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OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



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TO: Seema Verma, M.P.H.
Administrator
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FROM: /Daniel R. Levinson/
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SUBJECT: Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements (A-01-17-00504)

The purpose of this memorandum is to alert you to the preliminary results of our ongoing review of potential abuse or neglect of Medicare beneficiaries in skilled nursing facilities (SNFs). This audit is part of the ongoing efforts of the Office of Inspector General (OIG) to detect and combat elder abuse. The objectives of our audit are to (1) identify incidents of potential¹ abuse or neglect of Medicare beneficiaries residing in SNFs and (2) determine whether these incidents were reported and investigated in accordance with applicable requirements.

We are communicating these preliminary results to you because of the importance of detecting and combating elder abuse. Also, according to *Government Auditing Standards*, “early communication to those charged with governance or management may be important because of their relative significance and the urgency for corrective follow-up action.”²

RESPONSIBILITIES FOR REPORTING AND INVESTIGATING INCIDENTS OF POTENTIAL ABUSE OR NEGLECT

There are a variety of ways that incidents of potential abuse or neglect may be reported to appropriate law enforcement and regulatory authorities. In general, responsibility to report

¹ We use the term “potential” because actual abuse or neglect cannot be definitively determined until a thorough and formal investigation has been completed. Accordingly, we acknowledge that the actual number of Medicare beneficiaries whose injuries were the result of confirmed abuse or neglect could be less than we identified. However, we maintain that each potential case of abuse or neglect should be treated as a probable case of abuse or neglect until a thorough and formal investigation is completed to ensure the health and safety of the beneficiaries.

² Chapter 6.78.

incidents of potential abuse or neglect rests with individuals covered under section 1150B of the Social Security Act (the Act).³ SNFs also have a responsibility to ensure that reports of potential abuse or neglect are made internally and externally and are internally investigated within certain timeframes. Numerous State and local law enforcement and regulatory agencies, including the State Medicaid Fraud Control Units (MFCUs), are then responsible for the investigation of reported incidents of potential abuse or neglect. Finally, the Centers for Medicare & Medicaid Services (CMS) is responsible for maintaining oversight of compliance with Medicare health and safety standards and delegates many of these tasks to the State Survey Agencies (Survey Agencies).

Individuals Covered Under Section 1150B of the Social Security Act

Section 1150B of the Social Security Act (the Act)⁴ requires covered individuals in federally funded long-term care facilities to report immediately⁵ any reasonable suspicion of a crime committed against a resident of that facility. Those reports must be submitted to at least one law enforcement agency (with jurisdiction where the facility is located) and the Survey Agency. Covered individuals who fail to report under section 1150B are subject to various penalties, including civil monetary penalties of up to \$300,000 and possible exclusion from participation in any Federal health care program.⁶ Section 1150B of the Act became effective on March 23, 2011.⁷

Skilled Nursing Facilities

SNFs must ensure that all alleged violations, such as mistreatment, neglect, or abuse (including injuries of unknown source) and misappropriation of resident property, are reported immediately to the administrator of the facility and to other officials, including the Survey Agency, in accordance with State law through established procedures (42 CFR § 483.13).⁸ Furthermore, SNFs must investigate these allegations and report the results of the investigation within 5 days

³ The term “covered individual” means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that received at least \$10,000 of Federal funds during the preceding year. Long-term care facilities include SNFs.

⁴ Subtitle H of the Patient Protection and Affordable Care Act (Affordable Care Act) of 2010 is also known as the Elder Justice Act of 2009. Section 6703(b)(3) of the Affordable Care Act (which is located in this subtitle) amended the Social Security Act (the Act) by establishing new section 1150B entitled “Reporting to Law Enforcement of Crimes Occurring in Federally Funded Long-Term Care Facilities.”

⁵ Section 1150(B) of the Act defines “immediately” as within 2 hours if the suspected incident causes serious bodily injuries and within 24 hours if it does not.

⁶ Currently, hospital Conditions of Participation (CoPs) have no reporting requirements similar to those found in 42 CFR §§ 483.12 and 483.13. However, all 50 States have mandated reporter laws for elder abuse and neglect. These laws generally require medical professionals to report reasonable suspicion of elder abuse or neglect to appropriate authorities.

⁷ State and local authorities where the SNFs are located may impose additional reporting requirements.

⁸ Effective November 28, 2016, 42 CFR § 483.13 was removed and replaced by 42 CFR § 483.12.

to the administrator of the facility and to other officials, including the Survey Agency, and if the alleged violation is verified, appropriate corrective action must be taken.

Medicaid Fraud Control Units

MFCUs investigate and prosecute a variety of health-care-related crimes, including patient abuse or neglect in health care facilities.⁹ These health care facilities include Medicare-reimbursed SNFs. MFCUs operate in 49 States and the District of Columbia. The MFCUs, usually a part of the State Attorney General’s office, employ teams of investigators, attorneys, and auditors. OIG, in exercising oversight of the MFCUs, annually recertifies each MFCU, assesses each MFCU’s performance and compliance with Federal requirements, and administers a Federal grant award to fund a portion of each MFCU’s operational costs.

CMS and the Survey Agencies

CMS is responsible for maintaining oversight of compliance with Medicare health and safety standards by health care providers. CMS delegates a variety of tasks related to this oversight to the Survey Agencies under section 1864 of the Act. One of these tasks includes conducting investigations and fact-finding surveys to determine how well health care providers, including SNFs, comply with their applicable CoPs,¹⁰ including the reporting of potential abuse or neglect. When the Survey Agency or CMS Regional Office substantiates a finding of abuse, the Survey Agency or Regional Office must report the substantiated findings to law enforcement and, if appropriate, the MFCUs.¹¹

APPLICABLE CMS GUIDANCE AND FEDERAL AUDITS AND STUDIES

CMS Guidance

The State Operations Manual (SOM) is part of the CMS Online Manual System, which is used by CMS program components, partners, contractors, and Survey Agencies to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives.

Federal Audits and Studies

OIG is committed to protecting beneficiary health and safety. To that end, OIG has issued numerous reports that have detailed problems with the quality of care and the reporting and investigation of potential abuse or neglect at group homes, nursing homes, and SNFs. For

⁹ Section 1903(q) of the Act.

¹⁰ CMS developed CoPs that health care organizations must meet to start and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. Section 1150B is included in the CoPs (42 CFR § 483.12).

¹¹ See “CMS State Survey Agency Directors’ Letter,” S&C-02-20, issued March 28, 2002.

example, OIG’s recent audit reports on critical incident¹² reporting at group homes showed that group home providers did not report up to 15 percent of critical incidents to the appropriate State agencies. Furthermore, OIG’s study of adverse events¹³ in SNFs found that an estimated 22 percent of Medicare beneficiaries experienced adverse events during their SNF stays. These adverse events included infections, pressure ulcers, and medication-induced bleeding. Medical record review determined that 69 percent of these patient-harm events could have been prevented had the SNF provided better care. Over half of the residents harmed during their SNF stays required hospital care to treat the adverse event. OIG also has numerous ongoing or planned projects related to beneficiary health and safety and looks forward to sharing our results with CMS and the public as soon as they are available. The Government Accountability Office (GAO) has also issued several reports on these issues (Attachment A).

METHODOLOGY

We requested and reviewed the emergency room records¹⁴ for 134 Medicare beneficiaries with any of 12 primary diagnoses codes that explicitly indicate potential abuse or neglect.¹⁵ We also reviewed publically available Survey Agency reports for each SNF covering the period when the incident of potential abuse or neglect occurred.¹⁶ In addition, we reviewed the Medicare exclusion database and interviewed CMS officials to determine whether the U.S. Department of Health and Human Services (HHS) had implemented and used civil monetary penalties or excluded from Federal health care programs any providers under section 1150B since its effective date of March 23, 2011.

¹² The general definition of “critical incidents” includes but is not limited to events involving facility patients or residents who suffered serious injuries or illness requiring treatment at an emergency room.

¹³ The term “adverse event” describes harm to a patient or resident as a result of medical care or in a health care setting.

¹⁴ We also requested and reviewed the hospital inpatient record if the hospital admitted the Medicare beneficiary for further treatment of his or her injuries.

¹⁵ These 12 primary diagnoses codes were assigned by the emergency rooms’ staff treating the Medicare beneficiaries. We would not identify any Medicare beneficiaries who were injured at SNFs but not treated at an emergency room because there would be no record of their treatment. Therefore, there is a risk that other Medicare beneficiaries who were potentially abused or neglected remain unidentified.

¹⁶ Survey Agency reports of all complaints and incidents involving abuse and neglect are contained in CMS’s ASPEN Complaint/Incident Tracking System (ACTS). We did not request that CMS provide us with a data extract of relevant ACTS files while we were in the initial stage of our audit because of the possibility of compromising ongoing law enforcement investigations.

PRELIMINARY AUDIT RESULTS

We identified 134 Medicare beneficiaries¹⁷ whose injuries may have been the result of potential abuse or neglect¹⁸ that occurred from January 1, 2015, through December 31, 2016.¹⁹ We also found that a significant percentage of these incidents may not have been reported to law enforcement.²⁰ As a result, we determined that CMS has inadequate procedures to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported. Accordingly, this Early Alert contains suggestions for immediate actions that CMS can take to ensure better protection of vulnerable beneficiaries.

In addition, our prior audit reports showed that group homes did not report up to 15 percent of critical incidents to the appropriate State agencies. Our preliminary results combined with these prior report results raise significant concerns that incidents of potential abuse or neglect at SNFs have gone unreported.

Identification of Medicare Beneficiaries Who May Have Been Abused or Neglected

We identified 134 Medicare beneficiaries whose injuries may have been the result of potential abuse or neglect that occurred from January 1, 2015, through December 31, 2016. (See Table 1 for totals by diagnosis code.) We identified instances in 33 different States (Attachment B).

Table 1: Primary Diagnosis of Potential Abuse or Neglect

Diagnosis Code	Diagnosis Code Description	Total Beneficiary Count	Beneficiaries Treated in the Emergency Room	Beneficiaries Admitted to the Hospital
V715	Observation following alleged rape or seduction	48	48	0
Z0441	Encounter for examination and observation following alleged adult rape	32	32	0
T7621XA	Adult sexual abuse, suspected, initial encounter	28	26	2

¹⁷ We also determined that at least 1 of the 134 Medicare beneficiaries was a U.S. military veteran. This information may be pertinent to policy makers interested in veterans' health care.

¹⁸ As diagnosed by the emergency room' staff who treated the Medicare beneficiaries.

¹⁹ The audit report underlying this Early Alert will address the period January 1, 2016, through December 31, 2016. We chose to exclude calendar year 2015 from our audit to make our report more contemporary. This also made our evidence gathering easier as records that are more recent are generally more readily available.

²⁰ We determined whether incidents were reported to law enforcement based on the hospital and Survey Agency records we reviewed. Because of the number of potential law enforcement agencies involved, we did not contact each local law enforcement agency separately to determine whether it had been contacted. Such contact was not recorded in the records we reviewed. We did not determine why these incidents were not reported to law enforcement and will address that issue in our audit report.

99583	Adult sexual abuse	11	10	1
99581	Adult physical abuse	6	6	0
T7611XA	Adult physical abuse, suspected, initial encounter	2	2	0
T7421XA	Adult sexual abuse, confirmed, initial encounter	2	2	0
T7401XA	Adult neglect or abandonment, confirmed, initial encounter	1	1	0
T7411XA	Adult physical abuse, confirmed, initial encounter	1	1	0
99585	Other adult abuse and neglect	1	1	0
99580	Adult maltreatment, unspecified	1	0	1
29530	Sexual sadism	1	0	1
TOTAL		134	129	5

We found that, although the circumstances surrounding each of these incidents varied, 100 of the 135²¹ (74 percent) medical records contained indications, such as victim or witness statements and photographs, that the Medicare beneficiaries' injuries may have been caused by potential abuse or neglect (Attachments C and D) at the SNFs. For 35 of the 135 (26 percent) emergency room records, we were unable to determine whether potential abuse or neglect existed without further investigation, which was outside the scope of our audit. We have referred all 134 incidents to appropriate law enforcement officials and are sending CMS a list of these incidents separately.

Incidents of Potential Abuse or Neglect May Not Have Been Reported to Law Enforcement

Many of the incidents of potential abuse or neglect that we identified may not have been reported to law enforcement. According to the records we reviewed, 96 of the 134 (72 percent) incidents were reported to local law enforcement.²² However, we found no evidence in the hospital records that the remaining 38 incidents (28 percent) were reported to local law enforcement despite State mandatory reporting laws requiring the hospitals' medical staff to do so. We also found that the Survey Agencies substantiated 7 of the 134 total incidents in their survey reports.²³

²¹ There were 134 incidents. However, one Medicare beneficiary was treated at two different hospital emergency rooms for the same incident, resulting in 135 Medicare claims and 135 associated emergency room records.

²² An additional 6 of the 134 incidents (4 percent) were reported to the State, but the medical records are unclear as to which agency the incidents were reported.

²³ We are contacting the Survey Agencies to determine if they were aware of the remaining 127 (134 – 7) incidents and will provide them with the relevant information if they are not.

CMS Procedures Are Not Adequate To Ensure Incidents of Potential Abuse or Neglect Are Identified and Reported

We determined that CMS procedures are not adequate to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported. Specifically, CMS officials informed us that they do not match Medicare claims for reimbursement of emergency room services with claims for reimbursement of SNF services to identify instances of potential abuse or neglect.

Furthermore, CMS has not taken any enforcement actions using section 1150B of the Act or used the penalties it contains since its effective date of March 23, 2011, to ensure SNF employees report incidents of potential abuse or neglect. CMS did not update the SOM to include the regulations for section 1150B until March 8, 2017, with an effective date of November 28, 2017. Furthermore, CMS did not add section 1150B to the CoPs until November 2016.

CMS officials informed us that they have not taken any enforcement actions regarding section 1150B because the HHS Office of the Secretary has not delegated the enforcement of section 1150B to CMS. CMS began working with the HHS Office of the Secretary to receive the delegation of authority in June 2017. CMS officials also stated that they have not taken action under section 1150B because they have not identified any instances in which a covered individual failed to report an incident of potential abuse or neglect of a Medicare beneficiary.²⁴ CMS officials also acknowledged that the SOM did not include references to section 1150B until March 8, 2017;²⁵ however, they noted that CMS had issued the “CMS State Survey Agency Directors’ Letter” (S&C-11-30-NH) on June 17, 2011. This letter details the requirements and sanctions contained in Section 1150B and instructs the Survey Agencies to process reports received under section 1150B in accordance with existing CMS and State policies and procedures.²⁶ CMS officials stated that they have taken additional actions to protect residents in nursing homes by adding section 1150B requirements to training courses and issuing supporting interpretive guidance and training to surveyors.

Suggestions for Immediate Actions

These preliminary results combined with our prior report results raise significant concerns that incidents of potential abuse or neglect at SNFs have gone unreported. Detecting and combatting elder abuse requires covered individuals, SNFs, MFCUs, Survey Agencies, and CMS to meet their responsibilities. We acknowledge that CMS is committed to providing oversight of health care provider’s compliance with standards to ensure the health and safety of Medicare beneficiaries. Accordingly, we suggest that CMS take immediate action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported. These immediate actions include:

²⁴ OIG attributes CMS’s inability to identify violations of section 1150B in part to CMS’s failure to match Medicare claims for reimbursement of emergency room services with claims for reimbursement of SNF services to identify instances of potential abuse or neglect. Attachment C contains an example of a violation of section 1150B that we identified through our data match.

²⁵ These references do not become effective until November 28, 2017.

²⁶ State Survey agencies have used existing 42 CFR § 483.13(c) deficiency citations.

- implement procedures to compare Medicare claims for emergency room treatment with claims for SNF services to identify incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs and periodically provide the details of this analysis to the Survey Agencies for further review and
- continue to work with the HHS Office of the Secretary to receive the delegation of authority to impose the civil monetary penalties and exclusion provisions of section 1150B.

After receiving the delegation of authority, CMS should:

- promulgate appropriate regulations, if CMS determines it is necessary, to impose penalties under section 1150B;
- enforce section 1150B, including imposing penalties for violations;
- ensure that the SOM is updated as planned with an effective date of November 28, 2017, to include references to section 1150B, including its penalty provisions; and
- notify Survey Agencies when the SOM is updated to include references to section 1150B and direct them to refer suspected violations of section 1150B to CMS for appropriate action.

We plan to make formal recommendations to CMS when our audit is complete.

The information in this alert is preliminary, and our audit is continuing. We will issue a draft report at the conclusion of the audit and include CMS's comments and actions taken in response to this Early Alert. If you have comments or questions about this Early Alert, please provide them within 60 days. Please refer to report number A-01-17-00504 in all correspondence.

ATTACHMENT A: RELATED REPORTS

Report Title	Issuer	Report Number	Date Issued
<i>Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	OIG	A-01-14-00008	7/2016
<i>Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	OIG	A-01-14-00002	5/2016
<i>Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect</i>	OIG	OEI-07-13-00010	8/2014
<i>Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries</i>	OIG	OEI-06-11-00370	2/2014
<i>Criminal Convictions for Nurse Aides With Substantiated Findings of Abuse, Neglect, and Misappropriation</i>	OIG	OEI-07-10-00422	10/2012
<i>Unidentified and Unreported Federal Deficiencies in California's Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs</i>	OIG	A-09-09-00114	9/2011
<i>Nursing Facilities' Employment of Individuals With Criminal Convictions</i>	OIG	OEI-07-09-00110	3/2011
<i>Nursing Homes: Some Improvement Seen in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear</i>	GAO	GAO-10-434R	4/2010
<i>Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses</i>	GAO	GAO-08-517	5/2008
<i>Nursing Homes: More Can Be Done to Protect Residents from Abuse</i>	GAO	GAO-02-312	3/2002

ATTACHMENT B: INCIDENTS OF POTENTIAL ABUSE OR NEGLECT IN SKILLED NURSING FACILITIES DURING 2015 AND 2016

State	Number of Incidents ²⁷
Illinois	17
Michigan	13
Texas	9
California	8
New York	7
Ohio	7
Florida	6
Kentucky	5
Pennsylvania	5
Washington	5
Indiana	4
North Carolina	4
Tennessee	4
Virginia	4
Wisconsin	4
Arkansas	3
Iowa	3
Louisiana	3
Minnesota	3
Alabama	2
Georgia	2
Massachusetts	2
Nevada	2
Oklahoma	2
West Virginia	2
Connecticut	1
Maryland	1
Mississippi	1
Montana	1
New Jersey	1
New Mexico	1
Oregon	1
Utah	1
TOTAL	134

²⁷ Each incident involved 1 beneficiary for a total of 134 beneficiaries.

ATTACHMENT C: EXAMPLE OF POTENTIAL SEXUAL ABUSE

At the time of this incident, Jane Doe was a Medicare beneficiary receiving services at a SNF. Ms. Doe had a previous medical condition, which contributed to verbal and mobility limitations.

According to the emergency room record, a male resident of the SNF allegedly sexually assaulted Ms. Doe. Nursing aides found the man on top of Ms. Doe squeezing and touching her breast and ejaculating on her. The emergency room record further noted that Ms. Doe’s right breast was an “area of discomfort,” and two silver-dollar-sized bruises were observed on her breast (photograph 1).

Photograph 1: Breast Bruise²⁸



The SNF’s employees covered under section 1150B of the Act did not immediately report the incident to law enforcement.²⁹ Instead, according to the Survey Agency’s report, the following day the SNF’s employees informed Ms. Doe’s family of the incident who then contacted law enforcement, which investigated the incident. The emergency room record notes that the SNF staff assisted Ms. Doe with bathing, going to the bathroom, and changing her clothing after the incident. These actions could have destroyed any evidence that may have been detected using the rape kit.

The Survey Agency reviewed the incident³⁰ and cited the SNF for failure to:

²⁸ Altered to protect the victim’s privacy.

²⁹ This incident occurred after section 1150B of the Act became effective on March 23, 2011. Accordingly, the SNF’s employees should have reported the incident to law enforcement within 2 hours of witnessing the incident.

³⁰ This incident is 1 of 96 reported to law enforcement according to the medical records we reviewed.

- immediately tell the beneficiary’s doctor and a family member of the beneficiary of the incident,³¹
- report and investigate an instance of abuse,³²
- develop policies that prevent abuse,³³ and
- provide care in a way that keeps or builds each resident’s dignity.³⁴

The Survey Agency did not cite the SNF for failure to ensure the Medicare beneficiary was free from abuse³⁵ and classified the incident as resulting in “minimum harm or potential for actual harm.”³⁶

³¹ 42 CFR § 483.10.

³² The Survey Agency’s report noted that the SNF contacted local law enforcement in an attempt to keep law enforcement from investigating the incident. The Survey Agency’s report states, “I [SNF staff] notified the [redacted] Police Department of this situation and explained that we were required to report it but that we were doing our own internal investigation and did not need them to make a site visit. Explained to Officer [redacted] that no one was interested in pressing charges and that we were handling.” We noted that local law enforcement continued its investigation despite this contact by the SNF.

³³ 42 CFR § 483.13.

³⁴ 42 CFR § 483.15.

³⁵ 42 CFR § 483.13.

³⁶ SOM, Appendices P and Q.

ATTACHMENT D: EXAMPLE OF POTENTIAL PHYSICAL ABUSE

At the time of this incident, John Doe was a Medicare beneficiary receiving services at a SNF. Mr. Doe suffered from several medical conditions that affected his mental acuity.

According to the emergency room record, Mr. Doe was transferred from the SNF to the emergency room because he was having behavioral problems, including attempting to hit, bite, and throw feces at the SNF staff. The emergency room record notes that Mr. Doe was not aggressive in the emergency room, and the record states, “More concerning was the multiple bruises in various stages of healing including areas not easily banged (flanks, lower chest, back) [photographs 2 and 3]. There is a deep healing scratch on the right flank. Unfortunately, given [Mr. Doe’s] mental status, there is not a clear story of who has done this.”

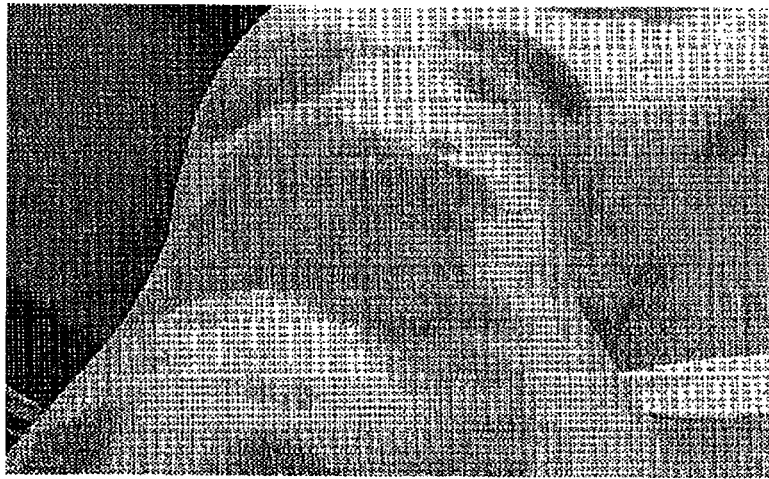
The emergency room record further notes that the SNF informed the hospital that the emergency room staff caused the bruises when they restrained Mr. Doe during his last emergency room visit. However, the emergency room record also notes that the bruises were not present in photographs taken during the previous emergency room visit. Furthermore, the State opened an adult protective service case based on that previous visit. The emergency room record states that Mr. Doe said that he was “being beaten with feet, hands and a broomstick.” Mr. Doe also claimed that he was beaten again after an adult protective services case was opened after his last hospital admission. The emergency room record further states that “[Mr. Doe] is not safe to return to [SNF].” The hospital subsequently contacted adult protective services and filed a complaint with the local police department.

The emergency room record later notes that a specialized placement was being sought³⁷ for Mr. Doe. While the State’s adult protective services officials agreed to Mr. Doe’s discharge back to the SNF, they were continuing their investigation into Mr. Doe’s alleged abuse by the SNF’s staff.³⁸

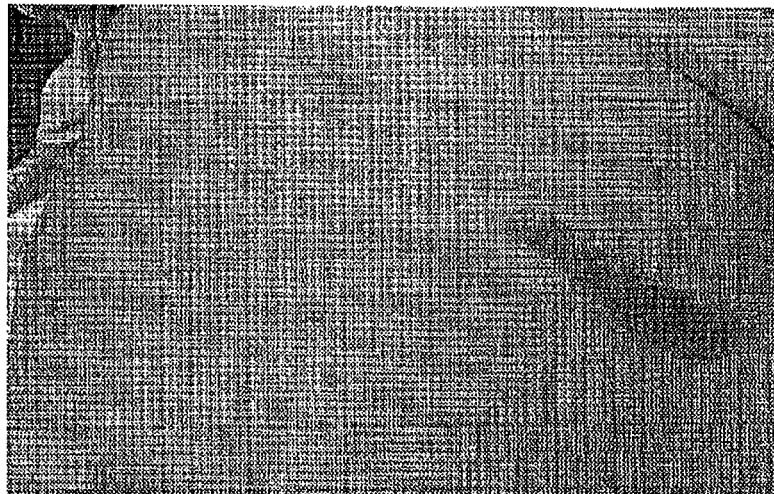
³⁷ The emergency room record is unclear regarding who was seeking the specialized placement for Mr. Doe.

³⁸ This incident is 1 of 96 reported to law enforcement according to the medical records we reviewed.

Photograph 2: Bruised Arm and Chest³⁹



Photograph 3: Bruised Chest and Flank⁴⁰



The Survey Agency's four survey reports on the SNF covering the period that Mr. Doe was treated at the emergency room do not include any mention of either incident involving Mr. Doe. We are contacting the Survey Agency to determine if they were aware of these incidents and will provide them with the relevant information if they are not.

³⁹ Altered to protect the victim's privacy.

⁴⁰ Altered to protect the victim's privacy.