HCCA's 12TH ANNUAL COMPLIANCE INSTITUTE

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MARs, TARs AND BARS: LESSONS OF FAILURE, STRATEGIES FOR SUCCESS

April 13, 2008

HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

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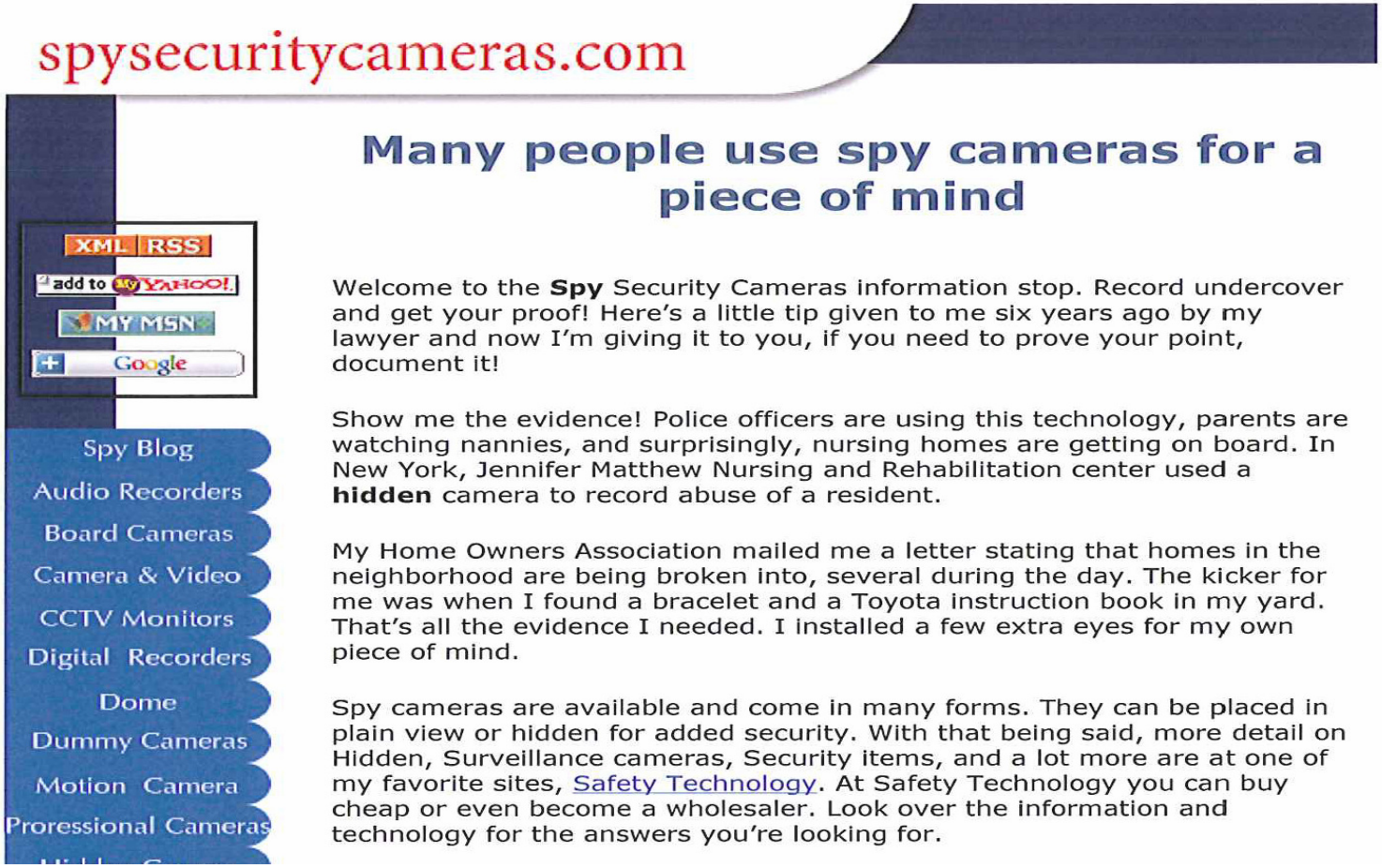
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Dummy Cameras
Motion Camera
Proressional Cameras
Many people use spy cameras for a piece of mind
Welcome to the **Spy** Security Cameras information stop. Record undercover and get your proof! Here's a little tip given to me six years ago by my lawyer and now I'm giving it to you, if you need to prove your point, document it!
Show me the evidence! Police officers are using this technology, parents are watching nannies, and surprisingly, nursing homes are getting on board. In New York, Jennifer Matthew Nursing and Rehabilitation center used a **hidden** camera to record abuse of a resident.
My Home Owners Association mailed me a letter stating that homes in the neighborhood are being broken into, several during the day. The kicker for me was when I found a bracelet and a Toyota instruction book in my yard. That's all the evidence I needed. I installed a few extra eyes for my own piece of mind.
Spy cameras are available and come in many forms. They can be placed in plain view or hidden for added security. With that being said, more detail on Hidden, Surveillance cameras, Security items, and a lot more are at one of my favorite sites, Safety Technology. At Safety Technology you can buy cheap or even become a wholesaler. Look over the information and technology for the answers you're looking for.

LESSONS OF FAILURE

Criminal Prosecutions

- Potential Federal Crimes – See Appendix
- 18 U.S.C. § 1035 – False statements relating to healthcare matters.
  - 18 U.S.C. § 1001 – Statements or entries generally
  - 18 U.S.C. § 1347 – Healthcare fraud
  - 18 U.S.C. § 1516 – Obstruction of federal audit
  - 18 U.S.C. § 371 – Conspiracy to commit offense or to defraud United States
  - 18 U.S.C. § 669 – Theft or embezzlement in connection with healthcare
- Various State Statutes.

Administrative and Civil Proceedings

- Licensure/enforcement actions.
- Recoupment/false claims.
- Negligence and/or malpractice cases.
- Other civil proceedings.

Civil Proceedings

- Juries generally view the medical record as the best evidence; the medical record is the most important evidence weighed by the jury in deciding whether or not the care was substandard.

Civil Proceedings

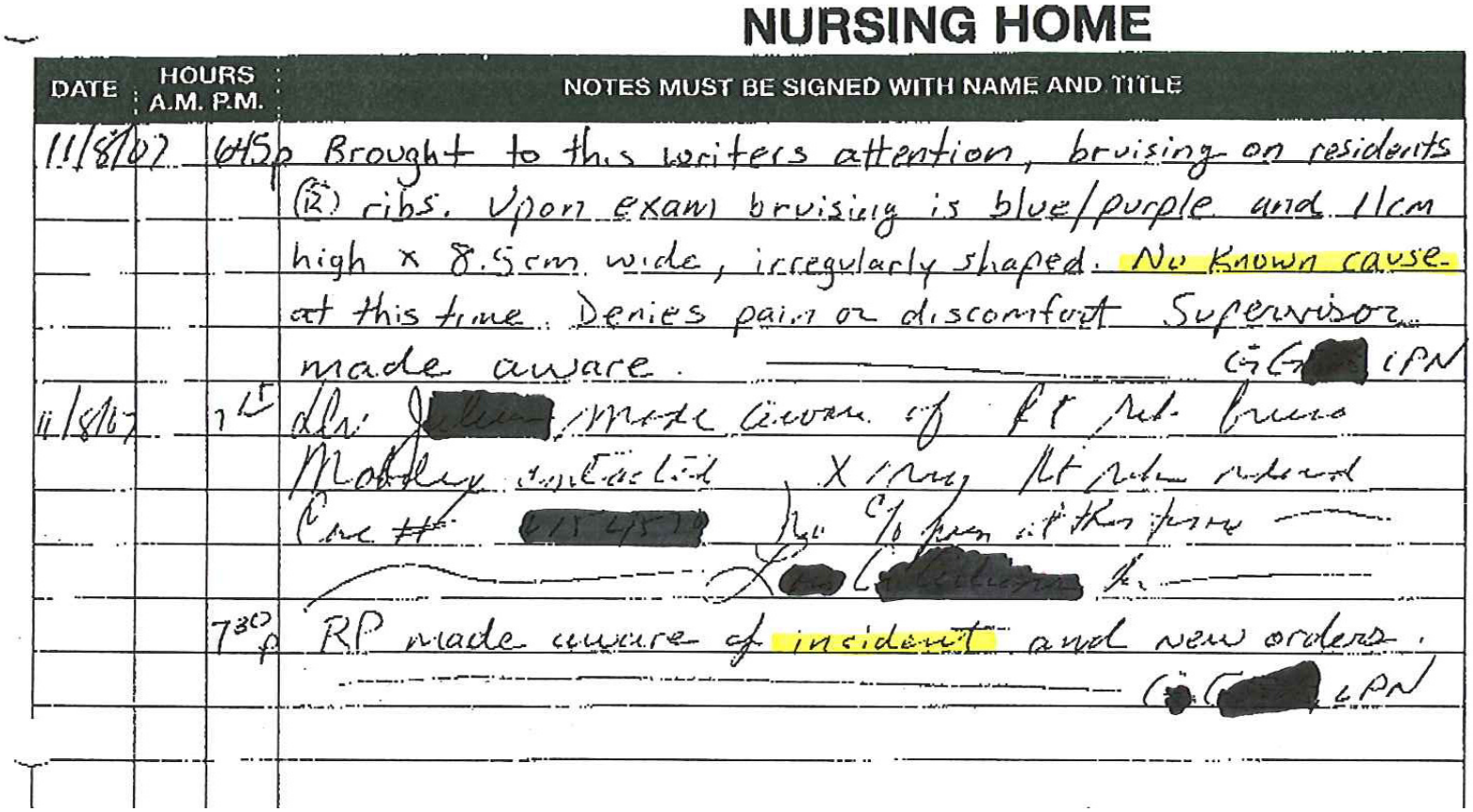
- Improper alteration or destruction of medical record may be a significant blow to credibility as a fact witness at trial.
- Could allow the judge to instruct the jury that it can come to an adverse inference about the medical records.
- *Gallagher v. Temple Univ. Hospital*, $20 million verdict.

Documentation Issues That Can Give Rise To Potential Criminal, Civil or Administrative Exposure

Failures

- Alterations in the medical record/white-out, blackened entries, writing over an entry.
- Failure to document fall precautions.
- Failure to include differential diagnosis.
- Inaccurate notations (e.g., fell out of bed).
- References to the incident report in the medical record.

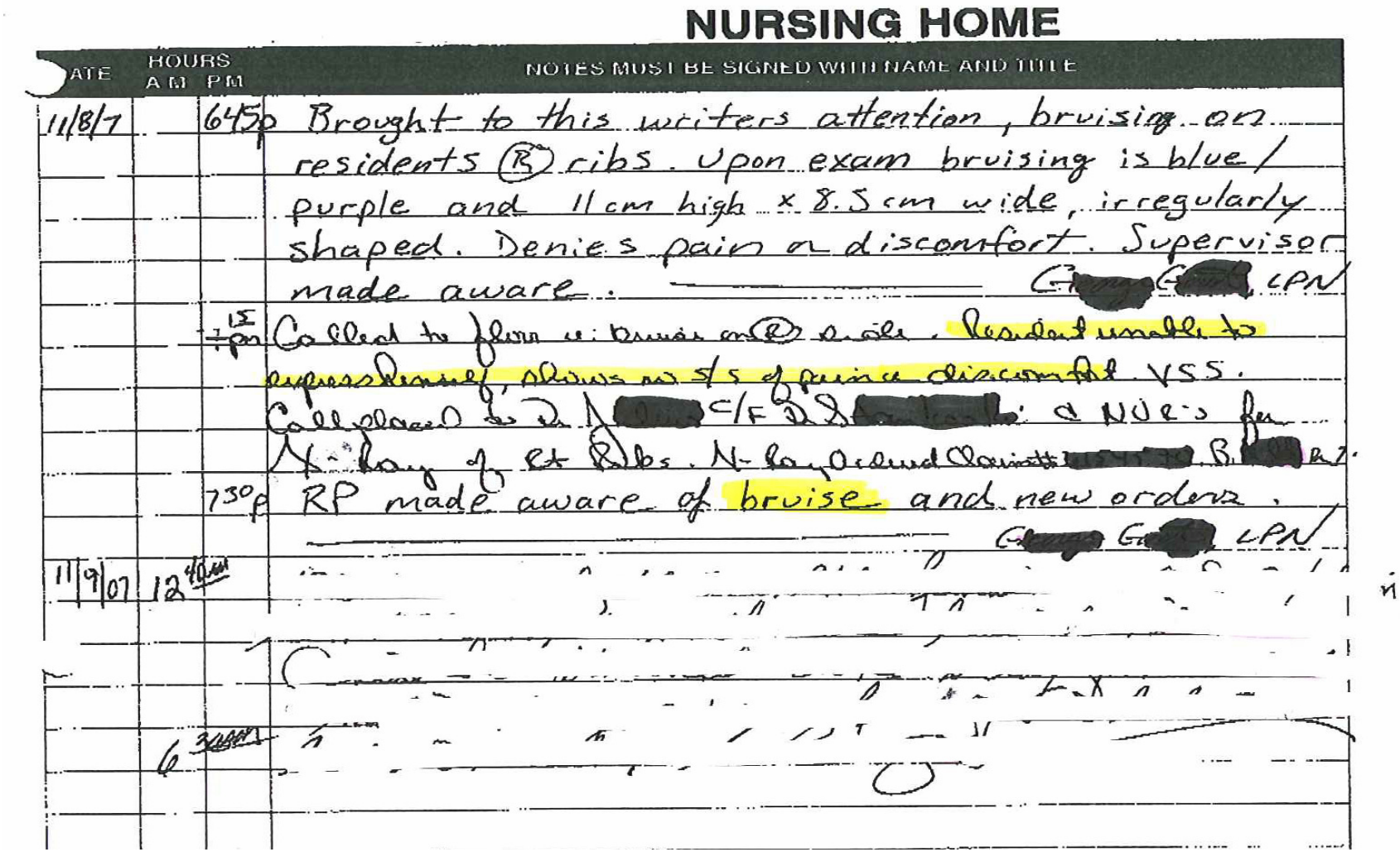
Case Study No. 1



NURSING HOME

DATE	HOURS A.M. P.M.	NOTES MUST BE SIGNED WITH NAME AND TITLE
11/8/07	6:45p	Brought to this writers attention, bruising on residents (12) ribs. Upon exam bruising is blue/purple and 11cm high x 8.5cm wide, irregularly shaped. No known cause at this time. Denies pain or discomfort. Supervisor made aware. — [redacted] LPN
11/8/07	7:15	dtr [redacted] made aware of Rt rib bruise. Motley notified. X ray Rt rib ordered. Case # [redacted] No c/o pain at this time. — [redacted]
	7:30p	RP made aware of incident and new orders. — [redacted] LPN

Case Study No. 1



NURSING HOME

DATE	HOURS A M	HOURS P M	NOTES MUST BE SIGNED WITH NAME AND TITLE
11/8/7		645p	Brought to this writers attention, bruising on residents (R) ribs. Upon exam bruising is blue/purple and 11 cm high x 8.5 cm wide, irregularly shaped. Denies pain or discomfort. Supervisor made aware. [redacted] LPN
		715pm	Called to floor re: bruise on (R) side. Resident unable to express herself, shows no S/S of pain discomfort. VSS. Call placed to Dr. [redacted] C/F [redacted] & NOR's for X-ray of Rt Ribs. N-ray ordered [redacted]
		730p	RP made aware of bruise and new orders. [redacted] LPN
11/9/07	12		
	6		

How is Altering an MAR a Federal Crime?

- Knowingly and willfully making a materially false and fraudulent writing and document, knowing the same to contain a materially false, fictitious and fraudulent statement and entry in connection with the delivery of healthcare items and services.
- Title 18, United States Code, Section 1035.

Case Study 2: U.S. v. Taibi

- June 2: 84-year-old resident, post-hip fracture; ordered Coumadin 5 mg/ maintain INR at 2.0.
- June 8: INR=3.1; Taibi takes verbal order to decrease Coumadin to 2 mg but doesn't note on MAR.
- June 12: INR=7; Taibi takes verbal order to d/c Coumadin.
- June 15: INR= 8.6.
- June 19: resident hospitalized.
- June 29: resident dies.

Case Study 2: U.S. v. Taibi

- Taibi crossed out the original 5 mg Coumadin order on the MAR to show that the 5 mg dose had been discontinued.
- Back-dated the discontinuance of the 5 mg order on the MAR to June 8.
- Created the 2 mg Coumadin order on the MAR.
- Forged the initials of several nurses on the MAR evidencing that the 2 mg dosage had been administered from June 8 --.June 12.
- Advised no one at the nursing home of her actions.

Case Study 2: U.S. v. Taibi

- Taibi's federal sentence:
  - 10 months plus 3 yrs. supervised release;
  - $1,000 fine;
  - 15 year exclusion.
- State Board of Nursing:
  - 2 year suspension of license which was stayed for probation;
  - Finding "not a risk to the public;"
  - Subject to court-imposed occupational restriction.

Case Study 2: U.S. v. Taibi – Civil Issues

- Facility civil settlement with DOJ: $25,000 and 1 year monitor.
- Written memorandum from corporate counsel to all licensed staff addressing:
  - Terms of settlement agreement;
  - Falsification of records, and the penalties for such conduct, including but not limited to:
    - Termination;
    - Referral to the appropriate licensing board; and
    - Referral to the United States Attorney's Office.

Case Study 2: U.S. v. Taibi – Civil Issues

- Physician practice paid $5,500 and agreed to 3 year settlement agreement.
- Agreed to maintain log book for physician verbal orders and cross-check with applicable nursing homes to ensure accuracy in receipt and implementation of verbal order.
- Agreed to co-sign all verbal orders within 48 hours.

Case Study 2: U.S. v. Taibi – Civil Issues

- Agreed to perform at least 3 in-service trainings annually at nursing home, submitting training topics and materials to government for review and comment 10 days prior to training.
- Agreed to provide sufficiently clear, legible written medication orders to staff to avoid misinterpretation and potential medication errors.

The "Cover-Up" Is Worse than the Crime

- 88-year-old Alzheimer's resident elopes.
- Found next morning in facility courtyard.
- Overnight temperature 40 degrees.
- Resident dead and cold.
- NHA and supervisor told employees to drag the resident's body inside, wash and place her in bed and claim she'd died peacefully in her sleep.

Case Study 3: U.S. v. Bell and PA v. Bell

- Bell, NHA of Ronald Reagan Atrium I Nursing & Rehabilitation Center, and Galati, shift supervisor, accused of directing staff to change records to reflect that proper care had been provided when, in fact, care was inadequate or non-existent.
- Employees who were reluctant to participate were threatened.
- Medicare and Medicaid paid for care that was not received or inadequate.

Case Study 3: U.S. v. Bell and PA v. Bell

- State and federal authorities conduct investigations.
- Discover a pattern of falsification in addition to elopement incident.
  - Resident with diabetic shock: some errors in judgment but entire nursing progress note page was pulled out and re-written.
- Survey process not sufficient to protect residents because records were falsified.

Case Study 3: U.S. v. Bell and PA v. Bell

- Federally, Bell convicted of 1 count of health care fraud (Sec. 1347) and 8 counts of false statements (Sec. 1035).
- Sentenced to five (5) years in prison.
- $50,000 fine.
- Three years probation upon release.
- Exclusion recommended for 10 years.

Case Study 3: U.S. v. Bell and PA v. Bell

- State prosecution against Bell:
  - Convicted of neglect of care-dependent persons, involuntary manslaughter, conspiracy to tamper with physical evidence (the body), and recklessly endangering another person.
  - Sentenced to a consecutive state incarceration of 22 to 44 months.

Case Study 3: U.S. v. Bell and PA v. Bell

- Federal prosecution of Ronald Reagan Atrium I Nursing & Rehabilitation Center:
  - Convicted of 1 count of health care fraud (Sec. 1347) and 10 counts of false statements (Sec. 1035);
  - Five (5) years probation; and
  - $490,000 fine.
- Closed by State in 2004, 3 years after elopement incident.

Case Study 3: Bell Redux -- PA v. Galati

- Galati, the RN Supervisor, pleaded guilty to perjury, false swearing, conspiracy and tampering with evidence.
- Sentenced to 5 years probation and barred from working in health care during that period.
- Galati told judge she was following orders from Ms. Bell, a boss she feared to defy, to which the judge responded, "We go back through history and hear, 'I was only following orders,'" he told Ms. Galati. "[Those orders] should have set off flashing lights to you."

Case Study 4: Green Valley Pavilion

- 2 former LPN employees file *Qui Tam* suit under federal and state FCAs.
- Allege facility, NHA, DON, Resident Care Coordinator and others altered medical records to make it appear that the residents required more care than they actually needed; or that they could benefit from restorative care when they were too ill to receive any benefit.
- DON was former surveyor.

Case Study 4: Green Valley Pavilion

- Allegations included, but not limited to:
  - Writing physician orders, signing physician orders, falsifying physician signatures;
  - Falsifying certifications and recertifications;
  - Falsifying documents and upcoding care;
  - Altering treatment records: preparing 4-6 months of Functional Care Summaries (FCS) in one sitting and backdating the care;
  - Backdating MARs to make it appear as if medications had been given as ordered; and
  - Substandard quality of care.

Case Study 4: Green Valley Pavilion

- Whistleblower alleged he was victim of retaliation.
- Received a written warning for his alleged failure to write an FCS for a patient.
  - FCS had been written by another staff nurse;
  - Same FCS was later removed from the chart and replaced by one written by Restorative Care Coordinator.
- Reported these false claims to facility, and to NHA, DON and Restorative Care Coordinator at nurses' meetings and other forums.

Case Study 4: Green Valley Pavilion

- Close cooperation between state and federal agencies.
- Multiple employees were interviewed, many of whom admitted their role in the fraud.
- State and federal law enforcement officers executed a search warrant, seizing 65 boxes of records and the contents of seven computers were digitally imaged.

Case Study 4: Green Valley Pavilion

- Although the investigation revealed that none of the individuals personally profited from the fraud, at least 6 RNs and LPNs were involved.
- At least 3 have been charged by the State of Delaware and have pled guilty to criminal charges. Cases are still pending in state and federal courts.
- Green Valley Pavilion settled with the Government for more than $500,000 in restitution.

Case Study 4: Green Valley Pavilion

- Green Valley entered into a 4 year CIA with HHS/OIG.
- Not only does the CIA require a nurse consultant/monitor to inspect Green Valley Pavilion, the five other facilities owned by Green Valley Pavillion's parent company will also be subject to inspection.
- The whistleblower suit is still pending.

Case Study 4: Green Valley Pavilion -- CIA Mandates

- Measures to ensure compliance with the completion of accurate clinical assessments and documentation as required by applicable Federal law, including:
  - All patient and resident care information be recorded in ink or permanent print;
  - Corrections shall only be made in accordance with accepted health information management standards;
  - Erasures shall not be allowable; and
  - Clinical records may not be rewritten or destroyed to hide or otherwise make a prior entry unreadable or inaccessible.

State Prosecutions: The Camera Cases

- Jennifer Matthew Nursing & Rehab Center - month long investigation using hidden camera in room of 70 year old resident with dementia and other conditions including decubitus ulcers.
- Camera showed staff members routinely moved call bells out of patient's reach so that the employees could watch movies, sleep or socialize rather than check on patients or give them medicine.

State Prosecutions: The Camera Cases

- Camera showed that staff failed to turn and reposition the resident every two hours or check for incontinence.

- Records falsely indicated that staff had provided this care and had regularly checked the patient for incontinence.

State Prosecutions: The Camera Cases

- Prosecutors allege that employees falsified records more than 300 times in 39 days to make it appear that proper care had been given to the monitored patient while the camera was running.
- Criminal cases filed against 14 nurses and aides, at least 10 have pleaded guilty to neglect and falsifying documents.
- Charges include willful violation of health laws and falsifying business records in the second degree, both misdemeanors.
- Civil suit against facility pending.
- Nursing home is now closed.

State Prosecutions: The Camera Cases

- The People of the State of New York v. Terri Galloway
  - Galloway was a CNA.
  - DON accused Galloway of, among other things, failing to perform required services and documenting that she provided care when the same was not provided.
  - Surveillance tapes in pertinent rooms allegedly confirm accusations.
  - As of January 22, 2008, case pending.

Strategies for Success:
Prevention and Risk Management

Strategies for Success: Prevention and Risk Management

- Document all inservice trainings.
- Do not assume common sense! Training should include:
  - Performing and documenting accurate, timely and relevant medical assessments:
    - Documentation must be specific.
    - Documentation must be objective.
    - Documentation must be accurate.
    - Documentation must be complete.
    - Documentation must be legible.
    - Must make and sign own entries.

Strategies for Success: Prevention and Risk Management

- Address Omissions:
  - Never simply fill in holes on medication treatment records or flow sheets;
  - Only provide addendums when there is total recall and other supporting information to provide the medication or treatment that was administered;
  - Should have self-monitoring shift-to-shift review or some alternative procedure to ensure all medications and treatments provided as ordered.

Strategies for Success: Prevention and Risk Management

- Implement a system of cross-checks.
- Implement a system that ensures that reasonable efforts are made to contact a resident's former primary physician, specialist or other relevant medical personnel.
- Properly identify/classify document to capture all applicable privileges.

Issues That Create Problems

- Use of unapproved abbreviations.
- Incomplete narrative note/missing narrative note.
- Untimed entry.
- Missing/lost record.
- Illegible medical record.
- Failure to document unusual incidents.
- Personal notes outside of the chart.

Practice Tip

- Do not play ostrich:
  - Investigate complaints
    - When to bring counsel into the mix
  - Verify cross-checks;
  - Fully assess scope of remediation.

Employment Considerations

- Facility policy re: falsification:
  - Progressive discipline or immediate termination.
- State regulations governing unprofessional conduct:
  - Altering/manipulating or falsifying records;
  - Intentionally charting incorrectly;
  - Failing to chart; and
  - Untimely charting.

Employment Considerations - Hypo

- LPN w/24 yrs. exp. and union steward for 20 yrs.
- Previous discipline for serious misconduct.
- Dialysis patient, pump speed ≤450.
- 6:58 a.m.: LPN sets pump speed at 420.
- LPN starts charting for 6:58 a.m. but is interrupted.
- 7:15 a.m.: LPN realizes log wasn't complete.
- LPN finds that RN "charted around" LPN's documentation.

Employment Considerations - Hypo

- 7:11 a.m.: RN charts that at 6:58 a.m. pump speed was 400.
- 7:11 a.m.: RN charts patient's blood pressure on line below 6:58 a.m. entry.
- 7:15 a.m.: LPN *corrects* pump speed *to accurately reflect* that at 6:58 a.m. pump speed was 420 believing RN's note is simply an oversight and she is *correcting an error*.

Employment Considerations - Hypo

- Chart clearly shows 400 is over-written with 420.
  - No effort to obliterate previous charting.
  - No effort to blend writing into previous data.
- Patient suffers no harm.
- Later on same shift RN subsequently discovers the charting error and reports it to supervisor.

Employment Considerations - Hypo

- LPN immediately suspended pending investigation.
- LPN terminated for violating policy and state regulations.
- What happens to RN?
- What does State Board of Nursing do?
- Does LPN get unemployment benefits?
  - Is this deliberate misconduct?
- What happens at grievance and arbitration?

Employment Considerations - Hypo

- Just cause if not contractually defined?
  - Clear policies with evidence of training;
  - Consistent enforcement of policies;
  - Records can be “corrected” by following appropriate procedures;
  - Purpose of the record – is care dependent on record?
  - Alteration puts resident safety in jeopardy (risk of significant injury or death);
  - Alteration denies colleague opportunity to correct own mistakes;
  - Alterations put facility in jeopardy for future liability;
  - Alterations jeopardize accreditation.

Hypo – The Double Set of Records

- Alert resident undergoing physical therapy to become weightbearing.
- PT provided walker to resident.
- During evening shift, CNA called by resident for assistance and found the resident sitting on the floor.
- Resident alert and stable; family called.
- Nursing notes state, “Advise pt to ask for assistance, it’s her 1st day of FWBAT and should not overdo it.”

Hypo – The Double Set of Records

- Resident closely monitored and examined.
- 3 days later Resident complains of headaches and, ultimately, transferred to hospital.
- Resident diagnosed with a subdural hematoma.
- Family requests resident's medical records.
- Two sets of nurses notes were discovered by facility.

Hypo – The Double Set of Records

- Staff claim first set of notes contained an error and the records needed to be "corrected" to "protect" the facility:
  - First set of notes re-written;
  - Review of first set of notes does not reflect any corrections or modifications thereto.
- Second set of notes much more elaborate.
- What do you do?

QUESTIONS?