ELDER CARE HEADLINES

KY Headlines:

Former Nurse at Nursing Home Faces Neglect, Theft Charges (01/25/12 The Courier-Journal)

A former nurse at the Cumberland Valley Manor Nursing Home in Burkesville, Ky., has been indicted on charges of neglect of an adult and theft of a controlled substance, Attorney General Jack Conway's office said this week.

A Cumberland County grand jury indicted Jinger Butler, 41, on Thursday on 11 counts of neglect and 11 counts of theft of a controlled substance after an investigation by Conway's Office of Medicaid Fraud and Abuse Control and the Burkesville Police Department. Members of the Cumberland County Sheriff's Office took Butler into custody Saturday, and she was released on her own recognizance, officials said.

The indictment for neglect alleges that, between May and November of 2010, Butler replaced and retained the medication of 10 adult residents while she was a caretaker at the nursing home, depriving the residents of needed medication. The indictment for theft of a controlled substance charges that Butler took hydrocodone pills from the residents.

Each count of neglect is a felony with a potential sentence of five to 10 years; theft of a controlled substance also is a felony with a potential sentence of one to five years.

Former Frankfort Nurse Neglect Charge Dismissed (01/27/12 LEX18.com)

A judge has dismissed without prejudice a case against a former Frankfort nursing home nurse.
Last summer, a grand jury indicted Elizabeth Elaine Royse on a felony charge of neglect of an adult. Prosecutors alleged Royse failed to order labs, push fluids, supervise nursing assistants and contact supervisors while caring for a patient at Golden Living Center in Frankfort.

According to court documents, on Jan. 19 Franklin Circuit Court judge Thomas Wingate dismissed the charge, finding that a Kentucky Attorney General's Office inspector, "made certain false and/or misleading statements to the grand jury in order to obtain the indictment."

Court documents indicate the inspector told grand jurors that Royse worked at Golden Living for "several months," when in fact she only worked there for eight weeks. Court documents also say the inspector told the grand jury that Royse failed to notify supervisors about the patient's declining condition. "In fact, defendant proved that she contacted her supervisor several times already and had given her resignation because she felt that the facility was not being operated in a way that allowed nurses to provide high-quality care."

Court documents indicate that the crux of the Commonwealth's case was that Royse failed to follow through with lab orders for the patient. "Yet defendant proved at the hearing with this court that she made several notations for labs to be taken, but those labs were not followed through with by her day shift coworkers."

Judge Wingate also expressed concern that Royse was arrested, noting that since the charge was a class C felony and Royse had no prior criminal record, a criminal summons was "the most appropriate means of notifying a defendant of these charges."

Wingate dismissed the case saying, "these facts clearly display to the court that the prosecution of defendant is unwise, misguided and not in the best interest of the public." The judge amended the dismissal to "without prejudice" on Jan. 20, leaving the door open for the state to refile charges.

CA Headlines:

Nursing Home Investigation Finds Errors by Druggists (01/26/12 The Bay Citizen) By Laurie Udesky

A woman with a medical history of seizures was prescribed the antipsychotic drug Seroquel, despite research showing that elderly people who take antipsychotic drugs are more likely to experience seizures. She was also given the antidepressant Trazodone, which has been linked to an increase in seizures among older patients. And then, according to a recent investigation by the California Department of Public Health, the woman was given a second antipsychotic drug, Risperdal. The combination of the two antipsychotic medications, the investigators said, could cause "life-threatening arrhythmias (irregular heartbeats)."

Despite these potentially dangerous side effects, the pharmacist responsible for reviewing the prescriptions of the woman, a resident of the Greenhills Manor nursing home in Campbell, told state investigators that he had not noted these irregularities or addressed them in the patient's chart.

Pharmacists responsible for reviewing the medication of patients in California nursing homes routinely allowed inappropriate and potentially lethal prescriptions of antipsychotic medications, and failed to correct other potentially dangerous drug irregularities, according to recent state investigations.

In reports obtained by The Bay Citizen, the department found that in 18 of the 32 investigations conducted in California nursing homes between May 2010 and June 2011 — 17 of the 32 were in the Bay Area — pharmacists failed to red-flag cases in which residents were inappropriately prescribed powerful antipsychotic medications like Seroquel, a drug used to treat schizophrenia. Pharmacists also overlooked or approved cases in which medications were prescribed at questionable levels or in unsafe combinations that could put patients at risk of seizures, accidents or even death, according to the public health department. "The consultant pharmacists' review, which is intended to identify unnecessary or potentially inappropriate drugs among nursing home residents, is defective in the state of California," said Jonathan Evans, a geriatrician and the vice president of the American Medical Directors Association. He called the problem "widespread."

The state investigations also suggested a "probable correlation" between the inadequate review of nursing home patients' medications by pharmacists and the failure of those nursing homes to pay a fair market rate for the pharmacists' services. A 1982 anti-kickback law requires nursing homes to pay a fair rate for pharmacy services to discourage consulting pharmacists from endorsing or extending the prescriptions of expensive, and potentially dangerous, drugs. A majority of the nursing homes where the state found patients who were inappropriately prescribed antipsychotic medications were paying below-average fees for pharmacy services.

The California investigations come in the wake of a report last year by the United States Department of Health and Human Services. The report revealed that, in nursing homes nationwide, at least 40 percent of all Medicare claims for so-called atypical antipsychotics, like Risperdal, are inappropriate, given in excessive doses, given for too long, given without the need for use, without adequate monitoring or "in the presence of adverse consequences" and should be reduced or discontinued.

By California state law, consulting pharmacists who work for nursing homes are required to review residents' charts monthly, and recommend to prescribing doctors that medications be stopped, reduced or changed if they pose potential dangers or are causing harmful side effects. The state health department found in its investigations that pharmacists failed to identify the misuse of antipsychotic medications in 90 percent of cases. In 59 percent of those cases, violations occurred in nursing facilities that were cited for accepting pharmacy services below cost.

The average pay rate for California pharmacists is $56.29 an hour, according to the Bureau of Labor Statistics. But a review of nursing home records indicated that some were billed much less, in some cases as low as $11 an hour. The state anti-kickback law bans nursing homes from accepting below-

market rates “from any pharmacist or pharmacy as compensation or inducement for referral of business to any pharmacy.”

“When pharmacy services are provided below cost, the pharmacist may be recouping the losses by making drug recommendations according to financial incentives instead of the best interests of the residents,” said Anthony Chicotel, a lawyer with the California Advocates for Nursing Home Reform, which plans to release a report on the state investigations. “When their independence is compromised, the integrity of their protective function is eviscerated.”
The state investigations yielded a number of examples where the pharmacists’ protective function appeared to be compromised.

At Hillside Senior Care nursing home in Fremont, for example, a consulting pharmacist was billed at a rate as low as $16.24 an hour, and no more than $19.16 an hour, between January and May 2011. In the same period, according to state investigators, a pharmacist at Hillside contradicted a doctor’s request to cut back antipsychotic medication.
“We have corrected this already with the department,” said Vilmar Agustin, Hillside’s director of nursing.

At the Herman Health Care Center in San Jose, investigators found that between August 2010 and January 2011, pharmacist services were billed for as little as $23.75 an hour and not more than $29.75. The state also found prescription irregularities. Mandy Sollis, Herman Health’s business office director, wrote in an email: “We did increase our rate of pay to the pharmacy per regulations.” She would not specify the amount, saying it was private.

In the case of the elderly woman in Campbell who was prescribed drugs that the state investigators said were potentially life-threatening, “With regard to the investigation, I know there was a deficiency and a plan of correction,” said Ed Basa, who had been the administrator at Greenhills Manor at the time of the investigation last June.

At the Empress Care Center in San Jose, investigators found that a resident was kept on Risperdal and that the dosage was increased “without evidence of effectiveness over an eight-month period.” Another patient was on the antipsychotics Seroquel and Haldol, despite side effects that included “continuous lip smacking and shaking of the arms and legs.” The resident told investigators “he had been like that for a very long time.” But the state found nothing in the resident’s chart to indicate that he suffered from side effects.

In another case at Empress, the state found that a resident with dementia who “refused to shower, dress and be groomed” was prescribed Zyprexa, one of a group of medications called “atypical” antipsychotics, which the Food and Drug Administration warned in 2005 were not approved for use in elderly people with dementia because they increase their risk of dying. That warning was extended in 2008 to include older antipsychotic drugs like Haldol.
Administrators at the Empress Care Center did not return calls asking for comment.

Anita Gore, a spokeswoman for the California Department of Public Health, said the recent investigations prompted her agency to pass a regulation limiting the prescription of antipsychotics for Medi-Cal recipients in nursing homes to uses approved by the federal Food and Drug Administration. As a matter of routine, Gore said, nursing homes found by the state to be deficient have 10 days to submit plans of correction, but they can request an extension. “There is no set deadline for submitting a plan of correction,” she said.

Chicotel of California Advocates for Nursing Home Reform said he was disappointed with the state’s response to its own findings. Chicotel said he was concerned that “not a single facility was issued a citation or fined.”

FL Headlines:

Assisted Living Facilities Under the Microscope in Florida (01/24/12 Globe Business Publishing)
By Mia L. McKown and Shannon Hartsfield Salimone

Beginning on April 30, 2011, The Miami Herald published a three-part series of articles on severe abuse and neglect taking place in Florida assisted living facilities (ALFs). The articles detailed horrific incidents and conditions in certain homes, and reported that Florida regulators have, in some cases, taken few actions to address situations where residents have been harmed. In response to The Miami Herald's investigative series, various Florida officials conducted reviews, which resulted in numerous recommendations on how to improve the state's ability to monitor quality and safety in ALFs and ensure the well-being of ALF residents.

Task Force Makes Recommendations On June 27, 2011, Governor Rick Scott vetoed House Bill 4045, which removed many reporting and filing requirements for ALFs.1 Governor Scott advised that until a deliberate examination of the regulation and oversight of ALFs was conducted, he would not approve legislation that relaxed any requirements for ALFs even though he recognized that these Florida facilities "provide safe, high quality housing for their residents."2 He then formed a task force, the Assisted Living Workgroup,3 and assigned it the responsibility of developing recommendations to improve the state's ability to monitor quality and safety in ALFs and ensure the well-being of ALF residents. The task force held meetings for purposes of receiving public testimony and presentations and conducted a focused review of ALF regulations, consumer protection and choice, and long-term care services and access. Ultimately, the task force made several recommendations including:

- increased qualifications and training for administrators and staff
- increased survey and inspection activity with a focus on facilities with poor track record
- a systematic appeal process for residents who contest a notice of eviction
- increased reporting of resident data by facilities
- enhanced enforcement capacity by state agencies
- creation of a permanent policy review and oversight council with members representing all stakeholder group
- requiring all facilities with at least one resident receiving mental health care to be licensed as a limited mental health facility
- providing greater integration of information from all agencies involved in ALF regulation in order to identify potential problems sooner

The Senate Health Regulation Committee also conducted a review of the regulatory oversight of ALFs in Florida. In order to better protect residents from abuse, neglect, or otherwise harmful conditions in ALFs, the committee submitted many recommendation for the Legislature to consider to improve the regulatory oversight of ALFs.4 On December 8, 2011, a Miami-Dade grand jury issued a final report criticizing Florida's Agency for Health Care Administration (AHCA) for lax enforcement. The report described a recent "explosion" in the number of licensed ALFs in Florida. The report did note that there will be an increased need for these types of homes as members of the baby boomer generation age. The report included numerous recommendations to address perceived problems of abuse and neglect in ALFs. These recommendations included:

- making AHCA the lead agency responsible for tracking an investigating complaints
- requiring all complaints of abuse and neglect called into Adult Protective Services be referred to the attorney general's office for possible criminal investigation
- increasing the state's focus on resident welfare, rather than focusing primarily on regulatory compliance

The report commanded AHCA to "Revoke the licenses. Impose the fines. Hit the offenders where it will hurt most, in their pockets." The report stated, "By failing to take action, or even by taking action in an untimely manner, AHCA may be unwittingly putting other residents at risk of harm."

In a press release issued January 12, 2012, AHCA indicated that, in the last six months of 2011, it issued $667,626 in fines against ALFs. Additionally, 13 facilities had their licenses denied or revoked, and "26 assisted living facilities closed during litigation or because of legal or regulatory pressure." AHCA terminated 13 ALFs from the Medicaid program. AHCA Secretary Liz Dudek stated:

The Agency takes seriously our role as the regulator of health care facilities and we continue to take action in cases of significant regulatory violations. The Agency has a comprehensive approach that includes reviewing licensure status and Medicaid eligibility when violations occur.

Two ALF Senate Bills Under Consideration

Although nursing homes and ALFs in Florida both serve elderly and vulnerable residents, there are almost twice as many statutes governing nursing homes. Based upon the recommendations from the recent studies, examinations and reviews, Florida lawmakers are currently considering several bills that would increase ALF regulation. In particular, there are two bills that promote substantial revisions to state law regarding ALFs.

1. Senate Health Regulation Committee Bill 7174

The Senate Health Regulation Committee has submitted a bill that increases ALF regulation in order to improve the safety of persons living in ALFs by requiring:

- an ALF to obtain a limited mental health license if any mental health resident resides in the facility; the bill also revises the eligibility requirements for licensure of a facility seeking to be a limited mental health licensee
- ALFs to provide notice to residents of the confidential nature of complaints to the Office of State Long-Term Care Ombudsman
- state and local agency employees to report abuse, neglect and exploitation of residents to the Department of Children and Families (DCF) central abuse hotline
- that certain facility licensure fees for ALFs with a history of certain violations be increased
- an increase in certain administrative and criminal penalties and reducing AHCA's discretion to impose certain penalties
- all ALF staff to complete at least two hours of pre-service orientation; require an ALF to operate under the management of a licensed administrator
- that the Board of Assisted Living Facility Administration (the "board") be created to issue licenses to administrators who meet delineated eligibility requirements, including age, education, training and examination requirements; the board is to develop training curricula for ALF staff; approve and certify training and testing centers; and certify and discipline core training providers; further, if funding is available, the board is to develop and maintain a database of core training providers and attendees of core training
- AHCA to serve as the central agency for receiving and tracking complaints against ALFs
- agencies, if funding is available, to develop or modify electronic systems to ensure the transfer of information between agencies pertaining to ALFs
- task forces be created to look at streamlining agency regulatory oversight of ALFs and to review AHCA inspection forms to ensure ALFs are being assessed appropriately for resident needs and safety
- AHCA to monitor a certain number of ALF elopement drills
- AHCA to have lead surveyors in each field office, who specialize in assessing ALFs, to train other surveyors of ALFs and facilitate consistent inspections
- a task force be created to review AHCA inspection forms to ensure ALFs are being assessed appropriately for resident needs and safety
- Department of Elder Affairs (DOEA) to have additional staffing in ALFs, depending on the number of residents receiving special care and the type of special care being provided
- ALFs to semiannually report to the AHCA information relating to occupancy rates and residents' acuity and demographics in order for the AHCA to track the information

- AHCA to develop a user-friendly rating system of ALFs
- that community living support plans be updated more frequently
- case managers to record interaction with residents
- consistent and adequate monitoring of community living support plans and cooperative agreements by DOEA.

2. Senate Bill 2050

The Senate Children, Families, Elder Affairs Committee has submitted Senate Bill 2050, which provides additional licensure under certain circumstances, raises the qualifications for ALF administrators, increases the training of administrators and staff, and grants residents and their families specific rights to utilize electronic monitoring devices in their rooms. More specifically, the bill requires:

- case managers to maintain records of face-to-face interaction with a mental health resident
- adequate and consistent monitoring and enforcement of community living support plans and cooperative agreements
- ALFs to provide notice to residents of the confidentiality of certain information when making a complaint to the long-term care ombudsman
- an employee or agent of an agency that has regulatory responsibilities concerning persons in state-licensed facilities to be a mandatory reporter of abuse, neglect, or exploitation of the elderly
- an assisted living facility that serves any mental health resident to obtain a limited mental health license
- a facility to follow specific rules when relocating or terminating the residency of a resident
- a process for a resident to challenge a facility's notice to relocate or terminate the residency of the resident
- a preservice orientation for all employees or administrators hired on or after July 1, 2012
- every ALF to be under the management of a licensed administrator by July 1, 2013, and provides educational and training requirements for an applicant to become an ALF administrator (applicant)
- a provisional license and inactive status in certain circumstances
- DOEA, in conjunction with other agencies, to develop a standardized curriculum for core training and competency tests related to the core training, and to develop curricula for continuing education
- applicants to have 40 hours of core training and successfully pass the competency test with a minimum score of 80
- applicants to complete 10 hours of supplemental training on certain topics
- staff members of an ALF who provide regular or direct care to residents to have 20 hours of core training and successfully pass the competency test with a minimum score of 70
- administrators and certain staff members of a limited mental health ALF to complete eight hours of mental health training within 30 days after employment and pass a competency test;
- administrators to have 18 hours every two years of continuing education and certain staff members to have 10 hours every two years of continuing education
- a certification process for trainers using a third-party credentialing entity approved by DOEA
- ALFs to allow a resident to submit a request to a facility to have electronic monitoring devices in the resident's room and requires certain notices and consents to be given

While the two Senate bills differ on issues such as the training and regulatory oversight, the bills clearly have the same goal? To better protect residents from abuse, neglect, or otherwise harmful conditions in ALFs. There is no word yet on which bill or provisions will be supported by Senate Leadership, but we note SB 2050 has been referred to the Children, Families and Elder Affairs, Health Regulation and Budget committees. Also, given the resistance of the Florida House to any legislation that increases governmental regulation, it is uncertain what measures, if any, will be approved during the 2012 legislative session.