*Welcome to LLA Reports, a podcast produced by the Louisiana Legislative Auditor’s office. This podcast is intended to be an oral representation of the written report it highlights and is primarily for the use of the Louisiana Legislature.*

This is Emily Dixon. I’m a manager for LLA’s Performance Audit Services. This episode of LLA Reports focuses on our new report titled “Abuse and Neglect in Intermediate Care Facilities for Individuals with Developmental Disabilities.”

This report provides the results of our evaluation of the Louisiana Department of Health’s – or LDH’s – activities related to abuse and neglect in Intermediate Care Facilities for Individuals with Developmental Disabilities – or ICFs.

LDH monitors the ICFs’ compliance with requirements through inspections called surveys. The department conducts an initial survey when an ICF opens, and then conducts a recertification survey at least once every 15 months. We found LDH improved the timeliness of its recertification surveys from 362 of 378, or 95.8 percent, conducted timely in fiscal year 2020 to 100 percent of 413 conducted timely in fiscal year 2023.

In addition, we found LDH received 718 complaints related to ICFs during fiscal years 2019 through 2023. Of those complaints, 193 received an Immediate Jeopardy priority, and LDH started an onsite investigation within two business days as required. However, LDH is not able to easily identify which complaints are related to abuse and neglect.

We found, too, that the ICFs reported more than 4,000 incidents of actual or alleged abuse and neglect during fiscal years 2019 through 2023. However, LDH did not ensure the ICFs reported the incidents in a timely manner.

Of 4,698 Facility-Reported Incidents – or FRIs – 1,103, or 23.5 percent, were not reported within 24 hours of discovery as required by state regulations.

In addition, as of May 2024, 25 of 64 sheriffs’ offices did not have access to the Statewide Incident Management System to respond to allegations of abuse and neglect within their jurisdictions.

Additionally, we found LDH cited the ICFs with 4,948 deficiencies during fiscal years 2019 through 2023. Of these, 614 – or 12.4 percent – were related to client protections, which included deficiencies related to abuse and neglect.

LDH could increase transparency and assist the public with making more informed decisions about care by posting information about deficiencies, complaints, and FRIs on its website.

LDH fined the ICFs a total of $450,250 dollars for deficiencies identified in surveys and investigations conducted during fiscal years 2019 through 2023. However, the amounts may not be adequate to deter noncompliance. Fine maximums established in state law have not increased since they were set in 1997.

We also found LDH could use Medicaid data to monitor the ICFs for compliance with Medicaid requirements. For example, we identified ICF residents who potentially did not receive annual doctor visits as required by Medicaid. A review of Medicaid data for medical services provided in fiscal year 2022 found that 135 – or 4.3 percent – of 3,165 ICF residents potentially did not receive an annual doctor visit.

As a result of our report, we developed eight recommendations.

We recommended that LDH continue reverting to its old complaint categories to allow it to more easily track allegations of noncompliance related to abuse and neglect so it can identify trends or systemic problems.

We also recommended thatLDH work with stakeholders to improve its process for communicating with complainants to help ensure they understand the department’s role is limited to identifying noncompliance with requirements.

In addition, we recommendedthat LDH monitor the ICFs’ compliance with the requirement to report FRIs within 24 hours of discovery and issue fines when the ICFs are late in reporting FRIs, as authorized by state law.

We recommended, too, thatLDH work with the state’s sheriffs’ offices to ensure user information for the Statewide Incident Management System is current and make data on the ICFs’ deficiencies, complaints, FRIs, and sanctions available to the public.

Additionally, we recommended that LDH modify its sanction policy to include timeframes for its process to ensure timely enforcement actions against ICFs.

Finally, we recommended that LDH use Medicaid data as another opportunity to identify noncompliant ICFs and to ensure appropriate care for ICF residents.

As part of its response, which is included in the report as Appendix A, LDH agreed with four of the recommendations, disagreed with two of the recommendations, and neither agreed nor disagreed with two of the recommendations.

*We hope you found this podcast informative, and that you’ll follow future episodes of LLA Reports.*

*This podcast was created as part of the audit report just discussed and is intended primarily for the use of the Louisiana Legislature. Both the full report and the podcast can be found on the LLA’s website at* [*www.lla.la.gov*](http://www.lla.la.gov)*.*

*Thank you for listening.*