

## Report in Brief

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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.