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Report to Congressional Requesters

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NURSING HOMES

More Can Be Done to Protect Residents from Abuse

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Abbreviations

AAHSA	American Association of Homes and Services for the Aging
AHCA	American Health Care Association
CMS	Centers for Medicare and Medicaid Services
DHR	Georgia Department of Human Resources
DOH	Pennsylvania Department of Health
DOJ	Department of Justice
FBI	Federal Bureau of Investigation
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IDPH	Illinois Department of Public Health
MFCU	Medicaid Fraud Control Unit
RN	registered nurse

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Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

March 1, 2002

The Honorable John Breaux
Chairman
Special Committee on Aging
United States Senate

The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

The 1.5 million elderly and disabled individuals residing in nursing homes are a highly vulnerable population. They often have multiple physical and cognitive impairments that require extensive assistance in the basic activities of daily living, such as dressing, feeding, and bathing. Many require skilled nursing or rehabilitative care. In recent years, increased attention has been focused on the quality of care afforded nursing home residents. Concerns with inadequate care involving malnutrition, dehydration, and other forms of neglect have contributed to mounting scrutiny from state and federal authorities. There is also growing concern that some residents are abused—pushed, slapped, beaten, and otherwise assaulted—by the individuals to whom their care has been entrusted. Accordingly, the ability to both apprehend those who have abused nursing home residents and prevent further abuse has generated considerable interest.

While nursing homes are expected to keep residents safe from harm, there are a variety of federal, state, and local agencies—including law enforcement entities—that typically play a part in investigating instances of resident abuse. The federal government and the states share oversight responsibility for the almost 17,000 nursing homes in the nation. The recently renamed Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA)[1]—within the Department of Health and Human Services (HHS)—is responsible for

[1]On June 14, 2001, the Secretary of Health and Human Services announced that the name of the Health Care Financing Administration had been changed to the Centers for Medicare and Medicaid Services. In this report, we will refer to HCFA where our findings apply to operations that took place under that organizational structure and name.

establishing standards that nursing homes must meet to participate in the Medicare and Medicaid programs. CMS contracts with state agencies, such as departments of health, to conduct annual inspections—called surveys—of nursing homes to certify that they are eligible for Medicare and Medicaid payments. These state survey agencies are also responsible for investigating complaints they receive about the care nursing homes provide. In some instances, state survey agencies may notify state or local law enforcement agencies to conduct criminal investigations involving resident abuse. Depending on the policy of the survey agency, it may opt to involve the state's Medicaid Fraud Control Unit (MFCU), typically an investigative component within the state's Office of the Attorney General, or the appropriate local police department in investigating abuse allegations.[2]

We have previously reported on deficiencies in the oversight of the quality of care provided to nursing home residents, noting weaknesses in states' complaint investigations, annual surveys, and enforcement actions. For example, in March 1999, we reported that inadequate state procedures and limited HCFA guidance and oversight resulted in, among other things, extensive delays in investigating serious complaints alleging harmful situations.[3] Also in March 1999, we reported that state surveys identified deficiencies that harmed residents or placed them at risk of death or serious injury in more than one-fourth of nursing homes nationwide.[4] Moreover, sanctions that HCFA initiated against a majority of these homes for noncompliance with federal standards were often not implemented and generally did not ensure that homes maintained compliance with standards. More recently, in September 2000, we reported that, although HCFA had begun requiring states to investigate complaints alleging harm

[2]MFCUs conduct investigations into criminal activity in the Medicare and Medicaid program. In some states, MFCUs may be located in other agencies, such as the state police, instead of the Office of the Attorney General.

[3]U.S. General Accounting Office, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, GAO/HEHS-99-80 (Washington, D.C.: Mar. 22, 1999).

[4]U.S. General Accounting Office, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, GAO/HEHS-99-46 (Washington, D.C.: Mar. 18, 1999).

within 10 working days of their receipt, states were not consistently meeting this time frame.[5]

In response to your concerns with the adequacy of protections afforded nursing home residents and the responsiveness of federal, state, and local agencies to allegations of resident abuse, we (1) determined whether allegations of abuse are reported promptly to local law enforcement and state survey agencies, (2) assessed the extent to which abusers are prosecuted and the impediments to successful prosecutions, and (3) evaluated whether sufficient safeguards exist to protect residents from abusive individuals.

To address these questions we limited our work to acts of alleged physical and sexual abuse committed by nursing home employees against nursing home residents. We did not address other forms of abuse such as neglect or verbal abuse nor did we examine instances of nursing home residents abusing other residents. We interviewed CMS officials and reviewed agency policies and procedures for overseeing nursing home care quality. We visited three states with relatively large nursing home populations—Georgia, Illinois, and Pennsylvania. During these visits, we interviewed state officials—including those in survey agencies and MFCUs—who are responsible for responding to, and investigating, allegations of abuse. We also reviewed relevant federal laws and regulations, as well as the state laws and regulations pertaining to these three states.

To learn more about the manner in which abuse investigations are conducted, we judgmentally selected and reviewed files documenting Georgia, Illinois, and Pennsylvania state survey agency investigations of 158 physical and sexual abuse allegations, mostly from 1999 and 2000. Our findings cannot be generalized or projected. Where the files indicated that states had cited the nursing homes for deficiencies, we obtained subsequent surveys conducted to determine what, if any, sanctions had been imposed. We also determined the states' policies and procedures concerning employees with criminal backgrounds and examined records of survey agencies' actions related to nurse aides who had allegedly abused residents. All three states we visited had established dedicated telephone lines exclusively devoted to reporting complaints. We called

[5]U.S. General Accounting Office, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, GAO/HEHS-00-197 (Washington, D.C.: Sept. 28, 2000).

these lines to verify that they were working properly and to verify that complaints of physical and sexual abuse would be accepted. We also made similar calls to other organizations we identified in local Georgia, Illinois, and Pennsylvania telephone books to determine whether these entities would accept complaints regarding the abuse of nursing home residents or make referrals to other organizations. Finally, to learn about law enforcement's role in responding to and investigating abuse allegations, we interviewed officials in these states who represented 19 local police departments and 4 local prosecutors' offices. See appendix I for more detailed information on our scope and methodology

We conducted our work from July 2000 through February 2002, in accordance with generally accepted government auditing standards.

Results in Brief

Allegations of physical and sexual abuse of nursing home residents frequently are not reported promptly. Local law enforcement officials indicated that they are seldom summoned to nursing homes to immediately investigate allegations of physical or sexual abuse. Some of these officials indicated that they often receive such reports after evidence has been compromised. Although abuse allegations should be reported to state survey agencies immediately, they often are not. For example, our review of state survey agencies' physical and sexual abuse case files indicated that about 50 percent of the notifications from nursing homes were submitted 2 or more days after the nursing homes learned of the alleged abuse. These delays compromise the quality of available evidence and hinder investigations. In addition, some residents or family members may be reluctant to report abuse for fear of retribution while others may be uncertain about where to report abuse. Although state survey agencies in the three states we visited had designated telephone numbers for reporting abuse, we found it difficult to identify these numbers in the government and consumer pages of local telephone books for some of the major and mid-size cities in these states. However, we did find a wide variety of other organizations that, by their name, appeared to be able to address abuse complaints, but, in fact, had no authority to do so. Although CMS requires nursing homes to post these numbers, it is not clear that this ensures that residents and family members have access to this information when it is needed. In recognition of the need to better inform residents and family members about abuse reporting, the agency initiated an educational campaign in 1998. The campaign included development of a new poster with removable information cards containing appropriate numbers for reporting abuse. Although a pilot test was conducted, the poster has not been approved for distribution nationwide.

Few allegations of abuse are ultimately prosecuted. The state survey agencies we visited followed different policies when determining whether to refer allegations of abuse to law enforcement. As a result, law enforcement agencies were sometimes either not apprised of incidents or received referrals only after long delays. When referrals were made, criminal investigations and, thus, prosecutions were sometimes hampered because witnesses to the alleged abuse were unable or unwilling to testify. Delays in investigations, as well as in trials, reduced the likelihood of successful prosecutions because the memory of witnesses often deteriorated.

Safeguards to protect residents from potentially abusive individuals are insufficient at both the federal and state level. There is no federal statute requiring criminal background checks of nursing home employees nor does CMS require them. Although the three states we visited required background checks to screen potential nursing home employees, they do not necessarily include all nursing home employees nor are they always completed before an individual begins working. They also focus on individuals' criminal records within the state where they are seeking employment. Safeguards at the state level are also insufficient. While nursing homes are responsible for protecting residents from abuse, survey agencies in the states we visited rarely recommended that certain sanctions—such as civil monetary penalties or terminations from federal programs—be imposed. Twenty-six homes were cited for deficiencies related to abuse from the 158 case files we reviewed. The survey agencies recommended a civil monetary penalty for 1 home, while the remaining 25 nursing homes faced less punitive sanctions such as a requirement to develop corrective action plans. State survey agencies also play a role in preventing homes from hiring potentially abusive caregivers through the states' nurse aide registries. These registries, among other things, identify aides that have previously abused residents. A finding of abuse should prevent a home from hiring an aide. However, delays in making these determinations can limit the usefulness of these registries as a protective safeguard. In addition, findings of abuse for several nurse aides could not be found in one state's Web-based registry, compromising its protective value. As a result, aides who the state survey agency had already determined had abused residents could have been hired by unsuspecting nursing homes. Finally, none of the three states we visited had a safeguard in place—similar to a nurse aide registry—to professionally discipline those nursing home employees who do not need certifications or licenses to perform their duties, such as maintenance or housekeeping personnel.

We are making recommendations to the CMS administrator to facilitate the reporting, investigation, and prevention of abuse and thus help ensure the protection of nursing home residents. In comments on a draft of this report, CMS generally agreed with our recommendations and said that it is committed to protecting nursing home residents from harm. It also elaborated on its initiatives to ensure their safety and described steps it would take in response to our recommendations.

Background

Experts who have conducted studies on the issue of physical and sexual abuse[6] of nursing home residents have reported that it is a serious problem with potentially devastating consequences.[7] Nursing home residents have suffered serious injuries or, in some cases, have died as a result of abuse. Nursing homes are required to protect their residents from harm by training staff to provide proper care and by prohibiting abusive behavior.

The vast majority of nursing homes participate in the Medicare and Medicaid programs and were projected to have received about $58.4 billion from the programs in 2001 for their care. State survey agencies—such as Georgia's Department of Human Resources, Illinois's Department of Public Health, and Pennsylvania's Department of Health—perform surveys at least every 15 months to assess nursing homes' compliance with federal and state laws and regulations. These surveys are designed to determine whether nursing homes are complying with Medicare and Medicaid standards. Nursing homes found to be out of compliance are cited with deficiencies, which can result in monetary penalties or other enforcement actions, including termination from federal programs, depending on their severity.

In addition to periodic surveys, state survey agencies investigate complaints of inadequate care, including allegations of physical or sexual abuse. CMS requires that states designate a specific telephone number for reporting complaints and that all nursing homes publicize these numbers.

[6]CMS defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish (42 C.F.R. § 488.301).

[7]Ann W. Burgess, Elizabeth B. Dowdell, and Robert A. Prentky, "Sexual Abuse of Nursing Home Residents," *Journal of Psychosocial Nursing*, 38, no. 6, (June 2000); and Brian K. Payne and Richard Cikovic, "An Empirical Examination of the Characteristics, Consequences, and Causes of Elder Abuse in Nursing Homes," *Journal of Elder Abuse and Neglect* (1995).

Complaints can be submitted by residents, family members, friends, physicians, and nursing home staff.[8] In addition, advocates of nursing home residents, such as long-term care ombudsmen, may file complaints.[9] When state survey agencies receive these complaints they are responsible for investigating all allegations, determining if abuse occurred, and identifying appropriate corrective actions.

CMS requires nursing home officials to notify the state survey agency of allegations of abuse in their facilities immediately. Nursing homes are also required to conduct their own investigations and submit their findings in written reports to the state survey agency within 5 working days of the incident. Depending on the severity of the circumstances, the state survey agency may visit the nursing home to investigate the incident or wait until the nursing home submits its report. Depending on the content of the facility's report, the survey agency may request the home to conduct additional work or the agency may investigate further on its own. If the agency opts not to investigate further, it may still review the manner in which the home conducted its investigation during the agency's next scheduled survey of the home.

To protect residents from potentially abusive personnel, nursing homes must adhere to federal and state requirements concerning hiring practices. CMS's regulations require that facilities establish policies prohibiting employment of all individuals convicted of abusing nursing home residents. Although there is no CMS requirement to do so, the three states we visited require nursing homes to conduct criminal background checks on some or all prospective employees. All nursing homes must also verify with the relevant state board of licensing the professional credentials of the licensed personnel, such as registered nurses (RN), they hire.

In nursing homes, the primary caregivers are nurse aides. According to federal law, each state must maintain a registry of all individuals who have satisfactorily completed an approved nurse aide training[10] and competency evaluation program in that state. Before employing an aide, nursing homes

[8]The three states we visited require that certain individuals, such as physicians, social workers, and law enforcement officers report suspected abuse to state survey agencies.

[9]The Older Americans Act of 1965 (P.L. 89-73) established the Long-Term Care Ombudsman program.

[10]Under certain circumstances, some individuals would be exempt from this training, such as student nurses or nurses trained in another country.

are required to check the registry to verify that the aide has passed a competency evaluation.[11] Aides whose names are not included on a state's registry may work at a nursing home for up to 4 months to complete their training and pass a state administered competency evaluation.

CMS requires that if a state survey agency determines that a nurse aide is responsible for abuse, neglect, or theft of a resident's property, this "finding" must be added to the state's nurse aide registry. The inclusion of such a finding on a nurse aide's record constitutes a ban on nursing home employment.[12] As a matter of due process, nurse aides have a right to request a hearing to rebut the allegations against them, to be represented by an attorney, and to appeal an unfavorable outcome. State survey agencies are not responsible for disciplining other nursing home professionals, such as RNs, who are suspected of abuse. Such personnel are referred to their respective state licensing boards for review and possible disciplinary action.

Local police departments may learn of suspected instances of resident abuse and conduct criminal investigations. In addition, state survey agencies may notify the state MFCU to pursue these allegations. States were provided financial incentives to establish MFCUs as a result of the enactment of the Medicare-Medicaid Anti-Fraud and Abuse Amendments to the Social Security Act of 1977.[13] Although one of their primary missions is to investigate financial fraud and abuse in the Medicare and Medicaid programs, MFCUs also have authority to investigate the physical and sexual abuse of nursing home residents. MFCUs typically learn of such allegations by receiving referrals from state survey agencies. If, after investigating an allegation, the MFCU decides that there is sufficient evidence to press criminal charges, it may prosecute the case itself or refer the matter to the state's attorney general or a local prosecutor.

[11]Nursing homes in the states we visited have several means of checking the nurse aide registries to determine whether aides are in good standing and eligible for employment. Homes receive quarterly bulletins listing all disqualified aides in their state. In addition, they may obtain this information from their state survey agency's Web site or by calling the survey agency.

[12]Nurse aides may petition the state to remove findings of neglect after one year.

[13]P.L. 95-142.

Delays in Reporting Abuse Preclude Immediate Response by Law Enforcement or Survey Authorities

Most of the local police departments in the three states we visited told us that they were seldom summoned to a nursing home following an alleged instance of abuse. Several police officials indicated that, when they were called, it was sometimes after others had begun investigating, potentially hindering law enforcement's ability to conduct a thorough investigation. Instead, state survey agencies were typically notified of allegations of abuse. However, these notifications were frequently delayed. Allegations of abuse may not be reported immediately for a variety of factors, including reluctance to report abuse on the part of residents, family members, nursing home employees, and administrators. In addition, individuals who are unaware that state survey agencies have designated special telephone numbers as complaint intake lines may have difficulty identifying these numbers in telephone directories, which could also result in delays.

Police Not Immediately Notified of Abuse or Routinely Involved in Survey Agency Investigations

Victims of crimes ordinarily call the police to report instances of physical and sexual abuse, but when the victim is a nursing home resident, the police appear to be notified infrequently. Residents and family members are not required to notify local police of abusive incidents. Several police officials told us that, like any crime, police should be summoned as soon as the incident is discovered. However, police told us that when they do learn of an allegation of abuse involving a nursing home resident, it is sometimes after another entity, such as the state survey agency, has begun to investigate, thus hampering law enforcement's evidence collection and limiting their investigations. Most of the police departments also indicated that they did not track reports of abuse allegations involving nursing home residents and thus did not have data on the number of such reports.

When residents and family members do report allegations of abuse, they may complain directly to the nursing home administrator rather than contact police. According to one long-term care ombudsman, resident and family members do not always view the abuse as a criminal matter. Nursing homes are usually not compelled to notify local law enforcement when they learn of such reports. There is no federal requirement that they contact police, although some states—including Pennsylvania—have instituted such a requirement. According to an Illinois state survey agency official, a similar requirement will go into effect in that state in March 2002.

Our discussions with officials from 19 local law enforcement agencies indicate that police are rarely called to investigate allegations of the abuse of nursing home residents. Besides infrequent contact from residents,

family members, and nursing homes, officials from 15 of the 19 police departments we visited told us that they had little or no contact with survey agencies. Officials from several of these departments reported that they were unaware of the role state survey agencies play in investigating instances of resident abuse.

Abuse Allegations Not Immediately Reported to State Survey Agencies

Our review of 158 case files—mostly from 1999 and 2000—indicated state survey agencies were often not promptly notified of abuse allegations.[14] While individuals filing complaints are not compelled to report allegations within a prescribed time frame, nursing homes in the states we visited are required to notify the state survey agency of abuse allegations the day they learn of the allegation or the following day. We found that both complaints from individuals and notifications from nursing homes are frequently submitted to survey agencies days, and sometimes weeks, after the abuse has taken place.

As table 1 shows, 20 of the 31 complaint cases we could assess for promptness of submission contained allegations that were reported to the state survey agency 2 days or more after the abuse took place. Further, eight were reported more than 2 weeks after the alleged abuse occurred.

Table 1: Timeliness of Complaints Submitted to State Survey Agencies in 1999 and 2000

			Summary of later submissions		
State	Submitted same day or next day	Submitted two or more days later	2-7 days	8-14 days	15+ days
Illinois[a]	6	5	5	0	0
Georgia	2	5	2	1	2
Pennsylvania	3	10	4	0	6
Total	**11**	**20**	**11**	**1**	**8**
Percent	**35.5**	**64.5**			

[a]Two Illinois cases were first reported in 1998.

Source: GAO analysis of 31 state complaint files.

There were comparable delays in facilities' notifications of alleged abuse to the state survey agencies. The three states we visited require that

[14]Eleven of the cases from Illinois were first reported in 1998.

nursing homes notify them of instances of alleged abuse immediately—interpreted by survey agency officials in all three of the states to mean the day the facility learns of the abuse or the next day. As table 2 shows, however, only about half of the 111 nursing home notifications we could assess for promptness were submitted within the prescribed time frame.

Table 2: Timeliness of Notifications to State Survey Agencies in 1999 and 2000

			Summary of later submissions		
State	Submitted same day or next day	Submitted two or more days later	2-7 days	8-14 days	15+ days
Illinois[a]	19	18	14	3	1
Georgia	26	18	13	2	3
Pennsylvania	12	18	10	4	4
Total	**57**	**54**	**37**	**9**	**8**
Percent	**51.4**	**48.6**			

[a]Nine Illinois cases were first reported in 1998.

Source: GAO analysis of 111 state notifications.

Delays in notifying survey agencies of abuse prevent the agencies from promptly investigating and ensuring that nursing homes are taking appropriate steps to protect residents. Residents may remain vulnerable to abuse until corrective action is taken.

Untimely Reporting Attributable to Multiple Factors

Allegations of abuse of nursing home residents may not be reported promptly for a variety of reasons. For example, a recent study found that nursing home staff may be skeptical that abuse occurred.[15] Residents may also be afraid to report abuse because of fear of retribution, according to another study and two long-term care ombudsmen we met with.[16] According to one law enforcement official, family members are sometimes fearful that the resident will be asked to leave the home and are troubled by the prospect of finding a new place for the resident to live. In addition, nursing home staff and management do not always report abuse promptly,

[15]Ann W. Burgess, Elizabeth B. Dowdell, and Robert A. Prentky, "Sexual Abuse of Nursing Home Residents," *Journal of Psychosocial Nursing*, 38, no. 6 (June 2000).

[16]Paul D. Hodges, "National Law Enforcement Programs to Prevent, Detect, Investigate, and Prosecute Elder Abuse and Neglect in Health Care Facilities," *Journal of Elder Abuse and Neglect* (1998).

despite requirements to do so. According to law enforcement and state survey agency officials, staff fear losing their jobs or facing recrimination from co-workers and nursing home management. Similarly, they also said that nursing home management is sometimes reluctant to risk adverse publicity or sanctions from the state.

We saw evidence of delayed reporting by family members, staff, and management in our file reviews, as illustrated by the following examples:

- A resident reported to a licensed practical nurse that she had been raped in the nursing home. Although the nurse recorded this information in the resident's chart, she did not notify nursing home management. She also allegedly discouraged the resident from telling anyone else. Two months later the resident was admitted to a hospital for unrelated reasons and told hospital officials that she had been raped. It was not until hospital officials notified police of the resident's complaint that an investigation was conducted. Investigators then discovered that the resident had also informed her daughter of the incident, but the daughter, apparently not believing her mother, had dismissed it. The resident later told police that she did not report the incident to other staff at the nursing home because she did not want to cause trouble. The case was closed because the resident could not describe the alleged perpetrator. However, the nurse was counseled about the need to immediately report such incidents.

- An aide, angry with a resident for soiling his bed, threw a pitcher of cold water on him and refused to clean him. Another aide witnessed the incident. Instead of informing management, the witness confided in a third employee, who reported the incident to the nursing home administrator 5 days after the abuse took place. The abusive aide was fired, and a finding of abuse was recorded in her nurse aide registry file.

- One nursing home employee witnessed an aide slap a resident; two other employees heard the incident. The aide denied the allegation, yet the resident developed redness, swelling, and bruising around her eye. The witnesses reported the matter to nursing home management, which investigated the situation and suspended the aide the next day. The aide was subsequently fired. However, the state survey agency was not notified of the incident by the home until 11 days after the abuse took place.

During our work we discovered that nursing home residents and family members who are prepared to report abuse to the state survey agency could encounter difficulty in identifying where to report a complaint of abuse, which can further delay reporting. For example, telephone books for Chicago and Peoria, Illinois, and Athens and Augusta, Georgia, did not

include complaint telephone numbers. Although telephone books in Philadelphia and Pittsburgh, Pennsylvania, contained the correct numbers for the state survey agency's offices, they did not identify the designated complaint number, making it difficult for an individual unfamiliar with the agency to recognize its telephone number as an appropriate place to report suspected abuse.

Individuals who are not already familiar with the state survey agency's role and its complaint telephone line may encounter a confusing array of numbers both public and private in their local telephone directory. In the three states we visited we reviewed the government and consumer pages in nine telephone books and identified a wide variety of organizations, which, by their names, appeared capable of addressing complaints. However, many did not have the authority to do so. In this review, we identified 42 entities that appeared to be organizations where abuse could be reported and were not affiliated with the state survey agencies. Only six of these entities represented organizations—such as long-term care ombudsmen—that are capable of pursuing abuse allegations. The remaining 36 entities either could not be reached or could not accept complaints, despite having listings such as the "Senior Helpline." Sometimes these entities attempted to refer us to a more appropriate organization, but with mixed success. For example, our calls in Georgia resulted in four correct referrals to the state survey agency's designated complaint telephone line but also led to five incorrect referrals. Five other Georgia entities offered us no referrals.

To facilitate reporting, nursing homes are required to post the telephone numbers of complaint lines in a prominent location within the facility. State survey agencies are expected to verify that these numbers are properly displayed when they conduct their annual inspections and have the option of citing homes with deficiencies if they fail to do so. However, deficiency data compiled by CMS do not specifically identify the number of homes cited for failure to display these numbers, and so it is not readily apparent how often nursing homes do not comply with this specific requirement.

Despite its requirement that nursing homes post the complaint telephone numbers, CMS recognized that a greater awareness of how to report abuse was warranted and so, in 1998, it initiated an educational campaign regarding abuse prevention and detection in nursing homes. Because publicizing the appropriate telephone numbers for reporting abuse is critical, a key component of the campaign was the development of a poster to be used by nursing homes nationwide. According to a CMS

official, the poster will identify several options for reporting abuse, including notifying nursing home management, local law enforcement, complaint telephone numbers, and CMS.[17] In addition to displaying these numbers, the posters will feature removable cards—which individuals may retain—listing the organizations and telephone numbers contained on the poster. A pilot test of the poster was conducted in 1999. Based on feedback received from the pilot test, the poster was revised, but it has not been approved for distribution.

Abusive Nursing Home Staff Difficult to Prosecute

Relatively few prosecutions result from allegations of physical and sexual abuse of nursing home residents. We identified two impediments to the successful prosecution of employees who abuse nursing home residents. First, allegations of abuse were not always referred to local law enforcement or MFCUs. When referrals were made it was often days or weeks after the incident occurred, compromising the integrity of what limited evidence might have still been available. Second, a lack of witnesses to instances of abuse made prosecutions difficult and convictions unlikely.

States' Policies Regarding Referrals to Law Enforcement Varied and Limited Prosecutions

Each of the states we visited had a different policy for referring instances of suspected abuse to law enforcement officials. While Illinois and Georgia both relied on their MFCUs to pursue criminal investigations concerning resident abuse, they followed different policies.[18] Our review of case files in Illinois showed that the state survey agency consistently referred all reports of physical and sexual abuse—regardless of whether they were complaints or incident reports—to the MFCU, which in turn determined whether to open an investigation. As a result, the Illinois MFCU appeared to play a substantial role in abuse investigations. On the other hand, the Georgia survey agency evaluated each allegation and selectively referred cases to its MFCU according to a mutually agreed upon procedure. In accordance with this procedure, the survey agency screened complaints and incident reports before making referrals to its MFCU based on an

[17]Although the same poster would be used nationwide, nursing homes would receive posters listing any telephone numbers unique to their state.

[18]The survey agency in Pennsylvania referred three abuse cases to its MFCU in 1999 because, by agreement, this MFCU typically investigates neglect matters, while local law enforcement agencies investigate abuse. Consequently, Pennsylvania's approach does not lend itself to a comparison with Illinois and Georgia.

assessment of the severity of the allegations or circumstances. Survey agency officials also told us that, in making these assessments, they considered the likelihood that reporting the abuse to the MFCU would result in a criminal conviction.

The differences in Illinois's and Georgia's referral policies yielded dramatically different results. While the Illinois survey agency referred approximately 300 allegations of abuse to its MFCU in 1999,[19] Georgia only referred 27 allegations in the same period. Although Illinois had more than twice as many nursing home residents as Georgia—81,500 vs. 33,800—the discrepancy in population size does not account for the significant difference in the number of referrals. Our review of the 50 Illinois cases revealed that the Illinois survey agency referred cases to its MFCU earlier than the Georgia survey agency. The Illinois cases were referred to the MFCU, on average, 3 days after receiving a report of abuse, while Georgia referred cases, on average, 15 days after learning about an allegation. Illinois's policy of routinely referring all allegations to its MFCU enables referrals to be made more quickly than Georgia's system of evaluating and screening all allegations prior to making selective referrals.

The state survey agencies in Illinois and Georgia referred 64 of the cases we reviewed to the MFCUs for investigation. As indicated in table 3, Georgia, which referred fewer cases to its MFCU, had fewer convictions. By referring more cases to its MFCU, the Illinois survey agency presented law enforcement with the opportunity to assess whether an abusive act had been committed and whether it should be criminally pursued. In addition, by referring its cases to its MFCU sooner, on average, than Georgia, Illinois also enhanced law enforcement's ability to conduct more timely and effective investigations. The Georgia survey agency's screening process provided law enforcement fewer and less timely opportunities to investigate allegedly abusive caregivers.

[19]The MFCU did not open investigations for each of the 300 referrals it received from the state survey agency. In some instances, the MFCU obtained insufficient information to pursue an investigation. In other instances, it conducted preliminary work and concluded that continuing the investigation was not warranted.

Table 3: Cases Referred by Survey Agencies to Their Respective MFCUs in 1999

State	Number reviewed	Number of MFCU referrals	Number of convictions
Illinois	50	50	18
Georgia	52	14	3

Source: GAO analysis of 102 case files.

In discussing Georgia's referral policy with survey agency and MFCU officials, we learned that the agency substantially changed its MFCU referral criteria in 2000, leading to an increased number of referrals—111—that year. This change followed a new understanding between survey agency and MFCU officials based on the MFCU's expressed willingness to investigate instances of abuse. Previously, the survey agency typically did not refer instances that it considered less serious—such as incidents involving nursing home employees slapping residents with no reported visible injuries—to the MFCU. According to survey agency officials, they did not refer such allegations because they believed that these cases did not meet the referral criteria. In their view, it was unlikely that the MFCU would consider such acts serious enough offenses to warrant an investigation and prosecution.

Lack of Witnesses Reduce Likelihood of Successful Prosecutions

The lack of compelling evidence often precludes prosecution of those who have abused nursing home residents. MFCU and local law enforcement officials indicated that nursing home residents are often unwilling or unable to provide testimony. The state survey agency and law enforcement officials we spoke to agreed with this determination. Our file reviews confirmed that residents were reluctant or unable to provide evidence against an accused abuser in 32 of the 158 cases we reviewed, thus making it difficult to pursue a criminal investigation. Our work also indicated that resident testimony could be limited by mental impairments or an inability to communicate. We noted several instances in which residents sustained unexplained black eyes, lacerations, and fractures. However, despite the existence of serious injuries, investigators could neither rule out accidental injuries nor identify a perpetrator.

Prosecutions of individuals accused of abusing nursing home residents are often weakened by the time lapse between the incident and the trial. Law enforcement officials and prosecutors told us that the amount of time that elapses between an incident and a trial could ruin an otherwise successful case because witnesses do not always remember important details about the incident. Although it is not uncommon for the memories of witnesses

in criminal cases to fade, impaired recall is even more prevalent among nursing home residents. Our review showed that nursing home residents may become incapable of testifying months after they were abused. For example, in one case, a victim's roommate witnessed the abuse and positively identified the abuser during the investigation. However, by the time of the trial—nearly 5 months later—she could no longer identify the suspect in the courtroom, prompting the judge to dismiss the charges. Moreover, given the age and medical condition of many nursing home residents, many might not survive long enough to participate in a trial. One recent study of 20 sexually abused nursing home residents revealed that 11 died within 1 year of the abuse.[20] Law enforcement officials told us that, without testimony from either a victim or a witness, conviction is unlikely.

Measures to Safeguard Residents from Abusive Employees Are Ineffective

The safeguards available to states do not sufficiently protect residents from abusive employees. CMS's requirements preclude facilities from employing an individual convicted of abusing nursing home residents but permit the hiring of those convicted of other abusive acts, such as child abuse. Although some states have established more stringent requirements, criminal background checks typically do not identify individuals who have committed a crime in another state. Nursing homes can be cited for deficiencies if they fail to adequately protect residents from abuse, but these deficiencies rarely result in the imposition of sanctions, such as civil monetary penalties, by state survey agencies. State survey agencies, which also oversee the operation of state nurse aide registries, do not adequately ensure that residents will be protected from aides who previously abused residents. Finally, states are unable to take professional disciplinary actions against other employees, such as security guards or housekeeping staff, who may have abused residents but who are neither licensed nor certified to care for residents.

CMS Employment Requirements and Background Checks Do Not Ensure Resident Protection

While CMS requires nursing homes to establish policies that prevent the hiring of individuals who have been convicted of abusing nursing home residents, this requirement does not include offenses committed against individuals outside the nursing home setting, nor does it specify that states conduct background checks on all prospective employees. CMS's requirement does not preclude individuals with similar convictions—such

[20]Ann W. Burgess, Elizabeth B. Dowdell, and Robert A. Prentky, "Sexual Abuse of Nursing Home Residents," *Journal of Psychosocial Nursing*, 38, no. 6 (June 2000).

as assault, battery, and child abuse—from obtaining nursing home employment.

The three states we visited all apply a broader list of offenses that prohibit employment in a nursing home. Each state's prohibition of employees includes those convicted of offenses such as kidnapping, murder, assault, battery, or forgery and is not limited to offenses against nursing home residents. However, the three states vary in their application of these prohibitions. For example, Illinois's prohibition does not apply to employees who are not directly involved in providing care to residents and allows nurse aides who have been convicted of such offenses to apply for a waiver. Waivers may be granted if there are mitigating circumstances and allow these aides to work in nursing homes. Pennsylvania's prohibition applies to all nursing home employees, not just those involved in patient care. Georgia's prohibition, enacted in 2001, also applies to all nursing home employees, but only if they were convicted of abuse-related crimes within the preceding 10 years.

Criminal background checks do not adequately protect residents, in part, because, as in Illinois, they may not apply to all nursing home employees.[21] More importantly, the background checks that are performed by state and local law enforcement officials in the three states we visited are typically only statewide. Consequently, individuals who have committed disqualifying crimes in one state may be able to obtain employment at a nursing home in another state.

Nationwide background checks on prospective nursing home employees can be performed by the Federal Bureau of Investigation (FBI) if nursing homes request them. These checks could identify offenses committed elsewhere, but not all states take advantage of this option. According to an FBI official, 21 states have requirements that subject some health care employees to these checks, but state requirements vary and do not always apply to prospective nursing home employees. This official told us that most of the requests the FBI receives on health care personnel are from these 21 states. He told us that, of the remaining states, only nursing homes in North Carolina and Ohio request such background checks

[21]Illinois requires the background check on employees providing direct care, except for licensed personnel.

regularly.[22] Of the three states we visited, only Pennsylvania submits background check requests to the FBI. However, these are limited to those individuals who have lived outside the state during the 2 years prior to applying for nursing home employment.

Two of the states we visited allow employees to report for duty before background checks are completed. Pennsylvania[23] and Illinois permit new employees to report to work before criminal background checks are completed, for up to 30 days and 3 months, respectively. However, Georgia survey agency officials told us that nursing homes could be cited with a deficiency if new employees assume their duties before the nursing home receives the results of the background checks. Georgia requires that these checks be completed within 3 days of the request.

CMS does not require that the results of criminal background checks be included in nurse aide registries. Of the three states we visited, only Illinois requires that the results be reported to the state survey agency by the nursing home.[24] If the check reveals a disqualifying criminal history, it will be included in the Illinois registry. Therefore Illinois nursing homes are able to identify some aides with disqualifying convictions before offers of employment are made and criminal background checks are initiated. Officials in Georgia and Pennsylvania explained that they verify the completion of background checks for new employees, including nurse aides, as they conduct their periodic nursing home surveys. As a result, they told us that they do not believe that the results of these checks need to be added to their registries.

[22]Under P.L. 105-277, Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, 112 Stat. 2681-73, nursing homes may obtain national, fingerprint-based background checks from the FBI for applicants for employment in positions involving direct patient care.

[23]Under Pennsylvania law, applicants who have lived in the state less than two years may be employed on a provisional basis for up to 90 days while their FBI background checks are being completed.

[24]A 1998 survey conducted by the Department of Health and Human Services Office of Inspector General reported that Illinois was the only state with this requirement (*Safeguarding Long-Term Care Residents*, A-12-97-00003 (Washington, D.C.: Sept. 14, 1998).

Nursing Homes Rarely Sanctioned for Improperly Responding to Abuse

For the states that we reviewed, sanctions were rarely imposed against nursing homes for deficiencies associated with their handling of instances of abuse. Deficiencies considered the most severe—those resulting in actual harm or immediate jeopardy to resident health or safety—could result in an immediate sanction, such as a civil monetary penalty. Deficiencies not resulting in actual harm or immediate jeopardy usually resulted in nursing homes being required to submit a plan of corrective action. Nursing homes that submit corrective action plans may also face other sanctions.

The Georgia, Illinois, and Pennsylvania survey agencies eventually cited 26 nursing homes—from the 158 cases we reviewed—for abuse-related deficiencies such as failing to report allegations of abuse in a timely manner or failing to properly investigate them, as well as inadequately screening employees for criminal backgrounds, as indicated in table 4.

Table 4: Number of Homes Cited for Abuse-Related Deficiencies

State	Number cited	Number assessed civil monetary penalties
Georgia	2	0
Illinois	7	1
Pennsylvania	17	0
Total	**26**	**1**

Source: GAO analysis of 158 case files.

The state survey agencies rarely recommended to CMS that civil monetary penalties be imposed against nursing homes for abuse-related deficiencies, primarily because most of the deficiencies cited for these 26 nursing homes were not categorized as placing residents' health or safety in immediate jeopardy or resulting in actual harm to residents. Only 1 of these 26 facilities—in Illinois—was assessed a civil monetary penalty. However, the penalty was reduced on appeal. State survey agencies did not recommend other sanctions on the 25 remaining nursing homes.

Nurse Aide Registries Do Not Ensure Resident Protection

We found that allegedly abusive nurse aides received different treatment depending on the state in which they worked. In addition, when states determined that aides were abusive, there were frequent and long delays in the inclusion of this information in their registry files. Residents could have been exposed to abusive individuals while their cases were pending.

Finally, we found that one state's Web-based nurse aide registry lacked complete information on aides who had been found to be abusive.

Inconsistent Treatment of Nurse Aides Poses Risks to Nursing Home Residents

CMS defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. CMS officials told us that states may use different definitions so long as they are at least as broad as the CMS definition.[25] While the three states we visited have definitions that appear at least as broad as the CMS definition, variations in the way these states interpret or apply their definitions affect whether aides' actions are reflected in state registries.

For example, the Georgia definition is very similar to CMS's and defines abuse to include, among other things, the "willful infliction of physical pain, physical injury, [or] mental anguish." Officials there told us, however, that in order to add a finding of abuse to an aide's registry file, they must be convinced that the aides' actions were intentional. They are less likely to determine that an aide has been abusive if the aide's behavior appeared to be spontaneous or the result of a "reflex" response. Officials said they would view an instance in which an aide struck a combative resident in retaliation after being slapped by the resident as an unfortunate reflex response rather than an act of abuse.

Similarly, Pennsylvania defines abuse to include, among other things, "infliction of injury . . . or intimidation or punishment with resulting physical harm, pain or mental anguish." While this definition appears to be at least as broad as the CMS definition, Pennsylvania officials told us that they would be unlikely to annotate an aide's registry file to reflect a finding of abuse unless the aide caused serious injury or obvious pain. Our review of Pennsylvania files indicated that most of the aides that were found to have been abusive had, in fact, clearly injured residents or caused them obvious pain. However, these files also indicated that in several instances in which residents were bumped or slapped and indicated that they were in pain as the result of aides' actions, the survey agency decided not to take action because the residents had no physical injuries. As in Georgia, agency officials indicated that they needed to establish that the action was intentional.

[25]CMS officials told us that a state must follow the federal definition of abuse when it is performing a federal survey.

In contrast, Illinois defines abuse as "any physical . . . or mental injury inflicted on a resident other than by accidental means." Incidents like those not reported to registries in Georgia or Pennsylvania—reflex actions and those devoid of serious injury or obvious pain—are added to Illinois's registry. We saw 17 such cases in Illinois in which state survey officials did find the aides to have been abusive. We also reviewed, in both Illinois and Georgia, what appeared to be comparable complaints in which a nursing home employee witnessed another staff member strike a combative resident. Both survey agencies made preliminary determinations that the employees had, in fact, abused residents. The Illinois survey agency not only included its determination in the aides' registry files, it also referred the matter to its MFCU, resulting in a criminal conviction.[26] The Georgia survey agency reversed its initial determination that the aide was abusive when the aide requested that the matter be reconsidered, even though the aide did not provide new evidence to disprove the allegation. Notes in the case file indicated that Georgia reversed its decision because the aide's action was reflexive. Consequently, Georgia did not annotate the aide's registry information to reflect a finding of abuse and did not refer this incident to its MFCU. We identified four additional instances among the 52 Georgia cases we reviewed involving nurse aides who hit or otherwise injured combative residents after these residents had tried, sometimes successfully, to harm them first. None of these cases resulted in determinations that aides were abusive. The files indicated that officials had determined that the aides did not intend to hurt the resident and were not abusive because the residents were combative. Consequently, no further actions were taken.

CMS officials agreed with state survey agency officials that intent is a key factor in assessing whether an aide abused a resident. However, they would not necessarily find a reflex response to be unintentional. These officials indicated that an aide who slaps a resident back could have developed intent in an instant and thus should be considered abusive.

Of the 158 cases of alleged physical and sexual abuse that we reviewed, 105 involved nurse aides. States notified 41 of these aides of their intent to annotate their registry files to reflect findings of abuse, which would prevent them from obtaining future employment in a nursing home. As

[26]As a result, this aide was sentenced to 2 years probation, directed to complete 100 hours of community service, and prohibited from employment that would involve contact with the elderly or disabled.

table 5 shows, 27 of these 41 aides eventually had their registry files annotated. Consistent with Illinois's broad definition of abuse and the fact that officials there have not narrowed its scope through its application, most of these aides were from that state.

Table 5: Cases of Alleged Abuse Involving Nurse Aides

State	Cases involving nurse aides	Aides notified of intent to annotate registry records	Aides with registry records annotated as of January 2002
Georgia	31	9	5
Illinois	40	27	22
Pennsylvania	34	5	0
Total	**105**	**41**	**27**

Source: GAO analysis of 158 reviewed case files and related nurse aide registry data.

Delays in Annotating Record Leave Residents Vulnerable

We found examples of delays between the time the state survey agencies learned that a nurse aide had allegedly abused a resident to the date of the agencies' final determinations. Our review of the 71 case files from Illinois and Georgia involving allegedly abusive aides, and our review of 1999 nurse aide registry records in Pennsylvania[27] indicated that while some determinations were made in less than 2 months, a substantial number—12—took 10 months or more. Three of these 12 determinations took at least 2 years. Such delays can put residents of other nursing homes at risk. By the time state survey agencies have determined that some aides are abusive, these aides may have already found employment in other homes.

The process of determining whether an aide actually abused a resident can be time-consuming. While CMS requires survey agencies to begin their investigation of an allegedly abusive aide within two days of learning of an allegation, it does not impose a deadline for completing these investigations. State survey agency investigations can be prolonged, particularly if law enforcement is involved.

Nurse aides are entitled to due process, but nursing home residents may remain vulnerable to abuse until final determinations are made. Once

[27]Thirty-four of the Pennsylvania case files we reviewed involved allegedly abusive nurse aides. As of January 2002, none of these aides had findings of abuse reflected in their registry records. In order to assess the time frames of Pennsylvania's abuse determinations, we reviewed files of all nurse aides who had been found abusive in 1999.

officials make an initial determination that an aide abused a resident, the aide must be informed in writing. The notification must also inform the aide that the agency intends to update the registry to reflect this determination, which would prevent the aide from obtaining future employment in a nursing home in that state. Because of the severity of these consequences, aides are entitled to hearings. Hearings must be requested in writing within 30 days of the notification from the state survey agency regarding its determination and its intent to include a finding of abuse in the registry. Hearings may not be held for several months, and hearing officers may not render their decisions immediately. No entry may be made in an aide's registry record until a final determination is made that the aide was abusive. Our analysis of nurse aide registry records from 1999 indicated that, for all aides with abuse findings recorded in their registry files in all three states, hearings added, on average, 5 to 7 months to the determination process.

Inaccuracies in Nurse Aide Registry Web Sites May Compromise Resident Safety

We identified problems with the accuracy of information contained in one state's nurse aide registry Web site that could have resulted in the provision of inaccurate information to nursing homes screening potential employees. Our test of the accuracy of the sites for the three states we visited showed that, in some instances, findings of abuse had been annotated to an aide's registry record but had not been included in registry information posted on the Web site. For example, four Georgia aides with final determinations of abuse did not have such findings reflected in their files at the state's registry Web site. Agency officials confirmed our results and consequently closed the agency site for more than a week. However, they told us that the problem was limited to the site and did not affect their ability to provide correct information by telephone or fax. They also reported that the agency's ability to provide a complete list of abusive aides in its quarterly bulletins to nursing homes was not compromised.

Just as background checks would typically reveal only offenses committed in the state in which an applicant seeks employment, nurse aide registries reflect an aide's history in a particular state. In 1998, the HHS Office of Inspector General recommended that HCFA assist in developing a national abuse registry and expand state registries to include all nursing home employees who have abused residents or misappropriated their property in facilities that receive federal reimbursement.[28] A CMS contractor is

[28]Department of Health and Human Services Office of Inspector General, *Safeguarding Long-Term Care Residents*, A-12-97-00003 (Washington, D.C.: Sept. 14, 1998).

currently conducting a feasibility study regarding the development of such a registry. The study includes a cost-benefit analysis to assess the implications of a centralized nurse aide registry and, to a lesser extent, the implications of tracking all nursing home employees. The implications of requiring other health care providers—such as home health agencies—to query nurse aide registries is also under study. The contractor is scheduled to report its findings as soon as March 2002.

Other Nursing Home Employees May Not Be Disciplined

Although nurse aides compose the largest proportion of nursing home employees, other employees, such as laundry aides, security guards, and maintenance workers have also been alleged to have abused residents. While survey agencies can prevent abusive aides from working in nursing homes and can refer licensed personnel, such as nurses and therapists, to state licensing boards for disciplinary action, they have no similar recourse against other abusive employees, who may continue to work in nursing homes. Survey agencies can, however, cite facilities for deficiencies if appropriate actions—such as reporting and investigating the allegations—are not taken.

Of the 158 cases of alleged physical and sexual abuse that we reviewed, 10 suspected perpetrators were employees who were not subject to licensing or certification requirements. None of the facilities in these cases were cited for deficiencies. Although there is no administrative process to enable the state to take actions against such employees, these employees could be criminally prosecuted. Of these 10 cases, 4 involved allegations that proved unfounded or for which evidence was inconsistent. One of the 10 employees ultimately pled guilty in court. Three others were investigated by law enforcement but were not prosecuted.[29] The remaining 2 employees were terminated by their nursing homes but were not the subject of criminal investigations.[30]

Conclusions

Nursing homes are entrusted with the well-being and safety of their residents yet considerable attention has recently been focused on the inadequacies of care provided to many nursing home residents. Along with

[29]Two of these employees were terminated. The third was a security guard, employed by a private company, who was removed from duty at the nursing home.

[30]These cases involved alleged physical abuse, but the residents did not sustain apparent injuries.

receiving quality care, residents are entitled to be protected from those who would harm them. Residents who are abused need to be assured that their allegations will be immediately referred to the proper authorities and investigated expeditiously. In addition, law enforcement authorities need to ensure that abusive individuals are prosecuted when appropriate, and survey agencies should recommend to CMS that available administrative sanctions be imposed against known abusers.

Our work shows that nursing home residents need both stronger and more immediate protections. Law enforcement agencies, such as state MFCUs or local police departments, are not involved as often or as soon as they should be, especially when there are indications of potential criminal activity. Additionally, determining where to report complaints of alleged abuse can be confusing. Prompt reporting is especially crucial given the often-limited evidence available.

CMS is taking important steps that may better protect residents. For example, its feasibility study on the development of a national abuse registry could lead to enhanced resident safety. However, other efforts have fallen short. For example, an important tool could be the agency's educational campaign using a new poster in nursing homes nationwide to better inform residents and family members about how to report abuse. However, the poster has been under development for more than 3 years.

More should be done to protect nursing home residents. CMS's requirement that nursing homes not employ individuals convicted of abusing residents does not sufficiently prevent the hiring of potentially abusive individuals. Those who have committed similar offenses, such as child abuse, are eligible to work in nursing homes unless states impose a more stringent requirement. While CMS does not require criminal background checks, some states have instituted them. However, they may not be required for all prospective employees and may not identify offenses committed in other states. In addition, CMS's definition of abuse is not sufficiently detailed to ensure that all states report every incident that CMS would consider abusive. Affording due process to nurse aides who have allegedly abused residents is important and necessary. However, determinations that nurse aides have been abusive can be time-consuming, leaving residents at risk if these aides continue to work in nursing homes. Finally, nurse aide registries may have incorrect information, allowing nursing homes to hire aides previously found abusive.

Recommendations for Executive Action

To better protect nursing home residents, we recommend that the CMS administrator:

- Ensure that state survey agencies immediately notify local law enforcement agencies or MFCUs when nursing homes report allegations of resident physical or sexual abuse or when the survey agency has confirmed complaints of alleged abuse.
- Accelerate the agency's education campaign on reporting nursing home abuse by (1) distributing its new poster with clearly displayed complaint telephone numbers and (2) requiring state survey agencies to ensure that these numbers are prominently listed in local telephone directories.
- Systematically assess state policies and practices for complying with the federal requirement to prohibit employment of individuals convicted of abusing nursing home residents and, if necessary, develop more specific guidance to ensure compliance.
- Clarify the definition of abuse and otherwise ensure that states apply that definition consistently and appropriately.
- Shorten the state survey agencies' time frames for determining whether to include findings of abuse in nurse aide registry files.

Agency Comments and Our Evaluation

We received comments on a draft of this report from CMS, the Department of Justice (DOJ), the three state survey agencies we visited (the Illinois Department of Public Health, the Georgia Department of Human Resources, and the Pennsylvania Department of Health), and the MFCUs in Illinois and Georgia.[31] We also received comments from two organizations representing the nursing home industry—the American Health Care Association (AHCA) and the American Association of Homes and Services for the Aging (AAHSA).

In its comments, CMS generally agreed with our recommendations and said that it is committed to protecting nursing home residents from harm and explained that it is currently investigating new ways to combat resident abuse and neglect. We have reprinted CMS's letter in appendix II.

[31]Because of the limited role of the Pennsylvania MFCU in abuse cases, we did not provide it a copy of our draft, although we briefed the MFCU officials on its contents.

CMS also provided technical comments, which we have incorporated as appropriate.

CMS agreed with our first recommendation and said it would instruct state survey agencies to immediately notify local law enforcement agencies or MFCUs of confirmed abuse allegations. CMS also said it would thoroughly review this recommendation when it completes its analysis of its Complaint Improvement Project. We believe that immediately notifying law enforcement of suspected abuse will enhance the safety of nursing home residents, and we urge CMS's prompt action.

In responding to our second recommendation—that CMS accelerate its education campaign—the agency said that it is working with HHS to release its new poster as soon as possible, but did not indicate when it might be distributed to nursing homes. In addition, CMS agreed to request states to prominently list telephone numbers for reporting abuse in local telephone directories.

CMS agreed with our third recommendation and said it will review state policies and practices and reissue guidance regarding employment prohibitions pertaining to individuals convicted of abusing nursing home residents. We believe that an assessment of the current requirements, that includes an evaluation of the states' implementation of these requirements, could have a lasting impact on resident safety.

In addressing our fourth recommendation—to clarify the definition of abuse and ensure that states consistently and appropriately apply this definition—CMS explained that states can use their own established definitions of abuse. According to CMS, the state's definitions may be used when citing homes for deficiencies under their state licensure program but, when performing a federal survey, CMS noted that the federal definition must be used. CMS added that it would clarify this distinction with the states. However, we believe that it is also of great importance to clarify the definition of abuse that states should apply when considering whether nurse aides have abused residents and consequently may have this action reflected in their nurse aide registry files.

CMS agreed to consider our fifth recommendation—to shorten the time frames for determining whether to include findings of abuse in the nurse aide registry. CMS acknowledged that a considerable amount of time may elapse before reports of abuse are finalized and reported to the nurse aide registry. CMS added this is largely attributable to steps associated with due process. CMS pointed out that, with the exception of the time taken by

the states to substantiate abuse allegations, all of these time frames are specified by regulation. However, the regulations do not specify a time frame for making a final decision once the hearing has been completed and the hearing record has been closed. CMS said it would take our recommendation into account when considering changes to these regulations. We believe that reducing this time period will provide residents with greater certainty that they will not be exposed to abusive aides.

We received oral comments from the Coordinator of DOJ's Nursing Home and Elder Justice Initiative. She agreed with the findings in our report. She also added that resident abuse may be underestimated, as studies suggest a significant number of abuse cases are never reported. She said that, in order to respond appropriately to victims of abuse, local law enforcement and other "first responders" such as firefighters and paramedics, would benefit from special training. In her view, this training should include guidance regarding how to distinguish signs of physical abuse from other types of injuries, advice on interviewing elderly and confused residents, and investigative techniques and evidence preservation strategies unique to the nursing home setting. Our work did not include an evaluation of the training programs offered to law enforcement officials or "first responders." In addition, she pointed out that DOJ could become actively involved in investigating abuse allegations in certain situations, such as those involving facilities where a pattern of abuse has been detected and instances where nursing home managers or employees have made false statements to state surveyors regarding resident care. In addition to these comments, we received technical comments from the FBI, which we incorporated as appropriate.

We received comments from all three of the state survey agencies we visited as well as the Illinois MFCU. These agencies described initiatives they have undertaken to increase awareness of resident abuse and improve reporting and offered technical comments, which we incorporated as appropriate. Although we provided our draft to the Georgia MFCU, it did not offer any comments.

Finally, we received comments from representatives of AHCA and AAHSA. Both organizations generally agreed with our recommendations. AHCA representatives told us that they suspect that abuse of nursing home residents is underreported. They said that they support providing more training to both caregivers and law enforcement officials. They noted that such training could discourage abusive behavior by nursing home staff and improve law enforcement's responsiveness to instances of resident abuse.

Our work did not include an evaluation of such training programs. Representatives of both AHCA and AAHSA indicated that they strongly support the establishment of a national nurse aide registry and a national criminal background check for nursing home employees. In addition, the AAHSA representatives said that they strongly agreed with our recommendation to clarify the definition of abuse. They noted that the definition of abuse has long been the subject of debate and its clarification by CMS is in the interest of residents, as well as nursing home management and staff. In addition to these comments, both AHCA and AAHSA offered technical comments, which we have incorporated as appropriate.

As agreed with your offices, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies to the CMS administrator, interested congressional committees, and other interested parties. We will then make copies available to others upon request. If you or your staff have any questions about this report, please call me at (312) 220-7600. An additional GAO contact and other staff who made major contributions to this report are listed in appendix III.

Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

Appendix I: Scope and Methodology

To determine the federal requirements for responding to, and investigating allegations of, abuse of nursing home residents, we reviewed federal laws and regulations. We interviewed officials from the Centers for Medicare and Medicaid Services (CMS) regarding these requirements and also discussed their oversight of the state survey agencies responsible for surveying nursing homes and certifying their compliance with federal laws and regulations. We conducted our work in three states with relatively large nursing home populations—Illinois, Georgia, and Pennsylvania—and discussed these requirements with survey and law enforcement officials in these states. In addition, we met with officials from the three states' departments on aging and local area agencies on aging because they may also receive abuse referrals and conduct investigations. We reviewed and discussed relevant state policies and procedures with these officials. Finally, to become familiar with the general progression of abuse investigations, we attended conferences and consulted with experts in the field of elder abuse.

For each of the three states we visited, we reviewed cases involving allegations of physical and sexual abuse.[1] Most of these cases were opened by Medicaid Fraud Control Units (MFCUs) or reported to state survey officials in 1999 or 2000. We focused on the survey agencies' and MFCUs' files. We did not review any of the allegations investigated by the state departments on aging or local area agencies on aging because of agency officials' concerns with confidentiality. In total, we reviewed 158 cases to determine the circumstances and nature of the cases, the extent to which the allegations were investigated and prosecuted, and the timeliness of referrals and investigations. However, our findings cannot be generalized or projected. To assess the timeliness of reporting abuse allegations, we used the information from our case review and compared these results to federal and state guidelines. For cases that the state survey agency referred to the MFCU, we calculated the number of days between agency receipt and referral to the MFCU. We also determined the number of convictions resulting from these referrals.

At the Illinois Department of Public Health (IDPH)—the state survey agency—we identified and reviewed 50 cases involving physical or sexual abuse that were reported by individuals as complaints or by nursing

[1]Our objectives were limited to allegations of physical and sexual abuse. Thus, we omitted all cases with allegations solely of neglect. In addition, we omitted those that were still under investigation at the time of our review.

homes in incident reports. All of these allegations were referred by IDPH to its MFCU. These included all of the allegations of physical or sexual abuse for which the MFCU had opened investigations in 1999 and closed at the time of our review.[2] We reviewed the relevant files at both agencies. We also examined 1 month of referrals that the MFCU reviewed but ultimately did not investigate. These referrals typically involved bruises of unknown origin, old injuries, a lack of witnesses, or instances in which the intent to hurt a resident was questionable or unfounded.

In Georgia, we reviewed 52 abuse allegations. Of these, 14 were either complaints or incident reports that the state Department of Human Resources (DHR)—in which Georgia's state survey agency is housed—had referred to the MFCU in 1999. These 14 cases represent all of the allegations of physical or sexual abuse that DHR referred to the MFCU in 1999 and for which the MFCU opened and subsequently closed an investigation. We reviewed these 14 cases at both agencies. Because DHR does not refer all physical and sexual abuse cases to the MFCU, we judgmentally selected and reviewed 38 additional abuse cases that DHR had received but had not referred to the MFCU. We chose these additional cases from the survey agency's 1999 log of complaints, which included 60 physical and 14 sexual abuse cases, as well as from its 1999 log of incident reports, which included 361 physical and 47 sexual abuse cases. We selected cases based on the proportion of the allegations that involved physical and sexual abuse, as well as complaints and incident reports.

Because local law enforcement in Pennsylvania is assigned primary responsibility for investigating the physical or sexual abuse of nursing home residents, our case file selection for this state differed from that of Illinois and Georgia. As the MFCU is typically not involved in these cases, the files we reviewed included 56 cases reported to Pennsylvania's state survey agency—the Department of Health (DOH)—in 1999 and 2000. These cases included a mix of complaints and incident reports as well instances of both physical and sexual abuse.

To identify agencies that might accept reports of abuse, we obtained several telephone books from each state, including those for large and small metropolitan areas. We reviewed government and consumer pages to identify complaint telephone numbers for state survey agencies, other social service and law enforcement agencies (excluding local police

[2]Eleven of these cases were reported to IDPH in 1998.

departments), and other organizations, such as long-term care ombudsmen, that appeared to be potential places for reporting abuse of nursing home residents. We called these numbers to verify that the organization would accept such a complaint. We also made follow-up calls when we were referred elsewhere.

To determine the extent of law enforcement's involvement in investigating abuse allegations, we interviewed MFCU officials in Illinois, Georgia, and Pennsylvania. We also spoke with representatives from 19 police departments from these states—including both urban and rural areas—and four prosecutors' offices. Some of these departments and prosecutors were chosen because of their involvement in some of the cases we reviewed.

To determine the extent to which nursing homes were sanctioned for violations related to abuse, we identified from the files we reviewed the nursing homes that had been cited for deficiencies related to the abuse allegations. We then searched state Web sites to obtain surveys pertaining to these homes from the time of the abuse allegation to the present and reviewed the surveys to determine what, if any, sanctions had been recommended.

To evaluate whether sufficient safeguards exist to protect residents from abusive individuals, we reviewed federal and state laws regarding criminal background check requirements for nursing home employees and state nurse aide registries. We also interviewed state survey agency officials and obtained relevant documentation.

We tested the accuracy of online nurse aide registry Web sites in each state we visited to verify that findings of abuse had actually been posted to the site. Survey officials in the three states provided us with lists of nurse aides who had been found to be abusive through their administrative processes. Using those lists, we tested the registries to determine whether all names and information provided to us were accurately reflected by each state's Web site. In addition, we obtained copies of state agencies' 1999 and 2000 quarterly bulletins that were sent to nursing homes and compared the names of nurse aides with abuse findings listed in these bulletins to the list originally obtained from the state agency.

In Georgia and Illinois,[3] we reviewed lists of aides notified by the survey agencies that their registry files would be annotated to reflect a finding of abuse. From these lists, we determined the number of aides requesting an administrative hearing and the number of findings actually entered in the registries. In Pennsylvania, we reviewed a similar list, although it only included those aides who actually had findings of abuse annotated in the registry. For all three states, we calculated the average length of time between when the state notified aides of its plan to annotate the registry to the date the agency ordered that the findings be posted. Finally, we interviewed state agency officials about their policies regarding professionals and other staff who abuse nursing home residents.

[3]In Georgia, this list included letters regarding findings of abuse, while in Illinois this list included all aides sent letters regarding findings of abuse, neglect, or theft.

Appendix II: Comments from the Centers for Medicare and Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 21 2002

TO: Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues
General Accounting Office

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Report, *NURSING HOMES: More Can Be Done to Protect Residents from Abuse* (GAO-02-312)

Thank you for the opportunity to review and comment on the above-referenced draft report. The information gathered by GAO in conjunction with information we have gathered from our own reports, will help us make sound policy decisions about how best to protect residents in nursing homes from abuse and neglect. This report helps to validate some of the information we have gathered while working on the Nursing Home Complaint Improvement Project and on a future Report to Congress: "*The Role of the Nurse Aide Registry, Impact of Institutional Environmental Factors, and Effectiveness of Other Sanctions in Preventing Abuse and Neglect in Nursing Homes*. The Nursing Home Complaint Improvement Project is scheduled to be completed this fall and the Report to Congress should be released by the end of this summer.

We are currently focusing our attention on developing solutions to this problem and we appreciate GAO's commitment to helping us achieve that goal. Along with beneficiary advocates, the nursing home industry, as well as other stakeholders, we are currently investigating the feasibility of expanding an existing program to allow us to create policies to combat the problems of abuse and neglect. The Centers for Medicare & Medicaid Services (CMS) remains committed to protecting nursing homes residents from harm. Thank you again for the opportunity to review this report.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises. Our comments on the GAO recommendations follow:

GAO Recommendation

Ensure that state survey agencies immediately notify local law enforcement agencies or Medicaid Fraud Control Units (MFCUs) when nursing homes report allegations of resident physical or sexual abuse or when the survey agency has confirmed complaints of alleged abuse.

CMS Response

The CMS will instruct state survey agencies that they are to immediately notify local law enforcement or MFCUs any time the survey agency confirms a complaint of abuse. The CMS will thoroughly review this recommendation when we evaluate all the information and recommendations that result from our Complaint Improvement Project.

GAO Recommendation

Accelerate its education campaign on reporting nursing home abuse by (1) distributing its new poster with clearly displayed complaint telephone numbers, and (2) requiring state survey agencies to ensure that these numbers are prominently listed in local telephone directories.

CMS Response

We have a developed a poster that contains the phone numbers for the state ombudsman, the state survey agency and the CMS 1-800-Medicare number and are working with the Department to release it as soon as possible. We will request that states ensure that the abuse contact numbers are prominently listed in local telephone directories.

In addition, as part of our educational activities, three videos were prepared for the nursing home industry. They are, "*The Importance of Being a Certified Nursing Assistant, Choosing Long Term Care, and Quality Living in a Nursing Home.*" The videos are ready for release pending Department clearance. The advocates and nursing home provider groups have examined these materials and all support the use and distribution of the products.

GAO Recommendation

Systematically assess state policies and practices for complying with the Federal requirement to prohibit employment of individuals convicted of abusing nursing homes residents and, if necessary, develop more specific guidance to ensure compliance.

CMS Response

The CMS will review state policy and practice and reissue guidance relating to the Federal prohibition of employment of individuals convicted of abusing nursing home residents. In July 1999 CMS published Task 5G – *Abuse Prohibition Review and Investigative Procedures in the State Operations Manual – Survey Procedures for Long-Term Care Facilities*. The objective is to determine if the facility has developed and operationalized policies and procedures that prohibit abuse, neglect, involuntary seclusion, and misappropriation of property for all residents. The review includes components on the facility's policies and procedures as contained in the Guidance to Surveyors at 42 CFR 483.13(c), F226. As part of the protocol, state surveyors evaluate whether the facility had screened potential employees for a history of abuse, neglect, or

mistreating residents as defined by applicable requirements at 42 CFR 483.13(c)(1)(ii)(A) and (B). This includes attempting to obtain information from previousemployers and/or current employers, and checking with appropriate licensing boards and registries. Surveyors cite facility noncompliance contained in the guidance to surveys at 42 CFR 48.13 (c) (1) (ii) and (iii), F225 when the facility is deficient in its commitment to hiring employees without histories of abusive behavior or in reporting and investigating allegations of abuse. The percentage of facilities cited for failures at F225 has steadily increased from 5.8 percent the first quarter in 1998 to 12 percent in the last quarter in 2000.

In 1998, CMS established the Abuse and Neglect Prevention Forum (the Forum) in an effort to raise awareness of the extent of the abuse and neglect problem affecting the elderly and people with disabilities. The Forum consisted of representatives from a cross-section of Federal, state, provider, and advocacy organizations. The group identified seven key components that can potentially reduce, detect, and prevent abuse and neglect. Pre-employment screening of potential staff is one of the seven key components.

In May 2001, CMS implemented an abuse and neglect detection and prevention train-the-trainer program for representatives from each state agency. In an October 2001 memorandum sent to the Associate Regional Administrators of the Division of Medicaid and State Operations and the state survey agency directors, CMS requested states to complete training within their respective areas by March 20, 2002. To monitor the number and type of individuals trained, we have asked each state to complete and submit a tracking plan. We will evaluate whether more guidance is needed to ensure the Survey Protocol and the Abuse and Neglect Prevention Program are being followed by each state survey agency. We will also evaluate the need to implement a policy to assess state policies and practices for complying with the Federal requirement to prohibit employment of individuals convicted of abusing nursing home residents.

GAO Recommendation

Clarify the definition of abuse and otherwise ensure that states apply the definition consistently and appropriately.

CMS Response

The regulatory definition of abuse is found in 42 CFR 488.301. This definition is reinforced and reiterated in the State Operations Manual Guidance to Surveyors in Long Term Care Facilities, and the CMS Abuse and Neglect Training manual that serve as a basis for training state surveyors. We want to clarify that a state can use any definition it has established when citing deficiencies under its own state licensure program. However, when the state is performing a Federal survey, the Federal definition must be followed when citing deficiencies for abuse. We will clarify this with state agencies.

GAO Recommendation

Shorten the state survey agencies' timeframes for determining whether to include findings of abuse in the nurse aide registry.

CMS Response

Since the findings of abuse must be substantiated, the accused notified in writing, and any due process for a hearing completed prior to reporting the substantiated findings to the nurse aide registry, considerable time may pass before reports to the registry are made. Currently, much of the timeframes are defined in regulation. The only part of the process not defined by regulation is the time it takes the state to substantiate abuse. The CMS can review these timeframes when changes to the regulations are considered.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact	Geraldine Redican-Bigott (312) 220-7678
Staff Acknowledgments	Lynn Filla-Clark, Tiffani Green, Barbara Mulliken, and Christi Turner also made key contributions to this report.

Related GAO Products

Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern. GAO-01-750T. Washington, D.C.: May 17, 2001.

Nursing Homes: Success of Quality Initiatives Requires Sustained Federal and State Commitment. GAO/T-HEHS-00-209. Washington, D.C.: September 28, 2000.

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives. GAO/HEHS-00-197. Washington, D.C.: September 28, 2000.

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality. GAO/HEHS-00-6. Washington, D.C.: November 4, 1999.

Nursing Homes: HCFA Should Strengthen Its Oversight of State Agencies to Better Ensure Quality Care. GAO/T-HEHS-00-27. Washington, D.C.: November 4, 1999.

Nursing Home Oversight: Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable. GAO/HEHS-99-154R. Washington, D.C.: August 13, 1999.

Nursing Homes: HCFA Initiatives to Improve Care Are Under Way but Will Require Continued Commitment. GAO/T-HEHS-99-155. Washington, D.C.: June 30, 1999.

Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit. GAO/HEHS-99-157. Washington, D.C.: June 30, 1999.

Nursing Homes: Complaint Investigation Processes in Maryland. GAO/T-HEHS-99-146. Washington, D.C.: June 15, 1999.

Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents. GAO/HEHS-99-80. Washington, D.C.: March 22, 1999.

Nursing Homes: Stronger Complaint and Enforcement Practices Needed to Better Ensure Adequate Care. GAO/T-HEHS-99-89. Washington, D.C.: March 22, 1999.

Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards. GAO/HEHS-99-46. Washington, D.C.: March 18, 1999.

California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes With Serious Care Violations. GAO/T-HEHS-98-219. Washington, D.C.: July 28, 1998.

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight. GAO/HEHS-98-202. Washington, D.C.: July 27, 1998.

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