Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NORTH CAROLINA DID NOT ENSURE THAT NURSING FACILITIES ALWAYS REPORTED ALLEGATIONS OF POTENTIAL ABUSE AND NEGLECT OF MEDICAID BENEFICIARIES AND DID NOT ALWAYS PRIORITIZE ALLEGATIONS TIMELY

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Office of Inspector General

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Report in Brief
Date: July 2020
Report No. A-04-17-04063

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

North Carolina Did Not Ensure That Nursing Facilities Always Reported Allegations of Potential Abuse and Neglect of Medicaid Beneficiaries and Did Not Always Prioritize Allegations Timely

Why OIG Did This Audit

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

Our objectives were to determine whether North Carolina: (1) ensured that nursing facilities reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments; (2) complied with Federal and State requirements for assigning a priority level, investigating, and recording allegations of potential abuse and neglect; and (3) operated its complaint and incident report program effectively.

How OIG Did This Audit

We reviewed a sample of 114 hospital claims for emergency department visits in 2016 by Medicaid nursing facility residents for which the medical diagnosis code indicated potential abuse or neglect of the resident. We reviewed whether nursing facilities properly reported and North Carolina properly prioritized, investigated, and recorded allegations of potential abuse and neglect. Additionally, we reviewed North Carolina's policies and procedures related to its complaint and incident report program.

What OIG Found

North Carolina did not ensure that nursing facilities always reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. In addition, it did not always fully comply with Federal requirements for assigning a priority level to reported allegations of potential abuse and neglect or for correctly recording the associated dates. Finally, North Carolina's complaint and incident report program may not have been effective in promoting and protecting the health, safety, and welfare of residents, patients, and other clients receiving health care services.

What OIG Recommends and North Carolina Comments

We recommend that North Carolina continue working with the Centers for Medicare & Medicaid Services (CMS) to provide clear guidance to nursing facilities regarding what constitutes a reportable incident and when to report and revise its policies and procedures to require that it: (1) assign a priority level to incident reports even if the nursing facilities' investigations are not complete, (2) enter into CMS's automated tracking system the date that North Carolina first receives incident reports, and (3) manage employee absences to better prevent them from interfering with assigning priority levels to allegations within appropriate timeframes. We also made procedural recommendations, including recommendations to address our concerns with the effectiveness of North Carolina's complaint and incident report program.

North Carolina concurred or partly concurred with most of our recommendations. However, North Carolina did not agree with our interpretation of Federal requirements that it should have assigned a priority level to incident reports even if the nursing facilities' investigation reports were not complete, and it indicated that it was awaiting new guidance from CMS before implementing that change. North Carolina did not concur with one procedural change because of the additional staffing resources required to implement that change. North Carolina stated that several of our recommendations would require significant additional staffing and funding.

We discussed the Federal requirements with CMS and maintain that our interpretation is correct. We also maintain that our recommendations would help North Carolina identify, monitor, investigate, and ultimately reduce abuse and neglect of nursing home residents.

The full report can be found at https://oig.hhs.gov/oas/reports/region4/41704063.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

This audit report is one of a series of Office of Inspector General (OIG) reports addressing the identification, reporting, and investigation of incidents of potential abuse or neglect of our Nation's most vulnerable populations, including the elderly and individuals with developmental disabilities. When health care professionals and caregivers fail to report abuse, or when those reports are not acted upon in a timely manner, vulnerable populations are at increased risk of abuse or neglect. We are committed to detecting and combating such abuse or neglect.

This audit focuses on the reporting and followup of allegations of potential abuse or neglect of Medicaid beneficiaries living in North Carolina nursing facilities.

OBJECTIVES

Our objectives were to determine whether the North Carolina Department of Health and Human Services (State agency) (1) ensured that nursing facilities reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments; (2) complied with Federal and State requirements for assigning a priority level, investigating, and recording allegations of potential abuse or neglect; and (3) operated its complaint and incident report program effectively.

BACKGROUND

The Medicaid Program

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 North Carolina, the State agency administers the Medicaid program.

Medicaid covers care in nursing facilities for eligible beneficiaries in need of skilled nursing services, rehabilitation services, or long-term care. A nursing facility participating in Medicaid must provide, or arrange for, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable well-being of each resident.

Nursing Facilities

CMS developed the Conditions of Participation (CoPs) that health care organizations, including nursing facilities, must meet to participate in Medicare and Medicaid. These CoPs establish

health and safety standards that are the foundation for improving quality and protecting the health and safety of beneficiaries. The CoPs specific to skilled nursing facilities (SNFs) and nursing facilities can be found at 42 CFR part 483, which covers a variety of health and safety topics related to the operation of nursing homes.

Residents of these facilities have the right to be free from verbal, sexual, physical, and mental abuse; corporal punishment; and involuntary seclusion. SNFs and nursing facilities must also ensure that all alleged violations involving mistreatment,[1] neglect,[2] or abuse[3] (including injuries of unknown sources[4] and misappropriation of resident property)[5] are reported immediately[6] through established procedures to the administrator of the facility and to other officials (including State survey and certification agency officials) in accordance with State law. The facilities must report the results of all investigations within 5 working days of the incident to the administrator or his or her designated representative and to other officials in accordance with State law. If a facility verifies the alleged violation, it must take appropriate corrective action (42 CFR § 483.13).[7]

[1] "Mistreatment" is inappropriate treatment or exploitation of a resident (42 CFR § 483.5).

[2] "Neglect" is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or emotional distress (42 CFR § 488.301).

[3] "Abuse" is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish (42 CFR § 488.301).

[4] Injuries should be classified as an "injury of unknown source" when both of the following conditions are met: (1) the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and (2) the injury is suspicious because of the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time (CMS State Survey Agency Directors' Letter (S&C-05-09), December 16, 2004).

[5] "Misappropriation of resident property" is the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent (42 CFR § 488.301).

[6] "Immediately" is as soon as possible within 24 hours after discovery of the incident (in the absence of a shorter State time requirement) (CMS State Survey Agency Directors' Letter (S&C-05-09), December 16, 2004).

[7] Effective November 28, 2016, 42 CFR § 483.13 was removed and replaced with 42 CFR § 483.12 (81 Fed. Reg. 68688 (Oct. 4, 2016)). Section 483.12 now requires 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.

Facilities that fail to comply with these requirements are subject to remedies including (but not limited to) directed Plans of Correction,[8] civil monetary penalties, and termination from participation in Medicare and Medicaid (42 CFR § 488.408).

CMS and the State Survey Agencies

CMS is responsible for overseeing compliance with health and safety standards by health care providers participating in Medicaid. CMS delegates a variety of tasks related to this oversight to the State survey agencies under section 1864 of the Social Security Act. One of these tasks includes conducting investigations and fact-finding surveys to determine how well health care providers, including nursing facilities, comply with their applicable CoPs, including the requirements for reporting potential abuse or neglect. CMS and the State survey agencies also work together to determine how best to educate providers about their reporting responsibilities.

State Operations Manual

The State Operations Manual (SOM) is part of the CMS Online Manual System that CMS program components, partners, contractors, and survey agencies use to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures that are based on statutes and regulations, guidelines, models, and directives. Chapter 5 of the SOM defines an allegation as "an assertion of improper care or treatment that could result in the citation of a Federal deficiency." Additionally, chapter 5 of the SOM prescribes the procedures for the State survey agencies to follow when they receive complaints and incident reports, including referrals from public entities. Self-reported allegations from a nursing facility are called incident reports. Allegations of noncompliance with the Federal or State requirements from a third party are called complaints.

CMS State Survey Agency Directors' Letters

CMS issues various forms of guidance to assist the State survey agencies with the tasks that they perform for CMS under the agreements in section 1864 of the Social Security Act. This guidance includes CMS State survey agency Directors' Letters, which provide clarifications, updates, and instructions related to the oversight process.

Management of Complaints and Incident Reports

The goal of the Federal complaint and incident report management system is to assist in promoting and protecting the health, safety, and welfare of residents, patients, and clients

[8] A "Plan of Correction" is a plan developed by the facility and approved by CMS or the State survey agency that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected (42 CFR § 488.401).

receiving health care services. Specifically, the three objectives of the complaint and incident report management system are to promote (1) protective oversight; (2) prevention of situations that would threaten the health, safety, and welfare of beneficiaries; and (3) efficiency and quality within the health care delivery system. State survey agencies are responsible for promptly reviewing complaints and incident reports; conducting unannounced onsite investigations of reports alleging noncompliance with the CoPs and other Federal requirements; and informing the CMS Regional Office, the State agency, or both any time they find that a nursing facility is not complying with the CoPs.

CMS's Automated Survey Processing Environment, Complaints and Incidents Tracking System (ACTS) is designed to track, process, and report on complaints and incident reports reported against health care providers and suppliers that are regulated by CMS. It is designed to manage all operations associated with complaint and incident report processing from initial intake and investigation through final disposition.[9] State survey agencies must assign a priority level to each complaint and incident report. The priority level determines the required action and the period for the investigation.[10] State survey agencies must record in ACTS all incident reports that require a Federal onsite survey and all complaint information gathered as part of Federal survey and certification responsibilities, regardless of whether the survey agencies conduct an onsite survey (SOM, chap. 5 §§ 5060 and 5070).

North Carolina's State Survey Agency

Within the State agency, the Division of Health Service Regulation functions as the State survey agency and is tasked to provide regulatory and remedial activities, such as training to nursing facility staff to ensure the health, safety, and well-being of all North Carolinians. Within the State survey agency, the Nursing Home Licensure and Certification Section licenses SNFs and nursing facilities to operate in North Carolina and investigates complaints filed against SNFs and nursing facilities. The Complaint Intake and Health Care Personnel Investigation Section, which is also part of the State survey agency, receives complaints and incident reports and determines whether to investigate. Within this section, staff have designated roles for either Complaint Intake or Personnel Investigations.

Personnel Investigations receives incident reports that nursing facilities must submit regarding alleged violations involving mistreatment, neglect, or abuse (including injuries of unknown sources and misappropriation of resident property). Within 24 hours of the allegation or upon becoming aware of the allegation, the State agency requires nursing facilities to submit to Personnel Investigations a "24-Hour Initial Report." Within 5 working days of the initial report,

[9] The final disposition is the conclusion of the review process and includes such information as the assigned priority level and the results of any investigation.

[10] The priority levels are "Immediate Jeopardy," "Non-Immediate Jeopardy—High" (High Priority), "Non-Immediate Jeopardy—Medium" (Medium Priority), "Non-Immediate Jeopardy—Low" (Low Priority), "Administrative Review/Offsite Investigation," "Referral—Immediate," "Referral—Other," and "No Action Necessary."

the State agency requires nursing facilities to submit a "5-Working Day Report" that states whether the allegation was substantiated.

Personnel Investigations reviews incident reports for allegations against unlicensed health care workers and, if warranted, investigates. Personnel Investigations lists the names of unlicensed health care personnel who are under investigation for an allegation (pending allegation investigation) or who have a substantiated allegation of an act defined in General Statutes of North Carolina 131E-256(a) in the North Carolina Health Care Personnel Registry (Personnel Registry).[11] The priority requirements and deadlines prescribed in chapter 5 of the SOM are not applicable to investigations of individuals named in incident reports.

If an incident report from a nursing facility does not indicate a specific, unlicensed health care worker, Personnel Investigations forwards the incident report to Complaint Intake for further assessment. Personnel Investigations also refers to Complaint Intake any facility compliance concerns that it identifies during its review of an incident report or during any investigation of a named unlicensed health care worker. If the incident report involves a licensed health care worker, Personnel Investigations refers it to the appropriate licensing board and forwards it to Complaint Intake.

Complaint Intake assesses and assigns a priority level to complaints from the general public regarding the care and services given by health care providers licensed by the State survey agency, including nursing facilities.[12] It also assesses and assigns a priority level to incident reports forwarded by Personnel Investigations that involve facility compliance concerns or do not contain the name of a health care worker. Complaint Intake records all complaints and incident reports that it receives in ACTS.

On the next page, Figure 1 shows the State agency's organizational structure for the complaint intake and incident report processes, and Figure 2 summarizes those processes.

[11] An unlicensed health care worker is any unlicensed nursing facility staff member who has direct access to residents, clients, or their property. Personnel Investigations only records the allegation in the Personnel Registry if an unlicensed staff member is named in a report.

[12] Complaint Intake has a hotline number to receive complaints.

Figure 1: Organizational Structure of the State Agency for the Complaint Intake and Incident Report Process

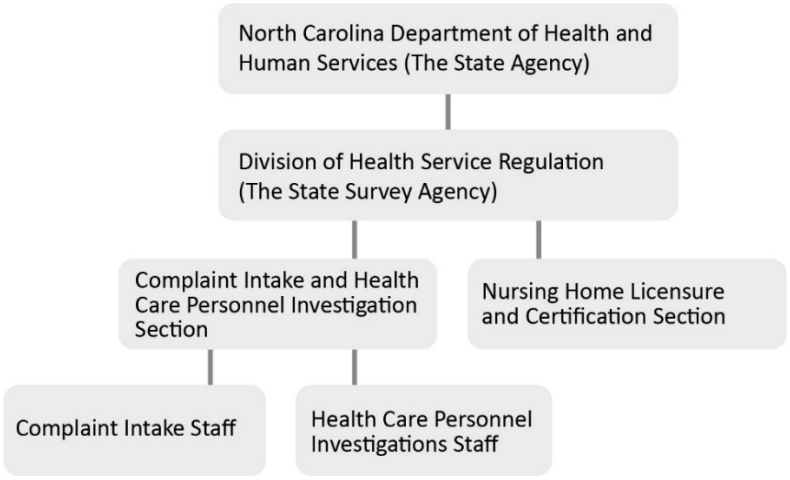
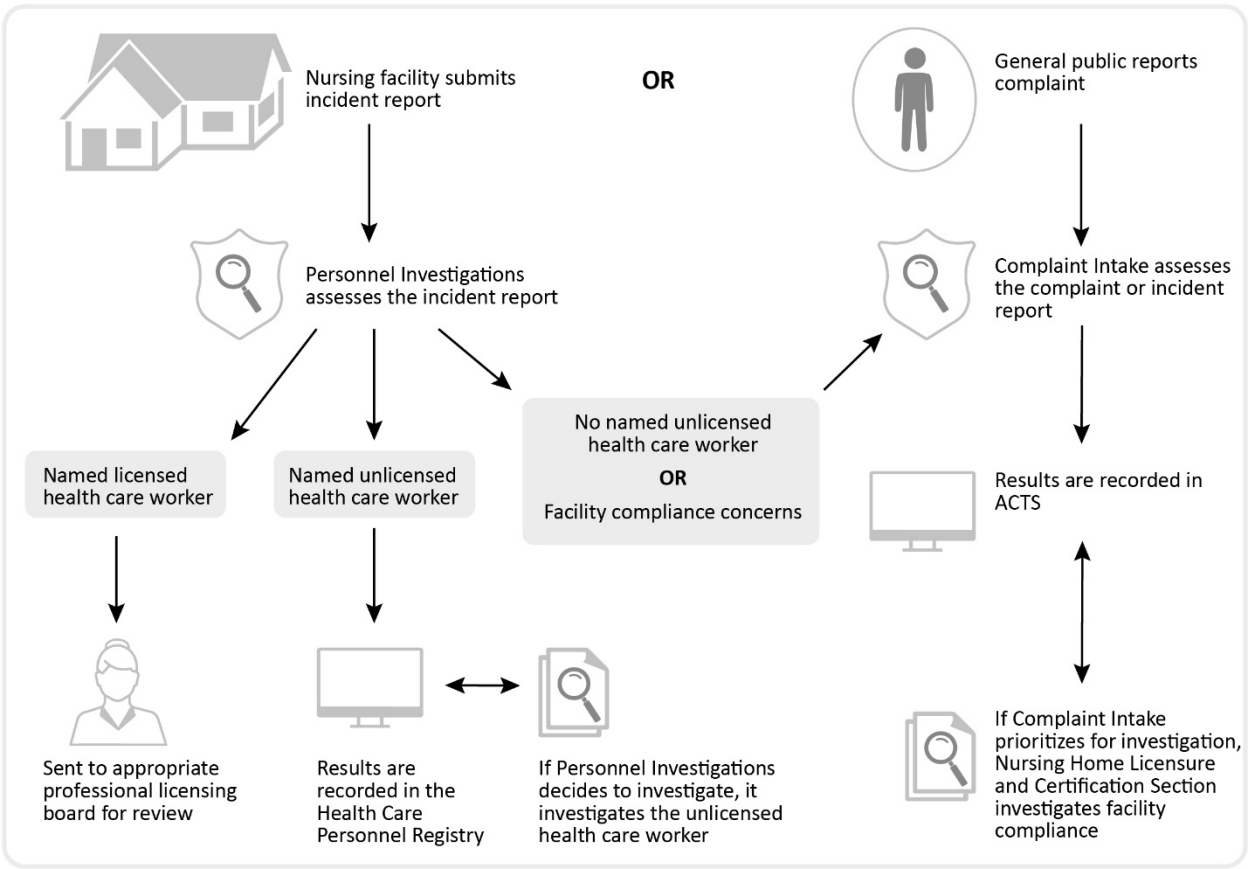


Figure 2: Diagram of the State Agency's Complaint Intake and Incident Report Process



HOW WE CONDUCTED THIS AUDIT

Using data provided by the State agency, we identified inpatient and outpatient hospital claims with dates of service for 2016[13] with an emergency department visit made by North Carolina's Medicaid beneficiaries residing in a nursing facility at that time. We matched the medical diagnoses for these inpatient and outpatient hospital claims against two lists of diagnoses associated with potential abuse or neglect that nursing facilities possibly should have reported under Federal or State law. The first list included diagnosis codes that we determined indicated a significant likelihood of abuse or neglect, and the second list included diagnosis codes that we determined indicated possible abuse or neglect. We identified 14 claims with diagnosis codes that matched the first list and 2,639 that matched the second list. Of these, we reviewed all 14 claims with emergency department visits associated with diagnoses that indicated a significant likelihood of abuse or neglect and a random sample of 100 claims with emergency department visits associated with diagnoses that indicated possible abuse or neglect.

For these 114 claims with emergency department visits, we reviewed nursing facility, hospital, and State agency documentation to determine whether the nursing facilities properly reported potential abuse or neglect and whether the State agency properly prioritized, investigated, and recorded allegations of potential abuse or neglect. We also reviewed the State agency's policies and procedures related to its complaint and incident report program.

We requested that the State agency review the hospital and nursing facility records to determine whether the emergency department visits involved allegations that nursing facilities should have reported to the State agency.[14] Additionally, we interviewed State agency officials and employees regarding investigative operations and analyzed the State agency's systems for processing complaints and incident reports.

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.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, Appendix C contains a list of the diagnosis codes indicating significant likelihood of abuse or neglect in our sample, and Appendix D contains a list of the diagnosis codes indicating possible abuse or neglect in our sample.

[13] When we began this audit, 2016 was the most current year for which complete data were available.

[14] CMS delegates to the State agency the responsibility to ensure that providers are meeting the requirements for reporting potential abuse or neglect.

FINDINGS

The State agency did not ensure that nursing facilities always reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Of the 114 claims with emergency department visits associated with diagnoses indicating potential abuse or neglect in our sample, 104 associated incidents were not reportable. Of the remaining 10 associated incidents, the nursing facilities reported 7 in a timely manner, reported 1 late, and did not report 2 that they should have reported to the State agency. Table 1 on page 9 shows the detailed results. (See Appendices C and D for a summary of the sample items by diagnosis code.)

Nursing facilities did not report the two incidents that should have been reported because of an error by a nursing facility and an incorrect interpretation of what constitutes a reportable event by another nursing facility. A nursing facility did not report one incident within required timeframes because it incorrectly interpreted the requirement that included reporting timeframes.

Although the State agency generally complied with Federal requirements for investigating allegations of potential abuse or neglect, it did not always comply with Federal requirements for assigning a priority level to complaints and incident reports within required timeframes or recording the actual date it received incident reports in ACTS. The State agency received eight incident reports from nursing facilities and seven complaints from the general public for events related to our sample items.[15] However, it did not assign a priority level to 4 of these 15 complaint and incident reports within required timeframes. Also, the State agency did not accurately record in ACTS the dates that it received some incident reports for 2016.

The State agency did not have effective policies and procedures to ensure that it (1) assigned a priority level to all complaints and incident reports within required timeframes and (2) recorded accurate dates within ACTS.

When nursing facilities do not report incidents as required and the State agency does not assess and assign a priority level as required, nursing facility residents may be at a greater risk of abuse or neglect because the State agency may not be able to pursue legal, administrative, or other appropriate remedies or investigate the incident reports in a timely manner to ensure the health, safety, and rights of the nursing facility residents. Additionally, without accurate data, CMS cannot assess the State agency's performance.

[15] Some sample items had multiple complaints or both complaints and an incident report. For five of the seven complaints, the State agency initiated investigations of facilities within the Federal timelines. For the other two complaints, which related to the same sample item, the investigation was delayed due to extenuating circumstances (inclement weather). For the eight incident reports, the State agency determined that none warranted an investigation of the facility.

The State agency's complaint and incident report program may not be effective in promoting and protecting the health, safety, and welfare of residents, patients, and other clients receiving health care services. We identified practices that could limit the effectiveness of the complaint and incident report program. Specifically, the State agency did not record all incident reports in ACTS and used different procedures to process and investigate incident reports with named unlicensed health care workers and reports with no named health care workers.

THE STATE AGENCY DID NOT ENSURE THAT NURSING FACILITIES ALWAYS REPORTED ALLEGATIONS OF POTENTIAL ABUSE OR NEGLECT OF MEDICAID BENEFICIARIES

Nursing facilities must ensure that all alleged violations involving mistreatment, neglect, or abuse (including injuries of unknown sources and misappropriation of resident property) are reported immediately and the results of all their investigations are reported to the State survey agency (42 CFR §§ 483.13(c)(2) and (4)).[16]

The State agency did not ensure that nursing facilities always reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments as required. Of the 114 claims with emergency department visits associated with diagnoses indicating potential abuse or neglect in our sample, 104 associated incidents were not reportable.[17] Of the remaining 10 associated incidents, the nursing facilities reported 8 to the State agency (1 of which was late) but did not report 2 (Table 1).

Table 1: Summary of Sampled Claims With Emergency Department Visits With Diagnoses That Indicated Possible Abuse or Neglect

Description	Sample Items
Incidents nursing facilities reported in a timely manner	7
Incidents nursing facilities reported late	1
Additional incidents nursing facilities should have reported	2
Incidents not reportable based on available evidence	104
Total	**114**

Incidents Nursing Facilities Reported, Reported Late, or Should Have Reported

Nursing facilities reported seven incidents in our sample in a timely manner, one late, and did not report two incidents that they should have reported to the State agency.

[16] See footnote 7 regarding revisions to the regulatory reporting requirements.

[17] The State agency made these assessments based on its judgment of the records available from the nursing facilities and hospitals. The State agency emphasized the limitations of making such an assessment retrospectively using records alone.

For the incident that was reported late, the nursing facility's director of nursing stated that she thought the incident must be reported within 1 business day, as opposed to within 24 hours. The director of nursing learned of the incident on a Friday and faxed the incident report to Personnel Investigations the following Monday. The State agency did not cite this facility for a failure to report in a timely manner until Complaint Intake received complaints from third parties and opened an investigation of the facility.[18]

One of the incidents that was not reported involved a resident whose care plan called for a full mechanical lift with two people to assist the resident any time the resident needed to be moved. On the basis of the records provided to us, it appeared that a health care worker attempted a one-person transfer without a mechanical lift, and the resident fell. The State agency informed us that, on the basis of its review of the records we provided, it considered the transfer of the resident without a mechanical lift and by one person to be neglectful and a reportable incident because the nursing facility did not follow the care plan and failed to provide services in a manner that would avoid physical harm, mental anguish, or emotional distress. However, the nursing facility did not use these criteria when determining whether it should report the incident. Instead, the nursing facility indicated that it only considered whether the fall resulted in injuries or fractures when determining whether the incident was reportable.[19]

For the other incident that should have been reported, the resident had multiple large bruises of unknown origin that caused suspicion of maltreatment. The nursing facility completed the required incident report forms but failed to fax them to the State agency. Ultimately, the State agency investigated the incident based on complaints from third parties; however, it did not cite the facility for a failure to report the incident. A lack of communication between Personnel Investigations and Complaint Intake led to this failure to cite the facility for a deficiency.[20]

When nursing facilities do not report incidents to the State agency within required timeframes or do not report incidents, the State agency may not be able to pursue legal, administrative, or other appropriate remedies or investigate the incident reports in a timely manner to ensure the health, safety, and rights of the nursing facility residents. Additionally, when Personnel

[18] We discuss this incident in greater detail later in the report under the heading "An Example of How Investigating Only an Unlicensed Healthcare Worker Resulted in Delays in Investigating a Facility Where Residents Were in Immediate Jeopardy." The State agency stated that Personnel Investigations did not forward the incident report to Complaint Intake for further assessment or investigation.

[19] Although the hospital determined that the fall did not result in any acute abnormal test results or fractures, hospital records indicated that the resident had complaints of back pain after the fall.

[20] The State agency, which investigated the nursing facility after receiving complaints from a family member and a social services representative, assumed that the nursing facility had faxed the incident report to Personnel Investigations. This assumption was based on communication with nursing facility officials and the observation that the nursing facility had completed incident report forms. The State agency acknowledged that it should have cited the nursing facility for failure to report the incident during the investigation.

Investigations and Complaint Intake do not adequately coordinate their efforts, the State agency may not identify facilities that do not comply with reporting requirements to help ensure future compliance.

Incidents Not Reportable Based on Available Evidence

For the remaining 104 incidents associated with claims in our sample, the State agency determined that, based on its review of the available evidence, the nursing facilities were not required to report the incidents. Even though the State agency determined that nursing facilities were not federally required to report these incidents to the State agency, State agency officials said that they might have identified deficiencies if they had investigated these nursing facilities. They also expressed concerns related to some of the incidents. See the "Other Matters" section of this report for a discussion of these incidents.

THE STATE AGENCY DID NOT ALWAYS COMPLY WITH FEDERAL REQUIREMENTS FOR ASSIGNING PRIORITY LEVELS IN A TIMELY MANNER OR RECORDING INCIDENT REPORTS WITH RELIABLE DATES

In chapter 5 of the SOM, CMS requires that each complaint or incident report be assessed and assigned a priority level by an individual who is professionally qualified to evaluate the nature of the problem based on his or her knowledge of both Federal requirements and current clinical standards of practice. The State agency should assign a priority level to the complaint or incident report within 2 working days of its receipt.[21] However, for complaints or incident reports assigned a priority other than "Immediate Jeopardy," assignment of a priority level may be delayed if there are extenuating circumstances that impede collection of relevant information. State agencies must begin investigation of "Immediate Jeopardy" situations within 2 working[22] days of receipt and begin investigation of "High Priority" situations within 10 working days of assigning a priority level. "Medium Priority" situations must be scheduled for investigation but with no specified timeframe, and "Low Priority" situations must be investigated during the next onsite survey. The remaining priority levels do not require an onsite investigation.

Three Incident Reports in Our Sample Were Not Assigned a Priority Level Within 2 Working Days

For three of the eight incident reports related to our sample items, the State agency did not assign a priority level within 2 working days. There were no extenuating circumstances justifying the delay. The State agency did not assign a priority level to these incident reports

[21] The requirement that the State agency prioritize complaints/incidents within 2 working days of its receipt was removed under Rev. 191, effective July 19, 2019, which falls after our audit period.

[22] CMS has updated the SOM and substituted all references to "working days" in chapter 5 with "business days" under Rev. 191, effective July 19, 2019.

within 2 working days mainly because it waited for the 5-Working-Day Report from the facilities before it fully assessed the incident reports. The State agency said that it waited for the 5-Working-Day Report because it did not have the resources to follow up and obtain additional information on the initial reports that it received. The State agency also said that, because of its limited resources, it did not want to prepare for an investigation only to later decide that an investigation was not warranted when additional information became available from the nursing facilities. However, waiting for a nursing facility to complete its investigation and submit its 5-Working Day Report is not an extenuating circumstance impeding the collection of relevant information and does not relieve the State agency from the requirement to assign a priority level within 2 working days.

In addition to the State agency's waiting for the nursing facilities to complete their reviews, its process of having Personnel Investigations review the incident reports before Complaint Intake's review caused additional delays. Before Complaint Intake could assign a priority level to the incident report, Personnel Investigations received and reviewed the reports first. After Personnel Investigations received the 5-Working Day Report and determined that the incident report did not include a named, unlicensed health care worker, it then forwarded the incident report to Complaint Intake for its review. For example, for one sample item, Personnel Investigations received a nursing facility's 24-Hour Initial Report on a Tuesday and the 5-Working Day Report the next day, but Complaint Intake did not record that it received the incident report in ACTS and begin its review of the incident report until the following Monday.

Actual Receipt Date Not Recorded for Some Incident Reports

For 2016, the State agency recorded 2,613 incident reports in ACTS.[23] We could not determine whether a priority level was assigned to those incident reports within 2 working days because, when Complaint Intake received incident reports from Personnel Investigations, it recorded the date it received the report from Personnel Investigations in ACTS as the "Received Start Date" rather than the date Personnel Investigations received the report from a nursing facility, as required.[24]

For example, for one sample item, Personnel Investigations received the 24-Hour Initial Report on Monday, August 22nd, but Complaint Intake recorded it in ACTS as having been received on Tuesday, August 30th, and assigned a priority level on Friday, September 2nd. As a result, in ACTS it appears that the State agency assigned a priority level to the incident report within 3 working days, but it actually took 9 working days. Complaint Intake's practice of recording

[23] The total number of complaints and incident reports in this report that came from the Personnel Registry and ACTS included allegations associated with patients in both SNFs and nursing facilities and were not restricted to residents with only Medicaid coverage.

[24] ACTS instructions define the "Received Start Date" as the date the State agency first received a complaint or incident report.

incorrect dates made it appear that the State agency was prioritizing and investigating incident reports faster than it actually was.

Complaints Were Not Assigned a Priority Level Within 2 Working Days

For one of the seven complaints related to one of our sample items, the State agency took 3 working days to assign the priority level, rather than the 2 allowed days.

The State agency explained that the individual who received the complaint handled multiple complaint calls after receiving this complaint, took leave the following day, and assigned a priority level to the complaint after returning from leave.

For 2016, Complaint Intake recorded 2,727 complaints in ACTS. For 2,456 of the 2,727 complaints, the State agency assigned a priority level to the complaint within 2 working days, as required. However, for the remaining 271 complaints[25] (10 percent), the State agency did not. Overall, Complaint Intake took an average of 1.7 working days to assign a priority level to a complaint, with a range of 0 to 29 working days. However, for the 271 complaints, Complaint Intake took an average of 4.1 working days to assign a priority level.

Residents at Increased Risk of Abuse or Neglect

When the State agency does not assign a priority level to allegations within required timeframes, nursing facility residents are at an increased risk of abuse or neglect. The priority level that the State agency assigns to a complaint or incident report is critical because it determines the State agency's required action and period for investigating. Additionally, without accurate data, CMS cannot assess the State agency's performance.

THE STATE AGENCY'S COMPLAINT AND INCIDENT REPORT PROGRAM MAY NOT HAVE BEEN EFFECTIVE IN ACCOMPLISHING ITS GOAL

The goal of the Federal complaint and incident report program is to establish a system that will assist in promoting and protecting the health, safety, and welfare of residents, patients, and other clients receiving health care services (SOM, chap. 5, § 5000.1). We identified practices that could have limited the effectiveness of the State's complaint and incident report program. Specifically, the State agency did not record all incident reports in ACTS and used different procedures to process and investigate incident reports with named unlicensed health care workers and incident reports with no named health care workers.

[25] Our audit did not include reviewing these 271 complaints to determine whether extenuating circumstances accounted for any delays. An example of an extenuating circumstance might be a caller leaving a recorded message with insufficient information to assign a priority without further information.

The State Agency Did Not Record All Incident Reports in ACTS

Chapter 5 of the SOM requires that the State agency record in ACTS all complaints regardless of whether they result in an onsite investigation but has no specific documentation requirements for incident reports that do not result in an investigation of the facility. However, CMS designed ACTS to manage all operations associated with complaint and incident report processing, from initial intake and investigation through final disposition (SOM, chap. 5 § 5060).

For all of 2016, Personnel Investigations recorded 2,260 incident reports in the Personnel Registry, most of which were not recorded in ACTS.[26] The State agency said that it did not record all incident reports in ACTS because, as described in the criteria above, it was not a requirement. For the four incident reports in our sample that contained information about a named unlicensed health care worker and did not result in an investigation of the facility, the State agency chose to record only one in both ACTS and the Personnel Registry.[27]

The State agency did not record all the incident reports in ACTS because it was not a Federal requirement. Instead of using ACTS, Personnel Investigations used a triage log and the Personnel Registry to process the incident reports provided by nursing facilities.

Omitting some allegations of potential abuse or neglect from ACTS could have reduced the effectiveness of the complaint and incident report program. Having complete information in ACTS would enable consistent and comprehensive tracking of trends across all allegations, whether the allegations are from incident reports or complaints.

The State Agency Used Different Procedures To Process and Investigate Incident Reports With Named Unlicensed Health Care Workers and Reports With No Named Health Care Workers

Chapter 5 of the SOM identifies the federally mandated priority levels, onsite deadlines for investigations, and possible citations for investigations of facilities. Chapter 5 of the SOM does not prohibit the State agency from distinguishing between facility compliance concerns and concerns regarding individuals employed by the nursing facilities.

[26] The State agency generally recorded incident reports in either ACTS or the Personnel Registry but not both. Complaint Intake would record incidents in ACTS if Personnel Investigations forwarded them to Complaint Intake or if Complaint Intake identified an existing, related incident report during its review of a complaint. We determined whether the State agency recorded the incident reports in both ACTS and the Personnel Registry only for incidents associated with our sample. There was not an efficient method to determine how many of the 2,260 incident reports recorded in the Personnel Registry corresponded with any of the 2,727 incident reports recorded in ACTS for calendar year 2016.

[27] For the one incident report with a named unlicensed health care worker associated with our sample, Complaint Intake recorded the incident report in ACTS after receiving a related complaint. Complaint Intake recorded the incident report in ACTS as "No Action Necessary" as Personnel Investigations had assigned it and the complaint as a "High Priority."

Nursing facilities submitted incident reports to Personnel Investigations as part of the State agency's designated process for managing federally required incident reports. The State agency could not determine whether an incident report was required to be reported without reviewing it for facility compliance concerns and assigning it a priority level. In other words, although it did not have to be documented, each incident report Personnel Investigations received should have had a priority level addressing facility compliance—even if that level was "No Action Necessary."

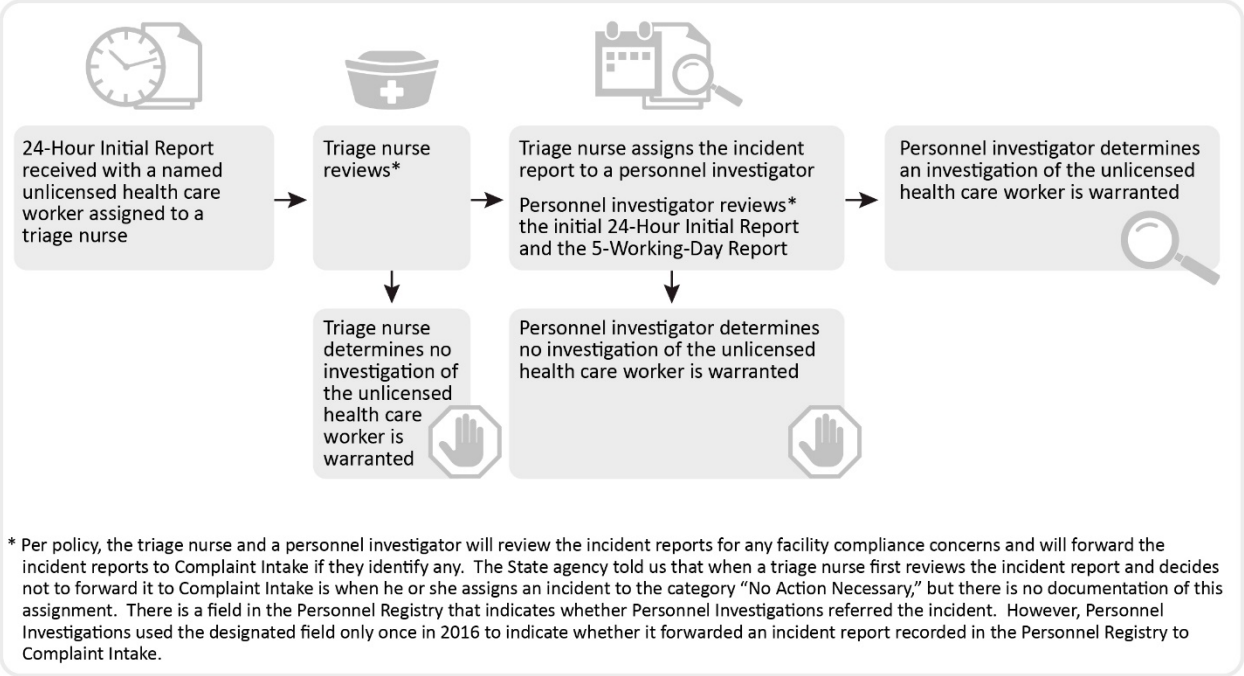
For the four sample items with incident reports with a named unlicensed health care worker, Personnel Investigations documented its decision whether to investigate those unlicensed health care workers. Although there is documentation that the triage nurse reviewed each of the four initial incident reports within 2 working days, the documentation does not show the priority level for any facility compliance concerns or whether Personnel Investigations forwarded the incident report to Complaint Intake.[28] The State agency said that the absence of a corresponding entry in ACTS and the dates that triage nurses noted that they reviewed the initial incident reports within a triage log was sufficient evidence that Personnel Investigations had assigned the facility compliance concerns a priority level of "No Action Necessary."[29]

Figure 3 on the next page shows the review process within Personnel Investigations for incident reports with named unlicensed health care workers.

[28] For example, for one sample item, Personnel Investigations received the 24-Hour Initial Report on a Tuesday and documented that it assigned the incident report to an investigator on Wednesday to investigate the health care worker. Personnel Investigations received the 5-Working-Day Report on Friday and, on the following Friday, documented that it would not investigate the health care worker.

[29] The State agency said that it was following its policies and procedures and that it was not required to document a priority level for any incident report that did not result in an investigation of the facility.

Figure 3: Incident Report Review Workflow Within Personnel Investigations of Reports With Named Unlicensed Health Care Workers



* Per policy, the triage nurse and a personnel investigator will review the incident reports for any facility compliance concerns and will forward the incident reports to Complaint Intake if they identify any. The State agency told us that when a triage nurse first reviews the incident report and decides not to forward it to Complaint Intake is when he or she assigns an incident to the category "No Action Necessary," but there is no documentation of this assignment. There is a field in the Personnel Registry that indicates whether Personnel Investigations referred the incident. However, Personnel Investigations used the designated field only once in 2016 to indicate whether it forwarded an incident report recorded in the Personnel Registry to Complaint Intake.

Unlike Personnel Investigations, Complaint Intake assessed all aspects of an allegation, in accordance with chapter 5 of the SOM, and did not distinguish between concerns with an individual and concerns with a facility within an allegation. Complaint Intake made one decision for each allegation (the priority level), whereas Personnel Investigations made two decisions: whether to forward the incident report to Complaint Intake for facility compliance concerns and whether to investigate the individual.

When Personnel Investigations only investigated the unlicensed health care worker, and Complaint Intake did not investigate the facility, the State agency (1) did not have a deadline to start an onsite investigation and (2) could not cite the facility for any deficiencies unless Personnel Investigations notified Complaint Intake of any facility compliance concerns identified during its investigation of the individual.[30]

Nursing facility residents may be better protected by a process under which all investigations are conducted in accordance with the timeframes and investigative procedures prescribed in the SOM. Importantly, delays of onsite investigations can put residents at an increased risk of abuse or neglect. The following example illustrates the consequences when an investigation of only an unlicensed health care worker is conducted.

[30] Only investigations of a facility can result in deficiency citations and applicable remedies of the facility (42 CFR § 488.408).

An Example of How Investigating Only an Unlicensed Health Care Worker Resulted in Delays in Investigating a Facility Where Residents Were in Immediate Jeopardy

Receipt of Allegations

For one of the eight incident reports associated with our sample, a nursing facility reported that a resident alleged that she had been sexually assaulted by a specific unlicensed health care worker. A few days later, the nursing facility reported that a second resident had accused the same health care worker of a sexual assault.[31] During its review of these incident reports, Personnel Investigations did not identify any facility compliance concerns for Complaint Intake to review. Eleven working days after it received the initial report, Personnel Investigations opened an investigation of the health care worker only, but it did not schedule or set a due date for the onsite investigation. On the 12th and 13th working days, Complaint Intake received complaints from an anonymous source and a Long-Term Care Ombudsman[32] about the alleged sexual assaults and assigned them priority levels of "High Priority" and "Immediate Jeopardy," respectively. The State agency started an onsite investigation within 2 working days of the complaint that it assigned with a priority level of "Immediate Jeopardy."

Results of Investigations

Once on site, the investigators noted that the two residents had been in "Immediate Jeopardy"—which means the residents were in immediate risk of serious injury, harm, impairment, or death—since the time of the alleged sexual assaults in part because of the nursing facility's inadequate responses to the allegations. The residents' "Immediate Jeopardy" status ended during the investigation after the nursing facility provided an acceptable response that specified the date by which all deficiencies would be corrected.

The State agency cited the nursing facility for multiple deficiencies in connection with these events, including a failure to properly report the allegations within required timeframes and a failure to implement its abuse policy in the areas of identification, protection, reporting, and responding. For example, the nursing facility waited over 24 hours to report the incidents to Personnel Investigations and allowed the accused health care worker to remain on the premises unsupervised after the first accusation.

[31] The incident reports indicated that the first resident did not initially want the nursing facility staff to report the incident to law enforcement, but the resident then called law enforcement herself the day after she informed the nursing facility staff of the allegation. The second resident declined to visit an emergency department and therefore was not in our sample or sampling frame.

[32] In North Carolina, Long-Term Care Ombudsmen assist residents of long-term care facilities in exercising their rights and attempt to resolve grievances between residents, families, and facilities. Complaint Intake reached out to the Long-Term Care Ombudsmen after receiving the initial anonymous complaint.

The health care worker was eventually convicted of sexually assaulting the two women associated with these incident reports. At the health care worker's sentencing, the prosecutor said that these two women were not his only victims.[33] Since 2008, this health care worker had five allegations at four different facilities recorded in the Personnel Registry by Personnel Investigations. Three involved "inappropriate touching,"[34] two resulted in an onsite investigation, and all five were unsubstantiated by the State agency.[35] For the two allegations that resulted in an onsite investigation, the State agency did not assign a due date for the onsite investigation. The State agency did not start its respective onsite investigations until 42 and 50 working days after the original incident reports.[36]

Why Personnel Investigations Did Not Forward Incident Reports to Complaint Intake

State agency officials could only speculate as to why Personnel Investigations did not forward the incident reports to Complaint Intake because of facility compliance concerns but noted that Personnel Investigations has new procedures that would require Personnel Investigations to forward incident reports with these types of allegations to Complaint Intake for further assessment regardless of whether it involved a named unlicensed health care worker.

Consequences of Investigating Only an Unlicensed Health Care Worker

For the incident report associated with our sample item, Personnel Investigations had already decided not to forward the incident report to Complaint Intake for a review of the facility. Had it not been for the related complaints, (1) Personnel Investigations may have taken longer to arrive onsite to investigate these allegations, (2) the Nursing Home Licensure and Certification Section may never have gone onsite to identify and ensure that the facility corrected those deficiencies (or at least not as quickly as it did), and (3) those allegations would not have been recorded in ACTS.

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[33] *Caregiver Convicted of Rape in Nursing Home* (2017, August 20 CNN). Available online at https://www.cnn.com/2017/08/20/health/nursing-home-aide-rape-trial-guilty/index.html. Accessed on February 20, 2020.

[34] One nursing facility reported to law enforcement one of the incidents involving inappropriate touching. These incidents occurred outside the scope of our audit period. However, section 1150B of the Social Security Act requires certain individuals in federally funded long-term care facilities to report immediately any reasonable suspicion of a crime committed against a resident of that facility. Those reports must be submitted to at least one law enforcement agency (with jurisdiction where the facility is located) and the survey agency.

[35] The health care worker is now listed in the Personnel Registry as having two substantiated findings of abuse of a resident. When hiring unlicensed health care workers, nursing facilities can only see substantiated allegations and allegations still under investigation within the Personnel Registry.

[36] Again, the State agency indicated that Personnel Investigations assigned a priority level to these incidents as "No Action Necessary" regarding facility compliance but decided to investigate the unlicensed health care worker. Investigations of unlicensed health care workers have no federally mandated deadlines.

RECOMMENDATIONS

We recommend that the North Carolina Department of Health and Human Services:

- continue working with CMS to provide clear guidance to nursing facilities regarding what constitutes a reportable incident and when to report;

- revise its policies and procedures to require that it:

  - assign a priority level to incident reports even if the nursing facilities' investigations are not complete,

  - enter into ACTS the date that the State agency first receives incident reports, and

  - manage employee absences to better prevent them from interfering with assigning priority levels to allegations within appropriate timeframes;

- integrate more fully the Personnel Investigations and Complaint Intake functions to ensure assignments of priority levels to incident reports occur within appropriate timeframes and to provide better oversight of nursing facilities that do not appropriately report required allegations;

- consider using ACTS to manage and record all operations associated with the complaint and incident report process; and

- consider having Complaint Intake be the initial recipient of all incident reports from nursing facilities to assist in conducting more effective and timely investigations of all aspects of an allegation within incident reports.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred or partly concurred with most of our recommendations. However, the State agency did not agree with our interpretation of chapter 5 of the SOM that it should have assigned a priority level to incident reports even if the nursing facilities' investigation reports were not complete, and it indicated that it was awaiting new guidance from CMS before implementing that change. Also, the State agency did not concur with our recommendation to have Complaint Intake be the initial recipient of all incident reports because of the additional staffing resources required to implement that change. In addition, the State agency said that several of our recommendations would require significant additional staffing and funding.

We discussed chapter 5 of the SOM with CMS and maintain that our interpretation is correct. We also maintain that our recommendations will help the State agency identify, monitor, investigate, and ultimately reduce abuse and neglect of nursing home residents.

In addition to comments received from the State agency, CMS provided technical comments, which we addressed as appropriate. The State agency's comments are included in their entirety as Appendix F.

THE STATE AGENCY DID NOT ENSURE THAT NURSING FACILITIES ALWAYS REPORTED ALLEGATIONS OF POTENTIAL ABUSE OR NEGLECT OF MEDICAID BENEFICIARIES

The State agency concurred with our recommendation to continue working with CMS to provide clear guidance to nursing facilities regarding what constitutes a reportable incident and when to report.

THE STATE AGENCY DID NOT ALWAYS COMPLY WITH FEDERAL REQUIREMENTS FOR ASSIGNING PRIORITY LEVELS TIMELY OR RECORDING INCIDENT REPORTS WITH RELIABLE DATES

State Agency Comments

The State agency said that it concurred in part with our recommendation that it revise its policies and procedures to require that it assign a priority level to incident reports even if the nursing facilities' investigations are not complete. However, the State agency said it would await further guidance and clarification from CMS before revising its policies and procedures.[37] The State agency said that, based on its interpretation of CMS's guidance, its process complies with CMS requirements and mirrors the process of some other States. The State agency said that it interprets chapter 5 of the SOM as stating that it should assign a priority level to an incident report *after* the facility submits its investigative report and described why it thinks that incident reports from facilities should be processed differently from complaints from a third party.

The State agency said that there is currently no requirement or guidance that addresses whether to prioritize facility self-reported incident intakes upon initial receipt of the allegation or upon receipt of the facility investigation report and that "comprehensive information" is usually available only after it receives the facility's investigative report. Also, the State agency said that the potential for harm to residents while the State agency awaits the information from the facility's investigative report is substantially and significantly less than the potential for harm when the facility is unaware of the matter. Finally, the State agency said that changing

[37] The State agency cited CMS's comments on a prior OIG report regarding CMS's commitment to issue new guidance specific to the reporting and tracking of facility reported incidents of potential abuse and neglect. (*Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated*, Report No. A-01-16-00509, page 47.)

the process as recommended would significantly increase the caseload for Complaint Intake and would require additional State and Federal funding to support the significant additional staffing needs.

The State agency did not specifically address the recommendation to revise its policies and procedures to ensure that it enters into ACTS the date that the State agency first receives incident reports. However, in its comments, the State agency said that it records information in ACTS in accordance with CMS requirements.

The State agency concurred with our recommendation to revise its policies and procedures to better manage employee absences. Specifically, it said that it would "work to identify a process where the pending work of an unexpectedly absent employee is more quickly triaged in order to best prioritize the management of the absent employee's workload."

The State agency concurred with our recommendation to integrate more fully the Personnel Investigations and Complaint Intake functions to ensure that assignments of priority levels to incident reports occur within appropriate timeframes and to provide better oversight of nursing facilities that do not appropriately report required allegations. It said it would carefully evaluate its processes and procedures to identify opportunities for further collaboration and streamlining of processes and procedures.

Office of Inspector General Response

We appreciate the State agency's intentions to improve its policies and procedures. However, based on our interpretation of chapter 5 of the SOM and discussions with CMS officials, we continue to disagree with the State agency's interpretation that it did not have to assign a priority level to incident reports until after the facility submitted its investigative report, and we maintain that it should have assigned a priority level to all complaints and incident reports within 2 working days unless there were extenuating circumstances. The requirement that facilities report the results of their investigations within 5 working days to the State agency is described in 42 CFR section 483.12.[38] This requirement is distinct from those requirements applicable to the State agency that are described in chapter 5 of the SOM. Chapter 5, section 5070, of the SOM specifically refers to a State agency's responsibilities when it receives both incident reports and complaints. This section makes no exceptions to allow the State agency to wait for the facility to complete its investigations before assigning a priority level. While the current version of chapter 5 of the SOM removed the language that a complaint or incident report must be assigned a priority within 2 working days of its receipt, the State agency would still need to assess incident reports prior to receiving the investigative reports to determine whether immediate jeopardy may be present and to start an onsite investigation within 2 working days if it is present.

[38] This requirement was found in section 483.13 during our audit period but has since been removed and replaced with section 483.12.

THE STATE AGENCY'S COMPLAINT AND INCIDENT REPORT PROGRAM MAY NOT HAVE BEEN EFFECTIVE IN ACCOMPLISHING ITS GOAL

State Agency Comments

The State agency concurred with our recommendation to consider using ACTS to manage and record all operations associated with the complaint and incident report process. However, the State agency explained that; because of specific State requirements regarding investigations of all unlicensed health care professionals for allegations of abuse, neglect, or exploitation; it intentionally has a different process for the investigation of incident reports with named unlicensed health care workers versus incident reports with unnamed unlicensed health care workers. Further, the State agency said that its current use of ACTS complies with CMS requirements and that any change would require additional staffing resources, which would likely not be possible given that existing funding is not adequate to support its current workload.

The State agency did not concur with our recommendation to consider having Complaint Intake be the initial recipient of all incident reports. The State agency said that CMS does not require that the State agency treat incident reports as complaints and that implementing this recommendation would require significant additional staff.

Office of Inspector General Response

We appreciate the State agency's consideration to use ACTS to manage and record all operations associated with the complaint and incident report process. CMS designed ACTS to manage all operations associated with complaint and incident report processing, from initial intake and investigation through final disposition (SOM, chapter 5 § 5060). While not currently required, we maintain that a more consistent treatment of complaints, incident reports with named unlicensed health care workers, and incident reports with unnamed unlicensed health care workers would help identify, monitor, investigate, and ultimately limit abuse and neglect of nursing home residents.

OTHER MATTERS

For 104 incidents associated with claims in our sample, the State agency determined that, based on its review of the available evidence, the nursing facilities were not required to report the incidents.

Table 2 on the next page shows the type and number of incidents.

Table 2: Incidents That Led to Emergency Department Visits

Number	Incident
81	Falls of various causes*
20	Infectious or respiratory issues
2	Resident-to-resident interactions†
1	Need for a psychiatric evaluation because of erratic behavior
104	**Total**

* The State agency did not consider the falls that nursing facilities recorded as unwitnessed to be reportable as injuries of unknown origin because it did not consider any of the injuries to be suspicious based on the extent or location of the injury and the assumption that the resident fell.

† Two sample items involved a resident with a severe cognitive impairment sucking on another resident. The nursing facility sent both residents to the emergency department. This incident was not reported to the State agency, and the State agency determined that this incident was not reportable in accordance with Federal guidelines because the perpetrating resident did not have the capacity for willful intent. The State agency noted that the perpetrator had a history of wandering and staff were to monitor his location, but the perpetrating resident did not have a history of sexually inappropriate behavior noted in his records. The State agency noted that there may be possible noncompliance regarding supervision to prevent accidents, but the nursing facilities are not required to report this type of potential deficiency by the State agency's interpretation of Federal guidelines.

Even though the State agency determined that nursing facilities were not federally required to report these incidents to the State agency, State agency officials said that they might have identified deficiencies if they had investigated these nursing facilities. State agency officials expressed concerns related to some of the incidents. For example, for 43 sample items, the State agency expressed concerns regarding supervision of the residents to prevent falls or accidents[39] or concerns with a resident's medication.[40]

Currently, the State agency does not analyze hospital claims with emergency department visits for residents of nursing facilities (as we did in this audit) as part of its oversight and monitoring. Such an analysis could enable the State agency to identify, monitor, and investigate future incidents of unreported potential abuse or neglect and to target corrective action accordingly.[41]

[39] In at least nine incidents, the resident fell while being assisted by a health care worker. For example, a resident dependent on assistance for showering fell while a health care worker was assisting the resident with a shower.

[40] For example, a nurse gave a resident sleeping medication in the middle of the night, and the resident fell getting out of bed shortly thereafter. In another example, the State agency noted that the resident was taking an antipsychotic medication with no diagnosis or behaviors noted in the file to warrant the use of antipsychotics.

[41] CMS noted that, to have this capacity, an automated system may need to be developed, which could be costly for State agencies.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Using data provided by the State agency, we identified inpatient and outpatient hospital claims with dates of service for 2016 with an emergency department visit made by North Carolina's Medicaid beneficiaries residing in a nursing facility at that time.

We matched the medical diagnoses for these inpatient and outpatient hospital claims against two lists of diagnoses associated with potential abuse or neglect that nursing facilities possibly should have reported under Federal or State law. The first list comprises diagnosis codes that we determined indicated a significant likelihood of abuse or neglect, and the second list comprises diagnosis codes that we determined indicated possible abuse or neglect. We identified 14 claims with diagnosis codes that matched the first list and 2,639 that matched the second list. Of these, we reviewed all 14 claims with emergency department visits associated with diagnoses that indicated a significant likelihood of abuse or neglect and a random sample of 100 claims with emergency department visits associated with diagnoses that indicated possible abuse or neglect.

For these 114 claims with emergency department visits, we reviewed nursing facility, hospital, and State agency documentation to determine whether the nursing facilities properly reported potential abuse or neglect and whether the State agency properly prioritized, investigated, and recorded allegations of potential abuse or neglect.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal laws, State statutes, and regulations for nursing facilities;
- held discussions with CMS officials to gain an understanding of the State agency's responsibilities for prioritizing, investigating, and recording allegations of potential abuse or neglect;
- reviewed State policies and procedures for prioritizing, investigating, and recording complaints and incident reports;
- discussed with State officials how the State agency prioritizes, investigates, and records complaints and incident reports;
- identified Medicaid hospital claims with emergency department visits made by North Carolina's Medicaid beneficiaries residing in a nursing facility at that time;

- reviewed the diagnosis codes on these Medicaid hospital claims to identify diagnosis codes that indicated a significant likelihood of abuse or neglect or a potential of abuse or neglect;

- selected any claim with a diagnosis code that indicated a significant likelihood of abuse or neglect;

- selected a random sample of 100 hospital claims from the remaining claims with a diagnosis code that indicated possible abuse or neglect;

- obtained and reviewed hospital and nursing facility medical records for 114 claims with emergency department visits made by Medicaid beneficiaries while residing in a nursing facility;[42]

- requested the State agency review the hospital and nursing facility records to determine whether the medical records indicated a reportable allegation;

- reviewed State agency determinations of whether the medical records indicated a reportable allegation and discussed the results with State officials;

- reviewed State agency supporting documentation for the complaints and incident reports received by the State agency and recorded in the Personnel Registry and ACTS, including any investigative reports;

- analyzed additional complaints and incident reports recorded in the Personnel Registry and ACTS for calendar year 2016; and

- discussed the results of our review with State officials.

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.

[42] See Appendix B for details.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of North Carolina Medicaid nursing facility resident visits to an emergency department with selected diagnosis codes and emergency department dates of service from January 1 through December 31, 2016.

SAMPLING FRAME

The State agency provided claims extracted from its Medicaid Management Information System. These data consisted of three parts:

1. room and board and other service line items for all Medicaid beneficiaries residing in nursing facilities for our audit period;

2. claim data for the beneficiaries listed in the nursing facility data for any inpatient or outpatient claim that contained either a place of service code for an emergency department at a hospital (place of service code 23) or an emergency department revenue code (revenue codes between 0450 and 0459—excluding 0456 for Urgent Care) for our audit period;[43] and

3. the remaining diagnoses associated with each inpatient or outpatient claim.

We matched the inpatient and outpatient claim lines against the room and board dates of services within the nursing facility data and identified instances for which it appeared the beneficiaries visited an emergency department during their nursing facility stay or the nursing facility transferred the beneficiaries to the emergency department.

We consolidated these inpatient and outpatient claim lines as distinct, unduplicated inpatient or outpatient claims. We then analyzed these inpatient and outpatient claims further and identified claims with diagnosis codes indicating significant likelihood of abuse or neglect and diagnosis codes indicating possible abuse or neglect. We identified 7 diagnosis codes within these claims with a diagnosis code indicating significant likelihood of abuse or neglect and 291 diagnosis codes within the remaining claims with a diagnosis code indicating possible abuse or neglect. For example, we classified code T76.11XA (Adult physical abuse suspected, initial encounter) as a diagnosis code indicating significant likelihood of abuse or neglect. We classified code S00.03XA (Contusion of scalp, initial encounter) as a diagnosis code indicating possible abuse or neglect. We analyzed all the diagnosis codes—e.g., admitting, principal, secondary, tertiary—to identify claims with a diagnosis code indicating significant likelihood of

[43] These claim data contained the outpatient principal diagnosis codes and the inpatient admitting and principal diagnosis codes.

abuse or neglect. We analyzed the admitting and principal diagnosis codes to identify claims with diagnosis codes indicating possible abuse or neglect.

The sampling frame was a Microsoft Access database containing 2,653 inpatient and outpatient claims that we had matched with the associated nursing facility claims.

SAMPLE UNIT

The sample unit was either an inpatient or outpatient Medicaid claim with a visit to the emergency department by a Medicaid beneficiary residing in a nursing facility.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified sample. We divided the sampling frame into two strata based on our diagnosis code risk analysis (Table 3).

Table 3: Claims by Stratum

Stratum	Diagnosis Codes	Claims in Sampling Frame	Claims in Sample
1	Diagnosis codes indicating significant likelihood of abuse or neglect	14	14
2	Diagnosis codes indicating possible abuse or neglect	2,639	100
	Total	**2,653**	**114**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services, statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We reviewed all items in stratum one. We consecutively numbered the claims within stratum two. After generating the random numbers, we selected the corresponding claims in that stratum.

ESTIMATION METHODOLOGY

We identified two incidents that the State agency determined should have been reported. However, we did not estimate a total number of unreported incidents in our sample frame.

APPENDIX C: SUMMARY OF THE DIAGNOSIS CODES INDICATING SIGNIFICANT LIKELIHOOD OF ABUSE OR NEGLECT

Code	Code Description	Reported Incidents	Reportable Incidents Not Reported	Not Reportable Based on Available Evidence	Total
S3993XA	Unspecified injury of pelvis, initial encounter*	1	0	4	**5**
T7421XA	Adult sexual abuse, confirmed, initial encounter	0	0	2	**2**
T7621XA	Adult sexual abuse, suspected, initial encounter	2	0	0	**2**
Z0441	Encounter for examination and observation following alleged adult rape	2	0	0	**2**
T7611XA	Adult physical abuse, suspected, initial encounter	1	0	0	**1**
T7691XA	Unspecified adult maltreatment, suspected, initial encounter	0	1	0	**1**
Z0471	Encounter for examination and observation following alleged adult physical abuse	1	0	0	**1**
	Total	**7**	**1**	**6**	**14**

* Based on our analysis of the State agency's survey documents and the Medicaid claim data, we identified a hospital claim for a resident treated at an emergency department for a potential rape, but this was the only diagnosis code coded by the hospital that related to a potential rape. As a result, we included all hospital claims in our frame with this diagnosis code in our "Diagnosis Codes Indicating Significant Likelihood of Abuse or Neglect" stratum. During our review, the hospital acknowledged that it had not coded the claim correctly and should have included a more specific diagnosis code related to the alleged rape. None of the other claims with a diagnosis code for an unspecified pelvic injury involved a potential rape or assault.

APPENDIX D: SUMMARY OF THE DIAGNOSIS CODES INDICATING POSSIBLE ABUSE OR NEGLECT

Code	Code Description	Sample
S0990XA	Unspecified injury of head, initial encounter*	24
J690	Pneumonitis due to inhalation of food and vomit	11
S0181XA	Laceration without foreign body of other part of head, initial encounter	9
Z043	Encounter for examination and observation following other accident	5
S0083XA	Contusion of other part of head, initial encounter	4
S72142A	Displaced intertrochanteric fracture of left femur, initial encounter for closed fracture	4
I96	Gangrene not elsewhere classified	2
S0003XA	Contusion of scalp, initial encounter	2
S0093XA	Contusion of unspecified part of head, initial encounter	2
S0101XA	Laceration without foreign body of scalp, initial encounter	2
S065X0A	Traumatic subdural hemorrhage without loss of consciousness, initial encounter	2
S20219A	Contusion of unspecified front wall of thorax, initial encounter	2
S72012A	Unspecified intracapsular fracture of left femur, initial encounter for closed fracture	2
L89154	Pressure ulcer of sacral region, stage 4	1
N493	Fournier gangrene	1
S0012XA	Contusion of left eyelid and periocular area, initial encounter	1
S0081XA	Abrasion of other part of head, initial encounter	1
S01112A	Laceration without foreign body of left eyelid and periocular area, initial encounter	1
S069X0A	Unspecified intracranial injury without loss of consciousness, initial encounter	1
S098XXA	Other specified injuries of head, initial encounter	1
S12090A	Other displaced fracture of first cervical vertebra, initial encounter for closed fracture	1
S20212A	Contusion of left front wall of thorax, initial encounter	1
S2242XA	Multiple fractures of ribs, left side, initial encounter for closed fracture	1

Code	Code Description	Sample
S300XXA	Contusion of lower back and pelvis, initial encounter	1
S32029A	Unspecified fracture of second lumbar vertebra, initial encounter for closed fracture	1
S32591A	Other specified fracture of right pubis, initial encounter for closed fracture	1
S3992XA	Unspecified injury of lower back, initial encounter†	1
S40011A	Contusion of right shoulder, initial encounter	1
S42001A	Fracture of unspecified part of right clavicle, initial encounter for closed fracture	1
S42022A	Displaced fracture of shaft of left clavicle, initial encounter for closed fracture	1
S43004A	Unspecified dislocation of right shoulder joint, initial encounter	1
S70312A	Abrasion, left thigh, initial encounter	1
S72001A	Fracture of unspecified part of neck of right femur, initial encounter for closed fracture	1
S72002A	Fracture of unspecified part of neck of left femur, initial encounter for closed fracture	1
S72141A	Displaced intertrochanteric fracture of right femur, initial encounter for closed fracture	1
S72402A	Unspecified fracture of lower end of left femur, initial encounter for closed fracture	1
S72492A	Other fracture of lower end of left femur, initial encounter for closed fracture	1
T17990A	Other foreign object in respiratory tract, part unspecified in causing asphyxiation, initial encounter	1
T18128A	Food in esophagus causing other injury, initial encounter	1
T420X1A	Poisoning by hydantoin derivatives, accidental (unintentional), initial encounter	1
T80211A	Bloodstream infection due to central venous catheter, initial encounter	1
Z9181	History of falling	1
	Totals‡	**100**

* One of these sample items involved an incident reported to the State agency.

† This item involved an incident that should have been reported to the State agency.

‡ This table only includes the diagnosis codes associated with our sample items. The claims in the sample frame contained other diagnosis codes not included in this table.

APPENDIX E: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-04003	7/9/2020
Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities	A-07-18-06081	3/27/2020
Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-03-17-00202	1/17/2020
CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect	A-01-17-00513	6/12/2019
Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated	A-01-16-00509	6/12/2019
Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-17-02006	6/11/2019
A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015	OEI-01-16-00330	9/28/2017
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	8/24/2017
Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-01-16-00001	8/9/2017
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	7/13/2016
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	5/25/2016
Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries	A-02-14-01011	9/28/2015

Report Title	Report Number	Date Issued
Nursing Facilities' Compliance With Federal Regulations for Reporting Allegations of Abuse or Neglect	OEI-07-13-00010	8/15/2014
Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries	OEI-06-11-00370	2/27/2014
Criminal Convictions for Nurse Aides With Substantiated Findings of Abuse, Neglect, and Misappropriation	OEI-07-10-00422	10/5/2012
Unidentified and Unreported Federal Deficiencies in California's Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs	A-09-09-00114	9/21/2011
Nursing Facilities' Employment of Individuals With Criminal Convictions	OEI-07-09-00110	3/1/2011

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director

May 22, 2020

Lori S. Pitcher
Regional Inspector General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3t41
Atlanta, GA 30303

Re: Report Number: A-04-17-04063

Dear Ms. Pilcher:

The North Carolina Department of Health and Human Services (NC DHHS), Division of Health Service Regulation (DHSR) appreciates the opportunity to review and comment on this Office of Inspector General (OIG) draft report entitled *North Carolina Did Not Ensure That Nursing Facilities Always Reported Allegations of Potential Abuse and Neglect of Medicaid Beneficiaries and Did Not Always Prioritize Allegations Timely* covering the audit period for January 1, 2016 through December 31, 2016. We also appreciate the professionalism your review staff displayed during this audit.

The safety of residents in North Carolina's nursing homes is a top priority for NC DHHS. As the State Survey Agency (SSA), NC DHHS, DHSR, must follow the requirements and guidance provided by the Centers for Medicare and Medicaid Services (CMS) in connection with the SSA's monitoring, complaint intake processes, receipt and review of facility self-reported incidents, and surveys of federally certified nursing homes in North Carolina. DHSR works closely with CMS to understand CMS' requirements and expectations for nursing facilities and for our SSA.

We have reviewed your draft report and the following represents our response and corrective action plan to the Findings and Recommendations.

OIG FINDINGS

THE STATE AGENCY DID NOT ENSURE THAT NURSING FACILITIES ALWAYS REPORTED ALLEGATIONS OF POTENTIAL ABUSE OR NEGLECT OF MEDICAID BENEFICIARIES

Nursing facilities must ensure that all alleged violations involving mistreatment, neglect, or abuse (including injuries of unknown sources and misappropriation of resident property) are

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reported immediately and the results of all their investigations to the State survey agency (42 CFR §§ 483.13(c)(2) and (4)).

The State agency did not ensure that nursing facilities always reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments as required. Of the 114 claims with emergency department visits associated with diagnoses indicating potential abuse or neglect in our sample, 104 associated incidents were not reportable. Of the remaining 10 associated incidents, the nursing facilities reported 8 to the State agency (1 of which was late) but did not report 2.

State Agency Comment: As reflected in the draft report, of the 114 claims reviewed by OIG, there were only two reportable incidents which were not reported by the nursing facility as required. Nursing facilities are required to comply with all CMS reporting requirements and when the SSA learns of a nursing facility's failure to comply, appropriate action is taken. However, the SSA cannot know of every situation where a nursing facility fails to comply with a reporting requirement. The SSA, when performing its surveys, is only able to survey a sample of a facility's data. The data/incidents surveyed by the SSA is determined by following a CMS prescribed method for identifying the data sample. Unless that data sample includes this incident or unless there is a complaint made to the SSA regarding an incident, the SSA has no way of knowing when a facility has failed to comply. While the SSA's expectation is that every nursing facility will comply with 100% of the regulatory and legal requirements 100% of the time, the rate of noncompliance identified in this audit, indicates that the nursing facilities in North Carolina were in substantial compliance with this requirement.

THE STATE AGENCY DID NOT ALWAYS COMPLY WITH FEDERAL REQUIREMENTS FOR ASSIGNING PRIORITY LEVELS IN A TIMELY MANNER OR RECORDING INCIDENT REPORTS WITH RELIABLE DATES

In chapter 5 of the SOM, CMS requires that each complaint or incident report be assessed and assigned a priority level by an individual who is professionally qualified to evaluate the nature of the problem based on his or her knowledge both of Federal requirements and of current clinical standards of practice. The State agency should assign a priority level to the complaint or incident report within 2 working days of its receipt. However, for complaints or incident reports assigned a priority other than "Immediate Jeopardy," assignment of a priority level may be delayed if there are extenuating circumstances that impede collection of relevant information. State agencies must begin investigation of "Immediate Jeopardy" situations within 2 working days of receipt and begin investigation of "High Priority" situations within 10 working days of assigning a priority level. "Medium Priority" situations must be scheduled for investigation but with no specified timeframe, and "Low Priority" situations must be investigated during the next onsite survey. The remaining priority levels do not require an onsite investigation. The following issues were identified:

- *Three Incident Reports in Our Sample Were Not Assigned a Priority Level Within 2 Working Days*
- *Actual Receipt Date Not Recorded for Some Incident Reports*

- *Complaints Were Not Assigned a Priority Level Within 2 Working Days*
- *Residents at Increased Risk of Abuse or Neglect.*

State Agency Comment: CMS differentiates between complaints received by the SSA (complaints are allegations reported to the SSA by someone other than a nursing facility), and a facility self-reported incident. CMS has different requirements and timelines for complaints versus facility self-reported incidents. North Carolina and the OIG, as we discussed during the pendency of this audit and during the exit interview, interpret the CMS requirements regarding facility self-reported incident tracking differently. Following is an explanation of North Carolina's interpretation and processes. We appreciate the OIG's interpretation and agree there are multiple interpretations of the CMS requirements and guidance in this area.

With respect to **facility self-reported incidents**, in the CMS State Operations Manual (SOM), (a CMS manual that provides guidance to SSAs regarding CMS's requirements), the SOM provides that violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, shall be reported immediately to the SSA by the nursing facility. (State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities § 483.12(c)). The CMS requirements as further explained in the SOM then require the self-reporting facility to investigate the incident. CMS allows the facility five (5) working days from the date of the incident to conduct and report the results of that investigation to the SSA. There are not current express requirements or guidance from CMS to nursing facilities as to what specific information should be reported initially or in the report of the results of the facility investigation.

As for **complaints**, the SOM explains that CMS' requirements regarding the SSA's complaint intake process is, "**Comprehensive information** should be collected during the intake process to allow for proper prioritization". (SOM, Chapter 5 Complaint Procedures, 5010.1, emphasis added). There is currently no requirement or guidance that addresses whether to prioritize facility self-reported incident intakes upon initial receipt of the allegation or upon receipt of the facility investigation report. However, "comprehensive information" is not available at the time of the initial facility self-report of the incident. It is only available after receipt of the results of the facility investigation – for which the facility is allowed five (5) days (from the date of the incident) to complete and report.

North Carolina determines the appropriate priority level at the point "comprehensive information" is received from the facility, which is usually only upon receipt of the results of the facility's investigation. In responding to this audit, North Carolina has contacted a number of other states to discuss their respective complaint intake processes and how those states process facility self-reported incidents. Based on the information provided to us by the states North Carolina contacted, the practice of most of the states contacted is to determine the correct prioritization of the facility reported incidents **after** the investigation report is received from the facility. Accordingly, other states interpret the CMS requirements and guidance regarding the processing of facility self-reported incidents the same as North Carolina.

It is important to understand the differences with respect to the potential for harm to a resident between facility self-reported incidents and complaints. When the SSA receives a complaint, it frequently is receiving an allegation regarding a matter of which a facility may be totally unaware – the complaint does NOT originate from the facility but rather from a third party. Accordingly, the SSA must quickly process and correctly triage the urgency of the complaint since there is no protection for the resident at that moment in time regarding the alleged incident since the facility is unaware of the allegation of noncompliance. In contrast, when a facility self-reports an incident, the facility is acknowledging to the SSA that it is aware of the alleged incident and is actively investigating the incident. The facility knows that once the SSA receives the investigative report there will likely be follow up action from the SSA. The facility knows that the SSA will be investigating the action the facility took to protect its resident upon first learning of the self-reported incident. Facilities understand that a failure to comply with regulations – even for a self-reported incident - will result in a deficiency being cited and depending on the severity of the deficiency, the potential for enforcement by CMS which could include the imposition of a civil monetary penalty. So, in contrast to a complaint, for a facility self-reported incident, the expectation is that the facility is aware of the incident and is actively managing the situation and taking the necessary protective action for the resident. (For instance, the facility may have been reporting an allegation of abuse to a resident from a facility employee. Facilities are required to act to protect residents as they conduct the investigation and then, based on the results of the investigation, to take appropriate action.) Therefore, the potential for harm to residents while the SSA awaits the information in the five day investigative report is substantially and significantly less in comparison to the potential for harm when the facility is unaware of the matter, is not actively investigating and acting to protect the resident as is the case for facility self-reported incidents.

The OIG interpretation of the CMS guidance and requirements would require a significant overhaul of North Carolina's current processes as well as require significant additional staff resources to collect information from facilities in advance of receiving the results of the facility investigation.

According to the OIG draft report, 90% of all complaint intakes for NC's SSA in 2016, and 86% of complaint intakes related to the OIG sampled items were recorded in ACTS within 2 working days, as required. Although there were outliers, , the OIG found that in North Carolina, complaint intakes were entered in ACTS in an average of 1.7 working days in 2016 which is compliant with the CMS required timeframes.

THE STATE AGENCY'S COMPLAINT AND INCIDENT REPORT PROGRAM MAY NOT HAVE BEEN EFFECTIVE IN ACCOMPLISHING ITS GOAL

The goal of the Federal complaint and incident report program is to establish a system that will assist in promoting and protecting the health, safety, and welfare of residents, patients, and other clients receiving health care services (SOM, chap. 5, § 5000.1). We identified practices that could have limited the effectiveness of the State's complaint and incident report program. Specifically, the State agency did not record all incident reports in ACTS and used different

procedures to process and investigate incident reports with named unlicensed healthcare workers and incident reports with no named healthcare workers.

State Agency Comment: North Carolina records information in the ACTS system in accordance with CMS requirements.

"ACTS" refers to the Automated Survey Processing Environment Complaints/Incidents Tracking System, a federal database that was designed by CMS. SSAs use ACTS as prescribed/permitted by CMS. The SOM explains that: "The SAs (State Agencies) and ROs (Regional Offices) are required to enter into ACTS (ASPEN Complaint Tracking System):

- All complaint information gathered as part of Federal survey and certification responsibilities, regardless if an onsite survey is conducted: and
- All self-reported incidents that require a Federal onsite survey". (Chapter 5 Complaint Procedures, 5060)

Furthermore, in a recent audit conducted by OIG to determine "the extent to which CMS requires incidents of potential abuse or neglect to be recorded and tracked", the OIG found that SSAs "are not required to record all incidents of potential abuse or neglect in ACTS. For example, Survey Agencies do not have to enter into ACTS incidents of potential abuse or neglect that SNFs self-report to the Survey Agencies that do not require a Federal onsite survey." (*Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated,* Report No. A-01-16-00509, page 15)

North Carolina intentionally has a different process for the investigation of incident reports with named (identified) unlicensed healthcare workers versus incident reports with unnamed (not identified) unlicensed healthcare workers. In addition to the federal requirements to investigate nursing facilities and nurse aides working in nursing facilities, North Carolina is one of a few states with state legal requirements requiring an investigation of allegations of abuse, neglect, exploitation of all unlicensed health care professionals. In accordance with North Carolina's state law and regulations, when the DHSR receives a facility self-report regarding a named unlicensed healthcare worker, the Health Care Personnel Investigation Unit investigates the allegation regarding the unlicensed but named (identified) health care worker. If an allegation of abuse, neglect, or exploitation is substantiated, action is taken against the worker and they are listed on the North Carolina Health Care Registry. If in connection with the investigation of the healthcare worker the investigator identifies potential facility noncompliance, the investigator reports the allegation of facility noncompliance to the Complaint Intake Unit.

In the situation when there is an allegation regarding an unnamed (unidentified) unlicensed health care worker (for example, someone is alleging an unlicensed healthcare worker abused them, but cannot identify the healthcare worker), since there is no specific healthcare worker to investigate, if the incident may involve facility noncompliance, the matter is reviewed and triaged by the Complaint Intake Unit. Since the identity of the healthcare worker is unknown, there is no matter that can be investigated by the Health Care Personnel Section.

Since the DHSR Complaint Intake Unit is combined with the DHSR Health Care Personnel Investigations Unit into one single organizational section within the SSA, reports received from nursing facilities are reviewed by the most appropriate professional staff within this Section, whether it be Complaint Intake staff or Health Care Personnel Investigation staff, and appropriate priority decisions are made. The staff in Complaint Intake and in Health Care Personnel Investigations occupy the same office space and already collaborate in reviewing reports and making determinations whether incidents require onsite investigation of facility practices or Nurse Aides in addition to its state requirement to investigate unlicensed health care personnel.

North Carolina has complied with CMS' requirements regarding the complaints and incidents it records in ACTS. Since 2002 NC has utilized ACTS to manage and record all operations associated with the complaint process and has entered all reported incidents determined to require a Federal onsite survey.

OIG RECOMMENDATIONS

OIG recommends that NC DHHS:

1. Continue working with CMS to provide clear guidance to nursing facilities regarding what constitutes a reportable incident and when to report.

Response: North Carolina concurs with this recommendation and will continue to work with CMS to develop and provide clear guidance for nursing facilities regarding the reporting requirements.

2. Revise its policies and procedures to require that it:

a. assign a priority level to incident reports even if the nursing facilities' investigations are not complete,
b. enter into ACTS the date that the State agency first receives incident reports, and
c. manage employee absences to better prevent them from interfering with assigning priority levels to allegations within appropriate timeframes.

Response: North Carolina appreciates this recommendation and concurs in part. The process in place to assign priority levels to facility self-reported incidents is consistent with CMS' current guidance and, in fact, mirrors the process of a number of other states as well. However, North Carolina understands that CMS has committed to issue new guidance specific to the reporting and tracking of facility reported incidents of potential abuse and neglect. (*Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated,* Report No. A-01-16-00509, page 47.) Upon receipt of further guidance and clarification, North Carolina will reevaluate its policies and procedures and revise them as necessary to assure compliance. To change the process as recommended, would significantly increase the caseload for the Complaint Intake Unit and would necessitate significant additional staffing resources. Additional staffing would require additional state and federal funding.

Although an employee's absence on one day did not substantially impact the prioritization and investigation of facility self-reported incidents, North Carolina agrees this is an area for improvement and concurs with OIG's recommendation to better manage employee absences. While many employee absences are not predictable, such as unexpected illness, North Carolina will work to identify a process where the pending work of an unexpectedly absent employee is more quickly triaged in order to best prioritize the management of the absent employee's workload.

3. Integrate more fully the Personnel Investigations and Complaint Intake functions to ensure assignments of priority levels to incident reports occur within appropriate timeframes and to provide better oversight of nursing facilities that do not appropriately report required allegations.

Response: North Carolina concurs with this recommendation and will review its processes and evaluate whether there are opportunities for even fuller integration than currently exists. These units are already organizationally aligned within one "section" and work collaboratively. North Carolina believes that the OIG's perception that North Carolina should "integrate more fully" these two units results from OIG's interpretation of the CMS requirements for tracking and reporting facility self-reported incidents, which differs from North Carolina's interpretation. Nonetheless, North Carolina appreciates this recommendation and will carefully evaluate its processes and procedures to identify opportunities for further collaboration between these units and further streamlining processes and procedures.

4. Consider using ACTS to manage and record all operations associated with the complaint and incident report process.

Response: North Carolina concurs with this recommendation and will consider using ACTS as recommended. However, North Carolina's current utilization of ACTS complies with CMS' requirements and guidance regarding what matters are required to be listed in the federal ACTS database. Furthermore, any such consideration will require careful evaluation as to how such a change would impact workloads and whether such a change could be realized without the need for additional staffing. Any change that would require additional staffing resources would likely not be possible given that existing funding is not adequate to support the current workload.

5. Consider having Complaint Intake be the initial recipient of all incident reports from nursing facilities to assist in conducting more effective and timely investigations of all aspects of an allegation within incident reports.

Response: North Carolina appreciates this recommendation but cannot concur because it would require significant additional staffing resources. Additionally, as noted in the discussion above, CMS does not require that the SSA treat facility self-reports as complaints. Overhauling North Carolina's current facility self-reported incident processes would require significant additional staffing resources to collect information from a facility prior to receiving the facility investigative report and would likely result in "complaints" being triaged at a higher level based

on the lack of comprehensive information regarding the matter. This would also necessitate the need for additional survey staff.

As CMS clarifies its guidance to facilities regarding what must be reported immediately with the initial self-report and provides further guidance to state agencies regarding when these incidents should be prioritized, North Carolina will certainly evaluate its policies and procedures and make any necessary revisions.

Thank you again for the opportunity to review and comment on this draft report. If you need any additional information, please feel free to contact me.

Sincerely,

Cindy Deporter
State Agency Director

cc: Mark Payne, Director, Division of Health Services Regulations
Emery Milliken, Deputy Director, Division of Health Services Regulations
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John E. Thompson, Director of Compliance and Program Integrity, Division of Health Benefits
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