ARIZONA Auditor General
Making a Positive Difference

Arizona Department of Health Services

Long-Term Care Complaints and Self-Reports

72-month Followup of Sunset Review Report 19-112

Although the Department was in the process of implementing most recommendations related to its prioritization and oversight processes, our review of the Department's investigation process found that the Department did not conduct and/or document thorough investigations in accordance with CMS requirements, and as a result, we were unable to assess whether it timely initiated, completed, and closed long-term care facility complaints and self-reports

Our 2019 performance audit and sunset review of the Arizona Department of Health Services (Department) found that the Department put long-term care facility residents at risk by failing to investigate or timely investigate some long-term care facility complaints and self-reports. We made **5 recommendations** to the Department to address these issues.

Since 2019, we have conducted 4 reviews that have resulted in the following:

1. In our **30-month followup report**, published in May 2022, we found that the Department had not implemented any of the 5 recommendations, and we identified additional significant complaint-prioritization and investigation failures that continued to put long-term care facility residents' health, safety, and welfare at risk. We made **4 additional recommendations** related to these new issues, including that the Department use a risk-based approach to review and reassess complaints and self-reports that it closed without an investigation or reprioritized to a lower priority, and to identify long-term care facilities that would require additional oversight to be brought into compliance.

2. In our **36-month followup report**, published in May 2023, we found that the Department was in the process of implementing 6 of 9 recommendations and had not implemented the remaining 3 recommendations. Specifically, the Department was in the process of implementing recommendations related to developing and implementing a time frame for completing investigations and closing complaints and self-reports and updating its policies and procedures to reflect current practices and requirements. It also was in the process of conducting the risk-based approach to review and reassess complaints and self-reports that it closed without an investigation or reprioritized to a lower priority and to identify long-term care facilities that would require additional oversight to be brought into compliance.

However, the Department had not allocated new or reallocated existing staff to prioritize, investigate, and resolve complaints and self-reports on a full-time basis and its own review of a sample of complaints and self-reports found that some complaints were inaccurately prioritized lower and that it closed most self-reports without an on-site investigation.

3. In our **48-month followup report**, published in December 2024, we found that the Department was in the process of implementing 7 of the 9 recommendations related to its prioritization process, staff assignments of responsibilities, and its risk-based approach to review and reassess complaints and self-reports that it closed without an investigation or reprioritized to a lower priority and to identify long-term care facilities that would require additional oversight to be brought into compliance. However, we were unable to determine the status of the remaining 2 recommendations related to ensuring complaints and self-reports are initiated and investigated in accordance with time frames and developing and implementing time frames for completing investigations and closing complaints and self-reports because of difficulties accessing unredacted records. In fact, at the time we published the 48-month followup report, the federal Centers of Medicare and Medicaid Services (CMS) had not approved our access to unredacted long-term care facility investigation and resolution records. As such, we and our contractor were unable to assess the Department's investigations process or determine the status of 2 of 9 recommendations that were related to timely initiating, completing, and closing complaints and self-reports. Additionally, our determination that the Department was in the process of implementing the remaining 7 recommendations was limited to information related to the Department's prioritization process.[1] We reported that we would issue a separate report on the Department's long-term care facility investigation and resolution process after we obtained those records. In January 2026, we received approval to access and provide our contractor with the unredacted long-term care facility investigation and resolution records.

4. In this 72-month followup report, our contractor's review of records from a sample of long-term care investigations found that the Department did not conduct and/or document thorough investigations in accordance with CMS requirements and guidance for the 10 sampled investigations. Additionally, because of the Department's failure to conduct and/or document thorough investigations, our contractor could not determine whether the investigations it reviewed should have resulted in enforcement action. Further, although our contractor found that the Department timely initiated 7 of 10 complaint investigations we reviewed based on their priority (see page 4 for more information on complaint priority levels), given the issues we identified with the quality of the investigations conducted, we will continue to assess the Department's implementation of the 2 recommendations related to timely initiating, completing, and closing complaints and self-reports.

The Joint Legislative Audit Committee (JLAC) has directed our Office to conduct the Department's next sunset review, which is due by October 1, 2027. As a result, rather than conducting a separate followup of the outstanding recommendations, we will conduct followup work on the Department's efforts to implement the 9 outstanding recommendations related to long-term care facility

[1] During our December 2024 48-month followup and this subsequent update, we contracted with an experienced healthcare management firm to conduct a portion of the review of the Department's complaint-prioritization and investigation processes. The contractor's staff who conducted this review were certified to have successfully completed the Surveyor Minimum Qualifications Test (SMQT). The SMQT addresses the knowledge, skills, and abilities needed to conduct surveys in long-term care facilities, including prioritizing, investigating, and resolving complaints.

complaints and self-reports during its sunset review, which we initiated in August 2025. Therefore, unless otherwise directed by JLAC, this followup report concludes our separate followup work on these 9 outstanding recommendations from the September 2019 report.[2]

Department did not conduct and/or document thorough long-term care facility investigations, which may put long-term care facility residents' health, safety, and welfare at risk

Long-term care facility investigations help ensure providers are compliant with federal requirements, and states should conduct sufficient investigations to substantiate or refute complaint allegations

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.[3] Accordingly, the CMS operation manual for states outlines a detailed process for handling complaints and self-reports.[4] Additionally, consistent with the CMS State Operations Manual, complaint investigations are not limited to investigating and verifying the specific allegation made in the complaint and self-report, but should also ensure the long-term care facility's overall compliance with federal requirements. States are expected to conduct sufficient investigations to substantiate or refute the allegation(s) to determine whether the identified issue represents an isolated occurrence or broader deficient processes.

Department did not conduct and/or document thorough investigations, putting long-term care facility residents' health, safety, and welfare at risk, and our contractor could not determine whether the investigations should have resulted in enforcement

Our contractor reviewed a stratified random sample of 10 investigation files for complaints and self-reports (complaints), consisting of 8 of 388 complaints classified as Immediate Jeopardy and 2 of 859 complaints classified as High Priority received by the Department between January 1, 2024 and March 31, 2025, and found that the Department lacked documentation in all 10 files to demonstrate that it completed a thorough investigation, putting long-term care facility residents' health, safety, and welfare at risk (see textbox, page 4, for information about complaint priority levels). Additionally, absent a thorough investigation, our contractor could not determine whether the investigations should have resulted in enforcement action against the facilities that were the subject of the complaints.

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2 Our September 2019 Department performance audit and sunset review also included 12 recommendations to the Department related conflict-of-interest, IT security, and other issues. As reported in our 72-month followup in October 2025, the Department had implemented 5 of these recommendations, and we will conduct work to follow up on the Department's efforts to implement the 7 outstanding recommendations during its next sunset review, which is due by October 1, 2027.

3 The Department operates as the State agency responsible for ensuring long-term care facilities meet applicable federal requirements for Medicare and Medicaid participation. This responsibility includes conducting initial certification surveys and complaint investigations in accordance with requirements and guidance outlined in CMS' State Operations Manual.

4 A self-report is an incident that a long-term care facility must report to the Department. Specifically, facilities must report 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.

Complaint and self-report priority levels our contractor reviewed[1]

Immediate Jeopardy—Alleged noncompliance has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Specifically, adverse outcomes that 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 or conditions. For example, this could include allegations of abuse or sexual assault. The Department must start its on-site investigation within 3 working days of receipt of the initial report.

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, and description of harm, factors into the assignment of this level. For example, this could include allegations of a resident found to have low blood pressure and blood sugar that was repeatedly left unattended for a significant period of time. The Department must start its on-site investigation within an annual average of 15 working days, not to exceed 18 working days of receiving the initial report.

[1] Federal standards also establish medium priority for complaints that allege noncompliance that 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 within 45 calendar days of receipt of the initial report for medium-priority complaints. Additionally, federal standards have a low priority 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.

Source: Auditor General staff review of CMS' State Operations Manual Chapter 5 and Appendix Q, and review of Department complaint-intake documentation.

Specifically, the Department:

- **Did not complete all required presurvey activities for all 5 investigations in which our contractor assessed these requirements, which are intended to ensure Department staff are sufficiently prepared to conduct a thorough investigation**

  CMS' State Operations Manual requires state survey agencies to complete presurvey activities designed to help investigators sufficiently plan for and conduct a thorough investigation prior to conducting the on-site visit at the long-term care facility (see textbox, page 5, for examples of required presurvey activities and their importance). However, our contractor was unable to confirm that the Department had completed all required presurvey activities for any of the 5 investigations it assessed for these requirements.[5] For example, none of the 5 investigations had documentation that Department staff reviewed past entity noncompliance, and 3 of the 5 investigations did not have documentation to show that Department staff had contacted or attempted to contact the long-term care facility's ombudsman.

[5] Our contractor conducted a stop-and-go approach when reviewing the 10 investigations. Specifically, after our contractor identified the lack of documentation of any presurvey activities for all 5 investigations, and subsequent discussions with the Department indicated it had followed its standard process during all 5 investigations, we determined our contractor should not review presurvey activities for the next 5 investigations.

Without documentation that Department staff completed these activities, neither our contractor nor Department management have assurance that Department staff completed the steps necessary to conduct a thorough investigation. For example, in 1 investigation our contractor reviewed, the complaint alleged that a long-term care resident—who has mental and physical challenges—was being molested by an unknown individual, and the resident was unable to determine whether it was a staff member or another resident. The Department's investigation file did not include information to support that Department staff completed all required presurvey activities, including not reviewing the entity's past noncompliance, contacting or attempting to contact the complainant to gather additional information, or developing an investigative plan.

Examples of presurvey activities that Department staff should complete prior to preparing for on-site complaint investigations

- Review entity's past noncompliance, including any active enforcement actions, to identify similar past incidents or patterns of past violations.
- Contact or attempt to contact the complainant to gather additional information as needed, unless the complainant was anonymous.
- Contact or attempt to contact the long-term care facility's ombudsman to obtain additional information about the complaint allegations, or to identify potential patterns and/or resident concerns.
- Develop an investigative plan to efficiently guide the on-site investigation and systematically uncover relevant information.

Source: Auditor General staff review of CMS' State Operations Manual Chapter 5 and information provided by our contractor.

Did not complete and/or document a thorough investigation for all 10 investigations our contractor reviewed

When completing an investigation, the Department should follow CMS protocols for conducting observations, interviews, and record reviews, such as interviewing the complainant and the resident who the complaint is about, as well as relevant staff who were working at the time the allegation occurred. However, in all 10 investigations our contractor reviewed, the Department's investigation files lacked key information to demonstrate that the investigator followed CMS protocols, requirements, or guidance for completing a thorough investigation or to support the investigators' determinations that the allegations were not substantiated. For example:

- In 1 investigation, the complaint alleged that a resident was the victim of abuse and was physically restrained when they were not a danger to themselves or others. The Department's investigation file lacked key information to demonstrate that a thorough investigation was completed. Specifically, our contractor found that the facility's medication and treatment record for this resident had inconsistent dates that our contractor determined caused uncertainty about the actual complaint incident date. The Department did not note this discrepancy in the investigation file. The Department's record review documentation was also incomplete, with Department staff

noting only that they "reviewed records" without providing any detail about the records they reviewed and/or what their review found. Additionally, there was no documentation to indicate Department staff completed interviews with the resident, complainant, alleged perpetrator, or other staff who may have had knowledge of the incident and/or the resident's history, as required by CMS guidance. Despite this incomplete information, the Department reported that it did not find evidence to substantiate the complaint's allegations and did not cite any deficiencies against the facility. However, our contractor determined that the investigation file did not have sufficient evidence to support this determination.

Further, as previously discussed, complaint investigations are not limited to investigating the specific allegation made in the complaint, but also to ensure the facility's overall compliance with federal requirements. As such, during the investigation into this complaint allegation, investigator(s) also reviewed records of other residents at the facility and found that a different resident had attempted suicide multiple times, but the facility had failed to update the resident's care plan to address the suicide risk. The investigation also found that the facility did not report the suicide risks to the Department, despite the facility being required to self-report suicide attempts. According to our contractor, based on the information documented in the complaint file, the lack of action by the facility indicated the facility failed to protect this resident, and the Department should have cited the facility for deficiencies for failure to report suspected neglect, but it did not.

- In another investigation, the facility submitted a complaint that a resident alleged they were the victim of sexual assault. Similar to the prior example, the Department's investigation file lacked key information to demonstrate that a thorough investigation was completed. Specifically, our contractor found that, although the file documented an interview with the resident named in the complaint as well as 3 other residents, other interviews with relevant individuals were either not conducted or interviews conducted may not have been with relevant staff. For example, the file indicated that interviews had been conducted with some specific nursing staff but did not indicate whether these staff were working at the time of the alleged incident, and there was no documented interview with the resident's representative.[6] Additionally, the investigation file contained no evidence that Department staff reviewed the resident's records, video surveillance from the incident's date, or the facility's own investigation into the incident. Although the Department indicated it did not find evidence to support that the alleged sexual abuse occurred and did not cite any deficiencies against the facility, our contractor determined that the investigation file did not have sufficient evidence to support this decision.

Without following all CMS requirements for documenting key information to demonstrate that a thorough investigation was completed, long-term care facility residents' health, safety, and welfare are at risk if facilities are operating out of compliance and the investigation does not identify and hold these facilities accountable. Additionally, this may

[6] According to the CMS State Operations Manual, a resident's representative could mean an individual chosen by the resident or authorized by State or federal law to act on behalf of the resident in decision-making, manage financial matters, or receive notifications. It could also be a legal representative or court-appointed guardian or conservator of the resident.

impact the Department's ability to gather and share further evidence to other applicable entities that may also be investigating to hold alleged perpetrators responsible, such as the Arizona Department of Economic Security's Adult Protective Services (APS).[7] Further, neither our contractor nor the Department have assurance that the investigation was thorough and supports the Department's determination of whether to seek enforcement or not. For all 10 investigations our contractor reviewed, the Department did not identify or cite any deficiencies against the facilities. However, because these investigations were missing key details to support thorough and complete investigations, our contractor was unable to determine whether any of the 10 investigations should have actually resulted in cited deficiencies and, thus, enforcement actions to address violations by the facility.

Department is taking steps to address these issues, including developing templates to ensure staff are completing thorough investigations

The Department lacks internal guidance and templates to guide its staff on how to document key investigation activities, which likely contributed to the issues we previously reported on and continued issues our contractor found. As a result, the Department has started taking some steps to address these issues to ensure its staff complete thorough investigations and adequately document their work, including developing new templates and procedures for Department staff to complete and document investigations.

Specifically:

- In June 2026, the Department developed a template checklist that requires Department staff to complete and document all presurvey activities that are completed prior to an investigation.

- In August 2026, the Department developed a template and procedures that require Department staff to gather and document information to summarize and document the complaint investigation, including the investigation activities conducted, observations and information gathered, and recommendations for further action, such as citations to be cited.

Additionally, in October 2026, the Department reported that after our contractor completed its work, it implemented an audit process to review a random sample of investigations to assess documentation and provide feedback to Department staff.

As previously discussed, we will initiate work in early 2027 as part of the Department's sunset review to assess the Department's long-term care facility complaint and self-report prioritization, investigation, and enforcement processes and its efforts in implementing the 9 outstanding recommendations from our 2019 followup and subsequent followups.

[7] Four of the 10 investigations our contractor reviewed were from complaints referred to the Department from APS.