United States Government Accountability Office

Report to Congressional Committees

June 2019

NURSING HOMES

Improved Oversight Needed to Better Protect Residents from Abuse

June 2019

NURSING HOMES

Improved Oversight Needed to Better Protect Residents from Abuse

GAO Highlights

Highlights of GAO-19-433, a report to congressional committees

Why GAO Did This Study

Nursing homes provide care to about 1.4 million nursing home residents—a vulnerable population of elderly and disabled individuals. CMS, an agency within the Department of Health and Human Services (HHS), defines standards nursing homes must meet to participate in the Medicare and Medicaid programs.

GAO was asked to review abuse of residents in nursing homes. Among other objectives, this report: (1) determines the trends and types of abuse in recent years, and (2) evaluates CMS oversight intended to ensure residents are free from abuse.

GAO reviewed CMS's policies, analyzed CMS data on abuse deficiencies from 2013 through 2017, the most recent data at the time of our review, and interviewed officials from CMS and state survey agencies in five states, as well as other key stakeholders in those states such as ombudsmen and law enforcement officials. The states were selected for variation in factors such as number of nursing homes and role of other state agencies in abuse investigations.

What GAO Recommends

GAO is making six recommendations, including that CMS: require state survey agencies to submit data on abuse and perpetrator type; require state survey agencies to immediately refer to law enforcement any suspicion of a crime; and develop guidance on what abuse information nursing homes should self-report. HHS concurred with all of GAO's recommendations and identified actions it will take to implement them.

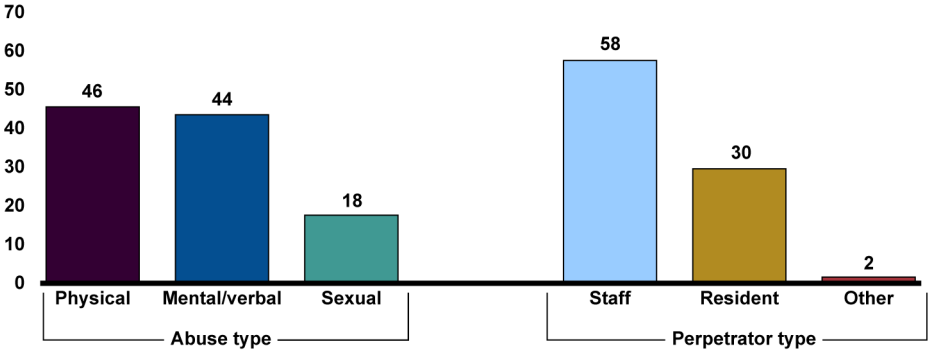
View GAO-19-433. For more information, contact John Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring nursing homes meet federal quality standards, including that residents are free from abuse. CMS enters into agreements with state survey agencies to conduct surveys of the state's homes and to investigate complaints and incidents. GAO analysis of CMS data found that, while relatively rare, abuse deficiencies cited in nursing homes more than doubled, increasing from 430 in 2013 to 875 in 2017, with the largest increase in severe cases. GAO also reviewed a representative sample of abuse deficiency narratives from 2016 through 2017. Physical and mental/verbal abuse occurred most often in nursing homes, followed by sexual abuse, and staff were more often the perpetrators of the abuse deficiencies cited. CMS cannot readily access information on abuse or perpetrator type in its data and, therefore, lacks key information critical to taking appropriate actions.

GAO Analysis of a Representative Sample of CMS Nursing Home Abuse Deficiency Narratives, 2016-2017

Percentage of abuse deficiency narratives



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data and supporting narratives. | GAO-19-433

Note: Percentages do not add to 100 because some narratives had multiple types of abuse, were missing or incomplete, or were not consistent with CMS's definition of abuse.

GAO also found gaps in CMS oversight, including:

- **Gaps in CMS processes that can result in delayed and missed referrals.** Federal law requires nursing home staff to immediately report to law enforcement and the state survey agency reasonable suspicions of a crime that results in serious bodily injury to a resident. However, there is no equivalent requirement that the state survey agency make a timely referral for complaints it receives directly or through surveys it conducts. CMS also does not conduct oversight to ensure that state survey agencies are correctly referring abuse cases to law enforcement.
- **Insufficient information collected on facility-reported incidents.** CMS has not issued guidance on what nursing homes should include when they self-report abuse incidents to the state survey agencies. Officials from all of the state survey agencies in GAO's review said the facility-reported incidents can lack information needed to prioritize investigations and may result in state survey agencies not responding as quickly as needed.

Contents

Figures

Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
OIG	Office of Inspector General
MFCU	Medicaid Fraud Control Unit

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

June 13, 2019

The Honorable Chuck Grassley
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Rob Portman
Chairman
The Honorable Thomas Carper
Ranking Member
Permanent Subcommittee on Investigations
Committee on Homeland Security and Governmental Affairs
United States Senate

Nationwide, more than 15,500 nursing homes participating in the Medicare and Medicaid programs provide care to about 1.4 million elderly or disabled nursing home residents. These residents often have physical and cognitive limitations that can make them particularly vulnerable to abuse. Abuse of nursing home residents can occur in many forms—including physical, mental, verbal, and sexual—and can be committed by staff, residents, or others in the nursing home. Little is known about the full scope of nursing home abuse, as incidents of abuse may be underreported.[1] Any incident of abuse is a serious occurrence and could result in potentially devastating consequences for residents, including lasting mental anguish, serious injury, or death.

Federal law mandates that nursing homes receiving Medicare and Medicaid payments must ensure that residents are free from abuse. To help ensure this, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), defines the quality standards that nursing homes must meet in order to

[1]C. Hawes, *Elder Abuse in Residential Long-Term Care Settings: What is Known and What Information is Needed?* National Research Council of the National Academies, Panel to Review Risk and Prevalence of Elder Abuse and Neglect. (Washington, D.C.: 2003).

participate in the Medicare and Medicaid programs.[2] To monitor compliance with these standards, CMS enters into agreements with agencies in each state government—known as state survey agencies—and oversees the work the state survey agencies do.[3] This work includes conducting required evaluations—referred to as standard surveys—approximately once each year of all nursing homes in a state that participate in the Medicare or Medicaid programs, as well as investigating both complaints from the public and facility-reported incidents regarding resident care or safety.[4] When a state survey agency finds a nursing home out of compliance with a federal standard, the home receives a deficiency citation, also known as a deficiency.

In addition to state survey agencies, other state-based agencies are charged with protecting nursing home residents from abuse. These agencies' roles, missions, and standards of evidence for determining whether or not abuse occurred can vary by state. For example, Adult Protective Services may also help ensure nursing home residents receive

[2]CMS defines abuse in its guidance, the State Operations Manual (dated November 22, 2017), as: "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being." This report addresses physical abuse, mental and verbal abuse—which we refer to as "mental/verbal abuse"—and sexual abuse but does not address other forms of abuse, such as financial abuse or neglect.

Medicare, the federal health insurance program for people age 65 and older, individuals under age 65 with certain disabilities, and individuals diagnosed with end-stage renal disease, covers some short-term skilled nursing and rehabilitative care for beneficiaries following an acute care hospital stay. Medicaid, a joint federal-state health program for low-income and medically needy individuals, is the nation's primary payer of long-term services and supports for children and adults with disabilities and aged individuals.

[3]Survey agencies are frequently housed in the human services department of state governments and may have different names in different states.

[4]By law, every nursing home receiving Medicare or Medicaid payment must undergo a standard survey during which teams of state surveyors conduct a comprehensive on-site evaluation of compliance with federal quality standards. These surveys must occur at least once every fifteen months, with a statewide average interval for surveys not to exceed 12 months. 42 U.S.C. §§ 1395i-3(g)(1)(A), (g)(2)(A)(iii), 1396r(g)(1)(A), (g)(2)(A)(iii).

State survey agencies are also required to investigate allegations of neglect and abuse in nursing homes in response to complaints and facility-reported incidents filed with state survey agencies. 42 U.S.C. §§ 1395i-3(g)(1)(C), 1396r(g)(1)(C). During an investigation, state surveyors evaluate the nursing home's compliance with a specific federal quality standard.

quality care in a safe environment by investigating allegations of abuse.[5] Law enforcement can also play a role in protecting nursing home residents from abuse and, in addition, Medicaid Fraud Control Units (MFCU) in each state are tasked with investigating and prosecuting a variety of health care-related crimes.

We have previously reported on problems in nursing home quality, including problems protecting residents from abuse and weaknesses in CMS's oversight. For example, in multiple reports dating back to 1998, we have identified weaknesses in federal and state activities designed to correct quality problems in nursing homes. Specifically, in a 2002 report, we found that CMS needed to do more to protect nursing home residents from abuse and made five recommendations to help CMS facilitate the reporting, investigation, and prevention of abuse in nursing homes.[6] More recently, in April 2019 we reported that CMS had failed to address gaps in federal oversight of nursing home abuse investigations in Oregon that persisted for at least 15 years until the Oregon state survey agency changed its practices in October 2018.[7] Further, a 2017 HHS Office of the Inspector General (OIG) report found that CMS does not have adequate procedures in place to ensure incidents of potential abuse in nursing homes are identified and reported.[8] In addition, news reports have

[5]Long-term care ombudsmen and Adult Protective Services may investigate and resolve complaints involving residents of nursing homes. In some states, Adult Protective Services may not have jurisdiction in nursing homes. While Adult Protective Services operates at the state level, some states receive federal funding for part or all of their programs.

[6]One of our recommendations was implemented—that CMS clarify the definition of abuse and otherwise ensure that states apply that definition consistently and appropriately. While CMS generally agreed with our recommendations, the other four recommendations were closed as not implemented. See GAO, *Nursing Homes: More Can Be Done to Protect Residents from Abuse*, GAO-02-312, (Washington, D.C.: March 1, 2002).

[7]GAO, *Management Report: CMS Needs to Address Gaps in Federal Oversight of Nursing Home Abuse Investigations That Persisted in Oregon for at Least 15 Years,* GAO-19-313R, (Washington, D.C.: Apr. 15, 2019).

[8]See Daniel R. Levinson, OIG, HHS, memorandum to Seema Verma, Administrator, CMS, *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 (Washington, D.C.: August 24, 2017).

described concerning examples of incidents where nursing home residents were abused.[9]

You asked us to review abuse of nursing home residents including, among other issues, what CMS data reveal about the prevalence of abuse and the extent to which CMS oversees nursing homes. In this report, we:

1. determine the trends and types of abuse occurring in nursing homes in recent years,
2. describe the risk factors for abuse and challenges facing stakeholder agencies involved in investigating abuse in nursing homes, and
3. evaluate CMS oversight intended to ensure that nursing home residents are free from abuse.

To determine the trends and types of abuse occurring in nursing homes in recent years, we reviewed CMS guidance and analyzed CMS data from 2013 through 2017, which represented the most recent data for a 5-year period at the time of our review. First, we reviewed the CMS State Operations Manual in effect during our period of review to determine the federal standards and associated deficiency codes related to resident abuse.[10] We focused our analysis on the deficiency code to be used by state surveyors when a nursing home fails to keep a resident free from abuse, which encompasses mental/verbal, sexual, or physical abuse.[11]

[9]For example, see Blake Ellis and Melanie Hicken, "Sick, Dying, and Raped in America's Nursing Homes," CNN, February 22, 2017. Also see Chris Serres, "Left to Suffer: A Five-Part Series," Minneapolis Star Tribune, November 12, 2017.

[10]Specifically, we reviewed Appendix PP of the State Operations Manual because it is the section that provides guidance to state surveyors about determining compliance with federal quality standards and their associated deficiency codes. There were multiple updates to Appendix PP of the State Operations Manual during the period of our review (January 1, 2013, through November 27, 2017). Specifically, there were eight updates to the appendix during the 5-year period, but none of these changed the abuse deficiency citation codes used by state surveyors. Therefore, we used the March 8, 2017, version of the Appendix PP—the most recent version during our period of review—when determining which deficiency codes to analyze for this report. CMS, *State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities.* (March 8, 2017).

CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

[11]For the purposes of this report, we refer to mental and verbal abuse as "mental/verbal abuse." Over the period of time examined in our review, CMS's abuse deficiency code also included involuntary seclusion.

We analyzed data provided by CMS to identify the number and severity of abuse deficiencies cited by surveyors in all 50 states and Washington D.C. between 2013 and 2017. We then tracked (1) whether these abuse deficiencies originated from a standard survey, complaint investigation, or facility-reported incident investigation and (2) the enforcement actions associated with these abuse deficiencies. Furthermore, we determined the number of nursing homes that had one or more abuse deficiencies from 2013 through 2017, as well as the homes with repeated abuse deficiencies in multiple years and the characteristics of those homes.[12]

Finally, because abuse and perpetrator type are not readily identifiable in CMS's data, we identified this information by reviewing a randomly selected representative sample of 400 abuse deficiency narratives written by state surveyors from 2016 through 2017 that describe the substantiated abuse. Specifically, two separate reviewers independently analyzed the text of each narrative and determined if the abuse was physical, mental/verbal, or sexual and whether the perpetrators were staff, residents, or others based on narrative descriptions written by state surveyors.[13] Any disagreements between the two reviewers were resolved by a third independent reviewer. We assessed the reliability of each of the datasets by checking for missing values and obvious errors and discussing them with CMS officials who were knowledgeable about the data. In the course of this assessment, we found some data limitations. Specifically, CMS officials told us that some state survey agencies may not have entered all facility-reported incidents into the CMS database while other state survey agencies did.[14] In a recent 2019 report, we also found that the Oregon state survey agency was not entering all abuse-related complaints or facility-reported incidents into the CMS database—a problem that could exist in other states.[15] In addition, CMS officials told us that it is possible there are additional incidents that may

[12]For the purposes of this report, we include Washington, D.C. when we refer to data for states.

[13]We analyzed the abuse deficiency narratives according to CMS's definitions in its State Operations Manual. CMS, *State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities*. (November 22, 2017).

[14]CMS guidance requires state survey agencies to enter facility-reported incidents into the CMS database that require a federal, on-site survey.

[15]See GAO-19-313R. Further, our 2011 report noted CMS's concerns regarding the underreporting of complaints from state survey agencies. See GAO, *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations*, GAO-11-280, (Washington, D.C.: Apr. 7, 2011).

not have been represented in the abuse deficiency data during the period of our review. Specifically, CMS officials noted that some incidents resulting from resident altercations—particularly those that do not show a willful intent to harm—may not be cited as an abuse deficiency by some state survey agencies. We therefore consider the number of abuse deficiencies that resulted from complaints or facility-reported incidents to be a conservative estimate. After reviewing the possible limitations of these data, we determined the data were sufficiently reliable for the purposes of this reporting objective. (See app. I for additional details on the scope and methodology of our data analyses.)

To describe the risk factors for abuse and challenges facing stakeholder agencies involved in investigating abuse in nursing homes, we interviewed officials from a non-generalizable sample of five state survey agencies—Delaware, Georgia, Ohio, Oregon, and Virginia. We selected these states for variation in geography, whether the states' Adult Protective Services has oversight over nursing home residents, the number of nursing homes in each state, CMS regional oversight, and congressional interest. In addition to speaking to officials from state survey agencies, we interviewed other stakeholders in these states, including officials from each state's long-term care ombudsmen, law enforcement, MFCUs, and, when appropriate, Adult Protective Services.[16] We also visited nursing homes and spoke to administrators and clinical staff in each state. We selected these nursing homes to obtain variation in factors such as bed count and profit or not-for-profit status. We asked stakeholders to describe the risk factors for abuse and the challenges involved in investigating abuse in nursing homes. In addition, we interviewed officials from national organizations with knowledge of nursing home abuse issues including the American Health Care Association, National Consumer Voice, and the National Adult Protective Services Association to learn more about the risk factors for abuse and the challenges facing stakeholders involved in investigating abuse.

To evaluate CMS oversight intended to ensure that nursing home residents are free from abuse, we reviewed relevant federal laws and CMS guidance, such as the State Operations Manual, that establishes CMS and state survey agency oversight responsibilities for nursing homes. We also interviewed officials at the CMS central office, the CMS

[16]We only interviewed officials from Adult Protective Services in Oregon and Virginia because, in those states, Adult Protective Services had nursing home oversight whereas in the other states in our review, it did not.

regional offices that oversee the five state survey agencies in our review, and the five state survey agencies themselves. We assessed CMS's oversight activities in the context of the federal standards for internal control related to information and communications and monitoring.[17]

We conducted this performance audit from October 2017 to June 2019 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.

Background

Nursing homes are required to keep residents safe from harm, but when abuse is alleged, a combination of federal, state, and local agencies—as well as the nursing homes themselves—play a role in investigating.

Federal Oversight of Nursing Homes

Federal laws establish minimum requirements nursing homes must meet to participate in the Medicare and Medicaid programs, including standards for the quality of care.[18] These standards cover a variety of categories, such as resident rights, quality of care, and quality of life. In 2016, CMS finalized a comprehensive update to its nursing home standards to reflect new requirements and align requirements with current

[17]GAO, *Standards for Internal Control in the Federal Government.* GAO-14-704G (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

[18]Titles XVIII and XIX of the Social Security Act, as amended, establish minimum requirements nursing homes must meet to participate in the Medicare and Medicaid programs, respectively.

The Social Security Act and their implementing regulations use the terms "skilled nursing facility" (Medicare) and "nursing facility" (Medicaid). For the purposes of this report, we use the term nursing home to refer to both skilled nursing facilities and nursing facilities.

clinical practices, among other things. The changes were implemented in three phases, starting November 28, 2016.[19]

The federal government and the states share oversight responsibility for the nation's nursing homes, with specific activities occurring at the national, regional, and state levels.

- **CMS central office.** At the national level, the CMS central office oversees the federal standards nursing homes must meet to participate in the Medicare and Medicaid programs. Primarily through its State Operations Manual, the office establishes the responsibilities of CMS's regional offices and state survey agencies in ensuring that federal quality standards for nursing homes are met.
- **CMS regional offices.** CMS's 10 regional offices oversee state activities and report back to the CMS central office the results of their efforts. Specifically, regional offices use the State Performance Standards System to evaluate state surveyors' performance on factors such as the frequency and quality of state surveys.
- **State survey agencies.** Under agreement with CMS, a state survey agency in each state assesses whether nursing homes meet CMS's standards, allowing them to participate in the Medicare and Medicaid programs. State survey agencies assess nursing homes using (1) recurring standard surveys and (2) as-needed investigations.
    - *Standard surveys.* State survey agencies are required by federal law to perform unannounced, on-site standard surveys of every nursing home receiving Medicare or Medicaid payment at least every 15 months, with a statewide average frequency of every 12 months. These surveys are a comprehensive assessment

[19]Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 686888 (Oct. 4, 2016).Phase 1 (effective November 28, 2016) implemented most minor modifications to the existing nursing home regulations; phase 2 (effective November 28, 2017) implemented new regulations and re-structured CMS's deficiency code system; and phase 3 (effective November 28, 2019) will implement the remaining requirements.

designed to determine whether nursing homes are complying with Medicare and Medicaid quality standards.[20]

- *Investigations.* In addition to standard surveys, state survey agencies are required by federal law to investigate (1) complaints submitted by residents, family members, friends, physicians, and nursing home staff; and (2) "facility-reported incidents," including incidents involving abuse of residents, that are self-reported by the nursing homes. State survey agencies review the information provided through these complaints and incidents and determine if an on-site investigation is required. During this unannounced investigation, the state surveyors assess available evidence to determine whether the allegation can be substantiated. These investigations offer the state survey agency the opportunity to identify and correct care problems in a more timely manner than through the standard surveys.

If a surveyor determines that a nursing home violated a federal standard during a survey or investigation, then a deficiency code specific to that standard is cited. For instance, one deficiency code for abuse of residents encompasses mental/verbal, sexual, or physical abuse; while a few additional deficiency codes encompass abuse-related issues, such as a failure by the nursing home to train staff on issues related to abuse. Cited deficiencies are then classified into categories according to scope (the number of residents potentially affected) and severity (the potential for or occurrence of harm to residents). (See table 1.) State survey agencies are required to enter data about deficiencies into CMS's survey database. For most deficiencies, the nursing home is required to prepare a plan of correction, and, depending on the scope and severity of the deficiency, surveyors may re-visit the facility to ensure that the nursing home has implemented its plan and corrected the deficiency. In any instances where surveyors substantiate the occurrence of resident abuse, the state survey agency is required to refer the case to three entities: 1) local law

[20]On November 28, 2017, as a part of implementation phase 2, CMS rolled out a new survey system—which implemented our 2015 recommendation that CMS establish timeframes for the development and implementation of a standardized survey system across all states. The new survey system was implemented simultaneously nationwide, so that all states are now using the same survey system when, prior to the change, states were split between two different survey systems, complicating assessments of nursing home quality. See GAO, *Nursing Home Quality: CMS Should Continue to Improve Data and Oversight*, GAO-16-33 (Washington, D.C.: Oct. 30, 2015).

enforcement; 2) the MFCU, if appropriate; and 3) the state's nurse aide registry or other applicable professional licensure authority.[21]

Table 1: Centers for Medicare & Medicaid Services' (CMS) Alphabetical Scope and Severity Categories for Nursing Home Deficiencies

	Scope		
Severity	**Isolated**	**Pattern**	**Widespread**
No actual harm with a potential for minimal harm[a]	A	B	C
No actual harm with a potential for more than minimal harm	D	E	F
Actual harm	G	H	I
Immediate jeopardy[b]	J	K	L

Source: CMS. | GAO-19-433.

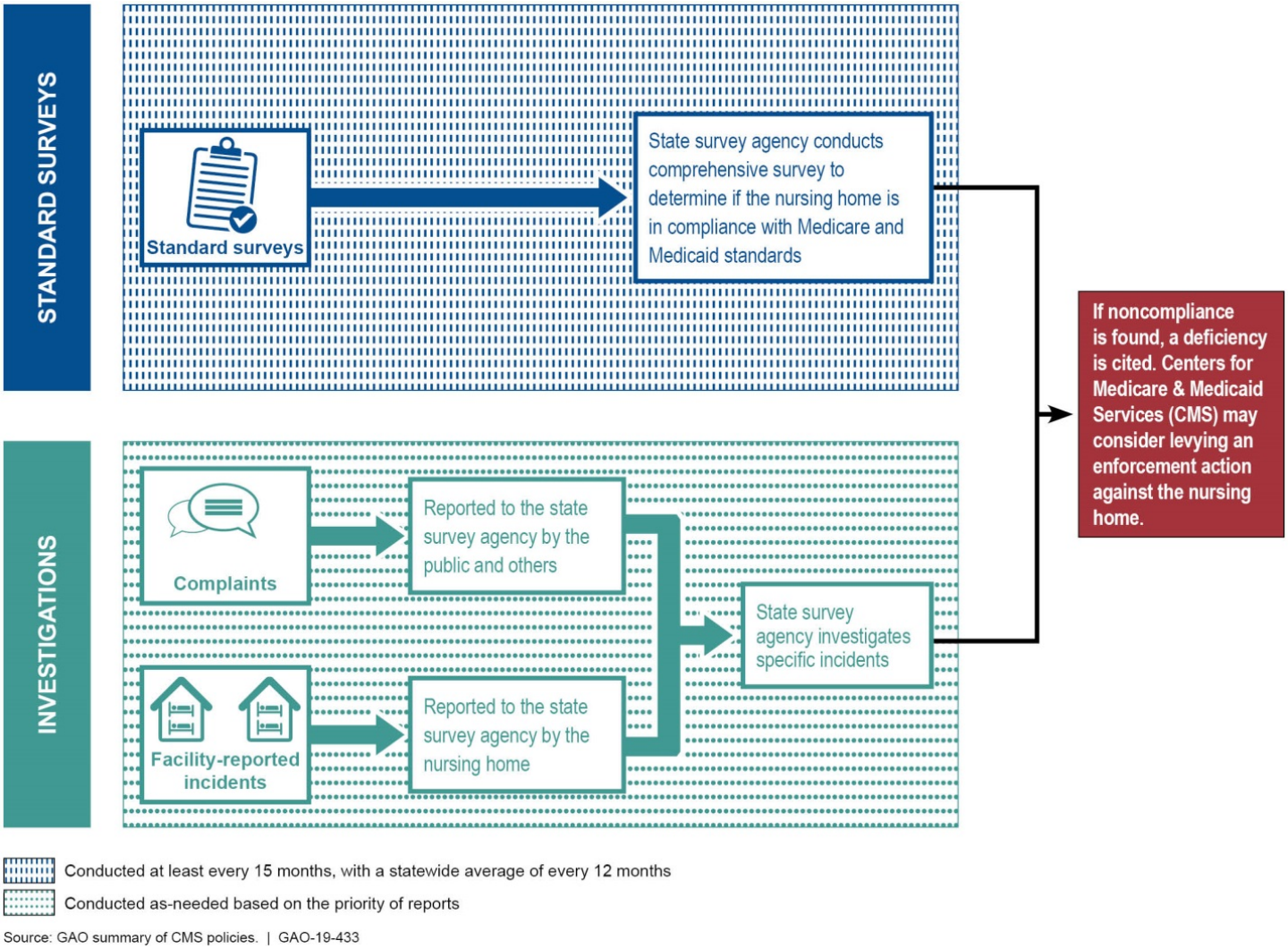
[a]Nursing home is considered to be in "substantial compliance."

[b]Caused, or is likely to cause, serious injury, harm, impairment, or death.

When nursing homes are cited with deficiencies, federal enforcement actions—or penalties—can be imposed to encourage homes to make corrections. In general, enforcement actions: (1) may be initially recommended by the state survey agency, (2) are transferred to the CMS regional office for review, (3) are imposed by the same CMS regional office, and (4) are implemented—that is, put into effect. Depending on the scope and severity of the deficiency cited, the CMS regional office may impose certain enforcement actions so that they are implemented immediately. However, for other enforcement actions, the regional office may provide the nursing home with an opportunity to correct the deficiencies, which, if corrected before the scheduled effective date, can result in the penalty not being implemented. Penalties include directed in-service training, fines known as civil money penalties, denial of payment, and termination from the Medicare and Medicaid programs, among others. (See fig. 1.)

[21]In nursing homes, the primary caregivers are nurse aides.

Figure 1: Primary Methods Used by State Survey Agencies to Assess Whether Nursing Homes Are Meeting Federal Standards



Source: GAO summary of CMS policies. | GAO-19-433

Reporting and Investigation of Abuse by Nursing Homes

When a nursing home becomes aware of an incident of alleged resident abuse, the home must: immediately report the allegation to the state survey agency and then conduct an investigation of the alleged incident. Specifically, the process is as follows:

- The nursing home must immediately report alleged abuse to the state survey agency. After notifying the state survey agency, the nursing home is also required to conduct its own investigation and submit its

findings in a written report to the state survey agency within 5 working days of the incident.

- Depending on the severity of the circumstances, the state survey agency may visit the nursing home to investigate the incident or wait until the nursing home submits its report.
- Depending on the content of the report, the state survey agency may request the home conduct additional work or the state survey agency may investigate further on its own.
- If the state survey agency opts not to investigate further, it may still review the manner in which the home conducted its investigation during the state survey agency's next scheduled standard survey.
- If a state survey agency determines that a nurse aide is responsible for abuse, the agency must add this finding to the state's nurse aide registry—a registry that each state is required to maintain that lists all individuals who have satisfactorily completed approved nurse aide training and a competency evaluation program in that state.[22] Nursing homes are prohibited from employing a nurse aide with a finding of abuse on the nurse aide registry.
- Further, if there is a reasonable suspicion that a crime has occurred that results in serious bodily injury, federal law requires certain covered individuals at the nursing home to immediately report to law enforcement in addition to the state survey agency.[23]

Before employing a nurse aide, nursing homes are required to check each relevant state's registry to verify that the nurse aide has passed a competency evaluation. All nursing homes must also verify with the relevant state board of licensing the professional credentials of the licensed personnel, such as registered nurses, whom they hire.[24]

[22]42 C.F.R. § 483.156 (2018).

[23]42 U.S.C. § 1320b-25(b). This is known as the 1150(b) requirement after its location in the Social Security Act. These covered individuals include nursing home owners, operators, and employees, among others.

[24]In contrast, state survey agencies are not responsible for disciplining other nursing home professionals, such as registered nurses, who are suspected of abuse. However, such personnel are referred by the state survey agency to their respective state licensing boards for review and possible disciplinary action.

Other State and Local Agencies That May Investigate Abuse in Nursing Homes

In addition to state survey agencies, there are other state and local agencies that may be involved in investigating abuse in nursing homes. These other state and local agencies that investigate abuse in nursing homes are generally focused on the different aspects of the specific alleged abuse incident, in contrast to the state survey agency, which focuses on the safety of individual residents, as well as on the facility's policies and procedures for preventing and effectively addressing abuse. These other state and local agencies include:

- **Adult Protective Services.** In some states, Adult Protective Services' investigators are trained to provide protection and intervention for older adults in nursing homes and can play a valuable role in helping to protect residents from abuse.[25]
- **Ombudsmen.** Long-term care ombudsmen, who serve as advocates for nursing home residents, may also investigate abuse complaints made by or on behalf of residents.
- **Local law enforcement.** Law enforcement may also play a role in investigating alleged nursing home resident abuse. Specifically, local police departments may learn of suspected instances of resident abuse and conduct criminal investigations.
- **MFCU.** The state MFCUs typically learn of abuse allegations through referrals from state survey agencies, which CMS requires if abuse is substantiated. If, after investigating an allegation, the MFCU decides that there is sufficient evidence to press criminal charges, it may prosecute the case itself or refer the matter to the state's attorney general or a local prosecutor.

[25]Adult Protective Services is generally responsible for identifying, investigating, resolving, and preventing abuse of older adults, although in some states, Adult Protective Services may not have jurisdiction in nursing homes. For more information, see GAO, *Elder Justice: Stronger Federal Leadership Could Enhance National Response to Elder Abuse*, GAO-11-208 (Washington, D.C.: Mar. 2, 2011).

In addition, the Administration for Community Living within HHS collects Adult Protective Services data voluntarily submitted by states as part of its National Adult Maltreatment Reporting System. The first year of data submission was federal fiscal year 2016.

More Abuse Deficiencies Were Cited in Nursing Homes from 2013 through 2017; Physical and Mental/Verbal Abuse and Staff Perpetrators Were Most Common

Abuse Deficiencies Cited and the Number of Nursing Homes Involved More than Doubled from 2013 through 2017, with the Largest Increase in Severe Cases

Our analysis of CMS data found that from 2013 through 2017, abuse deficiencies cited in nursing homes became more frequent, with the largest increase in severe cases.[26] While abuse deficiencies are relatively rare—they comprise less than 1 percent of the total deficiencies in each of the years we examined—they became more common over the 5-year period. Specifically, the number of abuse deficiencies cited more than doubled—from 430 in 2013 to 875 in 2017 (a 103.5 percent increase).[27] This trend for the abuse deficiencies is in contrast to the trend for all deficiencies, which decreased about 1 percent between 2013 and 2017.[28] At the state level, 32 states had more abuse deficiencies cited in 2017

[26]We analyzed the deficiency code cited when state surveyors determine that a nursing home failed to keep a resident free from abuse, which encompasses mental/verbal, sexual, or physical abuse. An abuse deficiency may represent a single incident of abuse with one perpetrator and one victim; however, an abuse deficiency could also encompass multiple incidents of abuse with more than one perpetrator and victim.

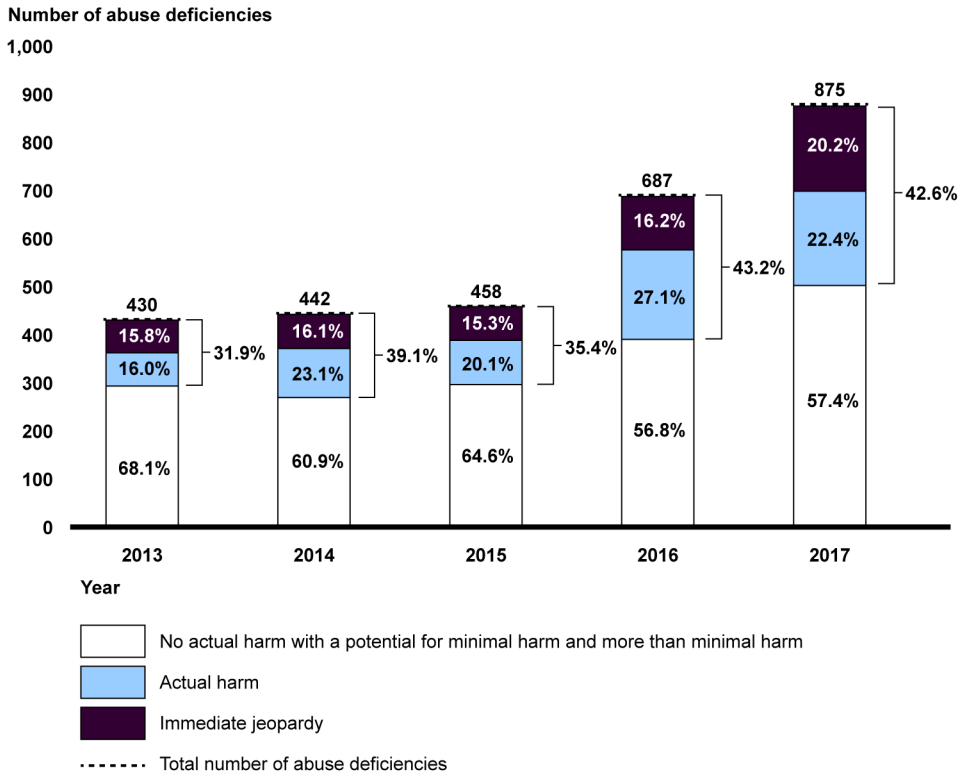
[27]The total average number of nursing home residents in surveyed nursing homes decreased slightly, by less than 1 percent—from about 1,258,089 in 2013 to 1,249,970 in 2017.

[28]All deficiency types increased at a much slower rate than abuse deficiencies through 2016 and then decreased slightly through the period examined in 2017.

We also found an increasing trend in abuse-related deficiencies—that is, a nursing home's failure to have proper policies in place to protect residents from abuse, such as established procedures to report and investigate alleged mistreatment, neglect, or abuse and to train staff on issues related to abuse—cited in nursing homes from 2013 through 2017. Specifically, abuse-related deficiencies increased by 9.9 percent over the 5-year period, from 4,899 deficiencies in 2013 to 5,383 deficiencies in 2017. See appendix II for more information.

than 2013, six states had a consistent number, and the remaining 13 had fewer. (See app. III for additional data on abuse deficiencies by state.) Furthermore, abuse deficiencies cited in 2017 were more likely to be categorized at the highest levels of severity—deficiencies causing actual harm to residents or putting residents in immediate jeopardy—than they were in 2013.[29] Specifically, 42.6 percent of the 875 abuse deficiencies were categorized as causing actual harm or posing immediate jeopardy to residents in 2017, compared to 31.9 percent of the 430 abuse deficiencies in 2013. (See fig. 2.)

Figure 2: Severity of Cited Abuse Deficiencies, 2013 through 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-433

Notes: CMS categorizes deficiencies into one of four severity categories based on whether the deficiency constitutes: (1) no actual harm with a potential for minimal harm; (2) no actual harm with a

[29]Abuse deficiencies were categorized by scope—whether the incident was an isolated occurrence, a part of a pattern of behavior, or a widespread behavior—consistently each year, with about 82 percent of abuse deficiencies cited categorized as isolated, about 15 percent categorized as a pattern, and about 3 percent categorized as widespread.

potential for more than minimal harm, but not immediate jeopardy; (3) actual harm that is not immediate jeopardy; or (4) immediate jeopardy to resident health or safety. We combined the first two categories in this figure.

CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

Percentages may not add to 100 due to rounding.

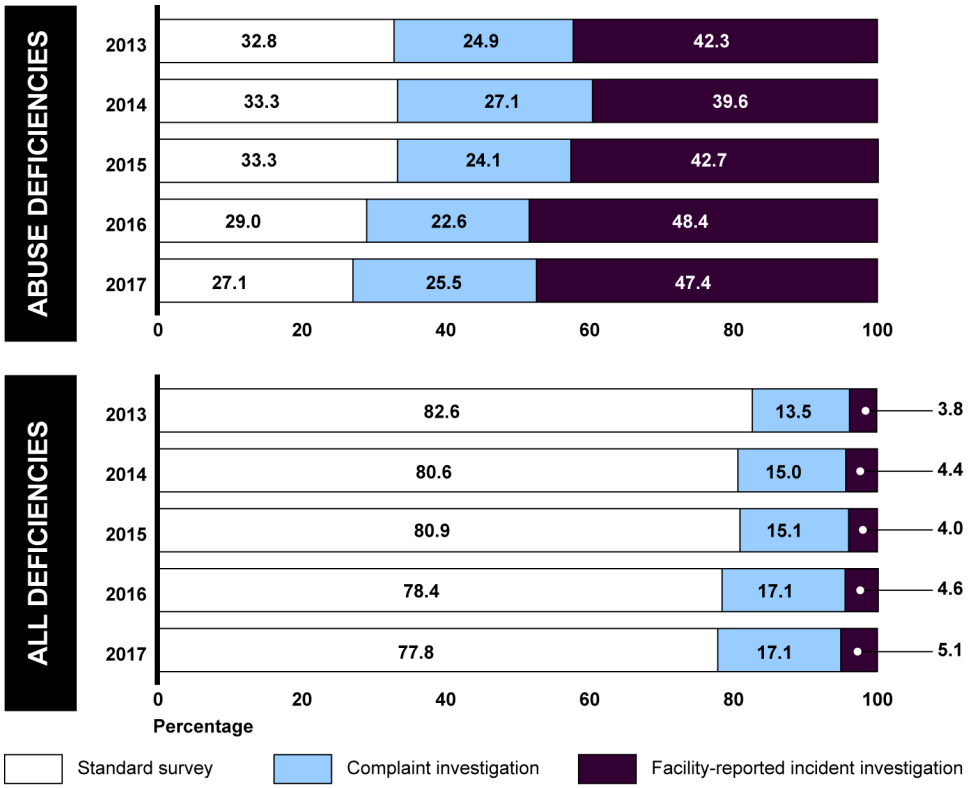
In examining the types of survey or investigations conducted to identify abuse deficiencies, we found that, from 2013 to 2017, the majority (about two-thirds in each year) were identified through either a complaint investigation or facility-reported incident investigation.[30] In contrast, for all types of deficiencies, we found the inverse—the vast majority were identified through a standard survey. This demonstrates the unique and significant role that complaint and facility-reported incident investigations have in identifying abuse deficiencies, because they allow for the identification and correction of abuse in a more timely manner than a standard survey. In fact, for the deficiencies for which we were able to identify the source, the percentage of abuse deficiencies identified through facility-reported incident investigations increased from 42.3 percent of the 430 abuse deficiencies in 2013 to 47.4 percent of the 875 abuse deficiencies in 2017.[31] Conversely, for all types of deficiencies, a very small percentage resulted from facility-reported incident investigations—about 5 percent or less each year. (See fig. 3.)

[30]We found that some deficiencies were identified through a combination of complaint investigations, facility-reported incident investigations, standard surveys, or all three. For instance, a family member could submit a complaint about an alleged abuse incident, and the facility could self-report that same incident, leading to a single investigation and abuse deficiency. We counted those deficiencies as originating from each relevant category.

We also became aware that while CMS guidance requires all complaints to be entered into its database, it does not require state survey agencies to enter all facility-reported incidents—only those that require a federal, on-site survey. As a result, our estimate may be conservative.

[31]For 375 out of 2,892 abuse deficiencies and 55,190 out of 538,559 total deficiencies cited over the 5-year time period, we were unable to determine from CMS's data whether the deficiency was identified during a standard survey, complaint investigation, facility-reported incident investigation, or a combination. We excluded these deficiencies from our percentages.

Figure 3: Type of Survey or Investigation Used to Identify Abuse Deficiencies and All Types of Deficiencies, 2013 through 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-433

Notes: For 375 out of 2,892 abuse deficiencies and 55,190 out of 538,559 total deficiencies cited over the 5-year time period, we were unable to determine from CMS's data whether the deficiency was identified during a standard survey, complaint investigation, facility-reported incident investigation, or a combination. We excluded these deficiencies from our percentages in the figure.

CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

Percentages may not add to 100 due to rounding.

We found that enforcement actions—or penalties—were imposed and implemented by CMS infrequently each year in response to abuse deficiencies, and that fines were the most common type of implemented penalty. Specifically, for each year from 2013 through 2017, we found that about one-third of abuse deficiencies had an enforcement action imposed but not implemented, and less than 8 percent of abuse deficiencies had

enforcement actions that were implemented against the nursing home.[32] This was fairly consistent over the 5-year period.[33] For example, in 2017, of the 875 abuse deficiencies cited, 275 (31.4 percent) resulted in enforcement actions that were imposed but not implemented and 65 (7.4 percent) had enforcement actions that were implemented against the nursing home. Furthermore, for abuse deficiencies cited at the most severe levels—that is, those causing actual harm or immediate jeopardy to residents—a smaller percentage of the deficiencies had an enforcement action imposed but not implemented compared to all abuse deficiencies, but a larger percentage were implemented. For example, in 2017, 373 of the 875 abuse deficiencies were cited at the most severe levels; of those, 81 (21.7 percent) resulted in enforcement actions that were imposed but not implemented, and 51 (13.7 percent) were implemented against the nursing home. Regardless of the severity, the predominant reason that CMS did not implement imposed enforcement actions was because the nursing home came into compliance prior to the implementation date of the penalty.[34]

For implemented enforcement actions, fines—known as civil money penalties—were overwhelmingly the most common type of penalty implemented against nursing homes with abuse deficiencies, increasing from 69.6 percent of the 23 abuse deficiencies with implemented enforcement actions in 2013 to 83.1 percent of the 65 in 2017. Denial of payments for new Medicare and Medicaid admissions—another financial penalty—was the second most common type of implemented enforcement action, but decreased from 34.8 percent in 2013 to 13.8 percent in 2017. Mandatory termination is the most severe enforcement action as it ends all payments for Medicare and Medicaid residents; it is

[32]The remaining abuse deficiencies did not have an enforcement action imposed or implemented.

CMS may impose or implement more than one enforcement action in response to a single deficiency.

[33]The percent of all deficiencies that had an enforcement action imposed was also consistent over time but at a lower rate than for abuse deficiencies—about 27 percent. Similarly, the percent of all deficiencies that ultimately resulted in an implemented penalty against the nursing home was less than for abuse deficiencies—staying at about 2 percent each year.

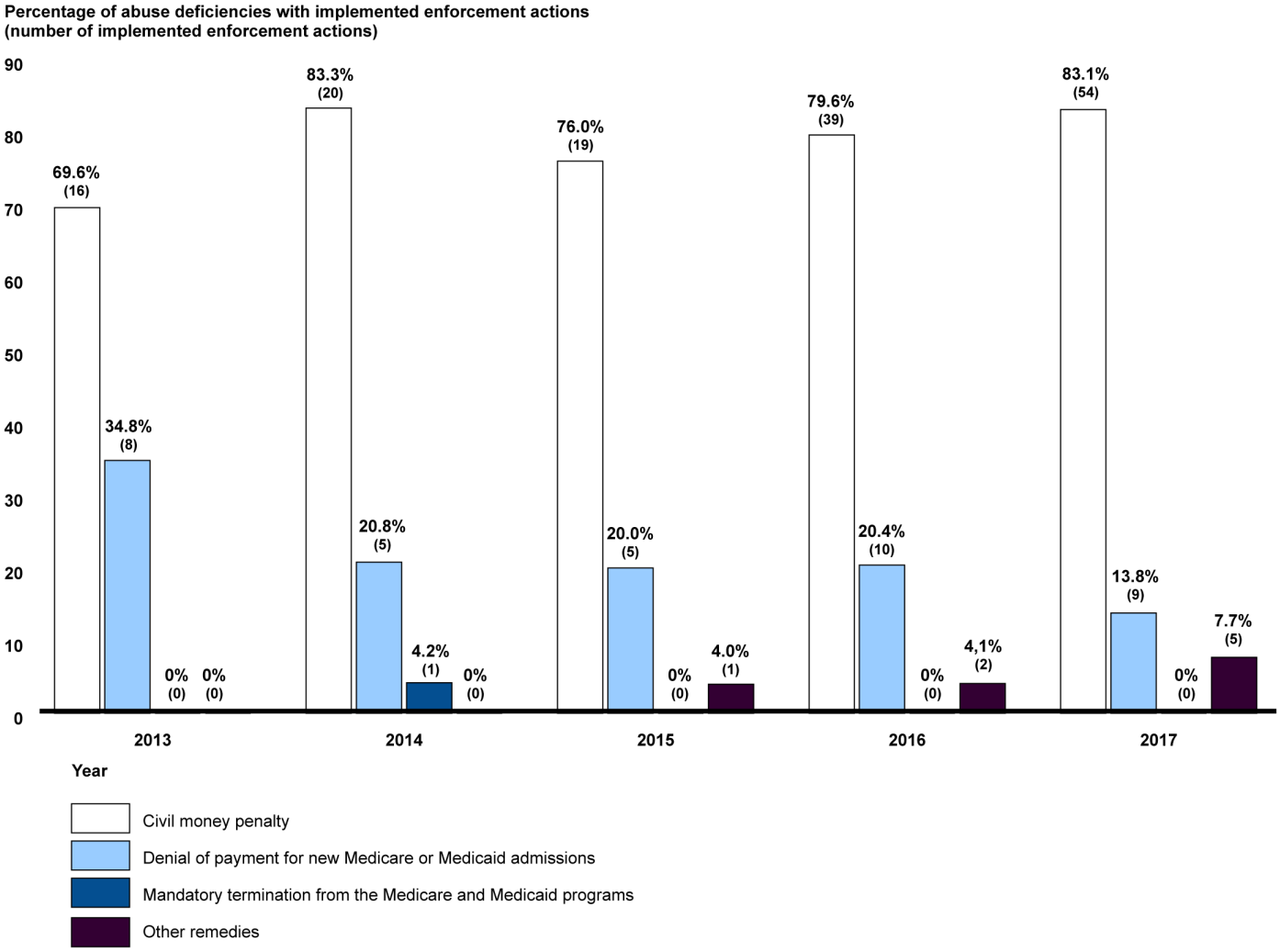
[34]Other reasons that an imposed enforcement action may not be implemented include the CMS regional office changing its decision, the state survey agency changing its recommendation, or that an informal dispute resolution removed the associated level of noncompliance, among others.

implemented very rarely, with only one abuse deficiency resulting in mandatory termination of the nursing home across all 5 years.[35] (See fig. 4.)

[35]Over the 5 years, some abuse deficiencies resulted in other types of enforcement actions, such as directed in-service training (where the nursing home is required to provide training to staff on a specific issue) and state monitoring (where an on-site monitor is placed in the nursing home to help ensure that the home achieves and maintains compliance).

We found similar proportions and trends in the enforcement actions implemented against nursing homes with any type of deficiency. For instance, civil money penalties were also the most commonly implemented enforcement action and increased from 61.5 percent of implemented actions in 2013 to 76.8 percent in 2017. Denial of payment for new Medicare and Medicaid admissions was also the second most common action implemented and decreased from 23.3 percent in 2013 to 16.2 percent in 2017. Mandatory termination was also rare, with a total of 43 nursing homes terminated over the 5 years. In 2007, we also found that the majority of enforcement actions implemented from fiscal years 2000 through 2005 were civil money penalties. See GAO, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, GAO-07-241 (Washington, D.C., Mar. 26, 2007).

Figure 4: Types of Implemented Enforcement Actions for Abuse Deficiencies, 2013 through 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-433

Notes: Percentages do not add to 100 because a single deficiency may result in more than one enforcement action.

Other remedies include enforcement actions such as directed in-service training (where the nursing home is required to provide training to staff on a specific issue) and state monitoring (where an on-site monitor is placed in the nursing home to help ensure that the home achieves and maintains compliance).

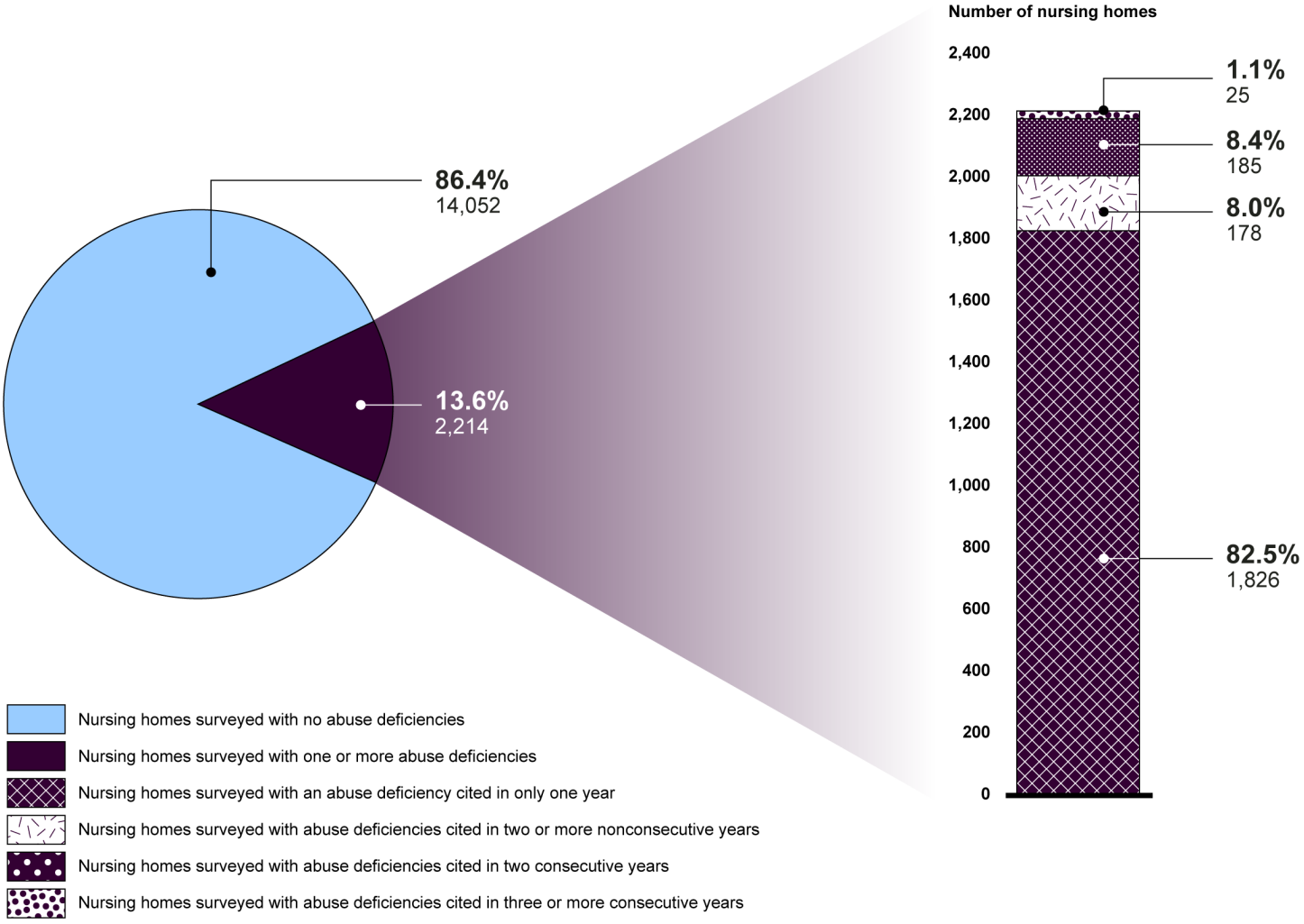
CMS restructured its deficiency code system beginning on November 28, 2017 and, due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

In addition, we found the number of nursing homes with abuse deficiencies also more than doubled over the 5-year period. In 2013, 394 nursing homes (2.7 percent of all surveyed nursing homes) had at least one abuse deficiency compared to 821 nursing homes (5.6 percent of all surveyed nursing homes) in 2017. A nursing home may have more than one abuse deficiency cited in a single year, such as from a standard survey early in the year and then a complaint investigation later in the year. We found that in 2013, of the 394 nursing homes that had a total of 430 abuse deficiencies cited, 85 of the homes had two or more abuse deficiencies that year. In 2017, of the 821 nursing homes that had 875 total abuse deficiencies cited, 155 had two or more that year.

Further, across the 5-year period, we found that a small proportion of all nursing homes with abuse deficiencies had them in multiple consecutive years. Specifically, across all years, 2,214 total unique nursing homes (13.6 percent of all surveyed nursing homes) had at least one abuse deficiency. A small portion of these nursing homes had at least one abuse deficiency in multiple consecutive years, indicating potential patterns in abuse at these nursing homes. Specifically, 185 of the 2,214 nursing homes with abuse deficiencies over the 5-year period—8.4 percent—had an abuse deficiency in any 2 consecutive years. In addition, 25 of the nursing homes—1.1 percent—had an abuse deficiency in 3 or more consecutive years.[36] (See fig. 5.)

[36]An additional 143 nursing homes had an abuse deficiency in any 2 nonconsecutive years, and an additional 35 nursing homes had an abuse deficiency in any 3 or 4 nonconsecutive years, from 2013 through 2017.

Figure 5: Nursing Homes with Abuse Deficiencies Cited in Multiple Years, 2013 through 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-433

Note: CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

Finally, we analyzed a selection of characteristics, including ownership type and bed size, for these nursing homes that had abuse deficiencies cited in multiple years and compared them to homes that had abuse deficiencies cited in a single year and surveyed homes that did not have any abuse deficiencies. We found that the nursing homes differed. For example, while for-profit organizations—the largest ownership group accounting for 67.9 percent of all surveyed nursing homes—owned 66.9

percent of nursing homes without any abuse deficiencies cited over the 5-year period, they accounted for 78.6 percent of nursing homes that had abuse deficiencies cited in 2 or more years.[37] In addition, nursing homes designated as Special Focus Facilities—a CMS program that provides increased oversight to homes with consistent poor performance—constituted 2.5 percent of all surveyed nursing homes compared to 1.9 percent of nursing homes without abuse deficiencies and 10.1 percent of nursing homes with abuse deficiencies cited in 2 or more years.[38] (See table 2.)

Table 2: Characteristics of Nursing Homes with Multiple Years of Abuse Deficiencies, a Single Year of Abuse Deficiencies, or No Abuse Deficiencies, 2013 through 2017

	Nursing homes with an abuse deficiency in 2 or more years	Nursing homes with an abuse deficiency in a single year	Nursing homes without any abuse deficiencies	All surveyed nursing homes
Percentage				
Type of ownership				
For-profit	78.6	73.0	66.9	67.9
Nonprofit	13.9	17.7	24.5	23.5
Government-owned	5.2	6.1	6.0	6.0
Mixed ownership[a]	1.3	2.0	1.1	1.2
Location				
Urban	76.3	69.1	68.1	68.4
Rural	19.6	27.1	27.8	27.5
Transitioning area[b]	3.1	2.7	2.8	2.8
Number of Medicare and Medicaid certified beds				
Small (Less than 50)	3.9	7.2	14.0	13.0

[37]These results are consistent with our analyses in both a 2009 and 2016 report. In those reports, we determined the number of nursing homes with consistent poor quality performance over time and found that they were also more likely to be for-profit or large homes with more than 100 beds compared to homes that performed well. However, our methodologies for each analysis vary. See GAO, *Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit*. GAO-09-689 (Washington, D.C.: Aug. 28, 2009) and GAO-16-33.

[38]Nursing homes with chronic noncompliance with federal standards can be selected for the Special Focus Facility program, which requires state survey agencies to conduct more frequent oversight and the nursing homes to improve performance or risk termination from the Medicare and Medicaid programs. For more information on this program, see GAO, *Poorly Performing Nursing Homes: Special Focus Facilities Are Often Improving, but CMS's Program Could Be Strengthened*, GAO-10-197 (Washington, D.C.: Mar. 19, 2010).

	Nursing homes with an abuse deficiency in 2 or more years	Nursing homes with an abuse deficiency in a single year	Nursing homes without any abuse deficiencies	All surveyed nursing homes
Medium (50 to 99)	35.1	38.0	36.3	36.5
Large (100 to 199)	49.7	47.6	42.6	43.4
Very large (200 or more)	11.3	7.2	7.0	7.1
Special Focus Facility program				
Participated in program	10.1	4.9	1.9	2.5
Average Five-Star System overall quality rating[c]				
1 star	16.8	11.0	4.5	5.5
2 stars	44.1	32.4	19.1	21.2
3 stars	22.2	28.8	25.9	26.1
4 stars	12.4	19.8	29.7	28.1
5 stars	3.6	6.8	19.0	17.3

Source: GAO analysis of Centers for Medicare & Medicaid Services' data. | GAO-19-433.

Notes: Percentages do not always add to 100 due to missing data and rounding. The percentage of nursing homes with missing data was less than 2 percent for each category.

CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

[a]"Mixed ownership" refers to nursing homes that changed their profit status at any point over the five-year period.

[b]A "transitioning area" is where the designation changed from rural to urban or vice-versa at some point during the five-year period.

[c]The Five-Star Quality Rating System assigns nursing homes with an overall "star" rating, ranging from one to five. Nursing homes with five stars are considered to have much above average quality, while nursing homes receiving one star are considered to have much below average quality.

Physical and Mental/Verbal Abuse Occurred Most Often, Followed by Sexual Abuse, and Staff Were More Often Perpetrators of Abuse in 2016 and 2017

Our analysis of a representative sample of CMS narrative descriptions—written by state surveyors—associated with abuse deficiencies cited in 2016 and 2017 found that physical and mental/verbal abuse occurred most often in nursing homes, followed by sexual abuse. Further, staff were more often the perpetrators of the deficiencies cited as abuse than were residents or others.[39] (See fig. 6.)

- **Physical abuse**, which CMS defines as hitting, slapping, punching, biting and kicking residents, was present in about 46 percent (+/- 5 percent) of the abuse deficiency narratives.
- **Mental/verbal abuse**, which CMS defines as verbal or nonverbal conduct that can cause a resident to experience humiliation and fear, among other things, was present in about 44 percent (+/- 5 percent) of the abuse deficiency narratives.
- **Sexual abuse**, which CMS defines as non-consensual sexual contact with a resident, was present in about 18 percent (+/- 5 percent) of the abuse deficiency narratives.[40]

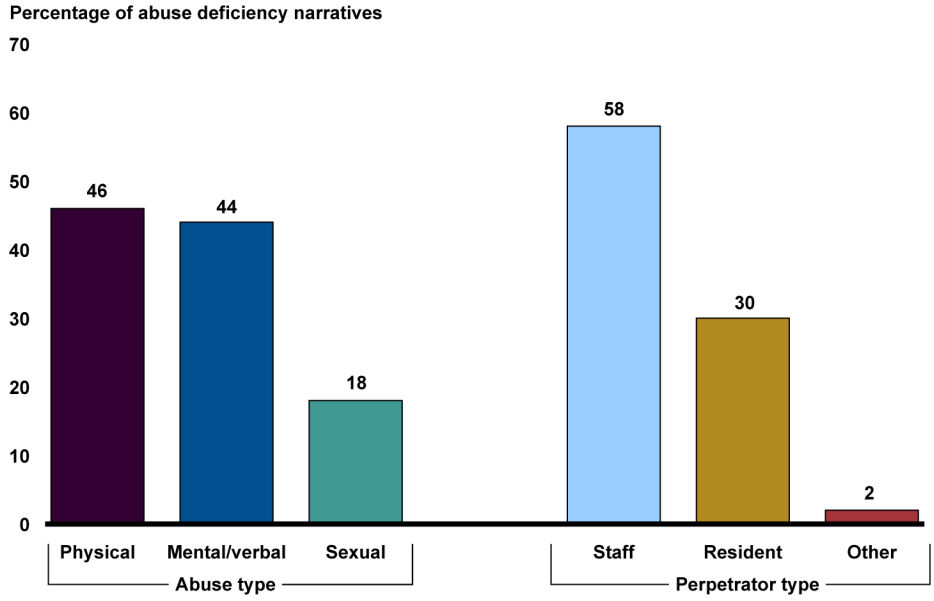
Staff, which includes those working in any part of the nursing home, were perpetrators in 58 percent (+/- 5 percent) of abuse deficiency narratives, followed by resident perpetrators (30 percent +/- 5 percent) and other types of perpetrators (2 percent +/- 5 percent).[41] Other types of perpetrators can include family members of residents or other visitors.

[39]Because abuse and perpetrator type are not readily identifiable in the CMS data, we identified this information by reviewing a representative sample of the narratives written by surveyors from 2016 through 2017 that describe substantiated abuse. Percentages may not add to 100 because some narratives had multiple types of abuse; some described involuntary seclusion, which was included in CMS's abuse deficiency code during the time period we examined; some deficiencies had narratives that were missing or incomplete; and some narratives described deficiencies that were not consistent with CMS's definition of abuse—for example, neglect or misappropriation.

[40]Upper and lower confidence levels were: physical (41 to 51 percent), mental/verbal (40 to 49 percent), and sexual abuse (14 to 22 percent).

[41]Upper and lower confidence levels were: staff-on-resident (54 to 63 percent), resident-on-resident (26 to 35 percent), and other (1 to 3 percent).

Figure 6: Representative Sample of Nursing Home Abuse Deficiency Narratives, by Abuse Type and Perpetrator Type, 2016 through 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data and supporting narratives. | GAO-19-433

Notes: We reviewed a representative sample of abuse deficiency narratives from CMS to determine the most common abuse type and perpetrator type. Percentages do not add to 100 because some narratives had multiple types of abuse, some deficiencies had narratives that were missing or incomplete, and some narratives described deficiencies that were not consistent with CMS's definition of abuse—for example, neglect or misappropriation. In addition, CMS's abuse deficiency code also included involuntary seclusion in the time period we examined. Our analysis found that 3 percent of the abuse deficiency narratives were attributable to involuntary seclusion.

Further, our analysis of the narratives found that sexual abuse perpetrated by residents (39 percent) occurred more frequently within our sample than sexual abuse perpetrated by staff (10 percent) or others (17 percent).[42] When staff were the perpetrators of abuse, we found within our sample that mental/verbal abuse was the most common type of abuse (60 percent), while physical abuse was most common in situations where residents (59 percent) or others (67 percent) were the perpetrators. For examples of the different types of abuse and perpetrators from our analysis, see table 3 below. Within our sample of narratives, mental/verbal abuse was less likely to be categorized by surveyors as severe compared to physical and sexual abuse. Specifically, we found in

[42]Information in this paragraph describes our sample but is not representative of all abuse deficiency narratives.

our sample that the proportion of mental/verbal abuse (30 percent) categorized by state surveyors as severe—defined as actual harm or immediate jeopardy—was smaller than the proportion of physical (40 percent) and sexual abuse (58 percent) categorized as severe. In addition, we found that most of the mental/verbal (88 percent), physical (91 percent), and sexual abuse (77 percent) narratives in our sample were categorized by surveyors as "isolated" in scope.[43]

Table 3: Examples from a Representative Sample of Nursing Home Abuse Deficiency Narratives, 2016-2017

Type(s) of abuse	Type(s) of perpetrator	Narrative details	Scope and severity
Physical abuse	Staff	A nurse aide grabbed a resident by both wrists, causing the resident to fall to the floor and resulting in bruising to the resident's left wrist and left hip.	Isolated scope, immediate jeopardy
Physical and sexual abuse	Resident	Resident 1, who had severe cognitive impairment, kicked another Resident 2, who also had significant cognitive impairment, in the face. Separately, Resident 3 shoved Resident 4 against a door, causing Resident 4 to fall. After being helped up by staff, Resident 4 was hit by Resident 3. The same resident (Resident 3) later slapped a different resident—Resident 5 in the head. Also in the narrative, Resident 6 fondled the breast of Resident 7, who appeared confused by the action.	Isolated scope, actual harm
Sexual and mental/verbal abuse	Resident and staff	A cognitively impaired resident (Resident 1) with a history of inappropriate sexual behavior grabbed Resident 2 in a sexually inappropriate manner. Resident 1 then grabbed the "private area" of Resident 3. Separately, a nursing home dietary staff member was verbally abusive to a resident (Resident 4), yelling and antagonizing the resident.	Widespread, immediate jeopardy
Sexual abuse	Staff	A nurse aide found a medical technician sexually assaulting a resident in the resident's room. The resident was non-verbal, with severe dementia, and was totally dependent on staff for mobility. The medical technician "begged" the nursing assistant not to tell anyone about witnessing the assault, and the medical technician later told a supervisor they had had "this problem for a while."	Isolated scope, immediate jeopardy
Mental/verbal abuse	Other	Resident 1 had an argument with Resident 2. Resident 2's family member arrived and threatened to kick Resident 1 out of her wheelchair if she did not stay away from Resident 2. Resident 1 was deeply concerned and felt frightened every time Resident 2's family member visited and she said that she had a nightmare about the family member.	Isolated scope, no actual harm with a potential for more than minimal harm
Mental/verbal abuse	Staff	A nurse assistant told a resident to "shut up and (expletive) off" when the resident requested to have their soiled brief changed, and the facility staff member put the resident's call light on the floor under the resident's bed so that the resident would not turn on the call light when they needed care. The state survey agency investigated this complaint, which had not been reported to the facility administrator.	Isolated scope, actual harm

Source: GAO summary of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-433.

[43]The remaining narratives in our sample were categorized as: "pattern" (mental/verbal—11 percent, physical—8 percent, sexual—19 percent) and "widespread" (mental/verbal—1 percent, physical—1 percent, sexual—4 percent).

Notes: We reviewed a representative sample of abuse deficiency narratives from CMS to determine the most common abuse type and perpetrator type.

Stakeholders Identified Resident Characteristics and Staffing Inadequacies as Risk Factors for Abuse, and Underreporting as among the Challenges to Investigating Abuse

Some Resident Characteristics and Inadequacies in Staffing, Training, and Staff Screening Can Increase Risk of Abuse

Stakeholder groups in most of the five states we interviewed—including state survey agencies, Adult Protective Services, law enforcement, MFCUs, ombudsmen, and nursing home administrators and clinical staff—identified risk factors for abuse in nursing homes that included resident characteristics, such as residents with infrequent visitors, and nursing home staffing characteristics, such as insufficient staffing levels. (See table 4 for a description of these risk factors.) Officials we interviewed from national organizations with knowledge of abuse in nursing homes also noted some of these same risk factors.

Table 4: Risk Factors for Nursing Home Abuse Identified by Stakeholders

Risk factor	Description
Resident characteristics	• Residents with infrequent visitors can be at an increased risk for abuse because regular visitors can notice and report changes in behavior or physical appearance. • Residents with cognitive impairment can be at an increased risk for abuse because they may have difficulty recalling recent events. • Elderly nursing home residents who are mixed with widely differing age groups, such as young adults with mental illness, can be at an increased risk for abuse.

Risk factor	Description
Nursing home staffing characteristics	• Nursing homes with insufficient staff can lead to too few staff attending to the needs of residents and to staff feeling overworked—both of which can lead to abuse. • Nursing homes with inadequate staff training can be at risk for abuse because staff may not know how to diffuse challenging situations with residents or know how to identify and report abuse. • Nursing homes with inadequate staff screening, such as through background checks and the nurse aide registry, could result in hiring staff with histories of abuse.

Source: GAO stakeholder interviews. | GAO-19-433.

Note: We interviewed officials from stakeholder groups including state survey agencies, Adult Protective Services, law enforcement, Medicaid Fraud Control Units, ombudsmen, and nursing homes.

Resident characteristics. Stakeholders in each of our five selected states noted that residents who do not have frequent visitors, are cognitively impaired, or mixed with widely different age groups may be at an increased risk for abuse.

- **Residents who do not have frequent visitors.** Stakeholders in four of the five states said that residents without regular visitors, such as family, may be at an increased risk for abuse because regular visitors could notice and report potential warning signs of abuse, such as changes in their behavior or physical appearance.
- **Residents who are cognitively impaired.** Stakeholders in each of the five states said that cognitively impaired residents may be especially vulnerable to abuse because they often cannot speak or may have difficulty recalling recent events, and they are therefore less likely to be able to remember or describe what happened. In addition to noting that cognitively impaired residents may be at an increased risk of abuse, some stakeholders said that some cognitively impaired residents may be more likely to be perpetrators of abuse as their condition can have behavioral symptoms, such as physical aggressiveness.
- **Residents mixed with widely different age groups.** Stakeholders in four of the five states also noted that elderly nursing home residents who are mixed with widely differing age groups, such as young adults with mental illness, may be at a higher risk for incidents of abuse due to the different characteristics of these groups. Combining these two populations, which have differing needs, can also be challenging for staff. For example, staff may have more experience caring for elderly residents with complex needs, such as dementia, and they may not have the necessary skills or training to care for needs of younger residents, who require other types of complex care. This can create a stressful environment for staff, which is a risk factor for staff as

potential perpetrators of abuse. Two stakeholders noted that younger residents who may have mental illness can have conflicts with older and frailer residents, potentially leading to abusive incidents between residents.

Nursing home staffing characteristics. Stakeholders we interviewed in each of our five selected states noted that nursing homes with insufficient staffing, inadequate staff training, and inadequate staff screening may be at risk for abuse.

- **Nursing homes with insufficient staff.** Stakeholders in each of the five states said that nursing homes with insufficient staff may be at risk for abuse because there may not be enough staff attending to the needs of residents.[44] Stakeholders noted that nursing homes have faced challenges hiring and retaining qualified staff and that, as a result, existing staff can feel overworked, stressed, or exhausted, which can lead to abusive behaviors. Staffing issues are not just risk factors for staff as perpetrators of abuse, but they can also limit a staff member's ability to identify and report abuse. For example, insufficient staffing may mean that there are not enough available staff to notice signs of abuse in a timely fashion, such as noticing a resident's bruises before they heal.
- **Nursing homes with inadequate staff training on abuse.** Inadequate staff training on abuse was noted by stakeholders we interviewed in four of the five states as a risk factor for abuse because; for example, staff may not know how to diffuse challenging situations with residents and identify and report abuse.[45] As previously noted, recognizing abuse can be challenging and, even when abuse is identified, it is often not reported. Officials from all of

[44]Numerous studies have established a relationship between higher nurse staffing levels and better care outcomes in nursing homes. In 1996, the Institute of Medicine concluded that a preponderance of evidence demonstrates a positive relationship between nurse staffing and quality of care in nursing homes. Federal law does not require a minimum nurse staff to resident ratio. A 2001 CMS study recommended a minimum staffing ratio per resident; however, CMS has not implemented these recommendations. See Institute of Medicine, U.S. Committee on the Adequacy of Nursing Staff in Hospitals and Nursing Homes, G Wunderlick, F Sloan, CK Davis, *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* (Washington, D.C.: National Academies Press, 1996). Also see Centers for Medicare & Medicaid Services, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report* (Baltimore, Md.: December 2001).

[45]Federal law requires nursing homes to provide training for all new and existing staff on preventing, identifying, and reporting abuse. 42 C.F.R. § 483.95(c) (2018).

the nursing homes that we visited said that they provide training to their staff on abuse, including on defining abuse, identifying or detecting different types of abuse, and reporting abuse.[46] Staff members we spoke with at one nursing home said that, not only are they trained to look for physical signs of abuse, such as bruising, but they are also trained to observe changes in behavior that may be warning signs for abuse, such as a resident suddenly withdrawing from group activities. Staff at another nursing home said that they are also taught to ask another staff member for assistance when they are feeling frustrated or stressed by caring for a particular resident. In contrast, staff at another nursing home noted the challenges of not having these types of resources and said they are needed at their facility.

- **Nursing homes with inadequate staff screening.** Stakeholders in three of our five states said that inadequate staff screening can be a risk factor for abuse. Some stakeholders said that a thorough background screening can be time consuming. Further, because staff screening through background checks and the nurse aide registry is not coordinated across the country, there are gaps that could enable individuals who committed crimes in one state to obtain employment at a nursing home in another state, a concern that we previously

[46]Some stakeholders also noted that they have provided training to residents on, for example, understanding their rights and how to report abuse.

reported.[47] Staff from a nursing home we visited said the prevention of abuse "starts with hiring the right staff" and noted the importance of conducting background checks and checking references for prospective employees.

Underreporting of Abuse, Cognitive Impairment of Victims, Lack of Nursing Home Cooperation, and Lack of Agency Coordination Pose Challenges for Abuse Investigations

The key challenges for abuse investigations most frequently identified by stakeholder groups in the five states we reviewed were underreporting of abuse, cognitive impairment of victims, lack of cooperation from nursing homes, and lack of agency coordination.[48] (See table 5 for a description of these challenges.) Officials we interviewed from national organizations with knowledge of abuse in nursing homes also noted some of these same challenges.

[47]CMS requires nursing homes to establish policies that prevent the hiring of individuals who have been convicted of abusing nursing home residents but does not require that they conduct background checks—either statewide or nationally. States, however, may require that background checks be conducted. States vary in terms of whether the background check must be statewide, national, or both, and in other requirements of these checks. A 2011 OIG report found that almost all nursing homes employed one or more individuals with at least one criminal conviction. See HHS OIG, *Nursing Facilities' Employment of Individuals with Criminal Convictions*. OEI-07-09-00110. (Washington, D.C.: March 2011). In 2010, the Affordable Care Act required the establishment of the National Background Check Program, which provides grants to states to design national comprehensive background check programs for long term care facility and provider employees. As of February 2019, CMS officials told us that there have been 29 states in the National Background Check program and 11 of these states are still active. CMS also requires nursing homes to check the state nurse aide registry before hiring a prospective nurse aide to ensure there is not a finding of abuse. However, nurse aide registries only reflect an aide's history in a particular state. And although there are multi-state registry verification requirements, including that nursing homes seek information from every state registry in states where they believe the aide has worked, we and HHS OIG have raised concerns about state nurse aide registries, and OIG recommended that CMS seek legislative authority to create a national nurse aide registry. See GAO-02-312 and HHS OIG, *Nurse Aide Registries: State Compliance and Practices. OEI-07-03-00380.* (Washington, D.C.: February 2005). While the Elder Justice Act required HHS to conduct a study on the feasibility of establishing a national nurse aide registry, HHS officials reported that because Congress has not appropriated funding for this provision of the Act, the study has not been completed.

[48]The stakeholders we interviewed included state survey agencies, Adult Protective Services, law enforcement, MFCUs, ombudsmen, and nursing homes.

Table 5: Key Challenges for Abuse Investigations Identified by Stakeholders

Key challenge	Description
Underreporting of abuse	Abuse in nursing homes may not be reported because residents or their family members may feel uncomfortable or fear retaliation from staff at the nursing home. In addition, nursing home staff may be afraid to report abuse out of fear of losing their jobs.
Cognitive impairment of victims	Residents with cognitive impairment may not recall the abuse that occurred, may not be able to verbalize a statement regarding the abuse, or may not be considered reliable witnesses.
Lack of cooperation from some nursing homes	Nursing homes may withhold, alter, or make it difficult for investigatory agencies to gain access to necessary, timely, or accurate information about alleged abuse.
Lack of agency coordination	Having multiple agencies involved in investigations can create challenges, such as coordinating investigations and notifying one another about investigation outcomes.

Source: GAO stakeholder interviews. | GAO-19-433.

Note: We interviewed officials from stakeholder groups including state survey agencies, Adult Protective Services, law enforcement, Medicaid Fraud Control Units, ombudsmen, and nursing homes.

Underreporting of abuse. Stakeholders in each of the five states in our review noted that abuse in nursing homes may be underreported because residents or their families feel uncomfortable or fear retaliation from nursing home staff.[49] For example, residents who were sexually abused may feel ashamed or embarrassed to report these incidents. In addition, residents may fear retaliation by the nursing home staff on whom they depend, which might include substandard care, exclusion from activities, or even eviction from the home. A fear of retaliation can also extend to nursing home staff, who may witness abuse by another staff member, but may be afraid to report it out of fear that they will lose their jobs or that they will face retaliation from co-workers. This underreporting creates challenges for investigators, who are unable to investigate if they do not know that abuse has occurred.

Cognitive impairment of victims. Stakeholders in each of the five states in our review said that victims with cognitive impairment may not be able to give statements regarding the abuse or may not be considered reliable witnesses. For example, residents with dementia may not be able to remember the details of an abusive incident, and their memory of the details may deteriorate over the course of an investigation. Or, residents with dementia may report abuse that stems from traumatic memories

[49]This is consistent with findings from a National Research Council publication: C. Hawes, *Elder Abuse in Residential Long-Term Care Settings: What is Known and What Information is Needed?* National Research Council of the National Academies. (Washington, D.C.: 2003).

from an incident that occurred earlier in their lives. One stakeholder said this can be a challenge for investigations because they do not know how much they can rely on a cognitively impaired resident's statement, making it difficult for them to corroborate an abuse allegation. However, one stakeholder noted that, while it can be difficult to interview abuse victims with cognitive impairment, it is important to treat their allegations seriously and with credibility. One law enforcement stakeholder noted that interviews with these victims require special training.

Lack of cooperation from some nursing homes. Stakeholders in each of the five states in our review said that some nursing homes may withhold, alter, or make it difficult for investigatory agencies to gain access to necessary, timely, or accurate information about alleged abuse. This may be, for example, because they may fear adverse publicity, litigation, or penalties from the state or CMS. In addition, as noted previously, nursing home staff may be fearful of losing their jobs. Stakeholders said that nursing home staff who witnessed abuse may be intentionally vague when interviewed by investigators; for example, by saying they cannot recall an incident. Some stakeholders also noted that nursing homes may delay investigators' access to patient records, or they may even alter patient records in order to fill in information that should have been documented but was not at the time of the incident. One stakeholder we interviewed noted that the problem is not necessarily widespread—that some nursing homes are open about sharing information while others can be more difficult. Another stakeholder noted that a nursing home's cooperation can sometimes depend on the seriousness of the allegation.

Lack of agency coordination. Stakeholders in three of the five states in our review said that having multiple agencies involved in investigations, such as the state survey agency, law enforcement, the ombudsman, and, in some states, Adult Protective Services, can create challenges, including coordinating investigations and notifying one another about investigation outcomes. One stakeholder said they sometimes begin an investigation without realizing another investigatory agency has already started its own investigation. Further, stakeholders in two of the five states in our review said that CMS does not allow state survey agencies to share important investigatory information with law enforcement. (We discuss this issue in more detail later in this report.)

CMS's Ability to Ensure Nursing Home Residents Are Free from Abuse May Be Limited by Gaps in Oversight

We found that CMS: (1) cannot readily access data on the type of abuse or type of perpetrator, (2) has not provided guidance on what information nursing homes should include in facility-reported incidents, and (3) has numerous gaps in its referral process that can result in delayed and missed referrals to other entities. Together, these gaps affect critical points in CMS's oversight of abuse in nursing homes including the prevention, identification, and timely investigation of abuse.

Information on Abuse and Perpetrator Types Is Not Readily Available

CMS cannot readily access information on abuse or perpetrator type in its datasets and, as a result, lacks key information critical to understanding and appropriately addressing nursing home abuse with its oversight. Specifically, in two of CMS's datasets—complaints/facility-reported incidents and deficiencies—agency officials told us they do not require the state survey agencies to record abuse and perpetrator type.[50] As a result, we found that CMS's data do not readily support CMS's understanding of the types of abuse and perpetrators that are most prevalent in nursing homes. CMS officials told us they believe that the majority of abuse is committed by nursing home residents, and that physical and sexual abuse were the most common types; officials said they based this current understanding of abuse and perpetrator types on professional experience, literature, and ad hoc analyses of deficiency narrative descriptions. However, our review of a representative sample of abuse deficiency narratives from 2016 and 2017 found that staff were more often the perpetrators of deficiencies cited as abuse than residents or others, and that physical and mental/verbal abuse occurred most often

[50]While there is a field in the complaints/facility-reported incidents database that allows state survey agencies to record data on abuse type and perpetrator type, as of March 2019 CMS officials told us that this field is optional for state survey agencies. We learned that two of the five state survey agencies in our review are recording and tracking data on abuse type and perpetrator type using this optional field in CMS's complaints/facility-reported incidents database. CMS officials told us that states can customize allegation sub-type for their internal use, and that, while its complaint/facility-reported incidents database does not capture perpetrator type data, states can customize the database to include optional data like alleged perpetrator type. CMS officials told us allegation sub-type data and data about alleged perpetrator type are not uploaded to national systems.

In the deficiency database, the narrative text associated with the deficiencies provides details on the incident, including information on the abuse type and perpetrator type. However, because these data are in an open text field format, they cannot be easily and accurately analyzed by the agency. Further, CMS officials told us they had not analyzed the abuse narratives.

in nursing homes, followed by sexual abuse. CMS officials noted that some incidents resulting from resident altercations—particularly those that do not show a willful intent to harm—may not have been cited as an abuse deficiency by some state survey agencies and may have been cited as other deficiencies not specified as abuse. This may have contributed to the difference between CMS's understanding of the prevalence of resident to resident abuse and what their abuse deficiency data show.

If CMS required information on abuse and perpetrator type to be recorded, the agency would have a better understanding of abuse in nursing homes. However, CMS officials told us they do not currently require the state survey agencies to specify abuse and perpetrator type because they consider the surveyor's job to be identification and documentation of noncompliance. Additionally, CMS officials told us they have not conducted a systematic review to gather information on abuse and perpetrator type. This is inconsistent with federal internal control standards directing management to use quality information to achieve program objectives.[51] Without the systematic collection and monitoring of specific abuse and perpetrator data, CMS lacks key information and, therefore, cannot take actions—such as tailoring prevention and investigation activities—to address the most prevalent types of abuse or perpetrators.

Facility-Reported Incidents Lack Key Information

All of the state survey agencies we spoke to told us that facility-reported incidents can lack key information that can cause potential delays in abuse investigations. Specifically, officials from each of the five state survey agencies told us that the facility-reported incidents they receive from nursing homes can lack key information that affects their ability to effectively triage incidents and determine whether an investigation should occur and how soon.[52] Two state survey agencies we spoke with said they sometimes have to conduct significant follow-up with the nursing homes to obtain the information they need to prioritize the incident for investigation—follow-up that delays and potentially negatively affects

[51]GAO-14-704G.

[52]Facility incident reports differ by state in the information requested and the method of delivery—for example, by online submission or by fax. These reports are filled out by facility staff and submitted to the state survey agency, which uses them to triage incident investigations.

investigations.[53] For example, one state survey agency told us that a facility reported abuse involving two residents but did not initially report that the residents were injured, and that the facility did not file an addendum to the facility-reported incident to indicate resident injury. As a result of this incomplete information, the state survey agency did not properly prioritize this incident response.

Despite federal law requiring nursing homes to self-report allegations of abuse, and covered individuals to report reasonable suspicions of crimes against residents, CMS has not provided guidance on what information should be included in these reports. Our review of CMS's State Operations Manual found that CMS does not have guidance related to the information that nursing homes or covered individuals should report to the state survey agencies or local law enforcement; in contrast, it does contain guidance on the type of information members of the public should include in a complaint about nursing home quality to the state survey agency—and CMS makes a standardized complaint template form available on its website.[54]

The lack of guidance on the information that state survey agencies should collect on facility-reported incidents is inconsistent with federal internal control standards directing management to use quality information to achieve program objectives.[55] CMS could outline basic information requirements that states must include on incident forms used by nursing homes and covered individuals to ensure the state survey agency is receiving the information it needs to accurately and quickly triage these incidents. CMS officials told us in November 2018 that they have efforts underway to examine guidance related to the information state survey agencies need to appropriately triage these facility-reported incidents and are developing a facility-reported incident template. Until the guidance

[53]According to CMS, an unintended effect of the state survey agency calling the facility to gather additional information is that this can tip off nursing homes to a state survey agency investigation. Alerting a nursing home to an impending investigation could result in it changing the conditions that are typically present—for example, by altering evidence or changing documentation.

[54]When we spoke to CMS officials in November 2018, they told us they recognize the need to provide more guidance on what information should be contained in facility incident reports, and that it is under development. However, they did not have a timeline available for implementation.

[55]GAO-14-704G.

and template are in place, these facility-reported incidents may lack key information that can cause potential delays in abuse investigations.

Gaps Exist in CMS Process for State Survey Agency Referrals to Law Enforcement and MFCUs

CMS requires state survey agencies to make referrals to law enforcement and, if appropriate, to MFCUs when abuse is substantiated; however, we found numerous gaps in CMS's referral process that can result in delayed and missed referrals. (See table 6.)

Table 6: Key Gaps in Centers for Medicare and Medicaid Services' (CMS) Process for Referrals

Gap in process	Description
Timing of abuse referrals	CMS requires state survey agencies to report abuse to law enforcement and Medicaid Fraud Control Units (MFCU), if appropriate, only after the abuse has been substantiated; as a result, investigations can be delayed.
Tracking of abuse referrals	CMS does not conduct oversight to ensure that state survey agency referrals to law enforcement and the MFCUs are occurring as required and may be missing non-compliance from the state survey agencies.
Definition of substantiated abuse	CMS's definition of substantiating an allegation is confusing to some state survey agencies, resulting in discrepancies in how state survey agencies interpret it and the potential that substantiated deficiencies would go unreported and not referred to law enforcement or MFCUs.
Information sharing with law enforcement	CMS's guidance on state survey agency referrals to law enforcement does not specify what information can be shared and may result in confusion or frustration for both state survey and law enforcement agencies and, ultimately, in delays in investigations.

Source: GAO analysis of information from CMS and state officials. | GAO-19-433.

Timing of abuse referrals. We found CMS's requirements for when state survey agencies should report abuse to law enforcement and MFCUs lag behind the federal requirements for when covered individuals should make such referrals, and, as a result, referrals may be significantly delayed. Specifically, federal law requires covered individuals to immediately report reasonable suspicions of a crime against a resident that results in serious bodily injury to law enforcement and the state survey agency.[56] Conversely, state survey agencies do not have to report suspicions of crime identified on complaints submitted to, and surveys conducted by, the state survey agency until the abuse has been substantiated—a process that can often take weeks or months.[57] Officials

[56]42 U.S.C. § 1320b-25(b). These covered individuals include nursing home owners, operators, and employees, among others.

[57]CMS guidelines require referrals to law enforcement only after a finding of abuse is substantiated and referrals to MFCUs after substantiation "when appropriate," without clearly defining when a MFCU referral is warranted.

from one law enforcement agency and two MFCUs that we interviewed told us the delay in receiving referrals limits their ability to collect evidence and prosecute cases—for example, bedding associated with potential sexual abuse may have been washed and wounds may have healed. This is consistent with the findings of our 2002 report, where we recommended that CMS should ensure that state survey agencies immediately notify law enforcement or MFCUs when nursing homes report allegations of physical or sexual abuse.[58] One state survey agency in our review established more stringent guidelines than CMS by requiring the surveyors to notify law enforcement and the MFCU promptly upon receiving a complaint of abuse. CMS officials told us their state survey agency reporting requirements are based on a March 2002 policy. This is inconsistent with standards for internal control, which state that management should communicate quality information externally so that external parties can help the entity achieve its objectives.[59]

Tracking of abuse referrals. In addition to delays in referring cases to law enforcement and MFCUs, CMS officials also told us that CMS does not conduct oversight to ensure that state survey agency referrals to law enforcement and the MFCUs are occurring as required for substantiated abuse, and, as a result, CMS cannot ensure that state survey agencies are complying with reporting obligations. For example, an official from one of the five state survey agencies we interviewed said they had never made a referral to law enforcement or the MFCU, despite having substantiated allegations of abuse. The state survey agency official told us that they do not refer cases to law enforcement, and that law enforcement referrals are the responsibility of the nursing home. This is incompatible with CMS guidelines requiring that substantiated abuse be referred to law enforcement; however, CMS officials told us that they do not track whether state survey agencies make referrals to law

[58]CMS did not implement this recommendation from our 2002 report: it was closed as not implemented. GAO-02-312.

We also found delays in the amount of time it takes state survey agencies to make referrals to the nurse aide registry, potentially leaving nursing home residents at risk, and we recommended the time frame for determining whether to include findings of abuse in nurse aide registry files be shortened. (CMS did not implement this recommendation). This is also consistent with findings from an HHS OIG report. See Daniel R. Levinson, OIG, HHS, memorandum to Seema Verma, Administrator, CMS, *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 (Aug. 24, 2017).

[59]GAO-14-704G.

enforcement and the MFCUs. This is inconsistent with federal standards for internal control, which state that management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.[60]

Definition of substantiated abuse. We found confusion among some state survey agencies about CMS's definition of what it means to substantiate an allegation of abuse—a challenge because substantiation is a trigger in the investigation process, and CMS requires state survey agencies to make referrals to law enforcement and staff registries when abuse is substantiated by evidence. As a result, there is a potential for substantiated abuse to not be reported and, subsequently, not referred to law enforcement or MFCUs for criminal investigation. Two of the five state survey agencies in our review told us they believed they could not substantiate an allegation unless they could also cite a federal deficiency. This is inconsistent with CMS's guidance, which says that state survey agencies can substantiate that an allegation occurred without citing a federal deficiency and that, subsequently, these substantiated allegations must be referred to law enforcement and staff registries.[61] For example, according to CMS guidance, if the state survey agency investigated and found evidence that a resident was abused, but the nursing home had taken preventive actions against the deficient practice, the state survey agency would then substantiate that the abuse occurred, but not cite a deficiency. However, state survey agencies may decide not to substantiate an abuse allegation verified by evidence if they believe no deficiency should be cited, such as if the nursing home had taken preventive action against the deficient practice, which could result in that abuse going unreported and not referred to law enforcement, MFCUs, or staff registries. Because substantiation of abuse is a critical trigger in abuse investigations, confusion around its interpretation could prevent these important next steps.[62] CMS officials told us they are aware that the state survey agencies have varying interpretations of what it means to substantiate abuse. According to federal standards for internal control,

[60]GAO-14-704G.

[61]The other three state survey agencies we interviewed told us that they substantiate allegations without necessarily citing a federal deficiency, depending on the circumstances, as provided for in CMS guidance.

[62]We noted similar findings in a previous report, see GAO-11-280. In that report, we recommended that CMS clarify guidance to states about how particular fields in the database should be interpreted, such as what it means to substantiate a complaint. CMS has not implemented this recommendation.

management should internally communicate quality information to achieve the entity's objectives.[63]

Information sharing. We also found that CMS's guidance on state survey agency referrals contained in its State Operations Manual does not specify what incident information can be shared with local law enforcement, either in response to local law enforcement's request for information or when the state survey agency refers substantiated findings of abuse to local law enforcement.[64] As a result, both state survey and law enforcement agencies expressed confusion and frustration about what information can be shared and said delays have occurred that can impede law enforcement investigations. Officials from two state survey agencies told us that CMS does not allow them to share any information with law enforcement without a written request.[65] For example, officials from one state survey agency said that they cannot share the name of the resident abused or the time when the incident occurred. One state survey agency said that information sharing can be uneven, and told us that law enforcement is required to share information with the state survey agencies, but the state survey agencies do not share their investigatory information with law enforcement. Officials from another state survey agency wrote to CMS notifying CMS of a change in their state survey agency protocol that would make the referral process timelier by providing un-redacted survey records of substantiated abuse to local law enforcement. However, in CMS's 2017 written response to the survey agency, CMS told them that all written requests for these records must continue to be forwarded to CMS for processing in accordance with the federal Privacy Act.

When we asked CMS officials what information state survey agencies can share with law enforcement in a referral, CMS explained that scenarios for requesting information can vary, and that CMS does not prescribe a

[63]GAO-14-704G.

[64]State survey agencies are required to report substantiated findings of abuse to local law enforcement and MFCUs, if appropriate. State Operations Manual, Complaint Procedures, § 5330, Revision 155, June 10, 2016, CMS.

[65]HHS regulations implementing the Privacy Act provide that disclosure of information to another governmental entity is permitted "for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of such [governmental entity] has submitted a written request to the Department [of Health and Human Services] specifying the record desired and the law enforcement activity for which the record is sought." 45 C.F.R. § 5b.9(b)(7) (2018).

specific method as it depends on the needs of the investigation. This lack of guidance is inconsistent with federal standards for internal control, which state that management should internally communicate quality information to achieve the entity's objectives.[66]

Conclusions

While nursing home abuse is relatively rare, our review shows that abuse deficiencies cited in nursing homes are becoming more frequent, with the largest increase in severe cases. As such, it is imperative that CMS have key information critical to understanding abuse and that the agency's oversight of nursing homes is strong. We found weaknesses in both CMS's understanding of abuse and in its oversight that need to be addressed. Specifically, because CMS cannot readily access information on abuse or perpetrator types in its data, it lacks key information critical to taking appropriate actions to address the most prevalent types of abuse and perpetrators. In addition, CMS has not provided guidance on what information should be included in facility-reported incidents, contributing to a lack of information for state survey agencies and, subsequently, delays in their investigations. This lack of guidance related to facility-reported incidents is important in light of our findings that abuse deficiencies are identified most commonly through facility-reported incidents. We also found other gaps in CMS's process related to ensuring timely referrals of abuse to law enforcement, tracking abuse referrals, defining abuse substantiation, and sharing information with law enforcement. These gaps affect CMS's oversight of abuse in nursing homes—including the prevention, identification and timely investigation of abuse—and may limit CMS's ability to ensure that nursing homes meet federal requirements for residents to be free from abuse.

Recommendations for Executive Action

We are making the following six recommendations to the administrator of CMS:

Require that abuse and perpetrator type be submitted by state survey agencies in CMS's databases for deficiency, complaint, and facility-reported incident data, and that CMS systematically assess trends in these data. (Recommendation 1)

[66]GAO-14-704G.

Develop and disseminate guidance—including a standardized form—to all state survey agencies on the information nursing homes and covered individuals should include on facility-reported incidents. (Recommendation 2)

Require state survey agencies to immediately refer complaints and surveys to law enforcement (and, when applicable, to MFCUs) if they have a reasonable suspicion that a crime against a resident has occurred when the complaint is received. (Recommendation 3)

Conduct oversight of state survey agencies to ensure referrals of complaints, surveys, and substantiated incidents with reasonable suspicion of a crime are referred to law enforcement (and, when applicable, to MFCUs) in a timely fashion. (Recommendation 4)

Develop guidance for state survey agencies clarifying that allegations verified by evidence should be substantiated and reported to law enforcement and state registries in cases where citing a federal deficiency may not be appropriate. (Recommendation 5)

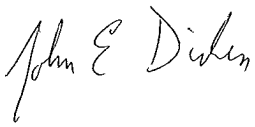
Provide guidance on what information should be contained in the referral of abuse allegations to law enforcement. (Recommendation 6)

Agency Comments

We provided a draft of this product to HHS for review and comment. In its comments, reproduced in appendix IV, HHS concurred with our six recommendations and identified actions it is taking to implement them. Specifically, HHS said that it will: (1) look into options for requiring state survey agencies to record data on abuse and perpetrator type so that HHS may assess trends in these data; (2) develop guidance that includes a list of standardized data elements to be included when nursing homes report facility-reported incidents and guidance specific to the reporting and tracking of facility-reported incidents involving abuse; (3) require state survey agencies to immediately refer complaints to law enforcement if a reasonable suspicion of a crime against a resident has occurred and share relevant survey information; (4) consider how to implement mechanisms for tracking law enforcement referrals; (5) identify opportunities to clarify in guidance situations where citing a federal deficiency may not be appropriate, but reporting the abuse is still required; and (6) develop a list of standardized elements that should be included when reporting an abuse allegation to law enforcement. HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of HHS and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.



John E. Dicken
Director, Health Care

Appendix I: Additional Detail on Analysis of Centers for Medicare & Medicaid Services' (CMS) Data

This appendix describes our scope and methodology for determining the trends and types of abuse occurring in nursing homes in recent years. For this examination, we reviewed CMS guidance and analyzed data from 2013 through 2017, which represented the most recent data for a 5-year period at the time of our review. Specifically, we first reviewed the CMS State Operations Manual's Appendix PP that was in effect during our period of review to determine which federal standards and deficiency codes were relevant to resident abuse.[1] We focused our analysis on the deficiency code to be used by state surveyors when a nursing home fails to keep a resident free from abuse, which encompasses mental/verbal, sexual, or physical abuse.[2] Surveyors can also use other deficiency codes for abuse-related issues, such as a failure by the nursing home to train staff on issues related to abuse, either in conjunction with an abuse deficiency or without an abuse deficiency. Since these abuse-related deficiency codes do not necessarily represent incidents of abuse, but do represent situations where a nursing home's inadequate policies could leave residents vulnerable to abuse, we conducted a limited analysis on the trends of these deficiencies, which is described in appendix II.

For our analysis, we identified abuse deficiencies cited by surveyors in all 50 states and Washington, D.C., between 2013 and 2017, using data provided by CMS from its Certification and Survey Provider Enhanced Reports system. Specifically, we calculated the number of abuse deficiencies cited each year and determined how many of these abuse deficiencies were at each level of severity—no actual harm with a potential for minimal harm, no actual harm with a potential for more than

[1]Specifically, we reviewed Appendix PP of the State Operations Manual because it is the section that provides guidance to state surveyors about determining compliance with federal quality standards and their associated deficiency codes. There were multiple updates to Appendix PP of the State Operations Manual during the period of our review (January 1, 2013, through November 27, 2017). Specifically, there were eight updates to the appendix during the 5-year period, but none of these changed the abuse deficiency citation codes used by state surveyors. Therefore, we used the March 8, 2017, version of the Appendix PP—the most recent version during our period of review—when determining which deficiency codes to analyze for this report. CMS, *State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities.* (March 8, 2017).

CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS deficiency data cited by surveyors after the implementation of that change.

[2]For the purposes of this report, we refer to mental and verbal abuse as "mental/verbal abuse." Over the period of time examined in our review, CMS's abuse deficiency code also included involuntary seclusion.

minimal harm, actual harm, and immediate jeopardy—for each year. We compared the results for abuse deficiencies with the results for all types of deficiencies in each year. To avoid over-counting deficiencies, deficiencies that were for the same violation on the same day for the same facility were counted as a single deficiency.[3] We then tracked (1) the origin of these abuse deficiencies and (2) enforcement actions implemented against nursing homes with these abuse deficiencies.

- **Origin of abuse deficiencies.** To identify trends in the origin of those abuse deficiencies—that is, whether the deficiency originated from a standard survey, complaint investigation, or a facility-reported incident investigation—we analyzed data provided by CMS from its Automated Survey Processing Environment Complaint/Incident Tracking System. Specifically, we matched the deficiencies with the complaint/incident data using provider number, survey date, and deficiency code. We found that some deficiencies were the result of a combination of complaints, facility-reported incidents, surveys, or all three. We counted those deficiencies as originating from each relevant category.
- **Enforcement actions.** To identify trends in the enforcement actions imposed and implemented against nursing homes with abuse deficiencies, we analyzed data provided by CMS from its Automated Survey Processing Environment Enforcement Manager. Specifically, we matched the deficiencies with the enforcement data using provider number, survey date, case identification number, and deficiency code. To avoid over-counting, deficiencies that share the same code and case identification number were counted as a single deficiency. For each year, we determined how many of the abuse deficiencies resulted in enforcement actions imposed or implemented, the severity of the abuse deficiencies with enforcement actions, and the types of enforcement actions implemented.

We then examined these abuse deficiencies to determine the number of nursing homes that had abuse deficiencies, as well as the number of homes with repeated abuse deficiencies cited across the 5 years and the

[3]There are instances where a complaint is filed and the complaint investigation window coincides with a scheduled standard survey. CMS data records the deficiency as two separate records—as the result of a standard survey and as the result of a complaint investigation. Following CMS procedure, we counted this deficiency only once; however, we flagged that the deficiency resulted from a complaint and a standard survey. Consequently, the sum of the source of the deficiencies (complaint, facility-reported incident, and standard survey) will be greater than the number of deficiencies.

characteristics of those homes. We also determined the proportion of surveyed nursing homes in a given year that had an abuse deficiency.[4]

- **Nursing homes that had repeated abuse deficiencies**. Since a nursing home can have more than one abuse deficiency cited in a given year, we determined the number of surveyed nursing homes each year that had at least one abuse deficiency, both nationally and by state. For each of those nursing homes, we determined if the home had an abuse deficiency repeated in multiple years and in two or more consecutive years.
- **Nursing home characteristics.** We attempted to identify commonalities among homes with multiple years of abuse deficiencies, homes with only a single year with an abuse deficiency, and surveyed homes without any abuse deficiencies throughout the 5-year period. Specifically, we matched deficiency data to CMS's publicly available Provider of Services files and the Nursing Home Compare Provider Information files for each nursing home; and we examined bed size, non-profit or for-profit status, Five-Star Quality Rating System overall rating, Special Focus Facility designation, and urban or rural location.[5]

Finally, because abuse and perpetrator type are not readily identifiable in CMS's data, we identified this information by reviewing the narratives written by surveyors that describe the substantiated abuse. Specifically, we obtained 1,557 narrative descriptions written by state surveyors for abuse deficiencies cited in 2016 and 2017 provided by CMS from its

[4]To determine the universe of nursing homes, we used the publicly available Nursing Home Compare Provider Information files to identify homes that had standard surveys with no deficiencies each year and combined those homes with homes that had deficiencies resulting from either standard surveys or investigations in data provided by CMS from its Certification and Survey Provider Enhanced Reports system.

[5]The CMS Provider of Services files were accessed on Dec. 14, 2018, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/index.html. The CMS Nursing Home Compare Provider Information files were accessed on Oct. 30, 2018, from https://data.medicare.gov/data/archives/nursing-home-compare.

Automated Survey Processing Environment database.[6] From that universe of abuse deficiency narratives, we selected a randomly selected representative sample of 400 narratives, and each narrative was reviewed by two separate reviewers who independently analyzed the text of each narrative to determine the abuse and perpetrator type according to the definitions that CMS implemented on November 28, 2017, in its State Operations Manual.[7] Any disagreements between the two reviewers were resolved by a third independent reviewer. (See table 7.) For those narratives where the abuse type could not reasonably be categorized under an existing CMS definition, reviewers had the option to mark narratives as "other." Furthermore, we analyzed the scope and severity for each narrative within our sample.

[6]As part of our data reliability checks, we matched the abuse deficiencies associated with the narrative descriptions in CMS's Automated Survey Processing Environment database with the abuse deficiencies in CMS's Certification and Survey Provider Enhanced Reports system. We found that we were unable to find matches for a relatively small number of records. CMS attributed these mismatches to differences in the source data used for the datasets. Specifically, state survey agencies enter data into the Automated Survey Processing Environment database, and that information is then uploaded by the states to CMS. These data from the states are then fed into CMS's Certification and Survey Provider Enhanced Reports system. In addition, officials said that there are some situations in which an abuse deficiency would not result in a narrative description written by surveyors. Correspondingly, there are some situations where a narrative description would be written by surveyors but not be uploaded by the state survey agency to CMS.

[7]We chose to use the definitions in CMS's current guidance for our narrative analysis despite the fact that they are more specific than the definitions in the CMS guidance that were in place at the time the narratives were written, because the specificity of the definitions in the current guidance allowed for us to perform a more consistent and reliable content analysis. For example, the older CMS guidance defines sexual abuse as "includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault," while the newer guidance that we used for our analysis defines it as "includes, but is not limited to: unwanted intimate touching of any kind especially of breasts or perineal area, all types of sexual assault or battery, such as rape, sodomy, and coerced nudity, forced observation of masturbation and/or pornography, and taking sexually explicit photographs and/or audio/video recordings and maintaining and/or distributing them." Using CMS's updated definition of these terms provides internal validity by assuring reviewers followed CMS's contiguous approach to the proper use of these terms. CMS, *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*. (November 22, 2017).

Table 7: Centers for Medicare & Medicaid Services' (CMS) Abuse and Perpetrator Type Definitions

	CMS definition
Abuse type	
Physical	Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. This definition includes corporal punishment, which includes, but is not limited to, pinching, spanking, slapping of hands, flicking, or hitting with an object.
Mental/verbal	Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.
Sexual	Sexual abuse is non-consensual sexual contact of any type with a resident and includes, but is not limited to: • Unwanted intimate touching of any kind especially of breasts or perineal area; • All types of sexual assault or battery, such as rape, sodomy, and coerced nudity; • Forced observation of masturbation and/or pornography; and • Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g., posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident.
Perpetrator type	
Staff	Staff perpetrators are perpetrators who are staff, at any level, of the nursing facility.
Resident	Resident perpetrators are perpetrators who are also residents at the facility.
Other	Other perpetrators are perpetrators who do not fall into the previous two categories, and can include but are not limited to family members of residents, visitors, or strangers.

Source: CMS, State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities. (November 22, 2017). | GAO-19-433.

CMS's abuse deficiency code also included involuntary seclusion in the time period we examined and is defined in its November 22, 2017, guidance as "separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident representative."[8] Our analysis of the narrative descriptions found that 3 percent of the abuse deficiency narratives in our sample were attributable to involuntary seclusion. We were unable to categorize the abuse and perpetrator type for about 11 percent of the deficiency narratives in our sample, because we determined the narrative description did not meet CMS's abuse definition.

We assessed the reliability of each of the datasets by checking for missing values and obvious errors and discussed them with CMS officials

[8]CMS. *State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities*. (November 22, 2017).

who were knowledgeable about the data. In the course of this assessment, we found some data limitations. Specifically, CMS officials told us that some state survey agencies may not have entered all facility-reported incidents into the Automated Survey Processing Environment Complaint/Incident Tracking System, while other state survey agencies did.[9] We also found underreporting, as noted in our 2019 report, where the Oregon state survey agency was not entering all abuse-related complaints or facility-reported incidents into this same database—a problem that could exist in other states.[10] In addition, CMS officials told us that it is possible there are additional incidents that may not have been represented in the abuse deficiency data during the period of our review. Specifically, CMS officials noted that some incidents resulting from resident altercations—particularly those that do not show a willful intent to harm—may not be cited as an abuse deficiency by some state survey agencies. We therefore consider the number of abuse deficiencies that resulted from complaints or facility-reported incidents to be a conservative estimate. After reviewing the possible limitations of these data, we determined the data were sufficiently reliable for the purposes of this reporting objective.

[9]CMS guidance requires state survey agencies to enter facility-reported incidents into the CMS database that require a federal, on-site survey.

[10]See GAO-19-313R. Further, our 2011 report noted CMS's concerns regarding the underreporting of complaints from state survey agencies. See GAO, *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations*, GAO-11-280, (Washington, D.C.: Apr. 7, 2011).

Appendix II: Trends in Abuse-Related Deficiencies

This appendix describes trends in abuse-related deficiencies over the 5-year period from 2013 through 2017. We reviewed Centers for Medicare & Medicaid Services (CMS) guidance that was in effect during this period of review to determine which federal standards and deficiency codes were relevant to resident abuse.[1] For the report, we focused our analysis on the deficiency code cited when state surveyors substantiate incidents of abuse, but there are also deficiencies that surveyors can cite for abuse-related issues, such as a failure by the nursing home to train staff on issues related to abuse, either in conjunction with an abuse deficiency or without an abuse deficiency. Since these abuse-related deficiencies do not necessarily represent incidents of abuse, but do represent situations where a nursing home's inadequate policies could leave residents vulnerable to abuse, we also conducted a limited analysis on the trends of these deficiencies. Specifically, we analyzed CMS data to identify the number of abuse-related deficiencies cited in each year in all 50 states and Washington, D.C., and determined how many were cited at each level of severity—no actual harm with a potential for minimal harm, no actual harm with a potential for more than minimal harm, actual harm, and immediate jeopardy.[2] We also tracked the source of these abuse-related deficiencies—that is, whether the deficiency originated from a standard survey, complaint investigation, or a facility-reported incident

[1]Specifically, we reviewed Appendix PP of the State Operations Manual because it is the section that provides guidance to state surveyors about determining compliance with federal quality standards and their associated deficiency codes. There were multiple updates to Appendix PP of the State Operations Manual during the period of our review (January 1, 2013 through November 27, 2017). Specifically, there were eight updates to the appendix during the 5-year period, but none of these changed the abuse deficiency citation codes used by state surveyors. Therefore, we used the March 8, 2017, version of the Appendix PP—the most recent version during our period of review—when determining which deficiency codes to analyze for this report. CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data recorded by surveyors after the implementation of that change. CMS, *State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities*. (March 8, 2017).

[2]We analyzed data provided by CMS from its Certification and Survey Provider Enhanced Reports system. To avoid over-counting deficiencies, deficiencies that were for the same violation on the same day for the same facility were counted as a single deficiency. For example, there are instances where a complaint is filed and the complaint investigation window coincides with a scheduled standard survey. CMS data records the deficiency as two separate records—as the result of a standard survey and as the result of a complaint investigation. Following CMS procedure, we counted this deficiency only once; however, we flagged that the deficiency resulted from a complaint and a standard survey. Consequently, the sum of the source of the deficiencies (complaint investigation, facility-reported incident investigation, and standard survey) will be greater than the number of deficiencies.

investigation.[3] Finally, we compared the results for abuse-related deficiencies with the results for all types of deficiencies cited by surveyors in each year.

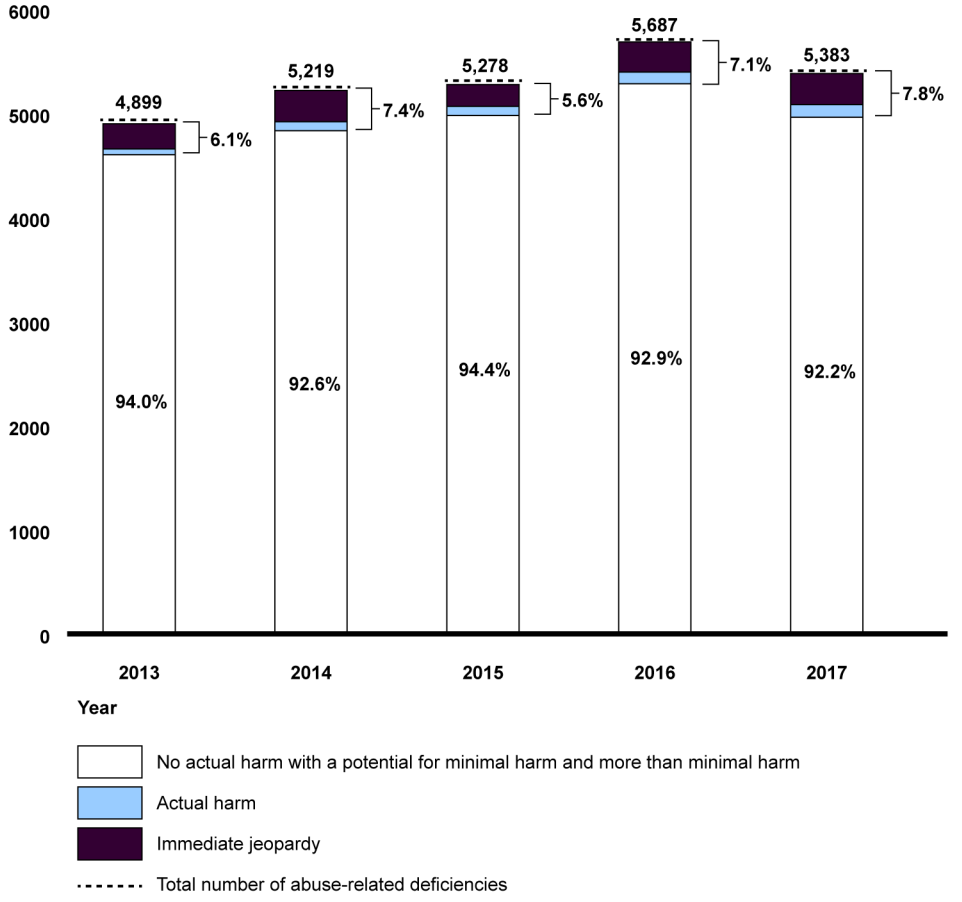
From 2013 to 2017, we found that abuse-related deficiencies became slightly more common with a resulting increase in severity. Specifically, abuse-related deficiencies increased by about 9.9 percent over the 5-year period, from 4,899 deficiencies cited in 2013 to 5,383 deficiencies cited in 2017, but peaked in 2016 with 5,687 deficiencies.[4] This increasing trend for abuse-related deficiencies is in contrast to the slight decrease in all deficiencies cited over the same period, but not nearly as high as the 103.5 percent increase in abuse deficiencies. In addition, the proportion of abuse-related deficiencies cited at the highest levels of severity—deficiencies causing actual harm to residents or putting residents in immediate jeopardy—fluctuated throughout the 5-year period. Specifically, about 6.1 percent of the 4,899 abuse-related deficiencies in 2013, about 5.6 percent of the 5,278 abuse-related deficiencies in 2015, and about 7.8 percent of the 5,383 abuse-related deficiencies in 2017 caused actual harm or immediate jeopardy.[5] (See fig. 7.)

[3]We matched the deficiencies with data provided by CMS from its Automated Survey Processing Environment Complaint/Incident Tracking System using provider number, survey date, and deficiency code. We found that some deficiencies were the result of a combination of complaint investigations, facility-reported incident investigations, standard surveys, or all three. We counted those deficiencies as originating from each relevant category.

[4]Similarly, the number of nursing homes that had abuse-related deficiencies cited also increased over the 5-year period from 3,318 (about 22.4 percent of all surveyed nursing homes) in 2013 to 3,563 (about 24.5 percent of all surveyed nursing homes) in 2017, but peaked in 2016 with 3,760 nursing homes (about 25.1 percent of all surveyed nursing homes) cited with abuse-related deficiencies. A nursing home can have more than one abuse-related deficiency cited within a single year.

[5]Abuse-related deficiencies were categorized by scope fairly consistently each year, with about two-thirds of abuse-related deficiencies categorized as isolated, about one-quarter categorized as a pattern, and less than 9 percent categorized as widespread.

Figure 7: Abuse-Related Deficiencies Cited, by Severity, 2013 through 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-433

Notes: CMS categorizes deficiencies into one of four severity categories based on whether the deficiency constitutes: (1) no actual harm with a potential for minimal harm; (2) no actual harm with a potential for more than minimal harm, but not immediate jeopardy; (3) actual harm that is not immediate jeopardy; or (4) immediate jeopardy to resident health or safety. We combined the first two categories in this figure.

CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

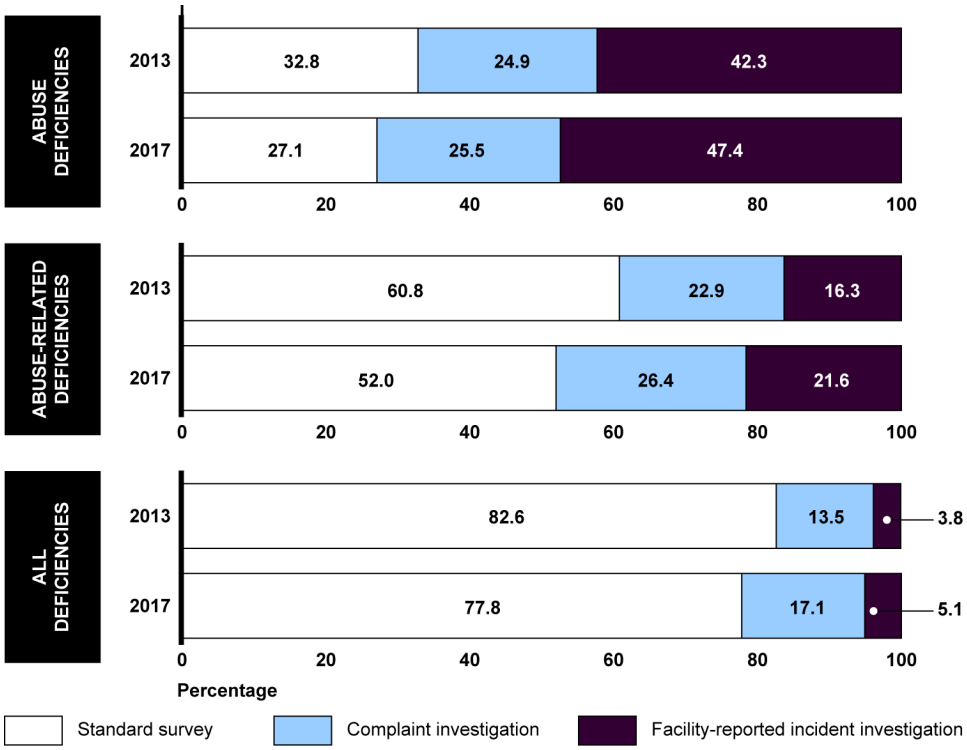
Percentages may not add to 100 due to rounding.

We also found that over half of the abuse-related deficiencies each year were cited by surveyors as a result of standard surveys, and the rest were

cited by surveyors as a result of either complaint or facility-reported incident investigations.[6] This falls between what we found for abuse deficiencies—the majority were a result of either complaint or facility-reported incident investigations—and all types of deficiencies—the vast majority were a result of standard surveys. Over the 5 years, similar to abuse deficiencies and all types of deficiencies, the percentage of abuse-related deficiencies that resulted from standard surveys decreased while the percentage that resulted from both complaint and facility-reported incident investigations increased. Specifically, over the 5-year period, the percentage of abuse-related deficiencies resulting from standard surveys decreased by about 8.8 percentage points, complaint investigations increased by about 3.6 percentage points, and facility-reported incident investigations increased by about 5.3 percentage points. (See fig. 8.)

[6]For 4,275 of the 26,466 total abuse-related deficiencies cited from 2013 through 2017, we were unable to determine from CMS's data whether the deficiency was identified during a standard survey, complaint investigation, facility-reported incident investigation, or a combination. We excluded these deficiencies from our percentages.

Figure 8: Source of Abuse Deficiencies, Abuse-Related Deficiencies, and All Types of Deficiencies, 2013 and 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-433

Notes: For 375 out of 2,892 abuse deficiencies, 4,275 of the 26,466 abuse-related deficiencies, and 55,190 out of 538,559 total deficiencies cited over the time period, we were unable to determine from CMS's data whether the deficiency was identified during a standard survey, complaint investigation, facility-reported incident investigation, or a combination. We excluded these deficiencies from our percentages in the figure.

CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

Percentages may not add to 100 due to rounding.

Appendix III: State Information on Abuse Deficiencies

Tables 8 and 9 provide state-level data on abuse deficiencies and the nursing homes that had abuse deficiencies cited in consecutive years.

Table 8: Abuse Deficiencies Cited, by State, 2013 and 2017

State	2013			2017[a]		
	Number of surveyed nursing homes	Number (percentage) of surveyed nursing homes with an abuse deficiency cited	Number (percentage) of cited deficiencies that were for abuse	Number of surveyed nursing homes	Number (percentage) of surveyed nursing homes with an abuse deficiency cited	Number (percentage) of cited deficiencies that were for abuse
AK	18	1 (5.6)	1 (0.5)	16	0 (0)	0 (0)
AL	220	1(0.5)	1 (0.1)	201	0 (0)	0 (0)
AR	230	3 (1.3)	4 (0.3)	217	8 (3.7)	8 (0.6)
AZ	134	5 (3.7)	5 (0.5)	131	7 (5.3)	7 (1.5)
CA	1,164	73 (6.3)	85 (0.7)	1,174	75 (6.4)	82 (0.6)
CO	212	3 (1.4)	3 (0.2)	187	3 (1.6)	3 (0.2)
CT	227	31 (13.7)	33 (1.7)	213	32 (15.0)	34 (2.3)
DC	19	2 (10.5)	4 (1.4)	18	2 (11.1)	2 (1.1)
DE	43	2 (4.7)	2 (0.3)	40	1 (2.5)	1 (0.3)
FL	644	4 (0.6)	4 (0.1)	646	18 (2.8)	18 (0.5)
GA	268	0 (0)	0 (0)	325	5 (1.5)	5 (0.5)
HI	26	0 (0)	0 (0)	37	1 (2.7)	1 (0.3)
IA	415	1 (0.2)	1 (<0.1)	400	30 (7.5)	32 (1.9)
ID	72	0 (0)	0 (0)	61	1 (1.6)	2 (0.4)
IL	753	29 (3.9)	30 (0.6)	728	106 (14.6)	114 (1.7)
IN	501	25 (5.0)	26 (0.7)	535	53 (9.9)	55 (1.4)
KS	312	2 (0.6)	2 (<0.1)	269	27 (10.0)	28 (1.5)
KY	281	4 (1.4)	4 (0.3)	264	5 (1.9)	5 (0.4)
LA	279	4 (1.4)	4 (0.2)	267	5 (1.9)	5 (0.5)
MA	407	1 (0.3)	1 (<0.1)	380	15 (4.0)	16 (0.8)
MD	229	6 (2.6)	6 (0.2)	219	22 (10.0)	24 (1.0)
ME	101	0 (0)	0 (0)	100	1 (1.0)	1 (0.3)
MI	421	58 (13.8)	68 (1.7)	430	80 (18.6)	91 (1.8)
MN	350	1 (0.3)	1 (<0.1)	333	6 (1.8)	6 (0.3)
MO	491	1 (0.2)	1 (<0.1)	480	1 (0.2)	1 (<0.1)
MS	202	6 (3.0)	8 (0.6)	191	2 (1.1)	2 (0.3)
MT	77	2 (2.6)	2 (0.3)	61	2 (3.3)	2 (0.4)
NC	387	0 (0)	0 (0)	407	11 (2.7)	11 (0.5)

State	2013			2017[a]		
	Number of surveyed nursing homes	Number (percentage) of surveyed nursing homes with an abuse deficiency cited	Number (percentage) of cited deficiencies that were for abuse	Number of surveyed nursing homes	Number (percentage) of surveyed nursing homes with an abuse deficiency cited	Number (percentage) of cited deficiencies that were for abuse
ND	78	0 (0)	0 (0)	69	0 (0)	0 (0)
NE	201	4 (2.0)	4 (0.3)	193	18 (9.3)	19 (1.5)
NH	73	1 (1.4)	1 (0.4)	69	0 (0)	0 (0)
NJ	351	4 (1.1)	4 (0.3)	334	0 (0)	0 (0)
NM	65	0 (0)	0 (0)	75	10 (13.3)	10 (1.2)
NV	50	1 (2.0)	1 (0.2)	59	1 (1.7)	1 (0.2)
NY	606	11 (1.8)	11 (0.3)	533	5 (0.9)	5 (0.2)
OH	862	56 (6.5)	58 (1.3)	901	79 (8.8)	85 (1.6)
OK	316	3 (1.0)	3 (<0.1)	283	11 (3.9)	11 (0.5)
OR	120	1 (0.8)	1 (0.2)[b]	129	2 (1.6)	2 (0.2)b
PA	690	2 (0.3)	2 (<0.1)	680	19 (2.8)	19 (0.3)
RI	78	0 (0)	0 (0)	79	0 (0)	0 (0)
SC	174	1 (0.6)	1 (0.1)	168	11 (6.6)	12 (1.0)
SD	100	2 (2.0)	2 (0.3)	96	0 (0)	0 (0)
TN	262	1 (0.4)	2 (0.1)	296	18 (6.1)	18 (1.3)
TX	1,161	8 (0.7)	8 (<0.1)	1,166	89 (7.6)	97 (1.2)
UT	92	0 (0)	0 (0)	80	2 (2.5)	2 (0.3)
VA	279	10 (3.6)	10 (0.4)	263	6 (2.3)	6 (0.3)
VT	36	11 (30.6)	13 (4.2)	36	2 (5.6)	3 (1.4)
WA	216	2 (0.9)	2 (0.1)	219	16 (7.3)	16 (0.6)
WI	372	9 (2.4)	9 (0.3)	351	7 (2.0)	7 (0.3)
WV	105	2 (1.9)	2 (0.2)	104	5 (4.8)	5 (0.5)
WY	36	0 (0)	0 (0)	37	1 (2.7)	1 (0.3)
Total	**14,806**	**394 (2.7)**	**430 (0.4)**	**14,550**	**821 (5.6)**	**875 (0.8)**

Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-433.

Notes:

[a]CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

[b]Our analysis of CMS data for Oregon does not include abuse deficiencies that may have resulted from investigations of complaints and facility-reported incidents. Specifically, we previously reported that Oregon was not following federal requirements that the state survey agency investigate all complaints and facility-reported incidents. Instead, for at least 15 years, Oregon's Adult Protective Services investigated complaints and facility-reported incidents of abuse in nursing homes and the results of those investigations were not shared with CMS. See GAO-19-313R.

Table 9: Nursing Homes with Abuse Deficiencies Cited in Consecutive Years, by State, 2013 through 2017

State	Total surveyed nursing homes, 2013 - 2017	Nursing homes with abuse deficiencies cited in only 1 year	Nursing homes with abuse deficiencies cited in multiple nonconsecutive years	Nursing homes with abuse deficiencies cited in two consecutive years	Nursing homes with abuse deficiencies cited in 3 or more consecutive years
AK	18	1	—	1	—
AL	232	5	—	—	—
AR	243	17	—	1	—
AZ	149	37	1	5	1
CA	1,258	225	33	29	9
CO	228	11	1	1	—
CT	231	74	11	15	1
DC	20	5	1	1	—
DE	47	6	1	—	—
FL	699	32	—	—	—
GA	365	14	—	1	—
HI	48	1	—	—	—
IA	460	78	3	14	—
ID	79	2	—	—	—
IL	791	141	21	15	1
IN	567	123	13	10	2
KS	369	68	2	7	—
KY	293	33	—	—	—
LA	280	17	1	—	—
MA	427	32	—	—	—
MD	234	38	3	4	—
ME	108	5	—	—	—
MI	456	101	33	29	7
MN	392	14	—	—	—
MO	531	11	—	—	—
MS	214	18	—	—	—
MT	84	13	1	1	—
NC	433	29	—	—	—
ND	82	5	—	—	—
NE	233	30	6	4	—
NH	77	4	—	—	—
NJ	374	18	1	—	—
NM	80	16	2	2	—

State	Total surveyed nursing homes, 2013 - 2017	Nursing homes with abuse deficiencies cited in only 1 year	Nursing homes with abuse deficiencies cited in multiple nonconsecutive years	Nursing homes with abuse deficiencies cited in two consecutive years	Nursing homes with abuse deficiencies cited in 3 or more consecutive years
NV	60	2	—	1	—
NY	637	27	—	1	—
OH	995	184	25	23	4
OK	333	27	2	—	—
OR	144	5	—	—	—
PA	716	30	1	3	—
RI	84	1	—	—	—
SC	192	20	2	1	—
SD	113	9	1	1	—
TN	337	29	1	1	—
TX	1,303	153	4	4	—
UT	105	7	—	—	—
VA	298	26	—	2	—
VT	38	7	4	4	—
WA	230	22	3	1	—
WI	409	33	—	2	—
WV	129	19	1	1	—
WY	41	1	—	—	—
Total	**16,266**	**1,826**	**178**	**185**	**25**

Legend: "—" = none.

Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-433.

Note: CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors after the implementation of that change.

Appendix IV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAY 2 2 2019

John Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse*" (GAO-19-433).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Matthew D. Bassett
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - NURSING HOMES: IMPROVED OVERSIGHT NEEDED TO BETTER PROTECT RESIDENTS FROM ABUSE (GAO-19-433)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office (GAO) draft report on the federal oversight of nursing homes. Resident safety in nursing homes and in all facilities that participate in the Medicare and Medicaid programs is a top priority for HHS.

Every nursing home resident deserves to retain their basic human dignity and to be treated with respect at all times. Abuse and neglect are never acceptable. HHS is undertaking a comprehensive review of the regulations, guidelines, internal structure, and processes related to safety and quality in nursing homes. HHS has demonstrated a commitment to this path by developing a five-part plan to ensure the care provided in nursing homes is of the highest possible quality. The five-part plan will strengthen oversight, enhance enforcement, increase transparency, improve quality, and put patients over paperwork.

HHS works in partnership with state survey agencies to oversee nursing homes, since these agencies are generally also responsible for state licensure. The state survey agencies visit and conduct survey inspections at every Medicare and Medicaid participating nursing home in the nation at least annually to ensure they are meeting HHS' health and safety requirements as well as state licensure requirements. State survey agencies can also conduct complaint surveys at any time, and anyone can file a complaint, including residents, family members, nursing home staff, and anyone else who has reason to suspect abuse or neglect is taking place. HHS's Nursing Home Compare website includes links and other helpful information to help patients and families determine when and how to file a complaint. Nursing homes are required to post similar information on how to file complaints and grievances in their facilities and with independent state entities. HHS will be updating Nursing Home Compare to make it easier for consumers to identify specific instances of non-compliance related to abuse.

Residents deserve consistent nursing home quality, regardless of location, so HHS is revising its oversight of state survey agency performance. HHS is examining the way surveyors identify issues such as abuse, facility staffing levels, and dementia care, and is clarifying expectations regarding when abuse must be reported to the state and law enforcement. This means setting clear timelines for state survey agencies to review allegations of abuse and neglect.

In addition, HHS conducts validation surveys to determine whether state survey agencies are identifying deficiencies correctly, investigating compliance effectively, and meeting all other obligations. The Centers for Medicare & Medicaid Services (CMS) Regional Offices conduct formal assessments annually of each state survey agency's performance relative to measures included in the State Performance Standards System (SPSS). The SPSS provides a framework to organize and measure important aspects of state survey activities and is comprised of three

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - NURSING HOMES: IMPROVED OVERSIGHT NEEDED TO BETTER PROTECT RESIDENTS FROM ABUSE (GAO-19-433)

domains: frequency, survey quality, and enforcement. These three areas also support HHS's efforts to standardize and promote consistency among state survey agencies.

HHS recently revised the process for validation surveys conducted of state survey agencies to add areas of concern that federal surveyors will examine to determine whether state surveyors are investigating for compliance effectively. In fiscal year 2018, HHS worked with states on three areas of concern: abuse and neglect, admission/transfer/discharge, and dementia care. In 2019, each Regional Office will again focus on identifying concerns related to abuse and neglect. They will also focus on facility staffing and other areas of improvement that are unique to the states in its region. HHS also recently launched an initiative to evaluate the entire SPSS program to identify ways to improve state performance. This is an ongoing, large-scale effort aimed at improving the efficiency and effectiveness of measuring and improving state performance.

HHS remains diligent in our duties to monitor nursing homes participating in Medicare and Medicaid across the country, as well as the state agencies that survey them. HHS appreciates the ongoing work of the GAO in this area and will continue to work with them as we make improvements to our oversight efforts.

GAO's recommendations and HHS' responses are below.

Recommendation 1
Require that abuse and perpetrator type be submitted by state survey agencies in CMS's databases for deficiency, complaint, and facility-reported incident data and that CMS systematically assess trends in these data.

HHS Response
HHS concurs with this recommendation. HHS requires state survey agencies to investigate and track complaints of abuse and neglect at nursing homes and will look into options for requiring state agencies to record alleged abuse type and alleged perpetrator type, when available, so that HHS may assess trends in these data.

Recommendation 2
Develop and disseminate guidance—including a standardized form—to all survey agencies on the information nursing homes and covered individuals should include on facility-reported incidents.

HHS Response
HHS concurs with this recommendation. HHS has training materials for state agency and nursing home staff on identifying and reporting potential abuse and neglect of beneficiaries and already has plans to issue new guidance specific to the reporting and tracking of facility-reported incidents of potential abuse and neglect. HHS will develop a list of standardized data elements that must be included when reporting facility-reported incidents to state survey agencies. Since reporting forms

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - NURSING HOMES: IMPROVED OVERSIGHT NEEDED TO BETTER PROTECT RESIDENTS FROM ABUSE (GAO-19-433)

vary depending on state laws and requirements, rather than creating a standardized form, HHS will provide guidance that any reporting form should include all of the standardized elements required by HHS.

Recommendation 3
Require state survey agencies to immediately refer complaints and surveys to law enforcement (and, when applicable, to MFCUs) if they have a reasonable suspicion that a crime against a resident has occurred when the complaint is received.

HHS Response
HHS concurs with this recommendation. Currently, state survey agencies are required to investigate and track complaints of abuse and neglect and report substantiated findings to local law enforcement and MFCUs when appropriate (CMS State Operations Manual, § 5330). In the case of alleged violations involving abuse, neglect, exploitation or mistreatment in a nursing facility, HHS requires the facility to report to the state survey agency and adult protective services where state law provides for jurisdiction in long term care facilities in accordance with state law through established procedures (42 CFR 483.12). In cases where the state survey agency cannot verify that the facility already reported to law enforcement, HHS will require state survey agencies to immediately refer complaints to law enforcement if a reasonable suspicion of a crime against a resident has occurred and share any subsequent relevant survey information.

Recommendation 4
Conduct oversight of state survey agencies to ensure referrals of complaints, surveys, and substantiated incidents with reasonable suspicion of a crime are referred to law enforcement (and, when applicable, MFCUs) in a timely fashion.

HHS Response
HHS concurs with this recommendation. HHS requires state survey agencies to investigate and track complaints of abuse and neglect and report substantiated findings to local law enforcement (CMS State Operations Manual, § 5330); however, we will consider how to implement mechanisms for tracking law enforcement referrals.

Recommendation 5
Develop guidance for state survey agencies clarifying that allegations verified by evidence should be substantiated and reported to law enforcement and state registries in cases where citing a federal deficiency may not be appropriate.

HHS Response
HHS concurs with this recommendation. Nursing homes are required under 42 CFR 483.12 to report alleged violations of abuse, neglect, exploitation, or mistreatment of residents to the appropriate authorities; however, HHS will review our guidance to state agencies for opportunities to provide additional clarification around allegations where a federal deficiency may not be appropriate..

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - NURSING HOMES: IMPROVED OVERSIGHT NEEDED TO BETTER PROTECT RESIDENTS FROM ABUSE (GAO-19-433)

Recommendation 6
Provide guidance on what information should be contained in the referral of abuse allegations to law enforcement.

HHS Response
HHS concurs with this recommendation. HHS will provide guidance to state agencies and nursing homes on identifying and reporting potential abuse and neglect of residents and will develop a list of standardized elements that should be included when reporting an abuse allegation to law enforcement.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Karin Wallestad (Assistant Director); Sarah-Lynn McGrath and Kathryn Richter (Analysts-in-Charge); Luke Baron; Summar Corley; Zosha Kandel; and Julianne Flowers made key contributions to this report. Also contributing were Laurie Pachter, Jennifer Whitworth, and Vikki Porter.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (https://www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to https://www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, https://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts.
Visit GAO on the web at https://www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: https://www.gao.gov/fraudnet/fraudnet.htm

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

Orice Williams Brown, Managing Director, WilliamsO@gao.gov, (202) 512-4400,
U.S. Government Accountability Office, 441 G Street NW, Room 7125,
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548