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## Abuse Complaints of Nursing Home Patients

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Attached for your information is our report on abuse complaints involving nursing home patients in selected States (OEI-06-98-00340). Our original purpose in conducting this study was to ascertain what can be learned about the extent and nature of abuse of nursing home patients based on data available from the abuse complaint systems of 11 large States. We used this data in conjunction with data from other sources (such as survey deficiencies and ombudsman complaints) to gain an understanding of conditions in nursing homes. The results were included in our report entitled, "Quality of Care in Nursing Homes: An Overview." That report and our corresponding congressional testimony demonstrated the existence of serious quality of care problems in some nursing homes.

With regard to abuse complaints, we were able to obtain reliable data from only 8 of the 11 States we contacted. We found that between 1 and 3 percent of their nursing home population have registered a complaint. One State indicates a much higher percentage of 17 percent. However, due to the lack of uniform data systems and definitions across States, we cannot draw generalizations from those observations. We also have no way of knowing whether States with higher reported abuse complaint levels actually have more abuse occurring, have more aggressive abuse reporting systems, or have some other outside influencing factors.

The data we obtained is about complaints made, but not necessarily substantiated. Thus, we cannot tell from the data to what extent nursing home patients are in jeopardy. However, we are able to see that what is being reported by patients is serious. These complaints relate directly to abuse and quality of patient care problems in an environment which should ensure each patient's well being.

We had planned to conduct a follow-up inspection on existing State patient abuse complaint systems. However, given the Health Care Financing Administration's (HCFA) plans to strengthen the complaint process and its recent letter to the State survey agencies clarifying HCFA's expectations for the collection, review, investigation, and reporting of complaints, we do not believe an Office of Inspector General review would be useful at this time. Instead, we

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will wait until the improved complaint process is implemented; we will then conduct an evaluation of how the process is working. We will work with your staff to develop the study so that it will give them the feedback they need to ensure the new system takes hold effectively.

In the meantime, we thought it might be useful for HCFA staff who are developing the new system to have the benefit of our work to date on abuse complaints. Thus, we are presenting our findings in the attached report. It provides more information on our attempts to obtain State data as well as information we could glean from the State-provided data. We hope that interested HCFA staff and the research community will find it useful.

We are closing out this particular inspection. There is no need for you to provide comments on it. However, if you have any questions please do not hesitate to call me or George Grob, Deputy Inspector General for Evaluation and Inspections, or have your staff contact Mary Beth Clarke at (202) 619-2481.

Attachment

# **Abuse Complaints of Nursing Home Patients**

Department of Health and Human Services  
Office of Inspector General  
Office of Evaluation and Inspections

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*For further information, please contact Leah K. Bostick at 214-767-3310 or 1-800-848-8960.*

# Abuse Complaints of Nursing Home Patients

## Purpose

To ascertain what can be learned about the extent and nature of abuse of nursing home patients based on data available from State abuse complaint data systems.

## Background

Recent reports by the Health Care Financing Administration (HCFA) on nursing home responsibilities and processes, and General Accounting Office reviews of patient care in California nursing homes have raised serious concerns for patients' care and well-being. The Senate Special Committee on Aging held two hearings in the summer of 1998 on these results. At the same time, the Office of Inspector General (OIG) undertook additional studies aimed at assessing the quality of care in nursing homes. We recently issued reports on the inadequacy of criminal background checks for potential employees and raised questions about States' responses to patient abuse. Future OIG reports will address a broad array of nursing home care issues, including a systematic review of all key provisions of the 1987 nursing home reform legislation and the Ombudsman role in nursing homes. This report examines the extent of patient abuse in nursing homes as described in formal State abuse complaint reporting systems.

**Federal Laws and Regulations Regarding Abuse Complaints** - The most important Congressional response to prior concerns for nursing home patients was the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). This law assured and strengthened certain personal rights and protections for nursing home patients. Personal rights include the right to not be physically or mentally abused, involuntarily secluded, and to be free from chemical and physical restraints.<sup>1</sup> The guidelines for these regulations specify that a nursing home's responsibilities for preventing abuse also apply to practices and omissions which can lead to abuse, if left unchecked. Abuse, including neglect, can be inflicted by nursing home staff, visitors, or even other patients.

The OBRA 1987 requires States to receive complaints and provide timely review and investigation of allegations of neglect, abuse, and misappropriation of resident property by any employee of the nursing home.<sup>2</sup> New Federal regulations issued by HCFA, including enforcement regulations with new survey processes implemented in July 1995, were designed to help ensure those protections for patients. The Older Americans Act (OAA) of 1965 and its subsequent amendments provide for State aging agencies to assess the need for elder abuse prevention services.<sup>3</sup> A companion OIG report addresses the trend of abuse as reported by State Ombudsman offices.<sup>4</sup>

**State Laws and Regulations** - All States have some form of legislation authorizing the protection of its vulnerable, incapacitated, or disabled adults in *domestic settings* (in the person's own home or that of a caregiver) by requiring reporting of abuse to either the State's adult

protective services or through a State long-term care ombudsman. While State statutes may not designate “elder abuse,” specifically, as a crime, most States do consider many forms of physical, sexual, and financial/material abuses of domestic elderly persons as crimes.

Fewer States legislatively equally address abuse of these same individuals in *institutional* settings (nursing homes and other long-term care settings). Most States have attempted to address this issue by legislatively mandating that physicians, nurses, and other health care professionals report suspected institutional abuse to a designated State office and requiring nursing homes to investigate, as well as report, any abuse occurrences in their facilities.

### **Difficulty Determining Abuse Frequency**

**Diversity of Government Agencies** - Many Federal and State agencies are responsible for protecting elderly and disabled nursing home patients.

At the Federal level, three Department of Health and Human Services (DHHS) agencies have either direct or indirect involvement with nursing homes and services to their patients: the Administration on Aging (AoA), HCFA, and the OIG. The HCFA has ultimate responsibility for the Medicare and Medicaid programs, which includes ensuring that the reforms of OBRA 1987 are implemented by States and nursing homes.

In response to raised concerns, HCFA will add a new survey task requiring State surveyors to review each nursing home’s abuse prevention plan aimed at preventing, identifying, and stopping physical or verbal abuse, neglect, and misappropriation of nursing home patients’ property.<sup>5,6</sup> However, sometimes the most glaring deficiencies and abuse incidences cited by surveyors against nursing homes are tagged as problems other than neglect or abuse, and rarely are deficiencies of nursing care, patients’ rights, or quality of care cross-tagged to neglect or abuse citations.<sup>7</sup> Consequently, State and Federal nursing home survey statistics probably do not accurately describe the incidence of abuse or neglect. The HCFA also announced its support of additional nursing home reforms announced by the President in July 1998. These reforms are directly related to abuse and neglect of patients, including the need to provide additional training to State nursing home surveyors in those States not adequately protecting nursing home patients from abuse.<sup>8</sup>

At the State level, there are many public and private agencies and organizations concerned and actively involved in deterring institutional abuse. These can include the State units on aging, law enforcement offices (police, attorney general), medical examiners’ offices, State long term care ombudsman offices, the State health department, and the agency responsible for licensing and certifying nursing homes. Most typically, this latter State agency, which ensures nursing homes meet Medicare and Medicaid requirements, is also designated as the primary contact for State-required institutional abuse reporting by physicians and other health care professionals. The

variation in Federal and State agency requirements, processes, and definitions compounds the difficulty of obtaining a realistic national picture of nursing home abuse occurrences.

**Lack of Standardized Definitions** - The AoA “Annual State Ombudsman Report” is the only current standardized means of collecting national abuse data. This report uses the Older Americans Act and HCFA guidelines for capturing complaints broadly classified as abuse, gross neglect, or financial exploitation.<sup>9</sup> In 1996, all States began submitting the report to AoA through its National Ombudsman Reporting System. This new system captures more specific data elements than were previously reported. Specifically, the categories for which AoA collects abuse or neglect information included physical abuse, sexual abuse, verbal/mental abuse, financial exploitation, gross neglect, and resident-to-resident physical or sexual abuse. However, unless the State Ombudsman has been designated by State statute as the entity to which all incidents and complaints of nursing home abuse and neglect must be reported, the AoA report will identify only those issues or complaints brought to them by their own nursing home ombudsmen and aware citizens.

Federal definitions first appeared in the 1987 Amendments to the Older Americans Act.<sup>10</sup> However, these definitions *only provide guidelines for identifying problems; they are not intended or used for enforcement purposes*. These definitions have recently been expanded to include language specific to the HCFA “Survey Forms and Interpretive Guidelines for the Long Term Care Survey Process, April 1992.”<sup>11</sup> As previously mentioned, in June 1995, HCFA released revised guidelines to Federal and State nursing home surveyors. However, these guidelines continue to provide non-enforceable definitions relating to sections of the law reviewed for compliance (generally citation tag numbers F221 through F224).

Ultimately, each State has the responsibility for protecting its older persons. As such, States usually define abuse of elderly persons through their State laws. However, these definitions vary between States regarding what constitutes abuse, neglect, or exploitation of an elderly individual. Defining abuse becomes even more difficult when adding the distinction of *elderly and disabled in nursing homes versus domestic abuse* (occurring in the community). In most cases, State statutes provide the necessary definitions for the reporting abuse occurrences by nursing homes and other health professionals, again, with varying degrees of specificity. Additionally, many researchers have coined their own unique definitions to study the problems of domestic and institutional abuse.

**Responsibility for Institutional Abuse Resolution** - States are required to ensure receipt and timely review and investigation of allegations of neglect, abuse, and misappropriation of resident property by any employee of the nursing home.<sup>12</sup> While many State agencies have some responsibility for resolving nursing home problems, each State usually designates to the nursing homes a coordinating entity (an individual or a particular State agency) with central State authority to receive complaints of mistreatment or neglect of nursing home patients. Several different State agencies may be assigned responsibility for designing, operating, and coordinating nursing home complaint processes including the:

State Ombudsman under the direction of the State Agency on Aging,  
Medicaid Fraud Control Unit (MFCU) or other legal authorities (State Office of the Attorney  
General),  
Agencies for nursing home certification and licensure,  
Licensure agencies for medical personnel,  
State adult protective services, and  
Local or State law enforcement agencies.

However, while coordination for nursing home abuse complaints may be located in any number of State agencies, the responsibility usually is assigned to the State nursing home survey and certification agency. In a few States, the State agency on aging, which houses the State Ombudsman Program (required by AoA), may have the primary responsibility for abuse or neglect complaints of nursing home patients.

**Available Research on Incidence** - Although there are many studies available on domestic abuse, much less research has addressed institutional abuse. This was recently reconfirmed by testimony of the Acting Principal Deputy Assistant Secretary for Aging, AoA, who stated that “In spite of all the anecdotal information, media exposes, ethnographic studies, and licensure and certification reports on nursing homes, little is known about the incidence of abuse in institutional settings, although all agree that it does exist.”<sup>13</sup> Also, most existing institutional studies were based on relatively small samples and did not provide national estimates of elder abuse prevalence or incidence.

However, one recent study provides, for the first time, national incidence estimates for *domestic* elder abuse and neglect. This study, “The National Elder Abuse Incidence Study,”<sup>14</sup> found that approximately one-half million (domestic) elderly persons were abused and neglected during 1996. The information for the national domestic abuse study was provided by State adult protective services (APS) offices, which generally coordinate policy and response to domestic abuse of elderly and disabled persons, and other sentinel agencies.<sup>15</sup>

## **Methodology**

### **Sample Selection**

We selected a purposive sample of 11 States (New York, California, Texas, Ohio, Illinois, Pennsylvania, Massachusetts, Florida, New Jersey, Tennessee, and Michigan) representing approximately 54 percent of the Medicaid recipients receiving services in nursing facilities, including skilled facilities, and 61 percent of the total skilled nursing beds. Additionally, these States represented 46.9 percent (\$23.9 billion) of Medicaid long term care expenditures for nursing facilities in 1996.<sup>16</sup> This purposive sample represents States of various sizes and different regions of the country. Michigan initially served as our test State for the methodology. That test resulted in no changes for the instrument used; therefore, we have included Michigan’s data in our findings.



We identified each sample State’s agency having responsibility for maintaining nursing home abuse complaints. We asked that office to complete and return a form identifying reported, investigated, and substantiated numbers of institutional abuse complaints during calendar years 1993 through 1997.

**Definitions**

In reviewing existing literature, we identified many categories of abuse and neglect defined and used by researchers. For this inspection, we attempted to choose and define specific types of abuse which appeared more readily identifiable for conversion from any State’s definitions and collection systems (manual or computerized process). However, we started with the Federal definitions provided as part of the State and Federal survey and certification processes for long-term care facilities located at 42 CFR 488.300 (Subpart E), Section 301:

- **Abuse** is defined as “willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.”
- **Neglect** refers to “failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.”

Based on our review, we selected four specific types of abuse as key indicators of recent nursing home patient abuse and neglect trends: physical abuse, inappropriate use of restraints, physical neglect, and medical neglect. The table below provides the definitions for the four specific sub-categories of abuse and neglect used in this study.

<b>Physical Abuse</b>	the infliction of physical pain or injury, including sexual abuse, which may result in bodily injury, physical pain, or impairment
<b>Inappropriate Use of Restraints</b>	chemical or physical control of a resident beyond physician’s orders or not in accordance with accepted medical practice
<b>Physical Neglect</b>	disregard for necessities of daily living (e.g., failure to provide necessary food, clothing, clean linens, or daily care of the resident’s personal necessities)
<b>Medical Neglect</b>	lack of care for existing medical problems (e.g., ignoring the need for a special diet, not calling a physician when necessary, not being aware of the possible negative effects of medications, or not taking action on a medical problem)

Our request letter to the 11 sample States clearly indicated our understanding that their internal definitions would differ from those above, as would their means of collecting the requested data (see Appendix A). With this understanding, we asked that States make the necessary conversions between their definitions and those we used for this study, reporting to us the process and components of that cross-walk.

During follow-up on data requests, States were provided an opportunity to simplify their processes by limiting the number of years to three and the categories to as few as two broad categories of abuse and neglect (combining only complaints meeting the definitions above). This proved helpful in a few instances when this was the only way to obtain the State information. Further, at any point, after multiple contacts to obtain the requested information, we accepted whatever data the States were able to provide.

## **Investigations and Substantiations**

Because of limitations of State data reporting systems and differences in their follow-up procedures, we were unable to analyze received information about States' investigations or substantiations of complaints. Furthermore, we did not analyze how effectively States and nursing homes inform patients about their opportunity to report complaints, nor did we determine what barriers, if any, may prevent patients from reporting complaints (we will study these issues in future reports). Thus, our study cannot determine the extent to which abuse is actually occurring in nursing homes, only the extent to which States report receiving complaints involving nursing home patients and the type of complaints they reported receiving. We are using this information in concert with other information to gain a general understanding of conditions in nursing homes.

## **State Response**

Eight of the sample States did provide limited data about reported complaints of nursing home abuse and neglect in their State, but only two of the sample States were able to produce the full data set of abuse and neglect trend information as requested. The primary difficulties for the States proved to be determining what abuse and neglect data their system (automatic or manual) captured; which of their data categories could be cross-walked to the requested abuse and neglect types; who ultimately had responsibility for responding to such a request; and coordinating with other offices to obtain abuse or neglect data not maintained in the office designated as the primary coordinator for nursing home abuse complaint. Once these issues were addressed internally, the final difficulty was assigning a staff person to the project and ensuring its completion. Many of the States were unable to have a person perform this function full-time for the potentially short period of time necessary (we anticipated two weeks maximum). As a result, the project was "interwoven" with other responsibilities and completed as time allowed.

Of the eleven sample States, only Illinois, Massachusetts, Michigan, and Texas attempted to complete the OIG request in the manner specified using the provided definitions to cross-walk their available data and reporting the information on the provided form. Both Michigan and Texas complied fully.<sup>17</sup>

- California provided their automated system reports for the years requested with no indication of which of their 11 categories of abuse and neglect could be cross-walked to our four specific abuse types (however, subsequent conversations with their staff allowed us to attempt this);

- Florida provided only the raw data pertaining to nursing home complaints in a spreadsheet, with no indication of which complaints were abuse or neglect as defined by that State (subsequently, we received printed State reports providing data maintained by Adult Protective Services, 1991 through 1995, but not reflective of the nursing home environment);
- Tennessee provided no State definitions for their provided data;
- New York provided its applicable “State Annual Complaint Reports” for 1991-1995 and raw counts for the 1996-1997 report, again with no attempt to cross-walk their captured data to the requested data;
- Pennsylvania was unable to provide any information concerning abuse and neglect trends and definitions for the data they collect internally; and
- New Jersey was unable to provide the requested information from their manual system, but was able to provide the number of overall complaints received each year.

Individual State definitions for abuse and neglect vary greatly. Of the 11 sample States, no two used the same State definitions for abuse and neglect complaints. Further, no two used the same State definitions or processes for collecting data on reported, investigated, and resolved abuse and neglect complaints. However, we must note that all of the sample States reported their State’s adherence to the Federal categories of abuse provided in 42 CFR. One State actually has no definitions for specific types of abuse or neglect beyond those provided at 42 CFR. Most of the sample States have some form of broad definition of abuse. Appendix B illustrates the variation in definitions provided in State law and regulations.

Many of the sample States were unable to cross-walk their definitions of abuse complaints to those used for this inspection, primarily because they were unable to devote the necessary staff time. Most of the States expressed concern about the perceived effort involved in responding to our data request. Many were concerned particularly because of the potential for taking considerable staff time to convert their State’s definitions to match those of this study and to retrieve the information from the State’s data collection system (manual or automated). Also, many of the sample States indicated they were in the process of changing, updating, or creating automated abuse data collection systems.

## **Individual State Results**

Based on available State data, we were able to calculate rough estimates of the extent and nature of overall trends for reported abuse and neglect complaints for each State; however, we are unable to compare the State results from one State to another. In order to compare States, we would require a common system of defining, reporting, and resolving complaints. Lacking this, we are only able to review the reported raw numbers of complaints within each State. The tables below present the abuse and neglect complaints as reported by eight sample States - California, Illinois, Massachusetts, New York, Michigan, Ohio, Tennessee, and Texas.

As can be seen in the following tables, the abuse complaints of nursing home patients are serious. We see a consistent reporting of abuse and neglect with each State reporting an increase in neglect complaints. These types of complaints relate directly to quality of patient care in an environment which should be ensuring each patient's well being.

### California

Possible Abuse and Neglect Categories	1995	1996	1997	Percent of Change**
Dietary	135	139	143	+5.9
Medication	138	150	126	-8.7
Patient Care	4,804	4,049	3,967	-17.4
Patient Rights	713	739	730	+2.4
Neglect/Abuse	743	665	744	+0.13
<b>TOTAL</b>	6,533	5,742	5,710	-12.6*

\* The totals for the trend do not reflect the sum of that column.  
 \*\* Trend reported is the percentage of increase or decrease of the raw counts of State-reported complaints between 1995 and 1997.

### Illinois

Complaints	1995	1996	1997	Percent of Change**
Abuse	495	502	567	+14.5
Misuse of Restraints	18	41	61	+238.0
Neglect	300	332	408	+36.0
<b>TOTAL</b>	813	875	1,036	+27.4*

\* The totals for the trend do not reflect the sum of that column.  
 \*\* Trend reported is the percentage of increase or decrease of the raw counts of State-reported complaints between 1995 and 1997.

### Massachusetts

Complaints	1995	1996	1997	Percent of Change**
Abuse	531	346	273	-48.6
Neglect	159	190	165	+3.8
<b>TOTAL</b>	690	536	438	-36.5*

\* The totals for the trend do not reflect the sum of that column.  
 \*\* Trend reported is the percentage of increase or decrease of the raw counts of State-reported complaints between 1995 and 1997.

### Michigan

Complaints	1995*	1996	1997	One-Year Change** 1996-1997
Physical Abuse	294	739	438	-40.7
Misuse of Restraints	7	25	20	-20.0
Physical Neglect	711	1,385	1,672	+20.7
Medical Neglect	19	82	130	+58.5
<b>TOTAL</b>	1,031	2,231	2,260	+1.3

\* The data for this year reflects only a six-month data period (July 1-December 31) from the date of the initiation of a new data system. Prior data was not accessible. We did not calculate a 1995-1997 trend for this State, but only show a one-year change between 1996 and 1997.

\*\* The totals for the one-year change only reflect the percentage of increase or decrease of the raw counts of State-reported complaints between 1996 and 1997.

### New York

Complaints*	1993	1994	1995	Percent of Change**
<b>TOTAL</b>	1,522	1,481	959	-37.0

\* New York's Chapter 340 Complaints.

\*\* Trend reported is the percentage of increase or decrease of the raw counts of State-reported complaints between 1995 and 1997.

### Ohio

Complaints	1995	1996	1997	Percent of Change**
Abuse	1,472	1,865	1,856	+26.0
Neglect	150	192	260	+73.3
<b>TOTAL</b>	1,622	2,057	2,116	+30.5*

\* The totals for the trend do not reflect the sum of that column.

\*\* Trend reported is the percentage of increase or decrease of the raw counts of State-reported complaints between 1995 and 1997.

### Tennessee

Complaints	1995	1996	1997	Percent of Change**
Abuse	515	431	429	-16.7
Neglect	113	110	130	+15.0
<b>TOTAL</b>	628	541	559	-11.0*

\* The totals for the trend do not reflect the sum of that column.

\*\* Trend reported is the percentage of increase or decrease of the raw counts of State-reported complaints between 1995 and 1997.

**Texas**

<b>Complaints</b>	<b>1995</b>	<b>1996</b>	<b>1997</b>	<b>Percent of Change**</b>
Physical Abuse	3,050	3,425	3,718	+21.9
Misuse of Restraints	337	292	360	+6.8
Physical Neglect	10,872	9,688	10,331	-5.0
Medical Neglect	2,322	2,235	2,420	+4.2
<b>TOTAL</b>	<b>16,581</b>	<b>15,640</b>	<b>16,829</b>	<b>+1.5*</b>

\* The totals for the trend do not reflect the sum of that column.  
 \*\* Trend reported is the percentage of increase or decrease of the raw counts of State-reported complaints between 1995 and 1997.

We were also interested in calculating reported complaints as a percentage of each State's nursing home population. To attempt this, we asked each State for the number of nursing home patients State-wide for each of three sample calendar years (1995-1997). However, most of the sample States were unable to fully meet this request, and Florida, New Jersey, New York, and Pennsylvania were unable to provide any acceptable nursing home patient census. Only Massachusetts and Texas provided sufficient information to calculate the percentage of change. The table below shows changes in total complaints over three years as a percentage of the nursing home population for these years using the State-provided raw counts. A more detailed description and analysis of each State's reported data is found in Appendix C.

<b>Massachusetts Complaints</b> Categories - abuse, neglect					
Percent by Calendar Year			Percent of Change over 3 Years		
1995	1996	1997	1995-1996	1996-1997	Trend
1.25	0.97	0.79	-22.40	-18.60	(-)
* Trend reported is the percentage of increase or decrease of the raw counts of State-reported complaints as a percentage of the nursing home population between 1995 and 1997. Total patient numbers are the same for each year, as provided by the State.					
Total Complaints			Percent of Change		
1995	1996	1997	-36.5		
690	536	438			
<b>Texas Complaints</b> Categories - physical abuse, misuse of restraints, physical neglect, medical neglect					
Percent by Calendar Year			Percent of Change over 3 Years		
1995	1996	1997	1995-1996	1996-1997	Trend
16.59	15.88	17.53	-4.3	10.4	(+)
* Trend reported is the percentage of increase or decrease of the raw counts of State-reported complaints as a percentage of the nursing home population between 1995 and 1997.					
Total Complaints			Percent of Change		
1995	1996	1997	+1.5		
16,581	15,640	16,829			

In summary, when we compare the raw counts of reported complaints to the nursing home populations in each of the sample States, we find most States report that between 1 and 3 percent of their nursing home population had abuse or neglect complaints. One State indicates a much higher percentage of 17 percent. We believe that this data represents each State's reported complaints. However, due to the lack of uniform data systems and definitions across States, we cannot draw generalizations from those observations. We have no way of knowing whether States with higher reported abuse complaint levels actually have more abuse occurring, have more aggressive abuse reporting systems, or have some other outside influencing factors.

The State-provided data allow the use of raw counts to show a trend in each State; however, we found no consistent trend in reported abuse complaints among all the 11 States. Some States report increases in complaints; others report decreases. And for the same reasons cited above, we are unable to explain the increases and decreases, even within individual States. The following table provides a summary, by State, which shows the result of calculating the trend of complaints as a percentage of the nursing home population for a three-year period.

<b>Trend of State-Reported Abuse and Neglect Complaints as a Percentage of State Nursing Home Populations<sup>(1)</sup></b>									
<b>Sample State</b>	<b>Nursing Home Patient Population by Year</b>			<b>Percentage of Complaints to Nursing Home Population</b>			<b>Amount of Change Over 3 Years and Trend</b>		
	1995	1996	1997	1995	1996	1997	1995- 1996	1996- 1997	Trend <sup>(5)</sup>
California <sup>(4)</sup>	94,239	NA	NA	1.48	NA	NA	NA	NA	NA
Illinois <sup>(2)</sup>	103,075	102,829	102,583	0.77	0.81	0.95	0.04	0.14	+
Massachusetts <sup>(3)</sup>	55,000	55,000	55,000	1.25	0.97	0.79	-0.28	-0.18	-
Michigan <sup>(2)</sup>	34,340	71,586	74,611	2.98	3.08	3.00	0.10	-0.08	NC
Ohio <sup>(2)</sup>	98,797	102,033	105,375	1.64	2.01	1.92	0.37	-0.09	+
Tennessee <sup>(2)</sup>	45,464	51,109	57,455	1.38	1.06	0.97	-0.32	-0.09	-
Texas	97,919	96,676	93,951	16.93	16.18	17.91	-0.75	1.73	+

(1) Florida, New Jersey, New York, and Pennsylvania were unable to provide any acceptable nursing home patient census.  
(2) In Ohio, Illinois, Michigan, and Tennessee, the 1997 total patient number was unavailable; we therefore used a linear extrapolation of two data points from 1995 and 1996 based on the unproven assumption that change in the number of total patients is similar to the previous two years.  
(3) Massachusetts provided us the same estimated numbers for each year.  
(4) California was unable to provide the patient figure for 1996 and 1997.  
(5) Trend reported is the percentage of increase or decrease of the raw counts of State-reported complaints over the 3-year period with a leveling effect applied.

NA Not Available  
NC No noticeable pertinent change

+ Increasing  
- Decreasing

Again, using only the State-provided total raw counts, it appears that the ratio of reported abuse and neglect complaints per nursing home patient are fairly stable, with minor increases in Illinois, Ohio, and Texas and minor decreases in Massachusetts and Tennessee, with Michigan remaining about the same. However, we are unable to explain the broad differences, ranging from less than one percent to 3 percent on average for six of the States to more than 17 percent for one State.

Actually, differences may not be reflective of more or less abuse complaints occurring in one State versus another State. For example, Texas' complaints of abuse and neglect appear to be much higher than the other reporting States. One possible reason for the high reporting of possible occurrences may be Texas' involvement in Operation Restore Trust in the prior two years. During that period, and subsequently, the State and interested patient advocacy and nursing home associations within the State provided a great deal of media coverage and education concerning abusive situations. This may be one factor leading to a higher awareness and concern for reporting such incidents.



# ENDNOTES

1. 42 Code of Federal Regulations § 483.13.
2. Omnibus Reconciliation Act of 1987 § 1919(g).
3. 42 U.S.C §§ 3001-3058ee (1994).
4. *Long-Term Care Ombudsman Program: Complaint Trends* (OEI-02-98-00350), Office of Inspector General, Department of Health and Human Services.
5. “Assuring the Quality of Nursing Home Care,” *HHS Fact Sheet*, Department of Health and Human Services, July 21, 1998.
6. “Nursing Home Initiative Update #1,” Health Care Financing Administration, Department of Health and Human Services, September 15, 1998.
7. OIG sample review of Health Care Financing Administration OSCAR deficiency tags for FY 1996.
8. “Message from the Administrator,” *HCFA Health Watch*, Health Care Financing Administration, Department of Health and Human Services, August 1998.
9. Program Instruction, Administration on Aging AOA-PI-98-05, September 29, 1998.
10. *Older Americans Act*, §§ 102(13) and 102(26).
11. *Instructions for Completing the State Long Term Care Ombudsman Program Reporting Form for the National Ombudsman Reporting System (NORS)*, Administration on Aging, OMB #0985-0005, expiration August 31, 2001.
12. Social Security Act § 1919(g).
13. Benson, W., Administration on Aging, Testimony to Older American Caucus Congressional Hearing, November 5, 1997. This statement is actually attributed by Mr. Benson to Rosalie Wolf, Institute on Aging, Medical Center of Central Massachusetts.
14. *The National Elder Abuse Incidence Study*, National Center on Elder Abuse and the American Public Welfare Association in collaboration with Westat, Inc., Final Draft Report, Second Revision, July 1, 1998. This study originated in 1992 when Congress directed that a study of the national incidence of abuse, neglect, and exploitation of elderly persons be conducted. This study was jointly funded by AoA and the Administration for Children and Families (ACF).

15. Data reported by sentinel agencies are not officially reported to the APS agencies, nor are they officially substantiated. There were four types of sentinel agencies in this study: law enforcement, elder care providers (i.e., adult care centers), financial institutions (banks), and hospitals, including public health departments.
16. *1997 Data Compendium and Medicaid Program and Financial Statistics Fiscal Year 1996*, Health Care Financing Administration, Department of Health and Human Services.
17. Michigan and Texas, essentially, use HCFA's survey deficiency tags as their means of collecting nursing home abuse and neglect information. After they determined which tags were related to the OIG definitions (for the four abuse categories of physical abuse, inappropriate use of restraints, physical neglect, and medical neglect), they cross-walked their data to provide us the information requested. They also provided their State's definitions of abuse and neglect and any related sub-categories.

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## Letter to State Agencies Requesting Abuse Trend Information

Dear Coordinator:

The Office of Evaluation and Inspections of the Office of Inspector General is responsible for conducting inspections designed to determine the effectiveness, efficiency, and vulnerability to fraud, waste, or abuse of Department of Health and Human Services programs. We recognize that the primary responsibility for designing, operating, and coordinating services for the elderly and disabled lies with the States. We are conducting a study to determine the recent trend in selected categories of nursing home patient abuse complaints reported and resolved in selected States. As part of that undertaking, your State has been selected as one of the participants.

While many State agencies have some responsibility for resolving nursing home problems, each State designates a coordinator with central State authority to receive complaints of mistreatment or neglect of nursing home patients. Based on our research and confirmation within your agency, you have been designated as having that role. We would like you to complete the data table provided. Following your completion of the form, we would like to know the amount of time the table required for completion.

Federal definitions of elder abuse, neglect, and exploitation first appeared in the 1987 Amendments to the Older Americans Act. However, these definitions were only provided as guidelines for identifying problems, not for enforcement purposes. Currently, elder abuse is defined by State laws, and their definitions vary in terms of what constitutes the abuse, neglect, or exploitation of the elderly. Additionally, researchers have used many different definitions to study the problem. Yet, in most cases, State statutes provide the necessary definitions with varying degrees of specificity.

The definitions we will use for reviewing four types of abuse in this study are as follows:

Physical Abuse	the infliction of physical pain or injury which may result in bodily injury, physical pain, or impairment, including sexual abuse
Inappropriate Use of Restraints	chemical or physical control of a resident beyond physician's orders or not in accordance with accepted medical practice
Physical Neglect	disregard for necessities of daily living (e.g., failure to provide necessary food, clothing, clean linens, or daily care of the resident's person necessities)
Medical Neglect	lack of care for existing medical problems (e.g., ignoring the need for a special diet, not calling a physician when necessary, not being aware of the possible negative effects of medications, or not taking action on a medical problem)

This means you may need to review and adjust your State's definitions of abuse and neglect for nursing home patients to conform with the definitions above. This also means you may have to adjust your collected data accordingly.

Please fax the completed form and your written comments to us at 214-767-2039 by {August 7}. We realize that this is a short time frame and greatly appreciate your efforts in this endeavor. If you have any questions, please contact Leah Bostick of my staff at 214-767-3310 or 1-800-848-8960. Thank you very much for your assistance.

Attachment - Form and Table



Examples of State Definitions of Abuse and Neglect

Sample State	State Definition Abuse	State Definition Neglect
California	No specific definitions; uses 12 categories of abuse, neglect, and exploitation each having no specified definition, a subjective decision determine which category to use for reported incident.	
Florida	Non-accidental infliction of physical or psychological injury or sexual abuse upon a disabled adult or an elderly person.	Failure or omission on the part of the caregiver of a disabled adult or an elderly person to provide the care, supervision, and services necessary to maintain the physical and mental health of the individual (including food, clothing, medicine, shelter, supervision, and medical services). Also means the failure of a caregiver to make a reasonable effort to protect a disabled adult or an elderly person from abuse, neglect, or exploitation by others. Repeated conduct or a single incident of carelessness which produces or could be expected to result in serious physical or psychological injury or a substantial risk of death.
Illinois	Physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means.  Complaint intake personnel also delineate by physical, sexual, verbal, and mental abuse as well as by sexual assault (only resident to resident).	Failure in a long term care facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition
Massachusetts	Physical contact with a patient or resident which harms, or is likely to harm, that patient or resident (certain standards apply).	Failure of a facility or individual to provide treatment or services necessary to maintain the health or safety of a patient or resident (certain standards apply).
Michigan	State law defines abuse using HCFA's "Guidance to Surveyors-Long Term Care Facilities," Tag F223, which is a tool which can be used by surveyors in the course of conducting a facility survey; differentiates abuse, involuntary seclusion, mental abuse, misappropriation of resident property, neglect, physical abuse, sexual abuse, and verbal abuse.	Failure, through inattentiveness, carelessness, or omission of an individual to provide timely, consistent, and safe services, treatment and care to a facility resident. <sup>22</sup>
New York	Inappropriate physical contact with a resident of a health care facility, while such resident is under the supervision of the facility, which harms or is likely to harm the resident (includes striking, and sexual molestation)	Failure to provide timely, consistent, safe, adequate, and appropriate services, treatment and/or care to a nursing home resident which such resident is under the supervision of the facility, including nutrition, medication, and therapies).

Ohio	Knowingly causing physical harm or recklessly causing a serious physical harm to a resident by physical contact with the resident or by use of physical or chemical restraint, medication, or isolation as punishment, for staff convenience, excessively, as a substitute for treatment, or in amounts that preclude habilitation and treatment.	Recklessly failing to provide a resident with any treatment, care, goods, or service necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident.
Texas	Any act, failure to act, or incitement to act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident. This includes verbal, sexual, mental/psychological, or physical abuse (each individually defined).	A deprivation of life's necessities of food, water, or shelter, or a failure of an individual to provide services, treatment, or care to a resident which causes or could cause mental or physical injury, or harm or death to the resident.



## State Specific Information Concerning Abuse and Neglect Complaints

**California** reported overall complaints of neglect and abuse generally appear to be decreasing. However, specific complaints of dietary, patient rights, and abuse/neglect problems increased slightly. California was able to provide the OIG with much of what was requested. The State captures complaint information under eleven general (broad) categories, but does not have specific definitions for those categories when complaints are reported. California may also categorize a complaint by its potential for serious and immediate threat, requiring prioritizing the number of days allowed from when the complaint is received to when it is investigated.

If we look at California's neglect/abuse category combined with other, possibly related categories (which California was willing to say could be inclusive of neglect or abuse situations), for those complaints designated as Priority 1 (investigation within two days) and Priority 2 (investigation within 20 days), we see that the overall trend is a drop in reported complaints. However, if we look at each specific Priority 1 and Priority 2 category, reported complaints increased slightly for dietary, patient rights, and abuse/neglect. A significant decrease occurred in patient care complaints (17.4 percent).

When a "reported event" is received, the responsible staff categorize it as one of these eleven: dietary, administration, physical plant, medication, patient care, patient rights, staffing, patient record, problem transfer, neglect/abuse, and other. Surveyors who conduct the reviews or investigations can subjectively determine the category in which to place a complaint. As a result, California staff confirmed that their neglect/abuse category does not reflect all the possible complaints of abuse and neglect. A possible neglect or abuse complaint can be categorized in another category, i.e., "medication" could include chemical restraints or medical neglect; "patient rights" could include inappropriate restraints; and "patient care" could include physical neglect.

**Illinois** reported that, overall, complaints increased, with significant increases occurring between 1995 and 1997. Abuse increased 14.5 percent with significant increases in neglect and restraints, 36 percent and 238 percent, respectively). This trend of increasing total complaints was confirmed when we reviewed the complaints in relation to the number of nursing home patients for the same years.

Illinois routinely collects abuse complaint information in four categories - physical abuse, sexual abuse, verbal abuse, and mental abuse. Definitions for type of abuse and neglect complaints are found in two different State laws. Basically, one set of definitions is for the complaint intake process, and the second set is for substantiated complaints when recording of the information is required. All forms of neglect are captured in the one category, "neglect." When a complaint is confirmed, it is then defined only by the general terms "abuse" and "neglect" for the purpose of

issuing violations. Restraint complaint information was obtained through a manual search of existing records.

**Massachusetts** reported a major decrease in abuse complaints, with a minor increase in neglect complaints. Overall, the reported complaints in Massachusetts decreased substantially. This decreasing trend was also found when we reviewed the number of possible occurrences against the number of nursing home patients during the same years. However, it is interesting to note that a concurrent OIG draft report, *Long-Term Care Ombudsman Program: Complaint Trends* (OEI-02-98-00351), indicates that abuse statistics for Massachusetts' annual Ombudsman's report show significant increases (108 percent for a five year period).

Massachusetts does not distinguish abuse or neglect within specific categories, choosing to use the broad Federal definitions located at 42 Code of Federal Regulations (CFR), section 488, Subpart E. During the intake process of receiving a complaint, the specific type of abuse or neglect is identified. Conversation with staff indicate that the State's complaint system provides complaint information in a singular category of "abuse" which includes neglect, with no differentiation of specific types. As a result, in order to provide the neglect category of information, a staff person had to manually segregate those complaints. No further information on definitions or reporting and collection processes were provided by Massachusetts.

**Michigan** reported only six months of data in 1995. Overall, there was a minor increase of 1.3 percent in complaints from 1996 to 1997. However, for estimation purposes, if we double the 1995 reported complaints (to obtain an annual figure), the result would show a slightly higher increase of 9.6 percent in the overall complaints. When we review the change in complaints reported between 1996 and 1997 for specific sub-categories, we see a significant increase in medical neglect and a moderate increase in physical neglect, 58.5 percent and 20.7 percent, respectively. Data for that period also indicate a significant decrease in physical abuse (40.7 percent) and a moderate decrease in misuse of restraints (20 percent).

Michigan initially served as our test State for the request process. Given that their system codes had no direct relationship to those of the request, they had to conduct the requested cross-walk of their data. This was partially a manual identification and retrieval process conducted in a relatively short time period. Their data reflect allegations rather than complaints, as one complaint may have multiple allegations. Each allegation is designated by type using the State's defined types of abuse and neglect. Generally, Michigan uses the typical broad definitions of abuse and neglect from both the State's *Complaint Investigation Manual* and the *Michigan Public Health Code*. However, the manual also provides definitions for the more specific types of abuse, including involuntary seclusion, mental abuse, physical abuse, sexual abuse, and verbal abuse.

**New Jersey** reported their number of overall complaints for calendar years 1995 through 1997. The numbers were 1,251; 1,221; and 1,366, respectively. The State does not use State definitions for their abuse complaint system; they do, however, utilize the HCFA survey tags. The

State Ombudsman office has responsibility for the investigation of physical abuse complaints. The Division of Long Term Care Systems (which provided the complaint statistics) was unable to obtain the physical abuse statistics from the Ombudsman's office.

**New York** reported a substantial decrease (37 percent) across combined categories of abuse and neglect between 1993 and 1995. New York provided three printed annual reports, "Resident Abuse and Complaint Investigation Program" (reflecting calendar years 1991; 1992-1993; and 1994-1995). The 1996-1997 report is not yet available. New York's reports show a small decrease from 1993 to 1994 followed by significant decrease from 1994 to 1995.

It is interesting to note that, as in several other sample States, New York's response to the most recent Federal surveillance and enforcement regulations enacted July 1, 1995, was a realignment of its data collection program to meet the Federal definitions. The State's "Patient Abuse Reporting Law" (Section 2803-d of the Public Health Law), requires the reporting of abuse occurrences in all nursing homes. Allegations resulting from complaints, initially reviewed for nature, scope, and severity, are then categorized as either Chapter 340 Complaints<sup>1</sup> or General Complaints, more commonly referring to facility systemic issues. New York defines each category by the nature of the complaint. The category of physical abuse includes slapping, pushing, holding, kicking, stabbing, exposure, fondling, and raping. Neglect, or the failure-to-provide-care category, most commonly includes safe care, appropriate care, adequate care, transfer, and restraints.

**Ohio** three-year data shows an extremely high increase in neglect complaints (73 percent). Abuse complaints also increased by 26 percent. Ohio provided statistics for the two broad categories of abuse and neglect. It does not collect or report statistics on specific types of abuse, such as "restraints" complaints (Ohio includes restraints in the broad category of Resident Rights Issues).

**Tennessee** reported an overall decrease in abuse and neglect complaints; however, neglect complaints are increasing. Tennessee's abuse complaints decreased 16.7 percent between 1995 and 1997; neglect complaints increased by 15 percent. Tennessee, like the other sample States, adheres to the Federal definitions at 42 CFR 488.301 for required reporting and investigation of abuse. According to staff, the State does not prescribe any specific definitions for abuse and neglect, choosing to use only the Federal definitions. The State maintains data only for three years, plus the current year. Tennessee is in the process of converting to an automated system for collecting and reporting on abuse and neglect.

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<sup>1</sup> New York's Laws of 1980, Chapter 340, amended the State's Public Health Law encouraged reporting of abuse occurrences, strengthened the provisions for immediate action and imposition of fines for committing or failure to report abuse, mistreatment, or neglect. The State Department of Health continues to refer to complaint allegations of patient abuse, mistreatment, and neglect as Chapter 340 complaints.

**Texas** reported an overall slight increase in the number of complaints received (1.5 percent). Yet, when one looks at the four reported categories individually, we find abuse complaints significantly increased by 21.9 percent with smaller increases reported for misuse of restraints (6.8 percent) and medical neglect (4.2 percent). During that same period, physical neglect reports showed a slight decrease of five percent. When we reviewed the number of complaints in relation to the number of nursing home patients in the same years, the slightly increasing trend was confirmed.

Texas' abuse and neglect complaint data is collected through a process which utilizes the Federal enforcement codes to define the complaints. This allowed Texas to provide the cross-walk from their collected data to the four definitions used for this study.