

Report in Brief

Date: July 2020

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

How OIG Did This Audit

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

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

What OIG Found

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

What OIG Recommends and North Carolina Comments

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

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

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