



441 G St. N.W.
Washington, DC 20548

April 15, 2019

The Honorable Alex M. Azar II
Secretary of Health and Human Services

Management Report: CMS Needs to Address Gaps in Federal Oversight of Nursing Home Abuse Investigations That Persisted in Oregon for at Least 15 Years

Nationwide, approximately 15,600 nursing homes provide care to about 1.4 million nursing home residents, a population of elderly and disabled individuals. To help ensure this population receives quality care and is free from abuse, consistent with federal statutory requirements, the Centers for Medicare & Medicaid Services (CMS) defines the standards nursing homes must meet in order to participate in the Medicare and Medicaid programs, including standards for resident care and safety.¹ To monitor compliance with these standards, CMS enters into agreements with agencies in each state government—known as state survey agencies—and oversees the work the survey agencies do.²

Survey agencies are required to conduct standard surveys, or evaluations, approximately once each year of the state’s nursing homes and investigate both complaints from the public and facility-reported incidents regarding resident care or safety, such as abuse.³ Investigations of nursing homes based on public complaints and facility-reported incidents offer a unique opportunity for the state survey agencies to identify potential abuse, as these can provide a timely alert of acute issues that otherwise might not be addressed until the standard survey. Deficiencies found as a result of federal nursing home surveys and investigations of complaints and facility-reported incidents can be cited and tracked by CMS, providing valuable information about nursing home quality. In addition, federal sanctions can be imposed on the nursing home

¹CMS is an agency within the Department of Health and Human Services (HHS).

CMS defines abuse in its guidance as “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.”

²In Oregon, the state survey agency is the Nursing Facility Survey Unit, which is part of Oregon’s Department of Human Services. Survey agencies are frequently housed in the health or human services departments of state governments and may have different names in different states.

³By law, every nursing home receiving Medicare or Medicaid payment must undergo a standard survey during which teams of state surveyors conduct a comprehensive on-site evaluation of compliance with federal quality standards. These surveys must occur at least once every fifteen months, with a statewide average interval for surveys not to exceed 12 months. 42 U.S.C. §§ 1395i-3(g)(1)(A), (g)(2)(A)(iii), 1396r(g)(1)(A), (g)(2)(A)(iii).

State survey agencies are also required to investigate allegations of neglect and abuse in nursing homes in response to complaints and facility-reported incidents filed with state survey agencies. 42 U.S.C. §§ 1395i-3(g)(1)(C), 1396r(g)(1)(C). During an investigation, state surveyors evaluate the nursing home’s compliance with a specific federal quality standard.

in order to prompt the correction of deficiencies, and quality information about deficiencies can be monitored by CMS and communicated to consumers.

In October 2017, we began work reviewing CMS oversight of nursing home abuse in response to a request from the Senate Homeland Security and Governmental Affairs Permanent Subcommittee on Investigations. As part of this review, we interviewed officials from survey agencies about how they investigate complaints and facility-reported incidents of resident abuse in nursing homes in five selected states.⁴ We became aware that Oregon—a state with 135 nursing homes caring for approximately 7,000 residents, as of December 2018—was not following federal requirements that the survey agency investigate all complaints and facility-reported incidents.⁵ Specifically, instead of the survey agency, Oregon’s Adult Protective Services (APS)—a state program that is part of Oregon’s Department of Human Services but is separate from the survey agency—was investigating complaints and facility-reported incidents of abuse—including physical, sexual, and mental/verbal abuse—in nursing homes.⁶ While APS investigators in Oregon are trained to provide protection and intervention for older adults across the state in various settings and to play a valuable role in helping protect nursing home residents from abuse, they are not trained in, or focused on, investigating abuse according to federal nursing home regulations. In addition, abuse investigated by APS is not reflected in

⁴Oregon was one of the five states we selected as part of the initial request. The selected states reflect variation in geography, CMS regional oversight, the number of nursing homes in the state, and the involvement of Adult Protective Services (APS) in nursing home oversight, as well as congressional interest. We expect to issue the report on CMS oversight of nursing home abuse later this year.

⁵In the context of this report, “investigate” denotes the process by which an agency does the intake and triage of complaints and facility-reported incidents, as well as the investigation of complaints and facility-reported incidents.

CMS data identified 135 nursing homes in Oregon as of December 2018, but Oregon officials told us there were 132 active nursing homes in Oregon as of December 2018, and information we received from Oregon identified three nursing homes on CMS’s list had closed.

⁶Oregon APS is a state program that provides protection and intervention for older adults and adults with physical disabilities in licensed long term care facilities, as well as in the general community, who are unable to protect themselves from abuse and self-neglect. In all states, APS is charged with receiving and responding to reports of adult maltreatment and working closely with clients and a wide variety of allied professionals to maximize client safety and independence, according to the Administration for Community Living. In some states, APS may not have jurisdiction in nursing homes, and the Administration for Community Living noted in a 2018 report that in 38 states, APS investigates allegations of maltreatment when they occur in at least some types of residential facilities. Department of Health and Human Services, Administration for Community Living, *NAMRS FFY 2017 Report 1: Agency Component* (Sept. 27, 2018).

A 2005 Oregon policy stated that APS should investigate nursing home complaints and facility-reported incidents that allege financial, verbal/mental, sexual, and physical abuse, involuntary seclusion, and neglect of care, and that the survey agency should investigate nursing home complaints and facility-reported incidents alleging falls, bone fractures, pressure ulcers, hospitalizations, emergency room visits, urgent care visits, deaths, and concerns relating to restraints. The policy notes that for complaints involving multiple allegations, if one or more of the allegations meet the referral criteria for the survey agency, all allegations contained in the complaint will be referred to the survey agency. According to Oregon survey agency officials, this delineation of responsibilities continued until October 29, 2018.

nursing home federal reporting to consumers, nor does it result in federal nursing home enforcement actions.⁷

When we learned that the Oregon survey agency was not investigating all complaints and facility-reported incidents of abuse in nursing homes, we collected more detailed information from CMS and Oregon. Specifically, we reviewed policy documents from CMS, including the State Operations Manual and the Oregon survey agency's agreement with CMS, and interviewed officials from CMS Central Office, CMS Regional Office 10, and Oregon's Department of Human Services (DHS)—which includes the survey agency and APS—to gather more information on CMS's oversight of the Oregon survey agency and the Oregon survey agency's activities.⁸ In addition, we examined information on substantiated nursing home abuse deficiencies from publicly available CMS and Oregon online resources.⁹ We also assessed CMS's oversight activities in the context of federal standards for internal control for monitoring activities and using quality information.¹⁰

We conducted this performance audit from December 2018 through April 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

CMS Failed to Address Gaps in Federal Oversight of Nursing Home Abuse Investigations in Oregon for at Least 15 Years

We found that, for at least 15 years, CMS's oversight failed to address that the Oregon survey agency was not investigating all abuse complaints and facility-reported incidents, as required by federal law. From at least the early 2000s through October 29, 2018, the Oregon survey agency did not investigate all allegations of abuse in nursing homes that came from complaints or facility-reported incidents—some of those, including allegations of sexual, physical, and mental/verbal abuse, were instead investigated by Oregon's APS, and the results of those

⁷Under federal law, if a state survey agency finds that a nursing facility does not meet federal requirements and finds that the facility's deficiencies immediately jeopardize the health or safety of its residents, the survey agency must recommend to CMS that enforcement action be taken. Such actions include the imposition of civil money penalties, denial of payment, assignment of a temporary manager, installation of a state monitor, and termination from participation in Medicare or Medicaid. In addition, if a survey agency finds that a nurse aide has engaged in abuse or neglect of a nursing facility resident (or misappropriation of resident's property), the agency must report this information to the state's nurse aide registry. 42 U.S.C. §§ 1395i-3(g)(1)(C), (h), 1396r(g)(1)(C), (h).

⁸CMS's 10 regional offices oversee state activities and report back to CMS central office the results of their efforts.

⁹CMS Nursing Home Compare: <https://www.medicare.gov/nursinghomecompare/search.html>? Accessed Nov. 7, 2018. Oregon's Facilities Search: <https://itclicensing.oregon.gov/Facilities> Accessed Aug. 14, 2018.

¹⁰GAO, *Standards for Internal Control in the Federal Government*. GAO-14-704G (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

investigations were not shared with CMS.¹¹ Complaints and facility-reported incidents are especially important in the context of abuse—in 2017, CMS data show that about three-quarters of the total abuse deficiencies nationwide originated from complaints or facility self-reported incidents.¹²

According to current CMS officials, CMS became aware that Oregon had been relying on APS and not the survey agency to investigate complaints and facility-reported incidents of abuse in a July 2016 conversation at a regularly scheduled meeting between state agencies and CMS regional office officials. CMS regional office officials said that, subsequent to that July 2016 conversation, they conducted additional analysis to better understand the issue, including an onsite visit with Oregon survey agency officials in 2017. According to CMS officials, at this onsite visit CMS officials confirmed that complaints and facility-reported incidents were not being properly handled in Oregon, and they informed the Oregon survey agency that it was not meeting the requirements of its agreement with CMS.

However, evidence suggests CMS had previously been aware of the issue in the early 2000s, and its oversight activities either did not detect or pursue Oregon's noncompliance. Oregon DHS officials told us that CMS has been aware of their practices for many years and said state policy changes made in 2002 regarding nursing home abuse complaints and facility-reported incidents were made at the direction of CMS. In addition, Oregon's abuse investigation practices were briefly noted in a 2003 GAO report, which cited CMS regional office officials explaining Oregon's longstanding practice of contracting out investigations of complaints and facility-reported incidents to local government entities not under the control of the Oregon survey agency, resulting in information about the investigations, including deficiencies identified, not being entered into CMS's database.¹³

In September 2018, Oregon survey agency officials provided a draft plan documenting a goal of having staff hired and being able to survey independently by September 2020, at which point they could be in compliance with the CMS requirement to have all nursing home complaints and facility-reported incidents screened, triaged and investigated by survey agency staff. Oregon officials told us in December 2018 that the timeline was subsequently accelerated when CMS required the Oregon survey agency to assume complete responsibility for investigating all nursing home complaints and facility-reported incidents. Oregon officials told us that, as of October 29, 2018, the policy of the Oregon survey agency is to be responsible for all nursing

¹¹We have previously reported on concerns with the complaint process more broadly. See GAO, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, HEHS-99-80 (Washington, D.C.: Mar. 22, 1999) and GAO, *Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations*, GAO-11-280 (Washington, D.C.: Apr. 7, 2011).

¹²See CMS's nursing home abuse reports available on its publicly available website: <https://qcor.cms.gov/main.jsp> Accessed 1/9/19. According to Oregon APS officials, they investigated nearly 1,000 complaints and facility-reported incidents of nursing home abuse in 2017, though the definition of abuse used by Oregon differs from the federal definition. Federal law requires that abuse allegations be investigated by federally contracted and trained survey agency surveyors. 42 U.S.C. §§ 1395i-3(g)(1)(C), 1396r(g)(1)(C).

¹³See GAO, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561, (Washington, D.C.: July 15, 2003). This irregularity was noted in a report section highlighting shortcomings with CMS's state performance standards and review, and the report included a recommendation to CMS that it further refine its annual state performance reviews.

home complaint and facility-reported incident investigations.¹⁴ CMS officials told us that Oregon officials communicated this policy change assuming responsibility for all nursing home complaints and facility-reported incidents as of October 29, 2018, and that CMS is planning additional follow up to confirm.

CMS officials told us they have not seen indications of other states being out of compliance for not assuming responsibility for all complaints and facility-reported incidents of abuse, but that their current approach for overseeing survey agencies does not specifically examine whether survey agencies are taking responsibility for investigating all nursing home complaints or facility-reported incidents. Federal standards for internal control direct management to establish and operate monitoring activities to monitor the internal control system and evaluate the results.¹⁵ Until CMS evaluates state survey agency processes specifically to ensure that state agencies are responsible for directly receiving and investigating complaints from the public and facility reported incidents from nursing homes, the agency cannot ensure all states are in compliance with this critical aspect of abuse investigations.

Gaps in Federal Oversight of Nursing Home Abuse Investigations in Oregon Resulted in Lack of CMS Oversight and Consumer Information

While transitioning responsibility of all nursing home investigations to the survey agency is an important first step, Oregon's longstanding non-compliance with CMS complaint and facility-reported incident investigation requirements means that CMS does not have information on more than 15 years of complaint and facility-reported abuse incidents in Oregon. Complete information on nursing home abuse for at least the last several years is important to several aspects of how CMS oversees nursing home quality, including CMS's ability to identify and address patterns of abuse within and across nursing homes in Oregon.

Example of patterns of abuse in Oregon not captured in Centers for Medicare & Medicaid Services (CMS) records. In March 2016, a CMS survey cited a nursing home for being slow to initiate an investigation when a resident had inappropriate sexual contact with another resident who was not able cognitively to consent. A pattern of the nursing home failing to adequately address similar incidents showed up in an Adult Protective Services (APS) report of two subsequent incidents. Specifically, an August 2016 APS investigation found that the nursing home failed to prevent a resident from inappropriately touching another resident. Three months later, another APS investigation found the nursing home failed to protect the same resident from abuse from the same resident perpetrator. As these last two incidents were not reported to CMS, CMS could not identify an overall pattern of the nursing home failing to prevent, investigate, or report abuse, nor could federal nursing home deficiency penalties be imposed.

Source: GAO analysis of CMS and Oregon Department of Human Services data | GAO-19-313R

¹⁴An Oregon survey agency official said the accelerated transition has resulted in a significant increase in staff workload, which will affect, among other things, the survey agency's ability to meet CMS timeliness standards for conducting standard nursing home surveys. Oregon officials told us they are hiring new staff to increase their capacity and expect to have staff hired, trained, and working independently to survey by early 2020. Oregon's long-term plan estimates that Oregon will be within CMS approved survey intervals by October 2020.

¹⁵[GAO-14-704G](#).

This incomplete information may make it more difficult for CMS to recognize when nursing homes in Oregon are not meeting program standards.¹⁶ In addition, because nursing home abuse complaints and facility-reported incidents were primarily investigated by APS for more than fifteen years, nursing homes in Oregon were subject only to state-imposed financial penalties for those complaints and facility-reported incidents, which were not investigated or enforced under federal nursing home regulations. Federal penalties, which can escalate for repeated violations, may only be imposed in response to a federal survey.

Finally, consumers looking for information on Oregon nursing homes using CMS's Nursing Home Compare, the CMS website used by consumers for information about nursing home quality, have not received a complete picture of nursing home quality, particularly related to issues of abuse. Specifically, information on abuse complaints and facility-reported incidents in Oregon investigated by APS instead of the survey agency has not been included on CMS's Nursing Home Compare, and CMS officials told us they have not incorporated APS information on nursing home abuse in Oregon from previous investigations into its monitoring and oversight efforts.¹⁷ While this information may be difficult for CMS and the survey agency to incorporate directly into Nursing Home Compare because the assessments were done by APS investigators using state standards, the information from APS investigations is still valuable.

Example of abuse information not available to consumers on Nursing Home Compare about Oregon nursing homes. Our analysis found instances of sexual and physical abuse substantiated by Adult Protective Services (APS) in Oregon that were not on the Centers for Medicare & Medicaid Services' (CMS) Nursing Home Compare website. In 2015, for example, Oregon APS investigated and substantiated an allegation of sexual abuse by a staff member, noting that the facility failed to protect the resident from sexual abuse and did not immediately report the suspected sexual abuse to law enforcement. GAO found no record of this incident on CMS's Nursing Home Compare website at the time of our review.

Source: GAO analysis of CMS and Oregon Department of Human Services data | GAO-19-313R

Further, CMS's Nursing Home Compare website did not note the lack of information from Oregon on all nursing home complaints and facility-reported incidents of abuse made through October 29, 2018. Without a complete picture of Oregon nursing home compliance, CMS and consumers have incomplete information on the actual quality of nursing homes in Oregon based on federal standards. These gaps in information are inconsistent with federal internal control standards directing management to use quality information to achieve program objectives—in this instance, internally for CMS and with regard to its stated objective for the Nursing Home Compare website to provide detailed information to consumers.¹⁸ CMS officials said they could

¹⁶Oregon survey agency officials told us that prior to October 29, 2018, state surveyors would review APS reports prior to a survey at a nursing home to identify patterns of abuse.

¹⁷Nursing Home Compare is a CMS website that allows consumers to find and compare nursing homes and that, according to CMS, provides "detailed information about every Medicare and Medicaid certified nursing home in the country." The Five Star Rating program, part of CMS's Nursing Home Compare, allows nursing home consumers, their families, and caregivers the ability to compare nursing homes more easily and to help identify areas about which they may want to ask questions. <https://www.medicare.gov/nursinghomecompare/search.html>? Accessed Nov. 7, 2018. Oregon's Facilities Search: <https://ltclicensing.oregon.gov/Facilities> Accessed Aug. 14, 2018.

¹⁸GAO-14-704G.

not use APS complaint investigation information because APS investigators do not have the authority to survey for noncompliance with CMS's federal nursing home requirements.

Conclusions

Investigations of complaints and facility-reported incidents of abuse in nursing homes provide a critical opportunity for CMS to quickly identify and correct abuse to safeguard residents. Without information from these investigations, the period of time in which residents potentially could be harmed may be prolonged and necessary corrective actions may be delayed. For many years, CMS's oversight failed to address the fact that the Oregon survey agency was not performing all of these investigations as required by federal law. Instead, abuse allegations from complaints and facility-reported incidents related to allegations of sexual, physical, mental/verbal and some other types of abuse were investigated by the state's APS program and not by the state survey agency, potentially resulting in CMS missing patterns of abuse, a lack of federal penalties for abuse-related deficiencies, and incomplete information on nursing home quality indicators on the CMS Nursing Home Compare website.

CMS and Oregon worked together to have the survey agency assume responsibility in October 2018 for investigating all complaints and facility-reported incidents, and CMS officials told us they are working to confirm Oregon's compliance with CMS policies. However, CMS has not performed oversight focusing on whether other state survey agencies are responsible for all nursing home complaints and facility-reported incidents to ensure that there are no other states with similar compliance concerns. Additionally, CMS officials told us they have not incorporated APS information on nursing home abuse in Oregon from previous investigations into its monitoring and oversight efforts. Without this information, CMS will continue to have incomplete information on nursing homes' histories of abuse in Oregon. This incomplete information significantly understates occurrences of abuse in Oregon nursing homes in CMS data, limits CMS's ability to take appropriate oversight action in situations where a pattern of abuse may exist, and makes it harder for consumers to make informed decisions about nursing homes.

Recommendations for Executive Action

We are making the following three recommendations to the administrator of CMS:

CMS should evaluate state survey agency processes in all states to ensure all state survey agencies are meeting federal requirements that state survey agencies are responsible for investigating complaints and facility-reported incidents alleging abuse in nursing homes, and that the results of those investigations are being shared with CMS. (Recommendation 1)

CMS should identify options for capturing information from Oregon's APS investigations of complaints and facility-reported incidents of abuse and incorporate this information into oversight of Oregon nursing homes. (Recommendation 2)

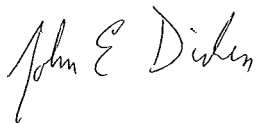
CMS should clearly communicate to consumers the lack of data on abuse complaints and facility-reported incidents in Oregon nursing homes contained in the CMS Nursing Home Compare website. (Recommendation 3)

Agency Comments

We provided a draft of this report to HHS and the Oregon Department of Human Services for review and comment. In its comments, reproduced in Enclosure I, HHS concurred with our three recommendations. HHS indicated that it will take action to confirm states are using appropriate personnel to investigate nursing home complaints and facility-reported incidents. HHS also indicated it has directed Oregon survey agency officials to develop a plan for identifying APS cases, if any, requiring additional investigation. Finally, HHS told us that until relevant data regarding cases requiring additional investigation are captured and reflected on the Nursing Home Compare website, HHS will post a notice on the Nursing Home Compare website directing consumers to Oregon's APS website for details on previous complaints and facility-reported incidents. The Oregon Department of Human Services also provided written comments, reproduced in Enclosure II, which described its prior practice in investigating allegations of abuse in nursing homes and noted understanding the need to shift responsibility to conduct investigations to the state survey agency as of October 2018. Oregon's comments also noted that the state Department of Human Services is coordinating with CMS to explore providing a link on the Nursing Home Compare website to state data. In addition, HHS and the Oregon Department of Human Services provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional offices and other interested parties. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report were Karin Wallestad (Assistant Director), Luke Baron (Analyst-in-Charge), and Sarah-Lynn McGrath. Also contributing were Kathryn Richter, Summar Corley, Jennifer Whitworth, and Laurie Pachter.



John E. Dicken
Director, Health Care

Enclosure I: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

MAR 29 2019

John Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Management Report: CMS Needs to Address Gaps in Federal Oversight of Nursing Home Abuse Investigations that Persisted in Oregon for At Least 15 Years*" (GAO-19-313R).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in blue ink that reads "M. D. Bassett for".

Matthew D. Bassett
Assistant Secretary for Legislation

Attachment

Enclosure I: Comments from the Department of Health and Human Services

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MANAGEMENT REPORT: CMS NEEDS TO ADDRESS GAPS IN FEDERAL OVERSIGHT OF NURSING HOME ABUSE INVESTIGATIONS THAT PERSISTED IN OREGON FOR AT LEAST 15 YEARS (GAO-19-313R)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office (GAO) draft report on the federal oversight of nursing homes. Resident safety in nursing homes and in all facilities that participate in the Medicare and Medicaid programs is a top priority for HHS.

Every nursing home serving Medicare and Medicaid beneficiaries is required to keep its residents safe and free from neglect and abuse. Monitoring patient safety and quality of care in nursing homes and other long-term care facilities serving Medicare and Medicaid beneficiaries is an essential part of HHS's oversight efforts and requires coordination between the federal government and the states. HHS has agreements with state survey agencies to survey participating providers and suppliers and certify whether each entity complies with federal participation requirements. For nursing homes, the state survey agencies not only inspect providers for compliance with Medicare and Medicaid health and safety standards, but also manage the intake of complaints and facility-reported incidents and conduct investigations accordingly.

When Oregon's state survey agency works on behalf of HHS, they are required to follow federal regulations and guidelines for the intake and investigation of complaints in all nursing homes serving Medicare and Medicaid beneficiaries in their state. Oregon's past practices for the intake and investigation of complaints are unacceptable for meeting federal survey requirements. While Oregon's Adult Protective Services may support Oregon's state survey agency work in protecting nursing home residents from abuse under state authorities, Adult Protective Services' work does not suffice for complying with federal requirements. When current Centers for Medicare & Medicaid Services (CMS) Regional Office officials became aware that Oregon's state survey agency was using Adult Protective Services to investigate certain complaints of nursing homes and not following federal guidelines for the intake and investigation of these complaints, they took immediate action to address the issue. HHS officials worked closely with Oregon state agency officials to bring the state's investigation practices back into full compliance with federal guidelines.

Abuse and mistreatment of nursing home residents is never tolerated by HHS, and the agency takes any allegation of these types of incidents very seriously. HHS requires nursing homes to report allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, promptly to their state survey agency. State survey agencies can conduct complaint surveys at any time, and anyone can file a complaint, including residents, family members, nursing home staff, and anyone else who has reason to suspect abuse or neglect is taking place. HHS's Nursing Home Compare website includes links and other helpful information to help patients and families determine when and how to file a complaint. Nursing homes are required to post similar information on how to file complaints and grievances in their facilities and with independent state entities.

HHS has taken many actions to improve the quality and timeliness of state agency reporting. HHS conducts validation surveys of states to determine whether states are identifying

Enclosure I: Comments from the Department of Health and Human Services

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MANAGEMENT REPORT: CMS NEEDS TO ADDRESS GAPS IN FEDERAL OVERSIGHT OF NURSING HOME ABUSE INVESTIGATIONS THAT PERSISTED IN OREGON FOR AT LEAST 15 YEARS (GAO-19-313R)

deficiencies correctly, investigating compliance effectively, and meeting all other obligations. The CMS Regional Offices conduct formal assessments annually of each state survey agency's performance relative to measures included in the State Performance Standards System (SPSS). The SPSS provides a framework to organize and measure important aspects of state survey activities and is comprised of three domains: frequency, survey quality, and enforcement. These three areas also support HHS's efforts to standardize and promote consistency among state survey agencies.

HHS recently revised the process for federal oversight surveys conducted of state survey teams to add areas of concern that federal surveyors will examine to determine whether state surveyors are investigating for compliance effectively. In fiscal year 2018, HHS worked with states on three areas of concern: abuse and neglect, admission/transfer/discharge, and dementia care. In 2019, each Regional Office will again focus on identifying concerns related to abuse and neglect. They will also focus on facility staffing and other areas of improvement that are unique to the states in its region. HHS also recently launched an initiative to evaluate the entire SPSS program to identify ways to improve state performance. This is an ongoing, large-scale effort aimed at improving the efficiency and effectiveness of measuring and improving state performance.

HHS remains diligent in our duties to monitor nursing homes participating in Medicare and Medicaid across the country, as well as the state agencies that survey them, and we appreciate the ongoing work of the GAO in this area and will continue to work with them as we make improvements to our oversight efforts.

GAO's recommendations and HHS' responses are below.

Recommendation 1

CMS should evaluate state survey agency processes in all states to ensure that all state survey agencies are meeting federal requirements that state survey agencies are responsible for investigating complaints and facility-reported incidents alleging abuse in nursing homes, and that the results of those investigations are being shared with CMS.

HHS Response

HHS concurs with GAO's recommendation. CMS Regional Offices will review state policies and procedures to confirm that they are using appropriate personnel to investigate nursing home complaints and facility-reported incidents in accordance with the federal guidelines provided in the State Operations Manual and sharing the results of those investigations with HHS. HHS officials in some regions have already met with states to evaluate their state survey agency processes for investigating complaints and confirmed these policies and procedures as presented by the states align with federal requirements.

Recommendation 2

Enclosure I: Comments from the Department of Health and Human Services

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MANAGEMENT REPORT: CMS NEEDS TO ADDRESS GAPS IN FEDERAL OVERSIGHT OF NURSING HOME ABUSE INVESTIGATIONS THAT PERSISTED IN OREGON FOR AT LEAST 15 YEARS (GAO-19-313R)

CMS should identify options for capturing information from Oregon's Adult Protective Services investigations of complaints and facility-reported incidents of abuse and incorporate this information into oversight of Oregon nursing homes.

HHS Response

HHS concurs with GAO's recommendation. HHS's priority is ensuring that current complaints and facility-reported incidents are properly triaged and investigated. While Oregon has indicated that Adult Protective Services reports were reviewed by state agency surveyors to identify patterns of abuse, CMS Regional Office officials have directed officials at Oregon's state survey agency to develop a plan for identifying if cases referred to Adult Protective Services require additional investigation to assess compliance with the Requirement for Participation for Long Term Care Facilities (42 CFR 483 Subpart B), and if so, conduct surveys to ensure compliance is achieved and resident health and safety is protected.

Recommendation 3

CMS should clearly communicate to consumers the lack of data on abuse complaints and facility-reported incidents in Oregon nursing homes contained in Nursing Home Compare.

HHS Response

HHS concurs with GAO's recommendation. CMS Regional Office officials have directed officials at Oregon's state survey agency to develop a plan for identifying if cases referred to Adult Protective Services require additional investigation to assess compliance with the Requirement for Participation for Long Term Care Facilities (42 CFR 483 Subpart B), and if so, conduct surveys to ensure compliance is achieved and resident health and safety is protected. These actions will ensure that relevant data will be reflected on Nursing Home Compare. In addition, until relevant data is captured, HHS will post a notice on the Nursing Home Compare website directing consumers to Oregon's Adult Protective Services website to obtain details on previous complaints and facility reported incidents.

Enclosure II: Comments from the Oregon Department of Human Services



Oregon

Kate Brown, Governor

Department of Human Services

Aging and People with Disabilities

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March 20, 2019

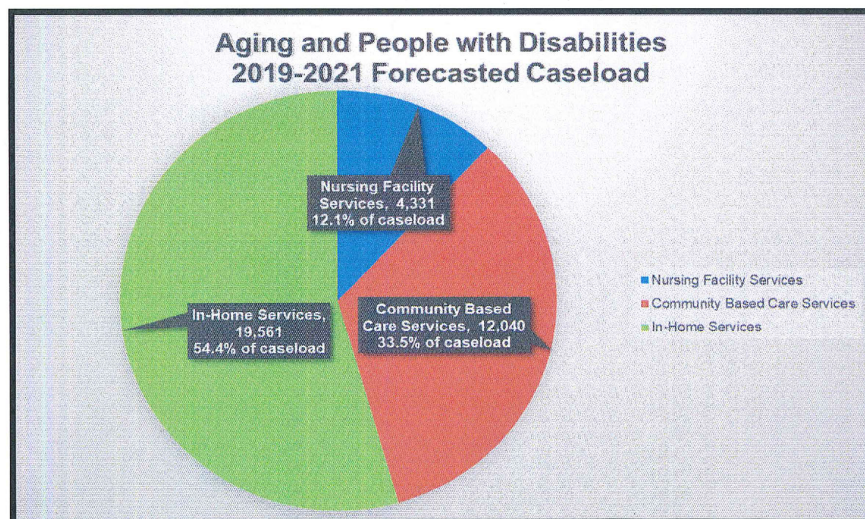
Mr. John E. Dicken
Director, Health Care
U.S. Government Accountability Office



Dear Mr. Dicken,

The State of Oregon appreciates the opportunity to comment on the Government Accountability Office (GAO) report entitled, *Management Report: CMS Needs to Address Gaps in Federal Oversight of Nursing Home Abuse Investigations that Persisted in Oregon for At Least 15 Years (GAO-19-313R)*.

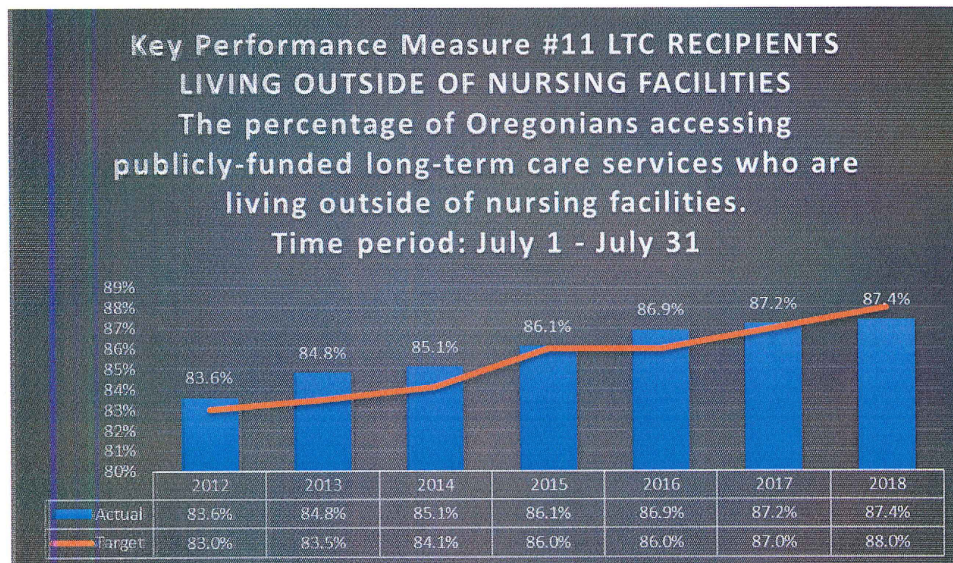
As a matter of background, the State of Oregon is committed to offering consumers a variety of choices of long-term care settings and has long been a leader in innovating around options for nursing home level of care in the community. Oregon has approximately 44,500 licensed beds, including those in community-based settings (assisted living, residential care facilities, memory care communities and adult foster homes), as well as nursing facilities. Oregonians living in community-based settings have as high a level of acuity, or care needs, and sometimes greater needs, than those living in nursing facilities.



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Enclosure II: Comments from the Oregon Department of Human Services

Approximately 7,000 residents (about 4,300 Medicaid consumers) choose to reside in Oregon’s nursing facilities, and we are committed to protecting their safety as well as the safety of the vast majority living in all other setting types unregulated by CMS. In 2017, Oregon’s legislature passed a law which among other things, created stronger penalties for abuse, new dementia training requirements, and a first-in-the-nation quality measurement council for community-based care.



Additionally, Oregon has a public-facing website (<https://ltclicensing.oregon.gov/>) that offers detailed information about nursing facility surveys, including CMS 2567 survey reports; abuse investigations and the ability to request copies of finalized APS reports; civil penalties assessed, and information related to conditions placed on a license due to non-compliance. (The site also lists this information for community-based care facilities.)

Oregon was one of five states selected for GAO’s work reviewing CMS oversight of nursing home abuse. GAO officials contacted our Safety, Oversight and Quality Unit, which licenses and regulates nursing homes as well as community-based care facility options. GAO staff also did site visits in Oregon throughout the course of 2018. During the interview process with Safety, Oversight and Quality Unit staff, GAO was made aware of Oregon’s long-standing practice of having certain allegations of abuse be investigated by local Adult Protective Services (APS) investigators and other allegations by the Nursing Facility Survey Unit (NFSU), within the Safety, Oversight and Quality Unit. Oregon’s state law requires an even faster response than the federal law, and trained APS workers were responding to abuse based on the state timelines.

Enclosure II: Comments from the Oregon Department of Human Services

CMS had been aware of Oregon's practice for abuse investigations in nursing facilities for many years. In fact, our CMS approved Medicaid State Plan, originally approved in 1992 with most recent updates made in 2018, (Transmittal #92-16; Attachment 4.40-B) indicates:

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. State law and policy/procedure specify nursing facility abuse complaints must be investigated within two hours of receipt. This function is carried out by specially trained local staff in conjunction with a Registered Nurse at the State level. Investigation reports are reviewed at the State level and sanctions are levied as indicated.

GAO also learned through discussions with the Safety, Oversight and Quality Unit team that Oregon had already been working with CMS to develop plans to transition all abuse investigations to the NFSU and away from APS over a certain amount of time, because CMS no longer thought our practice was acceptable. The NFSU short-term transition plan was accepted by CMS on March 3, 2018; however, in early October 2018, CMS informed us that as of the end of October 2018, we had to immediately transition all nursing facility complaint work to the NFSU and away from the field-based APS workers. Although we had confidence that nursing home residents were safe and protected under our prior system, we understood CMS's directive and immediately worked toward complying with it as quickly as possible. As of October 29, 2018, the NFSU has performed all aspects of intake, triage and investigation of all nursing facility complaints per CMS direction.

- In December 2018, Oregon's DHS Aging and People with Disabilities Director requested 12 nursing facility surveyor positions from the legislature in order to accomplish the transition of work. The legislature approved the request, and CMS has indicated full support in paying the federal match for these positions.
- On February 21, 2019, we received confirmation from CMS that our long-term plan, which outlines our capacity-building efforts and timeline, had been officially accepted. We subsequently shared that approval and plan with GAO.

Although complaints investigated by APS were not subject to CMS oversight or penalties, substantiated complaints were subject to state civil penalties, sanctions, placement on the State's nurse aide registry for any nurse aide who had engaged in abuse or neglect of residents, and other corrective action.

Enclosure II: Comments from the Oregon Department of Human Services

Finally, the state's <https://ltclicensing.oregon.gov> website includes survey and Adult Protective Services investigations back to 2010, five additional years of detailed information that is *not* currently available on the Nursing Home Compare website. In addition, we are in the process of consulting with CMS to explore the possibility of Nursing Home Compare providing a link to our website, which we hope will provide increased transparency and easily-accessible information to the public.

We appreciate the opportunity to respond to this report and we look forward to continuing our work with CMS to ensure the safety and wellbeing of Oregonians receiving long term services and supports.

Sincerely,



Ashley Carson Cottingham, Director
Aging and People with Disabilities
Department of Human Services
State of Oregon

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