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Prosecuting nursing home owners and operators for inadequate and overaggressive care

» Enforcement activity has dramatically increased—both in quantity and in consequence—in just the past few years.
» Civil actions against health care providers have proven enormously profitable for the government.
» Enforcement officials seem to have changed their focus from civil fines to criminal sanctions.
» Nursing home executives are being prosecuted in their individual capacities as never before.
» A robust compliance and ethics program is critical to sustained success.

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The aggressive enforcement of statutory regulations in the health care industry in general, and nursing homes more specifically, by federal and state governmental agencies has, in recent years, been markedly intensified. Through an array of criminal and civil legal actions, the Office of Inspector General (OIG), Department of Justice (DOJ), state Attorneys General (AG) and a plethora of other governmental agencies are carrying out the Obama Administration's tenacious battle against what Attorney General Eric Holder recently dubbed the health care fraud "epidemic."


Ostreicher

On the civil side, the government consistently shatters its own records in amounts collected from such suits, with the OIG reporting in the introductory message to its 2012 Work Plan that the government is now recovering an estimated $16.70 for every $1 invested in False Claims Act health care investigations and prosecutions. Despite these unprecedented successes, health care enforcement officials have lamented the persistence of compliance violations in calling for a fundamental change of focus from civil fines to criminal sanctions. Eric Blumberg, Deputy Chief for Litigation for the U.S. Food and Drug Administration, proclaimed at a major enforcement and litigation conference regarding the deterrence of health care fraud: "It's clear we're not getting the job done with large, monetary settlements…. Unless the government shows more resolve to criminally charge individuals at all levels in the company, we cannot expect to make progress."[1]

Holding individuals accountable

Senior Counsel for the OIG, Mary Riordan, endorsed the shift to implicating individuals in January 2011: "What we are hoping to do is change corporate behavior by holding individuals accountable…[because] the big dollar

fines aren't making the difference." This view seems to have taken hold, as the OIG proudly reported that convictions under the Health Care Fraud and Abuse Control Program increased by over 27% between 2009 and 2011, and the number of defendants facing criminal charges filed by federal prosecutors in 2011 increased by 74% compared with 2008.[2]

The ensuing relentless pursuit of nursing home owners, operators, administrators, and managers—which has focused on everything from provision of treatment to protection of private information, resource utilization group (RUG) scores to bribes, homicide to reimbursements, employee selection to conspiracy, tax evasion to forgery, and fraud to larceny—have resulted in prison sentences in excess of 25 years, ordered payments in the tens of millions of dollars, and exclusions from participation in health care programs that are permanent and unappealable.

One example of prosecutors' remarkable willingness to pursue charges against nursing home owners and operators for the goings on in their establishments involves what was the only criminal action against individuals directly related to Hurricane Katrina. In the aftermath of one of the most calamitous natural disasters in American history, Mabel and Salvador Mangano, the owners of St. Rita's Nursing Home in Violet, Louisiana, were charged with negligent homicide and cruelty to the infirm, stemming from the drowning deaths of 35 residents during Hurricane Katrina's catastrophic floods. The negligent homicide counts each carried a maximum penalty of 5 years in prison and a $5,000 fine, while the cruelty counts each carried a maximum sentence of 10 years and a $10,000 fine. The Manganos were accused of ignoring warnings and failing to evacuate the facility as the hurricane approached in August 2005. Prosecutors relied, in part, on evidence that three other nursing homes in St. Bernard Parish evacuated as the storm approached. Although a jury ultimately acquitted the Manganos of criminal charges in 2007, more than 30 wrongful-death and personal-injury lawsuits filed on behalf of the St. Rita's residents against them ensued. And the precedent of charging health care providers, in their individual capacities, for crimes of this magnitude was firmly established.[3]

And in light of the extraordinary additional resources the government has invested in compliance enforcement in just the last couple of years, and the impending implementation of various facets of the Patient Protection and Affordable Care Act of 2010 health care reform law, those holding key positions in nursing homes face an exponentially greater risk of legal action—and at far graver consequence—than ever before.

Prosecutors continue to hold providers personally liable for conventional health care crimes such as kickbacks, wrongful taking, and obstruction of justice—albeit with remarkably increased resolve of late. What is new is that law enforcement agencies have dramatically broadened their scope and extended their reach in recent years and are now bringing criminal actions against health care executives, in their individual capacities, for infractions such as those relating to quality of care and billing and documentation practices, for which only business entities traditionally bore culpability. It is this new genre of prosecutions that is the focus of this article. Below is a brief abstract of ten such recent cases, six of which involve the prosecution of the nursing home owners and the remainder targeting the administrators. The list is organized by alleged misconduct, although there is some overlap of topics because several entities and individuals were charged with multiple separate offenses as investigations often uncover numerous unrelated infractions.

This compilation is intended to serve as a useful tool for those in health care to avoid the pitfalls suffered by industry colleagues and to stress the urgency with which compliance issues must be addressed.

Notable cases

The following defendants were tried for billing for services that were substandard, worthless, and/or rendered in violation of law:

- **George D. Houser and Rhonda Washington Houser; Forum Healthcare Group**

In August 2012, a Rome, Georgia man was sentenced to 20 years in prison and ordered to pay more than $7.5 million in restitution, in addition to 3 years supervised release, for an alleged health care fraud conspiracy involving the misappropriation of government funds intended for the care of approximately 300 residents in the three-facility group he and his wife owned and managed. Beginning in at least 2004, when George and Rhonda Houser founded Forum Healthcare Group, Inc., and continuing until the State of Georgia closed down the Moran Lake, Mount Berry, and Wildwood Park Nursing and Rehabilitation Centers in 2007, the Housers allegedly conspired to defraud the Medicare and Medicaid programs of approximately $30 million by submitting claims for payments when the care they provided to the nursing home residents were so inadequate that it was worthless and harmful, thereby defrauding the programs of the money the defendants received. According to the April 2010 federal indictment, the homes were inadequately staffed and residents lived in substandard conditions with food shortages, broken air-conditioners, and leaky roofs, while the couple profited roughly $8 million.

Federal authorities further alleged that George Houser, a Harvard Law graduate, deducted federal income taxes from his employees' paychecks, but he failed to pay more than $800,000 of such funds to the IRS.

The Housers' motion to have the indictment dismissed was denied in May 2011, and a trial schedule was set for February 2012. Then, in December 2011, Rhonda Houser entered into a plea agreement with prosecutors pursuant to which she pled guilty to a felony charge of failure to report health care fraud which she knew was being committed—namely, that the home was collecting government money while providing "worthless" services. Rhonda Houser further agreed to fully cooperate in the ongoing investigation of the alleged criminal activities of her husband. Finally, she agreed to pay full restitution to all of the victims, exceeding $2.15 million. In exchange, the government agreed to dismiss additional charges against her and recommended a reduced sentence on the remaining fraud charge.

At George Houser's trial, in response to the damning testimony of two Forum Healthcare administrators, his attorneys insisted that, as owner of the business, he had a right to a profit and any issues brought to his attention were always resolved. This argument was rejected, as Houser was found guilty on 11 charges—one count of health care fraud, eight counts of willful failure to pay payroll taxes, and two counts of failure to file income tax returns. Even at his sentencing, Houser maintained his innocence, insisting that nearly all the testimony against him was false. Notably, the fraud conviction marks the first time that a defendant has been convicted after trial in federal court for submitting claims for payment for worthless services.

Rhonda Houser still awaits sentencing, facing up to 3 years in prison and $250,000 in fines, in addition to the aforementioned multi-million dollar restitution she agreed to pay.

- **Villaspring of Erlanger Healthcare Center and Rehabilitation; Carespring Healthcare Management; and Barry Bortz**

The United States Attorney's Office (USAO) for the Eastern District of Kentucky filed a civil complaint in Federal Court in July 2011 against a nursing home, its parent company and its owner for alleged violations of the Federal False Claims Act. Villaspring Healthcare Center, Carespring Healthcare Management, and majority owner Barry Bortz were accused of failing to provide adequate care for residents, resulting in egregious harm and even the death of multiple residents. The defendants purportedly defrauded the federal Medicare program and the Kentucky Medicaid program by seeking and receiving substantial reimbursements for care that was either non-existent or so inadequate as to be worthless.

The complaint alleges that from 2004 to 2008, numerous patients suffered serious injuries resulting from the worthless care—five of whom died as a result of their injuries. The alleged inadequate care included failure to follow physicians' orders, failure to treat wounds and pressure sores, failure to update resident care plans, and failure to monitor the blood sugar levels of diabetic residents.

Naming Bortz individually as a defendant, the complaint highlights that the majority owner signed the Medicare and Medicaid provider agreements on behalf of Villaspring, as well as multiple cost reports.

This is the first suit filed in Kentucky in which the government claimed that a nursing home defrauded Medicare and Medicaid by submitting bills for reimbursement while providing systemically poor resident care. The USAO Kerry Harvey referred to the filing as "an important milestone in the effort to insure [*sic*] effective care for Medicare and Medicaid recipients in long term care facilities."

The complaint stems from a five-year-old allegation thoroughly investigated by the Kentucky AG, who ultimately opted *not* to bring charges. The home insists that it cooperated fully with the state investigators every step of the way to make whatever changes were needed to put them in full compliance and, as such, the federal government's case lacks any merit. Moreover, Villaspring moved to dismiss the "worthless services" claim on grounds that services to residents could not be "worthless" because they were billed on a per-diem basis and Villaspring provided room, board, and at least some patient care. The District Court rejected this argument in December 2011, commenting that it "is not necessary to show that the services were completely lacking; rather, it is also sufficient to show that patients were not provided the quality of care which meets the statutory standard." The District Court allowed the case to proceed under an "implied certification" theory for violations of the provider agreement signed by the facility's CEO.

The parties were charged with violating the False Claims Act, committing common law fraud, and unjust enrichment. If found liable, the defendants face penalties between $5,500 and $11,000 per false claim and an order to repay Medicare and Medicaid three times the amount of the government's loss for the fraud. The court set a trial date of August 20, 2013 (after this article went to press).

- **Valley Rest Nursing Home; Victor Napenas**

The owner of a Totowa, New Jersey nursing home was sentenced in August 2010 to 30 days in jail; 3 years' probation; and was ordered to pay $380,000 in restitution, penalties, and back taxes after pleading guilty to Medicaid fraud relating to dubious billing practices and substandard care. After state surveyors noted severe deficiencies in the care delivered to residents at Valley Rest

Nursing Home, which resulted in the owner's voluntarily closing of the facility in 2007, a tangential financial audit revealed numerous irregularities on the facility's 2005 cost report submitted to Medicaid. The criminal investigation that ensued exposed that Valley Rest owner Victor Napenas billed the Medicaid program more than $300,000 in improper and unsubstantiated costs. Napenas was charged with third-degree Medicaid fraud. In addition to incarceration and monetary payments, Napenas was excluded from acting as a Medicaid provider for 8 years.

The following provider and individual were prosecuted for fraudulent billing for services not provided:

- **Umawa Oke Imo; City Nursing Services of Texas**

In October 2011, the owner of a Texas nursing home was sentenced to 327 months (more than 27 years) in federal prison for his role in a health care fraud conspiracy, which prosecutors say resulted in the billing of the federal Medicare and Texas Medicaid programs for $45 million over a two-and-a-half year period. Imo was found guilty of one count of conspiracy to commit health care fraud, 39 counts of health care fraud, three counts of mail fraud, and five counts of money laundering.

The alleged illicit activities that took place at the home included cash payments to program beneficiaries, the signing of undated blank treatment forms, and payment to marketers and recruiters to lure health care recipients. Former employees testified that when program beneficiaries took Medicare Explanation of Benefit statements to personnel to complain about the fraudulent billing, they were, on occasion, given hundreds of dollars in extra payments to "settle" matters. The employees further testified regarding City Nursing Services' billing of Medicare for services that were not provided, including treatment for individuals who were deceased. Imo was also accused of billing millions of dollars for physical therapy services, despite having never hired a single licensed physical therapist to work at the facility and having "treatments" that authorities contend were predominantly limited to short massages and hot packs.

A City Nursing Services clinical staffer, an alleged sham bookkeeper, Joann M. White, also testified for the government during Imo's trial. In limiting her sentence to 46 months in prison for the role she played in the conspiracy, the judge expressly considered her assistance to the government in prosecuting Imo.

In addition to the prison sentence, Imo was ordered to pay $30.2 million in restitution to the Medicare and Medicaid programs.

The following providers and individuals were prosecuted for improper scoring/upcoding:

- **Eufemia Fe Salomon-Flores; Glen Island Center for Nursing and Rehabilitation**

A former administrator at a Westchester, NY nursing home was sentenced in January 2012 to 1 to 3 years in state prison and signed a confession of judgment on the $2.2 million she admitted to defrauding from Medicaid. Eufemia Fe Salomon-Flores pleaded guilty to one count of Grand Larceny in the Second Degree, a class C felony, and one count of Criminal Tax Fraud in the Third Degree, a class D felony, for illicit activity carried out when she was administrator of New Rochelle's Glen Island Center for Nursing and Rehabilitation.

The investigation began after an informant revealed that the Glen Island Center had submitted information to the State Department of Health that falsified the type of care residents received by allegedly exaggerating residents' diagnoses, conditions, and required

treatments, thus inflating the Medicaid rate the home received. For example, it was alleged that Salomon-Flores routinely stated in the home's quarterly reports that residents were receiving suction and oxygen treatments, as well as receiving treatments for cancer and infections, when these treatments were not required and/or not provided.

The New York AG's investigation also revealed that Salomon-Flores received payments in excess of $300,000 from checks issued to two dubious entities she owned—payments she failed to report as income on her New York State tax returns.

- **Carolyn Wetterberg; Wetterberg Nursing Homes; and Pond View Nursing Facility**

Among the 118 criminal indictments against ten people linked to a series of Medicaid fraud schemes announced by Massachusetts AG Martha Coakley on September 30, 2011, were the charges of fraud and larceny brought against the owner of a 43-bed Boston nursing home. Carolyn Wetterberg, who owned Pond View Nursing Facility located in Jamaica Plain with her husband, was charged with defrauding the State Medicaid Program and billing MassHealth in excess of $600,000 for services not provided. The Wetterbergs also owned Wetterberg Nursing Homes, which managed the Pond View facility.

In June 2008, Pond View was shut down by the Massachusetts Department of Public Health due to poor quality of care provided to its residents and the Wetterbergs sold the facility for about $1.3 million.

After receiving an anonymous tip, the Medicaid Fraud Division began an extensive investigation, which soon focused on Wetterberg's misuse of residents' Management Minute Questionnaires (MMQs)—the form used to determine the reimbursement rate long-term care facilities receive under Massachusetts Medicaid. When the residents arrived at new facilities as a result of Pond View's closure and many of their MMQ scores dropped substantially, the authorities concluded that Wetterberg and Pond View had intentionally inflated residents' scores in order to receive a higher payment rate. The AG, in turn, accuses Wetterberg of grossly exaggerating many of her residents' disabilities; pointing to residents Wetterberg claimed to be in need of assistance walking who were able walk independently in their new facilities, and residents claimed by Wetterberg to need assistance eating who were able to eat unaided.

Wetterberg was charged with 12 counts of Medicaid False Claims and 12 counts of Larceny by False Pretenses. Each count of Medicaid fraud carries a sentence of up to 5 years in jail and up to $10,000 in fines. Each larceny charge carries a sentence of up to 5 years in jail and up to $25,000 in fines. (The outcome of this case was not known at the time this article went to press.)

The following providers and individuals were prosecuted for care issues—staffing and supervision, and abuse and neglect:

- **Sheila Noe; Hazard Nursing Home**

The administrator of a Kentucky nursing home and the company that owns the facility were criminally charged with failure to report the suspected sexual abuse of an elderly resident. Sheila Noe, as administrator of Hazard Nursing Home, was purportedly made aware of two incidents of sexual abuse sustained by an 88-year-old resident suffering from Alzheimer's disease perpetrated by two other residents. Noe failed to report the incidents to the Cabinet for Health and Family Services, as required by law. The Cabinet issued a Type A citation to the home—a reprimand issued when a nursing home has put the life or safety of a resident in danger through the violation of state regulations.

The AG's Office of Medicaid Fraud and Abuse Control followed with a criminal investigation. Criminal charges of failure to report (a Class B misdemeanor punishable by up to 90 days in jail and $250 in fines) were filed against Noe and the company ownership, First Corbin Long Term Care, which is owned by Forcht Group of Kentucky.

In July 2011, the AG's office and defendants reached a six-month deferred prosecution agreement whereby the charges would be dropped if the defendants (1) pay $20,000 to Kentucky's Civil Monetary Fund; (2) have all of the owner's nine nursing homes in the state conform to state policies regarding abuse and neglect; and (3) have all employees in the nine homes undergo additional training on reporting abuse and neglect.

In addition, Noe was permanently excluded from the position of nursing home administrator.

Notably, a spokesperson for the Kentucky AG's Office responded to widespread criticism for letting the defendants off "too lightly" by explaining that because this home was the only one in Hazard, a guilty plea would have required CMS to stop funding the facility, thereby forcing it to close and leaving the town without a nursing home.

- **Janice Burch; Skyview II**

In April 2012, the owner/administrator of a Nevada nursing home was sentenced for three gross misdemeanor offenses for Neglect of Duty in Willful or Wanton Disregard of Safety of Persons. In addition to the community service she must perform and the fine she must pay, Janice Burch has been excluded from participation in health care programs.

A full scale investigation of Skyview II was commenced after a caregiver filed a complaint with the Las Vegas Metropolitan Police Department that she had been instructed to forge daily medication documentation, as if the residents were appropriately receiving their medications when, in fact, they had not. Various law enforcement agencies participated in the investigation and ultimately found that the home had faulty operational documentation and inadequate toileting facilities. The Skyview residents were removed from the facility and transferred to other nursing homes, and the Nevada AG charged Burch for her "fail[ure] to provide oversight and direction for staff members to ensure adequate services and supervision of residents…and fail[ure] to ensure that the facility was in compliance with applicable regulations."

Burch received credit for time served and was required to perform 120 hours of community service and pay a $1,000 fine. She is prohibited from owning, being employed by, or having any connection with institutions that provide any personal care services.

- **Verdugo Valley Skilled Nursing Wellness Center; Phyllis Paver**

A Southern California skilled nursing facility and its former administrator were charged in July 2011 with felony abuse and neglect in the suicide of a mentally ill patient. When Charles Morrill was admitted to Verdugo Valley Skilled Nursing Wellness Centre in January 2009, the home lacked staff and training to care for mentally ill patients. Morrill, who was suicidal and had a history of mental illness, was admitted nonetheless.

Morrill allegedly attempted suicide twice in his first month at the facility—once by firing a fire extinguisher into his mouth and once by wheeling himself out into a street, trying to be hit by a car. Each time, he was hospitalized and then accepted back at the facility. A short time later, Morrill again fired a fire extinguisher in his mouth and succeeded in taking his own life.

In charging the home and its former administrator, Phyllis Paver, the indictment accused the two of proximately causing Morrill's death

Table 1: Nursing home owners and executives held individually liable in recent regulatory compliance actions

Individual(s)	Position(s)	Company/ Companies	State	Charge(s)	Prison	Fine/ Restitution	Probation/ Exclusion	Statute(s)	Note(s)
George and Rhonda Houser	Owners/ Managers	Forum Healthcare Group	GA	Misappropriating $30 million in government funds by submitting claims for payment while providing substandard and inadequate care and profiting roughly $8 million; deducting federal income tax from employees but failing to pay over $800,000 of such funds to IRS	George Houser: 20 years	George Houser was ordered to pay more than $7.5 million in restitution; Rhonda Houser agreed to pay more than $2.15 million in restitution	George Houser: 3 years supervised release	Conspiracy (18 U.S.C. § 1349); Medicare and Medicaid Fraud (18 U.S.C. § 1347); Willful Failure to Pay Payroll Taxes (26 U.S.C. § 7202); Failure to File Income Tax Returns (26 U.S.C. § 7203)	George Houser's August 2012 sentencing followed his April 2012 conviction—the first of its kind in federal court for submitting claims for "worthles" services. Rhonda Houser still awaits sentencing, facing 3 years in prison and $250,000 in fines.
Barry Bortz	Majority Owner	Villaspring Health Care Center; Carespring Health Care Management	KY	Defrauding the Medicare and Medicaid programs by seeking and receiving substantial reimbursements for care that was either non-existent or so inadequate as to be worthless				Federal False Claims Act (31 U.S.C. § 3729(a)(1)); Common Law Fraud; Unjust Enrichment	The complaint, filed in July 2011, was the first of its kind in Kentucky. If found liable, defendants face penalties of up to $11,000 per false claim plus repayment to Medicare and Medicaid for three times the amount of the government's loss for the fraud.
Victor Napenas	Owner	Valley Rest Nursing Home	NJ	Billing roughly $300,000 in improper and unsubstantiated costs and substandard care	30 days	$380,000	3 years probation; 8 year exclusion	NJ False Claims Act (N.J.S. §§ 2A:32C-1 et seq.); 3rd Degree Medicaid Fraud (N.J.S. 30:4D-17)	A survey in 2007 led to a tangential financial audit, which revealed irregularities in a 2005 cost report, leading to an August 2010 conviction.
Umawa Oke Imo	Owner	City Nursing Services of Texas	TX	Participating in a healthcare fraud conspiracy which included signing undated treatment forms and payments to recruiters, resulting in wrongfully billing Medicare and Medicaid $45 million	27 years	$30.2 million		Conspiracy to Commit Health Fraud (18 U.S.C. § 1349); Health Fraud (18 U.S.C. § 1347); Mail Fraud (18 U.S.C. § 1341); Money Laundering (18 U.S.C. § 1957)	This October 2011 sentence came on the heels of a clinical staffer's conviction for her role in the conspiracy, in which the judge expressly considered assistance provided to the government in prosecuting Imo when limiting the staffer's prison term to 46 months.
Eufemia Fe Salomon-Flores	Admin.	Glen Island Center for Nursing	NY	Defrauding Medicaid out of $2.2 million by exaggerating residents' diagnoses and required treatments, thus inflating payment rates; issuing checks to questionable entities she owned	1-3 years	$2.2 million		NY State 2nd Degree Grand Larceny (N.Y.P.L. § 155.40); 3rd Degree Criminal Tax Fraud (NY Tax Law § 1804)	The January 2012 sentencing followed Flores' guilty plea in September 2011.
Carolyn Wetterberg	Co-Owner	Wetterberg Nursing Homes; Pond View Nursing Facility	MA	Billing $600,000 in services not provided while intentionally inflating residents' MMQ scores in order to receive a higher payment rate				12 counts of Massachusetts Medicaid False Claims (Mass. Gen. Laws 12 §§ 5(A) et seq.); 12 counts of Larceny by False Pretenses (Mass. Gen. Laws 266 § 30)	Wetterberg faces up to 5 years in jail and up to $10,000 in fines for each charge of Medicaid fraud and up to 5 years in jail and up to $25,000 in fines for each larceny charge. The trial is scheduled to commence July 2012.
Sheila Noe	Admin.	Hazard Nursing Home	KY	Failing to report the suspected sexual abuse of an elderly resident, as required by state law		$20,000 (with co-defendant)	Permanent exclusion	Kentucky Failure to Report (K.R.S. § 209.030)	This July 2011 agreement was regarded as a pass from the AG since a guilty plea would have required a cessation of Medicaid funding for—and thus the closure of—the facility, which is the only nursing home in the area.
Janice Burch	Owner/Admin.	Skyview II	NV	Held liable for the home's faulty operational documentation and inadequate toileting facilities	120 hours community service	$1,000	Excluded from participation in healthcare programs	3 Nevada gross misdemeanor offenses for Neglect of Duty in Willful or Wanton Disregard of Safety of Persons (N.R.S. § 202.595)	This April 2012 sentencing was the culmination of a report filed by a caregiver to police.
Phyllis Paver	Admin.	Verdugo Valley Skilled Nursing Wellness Center	CA	Proximately causing the suicide of a mentally ill resident by permitting him to be placed in a situation in which his health was endangered				Elder Abuse (Cal. Penal Code § 368)	The charges against Paver—which carried a jail term of up to six years and fines of up to $6,000—were dropped in 2012.
Adelaida Guevarra-Tolentino	Admin.	Grace Elderly Care Home	NV	Neglecting the safety of nursing home residents via substandard living conditions	60 days		1 year probation; 3 years exclusion from administration	Nevada gross misdemeanor of Neglect of Duty in Willful or Wanton Disregard of Safety of Person or Property (N.R.S. § 202.595)	Tolentino was 73-years-old at the time of her sentencing in July 2010.

by permitting him to be placed in a situation in which his health was endangered.

Although the charges against Paver (which carried a jail term of up to 6 years and fines of up to $6,000) were later dropped, the home may still lose its license to operate as it negotiates an injunction with the AG whereby its operations would be monitored.

▶ Adelaida Guevarra-Tolentino; Grace Elderly Care Home

The former administrator of a Las Vegas nursing home was sentenced in July 2010 after being convicted of Neglect of Duty in Willful or Wanton Disregard of Safety of Person, a gross misdemeanor offense. Adelaida Guevarra-Tolentino was ordered

to serve 60 days in jail and suspended, with one year probation and preclusion from seeking employment as a licensed administrator or performing duties as an unlicensed administrator for at least 3 years.

The Nevada AG's Medicaid Fraud Control Unit commenced an investigation of the living conditions at Grace Elderly Care Home in the summer of 2008, after a social worker responding to a complaint from one of the residents at the facility contacted Nevada's Aging and Disabilities Service Division and its Bureau of Healthcare Quality and Compliance. The AG determined that Guevarra-Tolentino was accountable for the neglectful living conditions. The state agencies then worked to transport residents out of the facility.

Conclusion

These ten instances of prosecution for inadequate or over-aggressive care are ominous of an evolving course of action and may be regarded as the opening of the proverbial floodgates of legal proceedings against nursing home owners and operators—offering yet another reason a makeshift compliance and ethics program is unsatisfactory. It is essential that long-term care providers have a multidisciplinary team of professionals who have a thorough understanding of the health care industry and the controlling laws and regulations to help navigate in today's climate of heightened law enforcement activity. The staggering enhancement of enforcement tools and punishments at the disposal of law enforcement agencies, coupled with the resources being invested into utilizing these tools and the extraordinary willingness to hold individuals responsible, makes the potential risk of legal action much greater than ever before. As Aaron Lichtman, a health care lawyer who has worked hand-in-hand with nursing home executives for over a decade warns: "Nursing home owners and operators must properly address the issue of regulatory compliance *now*—any further procrastination is rolling the dice…with one's business, one's resources and one's freedom."

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