Department of Health

Oversight of Adult Care Facilities

Report 2023-S-34 | July 2025

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller
Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Department of Health adequately oversees adult care facilities to ensure quality of care and safety for residents. The audit covered the period from January 2018 through October 2024.

About the Program

Adult care facilities provide residential care to adults who are substantially unable to live independently because of physical or other limitations associated with age, disabilities, or other factors. They fill a need for individuals who need assistance but at a less intensive level of care than residents in nursing homes. Adult care facility residents are primarily older, need assistance with activities of daily living, and have multiple health conditions. In 2023, there were 534 adult care facilities with 37,547 residents in New York State.

The Department of Health (DOH) is responsible for the oversight of adult care facilities, primarily through regular inspections every 12 to 18 months and complaint investigations. DOH reports the results of its inspections and investigations to facilities so they may take any necessary corrective actions. For the period from January 2018 through December 2023, DOH conducted 1,362 full inspections, received 7,440 complaints, and completed 6,498 complaint investigations.

Key Findings

DOH is not adequately overseeing adult care facilities to ensure quality of care and safety for residents. We determined that DOH did not inspect facilities within the required time frames or conduct follow-up activities at facilities that received citations during the prior full inspections. For example, DOH:

- Did not begin full inspections for 21 of 30 sampled facilities (70%) within the required time frames, including eight that DOH started between 3 and 5 years late. When we conducted site visits at 20 of these facilities, we identified issues affecting health and safety, such as crumbling stairs, refrigerators that were not cold enough, and dishwashers that were not hot enough. Significantly, we found alcohol and marijuana paraphernalia left out in a medical office and an administrator's office, respectively. Such inspection issues may have been identified and corrected earlier through full inspections on the required schedule.
- Could not provide any evidence that it followed up on any of the citations in the 30 full inspection reports we reviewed to ensure the issues were actually corrected by the facilities. These citations included 89 violations that represent harm or risks to residents and quality of life, which require documentation of DOH follow-up actions. In addition, 18 of 20 facilities we visited did not correct all the issues identified in the full inspection reports that we reviewed, including 50 violations. During site visits, we also observed uncorrected issues from prior inspections, including a lack of staff certified in basic first aid, expired medications, and failure to conduct monthly fire drills.

We also determined DOH did not have evidence it investigated certain complaints or fully documented its investigation of others. Further, DOH did not issue investigation reports to facilities on time or at all in some cases, did not issue investigation result letters to complainants, and did not complete investigations within the required time frames. Specifically, we determined DOH:

- Did not have evidence it investigated 101 of 569 allegations (18%) on 38 complaints, including three complaints with 25 allegations that did not have evidence of any investigation being

conducted at all. These complaints included allegations of poor care, lack of resident supervision, and dirty or poorly maintained facilities.

- Did not issue 60 of 130 complaint investigation reports (46%) to facilities within 30 days after the inspection end date, as required, and did not issue seven reports at all. Of the 60 late reports, 34 were for investigations with substantiated allegations, including a resident abusing another resident, call bells not working correctly, and rooms not properly cleaned.
- Did not send 16 investigation result letters to complainants as required. In addition, 40 letters were issued more than 30 days after the investigation end date, including one that was not issued for more than a year. The letter still not issued more than a year after the investigation pertained to a complaint about an overall lack of care by the facility, including allegations that the facility did not sufficiently provide medications to, feed, or bathe a resident, resulting in family members having to do so.
- Took longer than 30 days to investigate 13 complaints, taking, on average, 67 days to complete them, with one taking 153 days. This complaint included substantiated allegations of mice in the resident's room, resulting in citations to the facility. Another allegation of a resident not receiving their insulin correctly took 97 days to investigate.

When inspection and follow-up activities are not completed as required, DOH cannot ensure facilities are complying with statutory and regulatory requirements, which ultimately may impact resident care and safety. When complaints aren't investigated within the prescribed time frames, potentially dangerous circumstances may go unaddressed. Additionally, the lack of, or late, reporting impacts DOH's ability to follow up and hold facilities accountable because the investigation result letters notify facilities of issues that need to be addressed so they can develop plans of correction when necessary. Further, without prompt investigation result letters, complainants have no assurance their complaints have been received or addressed.

Key Recommendations

- Review current procedures, guidance, and training and implement changes to ensure full inspections are completed on time and in accordance with laws and regulations and that facilities correct all violations in a timely manner.
- Establish and implement formal procedures to ensure that complaints are fully investigated and properly documented, and ensure monitoring procedures are followed so complaint investigation results are communicated to facilities within the required 30-day time period.
- Ensure DOH staff collect all required information from complainants who do not specifically request anonymity, and establish and document time frames for issuing investigation result letters to complainants.

Office of the New York State Comptroller
Division of State Government Accountability

July 9, 2025

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany NY, 12237

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Oversight of Adult Care Facilities*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
DOH	Department of Health	*Auditee*
ASPEN	Automated Survey Processing Environment	*Key Term*
ACTS	ASPEN Complaint Tracking System	*Key Term*
Backlog Report	Adult Care Facility Full Survey Backlog Report	*Key Term*
Division	Division of Adult Care Facility and Assisted Living Surveillance	*Key Term*
Manual	DOH Operations Manual	*Key Term*
Quality Committee	Quality Assurance Performance Improvement Committee	*Key Term*

Background

Adult care facilities provide residential care to adults who are substantially unable to live independently because of physical or other limitations associated with age, disabilities, or other factors. Adult care facilities fill a need for individuals who need assistance but at a less intensive level of care than residents in nursing homes.

Adult care facility residents are among society's most vulnerable individuals. They are primarily older, need assistance with activities of daily living, and typically have multiple health conditions. According to data from the Centers for Disease Control and Prevention, 94% of residents living in residential care communities (which include adult care facilities) are over age 65, and over half are older than 85. In addition, 88% of residents need assistance with at least one activity of daily living. Most commonly, residents need help with bathing, walking, and dressing. Further, 73% have been diagnosed with two or more health conditions.

The Department of Health's (DOH) mission is to protect and promote health and well-being for all, building on a foundation of health equity. In furtherance of this mission, DOH is responsible for the inspection and supervision of adult care facilities to ensure the health and well-being of the residents. Within DOH, the Division of Adult Care Facility and Assisted Living Surveillance (Division) is responsible for the oversight of adult care facilities. The Division maintains central office staff as well as staff at four regional offices who directly oversee the adult care facilities in their regions. At the end of 2023, the Division had 79 full-time equivalent staff.

DOH primarily supervises adult care facilities through regular inspections (also referred to as surveys by DOH) and complaint investigations. All adult care facilities must be licensed and DOH must, every 12 or 18 months, conduct at least one full inspection of each licensed facility to determine the adequacy of care. Facilities that received the highest rating from DOH during their prior inspection must have their next inspection within 18 months, while all others must be inspected every 12 months. Full inspections are unannounced, take 1 to 2 days to complete, and include a complete review of facility operations in four disciplines: program, medication, fire/safety, and nutrition. Inspections are completed according to the guidance found in the DOH Operations Manual (Manual).

When an inspection issue is identified, inspectors, in consultation with a supervisor, determine whether it is reported as a finding or a violation. Broadly defined, violations are incidents whose severity or scope represent harm or risks to residents and the quality of life at the facility. Findings are non-compliance of lesser significance that don't rise to the level of a violation. DOH must issue a written report to the facility that includes all citations—findings and violations—within 30 days of completing a full inspection. Facilities must submit evidence to DOH supporting that violations have been corrected or, for corrective actions that will take longer than 30 days, submit a plan of correction that includes the proposed time frame.

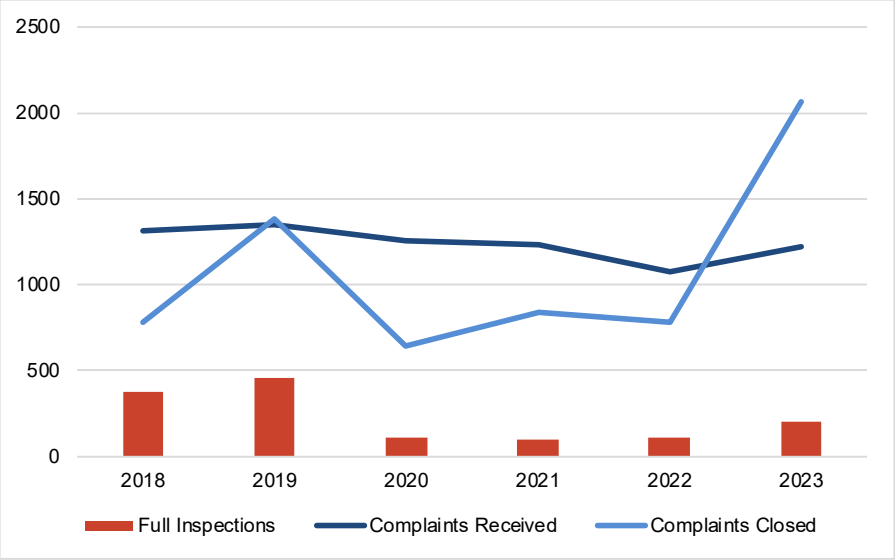
DOH is required to conduct follow-up activity for violations found during a full inspection and for any instances of endangerment (i.e., violations resulting in harm to a resident) cited, regardless of the inspection type. However, DOH has flexibility regarding how it follows up, and its methods may include telephone interviews,

faxes, or on-site visits. Regardless of the type of follow-up, the action must be documented in the inspection report. DOH may also conduct follow-up inspections to determine whether certain previously reported deficiencies have been corrected. To manage and track inspection information, DOH uses its Automated Survey Processing Environment (ASPEN) system.

In addition to regular inspections, DOH is responsible for receiving, prioritizing, and investigating complaints related to adult care facilities. Once started, DOH typically has 30 days to complete an investigation. As with a full inspection, DOH must issue a report to the facility within 30 days of the completion of its investigation, and the facility may be required to prepare a plan of correction to address certain investigation results. DOH must also send a letter detailing the results of the investigation to the complainant, when possible.

For the period from January 2018 through December 2023, DOH conducted 1,362 full inspections, received 7,440 complaints, and completed 6,498 complaint investigations. The COVID-19 pandemic began in March 2020. Consequently, from 2019 to 2020, full inspections fell by 76% and completed complaint investigations decreased by 53%. In 2018 and 2019, prior to the COVID-19 pandemic, DOH completed 376 and 458 inspections, respectively. Since 2021, DOH has conducted between 104 and 207 full inspections each year, or less than half the number per year prior to COVID-19 (see Figure 1).

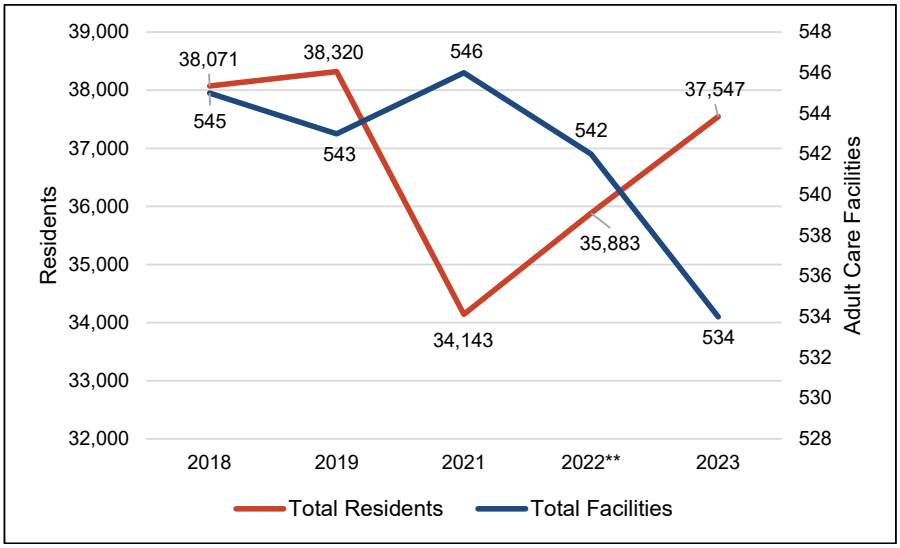
Figure 1 – Adult Care Facility Inspections and Complaints, 2018–2023*



*All data is as of December 31 for each year, except for 2022. The numbers for 2022 are as of 9/30/22 because they were not reported publicly due to data integrity concerns.

During this same time period, from 2018 to 2023, the number of adult care facilities and their residents decreased (see Figure 2).

Figure 2 – New York State Adult Care Facilities and Residents, 2018–2023*



*All data is as of December 31 for each year, except for 2022. The numbers for 2022 are as of 9/30/22 because they were not reported publicly due to data integrity concerns. In addition, this Figure does not include 2020 because reporting was suspended for the year due to the COVID-19 pandemic.

Adult care facilities, which range in size from nine to 363 beds, reported 38,320 residents at the end of 2019, a slight increase of 249 residents from 2018. Reporting requirements were suspended in 2020 during the COVID-19 pandemic, so no data was available, but facilities reported 34,143 residents at the end of 2021, a decrease of 11% from 2019. Since 2021, the number of residents has steadily increased, and at the end of 2023, DOH reported 37,547 residents. During that same period, the number of facilities decreased from 545 in 2018 to 534 in 2023, with most of the decrease occurring since 2021.

Audit Findings and Recommendations

DOH is not adequately overseeing adult care facilities to ensure quality of care and safety for residents. We determined that DOH did not inspect facilities within the required time frames, complete inspections on time, or conduct follow-up activities at facilities that received citations during the prior full inspections. Our review of 30 facilities identified 21 that did not have inspections within the required time frames, including eight that DOH started between 3 and 5 years late. As a result, DOH cannot ensure facilities are complying with statutory and regulatory requirements, which ultimately may impact quality of care and resident safety.

DOH also did not have any evidence that it took steps to ensure that citations in the full inspection reports we reviewed were actually corrected by the facilities. The citations included 89 violations that require documentation of DOH follow-up action. Consequently, certain issues were allowed to persist. When we conducted site visits at 20 facilities, we identified significant issues affecting health and safety, such as crumbling stairs, refrigerators that were not cold enough, and dishwashers that were not hot enough. We also identified uncorrected issues from prior inspections that could affect the health and safety of residents, including expired medications and a lack of staff certified in basic first aid.

We also determined DOH did not have evidence that it investigated certain complaints or fully documented its investigation of others. Additionally, DOH did not issue investigation reports to facilities on time—or at all—in some cases, did not issue investigation result letters to complainants, and did not complete investigations in the required time frames. The lack of reporting affects DOH's ability to follow up and hold facilities accountable and to reassure complainants that their concerns have been taken seriously and investigated. If results are not reported to facilities, they may not create plans of correction to address substantiated issues.

In response to our audit, DOH officials cited staff shortages and high staff turnover, particularly after COVID-19, as the biggest obstacles to adult care facility oversight activities. DOH officials stated that, during the pandemic, all DOH resources were focused on reducing public health threats. However, we also found that DOH lacks high-quality, accurate information to manage its limited staffing resources and evaluate its facility inspection program. Additionally, we determined DOH had not developed and issued sufficient guidance for how staff should complete and document complaint investigations and did not capture certain information necessary to send investigation result letters.

Inspections

DOH is not always inspecting adult care facilities within required time frames or following up on violations identified during the inspections when they occur. Unlike nursing homes, which are subject to both federal and State oversight and regulations, adult care facilities are only regulated at the State level by DOH. Therefore, maintaining a robust State oversight and investigation program is essential to ensuring these vulnerable individuals receive quality care in a safe environment.

Inspections and follow-up are DOH's primary means of ensuring that adult care facilities comply with State health and safety regulations and provide a safe environment for residents. When DOH does not conduct timely inspections and follow up on violations as required, it cannot ensure facilities are complying with statutory and regulatory requirements, which ultimately may impact quality of care and resident safety.

Inspections Not Completed Timely

Adult care facilities that received the highest rating from DOH during their prior inspection must have their next inspection within 18 months, while all others must be inspected every 12 months. Our evaluation of inspections for a sample of 30 facilities determined DOH did not begin full inspections for 21 of 30 facilities (70%) within the required time frames. Further, the time between inspections for many of the 21 facilities was much longer than it should have been, and DOH was between 3 and 5 years (37–60 months) late to start full inspections of eight facilities in our sample (see following table).

Late Inspections for Sampled Facilities

Timeliness	12-Month Schedule	18-Month Schedule	Total
Late 1–12 months	5	1	6
Late 13–36 months	5	2	7
Late 37–60 months	3	5	8
Totals	**13**	**8**	**21**

For example, for one facility on an 18-month schedule, as of May 2024, DOH was nearly 5 years (58 months) late to start its required full inspection, with the last full inspection taking place in January 2018. Another facility on the 18-month schedule received its last full inspection in March 2019. As of May 2024, DOH was nearly 4 years (44 months) late to start its next full inspection. The remaining nine facilities were inspected within the prescribed time frames.

Our sample of 30 facilities noted earlier included those due for inspections during the COVID-19 period, which we defined as March 2020—the beginning of the COVID-19 pandemic—through November 2021—the date that states should have resumed regular nursing home inspections, according to the Centers for Medicare and Medicaid Services. Of the 21 facilities where inspections did not begin on time, eight were due to begin during the COVID-19 period. However, seven of these eight were among the latest inspections overdue by between 3 and 5 years. As with inspections, we reviewed complaints received during the COVID-19 period. Of the 38 complaints that did not have evidence of an investigation into all allegations, 11 were received during the COVID-19 period, including the three complaints with no evidence of any investigation. Additionally, inspections for three of the 30 facilities in our sample took longer than 30 days, with completion times ranging from 57 to 198 days.

In response to our findings, DOH acknowledged that some facilities didn't receive a recertification inspection within the expected time frames but stated they did receive focused inspections during that period. However, while regional office staff may visit facilities to conduct a focused inspection or investigate specific complaints between full inspections, the specific complaint allegations are the focus of those visits, rather than the comprehensive set of detailed regulations reviewed in a full inspection.

When DOH does not conduct inspections in a timely manner, it cannot ensure facilities are complying with statutory and regulatory requirements, which ultimately may impact quality of care and resident safety.

Facilities With Health and Safety Issues

During our audit, we conducted site visits to 20 of the 30 facilities in our sample. Our site visits were limited to interviewing facility management, observing the general conditions of each facility, and requesting documentation about facility maintenance and safety procedures. Due to confidentiality concerns, we could not assess compliance with all the standards that DOH does during its full inspections. For example, we did not enter private rooms, interview residents, or review confidential medical records, such as those relating to medication administration. However, even with these limitations, we identified concerning conditions at nine of 20 facilities. We notified DOH immediately of any serious health or safety risks we observed, and DOH personnel logged our observations as complaints to ensure they would receive follow-up by the appropriate regional DOH office.

For example, we observed and notified DOH of conditions such as:

- A half-empty bottle of vodka in a medical room (see Figure 3)
- Marijuana paraphernalia in an administrator's office (see Figure 4)
- Crumbling stairs/walkways (see Figure 5)
- Kitchen appliances that did not operate at the correct temperatures, which could affect food safety (e.g., dishwashers not hot enough, refrigerators not cold enough)

Figures 3–5 (from left): A bottle of vodka in a medical room, marijuana paraphernalia in an administrator's office, and a crumbling walkway and stairs.

Many of these issues, such as incorrectly operating refrigerators, were noted in prior inspections several years earlier. We also observed issues that regular inspections should detect: three facilities did not have required information about ombudsmen (individuals who act as advocates for residents in assisted living facilities, helping them to understand their rights and refer complaints) and six did not have the DOH complaint hotline contact information publicly posted for residents in the facility.

Follow-Up Inspections Not Conducted

DOH is required to conduct follow-up activities when violations are found during a full inspection and to document its follow-up activities in the inspection report. However, DOH did not have any evidence that it took steps to ensure that the facilities actually corrected any of the citations in the 30 full inspection reports we reviewed. These citations included 89 violations, which require documentation of DOH follow-up actions.

Further, of the 20 facilities we visited, 18 (90%) did not correct all the issues identified in the full inspection reports that we reviewed. The most recent inspections for the 20 facilities we visited identified a total of 471 citations. Due to the previously explained confidentiality restrictions, we could not review 233 of the 471. Of the 238 citations we were able to review, 113 (47.5%) at 18 facilities were not corrected:

- 50 were violations that required DOH follow-up
- 63 were findings and, while not specifically requiring follow-up, DOH should have some assurance that facilities have addressed them

Some citations that went uncorrected could affect the health and safety of residents, including:

- Expired, unlabeled, or uncovered food
- Failure to conduct monthly fire drills
- Not having a current emergency shelter agreement in place
- Not maintaining equipment and furnishings in a clean, orderly condition and in good working order
- Not providing meals that matched the posted menu

Because DOH is behind in conducting its inspections, many of these issues were uncorrected for long periods of time. For example, in its last full inspection, one facility was cited for not having an employee certified in basic first aid on site and on duty at all times. During our site visit over 13 months later, we reviewed staff schedules and certifications and found the issue persisted. Similarly, for a facility cited in its last full inspection for having expired medications, we observed over 4 years later that it again had expired medications.

Without proper follow-up, inspections can lose their intended impact and diminish their deterrent effect. This not only undermines public trust but also signals to facilities that compliance is optional rather than mandatory. A lack of follow-up could also create a cycle where minor infractions lead to more dangerous situations that

could have been prevented with earlier intervention. Further, when DOH does not follow up on the problems it identifies, it may waste valuable resources by conducting inspections that ultimately fail to achieve their intended outcome.

In response to these findings, DOH officials stated they have established an internal Quality Assurance Performance Improvement Committee (Quality Committee) with the goal of improving quality and ensuring data reliability within the Office of Aging and Long Term Care. Officials said the Quality Committee reviews practices, improves inspector training, and develops new streamlined and more efficient processes, among other things. While the Quality Committee provides a vehicle to review a broad range of issues affecting long-term care facilities, it has not yet specifically addressed the problems we identified related to adult care facilities. DOH should take additional steps to ensure all facilities are inspected within the required time frames and that they are following up on citations that require corrective action.

Insufficient Program Monitoring

We found that DOH lacks high-quality, accurate information to manage its limited staffing resources and evaluate its adult care facility inspection program. DOH officials use dashboards and internal reports, including the Adult Care Facility Full Survey Backlog Report (Backlog Report), to monitor the inspection program during monthly meetings. However, our review of those reports identified certain inaccuracies. Officials provided a copy of their internal July 2024 Backlog Report used to monitor inspections, which showed that 265 of 516 facilities (51%) were overdue for their full inspections. However, the report included 17 more facilities than supporting details indicated. DOH officials said that the differences were due to coding discrepancies, and the coding has since been updated so everything aligns. Nevertheless, if DOH officials are using inaccurate information to assess inspection backlogs, this could impact how they deploy their limited staffing resources to satisfy inspection requirements and evaluate the inspection program.

In another example of inaccurate data, four inspections at two of the facilities we sampled were inaccurately classified as full inspections in DOH's data. Inspection reports showed that they were partial, follow-up, or simply an "other" type of inspection instead. When an inspection is classified as "full," it restarts the inspection timeline. As a result, the inaccurate classification delays when the facility appears on DOH's Backlog Report. Because DOH uses these reports to determine when a facility's next inspection is due, inaccuracies could cause future inspections to be delayed and fall outside the required time frames.

For example, one facility's most recent full inspection occurred in September 2022. Because the facility was on a 12-month inspection schedule, it would have been due for its next full inspection by September 2023. However, the facility had a partial inspection in May 2023 that was incorrectly recorded as a full inspection. As a result, according to DOH's data, the facility's next full inspection was due by May 2024 instead of the earlier September 2023 date. Further, the facility had another partial inspection in February 2024 listed as "complete/other" on the report, which was again coded incorrectly as a full inspection. Based on this new date, DOH's

data incorrectly indicated the due date for the next full inspection in February 2025—17 months later than it actually was due (September 2023 to February 2025).

We conducted a site visit to this facility in May 2024 and identified multiple concerning issues that we believed could put residents at risk for harm or injury. We immediately notified DOH officials and DOH immediately performed a full inspection of the facility, resulting in a total of 66 citations (54 violations and 12 findings). Had DOH's data correctly indicated the full inspection due date, the issues may have been identified and addressed sooner. Again, DOH officials explained that human error in system coding likely caused the inappropriate inspection types to be included in the full inspection data.

During our audit, we met with all four regional office directors, who discussed how they manage their inspection programs and provided feedback on opportunities for program improvements. For example, the Central New York region director created an inspection log that was used with their inspection schedule and another internal report to manage full inspections, rather than using the dashboard created by the DOH central office and used by the other regional offices. This log may have contributed to the Central New York region being the only regional office without a backlog of full inspections during our audit, despite having similar facility-to-staff ratios as the other regions.

Regional office officials also suggested providing consolidated guidance to inspectors on the large number of regulations that apply to adult care facilities. According to officials, even experienced inspectors have difficulty applying the regulations consistently because many can be open to interpretation. One region even developed its own "cheat sheet" to help its inspectors. Additional guidance could help streamline the inspection process, improve efficiency, and promote a more consistent application of the regulations across inspections. Regional office officials also suggested that a dedicated inspection trainer for all regions could help standardize the process.

Complaint Investigations and Reporting

DOH defines a complaint as a report or request made by anyone alleging non-compliance with State laws or DOH regulations, and in which a formal investigation of alleged non-compliance is sought. Complaints communicate potential non-compliance with regulations, poor care or facility conditions, or inappropriate staff behavior. Complaints may be submitted by residents, their families, advocates, facility staff, or even anonymously.

DOH's Centralized Complaint Intake Program receives adult care facility complaints centrally and records the key information, such as allegation specifics, dates, and locations in the ASPEN Complaint Tracking System (ACTS), where the appropriate regional office can access the complaints. Upon receiving and evaluating the complaint information, Centralized Complaint Intake Program staff classify complaints based on the seriousness of the allegations.

We reviewed a sample of 130 complaints at 20 adult care facilities and identified investigations that DOH did not handle according to guidance in its Manual, with some investigations having multiple deficiencies.

For example, we identified a variety of issues during our review including:

- Investigations not completed or fully documented
- Investigation result reports not issued to facilities
- Investigation result letters not issued to complainants
- Investigations not completed in required time frames

These issues are detailed in the following sections.

Complaint Investigations Not Completed or Fully Documented

As part of its responsibility to ensure the health and safety of adult care facility residents, DOH must investigate complaints made against facilities. A single complaint may contain multiple allegations. Regional office staff view the complaint information, conduct their investigation, and document their work in ACTS.

During our review, we did not see evidence that DOH investigated all parts of each complaint that it received. We reviewed information for a sample of 130 complaints representing 569 separate allegations and found no evidence in ACTS that DOH investigated 101 allegations (18%) on 38 complaints. This includes three complaints with 25 allegations that did not have evidence of any investigation at all. These complaints included allegations of poor care (e.g., residents confined to their rooms and waiting in hallways for long periods of time for assistance), lack of resident supervision, and dirty or poorly maintained facilities.

In addition, for the remaining 35 complaints, ACTS did not contain evidence that all the allegations were addressed by DOH's investigation. For example, ACTS did not contain any evidence that DOH investigated one of three allegations on a complaint received from the family of an adult care facility resident. The allegation with no investigation details claimed that there were no nurses on staff. Notes in ACTS simply stated staffing levels were unsubstantiated, with no indication of what, if any, documentation was reviewed or who was interviewed by the investigator to make that determination.

Other examples of allegations that did not have evidence of being addressed included:

- Medication mismanagement (e.g., not giving residents medications, giving residents incorrect medications, and lack of medication records)
- Lack of supervision of residents (e.g., staff not doing rounds or not answering call bells)

- Poorly maintained facilities (e.g., bed bugs, lack of cleanliness, and broken elevators)

We found evidence that DOH investigated the remaining 468 allegations. As with inspections, our review included complaints received during the COVID-19 period. Of the 38 complaints that did not have evidence of an investigation into all allegations, 11 were received during the COVID-19 period, including the three complaints with no evidence of any investigation.

DOH has not developed and issued sufficient guidance for staff regarding the completion and documentation of complaint investigations. Consequently, there is inconsistency in how investigations are performed and documented in ACTS. The Manual provides guidance on other parts of the complaint and inspection process, such as intake, assigning priority levels, and documenting other aspects of the inspection process, but it does not include steps to verify that all parts of a complaint are fully addressed and properly documented in ACTS. Similarly, while the Manual contains a quality assurance process for complaint investigations, that process focuses on other aspects of the investigation, such as complaint triaging, timeliness, and completion. In other cases, allegations may not relate directly to a regulation and, therefore, would not necessarily result in a citation, even if the allegation was substantiated. For example, an allegation about an administrative issue, such as a family member not getting a call back from a facility administrator, may not violate a specific regulation. However, the allegation should still be investigated and have a resolution documented.

In addition, orientation and training materials provided by DOH did not include instructions to ensure that every aspect of a complaint is investigated and properly documented in ACTS. Regional office officials stated that new staff are primarily trained on the job by more experienced staff, and use the required investigation forms to ensure that investigations cover everything they should and that staff issue the appropriate citations. According to a regional office director, staff investigation notes should support investigation steps taken. However, staff prepare notes differently, and, while some are thorough, others are not sufficiently clear or detailed enough to determine if all allegations on a complaint were fully addressed.

In response to our audit, DOH officials stated they have implemented several steps to ensure a more thorough investigative report. This includes requiring that inspectors complete the federal Survey or Minimum Quality Test standard, which establishes a foundation for long-term care residential surveillance complaint investigations, annually reviewing the Manual for opportunities to improve efficiency, and emphasizing the embedded quality assurance review process to further support comprehensive investigations.

Investigation Reports Issued to Facilities Late or Not at All

DOH must report the results of complaint investigations to the facility within 30 days of completing the investigation and enter the inspection report information into the

ASPEN system. When DOH doesn't report—or doesn't promptly report—the results of its complaint investigations to facilities, facility administrators don't know what needs to be corrected and can't prioritize those issues. Further, this impacts DOH's ability to follow up and hold facilities accountable. If results are not reported to facilities, plans of correction may not be established to address substantiated issues.

We reviewed 130 investigations for evidence of reports, finding:

- Sixty reports (46%) were issued more than 30 days after the complaint inspection ended. On average, these late reports were issued 88 days after an investigation was completed, with one report issued 388 days after the investigation. Of the 60 reports, 34 were for investigations with substantiated allegations, including a resident abusing another resident, call bells not working correctly, and rooms not properly cleaned.
- Seven reports (5%) were never issued. According to notes in ACTS, four of the seven investigations would have had citations that DOH would have required the facility to correct. Based on the notes in ACTS, the citations included an inappropriately admitted individual who did not meet facility admission standards and a resident who did not receive the proper physician referrals when they did not comply with medication requirements.

According to DOH officials, staffing and workload backlogs prevented the reports from being issued promptly. When an investigation is completed, DOH investigators communicate the results to facility administrators during the exit conference. However, the reports were not necessarily sent within the 30-day time period. For the seven complaints that didn't have reports issued, three were not investigated. DOH officials closed out the remaining four complaints in the ASPEN system due to the amount of time that passed from when the complaints were received. Officials stated that no corrective actions could be effectively enforced after such long delays.

According to the quality assurance procedures for complaints in the Manual, central office staff should determine whether the inspection reports for each completed inspection were issued within the required time frame. They should also compare the inspection reports due to the number issued. According to DOH officials, they use a tracker to ensure compliance with these requirements. Nevertheless, despite these procedures in place, we identified inspection result reports that were not issued on time or at all.

Investigation Result Letters Not Issued to Complainants

In addition to reporting the results of completed investigations to the facility, DOH is required to send a letter with the investigation results to the person or entity who made the complaint (complainant), when possible. When DOH does not issue investigation result letters or issue them in a timely manner, complainants cannot be certain their concerns were taken seriously and investigated.

We determined that DOH did not issue investigation result letters to 16 complainants in our sample who did not request anonymity. In addition, during our facility site

visits, we notified DOH of possible health and safety issues we observed at nine facilities. DOH recorded our notifications as complaints, and we received the required complainant acknowledgment letters. However, as of February 2025, we had not received two investigation result letters (for complaints initiated in August and October 2024) indicating the outcome of those investigations.

We also determined that, in some cases, DOH sent investigation result letters long after an investigation was completed:

- Letters for 40 of 130 complaint investigations (31%) we reviewed were issued to complainants more than 30 days from the end of the investigation.
- Of those, 11 were issued more than 3 months (100 days) after the investigation was completed, with one letter still not issued more than a year after the investigation (388 days). This particular complaint, about an overall lack of care by the facility, included allegations that the facility did not sufficiently provide medications to, feed, or bathe a resident, resulting in family members having to do so.

According to DOH officials, they may not always have enough information to send the investigation result letters to the complainants. For example, staff may not gather all necessary information upon receiving the complaint or may not be able to follow up on complaints made via phone message or email when complainants don't leave enough information to contact them. This was the case for two of the 16 instances we identified. There was no explanation for why the remaining letters were not sent. Further, DOH has not issued guidance specifying how long after an investigation is completed that an investigation result letter should be sent. The Manual simply requires a letter to be sent to the complainant upon completion of the investigation without giving any time frames for doing so.

Complaint Inspections Not Completed Timely

DOH should complete investigations quickly, especially for complaints involving resident health or safety, so that any substantiated allegations may be addressed promptly. Once a complaint investigation is started, DOH must complete it within 30 calendar days unless there are extenuating circumstances. When DOH doesn't investigate complaints within the prescribed time frames, potentially dangerous circumstances may be allowed to go unaddressed. Further, this impacts DOH's ability to follow up and hold facilities accountable. Investigations must be completed before any results can be communicated to facility administrators and, when necessary, plans of correction developed to help ensure that any substantiated issues are corrected.

DOH took longer than the allowed 30 days to complete investigations for 13 of 130 complaints (10%), and there was no documentation in ACTS indicating extenuating circumstances that would warrant a longer investigation period for any of those 13.

- On average, these 13 investigations took 67 days to complete, with the longest taking 153 days. This complaint included substantiated allegations of mice in a resident's room, resulting in citations to the facility.

- Another allegation of a resident not receiving their insulin correctly took 97 days to investigate.
- Other examples that took longer than 30 days to investigate included alleged instances of facilities with mold and a lack of resident supervision.

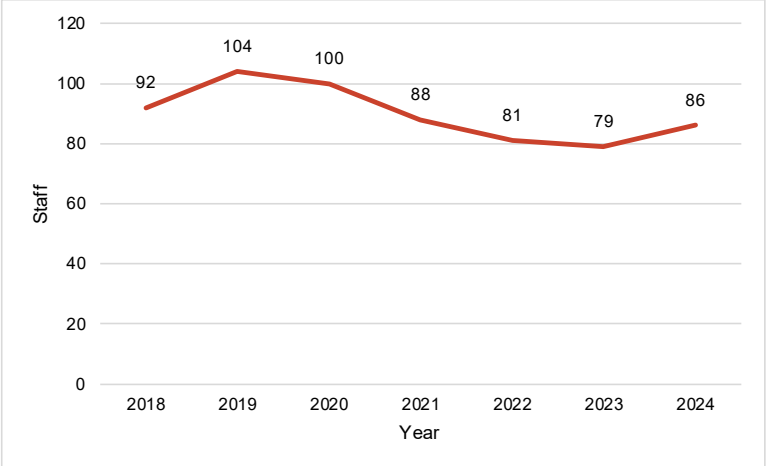
We also noted that DOH does not have usable internal reports for monitoring complaint investigations. During our audit, DOH complaint data was available only in a file format (PDF) that is not especially useful for monitoring purposes because it does not allow for data analysis to evaluate performance. In response to our audit, DOH created a new database query to provide complaint investigation information. However, despite testing to ensure accuracy, we identified inconsistencies in the complaint investigation data due to different sources of DOH data with different formats and structures. As a result, we also question the usefulness of this information to DOH for monitoring its complaint investigation process.

Staffing Shortages and High Turnover

In response to our audit, DOH officials cited staff shortages and high staff turnover, particularly after COVID-19, as the biggest obstacles to adult care facility oversight activities. DOH officials stated that, during the pandemic, all DOH resources were focused on reducing public health threats. Additionally, they stated facilities were still subject to comprehensive, focused complaint investigations and, in some cases, enforcement actions. Officials further noted that adult care facility inspection professionals also worked to educate facility staff, enforce public health safety measures, and participate in numerous health response activities.

In 2018, DOH reported 92 staff, including central and regional office staff, assigned to adult care facility oversight responsibilities. Staffing rose to 104 in 2019 before beginning a multi-year decline coinciding with the pandemic. As of December 2023, DOH had 79 staff to handle its same inspection and investigation responsibilities (see Figure 6).

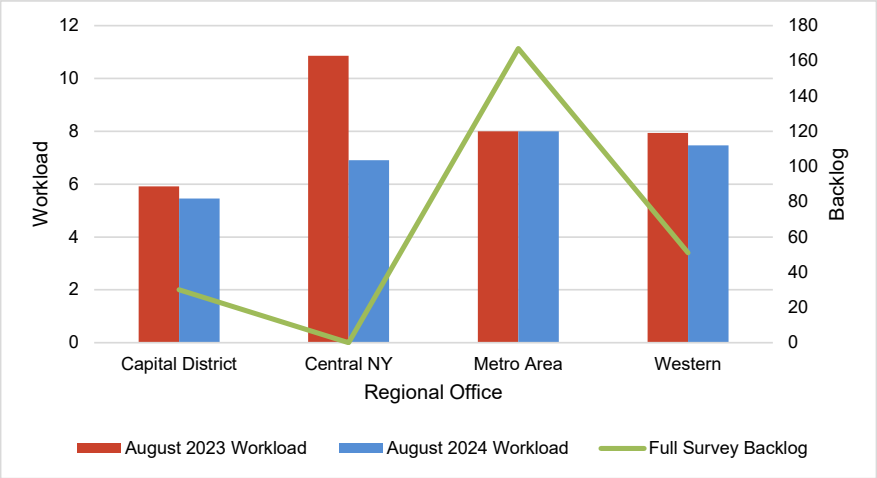
Figure 6 – DOH Staffing Levels 2018–2024



To address staffing challenges, DOH officials stated they have taken steps to hire more inspectors, including increasing recruiting efforts at job fairs and promoting the Hiring for Emergency Limited Placement and Hiring for Emergency Limited Placement Statewide programs. Officials said these efforts have led to more applicants and streamlined appointments. DOH reported an increase to 86 staff as of August 2024, which is still below its 2019 level. Additionally, our analysis of regional office staff workloads showed modest improvements between August 2023 and August 2024. Regional

office staff workload averaged eight facilities per staff member as of August 2023. Subsequent data provided through August 2024 shows staffing has improved, reducing the number of facilities per staff member to seven. While the regions had similar facility-to-staff ratios, as noted earlier, only the Central New York Regional Office had no inspection backlog (see Figure 7).

Figure 7 – Staffing Workload and Backlog by Region



Despite staffing improvements, officials stated that high turnover rates in the Division also meant the loss of institutional knowledge, which they say is key to ensuring that inspections are carried out properly and in a timely manner. DOH officials also said that more experienced staff have been overburdened in previous years due to understaffing and because of the stress of working through the COVID-19 pandemic.

Although we acknowledge these staffing issues, as stated earlier, developing and issuing sufficient guidance would assist existing staff with completing and documenting complaint investigations and sharing the results with complainants. Further, use of high-quality, accurate data could help DOH focus its limited staffing resources on inspection and monitoring activities and better ensure quality of care and safety at adult care facilities.

Recommendations

1. Review current procedures, guidance, and training and implement changes to ensure full inspections are completed on time and in accordance with laws and regulations and that facilities correct all violations in a timely manner.
2. Establish and implement formal procedures to ensure that complaints are fully investigated and properly documented, and ensure monitoring procedures are followed so complaint investigation results are communicated to facilities within the required 30-day time period.
3. Ensure DOH staff collect all required information from complainants who do not specifically request anonymity, and establish and document time frames for issuing investigation result letters to complainants.

4. Take steps to improve the accuracy, completeness, and usefulness of data used to monitor adult care facility oversight activities.
5. Direct resources to ensure that DOH has adequate staffing levels to meet its adult care facility oversight responsibilities.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether DOH adequately oversees adult care facilities to ensure quality of care and safety for residents. The audit covered the period from January 2018 through October 2024.

To accomplish our audit objective and to assess internal controls over DOH's oversight and monitoring of adult care facilities, we reviewed relevant laws and regulations; DOH policies and procedures; and relevant program records, including inspection forms, records, reports, and plans of correction. We also conducted on-site visits at a sample of adult care facilities where we interviewed facility administrators, observed the facility conditions, and reviewed certain records and documentation. We also interviewed DOH central and regional office officials to understand their adult care facility oversight process and accompanied DOH staff on a full inspection of a facility.

We used a non-statistical sampling approach to provide conclusions on our audit objectives and to test internal controls and compliance. We selected judgmental samples. However, because we used a non-statistical sampling approach for our tests, we cannot project the results to the respective populations. Our samples, which are discussed in detail in the body of our report, include:

- A judgmental sample of 30 of 657 adult care facilities across the four DOH regions to assess DOH oversight. Our judgments were based on factors including, but not limited to, the responsible regional office; inspection results, including number of citations and whether a plan of correction was warranted; and facility ownership. For the 30 adult care facilities in our sample, we reviewed the most recent full inspection report and assessed the timeliness of DOH inspections during our audit scope.
- A judgmental sample of 20 of the 30 adult care facilities sampled to observe the conditions at the facilities and assess whether DOH was conducting complaint investigations and reporting results as required. These 20 facilities were selected based on factors such as geographic location and the regional office responsible.
- A judgmental sample of 130 of the 567 complaints DOH received for the 20 adult care facilities from January 2018 to October 2023. The 130 complaints were judgmentally selected based on factors such as how long it took to complete an investigation, complaint status, and whether the data included errors.

We obtained adult care facility inspection and complaint data from DOH's ASPEN system. We assessed the reliability of that data by interviewing knowledgeable individuals about ASPEN, performing electronic testing, and tracing to and from source documents. We determined that the data from these systems was sufficiently reliable for the purposes of this report. Certain other data in our report was used to provide background information. Data that we used for this purpose was obtained from the best available sources, which were identified in the report. Generally accepted government auditing standards do not require us to complete a data reliability assessment for data used for this purpose.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of DOH's oversight of adult care facilities.

Reporting Requirements

We provided a draft copy of this report to DOH officials for their review and formal written comments. We considered their response in preparing this final report and have included it in its entirety at the end of the report. Although DOH officials disagreed with certain aspects of the report and offered explanations in response, they generally agreed with the recommendations and indicated actions they will take to address them. We have embedded State Comptroller's Comments to address the areas where they disagree.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

June 16, 2025

Nadine Morrell, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Nadine Morrell:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2023-S-34 entitled, "Oversight of Adult Care Facilities."

Thank you for the opportunity to comment.

Sincerely,

Johanne E Morne

Johanne E. Morne, M.S.
Executive Deputy Commissioner

Enclosure

cc: Melissa Fiore
Michael Atwood

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2023-S-34 entitled,
"Oversight of Adult Care Facilities"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2023-S-34 entitled, "Oversight of Adult Care Facilities."

General Comments:

OSC Use of A Judgmental Sample

OSC used judgmental samples to select the adult care facilities and complaints they would observe and review records for, which means the auditors selected the adult care facilities and complaints they would observe and review records for based on their professional judgement, opinion, and knowledge. As a result, the selected samples and any OSC findings or conclusions are not representative of the entire adult care facility and complaint populations.

State Comptroller's Comment – Consistent with auditing standards, we used judgmental (non-statistical) sampling to focus our audit resources where non-compliance with relevant laws, regulations, and program requirements was most likely. Our intent was not to project results to the entire population, as noted on page 22 of our audit report. This targeted approach allowed us to obtain evidence most likely to impact the health and safety of residents. The use of a judgmental sample was both appropriate and necessary to meet the audit's objective in an efficient manner.

Audit Recommendation Responses:

Recommendation #1

Review current procedures, guidance, and training and implement changes to ensure full inspections are completed on time and in accordance with laws and regulations and that facilities correct all violations in a timely manner.

Response #1

The Office of the State Comptroller sampled targeted facilities that the Department self-reported had not received a recertification inspection since the COVID-19 pandemic, a time during which survey professionals worked tirelessly to educate facility staff and residents, enforced public health safety measures, and participated in numerous health response activities, and when all Department resources were focused on reducing public health threats and impact.

State Comptroller's Comment – DOH's assertion that we targeted facilities that had not received a recertification inspection since the COVID-19 pandemic is incorrect. In fact, about half of the facilities we selected had received a recertification inspection since the pandemic ended. As stated on page 22 of our report, we selected our facility sample based on various risk

factors, including inspection results and number of citations, whether a plan of correction was warranted, and facility ownership. We did not consider the timing of a facility's last inspection when selecting our sample.

While the audit only considered the COVID-19 pandemic period from March 2020 through November 2021, its effects on healthcare are profound and long-term and, in some cases, still being learned even after the federal public health emergency expired in May 2022, a full six months after the Office of the State Comptroller applied as the date when the Department should have resumed business as usual based on resumption of "regular" nursing home inspections as directed by the federal government, which currently has no involvement in adult care facility oversight.

State Comptroller's Comment – DOH's concern regarding the use of November 2021 as the benchmark for resuming regular inspection overlooks that this date was selected because officials were unable to provide an alternative timeline for when inspections were expected to resume. Unlike similar types of facilities, such as nursing homes, DOH never officially suspended regular inspections, nor issued formal guidance on when regular inspections should resume for adult care facilities. Moving the date regular inspections should resume by 6 months would not change our overall conclusions. Furthermore, regardless of the impact of the COVID-19 pandemic, DOH remains responsible for ensuring that facilities meet all applicable requirements to protect resident safety and well-being.

However, notably, the federal government stated that nursing home recertification surveys could resume in November 2021, but also offered flexibilities to States including those evidenced in QSO-22-02- ALL.

State Comptroller's Comment – While federal guidance allowed for certain mandatory survey protocols to be discretionary or triggered based on specific concerns, QSO-22-02-ALL directed states to resume recertification surveys on a regular basis, as of November 12, 2021.

Regardless, throughout the public health emergency, adult care facilities were subject to comprehensive, focused infection control and complaint investigations, and in some cases, were the subject of enforcement actions.

The Office of the State Comptroller referred to the Department allegations from their onsite observations and where appropriate, complaints were opened. For some of the affected adult care facilities, significant enforcement action was pursued.

It is important to remember that adult care facilities are social, non-medical, homelike settings that serve individuals who are generally more functionally independent than those eligible for skilled nursing facility care. The facility is obligated to support the residents' right to dignity, independence, and freedom of choice. Residents may choose to imbibe, and facility staff facilitate such independent choices within the regulatory framework while preserving the homelike atmosphere of the setting.

State Comptroller's Comment – The concern regarding our observation of a half-empty bottle of vodka was not related to residents consuming alcohol, but rather the presence of alcohol stored in a medical room that was accessible only to staff.

Recommendation #2

Establish and implement formal procedures to ensure that complaints are fully investigated and properly documented, and ensure monitoring procedures are followed so complaint investigation results are communicated to facilities within the required 30-day time period.

Response #2

In 2024, the Department implemented a tracking system to monitor its compliance with prescribed timelines. Specifically, following the survey exit date, surveyors have 10 days to write their reports, then a supervisor has 10 days to perform a quality assurance review, their manager has 5 days to review and complete companion letters, with posting expected by day 30 post-exit. Notably, with limited exceptions including administrative closures due to the time between intake and investigation exacerbated by staffing issues and a global health pandemic, complaint determination letters are issued when complaints are closed.

The Draft Report summarized Regional Office staff's expression about the challenges by the complex regulatory framework that governs adult care facilities. The Department has mitigated the complexity through routine touchpoints and the wide broadcast of a centralized guidance portal directly accessible by all surveyors. Based on citation data, or at the suggestion or request of internal and external stakeholders, the Department frequently issues guidance documents to the industry and surveyors and hosts a variety of publicly posted webinars intended to enhance foundational clarity for both surveyors and industry professionals and result in improved overall quality of life in adult care facilities. Finally, real-time cross-program communication has been enhanced, leading to consistency and identification of best practices that strongly support this mission-critical survey activity.

Recommendation #3

Ensure DOH staff collect all required information from complainants who do not specifically request anonymity and establish and document time frames for issuing investigation result letters to complainants.

Response #3

The Department has implemented several steps to ensure that a consistent process to notify complainants not otherwise requesting anonymity is in place, including:

- Since 2022, all surveyors are required to complete the federal Surveyor Minimum Quality Test standard, which provides a strong, consistent foundation for long-term care residential surveillance complaint investigations.
- Adult care facility surveyors complete a rigorous onboarding procedure, whereby they are paired with a mentor to learn the disciplinary-specific nuances of investigations of violations against adult care facility regulations, report preparation, and use of the federal software platform.
- Annually, the program reviews its Operations Manual for efficiency, and in 2024 emphasized the quality assurance review process to better ensure that the components of each investigation are properly translated to the Aspen Complaint Tracking System (ACTS) software application.

- A Leadership Academy was launched in 2025 to educate and invest in the growth of mid-level surveillance managers and enhance their ability to share best practices, leverage technology to build efficiencies and consistency, and use data to drive performance improvements based on quantifiable benchmarks.

- The Quality Assurance Performance Improvement Committee reviews a sample of investigation summaries for completeness and to identify ongoing opportunities for improvement through the development of targeted trainings.

  State Comptroller's Comment – While DOH did identify steps to address this recommendation, the steps listed will not fix all problems identified in the report. For example, none of the steps establish specific time frames for issuing investigation result letters to complainants. In addition, many of the steps were already in place during the audit period and were ineffective in preventing the issues we identified. Furthermore, it is not clear how the recently implemented steps, such as the Leadership Academy, will specifically address this recommendation.

Recommendation #4

Take steps to improve the accuracy, completeness, and usefulness of data used to monitor adult care facility oversight activities.

Response #4

The Adult Care Facility Surveillance Program relies on an agreement from the federal Centers for Medicare and Medicaid Services (CMS) to use CMS' Aspen software platform for the purposes of categorizing and warehousing survey materials. The Office of the State Comptroller's audit team relied heavily on *ad hoc* data reports retrieved from the federal Aspen software package and were purportedly denied direct access to the Aspen system by CMS. Data limitation details were continually shared with the Office of the State Comptroller throughout the audit process, with the Department providing complicated query coding that could not be solely relied upon absent federal technical assistance to aid the Office of the State Comptroller. The Aspen software platform is slated for replacement for some survey settings in mid-2025, but there is no definitive transition date for State-only programs that had been using the platform under an agreement, such as adult care facilities. Until a software replacement is made, the Department's Data Officers will continue to explore alternative solutions necessary for reliable data translation.

In the interim, data dashboards were initiated prior to OSC engaging the audit in an effort by the Department to evaluate its programming and focus resources on troubled facilities, resulting in steady improvements to timeliness not otherwise referenced. In addition, the Office of Aging and Long-Term Care (OALTC) implemented an internal Quality Assurance Performance Improvement committee to analyze practices, guidance, and data necessary to address quality factors, and OALTC has used the findings of this committee to develop and deliver targeted education and guidance, with the goal of improving quality and data reliability.

Recommendation #5

Direct resources to ensure that DOH has adequate staffing levels to meet its adult care facility oversight responsibilities.

Response #5

The Department continues to evaluate its resource needs and resource gaps of its mission critical programs and services. As indicated in the Draft Report, the Department has taken steps toward securing the necessary resources to ensure timeliness of surveys and the correction of violations identified during such surveys. Steps have been taken to expand staffing using State programs, including the Hiring for Emergency Limited Placement (HELP) and Hiring for Emergency Limited Placement Statewide (HELPS) programs. The Department is confident that these measures will improve timeliness in the longer term and will continue to require a strong education and training structure on an ongoing basis.

Since 2022, the Office of Aging and Long-Term Care has and continues to employ multiple strategies to address workforce challenges, including: transformational leadership training, innovative and directed recruitment advertising, ongoing education for both staff and industry professionals, flexible work options, and unique employee opportunities, including a Leadership Academy to invest in the professional growth of mid-level surveillance managers. In addition, the team has established an internal Quality Assurance Performance Improvement committee to review practices, develop surveyor training, and implement technical procedural efficiencies. These steps have allowed the Department to maximize use of its available resources and have resulted in systemic improvement.

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