LINDSEY A. PERRY
AUDITOR GENERAL

ARIZONA
AUDITOR GENERAL

MELANIE M. CHESNEY
DEPUTY AUDITOR GENERAL

May 23, 2022

Members of the Arizona Legislature

The Honorable Doug Ducey, Governor

Mr. Don Herrington, Interim Director
Arizona Department of Health Services

We have issued a 30-month follow-up report on the Arizona Department of Health Services—Performance Audit and Sunset Review regarding the implementation status of the 5 recommendations related to long-term care facility (i.e., nursing home) complaints and self-reports from our September 2019 report (see Report 19-112). To operate in Arizona, nursing homes must be licensed by the State, and almost all are also federally certified. The Department is responsible for ensuring these long-term care facilities meet both State licensing and federal certification requirements, and for investigating complaints and self-reports involving these facilities.

To determine whether the Department made improvements meeting its long-term care facility and self-report investigative responsibilities, we reviewed Department complaint and self-report data for July 1, 2019 through April 21, 2021. As described in the transmitted follow-up report, we found that the Department has not implemented any of the 5 recommendations from our September 2019 report, and we identified additional significant complaint-prioritization and investigation failures that have continued to put long-term care facility residents' health, safety, and welfare at risk. For example:

- Contrary to federal requirements, the Department inappropriately closed most High-Priority complaints/self-reports without a required on-site investigation, including complaints involving allegations such as lack of pressure sore precautions, residents being left soiled for an extended time, and abuse or neglect.

- Of the 156 High-Priority complaints the Department investigated, it failed to initiate the on-site investigations for 73 percent of these within the required 10 working days. As discussed in our follow-up report, failing to timely investigate High-Priority complaints can have severe, adverse effects including compromised investigations impacting the Department's ability to substantiate allegations such as sexual abuse where time is of the essence and failing to take actions necessary to help protect that resident and other residents of the facility.

- The Department inappropriately changed 98 percent of its open High-Priority complaints to lower priorities, which artificially extended the time frame for responding to these complaints/self-reports from 10 days to 1 year.

A lack of staff or the COVID-19 pandemic do not explain the problems we identified in this follow-up report. Although the Department indicated in its response to our September 2019 report that it needed significantly more staff to timely investigate all long-term care facility complaints and self-reports and that adequate staffing is still a problem and may be a cause for the untimely investigations, it does not explain why the Department simply closed High-Priority complaints/self-reports, including those with abuse and neglect allegations, without an on-site investigation. It also does not justify changing High-Priority complaints/self-reports to lower priorities that do not need to be investigated as urgently. While we understand that the State's COVID-19 pandemic response has required significant Department time and resources and the Department experienced executive and licensing management changes during this time period, neither mitigate its failure to appropriately prioritize and investigate complaints/self-reports alleging abuse or neglect of long-term care facility residents.

Our Office will continue to follow up with the Department and report to you on its efforts to implement the recommendations from our 2019 report and the recommendations we have made to address the additional deficiencies identified in this followup.

Sincerely,

Lindsey A. Perry

Lindsey A. Perry, CPA, CFE
Auditor General

ARIZONA Auditor General
Making a Positive Difference

Arizona Department of Health Services Long-Term Care Complaints and Self-Reports 30-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. The Department has implemented 0 of the 5 recommendations.[1,2] Specifically, the Department's status in implementing each of the 5 recommendations is in the table below, followed by our test work results and concerns regarding the Department's continued failure to prioritize and investigate long-term care facility complaints and self-reports as required, which places residents' health, safety, and welfare at risk.

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** *See section—Department not implementing 2019 audit recommendations, pages 11 through 13*
b. Develop and implement a time frame for completing investigations and closing long-term care facility complaints and self-reports.	**Not implemented** *See section—Department not implementing 2019 audit recommendations, pages 11 through 13*
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.	**Not implemented** *See section—Department not implementing 2019 audit recommendations, pages 11 through 13*
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.	**Not implemented** *See section—Department not implementing 2019 audit recommendations, pages 11 through 13*
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** *See section—Contrary to CMS requirements, Department continued to fail to investigate, pages 2 through 9*

We will conduct another followup with the Department on the status of all 5 recommendations that have not yet been implemented.

---

[1] There was 1 legislative recommendation in this report: 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, related to 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, we will issue a separate 30-Month Follow-up Report on Conflict-of-Interest, Information Technology Security, and Other Recommendations.

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

In January 2020, the Department received a complaint from the wife of a long-term care facility resident, who reported that her husband had developed unexplained bruising on his bicep. Additionally, she reported that her husband had not been receiving physician-ordered respiratory treatments and had developed a pressure sore on his tailbone due to being left soiled for extended periods of time. According to the complaint record, the resident was assessed with severe cognitive impairment, which would have limited his ability to complain to facility staff about substandard care or report instances of physical abuse or injuries sustained due to unreported accidents.

Upon receipt of the complaint, the Department listed 7 separate allegations including abuse and quality-of-care deficiencies, such as failure to provide pressure sore care, and assigned the complaint a High-Priority level. Although this priority assignment required the Department to initiate an on-site investigation within 10 working days, the Department did not act on this complaint until April 2021, over a year later, when it downgraded the complaint to a Medium-Priority level. Approximately 2 weeks later, the Department closed the complaint without investigating any of the allegations.

This complaint is one of many long-term care facility complaints and self-reports we found during our follow-up review that the Department failed to prioritize and investigate according to federal Centers for Medicare and Medicaid Services (CMS) requirements, which placed residents' health, safety, and welfare at risk.[3] See textbox on page 3 for the Department's complaint and self-report priority levels.

Contrary to CMS requirements, Department continued to fail to investigate many High-Priority long-term care complaints and self-reports at all or on time before closing them, including quality-of-care complaints, and inappropriately changed open High-Priority complaints to lower priorities

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.[4,5] In addition, CMS' operations manual for states provides 3 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; 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; and 3) to promote efficiency and quality within the healthcare delivery system, which is accomplished by forwarding complaints/self-reports not

---

[3] 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.

[4] 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 2/2/2022 from https://oig.hhs.gov/oei/reports/OEI-01-19-00421.pdf; and U.S. Centers for Medicare & Medicaid Services (CMS). (2019). *State Operations Manual, Chapter 5 – Complaint Procedures (Rev.191, 07-19-19)*. Washington, DC. Retrieved 11/2/2021 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manual/Downloads/som107c05pdf.pdf.

[5] 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, recertification surveys, and complaint investigations.

directly related to federal requirements to the appropriate agency for follow up and investigation.[6] Accordingly, CMS' operations manual for states outlines a detailed process for handling complaints and self-reports that includes specific requirements for intake, prioritization, and investigation.

Complaint and self-report priority levels[1]

Immediate Jeopardy—An immediate and serious threat to health and safety that has caused or is likely to cause serious injury, harm, impairment, or death. The Department must start its on-site investigation within 2 working days of receipt.

High Priority—Actual harm that impairs a resident's mental, physical, and/or psychosocial status, or hazards to health and safety that may exist and are likely to cause a significant problem in care and treatment, but that do not rise to the level of an immediate and serious threat. The Department must start its on-site investigation within 10 working days of establishing this priority.

Medium Priority—Harm or potential harm of limited consequence that does not significantly impair the resident's mental, physical, and/or psychosocial status or function. The Department must start its investigation in 45 working days or no later than the next on-site inspection.

Low Priority—A situation that may have caused physical, mental, and/or psychosocial discomfort to a resident but that does not constitute injury or damage. The Department must investigate during next on-site survey.

Offsite Administrative Review—Intakes are assigned this priority if an on-site investigation is not necessary. However, the Department conducts and documents in the provider file an off-site administrative review to determine if further action is necessary.

No Action Necessary—Intakes are assigned this priority if the Department determines with certainty that no further investigation, analysis, or action is necessary. For example, this priority would be used if a previous survey investigated the exact same event and either did not find noncompliance, or noncompliance was previously identified and subsequently corrected.

[1] State and federal standards also establish 2 other priorities the Department uses when required to refer the intake to another agency or entity.

Source: Auditor General staff review of CMS' State Operations Manual Chapter 5 and the Department's Division of Licensing Services' policies and procedures.

Department failed to follow CMS' complaint investigation requirements just like during the 2019 audit—Our review of the Department's complaint and self-report data for July 1, 2019 through April 21, 2021, and a sample of complaint and self-report intake files to assess the Department's implementation of the recommendations from our 2019 performance audit and sunset review found the following regarding investigations of complaints and self-reports:[7]

- **Department inappropriately closed most High-Priority complaints without a required investigation, including those alleging abuse or neglect—**As shown in Figure 1 (see page 4), the Department closed without an investigation 543 of 691 long-term care complaints, or 79 percent, it had assigned a High-Priority level, contrary to CMS requirements and Department policy, which require an on-site investigation to be initiated within 10 working days (see textbox). Further, our review of a sample of 156 High-Priority complaints found that 158 of their 348 total allegations, or 45 percent, were quality-of-care concerns including lack of pressure sore precautions, residents

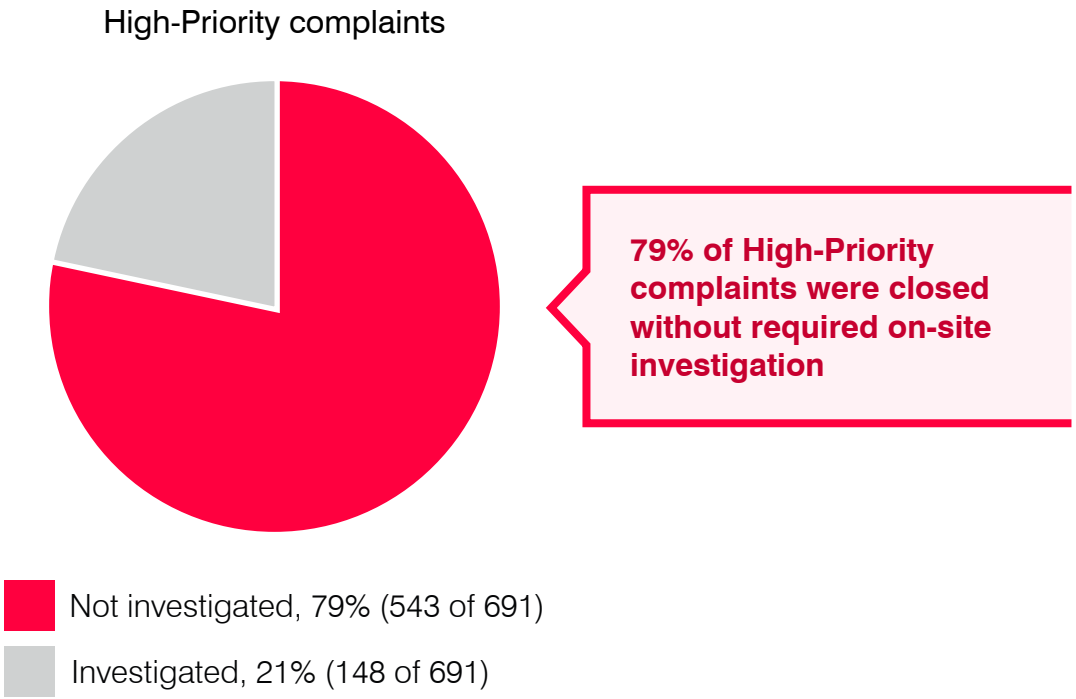
[6] CMS, 2019.

[7] See Methodology section, page 14, for more details on data analyzed and samples.

being left soiled for an extended time, and improper infection control procedures, and an additional 65 of the 348 allegations, or 19 percent, alleged abuse or neglect.[8] For example:

> In July 2019, the Department received a complaint from the daughter of a long-term care facility resident, who reported that her father, who had resided at the facility since April 2019, had been hospitalized in early July 2019 with a pressure ulcer resulting in necrosis of the skin and a bone infection. According to the complaint record, the father did not have pressure ulcers upon admission to the long-term care facility. In the complaint, the daughter noted that her father was nonverbal and would not have been able to complain about pain or other symptoms of the ulcer. Her father was subsequently placed in hospice care due to the pressure ulcer and bone infection he developed while in the facility's care and died at the end of July 2019.
>
> Upon receipt of the complaint, the Department classified it as alleged neglect and assigned it a High-Priority level; thus, the Department was required to conduct an on-site investigation of this complaint within 10 working days (see textbox, page 3). However, instead, and approximately 18 months later, the Department closed the complaint without an investigation and took no further action against the facility related to this complaint.

Figure 1
Department inappropriately closed most High-Priority complaints without required on-site investigation
July 1, 2019 through April 21, 2021
(Unaudited)

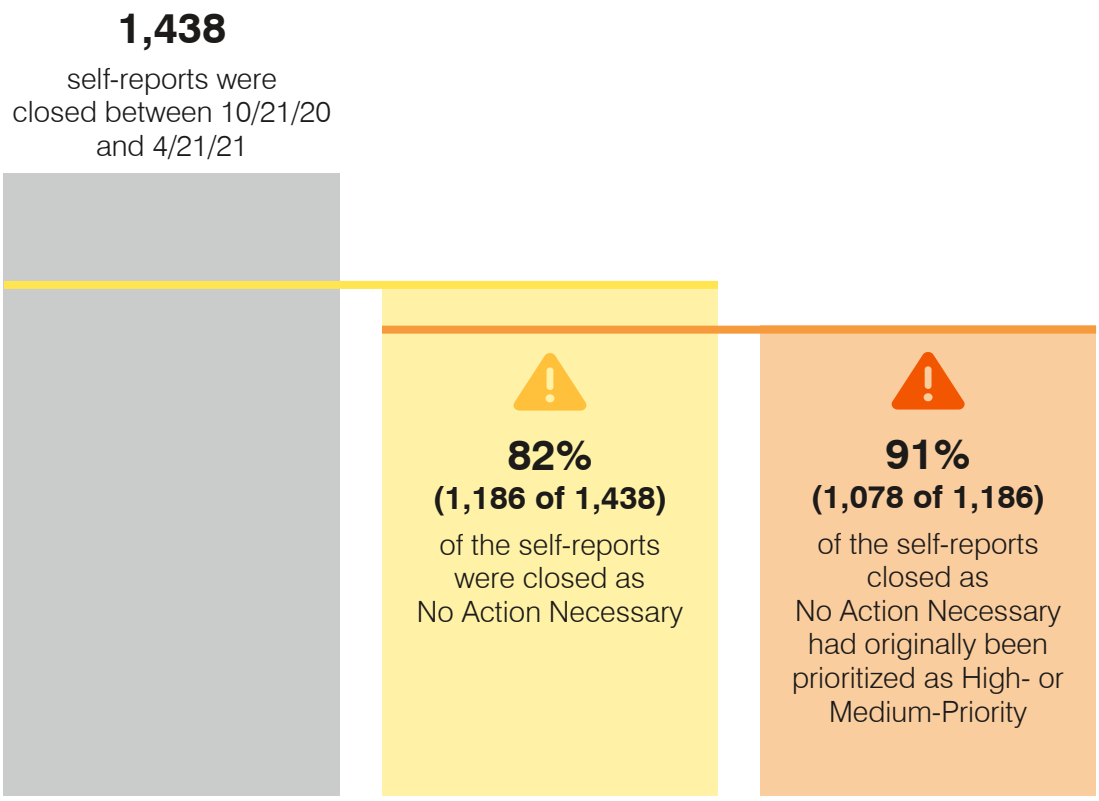


Source: Auditor General staff analysis of Department's data for complaints closed between July 1, 2019 through April 21, 2021, and an audit history report showing prioritization changes the Department made between July 1, 2019 through July 1, 2021.

[8] We analyzed 156 complaint intake files as follows: 45 of 47 intake files that the Department initially prioritized as High Priority but later changed to No Action Necessary—2 of these intake files could not be found at the time we pulled the intake file; and a random sample of 111 of 496 intake files that the Department initially prioritized as High Priority but later changed to an Off-site Administrative Review. This random sample is generalizable to the population of 496 intake files, with 90 percent confidence and a margin of error of 3 percent.

- **Department continued to inappropriately close most self-reports without a required investigation, including those alleging abuse—**In addition, contrary to CMS requirements, the Department has continued to assign or change the priority level of open self-reports to No Action Necessary and close them without an investigation, although we reported on the inappropriateness of this practice in our September 2019 report. Specifically, for the 1,438 self-reports the Department closed between October 21, 2020 and April 21, 2021, it closed 1,186 of them, or 82 percent, as No Action Necessary, which means the Department did not conduct its own investigation as required by CMS. Further, of the 1,186 self-reports it closed as No Action Necessary, it had initially assigned a High-Priority or Medium-Priority level to 1,078 of them, which would have required the Department to initiate an on-site investigation (see Figure 2 and textbox, page 3). Further, our review of a random sample of 19 of these self-reports found that approximately half of them involved allegations of abuse of long-term care residents.[9]

Figure 2
Department inappropriately changed most High- or Medium-Priority self-reports to No Action Necessary and closed them without required on-site investigation
October 21, 2020 through April 21, 2021
(Unaudited)



Source: Auditor General staff analysis of Department's data for self-reports closed between October 1, 2020 through April 21, 2021, and an audit history report showing prioritization changes the Department made between July 1, 2019 through July 1, 2021.

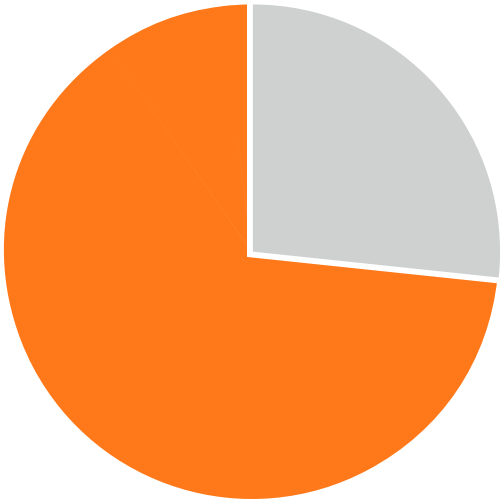
- **Department continued to fail to investigate High-Priority complaints on time, not initiating 73 percent of its High-Priority complaint investigations within the required 10 days—**As we previously reported in 2019, the Department has had a long-standing problem with timely initiating investigations for High-Priority complaints, and this problem continued. Specifically, we found that the Department did not initiate an on-site investigation within

[9] We randomly selected a sample of 19 self-reports for review from a total of 1,186 self-reports that the Department closed under the priority No Action Necessary between October 21, 2021 and April 21, 2021.

10 working days, as required, for 73 percent of the High-Priority complaints it investigated for complaints closed between July 1, 2019 and April 21, 2021 (see Figure 3). The Department initiated these untimely investigations between 11 and 476 working days after it received the complaint.

Figure 3
Department failed to initiate investigations for 73 percent of High-Priority complaints within 10 working days of prioritization as required, with most not being initiated until between 31 or more than 365 working days
July 1, 2019 through April 21, 2021[1]
(Unaudited)

High-Priority complaints by whether or not an investigation was initiated on time



Investigation initiated on time
27% (42 of 156)

Investigation not initiated on time
73% (114 of 156)

High-Priority complaints by number of days before the Department initiated an investigation

1 to 10 working days (on time)
27% (42 of 156)

11 to 30 working days
15% (24 of 156)

31 to 90 working days
27% (42 of 156)

91 to 180 working days
21% (33 of 156)

181 to 365 working days
8% (12 of 156)

More than 365 working days
2% (3 of 156)

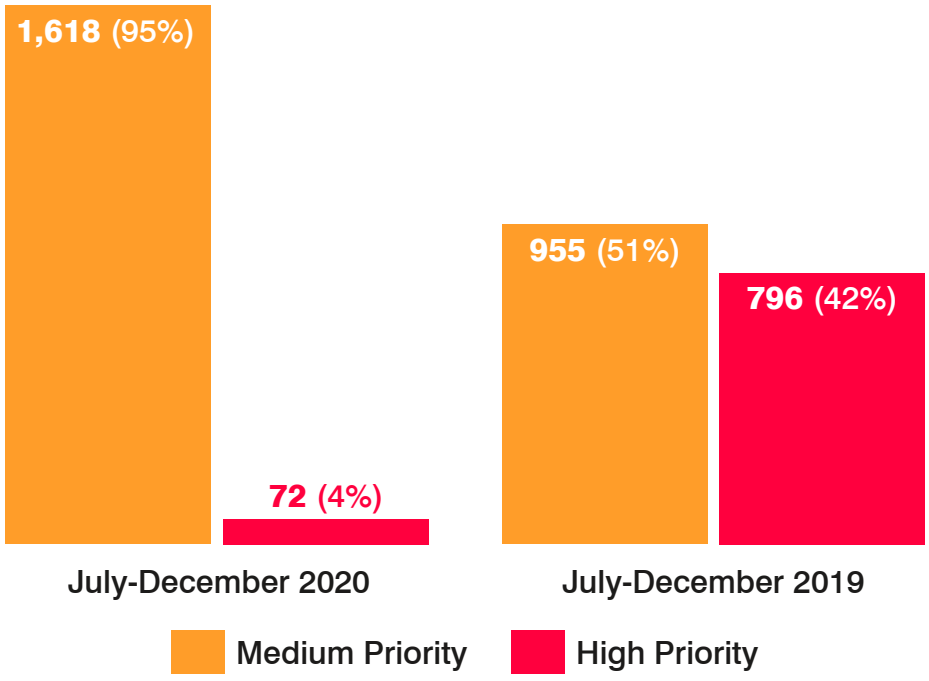
[1] Includes 2 complaints the Department received and prioritized as High Priority between March 4 through April 10, 2020, and later investigated. CMS restricted the Department's focus during this period to Immediate Jeopardy complaints and conducting targeted infection control surveys, so it would not have been able to initiate its investigation on these 2 complaints within 10 days. However, the Department did not initiate its investigation on these 2 complaints until 197 working days and 275 working days after they were prioritized as High Priority.

Source: Auditor General staff analysis of Department's data for complaints prioritized as High Priority and investigated that were closed between July 1, 2019 through April 21, 2021, or still open as of April 21, 2021, and an audit history report showing prioritization changes the Department made between July 1, 2019 through July 1, 2021.

Department failed to follow CMS' complaint and self-report prioritization requirements—We also found the following concerns regarding the Department's prioritization of complaints and self-reports:

- **Department assigned much higher percentage of complaints and self-reports it received in the last half of 2020 a lower priority than complaints and self-reports it received in the last half of 2019, substantially reducing the number of complaints requiring an investigation within 10 days—**Between July 1, 2020 and December 31, 2020, the Department prioritized approximately 95 percent of all complaints and self-reports it received as Medium Priority and 4 percent as High Priority.[10] In contrast, between July 1, 2019 and December 31, 2019, the Department initially prioritized approximately 51 percent of all complaints and self-reports it received as Medium Priority and 42 percent as High Priority (see Figure 4).[11] Because of the shift in prioritization trend, the Department had fewer complaints and self-reports that it was required to respond to quickly. As previously mentioned, although High-Priority complaints and self-reports require the Department to initiate an on-site investigation within 10 working days, Medium-Priority complaints and self-reports do not have the same stringent time frame for initiating an on-site investigation. Both CMS staff and the Department indicated that no changes had been made to CMS guidance that would account for the increased percentage of complaints and self-reports that Department staff assigned a Medium Priority level rather than High Priority level.

Figure 4
Department prioritized much higher percentage of complaints and self-reports as Medium Priority in July through December 2020 compared to July through December 2019 despite no changes in prioritization requirements
(Unaudited)



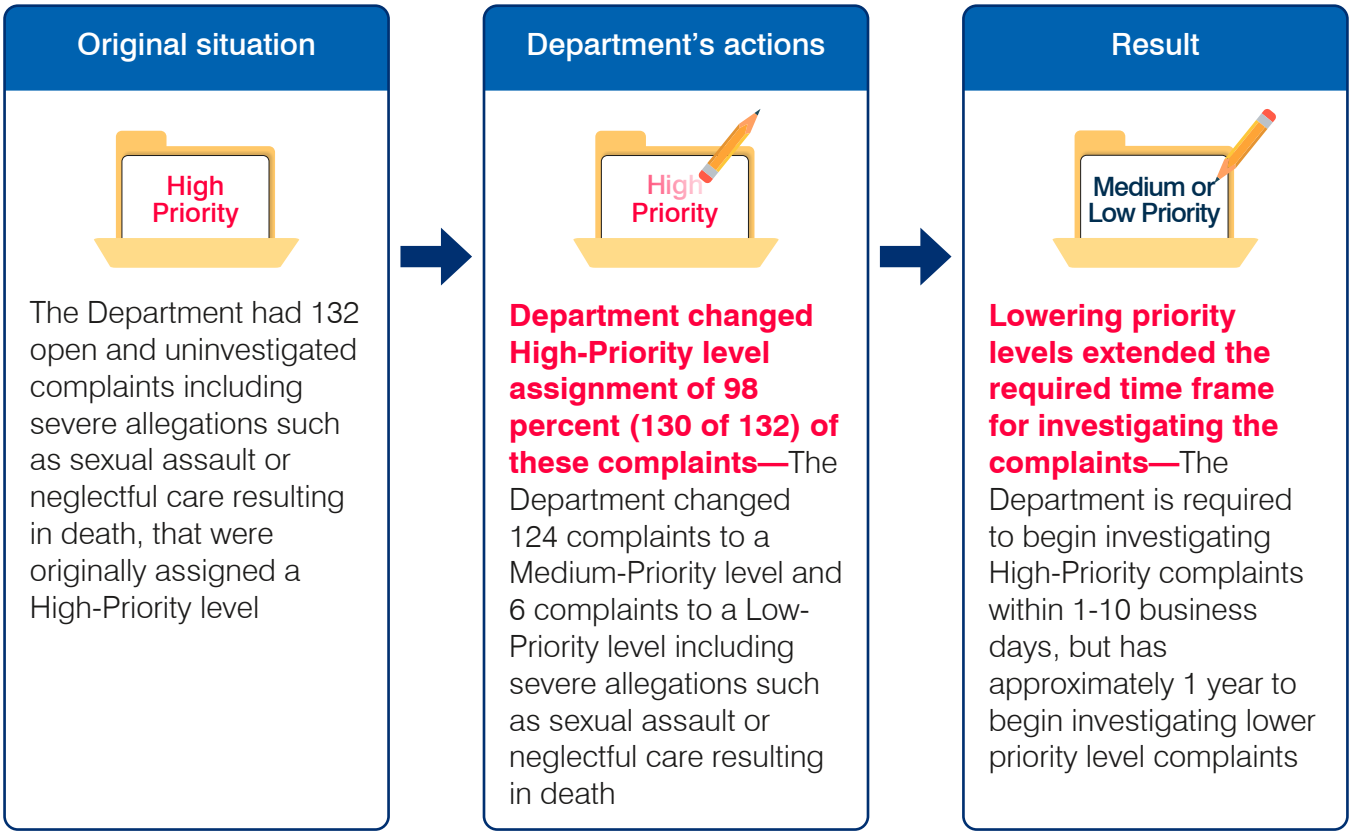
Source: Auditor General staff analysis of Department's complaint and self-report data for July through December 2019 and July through December 2020 and Department audit history report showing prioritization changes the Department made between July 1, 2019 through July 1, 2021.

[10] Between July 1, 2020, and December 31, 2020, the Department did not prioritize any complaints and self-reports as Immediate Jeopardy and prioritized 1 percent as either Low Priority or one of the other priorities used for complaints/self-reports of a less serious nature, such as those with allegations that occurred more than a year prior to intake or outside of the Department's jurisdiction.

[11] Between July 1, 2019 and December 31, 2019, the Department prioritized approximately 1 percent of the complaints and self-reports as Immediate Jeopardy and 6 percent as either Low Priority or one of the other priorities used for complaints/self-reports of a less serious nature, such as those with allegations that occurred more than a year prior to intake or outside of the Department's jurisdiction.

- **Department improperly changed open, uninvestigated High-Priority complaints to lower priorities, increasing its time to investigate them from 10 days to 1 year—**The Department improperly lowered the priority level of 130 of 132 (98 percent) complaints that were open and uninvestigated as of April 2021 that it had initially assigned a High-Priority level, which increased the required time frame for initiating an investigation from within 10 working days to approximately 1 year (see Figure 5). Specifically, of the 130 High-Priority complaints, the Department changed 124 to Medium Priority and 6 to Low Priority. Our review of a random sample of 69 of these complaints found that 101 of their total 146 allegations, or approximately 69 percent, included severe allegations such as sexual assault or neglectful care resulting in death.[12] However, contrary to CMS requirements, for 68 of the 69, or 99 percent, of complaints we reviewed, the Department did not have documentation indicating it had received additional information from the complainant to support changing the priority level of these complaints, some with severe allegations, from High Priority to Medium or Low Priority.

Figure 5
Department improperly reassigned 98 percent of its open High-Priority complaints to either Medium- or Low-Priority levels, which do not need to be investigated as quickly
As of April 21, 2021
(Unaudited)



Source: Auditor General staff analysis of Department's data for complaints open as of April 21, 2021, and an audit history report showing prioritization changes the Department made between July 1, 2019 through July 1, 2021.

[12] We reviewed a sample of 69 federal complaint files from a total of 130 open, uninvestigated federal complaints the Department initially assigned a High Priority and changed to a lower priority as of April 21, 2021. This sample is generalizable to the population of 130 complaints with 90 percent confidence and a margin of error of 3 percent.

Department's complaint investigation and prioritization failures are compounded because some facilities have multiple complaints/self-reports—Finally, we identified some instances where the Department's complaint investigation and prioritization failures are compounded because some long-term care facilities had multiple complaints or self-reports for which the Department had not acted consistent with CMS requirements, placing these facilities' residents' health, safety, and welfare at heightened risk. For example:

> Between January 2019 and April 2021, the Department received over 300 complaints and self-reports against a long-term care facility located in a western suburb of Phoenix. Approximately 90 percent of these complaints and self-reports were assigned a High or Medium Priority level, which requires the Department to initiate an on-site investigation and included allegations of neglect and injuries of unknown origin. As of April 2021, the Department had investigated 7 of these complaints and self-reports, 12 complaints and self-reports were open and uninvestigated, and the remaining 316 complaints and self-reports were closed without an investigation. Additionally, although this facility accounted for more complaints and self-reports received by the Department than any other licensed Arizona long-term care facility during this time period, the Department did not conduct an on-site complaint investigation until January 2022, approximately 2 years after investigating the 7 complaints/self-reports in December 2019.

Department's continued complaint investigation and prioritization failures put long-term care residents' health, safety, and welfare at risk; prevented public from making informed long-term care decisions for themselves or loved ones; and circumvented CMS' oversight of the Department

Long-term care residents remained at risk of continued abuse, neglect, exploitation, or inadequate care—When the Department failed to prioritize or investigate complaints in accordance with CMS requirements, all 3 objectives of the long-term care complaint system previously mentioned were not met (see page 2) and not only was the resident who was directly impacted by the incident not adequately protected but the Department also put the health, safety, and welfare of other residents in the facility at risk. Specifically, the Department failed to provide protective oversight by not responding to those complaints/self-reports that posed the greatest risk to residents and it failed at prevention by not investigating complaints/self-reports to determine if a problem existed that could negatively impact healthcare services or prevent problems escalating into more serious situations that would threaten residents' health, safety, and welfare. For example:

> In October 2020, the Department received a self-report from a long-term care facility regarding a nonverbal, dependent resident who was found to have a white, sticky substance on her vaginal area. The Department classified the reported incident as sexual abuse and assigned it a High-Priority level, which required the Department to initiate its own on-site investigation within 10 days of receipt. Further, CMS requirements indicate that sexual abuse allegations represent a crisis situation that requires immediate action. However, the Department failed to conduct a required on-site investigation and was unable to determine whether the sexual assault allegation could be substantiated. Thus, it could not take any actions that may have been necessary to protect that resident and other residents of the facility. In addition, although the Department became aware of issues with the facility's handling of the incident from the facility's internal investigation, the Department did not have information from its own investigation that it could use to take action against the facility. For example, the Department's record, which is based on information from the facility's internal investigation, indicates that the facility cleaned the resident and laundered her sheets before sending her to the hospital. Additionally, the record states that facility staff failed to tell the hospital that the resident was a potential sexual assault victim, which resulted in the hospital's examination being compromised. Eight months after receipt of the self-report, the Department closed it without taking any action against the facility.

As illustrated by this example, the Department's failure to investigate a complaint or self-report can result in compromised investigations and it being unable to substantiate the allegations, as appropriate, and thus be unable to require the facility to address problems or revoke the facility's license and no longer allow it to operate, as necessary. Further, the Department is unable to determine if a specific employee may need to be reported to law enforcement or one of the State's health regulatory boards for an investigation of their conduct. Absent such a referral from the Department to the regulatory board, that facility staff member may not be investigated and may be able to continue to work at the same or another facility in the State and potentially continue to cause harm to residents, with their professional record not reflecting any concerns regarding their conduct.

Additionally, for complaints and self-reports that the Department investigated after the required time frame, the Department also put the health and safety of long-term care residents at risk by allowing identified deficiencies to persist and increasing the risk of similar deficiencies occurring because it did not ensure that the facility implemented corrective actions in a timely manner.

Further, residents' risk was especially acute during the time frame we reviewed because of COVID-19 visitor restrictions, which meant that family and friends were unable to check on residents' welfare. Department staffs' complaint investigations and timeliness therefore became even more paramount.

Public has incomplete information upon which to make long-term care decisions and their confidence in the Department can be undermined—The Department is required to publicly disclose, which it does on its website AZ Care Check, a finding for all long-term care complaint and self-report investigations it conducts and provide documentation of the investigation findings to the facility. However, when the Department does not conduct an on-site investigation, it does not have any findings to report on its website or to the facility, and therefore the public and the facility are not made aware of the complaint. Specifically, the Department did not publicly report on over 5,000 complaints and self-reports it initially prioritized as High or Medium Priority but later inappropriately closed without an on-site investigation, thus depriving the public of complete information regarding the number of complaints and types of allegations filed against Arizona long-term care facilities. For example, for all 3 examples discussed earlier in this follow-up report (see pages 2, 4, and 9), the Department's website does not reflect that the facilities have these complaints against them, let alone any other information about them because, as previously discussed, in all 3 instances, the Department failed to conduct an on-site investigation. In addition, for the long-term care facility that received over 300 complaints/self-reports (see page 9), the Department's website has information on only 7 of these more than 300 complaints/self-reports.

Further, both the Department's failure to investigate High-Priority complaints at all or on time and lowering the priority of others can undermine public confidence in the Department and its effectiveness in protecting long-term care residents. Specifically, those who have filed complaints may contact the Department and question the status of their complaints and the Department's efforts to resolve the complaint when they do not hear a resolution in a reasonable time frame. For example:

> The Department received a complaint in December 2018 alleging abuse, injury due to accident, and failure to provide required medications to the complainant's sister, who had been a resident of a long-term care facility. The Department assigned the complaint a High-Priority level, which required it to start an on-site investigation within 10 days of receipt. The complainant called the Department 8 times seeking an update before the Department eventually initiated an investigation 14 months later in February 2020. During 1 call, the complainant expressed frustration with the Department and said she would write a letter to the Governor for answers.

Department's investigation and prioritization failures resulted in CMS' oversight of Department performance being circumvented—The Department's investigation and prioritization failures also reduced the number of long-term care complaints and self-reports available from which CMS could choose its samples to oversee the Department's performance. CMS uses Department data to annually assess whether the Department is meeting

expected performance standards for long-term care facility complaint and self-report prioritization and investigations.[13] Specifically, CMS reviews Department data to determine if it accurately prioritized complaints and investigated them within required time frames. However, the Department's trend to assign more complaints a Medium Priority level rather than a higher priority level and to close most complaints without an investigation reduced the number of complaints from which CMS selected its samples. For example, in calendar year 2020, only 62 of the 2,449 complaints and self-reports received by the Department met CMS' eligibility criteria for review to evaluate the Department's investigation timeliness.

Department not implementing 2019 audit recommendations and adopting practices contrary to CMS requirements contributed to its long-term care complaint investigation and prioritization failures

Department has not implemented any of the 5 recommendations from our 2019 audit report intended to address deficiencies in the Department's long-term care facility complaint and self-report investigation and prioritization practices—Despite 30 months having passed since we issued our September 2019 report that identified deficiencies with the Department's long-term care facility complaint prioritization and investigation practices, as indicated in the Table on page 1, the Department has not implemented any of the 5 recommendations to address the problems. For example, although the Department had developed some management reports that could help to monitor the timeliness of complaint prioritization and investigation consistent with 1 of our recommendations, Department staff were not able to provide evidence on how they were being used. We also recommended that the Department continue its efforts to allocate new or reallocate existing staff to work on long-term care facility complaints and self-reports on a full-time basis, but according to the Department, as of January 2021, it had dedicated only 1 position to process long-term care facility complaints/self-reports full-time. In addition, although the Department received funding in fiscal year 2022 for 16 additional staff to assist with its long-term care facility responsibilities, the Department reported that it was still in the process of creating and recruiting to fill these positions and indicated that a lack of staffing contributed to the problems identified in this follow-up report.

Department has adopted practices contrary to CMS requirements for investigating and prioritizing long-term care facility complaints and self-reports—Since we issued our September 2019 report, the Department has implemented practices that are not aligned with CMS requirements and used undocumented or unofficial policies to make improper decisions regarding long-term care facility complaint and self-report investigations and prioritization. Specifically:

- **Department made undocumented policy decisions to inappropriately close backlogged complaints—** Since we issued our September 2019 report, the Department implemented an undocumented process of closing thousands of backlogged complaints and self-reports. For example, starting in January 2020, the Department assigned an initial priority level for over 2,500 backlogged complaints and self-reports it received in calendar years 2017 through 2019. Then, as noted on pages 3 through 5, the Department closed many of them without conducting an on-site investigation, even though the initial priority assigned would have required one. Department staff confirmed that the steps taken to dispose of the backlogged complaints and self-reports were not authorized by CMS and explained that the Department chose to close them in this manner because the Department had gotten behind on handling complaints and self-reports and the surveyors had nothing else to do.[14] Further, although

[13] If the Department does not meet these performance standards, CMS requires the Department to develop and implement a corrective action plan. CMS may take further action such as conducting visits to evaluate the Department's processes for intake and triage of complaints, hiring a contractor to work on-site with the Department, or taking enforcement action by withholding federal funding. As reported in our September 2019 report, the Department did not meet CMS standards for high-priority complaint and self-report investigation timeliness for federal fiscal years 2015-2018 and was required to submit a plan of correction for each of those years.

[14] During some of the time period the Department was closing backlogged complaints and self-reports, it was required to temporarily focus on other activities. Specifically, to help ensure long-term care facilities were prepared to respond to the threat of disease caused by the COVID-19 pandemic, CMS had temporarily restricted the Department's activities to responding to Immediate Jeopardy complaints and self-reports and conducting targeted infection control surveys. The infection control surveys were to help providers implement actions to protect the health and safety of individuals during the COVID-19 pandemic. The CMS issued 2 memos restricting the Department's activities, one on March 4, 2020, and another one on March 20, 2020. The second memo specified that the period of the restricted activities was for 3 weeks, starting on March 20, 2020.

Department management stated that each complaint and self-report were reviewed by staff prior to closure and that each review would take between 15 and 60 minutes, we found that many were being closed at a more rapid pace. For example, one Department staff member closed approximately 200 complaints and self-reports over 3 days in April 2020, taking an average of only 6 minutes to close each one.

- **Department had been considering additional factors not permitted by CMS to assign complaint and self-report priority levels—**Our interviews with Department staff and management and review of Department complaint and self-report data and documentation found that the Department had been considering additional factors not included in CMS requirements to determine the priority levels it assigned to complaints and self-reports. These additional factors included whether staff were available to investigate the complaint or self-report within the required time frame, whether the long-term care facility resident to which the complaint was related was deceased, and whether the complaint was submitted by the Department of Economic Security's Adult Protective Services (APS) program. For example, the Department staff person responsible for assigning complaint/self-report priority levels indicated that it was more likely a decision would be made to assign a High-Priority level to a complaint/self-report if a surveyor were available to investigate it within the required time frame. In addition, we asked this same Department staff member why the priority assignments for 2 open and uninvestigated complaints that alleged neglect resulting in death were downgraded. The staff member responded that the residents had passed away and were no longer at the facilities so an investigation could wait because they could not correct what happened to the resident. Further, contrary to CMS requirements, the Department's complaint policy stated that complaints referred to the Department from other agencies should be prioritized differently than complaints received from other sources. The Department staff person responsible for assigning complaint/self-report priority levels stated to us that APS is not a credible source and often sensationalizes its reports to the Department. For example:

  > We provided the Department staff member with a complaint that alleged neglect resulting in a long-term care facility resident's death and asked the staff member to explain the reason for prioritizing the complaint as it was prioritized. Once the staff member noticed it was submitted by APS, the staff member dismissed the complaint and proceeded to explain to us how the long-term care facility's actions were likely being unfairly interpreted. We then showed the staff member a similar complaint submitted by a family member and the staff member told us that family members of residents who die often submit complaints against the facility alleging mistreatment of the resident (neglect, abuse, or quality of care allegations), but these allegations are not credible as the family is simply upset about the passing of the resident.

  Further, although CMS requires that the individual responsible for prioritizing complaints and self-reports have sufficient knowledge of federal requirements and current clinical standards of practice to accurately prioritize complaints/self-reports upon receipt, based on interviews with Department staff, it was not assigning priority levels based on allegation severity at the time of receipt. Rather, according to the Department, to mitigate the number of complaints and self-reports assigned a High-Priority level, the Department had implemented its unofficial policy of requiring the staff member responsible for prioritizing complaints/self-reports to report all potential High-Priority level complaints and self-reports to leadership staff for them to assign a priority level. Further, this Department staff person reported assigning some of the potential High-Priority level complaints/self-reports a Medium-Priority level pending leadership staff review of the allegations so these complaints would not get "lost" and not be prioritized at all. However, the Department's system did not distinguish between these complaints assigned a "temporary" Medium-Priority level and complaints assigned an actual Medium-Priority level, which raises concerns as to whether the complaints assigned a temporary priority level were all reassessed and assigned an accurate priority level.

- **Department management and staff lacked understanding of CMS requirements for handling long-term care facility complaints and self-reports—**Finally, our interviews with Department management and staff who were responsible for long-term care facility complaint handling found that they were unaware of or unfamiliar with many of the CMS requirements that the Department must follow, including the reporting requirements for substantiated abuse allegations, restrictions against announcing complaint/self-report investigations to the long-term care facility, the inappropriateness of closing self-reports as No Action Necessary, and requirements for maintaining documentation to support complaint-handling activities, such as changes to priority levels. For example, Department staff reported that it was appropriate for them to contact the long-term care facility to

obtain information regarding a High-Priority level complaint received from the public in lieu of initiating an on-site investigation despite CMS guidance specifically requiring the Department to conduct an unannounced on-site investigation within 10 days of complaint receipt.

Department should implement recommendations from 2019 audit and address additional deficiencies identified in this followup

To better protect the health, safety, and welfare of long-term care residents, the Department still needs to implement the 5 recommendations from the 2019 performance audit and sunset review and should also address the additional deficiencies we identified as part of this folllowup. Specifically, the Department should:

- 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.
- 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.
- Stop using undocumented, unofficial, unwritten, or contrary protocols and requirements for processing complaints and self-reports and instead follow CMS requirements.
- Ensure Department long-term care facility staff and management are trained on CMS requirements and monitored to ensure they comply with the requirements.

Methodology

To assess the Department's status in implementing the recommendations from our performance audit and sunset review (Report 19-112), which included findings. and recommendations related to long-term care facility complaints and self-reports, we conducted several interviews with Department management and staff and evaluated the Department's complaint-handling policies and procedures. We also analyzed the Department's long-term care facility complaint and self-report data and samples of long-term care facility complaint and self-report intake files for complaints and self-reports closed between July 1, 2019 through April 21, 2021, or still open as of April 21, 2021. Specifically:

- To evaluate whether the Department's practices for closing long-term care facility complaints and self-reports complied with CMS and state requirements, we analyzed the Department's data for the 1,405 long term-care facility complaints closed between July 1, 2019 through April 21, 2021, and the 1,438 long-term care facility self-reports closed between October 21, 2020 through April 21, 2021.[15,16] To further analyze the allegations contained in the closed complaints between July 1, 2019 through April 21, 2021, that were initially prioritized as High Priority, we selected and reviewed a random sample of 111 of the 496 complaints that the Department closed without conducting a required on-site investigation and reviewed 45 of the 47 complaints that were closed as No Action Necessary.[17,18] We also reviewed a random sample of 29 of 1,253 self-reports the Department closed as No Action Necessary between July 1, 2019 through April 21, 2021, to review the allegations in these self-reports.[19]

- To evaluate the Department's timeliness in initiating investigations, we analyzed the Department's data for all 161 complaints that were closed or still open between July 1, 2019 and April 21, 2021, and that were prioritized as Immediate Jeopardy or High Priority and had an investigation date. These included 5 closed Immediate Jeopardy complaints and 152 closed and 4 open High-Priority complaints.[20]

- To assess the Department's prioritization practices, including how it initially prioritized complaints and self-reports and when it changed priorities, we analyzed data from an audit history report from the Department's complaint tracking system, which showed the initial priority and changes to priorities the Department made to complaints and self-reports during July 1, 2019 through July 1, 2021. This report contained prioritization records for a total of 10,359 unique cases—4,214 complaints and 6,145 self-reports.

---

[15] Our work focused on long-term care facility complaints and self-reports the Department had categorized as federal, meaning there were potential violations of federal requirements. The Department categorized most complaints and self-reports that it closed during July 1, 2019, through April 21, 2021, as federal. Specifically, of the more than 1,900 closed complaints during this period—1,405 were federal, 510 were State, and 2 were not categorized. Similarly, of the more than 5,800 self-reports closed during this period—5,728 were federal, 131 were State, and 9 were uncategorized.

[16] We chose the starting point of July 1, 2019 because the Department indicated in its response to our initial followup, that it was focusing on implementing our recommendations for intakes from this point forward. Our ending point, April 21, 2021, is the date we requested the Department's data.

[17] Our randomly selected sample of 111 of the 496 complaints that the Department initially prioritized as High Priority but later changed to the lower priority, and closed between July 1, 2019 through April 21, 2021, is generalizable to the population of 496 complaints, with 90 percent confidence and a margin of error of 3 percent.

[18] The intake files for 2 of the 47 complaints closed as No Action Necessary could not be found at the time we pulled the intake files.

[19] We randomly selected a sample of 30 of the 1,253 self-reports the Department closed as No Action Necessary between July 1, 2019, and April 21, 2021; however, we were unable to locate 1 of the self-reports at the time the sampled files were pulled from the Department's complaint tracking system.

[20] The Department's data indicated that it had initiated investigations for the 5 complaints prioritized as Immediate Jeopardy within 2 days as required.