HDJN
The health law solution.

CLIENT ADVISORY

September 3, 2014

OIG Report: Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect

After a year-long process of evaluation, the Office of Inspector General has released a report detailing its findings relative to nursing facilities' compliance with the Elder Justice Act as well as federal regulations imposing reporting obligations relative to abuse, neglect, mistreatment, injuries of unknown source, and misappropriation of resident property ("Abuse and Neglect"). **https://oig.hhs.gov/oei/reports/oei-07-13-00010.asp** *"Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect", OEI-07-13-00010 (August 2014)*.

The U.S. Department of Health and Human Services Office of Inspector General, Office of Evaluation and Inspections began its study about a year ago, randomly selecting 250 nursing facilities from survey data in the Certification and Survey Provider Enhanced Reporting (CASPER) database, to participate in a survey and provide their written reporting policies. The survey requested that the selected facilities reveal the number of allegations of abuse by type that occurred in the facility in 2012 and requested feedback about the reporting process. The OIG also reviewed facility policies and procedures and surveyed administrators from sampled nursing facilities.

About the same time the OIG's study began, the Virginia Office of Licensure and Certification (OLC) removed from the agency website, its longstanding guidance to facilities for the reporting and investigation of allegations of Abuse and Neglect, citing inconsistency with CMS regulations and interpretive guidance. To date, the guidance has not been replaced, but the OIG Report offers some helpful information in the interim. As a threshold matter, CMS reiterated the definitions of abuse, neglect and misappropriation of resident property as found at 42 CFR 488.301, and injury of unknown source as defined in http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter05-09.pdf CMS Survey and Certification Memo S&C-05-09 (Dec. 16, 2004). Interestingly, "mistreatment" is not defined by CMS although it remains a reportable event. Notable OIG findings include:

Reporting

- 85% of nursing facilities reported at least one allegation of Abuse and Neglect (inclusive of all types) in 2012.
- The most commonly reported allegation was abuse.
- The top three types of reported abuse: 40% of the allegations were identified as employee to resident, 26% as perpetrator unknown, and 24% were identified resident to resident.
- 3.8% of the reported allegations were resident self-neglect /injury.
- Only .9% of the allegations consisted of resident to employee abuse.
- 53% of allegations of abuse or neglect were reported in compliance with federal regulations requiring 1) an immediate report to the nursing facility administrator and state survey industry, and 2)an investigation report 5 working days later.

Policies

- 76% of nursing facilities maintained policies that adequately addressed reporting allegations of Abuse and Neglect as well as subsequent investigation results.
- Only 61% of nursing facilities maintained documentation confirming their compliance with the requirements of the Elder Justice Act. The Report does not analyze the substance or adequacy of reports of the reasonable

suspicion of a crime; instead focusing on nursing facility obligations to notify covered individuals of their obligation to report and of employee rights to file a complaint. Examples of documentation that covered individuals were notified of their obligation to report reasonable suspicions of crimes included letters to employees, training logs, and employee-signed attestations. The Report also includes an example of a posted notification specifying employees' rights to file a complaint under the EJA.

OIG Recommendations

In view of the results of its investigation, the OIG is recommending that CMS update its guidance to clearly describe the reporting regulations that should be established in written policies and that CMS "take appropriate action to ensure that nursing facilities have [pertinent] policies". Regarding the Elder Justice Act, OIG recommends that CMS develop and share reporting templates such as annual notification letters to covered individuals and posters or other materials describing employees' rights to file a complaint. Finally, the OIG recommends that CMS re-issue guidance describing the timeframes and appropriate individuals for which allegations of abuse or neglect and investigation results should be reported.

However, CMS' response to the OIG recommendations reveals that it will not re-issue any guidance, because existing S&C memoranda and training toolkits adequately address the issue. CMS also references periodic conference calls with stakeholders that it will use to reiterate reporting obligations under the Elder Justice Act. In short, CMS believes that in general, its guidance relative to reporting obligations is clear, although it agreed to consider issuing templates and posters to assist nursing facilities in complying with the Elder Justice Act.

Conclusion

As a starting point, facilities should take this opportunity to make sure compliant reporting and investigation policies have been established and that documentation confirming compliance with requirements is maintained. CMS' reaction to the OIG study may be an indication that the Virginia OLC will likewise, choose not to reissue further guidance, relying instead on existing CMS guidance with which facility policy must comply.[1] Importantly, while Abuse and Neglect policies and processes have become virtually routine, policies that ensure compliance with the Elder Justice Act may not be. The OIG report reveals a renewed emphasis on compliance with the Elder Justice Act as well as the "traditional" reporting requirements that cannot be ignored.

If you have questions or need assistance with the development or review of reporting policies, please contact Mary Malone or Jeannie Adams at (866) 967-9604, or by email at mmalone@hdjn.com or jadams@hdjn.com. Additional information about Hancock, Daniel, Johnson & Nagle, P.C. is available on the firm's website at www.hdjn.com.

[1] Interpretive guidelines can be found in the State Operations Manual relative to F223, F224, F225, and F226. Furthermore, guidance concerning resident to resident altercations can be found in the interpretive guidelines for F323 (Accidents). See also, CMS Survey and Certification Memo S&C-05-09 (December 16, 2004).