United States Government Accountability Office

Testimony

Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 10:15 a.m. EDT
Tuesday, July 23, 2019

NURSING HOMES

Improved Oversight Needed to Better Protect Residents from Abuse

Statement of John E. Dicken

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Accessible Version

Chairman Grassley, Ranking Member Wyden, and Members of the Committee:

I am pleased to be here today to discuss our recent report on the abuse of nursing home residents and the Centers for Medicare & Medicaid Services' (CMS) oversight.[1] Nationwide, about 1.4 million elderly or disabled individuals receive care in more than 15,500 nursing homes. These nursing home residents often have physical or cognitive limitations that can leave them particularly vulnerable to abuse. Abuse of nursing home residents can occur in many forms—including physical, mental, verbal, and sexual—and can be committed by staff, residents, or others in the nursing home. Any incident of abuse is a serious occurrence and can result in potentially devastating consequences for residents, including lasting mental anguish, serious injury, or death. News stories in recent years have noted disturbing examples of nursing home residents who have been sexually assaulted and physically abused. However, little is known about the full scope of nursing home abuse, as incidents of abuse may be underreported.

Federal law mandates that nursing homes receiving Medicare or Medicaid payments ensure that residents are free from abuse. To help ensure this, CMS, an agency within the Department of Health and Human Services (HHS), defines the quality standards that nursing homes must meet in order to participate in the Medicare and Medicaid programs.[2] To monitor compliance with these standards, CMS enters into agreements with agencies in each state government—known as state survey agencies—and oversees the work the state survey agencies do. This work includes conducting required, comprehensive, on-site standard surveys of every nursing home approximately once each year and investigating both complaints from the public and incidents self-reported by the nursing home (referred to as facility-reported incidents) regarding

[1]GAO, *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse*. GAO-19-433, (Washington, D.C.: June 13, 2019).

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

resident care or safety.[3] If a surveyor determines that a nursing home violated a federal standard during a survey or investigation, then the home receives a deficiency citation, also known as a deficiency. In addition to state survey agencies, there are other state and local agencies that may be involved in investigating abuse in nursing homes, including Adult Protective Services, local law enforcement, and Medicaid Fraud Control Units (MFCU) in each state, which are tasked with investigating and prosecuting a variety of health care-related crimes.

We have previously reported on problems in nursing home quality, including challenges protecting residents from abuse and weaknesses in CMS's oversight. For example, in multiple reports dating back to 1998, we have identified weaknesses in federal and state activities designed to correct quality problems in nursing homes. Specifically, in a 2002 report, we found that CMS needed to do more to protect nursing home residents from abuse, and we made five recommendations to help CMS facilitate the reporting, investigation, and prevention of abuse in nursing homes.[4] More recently, in April 2019 we reported that CMS had failed to address gaps in federal oversight of nursing home abuse investigations in Oregon—an issue that we uncovered during the course of our broader work on nursing home resident abuse.[5] Further, reports by the HHS Office of the Inspector General (OIG) have also reviewed incidents of resident abuse and raised concerns about CMS's procedures.[6]

[3]By law, every nursing home receiving Medicare or Medicaid payment must undergo a standard survey at least once every fifteen months, with a statewide average interval for surveys not to exceed 12 months. 42 U.S.C. §§ 1395i-3(g)(1)(A), (g)(2)(A)(iii), 1396r(g)(1)(A), (g)(2)(A)(iii).

State survey agencies are also required to investigate complaints and facility-reported incidents filed with state survey agencies. 42 U.S.C. §§ 1395i-3(g)(1)(C), 1396r(g)(1)(C).

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

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

[6]For example, see Joanne M. Chiedi, Office of Inspector General, HHS, *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated*, A-01-16-00509, (Washington, D.C., June 7, 2019).

My testimony today highlights key findings and recommendations from our June 2019 report, which examined:

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

To conduct the work for our report, we reviewed federal laws and CMS guidance, analyzed CMS data, and interviewed stakeholders from selected states. First, we reviewed federal laws and CMS guidance to determine the federal standards and associated deficiency codes related to resident abuse. Second, we analyzed data provided by CMS to identify the number and severity of abuse deficiencies cited by surveyors in all 50 states and Washington, D.C., between 2013 and 2017.[7] Because abuse and perpetrator type are not readily identifiable in CMS's data, we identified this information by reviewing a randomly selected representative sample of 400 CMS abuse deficiency narratives written by state surveyors from 2016 through 2017 that describe the substantiated abuse. Finally, we interviewed CMS officials and officials from a non-generalizable sample of survey agencies from five states—Delaware, Georgia, Ohio, Oregon, and Virginia. We also interviewed other stakeholders in these states, including officials from each state's long-term care ombudsmen, law enforcement, MFCUs, and, when appropriate, Adult Protective Services. We also visited nursing homes and spoke to administrators and clinical staff in each of these states. We assessed CMS's oversight activities in the context of the federal standards for internal control.[8] Further details on our scope and methodology are included in our report. The work on which this statement is based was performed in accordance with generally accepted government auditing standards.

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

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

Improved CMS Oversight Is Needed to Better Protect Residents from Abuse

In our report, we found that, while abuse deficiencies cited in nursing homes were relatively rare from 2013 through 2017, they became more frequent during that time, with the largest increase in severe cases. Specifically, abuse deficiencies comprised less than 1 percent of the total deficiencies in each of the years we examined, which is likely conservative. Abuse in nursing homes is often underreported by residents, family, staff, and the state survey agency, according to CMS officials and stakeholders we interviewed. However, abuse deficiencies more than doubled—from 430 in 2013 to 875 in 2017—over the 5-year period.[9] (See appendix I.) In addition, abuse deficiencies cited in 2017 were more likely to be categorized at the highest levels of severity—deficiencies causing actual harm to residents or putting residents in immediate jeopardy—than they were in 2013. In light of the increased number and severity of abuse deficiencies, it is imperative that CMS have strong nursing home oversight in place to protect residents from abuse; however, we found oversight gaps that may limit the agency's ability to do so. Specifically, we found that CMS: (1) cannot readily access data on the type of abuse or type of perpetrator, (2) has not provided guidance on what information nursing homes should include in facility-reported incidents, and (3) has numerous gaps in its referral process that can result in delayed and missed referrals to law enforcement.

Information on Abuse and Perpetrator Types Is Not Readily Available

We found that CMS's data do not allow for the type of abuse or perpetrator to be readily identified by the agency. Specifically, CMS does not require the state survey agencies to record abuse and perpetrator type and, when this information is recorded, it cannot be easily analyzed by CMS. Therefore, we reviewed a representative sample of 400 CMS narrative descriptions—written by state surveyors—associated with abuse deficiencies cited in 2016 and 2017 to identify the most common types of

[9]The trend for abuse deficiencies is in contrast to the trend across all types of deficiencies, which decreased about 1 percent between 2013 and 2017. Specifically, all deficiency types increased at a much slower rate than abuse deficiencies each year through 2016 and then decreased slightly through the period examined in 2017.

abuse and perpetrators. From this review, we found that physical abuse (46 percent) and mental/verbal abuse (44 percent) occurred most often in nursing homes, followed by sexual abuse (18 percent).[10] Furthermore, staff, which includes those working in any part of the nursing home, were more often the perpetrators (58 percent) of abuse in deficiency narratives, followed by resident perpetrators (30 percent) and other types of perpetrators (2 percent).[11] (See appendix II for examples from our abuse deficiency narrative review.)

CMS officials told us they have not conducted a systematic review to gather information on abuse and perpetrator type. Further, based on professional experience, literature, and ad hoc analyses of deficiency narrative descriptions, CMS officials told us they believe the majority of abuse is committed by nursing home residents and that physical and sexual abuse were the most common types.[12] This understanding does not align with our findings on the most common types of abuse and perpetrators. Without the systematic collection and monitoring of specific abuse and perpetrator data, CMS lacks key information and, therefore, cannot take actions—such as tailoring prevention and investigation activities—to address the most prevalent types of abuse or perpetrators.[13] To address this, we recommended that CMS require state survey agencies to report abuse and perpetrator type in CMS's databases for deficiency, complaint, and facility-reported incident data and that CMS systematically assess trends in these data. HHS concurred with our recommendation.

[10]Percentages may not add to 100 either because some narratives had multiple types of abuse, were missing or incomplete, or were not consistent with CMS's definition of abuse. Upper and lower confidence levels were: physical abuse (41 to 51 percent), mental/verbal abuse (40 to 49 percent), and sexual abuse (14 to 22 percent).

[11]Upper and lower confidence levels were: staff-on-resident abuse (54 to 63 percent), resident-on-resident abuse (26 to 35 percent), and abuse by others (1 to 3 percent). Other types of perpetrators can include family members of residents or other visitors.

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

[13]The lack of a systematic review is also inconsistent with federal internal control standards directing management to use quality information to achieve program objectives. GAO-14-704G.

Facility-Reported Incidents Lack Key Information

Despite federal law requiring nursing homes to self-report allegations of abuse and covered individuals to report reasonable suspicions of crimes against residents, CMS has not provided guidance to nursing homes on what information they should include in facility-reported incidents, contributing to a lack of information for state survey agencies and delays in their investigations.[14] Specifically, officials from each of the five state survey agencies told us that the documentation they receive from nursing homes for facility-reported incidents can lack key information that affects their ability to triage incidents and determine whether an investigation should occur and, if so, how soon. For example, officials from two state survey agencies we interviewed said they sometimes have to conduct significant follow-up with the nursing homes to obtain the information they need to prioritize the incident for investigation—follow-up that delays and potentially negatively affects investigations.[15] Incomplete incident reports from nursing homes are particularly problematic given that nearly half of abuse deficiencies cited between 2013 and 2017 were identified through facility-reported incidents, which is dramatically different than the approximately 5 percent of all types of deficiencies that were identified in this manner. Therefore, facility-reported incidents play a unique and significant role in identifying abuse deficiencies in nursing homes, making it critical that incident reports provided by nursing homes include the information necessary for state survey agencies to prioritize and investigate. To address this issue, we recommended that CMS develop and disseminate guidance—including a standardized form—to all state survey agencies on the information nursing homes and covered individuals should include on facility-reported incidents. HHS concurred with our recommendation.

[14]42 C.F.R. § 483.12(c)(1); 42 U.S.C. § 1320b-25(b). These covered individuals include nursing home owners, operators, and employees, among others.

[15]The lack of guidance from CMS on the information that state survey agencies should collect on facility-reported incidents is inconsistent with federal internal control standards directing management to use quality information to achieve program objectives. GAO-14-704G.

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

We found gaps in CMS's process for referring incidents of abuse to law enforcement and, if appropriate, to MFCUs. These gaps may limit CMS's ability to ensure that nursing homes meet federal requirements for residents to be free from abuse. Specifically, we identified issues related to (1) referring abuse to law enforcement in a timely manner, (2) tracking abuse referrals, (3) defining what it means to substantiate an allegation of abuse—that is, the determination by the state survey agency that evidence supports the abuse allegation, and (4) sharing information with law enforcement. We made recommendations to CMS to address each of these four gaps in the referral process, and HHS concurred with each recommendation.

For instance, because CMS requires a state survey agency to make referrals to law enforcement only after abuse is substantiated—a process that can often take weeks or months—law enforcement investigations can be significantly delayed. Officials from one law enforcement agency and two MFCUs we interviewed told us the delay in receiving referrals limits their ability to collect evidence and prosecute cases—for example, bedding associated with potential sexual abuse may have been washed, and a victim's wounds may have healed.[16] As such, we recommended that CMS require state survey agencies to immediately refer to law enforcement any reasonable suspicion of a crime against a resident. HHS concurred with our recommendation.

In conclusion, while nursing home abuse is relatively rare, our review shows that abuse deficiencies cited in nursing homes are becoming more frequent, with the largest increase in severe cases. It is imperative that CMS have more complete and readily available information on abuse to improve its oversight of nursing homes. It is also essential that CMS require state survey agencies to immediately report incidents to law enforcement if they have a reasonable suspicion that a crime against a resident has occurred in order to ensure a prompt investigation of these incidents. As illustrated by this hearing, continued focus from Congress,

[16]Such delays are inconsistent with standards for internal control, which state that management should communicate quality information externally so that external parties can help the entity achieve its objectives. GAO-14-704G.

CMS, GAO, OIG, state survey agencies, and others are important steps towards ensuring that nursing home residents are protected from abuse.

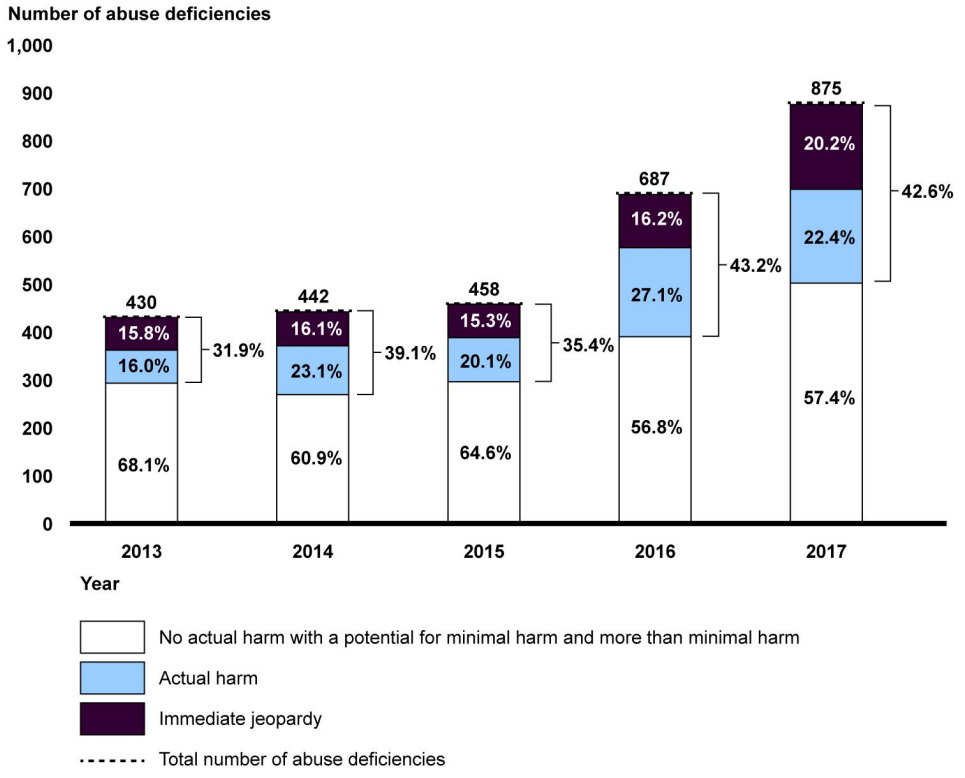
Chairman Grassley, Ranking Member Wyden, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. In addition to the contact named above, key contributors to this statement were Karin Wallestad (Assistant Director), Sarah-Lynn McGrath (Analyst-in-Charge), Luke Baron, Julianne Flowers, Laurie Pachter, Kathryn Richter, and Jennifer Whitworth.

Appendix I: Severity of Cited Abuse Deficiencies, 2013 through 2017

Figure 1: Severity of Cited Abuse Deficiencies, 2013 through 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-671T

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

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

Percentages may not add to 100 due to rounding.

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

Table 1: Examples from a Representative Sample of Nursing Home Abuse Deficiency Narratives, 2016-2017

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

Source: GAO summary of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-19-671T

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

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