

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**GEORGIA GENERALLY ENSURED THAT  
NURSING FACILITIES REPORTED  
ALLEGATIONS OF POTENTIAL ABUSE  
OR NEGLECT OF MEDICAID  
BENEFICIARIES AND PRIORITIZED  
ALLEGATIONS TIMELY**

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A-04-17-03084

# ***Office of Inspector General***

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## Report in Brief

Date: April 2021

Report No. A-04-17-03084

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



### Why OIG Did This Audit

This audit report is one of a series of OIG reports 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 Georgia: (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 program effectively.

### How OIG Did This Audit

We reviewed a sample of 117 claims for emergency department visits in calendar year 2016 (audit period) 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 whether Georgia properly prioritized, investigated, and recorded allegations of potential abuse or neglect. Additionally, we reviewed Georgia's policies and procedures related to its complaint and incident program.

## Georgia Generally Ensured That Nursing Facilities Reported Allegations of Potential Abuse or Neglect of Medicaid Beneficiaries and Prioritized Allegations Timely

### What OIG Found

Georgia generally ensured that nursing facilities reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Of 117 sampled claims with emergency department visits, 101 associated incidents were not reportable. Of the remaining 16 incidents, the nursing facilities reported 9 timely, reported 3 late, reported 2 that we could not determine had been reported timely, and did not report 2 that they should have reported. In addition, Georgia generally complied with Federal and State requirements for assigning a priority level, investigating, and recording allegations of potential abuse or neglect. Finally, Georgia generally operated its complaint and incident report program effectively.

### What OIG Recommends and Georgia's Comments

We recommend that the Georgia Department of Community Health: (1) remind nursing facilities of Federal and State requirements for reporting incidents of potential abuse or neglect, (2) strengthen its procedures for monitoring nursing facilities and follow up with those that may not be following required policies and procedures, (3) ensure that it documents actions it takes when nursing facilities fail to report incidents and fail to report incidents on time, and (4) ensure that it assigns a priority level to all incidents or complaints by the mandatory deadline.

In written comments on our draft report, Georgia concurred with our recommendations and described actions that it has taken to address them. Such actions included: (1) educating nursing facilities about State and Federal reporting requirements, (2) strengthening its procedures for monitoring nursing facilities, (3) strengthening its process for documenting actions when nursing facilities do not report incidents as required, and (4) strengthening its procedures for intake and triage of incidents and complaints.

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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.<sup>1</sup> When healthcare 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 combatting such abuse or neglect.

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

### OBJECTIVES

Our objectives were to determine whether the Georgia Department of Community Health (the 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 Georgia, 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.

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<sup>1</sup> Appendix B contains a list of related OIG reports.

## Nursing Facilities

CMS developed the Conditions of Participation (CoPs) that healthcare 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,<sup>2</sup> neglect,<sup>3</sup> or abuse<sup>4</sup> (including injuries of unknown source<sup>5</sup> and misappropriation of resident property<sup>6</sup>) are reported immediately<sup>7</sup> 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).<sup>8</sup>

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<sup>2</sup> “Mistreatment” is inappropriate treatment or exploitation of a resident (42 CFR § 483.5).

<sup>3</sup> “Neglect” is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or emotional distress (42 CFR § 488.301).

<sup>4</sup> “Abuse” is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish (42 CFR § 488.301).

<sup>5</sup> An injury should be classified as “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).

<sup>6</sup> “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).

<sup>7</sup> “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).

<sup>8</sup> 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 (no later than 2 hours after the allegation was made) if the events that caused the allegation involved abuse or resulted in serious bodily injury or be reported no later than 24 hours after the allegation was made if the events that caused the allegation did not involve abuse and did 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,<sup>9</sup> 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 healthcare 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 healthcare providers, including nursing facilities, comply with their applicable CoPs, including the requirements for reporting potential abuse or neglect.

## **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 incident reports and complaints, 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 receiving healthcare services. Specifically, the three objectives of the complaint and incident report management system are to promote: (1) protective oversight; (2) prevention of

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<sup>9</sup> 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).

situations that would threaten the health, safety, and welfare of beneficiaries; and (3) efficiency and quality within the healthcare 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 designed its Automated Survey Processing Environment, Complaints and Incidents Tracking System (ACTS) to track, process, and report on complaints and incidents involving healthcare providers and suppliers that CMS regulated. CMS also designed ACTS to manage all operations associated with complaint and incident report processing from initial intake and investigation through final disposition.<sup>10</sup> When entering a complaint or incident report into ACTS, State Survey agencies must assign a priority level. The priority level determines the required action and the period for the investigation.<sup>11</sup> 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).

### **Georgia's State Survey Agency**

The State agency's Healthcare Facility Regulation Division (the State Survey agency) inspects, licenses, and regulates healthcare facilities in Georgia according to statutory and regulatory standards. The State Survey agency licenses SNFs and nursing facilities to operate in Georgia and investigates complaints filed against SNFs and nursing facilities. The Complaint Intake Team, which is also part of the State Survey agency, receives complaints and incident reports and determines whether to investigate.

The State Survey agency receives incident reports that nursing facilities must submit regarding alleged violations involving mistreatment, neglect, or abuse (including injuries of unknown source and misappropriation of resident property). Within 24 hours of the allegation or upon becoming aware of the allegation, the State Survey agency requires nursing facilities to submit a "Facility Incident Report Form." Compliance specialists review the incident report forms for severity and to verify that the nursing facility has taken appropriate action. If additional information is needed to make that determination, the compliance specialist will contact the nursing facility administrator to obtain the additional details needed. If the nursing facility took sufficient action, the compliance specialist will wait for the 5-day followup report from the facility. If the nursing facility did not take appropriate action or the compliance specialist

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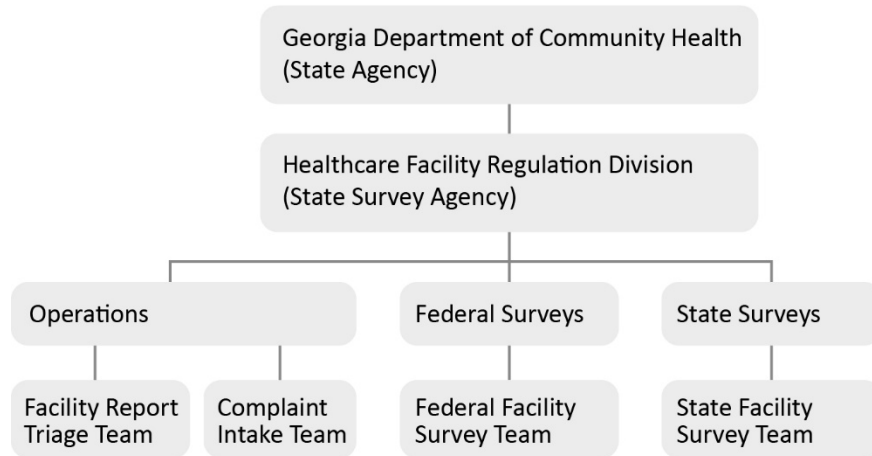
<sup>10</sup> The final disposition is the conclusion of the review process and includes such information as the assigned priority level and the results of any investigation.

<sup>11</sup> 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."

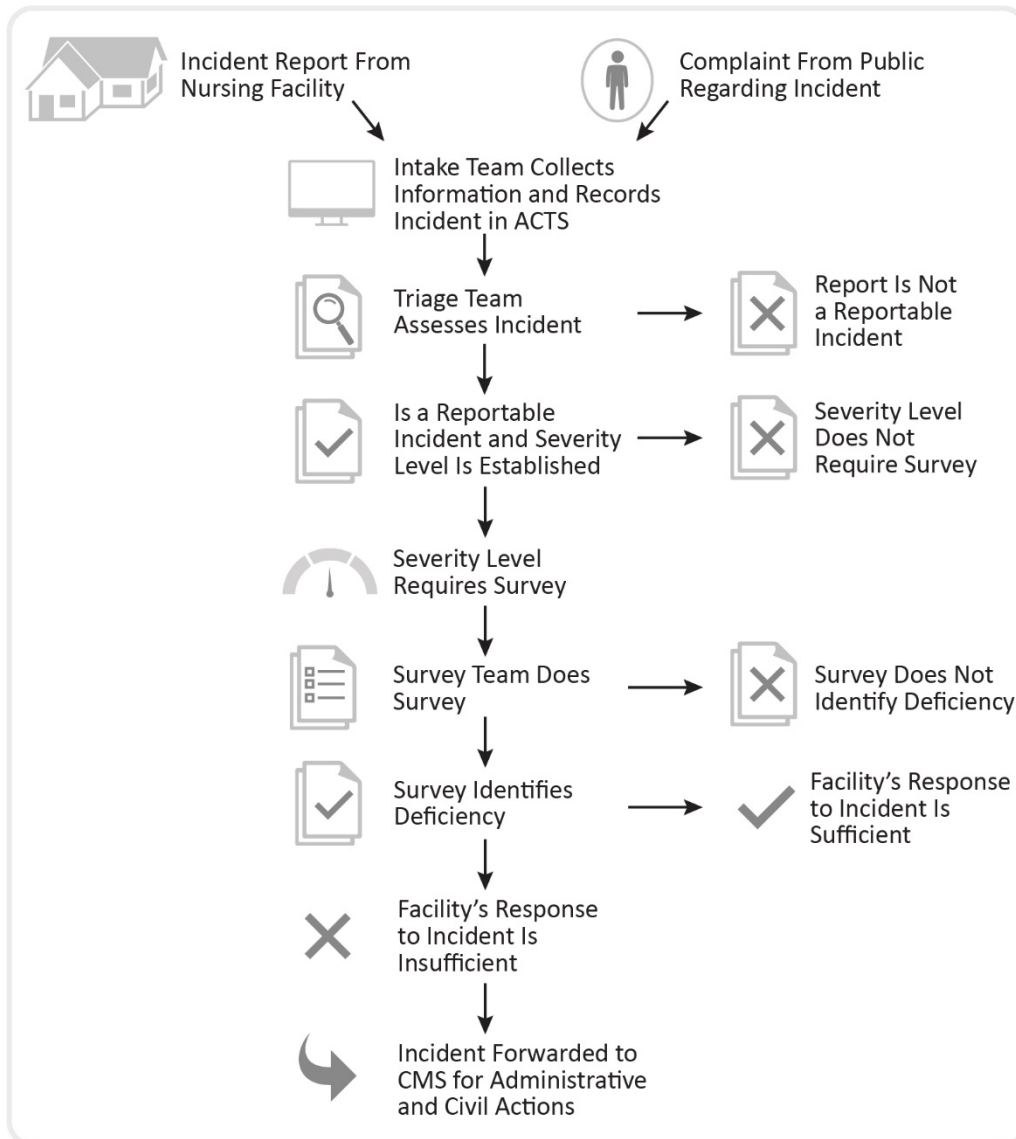
deems that an onsite visit is necessary, the compliance specialist will confer with the nursing facility manager and program director to determine whether the nursing facility's actions complied with Federal or State requirements.

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

**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<sup>12</sup> with an emergency department visit made by Georgia’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 17 claims with diagnosis codes

<sup>12</sup> When we began this audit, 2016 was the most current year for which complete data were available.

that matched the first list and 3,171 that matched the second list. Of these, we reviewed all 17 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 117 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.<sup>13</sup> 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 a list of related OIG reports, Appendix C contains our statistical sampling methodology, Appendix D contains a list of the diagnosis codes indicating significant likelihood of abuse or neglect in our sample, and Appendix E contains a list of the diagnosis codes indicating possible abuse or neglect in our sample.

## FINDINGS

The State agency generally ensured that nursing facilities reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments; complied with Federal and State requirements for assigning a priority level, investigating, and recording allegations of potential abuse or neglect; and operated its complaint and incident report program effectively.

The State agency generally ensured that nursing facilities reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Of the 117 sampled claims with emergency department visits associated with diagnoses

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<sup>13</sup> CMS delegates to the State agency the responsibility to ensure that providers are meeting the requirements for reporting potential abuse or neglect.

indicating potential abuse or neglect, the State agency determined that 101 associated incidents were not reportable. Of the remaining 16 incidents, the nursing facilities:

- reported 9 incidents in a timely manner,
- reported 3 incidents from 2 to 14 days late,
- reported 2 incidents for which documentation was not sufficient for us to determine whether the incidents were reported timely, and
- did not report 2 incidents to the State agency.

Nursing facility administrators were unable to determine why the three incidents were reported late, why the two incidents did not have sufficient documentation, or why the two incidents were not reported. However, these seven incidents were not properly reported or documented because the nursing facilities' control environments might have been adversely affected by inadequate training of nursing facility administrators, and they lacked procedures requiring all incidents to be properly documented.

When nursing facilities do not report incidents to the State agency or do not report incidents timely, the State agency may not be able to take appropriate action or investigate incident reports in a timely manner to ensure the health and safety of the nursing facility residents.

The State agency generally complied with Federal and State requirements for assigning a priority level, investigating, and recording allegations of potential abuse or neglect. Nursing facilities reported 15 incidents to the State agency.<sup>14</sup> For 1 emergency room visit associated with these 15 incidents, the State agency assigned a priority level in 5 working days rather than within the 2 working days required by CMS's SOM. In addition, the State agency did not accurately record in ACTS the date it received the incident report from the nursing facility. State agency officials did not explain why incorrect dates were recorded for the one incident report and we could not identify a reason based on the documentation it provided. 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 State agency generally operated its complaint and incident report program effectively because it generally complied with Federal and State requirements for assigning a priority level, investigating, and recording allegations of potential abuse or neglect.

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<sup>14</sup> The State Survey agency determined that one of these 15 incidents did not meet the criteria for a reportable incident.

## **THE STATE AGENCY GENERALLY ENSURED THAT NURSING FACILITIES REPORTED ALLEGATIONS OF POTENTIAL ABUSE OR NEGLECT OF MEDICAID BENEFICIARIES**

Nursing facilities must ensure that (1) all alleged violations involving mistreatment, neglect, or abuse (including injuries of unknown source and misappropriation of resident property) are reported immediately and (2) the results of all of their investigations are reported within 5 working days of the incident to the administrator of the facility, to the State Survey agency, and to other officials in accordance with State law (42 CFR §§ 483.13(c)(2) and (4)).<sup>15</sup>

Georgia requires workers at long-term care facilities to report to local law enforcement any reasonable suspicion of abuse or exploitation against any individual who is residing in the facility. Furthermore, persons are required to report incidents to the State agency within 24 hours (Official Code of Georgia Annotated (O.C.G.A.) § 31-8-82)).

The State agency generally ensured that nursing facilities reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments as required. However, nursing facilities did not always properly report incidents of potential abuse or neglect. We asked the State Survey agency to review nursing facility and hospital records for 117 claims with emergency department visits associated with diagnoses indicating potential abuse or neglect. The State Survey agency determined that 101 associated incidents were not reportable.<sup>16</sup> Of the remaining 16 incidents, the nursing facilities:

- reported 9 in a timely manner,
- reported 3 from 2 to 14 days late,
- reported 2 incidents for which documentation was not sufficient for us to determine whether the incidents were reported timely, and
- did not report 2 that they should have reported to the State agency.

### **Incidents Nursing Facilities Reported Late**

For three incidents, the nursing facilities reported the incidents between 2 and 14 days after discovering them rather than within 24 hours as required by O.C.G.A. § 31-8-82. The administrators for the two nursing facilities were unable to determine why these three incidents were reported late because staff changed at the facilities between the time of the

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<sup>15</sup> See Footnote 8 regarding revisions to the regulatory reporting requirements.

<sup>16</sup> The State agency made these determinations based on its judgment of the records available from the nursing facilities and hospitals.

incident and when we contacted the facility, and the facilities had insufficient documentation to determine why the incidents were reported late.

### **Incidents Nursing Facilities Reported in an Undetermined Time**

For two of the reported incidents, we were unable to determine whether the incidents were reported timely. The State Survey agency requires nursing facilities to submit a “Facility Incident Report Form” within 24 hours of an allegation or upon becoming aware of an allegation. However, the documentation for these two incidents was insufficient to determine whether the facilities complied with this requirement, because the date and time the facilities were informed of a possible incident were not clearly recorded.

### **Incidents Nursing Facilities Should Have Reported but Did Not**

Of the 16 incidents in our sample that the nursing facilities should have reported, 2 remained unreported as of March 2020. One of the two incidents that should have been reported involved a resident who suffered from shoulder pain due to a suspected dislocation. Based on the records we obtained from the hospital and nursing facility, we could not determine what caused this resident’s injury. The State agency informed us that, based on its review of these records, it considered this to be an injury of unknown source and therefore a reportable incident. However, the nursing facility considered this injury to be the result of the resident’s history of shoulder problems, not an injury of unknown source. The nursing facility did not complete an incident report because available documentation did not indicate a history of trauma or an adverse event. However, the hospital records indicated that the patient’s shoulder was dislocated, and the nursing facility did not provide documentation showing how the injury originated.

The second of the two incidents occurred at a second nursing facility. In this incident, the resident was assaulted during an altercation with another resident. The State agency informed us that, based on its review of records that we obtained from the hospital and nursing facility, it determined that this incident involved an allegation of abuse and was therefore a reportable incident that must be reported to the facility administrator and the State Survey agency.

A State Survey agency official said that the State Survey agency provides informal training on incident reporting requirements to nursing facilities through presentations at provider association events. The official said that, in October 2016, the State Survey agency provided training at the Georgia Health Care Association’s (GHCA’s) Quality Summit meeting. The official said that since 2017 the State Survey agency had participated in three events per year with the GHCA.

Although the State Survey agency provided training, it did not demonstrate that its controls were adequate to monitor and ensure that the nursing facilities had implemented the required processes and procedures that it had conveyed in the training.

In addition, we contacted the State agency several times to determine whether it cited these facilities for failure to report incidents or failure to report incidents on time. The State agency did not respond to our inquiries. Therefore, we could not determine whether the State agency took any corrective action.

Best practices require management to evaluate and monitor the design and operational effectiveness of internal controls and to use the results to determine the effectiveness of required procedures and processes. Differences between the results and what is required may indicate internal control issues.<sup>17</sup>

The nursing facility administrator for one of the two nursing facilities did not believe the incident was reportable. The nursing facility administrator for the other nursing facility was unable to determine why this incident was not reported. Both facilities did not report these incidents because their control environments might have been adversely affected by inadequate training of new administrators.

The administrators at both facilities had changed since 2016. One administrator gave a reason for not reporting an incident that did not agree with the State Survey agency's understanding of an injury of unknown source. This administrator's misunderstanding of the need to report an injury of unknown source and the other administrator's inability to provide a reason for not reporting an incident showed possible inadequate training of new administrators.

Another best practice<sup>18</sup> requires management to maintain documentation in a manner that allows the documentation to be readily available for examination. Neither nursing facility retained documentation that showed why the incidents were not reported.

While the State agency generally ensured that nursing facilities reported potential abuse or neglect, the State agency's monitoring was not sufficient to identify all incidents that were not reported timely or were not reported at all. The State agency's monitoring included site visits by survey teams, an incident report system for nursing facilities, and a complaint system for public use. Without strengthening its monitoring, the State agency may not be able to pursue

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<sup>17</sup> Government Accountability Office's *Standards for Internal Control in The Federal Government* (Green Book), "Monitoring," Principle 16.08 and 16.09. The Green Book principles are only applicable to Federal agencies. The principles do not apply to nursing facilities or State agencies. However, we included Green Book principle citations as best practices for improving State agency and nursing facility internal controls. Regarding internal controls for non-Federal entities, such as State agencies, 45 CFR § 75.303 (a) states that the non-Federal entity must establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should comply with guidance in the Green Book or in the *Internal Control Integrated Framework*, issued by the Committee of Sponsoring Organizations of the Treadway Commission.

<sup>18</sup> The Green Book, "Design Control Activities, Design of Appropriate Types of Control Activities, Appropriate documentation of transactions and internal control," Principle 10.03.

legal, administrative, or other appropriate remedies or investigate incident reports or complaints in a timely manner to ensure the health, safety, and rights of the nursing facility residents. Additionally, without accurate data, CMS cannot adequately assess the State agency's performance.

### **THE STATE AGENCY GENERALLY COMPLIED WITH FEDERAL REQUIREMENTS FOR ASSIGNING A PRIORITY LEVEL AND INVESTIGATING AND RECORDING ALLEGATIONS OF POTENTIAL ABUSE OR NEGLECT**

Chapter 5 of the SOM requires that each complaint or incident 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 within 2 working days of its receipt.<sup>19</sup> However, for complaints or incidents 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.<sup>20</sup> State agencies must begin investigation of "Immediate Jeopardy" situations within 2 working days<sup>21</sup> 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 State agency generally complied with Federal requirements for assigning a priority level to reported abuse or neglect allegations. Of the 15 reported incidents<sup>22</sup> associated with emergency room visits in our sample, the State agency assigned a priority level for 14 within 2 working days, as required by the SOM. However, the State agency did not assign a priority level within 2 working days for 1 of the 15 incidents.

The State agency did not accurately record in ACTS the date it received an incident report from a nursing facility. The State agency received an incident report on Sunday, May 8th, but recorded it in ACTS as having been received on Friday, May 13th, and assigned a priority level

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<sup>19</sup> The requirement that the State agency prioritize complaints and incidents within 2 working days of their receipt was removed under Rev. 191, effective July 19, 2019, which was after our audit period.

<sup>20</sup> This provision allowing for extenuating circumstances to delay the prioritization of complaints or incidents that are not immediate jeopardy was also removed under Rev. 191, effective July 19, 2019, which was after our audit period.

<sup>21</sup> 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.

<sup>22</sup> Although nursing facilities reported 15 incidents to the State agency, the State agency determined that only 14 of the 15 met the criteria for a reportable incident. The State agency determined that another 2 incidents should have been reported but were not, resulting in 16 reportable incidents.

on Friday, May 13th. Therefore, ACTS showed that the State agency assigned a priority level to the incident report within 2 working days, but it actually took 5 working days for the State agency to assign a priority level. The State agency recorded as the “Received Start Date”<sup>23</sup> the date it entered the report into ACTS rather than the date it actually received the report from the nursing facility, as required.

State agency officials did not explain why incorrect dates were recorded for the one incident report and we could not identify a reason based on the documentation it provided. However, State Survey agency officials stated that they had changed how nursing facilities submit incident reports so that documentation is now available to show the dates reports were received. Before February 2018, the State Survey agency received hardcopy incident reports and manually recorded the receipt date. Starting in February 2018, the State Survey agency began receiving electronic reports, which automatically document the receipt date.

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 is critical because it determines the State agency’s required action and period for investigating the complaint or incident. Additionally, without accurate data, CMS cannot assess the State agency’s performance.

## **RECOMMENDATIONS**

We recommend that the Georgia Department of Community Health:

- remind nursing facilities of Federal and State requirements for reporting incidents of potential abuse or neglect,
- strengthen its procedures for monitoring nursing facilities and follow up with those that may not be following required policies and procedures,
- ensure that it documents actions it takes when nursing facilities fail to report incidents and fail to report incidents on time, and
- ensure that it assigns a priority level to all incidents or complaints by the mandatory deadline.

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<sup>23</sup> ACTS instructions define the “Received Start Date” as the date the State agency first receives a complaint or incident report.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations. The State agency described actions it has taken to address our findings and recommendations. Such actions included:

- educating nursing facilities about State and Federal reporting requirements by:
  - participating in annual training events,
  - providing guidance to nursing facilities on how and when to report abuse and neglect, and
  - updating the abuse reporting flyer that it provides to nursing facilities;
- strengthening its procedures for monitoring nursing facilities by:
  - continuing to cite facilities that fail to comply with State and Federal reporting requirements,
  - tracking nursing facility surveys to ensure that a followup survey is conducted when required,
  - expanding its nursing home management team to include additional staff for managing complaints and facility-reported incidents,
  - establishing a Quality Council to review all pending nursing home enforcement cases, and
  - developing a performance dashboard to assist in the automated tracking of survey timeliness and other Federal oversight requirements;
- strengthening its documentation process by:
  - continuing to issue Statements of Deficiencies for all nursing facilities that it cites for noncompliance,
  - enhancing its online repository for facility inspection reports, and
  - continuing to refer nursing facility enforcement cases to CMS; and
- strengthening its procedures for intake and triage of incidents and complaints by:

- providing initial and annual refresher training for all intake and triage staff on the Federal priority criteria for complaints and incidents,
- automating its complaint and incident reporting process so that the complaint or facility-reported incident is automatically recorded when submitted online, and
- conducting regular internal reviews to audit the accuracy of priority assignments.

The State agency’s comments did not indicate how it would ensure that it documents actions it takes when nursing facilities fail to report incidents. Overall, the actions the State agency described should improve its compliance with Federal requirements.

The State agency’s comments are included in their entirety as Appendix F.

### OTHER MATTERS

The State agency determined that the nursing facilities were not required to report 101 incidents associated with the 117 claims in our sample (Table 1). The State agency did not investigate the 101 incidents further because it believed that the incidents did not “meet the criteria for a reportable incident.”<sup>24</sup>

Almost 70 percent of the 101 incidents were categorized as falls. Because these incidents were deemed as not reportable, they may not be subject to State oversight. Solely categorizing an incident as a fall may not be an appropriate indicator of the seriousness of an incident. A more in-depth analysis may be required to reduce the number of injuries from falls.

**Table 1: Incidents That Led to Emergency Department Visits\***

Number	Incident
70	Falls of various causes
15	Infectious or respiratory issues
9	Fractures, sprains, lacerations and head injuries
4	Hallucinations and altered mental status
1	Abnormal x-ray
1	Accidental poisoning
1	Welfare check
<b>101</b>	<b>Total</b>

\*This table shows the 101 incidents from our sample that the nursing facilities were not required to report. We obtained this information from hospital emergency room records, nursing facility records, and Georgia’s Medicaid Management Information System.

<sup>24</sup> For at least 1 of the 70 incidents categorized as falls, the State Agency investigated the incident based on a complaint, not because it was a reportable incident.

For example, a nursing facility patient fell while getting out of bed at night even though the patient was wheelchair dependent. The patient's fall resulted in a hip injury which required hospitalization and surgery, possibly indicating that the nursing facility had not put the proper interventions in place, such as having a lowered bed with raised rails, making this a reportable event. However, the State Survey agency determined that this was not a reportable incident and did not investigate the fall. According to a State Survey agency official, the incident did not meet the regulatory requirements in sections 483.12(c)(1) and (4) for a "reportable incident." Specifically, the facility knew that the injury was related to the resident having a fall, which is not required to be reported to the State Survey agency.

At our exit conference, a State Survey agency official said that although facilities are not required to report falls, many do. According to the official, if the State Survey agency determines a fall to be egregious, it will investigate the incident. The official also said that when it receives the incident reports, the State Survey agency can look at the patient's diagnoses, medications, and history of falls. The official further said that an example of an egregious fall would be a fall with a major injury such as a broken hip or a series of falls in which the interventions for a resident had not been put into place or properly assessed.

However, as discussed in our example above, the State Survey agency did not investigate this incident or consider it to be a reportable incident.

## **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 Georgia'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 comprised diagnosis codes that we determined indicated a significant likelihood of abuse or neglect, and the second list comprised diagnosis codes that we determined indicated possible abuse or neglect. We identified 17 claims with diagnosis codes that matched the first list and 3,171 that matched the second list. Of these, we reviewed all 17 claims with emergency department visits associated with diagnoses that indicated a significant likelihood of abuse or neglect and a sample of 100 claims with emergency department visits associated with diagnoses that indicated possible abuse or neglect.

For these 117 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 State 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;

- obtained and reviewed hospital and nursing facility medical records for 117 sample claims with emergency department visits made by Medicaid beneficiaries while residing in a nursing facility;<sup>25</sup>
- requested that the State agency review the hospital and nursing facility records to determine if the medical records indicated a reportable allegation;
- reviewed State agency determinations of whether the medical records indicated a reportable allegation and discussed those determinations with State officials;
- reviewed State agency supporting documentation associated with the complaints and incident reports received by the State agency and recorded in ACTS, including any investigative reports; and
- discussed the results of our audit 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.

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<sup>25</sup> See Appendix C for details.

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Florida Did Not Ensure That Nursing Facilities Always Reported Allegations of Potential Abuse or Neglect of Medicaid Beneficiaries and Did Not Always Assess, Prioritize, or Investigate Reported Incidents</i>	<a href="#"><u>A-04-17-08058</u></a>	3/4/2021
<i>New Jersey Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported</i>	<a href="#"><u>A-02-18-01006</u></a>	8/19/2020
<i>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</i>	<a href="#"><u>A-04-17-04063</u></a>	7/29/2020
<i>Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<a href="#"><u>A-06-17-04003</u></a>	7/09/2020
<i>Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities</i>	<a href="#"><u>A-07-18-06081</u></a>	3/27/2020
<i>Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<a href="#"><u>A-03-17-00202</u></a>	1/17/2020
<i>CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect</i>	<a href="#"><u>A-01-17-00513</u></a>	6/12/2019
<i>Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated</i>	<a href="#"><u>A-01-16-00509</u></a>	6/12/2019
<i>Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<a href="#"><u>A-09-17-02006</u></a>	6/11/2019
<i>A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015</i>	<a href="#"><u>OEI-01-16-00330</u></a>	9/28/2017
<i>Early Alert: The Centers for Medicare &amp; 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</i>	<a href="#"><u>A-01-17-00504</u></a>	8/24/2017

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<a href="#"><u>A-01-16-00001</u></a>	8/9/2017
<i>Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	<a href="#"><u>A-01-14-00008</u></a>	7/13/2016
<i>Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	<a href="#"><u>A-01-14-00002</u></a>	5/25/2016
<i>Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries</i>	<a href="#"><u>A-02-14-01011</u></a>	9/28/2015
<i>Nursing Facilities' Compliance With Federal Regulations for Reporting Allegations of Abuse or Neglect</i>	<a href="#"><u>OEI-07-13-00010</u></a>	8/15/2014
<i>Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries</i>	<a href="#"><u>OEI-06-11-00370</u></a>	2/27/2014
<i>Criminal Convictions for Nurse Aides With Substantiated Findings of Abuse, Neglect, and Misappropriation</i>	<a href="#"><u>OEI-07-10-00422</u></a>	10/5/2012
<i>Unidentified and Unreported Federal Deficiencies in California's Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs</i>	<a href="#"><u>A-09-09-00114</u></a>	9/21/2011
<i>Nursing Facilities' Employment of Individuals With Criminal Convictions</i>	<a href="#"><u>OEI-07-09-00110</u></a>	3/1/2011

## APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

### TARGET POPULATION

The target population consisted of Georgia Medicaid nursing facility resident visits to an emergency department with selected diagnosis codes and dates of service from January 1, 2016, 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. nursing facility claims for all Medicaid beneficiaries receiving services during our audit period;
2. demographic and nursing facility claim data for the beneficiaries listed in the nursing facility data from the first part for the beneficiaries that also had any inpatient or outpatient claim that contained an emergency room revenue code (revenue codes between 0450 and 0459) for our audit period;<sup>26</sup> and
3. the emergency room claims that occurred within our audit period for the beneficiaries identified in the second part.

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 11 diagnosis codes within these claims indicating significant likelihood of abuse or neglect and 404 diagnosis codes within the remaining claims 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 abuse or neglect. We then analyzed the admitting and principal diagnosis codes to identify claims with a diagnosis code indicating *possible* abuse or neglect.

The sampling frame was a Microsoft Access database containing 3,188 inpatient and outpatient claims that we had matched with the associated nursing facility claims.

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<sup>26</sup> These claim data contained the outpatient principal diagnosis codes and the inpatient admitting and principal diagnosis codes.

## 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 2).

**Table 2: Claims by Stratum**

<b>Stratum</b>	<b>Diagnosis Codes</b>	<b>Claims in Sampling Frame</b>	<b>Claims in Sample</b>
1	Diagnosis codes indicating significant likelihood of abuse or neglect	17	17
2	Diagnosis codes indicating possible abuse or neglect	3,171	100
	<b>Total</b>	<b>3,188</b>	<b>117</b>

## 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 sampling frame.

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

<b>Code</b>	<b>Code Description</b>	<b>Reported Incidents</b>	<b>Reportable Incidents Not Reported</b>	<b>Not Reportable Based on Available Evidence</b>	<b>Total</b>
Z0441	Encounter for examination and observation following alleged adult rape	4	0	0	4
S3993XA	Unspecified injury of pelvis, initial encounter	0	0	3	3
T7621XA	Adult sexual abuse, suspected, initial encounter	3	0	0	3
Z0471	Encounter for examination and observation following alleged adult physical abuse	1	1	0	2
T7401XA	Adult neglect or abandonment, confirmed, initial encounter	0	0	1	1
T7411XA	Adult physical abuse, confirmed, initial encounter	0	0	1	1
T7491XA	Unspecified adult maltreatment, confirmed, initial encounter	1	0	0	1
T7691XA	Unspecified adult maltreatment, suspected, initial encounter	1	0	0	1
Y042XXA	Assault by strike against or bumped into by another person, initial encounter	1	0	0	1
	<b>Total</b>	<b>11</b>	<b>1</b>	<b>5</b>	<b>17</b>

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

<b>Code</b>	<b>Code Description</b>	<b>Number of Claims Sampled</b>
J690	Pneumonitis due to inhalation of food and vomit	13
S0181XA	Laceration without foreign body of other part of head, initial encounter	11
S0990XA	Unspecified injury of head, initial encounter	11
S0083XA	Contusion of other part of head, initial encounter*	9
S0003XA	Contusion of scalp, initial encounter	8
S0101XA	Laceration without foreign body of scalp, initial encounter	7
S01111A	Laceration without foreign body of right eyelid and periorcular area, initial encounter	5
Z043	Encounter for examination and observation following other accident	3
S72002A	Fracture of unspecified part of neck of left femur, initial encounter for closed fracture	2
S01112A	Laceration without foreign body of left eyelid and periorcular area, initial encounter	2
S0093XA	Contusion of unspecified part of head, initial encounter	2
R6521	Severe sepsis with septic shock	2
S72142A	Displaced intertrochanteric fracture of left femur, initial encounter for closed fracture	1
S022XXA	Fracture of nasal bones, initial encounter for closed fracture*	1
S0191XA	Laceration without foreign body of unspecified part of head, initial encounter	1
S06319A	Contusion and laceration of right cerebrum with loss of consciousness of unspecified duration, initial encounter	1
S72092A	Other fracture of head and neck of left femur, initial encounter for closed fracture	1
S098XXA	Other specified injuries of head, initial encounter	1
S72402A	Unspecified fracture of lower end of left femur, initial encounter for closed fracture	1
S0012XA	Contusion of left eyelid and periorcular area, initial encounter	1
S72001A	Fracture of unspecified part of neck of right femur, initial encounter for closed fracture	1
S0993XA	Unspecified injury of face, initial encounter	1

<b>Code</b>	<b>Code Description</b>	<b>Number of Claims Sampled</b>
S72011A	Unspecified intracapsular fracture of right femur, initial encounter for closed fracture*	1
T80211A	Bloodstream infection due to central venous catheter, initial encounter	1
S72141A	Displaced intertrochanteric fracture of right femur, initial encounter for closed fracture	1
T148	Other injury of unspecified body region	1
S72401A	Unspecified fracture of lower end of right femur, initial encounter for closed fracture	1
T17820A	Food in other parts of respiratory tract causing asphyxiation, initial encounter	1
S060X0A	Concussion without loss of consciousness, initial encounter	1
T40601A	Poisoning by unspecified narcotics, accidental (unintentional), initial encounter	1
T383X1A	Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional), initial encounter	1
S40011A	Contusion of right shoulder, initial encounter	1
T426X1A	Poisoning by other antiepileptic and sedative-hypnotic drugs, accidental (unintentional), initial encounter	1
S43005A	Unspecified dislocation of left shoulder joint, initial encounter <sup>†</sup>	1
S4992XA	Unspecified injury of left shoulder and upper arm, initial encounter	1
S20212A	Contusion of left front wall of thorax, initial encounter	1
S300XXA	Contusion of lower back and pelvis, initial encounter	1
	<b>Totals</b>	<b>100</b>
* This sample item involved an incident reported to the State agency.		
† This sample item involved an incident that should have been reported to the State agency.		

## APPENDIX F: STATE AGENCY COMMENTS



GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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March 3, 2021

Lori S. Pilcher  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Audit Services, Region IV  
61 Forsyth Street, SW, Suite 3T41  
Atlanta, GA 30303

Re: Response to Draft Audit Report Issued February 2021, A-04-17-03084  
*Georgia Generally Ensured That Nursing Facilities Reported Allegations of Potential Abuse or Neglect of Medicaid Beneficiaries and Prioritized Allegations Timely*

Dear Ms. Pilcher:

This letter is written in response to the above-referenced audit of oversight activities conducted by the Healthcare Facility Regulation Division of the Georgia Department of Community Health (DCH):

**Audit Recommendation #1** - Remind nursing facilities of Federal and State requirements for reporting incidents of potential abuse or neglect.

**DCH Response:** The Department concurs with this recommendation and has taken the following actions to educate nursing homes about state and federal reporting requirements:

- The Department participates in at least three (3) provider association training events per year.
- In February of 2017, the Department released detailed guidance materials to nursing homes on how and when to report abuse, neglect and exploitation.
- In February of 2018, the Department automated the facility reporting process and updated its website to include a prominent link for online reporting of facility incidents.
- In October of 2019, the Department updated its abuse reporting flyer for redistribution to nursing homes.

**Audit Recommendation #2** - Strengthen its procedures for monitoring nursing facilities and follow up with those that may not be following required policies and procedures.



**DCH Response:** The Department concurs with this recommendation and has taken the following actions to strengthen its procedures for monitoring nursing facilities:

- The Department continues to survey nursing homes and to cite facilities that fail to comply with state and/or federal reporting requirements.
- The Department tracks all surveys of nursing homes to ensure that a revisit or follow-up survey is conducted when required under federal guidance.
- In 2017, the Department expanded its nursing home management team to include additional staff for managing complaints and facility reported incidents, as well as a full-time scheduler to ensure follow-up surveys are timely scheduled.
- In 2017, the Department established a Quality Council within the Healthcare Facility Regulation Division that meets weekly to review all pending nursing home enforcement cases to ensure timely follow-up action is taken as required under federal regulations and the CMS State Operations Manual.
- In 2019, the Department developed a performance dashboard to assist in automated tracking of survey timeliness and other federal requirements associated with oversight of nursing homes.

**Audit Recommendation #3** - Ensure that it documents actions it takes when nursing facilities fail to report incidents and fail to report incidents on time.

**DCH Response:** The Department concurs with this recommendation and has taken the following actions to strengthen its documentation process:

- The Department issues a Statement of Deficiencies, CMS Form 2567, for all citations of noncompliance against nursing homes.
- The Department publishes all survey inspection reports at the following link, <https://forms.dch.georgia.gov/HFRD/>. In 2019, the Department added enhancements to the online survey repository.
- The Department refers nursing home enforcement cases to CMS, in accordance with federal guidance.

**Audit Recommendation #4** - Ensure that it assigns a priority level to all incidents or complaints by the mandatory deadline.

**DCH Response:** The Department concurs with this recommendation and has taken the following actions to strengthen its procedures for intake and triage of incidents and complaints:

- The Department provides initial and annual refresh training for all intake and triage staff on the federal priority criteria for complaints and incidents.
- In 2018, the Department automated the complaint and facility reported incident reporting process so that the date of receipt is automatically recorded at the time of online submission.



- The Department conducts regular internal reviews to audit the accuracy of priority assignment.

Thank you for your interest in protecting Georgia’s nursing home residents from abuse, neglect and exploitation. If you have any questions about the information in this letter, please contact Melanie Simon, Executive Director of Healthcare Facility Regulation, at [msimon@dch.ga.gov](mailto:msimon@dch.ga.gov) or (404) 657-3990.

Sincerely,

A handwritten signature in blue ink, appearing to read "Frank W. Berry".

Frank W. Berry