

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW JERSEY DID NOT ENSURE THAT
INCIDENTS OF POTENTIAL ABUSE OR
NEGLECT OF MEDICAID
BENEFICIARIES RESIDING IN
NURSING FACILITIES WERE ALWAYS
PROPERLY INVESTIGATED AND
REPORTED**

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Office of Inspector General

<https://oig.hhs.gov>

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Report in Brief

Date: August 2020

Report No. A-02-18-01006

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



Why OIG Did This Audit

This audit report is one of a series of OIG reports that addresses the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's most vulnerable populations, including Medicaid beneficiaries in nursing facilities.

Nursing facility residents are at increased risk of abuse and neglect when health care professionals and caregivers fail to report abuse, or when incidents of potential abuse or neglect are not acted upon in a timely manner.

Our objective was to determine whether New Jersey ensured that incidents of potential abuse or neglect of Medicaid beneficiaries residing in nursing facilities in New Jersey were properly reported and investigated in accordance with applicable Federal and State requirements.

How OIG Did This Audit

Our audit covered 4,402 hospital claims with selected diagnosis codes for Medicaid beneficiaries who resided in nursing facilities in New Jersey and were transferred during calendar year (CY) 2016 to a hospital setting. We reviewed a stratified random sample of 103 of these claims. For each claim, we reviewed hospital and nursing facility records with New Jersey officials to determine whether the claims resulted from an incident of potential abuse or neglect.

New Jersey Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported

What OIG Found

New Jersey did not ensure that nursing facilities always investigated and reported incidents of potential abuse or neglect to the State in accordance with Federal and State requirements. Of the 103 claims in our sample, 79 were not the result of potential abuse or neglect; therefore, nursing facilities were not required to report the incident to the State. Of the remaining 24 claims, 10 were the result of potential abuse or neglect that should have been reported to the State. However, 5 of the 10 claims were not properly investigated and reported to the State. For the other 14 claims, nursing facilities did not provide documentation, or their records did not contain sufficient documentation for State officials to determine whether the incident should have been investigated and reported. These deficiencies occurred because nursing facility staff did not follow requirements for investigating and reporting potential incidents of abuse or neglect. In addition, New Jersey did not have adequate survey procedures for ensuring that nursing facilities documented all such incidents.

Based on our sample results, we estimated that 311 Medicaid hospital claims with selected diagnosis codes resulted from incidents of potential abuse or neglect at a nursing facility in New Jersey during CY 2016. Of this amount, we estimated that 220 claims were the result of potential abuse or neglect that the nursing facilities did not investigate and report to the State. In addition, we estimated that, for 616 claims, the associated beneficiary's nursing facility did not have records to sufficiently document the circumstances of the beneficiary's injuries or condition that led to the hospital transfer so that State officials could determine whether the incident was the result of potential abuse or neglect.

What OIG Recommends and New Jersey Comments

We recommend that New Jersey: (1) reinforce guidance to nursing facilities for ensuring potential incidents of abuse or neglect are reported in accordance with Federal and State requirements; and (2) develop additional procedures for its survey site visits, including reviewing nursing facilities' records related to hospital transfers for certain beneficiary injuries or conditions that could be the result of potential abuse or neglect. In written comments on our draft report, New Jersey did not indicate concurrence or nonconcurrence with our recommendations; however, it concurred with our findings.

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INTRODUCTION

WHY WE DID THIS AUDIT

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

OBJECTIVE

Our objective was to determine whether the New Jersey Department of Human Services (State agency) ensured that incidents of potential abuse or neglect of Medicaid beneficiaries residing in nursing facilities in New Jersey were properly investigated and reported in accordance with applicable Federal and State requirements.

BACKGROUND

Medicaid Coverage of Care in Nursing Facilities

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

The Medicaid program covers care in nursing facilities for eligible beneficiaries in need of skilled nursing services, rehabilitation services, or long-term care. Sections 1819 and 1919 of the Social Security Act (the Act) provide that nursing facilities participating in the Medicaid program must meet certain specified requirements (Federal participation requirements), including requirements related to quality of care, nursing services, and infection control. These sections also establish requirements for CMS and States to survey nursing facilities to determine whether they meet Federal participation requirements.

State Survey Agencies

A State survey agency is an agency designated as responsible for certifying and determining compliance of long-term-care facilities, including nursing facilities, with Medicaid program participation requirements. State survey agencies' oversight includes conducting investigations and fact-finding surveys to determine how well health care providers comply with their

applicable conditions of participation, including the reporting of potential abuse or neglect. In New Jersey, the New Jersey Department of Health serves as the State survey agency responsible for licensing and surveying nursing facilities.

State survey agencies are responsible for ensuring that nursing facilities comply with pertinent Federal requirements, including reporting allegations of abuse or neglect.¹ CMS requires State survey agencies to enter into the Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS) all information related to complaints and incidents that lead to an onsite survey of Federal requirements.² State survey agencies are required to promptly review and prioritize complaints and incidents; conduct unannounced onsite investigations, if necessary; and transmit the results of the required investigations and recommendations to CMS through ACTS.

Critical Incident Reporting for Nursing Facilities in New Jersey

Federal Requirements

Federal regulations require nursing facilities to immediately³ report allegations (referred to as incidents) of abuse or neglect, including injuries of unknown source, to the administrator of the facility, the State survey agency, and to other officials in accordance with State law. Nursing facilities must complete and report the results of all investigations to the administrator of the nursing facility and to other officials, including law enforcement officials, in accordance with State law within 5 working days of the incident. If a nursing facility verifies the alleged violation, it must take appropriate corrective action. The nursing facility must have evidence

¹ CMS defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or emotional distress (42 CFR § 488.301). An injury is classified as an “injury of unknown source” when both of the following conditions are met: (1) the source of the injury was not observed by any person or could not be explained by the resident and (2) the injury is suspicious because of its extent or location or because of the number of injuries observed at one time or the incidence of injuries over time (CMS, State Survey Agency Directors letter, S&C-05-09, *Clarification of Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, and Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property*, Dec. 16, 2004).

² Complaints are allegations from a third party of noncompliance with Federal and State requirements. Incidents are self-reported allegations from a nursing facility.

³ Federal regulations now require, effective November 28, 2016, that these allegations be reported immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. (81 Fed. Reg. 68688 (Oct. 4, 2016)).

that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.⁴

State Requirements

New Jersey requires nursing facilities to report complaints and incidents of potential abuse or neglect to the State survey agency in a timely manner.^{5, 6} The State survey agency is required to enter in ACTS all complaints reported against nursing facilities gathered as part of its Federal survey and certification responsibilities as well as incidents that require a Federal onsite survey. If the State survey agency conducts an onsite investigation, it must enter in ACTS the results of the investigation.⁷ The figure (following page) details the process for nursing facilities in New Jersey to report complaints and incidents of potential abuse or neglect.

⁴ 42 CFR § 483.13(c). Effective November 28, 2016, 42 CFR § 483.13 was removed and replaced with 42 CFR § 483.12 (81 Fed. Reg. 68688).

⁵ The State survey agency provides nursing facilities with training and guidance on how to investigate and report potential incidents of abuse or neglect in accordance with Federal and State requirements. For example, the State survey agency hosts training sessions and provides handouts to assist nursing facility staff in identifying and investigating incidents.

⁶ Title 52 § 27G-7.1.a of New Jersey Revised Statutes (2013). State regulations require nursing facilities to “immediately” report all incidents of suspected abuse or neglect followed by written notification (written notification includes the details of the internal investigation) within 72 hours to appropriate State officials, including the State survey agency (New Jersey Administrative Code (NJAC) 8:39-9:4(f)).

⁷ CMS *State Operations Manual* § 5060.

Figure: New Jersey Nursing Facility Incident Reporting



HOW WE CONDUCTED THIS AUDIT

Our audit covered 4,402 hospital claims with selected diagnosis codes for Medicaid beneficiaries who resided in nursing facilities in New Jersey and were transferred during calendar year (CY) 2016⁸ to an emergency room or other hospital setting. Specifically, we selected diagnosis codes (admitting, principal, and secondary diagnosis codes) that we determined had a risk of resulting from abuse or neglect.⁹ We reviewed a stratified random sample of 103 of these claims. For each claim, we worked with the State survey agency to review hospital and nursing facility records and to determine whether the claims resulted from an incident of potential abuse or neglect.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

⁸ The audit period encompassed the most current data available at the time we initiated our audit.

⁹ We relied on the methodology used in related OIG audits (A-01-16-00001, A-01-16-00509) to select inpatient and outpatient diagnosis codes that have a risk of resulting from abuse or neglect.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, Appendix C contains our sample results and estimates, Appendix D contains a summary of the diagnosis codes in our sample indicating a likelihood for abuse or neglect, and Appendix E contains a list of related OIG reports.

FINDINGS

The State agency did not ensure that nursing facilities in New Jersey always investigated and reported incidents of potential abuse or neglect to the State survey agency in accordance with applicable Federal and State requirements. In addition, several nursing facilities failed to document incidents sufficiently for the State survey agency to determine whether the incident should have been investigated and reported. Of the 103 sampled claims, 79 were not the result of potential abuse or neglect; therefore, nursing facilities were not required to report the incident to the State survey agency. However, of the remaining 24 claims, 10 were the result of potential abuse or neglect that should have been reported to the State survey agency. Of these 10 claims, 5 were properly investigated and reported by the nursing facility to the State survey agency, which entered the relevant information in ACTS and conducted required onsite investigations, but the remaining 5 claims were not. For the other 14 sampled claims, nursing facilities did not provide documentation, or their records did not contain sufficient documentation for the State survey agency to determine whether the incident should have been investigated and reported to the State survey agency.

These deficiencies occurred because nursing facility staff did not follow Federal and State reporting guidelines for investigating and reporting potential incidents of abuse or neglect. In addition, the State survey agency did not have adequate procedures for ensuring that nursing facilities documented all incidents of potential abuse or neglect.

On the basis of our sample results, we estimated that 311 Medicaid hospital claims with selected diagnosis codes resulted from incidents of potential abuse or neglect at a nursing facility in New Jersey during CY 2016. Of this amount, we estimated that 220 claims were the result of potential abuse or neglect that the nursing facilities did not investigate and report to the State survey agency. In addition, we estimated that for 616 hospital claims, the associated beneficiary's nursing facility did not have records to sufficiently document the circumstances of the beneficiary's injuries or condition¹⁰ that led to the hospital transfer so that the State survey agency could determine whether the incident was the result of potential abuse or neglect.

¹⁰ Examples of injuries and conditions included displaced fracture of right femur, head contusion, and severe sepsis.

POTENTIAL ABUSE OR NEGLECT NOT INVESTIGATED AND REPORTED

Nursing facilities must ensure that all alleged violations involving mistreatment, abuse, or neglect, including injuries of unknown source, are reported immediately to the facility administrator and State survey agency (42 CFR § 483.13(c)(2)).¹¹ New Jersey requires nursing facilities to report all incidents of suspected abuse or neglect immediately to appropriate State officials, including the State survey agency (NJAC 8:39-9:4).

Of the 10 sampled claims that the State survey agency determined were the result of potential abuse or neglect, 5 claims were properly investigated and reported by the nursing facility to the State survey agency, which entered the relevant information in ACTS and conducted required onsite investigations, but 5 other claims were not. Exhibit 1 describes two of the incidents not reported to the State survey agency.

We requested that the nursing facilities associated with the five incidents explain why the incidents were not reported. Representatives for two of the nursing facilities stated that they would review the incident at their facility and did not provide additional information. Available representatives at two other nursing facilities stated that they were not employed at the facility at the time of the incident and, therefore, had limited knowledge of the incident.¹² A representative of the remaining facility stated that she believed the incident did not need to be reported.

Because incidents were not reported to the State survey agency, the State survey agency could not record the incidents in the ACTS or investigate, if necessary, to determine whether abuse or neglect had occurred. Without an investigation, the injuries or condition that led to the potential incident of abuse or neglect could reoccur at the nursing facilities.

Exhibit 1: Examples of Incidents Not Reported to the State Survey Agency

- In one incident, a Medicaid beneficiary was thrown from her bed inside her room by another nursing facility resident, according to the notes provided by the nursing facility. The beneficiary was sent to a hospital emergency department for hip pain.
- In another incident, a Medicaid beneficiary was found on a hallway floor, bleeding from the top of her head. According to the notes provided by the nursing facility, she was confused and unable to explain how she ended up on the hallway floor.

¹¹ See footnotes 3 and 4 regarding revisions to the regulatory reporting requirement.

¹² One of the representatives stated that she checked with a nurse who worked during the shift who said that the beneficiary had been transferred to the hospital for a contusion of the head. The representative stated that the nurse did not know why the incident was not reported.

NURSING FACILITIES RECORDS NOT PROVIDED OR DID NOT CONTAIN SUFFICIENT INFORMATION TO DETERMINE WHETHER INCIDENTS SHOULD HAVE BEEN REPORTED

Nursing facilities must ensure that all alleged violations involving mistreatment, abuse, or neglect, including injuries of unknown source, are reported immediately to the facility administrator and State survey agency (42 CFR § 483.13(c)(2)). New Jersey requires nursing facilities to report all incidents of suspected abuse or neglect immediately to appropriate State officials, including the State survey agency (NJAC 8:39-9:4).

For 14 of the 103 sampled claims, the nursing facility did not provide records or the records it provided did not contain sufficient information for us (working with the State survey agency) to determine whether the claim was associated with an incident of potential abuse or neglect. Specifically, for 1 claim, the nursing facility did not provide records associated with the beneficiary and, for 13 other claims, the records provided by the nursing facility did not contain sufficient information for the State survey agency to determine whether the claim was associated with an incident of potential abuse or neglect. Exhibit 2 describes two incidents for which nursing facility records were not provided or not sufficient to document whether the incident should have been investigated or reported.

Exhibit 2: Examples of Incidents for Which Nursing Facility Records Were Not Provided or Not Sufficient To Determine Whether the Incident Should Have Been Investigated and Reported

- A Medicaid beneficiary with a history of dementia was transferred to a hospital emergency department after a fall, according to hospital records. The associated nursing facility provided no records for the beneficiary despite multiple requests for documentation.
- A Medicaid beneficiary was administered a medication designed to rapidly reverse opioid overdose at the nursing facility and then transferred to a hospital emergency department. However, the nursing facility's records did not contain documentation of the circumstances leading up to the drug being administered.

If nursing facilities do not maintain sufficient documentation for the State survey agency to determine whether the nursing facilities should have investigated and reported the incidents of potential abuse or neglect, the State survey agency cannot meet its obligation to ensure that nursing facilities report allegations of abuse or neglect.

These deficiencies occurred because nursing facility staff did not follow Federal and State reporting guidelines for investigating and reporting potential incidents of abuse or neglect. In addition, the State survey agency's procedures for conducting site visits at nursing facilities, although not required to, do not include a review of incidents that resulted in Medicaid beneficiaries being transferred to an emergency department or other hospital setting.

RECOMMENDATIONS

We recommend that the New Jersey Department of Human Services work with the New Jersey Department of Health to:

- reinforce guidance to nursing facilities for ensuring potential incidents of abuse or neglect are reported in accordance with Federal and State requirements; and
- develop additional procedures for its survey site visits, including reviewing nursing facilities' records related to hospital transfers for certain beneficiary injuries or conditions that could be the result of potential abuse or neglect.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations. The State agency indicated that the State survey agency is responsible for licensing and surveying nursing facilities in New Jersey and that these responsibilities include oversight of the requirements for the reporting of abuse and neglect. The State agency also provided comments from the State survey agency, which indicated concurrence with our findings. In addition, the State survey agency described steps that it has taken, since our audit period, to ensure nursing facilities properly investigate and report potential incidents of abuse or neglect.

The State agency's comments, including the State survey agency's comments, are included in their entirety as Appendix F.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 4,402 hospital claims for Medicaid beneficiaries who resided in nursing facilities in New Jersey and were transferred during CY 2016 to an emergency room or other hospital setting with selected diagnosis codes.^{13, 14} We reviewed a stratified random sample of 103 of these claims.

We limited our review of the State agency's and State survey agency's internal controls to those applicable to specific procedures related to reporting incidents of potential abuse or neglect because our objective did not require an understanding of all internal controls over the submission and processing of claims.

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

We conducted our fieldwork at hospitals and nursing facilities throughout New Jersey from May 2018 through April 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements for reporting and investigating abuse or neglect in nursing facilities;
- met with CMS and State officials responsible for overseeing nursing facilities to gain an understanding of the incident-reporting process;
- obtained from the State survey agency a list of incidents of potential abuse or neglect entered in the ACTS related to Medicaid beneficiaries residing in nursing facilities in New Jersey during the audit period;
- obtained from the State agency's MMIS a sampling frame of hospital claims for Medicaid beneficiaries who resided in nursing facilities in New Jersey and were

¹³ The diagnosis codes were outpatient and inpatient diagnosis codes (admitting, principal, and secondary diagnosis codes) that we determined had a risk of resulting from abuse or neglect.

¹⁴ The selected diagnosis codes did not always indicate potential abuse or neglect. We worked with the State survey agency to review hospital and nursing facility records and to determine whether an incident resulted from potential abuse or neglect.

transferred during CY 2016 from a nursing facility to an emergency room or other hospital setting;

- selected for review a stratified random sample of 103 claims and for each claim:
 - obtained and reviewed medical records for the associated beneficiary from the nursing facility and hospital setting, if available, and
 - worked with the State survey agency to review nursing facility and hospital records and to determine whether the claim resulted from an incident of potential abuse or neglect, and, for each claim resulting from an incident of potential abuse or neglect:
 - determined whether the nursing facility investigated and reported the incident to the State survey agency within required timeframes and
 - determined whether the State survey agency investigated the incident in accordance with Federal guidelines and entered required information in the ACTS;
- estimated the total number of incidents of potential abuse or neglect, potential abuse or neglect not reported by Federal and State requirements, and potential abuse or neglect with insufficient nursing documentation to the sampling frame (Appendix C); and
- discussed the results of our audit with the State agency and the State survey agency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusion based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 4,402 hospital claims for New Jersey Medicaid beneficiaries who resided in a nursing facility and were transferred to an emergency room or other hospital setting with selected diagnoses during CY 2016. The selected diagnosis codes are outpatient and inpatient diagnosis codes (admitting, principal, and secondary diagnosis codes) that we determined have a risk of resulting from abuse or neglect.^{15, 16}

SAMPLE UNIT

The sample unit was a hospital claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample design as described in the table below:

Table 1: Frame Description and Sample Size

Stratum	Description	Frame Size	Sample Size
1	Significant At-Risk Diagnosis Codes	3	3
2	At-Risk Diagnosis Codes	4,399	100
	Total	4,402	103

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

¹⁵ The selected diagnosis codes do not always indicate potential abuse or neglect. To determine whether an incident was potential abuse or neglect, State survey agencies must review the hospital and nursing facility medical records.

¹⁶ We classified 12 diagnosis codes as “Significant At-Risk Diagnosis Codes” and 617 diagnosis codes as “At-Risk Diagnosis Codes.” For example, we classified code T76.11XA (Adult physical abuse suspected, initial encounter) as a “Significant At-Risk Diagnosis Code.” We classified code S00.03XA (Contusion of scalp, initial encounter) as an “At-Risk Diagnosis Code.” We analyzed all the diagnosis codes on each claim—admitting, principal, and secondary diagnosis codes—to identify claims with “Significant At-Risk” or “At-Risk” diagnosis codes. Appendix D contains a summary of the diagnosis codes in our sample indicating potential abuse or neglect.

METHOD OF SELECTING SAMPLE UNITS

We reviewed all items in stratum 1. We consecutively numbered the sample units in the sampling frame from 1 to 4,399 for stratum 2. After generating 100 random numbers for stratum 2, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the number of instances of potential abuse or neglect, potential abuse or neglect not reported by Federal and State requirements, and potential abuse or neglect with insufficient nursing documentation. These estimates are limited to incidents of potential abuse or neglect that could be identified with the selected diagnosis codes using claims data from the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES¹⁷

Sample Details and Results

Stratum	Frame Size	Sample Size	No. of Incidents of Potential Abuse or Neglect	No. of Incidents of Potential Abuse or Neglect Not Reported as Required by Federal or State	No. of Incidents With Insufficient Nursing Documentation To Identify Potential Abuse or Neglect
1	3	3	3	0	0
2	4,399	100	7	5	14
Total	4,402	103	10	5	14

Estimated Number of Incidents of Potential Abuse or Neglect

(Limits Calculated for a 90-Percent Confidence Interval)

	No. of Incidents of Potential Abuse or Neglect
Point Estimate	311
Lower Limit	128
Upper Limit	494

Estimated Number of Incidents of Potential Abuse or Neglect Not Reported as Required by Federal or State Requirements

(Limits Calculated for a 90-Percent Confidence Interval)

	No. of Incidents of Potential Abuse or Neglect Not Reported
Point Estimate	220
Lower Limit	63
Upper Limit	377

¹⁷ The estimates in this section are limited to incidents of potential abuse or neglect that could be identified with the selected diagnosis codes using claims data from the audit period.

Estimated Number of Incidents with Insufficient Nursing Documentation To Identify Potential Abuse or Neglect

(Limits Calculated for a 90-Percent Confidence Interval)

	No. of Incidents With Insufficient Nursing Documentation To Identify Potential Abuse or Neglect
Point Estimate	616
Lower Limit	366
Upper Limit	865

**APPENDIX D: SUMMARY OF DIAGNOSIS CODES INDICATING
LIKELIHOOD OF ABUSE OR NEGLECT**

Significant At-Risk Codes for Stratum 1		
Code	Description	Count
T7421XA	Adult sexual abuse confirmed initial encounter	1
Z0441	Encounter of examination and observation following alleged adult rape	1
Z0471	Encounter for examination and observation alleged adult physical abuse	1
	TOTAL	3

At-Risk Codes for Stratum 2		
Code	Description	Count
B86	Scabies	1
I96	Gangrene, not elsewhere classified	2
J690	Pneumonitis due to inhalation of food and vomit	14
L89150	Pressure ulcer of sacral region, unstageable	4
L89153	Pressure ulcer of sacral region, stage 3	3
L89154	Pressure ulcer of sacral region, stage 4	11
L89224	Pressure ulcer of left hip, stage 4	1
L89303	Pressure ulcer of unspecified buttock, stage 3	1
L89304	Pressure ulcer of unspecified buttock, stage 4	1
L89313	Pressure ulcer of right buttock, stage 3	1
L89314	Pressure ulcer of right buttock, stage 4	2
L89323	Pressure ulcer of left buttock, stage 3	2
L89324	Pressure ulcer of left buttock, stage 4	2
L89613	Pressure ulcer of right heel, stage 3	2
L89623	Pressure ulcer of left heel, stage 3	2
L89893	Pressure ulcer of other site, stage 3	3
R296	Repeated falls	4
R6521	Severe sepsis with septic shock	8
S0003XA	Contusion of scalp, initial encounter	2
S0081XA	Abrasion of other part of head, initial encounter	1
S0083XA	Contusion of other part of head, initial encounter	5
S0093XA	Contusion of unspecified part of head, initial encounter	1
S0101XA	Laceration without foreign body of scalp, initial encounter	4
S01112A	Laceration without foreign body of left eyelid and periorcular area, initial encounter	3
S01311A	Laceration without foreign body of right ear, initial encounter	1
S01511A	Laceration without foreign body of lip, initial encounter	1
S02401A	Maxillary fracture, unspecified, initial encounter for closed fracture	1

At-Risk Codes for Stratum 2, con't.		
Code	Description	Count
S060X0A	Concussion without loss of consciousness, initial encounter	1
S062X0A	Diffuse traumatic brain injury without loss of consciousness, initial encounter	1
S0990XA	Unspecified injury of head, initial encounter	11
S0993XA	Unspecified injury of face, initial encounter	1
S20212A	Contusion of left front wall of thorax, initial encounter	2
S20229A	Contusion of unspecified back wall of thorax, initial encounter	1
S2232XA	Fracture of one rib, left side, initial encounter for closed fracture	1
S40011A	Contusion of right shoulder, initial encounter	3
S40021A	Contusion of right upper arm, initial encounter	2
S40811A	Abrasion of right upper arm, initial encounter	1
S4292XA	Fracture of left shoulder girdle, part unspecified, initial encounter for closed fracture	1
S4991XA	Unspecified injury of right shoulder and upper arm, initial encounter	1
S72012A	Unspecified intracapsular fracture of left femur, initial encounter for closed fracture	1
S72092A	Other fracture of head and neck of left femur, initial encounter for closed fracture	1
S72141A	Displaced intertrochanteric fracture of right femur, initial encounter for closed fracture	2
T148	Other injury of unspecified body region	1
T17890A	Other foreign object in other parts of respiratory tract causing asphyxiation, initial encounter	1
T402X1A	Poisoning by other opioids, accidental (unintentional), initial encounter	1
W19XXXA	Unspecified fall, initial encounter	4
Z9181	History of falling	9
	TOTAL	129¹⁸

¹⁸ The total is more than 100 because some claims in stratum 2 had more than 1 diagnosis code that matched an at-risk code.

APPENDIX E: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-06-17-04003</u>	7/9/2020
<i>Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities</i>	<u>A-07-18-06081</u>	3/27/2020
<i>Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-03-17-00202</u>	1/17/2020
<i>CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect</i>	<u>A-01-17-00513</u>	6/12/2019
<i>Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated</i>	<u>A-01-16-00509</u>	6/12/2019
<i>Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-09-17-02006</u>	6/11/2019
<i>Trends in Deficiencies at Nursing Homes Show That Improvement Are Needed To Ensure the Health and Safety of Residents</i>	<u>A-09-18-02010</u>	4/26/2019
<i>CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs To Be Improved to Help Ensure the Health and Safety of Nursing Home Residents</i>	<u>A-09-18-02000</u>	2/7/2019
<i>Florida Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid</i>	<u>A-04-17-08052</u>	4/27/2018
<i>A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015</i>	<u>OEI-01-16-00330</u>	9/28/2017
<i>Kansas Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid</i>	<u>A-07-17-03218</u>	9/6/2017

APPENDIX F: STATE AGENCY COMMENTS



State of New Jersey Department of Human Services

P.O. BOX 700
TRENTON NJ 08625-0700

PHILIP D. MURPHY
Governor

Carole Johnson
Commissioner

Sheila Y. Oliver
Lt. Governor

June 26, 2020

Brenda M Tierney
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Dear Ms. Tierney:

The New Jersey Department of Human Services is in receipt of the draft audit report issued by the Office of Inspector General entitled "*New Jersey Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported*" for the period of calendar year 2016.

The New Jersey Department of Health (DOH) is the survey agency responsible for licensing and surveying nursing facilities in the State. DOH's responsibilities include oversight of the requirements for the reporting of abuse and neglect. Attached please find DOH's response to the draft report.

Sincerely,

A handwritten signature in blue ink that reads "Carole Johnson".

Carole Johnson
Commissioner

- c. Judith M. Persichilli, Commissioner, DOH
- Jennifer Langer Jacobs, Assistant Commissioner
- Sarah Adelman, Deputy Commissioner
- Allan Brophy, Office of Auditing



State of New Jersey
DEPARTMENT OF HEALTH

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SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICILLI, RN, BSN, MA
Commissioner

June 24, 2020

The Honorable Carole Johnson
Commissioner
New Jersey Department of Human Services
222 South Warren Street
Trenton, NJ 08625-0700

Re: Comments to U.S. Department of Health and Human Services, Office of Inspector General, Draft Report Dated May 14, 2020

Dear Commissioner Johnson:

Thank you for the opportunity to review and respond to the U.S. Department of Health and Human Services, Office of Inspector General ("OIG"), draft report - *New Jersey Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported*, dated May 14, 2020 ("the Report"). Set forth herein are comments to be submitted to the OIG on behalf of the New Jersey Department of Health ("the Department" or "the New Jersey Survey Agency").

The Department is not seeking reconsideration of the findings of the Report, which are based on 2016 data. The findings include:

1. Over one third of the hospital claims (79 of the 103) from a sample of 4,402 total claims performed in calendar year 2016, were not the result of potential abuse or neglect.
2. For 10 of the 24 remaining hospital claims from the final sample selection, the determination was made that these were the result of potential abuse or neglect and should have been reported to the State. Of those 10 claims, 5 were properly investigated and reported to the State by nursing homes and 5 were not.
3. For 14 of the remaining 24 claims from the final sample, the nursing facility did not provide documentation, or their records did not contain sufficient documentation for the State officials to determine whether the incident should have been investigated and reported.

The Department responds to these four findings as follows:

1. The New Jersey Survey Agency is in concurrence with the fact(s) regarding 79 of the 103 claims in the final sample. These 79 claims were not the result of potential abuse or neglect. As an example, several were scheduled hospital admissions for wound care management.
2. The New Jersey Survey Agency is in concurrence with the fact(s) that 10 of the remaining 24 claims were the result of potential abuse or neglect and as such should have been reported to the State. Although 5 of the 10 incidences were properly investigated and reported to the State by the providers, there were 5 incidences in which a provider failed to do so.

Notably, the Department has taken multiple actions to ensure appropriate provider investigation and reporting of suspected incidents of abuse and/or neglect since 2016, as noted below:

- a. During the CY 2016, the Survey Agency initiated a new reporting process for facilities to submit reportable events. In addition to faxing and/or calling in all reportable events, including those of suspected abuse and/or neglect, to the State Agency office, the facilities now submit reportable events electronically. During the roll out of this new process, the State Agency provided in-person and webinar training for all long-term care providers during which the requirement for reporting incidents of suspected abuse and/or neglect and other reportable events was reviewed.
- b. On an ongoing basis during the CY 2017 through CY 2019, the State Agency provided in-person presentations to providers. These presentations detailed the requirements for reporting incidents of suspected abuse and/or neglect. Presenters included specific examples of suspected abuse and neglect incidents and allowed time for a Question and Answer session.
- c. Due to the current Covid-19 pandemic, planned in-person presentations for 2020 have not occurred, however, providers are encouraged to call should they have a question regarding if a specific situation is reportable to the State.
- d. In late December 2019, a revised reportable event grid was sent via mail to long-term care providers that are licensed by the Department and/or certified by the Centers for Medicare/Medicaid Services. The grid included the specific State and/or Federal regulations, by provider type, which require an event/incident to be reported to the State.
- e. During a standard recertification survey in CY2016 using the traditional survey process, the survey team would request and review the facility's new accident/incident reports that occurred since the last recertification survey as well

as review 3 closed medical records. These closed medical records could have included a resident who was transferred to an acute care hospital.

- f. Since November 2017 when the new survey process was implemented, the survey team, if indicated through residents' medical record reviews, follows applicable critical element pathways such as abuse and neglect. In addition, closed medical record reviews use the hospitalization, discharge, and death pathways to complete the closed record reviews. This process is ongoing.
 - g. Since CY 2016 to date, long-term care complaint/incident event only investigations/surveys include a review of residents' medical records specific to the complaint/incident allegation(s)
 - h. As part of the sample selection process for medical record review, the surveyor completes a review of additional residents' medical records with similar issues. Beginning in November 2017 complaint/incident investigators began using the new critical element pathway for abuse and neglect as a guide while investigating an allegation of abuse and/or neglect.
 - i. During a standard recertification survey or a complaint/incident investigation, should the surveyor discover, through document review, an incident, including one of suspected abuse and/or neglect that was not reported to the State as required, the State Survey Agency would issue a citation (deficiency) and the provider would be required to submit a plan of correction
3. The New Jersey Survey Agency is in concurrence with the fact(s) regarding the 14 incidents in which the providers' lack of documentation resulted in the New Jersey state officials' inability to determine if an incident should have been investigated. Providers must be in compliance with the following:
- a. Pursuant to N.J.S.A. 45:11-23, the practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means the identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen within the scope of practice of the registered professional nurse. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human responses mean those signs, symptoms, and processes which denote the individual's health need or reaction to an actual or potential health problem. The practice of nursing as a licensed practical nurse is defined as

performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.

- b. In relevant part, the New Jersey Standards for Licensure of Long-Term Care Facilities, Mandatory Policies and Procedures for Medical Records, require the following:

A medical record shall be initiated for each resident upon admission. The current medical record shall be readily available and shall include at least the following information, when such information becomes available: . . . Clinical notes for the past three months incorporating written, signed and dated notations by each member of the health care team who provided services to the resident, including a description of signs and symptoms, treatments and/or drugs given, the resident's reaction, and any changes in physical or emotional condition entered into the record when the service was provided.

N.J.A.C. 8:39-35.2(d)(6).

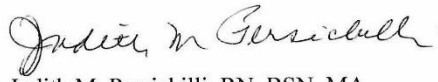
- c. Pursuant to 42 C.F.R. §483.35, Nursing Services, the facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). F726 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17). Pursuant to 42 C.F.R. §483.35(a)(3), the facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
- d. All nursing staff must also meet the specific competency requirements as part of their license and certification requirements defined under State law or regulations.
- e. In CY 2016 through to present, during presentations to provider groups, New Jersey state survey staff have included discussions regarding the importance of documentation particularly as it relates to incidents and investigations.
- f. In CY 2016 through to present, during a recertification survey and/or complaint/incident investigation survey, the New Jersey state surveyors review residents' medical records as part of the investigative protocols in determining a provider's compliance with State and/or Federal regulations. The survey staff will continue to review medical record documentation. Insufficient, inaccurate or lack

of documentation may result in a citation(s) (deficiency) in response to which the provider must submit a plan of correction.

4. For each nonconcurrency, please include specific reasons for the nonconcurrency and a statement of any alternative corrective action taken or planned. None.

Please contact Stefanie Mozgai, B.A., R.N., C.P.M., Assistant Commissioner, Health Facility Survey & Field Operations, New Jersey Department of Health, at 609-943-3013 or Stefanie.Mozgai@doh.nj.gov if you have any questions or need additional information.

Sincerely,



Judith M. Persichilli, RN, BSN, MA
Commissioner