RESIDENT ABUSE IN NURSING HOMES

RESOLVING PHYSICAL ABUSE COMPLAINTS

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EXECUTIVE SUMMARY

PURPOSE AND BACKGROUND

The OIG conducted this study to promote a better understanding of abuse in nursing homes. This is the second of two reports. It examines existing processes for resolving physical abuse complaints involving nursing home residents. The first report, *Resident Abuse in Nursing Homes: Understanding and Preventing Abuse*, examines the nature of abuse and ways to prevent it. Both reports reflect the experiences and perceptions of knowledgeable individuals who 1) play some part, directly or indirectly, in the resolution of abuse complaints, or 2) have an interest in nursing home or elder issues.

Abuse of the elderly is not a new phenomenon. Research findings and Congressional hearings of the 1970s and 1980s helped to increase public awareness of elder abuse. However, little research has focused on the issue of abuse of nursing home residents; certainly, no national survey has been initiated. Existing studies of abuse focus primarily on family members and caregivers in their homes. Research indicates from 1 to 10 percent of the non-institutionalized elderly population may be subject to abuse.

While there are no exact statistics on institutional abuse, any abuse is unacceptable. Each incident, 'major' or 'minor,' may be a terrifying experience and a significant breakdown in the responsibility of government to assure a safe and caring environment for elderly and disabled individuals. The price for abuse is measured in the physical and psychological harm to the resident as well as by the economic costs of treating the abused resident.

METHODOLOGY

Since national abuse statistics are not available and States vary in how they define and collect statistics, we decided to survey knowledgeable individuals involved directly or indirectly with nursing home care. Specifically, the inspection relied on 232 interviews with respondents representing State, national, and Federal organizations which are either 1) involved with receiving, investigating, and/or resolving nursing home abuse complaints, or 2) knowledgeable and concerned about nursing home or elder issues.

Respondents, based on their functional expertise and knowledge, answered a wide range of questions concerning the current State and Federal systems for resolving complaints involving nursing home residents. Further, selected respondents were

asked to provide 1) available statistics concerning complaints received and resolved, and 2) applicable State laws and/or regulations. The experiences and perceptions of the participants coupled with a review of State and Federal policies provide the basis for the findings and recommendations of this report.

MAJOR FINDINGS

Systems for reporting abuse complaints involving nursing home residents vary among States.

- State requirements for reporting abuse and penalties for non-reporting vary.
- Most States have identified an individual to receive complaints of nursing home resident abuse, often by means of a "hotline." Yet, reporting does not always occur.

Weaknesses exist in resolution of and follow-up activities for abuse complaints.

- According to many respondents, a lack of communication and coordination among involved agencies weakens the complaint resolution process.
- States vary in their interpretations of the investigative responsibilities of State Ombudsmen and Medicaid Fraud Control Units (MFCUs).
- Prosecution of substantiated abuse incidents is hindered by the difficulty of proving the abuse and obtaining the evidence required for prosecution. When confirmed, most instances of abuse will result in staff dismissal but no criminal prosecution.

State and Federal abuse record-keeping and oversight activities need strengthening.

- Analysis of national abuse statistics was not possible because of variations in the definitions and types of abuse statistics collected under existing State and Federal reporting requirements.
- Many respondents familiar with the Health Care Financing Administration (HCFA) nursing home certification survey guide identified problems with its use and application.

RECOMMENDATIONS

STATE AND LOCAL RESPONSIBILITIES

- Each State should establish a State-wide network of responsibilities and supporting processes to report, investigate, resolve, follow-up, and prevent abuse in nursing homes. Regardless of the components of the network, a single entity must be responsible for its operation.

- States should be permitted flexibility in deciding how best to establish such a system of State agency roles and responsibilities. However, States should consider the need to 1) enact new legislation or strengthen existing laws to implement this process, and 2) ensure appropriate resources for its operation.

FEDERAL RESPONSIBILITIES

- The HCFA should require stronger reporting, investigation, resolution, and follow-up of abuse incidents as part of its conditions of participation for hospitals and nursing homes.

- The Administration on Aging (AoA) should expand and strengthen its efforts to 1) issue periodic public reports concerning best practices for preventing and dealing with resident abuse, 2) promote public awareness and education concerning abuse occurring in nursing homes, and 3) promote use of volunteer Ombudsmen in all nursing homes.

- The HCFA and the AoA should jointly develop common definitions and categories of abuse for all State and Federal reporting purposes.

ADDITIONAL ACTION BY THE OIG

The OIG will, through its oversight responsibility, encourage State MFCUs to:

1) promptly evaluate reported incidents and complaints of suspected abuse and take timely, definitive action, with decisions not to prosecute reported to the designated State agency,

2) foster closer relationships with all local prosecutors involved in abuse cases, and

3) report abuse convictions to the OIG for possible sanctions.

DEPARTMENTAL COMMENTS

This report has been modified to reflect many of the comments received from within and outside the Department of Health and Human Services. Comments from the Assistant Secretary for Planning and Evaluation, the Office of Human Development Services, the AoA, and HCFA are included in the appendix to the report. They generally agreed with our findings and recommendations. The HCFA indicates it has already done much to accomplish the recommended changes.

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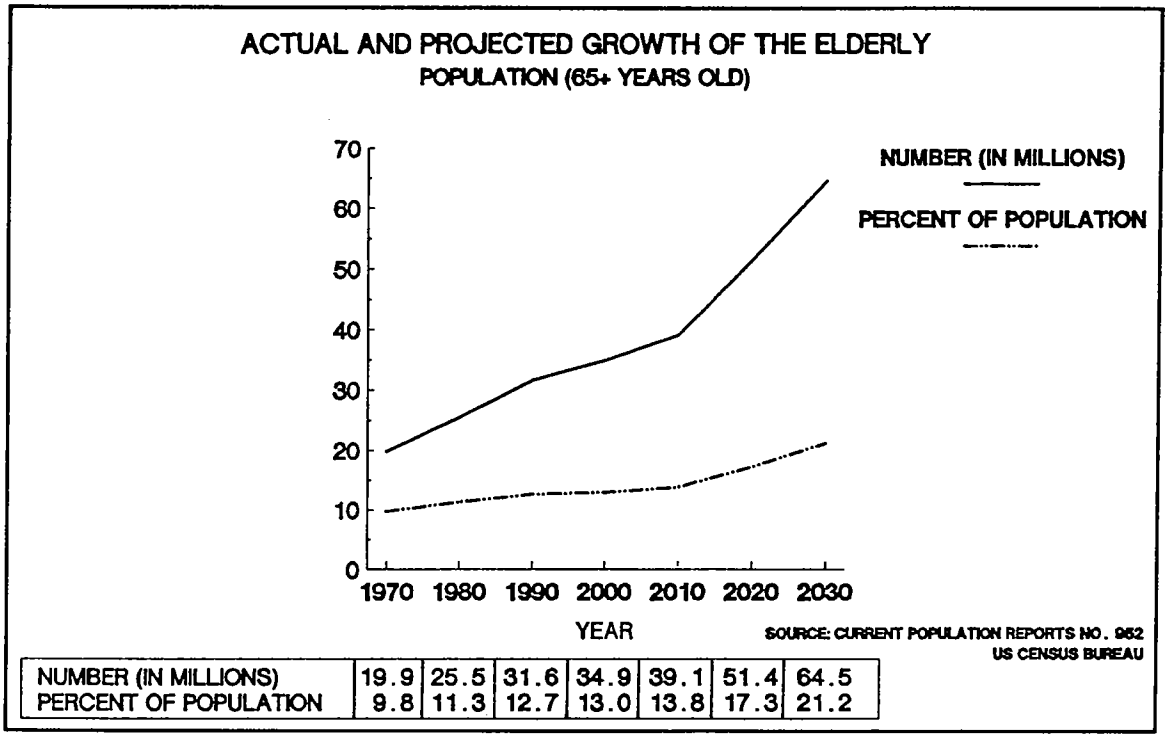


NUMBER (IN MILLIONS)	19.9	25.5	31.6	34.9	39.1	51.4	64.5
PERCENT OF POPULATION	9.8	11.3	12.7	13.0	13.8	17.3	21.2

FIGURE 1

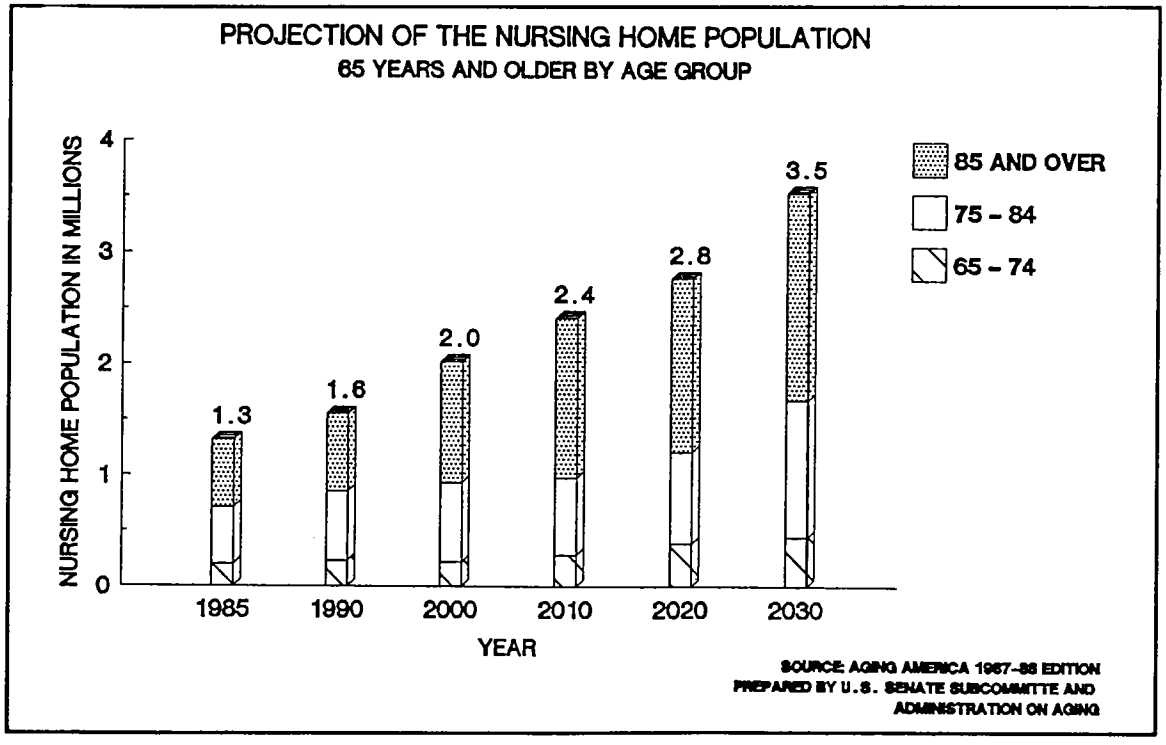


FIGURE 2

INTRODUCTION

PURPOSE

The OIG conducted this study to promote a better understanding of abuse in nursing homes. This is the second of two reports. It examines existing processes for resolving physical abuse complaints involving nursing home residents. The first report, *Resident Abuse in Nursing Homes: Understanding and Preventing Abuse*, examines the nature of abuse and ways to prevent it. Both reports reflect the experiences and perceptions of knowledgeable individuals who 1) play some part, directly or indirectly, in the resolution of abuse complaints, or 2) have an interest in nursing home or elder issues.

BACKGROUND

Americans are living longer, and the nation's elderly population is growing at an unprecedented rate, partially as a result of new technologies and medical advances. There are now 28 million people aged 65 or older; by 2030, they will number more than 60 million, or 21.2 percent of the total population (figure 1). As individuals live longer, their need for nursing home care may increase.

While only about five percent of the elderly population are in nursing homes at any given time, it is likely the nursing home population will continue to grow rapidly as the very old segment of the population continues to expand. Projections indicate 3.5 million elderly individuals will be living in nursing homes by 2030 (figure 2). The growth in the number of older people experiencing both disabilities and dependencies may place additional physical and emotional stress on both institutional and non-institutional caretakers. Persons advanced in age, limited by mental and/or physical impairments and dependent on others for their daily care, constitute the population most vulnerable to abuse.

Abuse of the elderly is not a new phenomenon. Research findings and Congressional hearings of the 1970s and 1980s have helped to increase public awareness of elder abuse. Existing studies of abuse have focused primarily on family members and caregivers in their own homes. Research indicates from 1 to 10 percent of the non-institutionalized elderly may be subjected to abuse. The incidence of and facts concerning institutional resident abuse are less known.

Doty and Sullivan (1983) note that both Federal and State sources report receipt of incidents of resident abuse each year. Monk, Kaye, and Litwin (1984) found that

State Long-Term Care Ombudsmen receive many complaints about nursing home staff treatment of residents. Further, they note a substantial amount of maltreatment is never reported.

Pillemer and Moore (1988) provide one random survey designed to assess the scope and nature of physical and psychological abuse in nursing homes. They found that 36 percent of the sampled nurses and nurse aides had seen at least 1 incident of physical abuse in the preceding year; 10 percent reported they had committed 1 or more physically abusive acts.

While there are no exact statistics on institutional abuse, any abuse is unacceptable. Each incident, 'major' or 'minor,' may be a terrifying experience and a significant breakdown in the responsibility of government to assure a safe and caring environment for elderly and disabled individuals. The price for abuse is measured in the physical and psychological harm to the resident as well as by the economic costs of treating the abused resident.

Federal Roles

Three Department of Health and Human Services (HHS) agencies have either direct or indirect involvement with nursing homes and services to residents of nursing homes: the Office of Human Development Services/Administration on Aging (OHDS/AoA), the Health Care Financing Administration (HCFA), and the Office of Inspector General (OIG).

Administration on Aging

The Administration on Aging (AoA) of OHDS is the primary Federal agency responsible for the State Long-Term Care Ombudsman (hereafter referred to as State Ombudsman) program. It further serves as the visible advocate for the elderly within HHS. The AoA meets the needs of the elderly mainly through a program of grants to State Agencies on Aging under Title III of the Older Americans Act (OAA) [as amended (42 U.S.C. 3001 et seq.)]. Title III also authorizes activities for the prevention of elder abuse. The Act requires each State Agency on Aging to establish and operate a State Ombudsman program to receive and review complaints concerning nursing home residents.

Health Care Financing Administration

The HCFA administers Medicare and Medicaid program operations. Within HCFA, the Health Standards and Quality Bureau (HSQ) has oversight responsibility for Medicare and Medicaid nursing home standards of care designed in part to ensure an environment free from abuse. To meet this obligation, HCFA develops and administers the regulatory requirements for nursing homes participating in either

Medicare or Medicaid, develops training requirements for surveyors who conduct nursing home inspections, conducts yearly compliance surveys of five percent of those facilities previously surveyed by the State, and monitors State compliance surveys for quality assurance.

The HCFA may directly receive complaints of abuse involving nursing home residents. However, these will usually be referred to the applicable State agency for nursing home certification unless the allegation involves an "immediate and serious threat" to patient health and safety.

Office of Inspector General

Through Public Law (P.L.) 94-505, enacted in 1976, the OIG was established as an independent unit in HHS with the authority to prevent and detect fraud and abuse in Department programs. The OIG is required to 1) recommend policies for the detection and prevention of fraud and abuse within programs and operations administered or financed by the Department and 2) conduct, supervise, or coordinate investigations related to such fraud and abuse.

Under Section 1128 of the Social Security Act, the OIG was provided authority to impose sanctions against health care providers convicted of Medicare or Medicaid offenses or suspended or excluded or otherwise legally or administratively sanctioned by appropriate State entities. In meeting this statutory authority, the OIG works with other Federal, State, and local governmental agencies and nongovernmental entities. As a further part of this authority, the OIG/Office of Investigations (OI) has oversight of and grant certification responsibility for State Medicaid Fraud Control Units (MFCUs).

The Medicare and Medicaid Patient and Program Protection Act of 1987 amends titles XI, XVIII, and XIX of the Social Security Act to protect beneficiaries from unfit health care practitioners. The Act states that if an individual is convicted of patient abuse in connection with the delivery of a health care item or service, exclusion from the Medicare and Medicaid programs is mandatory.

In September of 1986, the OIG/OI published an "Investigative Guide for the Detection of Patient Abuse." The guide was made available to State MFCUs for training and reference purposes.

Existing Nursing Home Requirements

The Medicare and Medicaid programs traditionally have used a condition of participation (COP) format to define requirements which must be met by facilities in order to participate in the programs. This format is based on the principle that each

condition level statement would be a statutory requirement while standard level statements would be lesser requirements within a condition.

Under current law, a skilled nursing facility (SNF) must meet COPs to participate in the Medicare or Medicaid programs; intermediate care facilities (ICFs) must meet standards. Current COPs and standards were originally published in 1974. The SNFs have a single uniform definition which extends the same level of care requirements to both Medicaid and Medicare programs. The ICF benefit was intended to allow facilities which did not meet SNF COPs to participate as ICFs and provide health-related care, not at the skilled level, to Medicaid patients.

Provisions for resident rights are ambiguous and enforcement is difficult because a resident's rights and a facility's obligations are sometimes unclear. Recognizing that a resident's rights, living conditions, and medical care are essential components of the quality of life in a facility, HCFA developed outcome oriented survey instruments in June 1988. The emphasis of current regulations is on process, not outcomes of that process as is relates to residents. The regulations do not contain any SNF COP or ICF standard for a resident assessment. Also, there is no quality of care COP utilizing resident care outcomes, especially negative ones, to assess whether residents are receiving satisfactory care.

Existing Medicare COPs are located at 42 CFR, Part 405, Subpart K and implement Section 1861(j) of the Social Security Act. Current Medicaid standards are in 42 CFR, Part 442, Subparts D, E, and F.

Omnibus Budget Reconciliation Act of 1987 (OBRA '87), P.L. 100-203

On December 22, 1987, OBRA '87 was enacted. The law includes extensive revisions to the Medicare/Medicaid statutory requirements for nursing facilities. Nursing home reform provisions, to be implemented October 1, 1990, establish uniform requirements for Medicaid SNFs and ICFs. The law revises the conditions under which nursing homes may participate in the Medicaid/Medicare programs, the process for monitoring compliance with law, and the remedies available to Federal and State agencies in the event of noncompliance. It further expands nursing facility resident rights to include freedom from 1) inappropriate use of physical or chemical restraints and 2) physical or mental abuse or punishment.

The NF (any Medicare SNF or Medicaid facility which is not an ICF for the mentally retarded) must inform residents orally and in writing of their legal rights. The HCFA draft regulations provide all incidents of abuse be reported to the nursing home administrator or to any other agency designated by State law. Residents may file a complaint concerning abuse or neglect with the State survey/certification agency. The NF must permit the State Ombudsmen access to the

resident and the resident's clinical records with the permission of the resident or the resident's legal representative.

The NFs will be required to verify the competency of applicants prior to their employment as nurse aides. No nurse aide may be employed for more than four months unless the individual has completed State-approved training or successfully passed a competency test. Verification of a nurse aide's competency will be strengthened through the required use of a State maintained nurse aide registry. This registry will certify that the individual has met the required training requirements and indicate the documented findings, not limited to convictions, of resident abuse, neglect, or misappropriation of resident property involving an individual listed in the registry. If the State determines a nurse aide has been involved in these activities, the State will, after notice and reasonable opportunity to rebut allegations in a hearing, notify the nurse aide and the nurse aide registry.

State and Local Roles

The primary responsibility for designing, operating, and coordinating services for the elderly lies with the States. Several State agencies may be responsible for resolving nursing home problems including:

- nursing home complaint coordinators,
- State Ombudsmen (under the direction of the State Agency on Aging),
- MFCU or other legal authorities where no MFCU is established,
- agencies for nursing home certification and licensure,
- licensure agencies for medical personnel,
- adult protective services, and
- local law enforcement.

The nursing home complaint coordinator is the individual designated to nursing home administrators as the central State authority to receive complaints of mistreatment or neglect of nursing home residents. This individual may be in any number of State agencies or part of a designated complaint unit, but is usually a staff member of the State nursing home survey and certification agency.

The State Agency on Aging, through the State Ombudsman, is required by the OAA:

1) to establish procedures for maintaining a State-wide reporting system to collect and analyze data related to complaints and incidents;

2) to monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long term care in the State;

3) to provide public education on their activities and long term care issues; and

4) to promote training and certification of ombudsman staff and volunteers.

The MFCUs are also required to review "complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan. If the initial review indicates substantial potential for criminal prosecution, the unit shall investigate the complaint or refer it to an appropriate criminal investigative or prosecutive authority" (Social Security Act, section 1903(q)). At the time of this inspection, there were MFCUs in 38 States. Those States without a MFCU have agencies with parallel responsibilities for investigation of fraud and abuse (e.g., State Attorney General).

SCOPE AND METHODOLOGY

At this time, there is no uniform definition of abuse among the States or researchers. The term abuse may cover many problem areas for nursing home residents ranging from environmental conditions needing correction to actual mistreatment of residents. For purposes of this inspection, abuse is defined as mistreatment or neglect of nursing home residents and encompasses seven categories of abuse, excluding environmental and financial issues. These seven categories were defined using simple definitions (figure 3) based on a review of the literature related to abuse (appendix F).

Since national abuse statistics are not available and States vary in how they define abuse and collect statistics, we decided to survey knowledgeable individuals involved directly or indirectly with nursing home care. Specifically, the inspection relied on 232 interviews with respondents representing State, national, and Federal organizations which are either 1) involved with receiving, investigating, and/or resolving abuse complaints involving nursing home residents, or 2) knowledgeable and concerned about nursing home or elder issues (e.g., State oversight agencies for nursing homes or advocates of the elderly or nursing homes). (See appendix A and figure 4 for summary information on respondents sampled.) These individuals were identified through contacts with the regional HCFA offices as well as several State agencies (e.g., State Ombudsman and single State agency for Medicaid).

A minimum of three principal entities were interviewed in each of 35 States: 1) State Ombudsman, 2) investigator or director of the State MFCU, or legal counterpart where no MFCU exists, and 3) State nursing home complaint coordinator (the nursing home administrators' primary contact for abuse complaints). These entities

were selected because our preinspection indicated they were the most often involved in nursing home abuse complaint receipt and resolution in most States. In 8 of the 35 States, we interviewed additional individuals including nursing home administrators, nursing home and resident advocates, and medical professional licensure personnel. Figure 4 shows the 35 States from which respondents were selected.

Participants, based on their practical expertise and knowledge, answered a wide range of questions, by telephone or in-person interviews, concerning different aspects of abuse in nursing homes including the prevalence and severity of the seven abuse categories. Further, selected respondents were asked to provide 1) available statistics concerning complaints received and resolved, and 2) applicable State laws and/or regulations.

This report focuses on the respondents' perceptions and understanding of existing processes for resolving physical abuse complaints. Unlike the other six categories of abuse, physical abuse is generally easy to recognize and has more consistency of definition. Further, it is a form of abuse for which States may have developed a process to resolve complaints. The responses, coupled with a review of State and Federal policy and available literature, provide the basis for our findings and recommendations and appear consistent with the information and statistics available from the States and independent researchers.

INSPECTION ABUSE DEFINITIONS

ABUSE: Mistreatment or neglect of nursing home residents.

1. Physical Abuse
   Infliction of physical pain or injury.
   Examples include individuals either 1) reacting inappropriately to a situation, such as pushing or slapping a resident, or 2) intentionally doing bodily harm.

2. Misuse of Restraints
   Chemical or physical control of a resident beyond physician's orders or not in accordance with accepted medical practice.
   Examples include staff failing to loosen the restraints within adequate time frames or attempting to cope with a resident's behavior by inappropriate use of drugs.

3. Verbal/Emotional Abuse
   Infliction of mental/emotional suffering.
   Examples include demeaning statements, harassment, threats, humiliation or intimidation of the resident.

4. Physical Neglect
   Disregard for necessities of daily living.
   Examples include failure to provide necessary food, clothing, clean linens or daily care of the resident's necessities (e.g., brushing a resident's hair, helping with a resident's bath).

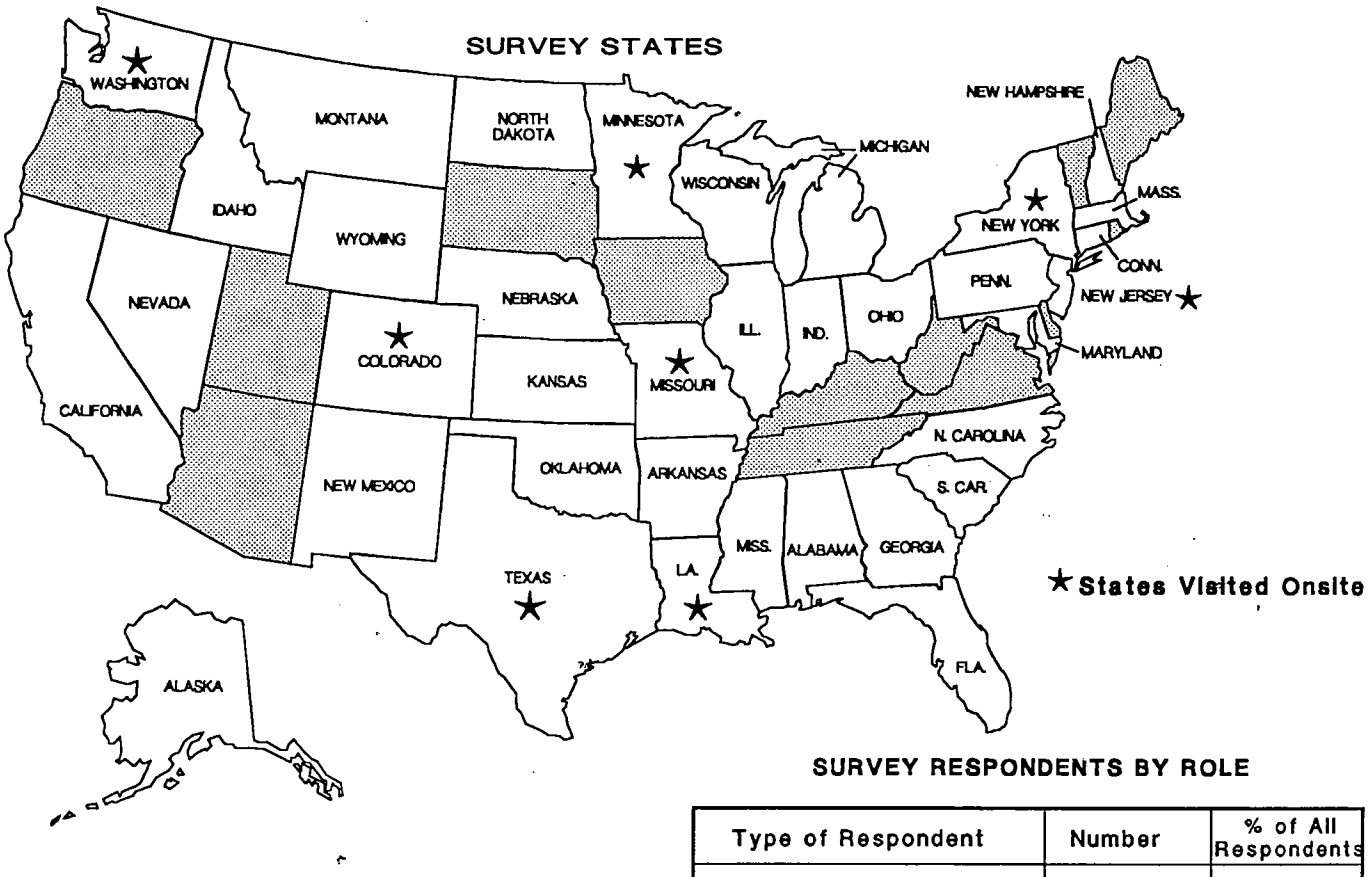
5. Medical Neglect
   Lack of care for existing medical problems.
   Examples include ignoring a necessary special diet, not calling a physician when necessary, not being aware of the possible negative effects of medications, or not taking action on medical problems.

6. Verbal/Emotional Neglect
   Creating situations in which esteem is not fostered.
   Examples include not considering a resident's wishes, restricting contact with family, friends or other residents, or more simply, ignoring the residents' need for verbal and emotional contact.

7. Personal Property Abuse (Material Goods)
   Illegal or improper use of a resident's property by another for personal gain.
   Examples include the theft of a resident's private television, false teeth, clothing or jewelry.

FIGURE 3

RESPONDENT SAMPLE



SURVEY RESPONDENTS BY ROLE

Type of Respondent	Number	% of All Respondents
State		
Complaint Coordinator	37	16%
Survey and Certification Surveyors	16	7%
MFCUs Or Counterpart	41	18%
Professional Medical Licensure Boards	18	8%
Ombudsman	38	16%
Resident Advocacy Organizations	14	6%
Nursing Home Industry	29	13%
National Organizations		
Consumer, Industry and Local Law Enforcement	14	6%
Federal		
HCFA	14	6%
OIG	11	5%

35 States Contacted

Alabama	Louisiana	New Mexico
Alaska *	Maryland	New York
Arkansas	Massachusetts	North Dakota *
California	Michigan	Ohio
Colorado	Minnesota	Oklahoma *
Connecticut	Mississippi	Pennsylvania
Florida	Missouri *	South Carolina *
Georgia *	Montana *	Texas
Idaho *	Nebraska *	Washington
Indiana	Nevada *	Wisconsin
Illinois	New Hampshire	Wyoming *
Kansas *	New Jersey	

* States with no Medicaid Fraud Control Unit

FIGURE 4

SYSTEMS FOR REPORTING ABUSE COMPLAINTS INVOLVING NURSING HOME RESIDENTS VARY AMONG STATES

State requirements for reporting abuse and penalties for non-reporting vary.

While a number of States lack legislation specific to abuse in nursing homes, almost all States have laws or regulations protecting the elderly. (See appendix B for a partial listing.) Included in at least 43 State laws for the elderly is a requirement that abuse be reported. Central to most reporting laws is the requirement for licensed medical personnel in a health care facility to report abuse. Some States also require reporting by unlicensed staff such as aides, orderlies, housekeepers, dieticians, and other staff. Some States require anyone with knowledge of abuse to report it. Although designated reporters may still be reluctant to report abuse, fear of penalties such as license revocation, fines, or even criminal prosecution may overcome the reluctance to report.

- **States provide some immunity from liability for the reporting of abuse.**

  State laws presume the good faith of the person filing a report and grant the person some immunity from liability. Also, reporting laws may protect the reporter ('whistle blower clause') from being discharged from employment or harassment. The 1987 Amendments to the OAA Ombudsman Program specifically require States to "prohibit retaliation and reprisals by a long term care facility or other entity with respect to any resident or employee for having filed a complaint with or providing information to, the Office" of the Ombudsman (OAA Sec. 307(a)(12)(J)(ii)).

- **Penalties for non-reporting vary among States.**

  Most respondents (80 percent) indicate there is a State penalty for non-reporting of known or suspected incidents of physical abuse. Such penalties are generally classified as misdemeanors with a designated fine and/or possible short-term prison sentence. Some respondents indicate non-reporting may also result in a loss of licensure or monetary fine for the involved facility. However, 83 percent of the respondents who indicated a State penalty for non-reporting, further indicate States rarely or never enforce those penalties.

Most States have identified an individual to receive complaints of nursing home resident abuse, often by means of a "hotline." Yet, reporting does not always occur.

This individual (labeled "complaint coordinator" in this study) may be in any number of State agencies, but is usually a staff member of the State nursing home survey and certification agency. While few States have funded special units to respond to nursing home complaints, most States have added the responsibilities of receiving, investigating, resolving, and follow-up to existing departments.

A hotline may be located in the coordinator's agency or in another agency. The hotline may or may not be a toll-free 24-hour manned line. When not manned, reports may have to be held until normal working hours. Sometimes there are several routes for reporting abuse, depending on where the abuse occurs, who the abuser is, or the severity of the incident.

- **A significant percentage of respondents (46 percent) believe abuse is only sometimes or rarely reported.**

  Thirty-seven percent of the respondents said abuse is reported only sometimes; nine percent indicate reporting rarely or never occurs. If these respondent perceptions are accurate, many cases of abuse go unreported each year.

- **Opportunities for residents, families or visitors to report abuse are available but are not always used.**

  Reasons given by respondents for non-reporting include:

  1) Residents and/or family members sometimes lack the knowledge of how and to whom reports of abuse should be made. Although nursing homes are required, as a condition of participation in the Medicaid/Medicare program, to explain and display resident rights, which include how to report complaints, some respondents believe this is not done adequately.

  2) Residents fear retaliation from nursing home staff. Part of the failure of residents to report abuse can be attributed to the nature of the nursing home resident/employee relationship. Residents are dependent on nursing home staff to respond to their basic needs. Some residents fearing retaliation (real or imagined) may choose to endure the suffering rather than risk the consequences of reporting acts of abuse. Similarly, residents, as well as family members, fear the nursing home might retaliate by discharging the resident for reports of mistreatment.

3) Physical or mental illness limits reporting. Many respondents report that the residents most vulnerable to abuse are physically or mentally impaired and, consequently, have difficulty reporting. Even those aware something is wrong may be unable to articulate their concerns or to recognize the perpetrator of the alleged abuse because of those impairments. The reporting and subsequent activities to resolve the complaint may be physically and emotionally taxing. Consequently, residents may simply choose not to report and thus avoid any further stress.

- **Abuse often goes unreported by nursing home staff.**

When asked specifically how often abuse is reported by nursing home staff, many respondents (51 percent) believe abuse is only sometimes or rarely reported by nursing home staff. This indicates many cases of abuse may go unreported by staff. Respondents believe the primary reasons staff do not report abuse include:

1) a basic fear of losing one's job,
2) the sense of loyalty shared among staff,
3) fear of retaliation by the nursing home or peers,
4) fear of fines or penalties,
5) fear of bad publicity,
6) lack of clear or sufficient facts, and
7) failure to recognize the less blatant forms of abuse.

According to one patient advocacy group, "almost every nursing home administrator [they] speak with seems to have a different view of what has to be reported and when." This advocacy group has "seen very inconsistent application of reporting requirement timeframes. The requirement that the reporting be 'immediate' is usually ignored."

- **A majority of respondents say attending nursing home physicians rarely or never report abuse; a large number indicate emergency room physicians also rarely or never report abuse of nursing home residents.**

Approximately 66 percent of the respondents report physicians attending nursing home residents rarely or never report abuse (appendix C). In fact, one State complaint coordinator reported never receiving a complaint from an attending physician. A large number of respondents (37 percent) also believe emergency room physicians rarely or never report abuse of nursing home residents who are injured severely enough to require emergency care.

Nearly half of all respondents (47 percent) say lack of frequent involvement with the residents is a primary reason nursing home physicians rarely report abuse. Some respondents believe emergency room physicians may not report because they are more concerned with the immediate treatment of the resident and either are too busy to report or do not recognize the abuse. According to respondents, other common reasons physicians, in general, may not report abuse are:

1) identification with the staff and their problems in coping with residents,
2) busy schedules,
3) apathy,
4) insufficient facts,
5) belief the incident has already been reported, and
6) may be unaware of requirement to report.

WEAKNESSES EXIST IN RESOLUTION OF AND FOLLOW-UP ACTIVITIES FOR ABUSE COMPLAINTS

According to many respondents, State and Federal procedures for resolving abuse complaints are inadequate.

Respondents perceive many overlapping and sometimes conflicting responsibilities of the involved local, State, and Federal entities. As a result, even in States with established procedures, there are weaknesses in the current systems to protect nursing home residents and to prevent abuse.

Of those respondents who reacted to questions about the effectiveness of current State and Federal efforts to protect residents from abuse, 41 percent indicate State systems are no better than "somewhat effective" at protecting residents. Of those respondents familiar with Federal responsibilities, 55 percent indicate the Federal roles are only somewhat effective in resolving abuse of nursing home residents.

- **Respondents report inadequacies in communication and coordination among the many State and Federal agencies having roles in the resolution of abuse complaints.**

  Assessing and resolving abuse is rarely simple. Many States have several agencies with parallel or overlapping roles which receive, investigate or resolve abuse complaints involving nursing home residents. A report by the American Public Welfare Association and the National Association of State Units on Aging (1986) identify 30 possible types of State agencies having roles in either the nursing home or the community.

Through contacts with the State agencies, we typically found at least four State entities usually involved with investigation and/or resolution of complaints involving abuse of nursing home residents: 1) the complaint coordinator, 2) the Ombudsman, 3) the MFCU or State counterpart, and 4) local law enforcement. In addition to these State entities, some respondents were familiar with responsibilities of two previously identified Federal agencies: the OHDS/AoA and HCFA. Few respondents, other than the MFCUs, had any knowledge of the role and responsibilities of the OIG. Most respondents were unfamiliar with any investigative role by Federal agencies. A few indicated HCFA might perform an investigative role. Additionally, respondents indicate HCFA and the AoA do not usually participate in investigations concerning individual abuse complaints and rarely have direct involvement in processes for resolving complaints.

Respondents indicate States have some process in place for resolving abuse complaints. However, no one State or Federal agency has responsibility for the full resolution process and for assuring all applicable entities are involved. Thus, the process can be impeded, particularly when clear role definitions are lacking. In many instances, the involved agencies operate through informal agreements with the State agency empowered to levy sanctions. Unfortunately, these agencies may not report back with their findings and resulting actions in a timely manner.

Many respondents identified weaknesses in State or Federal processes for coordination and communication among appropriate agencies. Communication, coordination, division of responsibility, and relative activity differ among States and among State and Federal entities. Even those few States with special units to investigate, resolve, and ensure follow-up activities of abuse complaints involving nursing home residents exhibit weaknesses in performing some of the essential functions (e.g., lack of communication with the OIG).

To summarize respondent concerns about inadequate coordination of investigative agencies, we present the following quote from a elder advocacy group concerning a particular state:

> We are concerned that there appears to be less than desirable arrangements to coordinate investigations of alleged abuse with other investigative agencies. Most notably, there is an apparent lack of coordination between the Patient Rights Investigation and Monitoring Section and the Attorney General's Health Care Fraud Unit. In almost all cases involving alleged abuse of nursing home residents, we file complaints with both offices. We have seen little evidence that investigations are coordinated in any significant way.

- **While most States have regulations or laws governing the initiation of an investigation, many respondents indicate their State does not have established time limits for completing investigations or staff with investigative backgrounds to perform all investigations regardless of the type of alleged abuse.**

  The time frames for an investigation by the authorized entity vary among States. Some States are vague and call for action "immediately," "promptly" or "as soon as possible." Those with definite time limits may range from "within 24 hours" to "within three days." Some State investigation agencies have been given the authority to determine the urgency for complaint investigations. Consequently, they have the authority to delay investigations.

  How an investigation proceeds is nearly as important as when an investigation occurs. Complaints should be investigated with the goal of quickly substantiating or negating the complaint. This process should determine the validity of the complaint while protecting the rights of both the abused individual and the suspect.

  When the investigation does take place, investigators should be familiar with investigative techniques, prosecutorial requirements of evidence, and interviewing techniques specific to the disabled or elderly nursing home resident. Yet, many respondents indicate these are deficiencies of many investigations. Some respondents believe the investigative function is also weakened by a lack of sufficient investigators and a need for medical expertise to support some investigations.

- **Respondents indicate the primary investigator for most nursing home abuse complaints is the nursing home administrator or someone to whom s/he has delegated this responsibility.**

  Complaint coordinators may investigate the situation themselves or delegate the responsibility to others such as a local social worker or the local police. When the incident is not severe in nature, as many are not, the complaint coordinator may delegate the responsibility for the investigation to the nursing home administrator. The administrator, or someone to whom s/he in turn has delegated the responsibility, will investigate and report the findings to the complaint coordinator. In some cases, administrators may initiate investigations and take corrective action but fail to report the incident.

- **Many respondents report local law enforcement authorities are rarely involved in the investigation or resolution of nursing home abuse.**

  Respondents indicate police are rarely called for incidents occurring in nursing homes. The severity of the abuse usually dictates whether or not there will be

police involvement. If an incident of abuse is reported to the police, they may choose not to work closely with other involved agencies. If they receive an abuse complaint involving a nursing home resident, many respondents indicate the police will refer the reporter to another entity because they feel no responsibility to deal with "nursing home issues" involving no perceived criminal activity.

If police are mandated to report and investigate abuse incidents reported to them, they must know whom to contact concerning a harmful situation requiring non-police remedies. Additionally, respondents believe a lack of knowledge by the police in dealing with elderly or disabled nursing home residents will impact on how effectively they perform their investigations. While police clearly have a role in investigating physical abuse and theft of property, their responsibility is less clear when the complaint is one of misusing restraints or verbal/emotional abuse or neglect.

In those instances in which the complaint is referred to and investigated by the police, many respondents indicate the police rarely report their findings to other State agencies. Most State Ombudsmen and complaint coordinators have no means of tracking the progress of the case (e.g., substantiation, arrest, prosecution) except, possibly, to obtain a copy of the police investigative report. These respondents voiced the same concern for referrals made to the MFCU. Further, in those States requiring nursing home administrators to report incidents to the police, as well as to the coordinator, there may be no measures to ensure such compliance.

States vary in their interpretations of the investigative responsibilities of State Ombudsmen and MFCUs.

Both State Ombudsmen and MFCUs have Federal mandates to investigate abuse complaints involving residents in nursing homes. However, States interpret those responsibilities and perform those functions differently.

Several MFCU respondents indicate different interpretations of which abuse complaints they are to investigate. Some investigate only those complaints involving residents receiving Medicaid, while others investigate abuse complaints involving any resident of a Medicaid-certified facility. A few MFCUs may investigate abuse complaints regardless of Federal certification.

State Ombudsmen have a similar problem. Operation of ombudsmen programs are not uniform within or among States. No Federal regulations interpreting the investigative responsibilities of the Ombudsmen have been established by the AoA.

Respondents report State Ombudsmen often lack authority over the actions of local ombudsmen even though they certify the local ombudsmen. In many instances, it is

the ombudsman at the local level who will receive and "investigate" an abuse complaint. Yet, the State Ombudsmen generally lack adequate direction, resources, and authority to ensure and enforce a consistent interpretation of the investigative role.

Additionally, both Ombudsmen and MFCU respondents report they are inadequately staffed to perform all investigations of abuse effectively. Respondents say funding for more staff would be needed to accomplish such goals.

- **In most States, State Ombudsmen serve as a referral source but do not have authority to take disciplinary action.**

  Most Ombudsmen may receive reports of abuse but must refer them to other agencies for action. They generally do not investigate the cases themselves. If an investigation is conducted by the Ombudsmen, it is usually parallel to an investigation being done by a designated investigatory agency (e.g., survey and certification). Although the Ombudsmen may substantiate complaints, they generally lack any sanctioning authority. They often rely on the nursing home certification and licensing agency or other appropriate designated agency for administrative remedies, and local law enforcement or the MFCU for prosecution.

- **Most respondents are unfamiliar with the responsibility of the MFCU to investigate and resolve complaints of nursing home resident abuse.**

  Typically, respondents are not aware of the MFCU or its responsibilities for the investigation or resolution of abuse complaints. As a result, many MFCUs may not be routinely notified of abuse complaints received by other agencies.

  The MFCUs can receive complaints directly from the reporter. At its discretion and if an initial review of the complaint indicates substantial potential for criminal prosecution, the MFCU may investigate the complaint or refer it to an appropriate criminal investigative (police) or prosecutive authority (local district attorney). If the initial review does not indicate substantial potential for criminal prosecution, the unit will usually refer the complaint to an appropriate State agency (survey and certification or professional licensure) for appropriate administrative action.

  Many MFCUs are not informed of complaints and incidents until after the complaint coordinator investigates and substantiates the complaint. Respondents from some States say substantiated complaints will usually be referred to local prosecutors rather than to the MFCU. According to respondents, by the time many MFCUs are notified of a substantiated complaint investigated by another agency, some of the evidence needed for successful prosecution may have been

lost. Such loss of evidence may occur through an insufficient initial investigation conducted by an individual not adequately trained in criminal investigative procedures and the evidentiary requirements necessary for successful prosecution.

MFCU and counterpart respondents cite the following weaknesses in the abuse investigative functions of their States:

- lack of coordinated investigative and resolution efforts between local law enforcement and other State and Federal agencies,
- lack of public awareness to recognize and report abuse,
- inadequately trained personnel conducting investigations,
- insufficient numbers of staff to conduct investigations,
- low priority given to abuse complaints not serious in nature,
- overly stringent evidentiary requirements for prosecution of substantiated complaints under criminal laws, and
- insufficient enforcement of existing laws and regulations.

In recognition of these and other weaknesses, the National Association of Attorneys General, through the efforts of the National Association of MFCUs, passed a resolution in 1988 encouraging the States to adopt model legislation to prohibit patient and resident abuse.

Prosecution of substantiated abuse incidents is hindered by the difficulty of proving the abuse and obtaining the evidence required for prosecution. When confirmed, most instances of abuse will result in staff dismissal but no criminal prosecution.

Across the nation, State penalties for confirmed abuse vary widely. Many laws governing prosecution of abuse were established for criminal assault cases. The evidentiary requirements for criminal assault are usually much more stringent than can be readily satisfied in instances of nursing home abuse. Many complaint coordinators urged giving abuse issues a higher priority for investigation and prosecution by police and local district attorneys.

In many instances, respondents said prosecution of substantiated abuse does not occur because:

1) the incidents may be perceived as minor and more easily handled administratively;
2) assembling the case can be difficult;
3) prosecution may not be 'a sure thing';
4) the time lapse to prosecution may lessen the chances of successful prosecution due to the mental or physical frailty of the victims or witnesses;

5) the abused individuals and witnesses may be reluctant to testify, particularly if the victim is the only witness or the witness may be confused as to the details of what actually happened; and
6) patterns of abuse may not be apparent, because repeated incidents may not have been identified and tracked.

Respondents say prosecution of a substantiated abuse complaint is rare. As a result, most confirmed instances result in dismissal of the involved employee. However, the employee may be retained by the nursing home following an incident of less severe abuse. In these instances, the employee may be placed on probation and may undergo further training and/or counseling.

STATE AND FEDERAL ABUSE RECORD-KEEPING AND OVERSIGHT ACTIVITIES NEED STRENGTHENING

There are no adequate national nursing home abuse statistics to provide an incidence rate or trend for nursing home abuse.

Nearly all respondents believe abuse, both mistreatment and neglect, is a problem in nursing homes. Unlike other categories of abuse, physical abuse is generally easy to recognize and has more consistency of definition. For this reason, we asked State complaint coordinators and Ombudsmen for statistics related to physical abuse. While a few States were able to give us either the number of complaints received or incidents reported by nursing homes for combined categories of abuse, most did not provide numbers for physical abuse.

State complaint coordinators in 26 of the 35 States were unable to report physical abuse statistics. According to these respondents, present record-keeping procedures do not provide for easy extraction (barring a manual count of every complaint received). Explanations for a State's inability to provide information range from not having any system for recording complaints to not defining nursing home physical abuse as a specific complaint category in their record-keeping system.

National summary data is lacking due to:

1) limited capacity of State information systems to provide detailed data on abuse categories,
2) variations in the definitions and types of abuse covered by existing State and Federal reporting requirements, and
3) weaknesses of State and Federal reporting and statistical analysis requirements regarding abuse problems occurring in institutional settings.

- **Many States define abuse and collect statistical information differently.**

  States vary in their reporting definitions and practices. Even if a State has an information system capable of providing abuse information, definitional differences exist which make it inappropriate to compare States. For example:

  1) States vary in how they define individuals protected from institutional abuse. Some State laws require reporting of abuse for anyone in a nursing home, while others require reporting of abuse specific to the elderly.

  2) Some States define abuse categories extensively, while others may only have a single category for all types of abuse.

  3) Some States lump incident reports from residential care facilities and long term institutions together (e.g., mental health/retardation institutions, boarding homes).

  4) Some States keep statistics on the number of complaints, while others keep statistics by allegation. Within each complaint, there may be one or more allegations. The complaint would be substantiated if just one of the allegations were true.

- **The State Ombudsman's annual report to AoA has definitional problems which limit its use for analysis of national incidence trends or the prevalence of abuse. The level of reporting detail is too broad for adequately monitoring nursing home resident abuse problems and trends.**

  State Ombudsmen are required by the OAA to collect and submit complaint data annually to the AoA. In fiscal year (FY) 1987, seven States either failed to report or did not use the AoA Complaint Classification System. The remaining 43 reported 62,941 complaints in nine major categories and an aggregate "other" category. The majority of the complaints were for incidents in nursing homes.

  The nine major categories contain 136 subcategories covering 1) resident physical, medical, and emotional care, 2) administrative problems, and 3) environmental issues. Of these, approximately 65 represent complaints which would most often fall under the broad category of abuse as defined by this study. However, the current and revised reporting forms being implemented require only aggregate information for most complaint types. This weakness will not allow for the reporting and analysis of complaint sub-categories (e.g., Resident Care is the aggregate category; improper restraints, physical abuse, mental abuse, verbal abuse, neglect, etc., are sub-categories not reported to the AoA for national analysis).

Respondents also noted problems in how abuse allegations and complaints are recorded. A complaint may be reported in several different categories. It may reflect a single incident or several incidents. Respondents indicate the complaint with several incidents may be recorded as a single complaint, recording only the primary incident, or as several complaints each based on one incident. Therefore, while the Ombudsman report is a major indicator of the occurrence of nursing home abuse, it cannot be used to obtain reliable national counts of abuse (particularly for specific problem areas).

Many respondents familiar with the HCFA nursing home certification survey guide identified problems with its use and application.

State survey agencies monitor the performance of nursing facilities by determining their compliance with the Federal conditions of participation. The HCFA has oversight responsibility for the surveys conducted by States for Medicare/Medicaid certification of nursing facilities. Of those respondents familiar with the Medicare/Medicaid Skilled Nursing Facility and Intermediate Care Facility Survey Report, which is used by State surveyors, respondents cited several inadequacies of the HCFA and State survey processes and guides, as listed below.

1) Survey deficiencies are facility oriented. Abuse is more often an individual issue rather than a facility-wide problem.

2) Because resident interviews are of short duration, surveyors may lack time to gain the resident's confidence and overcome his/her fear of reporting the abuse.

3) The survey processes leave little time for extensive investigation of problems.

4) Surveyors are not trained investigators.

5) Survey conduct varies considerably among States and Federal regions with respect to the intensity, focus, and quality of efforts and resources invested.

6) Survey guidelines are subject to varying interpretations by the individual surveyors. What one cites as a deficiency, another may not report due to "extenuating circumstances."

- **Respondents report surveyors often perform little or no analysis of complaints prior to conducting Federal or State nursing home surveys.**

  Nearly half of the respondents (47 percent) said analysis of prior nursing home complaints either does not occur or they were unaware of it being done prior to surveys. The usual reason given for this is the surveyors lack easy access to complaint files or all statistics specific to the nursing home being surveyed.

RECOMMENDATIONS

Respondents have identified many overlapping and, in some instances, conflicting responsibilities of the involved local, State, and Federal entities. As a result, even in States with established procedures, there are inconsistencies and weaknesses in the current systems with regard to protecting nursing home residents and preventing abuse. Based on these findings, we recommend the following:

STATE AND LOCAL RESPONSIBILITIES

- Each State should identify the various State authorities and interest groups with current responsibility for reporting, resolving, and follow-up of abuse complaints.

- Each State should establish a State-wide network of responsibilities and supporting processes to address abuse in nursing homes. The network must have a single entity accountable for its operation, although functions can be delegated. At a minimum, the network should include the following components: reporting, investigating, resolving, and follow-up action on abuse complaints.

  Reporting and Investigating

  Procedures should be established to receive and act on complaints of suspected abuse in a timely manner. Processes for reporting should be easily accessible and well publicized. There should be a central agency designated to coordinate the receipt of all abuse complaints. This entity should:

  1) require facility staff to report all instances of suspected abuse directly to the agency designated for that purpose. Mandatory reporters should include all licensed or unlicensed professional and non-professional nursing home staff, including nurses, doctors, administrators, nurses aides, orderlies, housekeeping, kitchen staff, etc.

a. There should be a mandatory orientation and ongoing training for all employees affected by the reporting requirement.

b. The nursing home administrators should not be allowed to delay reporting of possible cases of abuse in order to conduct internal investigations.

2) prohibit retaliatory action against individuals reporting suspected incidents of abuse and provide anonymity when possible.

3) take all necessary actions to ensure each abuse report is investigated timely, including:

-- notifying the local police and the MFCU (if there is one) of any incident or complaint of suspected abuse, and
-- notifying other appropriate State or local agencies responsible for supervising nursing facilities or personnel of the complaint.

Resolution and Follow-up

1) The process should:

-- ensure all necessary actions to a) provide appropriate medical care, if necessary and b) resolve the complaint timely,
-- maintain communication and coordination among all involved entities required for case resolution, and
-- document the resolution of each complaint and incident.

2) Each State should:

-- maintain readily retrievable data about abuse incidents and complaints, review and identify patterns of abuse, and then take appropriate action when patterns are identified;
-- ensure appropriate follow-up activities are performed (e.g., reporting substantiated incidents involving aides or medical personnel to either the aide registry or the State licensure authorities);
-- promote public and facility awareness of abuse and reporting requirements;
-- maintain retrievable statistical data for State management and Federal review; and
-- report all abuse convictions to State licensure authorities and to the HHS/OIG for possible Federal sanctions against the individual or facility.

Administration

Regardless of which entities are utilized in performing necessary roles in the system, ultimate responsibility for communication and coordination among all State and Federal roles must rest with a single clearly-identifiable entity. That entity should:

1) define individual roles and specify responsibilities of entities involved in the receipt, resolution, and necessary follow-up of abuse;
2) establish written protocols for conducting abuse investigations;
3) ensure qualified staff perform each function of the complaint resolution process; and
4) require reporting of all local level convictions to the designated central unit.

States should be permitted flexibility in deciding how best to establish such a system of agency roles, responsibilities and implementing procedures. Possible agencies which might have roles in the system include:

-- MFCUs
-- adult protective services agencies,
-- local police,
-- local area aging agencies,
-- State survey and certification agencies,
-- State Ombudsmen, and/or
-- new State and local agencies created for this purpose.

States should also consider the need to enact new legislation or strengthen existing laws to implement this process, and ensure appropriate resources for its operation. Wherever possible, formal agreements among involved State agencies and between State and Federal agencies should be developed which specify their respective responsibilities.

States should further plan, develop, and implement public education programs to inform the public about what constitutes abuse and what actions should be taken if abuse is suspected.

FEDERAL RESPONSIBILITIES

- The HCFA, as part of its conditions of participation for hospitals and nursing homes, should:

  1) require all nursing home staff and hospital medical personnel to report all suspected incidents of nursing home resident abuse to the nursing home administrator or local law enforcement, and to the central agency assigned responsibility for resolution of abuse complaints;

  2) require nursing homes to report all abuse incidents to local law enforcement, the central agency assigned responsibility for resolution of abuse complaints, and to the State survey and certification agency;

  3) require nursing homes to maintain reports of suspected incidents of abuse and the actions taken by the nursing home;

  4) require administrators to conduct analysis of all incident reports to determine implications and appropriate actions;

  5) require nursing homes to specify, as part of the nursing home resident's plan of care, a plan to prevent abuse of a resident who is either mentally or physically unable to protect him/herself; and

  6) require nursing homes to provide ongoing training, monitoring, and counseling of employees suspected of abusing residents.

- The AoA should expand and strengthen its efforts to:

  1) issue periodic public reports concerning best practices for preventing and dealing with resident abuse;

  2) promote public awareness and education concerning abuse occurring in nursing homes; and

  3) promote and ensure more widespread use of volunteer Ombudsmen in all nursing homes.

- The HCFA and the AoA should jointly develop common definitions and categories of abuse for all State and Federal reporting purposes.

ADDITIONAL ACTION BY THE OIG

The OIG will, through its oversight responsibility, encourage the MFCUs to:

1) promptly evaluate reported incidents and complaints of suspected abuse and take timely, definitive action, with decisions not to prosecute reported to the designated State agency.

2) foster closer relationships with all local prosecutors involved in abuse cases to:

   a) provide technical assistance and expertise in prosecuting abuse, and
   b) ensure MFCU awareness of abuse convictions by local prosecutors.

3) report abuse convictions to the OIG for possible sanctions.

DEPARTMENTAL COMMENTS

Comments were received from the Assistant Secretary for Planning and Evaluation, the Office of Human Development Services, the Administration on Aging, and the Health Care Financing Administration. (See appendix D for the full texts.)

Assistant Secretary for Planning and Evaluation (ASPE)

The ASPE agreed with the findings and recommendations of the report. More specifically, it "supports the OIG's recommendations for improved training of nurses aides and orderlies about how to cope with stressful situations and resident behaviors without resorting to abuse, improved abuse complaint investigation and resolution as part of State enforcement of Federal nursing home regulations, and improved systems for abuse reporting."

Office of Human Development Services (OHDS)

The OHDS concurred with the report.

Administration on Aging (AoA)

The AoA agreed generally with the findings and recommendations of the report. However, while concurring with the "observation that there are no data which can be used to provide an incidence rate or trend regarding nursing home abuse," the AoA states it is beyond their control to overcome the impediments to the collection of such data. Thus, they requested the recommendation for the AoA to issue periodic public reports on abuse trends be revised to read, "to issue best practices for preventing and dealing with resident abuse."

We recognize the concerns expressed by the AoA and have modified this recommendation. However, we continue to believe such reports will be possible if consistent definitions are developed.

Health Care Financing Administration (HCFA)

While HCFA generally agreed with the report, it did have concerns with the primary data gathering technique utilized, that is, an opinion survey rather than a scientifically controlled review, which resulted in such opinion data "presented as fact." The HCFA also felt it would be advisable to include more information about the interviews and information gathering processes used in the study.

Additional information has been provided in the Scope and Methodology section of the report. Although evaluation studies do not produce absolutely certain information, they can provide relatively objective data. As the report indicated, there was little relevant statistical or applicable published research data concerning abuse in a nursing home.

We started with an assumption that individuals who routinely receive complaints of abuse, survey for indicators of abuse, investigate abuse, or resolve abuse incidents are knowledgeable sources. The survey method was designed to provide descriptive information of existing processes using statements of opinion from a representative population. Findings and recommendations related to the survey (to identify whether abuse was a problem, to what extent, etc.) were a result of both content and qualitative analyses of the survey responses, available State statistics and legislation/regulation, and available research. We recognize the information provided by the respondents is significant only in the way it is regarded by the researcher or the readers. There is no absolute interpretation of the information provided.

Generally, HCFA agreed with the recommendations of the report. The HCFA believes their implementation of the applicable statutory requirements of the Omnibus Reconciliation Act (OBRA) of 1989 and the Social Security Act will fulfill most of the recommendations of the report. In meeting a portion of the legislative requirements, HCFA has revised the conditions of participation for nursing homes (effective October 1, 1990). The HCFA believes the revised requirements will contain many of the safeguards recommended by the OIG.

The HCFA indicates many of the recommendations will be met by the new regulations. We agree that draft regulations issued thus far represent a substantial improvement over regulations now in effect. However, some of these regulations are still in the public review and comment stage and may change. Even more importantly, the regulations defer to State law on the critical issues of complaint reporting, investigating, and follow-up. Hence, their impact will depend greatly on how aggressively the States move on these problems. Similarly, nursing homes will have to comply with the State law. We will, therefore, defer any assessment of whether our recommendations have been implemented until the new regulatory requirements are in place and States and nursing homes have made at least initial efforts to implement them.

The HCFA also took exception to aspects of some of the recommendations:

The HCFA did not agree with the recommendation for hospital medical personnel to report suspected incidents of abuse. The agency is unaware of a significant abuse problem in hospitals and do not believe there is a need to revise the conditions of participation for hospitals since they require hospitals to follow State law. Further, HCFA does not believe the OIG has demonstrated a significant problem with respect to hospitals.

We agree that the inspection did not indicate abuse occurring in the hospital setting; this was not the intent of the study. However, the inspection findings did indicate that emergency room physicians may rarely or never report abuse observed or treated involving a nursing home resident. For clarification of the recommendation, we have modified the recommendation to require hospital medical personnel to report suspected abuse involving a nursing home resident.

The HCFA disagrees with the recommended requirement for nursing homes to report "all abuse incidents to local law enforcement, the central agency assigned responsibility for resolution of abuse complaints, and to the State Survey and Certification Agency." The agency believes the new requirements to report to the nursing home administrator or outside official in accordance with State law will be sufficient. Further, HCFA believes minor abuse incidents can be effectively handled by the administrator without the need for involvement of law enforcement personnel.

We agree that reporting alleged abuse to the administrator and to an outside entity in conjunction with State law (which we believe should be a designated central agency) may be sufficient in most cases. However, we disagree that there is no need for involvement of law enforcement personnel. We understand HCFA's reasons for minor cases not to be reported to the police. Unfortunately, the distinction between minor abuse and major abuse is subjective and cannot always be left to the nursing home administrator to determine. We have noted that criminal investigations should be conducted by trained investigators who can make such distinctions. Nevertheless, we have modified the recommendation to require reporting to either the nursing home administrator or to law enforcement officials as well as to the central agency responsible for abuse.

The HCFA, finally, disagrees with the recommendation for nursing homes to provide ongoing monitoring and counseling of employees suspected of abusing residents stating counseling could be inadequate and employees must be removed from the job if expectations are not met (as to behavior).

We concur with HCFA that employees should be expected to conform to prescribed behavioral requirements. However, if staff suspected of abuse are retained, additional training, counseling, and monitoring should be required.

APPENDICES

NATIONAL ORGANIZATION RESPONDENTS

American Association of Homes for the Aging
1129 20th Street, NW
Washington, D. C. 20036

American Association of Retired Persons - Central Office
Criminal Justice Services
1909 K Street, NW
Washington, D. C. 20049

American Health Care Association
1201 L Street, NW
Washington, D. C. 20005

American Medical Directors Association
12100 Blue Paper Way
Columbia, Maryland 21044

National Aging Resource Center on Elder Abuse
Research and Demonstration Department
810 First Street, NE
Washington, D. C. 20002-4205

National Association of Attorneys General
444 N. Capitol Street, Suite 403
Washington, D. C. 20001

National Association of Chiefs of Police
1100 NE 125 Street
Miami, Florida 33161

National Association of State Units on Aging
2033 K Street, NW, Suite 304
Washington, DC 20006

National Citizen's Coalition for Nursing Home Reform
1424 16th Street, NW
Washington, D. C. 20036

National Sheriff's Association
1450 Duke Street
Alexandria, Virginia 22150

Police Executive Research Forum
2300 M Street, NW, Suite 910
Washington, D. C. 20037

Police Foundation
1001 22nd Street, NW Suite 200
Washington, D. C. 20037

Rehabilitation Care Consultants, Inc.
6401 Odara Road
Madison, Wisconsin 53719

STATE ELDERLY OR NURSING HOME LAWS AND REGULATIONS

The following is a compilation of laws and regulations provided by respondents and found in published abuse literature. The laws and regulations referenced are a partial list in some States due to incomplete respondent reporting and recent legislation or amendments.

Alabama

Long Term Residential Health Care Recipient Ombudsman Act, 1985.
Adult Protective Services Act of 1976, (Acts 1977, No. 780, p. 1340, Section 1).

Alaska

Protection of the Elderly, Chapter 24, Section 47.24.010, 1983.
Office of Long-term Care Ombudsman, Chapter 24, Section 44.21.

Arizona

Adult Protective Services Legislation, ARS 46-451, 452, 453, 454, and ARS 14-5310.01. (ARS 46-453 and 454 enacted 1984; remainder, 1980)

Arkansas

Arkansas Statue 59-1301, Adult Abuse Statute, 1977, amended 1981.

California

Assembly Bill 1805 (Felando) Chapter 1184, Statutes of 1982.
Senate Bill 1210 (Carpenter) Chapter 1273, Statutes of 1983.
AB 238 (Papan) Chapter 1164, Statutes of 1985.
AB 749, Chapter 25, Statutes of 1986, effective 1987.

Colorado

Disabled Adult Protective Services, 1983.
Licensure Standards, 1982, amendments 1986, 1988.

Connecticut

CGS 17-135 a-m, 1977.
Protection of the Elderly Act, 1978.

Delaware

Abuse, Neglect or Mistreatment of Residents in Medical or Long-term Care Facilities, Senate Bill 463, 1986.
Adult Protective Services Act, DE Code Title 31, Chapter 39, 1982.

District of Columbia

Adult Protective Services Act of 1984, DC Law 5-158.

Florida

Adult Protective Services Act, Section 415.101-113, Florida Statutes, 1987.
Nursing Home Residents Rights, Section 400.022, Florida Statutes.
Long-term Care Ombudsman Act, Section 400.301, Florida Statutes.

Georgia

Long-term Care Facility Resident Abuse Reporting Act of 1980, O.C.G.A., 31-8-80.
Bill of Rights for Residents of Long-term Care Facilities of 1981, O.C.G.A., 3-8-100.
Disabled Adults Protection Act of 1981, O.C.G.A., 30-5-1.
Domestic Violence Act of 1981, O.C.G.A., 19-13-1 et seq.

Hawaii

Hawaii Revised Statutes, Chapter 349C, Elder Abuse or Neglect, 1981.

Idaho

S.B. 1267, amended, Office of Ombudsman.
Elderly Abuse, Exploitation, Neglect, and Abandonment Reporting Act, Idaho Code, Chapter 52, Section 39-5201 - 39-5212, 1982.
Idaho Code, Chapter 286, Sections 2-734; 39-3301 - 39-3309, amendment 1983; 15-5-101-502.

Illinois

Nursing Home Care Reform Act of 1979, PA 81-223, 1980, amended 1981 et al; PA 85-940, 1988.
Life Space Care Facilities Act, Public Act 82-547, 1982, amended PA 82-783, 1982.
The Domestic Violence Act.
Elder Abuse Demonstration Act, amended 1984 by SB799, SB801.
Abused and Neglected Long-term Care Facility Residents Reporting Act, PA 82-120, 1982, amended PA 83-1530, 1985; PA 84-798, 1986; 1988.

Indiana

Indiana Code, PL 41-87, Dept. of Human Services, 4-28-1-1 through 4-28-6-3, 1987.
Indiana Code 4-27-7-1 et seq., Adult Protective Services, 1985.
Indiana Health Facilities Rules, 410 IAC 16.2, 1984.
Indiana Code 4-28-5-1 et seq., APS, 1987 (PL 42-1987).

Iowa

Iowa Code, Chapter 235B, Adult Abuse Services, 1983.

Kansas

Protection from Abuse Act, 1979.
Reporting Abuse or Neglect of Certain Persons, KSA Chapter 39, Article 14, 1980, amended 1985.
Abuse Care Homes - Unlawful Acts, 1961.

Kentucky

Protection of Adults Act, KRS 209, 1976, 1978, 1980.
Domestic Violence and Abuse Act, KRS Chapter 403, 715-785, 1984.

Louisiana

Louisiana Revised Statutes, Title 40, Act 687 of 1978.
Louisiana Revised Statutes, Title 14, Acts 519 and 551 of 1982 (Original APS Law), amended 1983, 1985, 1987.
Louisiana Revised Statutes, Title 14, Act 850, 1981, amended 1987.

Maine

Adult Protective Services Act, 22 M.R.S.A., Section 3470-3487, 1981.
Domestic Violence Act, 19 M.R.S.A., Section 761, 1979, amended 1983.
Act to Establish the Main Probate Code, 18A M.R.S.A., 1981.

Maryland

Abuse or Neglect of Vulnerable Adults, Article 27, Section 35B, 1988 draft.
Health General Article, Title 19, amended 1983.
Adult Protective Services Act, Chapter 148, enacted 1977, amended 1985.

Massachusetts

MA Patient Abuse Statute (MGL Chapter 111-72 F-L), 1980.
Massachusetts' General Laws 19A S. 14-26 or Acts of 1982, Chapter 604, 1982.
SB 2206, Chapter 83-544, 1983.

Michigan

Act Number 519, Public Acts of 1982, 1983.
MGL, Chapter 265, Section 13A, Assault & Battery.
Older Michigans Act, HB 4123, 1987.
Adult Protective Services, SB 223, 1982.
Michigan Health Code Act 368, Public Acts of 1978, Section 20201.

Minnesota

Vulnerable Adults Act, Minnesota Statutes 626.557, Reporting of Maltreatment of Vulnerable Adults, enacted in 1980, amended 1981, 1982, 1983, and 1985.
HF 365, Patient Bill of Rights, Chapter 248, 1983.

Mississippi

Adult Protective Services Act of 1982.
Protection from Domestic Abuse Law, 1981.
Mississippi Vulnerable Adults Act of 1986.

Missouri

Protective Services for Adults Act, RSMO 660.251, 1980 (Supp. 1981) et seq.
Omnibus Nursing Home Act, RSMO 198.001-198.186, amended 1979, 1987.
Institutional Services Manual, Section VII, 1988.
Institutional Services Manual, Section VIII, 1988.
Division of Aging, 13 CSR15.

Montana

Montana Elder Abuse Prevention Act, 1983, amended 1985 (Title 53, Chapter 5), revised 1987 to make a second offense of elder abuse a felony.

Nebraska

The Offenses Involving the Family Relation Law, 1979.
APS Act, 1988 (LB 463); Complaints (LB 235), 1983; Nurse Assistant (LB 273), 1983, (LB416), 1984, (LB 921), 1986.

Nevada

The Abuse, Neglect, Exploitation of Older Persons Act, NRS 200.5091 et seq., 1981, amended 1983, 1985, 1987.

New Hampshire

Protective Services to Adults Law, RSA 161-D, 1977, latest revision 1988.
Patient's Bill of Rights, RSA 151:21; Ombudsman Statute, RSA 126-A.

New Jersey

The Prevention of Domestic Violence Act, NJSA 2C:25-1 et seq., 1982.
Mandatory Reporting of Adult Abuse to the State Ombudsman Act, NJSA 52:27G-2, PL 1983, Chapter 43.
Enabling Legislation for the Office of the Ombudsman for the Institutionalized Elderly, NJSA 52:27G-1 to 16, Chapter 239, 1977.
Nursing Home Patients Bill of Rights, NJSA 30:13 to 11, PL 1976, Chapter 120, 1976.
Boarding Home Residents Bill of Rights, NJSA 55:13 B-1, et al., PL 1979, Chapter 500.

New Mexico

Adult Protective Services Act, 1982.

New York

Patient Abuse Reporting Law (Public Health Law, Section 2803-d), 1977, revised 1980).
Adult Protective Services Law, Article 9-B of the State Social Services Law, includes section 473, 473-a, and 473-b of the Social Services Law. Section 473, 1975, amended in 1979; Section 473-a, 1981; and Section 473-b, 1984.
Health Facility memoranda 80-53 and 80-76, Patient Abuse Reporting.

North Carolina

Protection of the Abused, Neglected, or Exploited Disabled Adult Act, 1973.
SB 18, Chapter 83-88, 1983.
SB 13, Chapter 83-143, 1983.

North Dakota

Bill of Rights for Health Care Facility Residents, Chapter 50-10.2.
Long-Term Care Ombudsmen, Chapter 50-10.1, SL 1983, Chapter 524; SL 1985, Chapter 524; SL 1987, Chapter 576.

Ohio

Patient Rights, Health-Safety-Morals 3721.10-18, H600, 1979; H694, 1981.
Protective Services for Adults Law, Section 5101.60-71 and 5101.99, 1981. Amended Section 5105.61, 1986.
Crimes Procedures, Reporting, 2921.22, H284, 1980.

Oklahoma

Nursing Home Care Act, 1980.
Protective Services for the Elderly and Incapacitated Adults, enacted 1977, amended 1985, 1986.

Oregon

Nursing Home Patient Bill of Rights, ORS 441.6 et al, 1979, amended 1981, 1983, 1985, 1987.
Reporting of Abuse of Elderly Persons Act, ORS 410.6 et al, 1981, amended 1983, 1987.
Patient Abuse Act, 1979.
Protective Services, ORS Chapter 411, 1975, amended 1980, 1981.
Assault and Related Offenses, Chapter 163, 1971, amended 1975, 1977.
Intimidation, Chapter 166, 1981, amended 1983.
Criminal Mistreatment, Chapter 163, 1973, amended 1981.

Pennsylvania

Older Adults Protective Services Act, 1979, 1987.
Protection from Abuse Act, PL 1090, 1976.

Rhode Island

An Act Relating to Elderly Persons, PL 0069-1981, 1982.
Domestic Violence Law, 1984.
Felony Act, Section 11-5-10, 1980, amended PL 1981, PL 1988.
Department of Elderly Affairs Legislation, Chapter 66, 66.1, and 66.2, amended 1985.
Abuse in Health Care Facilities, Health and Safety, Chapter 17.8, PL 1987, PL 1988.
Registration of Nursing Assistants, Health and Safety, Chapter 17.9, PL 1987, PL 1988.

South Carolina

Protective Services for Developmentally Disabled and Senile Persons, 1974.
Client- Patient Protection Act (CPPA), 1979, amended 1984, 1986.

South Dakota

SDCL 28-1-1, Public Welfare and Assistance, LS 1937, Chapter 220, Section 1.
SDCL 28-8-23, Title XX Social Services Program, SL 1975, Chapter 188, 1975.
An Act to Prohibit Abuse of Disabled Adults, SB 292, 1986.

Tennessee

Protective Services for Elderly Persons Act, 1974, repealed 1980.
Adult Protection Act, 1978, amended 1980, 1984, 1986.

Texas

Chapter 48 - Title 2 - Human Resources Code, passed as elderly protective law in 1981 and amended to include disabled adults in 1983.

Utah

Adult Protective Services Act, 1977, amended 1983.

Vermont

Reports of Abuse, Neglect and Exploitation of Elderly and Disabled Adults, Title 18, Chapter 22, amended 1983, 1985, 1986, 1987.
Abuse Prevention Law, Domestic Violence Law, Title 15, Chapter 21, 1979, amended 1981.

Virginia

Public Services Laws, Chapter 1, Section 63.1-55.1 through 63.1-55.7, and Chapter 24, Section 2.1-373 through 2.1-373.3.

Washington

RCW 70.124, Nursing Home Reporting Law, 1983.
RCW 74.34, Abuse of Vulnerable Adults Act, 1984.

West Virginia

Social Services for Adults, Chapter 9, Article 6, 1981, amended 1984.
Prevention of Domestic Violence, Chapter 48, Article 2A.

Wisconsin

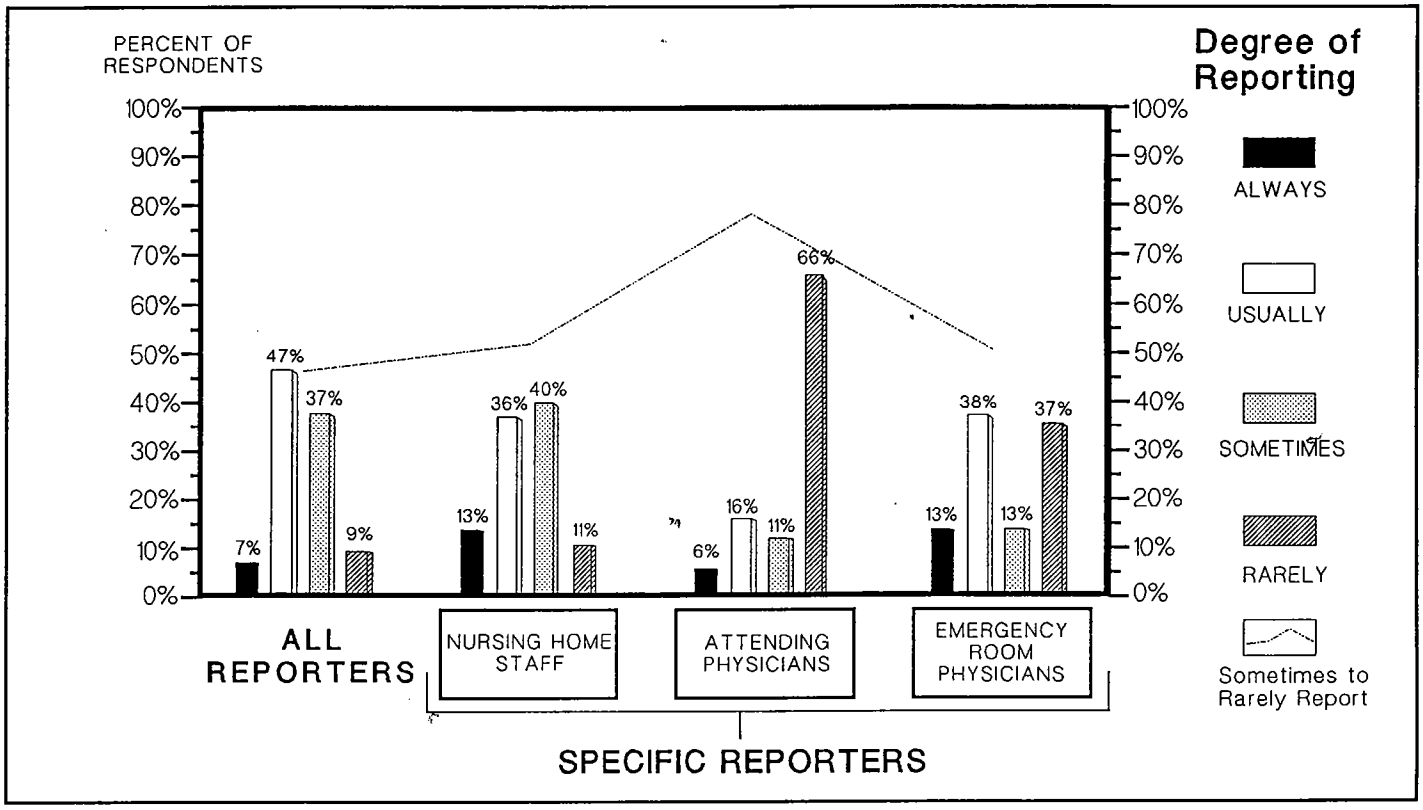
The 1983 Wisconsin Act 398, 1984.
Crimes and Bodily Security, Section 940.28-29, 1975, amended 1977, 1979, 1981, 1985.
Administration Code HSS 132.43, 1982; HSS 132.44, 1982, amended 1987; HSS 132.6, 1982, amended 1983, 1987.

Wyoming

Adult Protective Services Act, 35-20-101 to 35-20-109, 1981.

APPENDIX C

DEGREE OF NURSING HOME ABUSE REPORTING



Graph Interpretation:

Respondents were asked four questions related to reporting. First, how often is abuse reported in general by any possible reporter (All reporters). Second, how often is abuse reported by nursing home staff as a subgroup of all reporters. Thirdly, how often is abuse reported by attending physicians. And finally, how often is abuse reported by ER physicians.

As an example, for nursing home staff: 13 percent of respondents believe staff always report abuse, 36% believe staff usually report abuse, and so on.

DEPARTMENTAL COMMENTS

Comments on the draft reports were received from four Department of Health and Human Services entities - the Assistant Secretary for Planning and Evaluation, the Health Care Financing Administration, the Office of Human Development Services, and the Administration on Aging. The full texts of their comments are attached.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MEMORANDUM

DEC 29 1989

TO: Richard Kusserow
Inspector General

FROM: Arnold R. Tompkins
Acting Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Draft Reports: (1) "Resident Abuse in Nursing Homes: Respondent Perceptions of Issues" and (2) "Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints"

I commend the OIG staff for producing two excellent reports documenting the problem of resident abuse in nursing homes and recommending strategies for dealing with it. OASPE supports the OIG's recommendations for improved training of nurses aides and orderlies about how to cope with stressful situations and resident behaviors without resorting to abuse, improved abuse complaint investigation and resolution as part of State enforcement of Federal nursing home regulations, and improved systems for abuse reporting.

In my view, these two reports merit the widest possible dissemination among Federal and State agencies concerned with nursing home regulation as well as among the nursing home industry and consumer groups.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date

From Louis B. Hays
Acting Administrator

Subject OIG Draft Reports: Resident Abuse in Nursing Homes:
(1) Respondent Perception of Issues--OAI-06-88-00360, and
(2) Resolving Physical Abuse Complaints--OAI-06-88-000361

To The Inspector General
Office of the Secretary

We are responding to your request for comments on the two subject reports. First, we disagree with your study methodology, particularly with respect to the Respondent Perception of Issues study. However, we generally agree with the recommendations, and much has already been done to accomplish the requested changes. These studies were done under the current conditions of participation, which will be in effect until October 1, 1990. On that date, revised requirements, which contain many of the safeguards recommended by OIG in these reports will go into effect. We do not believe it would be appropriate to make additional changes at this time.

We believe it would be advisable to include more information about the interviews and information gathering processes used in the study. It appears the data-gathering process was an opinion survey, rather than a scientifically controlled review. Yet the data were presented as fact. This tends to produce the results found; i.e., ombudsmen and other officials who investigate abuse think it is a problem, while those representing nursing homes question the seriousness of the findings.

Our comments on the specific recommendations are attached. Please advise us whether you agree with our position at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA) on OIG Draft Audit Report on Resident Abuse in Nursing Homes: Respondent Perception of Issues--(OAI-06-88-00360)

Recommendation No. 1a

HCFA should require as part of its nurse aide training regulations, ongoing training concerning the aging process and mechanisms to cope with and avoid confrontational situations. Further, the nursing homes should be required to document staff training and understanding of abuse and reporting responsibilities and procedures for abuse incidents.

HCFA Comments

We agree with this recommendation and have been actively working to implement it. Sections 1819(f)(2) and 1919(f)(2) of the Social Security Act (the Act) require the Secretary to establish regulations for State nurse aide training and competency evaluation programs. Section 6901(b)(2) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) requires that the Secretary issue proposed regulations on nurse aide training and competency evaluation programs within 90 days of enactment. Section 6901(b)(3) of OBRA 89 modified the curriculum for this training to include "basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights." We believe that implementation of these statutory curriculum requirements will fulfill OIG's recommendation. HCFA is currently working to issue the proposed rules. Although we cannot be certain of the precise content of the final rules, we can assure you that they will provide for programs that encourage the best possible care for residents.

Recommendation No. 1b

HCFA should require, as part of the admission requirements for a new resident, nursing homes to provide guidance to residents concerning the differences in living in a nursing home environment, possible problems they may encounter and ways to deal with such problems.

HCFA Comments

We believe this recommendation is addressed in Federal regulations at 42 CFR 483.10 which are to be effective October 1, 1990. This provision requires that residents be notified of their rights and services.

Recommendation No. 1c

HCFA should require, as part of its conditions of participation for nursing homes, staff responsible for supervising or training direct care staff to acquire skills necessary to effectively train and supervise paraprofessional and nonprofessional staff.

HCFA Comments

We agree with this recommendation and have been actively pursuing this end. As part of the nurse aide training and competency evaluation program regulations mentioned in 1a, the Secretary is required to establish regulations for the qualifications of instructors of nurse aide training and competency evaluation programs. While we cannot predict the precise content of the final rules, there will be minimum qualifications for these instructors. Also, 42 CFR 483.30 indicates that facilities "must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessment plans and individual care plans." This would include the supervisory nursing staff having the necessary skills to supervise direct care staff in a manner consistent with resident rights, including the right to be free from abuse.

Recommendation No. 2

HCFA should conduct further research concerning long term care policies which promote staff stability and provide for adequate staff-patient ratios necessary to control stress and abuse.

HCFA Comments

We believe that we have already developed an appropriate mechanism for ensuring that facilities have adequate and appropriate staff. As mentioned in our response to Recommendation 1c, HCFA will require that facilities have sufficient staff to provide for the needs of the residents, however, it is clear that increasing staff-resident ratios alone will not control abuse. This outcome-oriented requirement gives facilities maximum flexibility in determining the ways they will provide for staff stability and ensure that the needs and rights of residents are met. We also note that any further research in this area would require additional funding.

Comments of the Health Care Financing Administration (HCFA) on the OIG Draft Report - Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints--(OAI-06-88-00361)

OIG recommends that HCFA, as part of its conditions of participation for hospitals and nursing homes, should:

Recommendation No. 1

Require all nursing home staff and hospital medical personnel to report all suspected incidents of abuse to the nursing home administrator or local law enforcement and to the central agency assigned responsibility for resolution of abuse complaints.

HCFA Comments

We do not agree entirely with this recommendation. We will require, effective October 1, 1990, at 42 CFR 483.13 (for nursing homes), that all alleged abuse be reported to the nursing home administrator or other official in accordance with State law. HCFA hospital conditions of participation and the Joint Commission on Accreditation of Healthcare Organizations standards do not require reporting of abuse. However, the hospital conditions of participation do require that hospitals follow State law. We are not aware of a significant abuse problem in hospitals and do not believe we need to revise our conditions of participation. We do not believe that the OIG has demonstrated a significant problem with respect to hospitals.

Recommendation No. 2

Require nursing homes to report all abuse incidents to local law enforcement, the central agency assigned responsibility for resolution of abuse complaints and to the State Survey and Certification Agency.

HCFA Comments

We do not agree fully with this recommendation. Again, effective October 1, 1990, we will require that all alleged instances of abuse be reported to the nursing home administrator or outside official in accordance with State law. We believe this is sufficient and that minor abuse incidents can be effectively handled by the administrator without the need for involvement of law enforcement personnel.

Recommendation No. 3

Require nursing homes to maintain reports of suspected incidents of abuse and the actions taken by the nursing home.

HCFA Comments

We agree and believe that the new regulations, which require that nursing homes conduct investigations of alleged abuse, maintain evidence of the investigations, and take corrective action when abuse is verified, will satisfy this recommendation.

Recommendation No. 4

Require administrators to conduct analysis of all incident reports to determine implications and appropriate actions.

HCFA Comments

We agree and believe that the new regulations cover this issue.

Recommendation No. 5

Require nursing homes to specify, as part of the nursing home residents plan of care, a plan to prevent abuse of a resident who is either mentally or physically unable to protect him/herself.

HCFA Comments

We agree and believe that the new regulations cover this issue. The regulations at 42 CFR 483.20 provide for a comprehensive assessment and development of a plan of care for every resident. The plan assessment and plan of care should include any special resident needs, including specific steps for prevention of abuse, if necessary.

Recommendation No. 6

Require nursing homes to provide ongoing monitoring and counseling of employees suspected of abusing residents.

HCFA Comments

We disagree with this recommendation. Counseling could be inadequate, and we do not believe that persons suspected of abuse should be allowed to continue to work with residents while being counseled. Their behavior must be appropriate or they must be removed from the job if expectations are not met.

Other Recommendations

HCFA agrees with the recommendation for State and local responsibilities, resolution and followup that requires each State to maintain retrievable data for HCFA.

In addition, HCFA also agrees with the joint recommendation that HCFA and the Administration on Aging develop common definitions and categories of abuse for all State and Federal reporting purposes. We will work toward this end.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Assistant Secretary
Washington DC 20201

DEC 22 1989

TO: Richard P. Kusserow
Inspector General

FROM: Assistant Secretary
for Human Development Services

SUBJECT: Draft Reports on (1) "Resident Abuse in Nursing Homes: Respondent Perceptions of Issues," OAI-06-88-00360 and (2) "Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints," OAI-06-88-00361

Thank you for the opportunity to review the draft reports on Resident Abuse in Nursing Homes. We concur with the draft reports.

If you have any questions, please contact Deborah Bass at 245-3176.

Mary Sheila Gall

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Administration on Aging

Washington, D.C. 20201

TO: Richard P.Kusserow
Inspector General

FROM: Acting Commissioner on Aging

SUBJECT: Comments on the OIG Draft Reports on Resident Abuse in Nursing Homes

The Administration on Aging (AoA) appreciates the opportunity to comment on the OIG draft reports "Resident Abuse in Nursing Homes: Respondent Perceptions of Issues" and "Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints." We are pleased that the current draft reports incorporate changes which respond to most of the concerns that AoA expressed about the earlier draft materials. We want to thank George Grob for his time and diligence in making the necessary changes.

While most of our comments have been addressed, we continue to have serious concerns about one major item in the report on Resolving Physical Abuse Complaints. The Executive Summary (p.iii) under Recommendations relating to Federal Responsibilities proposes, among other things, that the Administration on Aging should expand and strengthen its efforts to issue periodic public reports concerning abuse trends. This topic is discussed further on page 17 of the report which notes that, while the AoA Ombudsman Report is a major indicator of nursing home abuse, it cannot be used to obtain reliable national counts of abuse (particularly for specific problem areas.) The report goes on to state that, for several reasons which are cited (p. 18), there are no adequate national nursing home abuse statistics to provide an incidence rate or trend for nursing home abuse.

We concur with the observation that there are no data which can be used to provide an incidence rate or trend regarding nursing home abuse. The impediments to the collection of such data which the report cites are beyond the capacity of AoA to overcome. Therefore, it is not possible for AoA to respond to the report's recommendation to expand and strengthen its efforts to issue periodic public reports concerning abuse trends. In light of the report's own conclusions regarding the significant nature of impediments to the collection of trend data, we once again request that

the recommendation concerning AoA which appears on p.iii of the Executive Summary delete any reference to issuance of reports on abuse trends and be revised to read:

- The Administration on Aging (AoA) should expand and strengthen its efforts to 1) issue best practices for preventing and dealing with resident abuse, 2) promote public awareness and education concerning abuse occuring in nursing homes and 3) promote use of volunteer Ombudsman in nursing homes.

Again, we appreciate the opportunity to review and comment on the draft reports prepared by OIG.

Joyce T. Berry

Joyce T. Berry, Ph.D.

PUBLIC COMMENTS

Comments were received from several organizations with interests pertaining to the elderly, nursing homes, or law enforcement:

American Association of Homes for the Aging
American Health Care Association
National Aging Resource Center on Elder Abuse
National Association of Chiefs of Police
National Association of Medicaid Fraud Control Units
National Citizen's Coalition for Nursing Home Reform
Police Executive Research Forum

Additional comments were received from a select representation of State and local entities involved directly or indirectly with issues relating to the elderly, nursing homes, or law enforcement. All comments were reviewed and analyzed. Findings and recommendations in both reports reflect many of the pertinent concerns and issues raised by the commentors on the draft reports.

The following are short excerpts expressing concerns and observations of report reviewers:

"I am disturbed by the absence of national and state statistics in [the] two-part report and [the] reliance on the impressions of a small sample of individuals with a skewed view of the issue. I am further disturbed by your failure to adequately define the term, "abuse," which has resulted in confused and unreliable findings." [Nursing Home Advocate]

"MFCUs are required by law to review complaints only in Health Care Facilities that receive Medicaid funds and therefore may not even see a large number of complaints." [State MFCU]

"There should be a requirement for confidentiality in both the investigative and prosecutorial components. Information should not be released to the public until due process has been concluded." [State Complaint Coordinator]

"The subject of due-process is not fully explored. An individual who is charged with the patient abuse must have an opportunity to clear their name. This process is very time consuming and expensive. Sufficient attention has not been focused in this area and it must be considered more fully." [State Complaint Coordinator]

"All persons employed on a status such as aides, cleaning personnel, support people, etc., be required to be fingerprinted and their applications be sent to the FBI." [Law Enforcement]

"Law enforcement agencies normally only find out about the cases after the fact. A death or injury. In many cases the nursing home has a opportunity to destroy evidence to prevent publicity, to avoid lawsuits, et al. This would really mean that state and county health department would be the agencies who would be the enforcement arm." [Law Enforcement]

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