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Nursing Home Industry - Breeding Ground For Whistleblowers

By Evelyn Pringle

One of the most effective weapons the government has for unearthing fraud against Medicare and Medicaid in the nursing home industry is the False Claims Act. The fraud is so rampant in that industry that it should be officially designated as a breeding ground for whistleblowers.

A provision in the FCA, called Qui Tam, allows persons with evidence of fraud in federal programs or contracts to bring a lawsuit on behalf of the federal government. A notice should be posted in every nursing home broadcasting the fact that under the provision, whistleblowers are entitled to 15–30% of monies recovered in the lawsuit and maybe if enough lawsuits were filed, the industry would start cleaning up its act..

The roughly 16,400 nursing homes in the US house approximately 1.7 million residents. But despite years of evaluations, investigations, and more recently lawsuits, in 2006, the state of America's nursing home system, entrusted to provide care to the country's most vulnerable citizens, is every bit as shameful as it was 10 years ago.

Of the 16,437 certified nursing homes nationwide, just 314, or fewer than 2%, were found to be violation free during a fou- year period, according to an analysis of federal inspection and complaint investigation reports by Gannett News Service.

Where a nursing home is located and who owns it was found to be critical when evaluating the care provided to its residents. Nearly 75% of severe and repeated violations of patient care between 1999 and 2003 were found at nursing homes in 12 states, including Texas, Illinois, Arkansas, Washington, New Jersey, Kansas, Missouri, Indiana, Oklahoma, North Carolina, Mississippi

and Tennessee.

During its investigation, GNS interviewed dozens of people and analyzed 4 years of federal data on inspections and patient care and found that for-profit nursing homes accounted for 83% of the more than 500 nursing homes with repeated, serious violations, even though the for-profits accounted for only 65% of all Medicare and Medicaid certified nursing homes.

"Patients at for-profit homes had, on average," GNS said, "higher rates of infections and pressure sores than those the government and nonprofits own. Other violations found included failing to protect patients from mistreatment, hiring staff without running criminal background checks, and allowing patients to be abused and physically punished."

In the real world, running criminal background checks on staff or residents is a waste of time to nursing homes that fail to protect residents against known criminals.

A case on point, is Barbara "Bee" Becker, who has been a tireless advocate for nursing home residents since 1999 when her mother-in-law, Helen Straukamp, became a victim of a homicide at a nursing home in Evansville, Indiana when she was assaulted by a male resident.

Not satisfied with an inadequate investigation conducted by the facility, Bee began her own investigation of her mother-in-law's death and discovered that the perpetrator of the crime had a violent criminal record and the nursing home knew it.

The facility told the attending hospital, that Mrs Straukamp had been injured when she had suffered a fall. However, an employee later told the family that she had been assaulted, and an eyewitness described how Mrs Straukamp was picked up by her arms from a standing position, lifted off the floor and slammed into a wall and handrail, and fell to the floor unconscious.

Mrs Straukamp died 22 days later. The coroner ruled her death a homicide but the crime was never prosecuted.

On March 4, 2002, after listening to Bee describe how her mother-in-law had been a victim of a crime but there was no prosecution because it took place in a nursing home, at a hearing before the Senate Select Committee on Aging, Committee chairman, Senator John Breaux, announced

that "a crime is a crime wherever it is committed."

Bee says she looks forward to the day when all crimes against elderly citizens in nursing homes will be prosecuted in the same manner as they are when they occur elsewhere.

According to Indianapolis Attorney, Kennard Bennett, "there are some straightforward reasons why crimes in nursing homes are often not prosecuted."

First, he says, the victim is most likely unable to be their own witness as to what happened because of their dementia. "Nursing home residents are extremely vulnerable to predators for this very reason," he explained. "There may be no other witnesses to the crime."

Mr. Bennett also says cases of neglect and abuse, whether civil or criminal in nature, can be expensive to prosecute with numbers of witnesses, thousands of pages of exhibits, and oftentimes complicated medical issues involved. "I think this discourages many over-worked prosecutors from taking such cases on," he advised.

Combined, the Medicaid and Medicare programs spend more than $67 billion a year on nursing home care. The Centers for Medicare & Medicaid Services (CMS) define standards that facilities must meet to participate in the programs and contracts with the states to assess whether facilities meet the standards through annual surveys and complaint investigations. However, CMS is responsible for monitoring the state survey activities.

But as years goes by, instead of getting better, the inadequate policing of the industry through the survey process is getting worse. Between 1997 and 2003, the proportion of homes with no deficiencies declined from 21.6% to 9.5%, and the average number of deficiencies increased from 4.9 to 6.9 per home, according to a May 2005 report by Bernadette Wright, of the AARP Public Policy Institute, titled Enforcement of Quality Standards In Nursing Homes.

Yet, enforcement actions have declined in recent years. Between 2000 and 2003, "Barriers to Effective Nursing Home Enforcement," presented at April 19, 2004 CMS Leadership Summit, found (1) the number of homes penalized for any violations declined by 18%, from 2,622 to 2,146, (2) the number of civil monetary penalties

declined 12%, from 2,242 to 1,979; and (3) the number of nursing homes denied Medicare or Medicaid payment for new admissions fell 47%, from 1,312 to 698.

An April 2005 report by the Office of Inspector General on the use of civil monetary penalties found most fines were imposed at the low end of their allowable range, and they took an average of 6 months to collect for cases not appealed and an average of 14 months for appealed cases.

Of the $81.7 million in penalties imposed in 2000 and 2001, less than half (42%) had
been paid by December 2002.

Year after year, surveyors continue to understate deficiencies and quality care problems. Between June 2000 and February 2002, the Government Accountability Office determined that federal surveyors found actual harm or higher-level deficiencies in 22% of homes where state surveyors had documented none.

In a March 2003 study, the Office of the Inspector General reported that states varied widely not only in the average number of deficiencies cited per home, but also in which particular deficiencies the surveyor would cite for the same problem.

A July 2003 study by the GAO reviewed 76 state surveys and found understated actual harm or higher-level deficiencies in 39% of the surveys.

So who is to blame? The state surveyors or the Feds? Or both?

According to a July 7, 2004 letter to the CMS from Senator Charles Grassley (R-Iowa), corruption in the surveying process is rampant.

During a 2004 review of the state survey process by the staff of Senator Grassley,
chairman of the Senate Committee on Finance, which has oversight responsibility for the Medicaid and Medicare, a large number of surveyors said that their superiors instructed them to overlook or understate deficiencies.

He told the CMS, "that the Oklahoma Board of Health member Ron Osterhout said, "he received tips during the past six months from sources inside and outside the state Health Department alleging that surveyors are being

pressured to go easy on long-term facilities. . . Among those allegedly pressuring surveyors are state lawmakers acting on behalf of facility administrators."

"It is apparent from our review," Senator Grassley wrote, "that the survey and certification process upon which we rely for accurate, objective and independent data on the operation and activities of facilities, is just plain broke."

"It has been corrupted by unscrupulous individuals," he said, "and we need to restore the integrity of the system in every state and locale."

The surveyors described a bleak and dismal picture of America's nursing homes system. They themselves were demoralized, they said, when blatant quality of care deficiencies and findings were watered down, altered, or ignored or dismissed.

"These surveyors have raised enormously disturbing issues," Senator Grassley reported in the letter, "for anyone who cares a wit about the very health and safety of frail nursing home residents."

Surveyors said that they were "instructed" by their superiors to downgrade citations or not write up facilities for certain high level deficiencies.

Some surveyors said that if a high level deficiency was cited, most of the time it would be reduced to a lower level deficiency or completely deleted from the final report by management without consultation with the reporting surveyor.

Others said that they were told to "rewrite" or "change" survey findings to make the facility "look better" than it really was. And still others described how multiple violations were sometimes bundled and cited as one violation instead of several.

Some former surveyors even told Senator Grassley's staff, that they resigned or retired out of "sheer disgust" at how their hands were tied while doing their jobs.

The majority of surveyors interviewed complained that surveys remain too predictable. The predictability of surveys has been a major concern for many years and the reality is that most nursing home administrators know when a surveyor is coming. In fact, the GAO reported in July 2003, that one-third of the most recent surveys

nationwide occurred on a predictable schedule.

Indianapolis Attorney Kennard Bennett agrees that surveyors are too predictable in their patterns of annual surveys. If it occurred the second week of March one year, he says, it's most likely to occur the second week of March the next year.

"I have also known too many residents and their family caregivers," he adds, "who are able to see patterns of "sprucing-up" activity that just happen to come right before a survey.

Some surveyors said that they were told to rewrite survey findings to make facilities look better than they really were.

But then, none of these charges are new. The GAO has documented these and other serious problems throughout the nursing home industry repeatedly since 1998.

In one instance, the GAO reviewed a sample of nursing homes with a history of problems, but showed no actual harm deficiencies in their most recent inspections and determined that 40% of these homes had documented incidents of serious harm including avoidable pressure sores, severe weight loss, and multiple falls resulting in broken bones and other injuries, despite the fact that none were listed by the surveyors.

In the recent study released in December 2005, the GAO listed the exact same problems, that while the CMS's survey data shows a decline in the number of nursing homes with serious deficiencies since 1999, it said, the trend masks two continuing problems: (1) serious inconsistency in how states conduct surveys; and (2) the understatement of negative findings.

Inconsistency in states' surveys, it noted, is evidenced by vast interstate variability in the proportion of homes found to have serious deficiencies. For instance, from 2003 to 2005, the report said, California cited only 6% of its nursing homes for serious violations, while Connecticut cited 54% of its facilities.

The investigators found pervasive understatement of "serious deficiencies that cause actual harm or immediate jeopardy to patients," and includes severe weight loss, "multiple falls resulting in broken bones and other injuries, and serious, avoidable pressure sores," the report said.

In 5 large states that had a decline in deficiencies, federal surveyors determined that between 8% and 33% of the comparative surveys identified serious deficiencies that state surveyors missed. This finding is the same problem identified in earlier reports by the GAO showing that state surveyors missed serious care problems.

"Continued understatement of serious deficiencies," the GAO said, "is shown by the increase in discrepancies between federal and state surveys of the same homes from 2002 through 2004, despite an overall decline in such discrepancies from October 1998 through December 2004."

To ensure the safety of residents, the federal government adopts fire safety standards that all homes must meet, and state survey agencies conduct periodic inspections, to determine whether the standards are met.

Two deadly nursing home fires occurred in 2003 and brought considerable attention to the safety of nursing home residents. The enforcement of fire safety standards in nursing homes is critical because many residents have conditions that restrict their ability to escape if a fire breaks out.

According to data published by the National Fire Protection Association, about 2,300 nursing homes reported a structural fire each year for 1994 through 1999, and the average number of fire related deaths nationwide was about 5 each year. During this same time period, one multiple-death nursing home fire resulted in three fatalities.

In contrast, the fire related death toll in 2003 was 31, with nursing home fires in Hartford, Connecticut with 16 deaths, and Nashville, Tennessee with 15 deaths. Neither of these nursing homes was required to have a sprinkler system.

The results of CMS's federal fire monitoring surveys conducted during fiscal year 2003 found that state surveyors either missed or failed to cite an average of more than two deficiencies per home, such as inadequate construction to contain fire and smoke or missing or improperly maintained sprinkler systems.

In turn, the GAO determined that CMS provided insufficient oversight of state survey activities to address

fire safety concerns and did not comply with the requirement to conduct monitoring surveys in at least 5% of facilities in each state or a total of over 800 federal surveys annually.

The GAO found that only 40 federal surveys conducted in fiscal year 2003 covered fire safety. In fact, the GAO said, no federal assessments of fire safety were conducted in 27 states.

The Omnibus Act established the survey and certification process to maintain standards in nursing homes and lists several remedies that may be applied when a facility is not in "substantial compliance."

A facility is not in substantial compliance if the survey finds deficiencies that pose immediate jeopardy, actual harm, or potential for more than minimal harm to patients. When facilities are found to be have deficiencies that put residents in immediate jeopardy, states are required to refer the case information to CMS for enforcement action.

Mandatory remedies are actions that CMS is statutorily required to take to address egregious or extended cases of noncompliance and include termination of the facility's Medicare contract and the denial of payment for new admissions.

CMS is required to terminate contracts with facilities that fail to return to "substantial compliance" within 6 months, or have unabated immediate jeopardy deficiencies for 23 days.

CMS is required to apply the denial of payment for new admissions (DPNA) remedy for facilities that fail to return to substantial compliance within 3 months.

Once the state refers a case, CMS determines what actions are warranted. In addition to mandatory remedies, CMS may choose to apply discretionary, or optional, remedies such as civil money penalties.

If, within 23 days of the initial finding, a facility fails to eliminate a deficiency deemed to pose immediate jeopardy or fails to reduce the deficiency to the point that it no longer poses a threat, CMS must either terminate the facility's Medicare contract or appoint a temporary manager to remove the immediate jeopardy and correct the deficiencies

For all facilities that fail to reach substantial compliance within 3 months after the initial deficiency, CMS must apply the mandatory DPNA remedy.

For all facilities that fail to reach substantial compliance within 6 months, CMS is required to terminate the Medicare contract. This type of case arises when the facility still has not reached compliance after application of the required DPNA at 3 months.

For all facilities found to have provided substandard quality of care on 3 consecutive standard surveys, CMS must apply the remedies of DPNA and state monitoring of the facility and the state must notify the attending physician of each affected resident and the state licensing board.

CMS must notify nursing homes prior to applying a mandatory remedy. For immediate jeopardy cases, notice must occur at least 2 days prior to applying the remedy and for all other cases, notice must be sent 15 days prior to applying the remedy, eg, on day 75 for 3 months of noncompliance.

In April 2006, in a repeat performance of his July 2004 letter, Senator Grassley was writing to his pen pals at the CMS again, citing the exact same problems complained of in 2004.

He once again wrote, "the GAO discovered two consistent and longstanding problems: serious inconsistencies in the results of state surveys and the continual understating of negative findings."

"In addition," he said, "it has been reported that there is an imbalance in the effectiveness of CMS oversight initiatives."

"It is evident that there is questionable data resulting from state surveys in terms of both its accuracy and consistency," Senator Grassley wrote. "Often, the information is understated, misconstrued, or just plain inaccurate."

"A chronic and serious problem in the process has been the understating of negative findings by state surveyor agencies," he said.

"Random" nursing home surveys are many times not

random at all, he said. "The level of predictability of these visits are sometimes all too predictable," he told the CMS, "and this permits nursing home staff to conceal instances of poor quality care."

Bells are going off in my head. Duh - where have I heard all of this before?

Then in May 2006, the Office of Inspector General released a report on a study that determined the extent to which the CMS applied the required "mandatory remedies" for nursing homes not in compliance.

Of the 55 cases requiring termination during 2000-2002, the study found, CMS did not apply the mandatory remedy as required in 30 cases or 55% of the time.

CMS is required to terminate nursing homes that fail to return to "substantial compliance" within 6 months, or have unabated immediate jeopardy deficiencies for 23 days.

The study found that 23 cases that required termination were not terminated and these facilities returned to compliance on average 17 days after the termination should have been applied. Seven cases with unabated immediate jeopardy deficiencies were not terminated.

Of the 706 cases requiring DPNA in 2002, 28% percent were never applied and 14% were applied late, largely due to late referral of cases by state survey agencies, the report said.

In those instances for which the remedy was never applied, the facilities were out of compliance on average 19 days past the required date to begin denying payments. In those instances in which the remedy was applied late, the facilities were out of compliance on average 40 days past the required date. In both situations, the report said, facilities were allowed to receive payment past the required date.

In 95% of cases for which mandatory DPNA was handled inappropriately, states did not refer cases to CMS on time. In 2002, the State Performance Review data showed that 38 of the 48 states that had cases requiring the DPNA did not meet the standard of referring 95% of the cases on time.

Through a review of surveys following the study period,

the OIG determined that in subsequent surveys, all of the facilities not terminated had new cases of noncompliance serious enough to again require referral to CMS for enforcement action.

The report said, that after CMS eased the standard in 2003 and again in 2004, states still did not meet the performance standard regarding timely completion of referral in 2003, and 10 states did not meet the standard of referring 80% of their cases on time in 2004.

While the states and the feds continue to point the finger at each other, one thing is for sure, news reports and the watchdog group Taxpayers Against Fraud, have documented a consistent pattern of ongoing illegal activities all over the country in the nursing home industry and nothing seems to slow it down.

For instance, in September 2004, the US Attorney's office for the Eastern District of Pennsylvania reached a civil settlement of $143,000 with Green Acres Rehabilitation and Nursing Center after it had submitted false claims to Medicare and Medicaid, providing inadequate services related to nutrition, medications, falls, and pressure ulcer care.

In November 2004, a Chicago nursing home paid $1.9 million to settle Medicaid fraud charges in which the state and federal government and a whistleblower charged that residents were "routinely abused, neglected, mistreated, sexually assaulted, medicated as a form of punishment, unsupervised and otherwise untreated for their mental health, physical disability, and substance abuse problems."

On May 18, 2005, Hillcrest Healthcare of Connecticut paid $750,000 in civil penalties to settle federal and state charges that it had not provided care required by Medicare and Medicaid.

Hillcrest had already paid a $10,000 fine after pleading no contest to a manslaughter charge related to the death of a resident from a septic infection caused by improperly treated bedsores. The US Attorney said the resident who died was also suffering from anemia, malnutrition, and dehydration, problems he said were suffered by "many" other residents because the facility was inadequately staffed and failed to follow plans of care.

Connecticut's Attorney General said Hillcrest had "gross disregard for human life and the law—fatally neglecting

patients, while at the same time billing the state for the very services it failed to provide."

On October 24, 2005, according to Taxpayers Against Fraud, Illinois Nursing Home Companies and Owners: Robert D. Wacther, R. William Breece, American Healthcare Management, Inc. (AHM) and three nursing facilities managed by AHM; Claywest House HealthCare LLC, Lutheran HealthCare LLC and Oak Forest North LLC, settled a false claims action for $1.25 million.

The Illinois case involved fraudulent billings to public health care programs for substandard care where nursing homes residents suffered from dehydration and malnutrition, were left for extended periods of time without being cleaned or bathed, and contracted preventable pressure sores.

The Associated Press reported another case on May 18, 2006, where a North Idaho jury awarded $18 million in a nursing home abuse lawsuit for the death of an elderly man where the nursing home staff committed "more than 700 violations of federal nursing home regulations."

On May 19, 2006, the Indy Star reported: "A grand jury has indicted two former nursing home officials on neglect charges, alleging they allowed a resident to lay in his own waste for days with back sores and maggot-covered clothing."

In February 2001, the Justice Department's San Francisco office announced the largest settlement ever for fraud in a nursing home case. Beverly Enterprises Inc, agreed to pay a civil settlement fine of $170 million and to relinquish control of 10 nursing homes in California and the subsidiary, Beverly-California, paid a $5 million criminal fine.

The company pleaded guilty to one criminal count of fraud and 10 counts of making false statements to Medicare.

A series of False Claims Act lawsuits that began in the 1990s prove that they are the most effective weapon against nursing homes when they include heavy fines, monitors, and stringent quality of care standards.

The first was filed in February, 1996 by the US Attorney for the Eastern District of Pennsylvania against the owner and former manager of Tucker House, a 180-bed facility in Philadelphia. The complaint alleged inadequate nutrition

and wound care for 3 former residents and that the facility had violated the FCA by submitting claims for services provided when the residents had not received adequate care. The defendant signed off on a $600,000 settlement agreement with orders imposing stringent quality of care standards on the Tucker House.

In January, 1998 the same Assistant US Attorney who handled the Tucker House case filed similar lawsuits against 3 Philadelphia area nursing homes who quickly agreed to pay $500,000 and implement a comprehensive corporate integrity program to settle allegations that they billed Medicare and Medicaid for inadequate care provided to residents.

The complaint specifically identified 5 residents who were not adequately cared for by Chester Care Center, Bishop Nursing Home, and Manchester House Nursing and Convalescent Center. One resident died of injuries received when she was placed in a scalding tub of water by a nurse's aide and 3 other residents died of receiving inadequate diabetes care. Another resident died due to a failure to respond in a timely manner to the resident's progressive weight loss and failure to treat his pressure sores properly.

The reach of these enforcement efforts was further increased by a FCA action filed against Extendicare-owned Greenbelt, Nursing & Rehabilitation Center in Baltimore in August, 1998, which ended up settled in a month.

In this case, state officials had surveyed Greenbelt in January, 1998, and warned the facility in February that it was providing substandard care. Another survey in April, 1998 found that Greenbelt had lied in a report that claimed it was now in compliance.

The exact same pattern was repeated in July and August of 1998, but by then Greenbelt was being fined over $20,000 a month, and state surveyors were asking federal officials to double that amount.

Within a month, the government got Greenbelt to agree to a detailed court order under the FCA that included strict standards for quality assurance, staffing, staff training, medical care, nursing care, wound care, nutritional needs, psychiatric services, and resident safety.

In addition, the company had to hire a monitor and an interim manager, who had to be approved by the

government but paid for by Extendicare and allow the government to interview Greenbelt staff without supervisors or company lawyers present.

Thus, the FCA action achieved outstanding results in a month, when more than 7 months of surveys, warnings, and fines had accomplished nothing.

In 2001, Vencor Inc agreed to pay $104.5 million to settle a case with allegations that it had submitted false claims to Medicare, Medicaid, and other government programs and according to the Department of Justice, $20 million of the false claims were related to failure to provide care, including inadequate staffing, improper care of decubitus ulcers, and failure to meet residents' dietary needs.

Attorney Kennard Bennett believes that civil litigation has raised the awareness of the public about poor care in nursing homes.

"Litigation can hold corporations accountable for poor care," Mr. Bennett explains. "Over time, the goal of this type of litigation is to make it cost more to provide bad care than to provide good care."

Virginia Attorney John Harris III agrees and says, "the way to clean up nursing homes is to make it more expensive to neglect the residents than it is to take proper care of them."

Since there is no provision for fining offending nursing homes in Virginia, he says, the health department is helpless because they can only do one of two things, send the nursing home a dunning letter or close the nursing home.

"If the nursing home is closed," he points out, "where do you put 100 old folks?"

"If a dunning letter is sent," he advised, "the nursing home promises not to do it again and after a month or so goes right back to business as usual."

According to Irvine, California Attorney, James Daily, the situation is not getting better.
"Quite the opposite," he says, "people either need to not get old, or have lots of money – don't grow old poor."

Records are created, lies are told, he says, and the only way anyone can win an elder abuse case is by finding

former employees who will tell the truth about their employers – unless they themselves are licensed – then they will be afraid of speaking because they fear the nursing home making them lose their license.

He also believes litigation is the only effective weapon available to end the abuse and neglect. "My sworn goal as an elder abuse attorney," Attorney Daily advised, "is to make it more expensive to give poor care than it is to give good care."

"I want business to know you have to do it right," he warns, "or I am going to come after you."

"I want juries to understand that only hitting a company in their pocket book will they ever change," Mr Daily notes. "Otherwise it is just a cost of doing business."

"The families that pursue civil cases for the neglect and abuse of their elderly parents," Indianapolis Attorney George Gray says, "do so for two main reasons: 1) they want accountability for the unnecessary harm that was done to their mom or dad, and, 2) they hope that by pursuing a legal action, they are going to help prevent some other family going through the same tragedy with their mom or dad."

According to Attorney, Robert Rikard, nursing home abuse cases should enrage the public, where companies caring only about their bottom line create conditions in their facilities where our most vulnerable citizens are abused and neglected and the only remedy these people and their families have is the legal system.

I for one am enraged. After just one week of investigating the nursing home industry and recognizing the total inability to police it for whatever reasons, I agree with the legal profession, the only way to stop the fraud, and neglect and abuse of our most vulnerable citizens, is to sue the bastards.

More information for injured parties can be found at Lawyers and Settlements.com

http://www.lawyersandsettlements.com/articles.html

Evelyn Pringle
evelyn.pringle@sbcglobal.net

Authors Website: none

Authors Bio: Evelyn Pringle is a columnist for OpEd News and investigative journalist focused on exposing corruption in government and corporate America.

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