Elder Abuse

Life Safety
Abuse and Neglect

HHS Office of Inspector General

HHS-OIG Audits

Long-term Care Life Safety

Background

- In 2016, the Centers for Medicare and Medicaid Services (CMS) updated its health care facilities' Life Safety and Emergency Preparedness regulations to improve protections for all Medicare and Medicaid beneficiaries, including those residing in long-term care (LTC) facilities

Criteria

- Life Safety
  - 42 CFR §483.90 Requirements for Long-term Care Facilities, Physical Environment.
  - Life Safety Code (NFPA 101, 2012 Edition)
  - Health Care Facilities Code (NFPA 99, 2012 Edition)
  - Form CMS-2786R (Fire Safety Survey Report)

Methodology

- Judgmental selection of facilities with reported high-risk deficiencies
  - Potential for more than minimal harm
  - Potential for actual harm
  - Immediate jeopardy to resident life and safety
- Conducted unannounced onsite inspections

What we found

- Life Safety Code Violations
  - exit doors would not open
  - means of egress impeded
  - penetrations in smoke/fire barrier
  - exit signs missing or not illuminated
  - excessive garbage
  - hazardous storage
  - cooking areas (hoods not serviced and/or extinguishing system not checked)

What we found

- Life Safety Code Violations
  - inadequate fire alarm control functions
  - insufficient fire alarm testing/maintenance
  - lack of adequate smoke and/or carbon monoxide (CO) detectors
  - sprinkler system impeded by cluttered areas around sprinkler heads
  - insufficient sprinkler system testing/maintenance

What we found

- Life Safety Code Violations
  - fire extinguishers not checked
  - smoking regulations not followed
  - oxygen cylinder storage hazards
  - deficiencies with back-up generators
  - improper storage of hazardous material
  - unsanitary conditions
  - mold and water damage

What we found

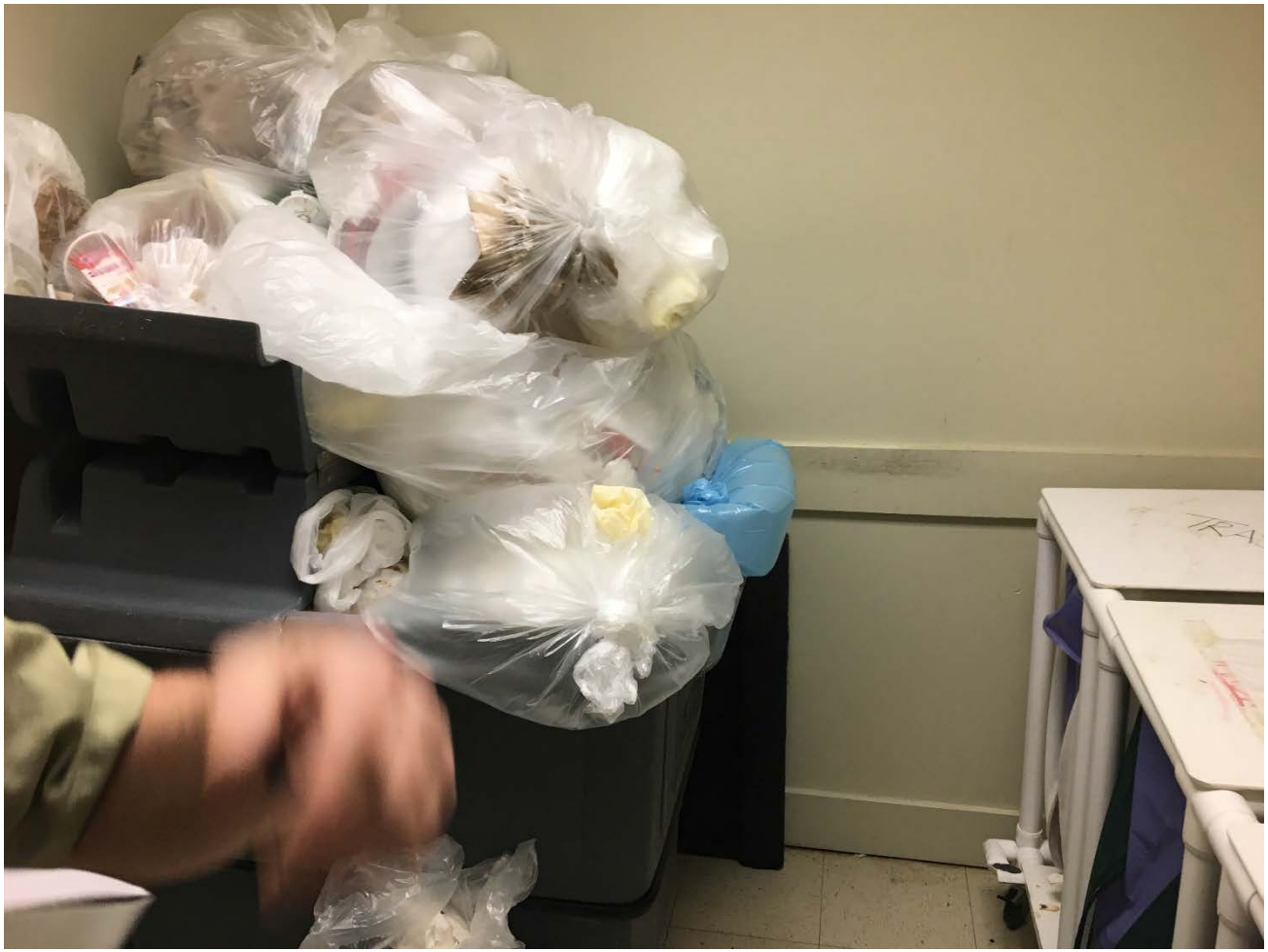
- Life Safety Code Violations
  - improper use of portable space heaters
  - rodents
  - unsecured kitchen utensil
  - unsafe bathroom fixtures
  - exposed wiring
  - unsafe outside patient space

Snow Covered Fire Access Road

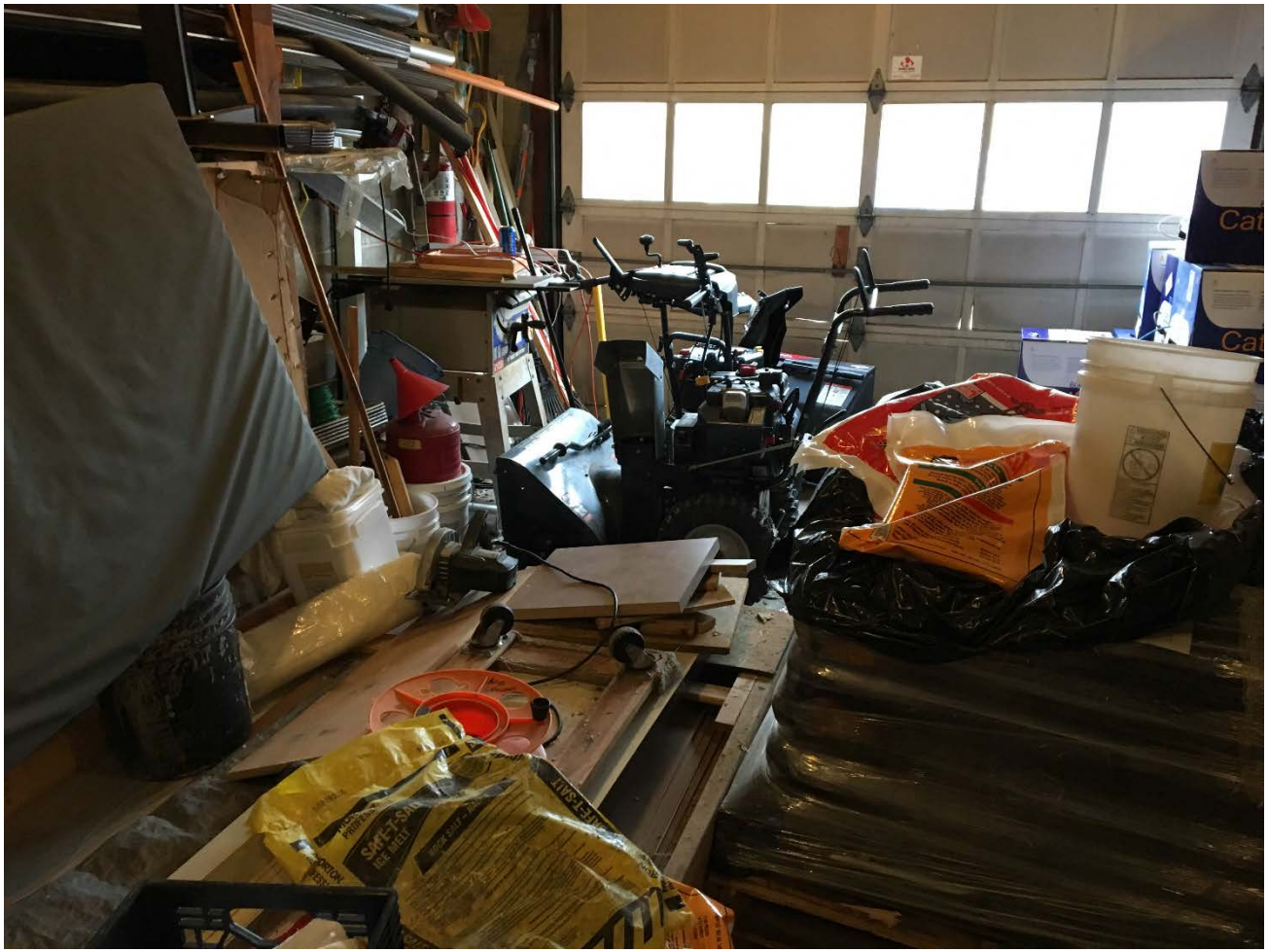
Fire Exit Door Would Not Open

Blocked Exit

Excessive Garbage



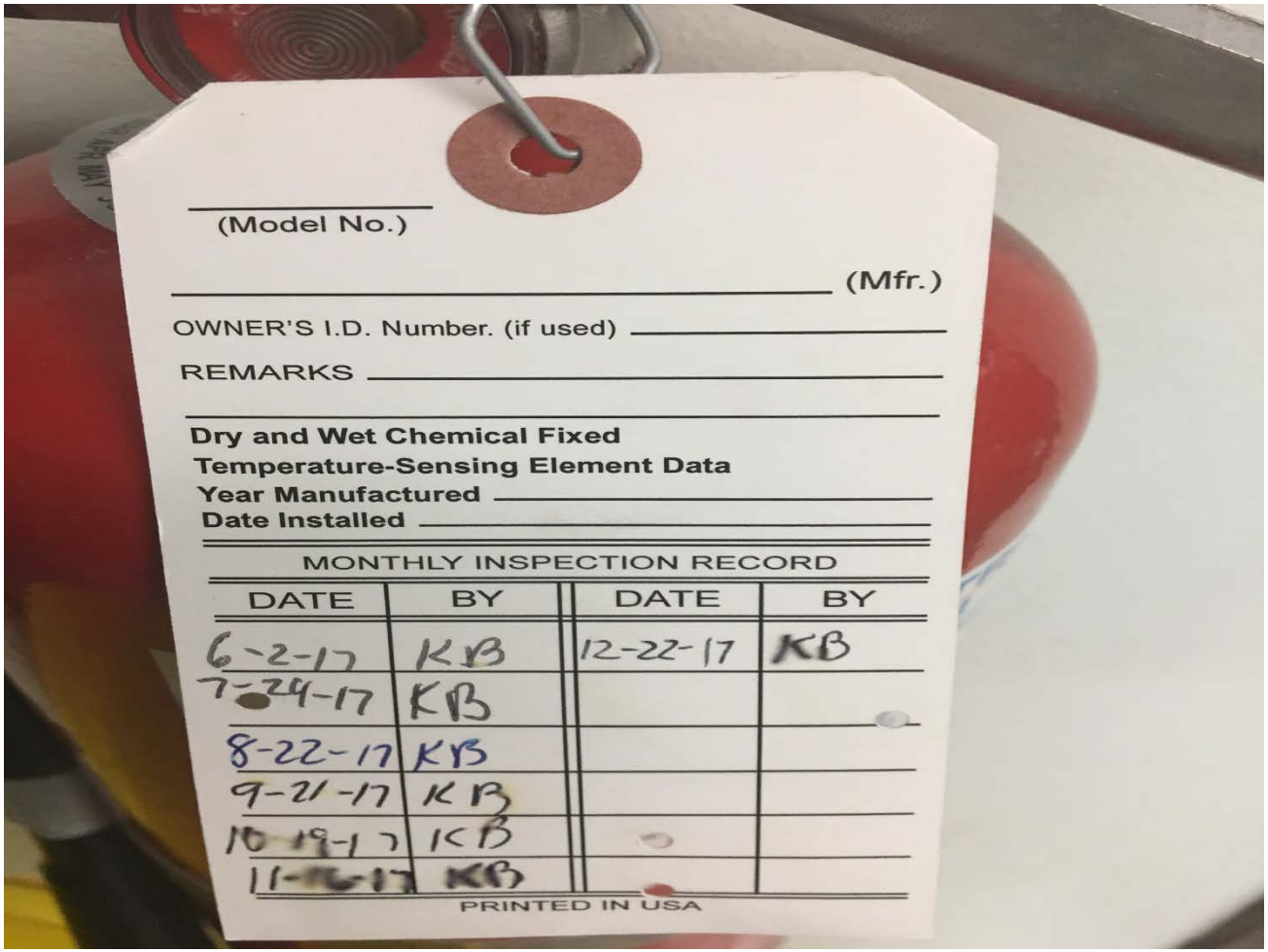
Hazardous Storage



Hazardous Storage

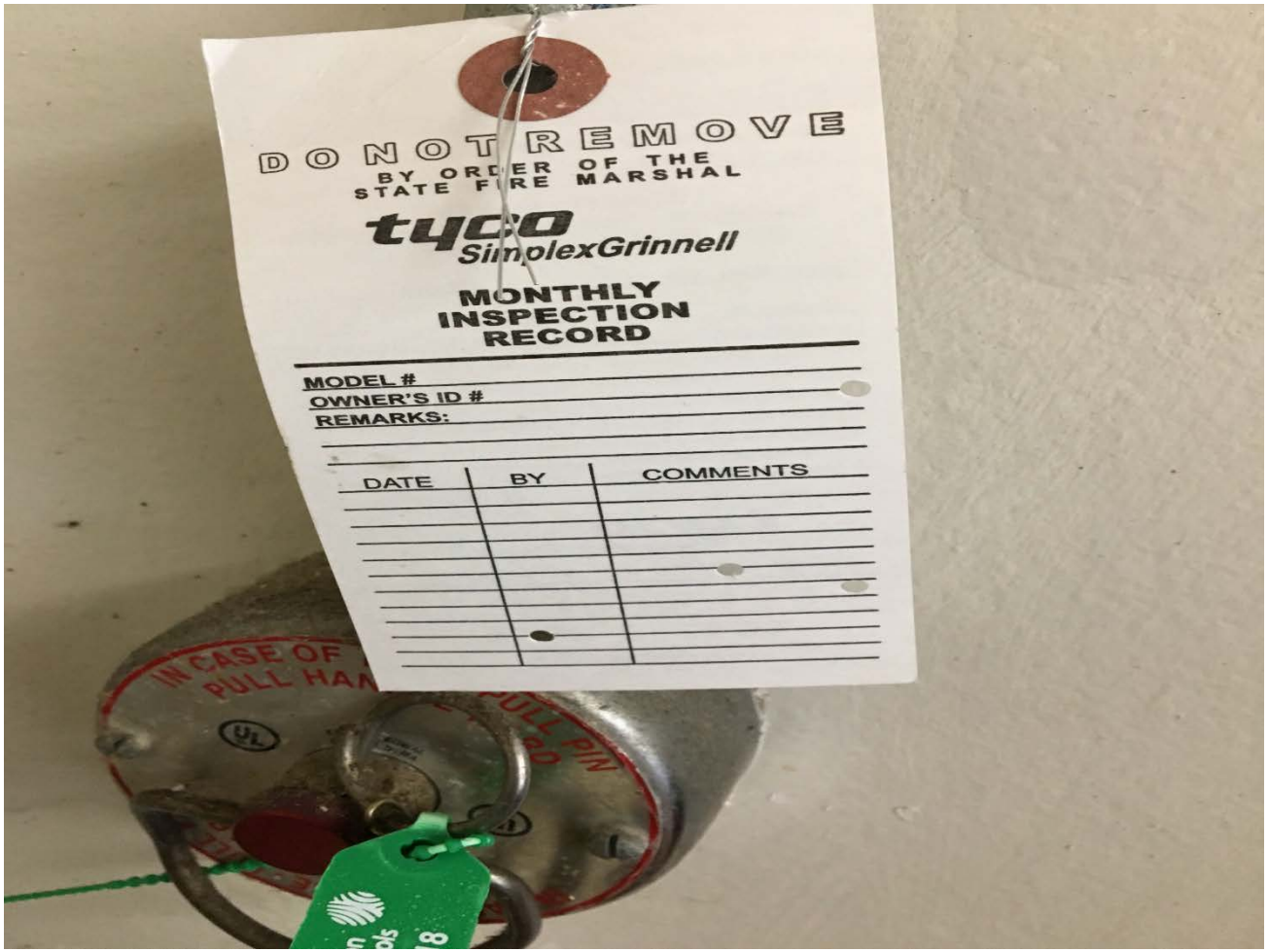
Dirty Kitchen Hood

Fire Extinguisher Not Checked



Inoperable Smoke Detector

Kitchen Hood Extinguishing System Not Checked



Smoking Regulation Not Followed

Improperly Stored Oxygen Cylinders

Old (Circa 1970) and Underpowered Generator

Generator Low Fuel Level

Unsecured Chemical

Unsanitary Spaces

Water and Mold

Speaks for Itself

Dead Rodent

Unsecured Kitchen Utensil

Unsafe Bathroom Fixture

Exposed Electrical Wiring

Unsafe Outside Patient Area

Potential Abuse and Neglect of Medicare Beneficiaries

Background

- The OIG
  - issued a series of reports that address the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's vulnerable populations, including the elderly and individuals with developmental disabilities
  - identified significant number of instances of abuse and neglect of Medicare beneficiaries residing at skilled nursing facilities (SNFs)
  - expanded oversight to include all Medicare beneficiaries regardless of the site of service.

Definitions

- *Abuse*: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish (42 CFR § 488.301).

- *Neglect*: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness (42 CFR § 488.301).

Criteria

- The Older Americans Act, P.L. No. 89-73 (enacted July 14, 1965) was reauthorized as P.L. No. 114-144 (April 19, 2016) with a variety of objectives, including the protection of older persons from abuse, neglect, and exploitation.
- The Elder Justice Act (EJA), enacted as part of the Patient Protection and Affordable Care Act on March 23, 2010, contains provisions that address certain public health and social services approaches to prevention, detection, and treatment of elder abuse primarily under the HHS's authority and administration.
- Section 1150B of the EJA states: Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

Methodology

- Data match between Medicare claims and hospital ER services (inpatient and outpatient claims)
- Data mined Medicare claims with hospital ER services (inpatient and outpatient claims)
- Focused on diagnoses that indicate abuse and neglect
  - Physical
  - Psychological
- Reviewed medical records
- Contacted law enforcement agencies

What we found

- Of the claims indicating abuse or neglect, an estimated one in five high-risk Medicare emergency room claims potentially resulted from abuse or neglect

What we found

- Head injuries (fractures, lacerations, contusions)
- Bodily injuries (fractures)
- Medical issues (pneumonia, sepsis)
- Safety issues (poisoning, accidents)
- Sexual abuse/assault
- Abandonment
- Nutritional neglect
- Deaths shortly after ER/inpatient visit

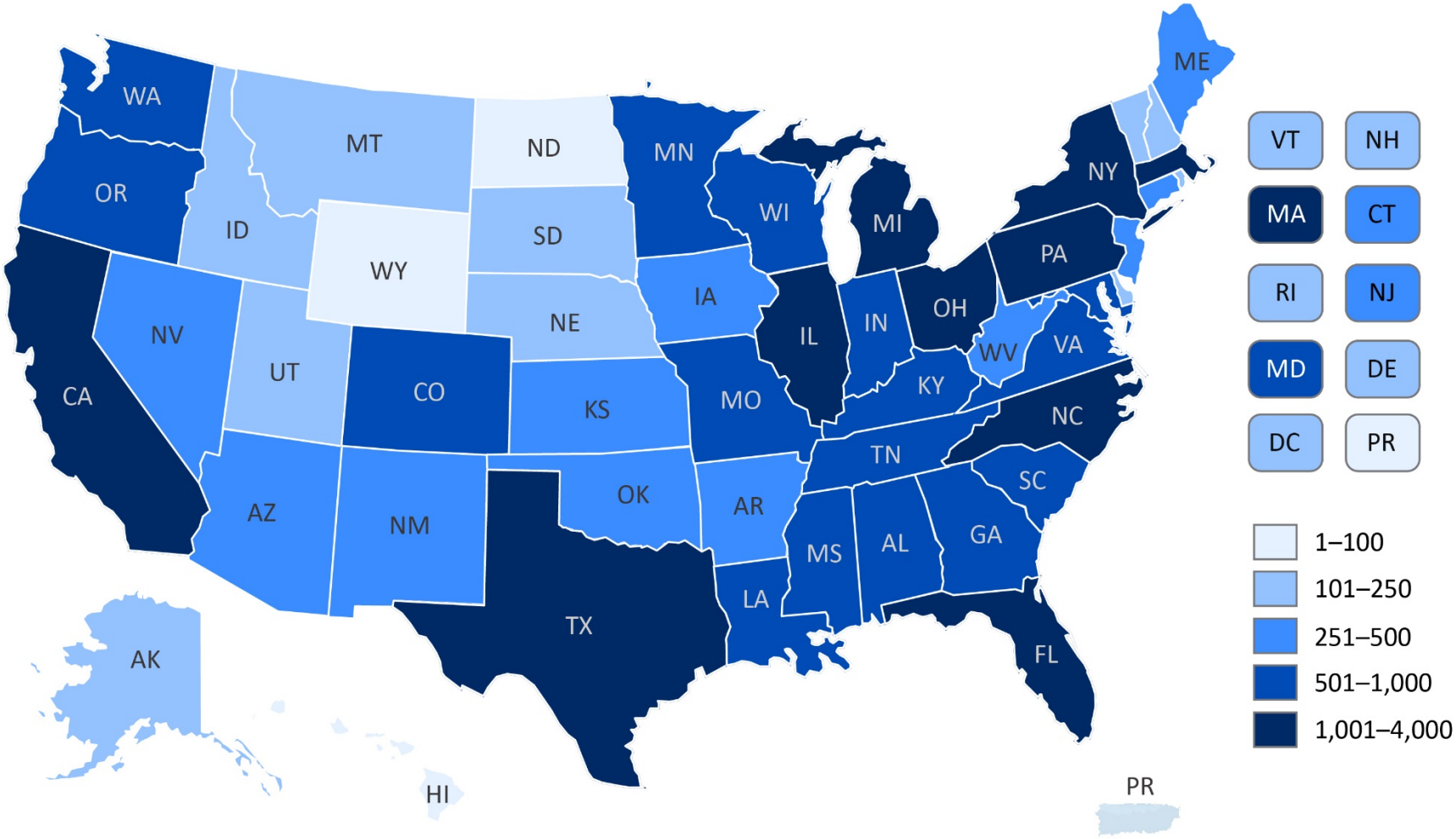
Perpetrators

- Family member
- Spouse or significant other
- Other known person
- Stranger to victim
- Medical provider
- Unable to determine

Location

- Beneficiary's home
- Another home or public place
- Medical facility
- Unknown

Medicare Claims for the Treatment of Potential Abuse and Neglect by State



Stats

- Estimated
  - Medical records contain evidence of potential abuse and neglect – 89%
  - Potential abuse and neglect occurred at a medical facility – 10%
  - Alleged perpetrator is a healthcare worker – 7%
  - Potential abuse and neglect went unreported to law enforcement – 27%

Issued reports

- https://oig.hhs.gov
- Search terms
  - Life Safety
  - Abuse and Neglect
  - Group Home