

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**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**

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**March 2021  
A-04-17-08058**

# ***Office of Inspector General***

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## Report in Brief

Date: March 2021

Report No. A-04-17-08058

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 Florida: (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 requirements for assigning a priority level, initiating onsite surveys, and recording allegations of potential abuse and neglect; and (3) operated its incident report program effectively.

### How OIG Did This Audit

We reviewed a sample of 104 hospital 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 Florida properly assessed, prioritized, recorded, and initiated surveys of allegations or incidents of potential abuse or neglect. Additionally, we reviewed Florida's policies and procedures related to its complaint and incident program.

## 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

### What OIG Found

Florida did not ensure that nursing facilities always reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Additionally, we could not determine whether Florida complied with Federal requirements for assigning a priority level, initiating onsite surveys, and recording allegations of potential abuse or neglect. Lastly, Florida's incident report program may not have been effective in accomplishing the program's goal and objectives. Certain internal control deficiencies and practices could limit the effectiveness of Florida's complaint and incident program. Specifically, Florida: lacked written policies and procedures for processing incident reports, had inadequate intake staffing, had inadequate incident report processing, lacked written policies and procedures for managing late incident report filings, and lacked written policies and procedures for managing APS abuse and neglect investigation notifications.

### What OIG Recommends and Florida Comments

We recommend that Florida: (1) work with CMS to provide clear guidance to nursing facilities regarding what constitutes a reportable incident; (2) establish procedures to require assessment start and end dates and priority level assignments; and (3) establish and implement written policies and procedures for incident report processing. We made further recommendations to improve the effectiveness of the complaint and incident report process.

In written comments on our draft report, Florida commented on two of our three findings and concurred or partially concurred with six of our seven recommendations. Florida described actions taken and processes modified or implemented to address our findings and recommendations. For example, Florida hired additional staff and created formal written policies and procedures for incident report processing. However, Florida did not concur with our recommendation to take specific steps to improve its intake process.

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## **GLOSSARY OF ABBREVIATIONS AND ACRONYMS**

### **FEDERAL**

ACTS ASPEN Complaint Tracking System  
ASPEN Automated Survey Processing Environment  
CMS Centers for Medicare & Medicaid Services  
CoPs Conditions of Participation  
OIG Office of Inspector General  
SNF Skilled Nursing Facility  
SOM State Operations Manual  
SSCA State Survey and Certification Agency

### **STATE**

AIRS AHCA Incident Reporting System  
AHCA Agency for Health Care Administration  
APS Adult Protective Services  
DCF Department of Children and Families  
DHQA Division of Health Quality Assurance  
FEDRPT AHCA Federal Incident Reporting System  
Florida Center Florida Center for Health Information and Transparency

### **OTHER**

CNA Certified Nursing Assistant

## **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 timely, vulnerable populations are at increased risk of abuse or neglect. We are committed to detecting and combating such abuse and neglect.

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

### **OBJECTIVES**

Our objectives were to determine whether the Florida Agency for Health Care Administration (AHCA), Division of Health Quality Assurance (DHQA): (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 requirements for assigning a priority level, initiating onsite surveys, and recording allegations of potential abuse or neglect; and (3) operated its incident 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 Florida, AHCA is the State Medicaid agency that 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. Section 1919 of the Social Security Act provide that nursing facilities participating in the Medicaid program must meet certain specified Federal Conditions of Participation (CoPs) requirements, including requirements related to quality of care, nursing services, and infection control. These sections also establish requirements for CMS and States to survey nursing facilities to determine whether they meet Federal participation requirements.

## State Survey and Certification Agencies

A State survey and certification agency (SSCA) is an agency designated as responsible for certifying and determining compliance of long-term-care facilities, including nursing facilities, with Medicare and Medicaid program participation requirements. SSCA oversight includes conducting onsite surveys to determine how well health care providers comply with their applicable CoPs, including the reporting of potential abuse or neglect. In Florida, AHCA's DHQA serves as the SSCA responsible for licensing and surveying nursing facilities.

SSCAs are responsible for ensuring that nursing facilities comply with pertinent Federal requirements, including reporting allegations of mistreatment, neglect, or abuse (including injuries of unknown source).<sup>1</sup> CMS requires SSCAs to enter into the Automated Survey Processing Environment (ASPEN), ASPEN Complaints/Incidents Tracking System (ACTS), all information related to self-reported incidents that require a Federal onsite survey and complaint information gathered as part of Federal survey and certification responsibilities, regardless of whether an onsite survey is conducted.<sup>2</sup> SSCAs are required to promptly review and prioritize complaints and incidents, conduct unannounced onsite surveys (also called investigations) if necessary, and transmit the results and recommendations including noncompliance penalties or remedies<sup>3</sup> to CMS through ASPEN.

CMS provides guidance to SSCAs in the State Operations Manual (SOM). Chapter 5 of the SOM contains procedures that the SSCAs follow when complaints and incident reports are received, including referrals from public entities such as Adult Protective Services (APS). An incident report contains self-reported allegations<sup>4</sup> from the nursing facility (i.e., the administrator or authorized official). The three objectives of the complaint and incident report management system are to promote:

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

<sup>2</sup> ASPEN is a suite of software programs designed to store information about surveys of health care facilities regulated by CMS. The software is federally owned and cannot be modified by SSCAs. ACTS is one of the software programs designed to link complaint and incident intakes to surveys and to upload information to a national repository. ACTS interacts with the other software programs in the ASPEN suite that are designed to schedule surveys, record and upload survey findings, and track and upload enforcement actions.

<sup>3</sup> 42 CFR § 488.406, "Available remedies," and 42 CFR § 488.408, "Selection of remedies."

<sup>4</sup> An allegation is an assertion of improper care or treatment that could result in the citation of a nursing facility's failure to meet a participation requirement (SOM, chapter 5, § 5010).

(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 (SOM chapter 5, § 5000.1). ACTS is one of the tools that SSCAs use to meet these objectives.

The SSCA must demonstrate clear-cut accountability for each step of the management process and assume a focal coordinating/controlling responsibility to ensure timely and appropriate action for each reported complaint and incident. The SSCA's responsibilities cannot be delegated to other organizations (SOM, chapter 5, § 5000.2). SSCAs are authorized by CMS to conduct onsite surveys to identify health care provider noncompliance with CoPs and initiate remedies under Federal law.

ACTS is a key software program used in the Federal complaint and incident report management system. ACTS is designed to track, process, and report on complaints and incidents 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 the final disposition.<sup>5</sup> SSCAs must assign a priority level<sup>6</sup> to each incident report. The priority level determines the required action and the deadline for beginning any onsite survey to be initiated. SSCAs must record in ACTS all incident reports that require an onsite survey<sup>7</sup> (SOM, chapter 5, §§ 5060 and 5070).

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<sup>5</sup> "ACTS must be used for the intake of all allegations against Medicare/Medicaid-certified providers . . ." (SOM, chapter 5, § 5060). "At a minimum, it is expected that noncompliance with Federal requirements resulting from a complaint or reported incident will receive follow-up and be documented in the ASPEN Complaint/Incident Tracking System (ACTS)" (SOM, chapter 5, § 5050). SOM, Exhibit 23-ACTS Required fields, contains the required fields for what data should be recorded in ACTS.

<sup>6</sup> The eight priority levels are: (1) "Immediate Jeopardy," (2) "Non-Immediate Jeopardy – High," (3) "Non-Immediate Jeopardy – Medium," (4) "Non-Immediate Jeopardy – Low," (5) "Administrative Review/Offsite Investigation," (6) "Referral – Immediate," (7) "Referral – Other," and (8) "No Action Necessary." SOM, chapter 5, § 5075, contains the priority level definitions for nursing homes.

<sup>7</sup> The SSCA conducts onsite surveys to determine whether it should cite facilities for noncompliance with statutes and regulations. The SSCA decides whether noncompliance occurred based upon observations of the facility's performance, practices, or conditions. The SSCA should evaluate the facility in terms of frequency or severity of the condition or practice (SOM, chapter 2, § 2712).

## Nursing Facility Requirements for Reporting Adverse Events

Florida nursing facilities must report adverse events<sup>8</sup> under both Federal and State requirements. Florida nursing facilities must file an immediate<sup>9</sup> Federal report (Federal 24-Hour Report), conduct their own internal investigation, file a report on the investigation results within 5 working days (Federal 5-Working-Day Investigation Report),<sup>10</sup> and file a State adverse incident report (State Adverse Report) within 15 calendar days.<sup>11</sup> Facilities may also be required to report the incident to other organizations, including Florida's APS<sup>12</sup> and local law enforcement.

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<sup>8</sup> For the purposes of this audit, the term "adverse events" includes mistreatment, neglect, abuse (including injuries of unknown source) under 42 CFR § 483.13(c)(2) (this regulation was removed and replaced with 42 CFR § 483.12 (81. Fed. Reg. 68688 (Oct. 4, 2016)), which includes this same provision at § 483.12(c)(1)), and preventable incidents defined under Florida Statute 400.147(5). Florida Statute 400.147(5) requires the reporting of the following conditions caused by an adverse incident: (1) death; (2) brain or spinal damage; (3) permanent disfigurement; (4) fractures or dislocation of bones or joints; (5) a limitation of neurological, physical, or sensory function; (6) any condition that requires medical attention to which the resident has not given his or her informed consent, including failure to honor advance directives; (7) any condition that requires the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care because of the adverse incident, rather than the resident's condition prior to the adverse incident; or (8) an event that is reported to law enforcement for investigation.

<sup>9</sup> "Immediate" 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). 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 abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, 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.

<sup>10</sup> In the Federal 5-Working-Day Investigation report and the State Adverse Report, the nursing facility indicates whether abuse or neglect was substantiated or not substantiated by its internal investigation and whether the incident was reported to and investigated by APS or law enforcement. CMS accepts State requirements that meet or exceed the intent of the Federal requirements, but Florida's requirements do not exceed the Federal requirements with respect to the 15-calendar-day reporting time requirement.

<sup>11</sup> Florida Statute 400.147(7) states, "The facility must complete the investigation and submit a report to the agency within 15 calendar days after the adverse incident occurred . . . ."

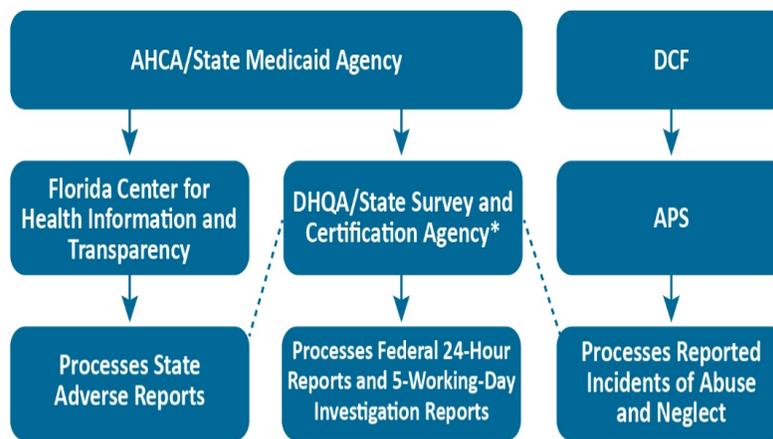
<sup>12</sup> APS is an office under the Florida Department of Children and Families (DCF).

**Florida Division of Health Quality Assurance, Florida Center for Health Information and Transparency, and Florida Department of Children and Families**

In Florida, the Agency for Health Care Administration (AHCA), Division of Health Quality Assurance (DHQA) is the SSCA. DHQA receives and processes Federal 24-Hour Reports and Federal 5-Working-Day Investigation Reports. AHCA’s Florida Center for Health Information and Transparency (Florida Center)<sup>13</sup> receives and processes State Adverse Reports.

The Florida Department of Children and Families (DCF) abuse hotline receives and processes complaints and reported incidents of abuse and neglect that APS investigates. Figure 1 reflects the Florida organizational structure responsible for receiving and processing reports of abuse and neglect incidents from nursing facilities.

**Figure 1: Florida Organizational Structure**



\* Dotted lines indicate that DHQA has access to both Florida Center and APS information that can be used to initiate unannounced onsite surveys.

During calendar year (CY) 2016, DHQA received 10,513 Federal 24-Hour Reports and corresponding Federal 5-Working-Day Investigation Reports through the AHCA Federal Incident Reporting System (FEDRPT).<sup>14</sup> DHQA’s established practice was to review Federal 24-Hour Reports for completeness, review Federal 5-Working-Day Investigation Reports for completeness, and close the reports in FEDRPT. If DHQA determined that an allegation rose to the level of requiring an onsite survey, the appropriate DHQA field office scheduled and conducted the onsite survey and entered the incident information into ACTS.

<sup>13</sup> The Florida Center is a separate unit within AHCA.

<sup>14</sup> FEDRPT is a State data system designed for tracking receipt of Federal incident reports. Nursing facilities use FEDRPT to file Federal 24-Hour Reports and Federal 5-Working-Day Investigation Reports. The State’s FEDRPT data system is independent of ACTS. Therefore, ACTS data about incident information must be manually entered from FEDRPT.

During CY 2016, the Florida Center received 1,597 State Adverse Reports through the AHCA Incident Reporting System (AIRS).<sup>15</sup> The Florida Center reviewed the State Adverse Reports for completeness and appropriate corrective action and closed the reports in AIRS. The Florida Center also conducts telephone consultations with nursing facilities to help administrators understand what needs to be done to facilitate compliance. Information from State Adverse Reports is used to identify types of preventable events and trends occurring in nursing facilities. The Florida Center can make referrals for investigation to other agencies, including DHQA.

DCF screens complaints and incident reports received through its abuse hotline. Screening involves determining whether there is reasonable cause to suspect that maltreatment, abuse, or neglect has occurred. If reasonable cause is present, APS accepts the report for investigation. APS notifies DHQA by email when it receives a complaint involving a resident at a licensed facility and again at the end of the investigation. When a preponderance of credible evidence supports the allegation of abuse or neglect, APS assigns the allegation a “verified” finding and notifies law enforcement. If a preponderance of credible evidence does not support the allegation, APS assigns the allegation a “not substantiated” finding and may notify law enforcement if a criminal investigation seems warranted. If there is no credible evidence to support the allegation, APS assigns the allegation a “no indicators” finding. After the investigation findings are assigned, the investigation is closed.

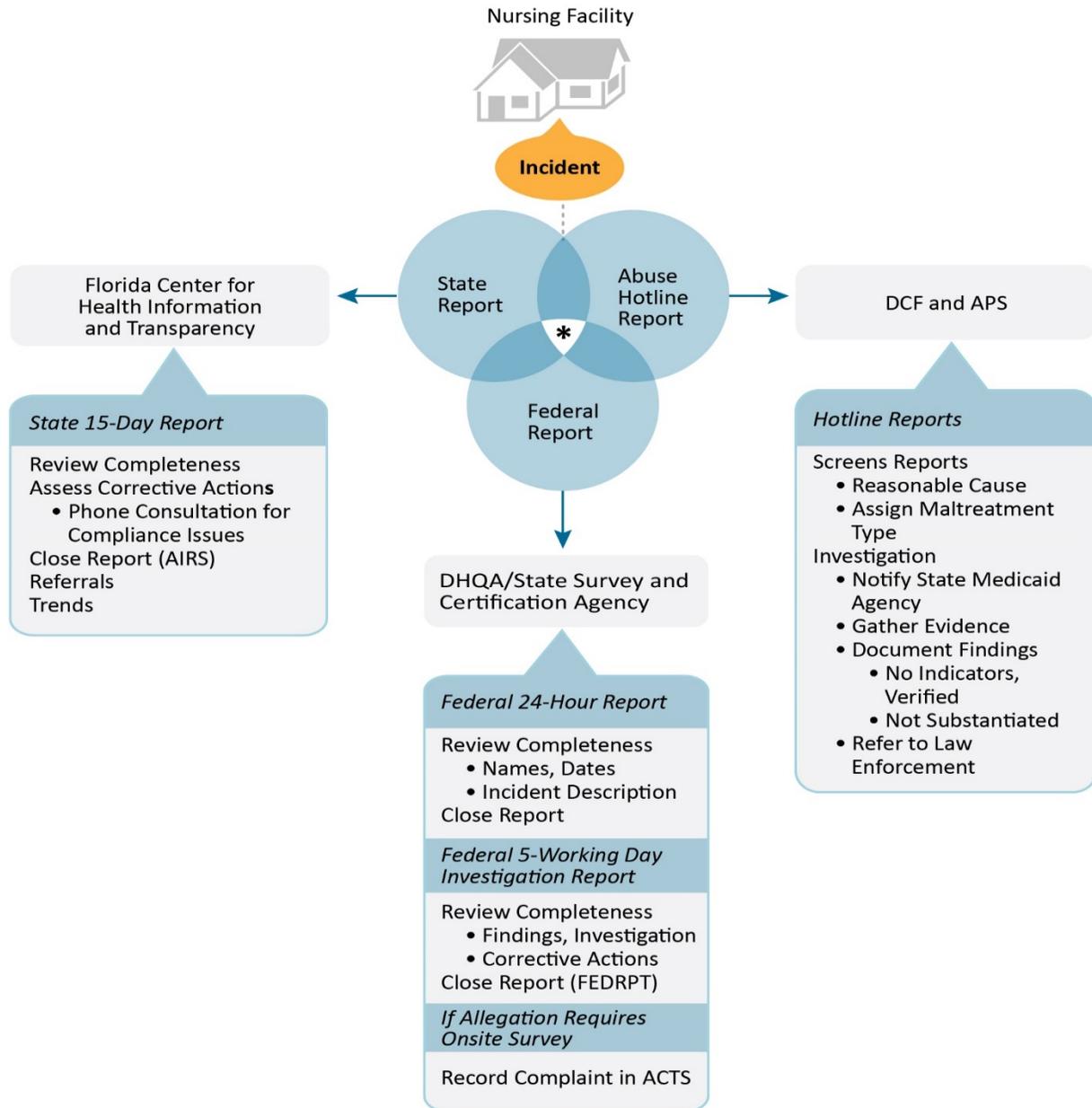
DHQA has access to State Adverse Reports and APS complaint and investigation information; it may use these sources of information to initiate onsite surveys.

Figure 2 shows the process for Federal and State reporting of abuse and neglect incidents in Florida.

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<sup>15</sup> AIRS is a State data system that nursing facilities use to file State Adverse Reports.

**Figure 2: Diagram of Florida Incident Reporting and State Processing**



\* Certain incidents, like neglect, are reported to all 3 State agencies.

## HOW WE CONDUCTED THIS AUDIT

Using data provided by AHCA, we identified 87,568 inpatient and outpatient hospital claims with dates of service for 2016<sup>16</sup> (audit period) and with emergency department visits made by Florida’s Medicaid beneficiaries residing in nursing facilities at that time. We matched the

<sup>16</sup> We used CY 2016 Medicaid claims because 2016 data were the most current and complete available from the State when we initiated this audit.

medical diagnoses on 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 indicated a significant likelihood of abuse or neglect, and the second list included diagnosis codes that indicated possible abuse or neglect.<sup>17</sup> We identified 4 claims with diagnosis codes that matched the first list and 2,535 that matched the second list. Of these, we reviewed all 4 claims with diagnosis codes that matched the first list and a random sample of 100 claims with diagnosis codes that matched the second list.

For these 104 claims with emergency department visits, we reviewed nursing facility, hospital, and DHQA documentation to determine whether the nursing facilities properly reported potential abuse or neglect and whether DHQA properly assessed, prioritized, recorded, and initiated surveys of allegations or incidents of potential abuse or neglect. We requested that DHQA review the hospital and nursing facility records to determine whether the emergency department visits involved improper nursing care or treatment that occurred in the nursing facility that nursing facility administrators should have reported to DHQA. We further reviewed DHQA's policies and procedures related to its complaint and incident program. Additionally, we interviewed DHQA, Florida Center, and DCF/APS officials and employees regarding operations and analyzed DHQA's systems for processing complaints and incident reports.<sup>18</sup> We visited 10 nursing facilities to confirm our understanding of the reporting process and verified whether nursing facility staff could access DHQA's FEDRPT and the Florida Center's AIRS electronic reporting portals used for filing Federal and State incident reports.

We attempted to evaluate DHQA compliance with Federal requirements, including deadline requirements where applicable, for completing an assessment of an incident and assigning a priority level, and initiating an investigation when applicable, and recording incidents of potential abuse or neglect in ACTS for facility-reported incidents. We reviewed how DHQA used ACTS, and we requested that the DHQA trace Federal 24-Hour Reports and State Adverse Reports to ACTS.<sup>19</sup> In addition, we determined the number of incidents (Federal 24-Hour Reports and State Adverse Reports) DHQA and the Florida Center received and the numbers of these incidents that resulted in an onsite survey during our audit period and were recorded in ACTS.

We performed additional procedures to evaluate DHQA's effectiveness to meet the program's goal of promoting and protecting the health, safety, and welfare of nursing facility residents.

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<sup>17</sup> We developed the diagnosis code lists and used them for other OIG audits including *CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect*, A-01-17-00513, June 2019.

<sup>18</sup> This audit focuses on adverse incidents required to be reported by nursing facilities and how DHQA manages those reported incidents. It also includes how DHQA manages Adult Protective Services (APS) investigation notifications sent to DHQA when APS initiates and closes an investigation of abuse or neglect in licensed nursing facilities. This audit excludes how DHQA manages complaints that it receives and processes. DHQA uses a different process for managing complaints.

<sup>19</sup> The SOM, chapter 5, provides no guidance on how information from the Federal 5-Working-Day Investigation Report should be processed or used to enter information into ACTS.

We reviewed DHQA staffing qualifications and staffing levels. We reviewed DHQA's established practice for conducting incident intake assessments and for processing Federal 24-Hour Reports and Federal 5-Working-Day Investigation Reports. Also, we reviewed how the established practice may have limited the number of onsite surveys conducted and how they affected the accuracy and completeness of information recorded in ACTS. For 8,334 Federal 24-Hour Reports involving abuse or neglect, we calculated the length of time between the incident occurrence and the date the nursing facility filed its report with DHQA to identify the number of Federal 24-Hour Reports and Federal 5-Working-Day Investigation Reports that nursing facilities filed late.<sup>20</sup> We reviewed how DHQA processed APS hotline complaints by matching our sampled claims with abuse or neglect investigations that APS had conducted during CY 2016 in which the beneficiary may have been named as a victim. We traced, or attempted to trace, six beneficiaries who were named as victims in APS investigations, two of whom DHQA staff determined were residents in immediate jeopardy situations, to nursing facility Federal 24-Hour Reports, Federal 5-Working-Day Investigation Reports, and State Adverse Reports to determine how DHQA staff had processed these 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 our sample results and estimates, Appendix D contains a summary of sample items with diagnosis codes indicating possible abuse or neglect, and Appendix E contains a list of related OIG reports.

## FINDINGS

DHQA did not ensure that nursing facilities always reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Of our sample of 104 Medicaid claims with emergency department visits associated with diagnoses indicating potential abuse or neglect, nursing facilities should have reported 15 incidents associated with claims as potential abuse or neglect or as adverse incidents to DHQA or the Florida Center but did not. Of the remaining 89 claims in our sample, 7 were associated with incidents that did not have sufficient nursing facility documentation for DHQA to determine whether the incident required reporting. For the remaining claims, 1 associated incident was reported, and 81 associated incidents did not require reporting. Facilities did not always report incidents when required because nursing facility officials and DHQA officials did not have the same understanding about what incidents must be reported. Also, Certified Nursing Assistants (CNAs) do not always identify or report to nursing staff incidents of improper care or treatment when they occur. When nursing facilities do not report incidents as required,

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<sup>20</sup> The Florida Center and DCF/APS are not authorized to conduct onsite surveys under the Federal Survey and Certification program; therefore, our testing of nursing home timely report submissions excluded State Adverse Reports and incidents reported to DCF/APS.

DHQA may not be able to conduct timely surveys or pursue legal, administrative, or other remedies to ensure the health, safety, and rights of nursing facility residents.

We could not determine whether DHQA complied with Federal requirements for assigning a priority level, initiating onsite surveys, and recording allegations of potential abuse or neglect. DHQA did not have documentation necessary to support that it complied with Federal requirements. Specifically, DHQA did not document an assessment start date, end date, or priority assignment information for 10,513 Federal 24-Hour Reports received. DHQA did not document this information because it interpreted the SOM as meaning that when onsite surveys were not performed, it was under no Federal obligation to have documentation to support assessment start and end dates and priority level assignments. Because DHQA did not document entry of required information into ACTS, we could not perform the testing necessary to express an opinion on compliance with the SOM, chapter 5, sections 5070 and 5075.1 through 5075.8 requirements.

Lastly, DHQA's incident report program may not have been effective in accomplishing the program's goal and objectives for: (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. Certain internal control deficiencies and practices could limit the effectiveness of DHQA's complaint and incident program. Specifically:

- the absence of written policies and procedures for processing incident reports increased the risk that DHQA would not prioritize and investigate incident reports within prescribed timeframes,
- inadequate intake staffing may have limited DHQA's ability to assess and prioritize incidents,
- inadequate incident report processing may have limited the number of onsite surveys that DHQA conducted and reduced the reliability of ACTS information,
- the absence of written policies and procedures for managing late incident report filings limited DHQA's ability to conduct timely surveys, and
- the absence of written policies and procedures for managing APS abuse and neglect investigation notifications increased the risk that DHQA may not assess and prioritize APS complaints or conduct onsite surveys.

#### **DHQA DID NOT ENSURE THAT NURSING FACILITIES ALWAYS REPORTED POTENTIAL ABUSE OR NEGLECT OF MEDICAID BENEFICIARIES**

DHQA did not ensure that nursing facilities always reported, as required by Federal and State regulations, potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Of our sample of 104 Medicaid claims with emergency department visits associated with diagnoses indicating potential abuse or neglect,

the nursing facilities should have reported 15 incidents associated with claims as potential abuse or neglect or as adverse incidents to DHQA or the Florida Center but did not. Of the remaining 89 claims in our sample, 7 were associated with incidents that did not have sufficient nursing facility documentation for DHQA to determine whether the incident required reporting. For the remaining claims, 1 associated incident was reported, and 81 associated incidents did not require reporting. Table 1 depicts the results of our review of sampled claims.

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

Description	Sample Items
Incidents nursing facilities should have reported under Federal requirements only	2
Incidents nursing facilities should have reported as neglect under both Federal and State requirements	6
Incidents nursing facilities should have reported under State requirements only	7
<b>Subtotal of incidents nursing facilities should have reported but did not</b>	<b>15</b>
Incidents not supported with sufficient nursing facility documentation for DHQA to determine whether the incidents required reporting	7
Incidents nursing facilities reported within 24 hours	1
Incidents not reportable based on available evidence	81
<b>Total</b>	<b>104</b>

Based on our sample of hospital claims of Florida Medicaid beneficiaries with a selected diagnosis who were transferred from a nursing facility to a hospital emergency department, we estimated that 380 of the 2,539 claims (15 percent) were associated with incidents of potential abuse or neglect or other adverse incidents not reported by Florida nursing facilities, and 177 of 2,539 claims (7 percent) were associated with incidents that did not have sufficient documentation for DHQA to determine whether the incident required reporting.

### Federal and State Requirements

Nursing facilities must report alleged violations involving mistreatment, neglect, or abuse (including injuries of unknown sources and misappropriation of resident property) immediately and ensure that the results of their investigations of such allegations are reported to the State Survey and Certification agency (42 CFR §§ 483.13(c)(2) and (4)).<sup>21</sup> Nursing facilities must have evidence that all alleged violations are thoroughly investigated and must prevent further

<sup>21</sup> See footnote 9 regarding revisions to the regulatory reporting requirements.

potential abuse while the investigation is in progress (42 CFR § 483.13(c)(3)).<sup>22</sup> Florida regulations also require reporting of specific adverse incidents<sup>23</sup> occurring in nursing facilities that were within the nursing facility's control or preventable. One of the conditions that requires reporting is the transfer of the resident to an acute care hospital because of an adverse incident. Nursing facilities must complete their internal investigations of such incidents and file State reports within 15 calendar days after the adverse incident occurs (Florida Statute 400.147(7)). CMS, the State Medicaid agency, and the SSCA are responsible for ensuring that nursing facilities continually meet Federal requirements (SOM, chapter 5, § 5000.2) including reporting incidents of potential abuse or neglect. Information regarding the care, treatment, and services provided to residents can come from a variety of sources (SOM, chapter 5, § 5010). The SSCA is required to promptly review information regardless of the source (SOM, chapter 5, § 5310.2) and identify immediate jeopardy situations where the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident (SOM, chapter 5, § 5075.1).

### **Nursing Facilities Did Not Report Some Incidents of Potential Abuse or Neglect**

The nursing facilities should have reported 15 incidents associated with claims in our sample, but they did not. Of the 15 incidents, the nursing facilities should have reported 2 incidents under Federal requirements only, 6 incidents under both Federal and State requirements, and 7 incidents under State requirements only.

Of the remaining 89 incidents associated with claims in our sample, 1 was reported, 7 did not have sufficient nursing documentation to support they did not require reporting, and 81 did not require reporting.

#### *Incidents Reportable Under Federal Requirements Only*

The nursing facilities should have reported 2 of the 15 associated incidents immediately in Federal 24-Hour Reports as either abuse or neglect.

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<sup>22</sup> Ibid.

<sup>23</sup> See footnote 8 for Florida Statute 400.147(5) requirements.

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### **A Representative Example of an Incident Reportable Under Federal Requirements Only**

A resident reported a fall to the facility and complained of breathing difficulty due to pain. The nursing facility sent the resident to a hospital emergency department where the hospital diagnosed the resident with fever, shortness of breath, abnormal rapid heart rate, blood poisoning caused by bacteria, multiple broken ribs, and lacerations to the right finger and left eyebrow. The x-rays showed evidence of previous rib fractures that had healed. DHQA informed us that the location of the broken ribs (5<sup>th</sup>, 8<sup>th</sup>, and 10<sup>th</sup>) was suspicious and indicative of being beaten, instead of a typical fall where sequential ribs (like 8<sup>th</sup>, 9<sup>th</sup>, and 10<sup>th</sup>) would have been broken. The facility had not conducted an internal investigation into the incident and could provide no evidence that the incident was not reportable. DHQA determined that the nursing facility should have filed a Federal 24-Hour Report. Had DHQA known of the incident and conducted a timely survey, it may have cited the nursing facility for noncompliance with the requirement for nursing facilities to file the Federal 24-Hour Report of potential violations of abuse, neglect, or mistreatment.<sup>24</sup>

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#### *Incidents Reportable Under Both Federal and State Requirements*

The nursing facilities should have immediately reported 6 of the 15 associated incidents as neglect and filed Federal 24-Hour Reports. The nursing facilities should then have investigated the incidents, filed the investigation results in the Federal 5-Working-Day Investigation Reports, and filed the State Adverse Report within 15 days.

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### **A Representative Example of an Incident Reportable Under Both Federal and State Requirements**

A resident transferred to the hospital emergency department after being found on the floor by a nurse. The hospital diagnosed the resident with congestive heart failure and a fractured hip. Based on its assessment of nursing records, DHQA determined that the nursing facility's fall risk assessment was incomplete and inaccurate. It should have shown a higher fall risk score. The nursing facility's fall care plan indicated that the resident had bed alarms prior to the current fall, but the resident was turning the alarms off. Nursing facility officials knew the bed alarms were ineffective for protecting the resident from falls, but they did not implement closer supervision to prevent falls. DHQA determined that the incident met the requirements for Federal reporting because the facility neglected to provide necessary services to prevent resident harm. DHQA believes that, had it known of the incident and conducted a timely survey, it may

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<sup>24</sup> 42 CFR § 483.13(c).

have cited the nursing facility for neglect and noncompliance with Federal and State reporting requirements.

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### *Incidents Reportable Under State Requirements Only*

The nursing facilities should have reported seven of the associated incidents as State adverse incidents within 15 days because they resulted in transfers to hospital emergency departments.<sup>25</sup>

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#### **A Representative Example of an Incident Reportable Under State Requirements Only**

A resident transferred to a hospital after a ground level fall at 3 a.m. in the nursing facility hallway. The resident fell forward, cutting an eyebrow and bruising an arm. Facility records indicate that the resident engaged in pacing behavior and had another fall 3 days earlier, evidence that the facility was aware of the resident's fall risk.<sup>26</sup> Because the incident was preventable and the resident was transferred to an acute level of care, a State Adverse Report should have been filed.

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### *Incidents Insufficiently Documented*

For 7 of the 104 sampled claims, nursing facilities did not have sufficient documentation to allow DHQA to determine whether the injury necessitating an emergency room visit was an associated incident caused by a Federal reportable violation or a State adverse event.

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#### **A Representative Example of an Insufficiently Documented Incident**

A resident transferred to a hospital after trying to pick up a cigarette from the ground. The resident fell from a seated position in a wheelchair and cut her head. The hospital performed a brain scan and closed the wound. The nursing facility's accident report, transfer form, and resident information did not include sufficient information for DHQA officials to determine whether this incident was reportable. The resident had a care plan that required a protective helmet and supervision when outside. Neither the accident report nor the nursing notes indicated whether the resident was wearing the helmet or was being supervised when the incident occurred. Given the head injury, it appears that the care plan

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<sup>25</sup> Five of the seven incidents involved falls, one incident involved choking, and one incident involved accidental drug poisoning.

<sup>26</sup> However, the nursing records did not support that staff knew the resident was awake at night, which would have required supervision at night to prevent falls; therefore, DHQA staff felt that the nursing facility was not required to file a Federal 24-Hour report for neglect.

may not have been followed. DHQA officials indicated that, based on the limited information provided on the nursing facility's accident report, this incident looked like facility neglect, which would have been reportable under Federal requirements. However, without information about whether the resident's care plan was followed, DHQA officials could not make a definitive determination that it was neglect.

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### *Incidents Reported or Not Reportable*

For 1 of the 104 sampled claims, the nursing facility properly reported and investigated a potential sexual abuse associated incident by filing the Federal 24-Hour Report, 5-Working-Day Investigation Report, and the State Adverse Report, and by calling the DCF Hotline and local law enforcement. For the remaining 81 sampled claims, DHQA determined that associated incidents were not reportable under Federal or State regulations.

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### **A Representative Example of an Incident Not Reportable**

A nursing facility sent a resident with a broken arm to the hospital emergency department. The resident was trying to transfer himself to a wheelchair from his bed when he fell. The resident had a care plan in place that required him to request assistance for transfers. He was cognitively intact and did not follow instructions to request assistance with this transfer. There was no evidence in the nursing records that the fall was caused by abuse or neglect, and there was no evidence that the fall could have been prevented by the nursing facility. Therefore, the incident was not reportable under Federal or State regulations.

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### *Nursing Facility Explanations for Not Reporting Incidents*

Nursing facility officials and DHQA officials did not always have the same understanding about what incidents must be reported. Some nursing facility administrators said that they may not have reported incidents because of different interpretations of what is reportable at the Federal and State levels. Other administrators suggested that they may not always be aware of the need for a Federal 24-Hour Report or State Adverse Report because CNAs do not always identify or report to the nursing staff incidents of improper care or treatment when they occur; the nursing staff is responsible for informing administrators of events that are reportable.

When nursing facilities do not report incidents to DHQA, DHQA may not be able to initiate timely surveys or pursue legal, administrative, or other appropriate remedies to ensure the health, safety, and rights of nursing facility residents.

## **WE COULD NOT DETERMINE WHETHER DHQA COMPLIED WITH FEDERAL REQUIREMENTS FOR PROCESSING INCIDENT REPORTS WITHIN 2 WORKING DAYS**

### **Federal Requirements**

SOM, exhibit 23, “ACTS Required Fields,” specifies data entry coding of the intake type (incident) and indicates that the nursing home should record a start date (when the incident was received), an end date (when there is sufficient information to prioritize the incident), and a priority level.

SOM, chapter 5, section 5070, requires that each incident be assessed and assigned a priority level within 2 working days of its receipt.<sup>27</sup> SOM, chapter 5, sections 5075.1 through 5075.8, specify the eight priority levels (footnote 13) that can be assigned in ACTS; SOM, chapter 5, section 5075.9, specifies the timeframes for initiating onsite surveys (when required).

### **DHQA Did Not Have Documentation Necessary To Support That It Complied With Federal Requirements**

DHQA did not have assessment start date, end date, and priority level assignment information for 10,513 Federal 24-Hour Reports received. Without this information, we could not determine whether DHQA complied with the 2-working-day assessment deadline, priority level requirements, or initiation of onsite surveys within prescribed timeframes.

DHQA did not document this information because it interpreted the SOM, chapter 5, section 5060, as meaning that when onsite surveys were not performed, DHQA was under no Federal obligation to have support for incident report assessment start date, end date, or priority level assignment.

Because DHQA did not document the assessment start date, end date, or priority level or record this information in ACTS, we could not perform audit testing necessary to express an opinion on compliance with requirements of the SOM, chapter 5, sections 5070 and 5075.1 through 5075.8, for assigning priority levels within 2 working days. DHQA officials told us that, as a result of our audit, DHQA changed its process on October 1, 2018, to enter ACTS required field information for all Federal 24-Hour Reports.

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<sup>27</sup> The requirement that incidents be assigned a priority within 2 working days, while in place during this audit period, was removed under revision 199, effective July 19, 2019. However, immediate jeopardy situations must still be investigated within 2 business days.

## DHQA'S INCIDENT REPORT PROGRAM MAY NOT HAVE BEEN EFFECTIVE

### Federal Requirements and Internal Controls

CMS notifies States in its section 1864 agreement<sup>28</sup> that they must follow 45 CFR section 75.303, which requires a non-Federal entity to establish and maintain effective internal controls over a Federal award. In addition, SOM, chapter 4, section 4003, specifies SSCA administrative responsibilities to establish and maintain organizational relationships with other State organizations, such as APS, for attaining program goals, and responsibilities for records that provide an evaluation of program operation effectiveness and workload analysis. SOM, chapter 5, section 5000.1, specifies the three objectives of the Federal complaint and incident management system and how the SSCA is to accomplish them. The first objective, protective oversight, is accomplished by analyzing reported incidents received to identify and respond to those that appear to pose the greatest potential for harming residents as evidenced by having caused, or being likely to cause, serious injury, harm, impairment, or death. Incidents of this type are prioritized and investigated immediately. The second objective, prevention, is accomplished by analyzing reported incidents received to identify and respond to them to determine whether a problem exists that could have a negative impact on the health care services provided by the nursing facility. Incidents of this type are also to be prioritized and investigated based on the seriousness of the incident. The third objective, efficiency and quality, is accomplished by analyzing reported incidents and identifying those that are not directly related to Federal CoPs and forwarding them to appropriate State organizations for follow-up and investigation. Incidents of this type may include, but are not limited to, Medicaid fraud and billing issues.

Internal control is a process affected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives will be achieved. In Florida, DHQA management is responsible for implementation and operation of the internal control system. Management should establish internal controls through written policies and procedures, staffing, and evaluations of results. A deficiency in internal controls exists when a control is missing or when properly designed controls are not implemented correctly.

We identified internal control deficiencies and practices that could limit the effectiveness of the incident report program. Specifically:

- the absence of written policies and procedures for processing incident reports increased the risk that DHQA would not prioritize or investigate incident reports within prescribed timeframes;

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<sup>28</sup> At the time of the drafting of this agreement in 1984, the requirements in 45 CFR § 75.303 were found within OMB Circular A-87, with which compliance is required per the agreement.

- inadequate intake staffing may have limited DHQA’s ability to assess and prioritize incidents;
- inadequate incident report processing may have limited the number of onsite surveys that DHQA conducted and reduced the reliability of ACTS information;
- the absence of written policies and procedures for managing late incident report filings limited DHQA’s ability to conduct timely surveys; and
- the absence of written policies and procedures for managing APS abuse and neglect investigation notifications increased the risk that DHQA may not assess and prioritize APS complaints or conduct onsite surveys.

**The Absence of Written Policies and Procedures for Processing Incident Reports Increased the Risk That DHQA Would Not Prioritize or Investigate Incident Reports Within Prescribed Timeframes**

SOM, chapter 5, section 5010, requires each SSCA to have written policies and procedures to ensure that the State responds appropriately for each complaint. Effective internal controls require that management communicates to personnel the policies and procedures so that personnel can implement the control activities for their assigned responsibilities.

DHQA had written policies and procedures for processing complaints it received, but it did not have written policies and procedures for processing Federal 24-Hour Reports, Federal 5-Working-Day Investigation Reports, and State Adverse Reports. DHQA officials told us that they did not believe that DHQA needed written policies and procedures for processing these reports because the SOM, chapter 5, section 5010, required written policies and procedures for processing complaints but not explicitly for reported incidents.

Written policies and procedures can help ensure that staff: (1) obtain comprehensive information to enable an accurate assessment of incident report information to identify potential noncompliance with CoPs, (2) assign the appropriate priority level to all incidents based on the urgency and severity of harm suffered by the resident, and (3) accurately record all incident and priority information in ACTS so that timely surveys can be initiated. Without written policies and procedures for processing Federal 24-Hour Reports and State Adverse Reports, the risk increases that DHQA will not assess reported incidents for noncompliance with CoPs, make priority assignments, or initiate surveys within the SOM, chapter 5, section 5075.9, prescribed timeframes. This increased risk could result in harm to nursing facility residents.

**Inadequate Intake Staffing May Have Limited DHQA’s Ability To Assess and Prioritize Incidents**

SOM, chapter 5, section 5070, requires that “incident intake must be made by an individual who is professionally qualified to evaluate the nature of the problem based upon his/her

knowledge of Federal requirements and his/her knowledge of current clinical standards of practice.”

DHQA had only 1 administrative staff member assigned to process 12,110 incident reports in CY 2016. Assuming that this individual worked 40 hours per week, and took no vacation, sick leave, or breaks, we calculated that processing this number of incident reports would have allowed her only about 10 minutes to process each report ((40 hours per week x 60 minutes per hour x 52 weeks per year)/12,110). In addition, the staff member assigned to process incident reports was not a clinician who would be required to maintain her knowledge of current clinical standards of practice. DHQA staff stated that nurses were available for consultation if the administrative staff member had a question. As a result of our audit, DHQA hired a nurse to conduct the assessments.

When DHQA does not assign a sufficient number of qualified individuals to evaluate incidents, the risk increases that DHQA will not: (1) assign an appropriate priority level to incidents or (2) perform onsite surveys to investigate incidents when required.

### **Inadequate Incident Report Processing May Have Limited the Number of Onsite Surveys That DHQA Conducted and Reduced the Reliability of ACTS Information**

SOM, chapter 5, section 5070, requires an assessment of reported incidents and provides that “for nursing homes, an onsite survey may not be required if there is sufficient evidence that the facility does not have continuing noncompliance and the alleged event occurred before the last standard survey.” SOM, chapter 5, sections 5075.1 through 5075.9, discuss the priority levels an SSCA should assign based on the urgency and severity of resident harm and the timeframes for initiating onsite surveys. SOM, chapter 5, section 5050, states that CMS expects that noncompliance with Federal requirements resulting from a reported incident or complaint receive followup and be documented in ACTS. Exhibit 23, “ACTS Required Fields,” specifies what data should be recorded in ACTS.

The administrative staff member assigned to process incident reports only assessed the reports for completeness<sup>29</sup> and evidence that an onsite survey was not required. The assessment was not documented in ACTS, and the established practice did not include an evaluation of compliance with CoPs, an assessment of the urgency and severity of harm to the resident, or the assignment of a priority level. In addition, the established practice did not include requests for the facility to provide any evidence, and the established practice relied on the 5-Working-Day Investigation Report as evidence to support that the facility did not have continuing noncompliance. Finally, the established practice did not include a determination of whether

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<sup>29</sup> DHQA’s established practice requires the review of the 24-Hour Initial Report for complete information including the resident’s name, alleged perpetrator (if applicable), incident date and time, a clear description of the incident, and whether the incident had been reported to DCF or law enforcement. For the Federal 5-Working-Day Investigation Report, the completeness review confirms that the report included investigation findings, results, and nursing facility corrective actions. If information was incomplete, staff could call the nursing facility to inquire about missing information.

the alleged incident occurred before or after the last standard survey.<sup>30</sup> A determination that an incident occurred after the last standard survey should have triggered an analysis of the urgency and the severity of harm to the resident, assignment of an appropriate priority level, and initiation of an onsite survey within the prescribed timeframes (when appropriate).<sup>31</sup>

Inadequate incident report processing occurred because DHQA had misinterpreted the SOM requirements as not requiring comprehensive assessments, priority assignments, and onsite surveys when nursing facilities submitted complete reports in which findings, nursing facility investigation steps, and corrective actions were specified. Under DHQA's established practice, DHQA said that it conducted only 40 onsite surveys based on its assessments of the 12,110 (Federal and State combined) reported incidents DHQA received.

Without proper processing of reported incidents, onsite surveys would not be initiated when residents are in immediate jeopardy situations, nursing facilities would not be held accountable for providing improper care or inadequate treatment to residents, and ASPEN/ACTS would not contain reliable information for monitoring nursing facility continual compliance with CoP requirements. As a result of our audit, DHQA officials said that since it began entering all reported incidents in ACTS in October 2018 and hired a nurse to conduct the assessments, it has increased the number of onsite surveys conducted.

#### **The Absence of Written Policies and Procedures for Managing Late Incident Report Filings Limited DHQA's Ability To Conduct Timely Surveys**

For allegations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, nursing facilities must ensure that they file a Federal 24-Hour Report (42 CFR § 483.13(c)(2)). Nursing facilities must also report the results of all investigations to the facility administrators and the SSCA within 5 working days of the incident (42 CFR § 483.13(c)(4)). The SSCA should promptly review incidents, conduct onsite investigations, and inform CMS and the State Medicaid Agency any time nursing facilities are found to be out of compliance (SOM, chapter 5, § 5000.2).

DHQA officials said that they did not have policies and procedures for how to manage late filings. Without written policies and procedures for managing late filings, there is an increased risk that late filings will not be assessed for noncompliance with CoPs, priority assignments will not be made, and surveys will not be initiated within the required timeframes.<sup>32</sup> Not managing late filings could increase the risk that residents, especially those in immediate jeopardy, are not protected from ongoing abuse or neglect that could result in serious injury or death.

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<sup>30</sup> A standard survey means a periodic, resident-centered inspection that gathers information about the quality of services furnished in a facility to determine compliance with the requirements of participation (42 CFR § 488.301).

<sup>31</sup> SOM, chapter 5, § 5070.

<sup>32</sup> See footnote 9 for the definition of "immediate" timeframe for filing.

## **The Absence of Written Policies and Procedures for Managing APS Abuse and Neglect Investigation Notifications Increased the Risk That DHQA May Not Assess and Prioritize APS Complaints or Conduct Onsite Surveys**

The APS investigative process mandates it notify DHQA, no later than the next working day, of receiving a report that alleges a nursing facility resident has been abused or neglected. SOM, chapter 5, section 5000.2, requires all the procedures in SOM, chapter 5, are followed when complaints and reported incidents, including referrals from public entities such as APS, involve Medicaid-certified providers. The investigation and resolution of complaints are critical certification activities. SOM, chapter 5, section 5010, states that each SSCA is expected to have written policies and procedures to ensure that the appropriate response is taken for each complaint.

DHQA did not have written policies and procedures to ensure that the appropriate response is taken for abuse and neglect complaints associated with investigation notifications received from APS. Written policies and procedures for responding to abuse and neglect investigation notifications received from APS are needed to ensure that that DHQA staff will assess these APS complaints for nursing facility noncompliance with CoPs, assign a priority level, and initiate an onsite survey (when required). For example, our sample included a claim associated with an incident that resulted in an APS hotline complaint and an APS investigation notification to DHQA. Because the APS complaint included allegations of a suspicious bone fracture,<sup>33</sup> inadequate supervision, medical neglect, and physical injury, DHQA should have assigned an immediate jeopardy priority level, recorded the incident in ACTS, and initiated a survey within 2 working days of receipt of the APS investigation notification. However, DHQA did none of these things.

If DHQA had written policies and procedures for how to process APS investigation notifications, it is likely that it would have assigned an immediate jeopardy priority level, recorded the incident in ACTS, and initiated a survey within 2 working days of receipt of the APS notification.<sup>34</sup> Had that happened, the nursing facility might have been cited for neglect that caused the harm, and AHCA might have initiated enforcement remedies to hold the nursing facility accountable and possibly prevent future neglect.

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<sup>33</sup> A bone fracture can be an injury of unknown origin and is an example of an allegation or assertion of improper care that could result in the citation of a Federal deficiency.

<sup>34</sup> At our request, DHQA staff reviewed the APS complaint and indicated that this resident was in an immediate jeopardy situation that required an onsite survey be initiated within 2 working days. Spiral bone leg fractures are suspicious because they can occur when health care workers neglect to follow the resident's care plan for transferring the resident from a wheelchair to a bed. A care plan for a resident with brittle bones requires a two-person assist to lift the resident from a wheelchair to a bed to prevent injuries. When only one worker is available and cannot lift the resident, the worker may force the resident to stand up and pivot from the wheelchair to the bed. This motion causes the leg to twist, resulting in a spiral-shaped fracture. Spiral leg fractures are often the result of neglect, which is the failure to provide sufficient staff to perform transfers in a manner that would avoid physical harm.

DHQA staff members said that they did not have any written policies or procedures for managing APS investigation notifications because APS officials believed it would be a duplication of investigative efforts if DHQA conducted noncompliance surveys of nursing facilities when APS also conducted investigations.<sup>35</sup>

The absence of written policies and procedures for managing APS investigation notifications increases the risk that DHQA: (1) will not assess APS complaints for noncompliance with CoPs, (2) may not record an APS complaint in ACTS, (3) will not make priority assignments, and (4) will not initiate onsite surveys that could identify CoPs noncompliance. By not having any written policies or procedures for managing APS investigation notifications, DHQA placed nursing facility residents at higher risk of abuse or neglect without adequate protection by AHCA enforcement actions.

## **CONCLUSION**

We shared our findings with DHQA so that it could take immediate corrective action. We also shared our findings with CMS. Although nursing facility management and staff are ultimately responsible for ensuring resident protection from abuse or neglect, DHQA can reduce the risk of resident harm by improving oversight and operational effectiveness of incident report processing.

DHQA did not ensure that nursing facilities always reported potential abuse or neglect of Medicaid residents transferred from nursing facilities to hospital emergency departments. Better DHQA oversight could hold nursing facilities accountable for accurate reporting and reduce occurrences of harm to residents.

Furthermore, because of limited documentation, we could not determine whether DHQA complied with Federal requirements for completing assessments of reported incidents, assigning priority levels, or initiating onsite surveys within prescribed timeframes. Without assessment and priority level information recorded in ACTS for the 12,110 reported incidents, we could not conduct the audit work necessary to express an opinion on compliance with Federally prescribed timeframes.

Lastly, internal control deficiencies and DHQA practices limited the effectiveness of DHQA's incident report processing. These deficiencies and practices included: the absence of written policies and procedures for processing incident reports; inadequate staffing without knowledge of clinical standards of practice responsible for making assessments; inadequate incident report intake processing for assessing report completeness instead of assessing for noncompliance with CoPs, resident harm, and whether the incident occurred after the last standard survey; the absence of policies and procedures for managing incident report late filings, and the absence of policies and procedures for processing APS investigation notifications and requiring assessment,

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<sup>35</sup> DHQA surveys do not duplicate APS investigations because only the State Survey and Certification Agency can perform surveys for compliance with CoPs, cite deficiencies, and initiate remedies that may better protect residents. SOM, chapter 5, § 5000.2, specifies that State Survey and Certification Agency responsibilities cannot be delegated to APS or other entities.

prioritization, and onsite surveys when APS abuse and neglect complaints indicate potential noncompliance with CoPs.

After our audit period, DHQA officials said that they planned to take a number of actions to improve the effectiveness of its operations. These actions included written procedures, hiring additional staff to process incident intakes, and recording all Federal incidents in the ACTS system. These actions, in conjunction with additional onsite surveys and implementation of our recommendations below, will improve DHQA's ability to hold nursing facilities accountable for continuous compliance with quality of care standards and to reduce the risk of abuse or neglect to nursing facility residents.

## **RECOMMENDATIONS**

We recommend that the Florida Agency for Health Care Administration, Division of Health Quality Assurance:

- work with CMS to provide clear guidance to nursing facilities regarding what constitutes a reportable incident;
- establish procedures that include documenting assessment start and end dates and priority level assignments;
- establish and implement written policies and procedures for incident report processing;
- evaluate its staffing levels to determine whether staffing is adequate;
- improve the intake process by:
  - assessing all Federal 24-Hour Reports to identify whether potential noncompliance with quality of care standards caused the incidents and whether the incident occurred after the last standard survey;
  - assessing the severity and urgency of harm to the resident(s) that may have been caused by abuse, neglect, or nursing facility noncompliance with CoPs to assign a priority level; and
  - using ACTS to create an incident record with start and end dates for all Federal 24-Hour Report assessments and to record priority assignments;
- establish and implement written policies and procedures for managing incident report late filings and consider immediately initiating onsite surveys of nursing facilities that file Federal 24-Hour Reports late; and

- establish and implement written policies and procedures for managing APS complaint notifications and conducting assessments of APS complaints to identify and survey more facilities where resident harm may have been caused by nursing facility noncompliance.

## **DIVISION OF HEALTH QUALITY ASSURANCE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, DHQA commented on two of our three findings and concurred or partially concurred with six of our seven recommendations. DHQA described actions taken and processes modified or implemented to address our findings and recommendations. However, DHQA did not concur with our recommendation to take specific steps to improve its intake process.

DHQA's comments are included in their entirety as Appendix F.

In addition to its formal comments on our draft report, DHQA also provided technical comments. Based on those comments and additional supporting documentation that it provided, we adjusted the number of incident reports processed in CY 2016.

### **DHQA DID NOT ENSURE THAT NURSING FACILITIES ALWAYS REPORTED POTENTIAL ABUSE OR NEGLECT OF MEDICAID BENEFICIARIES**

#### **Division of Health Quality Assurance Comments**

DHQA partially concurred with our recommendation that it work with CMS to provide clear guidance to nursing facilities regarding what constitutes a reportable incident and requested that we modify the title of the report and the heading of the finding associated with this recommendation. DHQA agreed that nursing facilities did not always report potential abuse or neglect of Medicaid beneficiaries, but it did not agree that this lack of reporting implied a failure on DHQA's part. DHQA also agreed that nursing facility staff did not always properly identify reportable incidents and that a lack of proper understanding of reporting requirements was a key cause of under-reporting by nursing facilities. However, DHQA maintained that failure to submit required reports of potential abuse or neglect was a failure of the nursing facility, not of DHQA, and that providing clear guidance to nursing facilities regarding what constitutes a reportable incident is CMS's responsibility. Therefore, DHQA requested the title of the report and the heading of the finding both be changed to "Nursing Facilities Did Not Always Report Incidents of Potential Abuse or Neglect."

#### **Office of Inspector General Response**

We agree that it is part of each nursing facility's responsibility to report incidents of potential abuse or neglect. However, as the SSCA, DHQA is responsible for ensuring that nursing facilities comply with pertinent Federal requirements, including reporting allegations of mistreatment, neglect, and abuse. Therefore, we maintain that the title of our report and the heading of our finding are accurate, and we maintain that our recommendation that DHQA work with CMS to

provide clear guidance to nursing facilities regarding what constitutes a reportable incident is valid.

## **WE COULD NOT DETERMINE WHETHER DHQA COMPLIED WITH FEDERAL REQUIREMENTS FOR PROCESSING INCIDENT REPORTS WITHIN 2 WORKING DAYS**

### **Division of Health Quality Assurance Comments**

DHQA partially concurred with our recommendation that it establish procedures that included documenting assessment start and end dates and priority level assignments, but it did not specifically comment on this finding. DHQA maintained that Federal regulations did not require ACTS entries for each reported incident during our audit period, unless an onsite investigation was initiated. Additionally, DHQA stated that, effective October 1, 2018, it had modified its processes to start entering all facility-reported incidents into the ACTS system, which included the start date, the end date, and the date and time the report was prioritized.

### **Office of Inspector General Response**

These modifications could have allowed us to determine whether DHQA processed incident reports within 2 working days, as required during our audit period by SOM, chapter 5, section 5070. We have not evaluated the changes to its processes, which DHQA implemented after our audit period, but, if they work as DHQA claims, then they should satisfy our recommendation that DHQA establish procedures that include documenting assessment start and end dates and priority level assignments and prevent a recurrence of this finding for incidents requiring such reporting.

## **DHQA'S INCIDENT REPORT PROGRAM MAY NOT HAVE BEEN EFFECTIVE**

### **Recommendation: Establish and Implement Written Policies and Procedures for Incident Report Processing**

#### *Division of Health Quality Assurance Comments*

DHQA partially concurred with our recommendation that it establish and implement written policies and procedures for incident report processing because, at the time of receiving the audit report in September 2020, DHQA had already improved its processes. Specifically, DHQA created a formal written process for ACTS entry in January 2019, and it continues to update the process as needed.

#### *Office of Inspector General Response*

Although we have not reviewed the improved processes, if DHQA has fully implemented written procedures, they should improve the effectiveness of its incident reporting program.

## **Recommendation: Evaluate Its Staffing Levels To Determine Whether Staffing is Adequate**

DHQA concurred with our recommendation to evaluate its staffing levels to determine whether staffing is adequate. DHQA stated that it hired two additional nurses in 2019, and it recently received approval for additional positions. Furthermore, it is in the process of making another full-time nurse available for review of incident reports.

## **Recommendation: Improve the Intake Process**

### *Division of Health Quality Assurance Comments*

DHQA did not concur with our recommendation to improve the intake process by: (1) assessing all Federal 24-Hour Reports to identify whether potential noncompliance with quality of care standards caused the incidents and whether the incident occurred after the last standard survey to identify incidents requiring onsite surveys; (2) assessing the severity and urgency of harm to the resident(s) that may have been caused by abuse, neglect, or nursing facility noncompliance with CoPs to assign a priority level; and (3) using ACTS to create an incident record with start and end dates for all Federal 24-Hour Report assessments and to record priority assignments. DHQA stated that it had a process in place for assessing all Federal 24-Hour Reports and the severity and urgency of potential harm and it has been using the Federal ACTS system according to CMS procedural manuals.

### *Office of Inspector General Response*

Although DHQA did not concur with the specific steps that we recommended to improve its intake process in this recommendation, DHQA indicated that it records information in ACTS and gives it a priority assignment. DHQA interpreted our original recommendation to imply that an onsite survey was required for all incident reports, but that was not our intent. We modified our recommendation to remove this possible implication and believe that the recommendation, as modified, is valid.

## **Recommendation: Establish and Implement Written Policies and Procedures for Managing Incident Report Late Filings**

### *Division of Health Quality Assurance Comments*

DHQA partially concurred with our recommendation that it establish and implement written policies and procedures for managing late incident report filings and consider immediately initiating onsite surveys of nursing facilities that file Federal 24-Hour Reports late. DHQA stated that it was monitoring for late reporting but admitted that the monitoring process was not in writing and implied that it has since described this process in writing. DHQA also stated that late reporting alone should not be the sole consideration to initiate an onsite survey. Finally, DHQA disagreed with the method used to determine that reports were filed late because we relied on summary data that was flawed.

### *Office of Inspector General Response*

After reviewing DHQA's response, we agreed that the method we used relied on summary data provided by DHQA that was flawed, so we removed these calculations from the report. Nevertheless, the finding regarding lack of written policies and procedures and the related recommendation remain valid.

#### **Recommendation: Establish and Implement Written Policies and Procedures for Managing APS Complaint Notifications**

Although DHQA indicated that it partially concurred with our recommendation, it indicated that it had established and implemented written policies and procedures for managing APS complaint notifications and conducting assessments of APS complaints to identify and survey more facilities in which noncompliance may have caused resident harm. DHQA said that it established a written protocol for processing APS reports in December 2018, and, now, it reviews each immediate report received along with the APS intake report.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Using data provided by AHCA, we identified 87,568 inpatient and outpatient hospital claims with dates of service for 2016 (audit period) and with emergency department visits made by Florida's Medicaid beneficiaries residing in nursing facilities 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 potentially 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 4 claims with diagnosis codes that matched the first list and 2,535 that matched the second list. Of these, we reviewed all 4 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 104 claims with emergency department visits, we reviewed nursing facility, hospital, and DHQA documentation to determine whether the nursing facilities properly reported potential abuse or neglect and whether DHQA conducted an assessment, assigned a priority level, initiated an onsite survey (when applicable), and recorded allegations or incidents of potential abuse or neglect in ACTS.

We did not review the overall internal control structures of either DHQA or the nursing facilities associated with the selected sample items. Rather, we reviewed only those internal controls related to our objectives.

### 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 SSCA's responsibilities for analyzing, prioritizing, investigating, and recording allegations of potential abuse or neglect;
- interviewed officials and staff at DHQA and APS to gain an understanding of each entity's responsibilities for protecting Medicaid beneficiaries from abuse and neglect;
- reviewed DHQA, Florida Center, and APS policies and procedures and organization charts;

- reviewed forms for nursing facility incident reporting and other documents including instructions to nursing facilities for using the State reporting portals (FEDRPT and AIRS), screen prints from ACTS and the State’s licensing system, and user manuals to gain more information about how incident reports and complaints are processed;
- observed how DHQA, Florida Center, and APS process incident reports and complaints and identified the electronic systems used to process them;
- obtained from FEDRPT and AIRS State lists of reported incidents of potential abuse or neglect and requested that DHQA trace selected incidents to ACTS;
- obtained a CMS report extracted from ACTS data showing the number of onsite surveys conducted that originated from nursing facility reported incidents and the number originating from complaints;
- discussed with APS officials:
  - the APS policies and procedures for conducting investigations,
  - how and when APS notifies DHQA when abuse or neglect complaints that involve licensed nursing facilities are investigated, and
  - what APS electronic systems and investigation information APS makes available to DHQA;
- reviewed State requirements for nursing facility State Adverse Reporting and compared those requirements to Federal incident reporting requirements;
- reviewed hospital and nursing facility medical records for 104 sampled claims with emergency department visits made by Medicaid beneficiaries while residing in a nursing facility;
- requested that DHQA staff review hospital and nursing facility records to determine whether the medical records indicated a reportable incident of potential abuse or neglect and:
  - reviewed those DHQA determinations and
  - requested DHQA staff identify incidents related to our sampled hospital claims that had been reported to DHQA or the Florida Center and obtained a copy of filed Federal 24-Hour Reports, Federal 5-Working-Day Investigation Reports, and State Adverse Reports;
- reviewed a list of APS investigations during CY 2016 that matched our sampled hospital claims data (patient name, birth date, Social Security number);

- reviewed copies of APS complaint and investigation information (1) to determine whether DHQA used the APS notification to assess harm, assign a priority level, and document the complaint in ACTS and (2) to match with any filed Federal 24-Hour Reports and State reports;
- observed DHQA staff trace APS complaints from DHQA’s electronic system to information recorded in ACTS, or match the APS complaints with electronically or manually filed Federal 24-Hour Reports that were not recorded in ACTS;
- compared APS complaints and investigation details with related Federal 24-Hour Reports to evaluate how DHQA processed and responded to the incident report information;
- obtained CMS officials’ opinions about how CMS expected DHQA to process and respond to specific Federal 24-Hour Reports;
- requested the number of complaints and incident reports received by DHQA in CY 2016 and the number of onsite surveys that DHQA conducted related to those complaints and incidents;
- compared the DHQA number of complaints and incident reports received and onsite surveys conducted with CMS ACTS information;
- compared the incident event date to the incident filing date to evaluate the timeliness of nursing facility compliance with Federal requirements, and evaluated how DHQA managed late filings;
- conducted onsite interviews of nursing facility administrators and Directors of Nursing at 10 nursing facilities with incidents that were—or should have been—reported and verified whether nursing facility officials could access and use the State’s electronic incident reporting portals for filing the Federal and State incident reports; and
- discussed the results of our audit with AHCA, DHQA, and CMS 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.

## **APPENDIX B: STATISTICAL SAMPLING METHODOLOGY**

### **TARGET POPULATION**

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

### **SAMPLING FRAME**

AHCA provided us with Medicaid beneficiary data and claims extracted from its Medicaid Management Information System. This data consisted of Medicaid beneficiary data for beneficiaries who resided in a nursing facility at some time between January 1 through December 31, 2016; hospital claims associated with these same beneficiaries for the same period; and Medicaid beneficiary demographic, nursing facility, and hospital provider information. We matched hospital claims against the nursing facility data and identified instances in which the beneficiaries received treatment in a hospital emergency room during their nursing facility stay.

We then analyzed these hospital claims further and identified claims with selected diagnosis codes. We identified 12 diagnosis codes as having a significant likelihood of being associated with potential abuse or neglect, and we identified 617 other diagnosis codes as possibly being associated with potential 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 the diagnosis codes (admitting, principal, and secondary codes) to identify claims indicating significant likelihood of abuse or neglect. We analyzed the admitting, principal, and secondary diagnosis codes to identify claims with diagnosis codes indicating possible abuse or neglect. The sampling frame was a Microsoft Access database containing 2,539 hospital claims.

### **SAMPLE UNIT**

The sample unit was a hospital claim.

### **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 and selected 104 claims for review as shown in 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	4	4
2	Diagnosis codes indicating possible abuse or neglect	2,535	100
	<b>Total</b>	<b>2,539</b>	<b>104</b>

**SOURCE OF RANDOM NUMBERS**

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS), 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 used the OIG/OAS statistical software to estimate:

- the number of incidents not supported with sufficient nursing documentation and
- the number of incidents that were unreported but required to be reported based on Federal or State regulations.

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

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 3: Sample Results**

<b>Stratum</b>	<b>Frame Size</b>	<b>Sample Size</b>	<b>No. of Incidents Not Supported With Sufficient Nursing Documentation</b>	<b>No. of Incidents Unreported but Required To Be Reported by Federal or State Regulations</b>
1	4	4	0	0
2	2,535	100	7	15
<b>Total</b>	<b>2,539</b>	<b>104</b>	<b>7</b>	<b>15</b>

**Table 4: Estimates of Incidents of Potential Abuse or Neglect During the Audit Period for Selected Diagnosis Codes**  
*(Limits Calculated at the 90-Percent Confidence Interval)*

<b>Attribute</b>	<b>Percent Point Estimate</b>	<b>Point Estimate</b>	<b>Lower Limit</b>	<b>Upper Limit</b>
Number of incidents not supported with sufficient nursing documentation	7%	177	73	282
Number of incidents unreported but required to be reported by Federal or State regulations	15%	380	234	527

**APPENDIX D: SUMMARY OF SAMPLE ITEMS WITH DIAGNOSIS CODES INDICATING POSSIBLE ABUSE OR NEGLECT**

<b>Diagnosis Code</b>	<b>Code Description</b>	<b>No. of Selected Claims</b>	<b>No. of Incidents of Potential Abuse or Neglect</b>
	<b>Head Injuries</b>		
S0081XA	Abrasion of other part of head, initial encounter	1	1
S0001XA	Abrasion of scalp, initial encounter	1	0
S060X0A	Concussion without loss of consciousness, initial encounter	1	0
S0512XA	Contusion of eyeball and orbital tissues, left eye, initial encounter	1	0
S0083XA	Contusion of other part of head, initial encounter	2	0
S0003XA	Contusion of scalp, initial encounter	1	1
S0232XA	Fracture of orbital floor, left side, initial encounter for closed fracture	1	0
S0181XA	Laceration without foreign body of other part of head, initial encounter	3	2
S0101XA	Laceration without foreign body of scalp, initial encounter	2	0
S06340A	Traumatic hemorrhage of right cerebrum without loss of consciousness, initial encounter	2	0
S066X9A	Traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, initial encounter	1	0
S066X0A	Traumatic subarachnoid hemorrhage without loss of consciousness, initial encounter	1	0
S065X0A	Traumatic subdural hemorrhage without loss of consciousness, initial encounter	3	1
S06300A	Unspecified focal traumatic brain injury without loss of consciousness, initial encounter	1	0
S0993XA	Unspecified injury of face, initial encounter	1	0
S0990XA	Unspecified injury of head, initial encounter	5	0
	<b>Subtotal</b>	<b>27</b>	<b>5</b>

Diagnosis Code	Code Description	No. of Selected Claims	No. of Incidents of Potential Abuse or Neglect
	<b>Bodily Injuries</b>		
S40012A	Contusion of left shoulder, initial encounter	1	0
S40021A	Contusion of right upper arm, initial encounter	1	0
S72112A	Displaced fracture of greater trochanter of left femur, initial encounter for closed fracture	1	1
S72142A	Displaced intertrochanteric fracture of left femur, initial encounter for closed fracture	3	1
S72141A	Displaced intertrochanteric fracture of right femur, initial encounter for closed fracture	3	0
S72032A	Displaced midcervical fracture of left femur, initial encounter for closed fracture	1	0
S72452A	Displaced supracondylar fracture without intracondylar extension of lower end of left femur, initial encounter for closed fracture	2	0
S72002A	Fracture of unspecified part of neck of left femur, initial encounter for closed fracture	2	0
S2242XA	Multiple fractures of ribs, left side, initial encounter for closed fracture	2	2
T148	Other Injury of unspecified body region	1	0
S32402A	Unspecified fracture of left acetabulum, initial encounter for closed fracture	1	1
S72302A	Unspecified fracture of shaft of left femur, initial encounter for closed fracture	1	0
S72012A	Unspecified intracapsular fracture of left femur, initial encounter for closed fracture	1	1
S72011A	Unspecified intracapsular fracture of right femur, initial encounter for closed fracture	3	0
	<b>Subtotal</b>	<b>23</b>	<b>6</b>

	<b>Safety Issues</b>		
Z0471	Encounter for examination and observation alleged adult physical abuse*	1	0
Z0441	Encounter of examination and observation following alleged adult rape*	1	1 <sup>†</sup>
S32511A	Fracture of superior rim of right pubis, initial encounter for closed fracture*	1	0

Diagnosis Code	Code Description	No. of Selected Claims	No. of Incidents of Potential Abuse or Neglect
S3993XA	Unspecified injury of pelvis, initial encounter*	1	0
T403X1A	Poisoning by methadone, accidental (unintentional), initial encounter	2	1
T402X1A	Poisoning by other opioids, accidental (unintentional), initial encounter	1	0
T40601A	Poisoning by unspecified narcotics, accidental (unintentional), initial encounter	2	1
T40604A	Poisoning by unspecified narcotics, undetermined, initial encounter	1	0
R296	Repeated falls	1	0
Z043	Encounter for examination and observation following other accident	1	0
	<b>Subtotal</b>	<b>12</b>	<b>3</b>

	Medical Issues		
T80211A	Bloodstream infection due to central venous catheter, initial encounter	3	0
I96	Gangrene not elsewhere classified	1	0
J690	Pneumonitis due to inhalation of food and vomit	21	1
L89623	Pressure ulcer of left heel, stage 3	1	0
L89624	Pressure ulcer of left heel, stage 4	1	0
L89153	Pressure ulcer of sacral region, stage 3	1	0
L89154	Pressure ulcer of sacral region, stage 4	4	1
L89150	Pressure ulcer of sacral region, unstageable	1	0
B86	Scabies	1	0
R6521	Severe sepsis with septic shock	8	0
	<b>Subtotal</b>	<b>42</b>	<b>2</b>
	<b>TOTAL</b>	<b>104</b>	<b>16</b>

\* These diagnoses are associated with stratum 1 sample items.

† This incident was properly reported by the nursing facility.

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

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<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
<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

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<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 F: DIVISION OF HEALTH QUALITY ASSURANCE COMMENTS



RON DESANTIS  
GOVERNOR

SHEVAUN L. HARRIS  
ACTING SECRETARY

October 29, 2020

Ms. 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: Report Number: A-04-17-08058

Dear Ms. Pilcher:

The State of Florida Agency for Health Care Administration (Agency) appreciates the opportunity to review and comment on the Department of Health and Human Services, Office of Inspector General (HHS/OIG) draft report entitled *Florida Did Not Ensure That Nursing Facilities Always Reported Allegations of Potential Abuse and Neglect of Medicaid Beneficiaries and Did Not Always Assess, Prioritize, or Investigate Reported Incidents* covering the audit period of January 1, 2016 through December 31, 2016.

We agree with the spirit of the report and the desire to identify new ways to explore the appropriate care and services for those vulnerable individuals who reside in nursing facilities. Our team works diligently each day to review complaints, evaluate available reports, and analyze resident and performance data to inform our onsite investigations of nursing facilities; all with the common goal to protect the residents. The Agency is consistently recognized as a leader in CMS Performance Standards for the timeliness and quality of regulatory investigations.

We consider any audit or review an opportunity to examine potential process improvements, consistent with a continuous quality improvement approach. From the start of the OIG review, we immediately moved to respond to observations, including taking action to formalize documentation of processes and modifying practices beyond the CMS requirements for our regulatory oversight. We appreciate the opportunity to provide comments and responses to Findings and Recommendations in the report.

### **Finding:**

Division of Health Quality Assurance Did Not Ensure That Nursing Facilities Always Reported Potential Abuse or Neglect of Medicaid Beneficiaries

### **Agency Comment:**

We request the title phrasing of the Report and Finding be changed to "*Nursing Facilities Did Not Always Report Incidents of Potential Abuse or Neglect...*". It is the responsibility of each nursing facility provider to report incidents of potential abuse or neglect. It is the provider's duty to remain in substantial compliance with Medicare and Medicaid program requirements, and nursing facilities must take the initiative and responsibility for continuously monitoring their own performance to sustain compliance. As the regulatory body, the State Agency reviews a provider's compliance with these responsibilities. According to GAO 2011 Revision,

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Government Auditing Standards, Chapter 7, one of the purposes of audit reports is to make results less susceptible to misunderstanding. Failure to submit required reporting is a failure of the nursing facility, rather than the Agency. The title selected is likely to confuse readers.

The draft report references 104 hospital claims pulled in 2018 from 2016 dates of service, eight of which should have been reported by nursing facilities under federal reporting and seven under state-only reporting requirements. Nursing facilities are required to comply with all CMS and state reporting requirements; when the State Survey Agency (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 an 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.

We appreciate the value of mining claims data as a source of information regarding resident care. The federal nursing home inspection process is driven by the Centers for Medicare and Medicaid Services (CMS) regulations, which does not include review of Medicaid or Medicare claims data. The process for billing and transferring claims data does not support timely use of this data as it generally takes six to 18 months after service before claims can be accessed and analyzed (most programs allow claims to be submitted up to 12 months after the date of service). Federal regulatory investigations generally evaluate current non-compliance (is the provider out of compliance at the date of the inspection); the use of claims data would be a retrospective review. Please refer to footnote #16 in the draft report: "We used CY 2016 Medicaid claims because 2016 data were the most current and complete available from the State when we initiated this audit." This audit was initiated at the end of 2017, almost two years after the dates of service reviewed.

The report cited the nursing facility officials and Certified Nursing Assistants working in nursing facilities did not agree on reportable events and did not always properly identify reportable incidents. We agree that the lack of proper understanding of reporting requirements is a key driver in under-reporting by nursing facilities, and continually review regulations and rules during routine industry training, in-services, and inspections to inform and remind nursing facility staff and operators.

In summary, we agree with the finding of facility under-reporting, but do not agree that it reflects a failure of the State Survey Agency.

**Finding:**

Inadequate Incident Report Processing May Have Limited the Number of Onsite Surveys that Division of Health Quality Assurance Conducted and Reduced the Reliability of ASPEN Complaint Tracking System (ACTS) Information

**Agency Comment:**

We understand the value of documenting review of each incident and moved quickly to add tracking information to formalize the review of each incident. As discussed during the audit our practice has always been to review incidents prior to onsite survey. The report inappropriately references 40 onsite surveys based on assessments of incident reports. We disagree that this

represents the total number of incidents reviewed during onsite inspections but concur that formalizing the process will assist in documenting our actions.

The OIG report references the Agency receipt of 7,323 state incident reports based on information we initially provided. After re-examining this information, our management team has determined that the number of Adverse Incidents originally provided to HHS/OIG was overstated based on a data retrieval anomaly. Our reporting tool was modified to ensure duplicative reports were not pulled and reflects a total of 1,597 nursing home State Adverse Incident reports for CY 2016 instead of the 7,323 number as referenced in the report. The corrected number of incident reports is consistent with historical trends and has been confirmed with staff in the DHQA Florida Center responsible for receipt of state adverse incident reports. We ask the auditors to revise the final report based on this information.

Please see below for responses to the specific recommendations:

**Recommendation #1**

Work with CMS to provide clear guidance to nursing facilities regarding what constitutes a reportable incident.

**Agency Response and Corrective Action Plan:**

The Agency partially concurs with this recommendation.

CMS establishes the requirements for nursing facilities. The Agency provides comments and feedback for improvement when given the opportunity by CMS. The Agency provides ongoing clarification as needed to ensure nursing facilities are reporting as required. This is demonstrated through ongoing partnership with the applicable Florida Nursing Home Associations, along with the annual Nursing Home Association and Agency joint training sessions.

In calendar year 2019, providers were trained on the updated requirements for reporting. Additionally, information is readily available on the Agency's website regarding reporting requirements. All users of the Federal Reporting system can view the definitions and specific examples of abuse and neglect to determine if the facility should report an incident. Staff are available at every survey to provide further information as needed and Agency staff responsible for managing the Federal Reporting system are available to answer questions should a provider need additional guidance.

It is the nursing facility's responsibility to ensure their staff are trained and knowledgeable of the requirements for reporting. Nursing home administrators and all staff are required to have regular abuse and neglect training. All nursing home staff have access to Quality Safety and Education Portal (QSEP) which includes the same training that state surveyors undergo.

The facilities themselves should overcome their barriers to reporting, as described by interviews with OIG staff, including "Nursing facilities did not report incidents because of many influencing factors including: tone at the top; high administrator turnover; self-reporting consequences on performance evaluations and bonuses; reporting increases facility operating costs; time limit to report is too short; conflicting interpretations of what is and is not reportable; complications with electronic reporting portals and passwords; preference for using the internal grievance process; and interpretations of changes in the resident's condition." These factors have less to do with training and education than with the facility's own culture of practices.

**Anticipated Completion Date:**

This recommendation is the responsibility of CMS. However, we will work with CMS as they provide draft revisions for state comment and input.

**Recommendation #2**

Establish procedures that include documenting assessment start and end dates and priority level assignments.

**Agency Response and Corrective Action Plan:**

The Agency partially concurs with this recommendation. The audit period was Calendar Year 2016. At the time of the receipt of this audit report in September 2020, the Agency already improved its processes.

The Agency maintains its position that the Automated Survey Processing Environment (ASPEN) Complaints/Incidents Tracking System (ACTS) entries for each reported incident were not required by federal regulation during the audit period of CY 2016 unless an onsite investigation was initiated. However, effective October 1, 2018, the Agency modified the process and started entering all facility reported incidents into the ACTS system.

It should be noted the federal ACTS system does not contain all the fields necessary to provide tracking of each of the assessment steps. An assessment is required at the receipt of the 24-hour (Immediate) report, as well as the 5-day report. There are only two date fields in ACTS for tracking the initial receipt (start date) and date of triage assessment (end date). There is no specific guidance within the CMS State Operations Manual (SOM) Chapter 5 - Complaint Procedures to indicate how these fields should be used. The Agency has been entering the "start" date within ACTS to indicate the date received and the "end" date as when the immediate report was prioritized. There was no way to indicate when the 5-day findings were submitted by the facility and reviewed by the Agency.

Within Chapter 5 of the SOM, "5060 – ASPEN Complaints/Incidents Tracking System (ACTS), 1 - Data Entry

The State Agencies and the CMS Regional Offices are required to enter the following in ACTS:

- 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 does not indicate that reports require input into ACTS, therefore no start and end dates would be entered unless there is a complaint.

Prior to the audit, each report is date and time stamped once the report is submitted. Additionally, once the Agency reviews the report, it is changed to a "completed" status. This too is date and time stamped. For all intents and purposes, the "start" date was considered when the information was received. The "end date" was considered when the Agency reviewed the report and considered there was enough information to close. Further, once the 5-day was reviewed, the same process was used.

The Agency has started entering date and times on when the report is prioritized on the receipt of both the immediate and 5-day report. ACTS is utilized for every Facility Reported Incident (FRI) received with a start date (date submitted to the Agency) and end date (date reviewed by

the Agency). Additional date and time information is added along with the nurse reviewer's comments for immediate and 5-day reports. If a complaint is generated, the end date recorded in ACTS is changed to the date of the complaint generation.

As described during the audit, the process for onsite review was not formalized in ACTS; our practice was to review all incident reports for a nursing facility prior to any onsite review including complaints and recertification inspections. Since the Agency began entering all facility reported incidents in Complaints/Incidents Tracking System (ACTS) October 1, 2018, we are able to track the incidents that result in onsite review. From October 1, 2018 to September 30, 2019 the Agency received 16,610 Facility Reported Incidents (FRI's) in addition to 1,936 state reported adverse incidents for a total of 18,546 for which the Agency documented review of adverse incidents for 560 onsite surveys. October 1, 2019 to September 30, 2020 the Agency received 13,798 FRI's and 1,118 state reported adverse incidents for a total of 14,4916; the Agency documented 864 onsite surveys.

**Anticipated Completion Date:**

Completed October 2018.

**Recommendation #3**

Establish and implement written policies and procedures for incident report processing.

**Agency Response and Corrective Action Plan:**

The Agency partially concurs with this recommendation.

The audit period was Calendar Year 2016. At the time of the receipt of this audit report in September 2020, the Agency had already improved processes. We strongly affirm that we had a process in place during the time of the audit that ensured resident protection and facility oversight, although it was not in a formal document. Facility incident reports were routinely shared with Field Office and survey staff for inclusion in onsite investigations. In addition, the regular survey process includes substantial review of facility reported incidents for trends and potential issues for additional investigation. A formal written process for ACTS entry was created in January 2019, and it continues to be updated as needed.

**Anticipated Completion Date:**

Completed January 2019.

**Recommendation #4**

Evaluate its staffing levels to determine whether staffing is adequate.

**Agency Response and Corrective Action Plan:**

The Agency concurs with this recommendation.

The audit period was Calendar Year 2016. At the time of the receipt of this audit report in September 2020, the Agency had already improved its processes and hired additional staff. To clarify the "administrative staff" referenced in the report was a trained professional staff member in the complaint administration unit, who was only reviewing federal reports during the CY 2016, the identified audit period.

The Agency hired two additional nurses in 2019 to this team. The Agency recently received approval for additional positions and is in the process of allocating another full-time nurse. In

total three additional registered nurses will be added to the team responsible for review of federal abuse reports, adverse incidents and abuse reports from adult protective services. The Agency is also expanding field staff to investigate complaints and incidents.

**Anticipated Completion Date:**

Partially completed with the hiring of additional staff in 2019.

**Recommendation #5**

Improve the intake process by:

- Assessing all Federal 24-Hour Reports to identify whether potential noncompliance with quality of care standards caused the incidents and whether the incident occurred after the last standard survey to identify incidents requiring onsite surveys;
- Assessing the severity and urgency of harm to the resident(s) that may have been caused by abuse, neglect, or nursing facility noncompliance with CoPs to assign a priority level;
- Using ACTS to create an incident record with start and end dates for all Federal 24-Hour Report assessments and record priority assignments.

**Agency Response and Corrective Action Plan:**

The Agency does not concur with this recommendation. The Agency had a process in place for assessing all federal 24-hour reports, assessing the severity and urgency of potential harm, and has been using the federal ACTS system according to CMS procedural manuals.

Immediate reports continue to be assessed for potential noncompliance with quality of care standards caused by the incidents. All federal reports are reviewed within two business days of their submissions with most occurring within one business day of submission. At the time of the nurse review, a priority is assigned.

Surveys are initiated when the information indicates an immediate jeopardy situation (SOM, Chapter 5-Complaint Procedures). There is no current requirement to conduct an onsite survey for each incident since the last standard survey. Although CMS has shared proposed draft changes, CMS operating procedures for states have not changed related to facility reported incidents.

As stated in Recommendation #2, ACTs is utilized for every federal report received with a start date (date submitted to the Agency) and end date (date reviewed by the Agency). Additional date and time information is added along with the nurse reviewer's comments for immediate and 5-day reports. If a complaint is generated, the end date recorded in ACTS is changed to the date of the complaint generation.

**Anticipated Completion Date:**

Current process was consistent with the State Operations Manual.

**Recommendation #6**

Establish and implement written policies and procedures for managing incident report late filings and consider initiating onsite surveys immediately for nursing facilities that file Federal 24-Hour Reports late.

**Agency Response and Corrective Action Plan:**

The Agency partially concurs with this recommendation.

Although the Agency was monitoring for late reporting, the process was not in writing. Late reporting alone, however, should not be the sole consideration to initiate an onsite survey. If a facility is not aware of an incident, they cannot be expected to report it. The Agency is initiating complaints for facilities failing to submit timely 5-day reports when a pattern is identified. The Agency is also now reviewing daily complaint intake to ensure an incident report is submitted by the facility. If a report is not submitted and should have been, the Agency adds that information to the complaint and adds the allegation of failure to submit the report.

It should be noted that we disagree with the method used to determine that reports were late. Initial review of the incidents noted to be late suggested that most reports were submitted timely. This was determined by reviewing the actual incident details and circumstances surrounding the report submission. The date of an incident and the date the facility determines the incident should have been reported may be different. Basing the audit finding on incident date and submission date alone, without closer review of the details surrounding the submission decision details, yielded an inaccurate audit finding.

Per the OIG Report: "Nursing facilities filed approximately 12.7 percent (1,062 of 8,334) of the Federal 24-Hour Reports between 1 and 367 days late, and they filed 9.3 percent (775 of 8,334) of the Federal 5-Working-Day Investigation Reports between 1 and 258 days late."

The report identified as being 367 days late actually had an error in the year for the date listed. The report was exactly one year off, indicating the report was submitted timely. This information was available in the body of the report, but the date listed in the date selected box was marked incorrectly.

All the explanations as to why the reports were late, including date errors, were readily available at the time of the OIG review within the body and/or notes section of each report.

Specific examples include:

Report# 34940: Facility was notified 10/30/2016 by the Department of Children and Families (DCF) regarding a resident transferred to hospital 10/9/2016. The incident date was 10/9/2016, but the immediate report was submitted 10/31/2016, one day after the facility was notified by DCF.

Report# 30378: Notes within the reporting system demonstrate that the state agency questioned the facility about the accuracy of the 1/21/2016 incident date since it was submitted on 7/21/2016. The facility noted the date of incident was 7/21/2016, but facility did not correct the date error (incorrect month) listed in report.

Report# 27634: Facility was first made aware of incident by the resident on 5/6/2016. The incident date was 3/29/2016. The report was submitted on 5/6/2016.

The Agency would like to also point out that nursing facilities were cited 125 times between 2018 and 2020 failing to report federal FRI's.

**Anticipated Completion Date:**

Completed.

**Recommendation #7**

Ms. Pilcher  
October 28, 2020  
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Establish and implement written policies and procedures for managing DCF- Adult Protective Services (APS) complaint notifications and conducting assessments of APS complaints to identify and survey more facilities where resident harm may have been caused by nursing facility noncompliance.

**Agency Response and Corrective Action Plan:**

The Agency partially concurs with this recommendation.

Prior to receipt of this draft report, the Agency had already established a written protocol for processing DCF-APS reports. Although the Agency had a process in place, we moved to formalize an already established process. This was completed in December 2018.

With regard to the information on page 9 of the OIG report, related to connecting claims data for six cases to APS reports, we are aware of only one case that involved an APS report. The APS report which was closed with "No Indicator" of findings for medical neglect.

Each immediate report received is now reviewed along with the DCF-APS intake report to ensure the facility is reporting incidents to the Abuse Registry and to obtain additional information regarding the self-reported incidents, and that the information reported is consistent. Staff review for any differences regarding the details surrounding the event. Staff include the Florida Safe Family Network (FSFN) intake number as well as the allegations provided to DCF-APS at intake.

**Anticipated Completion Date:**

Completed. December 2018.

We appreciate OIG team sharing information throughout the audit and moved quickly to address opportunities to formalize policies and improve procedures. As CMS provides updated guidance regarding the federal Facility Report Incident and complaint process, and as updates are made to the State Operation Manuals, the Agency will evaluate its policy and procedures to update as necessary.

Thank you for the opportunity to review and comment on this draft report.

Sincerely,



Kimberly R. Smoak  
State Survey Agency Director

cc: Molly McKinstry, Deputy Secretary, Division of Health Quality Assurance  
Mary Beth Sheffield, Inspector General  
Pilar Zaki, Audit Director