Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NURSING FACILITIES' COMPLIANCE WITH FEDERAL REGULATIONS FOR REPORTING ALLEGATIONS OF ABUSE OR NEGLECT

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EXECUTIVE SUMMARY: NURSING FACILITIES' COMPLIANCE WITH FEDERAL REGULATIONS FOR REPORTING ALLEGATIONS OF ABUSE OR NEGLECT OEI-07-13-00010

WHY WE DID THIS STUDY

To protect the well-being of residents, nursing facilities must develop and implement written policies related to reporting allegations of abuse, neglect, mistreatment, injuries of unknown source, and misappropriation of resident property (allegations of abuse or neglect). Further, allegations of abuse or neglect must be reported to the facility administrator or designee and the State survey agency within 24 hours. Results of investigations of these allegations must be reported to the same authorities within 5 working days. Nursing facilities must also notify owners, operators, employees, managers, agents, or contractors of nursing facilities (covered individuals) annually of their obligation to report reasonable suspicions of crimes.

HOW WE DID THIS STUDY

This study included a: (1) review of sampled nursing facilities' policies related to reporting allegations of abuse or neglect, (2) review of sampled nursing facilities' policies related to reasonable suspicions of crimes, and (3) survey of administrators from those sampled facilities. It also included an examination of a random sample of allegations of abuse or neglect identified from the sampled nursing facilities, and a review of documentation related to those sampled allegations.

WHAT WE FOUND

It is both required and expected that nursing facilities will report any and all allegations of abuse or neglect to ensure resident safety. We found that 85 percent of nursing facilities reported at least one allegation of abuse or neglect to OIG in 2012. Additionally, 76 percent of nursing facilities maintained policies that address Federal regulations for reporting both allegations of abuse or neglect and investigation results. Further, 61 percent of nursing facilities had documentation supporting the facilities' compliance with both Federal regulations under Section 1150B of the Social Security Act. Lastly, 53 percent of allegations of abuse or neglect and the subsequent investigation results were reported, as Federally required.

WHAT WE RECOMMEND

We recommend that the Centers for Medicare & Medicaid Services (CMS) ensure that nursing facilities: (1) maintain policies related to reporting allegations of abuse or neglect; (2) notify covered individuals of their obligation to report reasonable suspicions of crimes; and (3) report allegations of abuse or neglect and investigation results in a timely manner and to the appropriate individuals, as required. CMS concurred with all three of our recommendations.

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OBJECTIVES

1. To determine the extent to which nursing facilities:
    a. reported allegations of abuse or neglect in 2012;
    b. had written policies that address reporting allegations of abuse or neglect as required by Federal regulations; and
    c. complied with Federal regulations related to reasonable suspicions of crimes under Section 1150B of the Social Security Act (SSA).
2. To determine the extent to which allegations of abuse or neglect were reported by nursing facilities in compliance with Federal regulations.

BACKGROUND

It is estimated that approximately 5 million, or 10 percent, of elderly adults are abused, neglected, or exploited annually.[1] Between now and 2050, the United States is projected to experience significant growth in its elderly population. In 2050, the number of Americans aged 65 and older is projected to be 88.5 million, more than double the population of 40.2 million in 2010.[2] Nursing facilities are likely to experience increases in their resident population; therefore, it is important to ensure that residents are protected from abuse and neglect.

Types of Allegations

Pursuant to Federal regulations, all nursing facility residents must not be subjected to abuse by anyone, including, but not limited to, facility staff.[3] Nursing facility residents also have "the right to be free from mistreatment, neglect, and misappropriation of property."[4] Further, all Medicare and/or Medicaid-certified nursing facilities must report "alleged violations involving mistreatment, neglect, or abuse, including injuries of

[1] Administration for Community Living, *Release of the FY 2014 Budget Request to Congress*, February 13, 2013. Accessed at http://acl.gov/About_ACL/Budget/docs/FY2014_ACL_CJ.pdf on January 13, 2014.
[2] United States Census Bureau, *The Next Four Decades, The Older Population in the United States: 2010 to 2050*, May 2010. Accessed at http://www.census.gov/prod/2010pubs/p25-1138.pdf on January 28, 2014.
[3] Centers for Medicare & Medicaid Services (CMS), *State Operations Manual* (Internet-Only Manual), Pub. 100-07, Appendix PP: Guidance to Surveyors for Long Term Care Facilities, F223, § 483.13(b), Abuse.
[4] Ibid, F224, § 483.13(c), Staff Treatment of Residents.

unknown source, and misappropriation of resident property…."[5, 6] Table 1 includes CMS definitions of the terms abuse, injuries of unknown source, neglect, misappropriation of resident property, and mistreatment. For the purposes of this study, we will use the general phrase "allegations of abuse or neglect" to refer to all types of allegations.

Table 1: Definition of Each Type of Allegation

Allegation	Definition
Abuse	The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.[7]
Injuries of Unknown Source	An injury should be 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 the source of the injury could not be explained by the resident; and 2. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.[8]
Neglect	Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.[9]
Misappropriation of Resident Property	The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.[10]
Mistreatment	Not defined as of March 2014.

Source: CMS, Memorandum to State Survey Agency Directors, S&C-05-09, *Clarification of Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, and Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property*, December 16, 2004.

[5] 42 CFR § 483.13(c)(2). Pursuant to 42 CFR § 483.5, a "facility" is defined as a "skilled nursing facility (SNF) that meets the requirements of sections 1819(a), (b), (c), and (d) of the Act, or a nursing facility (NF) that meets the requirements of sections 1919(a), (b), (c), and (d) of the SSA." For the purposes of this report, we use the term "nursing facility" to refer to both Medicare skilled nursing facilities and Medicaid nursing facilities.

[6] All nursing facilities participating in the Medicare and/or Medicaid programs must be certified as meeting Federal nursing facility quality and safety requirements, including requirements regarding allegations of abuse or neglect. For the purposes of this study, we did not review deficiency citations or actions taken for noncompliance by State survey agencies.

[7] 42 CFR § 488.301.

[8] CMS, Memorandum to State Survey Agency Directors, S&C-05-09, Clarification of Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, and Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, December 16, 2004.

[9] 42 CFR § 488.301.

[10] Ibid.

Nursing Facilities' Policies Related to Prohibiting Abuse or Neglect

Pursuant to Federal regulations, nursing facilities must develop and implement written policies that prohibit abuse or neglect.[11] Nursing facilities' policies prohibiting abuse or neglect must address the following seven components: screening, training, prevention, identification, investigation, protection, and reporting/response.[12] For the purposes of this study, we focused our review on written policies regarding reporting allegations of abuse or neglect.

Reporting Allegations of Abuse or Neglect

Nursing facilities must report all allegations of abuse or neglect[13] immediately to the nursing facility administrator or designee, State survey and certification agency (State survey agency), and to other officials in accordance with State law.[14, 15] An allegation of abuse or neglect is required to be reported immediately; an investigation is subsequently conducted to determine and substantiate the allegation. Not all allegations of abuse or neglect are substantiated. Nursing facilities are required to report the results of investigations of these allegations to the nursing facility administrator or designee, State survey agency, and to other officials in accordance with State law within 5 working days of the incident.[16]

In December 2004, CMS sent a memorandum to State survey agency directors clarifying the nursing facility reporting regulations at

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[11] 42 CFR § 483.13(c). See also CMS, *State Operations Manual* (Internet-Only Manual), Pub. 100-07, Appendix PP: Guidance to Surveyors for Long Term Care Facilities, F226, § 483.13(c), Staff Treatment of Residents.

[12] Ibid.

[13] Nursing facilities may become aware of allegations of abuse or neglect through many sources. These sources may include: residents, family members of residents, and nursing facility staff.

[14] 42 CFR § 483.13(c)(2). State law may stipulate that nursing facilities report allegations of abuse to additional State officials beyond those specified in Federal requirements.

[15] Generally, if a State survey agency determines that a nursing facility fails to comply with a specific requirement (e.g., failure to report an allegation of abuse or neglect), the facility may receive a deficiency citation. For the purposes of this study, we did not review deficiency citations or actions taken for noncompliance by State survey agencies.

[16] 42 CFR § 483.13(c)(4). State law may stipulate that nursing facilities report investigative results to additional State officials beyond those specified in Federal requirements. No State law can override the obligation of a Medicare and/or Medicaid certified nursing facility to fulfill the requirements at 42 CFR § 483.13(c), including 42 CFR §§ 483.12(c)(2) and (4). Therefore, States may not establish longer timeframes for reporting than those mandated in the requirements at 42 CFR §§ 483.13(c)(2) and (4).

42 CFR §§ 483.13(c)(2) and (4).[17] The memorandum reiterated the reporting of allegations of abuse or neglect and the results of the investigations by nursing facilities to the State survey agency. In this memorandum, CMS also clarified the requirement that nursing facilities report allegations of abuse or neglect immediately by defining the term "immediately" to mean as soon as possible, but ought not to exceed 24 hours after discovery of the incident, in the absence of a shorter State timeframe requirement.[18]

Reporting Reasonable Suspicions of Crimes

Section 6703(b)(3) of the Elder Justice Act of 2009 amends the SSA by adding section 1150B.[19] Section 1150B requires owners, operators, employees, managers, agents, or contractors of nursing facilities (covered individuals) in applicable nursing facilities to report any reasonable suspicion of crimes committed against a resident of that facility to the appropriate entities (e.g., law enforcement entities).[20] The nursing facility's responsibility to report all allegations of abuse or neglect is separate from a covered individual's responsibility outlined in Section 1150B.

Section 1150B requires applicable nursing facilities to annually notify covered individuals of their obligation to report to the appropriate entities any reasonable suspicions of a crime.[21] Nursing facilities may not retaliate against covered individuals who lawfully report a reasonable suspicion of a crime.[22] Further, nursing facilities are required to clearly post a notice for employees specifying employees' rights to file a complaint under Section 1150B.[23]

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[17] CMS, Memorandum to State Survey Agency Directors, S&C-05-09, *Clarification of Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, and Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property*, December 16, 2004.

[18] Ibid.

[19] Elder Justice Act of 2009 (EJA), P.L. 111-148, title VI, subtitle H, § 6703(b)(3), adding SSA § 1150B, 42 U.S.C. § 1320b-25. The EJA was enacted as part of the Patient Protection and Affordable Care Act (PPACA). The PPACA (P.L. 111-148, enacted on March 23, 2010) was amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152, enacted on March 30, 2010). Together, these laws are referred to as the Affordable Care Act (ACA).

[20] SSA § 1150B. Applicable nursing facilities include those facilities that receive at least $10,000 in Federal funds under the SSA during the preceding year. Further, the law of the applicable political subdivision in which the long-term-care facility is located defines the meaning of the phrase "reasonable suspicion of a crime."

[21] SSA § 1150B(a)(2).

[22] SSA § 1150B(d).

[23] SSA § 1150B(d)(3).

In June 2011, CMS sent a memorandum to State survey agency directors that described the regulations related to reporting reasonable suspicions of crimes set forth in Section 1150B and provided answers to frequently asked questions.[24] In this memorandum, CMS also indicated that nursing facilities' policies should "address the mechanism for documenting that all covered individuals have been notified annually of their reporting obligations."[25] The memorandum further indicated that "[e]xamples of such documentation may include a copy of a notice or letter sent to covered individuals or a completed training/orientation attendance sheet specifying reporting obligations."

Related Reports

In 2006, the Office of Inspector General (OIG) conducted an evaluation entitled *Nursing Home Complaint Investigations* (OEI-01-04-00340), which found that State agencies did not investigate some of the most serious nursing home complaints within required timeframes; States did not take full advantage of the available complaint reporting system; and, in a targeted review of five States, State agencies followed protocol for intake and triage but followup letters to complainants often lacked meaningful information.[26]

METHODOLOGY

We conducted this study in two parts. The first part included a: (1) review of policies related to reporting allegations of abuse or neglect from a sample of 250 nursing facilities from two strata, as shown in Table 2, (2) review of the sampled nursing facilities' policies and procedures related to reasonable suspicions of crimes, and (3) survey of administrators from the sampled nursing facilities. All estimates for part one are projected to the population of nursing facilities.[27]

[24] CMS, Memorandum to State Survey Agency Directors, S&C: 11-30-NH, Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the SSA, June 17, 2011. The memorandum was revised on January 20, 2012, to include an updated questions-and-answers section and appendix.

[25] Ibid.

[26] OIG, *Nursing Home Complaint Investigations* (OEI-01-04-00340), July 2006.

[27] We received information from 245 of the 250 nursing facilities in our sample resulting in a 98 percent response rate. Therefore, the projected population for our sample is 15,550 instead of 15,854.

Table 2: Nursing Facility Population and Sample Size

Stratum Definition	Population Size	Sample Size
Nursing Facilities That Have a Total Certified Size Greater Than or Equal to 113 Beds (Large Facilities)	6,347	125
Nursing Facilities That Have a Total Certified Size Less Than 113 Beds (Small Facilities)	9,507	125
Total	**15,854**	**250**

Source: OIG analysis of the Certification and Survey Provider Enhanced Reporting database as of March 26, 2013.

The second part of this study included an examination of a sample of 301 allegations of abuse or neglect (from the population of 2,502 allegations) identified by the nursing facilities in the first part of the study. The second part included a review of documentation related to sampled allegations of abuse or neglect (e.g., investigation records). All estimates for part two are projected to the population of allegations of abuse or neglect reported by sampled nursing facilities from part one. See Appendix A for a detailed description of our methodology.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Nursing facilities are required to report all allegations of abuse or neglect to ensure resident safety; 85 percent of nursing facilities reported at least one such allegation to OIG in 2012

It is both required and expected that nursing facilities will report any and all allegations of abuse or neglect to ensure resident safety. Eighty-five percent of nursing facilities reported at least one allegation of abuse or neglect to OIG in 2012. An allegation of abuse or neglect is required to be reported immediately; an investigation is subsequently conducted to determine and substantiate the allegation. Not all allegations of abuse or neglect are substantiated.[28] Allegations of abuse or neglect include the following types: abuse, injuries of unknown source, misappropriation of resident property, neglect, or mistreatment. A total of 149,313 allegations of abuse or neglect were reported by facilities to OIG in 2012. Nursing facilities identified the type and nature of allegations that occurred.

Abuse was the most common type of allegation, accounting for half of the allegations in 2012. See Table 3 for information regarding the types of allegations that nursing facilities reported to OIG in 2012. Nursing facilities described the individuals involved in the alleged incidents by identifying the nature of the allegations (e.g., resident to resident). Nursing facilities identified 40 percent of allegations as employee to resident. See Table 4 for information regarding the nature of allegations of abuse or neglect that nursing facilities reported to OIG in 2012. See Appendix B for all estimates and 95-percent confidence intervals for projections.

[28] For the purposes of this study, we did not determine whether the allegations of abuse or neglect reported by the sampled nursing facilities were substantiated.

Table 3: Types of Allegations of Abuse or Neglect That Nursing Facilities Reported in 2012

Type of Allegation	Number of Allegations in Sample (n=2,502)	Projected Number of Allegations (N=149,313)	Percentage of Allegations
Abuse	1,265	75,658	50.7
Injuries of unknown source	476	27,759	18.6
Misappropriations of resident property	392	22,281	14.9
Neglect	275	17,553	11.8
Mistreatment	92	5,961	3.9
Other	2	102	0.1
Total	**2,502**	**149,314***	**100**

Source: OIG analysis of allegations of abuse or neglect reported by nursing facilities, 2014.

* Numbers do not total precisely because of rounding.

Table 4: Nature of Allegations of Abuse or Neglect That Nursing Facilities Reported in 2012

Nature of Allegation	Number of Allegations in Sample (n=2,502)	Projected Number of Allegations (N=149,313)	Percentage of Allegations
Employee to resident	1,010	60,132	40.3
Perpetrator unknown	659	39,099	26.2
Resident to resident	600	36,078	24.2
Resident self-neglect (e.g., resident self-inflicted injury)	89	5,733	3.8
Family or other visitor to resident	59	3,476	2.3
Nature not specified	46	2,538	1.7
Resident to employee	25	1,320	0.9
Outside medical professional to resident	14	938	0.6
Total	**2,502**	**149,314***	**100**

Source: OIG analysis of allegations of abuse or neglect reported by nursing facilities, 2014.

* Numbers do not total precisely because of rounding.

When we reviewed facilities on the basis of size, we found that 87 percent of large nursing facilities had allegations of abuse or neglect in 2012, and 84 percent of small nursing facilities had allegations of abuse or neglect.[29, 30]

Seventy-six percent of nursing facilities maintained policies that address Federal regulations for reporting both allegations of abuse or neglect and subsequent investigation results

Nursing facilities must have policies that prohibit abuse or neglect, which must include policies for reporting allegations of abuse or neglect and the subsequent investigation results to the appropriate individuals within the required timeframes. In 2012, 76 percent of nursing facilities (11,744 facilities) maintained policies that address Federal regulations for reporting both allegations of abuse or neglect and subsequent investigation results. Ninety-five percent of nursing facilities had policies that reflected Federal regulations for reporting allegations of abuse or neglect. Seventy-six percent of nursing facilities had policies that reflected Federal regulations for reporting subsequent investigation results of allegations of abuse or neglect. See Table 5 for the number and percentage of nursing facilities that had policies that address Federal regulations for reporting allegations of abuse or neglect.[31]

[29] Per our methodology in Appendix A, we define large nursing facilities as facilities that have a total certified size greater than or equal to 113 beds. We define small facilities as facilities that have a total certified size less than 113 beds.

[30] We did not identify a statistically significant difference (p=0.48) between these two types of nursing homes. See Table C-1 in Appendix C.

[31] The remaining 24 percent of nursing facilities maintained written policies that prohibit abuse or neglect; however, these policies did not address the Federal requirements related to reporting allegations of abuse or neglect and/or the investigation results. Further, we did not identify a statistically significant difference (p=0.52) between nursing facilities that maintained policies and those facilities that did not maintain policies with regard to reporting allegations of abuse or neglect in part one of this study. See Table C-2 in Appendix C.

Table 5: Nursing Facilities That Maintained Policies That Addressed Federal Regulations for Reporting Allegations of Abuse or Neglect

Federal Regulations	Number of Nursing Facilities in sample (n=245)	Projected Number of Nursing Facilities (N=15,550)	Percentage of Nursing Facilities That Maintained Policies That Addressed Federal Regulations
Allegations of abuse or neglect must be immediately reported to the nursing facility administrator or designee and the State survey agency	232	14,738	94.8
Investigation results must be reported to the nursing facility administrator or designee and the State survey agency within 5 working days of the incident	185	11,871	76.3
Total number of nursing facilities that had policies that addressed both Federal regulations	**183**	**11,744**	**75.5***

Source: OIG analysis of nursing facilities' reporting policies, 2014.

*The actual percentage of nursing facilities that addressed both Federal regulations is 75.52 percent. The actual number, 75.52, rounds to 75.5. As a whole number, this percentage rounds to 76 percent.

When we reviewed facilities on the basis of size, we found that 70 percent of large nursing facilities maintained policies that addressed both reporting allegations of abuse or neglect and reporting the investigation results. Seventy-nine percent of small nursing facilities maintained such policies.[32]

Sixty-one percent of nursing facilities had documentation supporting the facilities' compliance with both Federal regulations under Section 1150B of the SSA

Under Section 1150B of the SSA, nursing facilities must annually notify covered individuals (i.e., owners, operators, employees, managers, agents, or contractors of nursing facilities) of their obligation to report to the appropriate entities any reasonable suspicion of a crime. Further, nursing facilities must also clearly post a notice specifying employees' rights to file a complaint under Section 1150B. In 2012, 61 percent of nursing facilities (9,487 facilities) had documentation to support that both of these regulations were met. See Table 6 for the number and percentage of nursing facilities that had documentation to support that Federal regulations related to reporting reasonable suspicions of crimes were met.

[32] We did not identify a statistically significant difference (p=0.12) between these two types of nursing homes. See Table C-3 in Appendix C.

Table 6: Nursing Facilities with Documentation to Support That Federal Regulations Related to Reasonable Suspicions of Crimes Were Met

Federal Regulations	Number of Nursing Facilities in Sample (n=245)	Projected Number of Nursing Facilities (N=15,550)	Percentage of Nursing Facilities with Documentation to Support That Both Regulations Were Met
Nursing facility must annually notify covered individuals of their obligation to report to the appropriate entities any reasonable suspicion of a crime	162	10,400	66.8
Nursing facility must clearly post a notice for its employees specifying employees' rights to file a complaint under Section 1150B of the SSA	195	12,429	79.9
Total number of nursing facilities with documentation to support that both regulations were met	**148**	**9,487**	**61.0**

Source: OIG analysis of nursing facilities' submitted documentation regarding reasonable suspicion of crimes, 2014.

Nursing facilities provided various types of documentation to support that covered individuals were notified of their obligation to report reasonable suspicions of crimes. Examples of documentation provided included letters to employees, employee training logs, Employee Bill of Rights, and employee-signed attestations. See Appendix D for an example of a letter notifying a covered individual of his/her obligation to report reasonable suspicions of crimes.

Nursing facilities also provided various types of documentation supporting compliance with the requirement to post notification specifying employees' rights to file a complaint under Section 1150B of the SSA. Examples of documentation provided included copies of posters specifying rights, photographs of posted documentation in employee break rooms, and posted Employee Bill of Rights. See Appendix E for an example of a posted notification specifying employees' rights to file a complaint.

When we reviewed facilities on the basis of size, we found that 57 percent of large nursing facilities had documentation to support that both Federal regulations related to reasonable suspicions of crimes were met. Sixty-three percent of small nursing facilities had such documentation.[33]

[33] We did not identify a statistically significant difference (p=0.32) between these two types of nursing homes. See Table C-4 in Appendix C.

Fifty-three percent of allegations of abuse or neglect and the subsequent investigation results were reported, as Federally required

In 2012, 53 percent of allegations of abuse or neglect and the subsequent investigation results (1,338 allegations) were reported, as Federally required. Sixty-three percent of allegations of abuse or neglect were immediately reported to the nursing facility administrator or designee and the State survey agency, as required. Further, the subsequent investigation results for 63 percent of allegations of abuse or neglect were reported to the appropriate individuals within 5 working days, as required. See Table 7 for the number and percentage of allegations of abuse or neglect that were reported in compliance with Federal regulations.

Table 7: Allegations of Abuse or Neglect That Were Reported by Nursing Facilities in Compliance With Federal Regulations

Federal Regulations	Number of Allegations in Sample (n=301)	Projected Number of Allegations (N=2,502)	Percent of Allegations
Allegations of abuse or neglect must be immediately reported to the nursing facility administrator or designee and the State survey agency	189	1,571	62.8
Investigation results must be reported to the nursing facility administrator or designee and the State survey agency within 5 working days of the incident	191	1,588	63.4
Total number of allegations of abuse or neglect that were reported in compliance with both Federal regulations	**161**	**1,338**	**53.4**

Source: OIG analysis of documentation for allegations of abuse or neglect provided by nursing facilities, 2014.

When we reviewed facilities on the basis of size, we found that 57 percent of allegations of abuse or neglect were from large nursing facilities that provided documentation to support that allegations were reported in compliance with Federal regulations. Forty-seven percent of small nursing facilities had such documentation.[34]

Nursing facilities provided various types of documentation to support that allegations of abuse or neglect were reported in compliance with Federal regulations. Examples of documentation provided included copies of incident report forms signed and dated by the facility administrator, copies of facsimiles sent to the State survey agency, and copies of email

[34] We did not identify a statistically significant difference (p=0.07) between these two types of nursing homes. See Table C-5 in Appendix C.

confirmations from the State survey agency to the facility administrator regarding receipt of notification about the allegation of abuse.

Nursing facilities also provided various types of documentation to support that investigation results of allegations of abuse or neglect were reported in compliance with Federal regulations. Examples of documentation provided included copies of investigation report forms signed and dated by the facility administrator, copies of facsimiles sent to the State survey agency, and copies of screenshots from State reporting systems indicating that investigation results were reported to the State survey agency within the required timeframe.

CONCLUSION AND RECOMMENDATIONS

It is both required and expected that nursing facilities will report any and all allegations of abuse or neglect to ensure resident safety. Eighty-five percent of nursing facilities reported at least one allegation of abuse or neglect to OIG in 2012. Seventy-six percent of nursing facilities maintained policies that address Federal regulations for both reporting allegations of abuse or neglect and subsequent investigation results. Further, 61 percent of nursing facilities had documentation supporting the facilities' compliance with both Federal regulations under Section 1150B of the SSA. Lastly, 53 percent of allegations of abuse or neglect and the subsequent investigation results were reported, as Federally required.

Given the increasing elderly population in the United States and the growing number of individuals over age 65 receiving care in nursing facilities, elder abuse or neglect is likely to increase as well. To ensure quality of care for this vulnerable population, we recommend that CMS:

Ensure that nursing facilities maintain policies related to reporting allegations of abuse or neglect

To ensure that CMS reaches all nursing facilities that may be out of compliance, CMS could update guidance that clearly describes the reporting regulations that should be established in facilities' written policies for reporting allegations of abuse or neglect and the subsequent investigation results. We will provide to CMS a list of the nursing facilities in our sample that did not address Federal regulations for reporting allegations of abuse or neglect and investigation results in their written policies. CMS should take appropriate action to ensure these nursing facilities have the pertinent policies.

Ensure that nursing facilities comply with their responsibilities under Section 1150B of the SSA

To support nursing facilities' implementation of Federal regulations, CMS could develop and share reporting templates. For example, CMS could develop: (1) customizable templates of annual notification letters to covered individuals and (2) posters and materials describing employees' rights to file a complaint under Section 1150B of the SSA. Further, CMS could reissue guidance that recommends that nursing facilities maintain adequate documentation to support that they notified covered individuals. We will provide to CMS a list of the nursing facilities in our sample that did not have documentation to support that covered individuals were notified and notification was posted.

Ensure that nursing facilities report allegations of abuse or neglect and investigation results in a timely manner and to the appropriate individuals, as required

To ensure that CMS reaches all nursing facilities that may be out of compliance, CMS could reissue guidance that clearly describes the timeframes and appropriate individuals for which allegations of abuse or neglect and the subsequent investigation results should be reported. CMS should reiterate in this guidance that all allegations of abuse or neglect must be reported to the State survey agency, as required by Federal law. Further, the guidance could recommend that nursing facilities maintain adequate documentation to support that allegations of abuse or neglect are reported in compliance with these regulations. We will provide to CMS a list of the nursing facilities in our sample that did not report allegations of abuse or neglect and investigation results in compliance with Federal regulations for appropriate action.

AGENCY COMMENTS AND OFFCIE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all three of our recommendations.

In responding to our first recommendation, CMS stated that it previously distributed guidance related to the proper reporting of allegations of abuse or neglect via Survey and Certification memoranda provided to State agency directors and posted on the CMS Web site. Additionally, CMS stated that it distributed a training toolkit to State survey directors regarding reporting regulations and guidance related to Section 1150B of the SSA. CMS further stated that it would advise State agencies and providers to use the various resources that it had made available, such as the State Operations Manuals and Survey and Certification memoranda. Lastly, CMS stated that it would explore additional opportunities to promote compliance with Section 1150B of the SSA.

In responding to our second recommendation, CMS stated that it holds conference calls with stakeholders to discuss nursing facility issues and that it would use these calls to discuss and reinforce Section 1150B reporting regulations. CMS also stated that it provided guidance to State agency directors regarding the information that should be included in the posted notice about employees' right to file a complaint under Section 1150B of the SSA. CMS stated that it would consider OIG's recommendation to draft such materials as: (1) customizable templates of annual notification letters to covered individuals and (2) posters and materials describing employees' rights to file a complaint under Section 1150B of the SSA.

In responding to our third recommendation, CMS stated that it would discuss OIG's report results with State agency directors and reiterate covered individuals' reporting obligation timelines and regulations. CMS also stated that it would update or reissue guidance on this issue, as necessary.

We support CMS's efforts to address these issues and encourage continued progress, including taking appropriate action for those nursing facilities that did not comply with Federal regulations. For the full text of CMS's comments, see Appendix F.

APPENDIX A

Detailed Methodology

Part One

Nursing Facility Population and Sample Selection

We selected a stratified random sample from the population of 15,854 nursing facilities listed in the Certification and Survey Provider Enhanced Reporting (CASPER) database as of March 26, 2013.[35] To produce overall estimates of the number and percentage of nursing facilities that complied with Federal regulations related to reporting allegations of abuse or neglect, we selected a sample of 250 nursing facilities from 2 strata as shown in Table A-1.[36]

Table A-1: Nursing Facility Population and Sample Size

Stratum Definition	Population Size	Sample Size
Nursing facilities that have a total certified size greater than or equal to 113 beds	6,347	125
Nursing facilities that have a total certified size less than 113 beds	9,507	125
Total	**15,854**	**250**

Source: OIG analysis of CASPER database as of March 26, 2013.

We stratified our sample to determine whether the bed size of a nursing facility had any effect on whether it would have more or fewer allegations of abuse or neglect. Further, we wanted to determine whether the bed size of a nursing facility would affect whether the facility had policies related to allegations of abuse or neglect.

Data Collection

For each of the 250 sampled nursing facilities, we sent the nursing facility administrator a letter requesting (1) documentation of any policies related to allegations of abuse or neglect, (2) documentation supporting that all covered individuals were notified of their obligation to report reasonable suspicions of crimes, (3) documentation to support that the facility posted

[35] This population included both Medicare- and Medicaid-certified nursing facilities as of March 26, 2013. As such, the population of nursing facilities from which we selected our sample included both Medicare skilled nursing facilities and Medicaid nursing facilities. Pursuant to 42 CFR § 483.5, a "facility" is defined as a "skilled nursing facility that meets the requirements of sections 1819(a), (b), (c), and (d) of the SSA or a nursing facility that meets the requirements of sections 1919(a), (b), (c), and (d) of the SSA." For the purposes of this report, we use the term "nursing facility" to refer to both Medicare skilled nursing facilities and Medicaid nursing facilities.

[36] We established the two strata using a rule for forming strata boundaries developed by W.G. Cochran, founder of the Harvard Statistics Department.

notification specifying employees' rights to file a complaint under Section 1150B of the SSA, and (4) completion of a mail survey regarding allegations of abuse or neglect. We also requested that the nursing facility administrator identify the total number of allegations of abuse or neglect that occurred in the facility during 2012 and indicate the type of each allegation (e.g., abuse, neglect) and the nature of each allegation (e.g., the allegation involved a resident abusing another resident, the allegation involved an employee neglecting a resident). We sent a second letter to nursing facility administrators who did not respond to our initial request. We sent a final letter with confirmation of receipt through the United Parcel Service to those nursing facilities that did not respond to the second request. In a last attempt to contact the nonresponsive nursing facilities, we contacted the administrators by telephone to verify that the facility was open and whether the administrator intended to respond to our request.

We received responses from 245 of the 250 sampled nursing facilities from which we requested documentation, a response rate of 98 percent. For the other five sampled facilities, four nursing facility administrators did not respond to our request.[37, 38] The fifth nursing facility was closed in September 2012 by court order and the requested documentation was in the possession of the State in which the facility was located.[39] Because of the nonresponse of 5 nursing facilities (2 percent of our sample), all estimates are projected to a population of 15,550 nursing facilities instead of the population of 15,854 facilities.

Data Analysis

We determined whether the sampled nursing facilities' policies regarding abuse or neglect addressed reporting allegations of abuse or neglect and the results of investigations to the appropriate authorities and within the specified timeframes. We also determined whether the sampled nursing facilities had documentation supporting that (1) all covered individuals were notified of their obligation to report reasonable suspicions of crimes,

[37] We collected data for part one of the study from June 24, 2013, through August 31, 2013. Because data collection for part two of the study was dependent on the total number of allegations of abuse or neglect identified in part one, those nursing facilities that did not respond to our final request by August 31, 2013, were deemed nonresponders. Two of the four nonresponders submitted the requested documentation approximately two weeks after data collection ended for part one of the study. The information provided by these facilities was not included in our data analysis for this study.

[38] We referred the nursing facilities that did not respond to our request to CMS for appropriate action.

[39] The court-appointed receiver for this nursing facility provided documentation supporting that the facility was closed by the State's superior court in 2012; as a result, all facility records were in the possession of the State. We did not seek the documentation from the State.

and (2) that the facility posted notification specifying employees' rights to file a complaint under Section 1150B of the SSA. Finally, we determined the total number of allegations of abuse or neglect for 2012 and the type and nature of each allegation.

Determination of Whether Policies Address Reporting Regulations. For each nursing facility that responded to our request, we reviewed documentation of its policies and procedures for reporting allegations of abuse or neglect and results of the investigation to the appropriate authorities and within the specified timeframes. We considered nursing facilities' policies to address reporting allegations of abuse or neglect if the policies indicated that (1) allegations of abuse or neglect must be reported to the administrator or designee and the State survey agency, and (2) these allegations must be reported immediately (within 24 hours). We considered nursing facilities' policies to address reporting of results of the investigation if the policies indicated that (1) results of the investigation must be reported to the administrator or designee and the State survey agency, and (2) these results must be reported within 5 working days of the incident.

Determination of Whether All Covered Individuals Were Notified. For each nursing facility that responded to our request, we reviewed submitted documentation to determine whether it supported that the facility notified all covered individuals of their obligation to report reasonable suspicions of crimes. Such documentation included copies of inservice training logs, copies of notices provided to the covered individuals indicating such obligations, and examples of signed acknowledgments of the obligation to report reasonable suspicions of crimes.

Determination of Whether Nursing Facilities Posted Notification. For each nursing facility that responded to our request, we reviewed submitted documentation to determine whether it supported that the facility posted notification specifying employees' rights to file a complaint under Section 1150B of the SSA. Such documentation included copies of posters specifying rights, photographs of posted documentation in employee break rooms, and posted Employee Bill of Rights.

Identification of Allegations of Abuse or Neglect. We requested that each nursing facility administrator complete a survey identifying the total number of allegations of abuse or neglect in the facility during 2012. The survey also asked the administrator to indicate the type of each allegation (e.g., abuse, neglect) and the nature of each allegation (e.g., the allegation involved a resident abusing another resident, the allegation involved an employee neglecting a resident). We analyzed the responses of the 245 nursing facility administrators who completed the survey and found

that 209 of them indicated that at least one allegation of abuse or neglect occurred in their facilities in 2012.[40]

Part Two

Allegation Population and Sample Selection

We constructed the total population of allegations of abuse or neglect that occurred in the 209 nursing facilities that reported at least one such allegation in 2012. The total population included 2,502 allegations of abuse or neglect. From this population, we selected a simple random sample of 301 such allegations from the two strata as shown in Table A-2.[41] The 301 sampled allegations represent allegations of abuse or neglect reported by 121 nursing facilities.

Table A-2: Population and Sample Size

Stratum Definition	Population of Allegations Reported in Part One	Allegations Sample Size	Number of Nursing Facilities Represented
Nursing facilities that have a total certified size greater than or equal to 113 beds	1,621	195	68
Nursing facilities that have a total certified size less than 113 beds	881	106	53
Total	**2,502**	**301**	**121**

Source: OIG analysis of allegations of abuse reported by nursing facilities from part one of this evaluation, 2014.

Data Collection

Nursing Facility Documentation. For each of the 121 nursing facilities that had a sampled allegation of abuse or neglect, we sent the administrator a letter requesting documentation related to the sampled allegation(s) (e.g., incident reports, witness statements, forms sent to the State survey agency, investigation results). We sent a second letter to nursing facility administrators who did not respond to our initial request. After our second letter, we received responses from all 121 nursing facilities and received documentation for all 301 sampled allegations of abuse or neglect, a response rate of 100 percent.

[40] Thirty-four nursing facility administrators reported that no allegations of abuse or neglect occurred in their facilities in 2012. Two nursing facility administrators could not identify the number of allegations of abuse or neglect that occurred in their facilities in 2012 because they could not find the documentation.

[41] From each stratum, we selected a simple random sample of 12 percent of the population of allegations of abuse or neglect reported in part one of the study. This resulted in a sample of 301 allegations of abuse or neglect.

Data Analysis

We reviewed the submitted documentation for the 301 sampled allegations of abuse or neglect to determine whether nursing facilities complied with Federal regulations. Figures derived from our analysis in part two are projected to the population of 2,502 allegations of abuse or neglect reported by nursing facilities in part one.

Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect. We reviewed the submitted documentation to determine whether allegations of abuse or neglect were reported in accordance with Federal regulations. Specifically, we reviewed the documentation to determine whether it supported that nursing facilities reported all allegations of abuse or neglect within 24 hours to the administrator or designee and the State survey agency.[42] Such documentation included incident report forms signed by the nursing facility administrator or designee, copies of facsimiles sent to the State survey agency, and printed screen shots of the State survey agency's online reporting form.

Compliance with Federal Regulations for Reporting Investigation Results. We reviewed the submitted documentation to determine whether the results of investigations of allegations of abuse or neglect were reported in accordance with Federal regulations. Specifically, we reviewed the documentation to determine whether nursing facilities reported the results of investigations of allegations of abuse or neglect to the nursing facility administrator or designee and State survey agency within 5 working days of the incident. Such documentation included investigation summaries signed by the nursing facility administrator or designee, copies of facsimiles sent to the State survey agency, and printed screen shots of the State survey agency's online reporting form.

[42] Nursing facilities are required to report allegations of abuse or neglect immediately, which has been defined by CMS to mean as soon as possible, but ought not exceed 24 hours. For the purposes of our study, we considered nursing facilities to have complied with this requirement if the allegation of abuse or neglect was reported within 24 hours.

APPENDIX B

Table B-1: Point Estimates, Sample Sizes, and Confidence Intervals

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Finding 1: Estimates of allegations of abuse or neglect that nursing facilities reported in 2012			
Percentage of nursing facilities that reported at least one allegation of abuse or neglect in 2012	209	85.0%	80.4%–89.6%
Total number of allegations of abuse or neglect that nursing facilities reported in 2012	2,502	149,313	117,400–181,226
Total abuse allegations that nursing facilities reported in 2012	1,265	75,658	60,805–90,511
Percentage of abuse allegations that nursing facilities reported in 2012	1,265	50.7%	43.1%–58.2%
Total injuries of unknown source allegations that nursing facilities reported in 2012	476	27,759	9,077–46,441
Percentage of injuries of unknown source allegations that nursing facilities reported in 2012	476	18.6%	8.3%–28.9%
Total misappropriation of resident property allegations that nursing facilities reported in 2012	392	22,281	11,571–32,990
Percentage of misappropriation of resident property allegations that nursing facilities reported in 2012	392	14.9%	8.7%–21.1%
Total neglect allegations that nursing facilities reported in 2012	275	17,553	12,745–22,361
Percentage of neglect allegations that nursing facilities reported in 2012	275	11.8%	8.4%–15.2%
Total mistreatment allegations that nursing facilities reported in 2012	92	5,961	2,216–9,706
Percentage of mistreatment allegations that nursing facilities reported in 2012	92	3.9%	1.5%–6.5%
Total “other” allegations that nursing facilities reported in 2012	2	102	0–241
Percentage of “other” allegations that nursing facilities reported in 2012	2	0.1%	0.0%–0.2%
Total employee-to-resident allegations	1,010	60,132	44,805–75,459
Percentage of employee-to-resident allegations	1,010	40.3%	32.2%–48.4%
Total perpetrator-unknown allegations	659	39,099	19,940–58,258
Percentage of perpetrator-unknown allegations	659	26.2%	16.7%–35.7%
Total resident-to-resident allegations	600	36,078	25,158–46,997
Percentage of resident-to-resident allegations	600	24.2%	17.6%–30.7%

Continued—Table B-1: Point Estimates, Sample Sizes, and Confidence Intervals

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Total resident-self-neglect allegations	89	5,733	2,592–8,873
Percentage of resident-self-neglect allegations	89	3.8%	1.7%–6.0%
Total family- or other visitor-to-resident allegations	59	3,476	2,136–4,816
Percentage of other visitor-to-resident allegations	59	2.3%	1.4%–3.3%
Total nature-not-specified allegations	46	2,538	696–4,380
Percentage of nature-not-specified allegations	46	1.7%	0.5%–2.9%
Total resident-to-employee allegations	25	1,320	0–2,760
Percentage of resident-to-employee allegations	25	0.9%	0.0%–1.9%
Total outside medical professional-to-resident allegations	14	938	199–1,677
Percentage of outside medical professional-to-resident allegations	14	0.6%	0.2%–1.1%
Percentage of large nursing facilities that had at least one allegation of abuse or neglect in their facility in 2012	106	86.9%	80.9%–92.9%
Percentage of small nursing facilities that had at least one allegation of abuse or neglect in their facility in 2012	103	83.7%	77.2%–90.3%
Finding 2: Estimates of nursing facilities' written policies related to allegations of abuse or neglect			
Percentage of nursing facilities that had written policies that address both Federal regulations for reporting allegations of abuse or neglect	183	75.5%*	70.1%–80.9%
Total number of nursing facilities that had written policies that address both Federal regulations for reporting allegations of abuse or neglect	183	11,744	10,902–12,586
Total number of nursing facilities that had written policies that address reporting allegations of abuse or neglect immediately to the nursing facility administrator or designee and the State survey agency	232	14,738	14,299–15,177
Percentage of nursing facilities that had written policies that address reporting allegations of abuse or neglect immediately to the nursing facility administrator or designee and the State survey agency	232	94.8%	91.9%–97.6%
Total number nursing facilities that had written policies that address reporting investigation results to the nursing facility administrator or designee and the State survey agency within 5 working days of the incident	185	11,871	11,039–12,703

Continued—Table B-1: Point Estimates, Sample Sizes, and Confidence Intervals

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of nursing facilities that had written policies that address reporting investigation results to the nursing facility administrator or designee and the State survey agency within 5 working days of the incident	185	76.3%	71.0%–81.7%
Percentage of large nursing facilities that had written policies that address both Federal regulations for reporting allegations of abuse or neglect	86	70.5%**	62.3%–78.6%
Percentage of small nursing facilities that had written policies that address both Federal regulations for reporting allegations of abuse or neglect	97	78.9%	71.6%–86.1%
Finding 3: Estimates of nursing facilities that had documentation to support that Federal regulations related to reasonable suspicions of crimes were met			
Percentage of nursing facilities that had documentation to support that both Federal regulations related to reasonable suspicions of crimes were met	148	61.0%	54.8%–67.2%
Total number of nursing facilities that had documentation to support that both Federal regulations related to reasonable suspicions of crimes were met	148	9,487	8,521–10,452
Total number of nursing facilities that had documentation to support that they annually notified covered individuals of their obligation to report to the appropriate entities any reasonable suspicions of a crime	162	10,400	9,472–11,328
Percentage of nursing facilities that had documentation to support that they annually notified covered individuals of their obligation to report to the appropriate entities any reasonable suspicions of a crime	162	66.8%	60.9%–72.8%
Total number of nursing facilities that had documentation to support that they posted clearly a notice for its employees specifying employees' rights to file a complaint under Section 1150B of the SSA	195	12,429	11,638–13,220
Percentage of nursing facilities that had documentation to support that they posted clearly a notice for its employees specifying employees' rights to file a complaint under Section 1150B of the SSA	195	79.9%	74.8%–85.0%
Percentage of large nursing facilities that had documentation to support that both Federal regulations related to reasonable suspicion of crimes were met	70	57.4%	48.6%–66.2%
Percentage of small nursing facilities that had documentation to support that both Federal regulations related to reasonable suspicion of crimes were met	78	63.4%	54.8%–72.0%

Continued—Table B-1: Point Estimates, Sample Sizes, and Confidence Intervals

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Finding 4: Estimates of allegations of abuse or neglect that were reported by nursing facilities in compliance with Federal regulations			
Percentage of allegations of abuse or neglect that were reported by nursing facilities in compliance with both Federal regulations	161	53.4%	48.2%–58.8%
Total number of allegations of abuse or neglect that were reported by nursing facilities in compliance with both Federal regulations	161	1,338	1,206–1,471
Total number of allegations of abuse or neglect that were reported immediately to the nursing facility administrator or designee and the State survey agency	189	1,571	1,442–1,700
Percentage of allegations of abuse or neglect that were reported immediately to the nursing facility administrator or designee and the State survey agency	189	62.8%	57.6%–67.9%
Total number of allegations of abuse or neglect that had investigation results reported to the nursing facility administrator or designee and the State survey agency within 5 working days of the incident	191	1,588	1,461–1,715
Percentage of allegations of abuse or neglect that had investigation results reported to the nursing facility administrator or designee and the State survey agency within 5 working days of the incident	191	63.4%	58.4%–68.5%
Percentage of large nursing facilities that reported allegations of abuse or neglect in compliance with Federal regulations	111	56.9%	50.3%–63.5%
Percentage of small nursing facilities that reported allegations of abuse or neglect in compliance with Federal regulations	50	47.2%	38.1%–56.2%

Source: OIG analysis of policies, survey responses, and investigation documentation provided by nursing facilities, 2014.

*The actual percentage of nursing facilities that address both Federal regulations is 75.52 percent. The actual number, 75.52, rounds to 75.5. As a whole number, this percentage rounds to 76 percent.

**The actual percentage of large nursing facilities that address both Federal regulations is 70.49 percent. The actual number, 70.49, rounds to 70.5. However, as a whole number, this percentage rounds to 70 percent.

APPENDIX C

Means Testing Results for Specific Data Points

Table C-1: Chi Square Analysis on Reported Allegations of Abuse or Neglect and Nursing Facility Type

Nursing Facility Type Compared (Group A vs. Group B)	Group A Rate	Group B Rate	Wald Chi-Square Test Statistic	F-Test Degrees of Freedom	P-Value
Large nursing facilities vs. small nursing facilities	5,382	7,834	0.502	numerator = 1 denominator = 244	0.4793

Source: OIG analysis of survey responses provided by nursing facilities, 2014.

Table C-2: Chi Square Analysis on Reporting Allegations of Abuse or Neglect in Part One of This Study and Nursing Facility Type

Nursing Facility Type Compared (Group A vs. Group B)	Group A Rate	Group B Rate	Wald Chi-Square Test Statistic	F-Test Degrees of Freedom	P-Value
Nursing facilities that maintained policies for reporting allegations of abuse or neglect vs. nursing facilities that did not maintain policies for reporting allegations of abuse or neglect	12,480	736	0.418	numerator = 1 denominator = 243	0.5184

Source: OIG analysis of policies and survey responses provided by nursing facilities, 2014.

Table C-3: Chi Square Analysis on Maintained Policies That Addressed Federal Regulations and Nursing Facility Type

Nursing Facility Type Compared (Group A vs. Group B)	Group A Rate	Group B Rate	Wald Chi-Square Test Statistic	F-Test Degrees of Freedom	P-Value
Large nursing facilities vs. small nursing facilities	4,367	7,377	2.3705	numerator = 1 denominator = 244	0.1249

Source: OIG analysis of policies provided by nursing facilities, 2014.

Table C-4: Chi Square Analysis on Documentation Related to Reasonable Suspicions of Crimes and Nursing Facility Type

Nursing Facility Type Compared (Group A vs. Group B)	Group A Rate	Group B Rate	Wald Chi-Square Test Statistic	F-Test Degrees of Freedom	P-Value
Large nursing facilities vs. small nursing facilities	3,554	5,932	0.9704	numerator = 1 denominator = 244	0.3256

Source: OIG analysis of nursing facilities' submitted documentation regarding reasonable suspicion of crimes, 2014.

Table C-5: Chi Square Analysis on Reporting Allegations of Abuse or Neglect in a Timely Manner and to the Appropriate Individuals by Nursing Facility Type

Nursing Facility Type Compared (Group A vs. Group B)	Group A Rate	Group B Rate	Wald Chi-Square Test Statistic	F-Test Degrees of Freedom	P-Value
Large nursing facilities vs. small nursing facilities	923	415	3.22	numerator = 1 denominator = 300	0.0739

Source: OIG analysis of documentation for allegations of abuse or neglect provided by nursing facilities, 2014.

APPENDIX D

Example of Letter Notifying Covered Individual of Obligation to Report Reasonable Suspicion of Crimes[43]

Date
(Contract Employee)

Re: Reporting of Crimes in Long Term Care Facilities

Dear_____:

Please be advised that certain individuals associated with long term care facilities, (specifically nursing facilities, hospices that provide services in long term care facilities, and Intermediate Care Facilities for the Mentally Retarded), including [redacted], are subject to new federal requirements with respect to reporting the suspicion of a crime against a resident. The stated purpose of the law is to assure that serious offenses against nursing home residents are promptly and appropriately reported and investigated. Under this law, "covered individuals"* – defined below – must report a reasonable suspicion of a crime, as defined by the applicable political subdivision. The report of the suspicion of a crime must be made to local law enforcement within two hours (in cases of serious bodily injury) or twenty-four hours (no serious bodily injury) of becoming aware of a suspicion of crime against a resident.

Each "covered individual" present in the long term care facility who has a reasonable suspicion of a crime against a resident must submit a report to local law enforcement. In instances when multiple individuals develop the same reasonable suspicion, they may submit a joint notice.

Covered individuals associated with nursing facilities will be providing the same report to the agent of the Secretary of the U. S. Department of Health and Human Services, the State Survey Agency that is responsible for assuring nursing facilities' compliance with state and federal regulations.

Since you are a contract employee of the facility we are obligated to make sure you are aware of the reporting responsibility as you too are considered a "Covered Individual". You are required to report any observation or suspicion of a crime against a resident of our facility in the same timely manner to local law enforcement and the local state agency. I am providing you the information and need you to review it and sign the attached Acknowledgement Form. Also provided are my contact numbers to assist you in making a report and the local law enforcement and state agency number. You are able to make the report yourself however, our primary concern is protecting the resident, so our involvement as quickly as possible will aid in ensuring that happens. Please make sure that staff, from your organization, is aware of this directive and the importance of everyone following it. If you have any questions at all about this please do no hesitate to contact me at any time.

Sincerely,

* "Covered Individuals" means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that in the preceding year received at least $10,000 in Federal funds.

[43] This example was provided by one of the sampled nursing facilities in part one of this evaluation. The name of the nursing facility has been redacted.

APPENDIX E

Example of a Posted Notification Specifying Employees' Rights to File a Complaint under Section 1150B of the SSA[44]

IF YOU HAVE REASONABLE SUSPICION THAT A CRIME HAS OCCURRED AGAINST A RESIDENT OR PERSON RECEIVING CARE AT THIS FACILITY, FEDERAL LAW REQUIRES THAT YOU REPORT YOUR SUSPICION DIRECTLY TO BOTH LAW ENFORCEMENT AND THE STATE SURVEY AGENCY

***If you believe the crime involves serious bodily injury including criminal sexual abuse to the resident, you must report it immediately, but no later than* 2 hours after forming the suspicion.**

OR

***If the crime does not appear to cause serious bodily injury to the resident you must report it* Within 24 hours after forming the suspicion.**

WHO MUST REPORT

- Individuals who must comply with this law are: owner(s), operators, employees, managers, agents or contractors of this LTC facility. This law applies to the above individuals associated with nursing facilities, skilled nursing facilities, hospices that provide services in LTC facilities, and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

PENALTIES FOR NOT REPORTING

- **Individuals** – Who fail to report are subject to a civil monetary penalty of up to $300,000 and possible exclusion from participation in any Federal health care program as an "excluded individual."

NO PENALTIES FOR REPORTING

- **An LTC facility cannot punish or retaliate against you for lawfully reporting a crime under this law.** Examples of punishment or retaliation include: firing/discharge, demotion, threatening these actions, harassment, and denial of a promotion or any other employment-related benefit or any discrimination against an employee in the terms and conditions of employment. In addition, a facility may not file a complaint or a report against a nurse or other licensed individual or employee with the state professional disciplinary agencies because the individual lawfully reports the suspicion of a crime.
- Employees can file a complaint with the state survey agency against the facility if there is retaliation for reporting, causing a report to be made, or for taking steps in furtherance of making a report of a reasonable suspicion of a crime to the appropriate authorities.

HOW DO I REPORT

- Individuals reporting suspicion of a crime must call, fax, or email both local law enforcement and the state survey agency.
- Multiple individuals can report a suspicion of a crime jointly and will be considered in compliance with the law. However, an individual may report the suspicion separately if he/she choses to do so and the facility may not prevent an individual from reporting.

Contact the following agencies regarding the suspicion of a crime at [Nursing Facility]:

[Local Law Enforcement and Telephone Number]

[State Survey Agency and Telephone Number]

To file a complaint because you believe you have been punished or retaliated against for reporting the suspicion of a crime, contact the [State Survey Agency and Telephone Number].

[44] This example was provided by one of the sampled nursing facilities in part one of this evaluation.

APPENDIX F

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 11 2014

TO: Daniel R. Levinson
Inspector General

FROM: /S/
Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Nursing Facilities' Compliance with Federal Requirements for Reporting Allegations of Abuse or Neglect (OEI-07-13-00010)

Thank you for the opportunity to review and comment on the above subject OIG draft report which discusses the extent to which nursing facilities have met the requirements outlined in Section 1150B of the Social Security Act (the Act) for notifying individuals of their responsibilities to report suspicions of a crime including allegations of abuse, neglect or misappropriation of resident property. OIG's objectives for this report are to determine the extent to which — (1) Nursing facilities:

(a) Reported allegations of abuse or neglect in 2012.

(b) Had written policies that address reporting allegations of abuse or neglect as required by federal requirements.

(c) Complied with federal requirements related to reasonable suspicions of crimes under Section 1150B of the Social Security Act (SSA); and

(2) Allegations of abuse or neglect were reported by nursing facilities in compliance with federal requirements.

The CMS responses to OIG's recommendations are discussed below.

OIG Recommendation

The OIG recommends that CMS ensure that nursing facilities maintain policies related to reporting allegations of abuse or neglect.

CMS Response

The CMS concurs. CMS previously distributed guidance related to the proper reporting of allegations of abuse or neglect via Survey and Certification memorandums to state agency (SA) Directors and posted it on our website. The Survey and Certification memorandum entitled, "Reporting Reasonable Suspicion of Crimes in Long Term Care Facilities" (S&C 11-30-NH), covered the following: (1) Addressed the obligations of applicable long-term care facilities, states and covered individuals; (2) Defined terms in the Affordable Care Act and other sources; and (3) Provided answers to frequently asked questions.

In addition to distributing the Survey and Certification memorandum to SA Directors, CMS provided reporting requirements and Section 1150B guidance in the CMS Hand-in-Hand Nursing Home Toolkit. The training toolkit provides nursing homes with a high-quality training program that emphasizes person-centered care in caring for persons with dementia and preventing abuse, and was distributed at no cost to all nursing homes nationwide.

We will advise SAs and providers to use the various resources CMS has made available, such as the State Operations Manuals and Survey and Certification memorandum. CMS will also explore additional opportunities to promote compliance with Section 1150B and will continue to respond to Section 1150B-related inquiries from internal sources, long-term care facilities, states, covered individuals, provider organizations and law enforcement agencies as necessary.

OIG Recommendation

The OIG recommends that CMS ensure that nursing facilities comply with their responsibilities under Section 1150B of the SSA.

CMS Response

The CMS concurs. CMS holds regularly scheduled conference calls with stakeholders to discuss nursing home issues. CMS will use these calls to further discuss and reinforce Section 1150B reporting requirements. CMS will reissue, or update as necessary, guidance to facilitate compliance with covered individual responsibilities under Section 1150B of the Act. CMS will also recommend that facilities maintain adequate documentation to support that allegations of abuse or neglect are reported in compliance with these requirements.

The CMS provided guidance regarding the information that should be included in the employee's right to file a complaint posting in the Survey and Certification memorandum, entitled, "Reporting Reasonable Suspicion of Crimes in Long Term Care Facilities," but will consider OIG's recommendation to draft the following materials: (1) Customizable templates of annual notification letters to covered individuals; and (2) Posters and materials describing employees' rights to file a complaint under Section 1150B of the Act.

The CMS previously advised SAs to analyze and investigate these reports as allegations of noncompliance under the federal requirements. CMS will reiterate to SAs that existing Medicare Requirements for Participation require that reports of abuse, neglect and misappropriation of property must be reported; the majority of reports made under 1150B will likely fall into this type of reporting. Law enforcement will also receive a copy of the report and will investigate any criminal activities under their jurisdiction. SAs will continue to refer any investigated complaints to the appropriate agency for appropriate action (SOM 5075.6) which would include law enforcement.

OIG Recommendation

The OIG recommends that CMS ensure that nursing facilities report allegations of abuse or neglect and investigation results in a timely manner and to the appropriate individuals as required.

CMS Response

The CMS concurs. In the effort to ensure nursing facilities report allegations of abuse or neglect and investigation results in a timely manner and to the appropriate individuals as required, CMS will discuss OIG's report results with the SAs and reiterate covered individuals' reporting obligation timelines and requirements and update/reissue guidance as necessary.

The CMS thanks OIG for the work done on this issue and looks forward to working with OIG in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections, in the Kansas City regional office.

Rae Hutchison served as team leader for this study. Other Office of Evaluation and Inspections staff from the Kansas City regional office who conducted the study include Teresa Dailey, Conswelia McCourt, and Dennis Tharp. Central office staff who provided support include Clarence Arnold and Heather Barton.

Office of Inspector General

http://oig.hhs.gov

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The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.