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

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

Why OIG Did This Review

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

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

How OIG Did This Review

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

What OIG Found

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

What OIG Recommends and CMS Comments

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

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