



Testimony

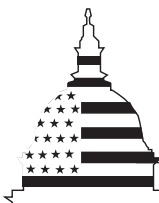
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NURSING HOMES

Many Shortcomings Exist in Efforts to Protect Residents from Abuse

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GAO

Accountability * Integrity * Reliability

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the issue of abuse in nursing homes. The 1.5 million elderly and disabled individuals residing in U.S. nursing homes constitute a population that is highly vulnerable because of their physical and cognitive impairments. Residents typically require extensive assistance in the basic activities of daily living, such as dressing, feeding, and bathing, and many require skilled nursing or rehabilitative care. Residents with dementia may be irrational and combative. This combination of impairments heightens the residents' vulnerability to abuse and impedes efforts to substantiate allegations and build cases for prosecution.

Our work for this committee on nursing home care quality has found that oversight by federal and state authorities has increased in recent years.¹ During these years, however, the number of homes cited for deficiencies involving actual harm to residents or placing them at risk of death or serious injury remained unacceptably high—30 percent of the nation's 17,000 nursing homes. Concerns exist that too many nursing home residents are subjected to abuse—such as pushing, slapping, beating, and sexual assault—by the individuals entrusted with their care. You therefore asked us to examine efforts by nursing home oversight authorities to protect residents against physical and sexual abuse. My remarks today will focus on (1) inherent difficulties in measuring the extent of the abuse problem, (2) gaps in efforts to prevent and deter resident abuse, and (3) the limited role of law enforcement in abuse investigations. My comments reflect the findings of a report we are issuing today. The report is based on our visits to three states with relatively large nursing home populations and discussions with officials at the Centers for Medicare and Medicaid Services (CMS)—the federal agency charged with oversight of states' compliance with federal nursing home standards.²

In brief, the ambiguous and hidden nature of abuse in nursing homes makes the prevalence of this offense difficult to determine. CMS defines abuse in its nursing home regulations and the states we visited maintain definition consistent with the CMS definition. However, the states vary in

¹U.S. General Accounting Office, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, GAO/HEHS-00-197 (Washington, D.C.: 2000).

²U.S. General Accounting Office, *Nursing Homes: More Can Be Done to Protect Residents from Abuse*, GAO-02-312 (Washington, D.C.: 2002).

their interpretation and application of the definitions. For example, nurse aides in two of the states we visited who struck residents were not considered abusive by state survey agency officials under certain circumstances, whereas the third state's nurse aides under similar circumstances were consistently cited for this offense. Incidents of abuse often remain hidden, moreover, because victims, witnesses, and others, including family members, are unable to file complaints or are reluctant for several reasons, including fear of reprisal. When complaints and incidents are reported, they are often not reported immediately, thus harming efforts to investigate cases and obtain necessary evidence.

Despite certain measures in place at various levels to prevent or deter resident abuse, certain gaps undermine these protections. For instance, states use a registry to keep records on nurse aides within the state, but these state registries do not include information about offenses committed by nurse aides in other states. Unlicensed or uncertified personnel, such as laundry aides and maintenance workers, are not listed with a registry or with a licensing or certification body, allowing those with a history of abuse to be employed without detection, unless they have an established criminal record. In addition, in the states we visited, nursing homes often did not notify state authorities immediately of abuse allegations. Moreover, states' efforts to inform consumers about available protections appeared limited, as the government agency pages in telephone books of several major cities we visited lacked explicitly designated phone numbers for filing nursing home complaints with the state.

Local and state enforcement authorities have played a limited role in addressing incidents of abuse. Several local police departments we interviewed had little knowledge of the state survey agencies' investigation activities at nursing homes in their communities. Some noted that, by the time the police are called, others may have begun investigations, hampering police efforts to collect evidence. Even the involvement of Medicaid Fraud Control Units (MFCU)—the state law enforcement agencies with explicit responsibility for investigating allegations of patient neglect and abuse in nursing homes—is not automatic. MFCUs get involved in resident abuse cases through referrals from state survey agencies. However, as demonstrated in the states we visited, the extent to which a state's MFCU investigates cases varies according to the referral policies at each state's survey agency. Our review of alleged abuse cases suggests that the early involvement of the state MFCU can be productive in obtaining criminal convictions.

In its federal oversight role, CMS could do more to ensure that nursing home residents are protected from abuse. Requirements for screening and hiring prospective employees, involving local law enforcement promptly when incidents of abuse are alleged, and ensuring the public's access to designated telephone numbers are among the protections that CMS could strengthen. Our report makes recommendations addressing these requirements.

Background

To help ensure that nursing homes provide proper care to their residents, a combination of federal, state, and local oversight agencies and requirements is in place. At the heart of nursing home oversight activities are state survey agencies, which, under contract with the federal government, perform detailed inspections of nursing homes participating in the Medicare and Medicaid programs. The purpose of the inspections is to ensure that nursing homes comply with Medicare and Medicaid standards. CMS, in the Department of Health and Human Services (HHS), is the federal agency with which the states contract and is responsible for oversight of states' facility inspections and other nursing-home-related activities.³ By law, CMS sets the standards for nursing homes' participation in Medicare and Medicaid.

State survey agencies also investigate complaints of inadequate care, including allegations of physical or sexual abuse. Once aware of an abuse allegation, nursing homes are required by CMS to notify the state survey agency immediately. They must also conduct their own investigations and submit their findings in written reports to the state survey agency, which determines whether to investigate further.

Certain federal and state requirements focus on the screening of prospective nursing home employees. CMS requires nursing homes to establish policies prohibiting employment of individuals convicted of abusing nursing home residents. Although this requirement does not include offenses committed outside the nursing home, the three states we visited—Georgia, Illinois, and Pennsylvania—do not limit offenses to those committed in the nursing home setting and have broadened the list of disqualifying offenses to include kidnapping, murder, assault, battery, or forgery.

³CMS was formerly the Health Care Financing Administration (HCFA) and was renamed in June 2001.

As another protective measure, federal law requires states to maintain a registry of nurse aides—specifically, all individuals who have satisfactorily completed an approved nurse aide training and competency evaluation program.⁴ This requirement is consistent with the fact that nurse aides are the primary caregivers in these facilities. Before employing an aide, nursing homes are required to check the registry to verify that the aide has passed a competency evaluation.⁵ Aides whose names are not included in 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' nursing home regulations require states to add to the registry any findings of abuse, neglect, or theft of a resident's property that have been established against an individual. The inclusion of such a finding on a nurse aide's record constitutes a lifetime ban on nursing home employment, as CMS regulations prohibit homes from hiring individuals with these offenses. As a matter of due process, nurse aides have a right to request a hearing to rebut the allegations against them, be represented by an attorney, and appeal an unfavorable outcome. Other nursing home professionals who are suspected of abuse and who are licensed by the state, such as registered nurses, are referred to their respective state licensing boards for review and possible disciplinary action.

Among the local and state law enforcement agencies that may investigate nursing home abuse cases are the MFCUs. MFCUs are state agencies charged with conducting criminal investigations related to Medicare and Medicaid. Generally, MFCUs are located in the state attorney general's office, although they can be located in another state agency, such as the state police. Part of their mission is to investigate patient abuse in nursing homes. MFCUs typically receive abuse cases from referrals by state survey agencies. If criminal charges are brought, prosecuting attorneys within the MFCU or attorneys representing the locality take charge of the case.

⁴In certain instances, some individuals would be exempt from this training, such as student nurses or nurses trained in another country.

⁵Nursing 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 the survey agency's website or by calling the survey agency.

Ambiguous and Hidden Nature of Nursing Home Abuse Makes Extent of Problem Difficult to Measure

The problem of nursing home abuse is difficult to quantify and is likely understated for several reasons. First, states differ in what they consider abuse, with the result that some states do not count incidents that CMS or other states would count as abuse. Second, powerful incentives exist for victims, their families, and witnesses to keep silent or delay the reporting of abuse allegations. Third, some research focuses on citations of nursing homes for abuse-related violations, which are maintained in a CMS database, but these data reflect only the extent to which facilities fail to comply with federal or state regulations. Abuse incidents that nursing homes handle properly are not counted, because no violation has been committed that warrants a citation.

States Do Not Share Common View of Resident Abuse

Some states may not be citing nurse aides for incidents that other states would consider abuse. Based on the definition of abuse in the Older Americans Act of 1965,⁶ CMS defines abuse as “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.”⁷ States maintain their own definitions that are consistent with the CMS definition. Our review of case files showed that states interpret and apply these definitions differently.

For example, on the basis of the abuse cases reviewed, we noted that Georgia survey agency officials were less likely to determine that an aide had been abusive if the aide’s behavior appeared to be spontaneous or the result of a “reflex” response. The Georgia officials told us that, to cite an aide for abuse, they must find that the individual’s actions were intentional. They 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. Among the Georgia case files we reviewed, we found 5 cases in which the aides struck back after residents hit them or otherwise made physical contact. In all five cases, Georgia officials had determined that the aides’ behavior was not abusive because the residents were combative and the aides did not intend to hurt the residents.

In Pennsylvania, officials emphasized other factors to determine a finding of abuse. They said that establishing intention was important, but they

⁶42 U.S.C. § 2002 (1994).

⁷42 C.F.R. § 488.301 (2001).

would be unlikely to cite an aide for 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. In several cases reviewed in which residents were bumped or slapped and reported being in pain as the result of aides' actions, the survey agency officials decided not to take action against the aides because, in their view, the residents had no apparent physical injuries.

In contrast, the Illinois survey agency considers any nonaccidental injury to be abuse. Thus, incidents not considered abusive in Georgia and Pennsylvania—reflex actions and incidents not involving serious injury or obvious pain—could be considered abusive in Illinois. In the 17 Illinois case files we reviewed involving either combative residents or residents who did not suffer serious injury, officials found that aides had been abusive. When Illinois handled a case similar to a Georgia case in which a nursing home employee witnessed a nurse aide strike a combative resident, the state not only included this information in the individual's nurse aide registry file, it also referred the matter to the state's MFCU, resulting in a criminal conviction.⁸

CMS officials indicated that states may use different definitions of abuse, as long as the definitions are at least as inclusive as the CMS definition. The officials agreed that intent is a key factor in assessing whether an aide abused a resident but argued that intent can be formed in an instant. In their view, an aide who slaps a resident, regardless of whether it was a reflexive response, should be considered abusive. In light of these different perspectives, we have recommended that CMS clarify the definition of abuse to ensure that states cite abuse consistently and appropriately.

People May Be Unable or Reluctant to Report Abuse Allegations

The physical and mental impairments typical of the nursing home population handicap residents' ability to respond to abuse. Some residents lack the ability to communicate or even realize that they have been abused, while others are reluctant to report abuse because they fear reprisal. For these reasons, elder abuse in nursing homes is likely

⁸As a result, the 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 people with disabilities.

underreported or often not reported immediately. In some cases, residents are unable to complain about what was done to them. In other cases, family members may hesitate to report their suspicions because they fear retribution or that, if reported, the resident will be asked to leave the home. In still other cases, facility staff fear losing their jobs or recrimination from coworkers, while facility management may not want to risk adverse publicity or sanctions from the state. In our file reviews, we saw evidence that family members, staff, and management did not immediately report allegations of abuse. (See figure.)

Figure: Examples of Allegations Not Immediately Reported

- A resident reported to a licensed practical nurse that she had been raped. Although the nurse recorded this information in the resident's chart, she did not notify the facility's management. The nurse also allegedly discouraged the resident from telling anyone else. About 2 months later, the resident was admitted to the hospital for unrelated reasons and told hospital officials she had been raped. Once hospital officials notified the police, an investigation was conducted and revealed that the resident had also informed her daughter of the incident, but the daughter dismissed it. The resident later told police that she did not report the incident to other staff 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 aide who threw the water on the resident was fired and was cited for resident abuse in the state's nurse aide registry.
- Nursing home management failed to promptly notify the state survey agency of an incident in which an aide slapped a resident and visibly bruised the victim's face. Although the home investigated the situation and took appropriate action by quickly suspending and ultimately firing the aide, it did not notify the state survey agency until 11 days after the abuse took place.

Source: Case files from state survey agencies in Georgia and Pennsylvania.

Data on States' Nursing Home Citations Provide Little Information About Resident Abuse

Data from states' annual inspections of nursing homes, while a source of information about facility compliance with nursing home standards, provide little precision about the extent of care problems, of which resident abuse-related problems are a subset. Abuse-related violations committed by nursing homes include failure to protect residents from sexual, physical, or verbal abuse; failure to properly investigate allegations of resident abuse or to ensure that nursing home staff have been properly screened before employment; and failure to develop and implement written policies prohibiting abuse.

In 2000, we reported on the wide variation across states in surveyors' identification and classification of serious deficiencies—conditions under which residents were harmed or were in immediate jeopardy of harm or

death.⁹ The extent to which abuse-related violations are counted as serious deficiencies depends on how the surveyor classifies the severity of the deficiency identified. In our analysis, the problem of “interrater reliability”—that is, individual differences among surveyors in citing homes for serious deficiencies—was one of several factors contributing to the difference of roughly 48 percentage points across states in the proportion of homes cited in 1999 and 2000 for serious deficiencies. The variation ranged from about 1 in 10 homes cited in one state to more than 1 in 2 homes cited in another.

We also found that one state’s tally of nursing homes with serious deficiencies would have been highly misleading as an indicator of serious care problems. Of the homes the state surveyed during the 1999-2000 period, it found 84 to be “deficiency free.” However, when we cross-checked the annual inspection results for these homes with the homes’ history of complaint allegations, we found that these deficiency-free homes had received 605 complaints and that significant numbers of these complaints were substantiated when investigated. This discrepancy illustrates the difficulty of estimating the extent of resident abuse using nursing home inspection data.

Gaps Exist in Efforts to Prevent or Deter Resident Abuse

Nursing home residents’ inability to protect themselves accentuates the need for strong preventive measures to be in place in both nursing homes and the agencies overseeing them. Although certain measures are in place, we found them to be, in some cases, incomplete or insufficient. In the states we visited, efforts to screen employees and achieve prompt reporting fell short of creating a net sufficiently tight to protect residents from potential offenders.

Sources Used to Screen Prospective Employees Do Not Contain Complete or Up-to-Date Information

Nursing homes have available three main tools to screen prospective employees: criminal background checks conducted by local law enforcement agencies, criminal background checks conducted by the Federal Bureau of Investigation (FBI), and state registries listing information on nursing home aides, including any findings of abuse committed in the state’s facilities. The information included in these sources, however, is often not complete or up to date.

⁹[GAO/HEHS-00-197](#).

State and local law enforcement officials in the three states we visited conduct background checks on prospective nursing home employees, but these checks are made only state wide. Consequently, individuals who have committed disqualifying crimes—including kidnapping, murder, assault, battery, and forgery—may be able to pass muster for employment by crossing state lines. On request, the FBI will conduct background checks outside the prospective employee’s state of residence, but in some states these requests are rarely made, according to an FBI official.

Some states allow individuals to begin working before facilities complete their background checks. Pennsylvania permits new employees to work for 30 days and Illinois, for 3 months, before criminal background checks are completed. In contrast, Georgia requires that background checks be completed within 3 days of the request and interprets this requirement to mean that the checks must be completed before prospective employees may assume their duties.

Of the three states we visited, only Illinois requires that the results of criminal background checks on prospective nurse aides be reported to the state survey agency, which enters the information in the registry. A 1998 survey conducted by HHS’ Office of Inspector General reported that Illinois was the only state with this requirement.¹⁰ Nursing homes in Illinois checking the state registry are able to determine if an aide has a disqualifying conviction well before an offer of employment is made and a criminal background check is initiated. Alternatively, the survey agencies in states without this requirement do not have the information necessary to warn their respective nursing home communities about inappropriate individuals seeking employment.

Nurse aide registries, designed to maintain background information on nursing home aides, also contain information gaps that can undermine screening efforts. To cite an individual in the state’s registry for a finding of abuse, authorities must first establish a finding, notify the individual of the intent to “annotate” the registry, and if the individual requests, hold a hearing to consider whether the finding is warranted. Specifically, the individual must be notified in writing of the state’s intent to annotate the registry and be given 30 days from the date of the state’s notice to make a written request for a hearing. Because the hearing may not be completed

¹⁰HHS Office of Inspector General, *Safeguarding Long-Term Care Residents*, A-12-97-00003 (Washington, D.C.: Sept. 14, 1998).

for several months after it is requested and decisions may not be rendered immediately, additional time may elapse. As with background checks, state registries do not track an aide's offenses committed at nursing homes in other states.

Our analysis of nurse aide records from 1999 indicated that hearings to reconsider an abuse finding added, on average, 5 to 7 months to the process of annotating an individual's record in the state registry. During this time, residents of other nursing homes were at risk because, even if an aide was terminated from one home, the individual could find new employment in other homes before the state's registry included information on the individual's offense. Thus, because of the amount of time that can elapse between the date a finding is established and the date it is published, the use of nurse aide registries as a screening tool alone is inadequate.

Facilities can screen licensed personnel, such as nurses and therapists, by checking the records of licensing boards for disciplinary actions, but screening other facility employees, such as laundry aides, security guards, and maintenance workers, is limited to criminal background checks. Unless such employees are convicted of an offense, problems with their prior behavior will not be detected. No centralized source contains a record of substantiated abuse allegations involving these individuals. Even when abuse violations identified through nursing home inspections are cited, they result in sanctions against the homes and not the employees. We identified 10 uncertified and unlicensed employees in the 158 cases we reviewed who allegedly committed abuse. One of the 10 pled guilty in court, thus establishing a criminal record. However, the disposition of five of these cases left no way to track the individuals through routine screening channels. Three of the nine—all of whom were dismissed from their positions—were investigated by law enforcement but were not prosecuted. Two others were also terminated by their nursing home employers but were not the subject of criminal investigations. (In these cases, physical abuse was alleged but the residents did not sustain apparent injuries.) The remaining four cases involved instances in which the allegations proved unfounded or the evidence was inconsistent; the individuals were thus not tracked, as appropriate.

In 1998, the HHS Office of the Inspector General recommended developing a national abuse registry and expanding state registries to include not only

aides but all other nursing home employees cited for abuse offenses.¹¹ A firm that CMS (then the Health Care Financing Administration) contracted with in September 2000 is currently conducting a feasibility study regarding the development of a national registry that would centralize nurse aide registry information and include information on all nursing home employees. The contractor intends to report its findings in March 2002.

Efforts to Alert Authorities of Abuse Incidents and Allegations Lack Sufficient Rigor

Enlisting the help of the facilities and the public to report incidents and allegations of abuse can supplement other efforts to protect nursing home residents. However, in the states we visited, nursing homes' performance in notifying the survey agencies promptly was well below par. In addition, access to information on phone numbers the public could use for filing complaints was limited.

In the three states we visited, nursing homes are required to notify their state survey agencies of abuse allegations immediately, which the agencies define as the day the facility becomes aware of the incident or the next day. Using this standard, we examined 111 abuse allegations filed by the three states' nursing homes. We found that, for these allegations, the homes in Pennsylvania notified the state late 60 percent of the time; in Illinois, late almost half of the time; and in Georgia, late about 40 percent of the time. Each state had several cases for which homes notified the state a week or more late and in each state at least one home notified the state more than 2 weeks late. Such time lags delay efforts by the survey agencies to conduct their own prompt investigations and ensure that nursing homes are taking appropriate steps to protect residents. In these situations, residents remain vulnerable to additional abuse until corrective action is taken.

As a nursing home resident's family and friends are another essential resource for reporting abuse to the state authorities, increasing public awareness of the state's phone number for filing complaints should be a high priority. CMS requires nursing homes to post phone numbers for making complaints to the state. However, in major cities of the states we visited, phone numbers specifically for lodging complaints to the state survey agency were not listed in the telephone book. This was the case in

¹¹HHS Office of Inspector General, A-12-97-00003.

Chicago and Peoria, Illinois; in Athens and Augusta, Georgia; and in Philadelphia and Pittsburgh, Pennsylvania.

At the same time, the telephone books we examined listed numbers in the government agency pages for organizations that appeared to be appropriate for reporting abuse allegations but did not have authority to take action. In the telephone books of selected cities in the three states we visited, we identified listings for 42 such entities that were not affiliated with the state survey agencies. Of these, six entities said they were capable of accepting and acting on abuse allegations. These included long-term care ombudsmen and adult protective services offices. The other 36 either could not be reached or could not accept complaints, despite having listings such as the "Senior Helpline" or the "Fraud and Abuse Line." Sometimes these entities attempted to refer us to an appropriate organization to report abuse, with mixed success. For example, calls we made in Georgia resulted in four correct referrals to the state survey agency's designated complaint intake line but also led to five incorrect referrals. Five entities offered us no referrals.

Law Enforcement's Involvement in Protecting Residents Is Limited

The involvement of law enforcement in protecting nursing home residents has generally been limited. Owing to the nature of the nursing home population, developing adequate evidence to investigate and prosecute abuse cases and achieve convictions is difficult. The states we visited had different policies for referring cases to law enforcement agencies.

Residents' Impairments Weaken Law Enforcement's Efforts to Develop Cases

Critical evidence is often missing in elder abuse cases, precluding prosecution. Our review of states' case files included instances in which residents sustained black eyes, lacerations, and fractures but were unable or unwilling to describe what had happened. However, despite what appeared to be signs of abuse, investigators could neither rule out accidental injuries nor identify a perpetrator.

The cases that are prosecuted are often weakened by the time lapse between the incident and the trial. Law enforcement officials and prosecutors indicated that the amount of time that elapses between an incident and a trial can ruin an otherwise successful case, because witnesses cannot always retain essential details of the incident. For example, in one case we reviewed, a victim's roommate witnessed an incident of abuse and positively identified the abuser during the investigation. By the time of the trial nearly 5 months later, however, the

witness could no longer identify the suspect in the courtroom, prompting the judge to dismiss the charges. Law enforcement officials told us that, without testimony from either a victim or witness, conviction is unlikely. Similarly, resident victims may not survive long enough to participate in a trial. A recent study of 20 sexually abused nursing home residents revealed that 11 died within 1 year of the abuse.¹²

Local Law Enforcement Authorities in States Visited Not Frequently Involved With Nursing Home Abuse Incidents

In the states we visited, local law enforcement authorities did not have much involvement in nursing home abuse cases. Our discussions with officials from 19 local law enforcement agencies indicate that police are rarely summoned to nursing homes to investigate allegations of abuse. Of those 19 agencies, 15 indicated that they had little or no contact with their state's survey agency regarding abuse of nursing home residents in the past year. In fact, several police departments we interviewed were unaware of the role state survey agencies play in investigating instances of resident abuse. Several of the police officials we met with noted that, even when the police are called, other entities may have begun investigating, hampering further evidence collection.

Involving law enforcement authorities does not appear to be common for abuse incidents occurring in nursing homes. Facility residents and family members may report allegations directly to the facility. There is no federal requirement compelling nursing homes that receive such complaints to contact local law enforcement, although some states, including Pennsylvania, have instituted such requirements.

MFCUs Not as Involved as Their Mission Would Suggest

The involvement of MFCUs—the state law enforcement agencies whose mission is to, among other things, investigate allegations of patient neglect and abuse in nursing homes—is not automatic. MFCUs get involved in resident abuse cases through referrals from state survey agencies. Each of the states we visited had a different referral policy. In Pennsylvania, by agreement, the state's MFCU typically investigates nursing home neglect matters, while local law enforcement agencies investigate nursing home abuse. In contrast, the survey agencies in Illinois and Georgia both refer allegations of resident abuse to their states' MFCUs, but these two states' referral policies also differ from one another.

¹²Ann W. Burgess, Elizabeth B. Dowdell, and Robert A. Prentky, "Sexual Abuse of Nursing Home Residents," *Journal of Psychosocial Nursing*, Volume 38, No. 6, June 2000.

Of the cases we reviewed in Illinois, the survey agency consistently referred all reports of physical and sexual abuse to the state's MFCU, regardless of whether the source of the report was an individual or a nursing facility. The Illinois MFCU, in turn, determined whether the cases warranted opening an investigation. The Georgia survey agency, on the other hand, screened its allegations before referring cases to the state's MFCU, basing its assessment of a case's merit on the severity of the harm done and the potential for the MFCU to obtain a criminal conviction.

Our review of case files from Illinois and Georgia suggests that the more the state's MFCU is involved in resident abuse investigations, the greater the potential to convict offenders.¹³ (This case file review consisted of only those cases that were opened in 1999 and closed at the time of our review.) The Illinois MFCU obtained 18 convictions from 50 unscreened referrals. In Georgia, however, where the survey agency tried to avoid referring weak cases to the state's MFCU, 14 of 52 cases were referred and 3 resulted in convictions. The state's small number of convictions from the cases opened in 1999 was not consistent with the expectation that prescreened cases would have greater potential for successful prosecution.¹⁴

In 2000, the Georgia survey agency substantially changed its MFCU referral policy, leading to a four-fold increase in the state's total number of referrals from the previous year. The policy change followed a meeting between survey agency and MFCU officials, at which the MFCU indicated a willingness to investigate instances that the survey agency had previously assumed the MFCU would have dismissed—such as incidents involving nursing home employees slapping residents.

The timeliness of referrals made to the MFCU may also play a role in achieving favorable results. Of the 64 cases referred in the two states, we determined that the Illinois survey agency referred its cases to the MFCU earlier than did Georgia's. Illinois referred its cases, on average, within 3 days after receiving a report of abuse, whereas Georgia referred its cases, on average, 15 days after learning about an allegation.

¹³Because of Pennsylvania's referral policy, its MFCU files, with a few exceptions, did not include resident abuse cases.

¹⁴Georgia's conviction results are lower than might be expected also given the state survey agency's practice of disregarding abuse allegations in which patient provocation is a factor.

Concluding Observations

The problem of resident abuse in nursing homes is serious but of unknown magnitude, with certain limitations in the adequacy of protections in the states we visited. Nurse aide registries provide information on only one type of employee, are difficult to keep current, and do not capture offenses committed in other states. At the same time, local law enforcement authorities are seldom involved in nursing home abuse cases and therefore are not in a position to help protect this at-risk population. MFCUs, which are likely to have expertise in investigating nursing home abuse cases, must rely on the state survey agencies to refer such cases. When a state's referral policy is overly restrictive, the MFCU is precluded from capitalizing on its potential to bring offenders to justice.

Several opportunities exist for CMS to establish new safeguards and strengthen those now in place. Our report includes recommendations for CMS to, among other things, clarify what is included in CMS' definition of abuse and increase the involvement of MFCUs in examining abuse allegations. Without such improvements, vulnerable nursing home residents remain considerably ill-protected.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or the committee members may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact me or Geraldine Redican-Bigott, Assistant Director, at (312) 220-7600. Sari Bloom, Hannah Fein, and Lynn Filla-Clark made contributions to this statement.