

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.