

UNITED STATES SENATE

Special Committee on Aging

Hearing Titled:

Abuse of Our Elders: How We Can Stop It

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Written Statement of the

National Association of Medicaid Fraud Control Units



NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

Chairman Kohl and Members of the Committee, thank you for the opportunity to submit written testimony to discuss the role of the Medicaid Fraud Control Units in investigating and prosecuting cases of abuse, neglect, and exploitation in our long-term care facilities and other Medicaid-funded facilities across the country. The Medicaid Fraud Control Units have been the vanguard in law enforcement efforts to combat abuse, neglect, and exploitation that tragically occur everyday in our nursing homes, residential care facilities, home health programs, and hospitals. We applaud the efforts of the Special Committee on Aging, and are particularly interested in the “Patient Safety and Abuse Prevention Act of 2007.” The purpose of our written statement today is to give you the background of the Medicaid Fraud Control Units and highlight the types of cases we have investigated and prosecuted in the last several years. We would also like an opportunity to specifically comment on S. 1577 once our entire membership has had an opportunity to review it and provide comment.

Respectfully Submitted,

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INTRODUCTION

Medicaid provider fraud costs American taxpayers hundreds of millions of dollars annually and hinders the very integrity of the Medicaid program. State Medicaid Fraud Control Units (MFCUs) have long been in the forefront of health care fraud enforcement. The need for the MFCUs came about when the public and Congress realized that too many nursing home patients were held hostage by the greed of a small number of facility operators and often dishonest health care practitioners who used the Medicaid program as their own private “ATM machine.”

In 1977, Congress enacted the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142) to “strengthen the capability of the government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs...” The legislation specifically provides that MFCUs were to (1) conduct a statewide program for the investigation and prosecution of health care providers who defraud the Medicaid program; (2) review complaints and prosecute cases of abuse or neglect against residents in long-term care facilities, defined as anywhere where two or more individuals reside and pay for care; (3) review complaints and prosecute cases of the misappropriation of patients’ private funds; and (4) investigate and prosecute cases of fraud in the administration of the Medicaid program. The Medicaid Fraud Control program was voluntary until 1995. Federal law now requires each state to have a Medicaid Fraud Control Unit (MFCU) unless the state can demonstrate to the satisfaction of the Secretary of the U.S. Department of Health and Human Services that it has a minimum amount of fraud in its Medicaid program and that Medicaid beneficiaries will be protected from abuse and neglect. Forty-nine states and the District of Columbia have MFCUs, North Dakota has been granted a waiver and does not have a MFCU.

Since 1978, the MFCUs across the nation have prosecuted thousands of billing fraud cases and in the course of these cases recovered billions of dollars for the Medicaid program. Perpetrators of Medicaid billing fraud run the gamut from the solo practitioner, who submits claims for services never rendered, to large institutions that exaggerate the level of care provided to their patients and then alter patient records to conceal the resulting lack of care. The MFCUs have prosecuted large pharmaceutical manufacturers who engaged in schemes to underpay Medicaid drug rebates; psychiatrists who demanded sexual favors from their patients in exchange for prescription drugs; and even funeral directors who billed the estates of Medicaid recipients for funerals they did not perform.

But the MFCUs also focus significant attention, and resources, on the patient abuse, neglect and exploitation cases that get reported to the MFCUs. When Congress created the MFCUs, it did so, not only because of the evidence of massive fraud and chicanery in the Medicaid program, but also because of the horrendous tales of nursing home abuse and resident victimization. The MFCUs are the only law enforcement agencies in the country specifically charged with investigating and prosecuting abuse and neglect of residents in nursing homes, other Medicaid-funded health care institutions, and in board-and-care facilities.

SELECTED SIGNIFICANT STATE RESIDENT ABUSE AND NEGLECT ENFORCEMENT EFFORTS BY THE MEDICAID FRAUD CONTROL UNITS

Many MFCUs use their criminal and civil enforcement authority to enforce different types of resident abuse cases that underscore the insidious, hidden, and often neglected concerns about the financial and physical safety of vulnerable, “at-risk” adults who can no longer care for themselves and who are disproportionately subject to abuse and debilitating injury. These cases include homicide and manslaughter, sexual abuse, physical abuse, misappropriation of patient trust funds, corporate neglect, failure to report, drug diversion and failure to check caregiver’s criminal records. In addition, the MFCUs across the country have launched innovative programs that include training and public outreach to help prevent resident abuse. Other important activities by the MFCUs include legislative efforts to enhance and reform the laws that protect residents from these abuses and referring state criminal convictions, judgments, and licensing actions to the HHS Office of the Inspector General so that individuals who are convicted of these crimes may be excluded from working in any facility or program that receives Medicaid funding.

Examples of elder/resident abuse cases prosecuted by the MFCUs in recent years include:

Involuntary Manslaughter/Homicide

Some of the most egregious types of crimes prosecuted by the MFCUs involve caregivers at nursing homes and group homes who commit negligent homicide, involuntary manslaughter, and homicide.

- The Louisiana MFCU opened a case upon the discovery of 34 bodies that drowned at a nursing facility from the Hurricane Katrina storm surge and flooding. The investigation involves negligence by the owners of the facility for allegedly ignoring evacuation orders and refusing offers of transportation to evacuate residents prior to the storm’s landfall.
- The Arkansas MFCU investigated a homicide at a nursing home. Two certified nursing assistants (CNAs) beat a resident to death with a set of brass knuckles. One CNA pled guilty and was sentenced to 30 years in prison.
- The manager of a group home in Missouri pled guilty to involuntary manslaughter and admitted to recklessly causing the death of a resident. She admitted that she failed to make adequate provisions for the appropriate treatment of decubitus ulcers developed by the resident. The victim, who was confined to a wheelchair, suffered from cerebral palsy and was physically and mentally handicapped. He was moved into the facility, and later admitted into a hospital, where he died due to severe ulcers.
- After a fire broke out at the group home and two residents died, the Nevada MFCU investigated and prosecuted the owner of the home for one count of Elder Neglect Resulting in Death and one count of Involuntary Manslaughter. The MFCU investigated criminal negligence and focused on licensing and regulatory compliance requirements of

group home operations. This included the need to have qualified care-givers present for residents. There were enough regulatory compliance shortcomings to support filing a criminal complaint. The owner agreed to plead to one count of Involuntary Manslaughter and was sentenced to prison for 12 to 30 months.

- The Oregon MFCU prosecuted an adult foster home owner and two caregivers on Criminally Negligent Homicide charges, for the death of a resident of the home. When paramedics responded to the home, they found the resident malnourished, dehydrated, hypothermic, and suffering from Dilantin toxicity. The victim, who died at the hospital, was 6'1" but at the time of death weighed 110 lbs and was suffering from approximately 60 decubitus ulcers.

Sexual Abuse

A type of abuse, which is unspeakable but occurs all too often, is sexual violence against elderly and disabled residents. Unlocked rooms and the fact that residents regularly submit to physical contact in order to receive care make them easy prey for sexual predators.

- A physician pled guilty to three counts of Unlawful Sexual Contact involving three separate patients. The physician was sentenced to a consecutive 30-day term of imprisonment and restitution to Medicaid in the amount of \$6,380. As a result of the convictions, the Maine Board of Licensure in Medicine summarily revoked his license to practice in the state.
- In Washington State, a caregiver at a residential facility for the mentally retarded was found guilty of Indecent Liberties and Kidnapping in the Second Degree. The defendant took the victim to a vacant room in the facility and had sexual relations with the victim. The case was ultimately solved based upon DNA evidence recovered from the victim that matched the defendant's DNA. He was sentenced to 48 months in prison and ordered to make restitution in the amount of \$6,375. This sentence was "exceptional" because of the victim's vulnerability and the status of the defendant as a caregiver.
- In Vermont, a mobile x-ray technician was prosecuted by the MFCU for the molestation of a 93-year-old female nursing home resident. The defendant was convicted of Lewd and Lascivious conduct based on his visit to a nursing home when he inserted his tongue in the elderly patient's mouth and touched her breast during a routine x-ray for a broken hip. He also pled guilty to violating a court order concerning his place of residence. The New Hampshire MFCU also prosecuted the same health care worker for a similar incident, which occurred at a nursing home in New Hampshire just ten days after the incident occurred at the Vermont facility. He was sentenced to serve 1 year of a 3 to 5 year sentence in Vermont.

Physical Abuse

It is difficult to conceive of a more vulnerable, less threatening group than residents of long-term care facilities. Yet, too often they are the target of cruel and, at times, sadistic violence and mistreatment. Most reprehensibly, in long-term care facilities, perpetrators of physical abuse are usually those charged with the care and well-being of patients.

- In Kansas, the owners and operators of a group home were found guilty on multiple counts of conspiracy, forced labor, involuntary servitude, health care fraud, money laundering, mail fraud, and obstructing a federal audit.

They owned and operated a residential facility for mentally ill adults where more than 20 residents lived. The owners and operators controlled virtually every aspect of the lives of the residents, determining which rooms they would sleep in, what furniture they were allowed to have, when they would eat, what recreational activities they could engage in, when they could be downstairs, and who could enter leave the houses. Rather than lawfully and responsibly carrying out their duties as caregivers, they used physical force and threats to intimidate the residents, to isolate them from their families, and to sexually humiliate them. At times, residents were forced to strip naked and were confined to a seclusion room, forced to urinate and defecate into a wastebasket, shocked on the genitals with a stun gun, and forced to perform sexual acts while being videotaped. Repeatedly, the residents were warned that if they did not obey their abusers they would wind up in jail or in state mental institutions.

Some of the residents of the home had previously attempted to report the abuse. However, because the abusive conduct was so horrific, the owners had been successful in concealing it for years by convincing local authorities, family members, and others that the reports of abuse were the unbelievable delusions of mentally ill residents. Verification of the abuse and the validation of the residents' reports were contained in over 100 hours of videotapes that were made by the owners and discovered by search warrant in their private residence – including some that were discovered under their bed.

The defendants received sentences of 30 years and 7 years and were sent to federal prison following sentencing.

- A caregiver at a group home for mentally retarded adults in the District of Columbia was found guilty of assault of a vulnerable adult, following a bench trial. According to trial testimony, the defendant pushed a vulnerable adult in his care to the ground, slapping his face and “kneeing” him in the back to restrain him. The victim of the assault testified at the trial. The defendant was sentenced to the maximum 180-day term of imprisonment, 90 days suspended, 2 years probation, and a fine of \$500. The defendant was permitted to serve the remaining 90 days with “work release privileges.” In addition, the defendant was ordered to stay away from the victim and the group home where the offense occurred.

In imposing sentence, the court stated that crimes against vulnerable citizens – children, elders, and persons with mental retardation and other cognitive deficits – must be taken seriously, especially when a perpetrator occupies a position in which he is entrusted with the care and protection of a vulnerable person. The court noted that government entities, the courts, and communities are taking notice of these crimes and are not taking them lightly, stating, “These crimes will not be tolerated.” The MFCU also requested that the defendant be suspended from participating in all federal health care programs for a term of five years.

- In Alabama, a nursing assistant was sentenced to one year and one day in jail and a suspended sentence of two years on supervised probation for injuring an elderly woman when moving her from a chair to a bed and dropping her. The judge ordered the defendant to complete an alcohol treatment program and banned her from working in any nursing home or other long-term care facility. The nursing assistant was administered a blood alcohol test that revealed she had an alcohol content that was more than three times the legal limit to operate a motor vehicle.
- An employee for a group home in Arizona which housed five developmentally disabled individuals was accused of abusing three vulnerable adults who resided in the group home. The defendant allegedly slapped the first victim on the left shoulder twice and pulled a second victim’s stomach hair to move him from one room to another. Additionally, she engaged in a pattern of verbal emotional abuse with the third victim. She was sentenced to 36 months of probation under the supervision of the adult probation department.
- A certified nurse assistant (CNA) in Arkansas pled to a misdemeanor assault for picking up a nursing home resident who did not want to get into bed and throwing him on the bed, slamming the resident’s head into the wall. He then took his tennis shoe and swatted the resident on the head. Although the resident suffered little actual injury and no permanent damage as a result of the assault, because he had suffered surgery to repair a ruptured blood vessel in his brain within months of the assault, a physician was prepared to testify that the resident was placed at actual risk of serious bodily harm or death by the CNA. The CNA was placed on a registry banning him from working in nursing homes, fined \$500, and given a one-year suspended sentence.
- In Kentucky, two CNAs were convicted of abusing elderly and medically fragile patients by administering laxative suppositories that were not medically necessary and not ordered as part of the patients’ treatment. The acts, which took place during a bed check at the end of the second shift on that date, were apparently done to harass the nurse assistants on the next shift. Some of the patients suffered pain and rectal bleeding after the suppositories were administered.

- A licensed practical nurse was indicted in Kentucky for punching and torturing a mentally retarded man for over 20 minutes as punishment for the victim's act of overturning his lunch tray. The entire abusive encounter was captured on videotape. The nurse was sentenced to five years in prison and probation was denied. After completing his sentence, he will be unable to work in the health care industry again, as his license was revoked.
- A certified nursing assistant in Massachusetts was found guilty of multiple counts of patient abuse and assault and battery for deliberately tripping a nursing home resident and striking him in the head and tormenting another resident by repeatedly striking him in his hearing aid. He was sentenced to serve eight months in the House of Corrections and ordered to pay \$2,550 in fines, in addition to losing his certification as a nursing assistant.
- A Rhode Island mental health worker was convicted of assaulting a patient at a hospital. The prosecution proved that he brought the patient into the shower room along with another patient who was needed to interpret for the worker. After a few brief words, the worker punched the patient in the eye, breaking his glasses and causing a laceration. He threatened the patients not to say anything about the assault. The next day, the patient-witness told another mental health worker what had happened. This case was particularly challenging because both patients were incarcerated at the mental hospital and they were incompetent to testify at trial. They suffer from low-level intellectual functioning and various mental illnesses. The defendant received a three-year suspended sentence and three years probation with community service.

Patient Funds

Federal regulations provide that the MFCUs may review complaints of the misappropriation of patients' private funds. Today, many of the Units investigate and prosecute these financial crimes.

- The business manager at a Minnesota nursing home was charged with 12 felony-level counts of Theft, Theft by Swindle, and Theft of Personal Needs Allowances. One of her responsibilities was to manage the nursing home's resident trust account and the individual resident funds that were deposited in and withdrawn from the account. Using various schemes, including writing checks on the account for petty cash or for false resident expenses, she stole resident funds from the trust account over the course of two and a half years. During the audit of the nursing home's records, she confessed to the crimes. She pled guilty and was sentenced to serve 45 months in prison on five of the counts. In addition, she was ordered to pay restitution to the victims in the amount of \$61,217.31.
- In New Jersey, a nursing home owner was sentenced to three years in state prison and ordered to repay \$110,000 in patient trust funds that she misappropriated. The MFCU investigation established that she used this money to pay an overdue mortgage on another

nursing home she operated and thousands of dollars in past due utility bills in yet another nursing home.

- In North Carolina, the administrator of a health care center pled guilty to two counts of Felonious Embezzlement of Recipient Funds. She was sentenced to 60 months of supervised probation and ordered to pay restitution of \$70,666.90 to the health care center resident trust fund. Her husband and a friend pled guilty to misdemeanor Solicitation of Embezzlement and were found jointly and severally liable for payment of part of the restitution. She deposited residents' checks into the patient trust fund and then moved the funds into the petty cash fund, from which she wrote checks totaling \$70,666.90 to herself, her husband, and her friend. She disguised these transactions by using the facility's automated patient trust fund and account receivables systems to create credit applied transactions that created false credit postings to the residents' accounts receivables.
- An administrator who managed the patient trust funds for an Oklahoma facility cashed Social Security checks of some residents of the facility, converted the funds to her own use, and did not use the funds to pay for the residents' care at the facility. She also used other resident trust funds for purchases of personal items including a camera, clothing, and videos at various businesses in the area. She pled nolo contendere to six counts of Felony Caretaker Exploitation and was sentenced to a five-year deferred sentence on each count to run concurrent, ordered to make restitution of \$30,592.30 and pay court costs of \$2,474.20.
- A residential coordinator for a residential program for the mentally retarded in Tennessee pled guilty to 13 counts of theft over \$500 and was sentenced to six years in a Department of Corrections facility. The court also ordered restitution to each of the 13 victims for a total of \$28,690.86. Through bank records and patient financial records, a MFCU auditor was able to show how much of the money was stolen.
- In Oregon, a home health care aide was sentenced on five counts of Criminal Mistreatment in the First Degree, four counts of Theft in the First Degree, one count of Aggravated Theft, and two counts of Possession of a Controlled Substance in the Second Degree. Despite having no prior criminal record, she was sentenced to a total of 36 months in prison and 36 months post-prison supervision. Additionally, she was ordered to pay \$22,760 in restitution, to undergo substance abuse evaluation and treatment, and prohibited from seeking or obtaining employment as a caregiver.

The aide was employed by an Oregon home health care service that received Medicaid funding. The aide was assigned by the agency to work for a woman who was looking for minor assistance in such things as light housekeeping, cooking, and shopping; she was paid by the victim's family. The family discovered that the aide had been ordering excessive amounts of prescription medications for the victim, and that many of those medications were missing. Shortly thereafter, the victim and her family discovered that

during the aide's five months of employment, approximately \$25,000 of unauthorized ATM withdrawals had been made from the victim's bank accounts. In the last months of employment, the aide withdrew over \$17,000 from the victim's accounts and during that same period, paid cash for a brand new car.

- In Vermont, a nursing home employee with access to patient trust accounts, in the course of three years, wrote 198 checks for her own benefit from the resident trust account, totaling \$41,152.21, and stealing from at least 22 nursing home residents.

Patient Neglect

Those who accept the position of trust as caregivers to dependent, vulnerable adults should be held accountable for neglecting those in their charge. Failure to provide care and treatment to residents of nursing homes and/or board and care homes is every bit as dangerous and harmful as intentional assaultive behavior. Many states have prosecuted patient neglect cases of caregivers in facilities, and sometimes owners, who have failed to provide adequate care and treatment to residents, resulting in residents suffering from decubitus ulcers, dehydration, and malnutrition.

Some states have utilized Medicaid fraud statutes to prosecute corporate owners of nursing homes. Others have reached civil settlement in lieu of prosecuting criminal charges against the facility. Imposing corporate liability may not always be the best course of action. There may be insufficient evidence or shutting down the facility may not be in the best interest of all patients or the community.

- The Colorado MFCU has been involved in an ongoing federal case against the proprietors of a nursing home that is now closed. The allegations are that the nursing home owners committed cost report fraud against the Medicaid program. The nursing home owners filed cost reports alleging a high level of care and staffing for the nursing home. The per diem for the nursing home was set based on the representations made in the cost report. In fact, the nursing home was providing a much lower level of care and staffing than represented in the cost reports, which resulted in negative outcomes for several residents.
- The Delaware MFCU was involved in a criminal and civil fraud and neglect investigation/prosecution involving a nursing home. After reviewing the evidence and conducting dozens of additional interviews, five former nurses from the facility were arrested for allegedly engaging in a "chart party" during which Medicaid residents' medical charts were altered in order to maximize reimbursement.
- The Florida MFCU received a referral from Adult Protective Services alleging abuse in a nursing home. The investigation revealed that the defendant, an LPN, was not giving insulin injections to six insulin-dependant patients. Further, the LPN was then falsifying the medication logs to indicate that such injections were being given. The defendant

admitted that the allegations were true and the defendant entered a plea of no contest to Neglect of the Elderly.

- A caregiver for an elderly woman in Hawaii failed to deliver the services for which she was being paid. As a result, the woman suffered serious gangrene and premature sores. The caregiver was sentenced to 60 months probation with 200 hours of community service and a \$2,000 fine.
- The Illinois MFCU conducted an investigation at a nursing home as a result of complaints of drug and alcohol abuse. The Illinois Department of Public Health ordered that an independent monitor be put in place to run the day-to-day operations of the facility. Eventually, the home was forced to close after a complaint was filed by the Illinois Attorney General.
- After a week-long trial, a Baltimore City, Maryland jury found a licensed practical nurse guilty of felony neglect for his failure to provide care for an 89-year-old nursing home patient. In spite of instructions in the patient's chart that she was not to be fed on his shift, and although the nurse found that the patient had received three times as much fluid as was called for during the previous shift, he hung another bag of tube feeding and kept the feeding tube running throughout the night. Although he was aware that the resident was in severe distress, sweating, moaning, and groaning, with a distended abdomen during the night, he failed to provide her with necessary and essential medical treatment and failed to call 911. The nurse on the next shift took action but the resident could not be revived and was pronounced dead at the hospital from asphyxia due to overfeeding. The licensed practical nurse received a suspended sentence of five years, was placed on supervised probation for three years, and ordered to refrain from providing patient care during the period of probation. The Board of Nursing also summarily suspended his license.
- The New Mexico MFCU is involved with the on-going criminal prosecution of a nursing home management corporation for harm caused to six residents, two of whom died from lack of adequate care.
- The New York MFCU used an investigative strategy never before used in a quality of care investigation in New York. The MFCU installed hidden cameras in patient rooms in two facilities in upstate New York to record care as it was delivered. One of the cases resulted in the arrest and conviction of numerous nurses and nurse aides.

With the permission of the family of a bedridden and comatose resident, the MFCU installed a hidden camera in the room of a resident. The evidence produced by this camera proved that nursing home staff repeatedly failed to deliver required care and routinely lied in patient care records by falsely recording that care had been delivered. Significantly, the records of one resident contained hundreds of false entries made by nearly 20% of the facility's staff. MFCU investigators compared events recorded by the camera with the care records prepared by staff, which purported to memorialize the care

rendered to the patient. The records repeatedly falsely reported that the patient had been given treatments and care when, in fact, the care had not been given. Indeed, during the 39-day period, nurses and aides made more than 300 false entries in the patient's records. These fabrications involved almost every aspect of the patient's care, including false entries regarding turning and positioning, temperature and blood glucose readings, skin treatment, pneumonia-preventive nebulizer treatments, oral hygiene, incontinence care, and tube feeding.

Based on the evidence developed through the video recording, facility management admitted under oath that the treatment of this patient constituted neglect. Moreover, they conceded "that if [the neglect] was true of [this patient], then it had to be true elsewhere in the facility, and in fact that it had to be widespread."

- A Texas Grand Jury returned an indictment against a registered nurse (RN) for Injury to the Elderly and Tampering with a Governmental Record. An elderly resident of the nursing home was noted to have swelling and bruising in her leg due to poor circulation. The nurse made the decision to wait to have the resident seen by a physician. However, the leg became much worse, causing a staff member to have the resident transported by ambulance to a hospital emergency room where the attending physician stated the resident was brought in much too late to save the leg, which was amputated shortly thereafter.
- For the first time in Vermont, the MFCU charged a residential care homeowner for criminal neglect of residents. The Vermont Medicaid Fraud and Residential Abuse Unit convicted the registered nurse and residential homeowner who admitted to recklessly failing to provide care for the residents of the home.

The investigation revealed that the owner was responsible for allowing conditions at the facility to deteriorate significantly, exposing the residents there to a reckless environment of filth, inattention and substandard care. Specific instances of neglect included the careless dispensing of inappropriate medications, failing to properly treat diabetic residents, which necessitated emergency care on several occasions, and the serving of meals lacking required nutritional value that was inconsistent with the care plans of numerous residents. Further, the facility was often found in an unsanitary condition, perpetuating a climate of depression and disregard.

The consistent absence from the facility of the owner, the only facility nurse, left the management of daily operations in the hands of ill-equipped and poorly trained staff members. The owner failed to consistently communicate with staff members or be available to make crucial decisions relative to the care of residents. As a result, the facility failed to provide a level of care appropriate to the needs of the residents and their families, and in violation of the law.

The Vermont Nursing Board suspended the owner's RN license, and she can no longer work in any capacity with vulnerable adults. She was sentenced to 18 months prison time and placed on probation. She served 30 days of her sentence on a work crew run by the Department of Corrections.

Failure to Report

Reporting requirements play an important role in protecting residents from abuse and/or neglect. Most states that have statutes dealing with patient abuse include a mandatory reporting section. The statutes differ, however, as to who are considered mandated reporters. State statutes also differ regarding which agency the report goes to. Some states require the report to go to the Department of Health, while others require that state agencies report to a law enforcement agency or to the MFCU. It is important for MFCUs to investigate and prosecute failure to report abuse when their state laws make it a crime. It is necessary because many victims are unable to speak coherently, and some witnesses may fear repercussions from the abuser, their associates, or, at times, the facility itself.

Drug Diversion

One of the most common types of neglect occurs when the professional caregiver fails to follow a plan of care or fails to provide medication pursuant to a physician's orders.

- An Indiana licensed practical nurse was charged with Theft and Possession of Drugs as a result of having taken morphine sulfate from the nursing facility where she was employed. She pled guilty and was sentenced to one and one half years, which was suspended, and was placed on probation and six months of home incarceration.
- In Iowa, a director of nursing was charged with four counts of Possessing Controlled Substances and one count of Second Degree Theft for stealing medications from nursing home residents. She pled guilty and received a deferred sentence, credit for jail time served, was ordered to pay \$3,471.31 in restitution, and was assessed fines and costs totaling \$2,820. She was referred to the State Board of Nursing Examiners and was placed on the State Caregiver Abuse Registry.
- In the first case in Mississippi for Felonious Abuse Due to Failure to Give Pain Medication, a licensed practical nurse pled guilty to taking the prescribed pain medication of a resident for her own benefit. She was sentenced to serve three years in jail, all suspended, and three years probation. She was also ordered to pay a fine totaling \$1,979.50 and restitution of \$100 to the state Crime Victims Compensation Fund.
- In Oregon, a registered nurse was convicted on four counts of Theft of Prescription Medications from three different long-term care facilities where she had worked as a nurse. At the time of her arrest, she was suspected of stealing over 1,000 pills from patients at one facility over the last five months. She only sought employment as a long-

term care facility nurse in 2003, after she was fired and prosecuted for stealing drugs from an area hospital where she was then working.

- A South Carolina registered nurse was convicted of Obstruction of Justice and Unlawful Possession of a Controlled Substance. She took controlled substances from a patient at a nursing center. She made an anonymous report to the local police department that a co-worker had been stealing drugs from patients at the nursing home. When local police arrived to investigate, she planted the controlled substance she had stolen on a medicine cart used by the co-worker. She was interviewed and said that she had stolen the controlled substances and had provided false information to the police. She pled guilty to Obstruction of Justice and Possession of a Controlled Substance.

Criminal Background Checks

An important step in preventing abuse in nursing homes or long term care settings is to prevent those with a criminal background from working as caregivers for the elderly or disabled in a care-giving capacity. While a number of states require various types of employers or facilities to check an applicant's record prior to hiring, in too many instances the requirements differ depending on the type of facility; there is broad discretion to waive the requirement; or the requirement is not enforced. Many individuals employed as caregivers for vulnerable seniors have been convicted of a crime or even a series of crimes.

- The Michigan Health Care Fraud Division conducted two comprehensive criminal background studies of nursing home employees. The first study reviewed criminal histories for all certified nurse's aides (over 5,500) in five metropolitan areas of the state. The second study reviewed the criminal histories for the entire staff (618) employees of four geographically diverse nursing homes.

The studies revealed that almost 10% of the employees who care for Michigan's vulnerable adults have criminal backgrounds. Some of the criminal backgrounds included homicide, criminal sexual conduct, weapon charges, and drug offenses. As a result, the Attorney General issued a formal report and submitted a legislative proposal to the Michigan Senate, which was enacted into law.

A second phase of the project continues. This involves the systematic checking of criminal histories of nursing home staff at facilities statewide. Finally, "abuse alerts" advising of the problem and warning of select individuals who are using false identification to gain employment, have been sent to all nursing homes in Michigan.

- In Vermont, the Director of Social Services at a nursing home pled guilty to one count of False Pretense, two counts of Abuse of a Vulnerable Adult, and a violation of probation charge for financially exploiting two elderly residents at the facility. She was ordered to serve one year in jail of a suspended 7 to 10 year sentence. While employed as the Director of Social Work the defendant put her own name on the credit card account of a

seventy-nine-year-old resident of the nursing home and then used the card to transfer \$500 to her own account. The employee also used the credit card for purchases and forged the nursing home resident's signature. The defendant also applied for and received another credit card in the name of an eighty-seven-year-old resident of the nursing home, without that resident's knowledge and permission, and then used the card to make purchases of \$2458. She also applied for a \$6000 personal loan in her name and that of an eighty-seven-year-old nursing home resident without that resident's permission or knowledge.

When she committed the new offenses, the employee was on probation for a 2002 Grand Larceny conviction. She had hidden her criminal convictions by intercepting the written confirmation of her convictions from the nursing home business mail before the administrator could receive it.

- A nursing assistant, who lied about her criminal conviction for purposes of her job application in a long-term care facility in Washington, pled guilty to one count of Forgery and was sentenced to 12 months probation, ordered to pay \$500 to the Crime Victim's Compensation Fund, \$200 in attorney fees, and \$110 in court costs.

The defendant applied for employment as a nursing assistant. The criminal background check revealed a conviction for theft in the first degree that the defendant claimed was a juvenile conviction. In fact, the defendant was 24-years-old at the time of her prior conviction making her ineligible for employment as a nursing assistant.

CONCLUSION

We live in a time of heightened concern for security. When our health becomes infirm, and we must depend on caregivers to assist us with or to supply the basic needs of daily existence, we have no security except what we can trust our caregivers to provide. Sometimes when we place that trust in a caregiver, what we find is a predator or abuser. The cases we have highlighted for you show that the resulting harm may be irreparable. The direct cost to victims may include death and maiming. As in any situation requiring security, the first line of defense is knowledge. A comprehensive, reliable system of criminal record background checks for employees and applicants for employment at care giving facilities would provide the information needed to help prevent many cases of abuse, neglect and exploitation. Long-term care workers should be carefully checked to make sure they don't have a history of substantiated abuse or serious criminal history before being hired and entrusted with the care of our defenseless elders.