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Nursing Facilities Still Struggle with Abuse Reporting Requirements

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Last month, the Office of Inspector General ("OIG") published a report entitled, "Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect." The report's purpose was to determine the extent to which nursing facilities reported allegations of abuse, as well as the extent to which such allegations were reported correctly. According to the report, in 2012, 85% of the nation's nursing homes reported almost 150,000 incidents of abuse or neglect. The OIG found that 53% of the incidents were correctly reported; that 61% of nursing facilities maintained documentation supporting compliance with the reporting requirements; and that 76% maintained appropriate policies and procedures for reporting allegations and investigation results. The OIG concluded: "It is both required and expected that nursing facilities will report any and all allegations of abuse and neglect to ensure resident safety." The OIG then recommended that the Centers for Medicare and Medicaid Services ("CMS") reissue guidance clearly describing the reporting requirements and "reiterate in its guidance that all allegations of abuse or neglect must be reported to the State survey agency, as required by Federal law."

The OIG's conclusions are not new. Historically, its audits of abuse reporting and investigations have concluded that the nation's nursing homes are either underreporting; reporting, but failing to report pursuant to federal standards; and/or inadequately investigating when reports are made. Because the OIG considers the problem to be significant, it implores CMS to take action to correct the problem by reissuing prior guidance.

Certainly, everyone in the nursing home business – owners, operators, and staff, as well as most of the patients and families they serve – understand the importance of reporting abuse. So will reminding the industry of something it already knows do any good? The answer to that may depend on the reason for the problem, i.e., the reporting percentages that the OIG clearly believes are too low. Is it that facilities are intentionally underreporting? Is it that the governing regulations are too vague to give the facility adequate and meaningful notice of when a report is necessary? Is it that a zero tolerance policy for any abuse, suspected or otherwise, by the state and federal enforcement agencies leads to data that tends to reflect underreporting, even if some of the regulations are vague? It is hard to know exactly where the answer lies. While each of these factors may play some role in the OIG's findings, a significant problem with the data and the OIG report may lie with the methodology utilized.

The OIG characterized the incidents of abuse/neglect as falling into five different categories. Four of the categories were abuse (50%); misappropriation of property (15%); neglect (12%); and mistreatment (4%). And the fifth category, constituting almost 20% of all cases of abuse in 2012? "Injuries of unknown source," or said another way, unexplained physical injury.

Given that the figures in the OIG report reflect significant noncompliance, the fact that *20% of all cases* are attached to such a subjective category raises the next – and very important – question: When is it fair to conclude that an unexplained physical injury is abuse? The answer depends on the presenting injury, the thoroughness of the investigation, and the facility's interpretation of the investigation results and governing regulations. But this may be easier said than done, as suggested by the following examples:

> A non-communicative nursing home patient on blood thinner medication, with no history of bruising or unexplained injury, is sleeping with side rails up to prevent falling out of bed. The resident is restless during sleep and is observed to move around. In the morning the resident has bruising around both eyes. The nursing assistant who has been assigned to the resident for months is a good employee with no history of any problems or discipline.

Is this unexplained physical injury abuse or the unfortunate result of self inflicted injury resulting from the resident banging himself against the side rails at night? And if the bruising is self-inflicted, does it constitute reportable neglect, even if "side rails up" is part of the current care plan?

Here is another example:

> A nursing home resident with severe osteoporosis and osteoarthritis is undergoing physical therapy. After a session of PT, the resident complains that the therapist was rough. Within a few days, some warm swelling is noticed on her hip. An X-ray reveals a minor hip fracture.

Same question: Is the unexplained physical injury abuse because the physical therapist overdid it, or is it the result of a spontaneous hairline fracture due to osteoporosis? If it turns out that the fracture was caused by handling during PT, should it be reported?

And finally:

> A nursing home resident has a history of falling at multiple facilities over the course of almost a year. At the resident's current facility, he sleeps on a low air mattress only a few inches above the floor to mitigate the risk of injury from falling out of bed. One morning, he is found off his mattress on the floor. Although the treating physician insists that sliding off the mattress could not have injured the resident, an MRI reveals the resident has suffered a subdural hematoma. However, the scan is inconclusive regarding the age of the hematoma.

Is this unexplained physical injury reportable as abuse?

All of these examples were taken from real cases. In each case, the state survey agency took enforcement action against the facility for failing to report the incident as abuse, even though the facility, after a thorough investigation, concluded no abuse or neglect occurred. The tension between underreporting and over reporting pervades the OIG report, as it does the industry as a whole. The solution is unclear and may not exist. The regulators and elder rights groups insist that any injury, even the most minor skin tear, should be reported as abuse, since almost any injury to a nursing home resident is abuse. Obviously, this approach would be far from optimal, unduly burdening not only facility operations, but also state and federal regulators, who are already struggling to keep up with large case loads. Underreporting, on the other hand, poses an unacceptable risk to the nation's frail and elderly nursing home population, as well as to facilities that wish to be compliant.

Of course, there are facilities that under report or ignore the reporting requirements altogether. It happens all the time. But there are also plenty of situations where a facility is cited even though it conducted a full and fair investigation and reasonably concluded that the injury did not constitute abuse.

CMS agreed with all the OIG's recommendations in its report, so the industry can expect updated or reissued guidance soon. Perhaps in its next round of guidance, CMS will provide additional direction to assist nursing homes in complying with the reporting requirements.

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