Report No. A-02-18-01006



This audit report is one of a series of OIG reports that addresses the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's most vulnerable populations, including Medicaid beneficiaries in nursing facilities.

Nursing facility residents are at increased risk of abuse and neglect when health care professionals and caregivers fail to report abuse, or when incidents of potential abuse or neglect are not acted upon in a timely manner.

Our objective was to determine whether New Jersey ensured that incidents of potential abuse or neglect of Medicaid beneficiaries residing in nursing facilities in New Jersey were properly reported and investigated in accordance with applicable Federal and State requirements.

How OIG Did This Audit

Our audit covered 4,402 hospital claims with selected diagnosis codes for Medicaid beneficiaries who resided in nursing facilities in New Jersey and were transferred during calendar year (CY) 2016 to a hospital setting. We reviewed a stratified random sample of 103 of these claims. For each claim, we reviewed hospital and nursing facility records with New Jersey officials to determine whether the claims resulted from an incident of potential abuse or neglect. New Jersey Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported

What OIG Found

New Jersey did not ensure that nursing facilities always investigated and reported incidents of potential abuse or neglect to the State in accordance with Federal and State requirements. Of the 103 claims in our sample, 79 were not the result of potential abuse or neglect; therefore, nursing facilities were not required to report the incident to the State. Of the remaining 24 claims, 10 were the result of potential abuse or neglect that should have been reported to the State. However, 5 of the 10 claims were not properly investigated and reported to the State. For the other 14 claims, nursing facilities did not provide documentation, or their records did not contain sufficient documentation for State officials to determine whether the incident should have been investigated and reported. These deficiencies occurred because nursing facility staff did not follow requirements for investigating and reporting potential incidents of abuse or neglect. In addition, New Jersey did not have adequate survey procedures for ensuring that nursing facilities documented all such incidents.

Based on our sample results, we estimated that 311 Medicaid hospital claims with selected diagnosis codes resulted from incidents of potential abuse or neglect at a nursing facility in New Jersey during CY 2016. Of this amount, we estimated that 220 claims were the result of potential abuse or neglect that the nursing facilities did not investigate and report to the State. In addition, we estimated that, for 616 claims, the associated beneficiary's nursing facility did not have records to sufficiently document the circumstances of the beneficiary's injuries or condition that led to the hospital transfer so that State officials could determine whether the incident was the result of potential abuse or neglect.

What OIG Recommends and New Jersey Comments

We recommend that New Jersey: (1) reinforce guidance to nursing facilities for ensuring potential incidents of abuse or neglect are reported in accordance with Federal and State requirements; and (2) develop additional procedures for its survey site visits, including reviewing nursing facilities' records related to hospital transfers for certain beneficiary injuries or conditions that could be the result of potential abuse or neglect. In written comments on our draft report, New Jersey did not indicate concurrence or nonconcurrence with our recommendations; however, it concurred with our findings.