LTCCC LONG TERM CARE COMMUNITY COALITION

MONITOR

Working to improve long term care through research, education & advocacy

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New Info on Federal Health Care Reform & LTC

The 2010 federal Patient Protection and Affordable Care Act (ACA), aka the federal health care reform law that passed into law last year, contains a number of provisions that are going to have a major impact on long term care consumers. With funding from NY Statewide Senior Action, LTCCC is developing educational materials and conducting programs on how NYS seniors will be impacted by healthcare reform and issues they need to know about to advocate for themselves and their loved ones on long term care

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Study on Assisted Living Oversight Indicates Persistent Problems

In June, LTCCC released its study: Care and Oversight of Assisted Living in New York State (see assisted-living411.org). The study was undertaken to identify the current state of the quality of care and life in the state's assisted living facilities.

The findings of the study indicate that, despite a long history of problems, and major initiatives over the years to address those problems, the assisted living industry in New York State still has serious issues related to resident care and quality of life. Medication citations are still rampant and, alarmingly, almost a quarter of them are repeats from earlier inspections. In addition, 19 percent of the environmental violations are repeats. These include safety issues as well as issues related to quality of life.

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LTCCC LONG TERM CARE COMMUNITY COALITION

CARE AND OVERSIGHT OF ASSISTED LIVING IN NEW YORK STATE

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In This Issue...

Join Us… Thursday, October 6th, 6-8pm

LTCCC to Hold 3rd Annual Reception

How Do We Continue To Improve Nursing Home Quality In The Midst Of Health Care Reform?

Join us in honoring an extraordinary individual whose career has focused on improving the life of nursing home residents

Karen Schoeneman, Technical Advisor for the Nursing Homes Division at the Centers for Medicare & Medicaid Services (CMS)

A true advocate at heart, Karen Schoeneman has been at CMS for over 20 years. Karen began her career as a social worker. After receiving her master's degree in Public Administration she went to work for the federal agency now known as CMS. Karen's passion for the elderly and their right to a quality life no matter where they reside is known throughout the country. Karen's optimism is catching, her commitment to improve the lives of the elderly is always evident, whether she is presenting at a Federal Basic Facility Surveyor Training course or if she is speaking to an audience about Culture Change. Her energy and passion is palpable. A founding member of the Pioneer Network, we honor Karen for her life-long career and commitment to improve the lives of the elderly and frail citizens that reside in nursing homes across the United States.

Tickets: $150 ($110 is tax-deductible) • All tickets must be purchased in advance

For tickets or more information call 212-385-0355

LTCCC
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Study on Assisted Living Oversight *continued from page 1*

From our perspective, it is – or should be – unacceptable that the very same areas identified as problematic over the last few decades are still causing harm to residents in assisted living today. It is particularly outrageous that two of the three major identified issues are repeated year after year by some of the same facilities.

To make matters worse, the number of problems may in fact be under-identified by DOH: some ombudsmen and resident advocates believe that DOH is not identifying major problems that they see relating to resident rights, discharge and transfer, personal funds and property. Our data indicate that, even after the investigations of the early 2000s, the impacted homes (homes with 25 percent or more residents with mental disabilities) still have significantly more problems when compared to non-impacted homes. The impacted homes have twice the number of violations as the non-impacted homes. This too, especially given the longstanding public acknowledgement of these issues, is simply unacceptable.

Ombudsmen and resident advocates suggest that one of the reasons inspectors are not citing problems that they believe are occurring is that inspectors are not speaking to enough residents and/or do not treat residents as credible sources of information about the facilities in which they live. LTCCC's analysis of the documentation of violations also indicates that inspectors may not be speaking to enough residents to identify the problems that ombudsmen and resident advocates see. Although the data did not permit us to analyze how many residents are being interviewed by inspectors, the infrequent times an inspector lists a resident interview as a source of a citation seems to indicate that they are either not interviewing enough residents and/or are not finding them credible.

Alarmingly, enforcement data indicate that too few homes are being held accountable for their violations in a timely fashion. Findings, or non-compliance that does not meet the threshold of a violation due to its scope and severity, are never referred for enforcement action. In addition, many homes escape an enforcement action, even for serious problems, because state law does not permit DOH to levy a fine if the home corrects or has implemented an acceptable correction and monitoring plan within 30 days of notice (except for an endangerment violation). Thus, even if a home is found to have repeatedly violated minimum standards, harmed their residents or put their residents at risk of harm, so long as it is not an endangerment violation or it is correcting within 30 days each time it is cited the home cannot be fined.

These are not the only reasons why the study found that few homes are being held accountable. The state law requirement that DOH can levy only a "per day" fine has led to referral for enforcement action of only those non-endangerment violations which have continued to occur at a second inspection. DOH needs evidence that the violation is continuing past one day and that the violation has not been corrected within 30 days. Another possible reason for a lack of strong and timely enforcement may be a lack of sufficient resources at DOH. For instance, preparing for hearings is extremely labor-intensive and the state simply does not appear to be allocating sufficient resources, particularly staff, to follow through on enforcement of violations.

The data sources for the study included the quarterly inspection reports posted on the Department of Health's (DOH) website; a random sample of nine percent of all the inspections of adult homes, enriched housing, Medicaid Assisted Living Programs and assisted living residences from 2002 to mid September 2010; ombudsmen complaint data from 2007 through 2009; a survey of ombudsmen and consumers to find out their perceptions of quality of care and of life in the state's assisted living as well as of the

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Study on Assisted Living Oversight *continued from page 3*

state's oversight and enforcement; follow up interviews with a select group of ombudsmen and consumer representatives; and all DOH enforcements from 2002 through 2010.

RECOMMENDATIONS

The study report presents a number of specific recommendations for state leaders to overcome the serious issues identified in the study.

In order to improve assisted living quality, the report urges the legislature to:

1. Amend Section 461-a of the Social Services Law (Responsibility for Inspection and Supervision) to require an annual inspection of each facility. Currently a facility receiving the "highest rating" may be inspected every 18 months rather than once a year. However, there is no definition of "highest rating." Furthermore, even facilities with few or no problems on one survey may deteriorate in a year and half. Given the vulnerability of the assisted living population and our increasing reliance on assisted living as a substitute for nursing home care, DOH should be furnished with sufficient inspectors and other resources to inspect annually.

2. Amend Article 46-b of the Public Health Law (Assisted Living) to require better training of direct care staff in facilities, particularly for individuals dealing with medication by mandating a specific curriculum. Currently, the law only permits guidelines for a training program for direct care staff.

3. Pass legislation to require licensure for administrators. Running an adult home or assisted living residence, especially an impacted home or one that has special/enhanced needs certification, requires specific training and competencies.

4. Pass legislation to require facilities to provide residents with additional hours of care per week for medication assistance in addition to the 3.75 now required. Currently facilities are required to give all residents, whether on multiple medications or not, at least 3.75 hours of care per week. It is clear that more time is needed for help with medications, especially now that more and more residents are on medications.

In order to encourage effective and speedy enforcement, the report urges the legislature to:

1. Amend Section 460-d of the Social Services Law (Enforcement Powers) in two ways similar to nursing home law:

a. Permit the levying of fines "per violation" in addition to the "per day" now permitted. Currently fines can be levied only for each day a violation exists and has not been corrected. Facilities should be sanctioned for each violation they incur, not just the ones that are continuing. Even a one-time violation may cause harm to a resident.

b. Remove the ability of a facility to escape a penalty for harming a resident or putting a resident at risk of harm by correcting within 30 days. Currently a facility that has either corrected within 30 days of receipt of the citation or has put in place a correction plan may not be fined unless the citation is considered to have endangered a resident. This permits facilities to be out of compliance, correct and then be out of compliance again and again without being held accountable. This may account for the persistence of repeat violations.

> **"...inadequate funding of inspection and enforcement is financially costly for the consumers and taxpayers..."**

2. Amend Section 460-d of the Social Services Law (Enforcement Powers) to increase current limits on fines. $1000 or less per day (or even per violation if 'a' above was adopted) may be too low a fine to be meaningful for some violations (especially for repeat violations).

3. Allocate sufficient funds to ensure adequate inspection and enforcement in the DOH budget. There are not enough inspectors to spend the time needed to interview the many residents they should be interviewing . There are insufficient staff attorneys to handle the large number of cases. As a result, serious problems continue. In addition to being directly deleterious to residents, inadequate funding of inspection and enforcement is financially costly for the consumers and taxpayers who continue to pay for substandard services (not to mention, often, its repercussions).

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Study on Assisted Living Oversight *continued from page 4*

In order to improve assisted living quality, the report urges the Governor and the Department of Health to:

1. Require better training of direct care staff in facilities, particularly for individuals dealing with medication by mandating a specific curriculum. Currently, DOH only recommends a training program for direct care staff.

2. Require licensure for administrators. Running an adult home or assisted living residence, especially an impacted home or one that has special/enhanced needs certification, requires specific training and competencies.

3. Require facilities to provide residents with additional hours of care per week for medication assistance in addition to the 3.75 now required. Currently facilities are required to give all residents, whether on multiple medications or not, 3.75 hours of personal services per week. It is clear that more time is needed for help with medications, especially now that more and more residents are on medications.

In order to encourage compliance, the report urges the Governor and the Department of Health to:

1. Evaluate effectiveness of different approaches to encourage compliance. DOH has inserted a number of different provisions into facility stipulations to encourage compliance such as: suspending one-half the fine if the facility stays in compliance or adding an additional fine if the facility reoffends. DOH should evaluate whether these approaches have in fact led to better compliance.

In order to improve inspections, the report urges the Governor and the Department of Health to:

1. Require inspectors to speak with more residents. Given the purpose of the rules and regulations – to protect residents and ensure quality of services to them – resident input should be sought after and regarded as an essential component of the inspection process.

2. Require investigations of complaints by residents to include interviews of large numbers of residents. In order to encourage residents who are afraid of cooperating, inspectors should speak to a variety of residents when investigating a complaint so that the complainant's identify is not obvious.

3. Train inspectors in how to interview residents and gain their trust.

4. Coordinate with both state and local ombudsmen. Find out what types of complaints they are getting and focus surveys on those areas as well as resident services and environment (e.g., resident rights, discharge and personal funds and property).

5. Evaluate consistency of survey process and outcomes and decisions to refer violations for legal action.

Encourage state policy makers to implement the recommendations of the report. Send an email by going to www.ltccc.org and clicking on CITIZENS ACTION CENTER on the right side. Take action on both assisted living alerts: one for the Governor and Department of Health officials (IMPROVE ASSISTED LIVING : HELP ASSISTED LIVING RESIDENTS) and one for legislators (PROTECT ASSISTED LIVING RESIDENTS: AMEND 460-d OF THE SOCIAL SERVICES LAW). ❑

Help LTCCC Go Green!

Do you use email? Access information and news online? If so, please help us save paper – and money – by subscribing to the electronic version of *The Monitor*. As an added bonus, you will get your *Monitor* before hard copies go out! Send an email to info@ltccc.org with the name that appears on the mailing label on the back of this issue and let us know the email address you would like the newsletter sent to. We will email you back to confirm. Thank you. ❑

Quarterly Enforcement Actions Against Nursing Homes

Selected Enforcement Actions By The NYS Attorney General

Medicaid Fraud Control Unit[1] Took Action Against 8 Nursing Home Personnel 3/16/11 - 6/15/11

Nursing Home	Location	Defendant	Narrative	Sentence
Crest Hall Care Center (also called Lakeview Rehabilitation and Care Center)	Middle Island	Thomas, Tamika, Receptionist	Defendant misused her access to residents' accounts, established for the payment of personal expenses, to steal $1,465 from several residents over time.	5/9/2011: Conditional Discharge[2] and $1,465 in restitution.
Ferncliff Nursing Home Co. Inc.	Rhinebeck	Post, Christopher, Certified Nurse Aide	Defendant falsely claimed he assisted another CNA in the transfer of a 94-year old resident, who slipped and suffered a broken arm.	5/5/2011: Unconditional Discharge and the surrender of her CNA certificate.
Ferncliff Nursing Home Co. Inc.	Rhinebeck	Thomas, Stephen, Certified Nurse Aide	Defendant transferred a 94-year old resident, who slipped and suffered a broken arm alone and asked another CNA to claim that they transferred the resident together in compliance with the care plan.	4/7/2011: Unconditional Discharge and the surrender of her CNA certificate.
Lily Pond Nursing Home	Staten Island	Ferry, Cynthia, Certified Nurse Aide	CNA was observed by EMT striking 40-year old resident about the head.	3/23/2011: Conditional Discharge, with the condition that she refrain from engaging in any employment in the health care field, and the surrender of her CNA certificate.
Lily Pond Nursing Home	Staten Island	Bernabe, Josefina V., Licensed Practical Nurse	Defendant, while working the evening shift as a Nurse Supervisor, was advised by an EMT worker that he witnessed CNA Ferry strike a 40-year old resident on the head. Defendant told the EMT worker not to report it to protect Ferry from getting in trouble.	3/23/2011: Conditional Discharge, with the condition the she refrain from engaging in any employment in the health care field, and the surrender of her LPN license.
McAuley Residence	Kenmore	Myers, Anne, Certified Nurse Aide	Defendant, working as the Range of Motion aide, filled in her initials on the patient records even though she did not complete the services the resident was supposed to receive.	3/24/2011: $205 surcharge and the surrender of her CNA Certificate.
Medford Multicare Center	Medford	Coleman, Janet, Licensed Practical Nurse	Defendant was the Unit Manager at the home during the AG's Hidden Camera investigation and falsified the resident's records that she provided treatments to him, including cleaning his g-tube site and ears.	5/19/2011: A term of five-years probation. Conditions of probation include that the defendant may not be employed caring for any incompetent person whether the incompetence is due to age, physical disability, mental disease or defect as well as narcotic and alcohol conditions. The defendant also surrendered her LPN license.
Willow Point Nursing Home	Vestal	Ortloff, Eugene, Licensed Practical Nurse	Defendant forcefully cut the finernails of an uncooperative resident, causing them to bleed.	4/19/2011: Conditional Discharge and the surrender of her LPN license.

[1]The unit prosecutes cases of patient abuse in nursing homes.
[2]Conditional discharge means if similar act is committed during the time period defendant can be brought back to court.

Federal Civil Money Penalties[1] Against 9 Nursing Homes: 3/1/11 – 5/31/11[2]

Name Of Home	Location	Survey Date	Amount
Blossom South Nursing & Rehab Center	Rochester	1/26/11	$8,000
Elant at Fishkill	Beacon	1/10/11	$46,450
Hempstead Park Nursing Home	Hempstead	9/28/10	$48,680[4]
Julie Blair Nursing & Rehab Center	Albany	1/28/11	$4,875[3]
Marcus Garvey Nursing Home	Brooklyn	11/30/10	$77,400
Pleasant Valley	Argyle	1/6/11	$26,585[3]
Sunnyside Care Center	East Syracuse	1/31/11	$3,055[3]
Van Duyn Home and Hospital	Syracuse	5/29/09	$73,650
Wingate at Beacon	Beacon	1/4/11	$45,435[3]

[1]Civil Money Penalties (CMPs) – a federal sanction against nursing homes that fail to comply with quality care requirements.
[2]As reported by CMS. For more detailed information contact the FOIA Officer at CMS 212-616-2220. This list will be posted on LTCCCs website every three months.
[3]Amount reflects a 35% reduction as the facility waived its right to a hearing as permitted under law. Original fine was 35% higher.
[4]Fine imposed in accordance with settlement agreement between CMS and the facility.

Quarterly Enforcement Actions Against Nursing Homes

NY State Fined 22 Nursing Homes: 3/18/11 – 6/30/11[1]

Name Of Home	Location	Date Of Survey	Amount[2]
Absolute Center for Nursing and Rehab-Endicott	Endicott	7/22/09	$2,000
Bishop Henry B Hucles Episcopal Nursing Home	Brooklyn	11/30/09	$12,000
Brooklyn United Methodist Church Home	Brooklyn	3/8/10	$22,000
Chataugua County Home	Dunkirk	1/6/09	$10,000
Elant at Newburgh Inc.	Newburgh	9/2/09	$72,000
Franklin County Nursing Home	Malone	6/26/09	$8,000
Grandell Rehab and Nursing Center	Long Beach	7/29/10 & 1/26/10	$34,000
Guilderland Center Nursing Home	Guilderland Center	9/10/09	$10,000
The Hamptons Center for Rehab and Nursing	Southampton	7/30/10	$10,000
Jewish Home and Hospital-Bronx	Bronx	6/23/09	$6,000
Medford Multicare Center for Living	Medford	3/17/10	$10,000
Medford Multicare Center for Living	Medford	4/1/09	$12,000
Mount Loretto Nursing Home Inc.	Amsterdam	7/6/10	$10,000
Northern Riverview Health Care Center, Inc	Haverstraw	4/8/10	$24,000
Petite Fleur Nursing Home	Sayville	4/9/10	$10,000
St. Johns Health Care Corporation	Rochester	9/27/10	$10,000
Sullivan County Adult Care Center	Liberty	4/16/09	$10,000
Summit Park Nursing Care Center	Pomana	12/4/09	$10,000
Sutton Park Center for Nursing and Rehab	New Rochelle	6/18/09	$4,000
Sutton Park Center for Nursing and Rehab	New Rochelle	1/19/10	$10,000
Van Duyn Home and Hospital	Syracuse	11/13/08	$2,000
Wayne Health Care	Newark	7/9/10	$2,000
Westmount Health Facility	Queensbury	2/25/10	$2,000
Wyoming County Community Hospital SNF	Warsaw	3/19/09	$10,000

[1]As reported by the Department of Health (DOH). For more detailed information call the DOH FOIL Officer at 518-474-8734 or e-mail – foil@health.state.ny.us.

[2]Under state law nursing homes can be fined up to $2,000 per deficiency. These fines may be increased to $5,000 if the same violation is repeated within twelve months and the violations were a serious threat to health and safety. These fines may also be increased up to $10,000 if the violation directly results in serious physical harm.

NY State Took Other Action Against 20 Nursing Homes 3/17/11 - 6/30/11[1]

Name of Home	Location	Resident Impact[2]	Survey Date	Actions[3]
Adirondack Medical Center Uihlein	Lake Placid	IJ/SQC	3/22/11	CMP, Monitor, DPOC, Inservice, DOPNA
Andrus on Hudson	Hastings-on- Hudson	IJ/SQC	5/19/11	CMP, Monitor, DPOC, Inservice, DOPNA
Bishop Francis J. Mugavero Center for Geriatric Care	Brooklyn	IJ/SQC	4/11/11	CMP, Monitor, DPOC, Inservice, DOPNA
Blossom South Nursing and Rehab Center	Rochester	GG	3/25/11	CMP, DPOC, Inservice, DOPNA
Crown Center for Nursing and Rehab	Cortland	GG	4/4/11	DPOC, Inservice, DOPNA
Ferncliff Nursing Home Co, Inc.	Rhinebeck	IJ/SQC	4/27/11	CMP, Monitor, DPOC, Inservice, DOPNA
Highland Nursing Home Inc.	Massena	GG	4/14/11	DPOC, Inservice, DOPNA
James Square Health and Rehab Center	Syracuse	GG	4/13/11	DPOC, Inservice, DOPNA
Julie Blair Nursing and Rehab Center	Albany	GG	3/28/11	DPOC, Inservice, DOPNA
Katherine Luther RHC & Rehab Center	Clinton	IJ/SQC	5/25/11	CMP, Monitor, DPOC, Inservice, DOPNA
Loretto Utica Nursing Home	Utica	IJ/SQC	4/16/11	CMP, Monitor, DPOC, Inservice, DOPNA
Lutheran Augustana Center for Extended Care & Rehab	Brooklyn	GG	4/29/11	DPOC, Inservice, DOPNA
MM Ewing Continuing Care Center	Canandaigua	IJ	6/24/11	CMP
Mosholu Parkway Nursing and Rehab Center	Bronx	IJ/SQC	4/12/11	CMP, Monitor, DPOC, Inservice, DOPNA
Northern Riverview Health Care Center, Inc.	Haverstraw	IJ/SQC	5/6/11	CMP, Monitor, DPOC, Inservice, DOPNA
Pleasant Valley	Argyle	IJ/SQC	4/26/11	CMP, Monitor, DPOC, Inservice, DOPNA
River Ridge Living Center, LLC	Amsterdam	IJ	4/11/11	CMP, Monitor, DPOC, Inservice, DOPNA
St. Camillus RHCF	Syracuse	IJ/SQC	6/10/11	Monitor
The Springs Nursing & Rehab Centre	Troy	IJ/SQC	4/1/11	CMP, Monitor, DPOC, Inservice, DOPNA
Van Duyn Home and Hospital	Syracuse	IJ/SQC	4/18/11	CMP, DPOC, Inservice, DOPNA

[1]As reported by the Department of Health (DOH). For more detailed information call the DOH FOIL officer at 518-474-8734 or e-mail – foil@health.state.ny.us.

[2]Immediate jeopardy (IJ), and substandard quality of care (SQC): The most serious level of deficiency causing harm; GG: Deficiencies that have caused isolated resident harm on two consecutive surveys.

[3]Civil Money Penalty (CMP): State recommends the fine to CMS; State Monitoring: State survey staff is onsite in the facility to monitor and oversee correction; Directed Plan Of Correction (DPOC): A corrective action plan that is developed by the State or CMS, and requires a facility to take action within specified timeframes. In New York State, the facility is directed to determine the root cause of the deficiency, identify and implement steps to correct the problem, and evaluate whether corrective measures are successful; In-Service Training: State directs in-service training for staff; which must be provided by a consultant who is not affiliated with the facility; Denial of Payment for New Admissions (DoPNA): Facility is not paid for any new Medicaid or Medicare residents until correction of deficiencies is achieved.

Quarterly Enforcement Actions Against Nursing Homes

Selected Administrative Actions By The NYS Office of Medicaid Inspector General

Action Taken Against 12 Nursing Home Personnel 3/16/11 - 6/15/11

Nursing Home	Location	Defendant	Narrative	Action Taken
Bishop Charles Waldo MacLean Nursing Home	Far Rockaway	Gwendolyn Nicolas, LPN	Ms. Nicolas willfully made false reports that she had administered medication to patients, when she in fact, had not.	Based on State Education Department Consent Order[1] OMIG Exclusion[2]: 5/3/2011
Chapin Home for the Aging	Jamaica	Sherett Denise Gaither, LPN	Ms. Gaither willfully falsely charted on 25 patient medication administration records that she had given these residents their medication at 9:00 pm as prescribed, when in fact the meds had been administered at least 2 hours earlier.	Based on State Education Department Consent Order OMIG Exclusion: 6/5/2011
Daleview Care Center	Farmingdale	Dieudonne Poulard, CNA	Ms. Poulard gave a false statement in order to conceal the crimes of other staff members related to a fall sustained by a resident which led to a fractured hip. Ms. Poulard lied to administrators saying she had no knowledge of the fall, when in fact she had participated in giving care to the resident after the apparent fall.	Based on a Nassau County Court Indictment brought by the NYS Attorney General's MFCU OMIG Exclusion: 3/27/2011
Daughters of Jacob Health Services	Bronx	Kwaku Asante, LPN	Mr. Asante failed to notify the charge nurses that a 75 year old resident was not present in the unit at 5:00 pm and again at 9:00 pm, during which time Mr. Asante was supposed to administer medications to the resident. Mr. Asante charted in the Medication Administration Record that at both those times he had administered medications to the resident when in fact he had not.	Based on State Education Department Consent Order OMIG Exclusion: 4/3/2011
Grace Plaza Nursing and Rehabilitation Center	Great Neck	Susan Baquial Sagaral, RN	Ms. Sagaral failed to perform a full assessment on a patient who had slipped and needed to be lowered to the floor and failed to report the incident.	Based on State Education Department Consent Order OMIG Exclusion: 5/26/2011
HCR and Coram Infusion; Blossom View Nursing Home	Rochester	Catherine Roome, RN	In addition to stealing hydromorphone pills from a home health patient, Ms. Roome stole morphine sulphate from Blossom View Nursing Home for her own personal use.	Based on Monroe County Court conviction based on guilty plea to Petit Larceny, and an SED Consent Order OMIG Exclusion: 4/3/2011
Manhattanville Rehabilitation and Healthcare	Bronx	Paula Pamela Smith-Morrison, LPN	Ms. Smith-Morrison willfully made false reports that she had administered medication to patients, when she in fact, had not.	Based on State Education Department Consent Order OMIG Exclusion: 5/2/2011
Peninsula Center for Extended Care & Rehabilitation	Far Rockaway	Kay-Dean Careen Jackson, LPN	Ms. Jackson failed to notify a supervisor or a physician that a patient was having difficulty breathing. Ms. Jackson also failed to initiate CPR on this patient upon finding the patient unresponsive.	Based on State Education Department Consent Order OMIG Exclusion: 6/5/2011

Quarterly Enforcement Actions Against Nursing Homes

Selected Administrative Actions By The NYS Office of Medicaid Inspector General

Action Taken Against 12 Nursing Home Personnel 3/16/11 - 6/15/11 (continued)

Nursing Home	Location	Defendant	Narrative	Action Taken
Petit Fleur Nursing Home	Sayville	Gudrun Doncourt, LPN	Ms. Doncourt failed to document the administration of controlled substances to three patients over several days.	Based on State Education Department Consent Order OMIG Exclusion: 6/6/2011
Smithtown Rehabilitation Center	Smithtown	Adam Rauer, RN	Mr. Rauer took Dilaudid, a narcotic, for his personal use, and also falsified business records, noting that the drugs were furnished to residents.	Based on MFCU Indictment OMIG Exclusion: 6/5/2011
Sullivan County Adult Care Facility	Liberty	Myra Siegel, RN	Ms. Siegel verbally and physically abused patients. In one instance she forcibly held down a resident while giving care, calling the resident an "evil witch." In the second instance, Ms. Siegel told a resident who was not ready to receive his medication that he had a death wish and was going to die if he didn't take his medicine.	Based on State Education Department License Surrender OMIG Exclusion: 6/6/2011
Willow Point Nursing Home	Vestal	Eugene Ortloff, LPN	Mr. Ortloff falsely filed a statement on a Resident Incident Report, stating that a resident had sustained two partially torn nails from nail biting. In fact, Mr. Ortloff had forcefully cut the fingernails of the resident, causing them to bleed.	Based on MFCU Indictment and subsequent guilty plea to Endangering the Welfare of an Incompetent person in the Town of Vestal Court OMIG Exclusion: 4/20/2011 and 5/22/2011

[1]An agreement between the State Education Department Office of Professional Discipline, Board of Regents, Committee of the Professions and the licensee who admits guilt to at least one of the alleged acts of misconduct. The Consent Order provides the details of the misconduct and the assigned penalties.

[2]No payments will be made to or on behalf of any person for the medical care, services or supplies furnished by or under the supervision of the defendant during a period of exclusion or in violation of any condition of participation in the program. Additionally, any person who is excluded from the program cannot be involved in any activity relating to furnishing medical care, services or supplies to recipients of Medicaid for which claims are submitted to the program, or relating to claiming or receiving payment for medical care, services or supplies during the period.

NEWS...

In June, James Sheehan, the state's Medicaid Inspector General, was asked to leave the Inspector General's Office. See LTCCC's July LTC e-newsletter for details. For information on his work to hold nursing home providers accountable for quality, see the Summer 2011 *Monitor*. Both are available at www.ltccc.org/newsletter/. James C. Cox became Acting Medicaid Inspector General on July 13, 2011.

CORRECTION...

In the last edition of *The Monitor*, the survey date listed for the basis of The Brightonian fine was incorrect. It was 2/12/10, not 1/12/10.

New Info on Federal Health Care Reform *continued from page 1*

related issues. The programs will be conducted through Statewide and all informational materials will be available on both LTCCC's website (www.ltccc.org) and Statewide's website (www.nysenior.org).

One of the major components of the materials will be factsheets for seniors and other long term care consumers on the provisions of the ACA that pertain to long term care. Though a substantial number of Republicans in Congress are fighting to overturn all or parts of the ACA, and there have been lawsuits in several states seeking to overturn or weaken it, it is likely that most (if not all) of the provisions will survive. From LTCCC's perspective, we strongly advocated for a number of components of the ACA that increased protections and accountability in nursing home care, strengthened protections against elder abuse, improved access to home and community based services for the elderly and disabled (so they can avoid institutionalization) and much more. The ACA put into effect some of the major recommendations LTCCC has been making for years to ensure that penalties collected from nursing homes when they fail to meet minimum standards (known as civil money penalties or CMPs) are used by the states to fund activities that truly make a difference in the lives of residents.

Following are some highlights from the factsheets, which we expect to post on the websites in the fall.

The CLASS Act

The CLASS (Community Living Assistance Services and Supports) Act is a federally administered long term care insurance program created under the ACA. When implemented, it will be available to working adults who are at least 18 years old, for voluntary enrollment either directly or through their employers, regardless of age and health. CLASS can help beneficiaries pay for non-medical services so that they can stay in their own homes longer. Such services include assistive technology, transportation, and help with activities of daily life (ADL's). One could also use CLASS to pay part of the cost of assisted living or nursing home care.

In order to receive the benefits of the program and be able to purchase long term services and supports, participants must meet certain eligibility requirements, such as having an eligible functional limitation (struggling with an ADL or having a cognitive impairment); earning wages for at least three years after they enroll; and paying monthly premiums for at least five years. Important note regarding implementation: The CLASS Act is very controversial and may be modified or even overturned prior to its implementation which, under current law, will take place by October 2012.

Expanded Home and Community Based Services

The ACA also initiates several programs to facilitate more expansive Home and Community Based Services (HCBS) programs in the states. Among these programs are several new Medicaid options which allow the states to offer HCBS to all people who are eligible for Medicaid (meaning that their income does not exceed 150% of poverty and that they meet state functional eligibility requirements for nursing home care); spousal impoverishment for HCBS; and a demonstration program to help people transition from institutional care back into the community.

Improved Nursing Home Oversight, Accountability & Transparency

The ACA sets forth a more consumer-friendly process for making and resolving complaints about nursing home care and requires that nursing homes participate in effective compliance and ethics programs as well as quality assurance and performance improvement programs. The Act also makes improvements to information provided on the Nursing Home Compare website, which contains quality, inspection and other information on all nursing homes in the US that take Medicare or Medicaid (www.medicare.gov/nhcompare) and, more specifically, to the five-star rating system used to compare nursing homes.

Enhanced Medicare Benefits

Medicare enrollees receive several new benefits. From now until 2020, Medicare Part D enrollees will receive phased-in discounts on prescription drugs purchased in the coverage gap (the so-called "donut hole") between what is covered by insurance and what is eligible for catastrophic coverage. By 2020, the coverage gap should be closed completely. Medicare Part B enrollees are also eligible for several new, free

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New Info on Federal Health Care Reform *continued from page 10*

preventative care services, like a yearly wellness checkup to identify potential health problems, a yearly flu shot, and screening for cancer, heart disease, and diabetes.

Protections Against Abuse & Neglect

The law authorizes funding for a variety of new and existing federal and state programs designed to improve elder justice and protect consumers of long term care, such as stronger requirements for the reporting of crimes against nursing home residents. New grant programs will support increased training for Long Term Care Ombudsmen, as well as for direct care workers in long term care facilities. Grants will also support the establishment of a national training institute for surveyors and several forensic centers for detecting and confirming instances of elder abuse. The ACA also requires several research and demonstration projects relating to the development of a national nurse aide registry, conducting of background checks on employees of LTC facilities, and facilitating implementation of culture change in nursing homes.

For more detailed information and resources, visit www.ltccc.org or www.nysenior.org. ❑

Free Seminar

On Nursing Home Reimbursement Offered At the National Consumer Voice Conference In Grand Rapids Michigan In October

You do not have to be an expert to make a difference in advocating for state nursing home reimbursement policies that benefit residents. This seminar will help you understand what you need to know about nursing home reimbursement to participate effectively in your state.

The seminar is offered by Cynthia Rudder, PhD, director of special projects at the Long Term Care Community Coalition, a citizen advocacy group in New York State, and Edward Alan Miller, PhD, MPA, Associate Professor of Gerontology and Public Policy and Fellow, Gerontology Institute, at the University of Massachusetts Boston and Adjunct Associate Professor of Community Health at Brown University. Through presentation and group activities, you will learn basic reimbursement methodologies and trends and how to use this information to influence nursing home quality, cost, access and encourage culture change. You also will learn about two states where advocates have successfully influenced the direction of nursing home reimbursement to the benefit of consumers.

Space is limited. Please sign up for the seminar by e-mailing or calling Sara Rosenberg at sara@ltccc.org or (212) 385-0355.

LTCCC
LONG TERM CARE COMMUNITY COALITION
Working to improve long term care through research, education & advocacy

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New York State Assembly:
To write to your representative in the Assembly, address your letters to him or her at NYS Assembly, Albany, NY 12248. The general switchboard for the Assembly is 518-455-4000. In addition to your personal representative, it is important that the following leaders hear from you:

Assemblymember Sheldon Silver, Speaker
speaker@assembly.state.ny.us

Assemblymember Richard N. Gottfried, Chair
Committee on Health
gottfrr@assembly.state.ny.us

Assemblymember Joan Millman
Chair, Committee on Aging
millmaj@assembly.state.ny.us

New York State Senate:
To write to your Senator, address your letters to him or her at NYS Senate, Albany, NY 12247. The general switchboard for the Senate is 518-455-2800. In addition to your personal senator, it is important that the following leaders hear from you:

Senator Dean Skelos
Temporary President and Majority Leader
skelos@nysenate.gov

Senator David Valesky
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valesky@senate.state.ny.us

Senator Kemp Hannon
Chair, Committee on Health
hannon@nysenate.gov

To obtain the names of your personal state government representatives, go to The Citizen Action Center on our website: www.ltccc.org.

FEDERAL OFFICIALS:
To contact your federal representatives visit our action alert center at www.ltccc.org or call the congressional switchboard 202-225-3121.