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FEDERAL LAW ENFORCEMENT IN LONG TERM CARE

MARIE-THERESE CONNOLLY, J.D.*

Scarce do I pass a day, but that I hear
Some one or other's dead, and to my ear
Me thinks it is no news. But oh! did I
Think deeply on it, what it is to die,
My pulses all would beat, I should not be
Drowned in this deluge of security.**

Records maintained by State surveyors, charged with inspecting certain types of long term care entities, contained the following notations for a single facility:

- *June 1992*: "More than 25 maggots removed from a patient's nostril and the tape holding in her nasogastric tube."
- *November 1993*: "Staffing has been depleted badly. Patients are not receiving good care, [There were] 6 deaths this past weekend."
- *January 1995*: "[Patient] was admitted about noon. . . ; died about midnight . . . patient was supposed to be suctioned every 10 - 20 minutes. Patient was not suctioned for the last 6 & 1/2 hours of her life. Patient choked to death."
- *March 1996*: "[An] anonymous complainant alleg[es] that there is an outbreak of scabies amongst the patients in the facility."
- *April 1996*: "On Sunday . . . there were 2 RNs and 2 CNAs for the entire [facility]. The census was 84 patients. There was 1 RN on [one area] for 18 critically ill patients. Complainant's mother has a Stage IV decubitus. She was not turned for 12 hours."¹

* Senior Trial Counsel, United States Department of Justice and Coordinator of the Department's Nursing Home and Elder Justice Initiatives. The views expressed in this article are my own and do not necessarily represent the views of the Department of Justice. I am grateful to my current and past colleagues at the Departments of Justice and Health and Human Services for their guidance, indulgence, and friendship which has been critical to the completion of this article and to the ongoing work on elder abuse and long term care issues. Any flaws in the article are mine alone.

** Philip Pain, *Meditation 8*, in *QUEST FOR REALITY* 71, (Yvor Winters & Kenneth Fields, eds.).

1. These are the findings of state survey teams assessing the conditions within a long-term care facility from June 1992-April 1996. The records are on file with the author.

INTRODUCTION

Despite the gravity of the findings above, and the fact that the facility in question was one of hundreds owned by the same chain, the allegations were not referred to law enforcement until long after 1996, and then by a former employee-whistleblower. Historically, law enforcement² rarely has been involved in matters relating to abuse and neglect in long term care. Reports of grave and wide-spread abuse and neglect in such facilities have persisted for decades, receiving attention in fits and starts.³ Despite some improvements over time, recent reports continue to cite serious ongoing problems, including that an estimated one third to one quarter of nursing homes provide seriously deficient or potentially life-threatening care;⁴ that almost one third of all nursing homes are cited for abuse-related deficiencies;⁵ and that an estimated 50%⁶ to 90%⁷ of all nursing homes are understaffed at levels that have been shown to harm residents.

2. The term "law enforcement" is used in this article to encompass the full range of potential federal, state, and local law enforcement responses including police intervention, investigation, and prosecution.

3. See U.S. Sen. Special Comm. on Aging, Elder Abuse: The Case for Congressional Action Now, 1974-present (on file with the author); Amanda Beeler & Scott Fornek, *Ideas, But No Easy Answers to Fight Abuse*, CHICAGO SUN, Dec. 19, 2001, available at http://www.sun-times.com/special_sections/elder/cst-nws-reform19.html; COMMITTEE ON NURSING HOME REGULATION, INSTITUTE OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES (1986) [hereinafter IMPROVING THE QUALITY OF CARE]; U.S. GEN. ACCOUNTING OFFICE, NURSING HOMES: MORE CAN BE DONE TO PROTECT RESIDENTS FROM ABUSE, (GAO-02-312)(2002) [hereinafter 2002 GAO Report].

4. See U.S. GEN. ACCOUNTING OFFICE, CALIF. NURSING HOMES: FED. AND STATE OVERSIGHT INADEQUATE TO PROTECT RESIDENTS IN HOMES WITH SERIOUS CARE VIOLATIONS, 2 (GAO/HEHS-98-219) (1998) [hereinafter 1998 GAO Report]. GAO examined California nursing homes and concluded that nearly one third had been cited for providing seriously or potentially life-threatening care. It reported that "even when the state cites serious deficiencies, HCFA's enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected." *Id.* The GAO examined care provided to a sample of 62 residents who had died during the year from malnutrition, dehydration, pressure sores, or urinary tract infections with sepsis, and found that more than half of those residents had received unacceptable care. *Id.* Soon thereafter, the Department of Health and Human Services (HHS) Office of Inspector General (OIG), Office of Evaluations and Inspections (OEI) issued a report reaching very similar conclusions: OEI concluded that 13 of 25 quality deficiencies were on the rise, including pressure sores, accidents, and failure to provide proper care for the activities of daily living; that long term care ombudsman complaints had increased since 1989 even while inadequate resources limit their capacity. See DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF INSPECTOR GENERAL, QUALITY OF CARE IN NURSING HOMES: AN OVERVIEW, 1-2 (OEI-02-00-00060) (1999). OEI also noted that it was still unclear whether new law enforcement initiatives would have any impact. See *id.* at 4.

5. See Minority Staff, Special Investigations Division, Comm. on Gov't Reform, U.S. H.R., *Abuse of Residents is a Major Problem in U.S. Nursing Homes*, July 30, 2001, at http://www.house.gov/reform/min/inves_nursing/index.htm#anch_abuse [hereinafter *Abuse of*

Even where misconduct by an entity or individual constitutes egregious abuse and neglect, causing illness, suffering, and sometimes death of frail residents, in the past, law enforcement rarely has been timely notified or become involved.⁸ When it did become involved, typically the cases were the province of state and local law enforce-

Residents]. This study, released in early August 2001 by Congressman Waxman, reports that about one third of nursing homes were cited for abuse-related deficiencies. The study examines four deficiencies or "tags" – F-223 is actual substantiated abuse, F-224 is cited when a facility fails to write or use policies that forbid mistreatment, abuse, neglect, and misappropriation, and F-225 is cited when a facility fails to hire staff without histories of abuse behaviors, or fails to report and investigate allegations of abuse, and F-226 is cited when a facility fails to implement the policies it writes to forbid mistreatment, abuse, neglect, and misappropriation. Thus, only one of the tags in question is for cases of substantiated abuse. What this and most reports have even greater difficulty capturing is neglect, even when it is systemic and/or egregious and leads to injury or death in at least one and sometimes numerous individuals.

6. See HEALTH CARE FINANCING ADMIN., REPORT TO CONGRESS: APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES, E.S.-5, 2000 [hereinafter STAFFING RATIOS]. OBRA '87 required HCFA/CMS to analyze nursing home staffing. HCFA/CMS released Phase I of the long anticipated study in July 2000. The study concluded that 54% of all nursing homes are understaffed for nursing aides and it demonstrated a correlation between understaffing and harm to residents. See *id.*

7. A companion study to the one described *supra*, note 6, announced the same day, concluded that 92% of all nursing homes are not staffed to "optimum" levels. See STAFFING RATIOS, *supra* note 6 at E.S.-5. Optimum levels were conservatively defined and assumed maximum productivity of nursing staff. See *id.* See also CENTER FOR MEDICARE & MEDICAID SERVICES, REPORT TO CONGRESS: APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES, PHASE II FINAL REPORT, 2002. A February 18, 2002 article by Robert Pear in the New York Times reports that the staffing study concludes that nine out of ten nursing homes "had nurse aide staffing levels that fell below the thresholds identified as minimally necessary to provide the needed care." See Robert Pear, *9 of 10 Nursing Homes Lack Adequate Staff; Study Finds*, N.Y. TIMES, 11. The article notes that the report "found 'strong and compelling' evidence that nursing homes with a low ratio of nursing personnel to patients were more likely to provide substandard care." *Id.* Patients in these homes were more likely to experience a variety of injuries and illnesses, including bedsores, malnutrition, weight loss, dehydration, pneumonia and serious blood-borne infections. See *id.* In addition, it reported that "over 40 percent of all nursing homes would need to increase nurse aide staffing by 50 percent or more to reach the minimum threshold associated with their resident population." *Id.*

8. See 2002 GAO Report, *supra* note 3, at 4. See also an Administration on Aging study that concludes that "for every abused and/or neglected elder reported to and substantiated by APS, there are over five abused and/or neglected elders that are not reported." See Admin. on Aging, *The National Elder Abuse Incidence Study; Final Report*, 1998, available at <http://www.aoa.dhhs.gov/abuse/report>. Many assume that this AoA study underestimates the amount of underreporting. See Sidney M. Stahl, *The Need for a National Investment in Research on Elder Abuse and Neglect*, in ELDER JUSTICE: MED. FORENSIC ISSUES RELATING TO ABUSE AND NEGLECT, ¶ 117 (U.S. Dep't of Justice., eds., 2001) [hereinafter MED. FORENSIC ISSUES]. (stating "The study design used to acquire these data is problematic and represent a significant underestimate.").

ment, and most often pursued against low level individual wrongdoers, to the extent cases were pursued at all.⁹

Against this background law enforcement at all levels has heightened its focus on this issue. The Senate Special Committee on Aging held a hearing in March 2002, during which the Government Accounting Office (GAO) released a report concluding, and witnesses testified, that physical and sexual abuse in nursing homes is not reported to law enforcement on a timely basis, and rarely prosecuted.¹⁰ Some state legislatures have enacted new laws providing additional causes of action that better fit the offenses in question.¹¹ Some states and communities have increased the priority of pursuing long term care and/or elder abuse and neglect issues.¹² Similarly, in recent years, the Department of Justice has made these issues a priority, launching its Nursing Home and Elder Justice Initiatives, pursuing more cases involving abuse and neglect in long term care, and expanding efforts in the "administration of justice."¹³

The first section of this article - *Summary* - provides an overview of *federal* efforts - both in the enforcement of federal law and in the administration of justice. The second section - *Background* - discusses the context in which these cases and issues arise, briefly reviewing sobering reports of abuse, neglect, and other problems in long term care, the demographic trends that are increasing the demand for quality long term care, the ever-shifting nature of providers, and the role of a few of the myriad entities and programs with a role in assuring the quality of long term care. The third section - *Federal Law Enforcement* - reviews examples of the civil, criminal, and civil rights cases that the Department of Justice (Department or DOJ) has pursued as the agency responsible for enforcing federal law. The fourth section - *Administration of Justice* - reviews the Department's efforts (other than pursuing cases) to enhance the knowledge base and to improve the prevention, intervention in, and prosecution of elder abuse and neglect.

9. *But see* cases cited *infra* notes 89-92 & 94.

10. *See* 2002 GAO Report, *supra* note 3; Hearings Before the Special Committee on Aging, United States Senate, Safeguarding our Seniors: Protecting the Elderly from Physical and Sexual Abuse in Nursing Homes, 107th Cong., 2d Sess (2002).

11. *See, e.g.*, 18 PA. CONS. STAT. § 2713 (2001).

12. *See, e.g.*, Warren Wolf, *Elder Abuse Team Striving to Protect the Vulnerable*, STAR TRIBUNE (Minnesota), Dec. 27, 2001, at <http://www.startribune.com/stories/462/923513.html>.

13. *See Elder Justice* (last modified June 6, 2001) <<http://www.usdoj.gov/elderjustice.htm>>. The Department's administration of justice efforts include providing for training and coordination, recommending new laws to fill gaps in legislation, increasing public awareness, funding promising research and programs, and pursuing other measures.

I. SUMMARY

Employed individually or in combination, federal law enforcement possesses a spectrum of tools that can be brought to bear to punish wrongdoing, recoup lost government funds, deter future wrongdoing, protect residents, and promote better care. Those tools include the False Claims Act,¹⁴ common law,¹⁵ equity,¹⁶ several potential criminal statutes,¹⁷ and the Civil Rights of Institutionalized Persons Act (CRIPA).¹⁸ Together with the exclusion authority, corporate integrity agreements and divestiture agreements pursued by the Department of Health and Human Service's Office of Inspector General (HHS/OIG), and the programmatic remedies available to the Centers for Medicare and Medicaid Services (CMS), the federal entities, working individually and in collaboration with one another have a variety of tools with which to punish wrongdoing, recoup government funds, protect residents, and promote better long term care.¹⁹

Significantly, the Department, HHS/OIG and CMS have worked closely and creatively on long term care matters, combining and balancing the entities' respective yet overlapping regulatory, public health, and law enforcement goals.²⁰ Similarly, vigorous anti-fraud efforts must remain a priority to protect the Medicare and Medicaid trust funds, so that those programs are not unnecessarily and unlawfully depleted, as the number of beneficiaries skyrockets and demand on the programs grows.

Greater involvement of federal law enforcement in this area is not only appropriate, but imperative. It is warranted to protect the more than \$50 billion in federal funds that flow to long term care

14. 31 U.S.C. § 3729 (2001).

15. See *United States v. Cripps*, 460 F. Supp. 289 (S.D. Ill. 1980).

16. See *Blusal Meats, Inc. v. United States*, 638 F. Supp. 825 (S.D. N.Y. 1986), *aff'd*, 817 F.2d 1007 (2d Cir. 1987).

17. See *infra* note 269.

18. 42 U.S.C. § 1997 (2001).

19. There is no federal long term care abuse and neglect statute. In 2000, the Department proposed, and OMB cleared, a proposal for such a statute providing the Department with authority to pursue criminal, civil and injunctive remedies where patterns of violations of underlying quality provisions resulted in harm to residents. The proposed bill never gained real momentum in Congress and was not enacted. 42 U.S.C. § 1395i-3(c)(1)(4)(ii) and 42 U.S.C. § 1396r (c)(1)(A)(ii), however, make explicit reference to the rights of nursing home residents to be free of abuse.

20. See Press Release, Department of Justice, Vencor and Ventas Paying U.S. \$219 Million to Resolve Health Care Claims as Part of Vencor's Bankruptcy Reorganization (Mar. 19, 2001).

annually *to care for beneficiaries*.²¹ It is warranted because many long term care providers are now multi-state or multi-national entities, necessitating national coordination.²² It is warranted in light of the large number of nursing home providers that have sought protection of federal bankruptcy laws.²³ It is warranted in light of the increasing number of failure of care False Claims Act *qui tam* cases that trigger a federal inquiry into allegations. It is warranted because reports of abuse and neglect persist and may be on the rise. And it is warranted because those who need long term care are extremely vulnerable and dependant on that care being provided consistent with legal standards. Sometimes their very survival depends on the full and proper enforcement of the law. For these reasons and more, there is a substantial federal interest in enforcing the relevant laws that bear on quality long term care.

While law enforcement should have a significant role in addressing failures in long term care, it is only one piece of the puzzle. Legislation, public awareness, reimbursement policy, regulation, facility surveys, administrative enforcement, advocacy, increased staffing, and – most critical of all – the providers' own commitment to the care they provide – in some combination usually come into play before law enforcement. In a perfect world those forces would obviate the need for law enforcement.

But the world is not perfect, and when these mechanisms fail, and especially when there are multiple failures and injuries or deaths due to wrongdoing, law enforcement should play a role. The converse of recognizing that law enforcement is a blunt tool that should be used sparingly, is the recognition that it is a powerful tool that *should* be used in appropriate circumstances. It can and should operate as a backstop to the many other mechanisms in place to promote quality long term care for our nation's most vulnerable citizens. As long as reports of abuses persist, law enforcement must do its part to redress those abuses.

Less well known than the Department's cases are its efforts to fund, promote, or provide education and training, assessment of needs, research, promising practices, coordination, recommending

21. See HCFA, Nursing Home Care Expenditures and Average Annual Percent Change, by Source of Funds: Selected Calendar Years 1970-2008, at <http://www.managedcaredigest.com/is2000/is2000.html>.

22. See U.S. HOUSE OF REP., NURSING HOME CONDITIONS IN THE DISTRICT OF COLUMBIA: MANY HOMES FAIL TO MEET FEDERAL STANDARDS FOR ADEQUATE CARE 7 (Jan. 7, 2002) [hereinafter NURSING HOME CONDITIONS].

23. See *infra* note 255 and accompanying text.

new laws, and raising awareness. These efforts are broad-based and their focus is not only prosecution, but also prevention, treatment, and interventions other than or in addition to prosecution. It is widely acknowledged that our knowledge of and response to elder abuse and neglect lags decades behind other complex problems, such as domestic violence and child abuse and neglect.²⁴ Whereas these other issues, over the course of the past decades, have come to be considered law enforcement issues, the same cannot yet be said for elder abuse and neglect.²⁵ A seasoned police officer who is knowledgeable about the topic recently remarked that many officers would rather go into a crack house than a nursing home.

As in any other type of prosecution, identification, collection, and preservation of forensic evidence also is critical in elder abuse and neglect cases. Unfortunately, little is known about forensic markers of abuse and neglect, or forensic methods that should be used in identifying and collecting evidence, because the area has been almost completely devoid of research.²⁶ For example, there are few evidence-based benchmarks to establish or even provide guidance on which types of bruising, fractures, decubitus ulcers, malnutrition, or dehydration (among other conditions) are more likely to be evidence of abuse and/or neglect as distinguished from those conditions that were caused by aging or disease unrelated to abuse or neglect.²⁷ Except in obvious cases, healthcare, social service, and emergency response professionals are not trained and do not possess the tools to identify likely abuse and neglect.²⁸ Even where it is suspected, few entities have reporting protocols, and it is very rarely reported,²⁹ despite mandatory reporting laws in all but six states.³⁰ Even when it is reported, it may not be prosecuted for reasons that may include inadequate causes of action, inexperience in the investigation and prosecution of these often complex cases, a paucity of medical experts in the area, and scarce if any resources or priority allocated to the pur-

24. See Catherine Hawes, *Elder Abuse in Residential Long-Term Care Facilities: What is Known and What Information is Needed?* 30 (Sept. 27, 2001) (unpublished manuscript, on file with the author) [hereinafter *Elder Abuse in Residential Long-Term Care*].

25. See *id.*

26. See Dyer et al., *The Clinical and Medical Forensics of Elder Abuse and Neglect* 3 (2001) (unpublished manuscript commissioned by the National Academy of Sciences) (on file with the author) [hereinafter *Clinical and Medical Forensics*].

27. See *id.*

28. See *id.* at 5.

29. See *id.* at 3; 2002 GAO Report, *supra* note 3.

30. The states that do not have mandatory reporting laws as of 12/31/2001 are Colorado, New Jersey, New York, North Dakota, South Dakota and Wisconsin.

suit of these matters. Progress in each of these issues is critical to the ability of law enforcement at all levels to effectively pursue these cases.

Experience in the fields of child abuse and neglect, domestic violence, and even in the less developed elder abuse and neglect field, suggests that multi-disciplinary and inter-disciplinary efforts are most effective.³¹ Factors including the often extreme vulnerability of the victim, the special relationships between abuser and victim, and victim dependence on those who may abuse and neglect them, demand the individual and collaborative attention of healthcare, social service, public safety, regulatory and law enforcement professionals to reach an effective resolution.³²

Enabling legislation and the ensuing creation of an Office of Juvenile Justice and Delinquency Prevention (OJJDP) in 1974 and the Violence Against Women Office in 1995 – have led to increased focus on, funding for, and great strides in these areas.³³ No similar infrastructure exists yet to create a focus at the national level on the prevention, intervention in, and prosecution of abuse and neglect of older Americans.

Some efforts, however, are underway, and there clearly is a significant role to be played by federal law enforcement, in coordination with other entities, to provide leadership, advance the knowledge base, and develop strategic, collaborative, and effective responses to address these issues, particularly as the number of frail and older Americans and the corresponding need for quality long term care soars.

II. BACKGROUND

To put the role of federal law enforcement in context, this article first briefly reviews the reported problems, the growing need for quality long term care, the nature of the industry, and the primary players and programs.

31. See Erik J. Lindbloom, *How Can We Identify Physical and Psychological Markers of Abuse and Neglect?* in MED. FORENSIC ISSUES, *supra* note 8, ¶ 133.

32. See Hawes, *Abuse in Long-Term Care*, *supra* note 24, at 7.

33. See Juvenile Justice & Delinquency Prevention Act of 1974, 42 U.S.C. § 5601 (1994). The Office of Juvenile Justice and Delinquency Prevention has a web site at <http://ojjdp.ncjrs.org/about/about.html>; Violence Against Women Act of 1994, 42 U.S.C. § 13981 (1995). The Violence Against Women Office has a web site at <http://www.ojp.usdoj.gov/vawa>.

A. *The Players and Programs*

Those discussing law enforcement involvement in long term care often conflate the many potential enforcement entities into a single monolith, when in fact there are many distinct players.³⁴ In examining the role of law enforcement in long term care, it is critical to consider both administrative and law enforcement options, as well as other potential players. A brief overview of some of the relevant entities and programs follows.

Providers. The entity with primary responsibility for assuring quality care is the provider itself and those responsible for its operation. The provider assumes the duty to have in place the staff, resources, and procedures necessary to provide the necessary care and comply with the relevant medical and legal standards.³⁵

The Medicare and Medicaid Programs. The Social Security Act of 1935³⁶ included a federal old age insurance program and grants to states for assistance to the elderly called "Old Age Assistance."³⁷ Federal jurisdiction over the quality of care that nursing homes provide began with the creation of the Medicare and Medicaid programs in 1965, as part of the Great Society programs.³⁸ Medicare pays for medical care for persons aged 65 and older, and for persons with disabilities.³⁹ The Medicaid Act established an elaborate statutory scheme under which the federal government and the states jointly finance medical assistance for individuals unable to afford necessary medical services.⁴⁰ Both Medicare and Medicaid pay for care provided in nursing homes. Medicare will pay for up to 100 days of skilled nursing

34. See Joan H. Krause, *The Fraud and Abuse Conundrum*, at http://law.slu.edu/health_law/research/doc_analysis/krause_essay.html (last visited 1/15/2002).

35. See 42 C.F.R. § 483.20 (2000). Among other things, providers are required, at the time of a resident's admission and regularly thereafter, to conduct a comprehensive, accurate, standardized assessment of the resident's medical and psychosocial needs, nutritional status, skin condition, continence, and functional capacity. See *id.*

36. 42 U.S.C. § 1381 (2000).

37. See 42 U.S.C. § 301 (2000). Nursing homes receive substantial government monies – about \$10.9 billion from Medicare in 2000 and \$42.3 billion from Medicaid (\$24.1 billion federal share and \$18.2 billion state share) in FY 2000. Spending for long term care is even greater – in 1999 approximately \$18 billion in Medicare and \$59 billion in Medicaid dollars, for a total of \$77 billion. In general, nursing homes receive about 65% of their funds from Medicaid, 10% from Medicare, and 25% through a combination of insurance, private pay and other.

38. See Pub. L. No. 89-97, 79 Stat. 291 (codified as amended at 42 U.S.C. § 1395).

39. See 42 U.S.C. § 1395 (1998).

40. See 42 U.S.C. § 1396 (1998). For a more extensive discussion of these provisions, see Kristine Blackwood and Howard Daniels, *Analysis & Perspective: Nursing Home Liability for Failure of Care Under False Claims Act*, 6 BNA HEALTH CARE FRAUD REP. 3 (2002).

care that follows a qualifying hospital stay.⁴¹ Medicaid eligibility is defined by the states, but usually is available to financially needy individuals who need skilled care or other assistance with activities of daily living.⁴²

To participate in the Medicare program, providers must be licensed by the state, enter into provider agreements with CMS,⁴³ and be certified as being in compliance with mandatory federal standards.⁴⁴ To participate in Medicaid, nursing facilities must enter into agreements with the states that incorporate the federal requirements for participation, as well as applicable state requirements, and be certified as being in compliance with the quality requirements under 42 U.S.C. § 1396r (b)-(d) and the standards governing payment under 42 C.F.R. Part 442.

In the mid-1970s, reports of widespread abuse and neglect in nursing homes, and the National Academy of Sciences' Institute of Medicine's (IOM) issuance of a report in 1986 called "Improving the Quality of Care in Nursing Homes,"⁴⁵ catalyzed enactment of a sweeping Nursing Home Reform Act, incorporated in the Omnibus Budget Reconciliation Act of 1987.⁴⁶ OBRA '87 aimed to ensure that nursing home residents achieve and maintain the "highest practicable physical, mental, and psychosocial well-being."⁴⁷

Among other things, OBRA '87 expanded and defined the quality of life and quality of care requirements on which Medicare and Medicaid participation is conditioned, changed the survey process to focus more on resident outcomes, and required state survey agencies and providers to share survey information with federal and state investigators, specifically including state Medicaid Fraud Control Units.⁴⁸

41. See 42 U.S.C. § 1395d(a)(2)(A) (2001).

42. See 42 U.S.C. § 1396 (2001).

43. See 42 U.S.C. § 1395cc(a)(1) (1998); 42 C.F.R. § 442.12 (2001).

44. See 42 U.S.C. § 1395i-3(b)-(d) (1998); 42 C.F.R. § 483.1 (2001).

45. See IMPROVING THE QUALITY OF CARE, *supra* note 3. The IOM recommended an overhaul of the nursing home regulatory system and the development of a comprehensive system that would focus on patients' rights, actual delivery and quality of care, and the results of that care. See *id.* See also Medicaid and Medicare Long Term Care Survey, 53 Fed. Reg. 22850, 22850 (1988).

46. See 42 U.S.C. § 1395i-3 (2001) (standards for Medicare-funded skilled nursing facilities); 42 U.S.C. § 1396r (2001) (parallel standards for Medicaid-funded nursing facilities).

47. 42 U.S.C. § 1395i-3(b)(2) (2001); see also 42 U.S.C. §§ 1396r(b)(2), 1395i-3 (2001) (governing quality of care for Medicare beneficiaries), 42 U.S.C. § 1396r (2001) (establishing identical standards for Medicaid-funded nursing facilities); 42 C.F.R. § 483 (1998) (implementing quality provisions).

48. See 42 U.S.C. §§ 1395i-3, 1396r (2001).

State and Federal Surveyors. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) administers the Medicare program, oversees the states' implementation of the Medicaid program, and is charged with ensuring that providers meet federal care standards. OBRA '87 established a review and enforcement scheme pursuant to which state agencies, under contract with CMS, are primarily responsible for regularly monitoring and enforcing compliance with the quality of care standards through on-site inspections.⁴⁹ In conducting these surveys, state surveyors must apply detailed federal standards and use the protocols and forms required in the federal regulations.⁵⁰ During such surveys, which are conducted unannounced approximately every 9 - 15 months, surveyors determine whether a particular facility is in compliance with criteria drawn from the statute and regulations set forth in the state operations manual (SOM).⁵¹ Problems uncovered by the surveyor, called "deficiencies," are in turn categorized (on a "grid") by scope and severity⁵² – and include the extent to which they jeopardize one or more residents' health or well being.⁵³

Federal surveyors, who work for CMS, may conduct "look behind"⁵⁴ surveys, which they do in about five percent of cases.⁵⁵ Both state and federal surveyors may respond to complaints – called "complaint surveys."⁵⁶ In the wake of the numerous bankruptcies of nursing home chains, CMS in 1999 asked the state surveyors also to conduct surveys of each facility owned by a bankrupt entity within 30 days of the bankruptcy filing to assure that the financial crisis did not have an immediate adverse effect on the residents.⁵⁷

Ombudsman. The Older Americans Act⁵⁸ (OAA) created the long term care ombudsman program in 1978.⁵⁹ Each state has state and local long term care ombudsmen who are responsible for represent-

49. See 42 U.S.C. §§ 1395aa(a), 1396r(g)(1)(A) (2001); 42 C.F.R. §§ 431.108, 488.10(a), 488.20, 488.301 (1998).

50. See, e.g., 42 C.F.R. § 431.610(f)(1) (1998).

51. See CMS, State Operations Manual, at http://www.hcfa.gov/pubforms/07_som/pub07.toc.htm [hereinafter State Operations Manual].

52. See generally 42 C.F.R. § 431.610(f)(1) (1998).

53. See *id.* See also State Operations Manual, *supra* note 51 § 7000.

54. See 42 U.S.C. §§ 1396a(a)(33)(B), 1396i(b)(1) (2001).

55. See 42 U.S.C. §§ 1396a(a)(33)(B), 1396i(b)(1) (2001).

56. See State Operations Manual, *supra* note 51 §§ 3281-3284.

57. See Testimony of Steven Pelovitz, Director, Survey & Certification Group, HCFA, on Nursing Home Bankruptcies before the Senate Special Committee on Aging, 9/5/2000, available at <http://www.hcfa.gov/testimony/2000/090500.htm>.

58. 42 U.S.C. § 3001 (1994).

59. See 42 U.S.C. § 3011 (1994).

ing the interests of nursing home residents.⁶⁰ Some ombudsmen are paid; many are volunteers.⁶¹ Some work for state departments of health, aging, or other government entities.⁶² Others work through legal services, or, in at least one case, through AARP.⁶³ Many ombudsman work on a shoe-string budget.⁶⁴ Ombudsman are required to maintain information they obtain from and about their clients confidential.⁶⁵ These confidentiality requirements have been upheld, even in the case of a subpoena.⁶⁶ Ombudsmen's authority vary from state-to-state. In a few states, long term care ombudsman are authorized to conduct investigations. For example, New Mexico's ombudsman are authorized to conduct undercover operations in long term care facilities, including nursing homes and assisted living facilities.⁶⁷

Adult Protective Services. In 1962 Congress enacted the Public Welfare Amendments to the Social Security Act authorizing payments to states for protective services to "persons with physical and/or mental limitations who were unable to manage their own affairs. . .or who were neglected or exploited."⁶⁸ In 1974 Title XX of the Social Security Act required the states to implement Adult Protective Services programs at the state level for adults 18 and older.⁶⁹ Most states within a few years passed elder abuse laws.⁷⁰ There was no model legislation, however, and state law is all over the map.⁷¹ Many states used child

60. *See id.*

61. *See* Long-Term Care Ombudsman Program, <<http://www.aoa.gov/factsheets/ombudsman.html>> (last modified 12/14/2001).

62. *See id.*

63. *See* AARP, *What We Do*, (visited 12/31/2001) <<http://www.aarp.org/foundation/capability.html>>.

64. *See e.g.*, Office of the Long Term Care Ombudsman-Budget, <http://www.sos.state.or.us/BlueBook/1999_2000/state/executive/Long_Term_Care/long_term_care_budget.htm> (visited 12/19/2001).

65. *See* 42 U.S.C. § 3058g (2001).

66. *See* Genesis Eldercare Network Serv. v. Courtland Healthcare, No. 98-06023 (Chester Co., Pa. Ct. C. P. 1998).

67. *See* New Mexico State Agency on Aging Three Year Plan, at <<http://www.nmaging.state.nm.us/plan2000.html>> (last visited 12/19/2001); Press Release, New Mexico State Agency on Aging, State Agency on Aging Uncovers Poor Treatment in Three Long-Term Care Facilities (Aug. 9, 1999).

68. Public Welfare Amendments of 1962, Pub. L. No. 87-543, § 106(b), 76 Stat. 172, 188 (codified as amended at 42 U.S.C. § 602(a)(7) (1996 & Supp. V 1981)).

69. *See* Social Services Amendment of 1974, Pub. L. No. 93-647, §§ 2000-2006, 88 Stat. 2337-48 (codified as amended at 42 U.S.C.A. § 1397a-e (West Supp. 1998)).

70. *See e.g.*, 720 ILL. COMP. STAT. ANN. 5/12-21 (West 1997); ME. REV. STAT. ANN. tit. 19-A §§ 4001-4014 (West 1999).

71. *See* Seymour Moskowitz, *Saving Granny From the Wolf: Elder Abuse and Neglect-The Legal Framework*, 31 CONN. L. REV. 77, 90 (1998).

abuse legislation as a model for reporting laws.⁷² This model sometimes was useful and other times was problematic and resulted in violation of some older people's civil rights.⁷³ APS has authority to investigate allegations of abuse and neglect in facilities in only about half of the states and the nature of its authority varies from state-to-state.⁷⁴

Administrative Enforcement. Often the term "enforcement" relating to long term care is used to refer to administrative efforts to enforce the statutory and regulatory standards governing nursing homes that are implemented by CMS and/or by state agencies for health, aging, and human welfare which have concurrent jurisdiction over nursing homes, and, in some states, other types of long term care facilities.⁷⁵ Federal and state administrative enforcement cases far outnumber law enforcement cases brought in response to problems in nursing homes.⁷⁶

OBRA '87 provided CMS with a broad panoply of potential remedies, ranging from the severe (termination) to the mild (directed plans of correction) and adding a number of intermediate measures.⁷⁷ These remedies include:

- (1) Termination of provider
- (2) Termination of payments to the provider
- (3) Imposition of Civil Monetary Penalties (CMPs)
- (4) Denial of payment for existing and new admissions
- (5) Temporary management
- (6) Temporary monitoring
- (7) Directed plans of correction⁷⁸

72. See *id.* at 158.

73. See Audrey S. Garfield, *Elder Abuse and the State's Adult Protective Services Response: Time for a Change in California*, 42 HASTINGS L. J. 859, 877-80 (1991).

74. See KAN. STAT. ANN. § 39-1401 (1995) (does allow intervention); HAW. REV. STAT. § 48.003 (1999) (does not allow intervention).

75. See 42 U.S.C. § 1395i-3 (1995); 42 U.S.C. § 1396r (1994); 42 C.F.R. § 483 (1997); 42 C.F.R. § 488 (1997); MO. REV. STAT. § 198 (1994 & Supp. 1998); ILL. COMP. STAT. ANN. 4/45 (West 1998); Special Committee on Aging, Ca. Nursing Homes: Care Problems Persist Despite Federal and State Oversight I (Letter Report, July 27, 1998, GAO/HEHS-98-202) [hereinafter *Care Problems Persist*]; Angela Snellenberger Quinn, Comment, *Imposing Federal Criminal Liability on Nursing Homes: A Way of Deterring Inadequate Health Care and Improving the Quality of Care Delivered?* 42 ST. LOUIS U. L. J. 653, 660 (1990).

76. Federal actors rarely have jurisdiction in cases relating to long term care facilities that do not receive federal funds. Depending on its law, a state may pursue administrative or law enforcement action.

77. See 42 C.F.R. § 488.400 (1998).

78. *Id.*

Notably, OBRA greatly expanded the administrative remedies available to CMS to enforce compliance with the federally-mandated standards⁷⁹ and provided it with greater flexibility and range in determining the appropriate remedy in any given case.⁸⁰ After a survey, facilities must submit a plan of correction to CMS and/or the state survey agency for approval, unless the agency has identified only isolated deficiencies.⁸¹ If a facility is not in compliance within three months after the agency's finding of non-compliance, CMS must deny payment for new admissions to the facility until it determines that the facility is in substantial compliance with all the requirements.⁸² Substantial compliance is defined in the regulations as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm."⁸³ If three consecutive standard surveys find evidence of substandard quality of care, CMS must deny payment for new admissions and monitor the facility until it comes back into compliance.⁸⁴

Many states also have enacted patient's rights and quality of care statutes paralleling or expanding on the provisions of OBRA.⁸⁵ Some of these provisions are additional requirements of participation in the health care programs.⁸⁶

Significantly, CMS' remedies arise out of the "participation agreement" entered into between CMS and the individual entity.⁸⁷ Thus CMS administrative enforcement actions run only to a single facility and not to a chain, which, in cases involving systemic problems originating from a national or regional headquarters, may limit the scope and effectiveness of a facility-specific remedy.

State and Local Law Enforcement. Law enforcement officials at the state and/or local levels include district attorneys, states attorneys, county attorneys, as well as state and local police, sheriffs, coroners, medical examiners and others. State law enforcement also includes Medicaid Fraud Control Units (MFCUs) which have a central role in prosecuting abuse and neglect in medicaid funded facilities, and which may under recent legislation pursue cases arising in non-Medi-

79. See 42 U.S.C. §§ 1395i-3(h), 1396r(h) (2001).

80. See 42 C.F.R. § 488.400 (2001).

81. See 42 C.F.R. § 488.402(d) (2001).

82. See 42 C.F.R. § 488.417(2)(b) (2001).

83. 42 C.F.R. § 488.301 (2001).

84. See 42 C.F.R. § 488.422(b) (2001).

85. See e.g., CONN. GEN. STAT. ANN. § 17b-357 (West 1997).

86. See e.g., CONN. GEN. STAT. § 19a-537 (1997).

87. See Provider Agreement, HCFA form 1561. See also 42 C.F.R. § 489 (1999).

caid funded facilities where two or more residents reside.⁸⁸ States' Attorneys General (AGs) in some states also pursue cases involving abuse and neglect in long term care facilities.

Historically, such abuse and neglect cases have been the province of state and local efforts, which have differed, sometimes significantly, from state-to-state and community-to-community⁸⁹ depending on the existing state laws, enforcement practices, priorities, and resources.⁹⁰ The Medicaid Fraud Control Units, which have taken the lead in pursuing long term care abuse and neglect, have pursued cases, not only against lower level employees accused of abuse and neglect, but also against owners, managers, controlling individuals, and corporate enti-

88. The MFCUs are federally funded and overseen, but often part of the state AG's offices. See, e.g., Medicaid Fraud Control Unit <<http://attorneygeneral.state.wy.us/mfcu.htm>> (last modified 12/17/2001) (Wyoming); AGO Online: Fighting Fraud, <<http://www.ago.state.mo.us/fraud.htm>> (last modified 8/21/2001) (Missouri).

Congress conditioned each state's participation in the MFCU program on its formulation of "procedures for reviewing complaints of the abuse and neglect of patients of health care facilities that receive payments under the State [Medicaid] plan" and, where appropriate, prosecuting such cases or referring them to other state agencies for prosecution. See 42 U.S.C. § 1396b(q) (2001); 42 C.F.R. § 1007.11 (1998). MFCUs also, at their discretion, may pursue cases arising in non-Medicaid funded facilities where two or more residents reside. See *id.* MFCUs devote substantial resources to patient abuse investigations and review thousands of referrals alleging patient abuse, neglect, and the misappropriation of patient funds. In 1996, over 4,000 of these cases were investigated by the MCFUs. See also National Ass'n of Medicaid Fraud Control Units, *Patient Abuse & Neglect: The Hidden Crime* (1998), at www.state.nv.us/ag/mfcu/intro-pabuse.htm.

89. There is no centralized data base of long term care abuse and neglect cases brought by state or local prosecutors, let alone one that sorts cases by category, such as those involving systemic violations brought against individual or corporate owners, managers, or other high level personnel in long term care entities.

90. A broad variety of state laws may have a bearing on abuse and neglect in long term care, for example laws redressing assault, battery, theft, rape, abuse, endangerment, and criminal neglect.

Charges have been successfully brought in state criminal prosecutions against both corporate and individual defendants. See D.P. Chapus, *Criminal Liability Under Statutes Penalizing Abuse or Neglect of the Institutionalized Infirm*, 60 A.L.R. 4th 1153 (1988). For example, in *Missouri v. Boone Retirement Center, Inc.*, 26 S.W. 3d 265 (Mo. 2000), a nursing home corporation and its administrator were convicted by a jury of two counts of felony neglect of nursing home residents. See *id.* at 268. The nursing home had been cited for numerous state and federal regulatory citations for issues related to prevention and care of pressure sores, nutrition, and nursing care. See *id.* These care deficiencies were linked to complications contributing to the deaths. See *id.* at 291. The appellate court found that there was sufficient evidence of the violations and affirmed the convictions. See *id.*

In *Missouri v. Dale*, 775 S.W. 2d 126 (Mo. 1989), three defendants (the corporate president, vice president/director, and a spouse who acted as a supervisor) were convicted of neglecting patients in a nursing care facility. See *id.* at 133-34. Inspections found the residents were not turned, kept dry, adequately fed or given water, and not properly given their medications. See *id.* Evidence connected these failures to insufficient staffing levels. See *id.* at 129. Evidence also established that records were falsely completed to indicate that services were provided when in fact they had not been provided. See *id.*

ties.⁹¹ In addition, at least one local District Attorneys office⁹² has

91. Examples, but by no means an exhaustive list of such cases, include the following:

The Oregon MFCU has brought cases for falsification of records, criminal mistreatment, and criminal negligence in failing to provide adequate physical and medical care to residents against nursing home owner/administrators, a director of nursing, and a corporate chain. These cases have resulted in loss of license (so that the defendant is no longer permitted to practice in Oregon), jail time, substantial fines, and consent agreements. *See, e.g., Oregon v. Beverly Enterprises*, No. 92-5-73 (Clackamas Co. Cir. Ct. May 7, 1992).

The Minnesota MFCU brought charges against Compassionate Home Care, Inc., a home health agency, alleging that it intentionally neglected or knowingly permitted conditions to exist that result in the neglect of a vulnerable adult. In 2000, the jury returned a guilty verdict and sentenced the defendant to pay a \$3,000 fine. *See State v. Compassionate Home Care, Inc.*, 639 N.W. 2d 393, 395 (Minn. App. 2002) (reversing conviction because the district court "abused its discretion in instructing the jury and erred in responding to a jury question without notifying counsel.").

The North Carolina MFCU brought a felony charge against Royal Crest Health Care Center, Inc., a nursing home, for medical assistance provider fraud, and misdemeanor charges for violating the N.C. Medical Care Commission Rules. *See N.C. GEN. STAT. § 131E-109(3)* (1998). The case involved a Royal Crest resident who was admitted to the hospital after developing stage IV decubitus ulcers. The nursing home falsified its records to show that the ulcers which developed during the course of the resident's stay at the home were present on admission. In a case arising out of the same facts the MFCU brought a felony charge against Barbara Whittle, the director of nursing for Royal Crest, for malfeasance by a corporate agent, N.C. GEN. STAT. § 14-254 (1993), and misdemeanor charges for violating the N.C. Medical Care Commission Rules, N.C. GEN. STAT. § 131E-109(3) (1998). Both were found guilty after a two week jury trial in 1993. Royal Crest was ordered to pay a \$40,000 fine. Barbara Whittle was sentenced to jail, although her misdemeanor conviction was overturned and a new trial ordered for an erroneous jury instruction. *See State v. Whittle*, 454 S.E. 2d 688, 692 (1995).

After years spent pursuing nurses and nurse aides in abuse and neglect cases, the Florida MFCU discovered that such cases arise more often than not from corporate policies that put profit over patient care. In January of 1996 Sandestin Health Center, Inc., was the first corporation in Florida to be convicted of patient abuse. After a grand jury returned four felony counts of abuse by neglect of four of the center's patients the corporation pled guilty and was sentenced to pay a fine of \$10,000 on each count plus a five percent surcharge to the statewide victim's fund and a ten percent surcharge to the elderly victim's fund, and restitution to the victim's families. The case originated with the state's protective services system, which referred the case after a local hospital stated that they received a patient that was in the worse condition they had ever seen coming from a skilled nursing facility. The resident had gangrene, pneumonia, septicemia, volume depletion, a urinary tract infection that was so severe an emergency room doctor said she likely would have died within a few hours had she not been brought to the hospital, several stage IV decubitus ulcers and extremely poor hygiene. *See Indictment, Florida v. Sandestin Health Center, Inc.* (Fl. 8th Judicial Circuit Ct. 1994).

The California MFCU, part of the state Attorney General's office, recently obtained a felony conviction against a corporate entity under California's elder abuse statute for serious failures of care at one of Sun Healthcare Group, Inc.,'s California facilities. *See California v. Rose Rehabilitation Center* (SF 313-431A) (San Mateo Co. Super. Ct. Oct. 3, 2001). The California MFCU also has pursued permanent injunctions and monetary penalties against the parent entities that own facilities where serious failures of care occur. *See California v. Sun Healthcare Group, Inc.* (Ca Civ. No. 418519) (San Mateo Co. Super Ct. Oct. 3, 2001); *California v. Moyle* (01-CR-1977) (Riverside Co. Super Ct. Aug. 13, 2001). These permanent injunctions and final judgments include comprehensive compliance provi-

pursued a case against owners, corporate entities, and/or operators of long term care facilities or chains. MFCU's, which often are housed in the state AG's office, have the authority to investigate, and many (but not all) have authority to prosecute abuse and neglect cases against providers under criminal and/or civil statutes.⁹³ Frequently, MFCUs and other federal, state or local enforcement entities work together on specific cases, or other issues.

A consumer protection approach would appear to provide another potential, if underused, vehicle to address problems in long term care. At least two state Attorneys General offices have used state consumer protection or "mini FTC" laws successfully in cases against long term care providers that did not deliver promised goods and services.⁹⁴

Federal Law Enforcement. Against this backdrop, and to respond to these increased reports of problems, the Department of Justice instituted its Nursing Home Initiative and Elder Justice efforts.⁹⁵ Given the complexity of the issues, their increasing demographic significance, and the substantial federal public health and fiscal interest, the law enforcement approach, like other efforts in this area, by necessity, is multi-faceted.

The Department is comprised of numerous Divisions or components. Those primarily involved in matters relating to long term care

sions, such as training, appointment of a compliance officer, quality assurance and internal review systems, confidential disclosure programs, and written standards on quality related measures. *See id.* The provisions in these cases are similar to those in HHS-OIG's corporate integrity agreements, with the exception of there not being a monitor.

MFCUs and state Attorneys General have pursued cases involving failures of care in other states as well, including Arkansas, Hawaii and Oklahoma. Moreover, in some states the MFCUs and federal law enforcement have cooperated closely on failure of care matters, for example in Kentucky (*see infra* note 231), Louisiana, (*see infra* text following note 254) and Minnesota (*see infra* note 261), and such collaborative efforts are underway in other states as well.

92. *See California v. Guardian Post Acute Serv., Inc.*, No. 99-210398 (Santa Clara Co. Superior Ct. May 26, 1999). In 1999, an Assistant District Attorney in Santa Clara County, California, having gathered gruesome evidence about systemic neglect and abuses in homes owned by Guardian Post Acute Services, Inc., indicted the entire chain. *See id.* *See also* Jason Baker, *Investigation Leads to Charges Against Guardian Post Acute Services*, LOS GATOS WEEKLY TIMES, 6/2/99, at <http://www.metroactive.com/papers/los.gatos.weekly-times/06.02.99/nursing-homes-9922.html>. After lengthy negotiations the case was resolved with a guilty plea and the exclusion of the two facilities most closely tied to the charges.

93. *See* 42 U.S.C. § 1396b (2001).

94. *See Oregon v. Tualatin Valley Health Care Ctr.*, No. CB 99-253 (D. Or. Mar. 2, 1999); *Massachusetts v. MCK, Inc.*, No. 97-3634 (Suffolk Sup. Ct. 1997); *Massachusetts v. Horizon Healthcare, Inc.* No. 98-5048C (Suffolk Sup. Ct. 1998).

95. These efforts included creation of the Department's Elder Justice web page, which may be found at <http://www.usdoj.gov> under the heading *Elder Justice*.

include three litigating divisions – the Civil, Criminal, and Civil Rights Divisions; the Department’s local offices – the United States Attorney’s Offices, the investigative entity – the Federal Bureau of Investigation (FBI); the grant making, research, and project-funding arm – the Office of Justice Programs (and its Bureaus), the Office of Legal Policy (formerly the Office of Policy Development), the Office of Legislative Affairs, the Office of Public Affairs, and the Department’s leadership offices – the Attorney General, Deputy Attorney General, and Associate Attorney General’s offices.⁹⁶

In matters relating to health care enforcement the Department works closely with the HHS Office of Inspector General (OIG). OIG’s Office of Investigations (OI) and Office of Audit Services (OAS) conduct investigations and audits in health care related matters.⁹⁷ Its Office of Counsel has authority to pursue a variety of remedies.⁹⁸ The Office of Evaluations and Inspections (OEI) – OIG’s “think tank” branch – conducts studies, and releases reports on a broad variety of topics, including problems in quality of long term care.⁹⁹

B. *The Problems*

Other articles in this Symposium issue of the *Journal* discuss various challenges faced by the long term care industry, including labor shortages that affect staffing, an influx of sicker patients, financial distress, and an increase in private lawsuits.¹⁰⁰ The residents entrusted to the care of that industry, who are the intended beneficiaries of the government programs paying for most of that care, however, face considerably more dire challenges in the face of abuse and neglect, including injury, suffering, and sometimes death.¹⁰¹

96. For more information see the Department’s organization chart, available at <http://www.usdoj.gov/> under the heading *Organizational Chart*.

97. The Office of Inspector General and Office of Audit Services websites are available at <http://www.oig.hhs.gov>.

98. The Office of Counsel’s website is available at <http://www.oig.hhs.gov> under the heading *Office of Counsel*.

99. The Office of Evaluations and Inspections website is available at <http://www.oig.hhs.gov> under the heading *Office of Evaluations and Inspections*.

100. See Karl Pillemer and Mark Lachs, *The Crisis in the Long-Term Care Workforce*, 4 J. HEALTH CARE L. & POL’Y (2001); T. Shanahan, *Statutory Limits on Punitive Damages in Nursing Home Negligence Tort Actions: Preventing the Collapse of the Private Nursing Home*, 4 J. HEALTH CARE L. & POL’Y (2001).

101. Failure to provide requisite care may constitute, in my view, neglect, abuse, or both. In many contexts, the terms abuse and neglect are terms of art. Their proper definitions have been a topic of considerable dispute the resolution of which is beyond the scope of this article.

One obstacle in formulating the appropriate response to abuse and neglect is the paucity of information about its scope:¹⁰² Does it occur in just a very few extreme outlier facilities? Is it the tip of the tail on the bell shaped curve, or is it creeping up the slope into the norm? How wide spread are significant problems? How many people suffer or die as a result? And what is the human, social, and economic cost of such problems?

Evaluation of the scope of the overall problem is critical to developing an overarching law enforcement response. In a single legal case, however, what matters most is not the scope of the overall problem, but instead the evidence, relevant laws and regulations establishing the standard of conduct, violations, applicable causes of action, remedies, and the resources and expertise that can be employed in investigating and pursuing the case. Greater understanding about the scope of the problem, however, can help law enforcement establish procedures, priorities, and practices in the area.

Concerns about quality of care in nursing homes have waxed and waned for four decades with occasional reports of horrors and bursts of public attention.¹⁰³ Stark reports of quality problems led the Institute of Medicine (IOM) to examine the topic and issue a report in 1986 discussing the widespread problems and recommendations for how to address them.¹⁰⁴ Concerted efforts of numerous entities led to the passage of the Nursing Home Reform Act in 1987 (Omnibus Budget Reconciliation Act of 1987, or OBRA '87),¹⁰⁵ which enhanced the survey system, quality of care and quality of life standards, and the administrative enforcement system.¹⁰⁶ The statute and many of the ensuing regulations took a more (although not entirely) outcome-based approach than previously had been the case, placing the emphasis on nursing homes finding ways to reach the desired outcomes – quality of care and life.¹⁰⁷

Although no national data on abuse and neglect in residential care facilities other than nursing homes have been collected, residents of such facilities share many of the same risk factors that place all elders and disabled persons at greater risk for being abused and ne-

102. See *supra* notes 24-30 and accompanying text. See also U.S. DEP'T OF JUSTICE, ELDER JUSTICE: MED. FORENSIC ISSUES RELATING TO ABUSE AND NEGLECT, at <http://www.usdoj.gov>.

103. See *supra* note 4.

104. See IMPROVING THE QUALITY OF CARE, *supra* note 3.

105. Pub. L. No. 99-509, § 9302(a), 100 Stat. 1874, 1982 (1986) (codified as amended in scattered sections of 42 U.S.C. §§ 1320, 1395 - 1397 (2001)).

106. See *id.*

107. See *id.*

glected in other settings as well.¹⁰⁸ These risk factors include chronic disease and significant disabilities,¹⁰⁹ particularly high levels of cognitive impairment or other mental health conditions,¹¹⁰ certain types of behavioral problems,¹¹¹ social isolation,¹¹² and poverty.¹¹³

Viewed in almost any light, existing reports on the quality of long term care are troubling. The problems of residential care settings other than nursing homes have not been well studied or quantified.¹¹⁴ What little we know, however, indicates the same types of problems as in other types of long term care. In one study fifteen percent of the residential care facility staff interviewed reported witnessing other staff engage in some form of abuse.¹¹⁵ Long term care ombudsmen report that physical abuse is one of the top five types of complaints registered with them.¹¹⁶ And several studies have suggested problems of inadequate care and neglect.¹¹⁷ The challenges faced by these types of facilities will only increase as demand rises, and the care needs of the residents grow increasingly complex.¹¹⁸

108. See *Elder Abuse in Residential Long-Term Care*, *supra* note 24, at 7.

109. See *id.*

110. See *id.*

111. See *id.*

112. See *id.*

113. See *id.*

114. See *id.* at 1, 6-7.

115. See *id.* at 16. Based on telephone interviews with staff, who reported witnessing other staff engage in verbal abuse, or punishment such as withholding food, excessive use of physical restraints, or isolating difficult residents.

116. Administration on Aging data and National Ombudsman Resource Center, indicating that physical abuse was one of the top five complaints registered with long term care ombudsman in both residential care settings as well as nursing homes. See Admin. on Aging, *The National Elder Abuse Incidence Study; Final Report*, 1998, available at <http://www.aoa.dhhs.gov/abuse/report>. Ombudsmen are advocates who address complaints for residents in assisted living facilities. Of the 121,686 complaints handled by long term care ombudsman in 1998, an estimated 82% were in nursing home settings. Among the remaining 17% arising in residential care settings, physical abuse was one of the top five complaints. See *id.*

117. See *Elder Abuse in Residential Long-Term Care*, *supra* note 24, at 24.

118. See *id.* Compared to nursing home residents, residential care facility residents may face more medication errors, high rates of psychotropic drug use, poor management of behavior problems among Alzheimers patients and other residents with dementia, and poorer functional outcomes. See *id.* However, the alternatives for many of these individuals often are limited to moving into a nursing home. Many people are so terrified of nursing homes that they would rather stay in a setting where they are abused or neglected - indeed some would choose to die - rather than go to a nursing home. See Thomas J. Mattimore, et al., *Surrogate and Physician Understanding of Patients' Preferences for Living Permanently in Nursing Homes*, 45 J. AM. GERIATRICS SOC'Y 7, 7 (1997) (reporting that 30% of the respondents said they would "rather die" than live permanently in a nursing home) [hereinafter Mattimore].

The reported problems in nursing homes are better defined. In a ground-breaking study, 36% of the nursing home nursing and aid staff surveyed reported that they had witnessed at least one incident of physical abuse during the preceding twelve months and ten percent reported that they had themselves committed physical abuse.¹¹⁹ More recent data appear to bear out these numbers, including reports that almost one third of all nursing homes are cited for abuse-related deficiencies;¹²⁰ that about one third to one quarter of nursing homes surveyed provide seriously deficient or potentially life-threatening care;¹²¹ that 50% to 90% of all nursing homes are understaffed;¹²² that understaffing harms residents;¹²³ that federal and state oversight is insufficient;¹²⁴ and that older people who have been abused or neglected die sooner than those who have not been similarly abused or neglected, even controlling for other underlying conditions.¹²⁵

These reports illustrate a stark truth: too many human beings who are utterly dependent on their caretakers are not fed, bathed, cleaned, turned, or positioned; they do not receive proper medication, clean sheets, wound care, treatment, or the assistance they need

119. See Karl Pillemer and David Moore, *Highlights from a Study of Abuse of Patients in Nursing Homes*, 2 J. ELDER ABUSE & NEGLECT 5, 5-30 (1990). The study, which surveyed nursing home personnel in one state, also found that 81% of staff reported that they had observed and 40% that they had engaged in at least one incident of psychological abuse during the same 12 month period. *See id.*

120. *See Abuse of Residents*, *supra* note 5 at i.

121. *See* 1998 GAO Report, *supra* note 4, at 2.

122. *See* STAFFING RATIOS, *supra* note 6, at E.S.-5.

123. *See id.* *See also* Press Release, Agency for Healthcare Research and Quality, *New Analysis Confirms Direct Link Between Nurse Staffing and Patient Complications and Deaths in Hospitals* (May 29, 2002).

124. *See* 1998 GAO Report, *supra* note 4, at 2. The GAO reported that federal and state oversight was insufficient, and that complaint investigation and enforcement were not used effectively to assure adequate quality. *See id.* In addition, with respect to the entire country, the GAO concluded that one quarter of all nursing homes have serious and oft-repeated deficiencies that result in immediate jeopardy or actual harm to residents, among other things by failing to prevent pressure sores, accidents, and failing to assess resident needs and provide proper care. *See id.*

125. *See* Lachs et al., *The Mortality of Elder Mistreatment*, 280 JAMA 428, 428-32 (1999). This study – one of the few in this area – reaches the stark conclusion that abuse and neglect significantly shorten the older victim's life, even when controlling for all other variables. Incidents of mistreatment that many would perceive as minor can have a debilitating impact on the older victim. A single episode of victimization can "tip over" an otherwise productive, self-sufficient older person's life. In other words, because older victims usually have fewer support systems and reserves (physical, psychological and economic) the impact of abuse and neglect is magnified. Thus, a single incident of mistreatment is more likely to trigger a downward spiral leading to loss of independence, serious complicating illness, and even death. *See id.*

with the activities of daily living (ADLs).¹²⁶ As a result, these vulnerable people too often endure unnecessary illness, injury, suffering, and premature death, deprived not only of health and sometimes life, but also of dignity and the joy in living. Those who are mistreated cannot simply get up and move to another facility. Often, they cannot give voice to their suffering or to their wishes. And even if they can, they may fear retaliation from those on whom they are dependent.

A long term care system with these types of problems is one that demands the prompt, thoughtful and substantial attention of *all* relevant entities, including law enforcement.

C. *The Growing Need For Long Term Care*

Of the great social and family issues facing us today, few are as complex or as pressing as the question of how we will care for our aging population. It is well documented that we are on the cusp of a profound demographic shift.¹²⁷ As the baby boomers age and medical advances allow us to live longer, the number of Americans over 65 will approximately double to 70 million by 2030.¹²⁸ During the same period it is estimated that the number of those in need of long term care will increase from 7 to 14 million, and those requiring nursing home or equivalent levels of care will increase from about 1.6 million to 6.6 million.¹²⁹ Although the number actually in a nursing home at any given time is about 1.6 million, more than 2.9 million Americans resided in a nursing home for at least some part of 2000.¹³⁰ Already, those 85 and older are the fastest growing age group, closely followed by those 100 and older.¹³¹ It is almost impossible to overstate the impact of these trends on all aspects of our families and society.

Most of us already have been or soon will be faced with navigating the options and obstacles inherent in finding or planning for quality long term care – either for ourselves or for family and friends. At the same time as the aging population and the need for long term care is

126. These are the types of failures that give rise to the sort of problems noted by the surveyors in the excerpts that begin this piece.

127. See NURSING HOME CONDITIONS, *supra* note 22, at 5-6

128. See Administrative on Aging, *Older Americans: 2000*, at <http://www.aoa.gov/aoa/stats/profile/default.html>.

129. See AMERICAN HEALTH CARE ASSOC., FACTS AND TRENDS: THE NURSING FACILITY SOURCEBOOK 15 (2001).

130. See CENTERS FOR MEDICARE AND MEDICAID SERVICES, NURSING HOME DATA COMPENDIUM ii (2000) [hereinafter DATA COMPENDIUM]. The data compendium provides data in figures and tables on all residents in Medicare and Medicaid certified homes in the United States.

131. See Elder Abuse in Residential Long-Term Care, *supra* note 24 at 2.

surging, the number of those who traditionally have fulfilled the care giver role is decreasing.¹³²

In what has been called the “longevity paradox,”¹³³ incredible advances in modern medicine allow us to live longer, but we have failed to assign equal importance to developing and funding the corresponding mechanisms that will assure adequate care to those who need it. Unless we embrace this challenge, the consequences will be dire – and disproportionately borne by our most vulnerable citizens. Given this scenario, we must strategically contemplate, develop, and adequately support an appropriate overall response, that includes an adequate law enforcement component.

D. *The Industry*

1. *Nursing Homes*

On any particular day, about 1.6 million people live in about 17,000 nursing homes in this country, but over the course of a year, almost 3 million people will have resided in a nursing home for some period of time.¹³⁴

In 2000 about 16,800 facilities were certified to participate in the Medicare and Medicaid programs.¹³⁵ Most homes participate in both programs.¹³⁶ Seven percent participate in Medicare only and 15 percent participate in Medicaid only.¹³⁷ About 65 percent of nursing homes operate on a for profit basis, 28 percent are not-for-profit, and the remaining seven percent are public entities.¹³⁸ Nursing homes receive about \$ 40 billion in federal dollars a year, and another \$ 20 billion through the states.¹³⁹ Occupancy rates for nursing homes have

132. See Deborah Stone, *Care and Trembling*, AM. PROSPECT 61 (Apr./May 1999), available at 1999 WL 3720366. Increasing numbers of women are in the work force, families are more geographically scattered than in previous generations, and, as the country ages, the number of people traditionally in the “caretaker age range” is decreasing. Of course, other types of caregivers may well step in to fill this void. See Mary Dellman-Jenkins et al., *Young Adult Children and Grandchildren in Primary Caregiver Roles to Older Relatives and their Service Needs*, 49 FAMILY RELATIONS 2, 2-4 (2000), available at 2000 WL 11794339.

133. See Joseph F. Coughlin, *Technology Needs of Aging Boomers*, ISSUES SCI. & TECH. ONLINE (Fall 1999) ¶ 5, at <http://www.bob.nap.edu/issues/16.1/coughlin.htm>.

134. See DATA COMPENDIUM, *supra* note 130, at ii. More than 2.9 million Americans resided in nursing homes for at least some part of 2000. See *id.*

135. See *id.*

136. See *id.* at iii.

137. See *id.*

138. See *id.*

139. See *id.*

been decreasing slowly since 1996, while the care needs of residents have been increasing.¹⁴⁰

Significant data sources exist that provide a picture of many different aspects of nursing homes and their residents. The Minimum Data Set (MDS) (a resident assessment and facility reimbursement tool), and OSCAR, (survey information), contain gargantuan amounts of information that increasingly are being analyzed to elicit information about nursing home residents, individual facilities, and chains, as well as state-wide and national trends. For example, it is possible to see how a particular nursing home fares in a particular area (for example prevalence of decubitus ulcers and other related factors) compared to other homes in that chain, in that state, or nationally.¹⁴¹

In recent years, the nursing home industry has been in financial straights, with the majority of the largest chains and many smaller entities forced to file for bankruptcy.¹⁴² The reasons for the financial crisis are much in dispute,¹⁴³ and will not be resolved here, but there are significant potential fiscal and public health implications of these bankruptcy actions, demanding the attention and coordination of myriad federal and state entities.

Amidst reports of resource problems in long term care and the diversity of views on why they plague this industry, there *are* facilities today that provide great care *with existing resources*.¹⁴⁴ Understanding these entities' success might be a valuable and important effort for others to undertake.

2. Residential Care Facilities

In addition to the 1.6 million people in nursing homes, nearly one million additional people live in an estimated 45,000 residential care facilities, and their number is reportedly on the rise.¹⁴⁵ These entities variously go by some thirty different names (including assisted

140. *See id.*

141. *See, e.g., Nursing Home Compare* (last modified 3/21/2002) <<http://www.medicare.gov/NHCompare/home.asp>>.

142. *See infra* note 255 and accompanying text.

143. *See* U.S. GEN. ACCOUNTING OFFICE, AGGREGATE MEDICARE PAYMENTS ARE ADEQUATE DESPITE BANKRUPTCIES, (GAO/T-HEHS-00-192)(2000); Debra Sparks, *Nursing Homes: On the Sick List*, BUS. WEEK, July 5, 1999, available at 1999 WL 8228378.

144. *See* Diane C. Lade, *Add Human Touch: An Alternative Philosophy Says it's Time to Change the Culture of Nursing Homes*, ORLANDO SENTINEL, Mar. 7, 2001, available at 2001 WL 9170090; The Wellspring Program, visited 1/31/2001, <<http://www.wellspringis.org>>.

145. *See* Elder Abuse in Residential Long-Term Care, *supra* note 24, at 1.

living facilities, board and care homes, congregate living, personal care homes, and homes for the aged).¹⁴⁶

Generally, these types of facilities are non-medical, community-based residential settings, housing two or more unrelated adults.¹⁴⁷ They typically provide some services, such as meals, medication supervision, activities, transportation and assistance with the activities of daily living (such as bathing, dressing, toileting, etc.).¹⁴⁸ As noted above, much less is known about residential care facilities than about nursing homes.¹⁴⁹ Unfortunately, there are many impediments to collecting such information, including the absence of consistent definitions, standards and reporting requirements.¹⁵⁰ In addition, the level of medical services provided in such circumstances range from someone who receives a check at the YMCA, to private home settings, to a specially-designated wing of a nursing home.¹⁵¹

Some states have promulgated laws and/or regulations governing and setting forth a standard of conduct for residential care facilities.¹⁵² Others have not. The same is true for oversight and enforcement.¹⁵³ These types of entities vary tremendously, and there is little uniformity from state-to-state in how they are defined, regulated and overseen. Most are not subject to federal regulation or oversight.¹⁵⁴ Often, the state entities charged with oversight of such providers already have stretched their available resources. Thus, even where requirements exist, as a practical matter, oversight nonetheless may be limited.

3. Other Types of Facilities

Long term care is provided in many settings. In addition to the 900,000 - 1 million residential care facility residents discussed above, it is estimated that another 1.5 million people reside in independent apartments with some services, about 625,000 live in retirement communities offering all levels of care depending on need, tens of

146. *See id.*

147. *See id.* at 20.

148. *See id.*

149. *See id.*

150. *See id.* at 19-20.

151. *See id.* at 20.

152. *See, e.g.,* FLA. ADMIN. CODE ANN. r §§ 400-401 (1997).

153. *See* U.S. GEN. ACCT. OFFICE, LONG-TERM CARE: CONSUMER PROTECTION AND QUALITY-OF-CARE ISSUES IN ASSISTED LIVING 4 (1997) [hereinafter 1997 GAO Report].

154. *See* 1997 GAO Report, *supra* note 153, at 4-5; U.S. Senate Special Committee on Aging, Hearing, Shopping for Assisted Living: What Consumers Need to Make the Best Buy, 4/26/99, at <http://aging.senate.gov/hr31ka.htm>.

thousands live in adult foster care, and an estimated six million chronically ill and disabled adults receive care at home.¹⁵⁵ The lines among categories of providers and the types of residents they serve have blurred. Today's assisted living facilities resemble the nursing homes of a decade ago.¹⁵⁶ Consumers' assumptions, whether accurate or not, also influence which types of long term care (including home care or the lack of it) are used.¹⁵⁷

Although there rarely is federal jurisdiction over these types of care when not federally funded, it nevertheless is important, when discussing long term care, to examine not only nursing homes, and not only assisted living or residential care, but the entire landscape of long term care options. A comprehensive and interrelated approach is necessary because the diverse and constantly shifting modalities of providing care are inextricably linked. Today's nursing homes serve a different population than they did a decade ago.¹⁵⁸ Residents are sicker.¹⁵⁹ Their stays are shorter.¹⁶⁰ (The refrain is "quicker and sicker.")¹⁶¹ These residents need more complex and more costly care.¹⁶² They need more supplies and equipment. They require more frequent care planning. They require more staff, who in turn need more training— issues at the core of failure of care problems.

III. PROSECUTING FEDERAL CASES RELATING TO FAILURES OF LONG TERM CARE¹⁶³

In recent years the Department of Justice has pursued an increasing number of cases involving abuse and neglect in long term care

155. See Joseph P. Shapiro, *Growing Old in a Good Home*, U.S. NEWS & WORLD REP., May 21, 2001, at 56, available at 2001 WL 6320370. Caring for growing numbers of older and frail people at home also presents increasing challenges, risks of abuse and neglect, enormous human and economic demands on (causing ensuing stress of) care givers. The mechanisms we develop for providing care to people in their homes and the fear of long term care that may keep people in an in appropriate home care environment also are important to the discussion about the crisis in long term care. These issues are only flagged, not discussed, in this paper.

156. See Susan Tresch Fienberg, *Time for a New Approach to Residential Care*, HEALTHCARE REV., Jan. 8, 2001, available at 2001 WL 30204033.

157. See Maureen Dixon, *An Alternative to Nursing Homes*, S.F. CHRON., June 2, 2000, 2000 WL 6483634. See also *supra* note 118.

158. See JOSEPH OUSLANDER ET AL., MEDICAL CARE IN THE NURSING HOME 112 (2d 1997).

159. See *id.*

160. See *id.*

161. See *id.*

162. See *id.*

163. The discussion in this article of cases pursued by the Department of Justice includes no attorney-client privileged, work product protected, or otherwise privileged or protected information.

facilities, and particularly, nursing homes. There is no federal civil or criminal abuse and neglect statute that makes failures of care actionable *per se*. But traditional theories of health care fraud enforcement more recently have been imported to cases involving failures in long term care. The number of these cases has been on the rise. In pursuing federal criminal, civil, and civil rights cases to redress failures in long term care, the Department's object – at each step – is to balance the law enforcement and public health goals. Or, said another way, to pursue the cases in such a way that they deter future wrongdoing, recoup lost funds, protect residents, and improve care.

A. Civil Cases

The majority of the Department's cases to date alleging abuse and neglect in residential care settings (failures of basic care leading to profound malnutrition, dehydration, pressure ulcers, scalding, and other illness, injury or death) have been pursued under the civil False Claims Act, a financial fraud statute.¹⁶⁴ Originally enacted after the Civil War to redress war profiteering,¹⁶⁵ the Act provides a cause of action, treble damages, and penalties where a "person" (either an individual or entity) knowingly submits, or causes to be submitted to the United States, a false claim for payment.¹⁶⁶ The FCA also permits private citizens, known as "relators," to file suit on behalf of the United States (these are called *qui tam* actions).¹⁶⁷ Once a relator or whistleblower has filed a *qui tam* action, the United States has options, including "intervening in" and taking over the case or "declining" it, and permitting the relator to proceed.¹⁶⁸ The statute requires that the case remain under seal for 60 days (or longer if the Court extends the period for good cause) to give the United States an opportunity to

164. 31 U.S.C. § 3729 (1988). Under the federal civil False Claims Act, an individual or entity that makes false claims or statements or causes false claims and statements to be made to the United States is liable for treble damages and penalties of \$5000 - \$10,000 per false claim. Liability under the false claims act occurs when a person:

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval; (2) makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; [or] (3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

Id.

165. See *United States v. McNinch*, 356 U.S. 595, 599 (1958).

166. See 31 U.S.C. § 3729 (1988).

167. See 31 U.S.C. § 3730 (b)(1) (1988).

168. See 31 U.S.C. § 3730 (b)(2) (1988).

investigate to determine how to proceed.¹⁶⁹ The FCA has been the government's primary tool in fighting health care fraud as well as other types of fraud (such as defense procurement fraud).¹⁷⁰

Moreover, the threat to government health care programs from continuing financial fraud and abuse will only be accentuated by the sharp increase in demand on those programs as the number of beneficiaries grows. Despite progress in anti-fraud measures, the estimated \$13 billion lost yearly by the federal healthcare programs because of fraud harms not only present *and* future beneficiaries (older, disabled, and impoverished Americans – sooner or later, almost all of us), but the long term care system itself.¹⁷¹ It also harms honest long term care providers who take compliance seriously, by decreasing the potential pool of funds as demand grows, necessitating more cutbacks on reimbursement, increasing scrutiny of claims, and harming the industry's reputation. Moreover, beneficiaries pay a very real price for health care fraud in the amount of their copayments and contributions. In short, those who defraud Medicare and Medicaid steal from all those who contribute to and rely on those programs.

The Department's health care fraud efforts, in partnership with other federal and state enforcement agencies, resulted in approximately \$1.3 billion in judgments, settlements and administrative impositions in health care fraud proceedings and cases in fiscal year 2000.¹⁷² Of that amount, more than \$717 million was collected and returned to various state and federal health care programs, with \$577 million returned to the Medicare Trust Fund.¹⁷³ These funds now can be used properly – to fund the requisite care for those who need it.

For the first time in 1996, and on several occasions since then, the United States has pursued “failure of care” cases under the False Claims Act premised on providers' knowingly billing for goods or services that were non-existent, worthless, or grossly deficient.¹⁷⁴

169. *See id.*

170. *See* S. REP. NO. 99-345, at 2 (1986).

171. *See* Testimony of Lewis Morris before the Senate Special Committee on Aging on Medicare Enforcement Actions: The Government's Anti-Fraud Efforts, July 26, 2001 at <http://oig.hhs.gov/testimony/index.htm>.

172. *See* Press Release, Department of Justice, Justice Recovers Record 1.6 Billion in Fraud Payments (Nov. 14, 2001).

173. *See id.*

174. *See* United States v. GMS Management-Tucker, Inc., No. 96-1271 (E.D. Pa. Feb. 21, 1996) (*Geri-Med*); United States *ex rel.* Aranda v. Community Psychiatric Ctr. of Okla., 945 F. Supp. 1485 (W.D. Okla. 1996).

1. *The Theories*

Failure of care cases stand for the unexceptional proposition that an entity may not bill the government for nonexistent, worthless, or grossly substandard products or services.¹⁷⁵ A failure of care case may be actionable under one or more of several alternative False Claims Act theories, including billing for nonexistent or worthless services, submitting express false certifications, false statements or false documents, and billing for goods or services that violate a statutory, regulatory or contractual provision with a nexus to payment.¹⁷⁶

Most failure of care cases will involve worthless or nonexistent services, false statements or documents, and often an express false certification.¹⁷⁷ Those few cases that do not involve either may fit comfortably within the third theory – billing for goods or services that violate a statutory, regulatory or contractual provision with a nexus to payment.¹⁷⁸

The submission of claims for items or services that are not what they purport to be, or that are not those for which the government bargained, can render such claims, if made with the requisite scienter, false.¹⁷⁹ A worthless services claim is the archetypical FCA case – the government paid for a product or service that was not provided.¹⁸⁰ Disclosures of billing for nonexistent or worthless goods during the Civil War prompted Congress to enact the False Claims Act in the first place.¹⁸¹ The viability of the nonexistent or worthless goods and services theory consistently has been recognized.¹⁸²

175. See *United States ex rel. Lee v. Smithkline Beecham, Inc.*, 245 F.3d 1048, 1053 (9th Cir. 2001).

176. See *United States ex rel. Marcus v. Hess*, 317 U.S. 537, 543-44 (1943); *United States v. NHC Health Care Corp.*, 163 F. Supp. 2d 1051, 1056-57 (W.D. Mo. 2001); *Aranda*, 945 F. Supp. at 1488; *United States v. General Dynamics Corp.*, 19 F.3d 770, 777 (2d Cir. 1994).

177. See *NHC Health Care Corp.*, 163 F. Supp. 2d at 1056-57; *United States v. Aerodex, Inc.*, 469 F.2d 1003, 1007-08 (5th Cir. 1973); *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 793 (4th Cir. 1999).

178. See *Marcus*, 317 U.S. at 543-44; *United States ex rel. Wright v. Cleo Wallace Ctr.*, 132 F. Supp. 2d 913, 926 (D. Colo. 2000); *United States v. Killough*, 848 F.2d 1523, 1526 (11th Cir. 1988); *General Dynamics Corp.*, 19 F.3d at 777.

179. See *Aerodex*, 469 F.2d at 1007-08; *United States ex rel. Oliver v. The Gyro House*, 2001 WL 312378 (9th Cir. 2001).

180. See *NHC Health Care*, 163 F. Supp. 2d at 1056-57; *United States v. McNinch*, 356 U.S. 595, 599 (1958).

181. See *McNinch*, 356 U.S. at 599.

182. See *Lee*, 245 F.3d at 1053; *United States ex rel. Compton v. Midwest Specialties, Inc.*, 142 F.3d 296, 302 (6th Cir. 1998); *Aerodex*, 469 F.2d at 1007-08; and *NHC Health Care*, 163 F. Supp. 2d at 1056 (W.D. Mo. 2000).

United States ex rel. Mikes v. Strauss,¹⁸³ affirmed the viability of non-existent and worthless services claims (despite concluding that defendants were not liable on other grounds).¹⁸⁴ The *Mikes* court set forth that “[a] worthless services claim asserts that the knowing request of federal reimbursement for a procedure with no medical value violates the Act irrespective of any certification.”¹⁸⁵ It went on to cite approvingly to *United State ex rel. Lee v. Smithkline Beecham, Inc.*,¹⁸⁶ in which the court reversed and remanded, noting that the district court had “overlooked the allegations. . .that supported a different theory – that Smithkline violated the FCA by seeking and receiving payment for medically worthless tests.”¹⁸⁷ In *Mikes*, which also involved allegedly worthless tests, the court found no FCA violation, not because worthless services are not actionable, but on the ground that the relator, *as a matter of law*, could not prove knowledge.¹⁸⁸ The *Mikes* court cited *Lee* approvingly, noting:

As the Ninth Circuit explained, “[i]n an appropriate case, knowingly billing for worthless services or recklessly doing so with deliberate ignorance may be actionable under § 3729 [of the False Claims Act], regardless of any false certification conduct.”¹⁸⁹

The *Mikes* court went on to conclude that a worthless services claim “is effectively derivative of an allegation that a claim is factually false because it seeks reimbursement for a service not provided. . . . In a worthless services claim, the performance of the service is so deficient that for all practical purposes it is the equivalent to no performance at all.”¹⁹⁰

In the failure of care case most directly on point, *United States v. NHC Health Care Corp.*, alleging that severe staff shortages led to the death of two residents, the court expanded on this, noting:

[I]t is likely that implied certification is not relevant herein because the Defendants are not being sued simply for violating the standard of care with regard to Residents 1 and 2. [fn3] Rather, Defendants are being sued because they allegedly failed to provide the services that they billed for. No cer-

183. 2001 WL 1628486 (2d Cir. 2001).

184. *See id.* at *13.

185. *Id.*

186. 245 F. 3d 1048 (9th Cir. 2001).

187. *Id.* at 1053.

188. *See id.*

189. *Mikes*, 2001 WL 1628486 at *13 (quoting *Lee*, 245 F. 3d at 1053).

190. *Id.* at *13.

tification, implied or otherwise, is necessary when the liability stems from the Defendants' activities of billing for procedures which they did not perform. This would plainly constitute fraud. The difficulty in proving that Defendants committed such a fraud lies in the per diem billing system utilized under Medicare/Medicaid. Obviously, if NHC billed the Government \$4 for turning Resident 1 on July 18, 1998, but in fact no one actually performed the task, a clear cut case of fraudulent billing would be presented. However, we are not blessed with such pristine circumstances. NHC billed the Medicare/Medicaid programs for the over-all care of each of these residents on a per diem basis. As previously stated by this Court, in so doing NHC agreed to provide "the quality of care which promotes the maintenance and the enhancement of the quality of life." [fn4] *Id.* at 1153. At some very blurry point, a provider of care can cease to maintain this standard by failing to perform the minimum necessary care activities required to promote the patient's quality of life. When the provider reaches that point, and still presents claims for reimbursement to Medicare, the provider has simply committed fraud against the United States. Whether the Government has demonstrated that a factual dispute remains as to whether NHC crossed into this admittedly grey area, is the proper focus of this Order.¹⁹¹

In a nonexistent or worthless services claim, a determination of falsity may turn on the value of the provided services. A showing that the defendant violated statutory or regulatory standards of care is some, though not necessarily *per se*, evidence, of the worthlessness of the services.¹⁹² The relevant standards of care could include those standards that require "sufficient numbers" of staff, appropriate assistance with the activities of daily living (bathing, toileting, ambulating, eating), appropriate steps to prevent bedsores, falls, unexplained weight loss and dehydration, appropriate range of motion and other exercises, and appropriate management of medication.¹⁹³ While these may sound like technical requirements, violation of these requirements often leads to rapid decline, illness, injury, suffering, and even death. Such violations also may frequently lead to significant additional costs borne by the resident, the resident's family, the govern-

191. *NHC Health Care*, 163 F. Supp. 2d at 1051 & n.3 & 4.

192. *See id.*

193. For an example of an independent, non-governmental standard of care, see AGENCY FOR HEALTH CARE POL'Y RESEARCH, *Treatment of Pressure Ulcers, Clinical Practice Guideline No. 15, 95-0652* (Dec. 1995), in CLINICAL PRACTICE GUIDELINES FOR THE PREDICTION, PREVENTION AND TREATMENT OF PRESSURE ULCERS.

ment and the taxpayers as the result of unnecessary hospitalizations and emergency or long term care.

Additional evidence of the worthlessness or deficiency of particular services could include a showing that the care provided also violated an independent non-governmental standard or by comparing the actual services provided to those set out in a resident's care plan.¹⁹⁴ It is likely that many failure of care cases will continue to involve nonexistent or worthless services claims.

As a condition to obtaining payment, the Centers for Medicare and Medicaid Services (CMS) and the states require providers to sign various forms, several of which contain certifications. The False Claims Act also is implicated, and an express false certification exists, where a facility certifies, as a condition of payment, that it has complied with the regulations and statutes governing the care provided, when in fact it has knowledge that it has not done so.¹⁹⁵ It is reasonable for the government to require certifications on claim forms to implement and promote accountability with respect to the Medicare statute.¹⁹⁶

In a third type of False Claims Act case, courts have found the violation of a statute, regulation, or contract provision with a nexus to payment to be sufficient to establish FCA liability, even absent an express certification and where services existed and were not entirely worthless.¹⁹⁷ Some parties and courts have used the short-hand term "implied certification" to describe such cases, although the term also has led to some confusion about what, precisely, is meant.¹⁹⁸ In each case the presentment of the claim at issue falsely represents entitlement to payment that the violation of the other statute, regulation or provision forfeited.¹⁹⁹

194. *See id.* *See also* United States v. Bapack, 129 F.3d 1320 (D.C. Cir. 1997) (finding liability under the False Claims Act for services that were outlined in care plans but never performed).

195. *See* Harrison v. Westinghouse, 176 F.3d 776, 793 (4th Cir. 1999).

196. *See* Peterson v. Weinberger, 508 F.2d 45, 51 (5th Cir. 1975), *cert. denied*, 423 U.S. 830 (1975).

197. *Cf.* United States v. Bornstein, 423 U.S. 303 (1976) (goods did not conform to contract specifications); United States v. Campbell, 845 F.2d 1374 (6th Cir. 1988); United States v. Mead, 426 F.2d 118 (9th Cir. 1970) (falsity depends on violation of Department of Agriculture regulations); Faulk v. United States, 198 F.2d 169 (5th Cir. 1952) (defendant used false labels in providing substandard milk).

198. *See, e.g.,* United States *ex rel.* Aranda v. Community Psychiatric Ctr. of Okla., 945 F. Supp. 1485, 1488 (W.D. Okla. 1996).

199. *See* United States *ex rel.* Marcus v. Hess, 41 F. Supp. 197, 210 (W.D. Pa. 1941); Shaw v. AAA Engineering & Drafting, Inc., 213 F.3d 519, 531 (10th Cir. 2000).

In enacting the Nursing Home Reform Act²⁰⁰ Congress sought to enact a statutory and regulatory scheme that was sufficiently comprehensive in its requirements to assure the well-being of vulnerable nursing home residents.²⁰¹ Thus, when providers bill for care that not only violates the relevant requirements, but is so inadequate that it harms or kills residents instead of caring for them, such violations go right to the core of the statutory and regulatory scheme. At the heart of the Medicare and Medicaid programs is the proposition that providers are being paid from public funds to take care of residents in the manner and in accordance with the standards specified by those programs.

The *NHC* court recognized this critical nexus between care and payment. Although *NHC* turned on a worthless services claim, the case includes language relevant to the statutory/regulatory violation theory.²⁰² The court concluded that the government's allegations concerning the residents' pressure sores, weight loss, and unnecessary pain were violations "at the heart" of the provider agreement, stating:

This Court has previously held that the standard of care is indeed at the heart of the agreement between the parties. See *NHC*, 115 F. Supp. 2d at 1155 ("When caring for the infirmed it is not the end product result that is crucial, it is the dignity and quality of life provided through the care process.") To the extent that implied certification is proper in healthcare cases, the facts of this case fit the definition set forth by previous case law. . . . [FN 4] While the court conceded that this is an amorphous standard, it is not a standard without meaning. . . . At some point the care rendered to a patient can be so lacking that the provider has simply failed to adhere to the standards it agreed to abide by and has thus committed a fraud.²⁰³

The only other court to explicitly consider the government's False Claims Act failure of care theory reached a similar conclusion.²⁰⁴ In *U.S. ex rel. Aranda v. Community Psychiatric Centers*, the United States alleged that children in a psychiatric hospital suffered serious injury and sexual abuse as the result of the facility's failure to conform to Medicaid program standards.²⁰⁵ The *Aranda* court concluded, with-

200. Pub. L. No. 100-203, 101 Stat. 1330 (codified as 42 U.S.C. § 1395i-3 (Medicare standards) and 42 U.S.C. § 1396r (Medicaid standards)).

201. *See id.*

202. *See NHC Health Care*, 115 F. Supp. 2d at 1154.

203. *Id.* at 1154-56 & n.4.

204. *See Aranda*, 945 F. Supp. 1485, 1488.

205. *See id.*

out finding any express false certifications, that compliance with the requisite standards of care was a condition of participation and an essential prerequisite to payments from the program.²⁰⁶ The court relied on the Medicaid participation requirements as the standard of care, violation of which was actionable under the FCA.²⁰⁷

It is worth noting with respect to all types of failure of care cases that facilities are on legal notice of all statutes and properly issued regulations, and may therefore be held to have knowledge of when their services fall below the minimum standard of care.²⁰⁸ In addition, although *not* an element necessary to prove in any failure of care case, it is likely that most will involve bad outcomes as well as falsity, as illustrated by the cases below. Indeed, each of the cases pursued by the Department to date has involved egregious and/or systemic failures of care, and serious harm, suffering, and/or death of one or more residents.²⁰⁹

2. *The Cases*

a. *United States v. GMS Management-Tucker (Geri-Med)*

The first failure of care nursing home case pursued under the False Claims Act was set in motion when an elderly man was admitted to a Philadelphia hospital in early 1994.²¹⁰ The man was malnourished, dehydrated, anemic, in severe pain, and had approximately 26 decubitus ulcers, all of which were necrotic and malodorous, and most of which were at stage IV level.²¹¹ One ulcer on his hip was the size of a grapefruit and to the bone, and another was so bad that it had more or less rotted away his shoulder.²¹² In addition, his right leg was gangrenous and the toes on his left foot were necrotic and in the process of falling off.²¹³ The emergency room staff were so troubled by what they saw that they called the long term care ombudsman who

206. *See id.*

207. *See id.*

208. *See Heckler v. Community Health Serv.*, 467 U.S. 51, 63-64 (1984) (provider has an affirmative duty to be familiar with Medicare requirements).

209. *See NHC Health Care*, 163 F. Supp. 2d at 1051-53. Although this is not an element that needs to be proven to establish a cause of action under the False Claims Act, the cases pursued to date involved such egregious wrongdoing and systemic failures of care, that in each case such harm to or death of residents occurred. *See id.*

210. *See United States v. GMS Management-Tucker, Inc.*, No. 96-1271 (E.D. Pa. Feb. 21, 1996) (*Geri-Med*). *See also* David Hoffman, *The Role of the Federal Government in Ensuring Quality of Care in Long-Term Care Facilities*, 6 ANN. HEALTH L. 147, 147 (1997) (discussing the *Geri-Med* case in greater depth) [hereinafter Hoffman].

211. *See Hoffman, supra* note 210, at 147-49.

212. *See id.*

213. *See id.*

in turn contacted Pennsylvania Attorney General's office which made a video tape showing the man's wounds and general condition.²¹⁴ At the time, however, the Attorney General's office did not have an adequate cause of action under state law to pursue the case.²¹⁵

The case also was brought to the attention of an Assistant United States Attorney in Philadelphia.²¹⁶ The ensuing investigation revealed that Tucker House, where the victim had been a resident, had failed to provide the basic care required by law and regulation.²¹⁷ As a result of the facility's systemic failure to provide necessary care other residents also suffered from unnecessary pressure sores, weight loss, malnutrition, and out-of-control blood sugars.²¹⁸ Like the man who triggered the investigation, other residents eventually died from the harm they suffered.²¹⁹ The U.S. Attorney's Office expanded the investigation to include not only Tucker House but also other facilities owned by the same owner, Geri-Med, a chain with a history of non-compliance.²²⁰ The investigation indicated that significant failure of care problems plagued not only Tucker House, but numerous facilities in the chain.²²¹

The *Geri-Med* case was settled for \$575,000 in False Claims Act damages – an amount based on the monies the facility received for the care of the residents who were harmed by the facilities' failures.²²² In addition, and perhaps more significantly, the United States consulted with a group of medical experts to assist in the development of protocols for non-monetary relief calculated to protect residents and improve care in the future. These measures were embodied in a consent judgment with two primary components: (1) imposition of a temporary-independent monitor (who reported to the United States and was paid by Geri-Med) whose role it was to oversee the chain's operations and make recommendations for improvement, and (2) specific protocols that Geri-Med was required to implement in its facilities that were intended to improve care, particularly in problem areas

214. *See id.*

215. Since then, state law has been supplemented and Pennsylvania now has a criminal cause of action for abuse of a care-dependent individual. *See* 18 PA. CONS. STAT. § 2713 (2001).

216. *See Hoffman, supra* note 210, at 148.

217. *See id.*

218. *See id.*

219. *See id.*

220. *See id.*

221. *See id.*

222. *See* Consent Order ¶ 6, *GMS Management-Tucker*, No. 96-1271.

such as wound care, diabetes management, weight loss, and the monitoring of lab values.²²³

The consent judgment covered not only Tucker House, but also Geri-Med's other 17 facilities, although the most stringent protocols applied to Tucker House and the eight other facilities with the most problematic compliance records.²²⁴ The consent judgment also required Geri-Med to write letters of apology to the families of three of the victims of Geri-Med's wrongdoing.²²⁵

b. United States ex rel. Aranda v. Community Psychiatric Ctr. of Oklahoma

In 1996, the same year *Geri-Med* was settled, a court for the first time considered and affirmed the viability of pursuing a False Claims Act case under a failure of care theory.²²⁶ As noted above, this case involved a psychiatric facility that, instead of providing adequate treatment for troubled adolescent boys, permitted an environment where boys ages eight through eleven were regularly sexually abused. The defendant moved to dismiss, arguing that the complaint failed to state a cause of action and that the quality of care requirements were too vague to be enforced.²²⁷ The court disagreed, ruling:

It may be easier for a maker of widgets to determine its product meets contract specifications than for a hospital to determine whether its services meet "professionally recognized standards of health care." In the Court's view, however, a problem of measurement should not pose a bar to pursuing a FCA claim against a provider of substandard health care services under appropriate circumstances.²²⁸

The court noted that "the risk of harm was sufficiently unreasonable, and the risks of harm known by [the facility] were sufficiently frequent and blatant" that the provider's decision to bill the government for such deficient or non-existent "care" was actionable under the False Claims Act.²²⁹ Because the care was deemed to be worthless, or worse than no care at all, the government assessed damages to be all Medicaid and TRICARE monies that flowed to the facility during the

223. *See id.* ¶¶ 7, 11.

224. *See id.* ¶¶ 7, 18.

225. *See id.* ¶ 12.

226. *See United States ex rel. Aranda v. Community Psychiatric Ctr. of Okla.*, 945 F. Supp. 1485 (W.D. Okla. 1996).

227. *See id.*

228. *Id.* at 1488.

229. *See id.* at 1489 (quoting Second Am. Compl. at 7, ¶¶ 28-29).

relevant period. The *Aranda* case settled for \$750,000 soon after the court denied the defendant's motion to dismiss.

Since *Geri-Med* and *Aranda* the Department has pursued several more cases against long term care facilities under failure of care theories. Many of these cases have been brought in the Eastern District of Pennsylvania²³⁰ with others being pursued in other jurisdictions.²³¹ In general, these cases have involved egregious failures of care with devastating consequences for the vulnerable victims.²³² Although the de-

230. See, e.g., *United States v. City of Philadelphia*, Civ. No. 98-4253 (E.D. Pa. Aug. 7, 1998) (settled for \$50,000, plus \$15,000 designated to improve residents' quality of life; and a judicially entered consent agreement imposing a monitor and detailed protocols), *United States v. Chester Care Ctr.*, No. 98-cv-139 (E.D. Pa. Jan. 13, 1998) (settled for \$500,000 and a consent order and judgment imposing a temporary manager and monitor as well as protocols covering three facilities); *United States v. IHS, at Penn Inc.*, (E.D. Pa. May, 1999) (settled for \$195,000 and settlement agreement terms to impose a temporary monitor for one year, three years of mandatory in-service training on wound care and dietary management, and incontinence management; the agreement covered only that facility, not the entire IHS chain); *United States v. Mercy Douglass Human Serv. Corp.*, No. 00-CV-3471 (E.D. Pa. July 10, 2000) (\$160,000 settlement amount and settlement agreement terms imposing a temporary manager to manage two (of three) homes and monitor all three homes owned by the parent company); *United States v. Ashton Hall Nursing and Rehabilitation Ctr.*, (E.D. Pa. 2000) (settled for \$60,000 plus an additional \$100,000 in specified improvements; settlement agreement provided for one year of temporary monitoring, improved training and protocols on wound care, and implementation within 90 days with HHS/OIG's Voluntary Compliance Guidance for Nursing Facilities); *United States ex rel. Placido v. Manor Care*, Civ. No. 98-3094 (E.D. Pa. Jan. 14, 2001) (settled for \$90,000, a consent order requiring an independent consultant who had all of the powers of a monitor, the implementation of a compliance program, and specific protocols).

231. See, e.g., *United States v. Kansas Healthcare Investigators, LP*, (D. Kan. 1999), which was resolved for a monetary settlement of \$175,000. In *United States v. Greenbelt*, (D. Md. 1998), a temporary manager was imposed while the case was ongoing. After two subsequent surveys showed increasing deficiencies, HCFA initiated a termination action pursuant to a statutory requirement that provides that a facility that does not come into substantial compliance within the proscribed time limit be terminated. The termination action was controversial because the temporary manager had only been in the facility a short amount of time before the action was initiated. Greenbelt unsuccessfully sought a temporary restraining order to enjoin CMS/HCFA from terminating it. Unable to continue in operation without government funds, Greenbelt closed. Despite the divergent views regarding how properly to proceed, the Greenbelt case has been instructive in the importance of planning, coordinating and consensus building among the many entities that are potentially involved in these matters, and in carefully thinking about which among the myriad potential remedies to pursue and in what sequence. See also *United States v. Pineview Extended Care Ctr.* (D. Md. 2001) (resolving civil and administrative claims for \$400,000 and a CIA imposing a monitor on most of the facilities managed by Future Care for a period of three years) *United States v. BEP Servs., LP* (D. Ky. 2001) (resolving civil and administrative claims for \$382,149 and comprehensive integrity provisions including a monitor at all BEP facilities and protocols to protect residents). Additional cases in other jurisdictions also are underway.

232. See Plaintiff's Complaint ¶¶ 16-20, *Chester Care*, No. 98-cv-139.

tails of each case will not be discussed here, a few additional cases bear note.

c. United States v. Chester Care

United States v. Chester Care demonstrates the range of remedies available to the United States. A False Claims Act action was resolved in 1998, but persistent allegations of failures of care after the initial settlement spawned both a contempt action in 2000²³³ and a permissive exclusion action in 2001.²³⁴

The facts giving rise to the first action were as follows. Although the facility had received notice that its water heater was malfunctioning, a mute resident – unable to cry out – was placed in a bath of scalding water, leading to her death.²³⁵ The aide responsible for placing her in the bath was prosecuted for manslaughter by the state.²³⁶ The allegation came to the attention of the United States Attorney's office, which opened an investigation revealing that three other Chester Care residents had died, apparently as a result of the facility mismanaging their treatment for diabetes. At another facility under the same ownership, a resident allegedly had died after suffering preventable weight loss and decubiti that lead to sepsis and death.²³⁷ A survey at a third facility under the same ownership indicated a potentially troubling and harmful downward trend in care.²³⁸

Resolution of *Chester Care* included a consent order imposing a temporary manager (to run two of the three Chester Care facilities), a temporary monitor (to periodically inspect all three facilities), and payment of \$500,000 to the United States.²³⁹

Despite some initial improvements, monitor reports in 1999 began to note problems with wound care, incontinence care, and other problems related to staff shortages and corporate pressure to admit new residents despite inadequate staffing.²⁴⁰ One of the Chester Care facilities, Manchester House, violated the consent order's requirements.²⁴¹ This resulted in a civil contempt action brought by the United States in January 2000.²⁴² Manchester House entered into a

233. See *United States v. Manchester House*, No. 98-cv-139 (stipulated order).

234. See 42 U.S.C. § 1320a-7(b) (2001).

235. See Plaintiff's Complaint ¶ 17-18, *Chester Care*, No. 98-cv-139.

236. See Plaintiff's Complaint ¶ 17, *Chester Care*, No. 98-cv-139.

237. See *id.* ¶ 19.

238. See *id.*

239. See Consent Order ¶¶ 8, 17, *Chester Care*, No. 98-cv-139.

240. See *United States v. Manchester House*, No. 98-cv-139 (stipulated order).

241. See *id.*

242. See *id.*

stipulated order acknowledging the violations and agreeing, among other things, that the facility would be run by a temporary-independent manager.²⁴³

In addition to the False Claims Act and contempt actions, another federal law enforcement measure available in failure of care cases – a permissive exclusion action pursued by the OIG – also came into play in *Chester Care*. Based on the evidence developed during the investigations, OIG Office of Counsel pursued a permissive exclusion action against Walter Strine in 2001. Strine, the managing partner and largest single owner in the limited partnership that owned Chester Care and Manchester House, exerted considerable control over the facility operations.²⁴⁴ Section 1128(b)(6)(B) of the Social Security Act authorizes the OIG to exclude any individual or entity that “has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under [Medicare] or under a State health care program) substantially in excess of the needs of such patients *or of a quality which fails to meet professional recognized standards of healthcare.*”²⁴⁵

The target of the exclusion (the respondent) has no right to an administrative hearing until after the exclusion takes effect.²⁴⁶ If the respondent files an appeal, there is a formal adversarial proceeding before an Administrative Law Judge (ALJ).²⁴⁷

Unfortunately, even deploying the federal remedies trifecta (False Claims Act, contempt, and exclusion actions) did not result in the facilities providing quality care. Since January 2000, Chester Care and Manchester House both have closed.²⁴⁸

243. *See id.*

244. *See* Patti Mengers, *Facing Tough Economy, Strines Move to Close Two Homes*, DEL. CO. TIMES, at http://www.delcotimes.com/site/news.cfm?newsid=1901233&BRD=1675&PAG=461&dept_id=449258&rfti=8.

245. 42 U.S.C. § 1320a-7(b)(6)(B) (2001) (emphasis added). Although by no means an exclusive list, examples of sources for the standard of care may be found at 42 C.F.R. § 1001.2 (1998) (defining “professionally recognized standards of care.”). *See also* 42 C.F.R. § 483 (1998) (setting forth the conditions a nursing facility must meet as a condition of participation in the Medicare and Medicaid programs). A facility’s own policies and protocols may provide more detail, setting forth how the facility expects its employees to deliver care. In addition, CMS’ interpretive guidelines for surveyors list additional sources for establishing the professional standards of quality care. *See* 42 C.F.R. § 483.20(k)(3)(i) (1998).

246. *See* 42 U.S.C. § 1320a-7(f)(1) (2001).

247. *See* 42 U.S.C. § 1320a-7(f)(2) (2001).

248. *See* Mengers, *supra* note 244.

d. *United States v. National Healthcare Corp.*

In *United States v. National Healthcare Corp.*,²⁴⁹ the government presented evidence that at least two residents died as the result of “woefully low staff numbers at [a] facility” rendering it impossible for the facility to have provided all the care for which it billed the Medicare and Medicaid programs.²⁵⁰ The False Claims Act liability arose as a result of the nursing home’s knowing failure to “care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life,”²⁵¹ as required by law, but nonetheless bill to the Medicare and Medicaid programs.²⁵² NHC was settled just before trial in late 2001 for a payment of \$250,000 to resolve both False Claims Act and administrative claims. NHC also entered into a Corporate Integrity Agreement (CIA) with OIG Office of Counsel, pursuant to which it agreed to the imposition of a temporary monitor and protocols designed to protect residents and improve care.

HHS/OIG routinely has negotiated and imposed CIAs covering financial compliance issues on defendants in exchange for not pursuing a permissive exclusion action. With the advent of failure of care cases OIG developed a CIA (in collaboration with CMS and DOJ) similar to the consent judgements and settlement agreements previously negotiated by the Department of Justice, that included terms designed to improve compliance with quality of care requirements.²⁵³ Such a CIA, aimed at improving care, was part of the settlement package resolving the NHC matter, as well as in several other recent failure of care cases discussed *infra*.²⁵⁴

e. *United States v. Twin Oaks*

In late 1998, in response to the announcement of the initiation of the Department’s Nursing Home Initiative, state and federal investigative and administrative agencies concerned with nursing home matters in Louisiana held a meeting to discuss and coordinate the activities of their respective agencies. After developing the goal of

249. 115 F. Supp. 2d 1149. See also *supra* text accompanying notes 191-192.

250. See *id.* at 1053.

251. 42 U.S.C. § 1396r(b) (2001).

252. See *NHC Health Care*, 115 F. Supp. 2d at 1053.

253. Expansion of a CIA to cover quality as well as financial issues, however, is a relatively recent occurrence. The first CIA that included provisions for training, internal oversight, and other procedures designed to enhance quality of care, was in the Guardian Post Acute matter. See *State v. Guardian Nursing Ctrs.*, (Cal. Super. Ct. 2000).

254. See *NHC Health Care Corporate Integrity Agreement*, available at <http://oig.hhs.gov/fraud/cias.html>. Other failure of care CIAs also are available at the same web site.

identifying and remedying the problems of particularly poor facilities within the state, the group began to systematically evaluate homes based on the information and records of each entity. Their review eventually focused on the Twin Oaks Nursing Home, a for-profit, 100 bed facility in LaPlace, Louisiana. The ensuing investigation by the FBI, OIG-HHS, the MFCU and the U.S. Attorney's Office uncovered systemic failures of care as a result of inadequate supervision and staffing. Numerous patients suffered injuries and some died from dehydration, malnutrition, and severe bedsores. Those pursuing the investigation relied heavily on the expertise and advice of independent medical experts who read and interpreted the patient and facility medical records. The case was settled in the latter part of 2001 for \$100,000 and included a CIA imposing a temporary monitor and protocols designed to improve care. This case, the result of the collaborative efforts and diligence of myriad federal, state and local entities, including the United States Attorney's Office, the FBI, HHS-OIG, the MFCU, and the State Department of Health, is a model for government cooperation and collaboration in failure of care cases. Similar efforts also are underway in a few other states.

f. Vencor (now Kindred Healthcare)

The last few years have presented new challenges in handling cases against long term care entities, with the financial decline and bankruptcy filings in 1999 and 2000 of five of the seven largest nursing home chains (owning approximately 300 to 450 facilities each).²⁵⁵ For five such substantial entities to file for bankruptcy in such a short period (in addition to many smaller entities) was extraordinary (and the subject of a hearing by the Senate Special Committee on Aging in September 2000). Further complicating the picture, the United State's False Claims Act investigations against some of these entities involved monetary claims of tens or hundreds of millions of dollars, in addition to troubling failure of care claims. In addition to the financial harm to the United States caused by the allegations of massive fraud, the bankruptcies posed a potential and oft-threatened public health threat of a chain suddenly closing, putting in question how to

255. See *in re* Vencor, Inc., No. 99-3199 (Bankr. D. Del. Sept. 13, 1999); *in re* Sun Healthcare, Inc., No. 99-3657 (Bankr. D. Del. Oct. 14, 1999); *in re* Integrated Health Serv., Inc., No. 00-00605 (Bankr. D. Del. Feb. 02, 2000); *in re* Mariner Health Grp., No. 00-0113 (Bankr. D. Del. Jan. 18, 2000); *in re* Genesis Health Servs. Corp, No. 00-02619 (Bankr. D. Del. June 22, 2000).

assure the continued care of and avoid the sudden eviction of and potential harm to tens of thousands of sick, frail residents.²⁵⁶

As these bankruptcy actions unfolded, the Department of Health and Human Services worked closely with the state survey agencies, long term care ombudsman, and others, to monitor whether and to what extent the care offered by the bankrupt facilities was compromised as a result of their financial problems and created "contingency plans" in the event any of the chains suddenly closed or liquidated. The Departments of Justice and Health and Human Services, balancing the government's public health, law enforcement, and fiscal interests, worked closely to negotiate appropriate settlements. On the one hand, bankruptcy should not provide general amnesty for massive fraud. On the other hand, the Departments were mindful of the potential public health ramifications of the sudden closure of any one of the chains.

Vencor, Inc., was one of the nation's seven largest nursing home chains, with more than 350 facilities (both nursing homes and long term acute care hospitals). In 1999 Vencor became the first of the major chains to file for bankruptcy.²⁵⁷ On May 1, 1998 Vencor changed its name to Ventas, and Ventas spun off everything it owned except the physical facilities and real estate to a new company called Vencor Operating, Inc. Vencor Operating, which changed its name back to Vencor, operated the hospitals, nursing homes, and rehabilitation facilities.²⁵⁸ In January 1999 Ventas began operating as a real estate investment trust (REIT).²⁵⁹ Ventas leased all or substantially all of its facilities to Vencor. Vencor, in turn, leased all or substantially all of its facilities from Ventas.²⁶⁰

Prior to filing for bankruptcy, numerous *qui tam* cases had been filed against Vencor, including one case that alleged serious failures, such as severe understaffing resulting in neglect, harm, and death of residents.²⁶¹ The relator's allegations brought the matter to the attention of federal law enforcement for the first time, leading to an investi-

256. See Administration on Aging, *Transfer Trauma: Minimizing the Impact on Community Based and Institutionalized Elders* (visited 12/20/2001) <<http://www.aoa.gov/aoa/disaster/manual/gtran.html>>.

257. See *in re Vencor, Inc.*, No. 99-3199 (Bankr. D. Del. Sept. 13, 1999).

258. See Vince Galloro, *Vencor Gone But Not Forgotten: Name Change to Kindred Doesn't End Company's Legal Battles or Those of its Landlord*, MODERN HEALTHCARE, June 11, 2001, at 22, available in 2001 WL 9418816.

259. See *id.*

260. See *id.*

261. See Press Release, Department of Justice, Vencor and Ventas Paying U.S. \$219 Million to Resolve Health Care Claims as Part of Vencor's Bankruptcy Reorganization (Mar. 19, 2001). One of these failure of care actions was investigated and settled by the U.S.

gation by the Department of Justice in conjunction with the Defense Criminal Investigative Service (DCIS) and HHS/OIG. The initial investigation uncovered the long history of non-compliance and thus was expanded, becoming the first investigation of its type to examine widespread systemic problems at a major chain in an effort to determine whether the problems alleged were chain-wide or isolated.

Despite having been identified, the problems were not reported to law enforcement until a *qui tam* whistleblower did so. Further, the problems appear to have persisted until the FCA investigation commenced as a result of the *qui tam* filing. The relator alleged knowing false statements and understaffing to satisfy corporate financial goals that resulted in patient harm. As part of the consensual plan of reorganization that lifted it out of Chapter 11 bankruptcy, Vencor agreed to settle False Claims Act claims with a payment to the United States of more than \$100 million.²⁶² Approximately \$20 million of that amount was attributable to failure of care claims, representing by far the largest failure of care case ever settled.²⁶³ Vencor also settled HHS overpayment claims for an additional \$25 million.²⁶⁴ The settlement was funded in part by Ventas, Inc., the real estate investment trust. As it emerged from bankruptcy, the first of the major chains to do so, Vencor changed its name to Kindred Health Care.²⁶⁵

As part of the Vencor reorganization, OIG pursued a groundbreaking national chain-wide CIA, encompassing not only financial integrity but also quality-of-care compliance issues. Like the consent decrees, settlement agreements, and CIAs in the failure of care cases involving individual facilities and smaller chains, the Vencor/Kindred CIA agreement calls for a temporary-independent monitor (paid for by the defendant).²⁶⁶ Because the chain consisted of approximately 350 facilities, instead of requiring specific detailed facility-specific protocols, the CIA calls for implementation of systemic controls, improve-

Attorney's Office in the District of Minnesota for over \$300,000. See Annual Report 2001, available at <http://www.usdoj.gov/usao/mn/index.html>.

262. See *id.*

263. See *id.*

264. See *id.*

265. See Shanon D. Murray, *Goodbye Vencor, Hello Kindred Healthcare*, DAILY DEAL, Apr. 24, 2001, available in 2001 WL 20232505.

266. The Kindred monitor is the Long Term Care Institute, a private, not for profit entity headed by David Zimmerman, PhD, of the University of Wisconsin. Dr. Zimmerman, an expert in nursing home data, is one of the creators of the "quality indicators," which are a synthesis of Minimum Data Set (MDS) information relating to resident status and care. Quality indicators, among other things, provide a way to analyze the MDS to reveal "red flags" and potential trouble areas that, while not dispositive, should receive additional scrutiny.

ments, and training, under the guidance of the monitor.²⁶⁷ The goal of the CIA was not only to improve care and practices in the short term, but to address problems in corporate culture in the hope that improvements would become standard operating procedure and remain in place even after the term of the agreement expires.²⁶⁸

Kindred's compliance director became involved early in the process by evaluating the factors relevant to quality, and was actively involved in negotiating and subsequently in implementing the CIA with OIG. Kindred's compliance team continues to work closely with the independent monitor and with OIG to identify and address isolated and systemic problems, to try to distinguish between them, and to implement safeguards to prevent future failures.

It appears that temporary monitors, specific and/or systemic protocols, and occasionally, temporary managers, have led to increased compliance with the law and improvements in the care provided in numerous long term care facilities. Such CIAs and other types of agreements containing similar requirements are being implemented in a growing number of cases. It therefore would be very useful to empirically evaluate their impact on the quality of care provided by the providers subject to those agreements. Such an analysis would provide valuable information in the types of modifications, if any, needed to adapt the agreements to different types of problems and providers, so that such agreements are as effective as possible. Until more data have been gathered, however, it remains critical to work toward those remedies such as these, that common sense and preliminary results indicate are beneficial.

Another factor in the success of bringing a problematic facility or chain into compliance is the willingness and commitment of the facility and those who run it to address the problems in a proactive, comprehensive, and thorough fashion. This includes a willingness to devote significant resources, energy, intelligence, and creativity, to promoting change, assigning top priority to the delivery of quality care, and creating a corporate culture that rewards such activity.

B. *Criminal Cases*

The Department to date also has resolved a few criminal cases that relate to failures in long term care, and other cases are underway. Federal law provides several statutes under which the Department may pursue criminal charges for false statements, false claims, or

267. See Kindred Corporate Integrity Agreement (on file with author).

268. See *id.*

other wrongdoing.²⁶⁹ The subject of that falsity may be care, services, billing, the condition of a resident, or it may be intended to conceal an error, condition, failure, or other wrongdoing.²⁷⁰

1. *Failure of Care Cases Against Individuals*

In the first known case of its kind, federal criminal charges were brought in a case involving an elderly woman who wandered away from the Arkansas nursing home where she was a resident.²⁷¹ She was found with a deep wound on her forehead and various cuts and bruises, lying in a fetal position on a gravel road outside of the facility. The home's Director of Nursing (DoN) and an aide returned her to the nursing home, where they changed her clothing and placed her in her bed before calling for an ambulance.²⁷² The ambulance transported the woman to a nearby hospital, along with an incident report prepared by the DoN that falsely reported that the woman had fallen in her room and struck her forehead on a night stand.²⁷³ This initial false report began a four year conspiracy between the DoN and the facility's administrator to conceal the circumstances surrounding the incident from the Arkansas Long Term Care Office, the FBI, and a state police detective.²⁷⁴ The woman died within 24 hours, after having been returned to the facility by the hospital, who failed to take x-rays or perform a physical exam.²⁷⁵ After repeatedly lying to investigators and continuing to submit false records and documents, the Administrator and DoN were charged under 18 U.S.C. §§ 1001 and 1518 with making and conspiring to make false statements to federal officials regarding the events leading to the resident's death.²⁷⁶ Both

269. Federal criminal statutes under which the United States might pursue prosecutions implicating quality or failure of long term care could include: 18 U.S.C. § 4 (2001) (misprision of a felony); 18 U.S.C. § 1347 (2001) (health care fraud incorporating definition from 18 U.S.C. § 1346); 18 U.S.C. § 1035 (2001) (false statements about health care matters); 18 U.S.C. § 1001 (2001) (false statements); 18 U.S.C. § 371 (2001) (conspiracy); 18 U.S.C. § 1341 (2001) (mail fraud); 18 U.S.C. § 1343 (2001) (wire fraud); 18 U.S.C. § 286 (2001) (false statements to the United States); 18 U.S.C. § 287 (2001) (same); 18 U.S.C. § 1516 (2001) (obstruction of a federal audit); 18 U.S.C. § 1505 (2001) (obstruction of proceedings before a grand jury); 18 U.S.C. § 1510 (2001) (obstruction of a federal investigation); 18 U.S.C. § 1518 (2001) (obstruction of a criminal health care investigation); 18 U.S.C. § 1623 (2001) (perjury).

270. *See, e.g.*, United States v. Crawford, No. 4:1998cr00219 (E.D. Ark. Mar. 15, 2000); United States v. Turner, No. 4:1998cr00215 (E.D. Ark. Mar. 15, 2000).

271. *See id.*

272. *See id.*

273. *See id.*

274. *See id.*

275. *See id.*

276. *See id.*

pled guilty²⁷⁷ and were sentenced to 18 months imprisonment. In such a case, the defendants also may have been prosecuted under other provisions for the false record entries made in the nursing home records.²⁷⁸

A second case involved a nurse who erroneously failed to note in the record a physician's verbal order to reduce a nursing home resident's Coumadin (anti-coagulant) dose.²⁷⁹ The nurse then administered the higher dose causing severe physical reactions and bleeding. After she discovered her mistake she falsified the medical record to conceal her error, thereby further compounding damage to the resident who continued to get too much Coumadin and did not get treatment to mitigate the ensuing problems.²⁸⁰ The resident subsequently bled to death.²⁸¹ The nurse who falsified the record was prosecuted under 18 U.S.C. § 1035. She was given a ten month sentence and is not allowed to practice nursing in the future without court approval.²⁸²

2. *Systemic Criminal Failure of Care Cases*

Federal criminal laws include provisions that might be used to redress systemic failures of care. Any scheme or artifice to defraud any health care benefit program or obtain payment by means of false representations in connection with the delivery of health care services or items is a felony under 18 U.S.C. § 1347. The phrase "scheme or artifice to defraud" is specifically defined in 18 U.S.C. § 1346 to include "depriv[ing] another of the intangible right of honest services."

In addition, more traditional criminal charges may be brought in various types of criminal cases. For example, conspiracy,²⁸³ mail fraud,²⁸⁴ and wire fraud,²⁸⁵ charges may be brought where material failures of care occur yet the facility continues to bill for care that was not provided or provided at such a substandard level as to be tantamount to no care at all. The mail and wire fraud statutes also may be applied where a provider's advertising and mailing of promotional brochures contain false statements about the type, level and quality of

277. See Plea Agreement, Turner, No. LR-CR-98-215; Plea Agreement, Crawford, No. LR-CR-98-219.

278. See, e.g., 18 U.S.C. § 1035 (2001).

279. See *United States v. Taibi*, No 01-212 (E.D. Pa. Nov. 21, 2001).

280. See *id.*

281. See *id.*

282. See *id.*

283. See 18 U.S.C. § 371 (2001).

284. See 18 U.S.C. § 1341 (2001).

285. See 18 U.S.C. § 1343 (2001).

care, or items such as staffing levels.²⁸⁶ In addition, certain false and knowingly executed certifications submitted in the course of billing Medicare/Medicaid might constitute felony violations. If nursing home personnel are aware of felony health care fraud violations and do not report them to appropriate authorities and take steps to conceal them, they may be charged with misprision of a felony under 18 U.S.C. § 4.

Finally, as occurred in the Arkansas case, the individuals who committed the criminal acts may lie to nursing home inspectors and thereby obstruct a federal audit in violation of 18 U.S.C. § 1516. False statements to federal agents investigating the matters violates 18 U.S.C. § 1001, and perjury before a federal grand jury violates 18 U.S.C. § 1623.

3. *Potential Quality Issues in Criminal Prosecutions*

As noted *infra*, HHS/OIG has the statutory authority to pursue the exclusion of certain providers from federal health care programs.²⁸⁷ Under the exclusion statute HHS/OIG may, in its discretion, seek “permissive” exclusion of providers for abuse and neglect or failure to provide services that meet the requisite standard of care.²⁸⁸ Once a provider has been convicted of a criminal healthcare related offence, however, exclusion is mandatory and OIG has no discretion.²⁸⁹ Thus, the criminal conviction of a long term care provider leads inexorably to its exclusion.²⁹⁰

In February 2000, the United States entered into a global settlement with Beverly Enterprises, the nation’s largest nursing home chain, to resolve claims that Beverly had committed financial fraud because it charged unallowable costs to Medicare.²⁹¹ The settlement required Beverly to pay a \$170 million civil settlement and a \$5 million criminal fine.²⁹² In addition, a Beverly subsidiary owning ten facilities in five states (Beverly of California, Inc.) pled guilty to a felony which required the mandatory exclusion of that subsidiary.²⁹³ The

286. See 18 U.S.C. § 1341 (2001).

287. See 42 U.S.C. § 1320a-7 (2001).

288. See 42 U.S.C. § 1320a-7(b) (2001).

289. See 42 U.S.C. § 1320a-7(a) (2001).

290. See *id.*

291. See Beverly Enterprises, Inc., Settlement Agreement (2000).

292. See *id.*

293. See Press Release, Department of Justice, Justice Department Recovers Over \$3 Billion in Whistleblowers False Claims Act Awards and Settlements (Feb. 24, 2000); Seth Rosenfeld, *Largest Ever Case Against Rest Home Nets \$170 Million*, S. F. EXAM’R, Feb. 2, 2000, at A4, available in 2000 WL 6158887.

Department worked closely with HHS/OIG and CMS to craft an agreement that would protect residents from the sudden closure of facilities as the result of a mandatory exclusion. The ensuing agreement, modeled on agreements entered into between the Federal Trade Commission and health care providers in other contexts, resulted in what is called a “divestiture agreement” between OIG and Beverly. The divestiture agreement required Beverly to divest itself of the facilities owned by Beverly of California, Inc., before the exclusion took effect and provided for various sanctions if it failed to do so.²⁹⁴

Divestiture agreements are important tools.²⁹⁵ They permit aggressive criminal prosecution of long term care providers, where appropriate, to protect residents and promote the integrity of the programs, while assuring that the potential impact of any ensuing exclusion is borne by the wrongdoing entity and not the frail residents who are the intended beneficiaries of the defrauded programs. In other words, divestiture agreements help to assure that vulnerable residents do not wind up paying the price for the crimes of the facilities charged with their care.

4. *Public Corruption Cases*

Another type of criminal case also may have a bearing on the quality of long term care. Public corruption can harm residents where the requisite nursing home standards are improperly compromised. A federal criminal public corruption case involving nursing homes arose in Oklahoma.²⁹⁶ In October 2000, the state’s deputy

294. The divestiture agreement required Beverly to operate the facilities and care for residents in a lawful fashion until divestiture, and divest itself of the ten facilities within a specified time frame *prior* to the effective date of exclusion. If Beverly failed to sell the facilities within that time frame, the agreement gave OIG the option of imposing a trustee (of OIG’s choosing) to dispose of the facilities on terms determined by OIG, imposing a daily fine until the facilities were sold, or exchanging one or more of the ten facilities on the list for another Beverly facility in the event that it was proven contrary to the government’s or the beneficiaries’ interests to sell one or more of the ten facilities owned by the entity to be excluded. As part of the overall deal, in addition to the divestiture agreement, OIG also entered into a corporate integrity agreement (CIA) with Beverly covering financial integrity concerns. See Beverly Enterprises, Inc., Settlement Agreement (2000).

295. A divestiture agreement also is a useful tool in the case of a state or local health care criminal conviction, which similarly triggers mandatory exclusion. Thus, OIG entered into a divestiture agreement in *State v. Guardian Post Acute*. See *supra* note 92. In the months that followed the indictment of Guardian Post Acute the assistant District Attorney became very familiar with OIG’s Office of Counsel of HHS/OIG and its mandatory exclusion authority, working closely with that office in negotiating a satisfactory resolution of the case.

296. See Randy Ellis, *Files Pleads Not Guilty to Federal Charges*, DAILY OKLAHOMAN, Feb. 28, 2002, at 1A, available in 2002 WL 14474916 [hereinafter Ellis 2002].

commissioner for health, Brent Van Meter, and a nursing home owner, James Smart, were convicted of agreeing to accept a bribe and of offering to pay a bribe, respectively.²⁹⁷ More recently, Van Meter again was charged with soliciting a bribe, this time from a different nursing home operator, E.W. "Dub" Jiles.²⁹⁸ Jiles also was indicted for allegedly paying bribes in exchange for relocating residents of closed homes to facilities in which he had a financial interest, and of conspiring with Van Meter to get preferential treatment.²⁹⁹

C. Civil Rights Cases

The Civil Rights Division of the Department of Justice may pursue cases involving public entities under the Civil Rights of Institutionalized Persons Act (CRIPA)³⁰⁰ when nursing homes or other public institutions have neglected or abused residents entrusted to their care, or have failed to meet residents' constitutional or federal statutory right to adequate care and services.³⁰¹ Public nursing homes make up approximately seven percent of all nursing homes.³⁰² CRIPA cases generally involve an extensive investigation of the conditions and practices at the facility, efforts to remedy the offending practices, and, where necessary, the filing of a CRIPA action.³⁰³ Resolution of CRIPA actions may include a written agreement between the Department and the jurisdiction that provides for remedial relief in each of the areas in which the institution failed to meet the needs of the residents, such as medical and nursing care, psychiatric care and services, physical, occupational and speech therapy, protection from harm, abuse and neglect, and undue or improper use of restraints.³⁰⁴ In order to ensure ongoing compliance the agreements typically provide for ex-

297. *See id.* Throughout 2001, a state grand jury that investigated "ghost" employment within the Oklahoma Health Department indicted 14 current and former employees on assorted state charges, primarily relating to obtaining pay for work not performed or falsifying time sheets. *See* Randy Ellis, *Fired Health Agency Worker Pleads Guilty*, DAILY OKLAHOMAN, Oct. 18, 2001, at 3A, available in 2001 WL 28492438. *See also* Indictment, United States v. Van Meter (W.D. Okla. 2000) (No. CR-00-067-T).

298. *See* Indictment, United States v. Jiles (W.D. Okla. 2002) (No. CR-02-029-C); Ellis 2002, *supra* note 296, at 1A.

299. *See id.*

300. 28 U.S.C. § 1997 (2001).

301. *See id.*

302. *See* DATA COMPENDIUM, *supra* note 130, at iii.

303. *See* Letter from Deval Patrick, Assistant Attorney General, *Civil Rights Division, United States Department of Justice*, to The Honorable Sharon Pratt Kelly, *Mayor of the District of Columbia* 1 (Oct. 3, 1994), at <http://www.usdoj.gov/crt/split/documents/dcvillfind.htm>.

304. *See* City of Philadelphia, Settlement Agreement, at <http://www.usdoj.gov/crt/split/documents/philsa.htm>.

tensive on-site monitoring of the remedial agreement and full access provisions.³⁰⁵

The Special Litigation Section of the Civil Rights Division pursues not only CRIPA cases involving nursing homes, but also matters involving other types of long term care institutions such as facilities for individuals with mental retardation or developmental disabilities, psychiatric institutions, juvenile detention facilities and jails and prisons.³⁰⁶ CRIPA actions usually result in consent decrees and monitoring of consent decrees by the Civil Rights Division.³⁰⁷

In 1995 the Department's Civil Rights Division investigated a public Philadelphia nursing home pursuant to CRIPA.³⁰⁸ The allegations included that residents had suffered sexual assaults, physical assaults, unexplained decubitus ulcers, weight loss, and nutritional problems. The investigation also revealed that the facility used unnecessary chemical restraints (psychotropic and other medications).³⁰⁹ The investigation established that only two physicians were caring for 480 patients, many of whom were critically ill, and that the nursing charts in many cases were non-existent or non-sensical.³¹⁰ Several residents allegedly died as a result of gross failures to provide the most basic care and other wrongdoing.³¹¹ The Civil Rights Division, together with the U.S. Attorney's office for the Eastern District of Pennsylvania, in *United States v. City of Philadelphia*, brought joint civil rights and False Claims Act claims in the same complaint.³¹² The matter was resolved for \$50,000 and a judicially entered settlement agreement that imposed a temporary monitor and required compliance with certain, very detailed protocols.³¹³

305. *See id.*

306. *See, e.g.,* *United States v. Michigan*, No. 97-CVB-71514-BDT (E.D. Mich. Mar. 10, 1997).

307. The statute requires that the complaint be signed by the Attorney General, a non-delegatable responsibility. In addition, by statute, CRIPA cases must be handled by the Civil Rights Division and cannot be delegated for handling by United States Attorney's offices.

308. *See* Plaintiff's Complaint ¶¶ 23-38, *United States v. City of Philadelphia*, Civ. No. 98-4253 (E.D. Pa. Aug. 7, 1998).

309. *See id.*

310. *See id.*

311. *See id.*

312. *See id.*

313. *See* *City of Philadelphia, Settlement Agreement*, at <http://www.usdoj.gov/crt/split/documents/philsa.htm>.

D. *Criticism of Cases*

Some in the nursing home defense bar have asserted that use of the False Claims Act in failure of care cases constitutes improper regulation and that law enforcement actions are an inappropriate response to failures of care in long term care facilities.³¹⁴ Some claim that such cases create an untenable “punitive” atmosphere, to the detriment of the industry.³¹⁵ Others in the provider bar have no complaint with the failure of care cases pursued to date, acknowledging that the Department has used the remedy carefully, appropriately, and in clearly egregious circumstances.

Vehement criticism also has issued forth from the other end of the spectrum. Some citizen advocates criticize the Department (as well as other advocates, HHS, Congress and virtually all relevant government entities) for being too lenient in pursuing these issues. They argue that more cases should be brought, more owners, corporate entities and high level personnel should be pursued, higher damage awards, fines and restitution should be sought, and that more people should go to jail.

Based on the relentless reports of unlawful abuse and neglect in long term care, and based on reports that it is widespread, under-reported, infrequently prosecuted, and the cause of untold suffering, injury, illness, and death, it certainly would appear that law enforcement should be playing a more significant role, and that more individuals and entities who cause the abuse and neglect should be held responsible.

A federal abuse and neglect statute could greatly facilitate federal law enforcement’s ability to prosecute such cases. In the meantime, however, it is important to continue identifying and pursuing cases with existing authority – the programmatic remedies available to CMS, the exclusion actions, CIAs, and divestiture agreements available to HHS/OIG, and the civil, criminal, and civil rights actions available to the Department of Justice. These measures provide a potent array of tools in the face of unlawful abuse and neglect. The vulnerable and growing number of long term care residents are almost entirely dependant on their care givers. When caregivers violate that trust, society and the victims themselves must be able to depend on those responsible for enforcing the law to pursue some form of justice.

314. See, e.g., Robert Fabrikant & Glenn Soloman, *Application of the Federal False Claims Act to Regulatory Compliance Issues in the Health Care Industry*, 51 ALA. L. REV. 105, 105-06 (1999).

315. See John Boese, *Can Substandard Medical Care Become Fraud? Understanding an Unfortunate Expansion of Liability Under the Civil False Claims Act*, BRIEF, Summer 2000, at 5.

IV. THE DEPARTMENT'S ROLE IN THE ADMINISTRATION OF JUSTICE

Justice may come in many forms. The best form of justice for all involved is prevention. Many other factors, however, also are relevant to promoting justice, such as increasing the knowledge base and identifying protocols that will enhance our ability to detect and diagnose abuse and neglect, effective treatment and other assistance for victims, prompt reporting of suspected violations, careful selection of caregivers, and myriad interventions, including emergency, medical, social service, policy, reimbursement, advocacy, legal, legislative, and multi-disciplinary interventions. Enhancing our capacity in each of these domains is critical if we are to address the problems in long term care, not just in the form of prosecutions after the fact, but in a more comprehensive manner. In other words, our ability to progress on each of these fronts will in turn have a bearing on our ability to promote justice.

A. Overview

Pursuing cases is not the only role to be played by federal law enforcement. Also vital is the Department's "administration of justice," in which the Department on its own, in collaboration with others, or by funding other entities, takes steps to assess the problem, study the phenomenon and what interventions work, promote awareness, coordinate the many relevant entities, provide training and education, and take other necessary steps to improve our ability to prevent, detect, treat, intervene in, report, investigate, and prosecute abuse and neglect of older and disabled people in long term care and other settings.

It is widely acknowledged that our response to abuse and neglect of elders and those in long term care lags decades behind our response to other complex and intractable problems such as domestic violence, sexual abuse, and child abuse and neglect. There are well-established gaps in our knowledge and in our ability to respond at each step in the process.

1. Detection

Because of a low level of awareness about the problem, a dearth of research, poor distribution of information that does exist, and the rarity with which the issue is assigned priority or taken seriously, those on the front lines, in the best position to detect abuse or neglect in

long term care, rarely are able, trained, or have the resources to do so.³¹⁶

2. *Diagnosis*

The physical conditions that accompany abuse and neglect in an older person often are masked by, or mimic, other physical conditions associated with aging and illness (for example decubiti, malnutrition, dehydration, falls, and bruising).³¹⁷ Because the physical conditions of aging and/or disease often so closely resemble those caused by abuse or neglect, it may be vital to have someone with expertise in distinguishing between the two assist with the diagnosis. This is complicated because there is little research to identify and isolate specific forensic markers (research, for example, that will guide practitioners in determining which bruises, fractures, decubitus, and types of malnutrition and dehydration are the result of abuse or neglect) or illuminate forensic methodology.³¹⁸ Moreover, unlike child abuse, where a group of forensic pediatricians assist with the management of these issues, there is as yet no similar group of forensic geriatricians.³¹⁹

3. *Reporting*

The paucity of reporting likely is caused in part by a lack of unfamiliarity with the problem and how to identify it, by the absence of protocols for what to do when someone sees something that concerns them, and by controversy about mandatory reporting laws themselves.³²⁰ The failure to report abuse and neglect likely precludes most intervention, treatment, or prosecution. Thus, a concerted effort is needed to promote, and if necessary compel, better reporting.

4. *Intervention*

When abuse and/or neglect come to light, there are several possible interventions, including emergency, medical, social service, religious, cultural, community, advocacy, and legal interventions. Little evidence-based information exists relating to which one or combination among the myriad possible interventions are feasible, most successful, and susceptible to replication.³²¹ It is broadly assumed,

316. See Mark Lachs, *Selected Clinical and Forensic Issues in Elder Abuse*, in MED. FORENSIC ISSUES, *supra* note 8, ¶ 116.

317. See *id.*

318. See *id.* ¶ 117.

319. See *id.*

320. See Catherine Hawes, *Elder Justice*, in MED. FORENSIC ISSUES, *supra* note 8, ¶ 75.

321. See *id.* ¶ 85.

however, based on experience in this and other fields, that multi-disciplinary and inter-disciplinary interventions are most effective, given the highly diverse nature of the disciplines implicated.³²² Thus, such programs should be developed, replicated and studied.

5. *Prosecution and Other Legal Interventions*

As noted above, the realm of possible interventions includes legal interventions. These may include public and private lawsuits, judicial and legislative action, and the government acting in a police power (prosecution) and *parens patriae* (protective) capacity. Specific types of cases range from private personal injury law suits, guardianship and power of attorney related actions, as well as failure of care cases, such as those discussed above. There is little uniformity in how these matters are prosecuted from state-to-state or from community-to-community. At the federal level, the existing laws, while providing some recourse, do not provide ideal causes of action for pursuing abuse and neglect in long term care. In addition, prosecutions at all levels are hampered by (1) the paucity of research developing “forensic markers” and methodologies to guide identification and diagnosis of abuse and neglect,³²³ (2) the paucity of experts (including forensic geriatricians or geriatric nurse practitioners) to provide assistance with the investigation, consultation and testimony,³²⁴ (3) infrequent reporting,³²⁵ (4) the rarity with which such cases are assigned priority or the necessary resources,³²⁶ and (5) a lack of information about which measures are most effective in remedying existing and deterring and preventing future abuse and neglect.³²⁷

These and many other unmet needs give rise to a vicious cycle in which each gap in knowledge or practice compounds the problems and makes solutions more elusive. For example, the paucity of research and forensic markers impede detection and diagnosis. Absent detection there can be no reporting. Absent reporting it is difficult to intervene with treatment or prosecution. Absent prosecution there

322. See Erik Lindbloom, *How Can We Identify the Physical and Psychological Markers of Abuse and Neglect*, in MED. FORENSIC ISSUES, *supra* note 8, ¶ 124.

323. See Kerry Burnright, *What Areas of Further Research Would Promote the Detection and Diagnosis of Elder Abuse and Neglect and Forensic Application Thereof?* in MED. FORENSIC ISSUES, *supra* note 8, ¶ 24.

324. See *id.* ¶ 28.

325. See Hawes, *Elder Justice*, in MED. FORENSIC ISSUES, *supra* note 8, ¶¶ 79-80.

326. See *Hearings on the Re-Authorization of the Older Americans Act Before the Subcommittee on Aging of the Senate Comm. on Aging*, 3/29/99 CONG. TEST. (statement of Paul Hodge, ABA Chairperson Nat'l Health Care Law Enforcement Alliance), available in 1999 WL 8086532.

327. See Hawes, *Elder Justice*, in MED. FORENSIC ISSUES, *supra* note 8, ¶ 89.

will be fewer deterrents to future abuses. The paucity of research narrows what is known and what can be taught. Absent comprehensive, uniform, and accurate data collection and reporting we will not know the incidence, prevalence, causes, risk factors, or costs that in turn make it very difficult to formulate a national response.

Perhaps most important, it is imperative to strive for a coordinated and comprehensive plan that includes all relevant entities. Otherwise, we likely will just continue to chip away at small parts of the problem but not achieve meaningful and lasting change. The problem is made more formidable by a lack of infrastructure to assure continued attention and resources. It is compounded by inadequate coordination among the many entities with authority to address the issues.³²⁸ These serious gaps in our handling of elder abuse and neglect not only impede enforcement, but also result in confusion and reluctance to grapple with the “big picture,” because it is so dauntingly big, so complex and so intractable.

The Department’s efforts to identify and address some of these “administration of justice” issues include the following:

B. Training, Coordination, and Outreach

1. Conferences, Symposia, and Working Groups

The number of entities with potential involvement in preventing and/or redressing abuse and neglect in long term care is daunting.³²⁹ In any given state or community, there may be twenty or more different entities or types of professionals with a role in the issue. Too often, these entities do not coordinate adequately, and sometimes they are unaware of one another’s existence or role.³³⁰

The Department organized a variety of events, including regional conferences, round table discussions and symposia, in an attempt to

328. See Scott Fornek, *Elder Abuse on the Rise*, CHI. SUN-TIMES, Dec. 16, 2001, at 15, available in 2001 WL 7255222 [hereinafter Fornek].

329. The list includes providers, family councils, family members and friends of residents, CMS, state licensing entities, state regulatory entities (if different), state surveyors, federal surveyors, resident advocates (state and local long term care ombudsman and adult protective services (APS), federal law enforcement, state law enforcement (MFCU, state AG’s offices; state police, investigators), and local law enforcement (DA, States Attorneys, local police/sheriffs), HHS/OIG (counsel, investigators, auditors), emergency responders (firefighters/EMS; ambulance/EMS), medical community (primary care physicians (resident’s personal doctor), emergency room staff, hospital staff, medical examiners, coroners, nurses, CNAs, therapists, medical directors), and professional licensing entities.

330. See Fornek, *supra* note 328 at 15 (reporting that many police chiefs in the Chicago area have little information on the Department of Aging, Illinois’ primary agency for dealing with elder abuse, and that there is a lack of coordination between that agency and law enforcement).

bridge these communication gaps. The demand to attend these events, which trained more than 1500 people, reflected significant interest among many disciplines, including law enforcement. Several groups have encouraged the Department to organize additional training and coordination efforts, and to continue to play a leadership role in addressing the issues. The Department's events and efforts to coordinate have included the following:

Four regional nursing home abuse and neglect prevention and prosecution conferences. These conferences, held between July 1999 and February 2000, covered problems in long term care, the federal, state and local enforcement options, case studies, promising practices, and special issues in cases against long term care facilities (for example, investigations, bankruptcies, and threats of facility closures). During these conferences, among other things, the Department formed State Working Groups intended to continue and expand multi-disciplinary coordination at the state and local levels, and promote such coordination on an ongoing basis.³³¹ The Department attempted to include representatives from each state and region, and from each relevant entity or discipline. At each conference the last session was a report back from the State Working Group meetings from each state. Among the most consistent problems discussed were the communication gaps between those on the front lines who see significant problems and those with authority to address them. Another problem identified was that cases of abuse and neglect (even egregious cases) were not being identified or reported to law enforcement, and that where there were referrals, law enforcement had insufficient resources or training to handle these difficult and very specialized cases.

State Working Group meeting. To solidify, support, and encourage the State Working Groups, the Department in June 2000 sponsored a meeting of State Working Group representatives as well as national representatives of the umbrella organizations. Then Attorney General Janet Reno delivered the keynote address in her first of five public appearances on the topic.³³² Educational and working sessions pro-

331. The conferences were held in Los Angeles, Philadelphia, Des Moines, and Columbia, South Carolina. The agenda generally followed the following sequence: (1) establishing the problem, (2) introducing the many potential players, (3) describing the case studies and the nuts and bolts of pursuing an investigation and prosecution in a nursing home abuse and neglect case, (4) describing what administrative and law enforcement remedies were available and how they could be employed alone or together, and (5) providing an overview of special issues, such as nursing home bankruptcies, the impact of closures, and how to distinguish abuse or neglect from benign conditions.

332. See Department of Justice, *Elder Justice* (last modified Mar. 3, 2002) <<http://www.usdoj.gov/elderjustice/>>.

vided an opportunity to learn from the others' successes and approach to challenges. More than 30 states reported active working groups at the time, and representatives from more than 40 states attended the meeting. Some states, for example Louisiana and Virginia, had and have active and productive working groups and outreach efforts that have resulted in referrals of cases to United States Attorney's offices in those states. Other states reported a variety of challenges, including dramatic differences of approach among the relevant entities, turf battles, and the refusal of crucial players to participate in the process. In general, however, active State Working Groups have reported that the group provides a very useful and productive forum for addressing and maintaining focus on the issues.

Promising Practices Symposium. In October 2000 the Department, in partnership with the Department of Health and Human Services, sponsored a national symposium that showcased coordinated, multidisciplinary approaches and encouraged collaborations for responding to elder victimization of all types, including (1) abuse and neglect in institutional and residential settings, (2) abuse and neglect in domestic and community settings, and (3) financial fraud and exploitation. State "delegations" met and prepared reports and recommendations, which, along with the proceedings, were included in a publication that, among other things, outlined the promising practices that were discussed.³³³

Elder Justice: Medical Forensic Issues in Elder Abuse and Neglect. In October 2000, the Department organized a roundtable of experts to discuss medical forensic issues in elder abuse and neglect.³³⁴

APRI grant. The Department has made a grant to the American Prosecutor's Research Institute (APRI) (the policy arm of the National District Attorney's Association) to examine the current status of elder abuse, neglect and exploitation cases pursued by local prosecutors and to examine and prepare a report discussing what local prosecutors need to more effectively identify, investigate and prosecute those cases.

NTIC grant. The Department has made a grant to the National Training and Information Center (NTIC) to promote awareness, outreach, and coordination in addressing elder abuse and neglect among community, social service, healthcare, and law enforcement groups at the local level. Among other things, this grant is intended to examine

333. See U.S. Department of Justice, *Our Aging Population: Promoting Empowerment, Preventing Victimization, and Implementing Coordinated Interventions*.

334. The transcript and report generated by that meeting are available at <http://www.usdoj.gov> under the heading *Elder Justice*. See *infra* text accompanying notes 340-350.

how to encourage prompt identification and reporting of elder abuse and neglect.

Coordination Efforts at the National Level. Recognizing that coordination is important not only at the state and local levels, but also at the national level, the Department has promoted and actively participated in a number of broad-based multi-disciplinary national collaborations.

Nursing Home Steering Committee. Coordination at the federal level has been significantly enhanced by productive monthly Nursing Home Steering Committee meetings attended by numerous components of the Departments of Justice and Health and Human Services to address specific cases as well as policy, training, and legislative issues.³³⁵ This group also has undertaken projects relating to data collection and analysis, identification of problematic facilities and/or chains, drafted and implemented a certification on the Minimum Data Set form, discussed and pursued a coordinated interagency approach, and developed consensus recommendations relating to numerous novel issues relating to long term care matters.

Interagency Elder Justice Working Group. Beginning in 2001 the Department also has been instrumental, and worked closely with the Administration on Aging, the National Institute on Aging and HHS-OIG, in the formation and ongoing efforts of an interagency working group focusing on elder abuse and neglect issues. This group meets regularly to discuss the many and varied entities' activities as they relate to elder justice and redressing abuse and neglect, and to identify potential areas for collaboration.

National Academy of Science Panel on Elder Abuse and Neglect. The Department worked in collaboration with the National Institute on Aging (NIA) which sponsored the National Academy of Sciences (NAS) to form a panel charged with creating a national research agenda on elder abuse and neglect. NAS empaneled a very diverse group of experts including geriatricians, gerontologists, nurses, attorneys, epidemiologists, and Adult Protective Services workers. The many issues addressed by that panel include how to create a tool to assist those who come in contact with older people to screen for and identify abuse. The Department has likewise urged the panel to set

335. The Department also participates in or chairs numerous other interagency and intergovernmental groups that have a bearing on the quality of long term care, for example, groups that meet to discuss topics such as health care fraud, elder abuse and neglect, long term care, aging, technologies to assist in safe and healthy aging (including those that mitigate institutional abuse and neglect), and international issues in aging. These activities are too numerous to discuss and beyond the scope of this article.

out a research agenda that will result in identifying and describing “forensic markers” and methodologies to assist practitioners and others to determine when abuse or neglect have occurred.

Other Outreach. The Department has reached out to and shared information with long term care providers in an attempt to understand their concerns regarding enforcement and other issues, and to keep open the lines of communication with those who do a very difficult job and, when done properly, perform a critical service. Similarly, the Department has reached out to, shared information with, and heard concerns of law enforcement, social service, and public health and public safety providers, advocates and academics.

C. Criminal Background Checks

The Department’s Steering Committee members have worked with the FBI, CMS and OIG to promote use of criminal background check provisions that permit nursing homes and home health providers to access the FBI’s fingerprint data base, the largest, most comprehensive, such data base in existence, with more than 39 million sets of prints.³³⁶

In October 1998 Congress enacted Public Law 105-277 which provides that “[a] nursing facility or home health care agency may submit a request to the Attorney General to conduct a search and exchange of [Federal Bureau of Investigation (FBI) criminal history] records . . . regarding an applicant for employment if the employment position is involved in direct patient care.”³³⁷ Providers also may obtain FBI criminal background checks through two other federal statutes.³³⁸ Such background checks are desirable because they are highly reliable (fingerprint checks are less subject to error or manipulation than name-based systems), and because they are national and thus provide a more comprehensive review than checking a single state’s criminal records.³³⁹ The Nursing Home Steering Committee has been working with the FBI to educate providers and the relevant state entities about the existence of and procedures for obtaining background information under this statute.

336. See Health Care Financing Administration, *Nursing Homes* (visited 1/22/2002) <<http://www.hcfa.gov/medicaid/scindex.htm>> (link to “Federal Statutes Authorizing Criminal Background Checks”); Pub. L. No. 105-277 (codified as amended at 42 U.S.C. § 5119 (2001)); Pub. L. No. 92-544.

337. Pub. L. 105-277 (codified as amended at 42 U.S.C. § 5119 (2001)).

338. See *supra* note 336.

339. See *id.*

D. Medical-Forensic Issues

The lack of research, training of experts, knowledge relevant to detection and diagnosis, and infrequency of multi-disciplinary collaborations has an impact on our ability to identify, pursue and treat elder abuse and neglect. It often goes undetected and healthcare professionals and others on the front line who come in contact with those who may have been abused or neglected rarely are trained to identify or report it.³⁴⁰ Even when it is suspected or identified, there are very few experts who can provide medical forensic testimony in any ensuing case.³⁴¹ In part, this is a result of the paucity of research in the area.³⁴² Unlike child abuse, where certain conditions have been demonstrated to be “diagnostic” of abuse, no research has been conducted to provide similar markers at the other end of the age spectrum.³⁴³ If anything, the medical, scientific, and forensic issues are more complex when arising in older people and institutional settings.³⁴⁴ Forensic markers will be more difficult to develop than similar markers for child abuse and neglect, because older people often suffer from numerous simultaneous conditions attending aging or the diseases of old age, that may mask or mimic signs of abuse or neglect.³⁴⁵ For example, older people bruise more easily than younger people, but it is important to be able to distinguish between a bruise caused by a beating versus by some other mechanism. Similarly, frail elders sometimes develop decubitus ulcers and malnutrition. We need markers to assist in the determination of whether such conditions were caused by neglect or by other unavoidable causes. Such markers, however, are urgently needed and would provide an important asset in identifying and prosecuting elder cases.

The Department thus hosted a roundtable discussion entitled *Elder Justice: Medical Forensic Issues in Elder Abuse and Neglect*, to address these issues.³⁴⁶ Experts in relevant healthcare, law enforcement, and social service fields participated in the discussion, which resulted in a

340. See Kerry Burnright, *What Areas of Further Research Would Promote the Detection and Diagnosis of Elder Abuse and Neglect and Forensic Application Thereof?* in MED. FORENSIC ISSUES, *supra* note 8, ¶¶ 19, 23-25.

341. See *id.* ¶ 25.

342. See *id.*

343. See Mark Lachs, *Selected Clinical and Forensic Issues in Elder Abuse*, in MED. FORENSIC ISSUES, *supra* note 8 ¶ 117.

344. See *id.*

345. See *id.*

346. See *supra* note 8.

report, recommendations, a transcript of the proceedings, and short papers submitted by the experts.³⁴⁷

Among the myriad suggestions, the experts recommended the creation of national or regional forensic centers for elder abuse and neglect, similar to those for child abuse and neglect,³⁴⁸ the creation of multi-disciplinary fatality or serious injury review teams to evaluate cases of suspected elder abuse and neglect,³⁴⁹ again, similar to those for other types of family violence, and the training of a group of geriatric-forensic experts, similar to forensic pediatricians who are of great assistance in identifying cases, referrals and interaction with the justice system.³⁵⁰ Each of these recommendations, if implemented, could have a significant impact on the justice system's ability to prosecute cases of abuse and neglect in residential and other settings.

To follow up on and solidify the gains of the medical forensic roundtable, the Department funded a cooperative agreement under which a legal-medical team of investigators will convene an advisory group and distill recommendations for next steps. The Department has funded a project relating to the creation of a community-based elder fatality or serious injury review team.

The Department also has funded two research grants to examine specific forensic issues. One grant examines elder sexual abuse and is intended to identify forensic markers that are indicators that such abuse has occurred. The other grant examines bruising in elders, to assist practitioners and others to identify what types of bruising are more likely to have been caused by abuse and neglect than by other factors. Both the sexual abuse and bruising grants specifically examine the phenomena in long term care as well as other settings.

347. *See id.*

348. *See* William E. Hauda II, *Development of a Forensic Center for the Collection of Forensic Evidence in Abuse and Neglect Cases*, in MED. FORENSIC ISSUES, *supra* note 8 ¶¶ 62-64.

349. *See* Laura Mosqueda, *Medical Forensic Issues in Elder Abuse: Attempting to Define the Issues*, in MED. FORENSIC ISSUES, *supra* note 8 ¶ 136.

350. After revelations of several unnatural deaths that had been called natural, Arkansas, in 1999, enacted legislation requiring a coroner to investigate all nursing home deaths. *See* Testimony of Mark Malcolm before the Senate Special Committee on Aging, Mar. 4, 2002. Such death reviews, employing forensic methods, may, with proper resources and evaluation, assist in the identification of unnatural deaths that require additional investigation and possibly, prosecution. In Pulaski County, Arkansas, the review by the county coroner has resulted in a significant increase in prosecutions, particularly by the Arkansas MFCU. *See* James Kuhnenn, *GAO: Nursing Homes Slow to Report Abuse Incidents*, MACON TELEGRAPH, Mar. 3, 2002, at 1, available at 2002 WL 8369034.

*E. Funding, Research, Programs, and Statistics to Fight
Elder Victimization*

The Department of Justice through its Office of Justice Programs (OJP) funds research, training, technical assistance, coordination efforts, promising practices, and the development of statistics, with the goal of improving understanding, preventing, intervening in, reporting, and prosecuting of unlawful activity, and to assist the victims of crime. Thus, OJP is uniquely situated to tap into existing expertise, apply lessons learned in other areas, and take a national view of the problems surrounding elder abuse and neglect. In addition to the elder sexual abuse and bruising research grants, and the medical forensic project discussed above, (administered through the National Institute of Justice's (NIJ) Office of Science and Technology (OST), examples of OJP's current activities relating to elder victimization are very briefly discussed below.

OJP's Office for Victims of Crime (OVC) elder abuse-related projects have included (1) cosponsoring, with HHS's Administration on Aging, a national summit of the National Center on Elder Abuse focusing on ways to address and reduce elder victimization, (2) production of a training module for law enforcement officers, deputies and other first responders, with the skills needed to investigate abuse and neglect in long term care facilities, (3) publishing a monograph highlighting emerging initiatives in the area, and (4) funding Baylor College of Medicine to develop an elder victimization curriculum targeted to physicians in emergency medicine, geriatrics and general medicine. The curriculum will cover screening, assessment, appropriate interventions, reporting, and working with adult protective services and law enforcement. The project also will generate a publication. OJP also has provided support to District Attorneys to develop a multi-agency approach to elder abuse using methodology that could be replicated and serve as a national mode.

CONCLUSION

Our older population is already large and it is growing at a prodigious rate. The oldest of the old – those 85 and older and those 100 and older – are the fastest growing age groups. Notwithstanding significant medical advances, advancing age often is still accompanied by increased needs for assistance, sometimes as the result of disability, sometimes due to other factors. The demographic imperative, thus, requires that we address, in a meaningful fashion, how to assure that those who need it will receive the necessary care. In the next thirty years the number of people who need long term care is expected to

double from about 7 to 14 million people, most of whom will rely on others for part or all of their daily care, and on the Medicare and/or Medicaid programs to fund part or all of their health care.

Promoting justice for this vulnerable population will continue to be an important if daunting challenge. Meaningful change will require an ambitious, multi-faceted, well-contemplated, comprehensive, and well-funded national plan. But it is not necessary to reinvent the wheel. There are many lessons that may be imported from other areas (for example child abuse and domestic violence) that may inform what efforts work and which ones should be assigned priority.

The problems are compounded by fraud and abuse that continue to unnecessarily deplete government health care programs, just as demand for those programs grows. The programs and their beneficiaries are harmed when the trust fund is unlawfully depleted by paying for goods or services that were worthless, not rendered at all, or provided in violation of a statute, regulation, or provision that is a condition of payment. In failure of care cases, the Department balances the law enforcement and public health goals. To that end, in addition to damages, most failure of care cases will involve non-monetary remedies of some sort. These important non-monetary remedies, designed to improve care and protect residents, may include imposition of temporary facility monitors and protocols designed to safeguard care. Thus, continued anti-fraud efforts (that last year alone recovered about \$1.2 billion) are vital to the welfare of the long term care system and its beneficiaries, particularly as the baby boomers age.

In the administration of justice the Department has supported efforts to bridge daunting gaps in our ability to prevent, detect, diagnose, intervene in, treat and, where necessary, prosecute elder abuse and neglect generally, and abuse and neglect of long term care residents in particular. The Department's activities designed to bridge some of those gaps include education, outreach, supporting prosecutions, proposing new legislation, grant-making, and sponsoring research, promising projects, statistical analysis and medical forensic activities.

These efforts are beginning to see results. Federal prosecutions with remedies designed to improve care and protect vulnerable residents are on the rise. Thousands of residents live in facilities that are now subject to greater scrutiny. Thousands of people have received training. Myriad entities are finding new ways to work collaboratively at the national, state and local levels. Some researchers have embarked on studies that promise to advance our state of knowledge. Numerous innovative and promising programs are underway.

But, while we are gaining a better understanding about some aspects of the problem much still remains to be done.

Given the chasm between what is and what should be, it is vital that the relevant entities be vigilant, coordinate, and undertake such measures as they possess and are able in their respective realms of responsibility and authority. Some such activities relating to federal law enforcement have been discussed in this article.

The importance of defending the universal human right to live free of suffering caused by abuse and neglect does not diminish with advancing age. We must be watchful that the insidious presumption that "*old people will die soon anyway*" does not beget inaction or excuse ignorance; that it does not result in the devaluation of lives just because they are old or frail. Otherwise victims suffer twice: once from the abuse or neglect itself; and a second time from the inadequate or nonexistent response to their suffering due to a lack of detection, treatment, intervention, and prosecution. The cost of abuse and neglect is high. It is paid in unnecessary human suffering, loss of life, higher healthcare costs and depleted public resources. And, it is borne disproportionately by the frailest among us. If we can unlock the mysteries of science to live longer lives, we also must take the corresponding measures to assure that those longer lives can be lived free of the indignities of abuse, neglect and exploitation.