Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CALIFORNIA DID NOT ENSURE THAT NURSING FACILITIES ALWAYS REPORTED INCIDENTS OF POTENTIAL ABUSE OR NEGLECT OF MEDICAID BENEFICIARIES AND DID NOT ALWAYS PRIORITIZE ALLEGATIONS PROPERLY

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June 2021
A-09-19-02005

Office of Inspector General

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Report in Brief
Date: June 2021
Report No. A-09-19-02005

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

California Did Not Ensure That Nursing Facilities Always Reported Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries and Did Not Always Prioritize Allegations Properly

Why OIG Did This Audit

This audit report is one in 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 Medicaid beneficiaries in nursing facilities. Nursing facility residents are at an increased risk of abuse or neglect when health care professionals and caregivers fail to report incidents of potential abuse or neglect or when allegations of abuse or neglect are not acted upon in a timely manner.

Our objectives were to determine whether California: (1) ensured that nursing facilities reported incidents of potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments and (2) complied with Federal requirements for recording, prioritizing, and investigating allegations of abuse or neglect.

How OIG Did This Audit

Our audit covered 4,965 claims with selected diagnosis codes for Medicaid beneficiaries who resided in California nursing facilities and were transferred to hospital emergency departments from July through December 2017. (We refer to these claims as "incidents.") We reviewed a statistical sample that consisted of: (1) all 18 incidents with diagnosis codes that indicated a significant risk of abuse or neglect and (2) 100 incidents with diagnosis codes that indicated a risk of abuse or neglect.

What OIG Found

California did not ensure that nursing facilities always reported incidents of potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Of the 118 sampled incidents reviewed, 81 were not the result of potential abuse or neglect; therefore, nursing facilities were not required to report the incidents to the State. However, of the remaining 37 incidents, 8 incidents were the result of potential abuse or neglect and should have been reported to the State: 2 were reported in a timely manner, 4 were not reported in a timely manner, and 2 were not reported to the State by the nursing facilities. Although the State issued guidance to nursing facilities on the proper reporting of potential abuse or neglect, facilities did not always report incidents or report them in a timely manner. For the other 29 incidents, nursing facilities provided documentation that did not contain sufficient information to determine whether the incidents were the result of potential abuse or neglect; therefore, the State was unable to determine whether the requirements for reporting potential abuse or neglect were met.

California complied with Federal requirements for recording allegations of abuse or neglect and generally complied with requirements for investigating allegations; however, California did not always comply with requirements for prioritizing allegations. Specifically, for the 118 sampled incidents, the State received 16 allegations; 8 were properly prioritized by the State, but 8 were not. According to State officials, changes in CMS's requirements contributed to inconsistencies in prioritizing complaints.

What OIG Recommends and California's Comments

We recommend that California: (1) strengthen guidance to nursing facilities on reporting incidents of potential abuse or neglect of Medicaid beneficiaries and (2) ensure that its staff are regularly trained on updated Federal and State requirements to ensure that appropriate priorities are assigned to allegations of abuse or neglect.

California agreed with both of our recommendations and described actions that it planned to take to implement our recommendations, including issuing a notice to remind nursing facilities of their obligation to report incidents of potential abuse or neglect and developing new training material for field staff.

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INTRODUCTION

WHY WE DID THIS AUDIT

This audit report is one in a series of Office of Inspector General (OIG) reports addressing the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's most vulnerable populations, including Medicaid beneficiaries in nursing facilities. Nursing facility residents are at an increased risk of abuse or neglect when health care professionals and caregivers fail to report incidents of potential abuse or neglect or when allegations of abuse or neglect are not acted upon in a timely manner.[1]

OBJECTIVES

Our objectives were to determine whether the California Department of Public Health (State agency): (1) ensured that nursing facilities reported incidents of potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments and (2) complied with Federal requirements for recording, prioritizing, and investigating allegations of abuse or neglect.

BACKGROUND

Medicaid Coverage of Care in Nursing Facilities

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In California, the Department of Health Care Services (DHCS) administers the Medicaid program.

The Medicaid program covers nursing facility care for eligible beneficiaries in need of skilled nursing services, rehabilitation services, or long-term care. Section 1919 of the Social Security Act (the Act) provides that nursing facilities participating in the Medicaid program must meet certain specified requirements (Federal participation requirements), including requirements related to quality of care, nursing services, and infection control. These sections also establish requirements for CMS and States to survey nursing facilities to determine whether they meet Federal participation requirements.

[1] Allegations are assertions of improper care or treatment that could result in the citation of a Federal deficiency (the Centers for Medicare & Medicaid Services (CMS) *State Operations Manual* (SOM), chapter 5, § 5010), which is a nursing facility's failure to meet Federal participation requirements (42 CFR § 488.301). An allegation may be either a complaint from an individual or an entity-reported incident. A complaint may be filed by anyone, including a patient, a facility resident, a relative, or a member of the public (SOM, chapter 5, § 5010). An entity-reported incident is one that a nursing facility reports to the State agency (SOM, chapter 9, exhibit 23).

State Survey Agencies' Responsibilities Related to Allegations of Abuse or Neglect

State survey agencies are responsible for certifying long-term care facilities, including nursing facilities, that provide services to Medicaid beneficiaries and ensuring that those facilities comply with Federal participation requirements.[2] In addition, State survey agencies are responsible for ensuring that nursing facilities comply with other Federal requirements, including those related to reporting allegations of abuse or neglect or injuries of unknown source (the Act § 1919(g)(1)(c)). (See the box to the right for definitions.)

Definitions of Abuse, Neglect, and Injury of Unknown Source

- **Abuse** is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish and includes verbal, sexual, physical, and mental abuse (42 CFR § 488.301).
- **Neglect** is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress (42 CFR § 488.301).
- **Injury of unknown source** is an injury that meets both of the following conditions: (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 or because of the number of injuries observed at one time or the incidence of injuries over time (*State Operations Manual,* Appendix PP).

CMS requires State survey agencies to enter into the Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS) all complaint information gathered as part of Federal survey and certification responsibilities, regardless of whether an onsite survey is conducted, as well as all entity-reported incidents that require a Federal onsite survey (CMS's *State Operations Manual* (SOM), chapter 5, § 5060). State survey agencies collect comprehensive information during the intake process,[3] promptly review each allegation, and assign a priority of immediate jeopardy or non-immediate jeopardy, among other options, based on the seriousness of the incident (SOM, chapter 5, § 5070).[4] The priority assignment determines the timeframe and action required, which may include an investigation by the State agency (SOM, chapter 5, § 5075.9). An investigation determines whether a deficiency is or was present and assesses the degree of harm. State survey agencies use ACTS to manage all

[2] CMS delegates to the State agency the responsibility to ensure that nursing facilities are meeting the requirements for reporting potential abuse or neglect (the Act § 1864).

[3] During the intake process, the State agency collects information necessary to make decisions (such as proper prioritization and anticipated timeframes) about the allegation (SOM, chapter 5, § 5010.1).

[4] Immediate jeopardy is defined as a situation in which a provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident (42 CFR § 489.3). Non-immediate jeopardy is defined as a provider's alleged noncompliance with one or more requirements that may have caused harm and is classified as high, medium, or low depending on the impact that the situation had on the individual's mental, physical, or psychosocial status (SOM, chapter 5, §§ 5075.2–5075.4).

operations associated with processing an allegation, from initial intake and investigation through the final disposition (SOM, chapter 5, § 5060).

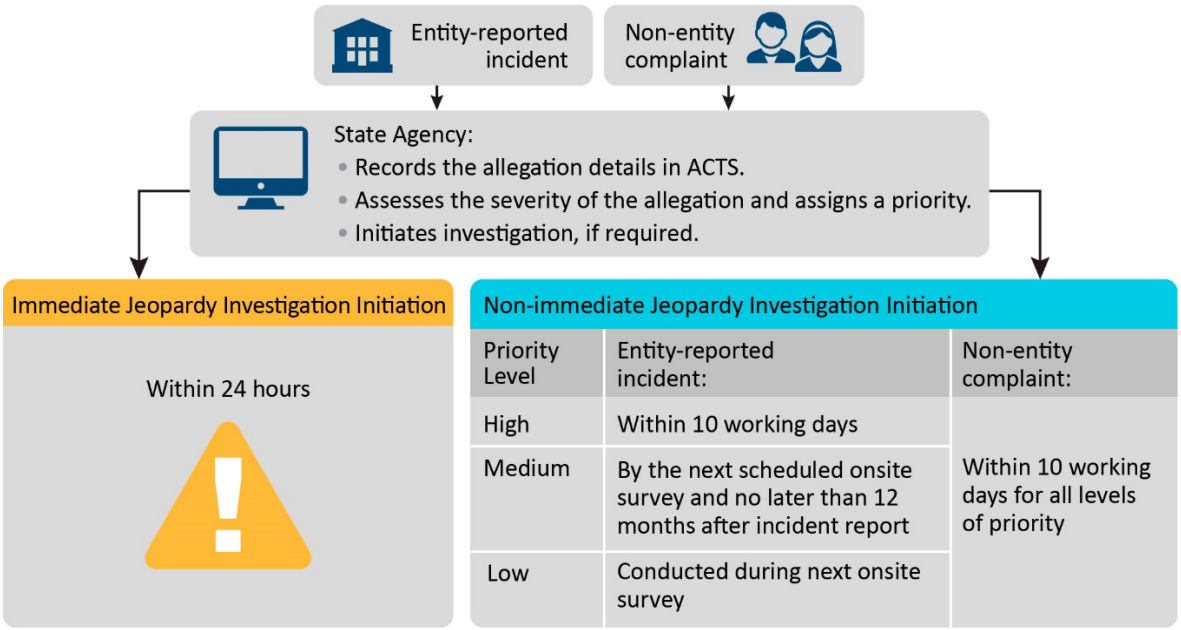
In California, the State agency is the designated State survey agency and is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and quality of health care for all Californians. The responsibilities include conducting periodic inspections and investigations of allegations to determine compliance with Federal and State laws and regulations.

California's Incident-Reporting Process

Nursing facilities are required to submit a written report to the State agency regarding allegations involving abuse or neglect. If the suspected abuse results in serious bodily injury, the written report must be submitted within 2 hours of observing, obtaining knowledge of, or suspecting the physical abuse. If the suspected abuse does not result in serious bodily injury, the written report must be submitted within 24 hours (California Welfare and Institutions Code § 15630).

When the State agency receives an allegation of abuse or neglect, the State agency: (1) records the allegation details in ACTS; (2) assesses the severity of the allegation and assigns a priority of immediate or non-immediate jeopardy; and (3) initiates an investigation, if required, within the timeframe determined by the priority. For non-immediate jeopardy, there are three priority levels (high, medium, and low). See the figure for details on the State agency's process for prioritizing allegations and initiating investigations.

Figure: The State Agency's Process for Prioritizing Allegations and Initiating Investigations



HOW WE CONDUCTED THIS AUDIT

Using data provided by DHCS, we identified inpatient and outpatient hospital claims for beneficiaries transferred from nursing facilities to hospital emergency departments from July 1 through December 31, 2017. (We refer to these hospital claims as "incidents.") We determined that 4,965 incidents indicated a potential risk of abuse or neglect that may have required reporting under Federal or State requirements.[5] We reviewed a statistical sample that consisted of: (1) all 18 incidents with diagnosis codes that indicated a significant risk of abuse or neglect and (2) 100 incidents (of the remaining 4,947 incidents) with diagnosis codes that indicated a risk of abuse or neglect.

For the 118 incidents, we reviewed documentation provided by nursing facilities, hospitals, and the State agency to determine whether: (1) the nursing facilities properly reported potential abuse or neglect and (2) the State agency recorded, prioritized, and investigated allegations of abuse or neglect in accordance with Federal requirements. We also reviewed the State agency's policies and procedures related to its complaint and incident reporting.

We requested that the State agency review hospital and nursing facility records to determine whether the 118 incidents were the result of potential abuse or neglect and should have been reported to the State agency by the nursing facilities. We also asked the State agency to determine, if applicable, whether the incidents were recorded and properly prioritized and investigated.

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 describes our audit scope and methodology, Appendix B describes our statistical sampling methodology, Appendix C contains a list of the diagnosis codes in our sample that indicated a likelihood of abuse or neglect for incidents, and Appendix D contains a list of related OIG reports.

FINDINGS

The State agency did not ensure that nursing facilities always reported incidents of potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. In addition, many nursing facilities provided documentation that did not contain sufficient information for the State agency to determine whether the incidents

[5] We determined that an incident had a risk of abuse or neglect based on the diagnosis code description. Incidents with a risk of abuse or neglect included lacerations, ulcers, and contusions. Incidents with a *significant* risk of abuse or neglect included assault and sexual abuse.

should have been reported. Of the 118 sampled incidents, 81 were not the result of potential abuse or neglect; therefore, nursing facilities were not required to report the incidents to the State agency. However, of the remaining 37 incidents, 8 incidents were the result of potential abuse or neglect and should have been reported to the State agency. Of the eight reportable incidents, two were reported in a timely manner, four were not reported in a timely manner, and two were not reported to the State agency by the nursing facilities. Although the State agency issued guidance to nursing facilities on the proper reporting of potential abuse or neglect, nursing facilities did not always report incidents or report them in a timely manner. State agency officials stated that they cannot speak on behalf of the facilities as to why the facilities did not report incidents as required.

For the other 29 incidents, nursing facilities provided documentation (e.g., medical records and incident reports) that did not contain sufficient information to determine whether the incidents were the result of potential abuse or neglect; therefore, the State agency was unable to determine whether the requirements for reporting potential abuse or neglect were met. According to State agency officials, nursing facility documentation varies by facility. The officials explained that although there are no specific Federal or State requirements for documenting incidents of potential abuse or neglect, the standard of practice is to document such incidents clearly and decisively.

The State agency complied with Federal requirements for recording allegations of abuse or neglect and generally complied with requirements for investigating allegations; however, the State agency did not always comply with requirements for prioritizing allegations. Specifically, for the 118 sampled incidents, the State agency received 16 allegations (12 entity-reported incidents and 4 non-entity complaints). Of these 16 allegations, 8 were properly prioritized by the State agency, but 8 were not. We found that the State agency did not always obtain sufficient information during the intake process to determine the proper priority level. According to State agency officials, changes in CMS's requirements contributed to inconsistencies in prioritizing complaints. In addition, the officials stated that another contributing factor may have been that the allegations lacked sufficient information when reported to the State agency and differed from what the surveyors found onsite.

When nursing facilities do not report incidents as required and the State agency does not prioritize allegations properly, nursing facility residents may be at an increased risk of abuse or neglect. As a result, the State agency may not be able to pursue legal, administrative, or other appropriate remedies or investigate the incidents in a timely manner to ensure the health, safety, and rights of nursing facility residents. In addition, when nursing facilities do not maintain documentation with sufficient information to determine whether incidents were the result of potential abuse or neglect, the State agency cannot meet its obligation to ensure that nursing facilities report incidents of abuse or neglect.

THE STATE AGENCY DID NOT ENSURE THAT NURSING FACILITIES ALWAYS REPORTED INCIDENTS OF POTENTIAL ABUSE OR NEGLECT OF MEDICAID BENEFICIARIES

The State agency did not ensure that nursing facilities always reported incidents of potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Of the 118 sampled incidents, 8 incidents were the result of potential abuse or neglect and should have been reported to the State agency. Of the eight reportable incidents, two were reported in a timely manner; however, four were not reported in a timely manner, and two were not reported.

Federal and State Requirements

CMS, the State Medicaid agency, and the State survey agency are responsible for ensuring that participating providers of health care services meet Federal requirements (SOM, chapter 5, § 5000.2). Nursing facilities must ensure that all allegations involving abuse or neglect are reported to the facility administrator and State survey agency within 2 hours if the incident results in serious bodily injury or within 24 hours if the incident does not result in serious bodily injury (42 CFR § 483.12(c)(1); California Health and Safety Code § 1418.91(a); California Welfare and Institutions Code §§ 15630(b)(1)(A)(i) and (ii)).

The State agency provides guidance to nursing facilities through an All Facilities Letter (AFL). The information contained in the AFL may include changes in requirements in health care, enforcement, or general information that affects the facility. For example, AFL 12-50 (December 19, 2012) provided guidance to nursing facilities on the timeframe for reporting suspected abuse and the responsibility of the facilities for following all applicable laws.

Nursing Facilities Did Not Report Four Incidents to the State Agency in a Timely Manner

Nursing facilities did not report four incidents to the State agency within the maximum 24-hour timeframe. Three incidents were resident-to-resident physical altercations, all of which led to injury, and one incident was a resident-to-resident sexual assault. All of the incidents were reported from 2 to 12 days after they had occurred.

Example: An Incident Was Not Reported in a Timely Manner

A resident reported to nursing facility staff that his roommate had sexually assaulted him. As a result, the resident was transferred to a hospital emergency department that same day. Although the staff supervisor was made aware of the incident on the day it occurred, the nursing facility did not report the incident to the State agency until 7 days later. The nursing facility was required to report the incident to the State agency within 24 hours upon discovery because the allegation involved abuse but did not result in serious bodily injury.

Nursing Facilities Did Not Report Two Incidents to the State Agency

Nursing facilities did not report two incidents to the State agency. One incident involved an injury that occurred because the nursing facility failed to follow its own plan of care, which required the presence of two staff members when turning or repositioning the resident. The other incident involved repeated physical abuse of a resident by another resident, which was caused by the facility's failure to monitor episodes of aggressive behavior.

Example: An Incident Was Not Reported

A family member took a resident to a hospital emergency department because he was experiencing pain after being assaulted by another resident. A couple of weeks after the incident, the State agency received a complaint from the family member, stating that the resident had been physically abused by the other resident repeatedly and that the nursing facility had not reported this to anyone. The State agency's investigation found that the facility should have reported the incident, and the State agency cited the nursing facility for noncompliance with quality-of-care and quality-of-life requirements.

Although the State agency issued guidance to nursing facilities on the proper reporting of potential abuse or neglect, the facilities did not always report incidents or report incidents in a timely manner. State agency officials stated that they cannot speak on behalf of the facilities as to why the facilities did not report incidents as required.

NURSING FACILITIES PROVIDED DOCUMENTATION THAT DID NOT CONTAIN SUFFICIENT INFORMATION TO DETERMINE WHETHER 29 INCIDENTS SHOULD HAVE BEEN REPORTED

Nursing facilities must ensure that all allegations involving abuse or neglect are reported to the facility administrator and State survey agency within 2 hours if the incident results in serious bodily injury or within 24 hours if the incident does not result in serious bodily injury (42 CFR § 483.12(c)(1); California Health and Safety Code § 1418.91(a); California Welfare and Institutions Code §§ 15630(b)(1)(A)(i) and (ii)).

Nursing facilities provided documentation (e.g., medical records and incident reports) that did not contain sufficient information to determine whether 29 of the 118 incidents were the result of potential abuse or neglect; therefore, the State agency was unable to determine whether the requirements for reporting potential abuse or neglect were met.

Example: Incident Without Sufficient Information To Make Determination

A resident, who was nonverbal and dependent on staff care, was diagnosed with an acute fracture of the upper arm. According to the hospital medical records, the emergency department suspected possible neglect. However, the documentation provided by the nursing facility did not describe what happened to the resident before the emergency room visit. Consequently, the State agency was unable to determine whether the incident was the result of potential abuse or neglect and therefore was unable to determine whether the requirements for reporting potential abuse or neglect were met.

According to State agency officials, documentation maintained by nursing facilities varies by facility. The officials explained that although there are no specific Federal or State requirements for documenting potential abuse or neglect, the standard of practice is to document clearly and decisively.

THE STATE AGENCY DID NOT ALWAYS COMPLY WITH FEDERAL REQUIREMENTS FOR PRIORITIZING ALLEGATIONS OF ABUSE OR NEGLECT

The State agency did not always comply with Federal requirements for prioritizing allegations of abuse or neglect. Specifically, for the 118 sampled incidents, the State agency received 16 allegations (12 entity-reported incidents and 4 non-entity complaints). Of the 16 allegations, 8 were properly prioritized by the State agency, but 8 were not.

Federal Requirements

CMS requires that the State survey agency promptly review allegations and conduct unannounced onsite investigations of incident reports alleging noncompliance (SOM, chapter 5, § 5000.2). Each allegation must be assessed and assigned a priority by State agency personnel who are professionally qualified to evaluate the nature of the problem based on their knowledge of Federal requirements and current clinical standards of practice. The priority assignment determines the maximum timeframe within which an investigation must be initiated, if one is required (SOM, chapter 5, § 5070).[6] Incidents such as falls resulting in fracture or serious injury, physical abuse, and sexual abuse should be assigned a priority of immediate jeopardy, and an onsite visit should be conducted within 2 working days, unless the intake information is sufficient to determine whether the conditions are not present and ongoing (*SOM,* chapter 9, exhibit 22).

[6] See the figure in the "Background" section of the report for the maximum timeframes within which an investigation must be initiated based on the priority assignment.

The State Agency Improperly Prioritized Eight Allegations

The State agency improperly prioritized eight allegations of abuse or neglect. Specifically, State agency intake personnel assigned these allegations a lower priority than was supported by the medical records, which resulted in the investigations of the incidents not being initiated within the required timeframes. Six allegations (four entity-reported incidents and two non-entity complaints) involved injuries. Two allegations (two entity-reported incidents) involved resident-to-resident sexual abuse.

Example: An Allegation Was Improperly Prioritized

A nursing facility reported to the State agency that a resident had been sexually abused by another resident (an entity-reported incident). A nurse found resident A in resident B's room, inappropriately touching resident B. According to the facility administrator, resident A showed no remorse when he was interviewed about the incident. The State agency improperly prioritized the allegation as non-immediate jeopardy, with a high priority level, which requires investigation within 10 days. (The State agency should have prioritized the allegation as immediate jeopardy, which requires investigation within 24 hours.) As a result, the State agency delayed taking the necessary action to ensure that the nursing facility was adequately protecting the resident from further harm.

We found that the State agency did not always obtain sufficient information during the intake process to determine the proper priority level. According to State agency officials, changes in CMS's requirements contributed to inconsistencies in prioritizing complaints.[7] Specifically, the State agency revised the processes followed by intake workers for recording allegations. According to officials, the changes led to confusion, and it took time to disseminate the information to employees. In addition, officials stated that another contributing factor may have been that the allegations lacked sufficient information when reported to the State agency and differed from what the surveyors found onsite.

RESIDENTS MAY HAVE BEEN AT INCREASED RISK OF ABUSE OR NEGLECT

When nursing facilities do not report incidents to the State agency or do not report incidents within required timeframes, nursing facility residents may be at an increased risk of abuse or neglect. As a result, the State agency may not be able to pursue legal, administrative, or other appropriate remedies or investigate the incidents in a timely manner to ensure the health,

[7] Effective November 22, 2017, CMS required State agencies to review resident-to-resident altercations as potential situations of abuse. When investigating an allegation of abuse between residents, the surveyor should not automatically assume that abuse did not occur, especially in cases where either or both residents have a cognitive impairment or a mental disorder (SOM, Appendix PP, Transmittal 173).

safety, and rights of nursing facility residents. In addition, when nursing facilities do not maintain documentation with sufficient information for the State agency to determine whether the nursing facilities should have reported incidents of potential abuse or neglect, the State agency cannot meet its obligation to ensure that nursing facilities report incidents of abuse or neglect.

When the State agency does not assign appropriate priorities to allegations, nursing facility residents may also be at an increased risk of abuse or neglect. The priority that the State agency assigns to an allegation is critical because it determines the State agency's required action and timeframe for investigating the incident of potential abuse or neglect.

RECOMMENDATIONS

We recommend that the California Department of Public Health:

- strengthen guidance to nursing facilities on reporting incidents of potential abuse or neglect of Medicaid beneficiaries and

- ensure that its staff are regularly trained on updated Federal and State requirements to ensure that appropriate priorities are assigned to allegations of abuse or neglect.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with both of our recommendations and described actions that it planned to take to implement our recommendations. These actions included: (1) issuing an AFL to remind nursing facilities of their obligation to report incidents of potential abuse or neglect and (2) developing new training material for field staff. The State agency's comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Using data provided by DHCS, we identified inpatient and outpatient hospital claims for beneficiaries transferred from nursing facilities to hospital emergency departments from July 1 through December 31, 2017. (We refer to these hospital claims as "incidents.") We determined that 4,965 incidents indicated a potential risk of abuse or neglect that may have required reporting under Federal or State requirements. We reviewed a statistical sample that consisted of: (1) all 18 incidents with diagnosis codes that indicated a significant risk of abuse or neglect and (2) 100 incidents (of the remaining 4,947 incidents) with diagnosis codes that indicated a risk of abuse or neglect.

We established reasonable assurance of the authenticity and accuracy of the data obtained from DHCS's Medicaid Management Information System, but we did not assess the completeness of the file.

We conducted our audit from June 2019 to April 2021, which included contacting hospitals and nursing facilities throughout California.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal and State requirements for nursing facilities' reporting of incidents of potential abuse or neglect and Federal requirements for State agencies' recording, prioritizing, and investigating allegations of abuse or neglect;

- held discussions with CMS officials to gain an understanding of the State agency's responsibilities for recording, prioritizing, and investigating allegations of abuse or neglect;

- reviewed State agency policies and procedures related to recording, prioritizing, and investigating reported allegations of abuse or neglect;

- interviewed State agency officials to determine how the State agency records, prioritizes, and investigates allegations of abuse or neglect;

- created a sampling frame of 4,965 incidents that indicated a potential risk of abuse or neglect and selected a statistical sample that consisted of: (1) all 18 incidents with diagnosis codes that indicated a significant risk of abuse or neglect and (2) 100 incidents (of the remaining 4,947 incidents) with diagnosis codes that indicated a risk of abuse or neglect (Appendix B);

- requested that hospitals and nursing facilities provide all relevant medical records related to the 118 incidents and requested additional information from nursing facilities that had not provided sufficient information to determine whether incidents were the result of potential abuse or neglect;

- requested that the State agency review the nursing facility and hospital medical records to determine whether the incidents were the result of potential abuse or neglect and, if applicable, whether the incidents were reported, recorded, and properly prioritized and investigated;

- reviewed supporting documentation, including investigative reports, for the incidents associated with allegations received by the State agency and recorded in ACTS; and

- discussed the results of our audit with State agency 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: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

DHCS provided inpatient and outpatient claims for beneficiaries' hospital visits for emergency department services in which the beneficiaries were transferred from nursing facilities from July 1 through December 31, 2017 (audit period). These claims were extracted from DHCS's Medicaid Management Information System. The data consisted of claims for: (1) Medicaid beneficiaries who resided in nursing facilities and (2) emergency department services for those nursing facility residents.

Our sampling frame contained 4,965 claims with selected diagnosis codes for Medicaid beneficiaries who resided in California nursing facilities and were transferred to hospital emergency departments during our audit period. These emergency department visits were for incidents that we determined, based on the diagnosis codes on the claims for the emergency department services, put the beneficiaries at a potential risk of abuse or neglect.[8, 9]

SAMPLE UNIT

The sample unit was a visit by a nursing facility resident to a hospital for emergency department services with selected diagnosis codes during our audit period.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample, consisting of two strata. (See the table.)

Table: Incidents by Stratum

Stratum	Stratum Description	Incidents in Sampling Frame	Incidents in Sample
1	Significant risk of abuse or neglect	18	18
2	Risk of abuse or neglect	4,947	100
Total		**4,965**	**118**

SOURCE OF RANDOM NUMBERS

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

[8] We analyzed the admitting, principal, secondary, and tertiary diagnosis codes to identify claims at risk of abuse or neglect. We analyzed all diagnosis codes to identify claims with a significant risk of abuse or neglect.

[9] An example of a diagnosis code indicating a risk of abuse or neglect is S00.03XA, Contusion of scalp, initial encounter. An example of a diagnosis code indicating a significant risk of abuse or neglect is T76.11XA, Adult physical abuse suspected, initial encounter.

METHOD OF SELECTING SAMPLE UNITS

We reviewed all items in stratum 1. We consecutively numbered the items within stratum 2. After generating 100 random numbers for stratum 2, we selected the corresponding sampling frame items.

ESTIMATION METHODOLOGY

We identified two incidents that the State agency determined should have been reported by the nursing facility. However, we did not estimate the total number of unreported incidents in our sampling frame.

APPENDIX C: DIAGNOSIS CODES INDICATING LIKELIHOOD OF ABUSE OR NEGLECT FOR INCIDENTS

Stratum 1: Diagnosis Codes With Significant Risk of Abuse or Neglect		
Diagnosis Code	**Description**	**No. of Incidents**
T74.21XA	Adult sexual abuse, confirmed, initial encounter	2
T76.01XA	Adult neglect or abandonment, suspected, initial encounter	1
T76.11XA	Adult physical abuse, suspected, initial encounter	1
T76.91XA	Unspecified adult maltreatment, suspected, initial encounter	1
Y00.XXXA	Assault by blunt object, initial encounter	3
Y04.0XXA	Assault by unarmed brawl or fight, initial encounter	4
Y04.2XXA	Assault by strike against or bumped into by another person, initial encounter	1
Y04.8XXA	Assault by other bodily force, initial encounter	2
Y09	Assault by unspecified means	2
Y90.7	Blood alcohol level of 200–239 mg/100 ml	1
Total		**18**

Stratum 2: Diagnosis Codes With Risk of Abuse or Neglect		
Diagnosis Code	**Description**	**No. of Incidents**
I96	Gangrene, not elsewhere classified	3
J69.0	Pneumonitis due to inhalation of food and vomit	16
L89.150	Pressure ulcer of sacral region, unstageable	1
L89.153	Pressure ulcer of sacral region, stage 3	3
L89.154	Pressure ulcer of sacral region, stage 4	5
R65.21	Severe sepsis with septic shock	11
S00.03XA	Contusion of scalp, initial encounter	2
S00.81XA	Abrasion of other part of head, initial encounter	1
S00.83XA	Contusion of other part of head, initial encounter	3
S01.01XA	Laceration without foreign body of scalp, initial encounter	5
S01.112A	Laceration without foreign body of left eyelid and periocular area, initial encounter	4
S01.511A	Laceration without foreign body of lip, initial encounter	2
S01.81XA	Laceration without foreign body of other part of head, initial encounter	2
S05.11XA	Contusion of eyeball and orbital tissues, right eye, initial encounter	1
S06.9X9A	Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter	1
S09.8XXA	Other specified injuries of head, initial encounter	1

Stratum 2: Diagnosis Codes With Risk of Abuse or Neglect		
Diagnosis Code	**Description**	**No. of Incidents**
S09.90XA	Unspecified injury of head, initial encounter	10
S10.93XA	Contusion of unspecified part of neck, initial encounter	1
S20.212A	Contusion of left front wall of thorax, initial encounter	1
S20.222A	Contusion of left back wall of thorax, initial encounter	1
S22.32XA	Fracture of one rib, left side, initial encounter for closed fracture	1
S32.059A	Unspecified fracture of fifth lumbar vertebra, initial encounter for closed fracture	1
S32.10XA	Unspecified fracture of sacrum, initial encounter for closed fracture	1
S39.92XA	Unspecified injury of lower back, initial encounter	1
S40.012A	Contusion of left shoulder, initial encounter	1
S72.011A	Unspecified intracapsular fracture of right femur, initial encounter for closed fracture	1
S72.092A	Other fracture of head and neck of left femur, initial encounter for closed fracture	1
S72.141A	Displaced intertrochanteric fracture of right femur, initial encounter for closed fracture	1
S72.341A	Displaced spiral fracture of shaft of right femur, initial encounter for closed fracture	2
T17.320A	Food in larynx causing asphyxiation, initial encounter	1
T17.800A	Unspecified foreign body in other parts of respiratory tract causing asphyxiation, initial encounter	1
T17.908A	Unspecified foreign body in respiratory tract, part unspecified causing other injury, initial encounter	2
T42.0X1A	Poisoning by hydantoin derivatives, accidental (unintentional), initial encounter	1
T50.902A	Poisoning by unspecified drugs, medicaments and biological substances, intentional self-harm, initial encounter	1
T80.211A	Bloodstream infection due to central venous catheter, initial encounter	5
Z04.2	Encounter for examination and observation following work accident	1
Z04.3	Encounter for examination and observation following other accident	4
Total		**100**

APPENDIX D: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Louisiana Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-02005	5/5/2021
Georgia Generally Ensured That Nursing Facilities Reported Allegations of Potential Abuse or Neglect of Medicaid Beneficiaries and Prioritized Allegations Timely	A-04-17-03084	4/12/2021
Florida Did Not Ensure That Nursing Facilities Always Reported Allegations of Potential Abuse or Neglect of Medicaid Beneficiaries and Did Not Always Assess, Prioritize, or Investigate Reported Incidents	A-04-17-08058	3/4/2021
New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-02-17-01026	2/16/2021
New Jersey Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported	A-02-18-01006	8/19/2020
North Carolina Did Not Ensure That Nursing Facilities Always Reported Allegations of Potential Abuse and Neglect of Medicaid Beneficiaries and Did Not Always Prioritize Allegations Timely	A-04-17-04063	7/29/2020
Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-04003	7/9/2020
Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities	A-07-18-06081	3/27/2020
Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-03-17-00202	1/17/2020
A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect	A-01-19-00502	7/26/2019
CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect	A-01-17-00513	6/12/2019
Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated	A-01-16-00509	6/12/2019
Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-17-02006	6/11/2019
Trends in Deficiencies at Nursing Homes Show That Improvements Are Needed To Ensure the Health and Safety of Residents	A-09-18-02010	4/26/2019

Report Title	Report Number	Date Issued
CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved To Help Ensure the Health and Safety of Nursing Home Residents	A-09-18-02000	2/7/2019
Florida Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid	A-04-17-08052	4/27/2018
A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011–2015	OEI-01-16-00330	9/28/2017
Kansas Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid	A-07-17-03218	9/6/2017
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	8/24/2017
Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-01-16-00001	8/9/2017
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	7/13/2016
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	5/25/2016
Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries	A-02-14-01011	9/28/2015

APPENDIX E: STATE AGENCY COMMENTS

State of California—Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

May 21, 2021

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IX
90 7th Street, Suite 3-650
San Francisco, CA 94103

Dear Ms. Ahlstrand:

The California Department of Public Health (CDPH) has reviewed the Department of Health and Human Services (HHS) Office of Inspector General (OIG) draft report titled, "California Did Not Ensure That Nursing Facilities Always Reported Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries and Did Not Always Prioritize Allegations Properly." CDPH appreciates the opportunity to respond to the report and provide our assessment of the recommendations contained therein.

Below we reiterate the audit findings to CDPH and our response to the auditor's specific recommendations.

Finding 1: "The State Agency Did Not Ensure That Nursing Facilities Always Reported Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries."

Finding 2: "Nursing Facilities Provided Documentation That Did Not Contain Sufficient Information To Determine Whether 29 Incidents Should Have Been Reported."

Finding 3: "The State Agency Did Not Always Comply With Federal Requirements for Prioritizing Allegations of Abuse or Neglect."

Finding 4: "Residents May Be At Increased Risk of Abuse or Neglect."

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Recommendation to CDPH:
Strengthen guidance to nursing facilities on reporting incidents of potential abuse or neglect of Medicaid beneficiaries.

Management Response:
We agree with this recommendation. CDPH will issue an All Facilities Letter (AFL) which reminds skilled nursing facilities of their obligation to report incidents of potential abuse or neglect. The AFL will include information regarding best practices and recommended documentation facilities should keep to assist in investigation of potential abuse incidents or injuries.

Recommendation to CDPH:
Ensure that its staff are regularly trained on updated Federal and State requirements to ensure that appropriate priorities are assigned to allegations of abuse or neglect.

Management Response:
We agree with this recommendation and concur that staff must be regularly trained and updated on all requirements. In our effort to continue training, we are reposting to our learning management system a training developed and delivered by CMS on Prioritization of Complaints and Facility Reported Incidents. To refresh our staff annually at Supervisory Academy and New Surveyor Academy and Quarterly Training Supervisor Meetings, we re-train on prioritization of intakes and concentrate in particular for those allegations containing abuse or neglect. Refresher videos are in development providing field staff up-to-date training on prioritization of abuse and neglect allegations as well as other related intakes. At our annual Training Event in October 2021, we will request CMS to present the most recent and updated Federal requirements for our field surveyors and training staff will review the state requirements.

We appreciate the opportunity to respond to the audit. If you have any questions, please contact Mónica Vázquez, Chief, Office of Compliance, at (916)306-2251.

Sincerely,

Tomás J. Aragón

Tomás J. Aragón, M.D., Dr. P.H.
Director and State Public Health Officer