indicate that comprehensive information should be collected during the intake process to allow for proper prioritization, and that subsequent communications may be necessary to obtain this information, but the Department did not document that it had attempted to obtain additional information in these instances. According to the Department, since February 2023, it has directed its staff to make every effort to obtain additional information to allow for proper prioritization and if they cannot quickly obtain that information, the Department will err on the side of caution and prioritize the complaint higher than a Medium Priority. In addition, the Department indicated that its staff have begun including notes in the intake record documenting their attempts to obtain additional information.

Department continued to assign much higher percentage of complaints and self-reports as lower, Medium Priority than complaints and self-reports it received in the last half of 2019, substantially reducing the number of complaints Department was required to initiate an investigation on within 10 working days—Similarly to what we reported in our 30-month follow-up report, for the complaints reviewed as part of this 36-month followup, the Department continued to prioritize most long-term care facility complaints and self-reports as a lower, Medium Priority. Specifically, in our 30-month followup we reported that the Department prioritized 95 percent of complaints and self-reports as Medium Priority between July 1, 2020 and December 31, 2020, compared to approximately 51 percent between July 1, 2019 and December 31, 2019, despite no changes in prioritization requirements that would have accounted for the change. Similarly, as illustrated in Figure 2, from April 22, 2021 through October 20, 2022, the Department prioritized 95 percent of its complaints and self-reports as Medium Priority. During this followup, the Department was unable to provide an explanation as to why its staff continued to prioritize most complaints and self-reports as Medium Priority. Additionally, despite the Department indicating that it started making changes to its prioritization process in July 2022, it continued to prioritize 92 percent of its complaints and self-reports as Medium Priority from August through October 2022.

Figure 2

Department continued to prioritize most complaints and self-reports as lower, Medium Priority despite no changes in prioritization requirements at least through October 2022[1]

(Unaudited)



[1] The Department prioritized the remaining 1 to 7 percent of the complaints and self-reports as Immediate Jeopardy, Low Priority, or 1 of the other priorities (see textbox, page 2). Specifically, between July 2019 and December 2019, July 2020 and December 2020, and April 2021 and October 2022, the Department prioritized approximately 1 percent, 0, and less than 1 percent of complaints and self-reports as Immediate Jeopardy, and used the Low Priority or another priority for the remaining percentage of complaints and self-reports.

[2] Our September 2019 Arizona Department of Health Services performance audit and sunset review found that the Department did not timely initiate 15 of the 20 complaints and self-reports we reviewed (see Report 19-112).

Source: Auditor General staff analysis of Department's complaint and self-report data for complaints and self-reports received on or after April 22, 2021 through October 20, 2022; and information from our 30-Month Follow-up Report.

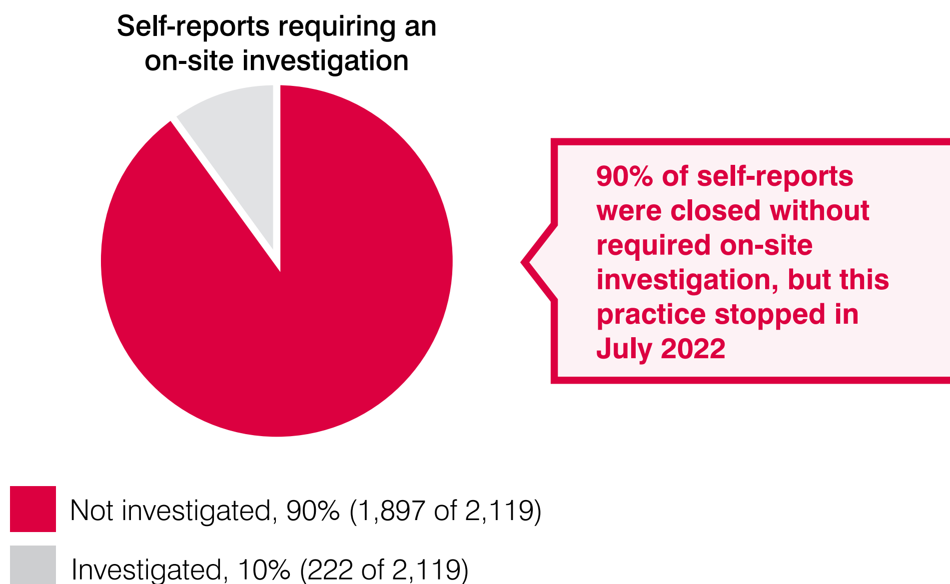
Department inappropriately closed most High- or Medium-Priority self-reports without required on-site investigation, but stopped this practice in July 2022—As reported in our 30-month follow-up report, the Department closed most self-reports without conducting an investigation, and it continued this inappropriate practice through June 2022. Additionally, as indicated in our 30-month report, 91 percent of the self-reports closed were initially assigned a High- or Medium-Priority level, which would have required the Department to conduct an on-site investigation according to CMS requirements. Similarly, as shown in Figure 3, for the 2,119 self-reports it closed between April 22, 2021 and October 20, 2022, that required an on-site investigation, the Department closed 1,897 of them, or 90 percent, without conducting an on-site investigation even though they were initially prioritized as High or Medium Priority. Our review of the Department's data also found that the Department discontinued its practice of closing self-reports prioritized as High or Medium Priority without an on-site investigation as of July 2022. For example:

> In August 2022, the Department received a complaint from another State agency. The complaint record indicated that a resident was sexually assaulted by a peer at the facility. Upon receipt of the complaint, Department staff categorized the allegation as sexual abuse and assigned the complaint a Medium Priority. When we asked the Department to review this complaint in February 2023, it indicated that based on information available, there was no indication of harm that negatively impacted the resident. However, to justify its prioritization as a lower, Medium Priority, the Department cited information about the incident that the facility had previously self-reported to the Department in April 2022 and was 1 of the nearly 1,900 self-reports noted earlier that were closed without the Department conducting an on-site investigation. Specifically, the Department told us the facility self-report described an investigation into pictures of a resident on another resident's phone, and possible inappropriate touching that included law enforcement interviews. The Department further explained that the facility self-report indicated that the resident stated she did not report any incidents and did not want anyone to report anything, and that facility staff were educated to not leave residents alone. The August 2022 complaint was still open as of January 6, 2023.

Figure 3

Department inappropriately closed most self-reports without required on-site investigation through June 2022[1]

(Unaudited)



[1] The self-reports closed without the required on-site investigation were prioritized as High and Medium Priority.

Source: Auditor General staff analysis of Department's self-report data for self-reports closed between April 22, 2021 through October 20, 2022.

4 months later, about half of Department's open Medium-Priority self-reports were overdue for investigation—Approximately 4 months after the Department stopped closing self-reports without an on-site investigation, it had many overdue for an investigation using the 45 working day initiation requirement CMS expects states to implement by October 2023. Specifically, 340 of 638, or 53 percent, of the Department's open, uninvestigated Medium-Priority self-reports were overdue for an on-site investigation.[9]

Department's continued complaint investigation and prioritization failures may put long-term care residents' health, safety, and welfare at risk

As illustrated by the case example below, when the Department fails to prioritize and investigate complaints in accordance with CMS requirements, it fails to meet 2 of CMS' objectives for the long-term care complaint system: 1) protective oversight, which is accomplished by identifying and responding to those complaints/self-reports that appear to pose the greatest risk to residents; and 2) prevention, which is accomplished by investigating complaints/self-reports to determine if a problem exists that could have a negative impact on the healthcare services provided to residents and to prevent the escalation of the problems into more serious situations that would threaten their health, safety, and welfare.

> In March 2022, the Department received a complaint from the father of a long-term care facility resident, who reported that he was notified by facility staff that his son had passed away and was found face down in a pillow on a mattress resting on the floor. According to the complaint record, facility staff did not provide the father with a cause of death and were unable to provide a consistent answer as to why his son's mattress was on the floor. The father stated that his son, who was diagnosed with schizophrenia, was physically healthy and strong and expressed concern that his son may have suffocated in the pillow because facility staff were giving his son tranquilizers to calm him down.
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> Upon receipt of the complaint, Department staff categorized the allegation as neglect, noting that it involved a failure to assess and monitor the resident, and assigned the complaint a Medium-Priority level. The Department did not conduct an on-site investigation until late August 2022, 5 months after receiving the complaint, and indicated that it was unable to substantiate the allegation due to lack of sufficient evidence. However, in February 2023, we asked Department management to review the complaint record and provide an opinion regarding the priority assignment. Based on this review, Department management indicated that the Department should have prioritized the complaint as Immediate Jeopardy, the most severe priority level, which would have required the Department to initiate an on-site investigation within 2 working days of receipt.

Failing to investigate self-reports and incorrectly prioritizing or using lower, Medium Priority for an Immediate Jeopardy or High-Priority complaint can have severe, adverse effects including compromised investigations impacting the Department's ability to substantiate allegations such as neglect, sexual abuse, and factors leading to death where time is of the essence, and failing to take actions necessary to help protect that resident and other residents of the facility.

Although Department has started to implement several prior report and follow-up recommendations, substantial work remains to fully implement them

To better protect the health, safety, and welfare of long-term care residents, the Department still has substantial work to do to implement the recommendations from the 2019 performance audit and sunset review as well as the additional recommendations from the 30-month followup on that report, which include recommendations for the Department to follow CMS requirements and monitor staff to ensure they comply with requirements.

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[9] This calculation is as of October 22, 2022. There were also 3 High-Priority self-reports that were overdue for an on-site investigation.

Status of 2019 performance audit and sunset review recommendations:

1. To help ensure all long-term care facility complaints and self-reports are prioritized, investigated, and resolved in a timely manner, the Department should:

   a. Continue with its efforts to allocate new or reallocate existing staff to prioritize, investigate, and resolve long-term care facility complaints and self-reports on a full-time basis.

   Not implemented—The Department has not allocated new or reallocated existing staff to prioritize, investigate, and resolve long-term care facility complaints and self-reports on a full-time basis despite having multiple staff qualified by CMS to do so. Instead, the Department reported that it plans to assign all compliance officer positions to prioritize, investigate, and resolve complaints and self-reports along with completing other responsibilities. As of April 2023, 29 of its 42 compliance officer positions were filled.[10]

   b. Develop and implement a time frame for completing investigations and closing long-term care facility complaints and self-reports.

   Implementation in process—In April 2023, the Department updated its policy and procedures to specify overall time frames, by priority level, from receipt through the closing of its long-term care facility complaints and self-reports. Prior to April 2023, the Department's policy had referred to these time frames as minimum time frames for reviewing complaints and self-reports. Although these time frames had been documented in Department policy since December 2019, the Department had indicated in previous followups that it was using these time frames to review complaints and self-reports after they were closed but had never provided any evidence it was doing so. We will test whether the revised policy change has been implemented during the next followup.

   c. Regularly update its policies and procedures to reflect changes in its current long-term care facility complaint and self-report investigation and resolution practices and CMS requirements.

   Implementation in process—The Department has updated its policies and procedures to reflect some changes in its long-term care facility complaint and self-report investigation and resolution practices and CMS requirements. For example, it has updated its policies to include changes in its complaint prioritization process and CMS revisions to time frames for initiating complaints and self-reports based on priority level. However, before April 2023, one of its procedures conflicted with CMS requirements and instructed Department staff to assign a lower priority to complaints received from outside agencies. In April 2023, the Department provided us with a revised policy and procedures that eliminated this conflict. During the next followup, we will test whether the revised policy and procedure change has been implemented and whether the Department has continued to update its policies and procedures.

   d. Develop and implement additional bimonthly management reports to monitor whether and how quickly its long-term care facility complaints and self-reports are being prioritized, investigated, and resolved.

   Implementation in process—The Department has developed a daily and weekly complaint prioritization and review meeting tracker and a dashboard that provides a visual summary of the Department's long-term care facility complaint and self-report data. Additionally, the Department has added procedures for how staff should use the tracker and dashboard during its complaint prioritization and review meetings. Although the tracker and/or its dashboard include information on how quickly long-term care facility complaints and self-reports are being prioritized and investigations are being initiated, neither the tracker or the dashboard includes information on how quickly complaints and self-reports are being investigated and resolved. Similarly, the tracker and/or the dashboard do not include information on how many complaints or self-reports are closed without an on-site investigation, which could have been helpful in identifying that Department staff were still closing most self-reports requiring an investigation without one through June 2022. In addition, the Department has not revised its policies and procedures to outline how Department

[10] This includes 9 of the 16 new positions for which it received funding in fiscal year 2022 to assist with its long-term care facility responsibilities. Like its other compliance officer positions, the Department has assigned these 9 positions responsibility for conducting complaint investigations and facility recertification surveys, but none had been assigned to handle complaint prioritization and investigation responsibilities on a full-time basis.

management should use the dashboard or how regularly they should review the dashboard information, which is important for providing governance and oversight of the Department's critical activities. For example, after the Department implemented the dashboard, Department management reported that they were unaware of the large percentage of complaints and self-reports Department staff continued to prioritize as Medium Priority between August and November 2022, despite this information having been available through the dashboard.

e. Ensure that any complaints and self-reports that are investigated during an annual survey or outside of the annual survey are initiated and investigated according to the time frames required by the assigned priority level.

Not implemented—Until the Department fixes the problems with its complaint prioritization process discussed earlier on pages 2 through 5, we are unable to conduct a reliable timeliness analysis because when the Department incorrectly prioritizes complaints and self-reports, the required time frame for initiating the investigation on these complaints/self-reports is also inaccurate (see page 2 for more information on the required investigation time frames for the different complaint/self-report priority levels). Specifically, the Department has continued to prioritize most complaints and self-reports as Medium Priority despite previously having prioritized a much smaller percentage of complaints and self-reports as Medium Priority but has been unable to explain why (see page 5). Additionally, the Department incorrectly prioritized some complaints/self-reports as Medium Priority that should have been prioritized as Immediate Jeopardy and High Priority (see pages 2 through 5), which require an on-site investigation to begin within 2 and 10 working days, respectively. As a result, incorrectly prioritizing complaints to lower, Medium Priority artificially extends the allowable time frame for initiating an investigation, allowing up to 45 days. Therefore, we will assess the status of this recommendation during the next followup.

Status of 30-Month follow-up report recommendations:

2. To better protect the health, safety, and welfare of long-term care residents, the Department should also address the additional deficiencies we identified as a part of this followup. Specifically, the Department should:

a. Use a risk-based approach to review and reassess the 543 complaints originally prioritized as High Priority and closed without an investigation, the 1,078 self-reports originally prioritized as High or Medium Priority and closed as No Action Necessary, and the 130 open complaints originally prioritized as High Priority and changed to Medium or Low Priority and ensure appropriate action is taken on the most serious complaints and self-reports.

Implementation in process—In December 2022, the Department developed and began using a risk-based review process to guide its review of inappropriately closed or reprioritized complaints and self-reports identified in our 30-month follow-up report. The Department's process considers certain factors such as whether the complaint or self-report is associated with a facility that has a high volume of complaints/self-reports or that is overdue for a recertification survey. As of April 2023, the Department's tracking document showed that it had completed an initial review of approximately 32 percent of the complaints and self-reports identified in our 30-month follow-up report, including some complaints and self-reports from all 3 of the problem areas we identified. According to the Department's tracking document, this initial review involves items such as determining the current risk based on the allegations, and whether the resident is still at the facility. However, the Department's tracking document does not include any information about whether it had reopened and/or investigated any of these complaints and self-reports, or the outcome. In addition, there are another 1,897 High- or Medium- Priority self-reports that were closed without an on-site investigation through June 2022 that the Department will also need to incorporate into its risk-based review and assessment process (see page 6).

b. Use a risk-based approach to identify those long-term care facilities that would require additional oversight and then determine the additional actions the Department should take to help bring those facilities into compliance.

Implementation in process—In August and October 2022, the Department identified which long-term care facilities had the most open, uninvestigated complaints and self-reports. Specifically, in August it identified 4 facilities that had between 86 and 195 uninvestigated complaints and self-reports; and in October 2022, it added 4 additional facilities that had between 90 and 118 uninvestigated complaints and self-reports. In April 2023, the Department provided a new 4-step procedure for how it will identify long-term care facilities that require additional oversight. One of the steps includes working with facility administrators to identify ways to help bring those facilities into compliance. We will assess whether the Department has implemented this new process and its effectiveness at bringing those facilities into compliance during the next followup.

c. Stop using undocumented, unofficial, unwritten, or contrary protocols and requirements for processing complaints and self-reports and instead follow CMS requirements.

Not implemented—Although the Department reported that starting in July 2022 it began changing its complaint and self-report prioritization process to follow CMS requirements, as previously discussed, its review of a sample of Medium- Priority complaints and self-reports found that some should have been prioritized as Immediate Jeopardy or High Priority, it continued to prioritize most of its complaints and self-reports as lower, Medium Priority, and closed most self-reports without an on-site investigation through June 2022 (see pages 2 through 6, for more information).

d. Ensure Department long-term care facility staff and management are trained on CMS requirements and monitored to ensure they comply with the requirements.

Implementation in process—The Department held a meeting in July and September 2022 with its long-term care facility staff to inform them of its expectations and priorities, including the importance of complying with CMS requirements. In addition, it provided a tracking document showing the date its staff completed training on CMS' changes to its complaint-handling process that became effective October 2022. In addition, in March 2023, the Department reported that it had contacted CMS to obtain additional training for its staff, and that its first training would focus on processing complaints and self-reports alleging abuse. The Department also provided its policy and procedures for monitoring complaints and documentation from its daily and weekly complaint prioritization and review meetings from July and August 2022 through December 2022. However, as previously discussed, the Department has not yet revised its policies and procedures to explain how Department management should use the dashboard or how regularly they should review the dashboard information, which is important for providing governance and oversight of the Department's critical activities (see explanation for Recommendation 1d.).