Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# INCIDENTS OF POTENTIAL ABUSE AND NEGLECT AT SKILLED NURSING FACILITIES WERE NOT ALWAYS REPORTED AND INVESTIGATED

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**Report in Brief**
Date: June 2019
Report No. A-01-16-00509

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

# Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated

## Why OIG Did This Review

This audit report is one of a series of OIG reports addressing the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's most vulnerable populations, including the elderly and individuals with developmental disabilities.

Our objectives were to determine (1) the prevalence of incidents of potential abuse or neglect of Medicare beneficiaries residing in skilled nursing facilities (SNFs) who had a hospital emergency room (ER) Medicare claim in calendar year 2016 containing a high-risk diagnosis code, (2) whether these incidents of potential abuse or neglect were properly reported by the SNFs, (3) whether the Centers for Medicare & Medicaid Services (CMS) and State Survey Agencies (Survey Agencies) reported findings of substantiated abuse to local law enforcement, and (4) the extent to which CMS requires incidents of potential abuse or neglect to be recorded and tracked.

## How OIG Did This Review

Our review covered 37,607 high-risk hospital ER claims for 34,820 Medicare beneficiaries residing in SNFs during calendar year 2016. We and the Survey Agencies reviewed supporting documentation for 256 high-risk hospital ER Medicare claims to determine whether the incidents were the result of potential abuse or neglect, and if so, reported to the Survey Agencies. We reviewed incidents that were not included in our sampling frame to determine whether CMS and the Survey Agencies reported findings of substantiated abuse to local law enforcement. We assessed how CMS tracks all incidents of potential abuse or neglect.

## What OIG Found

We determined that an estimated one in five high-risk hospital ER Medicare claims for treatment provided in calendar year 2016 were the result of potential abuse or neglect, including injury of unknown source, of beneficiaries residing in a SNF. We determined that SNFs failed to report many of these incidents to the Survey Agencies in accordance with applicable Federal requirements. We also determined that several Survey Agencies failed to report some findings of substantiated abuse to local law enforcement. Lastly, we determined that CMS does not require all incidents of potential abuse or neglect and related referrals made to law enforcement and other agencies to be recorded and tracked in the Automated Survey Processing Environment Complaints/Incidents Tracking System. Preventing, detecting, and combating elder abuse requires CMS, Survey Agencies, and SNFs to meet their responsibilities.

## What OIG Recommends and CMS Comments

We recommend that CMS take action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported by working with the Survey Agencies to improve training for staff of SNFs on how to identify and report incidents of potential abuse or neglect of Medicare beneficiaries, clarifying guidance to define and provide examples of incidents of potential abuse or neglect, requiring the Survey Agencies to record and track all incidents of potential abuse or neglect in SNFs and referrals made to local law enforcement and other agencies, and monitoring the Survey Agencies' reporting of findings of substantiated abuse to local law enforcement.

In written comments on our draft report, CMS concurred with our recommendations and provided details about the actions it has taken and plans to take to ensure incidents of potential abuse or neglect of Medicare beneficiaries in SNFs are identified and reported.

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# INTRODUCTION

## WHY WE DID THIS REVIEW

This audit report is one of a series of Office of Inspector General (OIG) reports that addresses the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's most vulnerable populations, including the elderly and individuals with developmental disabilities. We are committed to detecting and combating such abuse and neglect.

The majority of Medicare beneficiaries admitted to skilled nursing facilities (SNFs) are elderly. Elder abuse and neglect is a serious problem, with the elderly population expected to reach approximately 84 million by 2050.[1] In 2008, 1 in 10 elderly persons reported emotional, physical, or sexual abuse or potential neglect in the previous year.[2] However, many cases are not reported because the elderly are afraid or unable to tell protective services, police, friends, or family.[3] In addition, it is not always easy to identify elder abuse or neglect. For example, without proper training, it could be difficult to differentiate between the signs of elder abuse or neglect and the normal aging process.

## OBJECTIVES

Our objectives were to determine (1) the prevalence of incidents of potential abuse or neglect[4] of Medicare beneficiaries residing in SNFs who had a hospital emergency room (ER) Medicare claim in calendar year 2016 containing 1 of 580 diagnosis codes that we determined to be high risk, (2) whether these incidents were properly reported by the SNFs in accordance with applicable Federal requirements, (3) whether the Centers for Medicare & Medicaid Services (CMS) and State Survey Agencies (Survey Agencies) reported findings of substantiated abuse occurring in SNFs to local law enforcement, and (4) the extent to which CMS requires incidents of potential abuse or neglect to be recorded and tracked.

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[1] United States Census Bureau Press Release; *Fueled by Aging Baby Boomers, Nation's Older Population to Nearly Double in the Next Twenty Years, Census Bureau Reports*, issued May 6, 2014. Available online at https://www.census.gov/newsroom/press-releases/2014/cb14-84.html. Accessed on January 16, 2019.

[2] R Acierno, MA Hernandez, AB Amstadter, et al. "Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study." *American Journal of Public Health*; 2010; 100:292–297.

[3] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, press release; *Understanding Elder Abuse,* issued in 2016. Accessed at https://www.cdc.gov/violenceprevention/pdf/em-factsheet-a.pdf on January 16, 2019.

[4] This audit report covers incidents involving all eligibility types of Medicare beneficiaries, regardless of their age or the reason for their Medicare coverage. For the purpose of this report, an "incident" is defined as a Medicare claim involving the treatment of potential abuse or neglect. Our audit covered Medicare beneficiaries aged 20 to 109 years.

## BACKGROUND

### The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. CMS administers Medicare. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services, physician services, laboratory services, and ambulance services. There was a monthly average of 57.1 million Medicare beneficiaries in 2016.

### The Social Security Act

Section 2011 of the Act defines an elder as an individual aged 60 years or older and abuse as "the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm." Section 2011 defines neglect as "the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder."[5] It also defines exploitation as "the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets."

### The Older Americans Act

The Older Americans Act, P.L. No. 89-73 (enacted July 14, 1965) was reauthorized as P.L. No. 114-144 (April 19, 2016) with a variety of objectives, including the protection of older persons from abuse, neglect, and exploitation. The Older Americans Act created the National Aging Network, comprising the Administration on Aging at the Federal level, Units on Aging at the State level, and Area Agencies on Aging at the local level. This network provides funding, based primarily on the percentage of an area's population aged 60 years and older, for nutrition and supportive home and community-based services, disease prevention and health promotion services, elder rights programs, the National Family Caregiver Support Program, and the Native American Caregiver Support Program.

### Conditions of Participation

CMS developed the Conditions of Participation (CoPs) that healthcare organizations must meet to start and continue participating in Medicare and Medicaid. These CoPs establish health and

[5] This definition also includes self-neglect.

safety standards, which are the foundation for improving quality and protecting the health and safety of beneficiaries. The CoPs specific to SNFs and nursing facilities can be found at 42 CFR section 483, which covers a variety of health and safety topics related to the operation of SNFs and nursing homes. Residents of these facilities have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. SNFs and nursing facilities must also ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown sources and misappropriation of resident property, are reported immediately to the administrator of the facility and to other officials (including Survey Agency officials) in accordance with State law through established procedures. The facility must report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action must be taken (42 CFR § 483.13).[6]

Facilities that fail to comply with these requirements are subject to sanctions and corrective action requirements, including (but not limited to) Plans of Correction,[7] civil monetary penalties, and termination from participation in Medicare and Medicaid.[8]

**CMS State Operations Manual**

The *State Operations Manual* (SOM) is part of the CMS Online Manual System, which is used by CMS program components, partners, contractors, and Survey Agencies to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives.

**Skilled Nursing Facilities**

SNFs are nursing facilities with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related healthcare services. Skilled nursing care is care given or supervised by registered nurses. Examples of skilled nursing care include giving intravenous drugs, shots, or tube feedings; changing dressings; and teaching about diabetes care. Skilled rehabilitative services include physical therapy, occupational therapy, and speech therapy. Medicare does not consider skilled services to include any service that could be done safely by a nonmedical person without the supervision of a nurse (the Act § 1819). There were

[6] Effective November 28, 2016, 42 CFR § 483.13 was removed and replaced by 42 CFR § 483.12 (81 Fed. Reg. 68688 (Oct. 4, 2016)). Section 483.12 now requires that these allegations be reported immediately but (1) not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury or (2) not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The requirements of section 1150B of the Act were also added to this CoP at that time.

[7] A Plan of Correction is a plan developed by the facility and approved by CMS or the Survey Agency that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected (42 CFR § 488.401).

[8] 42 CFR §§ 488.406 and 488.408.

approximately 2.7 million SNF admissions involving approximately 1.9 million Medicare beneficiaries in calendar year 2016.

**State Survey Agencies**

CMS is responsible for overseeing compliance with Medicare health and safety standards. CMS delegates a variety of tasks related to this oversight to the Survey Agencies (the Act § 1864). One of these tasks is to conduct investigations and fact-finding surveys to determine how well healthcare providers, including SNFs, comply with their applicable CoPs, including the reporting of potential abuse or neglect. When the Survey Agency or CMS Regional Office substantiates a finding of abuse, the Survey Agency or Regional Office must report the substantiated finding to law enforcement and, if appropriate, the State's Medicaid Fraud Control Unit (MFCU) (SOM, chapter 5 § 5330). In fiscal year 2016, Federal funding of Survey Agencies was an estimated $397 million.

**CMS State Survey Agency Directors' Letters**

CMS issues various forms of guidance to assist the Survey Agencies with the tasks that they perform for CMS under the agreements in section 1864 of the Act. These forms of guidance include CMS State Survey Agency Directors' Letters, which provide clarifications, updates, and instructions related to the oversight process and are issued on an as-needed basis.

**The Complaint and Incident Tracking System**

The Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS) was designed by CMS to track, process, and report on complaints and incidents reported against healthcare providers and suppliers regulated by CMS. ACTS was also designed to manage all operations associated with complaint and incident processing, from initial intake and investigation through the final disposition of the complaint or incident. ACTS is used by both the Survey Agencies and CMS (SOM, chapter 5 § 5060).

**Medicaid Fraud Control Units**

Each State's MFCU investigates and prosecutes a variety of healthcare-related crimes, including patient abuse or neglect in healthcare facilities.[9] These healthcare facilities include SNFs that receive Medicare reimbursements. MFCUs operate in 49 States and the District of Columbia. MFCUs, which are usually a part of the State Attorney General's office, employ teams of investigators, attorneys, and auditors. OIG, in exercising oversight of the MFCUs, annually recertifies each MFCU, assesses each MFCU's performance and compliance with Federal requirements, and administers a Federal grant award to fund a portion of each MFCU's operational costs.

[9] The Act § 1903(q).

**Adult Protective Services Programs**

Each State has an adult protective services (APS) program authorized by State law. State and local APS programs are considered among the first responders to reports of abuse, neglect, or exploitation of adults.[10] Upon receiving an allegation of abuse involving an elderly or vulnerable adult, APS programs typically provide services, including an investigation of the allegation, evaluation of client risk and mental capacity, and ongoing monitoring of the delivery of services. APS programs also work closely with law enforcement if criminal abuse against elderly or vulnerable adults is suspected.

**Recent OIG Related Reviews**

OIG is committed to protecting beneficiary health and safety and has issued numerous reports that have detailed problems with the quality of care and the reporting and investigation of potential abuse or neglect at group homes, nursing homes, and SNFs.[11] For example, OIG's recent audit reports on critical incident[12] reporting at group homes showed that group home providers did not report up to 15 percent of critical incidents to the appropriate State agencies (A-01-14-00002, A-01-14-00008, A-01-16-00001). OIG's study of adverse events[13] in SNFs found that an estimated 22 percent of Medicare beneficiaries experienced adverse events during their SNF stays (OEI-06-11-00370). These adverse events included infections, pressure ulcers, and medication-induced bleeding. We determined through our medical record review that 69 percent of these patient-harm events could have been prevented if the SNFs had provided better care. More than half of the residents harmed during their SNF stays required hospital care to treat the adverse event.

In addition, we issued an Early Alert to CMS in August 2017 (Appendices B and C, A-01-17-00504). CMS needed to be notified before the release of this report on the potential abuse of Medicare beneficiaries residing in SNFs because of the severity of the incidents we identified. The Early Alert involved 12 diagnosis codes used by the treating medical providers that specifically indicated potential physical and sexual abuse or neglect of Medicare beneficiaries, such as "T7621XA, adult sexual abuse, suspected, initial encounter." (See

[10] Each State defines "adult" differently for APS purposes. For example, some States define an adult eligible for APS services as anyone aged 18 years or older, but other States define such an adult as anyone aged 60 years or older. Some States also require that the adults be vulnerable because of a physical or mental illness or a disability.

[11] See Appendix B for a list of previously issued OIG reports on this issue.

[12] The general definition of "critical incidents" includes but is not limited to events involving facility patients or residents who suffered serious injuries or illness requiring treatment at an ER.

[13] The term "adverse event" describes harm to a patient or resident as a result of medical care or in a health care setting.

Appendix C, pages 28 and 29, for a complete list of the 12 codes.) The 580 diagnosis codes covered in this report exclude the 12 diagnosis codes from the Early Alert.

## HOW WE CONDUCTED THIS REVIEW

Our review covered 37,607 high-risk hospital ER Medicare claims nation-wide,[14] which involved 34,820 of the approximate 1.9 million beneficiaries residing in SNFs during calendar year 2016. The beneficiaries associated with these claims were transported to the ER directly from a SNF during 2016. These claims were 27,127 hospital outpatient and 10,480 inpatient claims, totaling $163,207,281, and contained at least 1 of 580 diagnosis codes consisting of outpatient principal diagnosis codes and inpatient admitting diagnosis codes that we determined to be high risk for potential abuse or neglect.[15] The 580 diagnosis codes included head injuries, bodily injuries, and safety and medical issues. We selected these codes to identify incidents of potential abuse or neglect that were not specifically coded by the treating medical providers on the associated Medicare claim as involving potential abuse or neglect.

We selected a sample of 256 high-risk hospital ER Medicare claims (160 outpatient and 96 inpatient) from 8 States.[16] We obtained the medical records and other supporting documentation[17] associated with these Medicare claims and reviewed them with Survey Agency officials to determine whether the injuries or illnesses that required treatment were the result of incidents of potential abuse or neglect.[18] We then determined whether the SNFs properly reported these incidents of potential abuse or neglect in accordance with applicable Federal requirements.

As we analyzed our sample claims, we determined many incidents of potential abuse or neglect were not reported by SNFs. Therefore, we reviewed reported incidents that were not included in our sampling frame to determine whether CMS and the Survey Agencies reported findings of substantiated abuse to local law enforcement. The additional steps included reviewing ACTS

[14] We used a map to illustrate the number of Medicare claims per State (Appendix D).

[15] These 580 diagnoses codes were assigned by the ER staff who treated the Medicare beneficiaries. We did not identify Medicare beneficiaries who were injured or ill but not treated at an ER because there would have been no record of their treatment. Therefore, there is a risk that other Medicare beneficiaries who were potentially abused or neglected remain unidentified.

[16] We are not naming the eight randomly selected States because the results of our review should not be viewed as State-specific results.

[17] Examples of this documentation included hospital medical records, SNF medical records, SNF incident reports, and witness statements.

[18] Survey Agency staff in each State reviewed the medical records. The Survey Agency reviewers included program managers, medical professionals, and other trained staff.

data[19] provided by CMS to identify allegations of abuse reported to the Survey Agencies by SNFs or third parties and determining which allegations were substantiated by the Survey Agencies. We then determined whether the Survey Agencies reported the findings of substantiated abuse to local law enforcement and, if appropriate, the MFCU.

We also assessed the controls that CMS has in ACTS for tracking all incidents of potential abuse or neglect and referrals made to local law enforcement and other agencies. Specifically, we determined whether incidents reported to the Survey Agencies were always entered into ACTS and tracked. We also determined whether referrals made to local law enforcement or other agencies were always recorded in ACTS.

We conducted this 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology. Appendix E contains our statistical sampling methodology. Appendix F contains our sample results and estimates.

## FINDINGS

We determined that an estimated one in five high-risk hospital ER Medicare claims for treatment provided in calendar year 2016 were the result of potential abuse or neglect, including injury of unknown source,[20] of beneficiaries residing in a SNF. We determined that SNFs failed to report many of these incidents to the Survey Agencies in accordance with applicable Federal requirements. We also determined that several Survey Agencies failed to report some findings of substantiated abuse to local law enforcement. Lastly, we determined that CMS did not require all incidents of potential abuse or neglect and related referrals made to law enforcement and other agencies to be tracked and recorded in ACTS. Specifically, we determined the following:

- Of the 256 sampled high-risk hospital ER Medicare claims, 51 were the result of incidents of potential abuse or neglect that were reportable to the Survey Agencies under Federal requirements. Based on our sample results, we estimated that 7,831 of the 37,607 high-risk hospital ER Medicare claims were the result of incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs.

[19] The ACTS data provided by CMS contained information for all reported incidents and complaints for the 222 SNFs associated with the 256 sampled high-risk hospital ER Medicare claims for calendar year 2016.

[20] For the remainder of this report, when we refer to incidents of potential abuse or neglect, we are including incidents involving injuries of unknown source.

- Of the 51 sampled high-risk hospital ER Medicare claims that were the result of potential abuse or neglect, 43 were not reported by the SNFs to the Survey Agencies. On the basis of these sample results, we estimated that 6,608 high-risk hospital ER Medicare claims were associated with incidents of potential abuse or neglect that were not reported by the SNFs to Survey Agencies during calendar year 2016.

- Five Survey Agencies did not report findings of substantiated abuse to local law enforcement for 67 of 69 incidents outside of our sampling frame involving 34 SNFs.

- CMS did not require all incidents involving potential abuse or neglect to be entered in ACTS. In addition, CMS did not require referrals to law enforcement and other agencies to be entered in ACTS.

CMS did not ensure that all incidents of potential abuse or neglect were reported in accordance with applicable Federal requirements for several reasons. One reason was that CMS guidance was not clear and, therefore, subject to inconsistent interpretation by SNFs. Survey Agency officials informed us that there were multiple reasons they did not report findings of substantiated abuse to local law enforcement officials.

**AN ESTIMATED ONE IN FIVE HIGH-RISK MEDICARE EMERGENCY ROOM CLAIMS POTENTIALLY RESULTED FROM ABUSE OR NEGLECT**

SNFs are obligated to report alleged violations involving neglect or abuse, including injuries of unknown source, to the Survey Agency. CMS has issued guidance that defines neglect, abuse, and injuries of unknown source as follows:

- **Neglect:** Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness (42 CFR § 488.301).

- **Abuse:** The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish (42 CFR § 488.301).

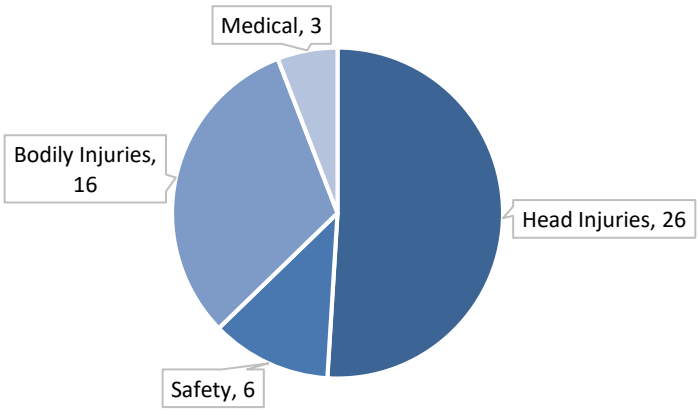
- **Injuries of unknown source:** An injury is classified as an "injury of unknown source" when both of the following conditions are met: (1) the source of the injury was not observed by any person or could not be explained by the resident and (2) the injury is suspicious because of its extent or location (e.g., the injury is located in an area not generally vulnerable to trauma) or because of the number of injuries observed at one time or the number of injuries over time ("CMS State Survey Agency Directors' Letter," (S&C-05-09), December 16, 2004).[21]

[21] Definitions of "abuse" and "neglect" have since been added to 42 CFR § 483.5 (81 Fed. Reg. 68688 (Oct. 4, 2016)) and the definition for "injuries of unknown source" has also since been added to the SOM, appendix PP (Rev. 173, effective Nov. 28, 2017).

At our request, the Survey Agencies reviewed available documentation and determined that 51 of the 256 sampled high-risk hospital ER Medicare claims were the result of incidents of potential abuse or neglect.[22] Specifically, we worked with the Survey Agencies to identify 24 incidents of potential neglect, 24 incidents involving injuries of unknown source,[23] and 3 incidents of potential abuse. The Survey Agencies determined that the remaining 205 sampled high-risk hospital ER Medicare claims were not the result of incidents of potential abuse or neglect. On the basis of our sample results, we estimated that nation-wide there were 7,831 high-risk hospital ER Medicare claims for Medicare beneficiaries residing at SNFs that resulted from incidents of potential abuse or neglect during calendar year 2016. This estimate represents 21 percent of the 37,607 claims we identified for review. Although the estimated high-risk claims involve only a small portion of Medicare beneficiaries residing in SNFs in 2016,[24] abuse and neglect should never occur.

These incidents of potential abuse or neglect resulted in a variety of injuries, which we categorized as head injuries, bodily injuries, medical issues, and safety issues on the basis of the diagnosis codes (Appendix G). The Figure identifies the diagnosis associated with the 51 ER claims that resulted from incidents of potential abuse or neglect. The beneficiaries were treated on either an outpatient basis or inpatient basis if the injuries required a hospital admission.

Figure: Diagnosis Associated With the 51 Medicare Claims Associated With Incidents of Potential Abuse or Neglect




[22] The Survey Agencies had professionally qualified individuals determine whether an incident was reportable under Federal requirements. The Survey Agencies' reviews were limited to the documentation provided by the hospitals and SNFs. In some cases, the Survey Agencies indicated that their determination may have been different if additional records had been available.

[23] The Survey Agencies made the determination that the incidents were injuries of unknown source because the incident was not observed and could not be explained by the patient and the circumstances surrounding the injuries were suspicious. Therefore, the SNFs should have reported the injuries to the Survey Agencies.

[24] There were approximately 2.7 million SNF admissions involving approximately 1.9 million Medicare beneficiaries during calendar year 2016.

**Head Injuries**

Of the 51 incidents of potential abuse or neglect, 26 involved head injuries (4 traumatic brain injuries, 3 facial or nasal fractures, 6 lacerations or abrasions, 6 contusions, and 7 unspecified head injuries).

**Bodily Injuries**

Of the 51 incidents of potential abuse or neglect, 16 involved bodily injuries (12 femur fractures, 3 vertebra fractures, and 1 shoulder dislocation).

**Safety Issues**

Of the 51 incidents of potential abuse or neglect, 6 involved safety issues (4 poisonings and 2 accidents).[25]

**Medical Issues**

Of the 51 incidents of potential abuse or neglect, 3 involved medical issues (2 aspiration pneumonia and 1 sepsis).

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**A Representative Example of a Medicare Emergency Room Claim That Potentially Resulted From Abuse or Neglect**

The Survey Agency determined that an incident involving a 72-year-old Medicare beneficiary[26] with a history of throat cancer, recent throat surgery, and a nasogastric tube in place potentially resulted from neglect. The beneficiary was transported to an ER following a postoperative followup appointment at the hospital due to a productive cough, dehydration, and fatigue and was diagnosed with aspiration pneumonia. At the ER, the beneficiary's wife expressed concerns regarding the quality of care at the SNF. Specifically, she stated that her husband's nasogastric tube had not been suctioned well at the SNF, and she believed he was not given all of his scheduled tube feeds. In addition, the SNF records indicated that 5 days prior the beneficiary was given a meal tray with liquids despite a strict "nothing by mouth" order. The SNF records also indicated that the nursing manager was planning to put steps in place to ensure this type

[25] The four poisonings were the result of accidental overdoses caused by the SNFs' over-administration of drugs. The two accidents were patient falls.

[26] This beneficiary was also a military veteran. We determined that of the 51 Medicare claims associated with incidents of potential abuse or neglect in our sample, 8 were associated with Medicare beneficiaries who were also veterans.

of error did not recur. The beneficiary was admitted to the hospital for 2 days, treated with antibiotics, and then discharged to his home.
The combination of the injuries suffered and the allegations made by the beneficiary's family gave reasonable cause to suspect potential neglect of this beneficiary.

**SKILLED NURSING FACILITIES FAILED TO REPORT MANY INCIDENTS OF POTENTIAL ABUSE OR NEGLECT TO THE SURVEY AGENCIES**

A SNF must ensure that all incidents involving alleged mistreatment, abuse, neglect, and injuries of unknown source are reported immediately to the administrator of the facility and to other officials, including the Survey Agency, in accordance with State law through established procedures (42 CFR § 483.13).[27]

Chapter 5 of the SOM states that the mission of the complaint/incident process is to protect Medicare and Medicaid beneficiaries from abuse, neglect, exploitation, and inadequate care or supervision. Survey Agencies are required to promptly review and prioritize complaints and incidents; conduct unannounced onsite investigations, if necessary; and transmit the results of required investigations and recommendations to the CMS Regional Offices through ACTS. CMS Regional Offices are responsible for monitoring the Survey Agencies' management of complaints and incidents to ensure that the Survey Agencies are complying with the provisions set forth in Federal regulations, the SOM, and CMS policy memoranda.

SNFs did not report all incidents of potential abuse or neglect to the Survey Agencies in accordance with State law through established procedures. Of the 51 high-risk hospital ER Medicare claims associated with incidents of potential abuse or neglect, we determined that 43 were associated with incidents of potential abuse or neglect that 42 SNFs[28] did not report to the Survey Agencies.[29] Accordingly, the Survey Agencies could not review, prioritize, and conduct an immediate onsite investigation, if necessary, to determine whether abuse, neglect, or other violations had occurred. Further, the CMS Regional Offices could not monitor the Survey Agencies' management of these incidents. For informational purposes, we also confirmed that none of these 43 incidents were reported to APS and that only 1 of the 43 incidents was reported to a MFCU.[30] On the basis of our sample results, we estimated that

[27] Effective November 28, 2016, 42 CFR § 483.13 was removed and replaced by 42 CFR § 483.12 (81 Fed. Reg. 68688 (Oct. 4, 2016)).

[28] One SNF had two unreported incidents.

[29] Of the 43 incidents of potential abuse or neglect, 3 were reported by third parties to the Survey Agencies.

[30] We reported all 256 sampled high-risk hospital ER Medicare claims to APS and the MFCUs. Additionally, we reported all 51 incidents of potential abuse or neglect to local law enforcement.

nation-wide there were 6,608 high-risk hospital ER Medicare claims associated with incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs that were not reported to the Survey Agencies during calendar year 2016. This estimate represented approximately 18 percent of the 37,607 high-risk hospital ER Medicare claims and 84 percent of the estimated 7,831 high-risk hospital ER Medicare claims that resulted from incidents of potential abuse or neglect.

We requested that each of the 42 SNFs explain to us why they did not report the 43 incidents to the Survey Agencies as required. Thirty-five SNFs responded to our request, but the remaining seven SNFs did not respond to our repeated requests.[31] In general, the 35 SNFs indicated that they did not believe the incidents met Federal reporting requirements even though the Survey Agencies determined that the incidents of potential abuse or neglect had met the requirements according to the available documentation and should have been reported.

SNFs did not report all incidents of potential abuse or neglect in accordance with Federal requirements because CMS guidance was not clear and, therefore, the SNFs interpreted it inconsistently. The "CMS State Survey Agency Directors' Letter" (S&C-05-09, December 16, 2004) was intended to clarify the SNF reporting requirements for alleged violations of mistreatment, neglect, and abuse (including injuries of unknown source and misappropriation of resident property), but several Survey Agencies noted that the correct classification of an incident, according to Federal requirements, was not always clear to the SNFs, particularly for injuries of unknown source. The CMS letter states that an injury is classified as an "injury of unknown source" when it has not been observed by any person or could not be explained by the resident and is suspicious because of the extent, location, or number of the injuries. The Survey Agency officials across the States in our sample interpreted the term "suspicious" in different ways when determining whether an incident should have been reported to the Survey Agency as an injury of unknown source. The lack of clear guidance from CMS results in incidents going unreported by the SNFs.

**A Representative Example of an Incident of Potential Neglect Not Reported by a SNF to the Survey Agency**

A SNF did not report to the Survey Agency an incident of potential neglect involving a 65-year-old Medicare beneficiary with a history of a stroke and diabetes. The beneficiary was brought to a hospital's ER from the SNF by ambulance. The beneficiary had become extremely lethargic and had breathing difficulties after the SNF had increased the beneficiary's opioid pain medication several days earlier. The hospital records indicated that the beneficiary was in critical condition with acute metabolic encephalopathy,[32] acute respiratory

[31] We provided the Survey Agencies with the names of the seven unresponsive SNFs.

[32] Encephalopathy is a general term meaning any disorder or disease of the brain.

failure, acute kidney failure, and hypoxemia[33] due to opioid toxicity. The beneficiary improved after receiving an opioid antidote in the ER and was admitted to the hospital for 2 days for further treatment. After the inpatient stay, the beneficiary was discharged to the SNF.

The SNF records attributed the opioid poisoning to a transcription error. Specifically, an opioid was administered to the beneficiary every 4 hours, but the physician order was for every 6 hours. The SNF records also noted that individualized education was provided to the nurse who incorrectly transcribed the physician order. However, the SNF did not report this incident to the Survey Agency.

The Survey Agency determined this incident involved potential neglect because of the combination of the medication error and injuries suffered; accordingly, the SNF should have complied with Federal requirements and reported the incident to the Survey Agency.

**SEVERAL SURVEY AGENCIES FAILED TO REPORT SOME FINDINGS OF SUBSTANTIATED ABUSE TO LOCAL LAW ENFORCEMENT**

As part of the investigation process, the Survey Agency or CMS Regional Office determines whether allegations are substantiated or unsubstantiated. When one or the other substantiates a finding of abuse, it must report the findings to local law enforcement and, if appropriate, the MFCU (SOM, chapter 5 § 5330 and the "CMS State Survey Agency Directors' Letter," (S&C-02-20), March 28, 2002).

As a result of our review of reported incidents that were not included in our sampling frame, we identified 69 allegations of abuse involving 34 SNFs that 5 Survey Agencies investigated and substantiated.[34] We determined that the 5 Survey Agencies did not report findings of substantiated abuse to local law enforcement for 67 of 69 incidents.[35] Specifically, we found that one of the five Survey Agencies reported the findings for two of its three substantiated incidents of abuse to local law enforcement but did not report the findings for one incident. The other 4 Survey Agencies did not report the findings for the remaining 66 incidents of

[33] Hypoxemia is an abnormally low concentration of oxygen in a person's blood.

[34] Three of the Survey Agencies did not substantiate any allegations of abuse in calendar year 2016 for the SNFs associated with our sample. Although we limited our review to the SNFs associated with our sample, the three Survey Agencies confirmed that they substantiated abuse at SNFs not associated with our sample in calendar year 2016.

[35] According to ACTS records, local law enforcement was involved with 19 of these incidents (16 physical assaults, 2 verbal assaults, and 1 sexual assault) before the Survey Agencies were notified that the incidents had occurred. However, the Survey Agencies did not report their findings of substantiated abuse for 18 of these 19 incidents to local law enforcement after the State agencies' investigations were completed. Accordingly, we provided all 69 findings of substantiated abuse to local law enforcement.

substantiated abuse to local law enforcement. Although the Survey Agencies did not report these findings to local law enforcement, we found that 2 Survey Agencies reported the findings for 24 incidents of substantiated abuse to the MFCUs.

Survey Agency officials gave multiple reasons for not reporting findings of substantiated abuse to local law enforcement. Several Survey Agency officials stated they rely on SNF officials to report incidents of abuse to local law enforcement. One Survey Agency informed us that releasing the investigative reports to local law enforcement would violate State law. Another Survey Agency stated that it contacts local law enforcement only for what it calls "the most serious abuse cases."

Table 1 shows the number of local law enforcement and MFCU notifications of findings for the 69 incidents of substantiated abuse.

**Table 1: Local Law Enforcement and MFCU Notifications of Findings for the 69 Incidents of Substantiated Abuse in 5 of the 8 Sampled States**

| State | Substantiated Abuse Incidents | Local Law Enforcement Notified | Local Law Enforcement Not Notified | MFCU Notified | MFCU Not Notified* |
|---|---|---|---|---|---|
| State 3 | 22 | 0 | 22 | 22 | 0 |
| State 4 | 2 | 0 | 2 | 2 | 0 |
| State 5* | 40 | 0 | 40 | 0 | 40 |
| State 7 | 2 | 0 | 2 | 0 | 2 |
| State 8* | 3 | 2 | 1 | 0 | 3 |
| **Total** | **69** | **2** | **67** | **24** | **45** |

* Although Survey Agencies for States 5 and 8 informed us that they did not notify the MFCU of the substantiated abuse incidents, these States stated that the MCFUs had access to their systems to identify the 45 substantiated abuse incidents.

CMS officials informed us that the Regional Offices did not report any additional cases to law enforcement or the MFCU.

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**A Representative Example of an Incident of Substantiated Abuse Not Reported by the Survey Agency to Local Law Enforcement**

A SNF resident was sitting in the dining room of a SNF when a staff member walked by. The staff member pushed the back of the beneficiary's head and continued walking out of the room. The staff member later denied the accusation, but the incident was confirmed on surveillance video. The ACTS

record noted the complainant's allegation was substantiated. The Survey Agency informed us that it did not report this to local law enforcement or the MFCU after substantiating the incident.[36]

Because the Survey Agency substantiated abuse by the staff member, the Survey Agency should have reported the incident to the local law enforcement and, if applicable, to the MFCU.

## CMS DOES NOT REQUIRE CERTAIN INFORMATION ABOUT INCIDENTS OF POTENTIAL ABUSE OR NEGLECT TO BE ENTERED INTO THE AUTOMATED SURVEY PROCESSING ENVIRONMENT COMPLAINTS/INCIDENTS TRACKING SYSTEM

### CMS Does Not Require All Incidents of Potential Abuse or Neglect To Be Entered Into the Automated Survey Processing Environment Complaints/Incidents Tracking System

The Survey Agencies are required to enter into ACTS (1) all complaint information gathered as part of their Federal survey and certification responsibilities, regardless of whether an onsite survey has been conducted and (2) all SNF-reported incidents that require a Federal onsite survey (SOM § 5060). The "CMS State Survey Agency Directors' Letter" (S&C-05-09, December 16, 2004) states that CMS will be conducting a feasibility study to discern the value of requiring the entry of data into ACTS of all federally mandated self-reported incidents.

Survey Agencies are not required to record all incidents of potential abuse or neglect in ACTS. For example, Survey Agencies do not have to enter into ACTS incidents of potential abuse or neglect that SNFs self-report to the Survey Agencies that do not require a Federal onsite survey. We found that of the eight incidents of potential abuse or neglect included in our sample that SNFs self-reported, only three required a Federal onsite survey. Survey Agencies entered these incidents into ACTS as required, but the remaining five incidents were not recorded in ACTS. As a result, CMS and the Survey Agencies did not have information about these incidents available for data analysis.

CMS officials stated that they do not know whether the feasibility study to discern the value of entry of data into ACTS of all federally mandated self-reported incidents was ever conducted. However, the officials said CMS was reviewing its policies for entering self-reported incidents into ACTS. In addition, the officials stated that CMS was in the process of transitioning to a new, more efficient complaint and incident-tracking system. CMS officials told us that they will consider adding additional functionality not present in its current system after they have transitioned to the new incident-tracking system. The transition is expected to be completed in 2021.

[36] This incident occurred in a State in which the Survey Agency informed us that the MFCU had access to all abuse findings. The records we reviewed did not indicate whether any legal or disciplinary action was taken against the staff member.

Although there are no Federal regulations requiring all incidents be recorded in ACTS, omitting some incidents of potential abuse or neglect from the ACTS reporting requirements reduces the effectiveness of the system established to detect or resolve incidents of abuse or to prevent them. Improved information will allow CMS to better meet the objectives of the complaint and incident management system, which include:

- to provide protective oversight by analyzing the complaint allegations and reported incidents to respond to those that pose the greatest potential for harming beneficiaries;

- to prevent the escalation of less serious complaints and incidents into more serious situations that would threaten the health, safety, and welfare of the individuals receiving services; and

- to promote efficiency and quality within the healthcare delivery system (SOM, chapter 5 § 5000.1).

**A Representative Example of a SNF Self-Reported Incident of Potential Abuse That Was Not Entered Into the Automated Survey Processing Environment Complaints/Incidents Tracking System**

A Survey Agency determined that a SNF self-reported incident of potential abuse involving a 71-year-old Medicare beneficiary with a history of dementia and a traumatic brain injury did not require a Federal onsite survey and, therefore, was not entered into ACTS. The beneficiary was found at the SNF in his wheelchair bleeding from his nose and ear and with multiple bruises and scratches to his face. He was brought to the hospital's ER from the SNF by ambulance. The hospital records indicate that the beneficiary had facial trauma with facial bruising, a laceration to his ear, and a swollen nose. After medical imaging did not show intracranial hemorrhaging or fractures, the beneficiary was discharged to the SNF. The SNF reported the incident to the Survey Agency and stated that the beneficiary was struck by another resident. Although the beneficiary could not explain what happened, the other resident was found with blood on his hand and stated that he struck the beneficiary after the beneficiary didn't comply with a request to leave after the beneficiary entered the resident's room. The SNF indicated in its report that it took several corrective measures, such as increased supervision, counseling, and a safety gate for the room's entrance.

It is difficult to identify patterns of potential abuse or neglect if not all incidents are recorded, tracked, and analyzed in ACTS, thus, limiting the Survey Agencies' and CMS's ability to detect and prevent incidents of potential abuse or neglect.

### CMS Does Not Require Referrals to Law Enforcement and Other Agencies To Be Entered Into the Automated Survey Processing Environment Complaints/Incidents Tracking System

ACTS facilitates the tracking of complainants; residents, patients, or clients; alleged perpetrators; allegations; investigations of complaints and incidents; and referrals. CMS officials confirmed that ACTS is capable of tracking referrals to law enforcement, MFCUs, or other agencies. However, Survey Agencies are not required to complete the referral field in ACTS, and they do not always complete it.[37] Furthermore, some of the Survey Agencies stated that their computer systems did not collect or track any data of substantiated abuse reports made to local law enforcement. Because CMS and the Survey Agencies do not track all referrals, CMS Regional Offices have a limited ability to monitor referrals made by Survey Agencies.

## CONCLUSION

Because many incidents of potential abuse or neglect were not reported to the Survey Agencies, CMS and the Survey Agencies were not always able to pursue legal, administrative, and other appropriate remedies to ensure the health, safety, and rights of Medicare beneficiaries residing in these SNFs. In addition, CMS's and the Survey Agencies' failure to report 67 of the 69 incidents of substantiated abuse to local law enforcement may have led to significant delays in the investigation of these incidents or subsequent prosecution of the perpetrators, as appropriate. Finally, CMS does not require certain information about incidents of potential abuse or neglect to be entered into ACTS. Preventing, detecting, and combating elder abuse requires CMS, Survey Agencies, and SNFs to meet their responsibilities.

## RECOMMENDATIONS

We recommend that CMS take the following actions to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported:

- work with the Survey Agencies to improve training for staff of SNFs on how to identify and report incidents of potential abuse or neglect of Medicare beneficiaries,

- clarify guidance to clearly define and provide examples of incidents of potential abuse or neglect,

- require the Survey Agencies to record and track all incidents of potential abuse or neglect in SNFs and referrals made to local law enforcement and other agencies, and

[37] We could not make the determination whether a field in ACTS was blank because a referral was not made or because the Survey Agency did not complete the field.

- monitor the Survey Agencies' reporting of findings of substantiated abuse to local law enforcement.

## CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and provided details about the actions it has taken and plans to take to ensure incidents of potential abuse or neglect of Medicare beneficiaries in SNFs are identified and reported. For example, CMS has plans to issue new guidance specific to the reporting and tracking of facility-reported incidents of potential abuse and neglect.

In addition, CMS said that although our review of claims data provides helpful insight into past incidents of potential abuse and neglect of nursing home residents, "this data may not be timely enough to address acute problems since providers generally have up to 12 months (one calendar year) from the date the service was provided to submit claims for services rendered." CMS described the details of its complaint intake and investigation process, which it said addresses the time-sensitive nature of these issues.

CMS also described many of its other requirements and safeguards to ensure SNF resident safety. For example, CMS said that it requires nursing homes to report allegations of abuse, neglect, exploitation, or mistreatment to its State survey agency and adult protective services when State law gives it jurisdiction in long-term-care facilities. CMS also said that it conducts validation surveys of States to determine whether States are identifying deficiencies correctly, investigating compliance effectively, and meeting all other obligations.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix H.

## OFFICE OF INSPECTOR GENERAL RESPONSE

With regard to CMS's statement about the timeliness of our claims data, we acknowledge that providers have up to 12 months from the date of service to submit claims for services rendered. However, on average, hospitals submitted the claims that were included in our sampling frame to the Medicare Administrative Contractor (MAC) 23 days after the dates of service. In fact, hospitals submitted more than 80 percent of all claims included in our sampling frame to the MAC in fewer than 30 days after the dates of service and more than 90 percent of all claims included in our sampling frame in fewer than 90 days after the dates of service. Accordingly, we maintain that these data are timely enough to address acute problems of potential abuse and neglect, including injuries of unknown source.

We acknowledge the significant number of actions CMS has taken and plans to take to ensure that incidents of potential abuse or neglect of Medicare beneficiaries in SNFs are identified and reported.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our review covered 37,607 high-risk hospital ER Medicare claims for 34,820 beneficiaries. These beneficiaries were transported to the ER directly from a SNF during January 1, 2016, through December 31, 2016. These claims included 27,127 outpatient and 10,480 inpatient claims totaling $163,207,281 and contained at least 1 of 580 targeted diagnosis codes that we determined to be high-risk for potential abuse or neglect. We used a multistage sample design based on probability-proportional-to-size to select 8 States as primary sample units and 256 high-risk hospital ER Medicare claims as secondary sample units (160 outpatient and 96 inpatient).

We performed additional steps outside of our sampling frame of 37,607 high-risk hospital ER Medicare claims to determine whether CMS and the Survey Agencies reported findings of substantiated abuse to local law enforcement. The additional steps included reviewing ACTS data provided by CMS for the 222 SNFs associated with the 256 sampled high-risk hospital ER Medicare claims to identify allegations of abuse reported to the Survey Agencies by SNFs or third parties and determining which allegations were substantiated by the Survey Agencies. We then determined whether the Survey Agencies reported the findings of substantiated abuse to local law enforcement and, if appropriate, MFCUs.

We also assessed the controls CMS has in ACTS for tracking all incidents of potential abuse or neglect and referrals made to local law enforcement and other agencies.

We limited our review of internal controls to obtaining an understanding of the laws and regulations concerning the reporting of potential abuse or neglect of Medicare beneficiaries in SNFs.

We performed our fieldwork from July 2016 through September 2018. We visited CMS and the eight Survey Agencies.

### METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;

- held discussions with CMS officials to gain an understanding of Medicare requirements for reporting potential abuse and neglect in SNFs and of CMS's oversight of SNFs;

- extracted inpatient and outpatient ER claims from CMS's National Claims History file for services provided from January 1, 2016, through December 31, 2016, and that contained at least 1 of 580 targeted diagnosis codes and the associated SNF claims data;

- identified a sampling frame of 37,607 inpatient and outpatient claims that contained at least 1 of the 580 targeted diagnosis codes for beneficiaries who were transported to the ER from a SNF from January 1, 2016, through December 31, 2016;

- randomly selected 8 States as our primary sample units and 256 ER claims (12 inpatient and 20 outpatient from each State) as our secondary sample units from the sampling frame;

- obtained the medical records from the hospital and SNF providers associated with our sample of 256 ER claims;

- held discussions with the Survey Agencies in the 8 sampled States to gain an understanding of their operations and oversight of SNFs;

- reviewed the medical records associated with our sample of 256 ER claims with the 8 Survey Agencies in our sample to determine whether each incident associated with the ER claims was:

    - the result of potential abuse or neglect in the SNF and

    - reported by the SNF to the Survey Agency;

- reviewed ACTS data for January 1, 2016, through December 31, 2016, to identify incidents of abuse outside of our sampling frame that the Survey Agencies investigated and substantiated and determined whether the Survey Agencies and CMS Regional Offices appropriately reported the findings to local law enforcement and the MFCUs;

- identified the number of Medicare claims in our sample of 256 claims that were associated with Medicare beneficiaries who were veterans;

- reviewed the 37,607 Medicare claims data to determine whether any Medicare beneficiaries died after ER treatment for injuries or illnesses;

- assessed the controls CMS has in ACTS for tracking all incidents of potential abuse or neglect and referrals made to local law enforcement and other agencies; and

- discussed the results of our review with CMS officials.

We conducted this 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 objectives.

We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

| Report Title | Report No. | Date Issued |
|---|---|---|
| *A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015* | OEI-01-16-00330 | September 2017 |
| *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements* | A-01-17-00504 | August 2017 |
| *Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities* | A-01-16-00001 | August 2017 |
| *Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* | A-01-14-00008 | July 2016 |
| *Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* | A-01-14-00002 | May 2016 |
| *Review of Intermediate Care Facilities in New York with High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries* | A-02-14-01011 | September 2015 |
| *Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect* | OEI-07-13-00010 | August 2014 |
| *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* | OEI-06-11-00370 | February 2014 |
| *Criminal Convictions for Nurse Aides With Substantiated Findings of Abuse, Neglect, and Misappropriation* | OEI-07-10-00422 | October 2012 |
| *Unidentified and Unreported Federal Deficiencies in California's Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs* | A-09-09-00114 | September 2011 |
| *Nursing Facilities' Employment of Individuals With Criminal Convictions* | OEI-07-09-00110 | March 2011 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

**OFFICE OF INSPECTOR GENERAL**

WASHINGTON, DC 20201

August 24, 2017

**TO:** Seema Verma, M.P.H.
Administrator
Centers for Medicare & Medicaid Services

**FROM:** /Daniel R. Levinson/
Inspector General

**SUBJECT:** Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements (A-01-17-00504)

The purpose of this memorandum is to alert you to the preliminary results of our ongoing review of potential abuse or neglect of Medicare beneficiaries in skilled nursing facilities (SNFs). This audit is part of the ongoing efforts of the Office of Inspector General (OIG) to detect and combat elder abuse. The objectives of our audit are to (1) identify incidents of potential[1] abuse or neglect of Medicare beneficiaries residing in SNFs and (2) determine whether these incidents were reported and investigated in accordance with applicable requirements.

We are communicating these preliminary results to you because of the importance of detecting and combating elder abuse. Also, according to *Government Auditing Standards*, "early communication to those charged with governance or management may be important because of their relative significance and the urgency for corrective follow-up action."[2]

## RESPONSIBILITIES FOR REPORTING AND INVESTIGATING INCIDENTS OF POTENTIAL ABUSE OR NEGLECT

There are a variety of ways that incidents of potential abuse or neglect may be reported to appropriate law enforcement and regulatory authorities. In general, responsibility to report

[1] We use the term "potential" because actual abuse or neglect cannot be definitively determined until a thorough and formal investigation has been completed. Accordingly, we acknowledge that the actual number of Medicare beneficiaries whose injuries were the result of confirmed abuse or neglect could be less than we identified. However, we maintain that each potential case of abuse or neglect should be treated as a probable case of abuse or neglect until a thorough and formal investigation is completed to ensure the health and safety of the beneficiaries.

[2] Chapter 6.78.

incidents of potential abuse or neglect rests with individuals covered under section 1150B of the Social Security Act (the Act).[3] SNFs also have a responsibility to ensure that reports of potential abuse or neglect are made internally and externally and are internally investigated within certain timeframes. Numerous State and local law enforcement and regulatory agencies, including the State Medicaid Fraud Control Units (MFCUs), are then responsible for the investigation of reported incidents of potential abuse or neglect. Finally, the Centers for Medicare & Medicaid Services (CMS) is responsible for maintaining oversight of compliance with Medicare health and safety standards and delegates many of these tasks to the State Survey Agencies (Survey Agencies).

**Individuals Covered Under Section 1150B of the Social Security Act**

Section 1150B of the Social Security Act (the Act)[4] requires covered individuals in federally funded long-term care facilities to report immediately[5] any reasonable suspicion of a crime committed against a resident of that facility. Those reports must be submitted to at least one law enforcement agency (with jurisdiction where the facility is located) and the Survey Agency. Covered individuals who fail to report under section 1150B are subject to various penalties, including civil monetary penalties of up to $300,000 and possible exclusion from participation in any Federal health care program.[6] Section 1150B of the Act became effective on March 23, 2011.[7]

**Skilled Nursing Facilities**

SNFs must ensure that all alleged violations, such as mistreatment, neglect, or abuse (including injuries of unknown source) and misappropriation of resident property, are reported immediately to the administrator of the facility and to other officials, including the Survey Agency, in accordance with State law through established procedures (42 CFR § 483.13).[8] Furthermore, SNFs must investigate these allegations and report the results of the investigation within 5 days

[3] The term "covered individual" means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that received at least $10,000 of Federal funds during the preceding year. Long-term care facilities include SNFs.

[4] Subtitle H of the Patient Protection and Affordable Care Act (Affordable Care Act) of 2010 is also known as the Elder Justice Act of 2009. Section 6703(b)(3) of the Affordable Care Act (which is located in this subtitle) amended the Social Security Act (the Act) by establishing new section 1150B entitled "Reporting to Law Enforcement of Crimes Occurring in Federally Funded Long-Term Care Facilities."

[5] Section 1150(B) of the Act defines "immediately" as within 2 hours if the suspected incident causes serious bodily injuries and within 24 hours if it does not.

[6] Currently, hospital Conditions of Participation (CoPs) have no reporting requirements similar to those found in 42 CFR §§ 483.12 and 483.13. However, all 50 States have mandated reporter laws for elder abuse and neglect. These laws generally require medical professionals to report reasonable suspicion of elder abuse or neglect to appropriate authorities.

[7] State and local authorities where the SNFs are located may impose additional reporting requirements.

[8] Effective November 28, 2016, 42 CFR § 483.13 was removed and replaced by 42 CFR § 483.12.

to the administrator of the facility and to other officials, including the Survey Agency, and if the alleged violation is verified, appropriate corrective action must be taken.

### Medicaid Fraud Control Units

MFCUs investigate and prosecute a variety of health-care-related crimes, including patient abuse or neglect in health care facilities.[9] These health care facilities include Medicare-reimbursed SNFs. MFCUs operate in 49 States and the District of Columbia. The MFCUs, usually a part of the State Attorney General's office, employ teams of investigators, attorneys, and auditors. OIG, in exercising oversight of the MFCUs, annually recertifies each MFCU, assesses each MFCU's performance and compliance with Federal requirements, and administers a Federal grant award to fund a portion of each MFCU's operational costs.

### CMS and the Survey Agencies

CMS is responsible for maintaining oversight of compliance with Medicare health and safety standards by health care providers. CMS delegates a variety of tasks related to this oversight to the Survey Agencies under section 1864 of the Act. One of these tasks includes conducting investigations and fact-finding surveys to determine how well health care providers, including SNFs, comply with their applicable CoPs,[10] including the reporting of potential abuse or neglect. When the Survey Agency or CMS Regional Office substantiates a finding of abuse, the Survey Agency or Regional Office must report the substantiated findings to law enforcement and, if appropriate, the MFCUs.[11]

## APPLICABLE CMS GUIDANCE AND FEDERAL AUDITS AND STUDIES

### CMS Guidance

The State Operations Manual (SOM) is part of the CMS Online Manual System, which is used by CMS program components, partners, contractors, and Survey Agencies to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives.

### Federal Audits and Studies

OIG is committed to protecting beneficiary health and safety. To that end, OIG has issued numerous reports that have detailed problems with the quality of care and the reporting and investigation of potential abuse or neglect at group homes, nursing homes, and SNFs. For

[9] Section 1903(q) of the Act.

[10] CMS developed CoPs that health care organizations must meet to start and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. Section 1150B is included in the CoPs (42 CFR § 483.12).

[11] See "CMS State Survey Agency Directors' Letter," S&C-02-20, issued March 28, 2002.

example, OIG's recent audit reports on critical incident[12] reporting at group homes showed that group home providers did not report up to 15 percent of critical incidents to the appropriate State agencies. Furthermore, OIG's study of adverse events[13] in SNFs found that an estimated 22 percent of Medicare beneficiaries experienced adverse events during their SNF stays. These adverse events included infections, pressure ulcers, and medication-induced bleeding. Medical record review determined that 69 percent of these patient-harm events could have been prevented had the SNF provided better care. Over half of the residents harmed during their SNF stays required hospital care to treat the adverse event. OIG also has numerous ongoing or planned projects related to beneficiary health and safety and looks forward to sharing our results with CMS and the public as soon as they are available. The Government Accountability Office (GAO) has also issued several reports on these issues (Attachment A).

## METHODOLOGY

We requested and reviewed the emergency room records[14] for 134 Medicare beneficiaries with any of 12 primary diagnoses codes that explicitly indicate potential abuse or neglect.[15] We also reviewed publically available Survey Agency reports for each SNF covering the period when the incident of potential abuse or neglect occurred.[16] In addition, we reviewed the Medicare exclusion database and interviewed CMS officials to determine whether the U.S. Department of Health and Human Services (HHS) had implemented and used civil monetary penalties or excluded from Federal health care programs any providers under section 1150B since its effective date of March 23, 2011.

[12] The general definition of "critical incidents" includes but is not limited to events involving facility patients or residents who suffered serious injuries or illness requiring treatment at an emergency room.

[13] The term "adverse event" describes harm to a patient or resident as a result of medical care or in a health care setting.

[14] We also requested and reviewed the hospital inpatient record if the hospital admitted the Medicare beneficiary for further treatment of his or her injuries.

[15] These 12 primary diagnoses codes were assigned by the emergency rooms' staff treating the Medicare beneficiaries. We would not identify any Medicare beneficiaries who were injured at SNFs but not treated at an emergency room because there would be no record of their treatment. Therefore, there is a risk that other Medicare beneficiaries who were potentially abused or neglected remain unidentified.

[16] Survey Agency reports of all complaints and incidents involving abuse and neglect are contained in CMS's ASPEN Complaint/Incident Tracking System (ACTS). We did not request that CMS provide us with a data extract of relevant ACTS files while we were in the initial stage of our audit because of the possibility of compromising ongoing law enforcement investigations.

## PRELIMINARY AUDIT RESULTS

We identified 134 Medicare beneficiaries[17] whose injuries may have been the result of potential abuse or neglect[18] that occurred from January 1, 2015, through December 31, 2016.[19] We also found that a significant percentage of these incidents may not have been reported to law enforcement.[20] As a result, we determined that CMS has inadequate procedures to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported. Accordingly, this Early Alert contains suggestions for immediate actions that CMS can take to ensure better protection of vulnerable beneficiaries.

In addition, our prior audit reports showed that group homes did not report up to 15 percent of critical incidents to the appropriate State agencies. Our preliminary results combined with these prior report results raise significant concerns that incidents of potential abuse or neglect at SNFs have gone unreported.

### Identification of Medicare Beneficiaries Who May Have Been Abused or Neglected

We identified 134 Medicare beneficiaries whose injuries may have been the result of potential abuse or neglect that occurred from January 1, 2015, through December 31, 2016. (See Table 1 for totals by diagnosis code.) We identified instances in 33 different States (Attachment B).

**Table 1: Primary Diagnosis of Potential Abuse or Neglect**

| Diagnosis Code | Diagnosis Code Description | Total Beneficiary Count | Beneficiaries Treated in the Emergency Room | Beneficiaries Admitted to the Hospital |
|---|---|---|---|---|
| V715 | Observation following alleged rape or seduction | 48 | 48 | 0 |
| Z0441 | Encounter for examination and observation following alleged adult rape | 32 | 32 | 0 |
| T7621XA | Adult sexual abuse, suspected, initial encounter | 28 | 26 | 2 |

[17] We also determined that at least 1 of the 134 Medicare beneficiaries was a U.S. military veteran. This information may be pertinent to policy makers interested in veterans' health care.

[18] As diagnosed by the emergency room' staff who treated the Medicare beneficiaries.

[19] The audit report underlying this Early Alert will address the period January 1, 2016, through December 31, 2016. We chose to exclude calendar year 2015 from our audit to make our report more contemporary. This also made our evidence gathering easier as records that are more recent are generally more readily available.

[20] We determined whether incidents were reported to law enforcement based on the hospital and Survey Agency records we reviewed. Because of the number of potential law enforcement agencies involved, we did not contact each local law enforcement agency separately to determine whether it had been contacted. Such contact was not recorded in the records we reviewed. We did not determine why these incidents were not reported to law enforcement and will address that issue in our audit report.

| | | | | |
|---|---|---|---|---|
| 99583 | Adult sexual abuse | 11 | 10 | 1 |
| 99581 | Adult physical abuse | 6 | 6 | 0 |
| T7611XA | Adult physical abuse, suspected, initial encounter | 2 | 2 | 0 |
| T7421XA | Adult sexual abuse, confirmed, initial encounter | 2 | 2 | 0 |
| T7401XA | Adult neglect or abandonment, confirmed, initial encounter | 1 | 1 | 0 |
| T7411XA | Adult physical abuse, confirmed, initial encounter | 1 | 1 | 0 |
| 99585 | Other adult abuse and neglect | 1 | 1 | 0 |
| 99580 | Adult maltreatment, unspecified | 1 | 0 | 1 |
| 29530 | Sexual sadism | 1 | 0 | 1 |
| **TOTAL** | | **134** | **129** | **5** |

We found that, although the circumstances surrounding each of these incidents varied, 100 of the 135[21] (74 percent) medical records contained indications, such as victim or witness statements and photographs, that the Medicare beneficiaries' injuries may have been caused by potential abuse or neglect (Attachments C and D) at the SNFs. For 35 of the 135 (26 percent) emergency room records, we were unable to determine whether potential abuse or neglect existed without further investigation, which was outside the scope of our audit. We have referred all 134 incidents to appropriate law enforcement officials and are sending CMS a list of these incidents separately.

**Incidents of Potential Abuse or Neglect May Not Have Been Reported to Law Enforcement**

Many of the incidents of potential abuse or neglect that we identified may not have been reported to law enforcement. According to the records we reviewed, 96 of the 134 (72 percent) incidents were reported to local law enforcement.[22] However, we found no evidence in the hospital records that the remaining 38 incidents (28 percent) were reported to local law enforcement despite State mandatory reporting laws requiring the hospitals' medical staff to do so. We also found that the Survey Agencies substantiated 7 of the 134 total incidents in their survey reports.[23]

[21] There were 134 incidents. However, one Medicare beneficiary was treated at two different hospital emergency rooms for the same incident, resulting in 135 Medicare claims and 135 associated emergency room records.

[22] An additional 6 of the 134 incidents (4 percent) were reported to the State, but the medical records are unclear as to which agency the incidents were reported.

[23] We are contacting the Survey Agencies to determine if they were aware of the remaining 127 (134 – 7) incidents and will provide them with the relevant information if they are not.

**CMS Procedures Are Not Adequate To Ensure Incidents of Potential Abuse or Neglect Are Identified and Reported**

We determined that CMS procedures are not adequate to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported. Specifically, CMS officials informed us that they do not match Medicare claims for reimbursement of emergency room services with claims for reimbursement of SNF services to identify instances of potential abuse or neglect.

Furthermore, CMS has not taken any enforcement actions using section 1150B of the Act or used the penalties it contains since its effective date of March 23, 2011, to ensure SNF employees report incidents of potential abuse or neglect. CMS did not update the SOM to include the regulations for section 1150B until March 8, 2017, with an effective date of November 28, 2017. Furthermore, CMS did not add section 1150B to the CoPs until November 2016.

CMS officials informed us that they have not taken any enforcement actions regarding section 1150B because the HHS Office of the Secretary has not delegated the enforcement of section 1150B to CMS. CMS began working with the HHS Office of the Secretary to receive the delegation of authority in June 2017. CMS officials also stated that they have not taken action under section 1150B because they have not identified any instances in which a covered individual failed to report an incident of potential abuse or neglect of a Medicare beneficiary.[24] CMS officials also acknowledged that the SOM did not include references to section 1150B until March 8, 2017;[25] however, they noted that CMS had issued the "CMS State Survey Agency Directors' Letter" (S&C-11-30-NH) on June 17, 2011. This letter details the requirements and sanctions contained in Section 1150B and instructs the Survey Agencies to process reports received under section 1150B in accordance with existing CMS and State policies and procedures.[26] CMS officials stated that they have taken additional actions to protect residents in nursing homes by adding section 1150B requirements to training courses and issuing supporting interpretive guidance and training to surveyors.

**Suggestions for Immediate Actions**

These preliminary results combined with our prior report results raise significant concerns that incidents of potential abuse or neglect at SNFs have gone unreported. Detecting and combatting elder abuse requires covered individuals, SNFs, MFCUs, Survey Agencies, and CMS to meet their responsibilities. We acknowledge that CMS is committed to providing oversight of health care provider's compliance with standards to ensure the health and safety of Medicare beneficiaries. Accordingly, we suggest that CMS take immediate action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported. These immediate actions include:

[24] OIG attributes CMS's inability to identify violations of section 1150B in part to CMS's failure to match Medicare claims for reimbursement of emergency room services with claims for reimbursement of SNF services to identify instances of potential abuse or neglect. Attachment C contains an example of a violation of section 1150B that we identified through our data match.

[25] These references do not become effective until November 28, 2017.

[26] State Survey agencies have used existing 42 CFR § 483.13(c) deficiency citations.

- implement procedures to compare Medicare claims for emergency room treatment with claims for SNF services to identify incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs and periodically provide the details of this analysis to the Survey Agencies for further review and

- continue to work with the HHS Office of the Secretary to receive the delegation of authority to impose the civil monetary penalties and exclusion provisions of section 1150B.

After receiving the delegation of authority, CMS should:

- promulgate appropriate regulations, if CMS determines it is necessary, to impose penalties under section 1150B;

- enforce section 1150B, including imposing penalties for violations;

- ensure that the SOM is updated as planned with an effective date of November 28, 2017, to include references to section 1150B, including its penalty provisions; and

- notify Survey Agencies when the SOM is updated to include references to section 1150B and direct them to refer suspected violations of section 1150B to CMS for appropriate action.

We plan to make formal recommendations to CMS when our audit is complete.

The information in this alert is preliminary, and our audit is continuing. We will issue a draft report at the conclusion of the audit and include CMS's comments and actions taken in response to this Early Alert. If you have comments or questions about this Early Alert, please provide them within 60 days. Please refer to report number A-01-17-00504 in all correspondence.

## ATTACHMENT A: RELATED REPORTS

| Report Title | Issuer | Report Number | Date Issued |
|---|---|---|---|
| *Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* | OIG | A-01-14-00008 | 7/2016 |
| *Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* | OIG | A-01-14-00002 | 5/2016 |
| *Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect* | OIG | OEI-07-13-00010 | 8/2014 |
| *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* | OIG | OEI-06-11-00370 | 2/2014 |
| *Criminal Convictions for Nurse Aides With Substantiated Findings of Abuse, Neglect, and Misappropriation* | OIG | OEI-07-10-00422 | 10/2012 |
| *Unidentified and Unreported Federal Deficiencies in California's Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs* | OIG | A-09-09-00114 | 9/2011 |
| *Nursing Facilities' Employment of Individuals With Criminal Convictions* | OIG | OEI-07-09-00110 | 3/2011 |
| *Nursing Homes: Some Improvement Seen in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear* | GAO | GAO-10-434R | 4/2010 |
| *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses* | GAO | GAO-08-517 | 5/2008 |
| *Nursing Homes: More Can Be Done to Protect Residents from Abuse* | GAO | GAO-02-312 | 3/2002 |

## ATTACHMENT B: INCIDENTS OF POTENTIAL ABUSE OR NEGLECT IN SKILLED NURSING FACILITIES DURING 2015 AND 2016

| State | Number of Incidents[27] |
|---|---|
| Illinois | 17 |
| Michigan | 13 |
| Texas | 9 |
| California | 8 |
| New York | 7 |
| Ohio | 7 |
| Florida | 6 |
| Kentucky | 5 |
| Pennsylvania | 5 |
| Washington | 5 |
| Indiana | 4 |
| North Carolina | 4 |
| Tennessee | 4 |
| Virginia | 4 |
| Wisconsin | 4 |
| Arkansas | 3 |
| Iowa | 3 |
| Louisiana | 3 |
| Minnesota | 3 |
| Alabama | 2 |
| Georgia | 2 |
| Massachusetts | 2 |
| Nevada | 2 |
| Oklahoma | 2 |
| West Virginia | 2 |
| Connecticut | 1 |
| Maryland | 1 |
| Mississippi | 1 |
| Montana | 1 |
| New Jersey | 1 |
| New Mexico | 1 |
| Oregon | 1 |
| Utah | 1 |
| **TOTAL** | **134** |

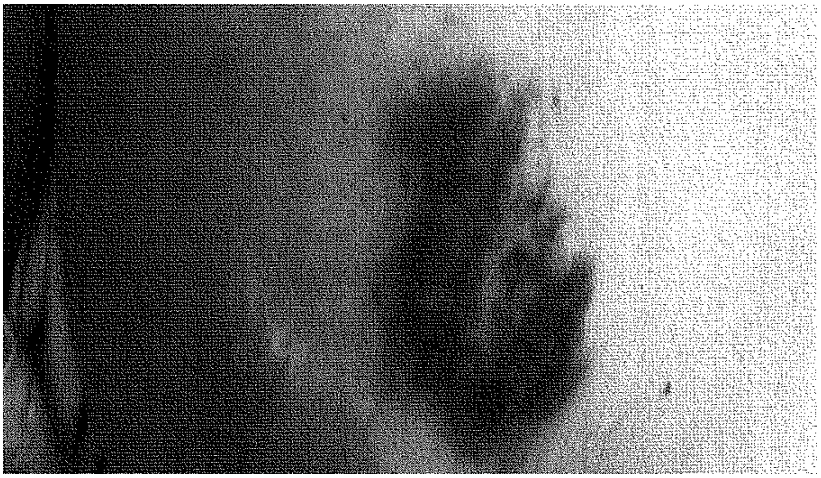
[27] Each incident involved 1 beneficiary for a total of 134 beneficiaries.

## ATTACHMENT C: EXAMPLE OF POTENTIAL SEXUAL ABUSE

At the time of this incident, Jane Doe was a Medicare beneficiary receiving services at a SNF. Ms. Doe had a previous medical condition, which contributed to verbal and mobility limitations.

According to the emergency room record, a male resident of the SNF allegedly sexually assaulted Ms. Doe. Nursing aides found the man on top of Ms. Doe squeezing and touching her breast and ejaculating on her. The emergency room record further noted that Ms. Doe's right breast was an "area of discomfort," and two silver-dollar-sized bruises were observed on her breast (photograph 1).

**Photograph 1: Breast Bruise[28]**



The SNF's employees covered under section 1150B of the Act did not immediately report the incident to law enforcement.[29] Instead, according to the Survey Agency's report, the following day the SNF's employees informed Ms. Doe's family of the incident who then contacted law enforcement, which investigated the incident. The emergency room record notes that the SNF staff assisted Ms. Doe with bathing, going to the bathroom, and changing her clothing after the incident. These actions could have destroyed any evidence that may have been detected using the rape kit.

The Survey Agency reviewed the incident[30] and cited the SNF for failure to:

[28] Altered to protect the victim's privacy.

[29] This incident occurred after section 1150B of the Act became effective on March 23, 2011. Accordingly, the SNF's employees should have reported the incident to law enforcement within 2 hours of witnessing the incident.

[30] This incident is 1 of 96 reported to law enforcement according to the medical records we reviewed.

- immediately tell the beneficiary's doctor and a family member of the beneficiary of the incident,[31]
- report and investigate an instance of abuse,[32]
- develop policies that prevent abuse,[33] and
- provide care in a way that keeps or builds each resident's dignity.[34]

The Survey Agency did not cite the SNF for failure to ensure the Medicare beneficiary was free from abuse[35] and classified the incident as resulting in "minimum harm or potential for actual harm."[36]

[31] 42 CFR § 483.10.

[32] The Survey Agency's report noted that the SNF contacted local law enforcement in an attempt to keep law enforcement from investigating the incident. The Survey Agency's report states, "I [SNF staff] notified the [redacted] Police Department of this situation and explained that we were required to report it but that we were doing our own internal investigation and did not need them to make a site visit. Explained to Officer [redacted] that no one was interested in pressing charges and that we were handling." We noted that local law enforcement continued its investigation despite this contact by the SNF.

[33] 42 CFR § 483.13.

[34] 42 CFR § 483.15.

[35] 42 CFR § 483.13.

[36] SOM, Appendices P and Q.

## ATTACHMENT D: EXAMPLE OF POTENTIAL PHYSICAL ABUSE

At the time of this incident, John Doe was a Medicare beneficiary receiving services at a SNF. Mr. Doe suffered from several medical conditions that affected his mental acuity.

According to the emergency room record, Mr. Doe was transferred from the SNF to the emergency room because he was having behavioral problems, including attempting to hit, bite, and throw feces at the SNF staff. The emergency room record notes that Mr. Doe was not aggressive in the emergency room, and the record states, "More concerning was the multiple bruises in various stages of healing including areas not easily banged (flanks, lower chest, back) [photographs 2 and 3]. There is a deep healing scratch on the right flank. Unfortunately, given [Mr. Doe's] mental status, there is not a clear story of who has done this."

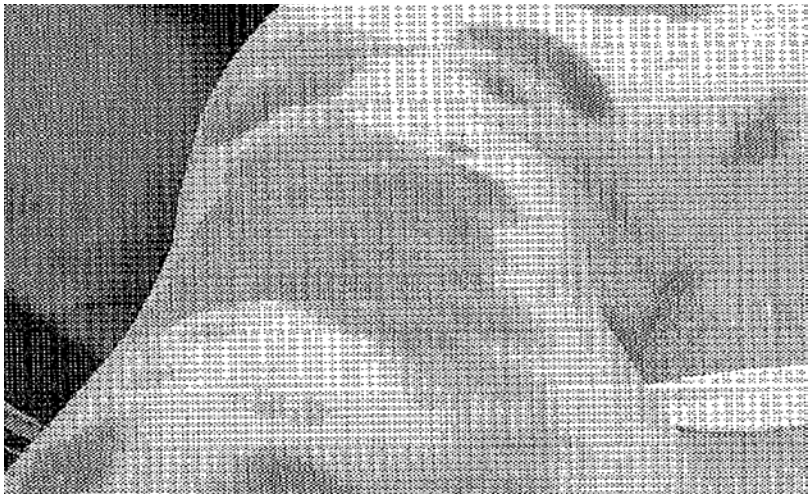
The emergency room record further notes that the SNF informed the hospital that the emergency room staff caused the bruises when they restrained Mr. Doe during his last emergency room visit. However, the emergency room record also notes that the bruises were not present in photographs taken during the previous emergency room visit. Furthermore, the State opened an adult protective service case based on that previous visit. The emergency room record states that Mr. Doe said that he was "being beaten with feet, hands and a broomstick." Mr. Doe also claimed that he was beaten again after an adult protective services case was opened after his last hospital admission. The emergency room record further states that "[Mr. Doe] is not safe to return to [SNF]." The hospital subsequently contacted adult protective services and filed a complaint with the local police department.

The emergency room record later notes that a specialized placement was being sought[37] for Mr. Doe. While the State's adult protective services officials agreed to Mr. Doe's discharge back to the SNF, they were continuing their investigation into Mr. Doe's alleged abuse by the SNF's staff.[38]

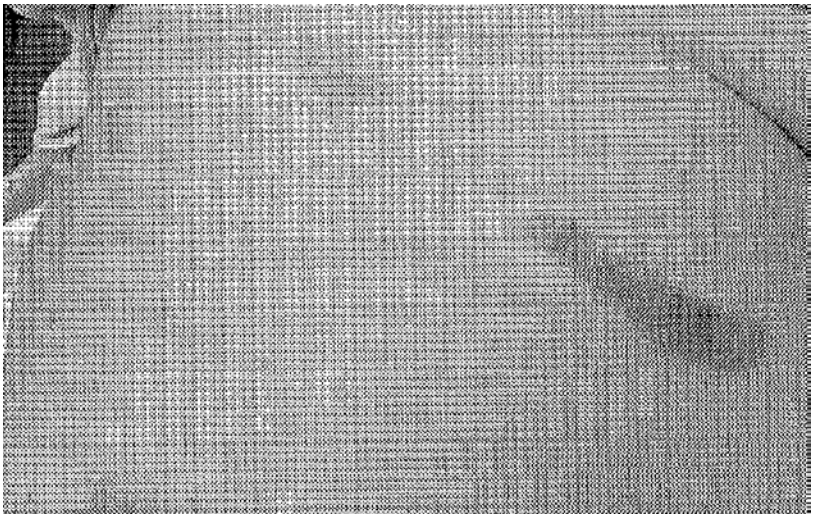
[37] The emergency room record is unclear regarding who was seeking the specialized placement for Mr. Doe.

[38] This incident is 1 of 96 reported to law enforcement according to the medical records we reviewed.

**Photograph 2: Bruised Arm and Chest[39]**



**Photograph 3: Bruised Chest and Flank[40]**

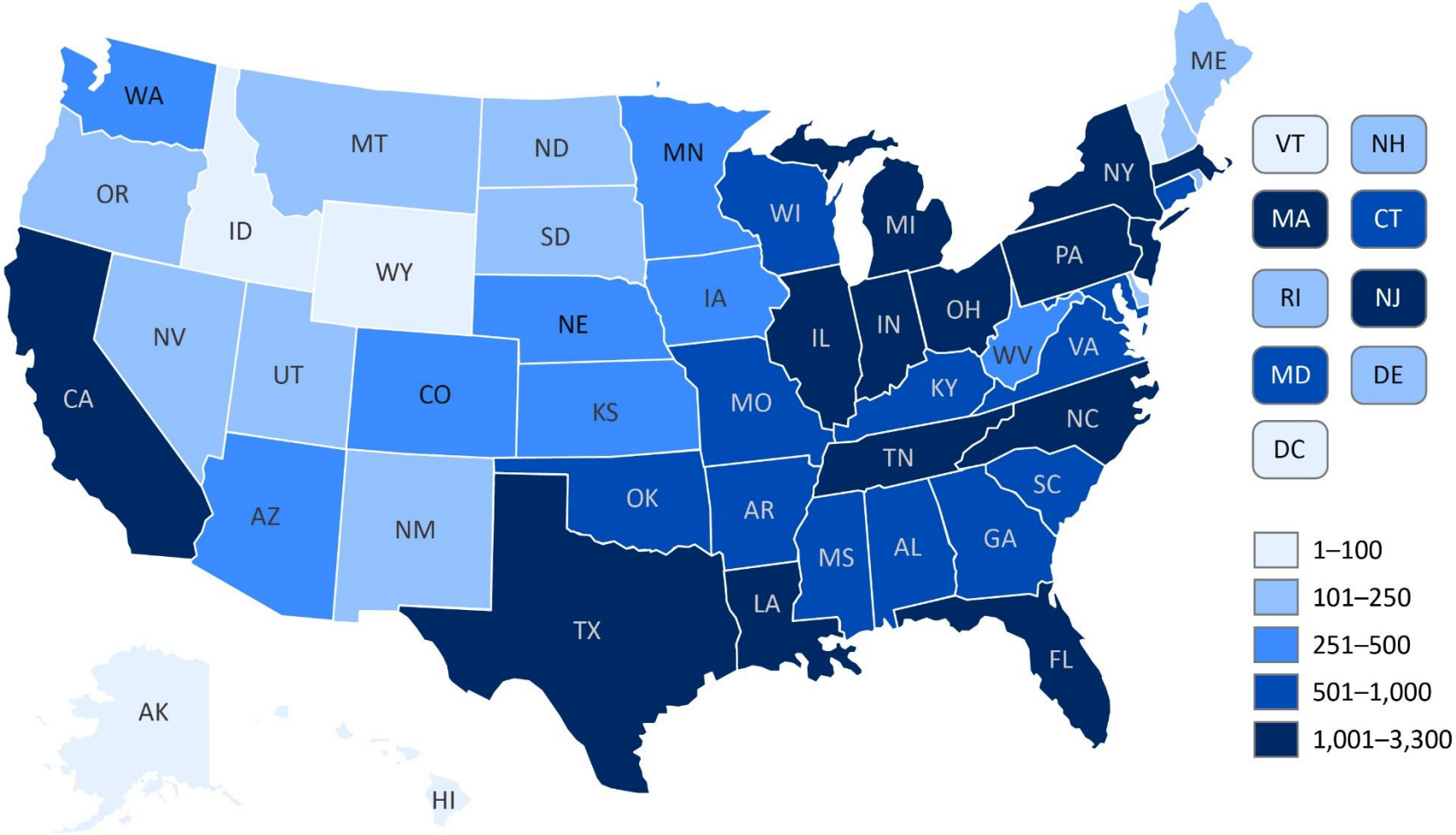


The Survey Agency's four survey reports on the SNF covering the period that Mr. Doe was treated at the emergency room do not include any mention of either incident involving Mr. Doe. We are contacting the Survey Agency to determine if they were aware of these incidents and will provide them with the relevant information if they are not.

[39] Altered to protect the victim's privacy.

[40] Altered to protect the victim's privacy.

**APPENDIX D: THE NUMBER OF HIGH-RISK HOSPITAL EMERGENCY ROOM MEDICARE CLAIMS PER STATE**



## APPENDIX E: STATISTICAL SAMPLING METHODOLOGY

### POPULATION

The target population consisted of nation-wide Medicare inpatient and outpatient claims for beneficiaries who had been transferred from a SNF to the ER with at least 1 of 580 diagnosis codes from January 1, 2016, through December 31, 2016. We determined that the 580 selected targeted diagnosis codes consisting of outpatient principal diagnosis codes and inpatient admitting diagnosis codes could indicate high risk for potential abuse or neglect.

### SAMPLING FRAME

We obtained databases of Medicare claims data from CMS's National Claims History data file for all Medicare inpatient and outpatient claims containing at least 1 of 580 targeted diagnosis codes and associated SNF claims data for Medicare beneficiaries who were transferred from a SNF to the ER from January 1, 2016, through December 31, 2016. The resulting sampling frame consisted of 37,607 claims totaling $163,207,281 that included at least 1 of the 580 targeted diagnosis codes.

### SAMPLE UNIT

The primary sample unit was a State. The secondary sample unit was a Medicare claim.

### SAMPLE DESIGN AND SAMPLE SIZE

We used a multistage sample design consisting of two stages. For the first stage, we used the Rao, Hartley, and Cochran (RHC) sample selection. This method uses probability-proportional-to-size,[38] weighted by the total number of Medicare ER claims[39] for each State. We randomly selected eight States as our primary sample units.

For the second stage, we selected a random sample of 32 ER claims (12 inpatient and 20 outpatient) from each of the 8 sampled States for a total of 256 secondary sample units (Table 2).

[38] Probability-proportional-to-size is a sampling method from a finite population in which a size measure is available for each population unit before sampling and where the probability of selecting a unit is proportional to its size.

[39] We used the State in which the SNF was located to determine the total number of Medicare ER claims by State.

**Table 2: Sample Design and Size for Secondary Units**

| State | Claim Type | No. of Frame Units | Sample Size | Dollar Value of Frame Units |
|---|---|---|---|---|
| 1 | Inpatient | 45 | 12 | $726,198 |
| | Outpatient | 125 | 20 | $60,507 |
| 2 | Inpatient | 164 | 12 | $1,950,044 |
| | Outpatient | 1,035 | 20 | $388,758 |
| 3 | Inpatient | 277 | 12 | $5,222,237 |
| | Outpatient | 556 | 20 | $372,639 |
| 4 | Inpatient | 345 | 12 | $5,683,415 |
| | Outpatient | 684 | 20 | $401,809 |
| 5 | Inpatient | 359 | 12 | $5,302,609 |
| | Outpatient | 673 | 20 | $343,108 |
| 6 | Inpatient | 639 | 12 | $12,781,419 |
| | Outpatient | 1,293 | 20 | $659,148 |
| 7 | Inpatient | 490 | 12 | $6,349,007 |
| | Outpatient | 1,152 | 20 | $496,802 |
| 8 | Inpatient | 724 | 12 | $8,857,757 |
| | Outpatient | 2,072 | 20 | $886,663 |
| **Totals** | | **10,633** | **256** | **$50,482,120** |

**SOURCE OF RANDOM NUMBERS**

We generated the random numbers using the OIG Office of Audit Services statistical software.

**METHOD FOR SELECTING SAMPLE ITEMS**

To select the primary sample units, we used the RHC sample selection, which used probability-proportional-to-size whereby the total number of Medicare ER claims by State were considered when the eight States were selected.

To select the secondary sample units, we consecutively numbered the claims in the sampling frame for each State and claim type group. We generated 12 random numbers for each State's inpatient group and 20 random numbers for each State's outpatient group and then selected the corresponding frame items.

**ESTIMATION METHODOLOGY**

We used a combination of Excel and the R software to calculate the following Horvitz-Thompson estimates:

- The number of claims associated with incidents of potential abuse or neglect.

- The number of claims associated with incidents of potential abuse and neglect not reported by the SNF to the Survey Agency.

In addition, we used the R software to calculate the two-sided 90-percent interval for each estimate. The confidence intervals were calculated in a manner that accounted for both the unequal sampling probabilities and the multistage nature of the design. The percentage estimates were obtained by dividing the count estimates by 37,607, which represents the total number of claims in the sampling frame.

## APPENDIX F: SAMPLE RESULTS AND ESTIMATES

### CLAIM ATTRIBUTES FOR PROJECTION

Attribute 1: ER visit was result of potential abuse or neglect.

Attribute 2: Potential abuse or neglect not reported by the SNF to the Survey Agency.

**Table 3: Sample Results by State**

| State | Claim Type | No. of Frame Units | Sample Size | Attribute 1 | Attribute 2 |
|---|---|---|---|---|---|
| 1 | Inpatient | 45 | 12 | 0 | 0 |
| | Outpatient | 125 | 20 | 2 | 1 |
| 2 | Inpatient | 164 | 12 | 2 | 2 |
| | Outpatient | 1,035 | 20 | 5 | 5 |
| 3 | Inpatient | 277 | 12 | 2 | 2 |
| | Outpatient | 556 | 20 | 4 | 4 |
| 4 | Inpatient | 345 | 12 | 2 | 2 |
| | Outpatient | 684 | 20 | 2 | 0 |
| 5 | Inpatient | 359 | 12 | 6 | 6 |
| | Outpatient | 673 | 20 | 6 | 5 |
| 6 | Inpatient | 639 | 12 | 0 | 0 |
| | Outpatient | 1,293 | 20 | 1 | 0 |
| 7 | Inpatient | 490 | 12 | 5 | 5 |
| | Outpatient | 1,152 | 20 | 4 | 2 |
| 8 | Inpatient | 724 | 12 | 6 | 5 |
| | Outpatient | 2,072 | 20 | 4 | 4 |
| **Totals** | | **10,633** | **256** | **51** | **43** |

**Table 4: Estimates by Attribute**
***(Limits Calculated at the 90-percent Confidence Level)***

| Attribute | Statistical Estimates | | |
|---|---|---|---|
| | **Lower Limit** | **Point Estimate** | **Upper Limit** |
| 1 | 4,652 (12 percent) | 7,831 (21 percent) | 12,367 (33 percent) |
| 2 | 3,554 (9 percent) | 6,608 (18 percent) | 11,408 (30 percent) |

## APPENDIX G: INJURY CATEGORY STATISTICS

| Diagnosis Code[40] | Description | No. of Selected ER Claims | No. of Incidents of Potential Abuse or Neglect |
|---|---|---|---|
| | **Head Injuries** | | |
| S0001XA | Abrasion of scalp | 1 | 0 |
| S0003XA | Contusion of scalp | 12 | 4 |
| S0012XA | Contusion of left eyelid and periocular area | 1 | 0 |
| S00511A | Abrasion of lip | 1 | 0 |
| S00512A | Abrasion of oral cavity | 1 | 0 |
| S0081XA | Abrasion of other part of head | 2 | 1 |
| S0083XA | Contusion of other part of head | 8 | 2 |
| S0093XA | Contusion of unspecified part of head | 8 | 0 |
| S0101XA | Laceration without foreign body of scalp | 8 | 1 |
| S01111A | Laceration without foreign body of right eyelid and periocular area | 2 | 0 |
| S01112A | Laceration without foreign body of left eyelid and periocular area | 3 | 1 |
| S0121XA | Laceration without foreign body of nose | 1 | 0 |
| S01511A | Laceration without foreign body of lip | 1 | 0 |
| S0181XA | Laceration without foreign body of other part of head | 14 | 3 |
| S0191XA | Laceration without foreign body of unspecified part of head | 3 | 0 |
| S022XXA | Fracture of nasal bones | 2 | 2 |
| S02401A | Maxillary fracture, unspecified | 1 | 1 |
| S028XXA | Fractures of other specified skull and facial bones | 1 | 0 |
| S0511XA | Contusion of eyeball and orbital tissues, right eye | 1 | 0 |
| S060X0A | Concussion without loss of consciousness | 2 | 1 |
| S062X0A | Diffuse traumatic brain injury without loss of consciousness | 2 | 1 |
| S065X0A | Traumatic subdural hemorrhage without loss of consciousness | 6 | 1 |
| S065X9A | Traumatic subdural hemorrhage with loss of consciousness | 1 | 0 |
| S066X9A | Traumatic subarachnoid hemorrhage with loss of consciousness | 1 | 1 |
| S098XXA | Other specified injuries of head | 4 | 1 |

[40] We determined that 580 diagnosis codes were indicative of high risk for potential abuse or neglect. The 256 sampled ER claims were associated with 75 diagnosis codes. The remaining 505 diagnosis codes were not associated with any of the sampled ER claims.

| | | | |
|---|---|---|---|
| S0990XA | Unspecified injury of head | 47 | 6 |
| S0993XA | Unspecified injury of face | 1 | 0 |
| | **Subtotal** | **135** | **26** |
| | | | |
| | **Bodily Injuries** | | |
| S12001A | Unspecified nondisplaced fracture of first cervical vertebra | 1 | 1 |
| S12031A | Nondisplaced posterior arch fracture of first cervical vertebra | 1 | 1 |
| S20212A | Contusion of left front wall of thorax | 1 | 0 |
| S22079A | Unspecified fracture of T9-T10 vertebra | 1 | 1 |
| S300XXA | Contusion of lower back and pelvis | 2 | 0 |
| S301XXA | Contusion of abdominal wall | 2 | 0 |
| S30810A | Abrasion of lower back and pelvis | 1 | 0 |
| S3121XA | Laceration without foreign body of penis | 1 | 0 |
| S32591A | Other specified fracture of right pubis | 1 | 0 |
| S32601A | Unspecified fracture of right ischium | 1 | 0 |
| S3992XA | Unspecified injury of lower back | 2 | 0 |
| S40011A | Contusion of right shoulder | 1 | 0 |
| S40022A | Contusion of left upper arm | 1 | 0 |
| S42001A | Fracture of unspecified part of right clavicle | 1 | 0 |
| S43005A | Unspecified dislocation of left shoulder joint | 1 | 0 |
| S43102A | Unspecified dislocation of left acromioclavicular joint | 1 | 1 |
| S72001A | Fracture of unspecified part of neck of right femur | 3 | 2 |
| S72002A | Fracture of unspecified part of neck of left femur | 8 | 4 |
| S72012A | Unspecified intracapsular fracture of left femur | 2 | 0 |
| S72021A | Displaced fracture of epiphysis (separation) (upper) of right femur | 1 | 0 |
| S72031A | Displaced midcervical fracture of right femur | 1 | 0 |
| S72111A | Displaced fracture of greater trochanter of right femur | 1 | 0 |
| S72141A | Displaced intertrochanteric fracture of right femur | 1 | 0 |
| S72142A | Displaced intertrochanteric fracture of left femur | 6 | 5 |
| S72145A | Nondisplaced intertrochanteric fracture of left femur | 1 | 0 |
| S7221XA | Displaced subtrochanteric fracture of right femur | 1 | 0 |
| S72491A | Other fracture of lower end of right femur | 1 | 1 |
| S7290XA | Unspecified fracture of unspecified femur | 1 | 0 |
| T148 | Other injury of unspecified body region | 4 | 0 |
| | **Subtotal** | **50** | **16** |
| | | | |
| | **Safety** | | |
| T17590A | Other foreign object in bronchus causing asphyxiation | 1 | 0 |

| | | | |
|---|---|---|---|
| T17890A | Other foreign object in other parts of respiratory tract, causing asphyxiation | 1 | 0 |
| T17920A | Food in respiratory tract, part unspecified causing asphyxiation | 1 | 0 |
| T17990A | Other foreign object in respiratory tract, causing asphyxiation | 1 | 0 |
| T18128A | Food in esophagus causing other injury | 1 | 0 |
| T383X1A | Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental | 1 | 1 |
| T402X1A | Poisoning by other opioids, accidental (unintentional) | 1 | 1 |
| T40601A | Poisoning by unspecified narcotics, accidental (unintentional) | 1 | 1 |
| T40604A | Poisoning by unspecified narcotics, undetermined | 1 | 0 |
| T424X1A | Poisoning by benzodiazepines, accidental (unintentional) | 1 | 0 |
| T43591A | Poisoning by other antipsychotics and neuroleptics, accidental | 1 | 1 |
| T80211A | Bloodstream infection due to central venous catheter | 1 | 0 |
| Z043 | Encounter for examination and observation following other accident | 14 | 2 |
| | **Subtotal** | **26** | **6** |
| | | | |
| | **Medical** | | |
| I96 | Gangrene | 4 | 0 |
| J690 | Pneumonitis due to inhalation of food and vomit | 27 | 2 |
| L89154 | Pressure ulcer of sacral region, stage 4 | 4 | 0 |
| L89224 | Pressure ulcer of left hip, stage 4 | 1 | 0 |
| R579 | Shock, unspecified | 1 | 0 |
| R6521 | Severe sepsis with septic shock | 8 | 1 |
| | **Subtotal** | **45** | **3** |
| | **TOTAL** | **256** | **51** |

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*
Washington, DC 20201

**Date:** APR -4 2019

**To:** Daniel R. Levinson
Inspector General
Office of Inspector General

**From:** Seema Verma
Administrator
Centers for Medicare & Medicaid Services

**Subject:** Office of Inspector General Draft Report: "Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated" (A-01-16-00509)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) draft report on the reporting, investigating, and tracking of incidents of potential abuse and neglect in skilled nursing facilities using Medicare claims data. Resident safety in nursing homes and in all facilities that participate in the Medicare and Medicaid programs is a top priority for CMS.

Abuse and mistreatment of nursing home residents is never tolerated by CMS, and the agency takes any allegation of these types of incidents very seriously. CMS requires nursing homes to report allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property promptly to their state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities.[1] Compliance with this and other federal program requirements are determined through unannounced on-site surveys conducted by state survey agencies at least annually. When state surveyors identify facility noncompliance with federal requirements, including the failure to report allegations of abuse, they document this for the facility in a survey report and, in cases where the facility is not substantial compliance, refer the case to CMS for enforcement. When we learn a nursing home failed to report or investigate incidents of potential abuse and neglect, CMS takes immediate action against the nursing home. For example, in 2018, when a state surveyor found that a nursing home did not properly investigate or prevent additional abuse involving two residents, placing other residents on the unit at risk for abuse, the nursing home was cited at the most serious level of noncompliance and assessed a civil monetary penalty of approximately $798,679. In addition to issuing civil monetary penalties, CMS can, and under certain circumstances must, deny payments to or terminate a facility's Medicare and Medicaid participation agreements when appropriate. CMS will review the

[1] 42 C.F.R. §483.12(c)

OIG's findings and take the appropriate action.

Monitoring patient safety and quality of care in nursing homes and other long-term care facilities serving Medicare and Medicaid beneficiaries is an essential part of CMS's oversight efforts and requires coordinated efforts between the federal government and the states. While OIG's review of claims data provides helpful insight into past incidents of potential abuse and neglect, including injuries of unknown source, involving nursing home residents, this data may not be timely enough to address acute problems since providers generally have up to 12 months (one calendar year) from the date the service was provided to submit claims for services rendered.

To address the time-sensitive nature of these issues, CMS has a complaint intake and investigation process. State survey agencies can conduct complaint surveys at any time, and anyone can file a complaint, including residents, family members, other healthcare facilities that receive nursing home residents (such as hospitals), and anyone else who has reason to suspect abuse or neglect is taking place. Nursing home staff as well as other covered individuals are required to report suspected abuse as specified under federal and state laws.[2] CMS's Nursing Home Compare website includes links and other helpful information to help patients and families determine when and how to file a complaint. Nursing homes are required to post similar information on how to file complaints and grievances in their facilities and with independent state entities.[3] State agencies, including law enforcement and adult protective services, play an integral role in investigating complaints of abuse and neglect in skilled nursing facilities and are responsible for reporting substantiated findings to local law enforcement and, if appropriate, to the Medicaid Fraud Control Units.

CMS has taken many actions to improve the quality and timeliness of state agency reporting. CMS conducts validation surveys of states to determine whether states are identifying deficiencies correctly, investigating compliance effectively, and meeting all other obligations. The CMS Regional Offices conduct formal assessments annually of each state survey agency's performance relative to measures included in the State Performance Standards System (SPSS). The SPSS provides a framework to organize and measure important aspects of state survey activities and is comprised of three domains: frequency, survey quality, and enforcement and remedy. These three areas also support CMS's efforts to standardize and promote consistency among state survey agencies.

In addition, CMS recently revised the process for federal oversight surveys conducted of state survey teams to add areas of concern that federal surveyors will examine to determine whether state surveyors are investigating for compliance effectively. In fiscal year 2018, CMS worked with states on three areas of concern: abuse and neglect, admission/transfer/discharge, and

[2] 42 C.F.R. §483.12(c)
[3] 42 C.F.R. §483.10

dementia care. In 2019, each Regional Office will again focus on identifying concerns related to abuse and neglect. They will also focus on facility staffing and other areas of improvement that are unique to the states in its region. CMS also recently launched an initiative to evaluate the entire SPSS program to identify ways to improve state performance. This is an ongoing, large-scale effort aimed at improving the efficiency and effectiveness of measuring and improving state performance.

CMS remains diligent in our duties to monitor nursing homes participating in Medicare and Medicaid across the country, as well as the state agencies that survey them, and we appreciate the ongoing work of the OIG in this area and will continue to work with them as we make improvements to our oversight efforts.

OIG's recommendations and CMS's responses are below.

**OIG Recommendation**

We recommend that CMS take action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported by working with the Survey Agencies to improve training for staff of SNFs on how to identify and report incidents of potential abuse or neglect of Medicare beneficiaries.

**CMS Response**

CMS concurs with this recommendation. CMS has training materials for state agency and nursing home staff on identifying and reporting potential abuse and neglect of Medicare beneficiaries and already has plans to issue new guidance specific to the reporting and tracking of facility reported incidents of potential abuse and neglect, which will help inform the training. In addition, as mentioned above, CMS conducts validation surveys of states to determine whether states are identifying deficiencies correctly, investigating compliance effectively, and meeting their other obligations.

**OIG Recommendation**

We recommend that CMS take action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported by clarifying guidance to clearly define and provide examples of potential abuse or neglect.

**CMS Response**

CMS concurs with this recommendation. Nursing homes are required under 42 CFR 483.12 to report violations to the appropriate authorities; however, CMS will review our interpretive guidance for opportunities to provide additional examples of potential abuse or neglect and clarifying existing guidance on reporting these violations.

**OIG Recommendation**

We recommend that CMS take action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported by requiring the Survey Agencies to record and track all incidents of potential abuse or neglect in SNFs and referrals made to local law enforcement and other agencies.

**CMS Response**

CMS concurs with this recommendation. In the case of alleged violations involving abuse, neglect, exploitation or mistreatment in a skilled nursing facility, CMS requires the facility to report to the state survey agency and adult protective services where state law provides for jurisdiction in long term care facilities in accordance with state law through established procedures (42 CFR 483.12). State survey agencies are required to investigate and track complaints of abuse and neglect and report substantiated findings to local law enforcement; however, we will look into options for expanding the current requirements for recording and tracking incidents and referrals.

**OIG Recommendation**

We recommend that CMS take action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported by monitoring the Survey Agencies' reporting of findings of substantiated abuse to local law enforcement.

**CMS Response**

CMS concurs with this recommendation. CMS requires state survey agencies to investigate and track complaints of abuse and neglect and report substantiated findings to local law enforcement; however, we will consider how to implement mechanisms for tracking law enforcement referrals.

## ACKNOWLEDGMENTS

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Allison Conway, Senior Auditor, served as team leader for this audit. Other Office of Audit Services (OAS) staff from the Boston regional office who conducted the audit include John Boujoulian, Shawn Dill, Ryan Evans, Andrew Felker, Jennifer Godbois, Richard Johnson, Karen Lowe, Charles McKenney III, Richard Miller, LeighAnn Phillips, and John Sullivan. Headquarters and OAS Centers for Medicare & Medicaid Services Baltimore Division staff provided support.