STAFF TRAINING AND POLICY REVIEWS NEEDED: OIG FINDS SKILLED NURSING FACILITIES FAILING TO REPORT AND INVESTIGATE INCIDENTS OF POTENTIAL ABUSE AND NEGLECT

Most skilled nursing facilities and state survey agencies are not correctly reporting and investigating abuse and neglect incidents that occur against skilled nursing residents, according to the June 7, 2019, Office of the Inspector General ("OIG") of the U.S. Department of Health and Human Services report titled *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* ("Report").

The Report found that one in five high-risk hospital emergency room Medicare treatment claims were the result of potential abuse or neglect of skilled nursing facility residents. The Report also found that facilities failed to report many of these incidents to the survey agencies in accordance with federal requirements and that several survey agencies failed to report some findings of substantiated abuse to local law enforcement.

DETAILED ANALYSIS

Federal regulations provide that residents of facilities have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Facilities must also ensure that all alleged violations involving mistreatment, neglect or abuse, including misappropriation of resident property, are reported immediately to the administrator of the facility and to other officials (including state survey agency officials) in accordance with state law procedures. Facilities that fail to comply with the requirements are subject to sanctions and corrective action requirements, including plans of correction, civil monetary penalties and termination from participation in Medicare and Medicaid.

The Centers for Medicare & Medicaid Services's ("CMS's") 2004 CMS State Survey Agency Directors' Letter (S&C-05-09, December 16, 2004) was intended to clarify the facility reporting requirements for alleged violations of mistreatment, neglect and abuse.

OIG REVIEW

OIG reviewed a sample of high-risk hospital emergency room claims from eight states and reviewed the medical records to determine whether the injuries or illnesses that required treatment were the result of incidents of potential abuse or neglect. Residents associated with these claims were transported to the emergency room directly from a facility. OIG then determined whether the facilities properly reported these incidents of potential abuse or neglect in accordance with applicable federal requirements.

OIG determined that an estimated one in five high-risk hospital emergency room Medicare claims for treatment provided in 2016 were the result of potential abuse or neglect, including injury of unknown source, of beneficiaries residing in a facility.

SKILLED NURSING FACILITIES FAILED TO REPORT TO THE SURVEY AGENCIES

OIG found that a majority of the high-risk hospital emergency room Medicare claims associated with incidents of potential abuse or neglect were not reported by facilities to the state survey agencies.

In general, the facilities indicated that they did not believe the incidents met federal reporting requirements, even though the state survey agencies determined that the incidents of potential abuse or neglect had met the requirements. The facilities did not report all incidents of potential abuse or neglect in accordance with federal requirements because CMS guidance was not clear and, therefore, the facilities interpreted it inconsistently.

SEVERAL STATE SURVEY AGENCIES FAILED TO REPORT TO LOCAL LAW ENFORCEMENT

OIG identified 69 allegations of abuse that five state survey agencies investigated and substantiated. OIG determined that the five state survey agencies did not report findings of substantiated abuse to local law enforcement for 67 of the 69 incidents. Specifically, OIG found that one of the five state 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 four state survey agencies did not report the findings for the remaining 66

incidents of substantiated abuse to local law enforcement.

OIG RECOMMENDATIONS

OIG recommended that CMS take specific actions to:

1. Work with the survey agencies to improve training for staff of facilities on how to identify and report incidents of potential abuse or neglect of Medicare beneficiaries;
2. Clarify 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 facilities and referrals made to local law enforcement;
3. Require the survey agencies to record and track all incidents of potential abuse or neglect in skilled nursing facilities and referrals made to local law enforcement and other agencies; and
4. Monitor the survey agencies' reporting of findings of substantiated abuse to local law enforcement.

CMS CONCURRED WITH RECOMMENDATIONS

CMS concurred with the OIG 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 facilities are identified and reported.

NEXT ACTIONS: POLICY AND TRAINING REVIEWS NEEDED

- Skilled nursing facilities should expect that state survey agencies will pay increased attention and take actions to confirm that incidents of potential abuse or neglect are reported to them.
- Facilities should carefully review and revise their policies and practices on when and how to identify and report incidents of potential abuse or neglect.
- Skilled nursing facilities should review and update training for staff on how to identify and report incidents of potential abuse or neglect.

Should you have any questions about this or how to update your policies and staff training, please contact:

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