The Constitution Revision Commission

COMMITTEE MEETING EXPANDED AGENDA

DECLARATION OF RIGHTS
Commissioner Carlton, Chair
Commissioner Stemberger, Vice Chair

MEETING DATE: Thursday, January 11, 2018
TIME: 1:00—5:00 p.m.
PLACE: *Room 105, Gerald L. Gunter Building,* 2540 Shumard Oak Boulevard, Tallahassee, Florida

MEMBERS: Commissioner Carlton, Chair; Commissioner Stemberger, Vice Chair; Commissioners Donalds, Gainey, Johnson, Joyner, and Lester

TAB	PROPOSAL NO. and INTRODUCER	PROPOSAL DESCRIPTION and COMMITTEE ACTIONS	COMMITTEE ACTION
		Workshop on Long-Term Care Resident Rights	Discussed

Note: Public comment will be taken on all noticed agenda items.

CONSTITUTION REVISION COMMISSION
2017 - 2018

WORKSHOP ON LONG-TERM CARE RESIDENT RIGHTS

DECLARATION OF RIGHTS COMMITTEE
January 11, 2018
1 PM – 5 PM
Room 105 – Gerald L. Gunter Building
2540 Shumard Oaks Boulevard
Tallahassee, Florida

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WORKSHOP PACKET

TAB 1

CHAPTER 400

NURSING HOMES AND RELATED HEALTH CARE FACILITIES

PART II

NURSING HOMES

(ss. 400.011-400.334)

400.022 Residents' rights.—

(1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:

(a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights.

(b) The right to private and uncensored communication, including, but not limited to, receiving and sending unopened correspondence, access to a telephone, visiting with any person of the resident's choice during visiting hours, and overnight visitation outside the facility with family and friends in accordance with facility policies, physician orders, and Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act regulations, without the resident's losing his or her bed. Facility visiting hours shall be flexible, taking into consideration special circumstances such as, but not limited to, out-of-town visitors and working relatives or friends. Unless otherwise indicated in the resident care plan, the licensee shall, with the consent of the resident and in accordance with policies approved by the agency, permit recognized volunteer groups, representatives of community-based legal, social, mental health, and leisure programs, and members of the clergy access to the facility during visiting hours for the purpose of visiting with and providing services to any resident.

(c) Any entity or individual that provides health, social, legal, or other services to a resident has the right to have reasonable access to the resident. The resident has the right to deny or withdraw consent to access at any time by any entity or individual. Notwithstanding the visiting policy of the facility, the following individuals must be permitted immediate access to the resident:

1. Any representative of the federal or state government, including, but not limited to, representatives of the Department of Children and Families, the Department of Health, the Agency for Health Care Administration, the Office of the Attorney General, and the Department of Elderly Affairs; any law enforcement officer; any representative of the State Long-Term Care Ombudsman Program; and the resident's individual physician.

2. Subject to the resident's right to deny or withdraw consent, immediate family or other relatives of the resident.

The facility must allow representatives of the State Long-Term Care Ombudsman Program to examine a resident's clinical records with the permission of the resident or the resident's legal representative and consistent with state law.

(d) The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to governmental officials, or to any other person; to recommend changes in policies and services to facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from restraint, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents.

(e) The right to organize and participate in resident groups in the facility and the right to have the resident's family meet in the facility with the families of other residents.

(f) The right to participate in social, religious, and community activities that do not interfere with the rights of other residents.

(g) The right to examine, upon reasonable request, the results of the most recent inspection of the facility conducted by a federal or state agency and any plan of correction in effect with respect to the facility.

(h) The right to manage his or her own financial affairs or to delegate such responsibility to the licensee, but only to the extent of the funds held in trust by the licensee for the resident. A quarterly accounting of any transactions made on behalf of the resident shall be furnished to the resident or the person responsible for the resident. The facility may not require a resident to deposit personal funds with the facility. However, upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility as follows:

1. The facility must establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

2. The accounting system established and maintained by the facility must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

3. A quarterly accounting of any transaction made on behalf of the resident shall be furnished to the resident or the person responsible for the resident.

4. Upon the death of a resident with personal funds deposited with the facility, the facility must convey within 30 days the resident's funds, including interest, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate, or, if a personal representative has not been appointed within 30 days, to the resident's spouse or adult next of kin named in the beneficiary designation form provided for in s. 400.162(6).

5. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Title XVIII or Title XIX of the Social Security Act.

(i) The right to be fully informed, in writing and orally, prior to or at the time of admission and during his or her stay, of services available in the facility and of related charges for such services, including any charges for services not covered under Title XVIII or Title XIX of the Social Security Act or not covered by the basic per diem rates and of bed reservation and refund policies of the facility.

(j) The right to be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and, except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to know the consequences of such actions.

(k) The right to refuse medication or treatment and to be informed of the consequences of such decisions, unless determined unable to provide informed consent under state law. When the resident refuses medication or treatment, the nursing home facility must notify the resident or the resident's legal representative of the consequences of such decision and must document the resident's decision in his or her medical record. The nursing home facility must continue to provide other services the resident agrees to in accordance with the resident's care plan.

(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

(m) The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Residents' personal and medical records shall be confidential and exempt from the provisions of s. 119.07(1).

(n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

(o) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter. Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

(p) The right to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home, or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act. For nonpayment of a bill for care received, the resident shall be given 30 days' advance notice. A licensee certified to provide services under Title XIX of the Social Security Act may not transfer or discharge a resident solely because the source of payment for care changes. Admission to a nursing home facility operated by a licensee certified to provide services under Title XIX of the Social Security Act may not be conditioned upon a waiver of such right, and any document or provision in a document which purports to waive or preclude such right is void and unenforceable. Any licensee certified to provide services under Title XIX of the Social Security Act that obtains or attempts to obtain such a waiver from a resident or potential resident shall be construed to have violated the resident's rights as established herein and is subject to disciplinary action as provided in subsection (3). The resident and the family or representative of the resident shall be consulted in choosing another facility.

(q) The right to freedom of choice in selecting a personal physician; to obtain pharmaceutical supplies and services from a pharmacy of the resident's choice, at the resident's own expense or through Title XIX of the Social Security Act; and to obtain information about, and to participate in, community-based activities programs, unless medically contraindicated as documented by a physician in the resident's medical record. If a resident chooses to use a community pharmacy and the facility in which the resident resides uses a unit-dose system, the pharmacy selected by the resident shall be one that provides a compatible unit-dose system, provides service delivery, and stocks the drugs normally used by long-term care residents. If a resident chooses to use a community pharmacy and the facility in

which the resident resides does not use a unit-dose system, the pharmacy selected by the resident shall be one that provides service delivery and stocks the drugs normally used by long-term care residents.

(r) The right to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other residents or unless medically contraindicated as documented in the resident's medical record by a physician. If clothing is provided to the resident by the licensee, it shall be of reasonable fit.

(s) The right to have copies of the rules and regulations of the facility and an explanation of the responsibility of the resident to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other residents.

(t) The right to receive notice before the room of the resident in the facility is changed.

(u) The right to be informed of the bed reservation policy for a hospitalization. The nursing home shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved for any single hospitalization for a period up to 30 days provided the nursing home receives reimbursement. Any resident who is a recipient of assistance under Title XIX of the Social Security Act, or the resident's designee or legal representative, shall be informed by the licensee that his or her bed will be reserved for any single hospitalization for the length of time for which Title XIX reimbursement is available, up to 15 days; but that the bed will not be reserved if it is medically determined by the agency that the resident will not need it or will not be able to return to the nursing home, or if the agency determines that the nursing home's occupancy rate ensures the availability of a bed for the resident. Notice shall be provided within 24 hours of the hospitalization.

(v) For residents of Medicaid or Medicare certified facilities, the right to challenge a decision by the facility to discharge or transfer the resident, as required under 42 C.F.R. s. 483.12.

(2) The licensee for each nursing home shall orally inform the resident of the resident's rights and provide a copy of the statement required by subsection (1) to each resident or the resident's legal representative at or before the resident's admission to a facility. The licensee shall provide a copy of the resident's rights to each staff member of the facility. Each such licensee shall prepare a written plan and provide appropriate staff training to implement the provisions of this section. The written statement of rights must include a statement that a resident may file a complaint with the agency or state or local ombudsman council. The statement must be in boldfaced type and include the telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone numbers of the local ombudsman council and the Elder Abuse Hotline operated by the Department of Children and Families.

(3) Any violation of the resident's rights set forth in this section constitutes grounds for action by the agency under s. 400.102, s. 400.121, or part II of chapter 408. In order to determine whether the licensee is adequately protecting residents' rights, the licensure inspection of the facility must include private informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to rights specified in this section and general compliance with standards and consultation with the State Long-Term Care Ombudsman Program.

(4) Any person who submits or reports a complaint concerning a suspected violation of the resident's rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from such complaint shall have immunity from any criminal or civil liability therefor, unless that person has acted in bad faith, with malicious purpose, or if the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

History.—s. 8, ch. 76-201; s. 1, ch. 77-174; ss. 1, 9, ch. 79-268; ss. 2, 18, ch. 80-186; s. 2, ch. 81-318; ss. 11, 19, ch. 82-148; ss. 5, 79, 83, ch. 83-181; s. 1, ch. 84-144; s. 15, ch. 90-347; s. 30, ch. 93-177; ss. 3, 49, ch. 93-217; s. 764, ch. 95-148; s. 226, ch. 96-406; s. 118, ch. 99-8; s. 5, ch. 99-394; ss. 70, 137, ch. 2000-349; s. 57, ch. 2000-367; s. 33, ch. 2001-62; s. 56, ch. 2007-230; s. 123, ch. 2014-19; s. 43, ch. 2015-2; s. 21, ch. 2015-31; s. 48, ch. 2016-10.

400.023 Civil enforcement.—

(1) An exclusive cause of action for negligence or a violation of residents' rights as specified under this part which alleges direct or vicarious liability for the personal injury or death of a nursing home resident arising from such negligence or violation of rights and which seeks damages for such injury or death may be brought only against the licensee, the licensee's management or consulting company, the licensee's managing employees, and any direct caregivers, whether employees or contractors. A passive investor is not liable under this section. An action against any other individual or entity may be brought only pursuant to subsection (3).

(a) The action may be brought by the resident or his or her guardian, by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death.

(b) If the action alleges a claim for the resident's rights or for negligence that caused the death of the resident, the claimant shall, after the verdict, but before the judgment is entered, elect survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the action alleges a claim for the resident's rights or for negligence that did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident.

(c) The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual and punitive damages for the violation of the rights of a resident or for negligence.

(d) A resident who prevails in seeking injunctive relief or an administrative remedy is entitled to recover the costs of the action, and reasonable attorney fees assessed against the defendant of up to $25,000. Fees shall be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure.

(e) This section does not preclude theories of recovery not arising out of negligence or s. 400.022 which are available to a resident or to the agency. Chapter 766 does not apply to a cause of action brought under ss. 400.023-400.0238.

(2) As used in this section, the term:

(a) "Licensee" means an individual, corporation, partnership, firm, association, governmental entity, or other entity that is issued a permit, registration, certificate, or license by the agency and that is legally responsible for all aspects of the operation of the nursing home facility.

(b) "Management or consulting company" means an individual or entity who contracts with, or receives a fee from, a licensee to provide any of the following services for a nursing home facility:

1. Hiring or firing of the administrator or director of nursing;
2. Controlling or having control over the staffing levels at the facility;
3. Having control over the budget of the facility; or
4. Implementing and enforcing the policies and procedures of the facility.

(c) "Passive investor" means an individual or entity that has an interest in a facility but does not participate in the decisionmaking or operations of the facility.

(3) A cause of action may not be asserted against an individual or entity other than the licensee, the licensee's management or consulting company, the licensee's managing employees, and any direct caregivers, whether employees or contractors, unless, after a motion for leave to amend hearing, the court or an arbitration panel determines that there is sufficient evidence in the record or proffered by the claimant to establish a reasonable showing that:

(a) The individual or entity owed a duty of reasonable care to the resident and that the individual or entity breached that duty; and

(b) The breach of that duty is a legal cause of loss, injury, death, or damage to the resident.

For purposes of this subsection, if, in a proposed amended pleading, it is asserted that such cause of action arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, the proposed amendment relates back to the original pleading.

(4) In a claim brought pursuant to this part alleging a violation of residents' rights or negligence causing injury to or the death of a resident, the claimant has the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

This part does not create strict liability. A violation of the rights set forth in s. 400.022, in any other standard or guidelines specified in this part, or in any applicable administrative standard or guidelines of this state or a federal regulatory agency is evidence of negligence but is not considered negligence per se.

(5) In a claim brought pursuant to this section, a licensee, individual, or entity has a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, individual, or entity would use under like circumstances.

(6) In a claim for a residents' rights violation or negligence by a nurse licensed under part I of chapter 464, such nurse has the duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse is that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(7) A licensee is not liable for the medical negligence of a physician rendering care or treatment to the resident except for the administrative services of a medical director as required under this part. This subsection does not protect a licensee, individual, or entity from liability for failure to provide a resident with appropriate observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care by nursing staff.

(8) The resident or the resident's legal representative shall serve a copy of a complaint alleging in whole or in part a violation of any rights specified in this part to the agency at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. The requirement of providing a copy of the complaint to the agency does not impair the resident's legal rights or ability to seek relief for his or her claim.

(9) An action under this part for a violation of rights or negligence recognized herein is not a claim for medical malpractice, and s. 768.21(8) does not apply to a claim alleging death of the resident.

History.—ss. 3, 18, ch. 80-186; s. 2, ch. 81-318; ss. 6, 79, 83, ch. 83-181; s. 51, ch. 83-218; s. 1, ch. 86-79; s. 30, ch. 93-177; ss. 4, 49, ch. 93-217; s. 765, ch. 95-148; s. 30, ch. 99-225; s. 4, ch. 2001-45; s. 34, ch. 2001-62; s. 1, ch. 2014-83.

400.0233 Presuit notice; investigation; notification of violation of resident's rights or alleged negligence; claims evaluation procedure; informal discovery; review; settlement offer; mediation.—

(1) As used in this section, the term:

(a) "Claim for resident's rights violation or negligence" means a negligence claim alleging injury to or the death of a resident arising out of an asserted violation of the rights of a resident under s. 400.022 or an asserted deviation from the applicable standard of care.

(b) "Insurer" means any self-insurer authorized under s. 627.357, liability insurance carrier, joint underwriting association, or uninsured prospective defendant.

(2) Prior to filing a claim for a violation of a resident's rights or a claim for negligence, a claimant alleging injury to or the death of a resident shall notify each prospective defendant by certified mail, return receipt requested, of an asserted violation of a resident's rights provided in s. 400.022 or deviation from the standard of care. Such notification shall include an identification of the rights the prospective defendant has violated and the negligence alleged to have caused the incident or incidents and a brief description of the injuries sustained by the resident which are reasonably identifiable at the time of notice. The notice shall contain a certificate of counsel that counsel's reasonable investigation gave rise to a good faith belief that grounds exist for an action against each prospective defendant.

(3)(a) No suit may be filed for a period of 75 days after notice is mailed to any prospective defendant. During the 75-day period, the prospective defendants or their insurers shall conduct an evaluation of the claim to determine the liability of each defendant and to evaluate the damages of the claimants. Each defendant or insurer of the defendant shall have a procedure for the prompt evaluation of claims during the 75-day period. The procedure shall include one or more of the following:

1. Internal review by a duly qualified facility risk manager or claims adjuster;
2. Internal review by counsel for each prospective defendant;
3. A quality assurance committee authorized under any applicable state or federal statutes or regulations; or
4. Any other similar procedure that fairly and promptly evaluates the claims.

Each defendant or insurer of the defendant shall evaluate the claim in good faith.

(b) At or before the end of the 75 days, the defendant or insurer of the defendant shall provide the claimant with a written response:

1. Rejecting the claim; or
2. Making a settlement offer.

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer of the defendant to reply to the notice within 75 days after receipt shall be deemed a rejection of the claim for purposes of this section.

(4) The notification of a violation of a resident's rights or alleged negligence shall be served within the applicable statute of limitations period; however, during the 75-day period, the statute of limitations is tolled as to all prospective defendants. Upon stipulation by the parties, the 75-day period may be extended and the statute of limitations is tolled during any such extension. Upon receiving written notice by certified mail, return receipt requested, of termination of negotiations in an extended period, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(5) No statement, discussion, written document, report, or other work product generated by presuit claims evaluation procedures under this section is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit claims evaluation procedure. Any licensed physician or registered nurse may be retained by either party to provide an opinion regarding the reasonable basis of the claim. The presuit opinions of the expert are not discoverable or admissible in any civil action for any purpose by the opposing party.

(6) Upon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery as provided in subsection (7).

(7) Informal discovery may be used by a party to obtain unsworn statements and the production of documents or things as follows:

(a) *Unsworn statements.*—Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of claims evaluation and are not discoverable or admissible in any civil action for any purpose by any party. A party seeking to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

(b) *Documents or things.*—Any party may request discovery of relevant documents or things. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce relevant and discoverable documents or things within that party's possession or control, if in good faith it can reasonably be done within the timeframe of the claims evaluation process.

(8) Each request for and notice concerning informal discovery pursuant to this section must be in writing, and a copy thereof must be sent to all parties. Such a request or notice must bear a certificate of service identifying the name and address of the person to whom the request or notice is served, the date of the request or notice, and the manner of service thereof.

(9) If a prospective defendant makes a written settlement offer, the claimant shall have 15 days from the date of receipt to accept the offer. An offer shall be deemed rejected unless accepted by delivery of a written notice of acceptance.

(10) To the extent not inconsistent with this part, the provisions of the Florida Mediation Code, Florida Rules of Civil Procedure, shall be applicable to such proceedings.

(11) Within 30 days after the claimant's receipt of the defendant's response to the claim, the parties or their designated representatives shall meet in mediation to discuss the issues of liability and damages in accordance with the mediation rules of practice and procedures adopted by the Supreme Court. Upon stipulation of the parties, this 30-day period may be extended and the statute of limitations is tolled during the mediation and any such extension. At the conclusion of mediation, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

History.—s. 5, ch. 2001-45.

400.0234 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility in accordance with s. 400.145 shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

(2) No facility shall be held liable for any civil damages as a result of complying with this section.

History.—s. 6, ch. 2001-45.

400.0235 Certain provisions not applicable to actions under this part.—An action under this part for a violation of rights or negligence recognized under this part is not a claim for medical malpractice, and the provisions of s. 768.21(8) do not apply to a claim alleging death of the resident.

History.—s. 7, ch. 2001-45.

400.0236 Statute of limitations.—

(1) Any action for damages brought under this part shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered or should have been discovered with the exercise of due diligence; however, in no event shall the action be commenced later than 4 years from the date of the incident or occurrence out of which the cause of action accrued.

(2) In those actions covered by this subsection in which it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event for more than 6 years from the date the incident giving rise to the injury occurred.

(3) This section shall apply to causes of action that have accrued prior to the effective date of this section; however, any such cause of action that would not have been barred under prior law may be brought within the time allowed by prior law or within 2 years after the effective date of this section, whichever is earlier, and will be barred thereafter. In actions where it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event more than 4 years from the effective date of this section.

History.—s. 8, ch. 2001-45.

400.0237 Punitive damages; pleading; burden of proof.—

(1) A claim for punitive damages may not be brought under this part unless there is a showing by admissible evidence that has been submitted by the parties that provides a reasonable basis for recovery of such damages when the criteria in this section are applied.

(a) The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of civil procedure in accordance with evidentiary requirements set forth in this section.

(b) The court shall conduct a hearing to determine whether there is sufficient admissible evidence submitted by the parties to ensure that there is a reasonable basis to believe that the claimant, at

trial, will be able to demonstrate by clear and convincing evidence that the recovery of such damages is warranted under a claim for direct liability as specified in subsection (2) or under a claim for vicarious liability as specified in subsection (3).

(c) The rules of civil procedure shall be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages. Discovery of financial worth may not proceed until the pleading on punitive damages is approved by the court.

(2) A defendant may be held liable for punitive damages only if the trier of fact, by clear and convincing evidence, finds that a specific person or corporate defendant actively and knowingly participated in intentional misconduct or engaged in conduct that constitutes gross negligence and contributed to the loss, damages, or injury suffered by the claimant. As used in this section, the term:

(a) "Intentional misconduct" means that the defendant against whom punitive damages are sought had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage.

(b) "Gross negligence" means that a defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.

(3) In the case of vicarious liability of an individual, employer, principal, corporation, or other legal entity, punitive damages may not be imposed for the conduct of an employee or agent unless the conduct of the employee or agent meets the criteria specified in subsection (2) and an officer, director, or manager of the actual employer, corporation, or legal entity condoned, ratified, or consented to the specific conduct as provided in subsection (2).

(4) The plaintiff shall establish at trial, by clear and convincing evidence, its entitlement to an award of punitive damages. The "greater weight of the evidence" burden of proof applies to a determination of the amount of damages.

History.—s. 9, ch. 2001-45; s. 2, ch. 2014-83.

400.0238 Punitive damages; limitation.—

(1)(a) Except as provided in paragraphs (b) and (c), an award of punitive damages may not exceed the greater of:

1. Three times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or

2. The sum of $1 million.

(b) Where the fact finder determines that the wrongful conduct proven under this section was motivated primarily by unreasonable financial gain and determines that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the managing agent, director, officer, or other person responsible for making policy decisions on behalf of the defendant, it may award an amount of punitive damages not to exceed the greater of:

1. Four times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or

2. The sum of $4 million.

(c) Where the fact finder determines that at the time of injury the defendant had a specific intent to harm the claimant and determines that the defendant's conduct did in fact harm the claimant, there shall be no cap on punitive damages.

(d) This subsection is not intended to prohibit an appropriate court from exercising its jurisdiction under s. 768.74 in determining the reasonableness of an award of punitive damages that is less than three times the amount of compensatory damages.

(e) In any case in which the findings of fact support an award of punitive damages pursuant to paragraph (b) or paragraph (c), the clerk of the court shall refer the case to the appropriate law enforcement agencies, to the state attorney in the circuit where the long-term care facility that is the subject of the underlying civil cause of action is located, and, for multijurisdictional facility owners, to the Office of the Statewide Prosecutor; and such agencies, state attorney, or Office of the Statewide Prosecutor shall initiate a criminal investigation into the conduct giving rise to the award of punitive damages. All findings by the trier of fact which support an award of punitive damages under this paragraph shall be admissible as evidence in any subsequent civil or criminal proceeding relating to the acts giving rise to the award of punitive damages under this paragraph.

(2) The claimant's attorney's fees, if payable from the judgment, are, to the extent that the fees are based on the punitive damages, calculated based on the final judgment for punitive damages. This subsection does not limit the payment of attorney's fees based upon an award of damages other than punitive damages.

(3) The jury may neither be instructed nor informed as to the provisions of this section.

(4) Notwithstanding any other law to the contrary, the amount of punitive damages awarded pursuant to this section shall be equally divided between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund, in accordance with the following provisions:

(a) The clerk of the court shall transmit a copy of the jury verdict to the Chief Financial Officer by certified mail. In the final judgment, the court shall order the percentages of the award, payable as provided herein.

(b) A settlement agreement entered into between the original parties to the action after a verdict has been returned must provide a proportionate share payable to the Quality of Long-Term Care Facility Improvement Trust Fund specified herein. For purposes of this paragraph, a proportionate share is a 50-percent share of that percentage of the settlement amount which the punitive damages portion of the verdict bore to the total of the compensatory and punitive damages in the verdict.

(c) The Department of Financial Services shall collect or cause to be collected all payments due the state under this section. Such payments are made to the Chief Financial Officer and deposited in the appropriate fund specified in this subsection.

(d) If the full amount of punitive damages awarded cannot be collected, the claimant and the other recipient designated pursuant to this subsection are each entitled to a proportionate share of the punitive damages collected.

(5) This section is remedial in nature and shall take effect upon becoming a law.

History.—s. 10, ch. 2001-45; s. 415, ch. 2003-261.

400.024 Failure to satisfy a judgment or settlement agreement.—

(1) Upon the entry by a Florida court of an adverse final judgment against a licensee as defined in s. 400.023(2) which arises from an award pursuant to s. 400.023, including an arbitration award, for a claim of negligence or a violation of residents' rights, in contract or tort, or from noncompliance with the terms of a settlement agreement as determined by a court or arbitration panel, which arises from a claim pursuant to s. 400.023, the licensee shall pay the judgment creditor the entire amount of the judgment, award, or settlement and all accrued interest within 60 days after the date such judgment, award, or settlement becomes final and subject to execution unless otherwise mutually agreed to in writing by the parties. Failure to make such payment shall result in additional grounds that may be used by the agency for revoking a license or for denying a renewal application or a related party change of ownership application as provided in this section.

(2) The agency is deemed notified of an unsatisfied judgment or settlement under subsection (1) when a certified copy of the judgment and a certified copy of a valid judgment lien certificate, filed in accordance with ss. 55.202 and 55.203, are served to the agency by process server or received by certified mail, return receipt requested. Within 60 days after receiving such documents, the agency shall notify the licensee by certified mail, return receipt requested, that it is subject to disciplinary action unless, within 30 days after the date of mailing the notice, the licensee:

(a) Shows proof that the unsatisfied judgment or settlement has been paid in the amount specified;

(b) Shows proof of the existence of a payment plan mutually agreed upon by the parties in writing;

(c) Furnishes the agency with a copy of a timely filed notice of appeal;

(d) Furnishes the agency with a copy of a court order staying execution of the final judgment; or

(e) Shows proof by submitting an order from a court or arbitration panel that is overseeing any action seeking indemnification from an insurance carrier or other party that the licensee believes is required to pay the award.

(3) If the agency is placed on notice pursuant to subsection (2) and proof pursuant to subsection (2) is not provided by the licensee, the agency shall issue an emergency order pursuant to s. 120.60 declaring that the facility lacks financial ability to operate and a notice of intent to revoke or deny a license.

(4) If, after the agency is placed on notice pursuant to subsection (2) and:

(a) The license is subject to renewal, the agency may deny the license renewal unless compliance with this section is achieved; and

(b) A change of ownership application for the facility at issue is submitted by the licensee, by a person or entity identified as having a controlling interest in the licensee, or by a related party, the agency shall deny the change of ownership application unless compliance with this section is achieved.

History.—s. 3, ch. 2014-83.

CHAPTER 429

ASSISTED CARE COMMUNITIES

PART I

ASSISTED LIVING FACILITIES

(ss. 429.01-429.55)

429.28 Resident bill of rights.—

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(a) Live in a safe and decent living environment, free from abuse and neglect.

(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.

(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.

(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.

(g) Share a room with his or her spouse if both are residents of the facility.

(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.

(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.

(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and, if applicable, Disability Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Abuse Hotline operated by the Department of Children and Families, and Disability Rights Florida.

(3)(a) The agency shall conduct a survey to determine general compliance with facility standards and compliance with residents' rights as a prerequisite to initial licensure or licensure renewal. The agency shall adopt rules for uniform standards and criteria that will be used to determine compliance with facility standards and compliance with residents' rights.

(b) In order to determine whether the facility is adequately protecting residents' rights, the biennial survey shall include private informal conversations with a sample of residents and consultation with the ombudsman council in the district in which the facility is located to discuss residents' experiences within the facility.

(c) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.

(d) The agency may conduct periodic followup inspections as necessary to monitor the compliance of facilities with a history of any class I, class II, or class III violations that threaten the health, safety, or security of residents.

(e) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.

(4) The facility shall not hamper or prevent residents from exercising their rights as specified in this section.

(5) A facility or employee of a facility may not serve notice upon a resident to leave the premises or take any other retaliatory action against any person who:

(a) Exercises any right set forth in this section.

(b) Appears as a witness in any hearing, inside or outside the facility.

(c) Files a civil action alleging a violation of the provisions of this part or notifies a state attorney or the Attorney General of a possible violation of such provisions.

(6) A facility that terminates the residency of an individual who participated in activities specified in subsection (5) must show good cause in a court of competent jurisdiction. If good cause is not shown, the agency shall impose a fine of $2,500 in addition to any other penalty assessed against the facility.

(7) Any person who submits or reports a complaint concerning a suspected violation of the provisions of this part or concerning services and conditions in facilities, or who testifies in any administrative or judicial proceeding arising from such a complaint, shall have immunity from any civil or criminal liability therefor, unless such person has acted in bad faith or with malicious purpose or the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

History.—ss. 12, 31, ch. 80-198; s. 2, ch. 81-318; ss. 55, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; s. 65, ch. 91-221; s. 19, ch. 91-263; ss. 23, 38, 39, ch. 93-216; s. 778, ch. 95-148; s. 11, ch. 95-418; s. 17, ch. 98-80; s. 20, ch. 2000-263; ss. 76, 143, ch. 2000-349; s. 63, ch. 2000-367; s. 38, ch. 2001-45; ss. 2, 51, ch. 2006-197; s. 37, ch. 2015-31; s. 13, ch. 2015-126.

Note.—Former s. 400.428.

429.29 Civil actions to enforce rights.—

(1) Any person or resident whose rights as specified in this part are violated shall have a cause of action. The action may be brought by the resident or his or her guardian, or by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death. If the action alleges a claim for the resident's rights or for negligence that caused the death of the resident, the claimant shall be required to elect either survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the action alleges a claim for the resident's rights or for negligence that did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident. The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual damages, and punitive damages for violation of the rights of a resident or negligence. Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover the costs of the action and a reasonable attorney's fee assessed against the defendant not to exceed $25,000. Fees shall be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought together with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. Sections 429.29-429.298 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a resident arising out of negligence or a violation of rights specified in s. 429.28. This section does not preclude theories of recovery not arising out of negligence or s. 429.28 which are available to a resident or to the agency. The provisions of chapter 766 do not apply to any cause of action brought under ss. 429.29-429.298.

(2) In any claim brought pursuant to this part alleging a violation of resident's rights or negligence causing injury to or the death of a resident, the claimant shall have the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

Nothing in this part shall be interpreted to create strict liability. A violation of the rights set forth in s. 429.28 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency shall be evidence of negligence but shall not be considered negligence per se.

(3) In any claim brought pursuant to this section, a licensee, person, or entity shall have a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances.

(4) In any claim for resident's rights violation or negligence by a nurse licensed under part I of chapter 464, such nurse shall have the duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(5) Discovery of financial information for the purpose of determining the value of punitive damages may not be had unless the plaintiff shows the court by proffer or evidence in the record that a reasonable basis exists to support a claim for punitive damages.

(6) In addition to any other standards for punitive damages, any award of punitive damages must be reasonable in light of the actual harm suffered by the resident and the egregiousness of the conduct that caused the actual harm to the resident.

(7) The resident or the resident's legal representative shall serve a copy of any complaint alleging in whole or in part a violation of any rights specified in this part to the Agency for Health Care Administration at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. The requirement of providing a copy of the complaint to the agency does not impair the resident's legal rights or ability to seek relief for his or her claim.

History.—ss. 12, 32, ch. 80-198; s. 2, ch. 81-318; ss. 56, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; ss. 24, 38, 39, ch. 93-216; s. 779, ch. 95-148; s. 31, ch. 99-225; s. 39, ch. 2001-45; ss. 2, 52, ch. 2006-197.

Note.—Former s. 400.429.

429.293 Presuit notice; investigation; notification of violation of residents' rights or alleged negligence; claims evaluation procedure; informal discovery; review; settlement offer; mediation.—

(1) As used in this section, the term:

(a) "Claim for residents' rights violation or negligence" means a negligence claim alleging injury to or the death of a resident arising out of an asserted violation of the rights of a resident under s. 429.28 or an asserted deviation from the applicable standard of care.

(b) "Insurer" means any self-insurer authorized under s. 627.357, liability insurance carrier, joint underwriting association, or uninsured prospective defendant.

(2) Prior to filing a claim for a violation of a resident's rights or a claim for negligence, a claimant alleging injury to or the death of a resident shall notify each prospective defendant by certified mail,

return receipt requested, of an asserted violation of a resident's rights provided in s. 429.28 or deviation from the standard of care. Such notification shall include an identification of the rights the prospective defendant has violated and the negligence alleged to have caused the incident or incidents and a brief description of the injuries sustained by the resident which are reasonably identifiable at the time of notice. The notice shall contain a certificate of counsel that counsel's reasonable investigation gave rise to a good faith belief that grounds exist for an action against each prospective defendant.

(3)(a) No suit may be filed for a period of 75 days after notice is mailed to any prospective defendant. During the 75-day period, the prospective defendants or their insurers shall conduct an evaluation of the claim to determine the liability of each defendant and to evaluate the damages of the claimants. Each defendant or insurer of the defendant shall have a procedure for the prompt evaluation of claims during the 75-day period. The procedure shall include one or more of the following:

1. Internal review by a duly qualified facility risk manager or claims adjuster;
2. Internal review by counsel for each prospective defendant;
3. A quality assurance committee authorized under any applicable state or federal statutes or regulations; or
4. Any other similar procedure that fairly and promptly evaluates the claims.

Each defendant or insurer of the defendant shall evaluate the claim in good faith.

(b) At or before the end of the 75 days, the defendant or insurer of the defendant shall provide the claimant with a written response:

1. Rejecting the claim; or
2. Making a settlement offer.

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer of the defendant to reply to the notice within 75 days after receipt shall be deemed a rejection of the claim for purposes of this section.

(4) The notification of a violation of a resident's rights or alleged negligence shall be served within the applicable statute of limitations period; however, during the 75-day period, the statute of limitations is tolled as to all prospective defendants. Upon stipulation by the parties, the 75-day period may be extended and the statute of limitations is tolled during any such extension. Upon receiving written notice by certified mail, return receipt requested, of termination of negotiations in an extended period, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(5) No statement, discussion, written document, report, or other work product generated by presuit claims evaluation procedures under this section is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit claims evaluation procedure. Any licensed physician or registered nurse may be retained by either party to provide an opinion regarding the reasonable basis of the claim. The presuit opinions of the expert are not discoverable or admissible in any civil action for any purpose by the opposing party.

(6) Upon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery as provided in subsection (7).

(7) Informal discovery may be used by a party to obtain unsworn statements and the production of documents or things, as follows:

(a) *Unsworn statements.*—Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of claims evaluation and are not discoverable or admissible in any civil action for any purpose by any party. A party seeking to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

(b) *Documents or things.*—Any party may request discovery of relevant documents or things. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce relevant and discoverable documents or things within that party's possession or control, if in good faith it can reasonably be done within the timeframe of the claims evaluation process.

(8) Each request for and notice concerning informal discovery pursuant to this section must be in writing, and a copy thereof must be sent to all parties. Such a request or notice must bear a certificate of service identifying the name and address of the person to whom the request or notice is served, the date of the request or notice, and the manner of service thereof.

(9) If a prospective defendant makes a written settlement offer, the claimant shall have 15 days from the date of receipt to accept the offer. An offer shall be deemed rejected unless accepted by delivery of a written notice of acceptance.

(10) To the extent not inconsistent with this part, the provisions of the Florida Mediation Code, Florida Rules of Civil Procedure, shall be applicable to such proceedings.

(11) Within 30 days after the claimant's receipt of defendant's response to the claim, the parties or their designated representatives shall meet in mediation to discuss the issues of liability and damages in accordance with the mediation rules of practice and procedures adopted by the Supreme Court. Upon stipulation of the parties, this 30-day period may be extended and the statute of limitations is tolled during the mediation and any such extension. At the conclusion of mediation, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

History.—s. 40, ch. 2001-45; ss. 2, 53, ch. 2006-197.

Note.—Former s. 400.4293.

429.294 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility within 10 days, in accordance with the provisions of [1]s. 400.145, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

(2) No facility shall be held liable for any civil damages as a result of complying with this section.

History.—s. 41, ch. 2001-45; s. 2, ch. 2006-197.

[1]**Note.**—Section 400.145 formerly provided for 7 days to provide copies of current resident records and 10 days to provide copies of former resident records. The section was substantially reworded by s. 4, ch. 2014-83, to provide 14 days for compliance regarding current resident records and 30 days for former resident records.

Note.—Former s. 400.4294.

429.295 Certain provisions not applicable to actions under this part.—An action under this part for a violation of rights or negligence recognized herein is not a claim for medical malpractice, and the provisions of s. 768.21(8) do not apply to a claim alleging death of the resident.

History.—s. 42, ch. 2001-45; s. 2, ch. 2006-197.

Note.—Former s. 400.4295.

429.296 Statute of limitations.—

(1) Any action for damages brought under this part shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered, or should have been discovered with the exercise of due diligence; however, in no event shall the action be commenced later than 4 years from the date of the incident or occurrence out of which the cause of action accrued.

(2) In those actions covered by this subsection in which it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event not more than 6 years from the date the incident giving rise to the injury occurred.

(3) This section shall apply to causes of action that have accrued prior to the effective date of this section; however, any such cause of action that would not have been barred under prior law may be brought within the time allowed by prior law or within 2 years after the effective date of this section, whichever is earlier, and will be barred thereafter. In actions where it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event more than 4 years from the effective date of this section.

History.—s. 43, ch. 2001-45; s. 2, ch. 2006-197.

Note.—Former s. 400.4296.

429.297 Punitive damages; pleading; burden of proof.—

(1) In any action for damages brought under this part, no claim for punitive damages shall be permitted unless there is a reasonable showing by evidence in the record or proffered by the claimant which would provide a reasonable basis for recovery of such damages. The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of civil procedure. The rules of civil procedure shall be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages. No discovery of financial worth shall proceed until after the pleading concerning punitive damages is permitted.

(2) A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct or gross negligence. As used in this section, the term:

(a) "Intentional misconduct" means that the defendant had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage.

(b) "Gross negligence" means that the defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.

(3) In the case of an employer, principal, corporation, or other legal entity, punitive damages may be imposed for the conduct of an employee or agent only if the conduct of the employee or agent meets the criteria specified in subsection (2) and:

(a) The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;

(b) The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or

(c) The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.

(4) The plaintiff must establish at trial, by clear and convincing evidence, its entitlement to an award of punitive damages. The "greater weight of the evidence" burden of proof applies to a determination of the amount of damages.

(5) This section is remedial in nature and shall take effect upon becoming a law.

History.—s. 44, ch. 2001-45; s. 2, ch. 2006-197.

Note.—Former s. 400.4297.

429.298 Punitive damages; limitation.—

(1)(a) Except as provided in paragraphs (b) and (c), an award of punitive damages may not exceed the greater of:

1. Three times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or

2. The sum of $1 million.

(b) Where the fact finder determines that the wrongful conduct proven under this section was motivated primarily by unreasonable financial gain and determines that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the managing agent, director, officer, or other person responsible for making policy decisions on behalf of the defendant, it may award an amount of punitive damages not to exceed the greater of:

1. Four times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or

2. The sum of $4 million.

(c) Where the fact finder determines that at the time of injury the defendant had a specific intent to harm the claimant and determines that the defendant's conduct did in fact harm the claimant, there shall be no cap on punitive damages.

(d) This subsection is not intended to prohibit an appropriate court from exercising its jurisdiction under s. 768.74 in determining the reasonableness of an award of punitive damages that is less than three times the amount of compensatory damages.

(e) In any case in which the findings of fact support an award of punitive damages pursuant to paragraph (b) or paragraph (c), the clerk of the court shall refer the case to the appropriate law enforcement agencies, to the state attorney in the circuit where the long-term care facility that is the subject of the underlying civil cause of action is located, and, for multijurisdictional facility owners, to the Office of the Statewide Prosecutor; and such agencies, state attorney, or Office of the Statewide Prosecutor shall initiate a criminal investigation into the conduct giving rise to the award of punitive damages. All findings by the trier of fact which support an award of punitive damages under this paragraph shall be admissible as evidence in any subsequent civil or criminal proceeding relating to the acts giving rise to the award of punitive damages under this paragraph.

(2) The claimant's attorney's fees, if payable from the judgment, are, to the extent that the fees are based on the punitive damages, calculated based on the final judgment for punitive damages. This subsection does not limit the payment of attorney's fees based upon an award of damages other than punitive damages.

(3) The jury may neither be instructed nor informed as to the provisions of this section.

(4) Notwithstanding any other law to the contrary, the amount of punitive damages awarded pursuant to this section shall be equally divided between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund, in accordance with the following provisions:

(a) The clerk of the court shall transmit a copy of the jury verdict to the Chief Financial Officer by certified mail. In the final judgment, the court shall order the percentages of the award, payable as provided herein.

(b) A settlement agreement entered into between the original parties to the action after a verdict has been returned must provide a proportionate share payable to the Quality of Long-Term Care Facility Improvement Trust Fund specified herein. For purposes of this paragraph, a proportionate share is a 50-percent share of that percentage of the settlement amount which the punitive damages portion of the verdict bore to the total of the compensatory and punitive damages in the verdict.

(c) The Department of Financial Services shall collect or cause to be collected all payments due the state under this section. Such payments are made to the Chief Financial Officer and deposited in the appropriate fund specified in this subsection.

(d) If the full amount of punitive damages awarded cannot be collected, the claimant and the other recipient designated pursuant to this subsection are each entitled to a proportionate share of the punitive damages collected.

(5) This section is remedial in nature and shall take effect upon becoming a law.

History.—s. 45, ch. 2001-45; s. 419, ch. 2003-261; s. 2, ch. 2006-197.

Note.—Former s. 400.4298.

WORKSHOP ON LONG-TERM CARE RESIDENT RIGHTS

DECLARATION OF RIGHTS COMMITTEE
January 11, 2018
1 PM – 5 PM
Room 105 – Gerald L. Gunter Building
2540 Shumard Oaks Boulevard
Tallahassee, Florida

WORKSHOP PACKET

TAB 2

By Commissioner Heuchan

heuchanb-00089B-17 201788__

A proposal to create
a new section in Article I of the State Constitution to establish certain rights for residents of assisted living facilities and nursing home facilities in this state.

Be It Proposed by the Constitution Revision Commission of Florida:

A new section is added to Article I of the State Constitution to read:

ARTICLE I
DECLARATION OF RIGHTS

Nursing Home and Assisted Living Facility Residents' Bill of Rights.—

(a) In addition to any other rights provided by law, the residents of nursing home facilities and assisted living facilities are entitled to be treated courteously, fairly, and with the fullest measure of dignity by the facilities' owners, operators, employees, professionals, and others who care for residents at such facilities.

(b) The right to be treated courteously, fairly, and with the fullest measure of dignity includes, but is not limited to:

(1) The right to adequate and appropriate health care and treatment that puts the residents' needs and best interests first.

(2) The right to a safe, clean, comfortable, and homelike environment that protects residents from harm and takes into account this state's challenges with respect to climate and natural disasters.

(3) The right to access courts and a jury system that allows for a speedy trial and relief and remedies, without

limitations, for loss, injury, and damages caused to residents and their families by the abuse, negligence, neglect, exploitation, or violation of residents' rights by the facilities' owners, operators, employees, professionals, and others who care for residents at such facilities.

(4) The right to know and hold accountable all persons or entities who own or operate the facilities, including the persons who are the owners of entities which own or operate the facilities.

(5) The right that the facilities will have the financial resources or liability insurance in order to ensure that residents and their families are justly compensated for any loss, injury, and damage they suffer because of abuse, negligence, neglect, exploitation, or violations of residents' rights by owners, operators, employees, professionals, and others who care for residents at such facilities.

(6) The right to have the state require and implement regular accountability, audit, and review programs that oversee the facilities, require annual cost reports for reimbursement, and safeguard the health and quality of life of the facilities' residents.

(c) Nursing home facilities and assisted living facilities, including the owners, operators, employees, professionals, and others who care for residents at such facilities, may not solicit, require, or ask residents, their families, their legal representatives, and their duly appointed guardians to waive the rights of residents provided herein or by other laws.

(d) Any rights granted under this section do not dissolve upon the death or incapacity of a resident. Upon the death or

incapacity of a resident, such resident's heirs, estate, family members, legal representatives, or other appropriate persons are entitled to any of the rights granted under this section and as may be provided by general law.

(e) This section is self-executing and does not require any implementing legislation or administrative rules. The legislature may enact legislation that protects, furthers, and enhances the rights established by this section. In addition, an executive branch agency may adopt rules, in accordance with general law, that protect, further, and enhance the rights of residents established by this section.

(f) Any statute, rule, common law, or other law that is inconsistent with the rights granted under this section is preempted.

WORKSHOP ON LONG-TERM CARE RESIDENT RIGHTS

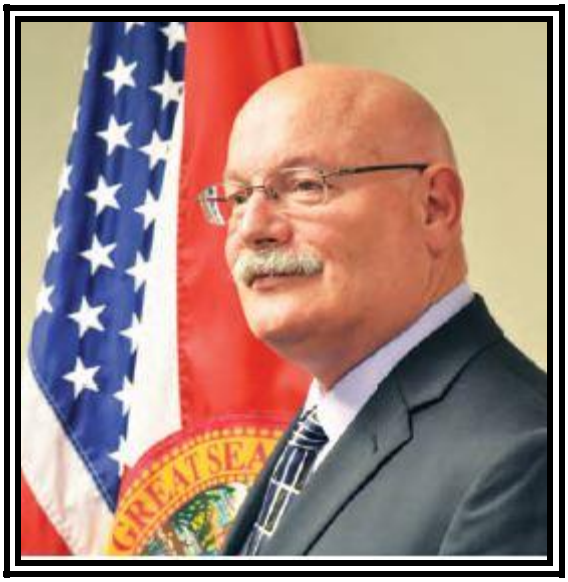
DECLARATION OF RIGHTS COMMITTEE
January 11, 2018
1 PM – 5 PM
Room 105 – Gerald L. Gunter Building
2540 Shumard Oaks Boulevard
Tallahassee, Florida

WORKSHOP PACKET

TAB 3

CONSTITUTION REVISION COMMISSION
2017 - 2018

SPEAKER BIOGRAPHY



MICHAEL MILLIKEN

State Ombudsman
Florida Long-Term Care Ombudsman Program
Florida Department of Elder Affairs

In 2017, Michael Milliken was appointed as the State Long-Term Care Ombudsman by Department of Elder Affairs Secretary Samuel Varghese. The Long-Term Care Ombudsman Program advocates for the health, safety, welfare, and rights of individuals residing in long-term care settings.

Mr. Milliken has advocated for long-term care residents for over a decade with the Florida Long-Term Care Ombudsman Program (FLCOP). He began his career with FLCOP in 2007 as the First Coast District Manager in the five-county region of Northeast Florida. During his tenure at FLCOP he also served as the North Region Manager with program responsibilities in 45 Florida counties. Serving in these roles and personally conducting nearly 600 investigations and assessments, he possesses hands-on experience, direct knowledge, and deep insight into the advocacy needs of long-term care residents.

Mr. Milliken grew up in Maine and received his Bachelor's Degree from Excelsior College in Albany, N.Y. After a tour of duty in the U.S. Army, he entered into service with the U.S. Coast Guard where he retired as a Senior Chief Public Affairs Specialist before joining the FLCOP.

CONSTITUTION REVISION COMMISSION
2017 - 2018

SPEAKER BIOGRAPHY

LAUCHLIN T. WALDOCH, ESQ.

Co-Founder, Waldoch & McConnaughhay, P.A.
Former Chair, Elder Law Section of the Florida Bar (2001-2002)
J.D. (with honors), University of Florida
B.A. (Phi Beta Kappa), Newcomb College of Tulane University

Lauchlin T. Waldoch is the co-founder of the Tallahassee, Florida law firm of Waldoch & McConnaughhay, P.A. She devotes her time exclusively to elder law and related issues. Her practice includes wills, trusts, probate, and incapacity planning, including powers of attorney and advance directives for health care such as living wills and health care surrogate designations. A substantial aspect of her practice also involves understanding and providing guidance to clients with regard to public benefits, particularly as related to long-term care such as Veterans Benefits, Medicaid, and Managed Care.

Ms. Waldoch has substantial experience with legislative and regulatory issues affecting seniors and persons with disabilities. She is the co-founder and former Chair of the Public Policy Task Force of the Academy of Florida Elder Law Attorney's (AFELA) where she served as Director from 1999-2003. She has also served on the Board of Directors of the National Academy of Elder Law Attorneys (NAELA), served as the NAELA Florida Public Policy Liaison, and chaired the NAELA Advocacy/Litigation Special Interest Group. She is also the former Chair of the Elder Law Section of the Florida Bar. Ms. Waldoch was selected as the Elder Law Section Member of the Year in 1999 and 2005 as well as for AFELA in 2001 and 2005. She is active in numerous national, state and community organizations related to the elderly and individuals with disabilities, including the Capital Coalition on Aging, Tallahassee Senior Center, Florida State Guardianship Association, and Special Needs Alliance.

She is a Florida Bar Board Certified Elder Law attorney and designated a Certified Elder Law Attorney (CELA) by the National Elder Law Foundation.

Center for Medicare Advocacy

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RSS

Quality of Care

Share

- What is "quality of care"?
- "Quality" is an arbitrary term. How is quality of care judged?
- Is there a process for complaining about the quality of my care?
- Won't enforcing quality of care cause costs for care to increase?
- I sometimes feel "out of the loop": how can I feel more in charge of my care?
- What is available to help choose the best quality caregiver?
- What is the issue of Medicare hospital readmissions that i have heard about?

For other information, follow one of the links below or scroll down the page.

INTRODUCTION: WHAT DO WE MEAN BY QUALITY OF CARE?

Quality of care is becoming an increasingly important topic of discussion for researchers and policy advocates. However, its importance as an advocacy tool for obtaining and maintaining services is often less obvious. Such issues are integral to understanding who receives care, the promptness and appropriateness of care, and to understanding systemically the reasons why quality and access problems occur. A focus on quality allows beneficiaries and their advocates to participate in the development of appropriate monitoring and enforcement of quality standards. The Center for Medicare Advocacy focuses on quality not only to raise general consumer awareness of this important topic, but to highlight the use of this growing body of knowledge by advocates to secure and expand services. Racial and ethnic minority populations and the larger disabled community should pay particular attention to these issues because these groups tend to be less supported by the health care community.

The U.S. Institute of Medicine (IOM) defines 'quality' as: the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. What this really means is that each individual consumer should receive the best possible health care available every time services are needed.

Health care providers should provide care that meets the needs of each individual patient, including the use of appropriate advances in medical technology. health care should also be non-discriminatory, providing the same quality of service regardless of race, ethnicity, age, sex or health status.

Quality of Care: Issues and Concerns

In November 1999, the Institute of Medicine published "To Err is Human," a groundbreaking study of the U.S. health care system. Their findings indicated that at least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented. (Institute of Medicine 1999) Since that time, multiple studies have been conducted on various issues and results have repeatedly substantiated the IOM's claims.

Quality of care remains an area for improvement, despite the increased attention it has received in recent years. Though researchers and survey organizations have focused on safety and quality through public campaigns and quality measurement and reporting, largely of a voluntary nature, little has been done with this information to make changes that would improve quality.

Everyone, nonetheless, has the right to receive in a timely manner care that meets the highest standards for quality health care. It is important that consumers and advocates understand the right to high quality care, and move to assure that quality care becomes universal. The task becomes one of working to translate written standards into practiced norms of treatment and care, including establishing an environment or "culture" that promotes patient safety and care of the highest quality.

Resource Tip: Make sure you are getting safe, quality care. See the Guide to Choosing Quality Care (http://www.jointcommission.org/topics/default.aspx?k=822&b=) from the Agency for Health Care Research and Quality and Speak Up™ from the Joint Commission on Accreditation of health care Organizations' (JCAHO).

Update: Patient Safety Five Years After To Err Is Human (.pdf)

Perception versus reality: The "Quality Chasm"

Repeated studies have shown that substandard care persists in the United States. In a 2003 article published in the New England Journal of Medicine, the RAND Corporation found that "...On average, Americans receive about half of recommended medical care processes....the gap between what we know works and what is actually done is substantial enough to warrant attention." (McGlynn, Elizabeth, et.al. 2003.) These 'quality gaps' are being persistently found as more and more organizations focus on this issue. Recent reports from the IOM produced these indicators:

- Only 55% of patients in a recent random sample of adults received recommended care, with little difference found between care recommended for prevention, to address acute episodes or to treat chronic conditions
- The lag between the discovery of more effective forms of treatment and their incorporation into routine patient care averages 17 years.
- 18,000 Americans die each year from heart attacks because they did not receive preventative medications, although they were eligible for them.
- Medical errors kill more people per year than breast cancer, AIDS, or motor vehicle accidents.

(Institute of Medicine 2003, http://content.nejm.org/cgi/content/full/348/26/2635)

Resource Tip: Take Action to Ensure that You get Quality Care with 20 Tips to Help Prevent Medical Errors from the Agency for health care Research and Quality.

A failure to deliver: causes of sub-standard care

What is wrong? The causes of sub-standard care can be broken down into two equally important parts:

- Structural factors in our health care system which result in poor quality care
- Structural factors in our society which result in poor care.

The first category can affect all Americans at random. The second disproportionately affects minority populations such as women, racial and ethnic minorities, elderly persons or disabled persons. Because these two causal categories impact quality of

care so strongly, it is imperative that advocates be aware of the unique problems posed by each category as well as how to deal with them to create the best solutions.

America's health care system, while among the best in the world, faces multiple systemic barriers to providing the best care possible to every patient. In its 2003 State of Health Care Quality Report, the National Committee for Quality Assurance cites six main factors that prevent many Americans from receiving the highest standards of care. They include:

- The slow pace with which new technology, information and guidelines are adopted by the health care industry.
- Current and historical lack of government incentives, standards, or direction.
- Inconsistent care by physicians and other health care professionals.
- Lack of widespread collaboration and information sharing among health care organizations.
- The failure of existing financing and reimbursement mechanisms to provide incentives for excellence.
- The failure of the health care system to measure and report on performance.

(National Committee for Quality Assurance 2003)

These problems are widespread and endemic to the health care system, and need to be addressed on a national level, as well as by each individual facility.

There are many people who do not receive quality care because of their race, ethnicity, gender, socio-economic status, age or health status. As evidenced in the current national debates over universal health care, not everyone has insurance, or access to health care. Beyond that, there are many specific groups that often find themselves unable to access the same quality of care as the general population. Some of these groups include: women, children, elderly, racial and ethnic minority groups, residents of rural areas, disabled or mentally handicapped persons, people in need of long-term-care, and others with special needs. In the 2003 National health care Disparities Report, the Agency for health care Research and Quality cite four factors that are key barriers to the provision of quality care. These include:

- Entry into the Health care system; the accessibility of care.
- Structural Barriers; the ease of navigating through the system to receive the best care.
- Patients' Perceptions; cultural and socio-economic relationship problems between patients and providers.
- Utilization of care; accessing appropriate care at the appropriate time.

(Agency for health care Research and Quality 2003)

These factors result in sometimes severe disparities in the quality of health care provided to the general population and care received by minority populations. It is important for both consumers and advocates to be aware of the multiple factors causing such disparities of care, and to learn how to combat them.

Resource Tip: Learn what providers can do to avoid health care disparities in the Provider's Guide to Quality and Culture.

Fact Sheet (.PDF format): Health Care Disparities: Facts and Issues

The Beneficiary Quality of Care Complaint Process

What can a beneficiary do if he or she believes that the medical care that the doctor prescribed was inadequate or incorrect in some way? In Medicare, beneficiaries may request a "quality of care review" and question the level or kind of services provided by their practitioner or provider.

The Centers for Medicare & Medicaid Services (CMS) oversees the Quality Improvement Organization (QIO) program, which is responsible for working with both providers and beneficiaries to improve the quality of health care delivered to Medicare beneficiaries. The program is a network of 43 contractors – some for-profit, most not-for-profit – with each one representing one or more of the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.

As part of its overall mission to improve the quality of health care for Medicare beneficiaries, the Social Security Act places the

responsibility for investigating and resolving "quality of care" complaints from Medicare beneficiaries with the QIOs. A quality review is defined as "a review focused on determining whether the quality of the services meets professionally recognized standards of care." Complaints triggering review can be about the quality of medical care, including concerns about the receipt of poor or inadequate treatment from health care workers, incorrect or inadequate medication, inappropriate or failed surgeries and procedures, or the premature discharge from a hospital.

Generally, beneficiary concerns about non-medical services that are ancillary to the care that they received are not considered to be reviewable by QIOs. For instance, during a hospital stay if a patient feels that he or she did not receive enough food or that the room temperature was uncomfortable, these issues are not considered to be "quality of care" complaints that the QIOs can review. Matters of this sort should be addressed through the health care provider's grievance process.

Resource Tips:

Find the Quality Improvement Organization (QIO) covering the area in which the hospital is located – http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793

Quality of care complaint form: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms10287.pdf.

General Medicare information about quality of care complaints: http://www.medicare.gov/claims-and-appeals/file-a-complaint/complaints.html.

For more information on how to file a complaint see http://www.medicareadvocacy.org/new-procedures-for-review-of-quality-of-care-complaints/.

The Center for Medicare Advocacy recently convened a conference with key stakeholders on Quality Improvement Organizations and the beneficiary complaint process. For more information on the conference, please see Beyond QIO: Modeling A Medicare Beneficiary Complaint Process For Quality Of Care.

On Thursday, August 2, 2007, Senators Chuck Grassley (R-IA) and Max Baucus (D-MT) introduced new legislation that would create a new organization to oversee the beneficiary quality of care complaint process, thereby removing that function from the QIOs. This action was one of the key recommendations in the 2006 Institute of Medicine report, Medicare's Quality Improvement Program: Maximizing Potential. The full text of the bill is available here: S. 1947.

What are the Standards of care by which Quality is judged?

There are several organizations that monitor the quality of care given by health care providers and set standards of acceptable care. Some of the major ones include: The Joint Commission on Accreditation of health care Organizations (JCHAO), Leapfrog, The American Health Quality Association, the Institute for Safe Medication Practices, The National Center for health care Leadership, the National Coalition for Quality Health Care, The National Committee for Quality Assurance, the National Health Quality Forum, and Center for Medicare and Medicaid Services (CMS).

Standards affect the accreditation status of hospitals and other health care facilities, and include many point-by-point processes of standard care with which all accredited hospitals must comply. Health care facilities are periodically surveyed by the standard-setting organization to determine their level of compliance with the organization's standards of care. The facility's accreditation status is then assessed and the report made available to consumers. The idea is that if a facility is found to be in compliance with the standards, it is accredited, and consumers will be able to know that they will receive care from that facility in line with the published standards.

There has been some criticism regarding the effectiveness and appropriateness of these standards. A consortium of employers called Leapfrog that has banded together to advocate for quality improvement has been specifically criticized. However, independent studies of the impact of standards on quality of care are few and far between. Most information on how well the standards work to effectively promote change comes from the standard setting organizations themselves. Because of this, it is important for consumers and advocates to be especially careful when relying on data gathered from these sources. It is helpful to compare more than one study to ensure a complete picture of the situation.

Resource Tip: Check out the accreditation status of health care facilities online at the JCHAO's Quality Check site.

Quality reporting systems: How to choose the best care givers?

Although some consumers are aware that quality problems exist, it is difficult to know how to choose a health care provider on the basis of quality of care. At the present time, there is no consistent or organized national system of quality reporting in the United States health care sector. Though private and public plans alike are making quality information available to their members (most notably CMS's Hospital Compare and Nursing Home Compare), most consumers rely on word-of-mouth recommendations to choose their health care providers. This is problematic, as reputation is often based on anecdotal evidence.

To improve quality of care, reporting systems must become more comprehensive, standardized and widely available. Plans, hospitals and other providers must then use the information they report to conduct meaningful reviews and make quality improvement changes. Measures must also be taken to encourage beneficiaries to utilize the available information when choosing their health care providers. Beneficiaries should exercise caution however, as data are presented in a variety of ways depending on the information source, sometimes causing confusion or incorrect interpretation. Most measures focus on one particular detail of care and should not be used as a proxy to measure overall quality. Many people see the internet becoming a valuable tool in the future of quality reporting, increasing the ease both of collecting and disseminating information about the quality of care. Because there is no national quality reporting system however, patients should verify the reliability of their sources. (Bates, David and Gawande, Atul. 2000)

Resource tip: The Agency for health care Research and Quality now has a website to help consumers choose the best health care provider for them. It can be found at www.ahrq.gov/consumer/qnt/.

Fact Sheet (.PDF): Reporting on Quality for Consumers

Also see our article on the Consumer Assessment of health care Providers and Systems (CAHPS) program.

What is the Business Case for Quality?

Although the incentives to provide quality care seem obvious, for many looking at the profit margins, there is a need to make a 'business case' for quality improvement. Many health care providers, focused on the "bottom line" profit margin, fail to take measures to improve quality because the improvements will cost money. Indeed, many quality improvements, while they may have a positive impact on patients, provide only marginal savings or profits to the health care facilities themselves. Without proof that there are indeed economic incentives to improve quality, it is unlikely that the private sector will move with any speed towards adopting proven quality improvements. (Leatherman, Shelia, et. al.,"The Business Case for Quality: Case Studies and an Analysis" Health Affairs, Vol 22, No. 2, March/April 2003, p. 18.) This lack of economic impetus provides a strong case for a working federal regulatory system that would ensure compliance with quality standards regardless of the economic consequences to the facility.

The structure of payment systems is one of the largest factors affecting the business case for quality. In many cases, because of the way our insurance system is structured, payment is unrelated to quality of care and consumers have little or no choice of health care providers. As many Americans rely on health benefits received from their employers, their choices of plans and providers are limited to those covered in the employer's plan. Similarly, the cost of medical procedures or care is determined independently between the employer's plan and the health care provider before care is ever received. The payment is completely independent of the quality of care given. Therefore, care providers have no incentive to provide quality care; the consumer cannot leave to choose another care giver, and cannot refuse to pay for bad care.

According to a study by the Agency for health care Research, "almost half (45%) of respondents with employer-based coverage say they are offered only one health plan through their work, leaving them with no selection of plans to compare and, understandably, less interested in comparative information." ("Americans as Health Care Consumers: The Role of Quality Information," 1/26/2003 www.ahrq.gov/qual/kffhigh.htm) There is a great need to change the system to both educate consumers to be sensitive to changes in quality of service, and to align payment with quality of care provided.

Resource Tip: Unfortunately, a firm business case for quality has not yet been established. For a more in depth look into this issue, take a look at NCQA's site on The Business Case for Quality.

Fact Sheet (.PDF): The Business Case For Quality: Facts and Figures

PAY-FOR-PERFORMANCE

Insurance companies, large corporations providing health benefits to their employees, Medicare, and other health care purchasers are looking to improve the quality of health care and control costs by changing the way they pay for health care – paying doctors, hospitals, and other providers more for high quality care, and less for poor quality care. This approach is often called pay-for-

performance or value-based purchasing and is gaining widespread popularity among private and public payers[1], despite the fact that no systematic study of the effectiveness of such programs exists[2]. Varying payment based on quality is an attempt to address the persistent and well documented "quality chasm" in our health care system[3], but details of the efficacy of such programs require further study.

While care quality, unfortunately, varies by location, population, and procedure[4], the United States nevertheless spends unprecedented amounts on health care regardless of quality or consistency. Most payment systems today reimburse hospitals, doctors, and other providers based on the quantity of services, with little review of appropriateness or whether the procedure resulted in the desired outcomes. Many believe that this system is one of the primary contributors to skyrocketing health care costs. In 2003, $1.7 trillion was spent on health care, representing 15.3% of Gross Domestic Product and a near 150% increase in spending since 1990.[5] This disconnect between the cost of care and the quality of that care has moved both private and public health care purchasers to leverage their position as payers to force providers to make quality improvements. At present, programs tend tooffer annual reward or bonus payments on top of the provider's regular income, representing an increase of up to 5%, to those who simply report quality data. In the future, these programs will condition payment on quality improvement and achievement.

Pay-for-performance is designed to respond to criticisms of the current payment structure, which rewards providers based on the quantity of services provided, regardless of quality. In the current system, a provider who makes investments in quality, resulting in fewer visits with the patient, for example, will save the health care system money. Yet the provider will actually lose income because he or she is providing fewer actual services. Pay-for-performance, proponents argue, would correct this disincentive by passing on a portion of those savings realized from higher quality care to the providers who help implement quality improvementMeasuring quality as a function of quantity of services delivered however, whether it involves more and fewer services, is not in isolation a measure of quality. Other factors such as the appropriateness of care and the patient's preferences must be considered to make such a system practicable and reliable.

While large employers and purchasers across the country move to incorporate pay-for-performance into their payment structures, Medicare and Medicaid are forging ahead with demonstration projects. Whether an experimental program or a full-fledged reimbursement structure, the evaluation of pay-for-performance as a quality assurance tool should consider:

1. Available and agreed upon standardized quality data: Most pay-for-performance programs seek to measure quality through standardized clinical measures. Measures might rate, for example, whether a heart-attack patient received beta-blockers upon release from the hospital. Payers such as Medicare decide which quality measures facilities and physicians must follow in order to receive bonus payments. Providers who wish to receive bonus payments must collect and report data that show how well they performed on those measures.

Though pay-for-performance may seem straightforward, complexities arise when deciding precisely how to measure quality.[6] There are quality measures upon which there is agreement in the medical community, yet there are an equal number, if not more, upon which there is much uncertainty. Uncertainty may arise when there is not enough research, when research results require interpretation, or when there are multiple, equally effective treatment options available.[7] In addition, there is no single clearinghouse for the development of quality measurements on which bonuses are based. Purchasers are therefore permitted to select quality measurements of their choosing. Indeed, there is much variation in the sets of quality measurements purchasers use for performance incentive programs, and in the way it is presented and explained.[8] One purchaser may, for instance, require hospitals to report on whether they followed recommended guidelines for the treatment of a heart attack patient, while another may provide bonuses to hospitals that implement computerized patient records.

It is also important to remember that medicine evolves. The scientific community is constantly discovering new treatments and refining old guidelines. What is considered "good medicine" today may be improved upon, or conversely considered inappropriate or harmful, tomorrow. A study published in the New England Journal of Medicine highlights this issue in relation to guidelines for cardiac care. The study revealed that while guidelines recommend giving beta blockers to patients at high risk for heart complications who are entering into non-cardiac surgery, hospitals often give them to cardiac patients at low risk as well. A review of patient records revealed that this practice actually increased the risk of mortality for low risk patients by 43 percent.[9] While most pay-for-performance programs rely only on the most accepted evidence-based measures, it is important to note that even trusted standards may need adjustment. Any viable pay-for-performance program must allow for such contingencies while maintaining consistent program principles and guidelines.

2. Evaluating and weighing self-reported quality data: No national quality reporting system currently exists for many categories of health care providers. Pay-for-performance therefore relies on providers to record and submit their own data. By making payment contingent on "good" data, providers may be inclined to inflate their numbers in order to receive payment. Further, to assure quality improvement, Medicare's Quality Improvement Organizations (QIOs) are charged with helping hospitals

implement pay-for-performance. Indeed, payment to the QIOs is contingent on their getting hospitals to achieve higher quality for particular indicators. This duplicate system is not only costly (QIOs have a budget of over $1 billion over three years, while Medicare is setting aside $21 million over three years for bonuses in its Premier, Inc. demonstration project), it also provides perverse incentives to both the providers and to the agencies responsible for oversight to game the system in order to receive bonuses.

3. The incentive to "score well" limits patient access to care: Pay-for-performance programs may provide perverse incentives for providers to limit access patients have to needed care. When performance measures are not adequate or do not exist for particular conditions, providers may be hesitant to accept patients with those conditions for fear of unfairly lowering their quality score.[10] This problem was highlighted in a study published in the Journal of the American Medical Association, which reported the inadequacy of certain clinical practice guidelines, especially when used for performance measurement purposes, for patients with multiple chronic conditions. The study concluded that there would likely be adverse drug interactions and disease complications for persons with multiple chronic conditions if the guidelines for each specific condition were followed.[11] In a pay-for-performance system, a doctor who recognizes the need to properly manage multiple conditions to avoid adverse reactions would not necessarily obtain high scores based on the clinical or performance guidelines. Such a system might therefore limit a provider's willingness to accept certain patients. A separate study on skilled nursing facilities by the Inspector General shows that reimbursement rates indeed affect providers' willingness to treat certain patients in a timely manner. In that report, the Inspector General concluded that patients whose conditions required expensive medications, treatments, or which were not adequately reimbursed experienced delays in accessing appropriate care.[12] These studies underscore the danger in oversimplifying performance measurement, as well as the complexities that arise in developing a performance measurement or variable payment system that does not discriminate against patients based on payment issues or health status.

4. Developing an appropriate balance between cost-control or cost-containment and quality: Though initially promoted as a quality improvement tool, pay-for-performance is increasingly discussed as a tool for cost-containment.[13] Many health care plans believe rising health care costs are the result of over-utilization. In their view, pay-for-performance provides an effective method to limit unnecessary services. Caution is appropriate however, as past experience has shown that access barriers such as co-payments also lower use of necessary services.[14] Using pay-for-performance to lower utilization by limiting access is an inappropriate and potentially more expensive use of a quality improvement tool.

Resource tip: Many brokers of quality information are publishing principles for pay-for-performance. These principles represent a set of first steps in the development of widely accepted program standards in this emerging field. See the American Medical Association (www.ama-assn.org/ama/pub/category/14416.html#ama), the Johns Hopkins Outcomes Evaluations Program in conjunction with American Healthways "Outcomes-Based Compensations: Pay-for-Performance Design Principles" at http://www.healthleadersmedia.com/content/145150.pdf.

When Quality Works: A Case Study

Is consistent, quality health care possible? In Pittsburgh, the answer is a resounding yes. Formed in 1997, the Pittsburgh Regional health care Initiative (PRHI) is creating an innovative model for achieving measurable and sustainable improvements in health care on a region-wide basis. Their aim is to achieve perfect patient care throughout the region using specific, patient centered goals. The PRHI consists of hundreds of clinicians, 42 hospitals, four major insurers, dozens of major and small-business health care purchasers, corporate and civic leaders, and elected officials throughout the Pittsburgh region. Although still in the developmental stages, the PRHI has achieved remarkable successes. Using a focus on leadership as a key to progress, the PRHI set four specific goals for 2003:

- Eliminate central-line associated bloodstream infections
- Eliminate medication errors
- Eliminate in-hospital mortality following coronary artery bypass graft surgery
- Share every major event or learning regionally as soon as possible

The PRHI relies on a system of working groups, real-time reporting, and aggressive problem solving systems to work towards these goals. Their achievements for 2003 will be released in February 2004. To find out more about this remarkable model click on the link above or go to http://www.prhi.org.

Resource Tip: Find out what others are doing that is working! Some statewide or regional organizations include: California's Health Scope; The Texas Business Group on Health, and the Massachusetts Health Quality Partners.

MAINTAINING DIGNITY: ADVOCACY TIPS FOR INSTITUTIONS AND PATIENTS

Patient dignity is a central, sometimes overlooked, facet of health care quality in hospitals and other institutions. Dignified care involves several aspects, the underlying theme of which is respectful, open communication between patients and providers. Patients should feel respected and involved in the decisions made about their health at all times. A lack of communication between providers and patients can cause patients to feel intimidated, confused about their plan of care, and entirely removed from the decision making process. What follows are some suggestions that advocates, institutions and patients can use to facilitate communication and promote patient dignity.

ADVOCATES AND INSTITUTIONS

- Advocates may wish to work with local hospitals to implement a system-wide protocol for staff interaction with patients. The protocol might include some simple but meaningful steps that providers can take to promote dignity:
- Knock before entering a patient's room and ask permission to enter;
- Give your name verbally and have it visibly displayed on your jacket in readable type;
- Before any procedure, ask for the patient's consent. Explain what the procedure is, why you are performing it, and how it will feel.
- Inform patients any time their care plan is altered and explain the reasons behind the changes.
- Hospitals should have an appropriate redress mechanism to document patient grievances regarding inappropriate behavior from staff. This may involve a wider effort to document patient satisfaction, an aspect Medicare should incorporate into its conditions for reimbursement or its certification requirements. Such grievance procedures should include:
- The provision of information to patients about their right to report a grievance, including how to initiate the process;
- The ability to initiate a grievance without feeling intimidated or disparaged by facility staff;
- The ability to have the grievance recorded in the patient record by someone other than the staff member in question;
- The serious review of complaints by institution administrators, with the goal of amending or implementing protocols to improve patient satisfaction and dignity.

PATIENTS

- Ask questions. It is okay to ask the doctor to repeat or explain information that is not clear. Ask the doctor to write instructions if you feel they are complicated or that you will forget them. The instructions should be legible and make sense to you.
- When possible, have a trusted family member or friend with you at all times who is willing to speak up and ask questions on your behalf.
- Ask to see physician orders for procedures being carried out by other staff. This duplicate process can make you feel more in control, and forces staff to review orders, which can reduce medical errors.
- Ask staff to explain the procedures they are performing, why they are performing them, how it will feel, and how long it will take.

These few steps can make a significant difference in a patient's health care experience. Patient-provider communication is crucial at every step of the process, from entry into a facility to discharge, and through recovery. Some of the steps outlined will not only improve patient dignity, but will also help assure patient safety.

Resource tips

For more information about what patients can do to facilitate communication with their providers and improve their safety while at the hospital and during their recovery, see the Joint Commission on Accreditation of health care Organizations' (JCAHO) Speak Up™ campaign. Medicare is also working to improve patient dignity and safety through their Medicare Health Support

pilot project, which provides chronically ill patients with health coaches help them manage their condition and keep up communication and coordination with their providers. More information is available at http://www.cms.gov/reports/downloads/MHS_Second_Report_to_Congress_October_2008.pdf. The project is described in the August 8, 2005 Associated Press article entitled "Health Coaches to Aid Medicare Patients".

Resource sheets for some states are available at: http://www.informedpatientinstitute.org/media.php#tip.

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- International Study: Privatization of Long-Term Care Facilities Does Not Lead to Greater Transparency or More Care March 23, 2016

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[1] Medicare is conducting pay-for-performance demonstration projects for hospitals, physicians and nursing homes, while five states (Iowa, Massachusetts, Rhode Island, Utah, and Wisconsin) are conducting Medicaid pay-for-performance demonstrations. Many private groups such as the Integrated Hospital Association in California and Bridges to Excellence have already incorporated pay-for-performance into their reimbursement system. The Leapfrog group has a compendium of private pay-for-performance plan organized by state and provider type, available at http://ir.leapfroggroup.org/compendium/.

[2] Rosenthal, Meredith, Rushika Fernandopulle, HyunSook Ryu Song, and Bruce Landon. "Pay for Quality: Providers' Incentives for Quality Improvement." Health Affairs. Vol. 23, No. 2. March/April 2004.

[3] The term "quality chasm" was first used in the ground breaking 2001 Institute of Medicine report Crossing the Quality Chasm, which brought to light the deep rifts in quality facing our health care system. See also AHRQ's 2004 National health care Quality Report and NCQA's 2004 State of Health Care Quality report.

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[5] Kaiser Family Foundation, Trends and Indicators in the Changing Health Care Marketplace.

[6]Garber, Alan M. "Evidence-Based Guidelines as a Foundation for Performance Incentives." Health Affairs. Vol. 24, No. 1. January/February 2005.

[7] Sepucha, Karen, Floyd Fowler Jr., and Albert Mulley Jr. "Policy Support for Patient-Centered Care: The Need for Measurable Improvements in Decision Quality." Health Affairs. Var. 54-62. 7 October 2005.

[8] A review of 51 hospital quality reporting websites listed nine separate types of sources for health quality information. Four different data sources were listed as "most frequently used": state data, CMS/JCAHO aligned core measures, Leapfrog Group data, and MedPAR. The report concluded that "there is wide variation in the measures reported by the websites, the terms used to describe those measures, the presentation formats, and the guidance given to users." "The State-of-the-Art of Online Hospital Public Reporting: A Review of Fifty-One Websites, 2nd Edition." Delmara Foundation. July 2005. Available at http://www.delmarvafoundation.org/html/content_pages/Press_Releases/08_18_05.pdf.

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[10] Rosenthal, Meredith. Hearing on Examining Pay-for-Performance Measures and Other Trends in Employer-Sponsored Health Care. House Subcommittee on Employer-Employee Relations. 17 May 2005.

[11] Boyd, Cynthia M., Johathan Darer, Chad Boult, Linda P. Fried, Lisa Boult, Albert W. Wu. "Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Diseases." Journal of the American Medical Association. Vol. 294, No. 6. 10 August 2005.

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[14] Julie Hudman and Molly O'Malley, Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations, Kaiser Commission on Medicaid and the Uninsured, April 2003, and Leighton Ku, Charging the Poor More for Health Care: Cost-Sharing in Medicaid, Center on Budget and Policy Priorities, May 7, 2003.

- Info by Topic
  - Affordable Care Act (ACA)
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  - Appeal Steps
  - Basic Introduction to Medicare
  - Chronic Conditions
  - Connecticut Consumer's Guide
  - Coverage & Appeals
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  - Glossary of Terms
  - Hearing Care and Audiology
  - Home Health Care
  - Hospice
  - Hospital
  - Improvement Standard and *Jimmo*
  - LGBT (Lesbian, Gay Bisexual and Transgender) Persons & Health: Available Resources
  - Long Term Care Commission
  - Long Term Care Hospitals
  - Medicare Advantage
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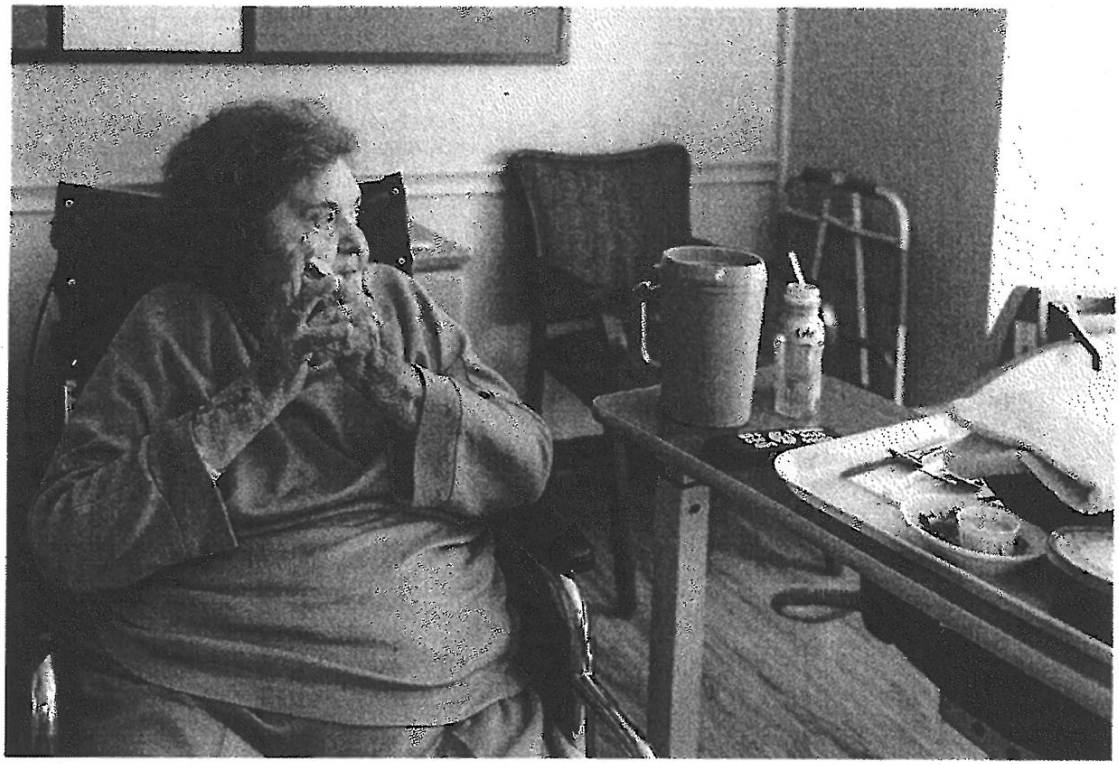


NEGLECT UNCHECKED

Infection Lapses Rampant In Nursing Homes But Punishment Is Rare

Georgina Morris fell ill to a particularly virulent strain of Clostridium difficile, known as C-diff, shortly after entering Astoria Nursing and Rehabilitation Center in Sylmar, Calif., in October 2015. (Heidi de Marco/KHN)

A Kaiser Health News analysis of federal inspection records shows that nursing home inspectors labeled mistakes in infection control as serious for only 161 of the 12,056 homes they have cited since 2014.

By **Jordan Rau** • Photos by **Heidi de Marco**
DECEMBER 22, 2017

Data journalist Elizabeth Lucas contributed to this report.

Basic steps to prevent infections — such as washing hands, isolating contagious patients and keeping ill nurses and aides from coming to work — are routinely ignored in the nation's nursing homes, endangering residents and spreading hazardous germs.

A Kaiser Health News analysis of four years of federal inspection records shows 74 percent of nursing homes have been cited for lapses in infection control — more than for any other type of health violation. In California, health inspectors have cited all but 133 of the state's 1,251 homes.

Although repeat citations are common, disciplinary action such as fines is rare: Nationwide, only one of 75 homes found deficient in those four years has received a high-level citation that can result in a financial penalty, the analysis found.

"The facilities are getting the message that they don't have to do anything," said Michael Connors of California Advocates for Nursing Home Reform, a nonprofit in San Francisco. "They're giving them low-level warnings year after year after year and the facilities have learned to ignore them."

Infections, many avoidable, cause a quarter of the medical injuries Medicare beneficiaries experience in nursing homes, according to a federal report. They are among the most frequent reasons residents are sent back to the hospital. By one government estimate, health care-associated infections may result in as many as 380,000 deaths each year.

The spread of methicillin-resistant *Staphylococcus aureus* (MRSA) and other antibiotic-resistant germs has become a major public health issue. While Medicare has begun penalizing hospitals for high rates of certain infections, there has been no similar crackdown on nursing homes.

As average hospital stays have shortened from 7.3 days in 1980 to 4.5 days in 2012, patients who a generation ago would have fully recuperated in hospitals now frequently conclude their recoveries in nursing homes. Weaker and thus more susceptible to infections, some need ventilators to help them breathe and have surgical wounds that are still healing, two conditions in which infections are more likely.

"You've got this influx of vulnerable patients but the staffing models are still geared more to the traditional long-stay resident," said Dr. Nimalie Stone, the CDC's medical epidemiologist for long-term care. "The kind of care is so much more complicated that facilities need to consider higher staffing."

The Centers for Medicare & Medicaid Services (CMS), which oversees inspections, has recognized that many nursing homes need to do more to combat contagious bugs. CMS last year required long-term care facilities to put in place better systems to prevent infections, detect outbreaks early on and limit unnecessary use of antibiotics through a stewardship program.

But the agency does not believe it has skimped on penalties. CMS said in a statement that most infection-control violations have not justified fines because they did not put residents in certain danger. For instance, if an inspector observed a nurse not washing his or her hands while caring for a resident, the agency said that would warrant a lower-level citation "unless there was an actual negative resident outcome, or there was likelihood of a serious resident outcome."

(Story continues below.)

In November, CMS waived penalties for 18 months against facilities that violate the new stewardship rule. The industry had said nursing homes needed more time to prepare. (The moratorium does not affect California's antibiotic stewardship requirement, which took effect last January.)

Holly Harmon, the senior director of clinical services at the American Health Care Association, a nursing home trade group, said the industry has made strides in combating infections through better training and encouragement for staff members to look for gaps in infection control and to speak up about them. The percentage of nursing home residents with urinary tract infections — the only type of infection all nursing homes must report to Medicare — has dropped by more than half since 2011.

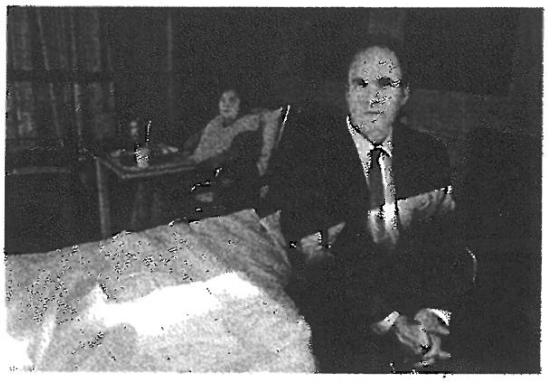
"Infection prevention control is a priority," Harmon said. "The path really is focused on continuous improvement."

> *"The facilities are getting the message that they don't have to do anything.*
>
> - MICHAEL CONNORS, CALIFORNIA ADVOCATES FOR NURSING HOME REFORM

A Sick Patient, A Family Complaint, Little Action

James Morris said he did not see such dedication when his mother, Georgina, entered Astoria Nursing & Rehabilitation Center in Sylmar, Calif., in October 2015. "Workers were coming in and out without washing their hands," he said.

While there, Georgina Morris, 86, fell ill to a particularly virulent strain of *Clostridium difficile*, known as C-diff. Morris said he insisted his 86-year-old mother, who was severely dehydrated, be sent to the hospital, where she stayed for 10 days. She has had subsequent flare-ups of the infection that required rehospitalization and, later, a fecal transplant, in which doctors transferred stool from a healthy patient into her bowels, a procedure that can treat the infection by introducing bacteria that counter the C-diff germs.



James Morris says he was disturbed by the unsanitary practices he saw at his mother's nursing home. "Workers were coming in and out without washing their hands," he says. (Heidi de Marco/KHN)

Since her Clostridium difficile infection, Georgina Morris has had subsequent flare-ups that require rehospitalization, her son says. (Heidi de Marco/KHN)

James Morris complained about Astoria to health authorities shortly after his mother left. Records show inspectors waited 18 months, until a regularly scheduled review in May 2017, before investigating her case. Such delays are common: California Department of Public Health cases remain open, on average, for nearly 20 months.

Although inspectors faulted Astoria workers for not cleaning their hands while treating Georgina Morris, they could not definitively determine whether she contracted the infection there or before she arrived. But the inspection found other infection-control lapses throughout the home. A housekeeper cleaned the wall with the same cloth used to wipe the toilet. A patient had a dirty intravenous line left in longer than necessary. The inspector watched as a worker failed to wash her hands after delivering a breakfast tray to a contagious resident in isolation.

It was the second consecutive year inspectors cited the home for substandard infection control that had the potential to harm residents. Both citations were below the level that could trigger fines.

Astoria did not respond to requests for comment.

Homes Cited Repeatedly But Few Punishments

Elsewhere, health regulators are similarly reluctant to assert that nursing home errors led to patient infections or put patients in imminent danger. Only 161 homes among the 12,056 that violated infection-control rules were cited at those higher levels since 2014, according to KHN's analysis.

The value of lower-level citations as deterrents is questionable: Authorities have cited 7,045 homes more than once over infection-control lapses, including 942 that racked up four or more violations, the analysis found.

"Perhaps a bigger stick might be more helpful," said Joseph Rodrigues, California's long-term-care ombudsman.

(Story continues below.)

In January, an inspection of Decatur Nursing and Rehabilitation in Decatur, Texas, found that one nurse didn't wash her hands after picking up a bottle of medication that fell on the floor and another nurse didn't properly clean a syringe.

Two months after citing the home, inspectors were back to issue another violation. This time, a resident died from the flu after a contagious resident who lived across the hall was let out of isolation earlier than the CDC recommends. Only then did inspectors issue a citation at the most serious level.

Decatur did not respond to requests for comment.

Inspection records show nurses and aides are often not familiar with basic protocols, such as wearing protective clothing when coming into contact with contagious residents and isolating them from others in the home and visitors. Others are not trained properly on how to clean patients. Still others, in a rush and understaffed, take shortcuts that compromise sanitary precautions.

"We've always been shocked at how often we've personally witnessed people providing care in facilities and not washing their hands, which has got to be the most basic thing in infection control and prevention," said Sherry Culp, who as Kentucky's long-term-care ombudsman advocates for aggrieved nursing home residents.

This year in New Mexico, 25 residents of the Rehabilitation Center of Albuquerque, part of the Genesis Healthcare chain, developed urinary tract infections because nurses and aides cleaned residents' genitals and catheters in unsanitary ways, according to an inspection report.

Another recurring problem stems from nurses and aides infecting residents because they come to work ill knowing they would not get paid for the sick time, said Dr. David Nace, an associate professor at the University of Pittsburgh School of Medicine.

During a norovirus outbreak in January at Fir Lane Health & Rehabilitation Center in Shelton, Wash., at least six infected employees returned to work without waiting the minimum 48 hours after their symptoms abated. Inspectors discovered the virus ultimately spread to 32 employees and 43 residents — more than 40 percent of those living in the home.

Fir Lane and the Albuquerque home did not respond to requests for comment.

"They have these draconian policies for taking off," Nace said, speaking broadly about the nursing home industry. "And if you don't have the draconian policies, then everyone takes off. That plagues the entire health care industry."

KHN's coverage of these topics is supported by John A. Hartford Foundation and

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IMPACT 05/08/2011 09:22 pm ET | **Updated** Dec 06, 2017

Report Reveals Elder Abuse In Florida Assisted Living Facilities

"Angel Joglar, 71; killed when left in a bathtub of scalding water."

"Gladys Horta, 74 years old; strapped so tightly the restraints ripped into her skin, causing a blood clot that killed her."

"Walter Cox, 75 years old; Alzheimer's patient. Wandered out of a facility for the fourth time; his body was found torn apart by an alligator."

These are just a few of the stories uncovered during *The Miami Herald*'s yearlong investigation into Florida's assisted living facilities. Thousands of documents revealed a nearly hidden world of questionable deaths, abuse, and cases of neglect towards the elderly and mentally ill.

Their project, "Neglected To Death," chronicled years of caregiver malpractice, unsuitable living conditions, and exposed Florida's state regulators' failure to monitor and enforce the laws protecting some of society's most vulnerable residents. *The Miami Herald* and *WLRN* uncovered 70 questionable deaths within the last decade alone.

While Florida supposedly holds some of the strictest elder-abuse laws in the nation, in nearly all cases recorded, *The Herald* found the vast majority of abuse and neglect by caregivers did not end in criminal charges or arrests by police agencies. *NPR* reports the AHCA found enough violations in 2008 and 2009 that it could have revoked the licenses of 70 facilities -- instead, it only closed seven.

Even more, the state's Agency for Health Care Administration, which monitors assisted living facilities, is underfunded, understaffed, and only performs inspections on each facility once every two years.

And these problems extend far beyond the borders of Florida.

Just last month, a lawsuit was filed against Washington Odd Fellows Home for patient neglect, reports *The News Tribune*.

Reports say the patient was assigned to a room on the top floor at the facility despite the fact that she had increased suicide attempts and was experiencing worsening depression and paranoia. The room had unlocked windows and a door that locked from the inside.

Last year, a North Carolina assisted living home had to declare bankruptcy for what a judge called "a pattern of neglect by under-trained and understaffed employees," reports the *Associated Press*.

Nearly every day, U.S. headlines paint a picture of seniors who are abused, neglected and exploited. And according to the National Center on Elder Abuse (NCEA), a government resource committed to ensuring older American live with with dignity, no one truly knows the extent of the problem since few cases are identified.

The NCEA website explains:

> *"Research indicates that more than one in ten elder may experience some type of abuse, but only one in five cases or fewer are reported."*

This means very few seniors get the help they need -- it's an unfortunate trend that rarely gets worthy documentation. But there are ways you can help.

First, the Miami Herald provides a list of ways to protect yourself and your loved ones, from choosing your assisted living location to knowing what to do if something goes wrong.

There are also nonprofit advocacy groups and government agencies that aim to protect against elder abuse:

The National Committee for the Prevention of Elder Abuse is a nonprofit organization dedicated to the prevention of abuse and neglect of older persons and adults with disabilities. Direct donations will help increase recognition by policy makers, professionals, and the public about elder abuse and the need for new services, maintain the website, and support affiliates in building grassroots and coalitions to meet local needs.

A similar organization, Citizens' Committee to Protect the Elderly, provides guidance, assistance, and support to families and residents of nursing homes and assisted living facilities through three different programs: The Humanitarian Visitor Program, Information and Guidance Program, and Community Service Projects. You can donate money or volunteer to visit residents directly at their locations.

However, many people still feel powerless to protect their loved ones from the perils of elder abuse. Government-sponsored advocacy websites are often woefully out-of-date and there is little information available for the public to take action without help from government officials.

We at HuffPost want to ask you if you have ever experienced, or had a family member experience elder abuse. What actions did you take and how would you suggest others protect themselves, their loved ones and others in their communities? **Please let us know by leaving a message in the comments or tweeting @HuffPostImpact with the hashtag #elderabuse.**

NEGLECTED TO DEATH

NEGLECTED TO DEATH | Part 1: Once pride of Florida; now scenes of neglect

By Rob Barry, Michael Sallah and Carol Marbin Miller

APRIL 30, 2011 05:00 AM

UPDATED JUNE 25, 2012 03:50 PM

*This is part one in a three-part series. Read part two here.*For more than a decade, Bruce Hall ran his assisted-living facility in Florida's Panhandle like a prison camp.

He punished his disabled residents by refusing to give them food and drugs. He threatened them with a stick. He doped them with powerful tranquilizers, and when they broke his rules, he beat them — sending at least one to the hospital.

"The conditions in the facility are not fit even for a dog," one caller told state agents.

When Florida regulators confronted Hall in 2004 over a litany of abuses at his facility in the rolling hills of Washington County, they said he chased them from the premises while railing against government intrusion.

Under state law, regulators could have shut down Sunshine Acres Loving Care or suspended the home's license, but they did neither. Instead, they ordered the 50-year-old Hall to see a therapist for his anger and to promise not to use "any weapon or object" on his residents — allowing him to keep his doors open for five more years.

In that time, Hall went on to break nearly every provision of Florida's assisted-living law: He threw a woman to the ground, and forced her to sleep on a box spring for six days after she urinated on her covers. Though the temperature outside reached 100 degrees, he forced his residents to live without air conditioning. And during a critical overnight shift, he fell asleep on the job while a 71-year-old woman with mental illness wandered from her bed, walked out the door and drowned in a nearby pond.

In a state where tens of thousands reside in assisted-living facilities, the case of Hall's Sunshine Acres represents everything that has gone wrong with homes once considered the pride of Florida.

Created more than a quarter-century ago, ALFs were established in landmark legislation to provide shelter and sweeping protections to some of the state's most vulnerable citizens: the elderly and mentally ill.

Tragedies revealed

But a Miami Herald investigation found that the safeguards once hailed as the most progressive in the nation have been ignored in a string of tragedies never before revealed to the public.

In Kendall, a 74-year-old woman was bound for more than six hours, the restraints pulled so tightly they ripped into her skin and killed her.

In Hialeah, a 71-year-old man with mental illness died from burns after he was left in a bathtub filled with scalding water.

In Clearwater, a 75-year-old Alzheimer's patient was torn apart by an alligator after he wandered from his assisted-living facility for the fourth time.

The deaths highlight critical breakdowns in a state enforcement system that has left

thousands of people to fend for themselves in dangerous and decrepit conditions.

The Miami Herald found that the Agency for Health Care Administration, which oversees the state's 2,850 assisted-living facilities, has failed to monitor shoddy operators, investigate dangerous practices or shut down the worst offenders.

Time and again, the agency was alerted by police and its own inspectors to caretakers depriving residents of the most basic needs — food, water and protection — but didn't take action.

When AHCA agents were forced to end their inspection of Sunshine Acres in 2008 because of threats by the owner — the second time in four years — the agency didn't return for eight months.

By the time agents went back, they found a resident eating from a filthy food bin, four inches of dirt on the floor of a dorm room and six residents drugged on tranquilizers without doctors' orders.

"Lord help us all if he gets mad," one resident told state regulators about the owner.

Frustrated over the state's inability to close Sunshine Acres, neighbors began gathering at the local fire station to launch a plan to prompt regulators to act.

"It took the whole damn neighborhood," said Dewayne Anderson, 55, who lives next door to the home.

A representative of the group fired off several e-mails to AHCA, demanding the state enforce its laws and pointing out a litany of problems created by the facility.

After 14 years of running the home and racking up more than 100 violations, Hall was finally told by AHCA to sell Sunshine Acres. But once again, regulators struck another deal: Hall was given a year to find a buyer.

Failure to protect

Close

The Miami Herald spent a year examining thousands of state inspections, police reports, court cases, autopsy files, e-mails, death certificates and conducting dozens of interviews with operators and residents across the state.

Reporters found that as the ranks of assisted-living facilities grew to make room for Florida's booming elderly population, the state failed to protect the people it was meant to serve.

For example:

· Nearly once a month, residents die from abuse and neglect — with some caretakers even altering and forging records to conceal evidence — but law enforcement agencies almost never make arrests.

· Homes are routinely caught using illegal restraints — including powerful tranquilizers, locked closets and ropes — but the state rarely if ever punishes them.

· State regulators could have shut down 70 homes in the past two years for a host of severe violations — including neglect and abuse by caretakers — but in the end, closed just seven.

· While the number of new homes has exploded across the state — 550 in the past five years — the state has dropped critical inspections by 33 percent, allowing some of the worst facilities to stay open.

· Though the state has the power to impose fines on homes that break the law, the penalties are routinely decreased, delayed or dropped altogether.

· The state's lack of enforcement has prompted other government agencies to cut off funding and in some cases refuse to send clients to live in homes AHCA won't close.

Close

For example, the Miami-Dade Court's mental health project won't send clients to All America ACLF, where Angel Joglar, a 71-year-old man with schizophrenia, was scalded in a bathtub after his caretaker left him alone in 2006, dying from the burns weeks later.

Since his death, AHCA has cited the home for at least 100 violations — including untrained staff failing to stop residents from beating each other with two-by-fours.

After Hillandale ALF was caught locking residents with mental illness in a closet to punish them — along with a host of other violations — the state Agency for Persons with Disabilities cut off hundreds of thousands of dollars it was sending to the home in Pasco County.

Both facilities are still licensed by AHCA.

AHCA, which is empowered with tough tools to enforce the law, said its goal is to get facilities to obey the rules — and imposing fines or other penalties are secondary measures.

Reluctant to punish

The agency, which would only respond to questions in writing, said pushing to revoke a home's license is a "very harsh penalty" used as a last resort. Before doing so, it considers several issues, including the immediate danger to residents and the ability to relocate them to a new home.

Each penalty is considered based on "unique circumstances," and other actions are explored "prior to the most serious sanction of revocation," the agency wrote.

However, The Miami Herald found that AHCA repeatedly catches homes breaking the law but fails to act, at times with dire consequences.

At Hampton Court in Haines City, regulators caught caretakers 11 times in the past five years failing to give out medication, not keeping records of drugs given to residents and falsifying records to show drugs had been given when they hadn't. The state could have imposed emergency measures, including a ban on new residents until the home cleaned up its practices, but never did.

Close

Eventually, someone died.

Norman Dube, a 74-year-old retired postal worker suffering from diabetes and depression, went 13 days last March without crucial antibiotics — and several days without food or water. As he slipped into unconsciousness, he began telling people "things were crawling on his skin," a state report said.

At the same time, the home failed to tell his doctor he wasn't getting his drugs, which included blood pressure medications and anti-psychotics.

The next month, Dube died. A state Department of Children & Families investigation concluded the home committed medical neglect.

But the problems didn't end. On June 25, two months later, state agents returned to the home and found two more residents languishing without their medication, despite doctor's orders.

The home promised to correct the problems, but in August it happened again — this time, three more residents were not getting their drugs. Two months ago, the facility was taken over by a new owner.

When it comes to imposing fines, AHCA said it doesn't routinely drop or reduce them, saying it only lowered fines by 7 percent this fiscal year.

But an analysis shows the agency rarely asks for what's allowed by law. Consider: In 2009 — the same year lawmakers expanded AHCA's power to levy fines — the agency could have imposed more than $6 million, but took in just $650,000.

Homes of horror

The law that empowered the state to discipline homes was passed three decades ago in response to a growing crisis: Elderly people moving to Florida were ending up in group homes run by abusive caretakers.

The state passed a celebrated Residents Bill of Rights in 1980 — championed by veteran Miami congressman Claude Pepper — pledging that people in those homes would be protected and treated with dignity.

The homes would shelter two of the state's fastest-growing groups — the elderly and mentally ill — and at the same time offer an alternative to nursing homes.

Now, people who needed help with everyday chores but didn't require 24-hour nursing care could live independently.

But as the industry boomed, the state began a series of crucial moves that would change the way it regulated homes.

Instead of inspecting ALFs once a year like most large states — including Arizona, Texas, Pennsylvania, North Carolina and Illinois — Florida cut inspections to just once every two years.

The same trend took place with investigations of serious incidents like deaths and injuries — known as adverse incidents — which were slashed by 90 percent between 2002 and 2008.

Regulators never investigated Isabel Adult Care III after the owner reported that Aurora Navas, an 85-year-old grandmother with dementia, had quietly wandered from the Miami-Dade home and drowned in a pond in the backyard in 2008.

"Her lack of ability to find her way back caused her accidental death," wrote the home's administrator, Isabel Lopez, in a report to AHCA. "We found that all procedures were followed. The facility has door alarms, proper door locks, and a fenced backyard."

But records show that if regulators had carried out what was once a routine exercise, they would have found just the opposite: The door alarm and video cameras weren't working, the back gate was unlocked and an attendant had fallen asleep, Miami-Dade police records show.

Navas, who had a history of wandering, was found floating in 18 inches of water, clad only in her lavender sleeping gown, a blue slipper on the ground nearby.

To this day, Alfredo Navas says he's enraged the state never investigated his mother's death at the quiet suburban home just north of Kendall.

"You don't follow up when it comes to human beings who are supposed to be watching other human beings. They get nothing," said Navas, 59, adding that his mother was afraid of water most of her life. "The safeguards you thought in place weren't in place."

In an interview, Lopez said she was ordered by fire inspectors to remove the locks from the rear door. But county records show that was not the case: Inspectors simply told her to get new locks.

Cases skyrocket

While inspections of homes were dropping across the state, another troubling trend was under way that would set new records.

The state Department of Elder Affairs ombudsman program was uncovering more cases of abuse and neglect than it had seen in the last three decades, with numbers doubling in the past five years.

Though the program sends its findings to AHCA, regulators failed to investigate the vast majority of the cases, records show. In fact, a state audit in 2008 found that AHCA couldn't locate two-thirds of the complaints sent to the agency.

"It's baffling to me," said Brian Lee, the ombudsman program's past director. "We find things, and it's like, how did they not see the same things?"

Even when AHCA does find problems — including people dying from abuse and medical neglect — it rarely moves to close homes, allowing the same dangerous violations to turn up again.

Though Briarwood Manor has been the target of more than 1,200 police and rescue calls in the past five years — with residents stabbing, fighting and suffering psychiatric breakdowns — the Broward County facility has been allowed to stay open.

The drab, stuccoed home in the heart of Lauderhill has been slapped with scores of violations by AHCA — 100 in the past five years — including an episode in which a man slashed his roommate with a knife during a crack binge while the night caretaker was nowhere to be found. Twice in the past five years, the state could have revoked or suspended the home's license, but did neither.

Close

Instead, AHCA allowed Briarwood to operate for four years while it owed massive fines that peaked at more than $370,000, with AHCA eventually agreeing to reduce the amount by 74 percent in 2008.

Briarwood is among the hundreds of ALFs that opened their doors in the past decade, driven by the closing of state mental health institutions.

But as the industry boomed, AHCA failed to keep up with the growth, with state agents taking longer to respond to dangerous breakdowns. A Miami Herald analysis shows it took inspectors an average of 37 days to complete complaint investigations in 2009, 10 days longer than five years earlier.

At least five times, other agencies were forced to take the lead in shutting down homes when AHCA didn't act.

One Hardee County sheriff's detective said he was unable to prod AHCA to shut down Southern Oaks Retirement Center last year after he found residents sleeping on torn, urine-soaked mattresses surrounded by moldy, cracked walls and boarded-up windows.

Though AHCA had turned up the same hazards at the Central Florida home for eight years — including just a month earlier — the facility stayed open until fire officials ordered the evacuation of all 49 residents on June 22, 2010.

Not until the home made critical repairs five weeks later was the order lifted.

For Rosalie Manor, it was a longer battle.

For years, Pinellas County sheriff's deputies had been forced to round up dozens of residents with mental illnesses found wandering the small town of Dunedin, breaking into a school and homes, and shoplifting from businesses.

When deputies finally investigated, they found Rosalie Manor owner Erik Anderson had placed a 53-year-old man just released from a psychiatric ward in charge of dispensing powerful psychotropic drugs to others in the home.

When two residents suffered breakdowns after not getting their crucial medications, detectives sent a warning to AHCA: Shut the place down.

But regulators dropped the case a month later, citing a lack of evidence — prompting an angry response from Sgt. J. Michael Daily, who slammed AHCA for its "inability to take action on this and other valid complaints at Rosalie Manor," records show.

During the next two months, deputies joined prosecutors in a rare effort to close the 34-bed facility.

Detectives brought forward reams of paperwork in 2006 detailing abuse and neglect inside the cluster of cottages near downtown Dunedin — including violations turned up by AHCA year after year.

They found Anderson had covered up crucial evidence in death investigations of the home's residents.

In one case in 2003, he threatened to fire any employee who called police after finding blood splattered on the walls of a 72-year-old man's bedroom and a suicide note on the dresser.

In 2005, he drove a male resident with a criminal history to a pharmacy to fill a prescription for powerful narcotics, but failed to collect the drugs from the man, who then fed them to a 20-year-old female resident with mental illness. She was then raped by the man and died in her bedroom from an overdose.

Administrator charged

In the end, prosecutors charged Anderson, 60, with neglect, witness tampering and falsifying medical records. He pleaded guilty and surrendered his ALF license. His sentence: probation.

Caretaker Mary Pressley, 47, who worked at Rosalie for nearly a decade, said she couldn't understand why AHCA never moved to close the home. "I don't know how he got away with what he did," she said.

Since 2005, Rosalie was among more than 40 homes found to be placing residents in immediate danger — the most serious breach of Florida's ALF law — with a quarter of the homes going on to do it again.

Even after AHCA inspectors warned their own agency that Bruce Hall was running a dangerous facility in 2004, he was allowed to renew his license and expand the home to make room for eight more beds.

Close

It was the third time the troubled facility was granted a renewal by AHCA, despite breaking the state's ALF law 51 times.

The next year, Hall fell asleep on night watch duty just long enough for 71-year-old Elnora Shuler to wander out the door with her baby doll and slip into a pond on the premises.

When AHCA investigators asked Hall why the fence around the pond was only half finished, an inspection report states he responded: "My complacency is the reason I knew I'd find [Shuler] down there in that pond someday."

When agents visited the ramshackle 52-bed home in North Florida to investigate a tip that Hall threatened residents with a gun, he flew into a rage, referring to the residents as "deranged, mental retarded sons of bitches," while lashing out at state agents, reports showed.

In the end, inspectors Patty McIntire and Kara Cowart, along with a Washington County sheriff's deputy, left the property without completing their investigation, citing "safety concerns."

For his tirade, Hall was fined $1,756 and ordered to visit a therapist because of his anger. But just 17 days later, he shoved a woman diagnosed with mental retardation to the ground, sending her to the hospital with a sprained ankle and cuts on her arm, elbow, knee and shin.

Hall told regulators he was protecting his wife after the resident grabbed her arm, but state agents cited him for abuse.

In an interview with The Miami Herald, Hall said regulators were "bureaucrats" who didn't understand the challenges of dealing with people with mental disabilities — and that he had a right to impose force on residents when they got unruly.

"If one of them jumps on you and you got to beat the hell out of them to get them off you, then you get held responsible," he said. "I'm the damn culprit that's the bad guy in all this?"

He blamed residents and his neighbors for bringing unwarranted scrutiny to the facility.

"These mentally handicapped residents, they know the game," he said. "They will play you. They are of the system, they know the system — just like a prisoner. They know what they can get away with."

He said if he hadn't imposed discipline on his residents, they would have taken control of the facility. "They're going to realize they can continue to treat you like a dog," he said.

During a state inspection in 2006, 14 residents at Sunshine Acres refused to give their names to AHCA agents, saying they feared retaliation.

Between 2007 and 2008, five employees quit their jobs, saying they were tired of the abuse at the home, state reports show.

During that same period, sheriff's deputies and rescue workers were called to the home more than 400 times for, among other things, fights between residents and people suffering psychiatric breakdowns.

"It was like a damn nightmare," said Dewayne Anderson, a next-door neighbor who joined the community coalition to close the home.

In 2008, Hall ran AHCA agents off the premises a second time after berating an elderly female resident who was trying to talk privately to them.

Hall "dropped to his knees in front of the resident" and with "flushed face, clenched jaw, rapid, loud speech, flaying [flying] arms," he said he was throwing her out for complaining about him.

"The survey was discontinued at this point due to a fear for the safety of the surveyors," inspectors wrote.

After the event, the state threatened to kick Hall out of the business.

In April, agents sent a letter saying Sunshine Acres' license would not be renewed. But it was. In October, regulators told Hall to get out — but once again, bargained the punishment down, giving him a year to sell the troubled home.

Through it all, agents continued to find more problems: Six residents were illegally given powerful drugs known as "chemical restraints," designed to keep them under control — without a doctor's consent, agents wrote.

Finally, after more than 115 citations from AHCA, Hall sold the home in September 2009 — still holding the mortgage in a deal that will earn him $1.1 million during the next 10 years.

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NEGLECTED TO DEATH

NEGLECTED TO DEATH | Part 2: Assisted-living facility caretakers unpunished: 'There's a lack of justice'

By MICHAEL SALLAH, CAROL MARBIN MILLER and ROB BARRY

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While his caretakers watched him die, William Hughes shivered under the covers in a cramped and dirty bedroom.

They didn't give him food. They didn't give him water. Despite doctor's orders, they never gave him the very medicine that would have saved his life.

Instead, they let him languish for days at the Tampa assisted-living facility where he lived in 2006 — vomiting and defecating in his bed — refusing to clean him because the stench was too strong.

Despite pleas from residents that he desperately needed help, caretakers never called paramedics to try to save the severely diabetic man.

"They let this man just die," said resident Kevin Conway. "It just boggles my mind to this day."

His body was sent to the Hillsborough County morgue and cremated at state expense — his ashes sent to his mother in Ohio, the state investigation closed.

The 55-year-old musician was among dozens who died at the hands of their caretakers in assisted-living facilities across Florida.

One starved to death; another burned in a tub of scalding water. Two were fed lethal doses of drugs. Three died from the ravages of gangrene when their wounds were ignored for weeks.

The state Agency for Health Care Administration — the entity entrusted with overseeing ALFs — refuses to release the records of more than 300 questionable deaths during the past decade, citing state law.

But The Miami Herald obtained confidential records of 70 people who died in the past eight years from the actions of their caregivers.

The records from the Department of Children & Families, another agency tasked with investigating deaths, show people are routinely abused and neglected to death in assisted-living facilities — but in the end, few are ever held accountable.

"There comes a point when you need to say people's lives are in danger and we need to do more," said Nick Cox, a former DCF regional administrator who is now Florida's statewide prosecutor.

Though Florida boasts one of the toughest elder-abuse laws in the country, The Miami Herald found few caretakers are ever charged in the deaths of the people they are supposed to protect.

In an analysis of each of the deaths, including a review of police and autopsy reports, medical records, and interviews with relatives, residents and employees, The Miami Herald found:

• An average of nearly once a month, law enforcement agents were called to investigate cases of residents who died from abuse or neglect — with caretakers even admitting to breaking the law — but almost never made arrests. In at least five cases, caregivers were fired from homes after people directly under their care died from neglect, but none were charged.

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• In the two cases in which arrests were made, caregivers were granted plea agreements, never spending a day in prison. One owner was given probation in the death of a 74-year-old woman who was strapped so tightly to her bed that she suffered blood clots and died. The charges were later expunged from the caretaker's record.

• Four caretakers were caught forging and shredding medical records during death investigations — concealing key evidence. None was charged.

• Records of deaths at the homes are kept secret by the state — hidden even from family members — allowing facilities to conceal the critical mistakes that took the lives of their residents.

Close

• In three cases, family members were told relatives died of natural causes, but records show their caretakers had abused and neglected them.

The wrong drugs

When the Marrones gathered to bury the 82-year-old matriarch of the family two years ago, they believed Magdalena Marrone had succumbed to old age.

What they didn't know: Caretakers at Emeritus at Crossing Pointe had violated a doctor's orders and failed to give her critical heart medication for four days — and then gave her the wrong drugs on the day she died.

The elderly grandmother was found blue and frothing at the mouth in the Orlando home's activities room. Home administrators later admitted they never read her chart.

"What happened to my grandmother is just devastating," said Kevin Marrone. "We assumed as a family that it was natural."

When Suzanne Hughes got the call from the Hillsborough County medical examiner's office in 2006, she was told her younger brother William died at Escondido Palms from complications of diabetes.

What she wasn't told: He didn't get his insulin for 27 days, and caretakers refused to call an ambulance as he slipped into the throes of diabetic shock.

It would be five years before she would learn from a Miami Herald reporter the fate of William Hughes and the medical neglect that killed him.

The case is among dozens buried in the archives of state regulators — the names blacked out and the details sparse — revealing the blunders and mistakes that cost people their lives in ALFs.

As William Hughes shook in the darkness of his room in the aging facility, two caretakers refused to clean him while his body was shutting down — one complaining the odor was too strong and the other saying she was pregnant.

Close

"No one is helping this man," recalled resident Larry Thrall, 41. "He's still laying there in his own feces."

In the end, Thrall was forced to call paramedics from a cellphone using an alias after the caretakers refused to dial 911, records state.

By the time rescue workers arrived, it was too late: Hughes was dead from a lack of diabetes medication. "One shot of insulin would have revived him immediately," said Hillsborough County associate medical examiner Leszek Chrostowsk, who performed the autopsy.

Though a state attorney general's agent called for prosecutors to charge chief caretaker Charlotte Allen with neglect after she admitted to never reading his charts, the case took a familiar turn. Instead of pursuing charges, the Hillsborough County state attorney's office dropped the case, saying there wasn't enough evidence to prove culpable negligence.

Though a witness told police Hughes had gone four times to the office asking for his drugs, assistant state attorney Jay Pruner said he couldn't prove the requests were made to Allen.

"We were looking to make a case against her," Pruner said. "This was a horrific situation."

But under Florida law, prosecutors have charged entire facilities with criminal neglect — and have won convictions.

"I don't have a response to that," Pruner said.

Two years after Hughes' death, Allen, 60, pleaded guilty to stealing $9,000 in disability checks from another resident at the home after being charged by the state attorney's office. The facility has since been sold.

Fatal mistakes

The lack of prosecutions come as the number of assisted-living facilities rises in Florida — 408 new ones in the past three years.

During the past decade, the DCF death cases reveal a stunning sequence of fatal mistakes made by caretakers who are supposed to protect their vulnerable wards. Close

In more than 40 percent of the death cases reviewed by The Miami Herald — 29 in

all — the people who died of neglect or abuse were suffering from dementia.

At one West Melbourne home, caretakers were supposed to follow a simple rule when the home's exit alarm was triggered: do a head count and call 911.

But when 74-year-old Waymon Cross slipped out the door of Alterra Clare Bridge in the early hours in 2003, his caretaker shut off the alarm and went back to work.

It was hours before another employee spotted his cap floating in a pond near the home, his body drifting nearby.

"Her job is to protect and take care of [Cross], and she didn't do that," recalled West Melbourne police Detective Barbara Smith, adding the caretaker twice changed her story before admitting to what happened.

The home's administrator did not return repeated phone calls.

For a month in 2008, workers at Living Legends Retirement Center were finding Frances Tremblay sprawled on the floor, her body covered in cuts and bruises.

Instead of taking steps to protect her, administrators at the Deerfield Beach home ignored warnings from a staff nurse that the woman was constantly falling.

The end came after the 11th fall.

When a Broward County sheriff's deputy showed up, the 98-year-old grandmother was lying in a puddle of blood in a locked room, screaming for help.

At the hospital, doctors found she had two black eyes, a gash over her nose and a fractured neck. She died months later without ever recovering from her injuries.

"What they did to her was criminal," said William Dean, an attorney who represents Tremblay's family.

Though charges were never filed in the case, the details of her death emerged for the first time this year, when a Broward County jury found sweeping negligence in Tremblay's death, awarding her estate $2.39 million in one of the county's largest jury awards ever rendered against an ALF.

As people were dying in homes across the state — 40 in the past five years — another agency joined regulators in probing deaths: the state attorney general's office.

In the past eight years, the office reviewed more than half the death cases turned up by DCF — including drownings, medical neglect and drug overdoses — but made just one arrest.

The DCF files show that even when caretakers were caught destroying evidence in death cases — shredding and in some cases falsifying key medical records — the attorney general's office didn't act.

Baseball-size sore

When Dorothy Archer arrived at a Pasco County hospital two years ago, rescue workers discovered a blackened hole the size of a baseball festering on her back.

"Egregious neglect" was how the wound was described by DCF agents investigating her treatment at Edwinola ALF.

But when agents tried to find out how the 90-year-old developed the septic sore, they hit a barrier: Key records describing her final two months at Edwinola had disappeared. Worse, nurses' notes detailing the wound appeared fabricated.

"For such a serious wound to develop undetected in the ALF was inexplicable," DCF agents wrote after she died.

The home's only punishment: a $1,000 fine levied by the Agency for Healthcare Administration for failing to seek medical care or keep proper records.

Archer's husband of 37 years, Theodore Robert Archer, said he's still angry over the home's treatment of his wife. "They never told me a thing about her condition," he said. "Oh God, she was suffering." Janice Merrill, an attorney representing the home, declined to comment.

Beyond problems at the homes, the DCF records reveal another troubling breakdown in the death cases: dozens of bodies found at the homes were sent to the grave without any forensic scrutiny.

The Miami Herald found 33 cases in which bodies were already embalmed or cremated by the time state agents found sweeping evidence of neglect.

Take the case of Muriel Christine Staab, a blind woman in a wheelchair, whose body was cremated before state agents found she had been a victim of neglect.

Clay County sheriff's deputies responded three years ago to a call to the state's abuse hotline: The 101-year-old woman developed a severe infection that went untreated and weeks later was found sprawled on the bathroom floor at Park of the Palms.

Under state law, sheriff's deputies could have asked for an autopsy, but instead allowed a doctor to sign the death certificate saying the death was due to natural causes.

Dr. Daniel B. Cox told police he would simply declare she died from natural causes, even though he was told she had fallen and injured herself. "Dr. Cox said that he would not list the bump on the back of the victim's head as a contributing factor to death because she probably had a heart attack and then fell to the floor," a Clay County sheriff's report states.

Two days later, her body was cremated at Watts Funeral Home in Keystone Heights with no autopsy.

In the end, DCF agents concluded Cox had "signed the death certificate with limited information."

Agents later found the home had failed to call a doctor when Staab came down with a serious stomach virus, and then waited 15 minutes to call 911 after finding her on the bathroom floor the night she died.

"There is a strong possibility had medical attention been sought earlier in the day or evening, or 911 called immediately, [the victim] may have survived," investigators wrote.

Cox said the call from sheriff's deputies the night she died "didn't raise any red flags," and he decided to declare her cause of death — without examining her. Home administrator Larry Henderson declined to comment, citing privacy restrictions.

Bentley Lipscomb, a former secretary of Elder Affairs, said the DCF files show for the first time the extent of neglect in homes, and the lack of criminal prosecutions that follow. "They just don't value old people's lives," he said.

He and others spearheaded the changes 15 years ago that toughened state law to allow prosecutors to charge caretakers with neglect when people die under their care. "I was tired of seeing people die unnecessarily and no one doing anything about it," he said.

George Sheldon, the former DCF secretary, said prosecutors are still failing to look for ways to hold caretakers accountable. He said his former agency — which investigates abuse of the elderly and children — has been frustrated by the number of cases turned over to law enforcement that don't get prosecuted.

"A lot of attention is paid to children," he said. "Somehow, we don't have the same kind of outrage when a person is 70 or 80. There's clearly a lack of justice."

One of two cases that prosecutors took to court began on Mother's Day in 2004 when Gladys Horta's family got a call from caretakers: the 74-year-old had fallen in the shower, but she wasn't hurt.

When one of her relatives arrived at The Gardens of Kendall that night to take Horta to dinner, however, she found the elderly woman in bed, curled up in pain.

By the time Horta arrived at the hospital, she was soaked in urine and unconscious, with blackened feet and deep bruises inexplicably circling her legs.

Though doctors performed emergency surgery, Horta died two days later.

In the ensuing weeks, investigators found there was more to the story than what the family was told on Mother's Day.

Instead of a fall in the shower, Horta's injuries were caused by a caretaker who had gone to extremes to keep the elderly woman from wandering: Horta was strapped down for at least six hours — so tightly she lost circulation in her legs, forming the blood clot that killed her, DCF reports state.

After an investigation by the attorney general's office, facility owner Mayra Del Olmo was charged with aggravated neglect and later sentenced to one year of house arrest and five years' probation in 2006, a state attorney general report said.

But to this day, there is no record of her conviction. The reason: Her case was later expunged.

Miami Herald staff writer Jared Goyette contributed to this report.

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Delay in closing Williston facility questioned

By Cindy Swirko
Posted Jan 6, 2018 at 4:15 PM
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Elder advocate says police prodding finally got state to act

When the state suspended the license to operate the Good Samaritan Retirement Home in Williston days before Christmas, people familiar with its unsavory history were thankful.

Some went further, wondering what took the Florida Agency for Health Care Administration — commonly referred to as AHCA — so long.

Among them is Brian Lee, executive director of Families for Better Care, a watchdog group for adult living facilities nationwide.

"We looked at (Good Samaritan's) ranking as far as fines and sanctions, and we found that they were the No. 1 in fines. We were like, wow, that's pretty shocking," Lee said. "They are pretty horrific. They have been on the radar screen for AHCA for a long time ... What really stuck out to me was how long it took them to bring about the suspension."

From 2007 through its suspension late last month, Good Samaritan has been fined $75,850 for infractions ranging from bed bugs to lax supervision of residents that resulted in the death of one and the beating of another.

AHCA twice slapped it with a moratorium on new admissions, including one in November, but allowed it to remain open despite life-threatening carelessness in giving medicine to residents and other serious issues.

Williston police officials said they have long had concerns about Good Samaritan and it was the police investigation of the death of a resident that led to the eventual closing.

Chief Dennis Strow said investigations of Good Samaritan are continuing. Police would not say much else because of the ongoing investigation.

But Lee said the police department's contact with AHCA concerning Good Samaritan was instrumental in convincing AHCA to shut it down.

"It took nudging and begging and pleading from the law enforcement officials on the ground to say, 'Hey, this place needs to be closed down,'" Lee said.

AHCA said in an email response that it has taken swift action to hold Good Samaritan accountable, including forcing a change of ownership and barring the previous owner from working or volunteering in any facility we license in 2013 after the majority of the fines were levied.

"AHCA is required by law to take the least intrusive action to ensure resident safety. AHCA was closely monitoring this facility since halting new admissions in November of 2017, and worked with state and local partners, including local law enforcement, to monitor compliance and resident safety throughout this process," the agency said. "It is important to note that an assisted living facility is not a health care facility, but is a place of residence, a home. There are steps that must be taken, by law, when shutting down a facility."

Good Samaritan at 507 SE First Ave. is shut for good but the tentacles of its ownership reach to other assisted living facilities that have also been fined and disciplined by AHCA.

And the Williston building may not be vacant for long. Lifestairs Behavioral Health Center Inc. is trying to get licensed to operate a facility for substance abuse and behavioral therapy. Major Causing, the agent for the company, said it may offer assisted living for people with mental health issues.

The record for care of residents left behind at Good Samaritan is troubling.

Two former Good Samaritan employees have been arrested on charges of elder abuse: Rhaimley Yap Romero, 31, and Nenita Alfonso Sudeall, 48.

AHCA began its latest investigation following a Williston Police Department report of resident Betty Hurst, 72, falling while outdoors on Nov. 1 and hitting her head.

Police allege Sudeall brought Hurst back inside, but she didn't receive any first-aid care and was put into the lockdown unit. About six hours later, Hurst was found unresponsive and 911 was called. Hurst was taken to UF Health Shands Hospital where she died the next afternoon, police said.

Rhaimley Romero, 31, replaced Sudeall as administrator when she left shortly after Hurst's death. He was charged with elderly neglect for a Dec. 7 incident, police said.

A resident had an outpatient procedure and was transported back to Good Samaritan, police said. A nurse told Rhaimley Romero to inform the nurse if the resident's condition changed.

On two occasions that weekend, on-duty staff contacted him about the resident's declining health, but he did not contact the nurse until he returned to work Monday, police said.

AHCA investigators who went to Good Samaritan found more disconcerting evidence of shoddy care of residents.

A closed-circuit recording at Good Samaritan showed that while no staff members were in the secure unit, a 52-year-old resident whose health issues include a traumatic brain injury assaulted an 86-year-old resident.

The younger man knocked the older man to the ground twice and over a two-minute period punched or hit him about 56 times, the order states.

Also found were instances of employees not following the protocols of doctors when giving residents medicine. Meanwhile, several residents refused to take prescribed medication yet their health care providers were not notified.

AHCA on Nov. 22 issued a moratorium on new admissions. On Dec. 20, it suspended the facility's license effective Dec. 23.

Good Samaritan's license was issued to PRY Inc. Its ownership is split between Helen Romero, Rhaimley Romero's mother, and Jhoana Paz.

PRY is a relatively new operator in Williston and even before the Romeros took over, Good Samaritan was fined multiple times by AHCA.

In 2007, Good Samaritan's property and license were held by Andrada Sunshine Corp.

Documents on AHCA's website show that in 2007, Good Samaritan was fined because staff failed to properly assess a resident, had high levels of radon and failed to provide necessary training.

AHCA in 2012 placed a moratorium on new admissions after a bunch of violations were found. Among them were a lack of staff training, failure to provide a decent and safe environment for residents, run-down equipment including loose toilet seats, faulty fire alarms and failure to properly give medicine.

The case was settled in 2013 when Andrada agreed to arrange a sale of Good Samaritan. It continued to run the facility.

A 2014 AHCA case lists the owner as PHI 413. AHCA found that a required background check was not done on an employee. The Florida Division of Corporations listed Marilou Zananski as the officer and director of the company.

AHCA documents show Zananski was associated with several assisted living facilities in Central Florida.

By 2015, Helen Romero is listed as the administrator of Good Samaritan. The next year, AHCA was finding problems under her administration.

The facility had a bedbug infestation with the insects found in two rooms, according to an AHCA document. AHCA also found the some beds did not have adequate side rails. The punishment was a $2,500 fine.

Then came the investigation prompted by the death of Hurst, resulting in the current suspension.

Helen Romero is also named as the administrator and financial officer of Apopka Retirement Center, whose owner is named by AHCA as A Dream Lake Manor Inc. Its corporate reports list Romero as the company director.

The Apopka Retirement Center has been cited for deficiencies, thought the documents do not specify who the owner or administrator was at the time of the investigations.

Paz is listed by the Florida Division of Corporations as the president of JHHANE Inc. while Rhaimley Romero is named as treasurer.

JHHANE holds the license for the Amber Lake Assisted Living Facility in Kissimmee. Minor deficiencies have been found at it by ACHA inspectors but no fines were levied.

The Good Samaritan property is owned by Gregorio and Editha Andrada. The Division of Corporations show Editha as president and Gregorio as manager of GAEA Realty in Kissimmee.

Causing said the Andradas contacted him about renting the building several years ago. Causing said he declined because of the repair work that would be needed.

On Thursday, Causing was at the building evaluating its needs. Causing said he is applying for a license from AHCA. The agency said a facility owned by Causing named Lifekeepers in Kissimmee has an exemption from licensing as a health care clinic.

Causing added that plans are to eventually buy the Williston property from GAEA Realty.

"It's a behavioral health center where we will be putting up substance abuse, behavioral psychotherapy. It will still be an assisted living facility but we will focus on mental behavioral health — not for the elderly anymore," Causing said. "It will be an inpatient/outpatient kind of thing. It's a nonprofit organization. We will be inviting everybody to a grand opening."

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SPEAKER BIOGRAPHY

DONNA J. FUDGE, ESQ.

Partner, Fudge & McArthur, P.A.
J.D. (with honors), Marquette University Law School
B.S. (with honors), Marquette University

Attorney Donna J. Fudge has developed a nationwide practice specializing in the defense of health care providers over the past 19 years. She has argued before the Florida and Wisconsin Supreme Courts, and the Florida, Pennsylvania, New Jersey, Iowa and Wisconsin Appellate Courts in cases involving the defense of health care providers.

Ms. Fudge has served as co-chair of the Long Term Care Subcommittee for the Defense Research Institute and the American Conference Institute's Annual Forum on Preventing and Defending Long Term Care Litigation. She is also a frequent speaker at national seminars regarding the defense of nursing homes, ALF's, and other health care providers and has been published in national legal magazines on topics related to defense of the health care industry.

She is a recognized expert in Arbitration, including the drafting and enforcement of arbitration agreements as well as in successfully defending health care providers in the Arbitration forum. Ms. Fudge also has experience in numerous other areas of civil litigation such as products liability, premises liability and insurance defense.

Ms. Fudge is licensed to practice law in Florida, New York, Pennsylvania, Wisconsin, Illinois, Iowa and Minnesota.

CONSTITUTION REVISION COMMISSION
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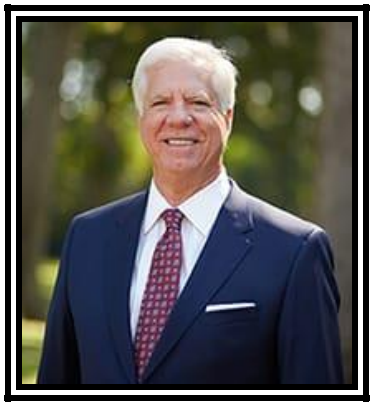
SPEAKER BIOGRAPHY



KENNETH L. CONNOR, ESQ.

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J.D. (with honors), Florida State University

Kenneth L. Connor, a founding member of Connor & Connor, LLC, has been an active trial lawyer and member of the Florida Bar for over 45 years. Licensed to practice law in fourteen states and the District of Columbia, he has tried cases involving elder abuse and neglect from Florida to California. His representation of clients has included former Florida Governor Jeb Bush in the Terri Schiavo case.

Mr. Connor previously served as Chair of the Florida Commission on Ethics and as a member of the 1997-1998 Florida Constitution Revision Commission where he was recognized as "Most Effective in Debate." Additional highlights of his lifetime of advocacy include serving as President of the Family Research Council in Washington DC from 2000-2003, as Chairman of the Center for a Just Society, serving on Florida's Task Force on the Availability and Affordability of Long Term Care, and testifying before Congress on multiple occasions regarding long-term care issues. In 2013, he was designated "Distinguished Fellow for Law & Human Dignity" by the John Jay Institute located in Philadelphia.

He is also a widely-published author who has written over 500 articles. His works include the book, *Sinful Silence: When Christians Neglect their Civic Duty*, co-authored with John Revell. He has also lectured on a number of legal topics on college campuses, including Harvard University, The United States Military Academy at West Point, Catholic University in Washington, Florida State University, the University of Florida, and Stetson University College of Law.

Mr. Connor has been selected for inclusion in the Best Lawyers in America and named as one of Florida's "Legal Elite" by Florida Trend Magazine. He was also named one of "Washington's Top Lawyers" in 2007 by Washingtonian Magazine and identified among the Top Lawyers in South Carolina for 2013 by The Legal Network.

Protecting Florida's Frail Elderly Proposal OO88

Florida Constitution Revision Commission

Kenneth L. Connor

January 11, 2018

EPIDEMIC OF ABUSE AND NEGLECT

- Pressure Sores
- Malnutrition
- Dehydration
- Falls
- Infections
- Contractures
- Assaults

PERFECT STORM

- Demographic
- Economic
- Cultural

DEMOGRAPHIC

- Graying of America
- Mass Geriatric Society

FLORIDA

- 20% of residents over 65
- 85+ is fastest growing age group
- 73,000 in Nursing Homes
- 100,000 in ALFs
- 1 million 65+ without living relative in state

ECONOMICS

Medicare

$1 Billion vs $600 Billion

Medicaid

$1 Billion vs $ 500 Billion

Social Security

16:1 vs 2.9:1 vs 2:1

CULTURAL

- Quality of Life vs Sanctity of Life

NET WORTH

- Cost/Benefit Ratios
- Quality of Life Assessments
- Functional Capacity Studies

INCIDENCE OF ABUSE OF NEGLECT

- 20-25%

Culture of Death: The Assault on Medical Ethics in America

- "Our culture is fast devolving into one in which killing is beneficent, suicide is rational, natural death is undignified and caring properly and compassionately for people who are elderly…disabled, despairing or dying is a burden that wastes emotional and financial resources."

Wesley J. Smith

PROBLEMS PERSIST DESPITE EXISTING REGULATORY REGIME

SOCIAL PURPOSE OF TORT LAW

- Affirms basic human dignity and the sanctity of human life
- Promotes responsibility by holding wrongdoers accountable for their actions
- Promotes local control
- Provides for just compensation from wrongdoers and relieves the rest of society of unfair burdens

ADVANTAGES OF JURY SYSTEM

- Juries are made up of local citizens
- Jury composition is not known in advance of the trial
- Jurors cannot be paid by either side
- Jurors commonly complete their service in just a few days or weeks and then return to their private lives.

ARBITRATION IS NOT A PANACEA

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Protecting Nursing Home Companies: Limiting Liability Through Corporate Restructuring

Joseph E. Casson
Julia McMillen

AMERICAN HEALTH LAWYERS ASSOCIATION

SAINT LOUIS UNIVERSITY SCHOOL OF LAW

Protecting Nursing Home Companies: Limiting Liability Through Corporate Restructuring

*Joseph E. Casson**
*Julia McMillen***

ABSTRACT: Nursing homes face two potential risks: exclusion from the Medicare and Medicaid programs; and financial liability through Medicare and Medicaid overpayments, false claims, and negligence actions. Given the current budget crisis and the scrutiny of nursing homes, the magnitude of these risks is only expected to increase. The authors address the increasing risks that nursing homes face and propose the creation of single-purpose ownership entities and single-purpose operating entities to minimize risk. In addition, they examine recent cases to show what factors the courts use to allow the United States and private plaintiffs to pierce the corporate veil. The authors conclude by showing how restructuring can reduce the unnecessary risks of exclusion and financial liability.

> A corporation is an autonomous entity "separate and distinct from its shareholders, directors and officers, and generally, from other corporations with which it may be affiliated." . . . This autonomy shields parties related to a corporation from the liabilities of that corporation. . . . Indeed, one of the primary purposes of the corporate form is to insulate shareholders from financial liability for a corporation's debts. . . . . Equity, however, has created a device called "piercing the corporate veil," which prevents purveyors of fraud and injustice from hiding behind the corporate form of organization. . . . Using this

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> device in appropriate circumstances, courts will disregard the separate identities of corporations controlled by a common parent.[1]

In that concise statement, the Seventh Circuit outlined the essential purpose of the corporate form of doing business, and the circumstances in which the protections of that form will be denied to its owners. The creation of the legal concept of a corporation is viewed by many as one of the essential factors that fueled the Industrial Age and permitted the accumulation of resources to advance undertakings beyond the capacity of the wealth of individuals. Whether it was a corporation formed for the exploration and development of the New World or a corporation formed for the mass production of automobiles, the corporate form allowed the accumulation of wealth from a large number of investors without exposing their personal fortunes to loss if the venture failed. The corporation was invented for the express purpose of limiting the liability of investors to the amount of their investment. Thus, the use of the corporate structure to create insulation from liability is hardly a perversion of the corporate form; rather, it is an application of its primary purpose.

Recently, the principles underlying the corporate form of doing business have expanded to apply to other forms of legal entities, such as limited liability companies and limited liability partnerships. Today, business enterprises can select among various legal forms to pool resources and limit the liability of investors.

In the context of nursing home ownership and operation, legal entities such as corporations, limited liability companies, and limited liability partnerships can be formed to benefit nursing home companies by limiting the financial liability and Medicare and Medicaid exclusion exposure of the real-estate investors and business owners. For example, the business entities that result from restructuring can help a nursing home operator avoid unnecessary exclusion of all Medicare and Medicaid providers currently owned by the same entity, in the event that any one of them is excluded from the Medicare or Medicaid programs. The business entities can also prevent litigants from obtaining judgments against related companies, and the owners personally, in proceedings alleging Medicare or Medicaid overpayments, false claims, or negligence.

In addition to providing a shield to protect against exposure to risk, the creation of multiple asset-holding entities can affirmatively benefit a nursing home company. For example, commer-

cial lenders and private investors often are more willing to lend to owners of real estate that are not engaged in the actual operation of nursing homes. Further, acquisition and divestiture of individual nursing homes often can be more easily accomplished if the assets are held in a single-purpose entity (SPE). The focus of this Article, however, will be limited to the avoidance of risk by use of multiple SPEs.

Due to the risks associated with exclusion from the Medicare and Medicaid programs and being named a defendant or respondent in a lawsuit or administrative proceeding, nursing home companies should seek to carefully protect the assets of their owners. One way to accomplish this is to divide the business into real-estate investment and nursing home operations. This can be achieved by forming SPEs to own the nursing home real estate, and separate SPEs to operate the nursing home business. Numerous SPEs may be less attractive as defendants than a single company with multiple operating interests and multiple real estate holdings. Moreover, upon the unfortunate occasion of receiving a notice of intent to exclude, a nursing home that is operated by a SPE is more easily divested. Further, it is divested without the impendent substantial losses often associated with having to divest a number of homes that happen to be owned by the same entity that owns the home to be excluded.

Ultimately, any decision to restructure must be made based on an assessment of the nursing home company's business goals. That assessment involves a balancing of acceptable risk with acceptable costs. Fortunately, restructuring need not be an "all or nothing" exercise. Restructuring can be undertaken at a variety of different levels, depending on the individual company's balancing of risk and cost.

For example, a company could decide to restructure down to the individual facility level by forming real property SPEs to own each piece of real estate that is used as a nursing home, and by forming a corresponding number of operating SPEs to lease and operate the nursing homes. Alternatively, a company could decide to subdivide its operations into subsidiaries that own and operate only a certain number of facilities each, based upon the level of risk the company is willing to accept. In addition, a company could elect to place all of its real estate in a real property SPE, but operate each facility through an operating SPE. In effect, any restructuring should be customized to the particularized needs of each company.

Finally, in order to preserve the integrity of the restructuring, nursing home companies must continue to eschew unnecessary and avoidable risk. The sanctity and independence of the business entity must be preserved because litigants and the government may attempt to disregard the legal structure of a SPE to collect judgments and overpayments against owners and related companies. Whatever form they take, nursing home business entities must adhere to statutory formalities, preserve the distinction between the business entity and those individuals or entities with ownership or control interests, be adequately capitalized, and avoid even the appearance of siphoning revenues to individuals or entities with common ownership or control.

I. Two Risks Facing Nursing Homes: Exclusion and Financial Liability

There are two types of exposure that nursing homes seek to avoid: exposure to exclusion from the Medicare and Medicaid programs and exposure to financial liability. The first type of exposure, exclusion exposure, is premised upon federal law that authorizes the Secretary of the United States Department of Health and Human Services (DHHS), acting through the Office of Inspector General (OIG), to exclude a provider from federal healthcare program participation upon the occurrence of certain events.[2] Under this authority, the DHHS Secretary may exclude a provider and its related entities when the provider has violated certain laws.

The second type of exposure, financial exposure, is that liability which makes the assets of owners vulnerable to claims made upon the business entity. It arises most frequently in the context of tort liability; that is, liability that generally stems from negligence-based actions against nursing homes. Financial exposure, however, can also occur in the regulatory context. This refers to liability that stems from Medicare and Medicaid overpayments, fraud, or false claims.

A. Exposure to Exclusion from the Medicare and Medicaid Programs

The Social Security Act vests in the Secretary of DHHS both mandatory and permissive exclusion authority.

Under the mandatory exclusion provisions, the DHHS Secretary must exclude certain individuals and entities from participation in federal healthcare programs for at least five years if, among

other things, the individual or entity is convicted of "a criminal offense related to the delivery of an item or service" under the federal Medicare program or under any State healthcare program.[3]

Under the permissive exclusion provisions, the DHHS Secretary may exclude additional individuals or entities from participation in federal healthcare programs.[4] In addition to excluding the individuals or entities that engaged in the prohibited conduct, the DHHS Secretary may exclude entities owned[5] or controlled[6] by a sanctioned individual or entity, even if those entities have been convicted of nothing.[7] As such, the DHHS Secretary may exclude an entity from federal healthcare-program participation if a five-percent owner of the stock or assets or an officer, director, partner, agent, or managing employee is sanctioned.[8] Moreover, the exclusion cannot be circumvented by having the excluded individual or entity transfer or sell the interest in the entity to an immediate family member or sibling.[9] To avoid application of these provisions, the ownership or control interest must be transferred to an unrelated entity or person.

Thus, if all of the company's nursing homes are owned and operated by a single company and that company is excluded from the Medicare and Medicaid programs based on the conduct of just one of the nursing homes, the company's nursing home real estate and operations are at unnecessary risk of exclusion. All of the nursing homes could be excluded from the Medicare and Medicaid programs. Furthermore, to avoid permissive exclusion attaching to the real estate owned by the company, the real estate would have to be transferred out of the company. This type of a divestiture can result in substantial loss of value in the asset, especially because many such divestitures must be accomplished on very short notice and under very adverse conditions.

B. Exposure to Financial Liability

Exposure to financial liability has specific meaning in the context of structuring nursing home organizations. Certainly every business entity has some form of financial liability exposure based upon contractual obligations, potential negligence actions, employment-related litigation, tax law matters, and other risks that occur in the ordinary course of conducting a business. The financial exposure that a nursing home operator is most concerned with, however, is the liability exposure particular to operators of nursing homes.

1. Medicare and Medicaid Overpayment Liability

A Medicare fiscal intermediary may suspend payments to or recoup payments from the individual or business entity that enters into an agreement with the Medicare program to provide services to Medicare beneficiaries. This can occur if, for example, it finds fraud, misrepresentation, incorrect payments, payments for unnecessary services, or overpayments related to that Medicare provider.[10] The fiscal intermediary has no authority, however, to suspend payments to or recoup payments from entities *other than* the provider for allegations raised against that provider.[11] Thus, the fiscal intermediary may not recoup overpayments from another entity merely because it is affiliated with the provider by common ownership or control.

Under many states' laws, the state Medicaid agency similarly may suspend payments to or recoup payments from a provider if it finds fraud or overpayments related to that provider.[12] Generally, the Medicaid agency's authority is limited to recouping overpayments from the provider only, and the agency cannot recoup from or offset against other entities merely because they are affiliated with the provider by common ownership or control.[13]

Federal and state governments' efforts to aggressively recover overpayments from providers are expected to increase in the future. Recent reports indicate approximately $8 billion is owed to the federal government in Medicare overpayments at a time when Medicare spending is on the rise and budgets are being cut.[14] Both the General Accounting Office and the OIG have noted the Medicare program's lack of progress in collecting debts, such as provider overpayments.[15] States also are facing shortfalls in Medicaid budgets, and the fiscal outlook for states does not appear to be improving.[16] They project worsening budget conditions, and many are looking at new methods of controlling Medicaid deficits, such as increasing fraud and abuse control and increasing third-party liability collections.[17] Given these pressures, it is expected that federal and state governments will aggressively pursue overpayment liability, which has the potential to cause cash-flow problems of enormous magnitude for any nursing home that might be targeted, as well as any successor or assignee of such a provider.

2. False Claims Liability

The federal False Claims Act and its whistleblower provisions create liability for Medicare and Medicaid providers who know-

ingly submit false or fraudulent claims for payment to federal healthcare programs.[18] The False Claims Act also has been used as a mechanism for prosecuting nursing home providers that receive Medicare and Medicaid payments, but that allegedly provide substandard quality of care.[19] The government can threaten a company with monetary penalties of enormous magnitude because the False Claims Act authorizes penalties of between $5,500 and $11,000 per false claim, as well as treble damages.[20] One nursing home company recently paid approximately $176 million to settle criminal and civil false-claims allegations related to its billing practices.[21] Another nursing home company recently paid $104.5 million to settle civil false-claims allegations for, among other things, failing to provide care, inadequate staffing, improper care of decubitus ulcers, and failure to meet residents' dietary needs.[22]

In addition, many states have false-claims statutes that create additional liability for Medicaid providers who knowingly submit false or fraudulent claims for payment to the state Medicaid program.[23] Moreover, several states have false-claims statutes that contain whistleblower provisions.[24]

Nursing homes' exposure to false-claims allegations is not expected to wane in the near future. Recent reports indicate that dollars spent by the federal government for anti-fraud enforcement activities are well-invested.[25] Recent reports also suggest that similar returns could result from investigating and prosecuting Medicaid fraud and enhancing state whistleblower provisions.[26] As a result, it is expected that federal and state governments will aggressively pursue Medicare and Medicaid false-claims actions, and nursing homes will remain ever-popular targets.

3. Malpractice/Negligence Liability

Plaintiffs may bring lawsuits against nursing home companies seeking damages under a variety of tort theories. More than a few judgments against nursing homes have been based on specious allegations. Nonetheless, the reality is that nursing homes are unsympathetic defendants. Nursing homes care for those with little or no potential for improved health outcomes and those with unavoidable negative outcomes, and they rely primarily on public funds from the Medicare and Medicaid programs for payment. Nursing homes, however, are often viewed as nothing more than vehicles for mistreating and profiting from the elderly and fragile.

As a result of their image, nursing homes are relatively easy targets for plaintiff's attorneys, who can reap extremely high jury verdicts that include punitive-damage awards. For example, one jury recently awarded approximately $2.8 million in actual damages and $310 million in punitive damages to the family of a nursing home resident who suffered malnourishment and bed sores while residing at the nursing home.[27]

Recent reports estimate the number and amount of nursing home liability claims to be on the rise. Claims against nursing homes have tripled from 4.6 claims per 1,000 beds in 1991 to 14.5 claims per 1,000 beds in 2002.[28] Moreover, the average size of a claim has tripled from $63,500 in 1991 to just under $200,000 in 2002.[29]

The financial reality of these claims is a "multi-billion dollar a year cost to the nursing home industry."[30] The insurance industry has responded to the increase in the number and amount of claims by raising premiums and restricting the availability of general and professional liability insurance.[31] Recent reports indicate that nursing home liability-insurance premiums have sharply increased in recent years—some nursing home operators experienced increases of 143% from 2001 to 2002.[32] Furthermore, in those states in which the losses were highest, such as Florida and Texas, nursing home liability insurance often is not available.[33]

As a result of the increase in insurance premiums and the unavailability of coverage, many nursing homes significantly decreased their coverage and many are without any coverage at all. This phenomenon places the nursing home's assets at greater risk: In the event of a malpractice or negligence judgment against the nursing home, judgment creditors will pursue all available assets of the nursing home company to satisfy the judgment.

If all of the company's nursing homes are owned and operated by one company and if there is a substantial recoupment action against one of the nursing homes, a False Claims Act treble-damages award against another, and a punitive-damages verdict against a third, the assets and operations of all of the nursing homes are potentially in jeopardy. The nursing home company would bear the responsibility for the liabilities incurred as a result of the conduct of the three facilities, as well as the ongoing operations of all of the facilities. Assuming the liabilities all related to the poorest-performing nursing homes in the portfolio

it is likely that, unless the company has substantial reserves, operating revenues derived from the other nursing homes would become necessary to satisfy the creditors.

Furthermore, the creditors would look not only to the operating revenues to satisfy the judgments, but would also aggressively pursue all available assets, including real estate, owned by the company. Instead of isolating the risk at the facility level and with the operating entity, the company has exposed its real estate and operating assets to the financial liability associated with only a subpart of its nursing home operations. Finally, in the event the judgments preclude the company from satisfying its monthly mortgage payments, the real estate may be unnecessarily at risk of liens or foreclosure, and the company at risk of a foreclosure on a pledge of its stock or membership interests.

II. Structuring to Reduce Risk: Separating the Real-Estate Investment from the Nursing Home Operations

These risks—exclusion and financial liability in the form of Medicare or Medicaid overpayments, false-claims settlement or treble-damages awards, and punitive-damages verdicts—arise as a result of the operation of the nursing home business. Individually or in the aggregate, they can lead to a crisis for any nursing home company. Restructuring can help reduce the overall risk.

Dividing the nursing home business into real-estate investment and nursing home operations will reduce the nursing home company's exposure to risks associated with owning and operating one or more nursing homes. The degree to which this reduction of risk can be maximized will be a function of how elaborate a corporate structure the particular company is willing to create. The ultimate structure would consist of forming a real property SPE to hold each piece of real estate, as well as a separate operating SPE for each nursing home business. Thus, a nursing home company currently owning and operating ten nursing homes would form twenty entities: ten real property entities that would own and lease the real estate to the ten nursing home operating companies that would obtain the licenses and Medicare and Medicaid certifications.

While a company can modify its particular mix of real property and operating entities to suit its individual needs, the analysis of the structures is identical in all situations. This discussion, therefore, will focus on a structure that employs a maximum

division of real estate and operating interests, although lesser groupings will be subject to the same general principles. In all instances, there is an emphasis on separating the ownership of the real estate from the ownership of the operating entity that holds the license and Medicare and Medicaid provider agreements. This is normally achieved by having the operating entity lease the facility from the real-property entity. This can be accomplished even where there is identical ownership and control between and among the real-property entity and the operating entity.

III. Legal Entities with Limited Liability

The structure discussed earlier is successful due to the protections accorded investors who form legal entities to pool resources and carry out their business endeavors.

Most individuals who own nursing-home operating companies that participate in the Medicare and Medicaid programs form legal entities, such as corporations, limited liabilities companies, or limited liability partnerships, to protect the individual owners from personal liability for the overpayment, malpractice, and false-claims liabilities attributable to the acts or omissions of the operating company/provider. Although certain jurisdictions, such as New York, have restrictions on for-profit corporate ownership of healthcare providers, this is the prevailing method of nursing home ownership in the United States.[34]

A. The Corporation

As a general rule, under the law in every state, a corporation is a legal entity separate from its shareholders. Thus, individuals who own the stock of a corporation are not personally liable for acts or omissions of the corporation, and parent corporations that own the stock of a subsidiary are not liable for acts of the subsidiary.[35] The policy served by creating a separate corporate identity to insulate shareholders and parent corporations from liability is the promotion of commerce and industrial growth.[36]

B. The Limited Liability Company

Recently, the limited liability company has become an increasingly popular vehicle for business owners.[37] Limited liability company statutes generally are flexible and allow the business owners, or members, substantial freedom to operate their business pursuant to the limited liability company operating agreement.[38] The company is managed either by the members directly

or by a board of managers, thereby allowing the separation of ownership and control in a manner similar to a corporation.[39] Furthermore, the limited liability company form of doing business offers its members tax benefits akin to a partnership, and offers its members and managers limited liability akin to a corporation.[40]

As with the corporate form of doing business, limited liability company formation statutes provide that the members and managers of a limited liability company are not personally liable for the liabilities of the company.[41] Under Delaware's Limited Liability Company Act, for example, except as otherwise set forth in the statute,

> the debts, obligations and liabilities of a limited liability company, whether arising in contract, tort or otherwise, shall be solely the debts, obligations and liabilities of the limited liability company, and no member or manager of a limited liability company shall be obligated personally for any such debt, obligation or liability of the limited liability company solely by reason of being a member or acting as a manager of the limited liability company.[42]

The limited liability principles applicable to corporations and limited liability companies exist whether the owners, members, or shareholders are individuals or other legal entities, such as corporations or limited liability companies.

IV. Holding Owners Liable

Notwithstanding these legal protections, in matters involving lawsuits against companies with few assets, injured parties may attempt to "pierce the veil" and hold the principals, owners, or related companies personally liable for the obligations, acts, or omissions of the company.

A. Piercing the Corporate Veil

Generally, the corporate veil may be pierced and liability may attach if a shareholder or parent corporation so controls the operation of the corporation or subsidiary corporation as to make it a mere adjunct, instrumentality, or alter ego of the shareholder or parent corporation—and fraud or injustice would result if the corporate form were upheld.[43] Despite this general rule, however,

corporate veil-piercing is subject to different standards, depending on whether federal law or state law is applied.

B. Liability of Limited Liability Company Members and Managers

In the limited liability company context, notwithstanding the protections accorded members and managers under formation statutes, courts may hold members and managers responsible for company liabilities on other grounds. A member or manager may be personally liable to the limited liability company for the member's or manager's failure to comply with statutory requirements or pursuant to the company operating agreement.[44] For example, under Delaware's Limited Liability Company Act, a limited liability company "shall not make a distribution to a member to the extent that at the time of the distribution, . . . all liabilities of the limited liability company . . . exceed the fair value of the assets of the limited liability company."[45] A member who receives a distribution knowing that it was made in violation of the statute is liable to the limited liability company for the amount of the distribution.[46]

In addition, courts may hold members and managers personally liable by applying the "piercing the corporate veil" doctrine to the limited liability company form of doing business. Some states' limited liability company acts specifically authorize the application of the corporate veil-piercing doctrine in the limited liability company context.[47] Even in those states with limited liability company statutes that do not specially authorize the application of the corporate veil-piercing doctrine, some courts are willing to pierce the veil of the limited liability company.[48]

Despite the willingness of many courts to pierce, there are arguments against applying corporate veil-piercing principles to limited liability companies.[49] One rationale is that the limited liability company statutes expressly define circumstances in which the member or manager will be held liable. For example, limited liability company statutes impose liability on members and managers for withdrawing funds and making distributions from struggling companies, particularly where the distributions would exceed the fair value of the assets of the company.[50] It is unnecessary, therefore, to pierce the veil of the limited liability company based on undercapitalization, a factor commonly applied in corporate veil-piercing cases.[51] The same result can be

reached against members of limited liability companies by applying the statute.[52]

A second rationale for not applying corporate veil-piercing standards to limited liability companies is that "many of the organizational formalities applicable to corporations do not apply to [limited liability companies]."[53] Thus, while failure to follow formalities is a frequent factor in corporate veil-piercing cases,[54] it is inappropriate to pierce the veil of a limited liability company on this basis. Furthermore, some limited liability company statutes specifically preclude liability of members and managers for failure to adhere to management formalities.[55]

At least one state legislature appears outwardly to have recognized that veil-piercing in the context of corporations and veil-piercing in the context of limited liabilities companies may not completely overlap. Four years after it was enacted, Illinois' Limited Liability Company Act was amended to remove language from the original act that held a member of a limited liability company "personally liable . . . to the extent that a shareholder of an Illinois business corporation is liable in analogous circumstances under Illinois law."[56] As amended, the act now provides that "the debts, obligations, and liabilities of a limited liability company, whether arising in contract, tort, or otherwise, are solely the debts, obligations, and liabilities of the company."[57] Moreover, members are now liable if "(1) a provision to that effect is contained in the articles of organization; and (2) a member so liable has consented in writing to the adoption of the provision or to be bound by the provision."[58]

Limited liability companies are relatively new structures[59] and, as a result, jurisprudence in this area is unsettled.[60] If statutory requirements are satisfied, therefore, defendant members or managers of limited liability companies may benefit by arguing that the statute controls on the particular issue and common law piercing principles are inapplicable to the analysis.

V. The Standards and Factors Applied in Veil-Piercing Cases

The arguments asserted in support of veil-piercing are identical, whether made against corporate shareholders, parent corporations, or members or managers of limited liability companies. As such, this Article draws no further distinction between limited liability companies and corporations.

A. *The Federal Standard in Medicare Overpayment and False Claims Veil-Piercing Cases*

More and more frequently, the United States attempts to pierce the corporate veil and recover from owners and related companies for Medicare overpayments and violations of the False Claims Act.[61] When addressing Medicare veil-piercing cases, federal courts generally apply a federal common law standard fashioned by the Third Circuit in *United States v. Pisani*.[62] The *Pisani* court concluded that "a uniform federal rule" was needed because application of state law could "frustrate specific objectives of the Medicare program."[63] The specific objectives identified by the court were "prompt reimbursements to providers," paying providers no more than their "reasonable costs," and "uniformity in the Medicare program."[64] The court found that application of state common law, which required proof of fraud,[65] would frustrate the goals of the Medicare program. This conclusion was reached because a provider could circumvent the objectives of the Medicare act by implementing ploys to obtain overpayments, avoid repaying them, and keep few or no records for the Medicare program to audit, making it difficult for the Medicare program to prove fraud.[66]

The *Pisani* court identified the following factors to consider when determining whether to hold an owner or related company liable for Medicare overpayments to or false claims of a provider company:

> First is whether the corporation is grossly undercapitalized for its purposes. Other factors are "failure to observe corporate formalities, non-payment of dividends, the insolvency of the debtor corporation at the time, siphoning of funds of the corporation by the dominant stockholder, non-functioning of other officers or directors, absence of corporate records, and the fact that the corporation is merely a facade for the operations of the dominant stockholder or stockholders." . . . Also, the situation "must present an element of injustice or fundamental unfairness," but a number of these factors can be sufficient to show such unfairness.[67]

Applying these factors, the court concluded that Pisani, the sole shareholder, president, and registered agent of Eaton Park Nursing Home, was personally liable for Medicare overpayments made to the nursing home.[68] The court found that Pisani

"followed no corporate formalities, operated the corporation with his personal funds, loaned large sums to the corporation and then repaid the loans to himself with corporate funds while the corporation was failing, and kept the corporation undercapitalized by loaning it money instead of investing equity in it."[69]

Although most federal courts apply the laundry list of factors identified by the *Pisani* court in determining whether to pierce the corporate veil, some federal courts apply the following three-factor test: "[T]he veil may be pierced only if the parent and subsidiary lacked independence, the principals conducted their affairs with a requisite degree of 'fraudulent intent,' and failure to pierce the veil would work substantial injustice."[70] This test seems to require proof of fraud, which the *Pisani* court found would frustrate the goals of the Medicare program by allowing a defendant to encourage overpayments and circumvent the repayment procedures. The cases, however, reveal that courts will infer fraud or intentional wrongful conduct from the facts of the case.[71]

Notwithstanding federal courts' routine application of federal common law in Medicare veil-piercing cases, "when there is little need for a nationally uniform body of law, state law may be incorporated as the federal rule of decision."[72] As will be addressed, some states have more-stringent requirements for piercing the corporate veil—such as a showing of fraud—that benefit defendants. Thus, in every case the choice of law should be considered carefully, even if the plaintiff is the United States and the allegations relate to Medicare overpayments or false claims. This is particularly true when the defendant is not a corporation, but a limited liability company, because limited liability company members can argue that veil-piercing is inapplicable and the liability of members should be determined based on the state law under which the limited liability company is formed.

B. State Standards

State Medicaid agencies often attempt to pierce the corporate veil and recover from owners and related entities for Medicaid overpayments.[73] In addition, private plaintiffs frequently attempt to pierce the corporate veil and recover in tort from owners and related companies.[74]

In veil-piercing cases, depending on state choice of law rules or agreements between the parties as to choice of law, a court may apply the law of the state in which the facility is located or the law

of the state in which the defendant company is formed.[75] Once again, choice of law should be carefully considered, due to the differences in states' application of veil-piercing standards.

No common standard exists among the various jurisdictions, and the factors that courts apply differ from state to state and case to case.[76] Nonetheless, factors commonly applied by state courts include the following: failure to observe corporate formalities; inadequate capitalization; commingling of assets; siphoning of funds; nonpayment of dividends; unjust loss or injury; and improper conduct, fraud, or illegality.[77] These factors often boil down to two categories: (1) unity of interest or no separate personality, and (2) fraud or injustice.[78]

Courts vary in the number of factors considered and the weight assigned to those factors in determining whether or not to pierce the corporate veil. The courts' discretion is reflected in the large, murky body of case law.[79] For example, some jurisdictions require a finding of fraud before piercing the corporate veil.[80] Other courts will infer the indicia of fraud from the facts of the case.[81] Finally, some courts do not require fraud or indicia of fraud, but simply a showing of injustice.[82]

C. Discussion of Veil-Piercing Cases

The following cases demonstrate under what circumstances the United States and private plaintiffs will attempt to pierce the corporate veil to recover Medicare overpayments, false claims, and malpractice judgments.

1. Owners Personally Liable for Medicare Overpayments

In *United States v. Bridle Path Enterprises, Inc.*, a Massachusetts federal district court held the owners of a home health agency personally liable for the Medicare overpayment debt of the provider, Bridal Path.[83] For cost year 1993, the Medicare fiscal intermediary determined that Bridal Path had received an overpayment of $231,568.[84] Bridal Path never requested an administrative hearing to challenge that determination.[85] Bridal Path made payments toward the overpayment until July 1997, when it sold all of its assets to Prism Home Care, Inc. (Prism), and notified the Medicare program that it was terminating its Medicare participation.[86] At the time of the sale and voluntary termination, $64,807.84 was outstanding on the overpayment liability.[87]

The United States sought to hold Bridle Path's owners personally liable for the Medicare overpayment, on the grounds that

Bridle Path was defunct and had little or no assets to satisfy the debt.[88] Noting there was "no single 'litmus' test" for determining whether to pierce the veil, the court looked at three factors: (1) the corporate identity; (2) the injustice that would result from not piercing the veil; and (3) the fraudulent intent of the defendants.[89]

Due to the number of checks Bridle Path wrote in 1996 and 1997 to its owners, their home health agency, and their real-estate holding company, the court found that the owners did not treat Bridle Path as a separate corporate entity.[90]

> During 1997, [the owners] made numerous sizeable payments to themselves from [Bridle Path]'s operations and payroll accounts, either directly or through one of their other companies. There is no evident rational business purpose to these payments, especially since [Bridle Path] was operating at a severe net loss at the time. In July 1997, when [Bridle Path] received an infusion of cash from its asset sale to Prism, the defendants used $68,573.36 of this income to pay for renovations to their personal residences. The defendants also funneled a generous portion of the proceeds into their own pockets in the months immediately following the sale. In contrast, the defendants did not apply any of the $750,000 Prism paid for [Bridle Path]'s assets to the Medicare debt. Such wrongful diversion of corporate assets at a time when the corporation was failing, and in fact dissolving, justifies piercing the corporate veil.[91]

Unfortunately, there is little discussion of why Bridle Path made payments to the owners. Bridle Path paid $40,000 to one owner, $56,000 to a home health agency owned by the owners, $6,800 to a real-estate holding company owned by the owners, $17,600 to an individual from whom the owners acquired a physical therapy company, and $68,000 to a contractor who testified that the payment was for work at the owners' private residence.[92] Bridal Path also increased payments to the owners out of Bridle Path's payroll accounts.[93] The owners did "not dispute or explain any of these payments."[94] Thus, the inference is that all the payments, even those arguably to legitimate service providers or landlords, were not made in the ordinary course of business.

The owners made two arguments to support their claim that they did not intend to defraud the government. First, they argued that the Internal Revenue Service (IRS) instructed them not to pay creditors prior to paying tax liabilities. Second, they claimed that they anticipated an additional $750,000 payment from Prism if, as stated in the purchase agreement, Prism achieved certain net revenues within the first year of operation.[95] The court disagreed. According to the court, "[a] strong inference of intentional fraud arises from these facts" and the owners offered "no facts to defeat the inference—only their flat assertion."[96]

In addition to piercing the corporate veil, the court held the owners personally liable under the federal priority statute, which prohibits a person indebted to the government from making a voluntary assignment of property to themselves or another entity instead of paying the government debt.[97] The owners made several payments to themselves out of Bridle Path's corporate accounts after they stopped making payment toward the Medicare overpayment.[98] The court found "no reason not to conclude that the defendants are personally liable for the [Bridle Path] Medicare debt."[99]

2. Owner and Related Companies Liable for False Claims Act Judgment

In *United States v. Lorenzo,* a Pennsylvania district court pierced the corporate veil to reach a shareholder and related companies in a Medicare false-claims action.[100] There, the government pursued a false-claims action against a dentist and his related companies for Medicare claims filed for oral cancer examinations of nursing home residents.[101] After concluding that the claims submitted by U.S. Mobile, a company owned and controlled by the dentist, constituted false claims, the court addressed the liability of the dentist and his related companies.[102]

The court held the dentist and his related companies jointly and severally liable for U.S. Mobile's false claims.[103] The dentist placed the Medicare revenues into the accounts of U.S. Mobile and his own professional bank account.[104] U.S. Mobile transferred undocumented funds to related companies, including suspicious rental transactions with related companies where the rental amount nearly doubled from the previous lease and documentation failed to show any other related party paying similar rents.[105] In addition, U.S. Mobile entered into contracts for services and equipment with the dentist and other related companies.[106] Further, the dentist transferred the services of another dentist to

his private practice, but continued to pay the dentist from U.S. Mobile funds.[107] The court found:

> There can be no question that corporate formalities were not observed; that significant inter-entity transactions were not documented; and that the corporations and partnerships were treated as a single unit and the alter ego of [the dentist].
>
> Finally, it is clear that U.S. Mobile was undercapitalized and that revenues were siphoned off from other ventures.[108]

Consequently, the court pierced the veil and held the dentist and related companies liable for U.S. Mobile's false claims.[109]

3. Parent Corporation Dismissed from a False-Claims Action Against Subsidiary

In *United States ex rel. Kneepkins v. Gambro Healthcare, Inc.,* the Massachusetts district court dismissed a parent corporation from the government's false-claims action because the government's allegation that the parent was the sole owner of the subsidiary corporation was insufficient to pierce the corporate veil.[110] There, the government brought a false-claims action against, among others, Dialysis Holdings, a successor in interest to a Medicare lab, and its sole owner, Gambro Healthcare, for allegedly performing unnecessary and wasteful blood tests at a medical testing lab.[111] Dialysis Holdings, Gambro's wholly-owned subsidiary, was the only link between Gambro Healthcare and the alleged wrongdoers.[112]

The court applied a three-factor standard to determine whether to pierce the veil: (1) the corporate identity; (2) the injustice that would result from not piercing the veil; and (3) the fraudulent intent of the defendants.[113] It concluded that the government's pleadings were insufficient as to Gambro because "[t]he only fact alleged is Gambro's sole ownership of Dialysis Holdings" and "[t]hat alone is plainly not enough."[114]

The government raised three arguments in opposition to Gambro's motion to dismiss. First, the government argued that the court should disregard the corporate form, "in the interests of 'public convenience, fairness and equity'" and, furthermore, "that the corporate form garners less respect in matters involving the enforcement of federal statutes."[115] The court rejected

the argument, finding that the government did not allege that Gambro filed a false claim itself and did not allege that Gambro had stripped Dialysis Holdings of its assets.[116]

Second, the government argued that "Gambro, a privately-held corporation whose affairs are not open to scrutiny, must be kept in the case because the information concerning its relationship with Dialysis Holdings and Vivra is within its control, unavailable to the government for pleading purposes, and may only be unearthed through discovery."[117] The court rejected the argument, because the government had not alleged facts supporting that belief.[118]

Finally, the government argued that the pleadings were sufficient to put Gambro on notice of the claims.[119] The court rejected the argument, concluding that the government "may not require a defendant to guess at what the contours of the claims against it may be when they take shape at some uncertain future time."[120]

4. Owners and Related Companies Not Liable for Medicaid Overpayment Judgment

In *State v. Woodvale Management Services, Inc.*, a Minnesota appellate court refused to find shareholders, officers, directors, and related companies liable for Medicaid overpayments made to an intermediate care facility for the mentally retarded (ICF/MR).[121] There, two individuals were the sole officers, directors, and shareholders of a corporation that operated an ICF/MR.[122] The individuals formed a management corporation and transferred all of the ICF/MR corporation's stock to the management corporation.[123] The individuals also owned a sole proprietorship that leased property to the ICF/MR corporation.[124] Eventually, the state closed the ICF/MR, which was in poor financial condition at the time.[125] The State of Minnesota subsequently attempted to pierce the corporate veil and recover the Medicaid payments owed by the ICF/MR from the individuals and the parent management company.[126]

Absent a showing of improper conduct, the court refused to find the individuals and related corporation liable for the debt of the ICF/MR.[127] It found the corporate entities "were, in fact, operated as separate corporations, observing all of the requisite and statutory corporate formalities."[128] It noted that "corporate dividends were not paid but reinvested in the corporation and . . . there was no evidence that [the parent] siphoned funds from [the ICF/MR]."[129] The court also found that it was "undisputed"

that the ICF/MR was adequately capitalized.[130] Although the ICF/MR was insolvent at the time the judgment became due, it was solvent during the period that gave rise to the judgment.[131] The court noted that "it is the State that directly caused the insolvency of [the ICF/MR] by closing the facility."[132]

Furthermore, the court found no indicia of fraud. Rather, it found that the management company provided management services to the ICF/MR, which in turn provided services to residents.[133] Although the state argued that the $3,000 initial capitalization of the ICF/MR corporation was inadequate, the court found that at the time it was capitalized, "there was no indication that the amount would prove insufficient."[134]

5. Jury to Hear Question of Whether Nursing Home Corporation was Adequately Capitalized

In *Autrey v. 22 Texas Services, Inc.*, plaintiffs filed a malpractice action against a nursing home operator and its general and limited partners, as well as the operator's management company and its general and limited partners.[135] The defendant general and limited partners moved for summary judgment on the grounds that plaintiffs failed to produce any evidence to justify piercing the corporate veil.[136] Applying Pennsylvania law, under which "there is a strong presumption against piercing the corporate veil," the Texas district court concluded that plaintiffs raised a genuine issue of fact as to the liability of the general and limited partners.[137]

With respect to the management company, the court found that the general partner of the management company, which was responsible for 100% of the operations of forty-nine nursing homes in Texas, as well as others in other states, had $42,000 in assets and virtually no liquid assets.[138] It noted that the "financial condition raises disturbing questions," especially where "undercapitalization" is a basis for piercing the corporate veil.[139] In addition to undercapitalization, the court looked to the corporate structure of the general partner.[140] It found that "[a]t the time of incorporation, [the company] had no employees, office space, or expenses; consequently, the company paid no rent and spent no money on advertising."[141] Furthermore, the court found it "suspicious" that the general partner "had nonfunctioning corporate officers."[142] The court concluded that if plaintiffs could prove at trial that defendants "asserted control over the management and ownership of the Texas nursing homes owned by [the general partner], it would add credence to their claim that [the general partner] represents nothing more than a corporate sham benefitting Defendants,

all of whom serve as the sole shareholders of [the general partner]."[143]

With regard to the operating company, the court found that six months after its formation, it had more than $54,000 in liabilities with no accompanying net assets.[144] "Based on the nature and risk of the nursing home business, the Court notes that engaging in the ownership of forty-nine nursing homes while also maintaining no net assets appears to amount to nothing less than a disputable issue regarding undercapitalization."[145]

These factual issues were sufficient to survive defendants' motion for summary judgment. The court held that "[g]iven the dispute surrounding whether [the entities] were adequately capitalized, the Court finds it reasonable to allow a jury to decide the issue."[146]

6. Veil-Piercing Inappropriate on Summary Judgment in Medicaid Overpayment Liability Action

In *Community Care Centers, Inc. v. Hamilton,* a nursing home corporation appealed an Indiana trial court decision in favor of the state Medicaid agency, rendering the nursing home shareholders personally liable for over $6 million in Medicaid overpayments.[147] The trial court had granted the Medicaid agency's motion for summary judgment on the grounds that the shareholders "through the manipulation of the corporate form, were the wrongful recipients of [over $6 million] in taxpayer-derived Medicaid funds," which was "enhanced by the absence . . . of corporate budgetary records, payment by the corporation of individual obligations and vice versa, commingling assets and affairs, together with the transfer of assets by salaries which were on their face fundamentally, unreasonably disparate to any value received."[148]

Applying Indiana law, under which courts are "reluctant to disregard corporate identity and do so only to protect third parties from fraud or injustice,"[149] the court examined the evidence as it related to the following eight factors: (1) undercapitalization; (2) absence of corporate records; (3) fraudulent representation by shareholders; (4) use of the corporation to promote fraud, injustice, or illegal activities; (5) payment by the corporation of individual obligations; (6) commingling of assets and affairs; (7) failure to observe required corporate formalities; and (8) other shareholder acts or conduct ignoring the corporate form.[150] The appellate court reversed the trial court's grant of summary judgment:

> While it may be that [the company's] corporate veil should be pierced, it should not have been pierced on summary judgment. Piercing the corporate veil should only be accomplished on summary judgment in extraordinary circumstances such as when it is patently obvious that the sole purpose for a corporation's existence is to perpetrate a fraud or injustice.[151]

VI. Conclusion

A. Restructuring to Reduce Unnecessary Risk of Exclusion

Forming operating SPEs, such as limited liability companies, to operate each nursing home will avoid unnecessary exclusion of all other nursing homes under common ownership or control in the event of exclusion of any one of the nursing homes.

The benefit of having the company's nursing homes owned and operated by SPEs is further demonstrated by the following example. In this example, *Company X* is neither the licensed operator nor the certified provider of any of the nursing homes. Instead, *Company X* forms three single-purpose operating company subsidiaries—*Company A*, *Company B*, and *Company C*, each wholly owned by *Company X*—to be the licensed operators and certified providers of the nursing homes. *Company A* operates the Friendly Nursing Home, *Company B* operates the Caring Nursing Home, and *Company C* operates the Loving Nursing Home. *Company A* enters into a plea agreement with the United States to settle civil and criminal claims arising under the False Claims Act for allegedly providing substandard quality of care to the residents of the Friendly Nursing Home, and for billing and receiving payment from the Medicare and Medicaid programs for that substandard care. The DHHS Secretary excludes *Company A* from the Medicare and Medicaid programs.

Under this scenario, the DHHS Secretary does not exclude the Caring Nursing Home and the Loving Nursing Home for the conduct attributable to the Friendly Nursing Home, because the former are neither owned nor controlled by *Company A*. In addition, under this scenario, entities participating in the Medicare and Medicaid programs that provided items or services to all three nursing homes would be precluded from billing for items or services related to business conducted only with the Friendly Nursing Home. They could continue to seek reimbursement from any federal program for any business done with the Caring Nursing Home and the Loving Nursing Home.

In this example, *Company A*'s nursing home operations will have the maximum protection against exclusion if each nursing home is operated by an operating SPE. If a nursing home must be excluded, it will mandate neither the exclusion nor the divestiture to avoid exclusion of any other nursing home provider.

Moreover, *Company A*'s real estate holdings will have the maximum protection in the event of exclusion if the operating interests are held separate and apart from the real estate. Placing the real-estate interests in a real-property SPE and the operating interests in an operating SPE will avoid from the outset the possibility of restructuring on short notice to avoid a permissive exclusion attaching to the real estate.

Forming operating SPEs with ownership identical to other operating SPEs does not present unreasonable exposure to the owners or related companies. The DHHS Secretary may exclude any individual who has a direct or indirect ownership or control interest in, or is an officer or managing employee of, a sanctioned entity.[152] There is, however, no requirement or authority for the DHHS Secretary to exclude an individual who *had* a direct or indirect ownership or control interest in, or who *was* an officer or managing employee of a sanctioned entity.[153] The owners, shareholders, members, directors, or officers of the soon-to-be excluded operating entity could divest their interest in the company without having to divest their interests in any other nursing home operations, because the DHHS Secretary must give notice of intent to exclude.[154] This approach is commonly employed in divestiture situations with the knowledge and consent of the OIG.

B. Restructuring to Reduce Exposure to Financial Liability

Forming operating SPEs for each nursing home can prevent third-party and government litigants from obtaining and enforcing judgments against related operating companies, the real estate, and investors in the event that the operating company is sued to recoup Medicare or Medicaid overpayments, for False Claims Act violations, or for nursing-home malpractice.

Furthermore, holding the real estate in a separate real-property entity that leases the nursing home to the operating entity protects the assets by making the real estate unavailable for collection by judgment creditors of the operating entity. This, in turn, can serve to make the real estate more attractive to potential lenders because the most problematic risks of nursing home operations do not reach the real estate. Indeed, many

current investors and lenders are requiring that the real property owner not engage in the operation of the facility. The model for such an approach is the Real Estate Investment Trust (REIT), which prohibits owners from engaging in the operations of the real estate they own. There are other legitimate corollary benefits and uses for a separate real-property SPE. For example, the real estate could be placed in a trust for estate-planning purposes while the current operators directly own the operating entity. In addition, the real-property entity could attract investors who are leery of operating risks, thereby altering the ownership composition between the real-property entity and the operating entity.

Forming operating SPEs with ownership identical to other operating SPEs, or ownership identical to the real property entities, does not present unreasonable exposure to the owners or related companies. Although there is no single litmus test for determining when courts will pierce the corporate veil, the following factors alone are insufficient: wholly owned, sole shareholder, or sole member companies;[155] insolvency;[156] and failure to pay corporate dividends.[157] Due to the variation among courts in applying veil-piercing analyses, defendants should carefully evaluate choice-of-law provisions when faced with a veil-piercing claim. Some jurisdictions require a showing of fraud, or indicia of fraud, an element favorable to defendants. Finally, defendant limited liability companies should assert that the corporate veil-piercing doctrine is inapplicable to the company, which instead should be held to the statutory standards in the state where it was formed.

APPENDIX: Practice Guide

I. Avoiding Veil-Piercing

Mere ownership of a nursing home operating company is insufficient to hold the shareholders, members, or parent company liable for the acts and omissions of the company, even if the related companies have identical directors and officers. That said, there are steps that nursing home companies should take to minimize the risk of veil-piercing exposure.

A. Adhere to Formalities. The following are formalities that courts have found significant:

- Adopt bylaws;
- Conduct meetings of the shareholders/directors/officers/members;

- Maintain meeting minutes that reflect business decisions made by the officers; and
- Maintain separate banking and accounting records that account for the cash and assets of the company separate and distinct from the cash and assets of shareholders, directors, officers, members, and affiliates.

B. Preserve the distinction among the operating entity and its shareholders, directors, officers, members, and affiliates. Conduct business in the company name, not in the name of an affiliate, shareholder, director, officer, or member of the company. Relevent measures include the following:

- Hold out to the public only the operating entity, not its shareholders/members or affiliates, as operating the nursing home;
- Have the operating entity, not related/affiliate companies, rent the property;
- Enter into product and service agreements on behalf of the operating entity;
- Market the services of the nursing home, not those of its affiliates;
- Use admissions agreements that identify the nursing home operating entity only, not its "chain" affiliates; and
- Employ and pay nursing home personnel at the company level, not at the chain level.

C. Adequately Capitalize the Operating Entity. There is little guidance concerning what constitutes adequate capitalization of a nursing home. In one case, $3,000 was deemed to be sufficient capitalization of an ICF/MR at the time of incorporation. In another case, $500 was viewed as "thin capitalization," but the court did not decide whether that amount of capitalization was too thin. In the recent *Autrey* case discussed in the Article, the court questioned the adequacy of a nursing home management company's capitalization where the management was responsible for the operations of forty-nine nursing homes, had $42,000 in assets, and virtually no liquid assets.[158] The following are indicia of capitalization that courts will consider.

1. Initial Capitalization

- Capitalize to meet state minimum statutory requirements.
- Capitalize to meet industry standards. Some states require Medicaid providers upon enrollment to show financial

statements and demonstrate minimum working capital capacity.
- The lack of some amount of operating capital will be found to be inadequate capitalization.

2. **Solvency**

- Maintain capital necessary to pay immediate and foreseeable obligations.

3. **Insurance**

- Maintain adequate insurance according to state-law and industry standards.
- Maintain capital necessary to pay out insurance deductibles as foreseeable obligations of the company.

D. Avoid even the appearance of siphoning revenues to related entities or shareholders/members. Indicia of siphoning include the following:

- Repayment of loans from shareholders at a time when other creditors are not being paid;
- Payment of rent to related companies for greater than fair market value; and
- Payment of management fees to related companies for greater than fair market value.

II. Deciding Whether to Restructure

Ultimately, the decision to restructure is made based on an assessment of the organization's business goals, which involves a balancing of acceptable risk with acceptable costs. If the business goal is minimizing liability and exclusion exposure, the costs associated with creating SPEs to hold the real estate and operate the nursing home may outweigh the risks of losing several nursing homes to exclusion or malpractice judgments. On the other hand, if the business goal is administrative simplicity, the balance likely would not tip in favor of creating a real-property SPE and an operating SPE for each nursing home. There is a point at which the goals of administrative simplicity and minimizing liability and exclusion exposure converge, coupled with the costs associated with restructuring, no longer outweigh the risk of losing several nursing homes.

The costs of restructuring can be high. For each entity, there are costs associated with:

- Deciding upon the legal structure to form and in which state to form it;
- Forming the legal structure;
- Preparing the articles of incorporation or limited liability company operating agreements;
- Qualifying the entities to do business in the state in which the nursing home is located;
- Annual company and business registration fees;
- Maintaining corporate formalities;
- Maintaining adequate capitalization;
- Locally managing day-to-day operations and financials; and
- Locally establishing facility policy.

Moreover, restructuring has financing, tax, and employment implications that go beyond the scope of this Article.

Nevertheless, the benefits of restructuring can be great. Establishing real property SPEs and operating SPEs benefits the organization by:

- Making real estate unavailable for collection by judgment creditors;
- Shielding from exclusion affiliate nursing homes operated by separate entities with the same ownership and control;
- Shielding from judgment creditors the operating cash and assets of affiliate nursing homes;
- Precluding the poor-performing nursing home from depleting the cash and assets of more successful operations, and driving into bankruptcy the business operation of all of the commonly-owned nursing homes; and
- Increasing opportunities for commercial and government financing.

Endnotes

[1] Liberty Mutual Ins. Corp. v. M & O Springfield Co., No. 97-4146, 1998 WL 894654, *2 (7th Cir. Dec. 17, 1998) (unpublished opinion) (quoting Van Dorn Co. v. Future Chem. & Oil Corp., 753 F.2d 565, 569 (7th Cir. 1985)) (citations omitted).

[2] U.S. Dep't of Health and Human Servs., Office of Inspector Gen., Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal

Health Care Programs, 64 Fed. Reg. 52,791 (Sept. 30, 1999) (discussion of the OIG's role in exclusions).

[3] 42 U.S.C. § 1320a-7(a) (2003); 42 C.F.R. § 1001.101 (2003). Specifically, under 42 U.S.C. § 1320a-7, Congress requires the Secretary of DHHS to exclude an individual or entity from participation in the federal health care programs where he or it has been convicted of: "(1) a criminal offense related to the delivery of an item or service under subchapter XVIII . . . or under any State health care program;" (2) "a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service;" (3) certain offenses "in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program . . . consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;" and (4) an offense "consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance."

[4] Under the permissive exclusion authority, the Secretary of DHHS may exclude individuals and entities who have committed fraud or other criminal acts, or who have been "otherwise sanctioned" under a federal or state health care program for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity. 42 U.S.C. § 1320a-7(b)(5)(B) (2003); 42 C.F.R. § 1001.601(a)(1) (2003).

[5] An ownership interest means a five-percent or greater interest in the capital, stock, or profits of the entity or any mortgage, deed, trust, note, or other obligation secured in whole or in part by the property or assets of the entity. 42 U.S.C. § 1320a-7(b)(8)(A)(i) (2003); 42 C.F.R. § 1001.1001(a)(ii)(A)(2) (2003).

[6] A controlling interest includes officers, directors, agents, partners, and managing employees. 42 U.S.C. § 1320a-7(b)(8)(A)(ii) (2003); 42 C.F.R. § 1001.1001(a)(ii)(A)(3)-(6) (2003).

[7] 42 U.S.C. § 1320a-7(b)(8) (2003); 42 C.F.R. § 1001.1001(a)(ii)(A) (2003).

[8] 42 U.S.C § 1320a-7(b)(8)(A)(i) (2003); 42 C.F.R. § 1001.1001(a)(ii)(A) (2003).

[9] 42 U.S.C § 1320a-7(b)(8)(A)(iii) (2003); 42 C.F.R. § 1001.1001(a)(ii)(B) (2003).

[10] *See* 42 C.F.R. §§ 405.370, 405.371(a), 405.372, 405.373 (2003). *See also* CENTERS FOR MEDICARE AND MEDICAID SERVICES, CMS-PUB. 13-2, MEDICARE INTERMEDIARY MANUAL, PART 2 §§ 2225, 2229 (2003) (procedures for suspending interim payments and recovery of overpayment resulting from unnecessary services). A Medicare fiscal intermediary may also suspend Medicare payments to recover Medicaid overpayments owed to a provider. In addition, it may withhold the federal share of Medicaid payments to a Medicaid provider that has Medicare overpayment liability. *See id.* §§ 2226.1, 2226.2.

[11] *See* 42 C.F.R. §§ 405.370, 405.371(a), 405.372, 405.373 (2003).

[12] *See, e.g.*, CONN. AGENCIES REGS. § 17-311-53(b) (2003) ("Whenever the Commissioner . . . renders a rate decision . . . which decision results in the facility being indebted to the Department . . . for past Medicaid overpayments, the department shall recoup said Medicaid overpayments as soon as possible from the department's monthly Medicaid payments to the facility.").

[13] It is worth noting that some states' laws specifically authorize the Medicaid agency to recoup overpayments from another provider that is owned or controlled by the same individual or entity that owns the provider that is subject to the overpayment recoupment. In Connecticut, for example,

> [i]f a facility owes money to the department, the department may offset against such indebtedness any liability of the department to another provider which is owned or controlled by the same person or persons who owned or controlled the first facility at the time the indebtedness to the department was incurred. In the case of the same

> person or persons owning or controlling two or more facilities but separately incorporating them, whether the person or persons own or control such corporations shall be an issue of fact. Where common ownership or control is found, this subsection shall apply notwithstanding the form of business organization utilized by such persons e.g. separate corporations, limited partnerships, etc.

CONN. AGENCIES REGS. § 17-311-53(f) (2003).

[14] *See* U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, SUBCOMMITTEE ON GOVERNMENT EFFICIENCY, FINANCE MANAGEMENT AND INTERGOVERNMENTAL RELATIONS, COMMITTEE ON GOVERNMENT REFORM, HOUSE OF REPRESENTATIVES, DEBT COLLECTION IMPROVEMENT ACT OF 1996, HHS'S CENTERS FOR MEDICARE & MEDICAID SERVICES FACES CHALLENGES TO FULLY IMPLEMENT CERTAIN KEY PROVISIONS, GAO REP. NO. 02-307, at 5 (Feb. 22, 2002).

[15] *See id* at 1; U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF INSPECTOR GEN., DELINQUENT MEDICARE DEBT AND COMPLIANCE WITH THE DEBT COLLECTION IMPROVEMENT ACT BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, OIG REP. NO. A-17-01-02003, at 3 (2002).

[16] *See* VERNON SMITH ET AL., THE HENRY J. KAISER FAMILY FOUNDATION, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID SPENDING GROWTH: A 50-STATE UPDATE FOR FISCAL YEAR 2003, at 1, 2, 4, 6-7, 13 (2003), *available at* www.kff.org/content/2003/4082/4082.pdf (last visited Sept. 30, 2003).

[17] *See* JOHN HOLAHAN ET AL., THE HENRY J. KAISER FAMILY FOUNDATION, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE STATE FISCAL CRISIS AND MEDICAID: WILL HEALTH PROGRAMS BE MAJOR BUDGET TARGETS? 12 (2003), *available at* www.kff.org/content/2003/4073/4073.pdf (last visited Sept. 30, 2003).

[18] 31 U.S.C. § 3729(a) (2003).

[19] *See, e.g.*, Press Release, U.S. Attorney's Office, U.S. Reaches Settlement with Temple University Health System Affiliates (Mar. 5, 2003) (announcing $500,000 civil settlement involving two nursing homes for failing to provide adequate resident assessments and evaluations, nutrition, falls prevention, and pain management, among other care), *available at* www.usao-edpa.com/Pr/2003/mar/temple.html (last visited Sept. 30, 2003).

[20] 31 U.S.C. § 3729(a) (authorizing penalties of $5,000 to $10,000); 64 Fed. Reg. 47,099-104 (Aug. 30, 1999) (In accordance with other legislation, DOJ provides increase of penalty amounts to $5,500 and $11,000 to account for inflation).

[21] *See* Press Release, Beverly Enterprises, Inc., Beverly Enterprises Finalizes Medicare Settlements (Feb. 3, 2000), *available at* www.beverlycares.com/beverly_internet/investor/corporate_info/investor_news/february_3_2000_medicare_settlement.html (last visited Sept. 30, 2003).

[22] Press Release, U.S. Dep't of Justice, Vencor and Ventas Paying U.S. $219 Million to Resolve Health Care Claims as Part of Vencor's Bankruptcy Reorganization (Mar. 19, 2001), *available at* www.usdoj.gov/opa/pr/2001/March/115civ.htm (last visited Sept. 30, 2003).

[23] *See, e.g.*, MICH. COMP. LAWS ANN. § 400.601 (West 2003) (Michigan Medicaid False Claims Act).

[24] *See, e.g.*, CAL. GOV'T CODE § 12650 (West 2003) (California False Claims Act); D.C. CODE ANN. § 2-308.03 (2003) (claims by the District government against contractor).

[25] *See, e.g.*, JACK A. MEYER, TAXPAYERS AGAINST FRAUD EDUCATION FUND, FIGHTING MEDICARE FRAUD: MORE BANG FOR THE FEDERAL BUCK (2003) (finding benefit to cost ratio of nearly 9 to 1 for federal government funds spent on investigating fraud and prosecuting cases), *available at* www.taf.org/publications%5Cpdf%5Cfighting medicarefraud.pdf (last visited Sept. 30, 2003).

[26] *See, e.g.*, ANDY SCHNEIDER, TAXPAYERS AGAINST FRAUD EDUCATION FUND, REDUCING MEDICAID FRAUD: THE POTENTIAL OF THE FALSE CLAIMS ACT 33 (2003), *available at*

www.taf.org/publications/PDF/reducingmedicaidfraud.pdf (last visited Sept. 30, 2003).

[27] Fuqua v. Horizon/CMS Healthcare Corp., No. 4:98-00-CV-1087-Y, 2001 WL 267650, at *1 (N.D. Tex. Feb. 14, 2001) (final judgment).

[28] *See* THERESA W. BOURDON & SHARON C. DUBIN, AON RISK CONSULTANTS, INC., LONG TERM CARE GENERAL LIABILITY AND PROFESSIONAL LIABILITY ACTUARIAL ANALYSIS 3, 6, 13 (2003), *available at* www.ahca.org/brief/aon_ltcanalysis2003.pdf (last visited Sept. 30, 2003).

[29] *Id.* at 3, 7, 13.

[30] *Id.* at 3.

[31] *See id.* at 31-34.

[32] *Id.* at 31.

[33] *See* NAT'L CONF. OF ST. LEGISLATURES, HEALTH POLICY TRACKING SERVICE SNAPSHOTS: LONG TERM CARE: 2003 MID-YEAR REPORT, NURSING HOME LIABILITY INSURANCE (Aug. 2003), *available at* www.ncsl.org/programs/health/ss3longcare.htm (last visited Sept. 30, 2003).

[34] *See, e.g.*, N.Y. PUB. HEALTH LAW § 2801-a(9) (McKinney 2003) (with limited exceptions, authorizing only a "natural person, a partnership or limited liability company" to engage in the business of operating a hospital for profit); *id.* § 2801 (including nursing home in the definition of hospital).

[35] *See* RESTATEMENT (SECOND) OF AGENCY: CORPORATE SUBSIDIARIES § 14M (1983) [hereinafter RESTATEMENT].

[36] *See generally* 18 AM. JUR. 2D, *Corporations* § 43 (1985).

[37] *See* LARRY E. RIBSTEIN & ROBERT R. KEATINGE, RIBSTEIN AND KEATINGE ON LIMITED LIABILITY COMPANIES 1 n.1 (2002) (limited liability companies growing by more than 30% per year).

[38] Elf Atochem North America, Inc. v. Jaffari, 727 A.2d 286, 290-91 (Del. 1999) (noting that Delaware's Limited Liability Company Act provides "substantial freedom of contract").

[39] RIBSTEIN & KEATINGE, *supra* note 37, § 8.02 at 2.

[40] *Id.*

[41] *See, e.g.*, CONN. GEN. STAT. ANN. §§ 34-133(a), 34-133(b), 34-134 (West 2003); DEL. CODE ANN. tit. 6, § 18-303(a) (2003).

[42] DEL. CODE ANN. tit. 6, § 18-303(a).

[43] *See generally* RESTATEMENT, *supra* note 35, at § 14M cmt. a.

[44] *See, e.g.*, CAL. CORP. CODE § 17101(e) (West 2003) ("a member . . . may agree to be obligated personally . . . as long as the agreement . . . is set forth in the articles of organization or in a written operating agreement"); CONN. GEN. STAT. ANN. § 34-134 (West 2003) ("[a] member or manager of a limited liability company is not a proper party to a proceeding by or against a limited liability company . . ., except where the object of the proceeding is to enforce a member's or manager's right against or liability to the limited liability company or as otherwise provided in an operating agreement"); *id.* § 34-141 (a member or manager is required to discharge his duties in good faith and shall not be liable to the limited liability company if he acts in good faith); DEL. CODE ANN. tit. 6, § 18-303(b) (2003) ("under a limited liability company agreement . . . , a member or manager may agree to be obligated personally for any or all of the debts, obligations and liabilities of the limited liability company"); 805 ILL. COMP. STAT. 180/10-10 (West 2003) (members are liable if a provision to that effect is in the articles of organization and a member has consented in writing to the adoption of the provision).

[45] DEL. CODE ANN. tit. 6, § 18-607(a) (2003).

[46] *Id.* § 18-607(b).

[47] *See, e.g.*, CAL. CORP. CODE § 17101(b) (West 2003) (member may be liable "under the same or similar circumstances and to the same extent as a shareholder of a corporation"); GA. CODE ANN. § 14-11-314 (2003) ("this chapter does not alter any law with respect to disregarding legal entities");

MINN. STAT. § 322B.303, subd. 2 (West 2003) ("case law that states the conditions and circumstances under which the corporate veil of a corporation may be pierced under Minnesota law also applies to limited liability companies"); N.D. CENT. CODE § 10-32-29, 3 (2003) ("case law that states the conditions and circumstances under which the corporate veil of a corporation may be pierced under North Dakota law also applies to limited liability companies"); WASH. REV. CODE § 25.15.060 (2003) (members "shall be personally liable for any act, debt, obligation, or liability of the limited liability company to the extent that shareholders of a Washington business corporation would be liable in analogous circumstances"); WIS. STAT. ANN. § 183.0304(2) (West 2003) ("nothing in this chapter shall preclude a court from ignoring the limited liability company entity under principles of common law of this state that are similar to those applicable to business corporations and shareholders in this state"). Some states have limited the application of the corporate veil-piercing doctrine to specifically exclude the failure to follow formalities applicable to corporations. *See also* CAL. CORP. CODE § 17101(b) (West 2003); COLO. REV. STAT. ANN. § 7-80-107(2) (West 2003); WASH. REV. CODE § 25.15.060 (2003).

[48] *See, e.g.,* STEPHEN B. PRESSER, PIERCING THE CORPORATE VEIL § 401[2] (West 2002); KLM Indus., Inc. v. Tylutki, 815 A.2d 688, 689 n.2 (Conn. App. Ct. 2003) ("the determination of whether to pierce the corporate veil of a stock corporation or to disregard the protections afforded a limited liability company requires the same analysis"); Curole v. Ochsner Clinic, L.L.C., 811 So. 2d 92, 96 (La. Ct. App. 2002) (limited liability company veil may be pierced based on a "totality of the circumstances" review, but finding insufficient allegations to support veil-piercing claim for venue purposes) (citing Hollowell v. Orleans Reg. Hosp., LLC, 217 F.3d 379, 387 (5th Cir. 2000)); J.C. Compton Co. v. Brewster, 59 P.3d 1288, 1293 (Or. Ct. App. 2002) (reversing judgment in favor of plaintiff on LLC veil-piercing claim where plaintiff failed to show a relationship between the misconduct and the plaintiff's injury); Bonner v. Brunson, No. A03A1514, 2003 WL 21730686, at *1 (Ga. Ct. App. July 28, 2003) (a Georgia court may pierce the veil of the limited liability company if the member, "in order to defeat justice or perpetrate fraud, conducts his personal and limited liability company business as if they were one by commingling the two on an interchangeable or joint basis or confusing otherwise separate properties, records, or control"); Kaycee Land & Livestock v. Flahive, 46 P.3d 323, 328-29 (Wyo. 2002) (holding that the doctrine of piercing the veil should apply to limited liability companies, although the factors that would justify piercing an limited liability company veil might differ).

[49] *See, e.g.,* New Horizons Supply Co-op. v. Haack, No. 98-1865, 1999 WL 33499, at *3 (Wis. Ct. App. Jan. 28, 1999) (rejecting trial court's theory of piercing limited liability company veil, but upholding trial court's decision based on failure to follow statutory formation requirements). *See also* Warren H. Johnson, *Limited Liability Companies (LLCs): Is the LLC Liability Shield Holding Up Under Judicial Scrutiny?*, 35 NEW ENG. L. REV. 177, 209-214 (2000) (arguing in favor of a "juridical personality" for limited liabilities companies and rejecting the treatment of limited liability companies "like a partnership" or "like a corporation").

[50] *See, e.g.,* DEL. CODE ANN. tit. 6, § 18-607(a) (2003).

[51] *See, e.g.,* Autrey v. 22 Tex. Servs., Inc., 79 F. Supp. 2d 735, 745 (S.D. Tex. 2000); Cmty. Care Ctrs., Inc. v. Hamilton, 774 N.E.2d 559, 565-66 (Ind. Ct. App. 2002). *C.f.,* RIBSTEIN & KEATINGE, *supra* note 37, § 12.03 at 6 (noting that inadequate capitalization is rare, even in corporations).

[52] The converse also applies. For example, in Pepsi-Cola Bottling Co. v. Handy, No. 1973-S, 2000 WL 364199, at *3-*6 (Del. Ch. Mar. 15, 2000), the court looked to the Delaware Limited Liability Company Act and found that the

defendants were not entitled to statutory protections as members of a limited liability company because the allegations were "based on conduct [that] occurred before the LLC was formed." Thus, defendants could not use the Delaware Limited Liability Company Act to shield them from liability under other theories.

[53] Kaycee Land & Livestock v. Flahive, 46 P.3d 323, 328 (Wyo. 2002). *See also,* RIBSTEIN & KEATINGE, *supra* note 37, § 12.03 at 5-7 (discussing distinctions between corporations and limited liability companies in the context of veil-piercing).

[54] *See* United States v. Pisani, 646 F.2d 83, 88 (3rd Cir. 1981); *Cmty. Care Ctrs., Inc.,* 774 N.E.2d at 565. *See also Kaycee Land & Livestock,* 46 P.3d at 328 (holding that "the doctrine of piercing the veil should apply to limited liability companies," although the factors that would justify piercing an limited liability company veil might differ because, for example, "many of the organizational formalities applicable to corporations do not apply to LLCs").

[55] *See, e.g.,* CAL. CORP. CODE § 17101(b) (West 2003); COLO. REV. STAT. ANN. § 7-80-107(2) (West 2003); MONT. CODE ANN. § 35-8-304(2) (2002); WASH. REV. CODE ANN. § 25.15.060 (West 2003).

[56] *See* 805 ILL. COMP. STAT. § 180/10-10 (West 2003), *amended by* P.A. 90-424, § 10, effective Jan. 1, 1998.

[57] *Id.* § 180/10-10(a).

[58] *Id.* § 180/10-10(d).

[59] RIBSTEIN & KEATINGE, *supra* note 37, § 1.02 at 2 n.2. The first limited liability company act was enacted in Wyoming in 1977. *Id.* at 6. *See* Kaycee Land & Livestock v. Flahive, 46 P.3d 323, 326 (Wyo. 2002). By the mid-1990s, all fifty states and the District of Columbia had enacted limited liability company statutes. RIBSTEIN & KEATINGE, *supra* note 37, at 8.

[60] RIBSTEIN & KEATINGE, *supra* note 37, § 12.03 at 3-5 (noting uncertainty in how courts have treated and will treat veil-piercing in the limited liability company context).

[61] For a sampling of cases involving attempts to pierce the veil of Medicare provider companies, see United States v. Pisani, 646 F.2d 83, 87 (3d Cir. 1981); United States v. Bridle Path Enters., Inc., No. CIV.A.99-11051-GAO, 2001 WL 1688911, at *2 (D. Mass. Dec. 4, 2001) (piercing the corporate veil to recover Medicare overpayments); United States ex rel. Kneepkins v. Gambro Healthcare, Inc., 115 F. Supp. 2d 35, 39-41 (D. Mass 2000) (dismissing a parent corporation from a Medicare false-claims action); Healthcare Tech. Servs., Inc. v. Shalala, No. CIV.A.99-4467, 2000 WL 537448, at * 3–4 (E.D. Pa. Apr. 25, 2000) (declining to dismiss related companies from action seeking to recover Medicare overpayments on allegations that one individual was President and CEO of four companies, all four companies were located in the same city, and four companies "shifted patients between them to increase payments flowing to one company, and avoid or bypass various actions . . . that reduced payments to another related company"); United States ex rel. Piacentile v. Wolk, No. CIV.A.93-5773, 1995 WL 20833, at *4 (E.D. Pa. 1995) (holding shareholder not liable for corporation's violation of the False Claims Act where there was no basis for piercing the corporate veil); United States v. Lorenzo, 768 F. Supp. 1127, 1132-33 (E.D. Pa. 1991) (piercing the corporate veil in false-claims action against dentist and related companies); United States v. Arrow Med. Equip. Co., No. CIV.A.90-5701, 1990 WL 210601, at *8 (E.D. Pa. Dec. 18, 1990) (declining to dismiss officers and related companies from action seeking to recover Medicare overpayments because defendants "cannot be permitted to use the corporate form as a defensive shield to ward off . . . overpayment claim[s] and to escape the reach of the Medicare regulations from which they previously benefited"); United States v. Thomas, 515 F. Supp. 1351, 1357 (W.D. Tex. 1981) (piercing the corporate veil to recover Medicare payments

where assets were dissipated to sole shareholder's benefit at time that corporation was failing).

[62] *Pisani*, 646 F.2d at 86, 88.

[63] *Id.* at 86.

[64] *Id.* at 86-87.

[65] *See Id.* at 87. Notwithstanding the fraud factor applied in many federal (and state) cases, the Court of Appeals for the District of Columbia Circuit recently noted: "The difference between being a fraud and conducting one is important. Even a fully-capitalized, Fortune 500 corporation can embark on a fraud, but that would not make its corporate form a sham or its shareholders personally liable." United States v. Jamieson Sci. and Eng'g, Inc., 322 F.3d 738, 741 (D.C. Cir. 2003) (citations omitted) (holding President and CEO of corporation not personally liable under False Claims Act based on the company's alleged fraudulent conduct).

[66] *Pisani*, 646 F.2d at 88-89.

[67] *Id.* at 88 (citations omitted) (quoting DeWitt Truck Brokers v. W. Ray Flemming Fruit Co., 540 F.2d 681, 686-87 (4th Cir. 1976). *See also* United States v. Jon-T Chem., Inc., 768 F.2d 686, 691-93 (5th Cir. 1985) (applying "a laundry list of factors" and concluding that government's claims for fraudulent misrepresentation and conversion sounded in tort rather than contract and, thus, indicia of fraud were unnecessary to uphold ruling piercing the corporate veil); Healthcare Tech. Servs., Inc. v. Shalala, No. CIV.A.99-4467, 2000 WL 537448, at * 3 (E.D. Pa. Apr. 25, 2000); United States v. Lorenzo, 768 F. Supp. 1127, 1132-33 (E.D. Pa. 1991); United States v. Golden Acres, Inc., 702 F. Supp. 1097, 1104-07 (D. Del. 1988) (applying these factors, court held related companies and individuals liable for HUD judgment against defendant company for company's failure to make mortgage payments to HUD).

[68] *Pisani*, 646 F.2d at 84, 89-90.

[69] *Id.* at 88.

[70] United States ex rel. Kneepkins v. Gambro Healthcare, Inc., 115 F. Supp. 2d 35, 39-40 (D. Mass 2000) (applying three-factor test in Medicare false-claims action). *See also* United States v. Bridle Path Enters., Inc., No. CIV.A.99-11051-GAO, 2001 WL 1688911, at *3 (D. Mass. Dec. 4, 2001) (applying three-factor test in Medicare overpayment-recoupment action).

[71] *See, e.g., Bridle Path Enters.*, 2001 WL 1688911, at *3 (noting a "strong inference of intentional fraud" based on payments made to owners and related companies while Medicare provider was operating at a net loss).

[72] United States v. Kimbell Foods, Inc., 440 U.S. 715, 728 (1979).

[73] Cmty. Care Ctrs., Inc. v. Hamilton, 774 N.E.2d 559, 562 (Ind. Ct. App. 2002).

[74] *See, e.g.*, Autrey v. 22 Tex. Servs., Inc., 79 F. Supp. 2d 735, 746-47 (S.D. Tex. 2000) (plaintiffs' allegations against nursing home and related companies created triable issue of fact as to veil-piercing that survived defendants' motion for summary judgment); House v. 22 Tex. Servs., Inc., 60 F. Supp. 2d 602, 610, 614 (S.D. Tex. 1999) (court pierces corporate veil to obtain personal jurisdiction over individual defendants).

[75] *See, e.g.*, Wausau Bus. Ins. Co. v. Turner Const. Co., 141 F. Supp. 2d 412, 416–17 (S.D.N.Y. 2001) (court applied New York law by agreement of the parties, although New York choice of law principles would apply the law of the state of incorporation [Delaware] to determine whether to pierce the corporate veil); *Autrey*, 79 F. Supp. 2d at 740 (in nursing home malpractice action, court applied the law of the state of incorporation of the corporate defendants to determine whether to pierce the corporate veil); Downing v. Jameson, No. CV 96-0323910S, 1998 WL 811876, at *3-*4 (Conn. Super. Ct. Nov. 13, 1998) (court applied Connecticut law to assess whether veil-piercing allegations against foreign company survived a motion for summary judgment).

[76] *See* PRESSER, *supra* note 48, § 1.03[4] at I-27 to 31 (West 1991) (citing FREDERICK J. POWELL, PARENT AND SUBSIDIARY CORPORATIONS: LIABILITY OF A PARENT CORPORATION FOR THE OBLIGATIONS OF ITS SUBSIDIARY (1931) (the seminal treatise on piercing the corporate veil); WILLIAM MEADE FLETCHER, FLETCHER CYCLOPEDIA OF THE LAW OF PRIVATE CORPORATIONS §§ 41 at 557-61, 41.30 at 617-18 (West 1999)).

[77] *See* PRESSER, *supra* note 48, § 1.03[4] at I-29; FLETCHER, *supra* note 76, § 41.30 at 625-31. *See also* Messick v. Moring, 514 So. 2d 892, 894 (Al. 1987); Angelo Tomasso, Inc. v. Armor Constr. & Paving, Inc., 187 Conn. 544, 557 (1982); SFA Folio Collections, Inc. v. Bannon, 217 Conn. 220, 232 (1991) (citing H. HENN & J. ALEXANDER, LAWS OF CORPORATIONS, §149 at 355 (3d ed. 1983)); Dania Jai-Alai Palace, Inc. v. Sykes, 450 So. 2d 1114, 1118 (Fla. 1984) (quoting Riesen v. Maryland Cas. Co., 14 So. 2d 197, 199 (Fla. 1943)); Solomon v. Betras Plastics, Inc., 550 So. 2d 1182, 1184 (Fla. Dist. Ct. App. 1989); Hanson v. Bradley, 10 N.E.2d 259, 264 (Mass. 1937); RLI Ins. Co. v. Martin Ginden Ins. Agency, Inc., No. 917614F, 1994 WL 879678, at *2 (Mass. Super. Ct. June 22, 1994); My Bread Baking Co. v. Cumberland Farms, Inc., 233 N.E.2d 748, 751-52 (Mass. 1968), *cited in* Markham v. Fay, 884 F. Supp. 594, 603 (D. Mass. 1995) (referring to *My Bread Making Co.* as a "seminal decision"); Glenn v. Wagner, 329 S.E.2d 326, 330 (N.C. 1985) (quoting B-W Acceptance Corp. v. Spencer, 149 S.E.2d 570, 576 (N.C. 1966)); Castleberry v, Branscum, 721 S.W.2d 270, 271-272 (Tex. 1986).

[78] PRESSER, *supra* note 76, 1.03[4] at I-28 (noting Powell's test requiring (i) that the subsidiary is an "alter ego," or "mere instrumentality" of the parent; (ii) that a "fraud or wrong" occurred; and (iii) that "unjust loss or injury" resulted); FLETCHER, *supra* note 76, § 41.32 at 637 ("fraud, illegal activity or fundamental unfairness are required in many jurisdictions"). *See also id.* § 41.25 at 605-06.

[79] RIBSTEIN & KEATINGE, *supra* note 37, § 12.03 at 4-5.

[80] *See e.g.*, Gen. Ins. Servs., Inc. v. Marcola, 497 S.E.2d 679, 683-84 (Ga. Ct. App. 1998) (lack of intentional misrepresentation by president supported refusal to pierce the veil); TEX. BUS. CORP. ACT ANN. art. 2.21(A)(2) (2003) (in contract actions, Texas requires actual fraud: the liability of shareholders for contractual obligations of a corporation is limited to instances where the shareholder "caused the corporation to be used for the purpose of perpetrating and did perpetrate an actual fraud . . . primarily for the direct personal benefit of the" shareholder).

[81] *See, e.g.*, United States v. Bridle Path Enters., Inc., No. CIV.A.99-11051-GAO, 2001 WL 1688911, at *3 (D. Mass. Dec. 4, 2001).

[82] *Messick*, 514 So. 2d at 894-95; *Castleberry*, 721 S.W.2d at 271.

[83] *Bridle Path Enters., Inc.*, 2001 WL 1688911, at *1.

[84] *Id.*

[85] *Id.*

[86] *Id.*

[87] *Id.*

[88] *Id.* at *2.

[89] *Bridle Path Enters., Inc.*, 2001 WL 1688911, at *3.

[90] *Id.* at *2.

[91] *Id.* at *3.

[92] *Id.* at *2.

[93] *Id.*

[94] *Id.*

[95] *Bridle Path Enters., Inc.*, 2001 WL 1688911, at *3.

[96] *Id.*

[97] *Id.* at *4.

[98] *Id.*

[99] *Id.*

[100] United States v. Lorenzo, 768 F. Supp. 1127, 1133 (E.D. Pa. 1991).
[101] *Id.* at 1128.
[102] *Id.* at 1132.
[103] *Id.* at 1133.
[104] *Id.* at 1132.
[105] *Id.* The court describes the "undocumented" transactions as: a ten-year lease entered into in 1985 that required U.S. Mobile to pay twice the rent it paid under a 1984 ten-year lease, with the dentist and his wife as signatories to the leases; and loans made with undocumented terms between U.S. Mobile and the related companies and the dentist and his wife. *Id.*
[106] *Lorenzo*, 768 F. Supp. at 1132-33. The court described the contracts for services and space as rental by U.S. Mobile of space and services from a related company that resulted in U.S. Mobile owing in excess of $200,000 over a three-year period; contracts between U.S. Mobile and a related company for services, staff, and the use of a computer; and the purchase of a photocopier by U.S. Mobile to benefit the dentist's private office.
[107] *Id.* at 1133.
[108] *Id.*
[109] *Id.*
[110] United States ex rel. Kneepkins v. Gambro Healthcare, Inc., 115 F. Supp. 2d 35, 39-40 (D. Mass 2000).
[111] *Id.* at 37, 39.
[112] *Id.* at 39.
[113] *Id.*
[114] *Id.* at 40.
[115] *Id.* (quoting Town of Brookline v. Gorsuch, 667 F.2d 215, 221 (1st Cir. 1981)).
[116] *Kneepkins*, 115 F. Supp. 2d at 40.
[117] *Id.*
[118] *Id.*
[119] *Id.* at 41.
[120] *Id.*
[121] State v. Woodvale Mgmt. Servs., Inc., No. C2-98-584, 1998 WL 811554, *1 (Minn. Ct. App. Nov. 24, 1998).
[122] *Id.*
[123] *Id.*
[124] *Id.*
[125] *Id.*
[126] *Id.*
[127] *Woodvale Mgmt. Servs., Inc.*, 1998 WL 811554, at *2.
[128] *Id.* at *3.
[129] *Id.*
[130] *Id.*
[131] *Id.*
[132] *Id.*
[133] *Woodvale Mgmt. Servs., Inc.*, 1998 WL 811554, at *3.
[134] *Id.* at *4.
[135] Autrey v. 22 Tex. Servs., Inc., 79 F. Supp. 2d 735, 738 (S.D. Tex. 2000).
[136] *Id.* at 740.
[137] *Id.* at 740, 741.
[138] *Id.* at 740.
[139] *Id.* at 740-41.
[140] *Id.* at 741.
[141] *Autrey*, 79 F. Supp. 2d at 741.
[142] *Id.*
[143] *Id.*
[144] *Id.*

[145] *Id.* at 742.
[146] *Id.* at 746-47.
[147] Cmty. Care Ctrs., Inc. v. Hamilton, 774 N.E.2d 559, 562 (Ind. Ct. App. 2002).
[148] *Id.* at 564.
[149] *Id.*
[150] *Id.* at 564-70.
[151] *Id.* at 570.
[152] 42 C.F.R. § 1001.1051(a)(1) (2003).
[153] *See id.* § 1001.1051(a)(1), (2).
[154] 42 C.F.R. §§ 1001.2002(a), 2003 (2003).
[155] United States ex rel. Kneepkins v. Gambro Healthcare, Inc., 115 F. Supp. 2d 35, 39 (D.Mass 2000).
[156] State v. Woodvale Mgmt. Servs., Inc., No. C2-98-584, 1998 WL 811554, *2 (Minn. Ct. App. Nov. 24, 1998).
[157] *Id.*
[158] Autrey v. 22 Tex. Servs., Inc., 79 F. Supp. 2d 735, 738-39 (S.D. Tex. 2000).

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BUSINESS DAY

Care Suffers as More Nursing Homes Feed Money Into Corporate Webs

By JORDAN RAU JAN. 2, 2018

MEMPHIS — When one of Martha Jane Pierce's sons peeled back the white sock that had been covering his 82-year-old mother's right foot for a month, he discovered rotting flesh.

"It looked like a piece of black charcoal" and smelled "like death," her daughter Cindy Hatfield later testified. After Mrs. Pierce, a patient at a nursing home in Memphis, was transferred to a hospital, a surgeon had to amputate much of her leg.

One explanation for Mrs. Pierce's lackluster care in 2009, according to financial records and testimony in a lawsuit brought by the Pierce family, is that the nursing home, Allenbrooke Nursing and Rehabilitation Center, appeared to have been severely underfunded at the time, with a $2 million deficit on its books and a scarcity of nurses and aides. "Sometimes we'd be short of diapers, sheets, linens," one nurse testified.

That same year, $2.8 million of the facility's $12 million in operating expenses went to a constellation of corporations controlled by two Long Island accountants who, court records show, owned Allenbrooke and 32 other nursing homes. The homes paid the men's other companies to provide physical therapy, management, drugs and other services, from which the owners reaped profits.

In what has become an increasingly common business arrangement, owners of nursing homes outsource a wide variety of goods and services to companies in which they have a financial interest or that they control. Nearly three-quarters of nursing homes in the United States — more than 11,000 — have such business dealings, known as related party transactions, according to an analysis of nursing home financial records by Kaiser Health News. Some homes even contract out basic functions like management or rent their own building from a sister corporation, saying it is an efficient way of running their businesses and can help minimize taxes.

Contracts with related companies accounted for $11 billion of nursing home spending in 2015 — a tenth of their costs — according to financial disclosures the homes submitted to Medicare.

These arrangements offer an additional advantage: Owners can arrange highly favorable contracts in which their nursing homes pay more than they might in a competitive market. Owners then siphon off higher profits, which are not recorded on the nursing home's accounts.

The two Long Island men, Donald Denz and Norbert Bennett, and their families' trusts collected distributions totaling $40 million from their chain's $145 million in revenue over eight years — a 28 percent margin, legal documents show. In 2014 alone, Mr. Denz earned $13 million and Mr. Bennett made $12 million, principally from their nursing home companies, according to personal income tax filings. Typical nursing home profits are "in the 3 to 4 percent range," said Bill Ulrich, a nursing home financial consultant.

In California, the state auditor is examining related party transactions at another nursing home chain, Brius Healthcare Services, regarding reimbursements from the state's Medicaid program. Rental prices to real estate companies related to the chain of homes were a third higher than rates paid by other for-profit nursing homes in the same counties, according to an analysis by the National Union of Healthcare Workers.

Dr. Michael Wasserman, the head of the management company for the Brius nursing homes, called the subject of corporate structures a "nonissue" and said, "What matters at the end of the day is what the care being delivered is about."

Such corporate webs bring owners a legal benefit, too: When a nursing home is sued, injured residents and their families have a much harder time collecting money from the related companies — the ones with the full coffers. Courts set a high bar for plaintiffs to bring these ancillary companies into their cases.

After the Pierce family won a rare verdict against the nursing home owners, Mr. Denz and Mr. Bennett appealed, and their lawyer, Craig Conley, said they would not discuss the case or their business while the appeal was pending.

"For more than a decade, Allenbrooke's caregivers have promoted the health, safety and welfare of their residents," Mr. Conley wrote in an email.

Networks of jointly owned limited liability corporations are fully legal and widely used in other businesses, such as restaurants and retailers. Nonprofit nursing homes sometimes use them as well. Owners can have more control over operations — and better allocate resources — if they own all the companies. In many cases, industry consultants say, a related company will charge a nursing home lower fees than an independent contractor might, leaving the chain with more resources.

"You don't want to pay for someone else to make money off of you," Mr. Ulrich, the consultant, said. "You want to retain that within your organization."

But a Kaiser Health News analysis of inspection and quality records reveals that nursing homes that outsource to related organizations tend to have significant shortcomings: They have fewer nurses and aides per patient, they have higher rates of patient injuries and unsafe practices, and they are the subject of complaints almost twice as often as independent homes.

"Almost every single one of these chains is doing the same thing," said Charlene Harrington, a professor emeritus of the School of Nursing at the University of California, San Francisco. "They're just pulling money away from staffing."

Early Signs of Trouble

Martha Jane Pierce moved to Allenbrooke in 2008 in the early stages of dementia. According to testimony in the family's lawsuit, when her children visited

they often discovered her unwashed, with an uneaten, cold meal sitting beside her bed. Mrs. Hatfield said in court that she had frequently found her mother's bed soaked in urine. The front desk was sometimes vacant, her brother Glenn Pierce testified.

"If you went in on the weekend, you'd be lucky to find one nurse there," he said in an interview.

After a stroke, Mrs. Pierce became partly paralyzed and nonverbal, but the nursing home did not increase the attention she received, said Carey Acerra, one of Mrs. Pierce's lawyers. When Mrs. Pierce's children visited, they rarely saw aides reposition her in bed every two hours, the standard practice to prevent bedsores.

"Not having enough staffing, we can't — we weren't actually able to go and do that," one nurse, Cheryl Gatlin-Andrews, said in a deposition.

Kaiser Health News's analysis of inspection, staffing and financial records nationwide found shortcomings at other homes with similar corporate structures:

■ Homes that did business with sister companies employed, on average, 8 percent fewer nurses and aides.

■ As a group, these homes were 9 percent more likely to have hurt residents or put them in immediate jeopardy of harm, and amassed 53 substantiated complaints for every 1,000 beds, compared with 32 per 1,000 beds at independent homes.

■ Homes with related companies were fined 22 percent more often for serious health violations than independent homes, and penalties averaged $24,441 — 7 percent higher.

For-profit nursing homes utilize related corporations more frequently than nonprofits do, and have fared worse than independent for-profit homes in fines, complaints and staffing, the analysis found. Their fines averaged $25,345, which was 10 percent higher than fines for independent for-profits, and the homes received 24 percent more substantiated complaints from residents. Overall staffing was 4 percent lower than at independent for-profits.

Ernest Tosh, a plaintiffs' lawyer in Texas who helps other lawyers untangle nursing company finances, said owners often exerted control by setting tight budgets that restricted the number of nurses the homes could employ. Meanwhile, "money is siphoned out to these related parties," he said. "The cash flow gets really obscured through the related party transactions."

The American Health Care Association, which represents nursing homes, disputed any link between related businesses and poor care. "Our members strive to provide quality care at an affordable cost to every resident," the group said in a statement. "There will always be examples of exceptions, but those few do not represent the majority of our profession."

'Piercing the Corporate Veil'

The model of placing nursing homes and related businesses in separate limited liability corporations and partnerships has gained popularity as the industry has consolidated through purchases by publicly traded companies, private investors and private equity firms. A 2003 article in the Journal of Health Law encouraged owners to separate their nursing home business into detached entities to protect themselves if the government tried to recoup overpayments or if juries levied large negligence judgments.

"Holding the real estate in a separate real-property entity that leases the nursing home to the operating entity protects the assets by making the real estate unavailable for collection by judgment creditors of the operating entity," the authors wrote. Such restructuring, they added, was probably not worth it just for "administrative simplicity."

In 2009, Harvard Medical School researchers found the practice had flourished among nursing homes in Texas, which they studied because of the availability of state data. Owners had also inserted additional corporations between themselves and their nursing homes, with many separated by three layers.

To bring related companies into a lawsuit, attorneys must persuade judges that all the companies were essentially acting as one entity and that the nursing home

could not make its own decisions. Often that requires getting access to internal company documents and emails. Even harder is holding owners personally responsible for the actions of a corporation — known as "piercing the corporate veil."

At a conference for executives in the long-term health care industry in Nashville in 2012, a presentation slide from nursing home attorneys titled "Pros of Complex Corporate Structure" said, "Many plaintiffs' attorneys will never conduct corporate structure discovery because it's too expensive and time consuming." The presentation noted another advantage: "Financial statement in punitive damages phase shows less income and assets."

A lawyer in Alabama, Barry Walker, is still fighting an 11-year-old case against another nursing home then owned by Mr. Denz and Mr. Bennett. Mr. Walker traced the ownership of Fairfield Nursing and Rehabilitation Center back to the men, but he said the judge had allowed him to introduce the information only after the Alabama Supreme Court ordered the judge to do so. That trial ended with a hung jury, and Mr. Walker said a subsequent judge had not let him present all the information to two other juries, and he dropped the men from the lawsuit. The home closed a few years ago but the case is still ongoing, after two mistrials.

"The former trial judge and the current trial judge quite frankly don't seem to understand piercing the corporate veil," he said. "My firm invested more in the case than we can ever hope to recover. Sometimes it's a matter of principle."

The complexity of the ownership in Mrs. Pierce's case was a major reason it took six years to get to a trial, said Ken Connor, one of the lawyers for her family. "It requires a lot of digging to unearth what's really going on," he said. "Most lawyers can't afford to do that."

The research paid off in a rare result: In 2016, the jury issued a $30 million verdict for negligence, of which Mr. Denz and Mr. Bennett were personally liable for $20 million. The men's own tax returns had bolstered the case against them. They claimed during trial they delegated daily responsibilities for residents to the home's administrators, but they reported on their tax returns that they "actively" participated in the management. The jury did not find the nursing home responsible for her death later in 2009.

The appeal brought by Mr. Denz and Mr. Bennett challenges both the verdict and their inclusion. They argue that Tennessee courts should not have jurisdiction over them since they spent little time in the state and neither was involved in the daily operations of the home or in setting staffing levels. Their lawyers said jurors should never have heard from nurses who hadn't cared directly for Mrs. Pierce.

"No way did I oversee resident care issues," Mr. Bennett said in a deposition.

Deficient in the End

Whoever was responsible for Mrs. Pierce's care, her family had no doubt it had been inadequate. Her son Bill Pierce was so horrified when he finally saw the wound on his mother's foot, he immediately insisted that she go to the hospital.

Mrs. Hatfield said the surgeon had told the family that "he had never seen anything like it."

"He amputated 60 percent of the leg, above the knee," she said.

After the amputation, Mrs. Pierce returned to the nursing home because her family did not want to separate her from her husband, who was also there.

At the trial, the nursing home's lawyers argued that Mrs. Pierce's leg had deteriorated not because of the infection but because her blood vessels had become damaged from a decline in circulation. The jury was unpersuaded after nurses and aides testified about how Allenbrooke would add staffing for state inspections while the rest of the time their pleas for more support went unheeded.

Workers also testified that supervisors had told them to fill in blanks in medical records regardless of accuracy. One example: Allenbrooke's records indicated that Mrs. Pierce had eaten a full meal the day after she died.

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Nursing homes that harm seniors face fewer fines under Trump

Jordan Rau, Kaiser Health News Published 12:48 p.m. ET Jan. 3, 2018 | **Updated 3:20 p.m. ET Jan. 3, 2018**

(Photo: Mark Wilson, Pool/EPA)

The Trump administration — reversing guidelines put in place under President Barack Obama — is scaling back the use of fines against nursing homes that harm residents or place them in grave risk of injury.

The shift in the Medicare program's penalty protocols was requested by the nursing home industry. The American Health Care Association, the industry's main trade group, has complained that under Obama inspectors focused excessively on catching wrongdoing rather than helping nursing homes improve.

"It is critical that we have relief," Mark Parkinson, the group's president, wrote in a letter to then-President-elect Donald Trump in December 2016.

Since 2013, nearly 6,500 nursing homes — 4 of every 10 — have been cited at least once for a serious violation, federal records show. Medicare has fined two-thirds of those homes. Common citations include failing to protect residents from avoidable accidents, neglect, mistreatment and bedsores.

FROM 2015: Look up nursing home ratings in your city (https://www.gannett-cdn.com/experiments/usatoday/2015/02/nursing-homes/index.html)

The new guidelines discourage regulators from levying fines in some situations, even when they have resulted in a resident's death. The guidelines will also probably result in lower fines for many facilities.

The change in policy aligns with Trump's promise to reduce bureaucracy, regulation and government intervention in business.

Dr. Kate Goodrich, director of clinical standards and quality at the Centers for Medicare & Medicaid Services (CMS), said in a statement that unnecessary regulation was the main concern that health care providers raised with officials.

"Rather than spending quality time with their patients, the providers are spending time complying with regulations that get in the way of caring for their patients and doesn't increase the quality of care they provide," Goodrich said.

But advocates for nursing-home residents say the revised penalties are weakening a valuable patient-safety tool.

"They've pretty much emasculated enforcement, which was already weak," said Toby Edelman, a senior attorney at the Center for Medicare Advocacy.

Medicare has different ways of applying penalties. It can impose a specific fine for a particular violation. It can assess a fine for each day that a nursing home was in violation. Or it can deny payments for new admissions.

The average fine in recent years has been $33,453, but 531 nursing homes amassed combined federal fines above $100,000, records show. In 2016, Congress increased the fines to factor in several years of inflation that had not been accounted for previously.

The new rules have been instituted gradually throughout the year.

In October, CMS discouraged its regional offices from levying fines, even in the most serious health violations, if the error was a "one-time mistake." The centers said that intentional disregard for residents' health and safety or systemic errors should still merit fines.

A July memo from CMS discouraged the directors of state agencies that survey nursing homes from issuing daily fines for violations that began before an inspection, favoring one-time fines instead. Daily fines remain the recommended approach for major violations discovered during an inspection.

Dr. David Gifford, the American Health Care Association's senior vice president for quality, said daily fines were intended to prompt quick remedies but

were pointless when applied to past errors that had already been fixed by the time inspectors discovered them.

“What was happening is you were seeing massive fines accumulating because they were applying them on a per-day basis retrospectively,” Gifford said.

But the change means that some nursing homes could be sheltered from fines above the maximum per-instance fine of $20,965, even for egregious mistakes.

In September 2016, for instance, health inspectors faulted Lincoln Manor, a nursing home in Decatur, Ill., for failing to monitor and treat the wound of a patient whose implanted pain-medication pump gradually slipped over eight days through a ruptured suture and protruded from her abdomen. The patient died.

CMS fined Lincoln Manor $282,954, including $10,091 a day for 28 days, from the time the nursing home noticed the problem with the wound until supervisors had retrained nurses to avoid similar errors. An administrative law judge called the penalties “quite modest” given the “appalling” care.

The fines were issued before the new guidelines took effect; if the agency had issued a one-time fine, the maximum would have been less than $21,000.

Lincoln Manor closed in September. Its owner could not be reached for comment, and his lawyer did not respond to an interview request.

Advocates for nursing home residents say that relaxing penalties threatens to undo progress at deterring wrongdoing. Janet Wells, a consultant for California Advocates for Nursing Home Reform, said the changes come as “some egregious violations and injuries to residents are being penalized — finally — at a level that gets the industry’s attention and isn’t just the cost of doing business.”

In November, the Trump administration exempted nursing homes that violate eight new safety rules from penalties for 18 months. Homes must still follow the rules, which are intended, among other things, to reduce the overuse of psychotropic drugs and to ensure that every home has adequate resources to assist residents with major psychological problems.

Rodney Whitlock, a health policy consultant and former Republican Senate staffer, said health inspectors “are out there looking for opportunities to show that the nursing homes are not living up to some extremely tight standards.” He said while the motivation for tough regulation was understandable, “the fines don’t make it easier to hire people and doesn’t make it easier to stay in business.”

In June, CMS rescinded another Obama administration action that banned nursing homes from pre-emptively requiring residents to submit to arbitration to settle disputes rather than going to court.

“We publish nearly 11,000 pages of regulation every year,” the agency’s administrator, Seema Verma, said in a speech in October. That paperwork is “taking doctors away from what matters most: patients.”

Janine Finck-Boyle, director of health regulations and policy at LeadingAge, a group of nonprofit nursing homes and other entities that care for older people, said the group’s members had been struggling to cope with regulations.

“If you’re a 50-bed rural facility out West or in the Dakotas,” she said, “you don’t have the resources to get everything done from A to Z.”

IN HURRICANE IRMA: Why did nursing home patients have to die? (/story/opinion/2017/09/21/hurricane-irma-why-did-nursing-home-patients-die-editorials-debates/685551001/)

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CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Longterm Care Resident Rights

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Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☑ No

If yes, who?

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

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APPEARANCE RECORD

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1-11-18
Meeting Date

Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** RESIDENT RIGHTS

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Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☒ Yes ☐ No

If yes, who? ELDER LAW SECTION / FLA BAR

Are you a registered lobbyist? ☐ Yes ☒ No

Are you an elected official or judge? ☐ Yes ☒ No

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CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

Jun 11, 2018
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposed Amendment 88

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Are you representing someone other than yourself? ☒ Yes ☐ No

If yes, who? Fudge + McArthur, PA

Are you a registered lobbyist? ☐ Yes ☒ No

Are you an elected official or judge? ☐ Yes ☒ No

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CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

0086
Proposal Number (if applicable)

***Topic** Protecting the Rights of Florida's Frail Elderly

Amendment Barcode (if applicable)

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(The Chair will read this information into the record.)

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If yes, who? _____

Are you a registered lobbyist? [ ] Yes [X] No

Are you an elected official or judge? [ ] Yes [X] No

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WORKSHOP ON LONG-TERM CARE RESIDENT RIGHTS

DECLARATION OF RIGHTS COMMITTEE
January 11, 2018
1 PM – 5 PM
Room 105 – Gerald L. Gunter Building
2540 Shumard Oaks Boulevard
Tallahassee, Florida

WORKSHOP PACKET

TAB 4

The Florida Senate

Interim Project Report 2001-025 *February 2001*

Committee on Health, Aging and Long-Term Care Senator Saunders, Chairman

LONG-TERM CARE AFFORDABILITY AND AVAILABILITY

SUMMARY

Florida has grappled with issues surrounding the provision of long-term care for many years. Substantial problems remain. The state does not have a comprehensive strategy for economically and efficiently meeting the needs of an increasingly elderly population. There continue to be concerns about the quality of the care being provided in long-term care facilities. Public spending for nursing home care is increasing. Long-term care facilities are sued much more frequently in Florida than in the rest of the nation, and liability insurance for nursing homes is becoming more difficult to obtain and is much more expensive.

This report provides recommendations in three areas: developing a coordinated planning structure for the long-term care system, improving the quality of care in long-term care facilities and developing ways to make liability insurance more affordable for long-term care facilities.

BACKGROUND

Most states are facing an increasingly aged and disabled population in need of long-term, supportive services at the same time as demands on resources in other areas increases. Florida's elderly population is currently 2.9 million individuals, 18.3% of the state's population. "Baby boomers" will add 600,000 to that number by 2010. While the majority of Florida's elders live independent and healthy lives, the number of frail elders in need of long-term care services in nursing homes, assisted living facilities and formal home care programs is expected to increase over the next ten years. Florida's challenge is the result of years of state policy decisions about the structure and funding of its long-term care services, the rapid growth in the number of frail elders and disabled people in our state, and significant changes in society's ability to sustain and prolong life.

Long-term Care

Long-term care generally means care that is provided on a continual basis to persons with chronic disabilities. This care is often supportive, rather than curative in nature, and is provided in institutions, home-like institutional settings and to persons living in their own residence. Long-term care may be care provided in a nursing home, in a residential setting such as an assisted living facility, in an adult day care center, or may be delivered to a person as home care. Long-term care in nursing homes is more medically oriented and is often provided by licensed and certified personnel to people with severe limitations and severe cognitive disorders. Much of long-term care provided in the home is supportive in nature, such as assistance with the activities of daily living of eating, toileting, and dressing.

Since the late 1960's there has been an on-going process of "downward substitution" of care from highly institutional settings to less expensive, less institutional and more home-like settings for people with many types of disabilities. In the case of elderly individuals, this trend was significantly accelerated with passage of the federal Omnibus Budget Reconciliation Act of 1989 which created financial incentives for hospitals to discharge Medicare patients earlier, with the result that many nursing home residents are more acutely ill and disabled than in prior years.

Medicare primarily pays for short-term transitional care in nursing homes. Medicaid pays for longer-term care. Assisted living facilities provide supportive care to individuals who require assistance with the activities of daily living but who do not require continuous nursing care. Medicaid and Medicare do not generally pay for care in assisted living facilities; however, Florida has an assisted living facility waiver program which allows Medicaid to reimburse additional care required by severely disabled assisted living facility residents.

In the late 1970's Florida implemented the Community Care for the Elderly program to assist frail older people to remain in their homes. In 1980, the federal government began granting waivers to allow states to use Medicaid funds for the purpose of assisting disabled individuals to remain in their homes as an alternative to institutionalization. Florida was one of the first states to implement such a waiver program.

For many years elder advocates have hypothesized that increased levels of less expensive state-supported home care could replace more expensive nursing home care. There has been considerable skepticism about the cost-effectiveness of this notion due to the difficulty of choosing recipients to ensure that services are provided to the same people who would otherwise be served in nursing homes, the loss of economies of scale incurred in bringing into people's homes the intensive services required by very frail individuals, and the tendency of case managers to over-prescribe services in an effort to meet patient desires and preferences.

A major impediment for states in planning an efficient long-term care system has been the difficulty of managing the interrelationship of incentives between the Medicare and Medicaid financing systems, and the effect that care of acute illnesses has on the eventual need for long-term care. States often have little control over the admission of a patient into a nursing home since the initial portion of a nursing home stay is usually financed by Medicare or other sources. Once these resources are exhausted (often after community support systems have unraveled) state Medicaid programs become responsible for financing continuing stays.

Responsibility for long-term care programs is split between state agencies in Florida. The Agency for Health Care Administration Medicaid program finances nursing home care for Medicaid recipients. The Agency also determines how many nursing home beds are constructed, licenses nursing facilities, and regulates the quality of their care. Medicaid directly funds programs providing home care services. The Department of Elder Affairs operates the state's aging/disabled waiver program, the General Revenue- funded Community Care for the Elderly program and federally-funded Older American's Act programs.

The Department of Elder Affairs was created by the 1990 Legislature in response to a 1988 general election constitutional referendum calling for a state agency focused specifically on the needs and concerns of elders. Chapter 430, F.S., assigns the department lead responsibility for administering human services programs for the elderly and for developing policy recommendations for long-term care.

In 1994, the Legislature created the Commission on Long-term Care, chaired by former Senator Curtis Kiser. In 1995 the Commission developed recommendations for long-term care system reform, to be implemented by the Department of Elder Affairs, the Agency for Health Care Administration and the Department of Children and Family Services. The Commission's primary recommendation was that the state should begin planning to meet its residents' long-term care needs in order to ensure that the state's long-term care dollars are spent on the most appropriate and cost-effective mix of institutional, residential and community services. The report also recommended the development of alternative systems of care, including transitioning the state's entire long-term care delivery system from an institutional to a community and risk-based managed care model integrating acute and long-term care services by the year 2000, and establishing a long-term care planning and coordination advisory body.

Lawsuits Against Nursing Homes and Assisted Living Facilities

There is a growing concern among long-term care policy experts that lawsuits against nursing homes and assisted living facilities in Florida are growing at a disproportionate rate compared to the rest of the country. The purported cause of these suits is reported to be Florida's unique statutory scheme of liability which combines a broad residents' rights civil liability cause of action with unlimited compensatory and punitive damages, combined with the lure of add-on attorney's fees. The long-term care industry perspective is that this has created an atmosphere in which nursing homes are an easy and lucrative target for litigation, and that conditions produced by the normal process of aging and frailty at the end of life are responsible for a substantial portion of the lawsuits.

Availability of Liability Insurance

The effect of the increase in suits and judgments is that nursing homes and assisted living facilities are experiencing large insurance premium increases and are increasingly unable to secure liability insurance coverage from regulated carriers. Liability insurance which is available is increasingly expensive, with the result that 9% of Florida's nursing homes do not have liability coverage. Nursing homes are not required to have liability insurance. Assisted living facilities are required, as a condition of licensure, to maintain liability insurance.

Financial Viability of the Nursing Home Industry

Approximately 20% of Florida nursing homes are currently under Chapter 11 bankruptcy protection. Other nursing homes are reported to be teetering on the brink of bankruptcy. The causes of this situation are variously described as a change in Medicare reimbursements to nursing homes, bad business decisions on the part of nursing home companies, reimbursements to government programs for revenues generated through

fraudulent billing, Medicaid reimbursement which does not cover the rapidly increasing cost of providing care to residents, lawsuits, and increasing liability insurance premiums.

Adequacy of Government Payments

Nursing homes have stated that Florida Medicaid payment rates are inadequate to reimburse their costs. Nursing homes were able to stay in business by subsidizing costs associated with these residents from revenues received from the Medicare program and private pay residents. The Balanced Budget Act of 1997, however, was implemented for the purpose of eliminating perceived inappropriate charges by nursing homes to the Medicare system. The Balanced Budget Act of 1997 modified the Medicare reimbursement scheme to ensure that the federal government reimbursed only for care necessary to meet the needs of patients.

Quality of Care in Nursing Homes

Nursing homes have long been seen as care settings for the elderly of last resort, both because they were seen as institutions where the elderly went to die, and because of perceptions of indifferent, callous and uncaring treatment by nursing home staff. Patient advocates, family members of people in nursing homes and attorneys representing nursing home residents often have taken the position that the state system for assuring quality and humane care in nursing homes has failed and that recourse to the courts is the method of last resort to force nursing homes to provide quality care and to punish those who do not.

For more than 20 years, the State of Florida has grappled with issues relating to the quality of care that nursing homes provide to their residents. A staff analysis for Committee Substitute for Senate Bill 1218 (1980), describes the findings of a Dade County grand jury convened to investigate nursing homes operating in that county. At the time, there were 331 state-licensed nursing homes operating in Florida. The analysis states:

> The report described health hazards and deficiencies in patient care that allegedly have been allowed to continue for years. Of the 38 Dade County nursing homes surveyed by the Grand Jury, 60 percent provided either generally unacceptable or consistently very poor care. The Jury found that sanctions against homes are invoked 'rarely, timidly, and ineffectively,' and that once a deficiency is identified, on-site follow-up visits are too infrequent to ensure correction. [p. 1, *Senate Staff Analysis and Economic Impact Statement*, June 10, 1980]

The 1987 Omnibus Budget Reconciliation Act (OBRA-87) was the most sweeping set of reforms to nursing home regulations enacted by Congress since the passage of Medicare and Medicaid. These reforms were passed in response to consumer complaints and a host of state and federal reports criticizing both nursing home quality and government regulatory efforts. They also responded to a congressionally mandated study by the Institute of Medicine on how to improve nursing home quality, and they embodied most of the Institute's recommendations. The reforms were endorsed by a substantial bipartisan majority in Congress and enjoyed widespread support from nursing home residents, families, organizations representing the elderly, and a host of long-term care providers, including nursing home owners, administrators, nurses, social workers, therapists, and physicians.

The quality of nursing home care continues to be a concern because residents are generally showing increasing levels of acuity and disability and require increasingly more complex treatments. These concerns about problems in the quality of long-term care persist despite some improvements in recent years, and are reflected in, and spurred by, recent government reports, congressional hearings, newspaper stories, and criminal and civil court cases. Debate also continues over the effectiveness and appropriate scope of state and national policies to regulate long-term care, reduce poor performance of providers, and improve the health and well being of those receiving care. These questions and debates extend beyond nursing homes to home and community-based services and residential care facilities.

Residents' bill of rights suits

Section 400.023, F.S., creates a statutory cause of action against nursing homes who deprive or infringe upon the rights of residents specified in s. 400.022, F.S. Sections 400.428 and 400.429, F.S., contain similar provisions for assisted living facilities. Prevailing plaintiffs may be entitled to recover reasonable attorney's fees, and costs of the action, along with actual and punitive damages. Prevailing defendants may be entitled to receive attorney's fees. The statutes require that attorney's fees be based on a number of factors including time and labor involved, difficulty of the case and other similar factors.

Suits may be brought by the resident, his guardian, a person or organization acting on behalf of the resident, or the personal representative of the estate of a deceased resident. If the suit alleges a deprivation of the right to receive adequate health care which results in injury or

death, claimants are required to conduct an investigation which includes a review of the case by a physician or registered nurse familiar with standards of care for nursing home residents, and a statement that the deprivation of the right occurred during the resident's stay in the nursing home.

Punitive damages may be awarded for conduct which is willful, wanton, gross or flagrant, reckless, or consciously indifferent to the rights of the resident. In addition to any other standards for punitive damages, any award for punitive damages must be reasonable in light of actual harm suffered, and the egregiousness of the conduct which caused the harm. Section 768.735, F.S., limits punitive damages against nursing homes pursuant to ch. 400 to three times compensatory damages unless the claimant demonstrates to the court by clear and convincing evidence that an award in excess of the limitation is not excessive in light of the facts and circumstances that were presented.

Medical Malpractice Suits

Medical malpractice actions are the subject of ch. 766, F.S. In medical malpractice actions, the burden is on the claimant to prove by a greater weight of the evidence that the actions of a health care provider represented a breach of the prevailing professional standard of care for that provider. Claimants must notify defendants of their intent to sue, and defendants' insurers must conduct a review to determine the liability of the defendant. The defendant may admit liability and offer to arbitrate the amount of damages. Alternatively, the court may, upon motion of any party, require the parties to submit to non-binding arbitration. Chapter 766 also provides a third method of voluntary binding arbitration. In this scheme, the defendant does not admit liability, but does agree to arbitrate the amount of damages. Economic damages are limited to past and future medical expenses, and 80% of lost earning capacity, reduced by collateral payments. The statute provides for the settlement to be reduced by the amounts of payments made to or on behalf of the claimant, and that future damages be reduced to present value. Non-economic damages are limited to $250,000 per incident, calculated on a percentage basis with respect to capacity to enjoy life. Punitive damages are not allowed. Defendants shall pay attorneys fees for claimants, limited to 15% of the award, reduced to present value. If a defendant refuses binding arbitration, there is no cap on damages at trial, and attorney's fees are recoverable up to 25% of the award. If a claimant rejects binding arbitration, damages at trial are limited to net economic damages and $350,000 in non-economic damages. Malpractice suits may be brought by the injured patient or, if the patient dies, the personal representative of the patient's estate.

Wrongful Death Suits

Wrongful death is the subject of ss. 768.16-768.27, F.S. Suits for wrongful death may be brought by the decedent's personal representative on behalf of survivors and the decedent's estate. Personal injury suits abate when a personal injury results in death. Survivors may recover the value of lost support and services, spouses may recover for loss of companionship and mental pain and suffering, minor children (or all children if there is no spouse) may recover for lost companionship, guidance and mental pain and suffering, and parents may recover for mental pain and suffering. The Wrongful Death Act prohibits adult children from recovering damages for mental pain and suffering when their parent dies as a result of medical malpractice. Additionally, parents of an adult child who dies as a result of medical malpractice may not recover damages for pain and suffering. The decedent's estate may recover damages for lost earnings from the date of injury to the date of death, loss of prospective net accumulations, and medical and funeral bills.

Civil Damages

Damages are the subject of ss. 768.71-768.81, F.S. A claim for punitive damages is not permitted unless there is a reasonable showing by evidence that there is a reasonable basis for recovery of such damages. Punitive damages are awarded only after a determination, based on clear and convincing evidence that the defendant was personally guilty of intentional misconduct or gross negligence. Intentional misconduct is defined as the defendant knowing the wrongfulness of the conduct and the high probability that injury would result, and still intentionally pursuing the course of the conduct, resulting in the damage. Gross negligence means that the conduct was so reckless or wanting in care such that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.

Punitive damages may be imposed on a corporation or employer only if the above criteria are met and the corporation knowingly participated in the conduct, condoned or consented to the conduct or the corporation engaged in conduct which was grossly negligent and contributed to the loss suffered. Punitive damages are limited to three times compensatory damages, or $500,000, whichever is greater. If the defendant's conduct was motivated solely by financial gain, then punitive damages may not exceed the greater of four times compensatory damages or $2,000,000. There is no cap on punitive damages if the defendant had a specific

intent to harm the claimant.

As noted earlier, these damage standards do not apply to ch. 400 suits, in which case punitive damages are limited to three times compensatory damages unless the claimant demonstrates to the court by clear and convincing evidence that an award in excess of the limitation is not excessive in light of the facts and circumstances that were presented.

Senior Housing

A sizable percentage of the more than 80,000 senior residents in Florida's rent subsidized housing facilities are having trouble living independently. This group tends to be women living alone, members of ethnic and racial minorities, and those reliant on Medicaid benefits. They often experience health problems and declines in physical and mental functioning. There is little coordination between state-funded community care programs and public housing providers.

Medicaid Nursing Home Budget

Florida's Medicaid nursing home expenditures will increase by nearly $100 million between FY 1999-2000 and FY 2000-2001. Florida has a relatively low number of nursing home beds per 1,000 aged 65+, at 30.1. Over the past two decades, however, the growth in the number of nursing home beds (129%) in Florida was more than double the increase in the state's 65+ population (63%). The result is the ratio of nursing home beds in Florida increased from 21 to 30 beds per 1,000 persons aged 65+ from 1980 to 1998. Despite the fact that this is a relatively low bed rate compared to the rest of the country, Florida continues to experience substantial growth, and a high percentage increase in nursing home utilization, as measured by total days of care and nursing home expenditures. Medicaid pays for approximately two-thirds of the patient days in nursing homes in Florida.

The Task Force on the Availability and Affordability of Long-Term Care

The Legislature created, in the 2000 Session, the Task Force on the Availability and Affordability of Long-Term Care. The purpose of the task force was to assess the current long-term care system in terms of the availability of alternatives to nursing homes, the quality of care in nursing homes and the impact of lawsuits against nursing homes and other long-term care facilities on the costs of care and the financial stability of the long-term care industry. The task force was chaired by the Lieutenant Governor and received staff support from the Florida Policy Exchange Center on Aging, which prepared a comprehensive report based on a wide range of research materials, public testimony and the contributions of task force members. On December 18, 2000, the members of Task Force determined that they would not reach consensus on recommendations and decided not to submit recommendations to the Legislature.

METHODOLOGY

To complete this report Senate staff reviewed both national and Florida literature regarding long-term care, met with staff of the Florida Policy Exchange Center on Aging at the University of South Florida, the Department of Elderly Affairs, The Agency for Health Care Administration, and the nursing home and assisted living facility industries. Staff attended meetings of the Task Force on the Availability and Affordability of Long-term Care in Tallahassee, Tampa, Pensacola, Miami and Jacksonville.

FINDINGS

Lawsuits

One of the tasks assigned the Task Force was to determine "the kinds of incidents which lead to the filing of lawsuits and the extent to which frivolous lawsuits are filed." In an attempt to determine the merits and costs of nursing home lawsuits the task force performed several separate analyses of lawsuits in Florida. Staff of the Task Force reviewed all ch. 400 nursing home lawsuits filed in Hillsborough County since 1990, reviewed all jury-tried nursing home lawsuits statewide since 1990, analyzed the relationship between Agency for Health Care Administration survey data and lawsuits, and reviewed all lawsuit settlement data which was publicly available. In addition the Task Force reviewed a study of the costs and frequency of lawsuits submitted by Aon Actuarial Services under contract with the Florida Health Care Association (FHCA). Significant findings were:

1. Since 1990, 256 nursing home care resident suits had been filed in Hillsborough County. Eighty percent of the nursing homes in Hillsborough County had at least one lawsuit, with most (51%) having fewer than five suits.

2. No frivolous suits were found. All suits contained serious allegations pertaining to the resident's physical condition and cite the violation of the statutory right to adequate and appropriate health care as the cause of action. These lawsuits are fundamentally about pressure sores, falls, dehydration, and malnutrition or weight loss among nursing home residents.

3. In virtually all the suits, infringement on the right to receive adequate and appropriate health care was the primary cause of action. In many of the suits, an infringement of the right to privacy and dignity were secondary causes of action.

4. Suits were filed by the resident, spouses, sons and daughters and personal representatives in 88% of the cases. Wrongful death was alleged in 89 of the 256 suits.

5. Data from the FHCA/Aon study of losses reported by 12 predominantly multi-facility, for-profit chains in Florida indicated that the average size of claims for these facilities in Florida was $278,637, which is 250% greater that the average claim in other states ($112,351). The average loss per occupied bed in these facilities in Florida in 1999 was $6,283, which is 8 times the average loss in the other 49 states ($809).

6. Add-on attorney fees were not regularly awarded in nursing home lawsuits. In 68% of the Hillsborough cases, each party paid its own attorney's fees.

7. Agency for Health Care Administration survey violations, severity of patient condition, for-profit status and Medicaid patient ratios were not predictive of lawsuits being filed.

8. The number of lawsuits filed per year in Hillsborough County peaked in 1998 with 26 suits being filed. In 1999 17 suits were filed, and 3 had been filed by August 2000. The task force hypothesized that closure or change in ownership of the three nursing homes having the most suits (more than 20 times) had caused the drop in the number of lawsuits filed.

9. The Hillsborough survey identified 16 lawsuits against assisted living facilities since 1990. These suits generally involved charges of failure to provide adequate and appropriate health care.

Other State Resident Bill of Rights and Tort Systems

A review of other state (including Washington D.C. and Puerto Rico) nursing home resident rights laws and tort practices performed by GeneralCologne Reinsurance (*GeneralCologne Re: 50-State Long Term Care and Tort Liability and Survey Information*) indicated that 36 states had a resident's bill of rights. Of these, 31 allowed tort recovery for violation or deprivation of resident's rights. In six states, punitive damages are recoverable for resident's bill of rights violations. In two, punitive damages are recoverable under adult protection or elder abuse statutes. Attorney's fees are recoverable under resident's bills of rights or elder abuse statutes in 15 states. Tort damages are unlimited in 28 states. In 15 states, there is a resident's bill of rights, punitive damages are recoverable under that bill of rights or under common law, and tort damages are unlimited.

Availability of Liability Insurance

The Department of Insurance conducted research to determine the status of the Florida long-term care liability insurance market for nursing homes, assisted living facilities and continuing care retirement communities. The department concluded that the long-term care liability market had shrunk significantly, as it has in the rest of the nation. As of September, 2000, 17 companies were writing coverage in Florida, however, 6 of the 17 insurers wrote only two policies in 2000. Twenty-three other companies, which did provide this coverage in the last three years, no longer provide this type of insurance. Companies which were withdrawing from the long-term care market reported that they are doing so nationally. Of those companies which are still providing this type of coverage, most have tightened underwriting criteria, particularly in Florida and Texas, and raised rates and deductibles, citing high loss ratios, the legal climate, and problems with obtaining reinsurance. Companies withdrawing from selling this type of coverage began initial withdrawals in Florida and California, each of which allows unlimited punitive damage recoveries for resident bill of rights violations and permits unlimited damages in tort actions, and Texas, which excluded elder abuse matters from its tort reform and has been the site of several high nursing home verdicts ($83 million, $65 million, and $28 million in 1997, 1999, and 1998, respectively).

According to testimony from an insurance underwriter who testified before the task force, his company, the last admitted (regulated) carrier writing policies in Florida will stop renewing policies effective February, 2001, forcing facilities to purchase coverage from unregulated excess and surplus lines companies. Representatives from insurance agents reported that some excess and surplus lines companies were also planning to withdraw from the market for reasons similar to the admitted carriers.

Risk Pooling

During Task Force deliberations and in public testimony, considerable concern was expressed by and about nursing facilities which had experienced no suits but nevertheless were unable to purchase liability insurance or which had been forced to pay extremely high premiums in order to obtain coverage. Many of these were faith-based or non-profit facilities. Some public

testimony suggested establishing separate risk pools for facilities with no quality of care difficulties as a possible solution.

Insurance representatives explained that their practice is to set rates based on the entire universe of facilities in a single risk pool providing a given type of care. Assisted living facilities, for-profit and non-profit facilities, since they provide the same type of care, are included in the same risk pool. Once rate levels are established at base limits, the prospective client is evaluated for discounting by review of claims history, financial condition, risk management practices, staff skills and subjective factors. Separating facilities into good and bad risk pools would, in the insurance industry's opinion, create a group of facilities which was uninsurable since it would be impossible to spread the costs of the losses for these facilities to those which had fewer losses.

Financial Viability of the Nursing Home Industry

A number of major nursing home chains (Vencor, Mariner, Genesis Health Ventures, Sun Healthcare, and Integrated Health Services) are currently in bankruptcy proceedings. In Florida, 21 percent of nursing home beds (17,000) are in facilities which have filed for Chapter 11 bankruptcy protection. The precarious condition of many nursing homes appears to be due to a variety of factors including changes made to the Medicare reimbursement system in the Balanced Budget Act of 1997, business decisions made and debt burdens acquired based on a belief that Medicare payment would continue to increase, decreased revenues due to efforts to fight fraud and waste in the health care industry, and litigation and insurance costs.

Changes to the Medicare reimbursement system stemmed in part from a GAO report in 1995 which found that nursing homes were engaging in widespread overcharges, inflated markups, and exploitation of regulatory weakness in the Medicare system. The GAO described the problem as "national in scope and growing." Abusive billing practices in the nursing home industry were characterized as pervasive. The GAO cited complaints from Medicare patients of nursing homes billing for unnecessary and unprovided services, concluding that lax Medicare rules invited abuse. The result of this system was a rise in ancillary costs at a rate of 19% per year while routine costs rose at 6% per year. The GAO noted that the rise in ancillary costs was "not explained by increase in beneficiary health needs."

Of the seven largest chains, most had higher than average costs. In two, capital costs are substantially higher than the national average and a third reported a four-fold increase in rent due to renting from its own subsidiary. Most of the chains in bankruptcy had invested heavily in selling ancillary services to themselves and others.

The BBA of 1997 closed loopholes by gradually phasing out the system which allowed for unlimited cost based reimbursement and gradually phasing in a system in which payment was a per day amount based on severity of patient health care need. The average Medicare per diem declined by about 9% between FY 1998 and 1999, reaching the same average rate as in 1996. The GAO found this noteworthy, because payment rates in 1996 were believed to be excessive given that they reflected 6 years of growth at more than 12% per year at a time when prices for goods and services purchased by nursing homes were rising about 3% each year.

According to the GAO, the Balanced Budget Reconciliation act of 1999 restored some of the funding to facilities which had been hurt by the BBA 1997 changes by increasing payments across the board by 4% for 2001 and 2002, adding an estimated $200 million to Medicare nursing home spending in FY 2000. The GAO estimated that if the increases were allowed to remain in place for five years, total Medicare nursing home spending would increase by $1.4 billion nationwide. In December, 2000, the Congress added an additional $1.6 billion to Medicare payments to nursing homes.

Industry analysts and government officials expect that most public chains currently operating in bankruptcy will recover. In states where a large number of nursing homes are operating in bankruptcy, however, it is important that contingency plans be developed to address the closure of some bankrupt facilities.

Adequacy of Government Payments

Florida Medicaid pays nursing homes a facility-specific per diem rate based on the facility's reported costs. The per diem is the aggregate of costs in four specific domains: operating expenses, patient care, property costs and return on equity. The operating component includes administration, laundry, plant operations and housekeeping. The patient care component includes nursing, dietary, social services, and ancillary expenses. The property component includes interest, depreciation, insurance, property taxes, and equipment rental. Each of these components is calculated separately and the components are combined to determine the per diem. Reimbursement ceilings limit the level of increase in facility per diem rates. According to the Medicaid program, per diem rates as of July 1, 2000, are reimbursing 89% of facility Medicaid costs.

House bill 1971, passed during the 1999 Legislative session, created the Panel on Medicaid Reimbursement to study the state's Medicaid reimbursement plan and recommend changes. The panel was housed at and staffed by the Agency for Health Care Administration. The panel determined that quality of care to nursing home residents was likely to be negatively affected by the increasing difficulty providers are experiencing in hiring and retaining direct caregiver staff and the lack of current incentives for nursing homes to renovate and update physical plants. The panel recommended rebasing the patient care component and gave options to modify the Fair Rental Value System in the property component.

Nursing Home Staffing

Currently, according to the Institute of Medicine, the key indicators by which quality is monitored and measured in the nursing home environment are: (1) pain, (2) use of physical and chemical restraints, (3) pressure sores, (4) malnutrition, (5) continence care, and (6) aspects of care related to quality of life. The quality of services provided in nursing homes is increasingly dependent on the personnel available. This dependence is based on the reality that most nursing home residents are sicker than nursing home residents being admitted just a few years ago.

In January 2000 the University of California released the results of a study funded by the Health Care Financing Administration entitled *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1992 Through 1998*, by Charlene Harrington, Ph.D., et al. The report provides several statistical findings relating to nursing homes throughout the United States, presented in a state-by-state format. In Table 30 of the study, statistics cited for Florida show that the state's nursing homes, for each of the focus years, slightly exceeded the national average in staffing as computed using payroll hours per resident day rather than actual hours of care delivered directly to residents. These data were reported by each facility for the two weeks prior to the facility survey. Despite the fact that on average, Florida facilities had higher staffing ratios, Florida facilities were cited more often than the national average on a number of key indicators.

Percent of Nursing Homes Cited for Top Ten Deficiencies

Indicator	% Nat'l	% Fl
Food Sanitation	23.7	30.5
Dignity	14.1	24.7
Quality of Care	17.2	20.3
Pressure Sores	17.1	20.5
Comp.Care Plans	15.2	24.8
Comp. Assessments	15.1	17.7
Physical Restraints	12.7	15.5
Accident Prevention	14.7	10.0
Accidents	18.0	10.8
Housekeeping	14.4	13.3

Source: U. Cal report, 2000

Two trends, relating to staffing, detected from data presented in the report are particularly noteworthy. First, the study illustrates that while facilities in Florida, on average, exceeded the national average in staffing ratios, the percentage of nursing homes in Florida cited for nutrition deficiencies, from 1992 through 1998, exceeded the national average, and were more than double or almost double the national average for several years.

Percent of Nursing Homes Cited for Nutrition Deficiencies

	1995	1996	1997	1998
National Average	8.1%	8.1%	8.3%	8.1%
Florida Average	16.2%	16.6%	15.5%	13.2%

Source: U. Cal report, 2000

In addition, Florida has seen a steady increase in the percentage of facilities with deficiency citations issued for insufficient staffing, while the national average which has stayed within a narrow range of variation for most of the study's focus years

Percent of Nursing Homes Cited for Staffing Deficiencies

Year	% Nat'l	% FL
1992	6.0	4.8
1993	6.2	5.6
1994	7.0	7.1
1995	5.7	9.3
1996	4.2	10.9
1997	3.8	10.8
1998	4.6	13.9

Source: U. Cal report, 2000

Senior Housing

Administrators of public housing for the elderly judge that 14 to 17% of elder tenants are having trouble remaining responsible for themselves and that 11-17% are confused, abusive, or depressed. Elder tenants themselves reported higher self-estimates of their dependency, and only 37% of them felt that if they were sick or disabled, they could rely on someone to help them as long as needed. The top two services they felt lacking: handrails or grab-bars in their bathroom and transportation to and from a doctor's appointment. Over a third of elder tenants have no idea where they would move if they had to vacate their apartment. In practice, an average of 30% of the tenants who do annually vacate their apartments enter a nursing home.

Finding appropriate and affordable supportive services is stressful and difficult. This is especially the case for seniors who cannot rely on family assistance, who are less educated, have trouble speaking English, or are easily intimidated by bureaucratic ways. State funded community-based service providers compound this problem by either underestimating these elder tenants' needs, identifying them as a lower-priority group, or by offering only overly narrow care. In some cases service providers are simply too over-committed to reach this group.

Many public housing facilities have expressed interest in converting existing public housing to assisted living to meet these needs. The drawbacks of this approach are that these providers often want government to pay for both the conversion and the ongoing services which will be provided to these residents, there are regulatory requirements for assisted living which are not present for public housing, and this strategy creates a deficit in the number of public housing units available to low-income elderly individuals.

In December, 2000 the federal Department of Housing and Urban Development announced that $20 million in federal assistance would be made to convert existing low-income senior housing into assisted living facilities. The grants will cover only construction costs; project owners will be responsible for providing supportive services to individuals residing in the converted facilities. Florida's allocation of these conversion funds is $2.75 million.

RECOMMENDATIONS

1. Florida should develop a plan to build a system of delivering long-term care to elderly residents which provide maximum choice of alternatives so that elderly citizens can receive care in the most cost-effective settings appropriate to their needs.

- The Legislature should establish, in the Executive Office of the Governor, an interagency panel responsible for analyzing Florida's long-term care system, ensuring coordination among the agencies responsible for the long-term care continuum, and making recommendations to executive agencies and the legislature designed to increase quality of care and the use of non-institutional settings to provide care to the elderly.
- The Legislature should require the Department of Elder Affairs and its local contractors to develop formalized linkages to public housing providers, and to increase services to residents of these facilities who are at risk of nursing home placement
- The Agency for Health Care Administration should develop a strategy for insuring that, if the state's inventory of nursing homes is reduced due to closures, care of patients is re-directed to the highest quality facilities or alternative care settings.

2. Florida should take steps increase the quality of care for persons in nursing homes and assisted living facilities.

- The Legislature should increase staffing standards in nursing homes, and ensure that Medicaid reimburses these costs for Medicaid recipient care.
- The Legislature should prohibit renewal of nursing home and assisted living facility licenses if there are unpaid fees or sanctions due to the state.
- The Legislature should require the Agency for Health Care Administration to increase the frequency of on-site visits to long-term care facilities, and increase licensure fees to support this increased oversight.
- The Legislature should require the Agency for Health Care Administration and Department of Elder Affairs to develop contingency plans for mitigating the effects of closure of some of the state's nursing homes.
- The Legislature should increase funding to the Long-Term Care Ombudsman program to expand recruitment, training, and support of volunteers.
- The Legislature should increase funding for public guardians to protect the interests of nursing home residents who need but do not have guardians.

3. The Legislature should attempt to stabilize liability risks for long-term care facilities.

- The Legislature should consider capping attorneys fees and damages in resident rights lawsuits to bring

stability and predictability to the long-term care liability market. Such caps should; however, insure that residents have access to judicial remedies in instances of abuse, neglect and resident's rights violations.

- The Legislature should remove the requirement that assisted living facilities maintain liability insurance as a condition of licensure.

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***
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The Nursing Home Problem in Florida

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The nursing home problem in Florida was characterized as a debate over quality of care and the rapid increase of lawsuits against nursing homes that led to a decline in the availability of affordable liability insurance. The staff for Florida's Task Force on Availability and Affordability of Long-Term Care analyzed lawsuit and quality-of-care data from one county in Florida and quality-of-care data statewide to understand the relationship between the two sides of the argument. Analyses showed support for both positions and a middle-ground policy position was achieved. The subsequent nursing home reform legislation and implications for the future of long-term care in Florida are discussed.

Key Words: Long-term care, Nursing homes, Assisted living facilities, Litigation, Liability insurance, Quality of care

In May 2000, the Florida Legislature established the Task Force on Availability and Affordability of Long-Term Care (Task Force). The challenging mission of the Task Force was to assess the current long-term care system in terms of the availability of alternatives to nursing homes, the quality of care in nursing homes, the impact of lawsuits against nursing homes and other long-term care facilities, and financing long-term care. The Task Force received staff support from the Florida Policy Exchange Center on Aging (FPECA), which prepared a comprehensive report with policy, program, and fiscal recommendations based on research and public testimony. The focus of the debate in Florida was over the quality of care in nursing homes, the rapid increase in lawsuits against nursing homes since the mid-1990s, and the declining availability of nursing home liability insurance. These issues constituted the "nursing home problem" that had been on the legislative agenda for several years before the Task Force was appointed. Legislation addressing the problem passed in 2001. The delay in a legislative response to these issues was caused by a highly divisive struggle between the nursing home industry and the trial lawyers over the definition of the problem—excessive quality of care deficiencies versus out-of-control litigation—and the most effective legislative response to it: tighter regulation versus tort reform.

The legislature, with the help of the Task Force, achieved a middle-ground position in the form of Senate Bill (SB) 1202, which was signed into law on May 15, 2001 and provided something for both camps by requiring more stringent regulatory standards and procedures, increasing nursing home staffing standards, and placing caps on punitive damages along with other tort reform measures. This article summarizes the review of the literature and data analyses conducted by FPECA staff and the subsequent nursing home reform legislation. We conclude with a discussion of the policy implications arising from the legislation and the larger context of long-term care policy and politics. Our purpose in reporting research findings in a forum article is to show how the analyses conducted for the Task Force supported legislation and how the legislation may ultimately affect long-term care reform. Forthcoming research provides a more detailed examination of

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the analyses summarized here and examines multi-year predictors of nursing home deficiencies in Florida (Johnson and Hyer, 2002), predictors of lawsuits (Johnson et al., 2002), and a ten-year review of lawsuits against nursing homes (Hedgecock, Oakley, Johnson, Salmon, Polivka et al., in preparation).

Nursing Home Quality of Care

Quality of care in nursing homes is a multidimensional construct that includes structure, process, and outcomes (Donabedian, 1966, 1980) and is affected by the nature and scope of quality indicators (QIs) and how indicators are operationalized and interpreted (Wunderlich & Kohler, 2001). Resident satisfaction is a critical quality-of-care indicator, but is not routinely collected (Kane, 2001) and, given the 6-month timeframe for the Task Force, was not addressed by FPECA staff. Many Task Force members, a priori, stated that poor quality of care was because of too few staff and resulted in higher deficiencies. This regulatory definition of quality of care was likely because of the availability of deficiency data and was commonly used by advocates and legislators. In fact, the Florida legislature passed House Bill 1971 in 1999 to provide $32 million in new Medicaid dollars to increase direct care staff (through hiring and staff retention incentives). The State's Medicaid agency, the Agency for Health Care Administration (AHCA, 2002), published deficiency data in its quarterly *Nursing Home Watch List* and was planning to rank nursing homes based on total deficiencies in its *Nursing Home Guide* to inform consumers about nursing home performance (AHCA, 2002). At the time of the Task Force, the Health Care Financing Administration (HCFA; now the Centers for Medicare and Medicaid Services [CMS]) released its study that examined the effects of nurse staffing and found that quality of care (defined by several clinical outcomes) was seriously impaired when nursing homes were staffed below HCFA minimum staffing levels at that time (2.0 certified nursing assistant (CNA) hours per resident day [hprd], .75 registered nurse (RN) and licensed practical nurse (LPN) and .20 RN; HCFA, 2000). The Task Force members' compelling interest in deficiency and staffing data focused staff research on this definition of quality of care. Staff included structural indicators, such as ownership and percentage of residents who are on Medicaid, as well. The policy and research literature that address deficiencies, staffing, and these structural variables are briefly reviewed next.

Deficiencies

CMS defines the standards that nursing homes must meet to participate in Medicare and Medicaid programs, and contracts with states to hire survey staff to certify that homes meet these standards during an annual survey. Violations of the health or safety regulations result in deficiencies and are included in the Online Survey Certification and Reporting (OSCAR) database. The OSCAR data are published annually and are the basis for the comparisons across states and indicate changes within states over time (Harrington, Carrillo, Thollaug, Summers, & Wellin, 2000). Citations, facility characteristics, resident characteristics and conditions, and staffing information are available for research purposes.

Deficiencies are limited as a proxy for quality of care because of underreporting or false negatives (U.S. General Accounting Office, 1998), the inconsistent enforcement of standards (U.S. Office of the Inspector General, 1999), the wide range in resources available for state enforcement (Walshe & Harrington, 2002), and the fact that staffing predicts only 1% of variance in total deficiencies when it is found to be important to quality of care (Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000). Improvements in assessing quality of nursing home care are expected to be more reliable with the use of QIs (Zimmerman et al., 1995). For example, in a recent study of the validity of QI measures for chronic care residents, the following items were recommended: prevalence of an in-dwelling catheter, bladder/bowel incontinence, urinary tract infections, inadequate pain management, pressure ulcers, late-loss activity of daily living (ADL) worsening, ADL and locomotion worsening, improvement in walking, and worsening bladder continence (Morris et al., 2002). CMS now publishes these QIs in Florida and five other states to inform residents and their families about quality of care in long-term care facilities. Harrington, Zimmerman and colleagues (2000) recommend that the relationship between QIs, Minimum Data Set (MDS) data, and survey deficiencies be tested to improve our understanding of correlates of nursing home quality.

In 1999, Florida ranked both higher and lower than the national average in the ten most commonly cited deficiencies (Figure 1; Harrington, Carrillo, et al., 2000). Florida received more citations in the areas of food sanitation, care planning, dignity, and care plan assessments than most other states. Florida received fewer violations than the national average and was among the top 20 states for quality of care, accidents, accident prevention, pressure sores, housekeeping, and assistance with functional impairments. Over time, the percentage of residents in Florida with severe conditions, such as contractures, increased from a low of 16.5% in 1993 (not displayed) to 18.3% in 1999, but remained below the national average (24% in 1999; Harrington, Carrillo, et al., 2000). The percentage of residents with physical restraints in Florida had significantly decreased since 1993 and was lower than the national average in 1999 (7.4% vs. 10.9% for the nation). At the same

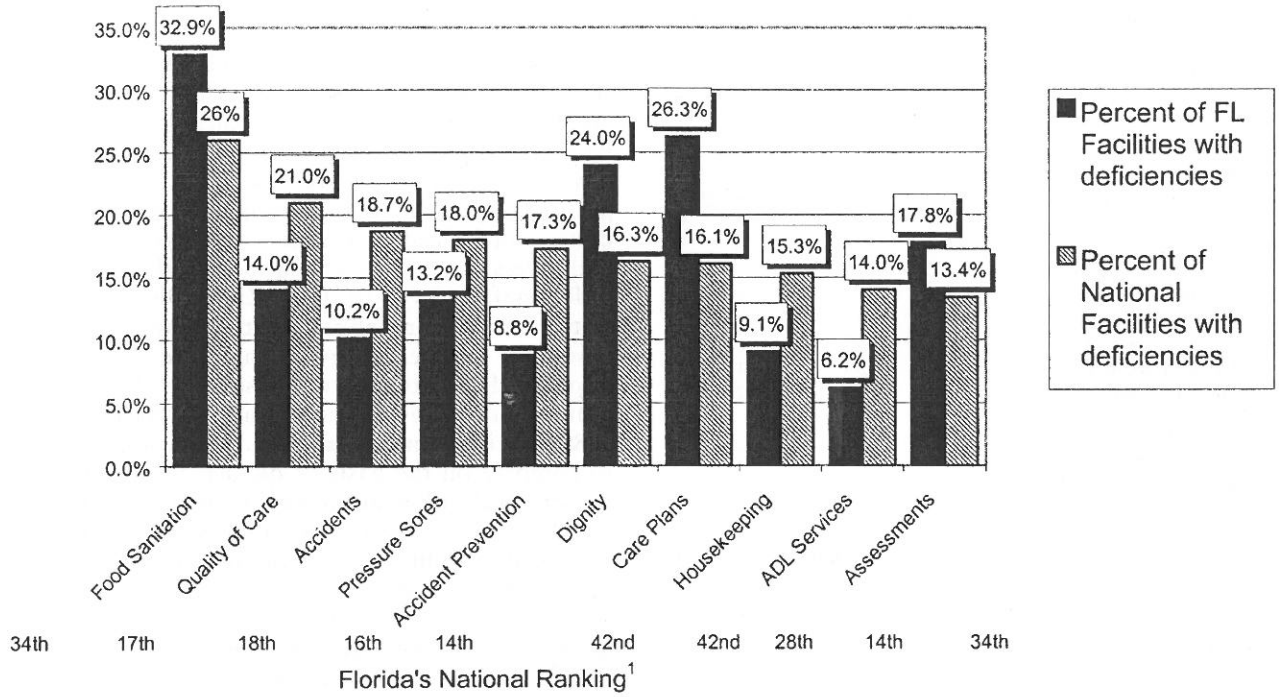

Figure 1. Comparison of Florida facilities to nation on top ten deficiencies in the United States: 1999. FL = Florida; ADL = activity of daily living. [1] This ranking includes all states and Washington, DC. 1 = best ranking. From *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1993 Through 1999,* by C. Harrington, H. Carillo, S.C. Thollaug, P.R. Summers, & V. Wellin, San Francisco, University of California.

time, the percentage of Florida nursing homes cited for inadequate staffing increased from 5.6% in 1993 to 12.4% in 1999 (Harrington, Carrillo et al., 2000).

Staffing

Research is consistent regarding the impact of the number of registered nurse staff on the quality of resident care, but there is also a significant relationship between levels of LPNs, CNAs and resident outcomes involving intensive levels of personal care (Harrington, Carrillo, et al., 2000; Harrington, Zimmerman, et al., 2000; Health Care Financing Administration, 2000). CMS (2001) released the first comprehensive analysis of the impact of different staffing mix on patient care outcomes. The authors acknowledge that the mix of RNs, LPNs, and CNAs in nursing homes varies widely, and obtaining accurate measures of specific nurse staffing was difficult. However, using Medicaid cost reports and nurse researchers, the authors found hospital transfer rates for avoidable conditions was clearly linked with CNAs, LPNs, and other licensed staff. The convincing evidence indicated that adequate nursing—both licensed and nonlicensed—was necessary to assess and care for residents with high-risk chronic conditions. Similarly, the CMS report was the first large-scale study to confirm the relationship between all levels of nurse staffing and incidence of pressure ulcers, refuting Cohen and Spector (1996) who found no relationship between total staff intensity and resident outcomes. The labor-intensive efforts needed to reposition patients required CNAs, but the skill needed to assess, treat, and supervise nonlicensed staff required licensed staffing. Consistent with earlier research (Cohen & Spector, 1996; Spector & Takada, 1991), functional improvement is related to licensed staff. Improvement in resisting ADL assistance, a quality of interpersonal relationships between staff and residents, is related to RN staffing. Others have found that inadequate staffing and supervision led to serious dehydration of residents (Kayser-Jones, Schell, Porter, Barbaccia, & Shaw, 1999), and RN staffing improves nursing home care on a range of outcomes (Anderson, Hsieh, & Su, 1998; Bliesmer, Smayling, Kane, & Shannon, 1998; Castle, 2000).

In 2000, Florida's minimum staffing levels for nursing homes were 1.7 CNA hprd and .6 RN plus LPN hprd. Nine percent of nursing homes were below the minimum for CNA staffing, and 1% were below the RN plus LPN staffing minimum (Alan Eddy, AHCA Medicaid Analyst, personal communication). Using HCFA minimum staffing standards at that time, 45% of Florida's nursing homes were below the CNA staffing level (2.0 hprd), and 16% were below the RN staffing level (.20 hprd). Florida's staffing was better than the nation, which reported 54% below the CNA minimum and 31% below the RN minimum.

Table 1. Predictors of Quality Deficiencies in Nursing Homes

Predictor	Coefficient	*t*
Structural		
Beds	.00	.89
Not for profit	−.45	−.82
Medicaid ratio	6.30	5.32**
Case-Mix		
Eating dependency ratio	.11	.08
Incontinence ratio	1.60	1.13
Bed/chairfast ratio	.57	.48
Tube feeding ratio	−8.56	−2.28*
Rehab patient ratio	3.53	1.71
Dementia ratio	−3.16	−2.32*
Deficiencies		
Medication errors	.25	5.86**
Cited for low staff	6.25	8.99**
Acquired pressure sores ratio	1.84	2.37*

Note: Dependent variable—number of quality deficiencies (quality of care + quality of life). $N = 654$ nursing homes. $R^2 = .23$.

Source: Online Survey Certification and Reporting (OSCAR).

*$p \leq .01$; **$p \leq .05$.

For-Profit and Not-for-Profit Ownership

Ownership type may influence the quality of care provided to nursing home residents. For example, not-for-profit facilities consistently have more staff at all nursing levels than for-profit facilities with the greatest difference in RN levels (CMS, 2001; Cohen & Spector 1996; Harrington, Woolhandler, Mullan, Carrillo, & Himmelstein, 2001; Kanda & Mezey, 1991). Insofar as not-for-profit or for-profit ownership status encourages higher skill mix among the nursing staff, it also encourages quality. Staff philosophy, an important aspect of institutional mission influenced by not-for-profit status, also appears to influence care quality (Anderson & Lawhorne, 1999).

The evidence regarding the relationship of nursing home ownership and clinical care outcomes is more mixed. Not controlling for size, for-profit nursing homes were more likely to have poor quality of care, compared with not-for-profit nursing homes (Harrington et al., 2001). For-profit nursing homes were also more likely to receive deficiencies for the use of restraints (Aaronson, Zinn, & Rosko, 1994; Castle, 2000), have a higher percentage of decubitus pressure ulcers (Aaronson et al., 1994) and mortality for private-pay residents (Spector, Selden, & Cohen, 1998). Not-for-profit nursing homes were more likely to have reduced adverse outcomes (Spector et al., 1998) and fewer hospitalizations (Freiman & Murtaugh, 1993). Yet, others report that ownership type has little overall consistent effect on quality (Castle & Shea, 1988; Porrell, Caro, Silva, & Monane, 1998).

Residents on Medicaid

To some extent, the lack of consensus on ownership status may be because of the difference in the number and percentage of Medicaid residents. In Florida, for-profit nursing homes are more likely to have residents who are on Medicaid. Higher proportions of Medicaid recipients in a nursing home—an indicator of lower resource availability and excess demand—are associated with lower levels of RN staffing (Nyman, 1988; Zinn, 1994). For many states, Medicaid reimbursement is focused on lower costs, not on the quality of care, and Medicaid is a proxy for poorer care presumably because reimbursement is low (Harrington et al., 2001; Nyman, 1988). Facilities in such areas may have less incentive to compete on the basis of quality as evidenced by higher levels of state survey violations. Adequate reimbursement levels are a necessary, but not sufficient condition for quality. Finally, Hirth (1999) argues that areas with higher not-for-profit market share may encourage competition based on quality because of differential preferences of often poorly informed consumers to use not-for-profit ownership as a substitute indicator for quality. Evidence has been found for such preferential choice (Hirth, 1993; Spector et al., 1998).

Predictors of Nursing Home Quality in Florida

To examine further the relationship between staffing, clinical deficiencies, for-profit status, and ratio of Medicaid residents on nursing home quality, a multivariate analysis was conducted using 1999 cross-sectional OSCAR data for Florida. We hypothesized that nursing homes would have fewer quality deficiencies against them if (1) the facility met minimum HCFA staffing levels; (2) were not-for-profit; (3) had fewer residents on Medicaid; and (4) had fewer poor quality outcomes, such as in-house pressure sore development. Because the validity and reliability of OSCAR staffing deficiency data have been questioned (Harrington, Zimmerman, et al., 2000; Wunderlich & Kohler, 2001), we used the low staffing citation as a staffing compliance indicator.

Our dependent variable is labeled quality deficiencies. It is based on OSCAR data that include 185 standards in 17 categories each with many deficiencies (U.S. Office of the Inspector General, 1999). The standards were categorized by others into three groups: quality of care, quality of life, and administrative (Harrington, Zimmerman, et al., 2000). Surveyor discretion affects how a particular deficiency is classified (Harrington, Zimmerman, et al., 2000; U.S. Office of the Inspector General, 1999). Therefore, for our purposes, we combined the quality of life and quality-of-care deficiencies as categorized by Harrington and colleagues because they (1) more thoroughly covered areas of concern to the Task Force (e.g. resident rights *and* quality of

care) and (2) together corrected for any discretion by the surveyors. For instance, all deficiencies are recorded, but the same deficiency may have been coded by different surveyors in two or more areas that, in the abbreviated classification scheme, would force them into either quality of care or quality of life. If we disaggregated the analysis, we would lose relevant deficiencies. In a times-series analysis (not displayed here), we determined that combining these two categories accounted for more variance ($R^2 = .15$ vs. $R^2 = .09$ with quality of care alone). Other researchers measured quality as the total combined quality of life, quality of care, and administrative deficiencies or disaggregated them (Harrington, Zimmerman, et al., 2001) but did not combine the two, as we have done here.

One structural variable (ratio of Medicaid residents) was associated with higher deficiencies(Table 1). All of the deficiency variables (medication errors, inadequate staffing, and ratio of acquired pressure sores) were associated with quality deficiencies in a nursing home. Two variables that measured the relative acuity levels of residents (case mix) were associated with lower quality deficiencies. The ratios of residents who receive tube feeding and who have some form of dementia decreased the number of quality deficiencies. Not-for-profit status was not associated with quality deficiencies.

There are two problems with using OSCAR quality deficiencies as an outcome variable. First, quality deficiencies represent a minimum standard and are not representative of all the dimensions of quality outlined by Donabedian (1966; 1980). Second, quality deficiencies include the low staff citation variable in the multivariate model. It is used here as a predictor variable because it is a better indicator of failure to meet overall Florida staffing standards than other options available in the OSCAR data that were highly correlated with the low staffing citation indicator. As mentioned earlier, disaggregating deficiencies into quality of care and quality of life deficiencies produced a less robust model, compared with combining these deficiencies. Future research will examine how process and structure measures relate to the scope and severity of deficiencies and use longitudinal rather than cross-sectional data.

The multivariate model supports the hypothesis that being cited for failure to meet minimum staffing levels is related to higher quality deficiencies. The importance of staffing is supported by other research (Anderson et al., 1998; Castle & Fogel, 1998; CMS, 2001; Harrington, Kovner, et al., 2000; Harrington, Zimmerman, et al., 2001). For example, Harrington, Zimmerman, and colleagues (2000) found that lower RN staff levels and lower CNA hours predicted total deficiencies, but LPN hours were not related to deficiencies. They also found that facilities with more incontinent residents and residents with pressure sores had more quality deficiencies, which is partially supported here. Increasingly, the evidence indicates that the clinical skill mix for frail and ill nursing home residents, geriatric training of staff, and use of best-practice knowledge is critical to the quality of nursing home care (Harrington, Kovner, et al., 2000; Stone et al., 2002).

Our model also supports the hypothesis that nursing homes serving more Medicaid residents will have higher quality deficiencies. This may be from lower reimbursement and therefore a lack of resources to pay for adequate staffing (Harrington et al., 2001; Nyman, 1988). At the same time, there was no support for the hypothesis that not-for-profit nursing homes will have fewer quality deficiencies when controlling for other structural variables and case-mix. In another analysis (not shown here), the interaction between for-profit status and ratio of Medicaid residents did not improve the model fit ($R^2 = .22$), but the interaction approached significance ($p = .07$), although the ratio of Medicaid residents continued to be one of the strongest indicators of deficiencies.

Although Florida was worse in some deficiencies and better in others, compared with the rest of the nation, Florida was among the worst for low staffing. Our analysis supported the importance of nurse staffing at all levels, provided evidence that higher staffing is linked to fewer quality deficiencies, and led to recommendations for higher mandated staffing levels. Our analytic model also raised concerns about the Medicaid reimbursement rate to care for elders and supported the for-profit nursing homes' argument that the Medicaid formula and rates needed to be revised. This argument was supported by a separate panel on the Medicaid reimbursement rate.

Nursing Home Litigation

The second major issue that constituted the nursing home problem was the perception there was a high level of litigation against nursing homes in Florida that was driving up the cost and availability of liability insurance. The research on the prevalence, causes, and costs of lawsuits against nursing homes is scant (Kapp, 2001; Williamson, 1999), but is reviewed here followed by a brief description of two research studies conducted for the Task Force that looked at the prevalence and cost of lawsuits in a representative county and tests a model for predicting the causes of lawsuit activity.

Prevalence of Lawsuits

For the most part, the numbers of nursing home lawsuits is known through jury verdicts that represent 1% of all lawsuits. In some cases, insurance companies and actuaries have provided data about a number of lawsuits. St. Paul Fire and Marine Insurance Co. closed 2,500 nursing home claims nationwide from 1988 through 1992, and 4,200 such claims between 1993 and 1997 (Hawryluk, 1999).

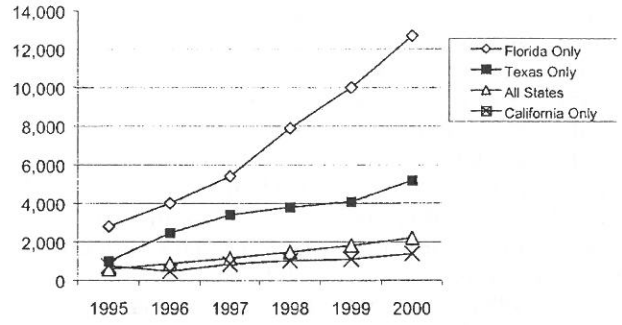

Figure 2. Loss cost per occupied bed. Data are from *Florida Long Term Care General Liability and Professional Liability Actuarial Analysis*, by T. W. Bourdon and S. C. Dubin, 2001, Columbia, MD, AON Risk Consultants, Inc.

California, Texas, Illinois, and Florida had the largest number of lawsuits that has been explained by their large older adult populations (Bennett, O'Sullivan, DeVito, & Remsburg, 2000). Yet, as a percentage of nursing home beds, they had a disproportionate number of lawsuits, as well. Florida had approximately 29 claims per 1,000 occupied nursing home beds, whereas Texas had 19 claims, and California had approximately eight (Bourdon & Dubin, 2002). Some insurance underwriters consider Florida, Texas, and California as "plaintiff friendly," which might explain the disproportionate number of professional liability claims (Kilduff, 2001).

Causes of Lawsuits

The upsurge in nursing home litigation has been attributed to several factors. Some point to poor quality of treatment and care of elderly nursing home residents (Berlowitz, Bezerra, Brandeis, Kader, & Anderson, 2000), and yet medical malpractice research does not support this hypothesis (Brennan et al., 1991; Localio et al., 1991).

The Omnibus Budget Reconciliation Act in 1987 (OBRA-87) with its required use of the Resident Assessment Instrument and MDS provided a national standard of care that could be used in nursing home litigation. Indeed, Bennett and colleagues (2000) identified 173 pressure ulcer cases that had been filed and settled from 1937 through 1997. Nearly all (94%) of these lawsuits were filed after 1982, with a significant increase in the average number of cases identified per year occurring in the 5-year period after publication in 1992 of the OBRA-87 regulations. The majority of cases involved nursing homes as defendants, although 24% were filed against hospitals. In addition, from 1987 to 1994, the average nursing home negligence lawsuit award rose 120%, which could be attributed to the new OBRA standards, although this association has not been demonstrated (Felsenthal, 1995; Williamson, 1999).

Finally, state and federal tort reforms have made it tougher for personal injury lawyers to sue hospitals, so plaintiffs' attorneys may have broadened their scope of work to related arenas, such as nursing homes (Sullivan, 1996).

Cost of Lawsuits

Jury verdicts for nursing home lawsuits over an 8-year period showed that average awards increased 120%, from $238,285 in 1987 to $525,853 in 1994 (Felsenthal, 1995). The majority of nursing home lawsuits are settled out of court and are not included in national databases of jury verdicts. High-profile jury awards in nursing home lawsuits are one reason lawsuits are settled out of court. The awards have reached as high as $250 million (Hawryluk, 1999) and have been attributed to the perception of nursing home indifference (Bennett et al., 2000), jury members' experience with aging parents in nursing homes, or their concern about their own future use of long-term care (Moss, 1998). In fact, 20% of plaintiffs were awarded damages in nursing home lawsuits, compared with 5% of plaintiffs in other personal injury suits.

The average size of a nursing home litigation claim in Florida, according to actuaries who represent the for-profit industry, was $278,637 in 1999, which was 250% more than the average claim in the other states ($112,351; Bourdon & Dubin, 2001). For-profit nursing homes in Florida had 4 times as many claims filed against them than the rest of the nation, and the average loss cost per annual occupied bed in Florida was $12,700, which was 12 times more than the average loss cost in the other 49 states ($1,050; Figure 2; Bourdon & Dubin, 2001).

Nursing Home Lawsuits in Florida

Nursing home lawsuits in Florida began to increase around 1997 because of trial attorneys' perceptions that there was inconsistent and weak enforcement of federal and state nursing home regulations and a need to punish facilities for wrongful actions (Williamson, 1999). Infringements of the Resident Rights statute (Florida Statutes §400.022–400.023) was the primary cause of action. The statute created a different burden of proof for nursing homes than those found under malpractice law. Malpractice law requires the plaintiff to show that the care provided within the nursing home was done so in a negligent manner. Lawsuits brought under the Florida Resident Rights statute requires that the nursing home proves that it did not violate the resident's rights as defined by the statutes. Criteria for attorney fees associated with nursing home lawsuits are explicitly defined in a manner different than found under malpractice law (Williamson, 1999). The effects of the increased lawsuits on nursing homes were: (1) insurance carriers required nursing homes to settle cases even if faci-

lities were in compliance with regulations; (2) nursing homes were increasingly portrayed negatively; (3) jury verdicts increased because of negative publicity; (4) operating funds were reduced and affected hands-on care and resident services; and (5) nursing home closures increased (Williamson, 1999). There was also a perception that nursing homes were at higher risk of being sued because of increased acuity of residents who were discharged earlier from hospital stays.

There is no statewide database of lawsuits filed against Florida nursing homes. A systematic review of the record-keeping systems of Florida's 20 circuit courts revealed that two courts provided easily accessible, computerized public records systems. One court was in a county with just three nursing homes and the other was the Circuit Court of Hillsborough County, which had 35 nursing homes. Hillsborough County was comparable with the state average on a number of variables related to access to long-term care options (e.g., the ratio of nursing home and assisted living beds per 65+ population, and allocations for home- and community-based alternatives).

From 1991 to 1995, 87 lawsuits were filed against 35 nursing homes in Hillsborough County in the Tampa Bay area (Hedgecock et al., 2002). From 1995 to 2000, 369 lawsuits were filed, representing a four-fold increase. The *Sun Sentinel* (Lamendola, 2001) and *South Florida Sun-Sentinel* (Groeller, 2001) newspapers conducted a study of circuit court data in south and central Florida, and found that 924 lawsuits had been filed against 241 nursing homes between 1996 and 2000, which represented a 157% increase over the 5-year period and a 300% increase in central Florida alone. Statewide, there were 67 jury-tried lawsuits in 10 years. Of these, four were from Hillsborough County (1% of all lawsuits in Hillsborough County). Plaintiff and defense attorneys believe that 1% or less of all lawsuits against nursing homes go to trial. If this is the case, then there were an estimated 6,700 lawsuits statewide during this 10-year period.

Every year from 1995 through 2000, an average of 61.4% of nursing homes in Hillsborough County had at least one lawsuit. The size of the claims (for those that were not sealed) averaged $285,667 in the early 1990s and $484,680 in the late 1990s. This level of lawsuit activity is one of the reasons that 9% of nursing homes in Florida were entirely without liability insurance as of February 1, 2001. This was up from 1% in June 2000. The last admitted insurance carrier (one that is regulated by the Department of Insurance) announced that it was ending its liability coverage for long-term care facilities in February 2001 (Oakley & Johnson, 2001).

According to public testimony given during Task Force hearings, the remaining unregulated insurers were offering premiums that were 100% to 1,000% above rates last paid by many providers. Assisted living facilities (ALFs), which are required by statute to hold liability insurance, were told by insurers to give up their Extended Congregate Care (ECC) or Limited Nursing Service (LNS) licenses in order to receive liability insurance. ALFs are required to hold an ECC or LNS license to accept residents who are covered by Medicaid. Without an ECC or LNS license, these ALFs would have to discharge many residents who would be forced to move to nursing homes (Oakley & Johnson, 2001).

Continuing Care Retirement Communities (CCRC) experienced a 74% increase in their premiums in 2000 (the average increases in 1998 and 1999 were 15%). Because CCRCs are required to have 15% of their operating costs (including expected liability insurance costs) set aside in a reserve fund, this trend, if continued, could place them in financial jeopardy, or at least necessitate major increases in charges to residents (Oakley & Johnson, 2001). Just as Task Force members decided a priori that nursing home quality was directly related to staffing, there was also a belief that nursing homes in Florida were sued more often because they were of poorer quality than other states. It was thought that for-profit nursing homes would be sued more often because they were motivated by profits rather than caring for their frail residents. We used a similar model for predicting quality deficiencies to predict total lawsuits with a few modifications. We added three deficiency variables: acquired contractures, unplanned weight loss, and total F-tag deficiencies. The first two variables were added because they were considered important by Task Force members. Total quality deficiencies were added here to indicate that a facility is not meeting minimum standards and thus may be open to more lawsuits. Here, we hypothesized that nursing homes would have more lawsuits filed against them if they (1) had more financial resources available to them (for-profit), (2) were exposed to more risk (bed size), and (3) had more deficiencies. A database of OSCAR and lawsuit data for 31 nursing homes that were in business from 1996 to 2000 was used in this analysis. Data were analyzed using a lagged lawsuit variable as a regressor to examine the effects of last year's lawsuits on the current year's litigation against the home. One structural variable, the number of beds, was associated with higher lawsuit activity (Table 2). No other variables, including both case-mix (acuity of residents) and deficiencies, were associated with higher lawsuits.

Data on lawsuits were mostly limited to one county in the state of Florida. Although the county was representative, it is also the location of one law firm that has a national reputation for bringing lawsuits against nursing homes. Even so, the volume of lawsuit activity in this county allowed for a better analysis of the relationship between structure, process, and outcome indicators, and the number of lawsuits against a nursing home. Statewide data on lawsuits was limited to extrapolating from the

Table 2. Nursing Home Litigation Predictors

Predictor	Coefficient	z
Structural		
Beds	.01	3.25**
Not for profit	.11	.25
Medicaid ratio	−.26	−.28
Case-mix		
Incontinence ratio	1.52	1.13
Eating dependency ratio	−.55	−.43
Bed/chairfast ratio	.06	1.00
Tube feeding ratio	5.79	1.87
Rehab patient ratio	.97	.48
Dementia ratio	.02	.02
Deficiencies		
Medication errors	−.02	−.23
Cited for low staff	.26	.62
Acquired pressure sores ratio	.20	.29
Acquired contractures ratio	5.32	.91
Unplanned weight loss ratio	.19	.07
Total *F*-tag deficiencies	−.01	−.28

Note: Dependent variable—number of lawsuits. $N = 28$ nursing homes. $\chi^2 < .000$.

Source: Online Survey Certification and Reporting and Hillsborough County Circuit Court Database.

**$p \leq .01$.

statewide jury verdict reporter and newspaper reporting.

Nursing home size was the only predictor of lawsuit activity and may be because of increased exposure to potential lawsuits. On the other hand, for-profit status, ratio of Medicaid residents, or deficiencies do not determine whether or not a nursing home will be sued. The documented sharp increases in lawsuit activity in the latter half of the 1990s gave credence to the concern that there was a high level of litigation against nursing homes (Williamson, 1999). With average settlements of $295,667 (19% of lawsuits in early 1990s) to $485,000 (81% of lawsuits in late 1990s), the estimated 6,700 lawsuits against nursing homes during the past decade may have cost the industry 2.9 billion dollars. The flight of the insurance industry is not surprising, given these potential costs. Our findings supported the initial concern by the nursing home industry and the legislature that there was a notable increase in lawsuit activity, and it was not explained by quality deficiencies in nursing homes.

Policy Response

The Governor and the Florida legislature responded to the staff research and recommendations and to pressures from interest groups representing the nursing home and ALF industry, the trial lawyers, and consumer groups. Soon after the Task Force completed its report in February 2001, the Governor provided an initial set of recommendations that the legislature developed further into SB 1202 and passed in May 2001 (Tables 3 and 4). The legislation represents a balance between stiffer regulation and tort reforms. In this way, it provided the trial lawyers and some consumer groups a strong regulatory mandate and it provided the long-term care industry a stricter standard for filing lawsuits with fewer incentives, such as add-on attorneys' fees. Even so, the reforms themselves were limited.

Table 3. Major Provisions of Florida Senate Bill 1202 Addressing Quality of Care for Nursing Homes

New Staffing Mandates

1. Increased the CNA minimum staffing from 1.7 (hprd) to 2.3 hprd by January 1, 2002, to 2.6 in 2003, and to 2.9 by 2004.
2. Increased licensed nursing to 1.0 hprd effective 2002.

Improved Florida's Ability to Deny or Revoke Nursing Home License

1. Mandated that the Agency *shall* revoke or deny a license if the licensee or controlling interest operates a facility that has had: (1) two moratoria for substandard quality of care within any 30-month period; conditionally licensed for 180 days; cited for two Class I deficiencies; or (2) is cited for two Class I deficiencies in separate surveys within a 30-month period.
2. Allowed the denial, revocation, or suspension of a license for any applicant, licensee, or controlling interest for a demonstrated pattern of deficient practice; failure to pay final order fines; exclusion from Medicare/Medicaid; or for an adverse action by a regulatory agency.

Increased Number of Surveys

1. Mandated a survey every 6 months for 2 years for facilities cited for a Class I deficiency or two or more Class II deficiencies from separate surveys within a 60-day period or three or more substantiated complaints, resulting in either a Class I or Class II deficiency within 6 months.
2. Imposed an additional $6,000 fee for the 2-year period, with one half due after the additional 6-month survey.

Risk Management

1. Mandated a Risk Management program and Risk Manager in each facility.
2. Required risk management policies and procedures; adverse incident reporting within one business day, and a written report to the Agency within 15 calendar days after a full investigation.
3. Required an annual report to the legislature on nursing home adverse incidents by county and types of liability claims filed based on adverse incidents.

Increased Training for Nursing Home Staff and Surveyors

1. Increased the annual CNA training from 12 hours to 18 hours and specified the content.
2. Required new nursing home surveyors to observe a nursing home.
3. Required that at least 50% of surveyor continuing education credits be in geriatric care.
4. Mandated increased dementia training for all staff.

Note: A full listing of all of the quality-of-care provisions in Senate Bill 1202 may be retrieved from http://www.leg.state.fl.us/session/index. CNA = certified nursing assistant; hprd = hours per resident day.

Among the many reforms in SB1202, the bill increased staffing minimum standards over the next 3 years that would place Florida with the highest staffing levels in the nation if other states do not follow suit (Table 3). Nursing homes are required to increase CNA staffing from 1.7 hprd to 2.9 hprd by January 1, 2004. This is higher than the CMS minimum or preferred staffing levels (HCFA, 2000). Licensed nurses will also be increased. CNAs will be required to increase their continuing education units from 12 to 18 hours a year, and dementia training is mandated for all staff.

SB1202 provides AHCA the means to revoke or deny licenses to nursing homes much sooner than previously allowed. Surveys with a pattern of deficiencies will be surveyed more often and will pay a fine for additional surveys. Nursing homes will be required to have a risk management program with a certified risk manager in each facility.

SB1202 created a new negligence standard for filing residents' rights lawsuits, limited add-on attorneys' fees, reduced the statute of limitations on most lawsuits, and placed caps on punitive damages but not on compensatory damages (Table 4). It should be noted that nursing homes are responsible for paying punitive damages, whereas insurance companies are responsible for compensatory damages. The lack of relief to insurance companies for compensatory damages may reduce the overall impact on insurance costs. Given the complexity and urgency of the issues at stake and the many competing forces confronting the legislature, the decision not to limit compensatory damages reflected the limits of what was achievable in a contentious political environment.

SB1202 was one of the most comprehensive nursing home reform packages ever passed by the legislature. Its first year costs were $76 million in additional funding for nursing homes and may cost more than $300 million when fully implemented. The fact that the legislature was able to pass tort reform in combination with the nursing home quality-of-care measures described earlier, with strong bipartisan support (Senate voted 38-0 and House voted 112-8), was surprising to many veteran observers of the Florida Legislature.

Table 4. Major Provisions of Florida Senate Bill 1202 Addressing Tort Reform for Nursing Homes

Standard for Filing Lawsuit Against Nursing Home

1. Created a negligence standard for filing residents' rights lawsuits.
2. Defined burden of proof for bringing a lawsuit against a nursing home.
3. Created pre-suit notification process similar to what is in effect for other health care providers.

Attorneys' Fees

1. Limited add-on attorneys' fees to $25,000 for lawsuits that can be solved through an injunction or administrative remedy.
2. No limits on contingency fees for a plaintiff's lawyer.

Statute of Limitation

1. Reduced statute of limitation from 4 years to 2 years; allowed for extensions of up to 6 years from date of injury when information was concealed to prevent discovery of injury.

Punitive Damages

1. Allowed for continued recovery of punitive damages in cases involving intentional misconduct or gross negligence.
2. Placed limits on punitive damages at the greater of three times the amount of compensatory damages awarded to each claimant—or the sum of $1 million.
3. Provided for super punitive damages at the greater of four times the amount of compensatory damages awarded to each claimant—or the sum of $4 million.
4. Provided for no cap on punitive damages when it is determined that the defendant had a specific intent to harm a resident, and that harm occurred.
5. Divided punitive damage awards equally between the claimant and the Long-Term Care Facility Improvement Trust Fund.

Administrative

1. Required resident or resident's legal representatives to serve a copy of a complaint alleging a violation of a nursing home or assisted living facility resident's rights to the Agency.
2. Eliminated the possibility of bringing residents' rights lawsuits against a nursing home or assisted living facility under Florida's elder abuse law.

Note: A full listing of all of the quality-of-care provisions in Senate Bill 1202 may be retrieved from http://www.leg.state.fl.us/session/index

Discussion

Florida's long-term care system has become too dependent on nursing home care and that has greatly limited the capacity of consumers to receive care in home- and community-based alternatives, which remains the major failing of long-term care policy in Florida and most other states. However, nursing homes, ALFs, and other forms of residential care will continue to play major roles in a more rational and consumer-responsive long-term care system than presently exists. The question then becomes, "How do you ensure their existence and achieve the highest quality of care feasible, given finite resources, and preserve the right to sue?"

SB1202 addressed this question by providing significant tort protection (caps on punitive damages, a negligence standard, and removal of automatic attorneys' fees) for nursing homes and ALFs, by imposing more stringent regulatory and staffing standards, and by providing the necessary funding for their implementation. Whether or not these initiatives will be sufficient to mitigate litigation and make liability insurance available on an affordable basis is an empirical question we will not be able to answer for at least another year or two, although an estimated tail

of more than 3,000 existing claims may be 2 to 4 years long, and may, in itself, substantially limit the availability of insurance (Hedgecock & Salmon, 2001).

The costs of the quality-of-care initiatives, mainly the nursing home staff increases, may significantly constrain the state's ability to expand home- and community-based services. In fact, Florida's continuing heavy reliance on nursing homes makes the state more vulnerable to litigation/liability insurance crises than states that have developed the capacity to serve a far greater percentage of those requiring long-term care in home- and community-based programs. Failure to expand home- and community-based services at an accelerating rate over the next several years would represent a major policy setback and create the conditions for an even deeper long-term care crisis in the years ahead as Florida's already large population of older persons grows steadily larger (currently, 19% are 65+; by 2010, 25% are expected to be 65+).

SB1202 also imposed a moratorium on the construction of new nursing home beds over the next 5 years that may help offset the additional costs of increased staffing and give the state enough fiscal leeway to spend substantially more on home- and community-based services than it did over the previous 10 years to create a more balanced, consumer-responsive, long-term care system. This will, however, require major changes in methods of funding and delivering long-term care services—changes designed to target enhanced home- and community-based services more rigorously to those at greatest risk of requiring nursing home care.

Policymakers are counting on a significant improvement in the quality of nursing home care resulting from their investment in increased staffing and the legislation requiring more stringent regulation. The new staffing levels, although higher than any other state at this time, will still be lower than the new recommended staffing levels for licensed staff (1.3 RN+LPN [CMS, 2001], .70 LPN, 1.15 RN [including administrative hours; Harrington, Kovner, et al., 2000]).

Beyond the conventional, quality-of-care regulatory issues, however, advocates, researchers, and policy makers need to begin addressing quality-of-life issues in nursing homes. Enhancing the quality of life in long-term care has been a major motivating force in the development of less restrictive, more consumer-oriented home- and community-based programs for 20 years. We have been negligent, however, by overlooking the need to humanize the nursing home environment, as well. Creating conditions designed to maintain and nurture autonomy, privacy, dignity, and affectionate ties should have as high a priority in the development of nursing home policy and day-to-day practices as it has historically in the creation and operation of home- and community-based services. This represents the next frontier in the evolution of nursing home care, and we should address it with at least as much resolve and moral commitment as we have the regulation of quality of care.

If the tort reform provisions of SB1202 fail to contain litigation costs and make liability insurance affordable, policy makers will probably be confronted with urgent demands for more tort reform measures, including caps on compensatory damages and lowering the new punitive caps. There may be more interest in developing a large, comprehensive state-run joint underwriting association. The political climate within which these events would unfold, however, may be just as unsympathetic to the interests of the nursing home industry as it has been for the last several years. It is impossible to predict how this scenario, if it were to emerge, would play out. One strong possibility, however, is that policy makers would respond by combining support for more tort reform with support for not-for-profit nursing home providers in the form of various incentives, including insurance subsidies, elimination of certificate of need restrictions and other incentives. In many quarters, including the media, for-profit providers are viewed as having an inherent conflict of interest (profits vs. care) and are often invidiously compared with not-for-profit nursing homes, many of which are operated by faith-based organizations and benefit from a greater reservoir of trust within the community and the perception that they provide a higher quality of care, even though they have been almost as likely to be sued as for-profit facilities. The efficacy of this approach, however, would depend on successfully addressing several limiting factors, including the following.

Not-for-profit providers constitute only 17% of the nursing homes in Florida and have been a shrinking percentage for several years. Reversing this trend would take time and would probably require substantial incentives well beyond the relatively marginal incentives most often mentioned, including assistance with high liability insurance costs. For-profit providers serve a much higher percentage of Medicaid recipients than the not-for-profit providers (70% of residents in a for-profit nursing home are on Medicaid). One major reason for this discrepancy is that not-for-profit providers' costs are higher (often substantially higher) than Medicaid reimbursement rates and as long as there are a sufficient number of private-pay residents able and willing to pay for what they perceive to be a higher quality of care and quality of life in not-for-profit facilities, there is little reason to cut their costs to serve a higher number of Medicaid recipients. (The for-profit providers also claim that their costs are higher than Medicaid pays.) In short, the state would probably have to increase its Medicaid nursing home expenditures substantially to attract more not-for-profit providers. This would be difficult, given that the nursing home budget has already grown by more than 100% since 1992.

There is no clear evidence that the not-for-profit provider community is interested in substantially expanding their operations. Providing nursing home care is an extremely demanding enterprise, with multiple constituencies that often have inconsistent, if not opposing, agendas. Furthermore, not-for-profit providers have been sued at an accelerating rate in Florida over the last few years (68% had been sued by June 2000) and are not likely to consider expanding, absent a qualitative reduction in litigation and the return of affordable insurance. Few doubt that the quality of nursing home care would benefit from a greater presence of mission-driven, faith-based providers governed by an ethic of care. Their expansion, however, is as contingent on a predictable, affordable business environment as would be required for proprietary providers.

The most immediate effect of the litigation and liability insurance crisis on the availability of home- and community-based services may be the pressure from insurers on ALFs to give up or not apply for the ECC license. The ECC license was created by the Florida Legislature to allow ALFs to serve more impaired residents with higher levels of health care needs than can be admitted to or remain in facilities without the license. The major purposes of the license are to provide a community–residential alternative to nursing homes and to enhance opportunities for residents to age in place. In short, ECC-licensed facilities, in combination with assisted living Medicaid waiver funding, are intended to play an essential role in the future growth of Florida's underdeveloped home- and community-based, long-term care system. The loss of this option through the withdrawal of affordable insurance for ECC-licensed facilities would greatly limit the state's capacity to create a more balanced and cost-effective, long-term care system and expand the range of choice available to long-term care consumers.

The debate over litigation and nursing home quality should not take our eye off the prize of long-term care reform that most fundamentally entails greatly expanding the ability of consumers to choose from an array of community-based services and community–residential programs and improving the quality of care in nursing homes. The Florida Legislature took a major step in this direction with the passage of SB1202 in 2001, which may be interpreted as Phase I of long-term care reform in Florida. Phase II will require a sustained multiyear effort to increase the availability of home- and community-based services and create a far more balanced long-term care system than currently exists.

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THE NURSING HOME LIABILITY INSURANCE MARKET:

A CASE STUDY OF FLORIDA

June 2006

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

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The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

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THE NURSING HOME LIABILITY INSURANCE MARKET: A Case Study of Florida

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INTRODUCTION

The market for professional liability insurance for nursing facility operators is in a state of flux, and the cost of professional liability insurance has increased substantially in all areas of the country, though more so in some states than in others. At the same time, the number of insurance carriers offering liability coverage to nursing homes has decreased dramatically, as many regulated insurance carriers incurred huge losses in this product line in the late 1990s, and consequently decided to get out of the market altogether. Those carriers that have decided to stay in the market have changed the terms and conditions of liability coverage dramatically, taking on far less risk at much higher prices.[a] Consequently, in some areas of the country, many nursing facility owners have decided to operate without any professional liability insurance coverage whatsoever.

A major contributing factor to increased cost and reduced availability of professional liability insurance for nursing homes has been increased litigation. However, the nature of the link between nursing home litigation and the cost and availability of professional liability insurance is a matter of considerable debate in the policy arena.

This report presents an update of the nursing home liability insurance market in Florida. The report is one of five case studies that were prepared as part of a larger study sponsored by the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services (HHS) on trends and issues in the nursing home liability insurance market. Additional case studies have been conducted of the nursing home liability insurance market in the states of California, Ohio, Texas, and Georgia. The case studies are designed to provide greater insight into the dynamics of the liability insurance market by examining the experience of states with differing long-term care, economic, political, legal, and insurance landscapes. This report presents the case study on nursing home facility litigation and insurance issues in Florida.

The methodology employed in the Florida case study was somewhat different than the methodologies employed in the other four case studies. Initially, Florida was not selected as a case study state because, due to the extremely severe liability insurance crisis in that state, a number of other research projects focusing on Florida had been recently completed or were currently underway. However, it was later decided to conduct an abbreviated case study analysis of Florida, focusing on the impacts of Senate Bill 1202, a comprehensive tort reform initiative enacted by the Florida legislature in 2001. The Florida case study was conducted primarily through an analysis of secondary materials and phone interviews with key informants, including

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[a] For a more extensive discussion of recent trends in the nursing home liability insurance market, see Burwell, B., Stevenson, D., Tell, E., and Schaefer, M. *Recent Trends in the Nursing Home Liability Insurance Market.* Report prepared for the Office of the Assistant Secretary for Planning and Evaluation HHS, June 2006. [http://aspe.hhs.gov/daltcp/reports/2006/NHliab.htm]

nursing home providers, state officials, plaintiff and defense attorneys, insurance carriers, and researchers.

STATE ENVIRONMENT

For the past decade, Florida has been a focal point of the national nursing home liability insurance crisis. In the mid 1990s, Florida was one of the first states to experience a significant increase in liability claims against nursing homes.[1] By the late 1990s, most commercial insurers had stopped selling professional liability coverage to Florida nursing homes altogether, and had decided to exit the market. As a result, a large number of nursing home operators in the state (some stakeholders estimated 50%) were operating without liability insurance coverage at all. In 2001, the Florida state legislature enacted major tort reform legislation (Senate Bill 1202 or S.B. 1202) which had the dual policy objectives of: (1) improving the quality of care provided in Florida's nursing homes; and (2) limiting both the frequency and severity of nursing home claims. This case study provides an update on Florida's nursing home liability insurance crisis since the enactment of S.B. 1202 in 2001.

Florida Nursing Home Industry

One impact of the nursing home liability insurance situation in Florida, and to a lesser extent elsewhere, has been the divestiture of nursing home facilities by large national chains. Many of the larger, multi-state nursing facility operators adopted a strategy of identifying facilities accounting for a disproportionate share of patient liability costs and reducing their liability exposure by divesting those facilities entirely. In some cases, national chains have elected to exit specific states entirely. In a 2003 Health Care Industry Market Update conducted by the Centers for Medicare and Medicaid Services (CMS) it was noted that the top ten largest nursing facility companies accounted for a decreasing percentage of all nursing home beds.[2] Moreover, the report noted that the nation's largest chains were divesting at a faster rate than the overall nursing home sector. While the overall nursing home bed count dropped by 2.1%, the combined bed count of the largest ten chains declined 17.9%. The report speculated that this development may be attributable to the recent departures of some of the larger chains from states with high liability exposure such as Florida.[3] As described further below, four of the top ten largest nursing home chains have completely divested their Florida operations in recent years.

In January 2002, Beverly Enterprises, the nation's largest nursing facility operator, with over 40,000 beds in 355 facilities across 25 states, sold the entirety of its Florida operations. Beverly's 49 nursing facilities and four assisted living centers were purchased for $165 million by FC Properties. FC Properties arranged a leasing agreement with Florida Health Care Properties, which continues to operate the facilities. Beverly stated that the sale was part of a strategy to divest facilities that accounted for a disproportionately high share of its patient care liability costs.[4]

Kindred Healthcare, Inc., the nation's third largest nursing facility operator with 250 facilities in 29 states, exited Florida completely in July 2003. To execute the Florida

divestiture, Kindred initially purchased its 15 leased properties and then sold the properties to a third company. The lease buyout cost Kindred $64 million, approximately the same price the company negotiated for the subsequent sale of the properties. In connection with the Florida divestiture and a simultaneous divestiture of its Texas facilities, Kindred reported a pre-tax loss of $43 million for the second quarter of 2003.[5]

In December 2003, Mariner Health Care, Inc., completed the divestiture of its remaining facilities in Florida by terminating the leases associated with seven properties throughout the state. Mariner, the fourth largest nursing facility operator in the U.S., with 260 facilities in 20 states, once operated 27 facilities in Florida. Following the divestiture of 20 Florida facilities in August 2003, Mariner's chief executive officer (CEO) cited liability cost concerns as a primary reason for the sale: "[T]his transaction affords us the opportunity to substantially reduce our exposure to liability insurance costs and litigation risks in the State of Florida and at the same time de-leverage the company."[6]

Another top ten nursing facility operator, Extendicare Health Services, Inc., ceased all of its nursing home operations in Florida in January 2001. Extendicare, an operator of 266 long-term care facilities in 12 states, launched a plan to divest all Florida operations much earlier, in December 1999. The 2001 announcement marked the sale of its remaining 16 facilities in the state for a combined sum of $62.4 million.

In late 2000, National HealthCare Corporation (NHC), operator of 76 long-term health centers in 11 states, divested completely its nursing facility business in Florida through the sale of its 12 nursing facilities to 12 newly formed companies. At the time of the divestiture, the President of NHC stated that their decision to leave Florida was motivated by their inability to secure affordable liability insurance coverage. The NHC divestiture was especially newsworthy due to the controversial nature of its sale. The change-of-ownership papers filed by the company identified a former NHC official as the leader of the group of investors taking over the facilities.[7]

Nursing Home Quality and Oversight in Florida

One of the policy objectives of S.B. 1202 was to enact reforms that would improve the quality of nursing home care in Florida. Since its enactment, there have been some signs of improved quality throughout Florida's nursing facilities. Most notably, the Joint Select Committee on Nursing Homes reported in 2004 that the stakeholders who testified before the Committee unanimously agreed that the quality of care in Florida nursing homes was improving. Many experts and industry insiders attributed the improvement to the implementation of S.B. 1202, primarily its mandate for (and funding of) increased staffing levels. Nursing facilities in Florida had achieved a reduction in quality of care deficiencies, in both frequency and severity. The Florida Health Care Association testified that since S.B. 1202 the state had enacted the highest nursing home staffing standards in the nation, and Florida's facilities performed better than the national average on multiple standardized quality indicators. In testimony, these

sentiments were also supported by consumers and advocates including the American Association of Retired Persons (AARP) and the National Citizen's Coalition for Nursing Home Reform.[8]

CMS recently released data that concur with the findings of the Joint Select Committee on Nursing Homes. As part of the national Nursing Home Quality Initiative, Florida's facilities have been working with the state Quality Improvement Organization, Florida Medical Quality Assurance, Inc. (FMQAI). The CEO of FMQAI applauded the efforts of Florida's facilities, citing the 2004 CMS finding that the state's nursing homes had improved significantly across several important quality indicators, including measures of chronic pain and post acute pain.[9]

Finally, in January 2005, Florida's Agency for Health Care Administration announced that it would begin providing small grants to fund innovative nursing home quality improvement projects. The agency is utilizing the state's Quality of Long Term Care Improvement Trust Fund to provide $500,000 for the first year of grants. Nursing facilities can submit proposals with ideas to improve care and enhance the quality of life for their residents.[10]

Nursing Home Litigation and Liability Insurance Trends in Florida

A 2003 study conducted by researchers at Harvard University's School of Public Health estimated that compensation payments to plaintiffs in cases of nursing facility litigation in Florida amounted to $1.1 billion in 2001.[11] Data from the Insurance Services Office (ISO) reported in 2002 indicated that claim severity in Florida was an estimated 2.1 times the national average.[12] The ISO report also stated that while the national average loss ratio was 357%, Florida's average was 1072%. While only 17% of claims nationally generated losses in excess of $50,000, that number soared to 56% in Florida. A 2003 study conducted by Aon Risk Consultants estimated average loss costs per occupied bed of $10,480, over four times the national average.[13] This estimate was derived from liability claims data representing 54% of all nursing home beds in the state.

The second policy objective of S.B. 1202 was to limit both the frequency and severity of nursing home claims. An initial effect of the legislation was an immediate increase in the number of lawsuits filed, as litigators rushed to file their suits before the effective date of the legislation, October 5, 2001. A survey of 675 Florida nursing facilities found that 62% were sued in the first nine months of 2001. Researchers at the University of South Florida's (USF) Florida Policy Exchange Center on Aging theorized that if S.B. 1202 was unable to improve the situation for the state's nursing facilities, legislators would likely face new demands for further tort reform, including lower limits on punitive damages and new limits on compensatory damages.[14] Many insurance industry insiders agreed with this point of view and believed that S.B. 1202 would fall short of curbing litigation to an extent sufficient to lure insurers back into the Florida market. Insurers praised the patient care quality measures enacted in the law but

expressed the view that the legislation would have minimal impact on curbing frivolous litigation.[15]

Evidence of the effect of S.B. 1202 on reducing the frequency and/or severity of nursing home lawsuits is mixed. The Tampa-based plaintiff firm of Wilkes & McHugh, one of the most aggressive nursing home litigators in the entire country, reported that the number of suits brought against nursing homes in Florida in 2003 was down 17% from the year 2000. Separate research conducted by the Orlando Sentinel found that the number of lawsuits brought against nursing homes declined sharply after the enactment of S.B. 1202, and was at a four-year low in five Central Florida counties.[16] Attorneys representing the nursing home industry offered an explanation for the decline in suits during testimony before the Joint Select Committee on Nursing Homes. They claimed that liability insurance policies with minimal coverage limits (e.g., $25,000) had discouraged plaintiffs from filing lawsuits. The nursing home attorneys testified that when plaintiffs' lawyers learn through pre-suit inquiries that a facility has a very low coverage limit, they often choose to settle the claim within policy limits. They noted that the opposite is true as well; large insurance caps act as an incentive to bring suits.[17]

Other data suggest that S.B. 1202 has had a minimal effect on reducing nursing home liability costs in the state. In December 2003, the Florida Health Care Association estimated the pace of lawsuits for Florida nursing facilities continued at 2-3 per day.[18] In its most recent analysis of general and professional liability insurance costs in the nursing home industry, published in March 2005, Aon Risk Consultants significantly lowered its estimates of average loss costs per occupied bed in Florida during the 2002-2004 time period from estimates made in previous studies.[19] However, average loss costs in Florida still exceeded average loss costs in the country as a whole by a factor of three ($7,500 in Florida in 2004 versus $2,310 nationwide). Regarding the impact of S.B. 1202 and other tort reform bills enacted in Florida, Aon concluded "based on our current study, it is inconclusive whether or not the bills have had an effect on reducing claim frequency in Florida."[20] Furthermore, Aon concluded "the impact of Senate Bills 1200 and 1202 on claim severity is similarly inconclusive at this time."[21]

One intention of S.B. 1202 was to reduce the number of frivolous lawsuits filed against nursing homes. However, some evidence has come forward suggesting that the majority of lawsuits in Florida are not frivolous. When Florida's 2001 Task Force on Availability and Affordability of Long-Term Care released its report, it concluded that all of the 225 cases it examined had merit.[22] Also, two large Florida newspapers, the South Florida Sun Sentinel and the Orlando Sentinel, conducted their own review of nearly 1,000 lawsuits filed from 1997-2001, and concluded that virtually all of the lawsuits reviewed had merit.[23]

The reforms passed in S.B. 1202 may have had an effect on reducing lawsuits brought against facilities that carry finite policies. As discussed earlier, the provisions of S.B. 1202 did not include a mandatory minimum coverage amount or scope; it only required that facilities maintain an active liability policy. In the face of increasing costs, many facilities chose to buy finite policies with extremely low coverage limits (e.g.,

$25,000 per claim). Anecdotal accounts surfacing since the passage of S.B. 1202 indicate that facilities carrying policies with low limits are far less likely to be sued. Note that large self-insured chains are not similarly protected by low coverage limits, simply due to the fact that they are self-insured. This may partly explain why the large nursing home chains were leaving the Florida market altogether.

Figure 1 below, provided by the Florida Agency for Health Care Administration, shows that the frequency of attorney notices of intent has trended down in recent years. If, in fact, future research finds that lawsuit frequency is decreasing, it will remain unclear whether the decline was primarily attributable to the frivolous lawsuit deterrents set forth in S.B. 1202, or to the increasing use of finite liability insurance policies.

Nursing Home Liability Insurance Market in Florida

In the mid to late 1990s, many commercial insurers experienced significant losses in their nursing home professional liability product lines, particularly in the Gulf and southern states, as loss costs greatly exceeded insurance reserves. Consequently, many commercial insurers decided to exit the nursing home liability insurance market altogether. When researchers from the AARP Public Policy Institute commissioned Weiss Ratings, Inc., to survey nursing home liability insurers, they found that insurers mentioned Florida, Alabama, and Texas most frequently as the states where they had stopped offering coverage.[24] A University of South Florida study found that from February through October of 2001, there were no admitted insurance carriers (which adhered to state insurance regulations) offering nursing home liability coverage in Florida.[25] The USF study found that at the time of the survey, nearly 20% of nursing facilities in the state were without liability coverage entirely, while an additional 36% were self-insured.[26] In March 2004, Florida's Joint Select Committee on Nursing Homes asked Florida's Office of Insurance Regulation (OIR) to survey the 21 admitted insurers that at one time offered liability coverage for nursing homes. OIR found that only six were still offering coverage at the time, although all on a "non-admitted" basis.[27] The Committee's final report concluded that "[g]eneral and professional liability insurance, with actual transfer-of-risk, is virtually unavailable in Florida."[28]

Compounding the insurance availability problem, Florida's 2001 landmark passage of S.B. 1202 set forth a requirement that all facilities had to have professional liability insurance by January 1, 2002, but set forth no minimum requirement for the amount of coverage. Without any state-licensed liability insurance carriers to provide coverage, nursing facilities were left with few, generally inadequate, options for purchasing liability coverage. According to the Florida Health Care Association, most nursing home facilities faced only two legitimate options for coverage: limited coverage from commercial surplus lines carriers, or costly coverage through the Long Term Care Risk Retention Group (LTCRRG).[29]

Commercial insurers remaining in Florida were providing professional liability coverage on a "non-admitted" basis only. The USF study found that in 2001, insured

Florida facilities paid a liability insurance premium minimum average cost of $6,434 per bed.[30] That compared to a national per bed minimum average of $2,340. An in-depth examination of the issue confirmed the extent of the insurance availability and affordability problem when Florida's Joint Select Committee on Nursing Homes was re-appointed by the Florida Legislature in late 2003. The Committee, charged with examining the liability insurance crisis and assessing the impact of S.B. 1202, detailed in their report that excess and surplus line carriers were exclusively offering "finite policies" to nursing facilities with very low limits in the range of $25,000-$50,000 per single occurrence. Typically, a $25,000 finite liability policy cost a Florida nursing home operator $32,500. In the event of a liability claim, insurers paid out only up to the limit amount offered under the policy. These finite policies accomplished little more than allowing facilities to meet the coverage requirement established in S.B. 1202, without insurance carriers assuming any real risk for professional liability. Due to their size and financial stability, some of the publicly-traded, multi-state nursing facility chains were able to purchase catastrophic coverage with higher coverage amounts, albeit with very high deductibles. For example, a Florida representative for Manor Care/HCR told the Committee that they were able to purchase coverage from a European carrier with a $5 million per case deductible.[31]

The other option for liability insurance coverage available to Florida's nursing facilities is the LTCRRG. Announced in February 2003, the LTCRRG is a stock certificate company providing general and professional liability insurance to nursing facilities, assisted living centers, and independent living centers. The LTCRRG is licensed by the Florida OIR and was initially capitalized with an interest-free surplus note of $6 million from the Florida Agency for Health Care Administration. By law, all facilities insured through the LTCRRG must be stockholders in the Group as well. Nursing facilities were required to invest $780 per insured bed, with this "capitalization charge" used to repay the $6 million surplus note. Over and above the initial capitalization charge, the average premium for nursing facilities was set at $1,049 per bed. The LTCRRG limits coverage to $250,000 per claim with an aggregate limit of $500,000.[32] As of January 15, 2004, the Group had 182 policy holders accounting for over $2 million in premiums. However, of the 182 policy holders, only two were nursing facilities. The vast majority (176) were assisted living facilities.[33] The Joint Select Committee on Nursing Homes found that the capitalization charge was the main factor deterring nursing facilities from joining the LTCRRG.[34] Given the choice, most facilities were choosing the less expensive option of purchasing the minimal amount of liability coverage available, from surplus line carriers, as previously discussed.

At the time of this writing, it is unclear when professional liability insurance carriers will return to the Florida market on an admitted basis. In a February 2004 interview, the President of Uni-Ter, a major underwriting management corporation, captured the gravity of the liability insurance availability situation for nursing facilities in Florida. "[Nursing facilities] are up against it in terms of what is worse. Losing your assets by going broke because you're buying insurance or going broke because you can't afford to buy insurance and get sued."[35]

Legal and Legislative Environment in Florida

In response to the nursing home liability insurance crisis, the Florida legislature enacted S.B. 1202 in 2001 with the policy objective in restoring stability to the liability insurance market. The legislation included a relatively long list of reforms that were intensely negotiated between constituencies who believed that the fundamental cause of the crisis in Florida was substandard quality of care, and constituencies who believed that unrestrained litigation and frivolous lawsuits were the root cause of the situation. Some of the more significant tort reform measures in the bill included caps on punitive damages, a shortening of the statute of limitations, the application of a higher negligence standard for filing residents' rights lawsuits, and the removal of automatic attorney's fees. Importantly, however, the legislation included no absolute caps on claims for non-economic damages.

Since the passage of S.B. 1202, other noteworthy legislative measures have been debated. In April 2004, a proposed constitutional amendment that may have reduced the number of lawsuits in Florida died on the floor in Committee on Health, Aging, and Long-Term Care. The proposed amendment, S.B. 3020, would have required that a claimant receive at least 70% of the first $250,000 of recovery in a medical liability claim involving a contingent fee. The amendment would have also required that claimants receive at least 90% of all damages in excess of $250,000.[36]

A recent court decision may also have a positive impact on reducing loss costs in Florida, thereby bringing down insurance costs. In December 2004, the Florida Supreme Court in *Knowles v. Beverly Enterprises* held that the survivors of deceased nursing home patients had a right to recover damages under the nursing home residents' bill of rights only in cases when alleged abuse and neglect directly resulted in the patient's death. The four-to-two decision applied only to lawsuits filed before May 15, 2001, the date when Governor Bush signed S.B. 1202 into law. The ruling applied to an estimated 600-1,500 outstanding cases, and according to one source, eliminated approximately 20%-50% of all active nursing home abuse and neglect cases.[37]

SUMMARY

Some five years after enactment, the impact of S.B. 1202 on stabilizing the nursing home liability insurance market remains inconclusive. The available data, on the whole, suggest that the frequency of nursing home lawsuits in Florida is declining. However, some attribute this decline in claim frequency to the lack of insurance coverage among many nursing home facilities, thereby reducing the incentive for plaintiffs to litigate. The divestiture of large national chains of their Florida facilities has had the same effect of limiting opportunities for plaintiffs to target nursing home operators with "deep pockets." Thus, in addition to the legislative impacts of S.B. 1202 itself, it is reasonable to conclude that the dramatic increase in nursing home litigation during the late 1990s planted the seeds of its own demise by decimating the insurance market which fed it. Should the liability insurance market again stabilize, it will be interesting to observe whether increased insurance coverage for Florida's nursing home facilities might spark another increase in litigation activity in the future.

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26. Ibid.

27. Report of the Joint Select Committee on Nursing Homes, op. cit.

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GLOSSARY

Admitted Carriers are commercial insurers whose nursing home liability insurance products are regulated by state departments of insurance. These carriers enjoy some advantages over non-admitted carriers. They can participate in state guaranty funds, which help protect policyholders in the case of insurer insolvency. Also, they have a marketing advantage over non-admitted carriers because some brokers, facility providers and lenders value state oversight and participation in the guaranty fund.

The **Alternative Market** to nursing home liability insurance is composed of various forms of self-insurance, meaning the risk is borne by the participants and not an insurance company. The different forms of self-insurance include risk retention and risk purchasing groups (RRGs), captives, rent-a-captives, and sponsored captives (Joint Underwriting Associations).

Arbitration Agreements are contracts, the terms of which are determined by an arbitrator, entered into by opposing parties. An arbitrator is a person or panel of people who are not judges and may be: (1) agreed to by the parties; (2) required by a provision in a contract for settling disputes; or (3) provided for under statute. Arbitration is designed to be a fair and equitable means of dispute resolution agreed to by both parties to avoid a court trial and the associated expenses and time investment.

Capitalization means funding the reserves of an insurance or self-insurance program to pay claims**.**

A **Cell Captive** is a captive in which member providers share administrative expenses but not risk.

A **Captive** is a self-formed pool of providers who share risk among themselves, thus acting as their own insurance company. Members do their own underwriting, meaning they decide among themselves which providers to admit to the captive. Members will share liability risk with the providers they admit.

Claims Made Policies provide coverage for insured events that both occur and *for which a claim is made* during the term of the policy. Thus, if an incident occurs, but the policy is terminated before a claim is made, liability for the incident is not insured.

Claims Occurrence Policies provide coverage for all incidents and events that occur during the term of the policy, regardless of when a liability claim is made, or when a lawsuit is settled.

Collateral Damages are damages incurred by the plaintiff that are already covered by other sources of payment. ‘‘Collateral source offset’’ rules reduce awards by denying plaintiffs compensation for losses that are recouped from other sources,

such as health insurance. These rules aim to prevent plaintiffs from ‘‘double dipping’’ by recovering for losses for which the plaintiff has already been remunerated through other sources of payment.

Deductibles are initial amounts of claims incurred by the policyholder not covered by the insurance policy. Insurance coverage begins only for losses incurred above the deductible amount.

Economic Damages in civil litigation is compensation due the plaintiff for financial losses caused by the wrongful actions of another party (e.g., awards for the medical bills of a nursing home resident caused by an abusive employee).

Estimated Liability Costs are approximate calculations of expenses for damages to which a nursing home is exposed. Because estimates are derived from information provided by nursing homes and the cost of settlements of lawsuits is confidential information known only to the insurance carrier, plaintiff's attorney and defense attorney, these calculations are only estimates and are subject to change.

General Liability Claims/Losses are amounts a nursing home liability insurer is legally obligated to pay as damages to a plaintiff due to bodily injury or property damage.

A **Joint Underwriting Association** is a state-sponsored organization that creates insurance pools and functions as an insurer in markets without a significant number of licensed insurers. It has the power to sell insurance policies, collect premiums, and purchase reinsurance and it can usually guarantee a certain level of premium rates to its members. It can also levy surcharges on policyholders and, in some cases, on licensed insurers selling liability insurance, to create reserves to pay claims.

Joint and Several Liability in civil litigation is a situation in which the concurrent acts of two or more defendants bring harm to the plaintiff. Such acts need not occur simultaneously, but must contribute to the same event. In such a case, the damages may be collected from one or more of the defendants. If the court does not apportion blame in specific shares, the damages may be collected from any and all defendants. If a defendant does not have the financial wherewithal to pay, the others must make up the difference.

Non-admitted Carriers, also called **Surplus Line Carriers**, are commercial insurers whose nursing home liability insurance products are not regulated by state departments of insurance. These insurers enjoy some advantages over admitted carriers. They have greater flexibility in designing and pricing products. Because they are not subject to state regulation, they can also change coverage forms and application protocols more quickly. However, they must pay an “excess and surplus lines” tax that is not levied on admitted carriers. They cannot participate in state guaranty funds, which help protect policyholders in the case of insurer insolvency

Non-economic Damages in civil litigation is compensation due the plaintiff for intangible harms (e.g., pain and suffering).

Nursing Home Liability Insurance is indemnification of nursing home providers against damages for negligent care and abuse.

Nursing Home Residents' Rights Statutes are state and federal laws to protect each nursing home resident's civil, religious and human rights.

Offshore Captives are captives located outside the United States. The most popular host states for offshore captives include Bermuda, Guernsey and the Cayman Islands.

Premium is the charge paid by a policyholder for insurance coverage.

Professional Liability Claims/Losses are amounts a nursing home liability insurer is legally obligated to pay as damages and associated claims and defense expenses to a plaintiff due to a negligent act, error or omission in a nursing home provider's rendering or failure to render professional services.

Punitive damages in civil litigation means monetary compensation awarded by a judge or jury which exceeds the losses suffered by the injured party in order to punish the defendant.

Regulated Insurance Carriers are admitted carriers (see definition above).

Reinsurance is the practice of insurance carriers ceding risk to other firms, called reinsurance companies, in order to limit their liability exposure. Reinsurance companies essentially provide insurance to insurance companies. Instead of assessing the risk of individual policyholders, reinsurance companies assess risk on a broader scale, such as on the basis of a particular product line (nursing home liability insurance) or a geographic region.

A **Rent-A-Captive** is a captive, usually formed by an insurance company, broker or captive manager, and rented out to users (in this case nursing home providers) who avoid the cost of funding their own captive. The user provides some form of collateral so that the rent-a-captive is not at risk from any underwriting loss suffered by the user.

Risk Management Programs are structured approaches to purposefully limit liability risk. They include systematic efforts to improve and maintain high standards for care quality, but can also include additional management techniques to minimize liability exposure, such as improving written documentation. They are often formalized within the management structure of nursing home providers in the form of Risk Management Committees, and/or a designated Director of Risk Management along with formal Risk Management plans that are implemented and monitored by senior management.

A **Risk Retention Group (RRG)** is an insurance company that is owned by its members. The members of an RRG come from the same industry. For instance, nursing home providers can form an RRG in order to obtain nursing home liability coverage.

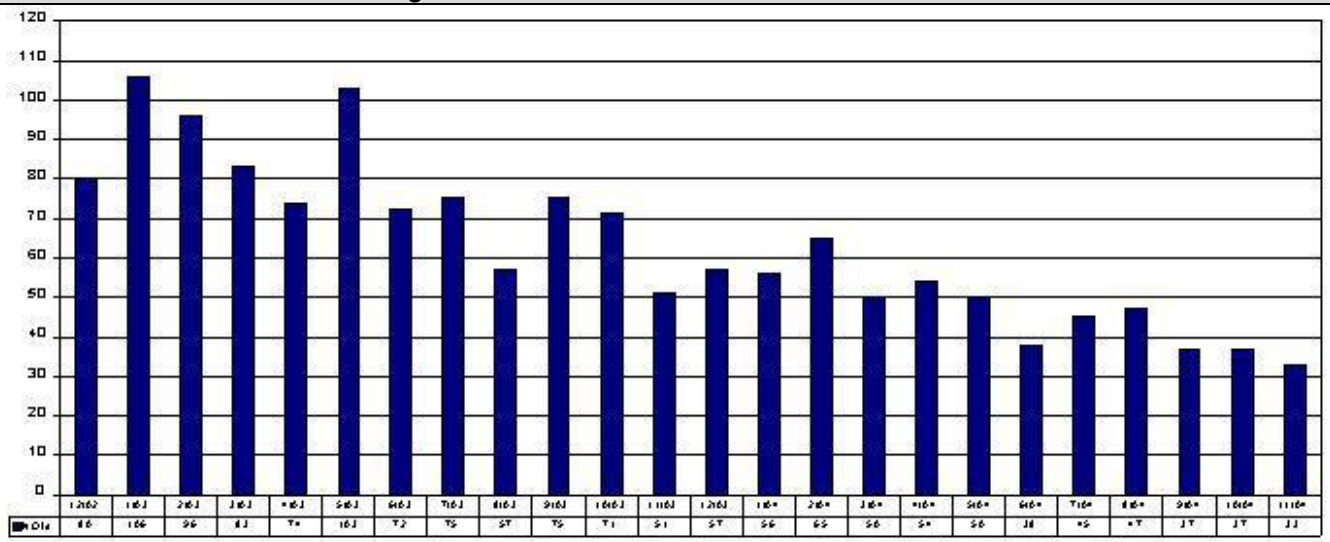
A **Settlement** is an agreement reached between the legal counsel of the plaintiff and the defendant that terminates a civil litigation before a verdict is reached by the court.

Tort Reform generally means a movement intended to curb litigation and damages in the civil justice system. With respect to nursing home liability insurance, many states have enacted tort reform through legislation and it has changed the legal framework under which residents and/or family members can seek damages for negligent or abusive care practices. States also placed limits on the amount of damages that could be awarded to plaintiffs and/or their family members, particularly non-economic damages for pain and suffering.

Underwriting is the process by which an insurer assesses the risk of insuring a particular applicant for coverage. Risk retention groups also underwrite by assessing the risk of accepting a prospective member.

FIGURES

FIGURE 1: Nursing Home Notices of Intent December 2002 - November 2004



SOURCE: The State of Florida Agency for Health Care Administration at http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/FDAU/Reports.shtml.

NURSING HOME LIABILITY INSURANCE MARKET

Reports Available

Recent Trends in the Nursing Home Liability Insurance Market (Main Report)
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab.pdf

Nursing Home Liability Insurance Market: A Case Study of California
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-CA.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-CA.pdf

Nursing Home Liability Insurance Market: A Case Study of Florida
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-FL.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-FL.pdf

Nursing Home Liability Insurance Market: A Case Study of Georgia
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-GA.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-GA.pdf

Nursing Home Liability Insurance Market: A Case Study of Ohio
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-OH.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-OH.pdf

Nursing Home Liability Insurance Market: A Case Study of Texas
HTML: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-TX.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2006/NHliab-TX.pdf

WORKSHOP ON LONG-TERM CARE RESIDENT RIGHTS

DECLARATION OF RIGHTS COMMITTEE
January 11, 2018
1 PM – 5 PM
Room 105 – Gerald L. Gunter Building
2540 Shumard Oaks Boulevard
Tallahassee, Florida

WORKSHOP PACKET

TAB 5

I have to leave at 3:30

3:15-

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** CRC Proposal 88

***Name** Bret Brown

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Email admin.washington@shccs.com

***Speaking:** ☐ For ☑ Against ☐ Information Only

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☐ No

If yes, who? Washington Rehab & Nursing Center

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1-10-18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Whitney Bolden

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Tallahassee FL 32311 Email
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***Speaking:** ☐ For ☑ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☑ Yes ☐ No

If yes, who? Centre Pointe Health & Rehabilitation

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Jennifer McConnell

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Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☑ No

If yes, who? _____

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

11/11/18
Meeting Date

Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Long term Care

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***Speaking:** ☐ For ☒ Against ☒ Information Only

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☒ Yes ☐ No

If yes, who? Florida Sr. Living Association

gmatillo@floridaseniorliving.org

Are you a registered lobbyist? ☒ Yes ☐ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record. ****Required***

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

01/11/2018
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** PROPOSAL 88

***Name** PAUL E. KOVARY

Address 3333 CAPITAL MEDICAL BLVD.
Street
TALLAHASSEE FL 32308
City *State* *Zip*

Phone 850-877-4115

Email admin@sevenhillshealthandrehab.com

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☑ No

If yes, who? _____

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record. ***Required***

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/13
Meeting Date

Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** CRC proposal 88!

***Name** Joanne Watson.

Address 2481 E. U.S. Hwy 90 *Street*

Phone

Madison FL 32340
City *State* *Zip*

Email

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☒ No

If yes, who?

Are you a registered lobbyist? ☐ Yes ☒ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** CRC Proposal 88

***Name** Brittany Seiph

Address 248 W US Hwy 90
Street

Phone 850-973-4880

Madison FL 32340
City *State* *Zip*

Email don@madisonhealthandrehab.com

***Speaking:** ☐ For ☑ ~~Against~~ ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☐ No

If yes, who? _____

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

11/1/18
Meeting Date

Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Mary Johnson

Address 3333 Capital medical blvd
Street
Tallahassee Fla 32308
City *State* *Zip*

Phone 850-877-4117

Email mjohnson@sevenhillshealth andrehab

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☑ ~~No~~

If yes, who? _____

Are you a registered lobbyist? ☐ Yes ☑ ~~No~~

Are you an elected official or judge? ☐ Yes ☑ ~~No~~

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1-11-18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** 88

***Name** Jennifer Williamson

Address 3003 SW 28th St. *Street*

Phone 772-287-2600

Okeechobee FL 34974
City *State* *Zip*

Email jlw@craigbuchanan.com

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☒ Yes ☐ No

If yes, who? Okeechobee Health Care Facility

Are you a registered lobbyist? ☐ Yes ☒ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1-11-18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Long-Term Care

***Name** Susan Anderson

Address 2292 Wednesday St.
Street

Phone 850-708-4971

Tallahassee FL 32308
City *State* *Zip*

Email sanderson@floridaseniorliving.org

***Speaking**: ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☑ Yes ☐ No

If yes, who? Florida Senior Living Assoc

Are you a registered lobbyist? ☑ Yes ☐ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Ron E Reid

Address 2255 Centerville Rd
Street

Phone 850-386-4054

Tallahassee FL 32308
City *State* *Zip*

Email

***Speaking**: ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☑ Yes ☐ No

If yes, who? Centre Pointe Health + Rehabilitation

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1-11-1
Meeting Date

Proposal 88

'88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** American Senior Alliance

***Name** Willie Harris

Address 4228 - Cedar Creek Circle
Street
Montgomery AL 36106
City *State* *Zip*

Phone 334-306-4164

Email WillieHarris84gmail.com

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☐ No

If yes, who? American Senior Alliance

Are you a registered lobbyist? ☐ Yes ☐ No

Are you an elected official or judge? ☐ Yes ☐ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** CRC proposal 88

***Name** Graham Campbell-work

Address 785 S 2nd St.
Street

DeFuniak Springs FL 32435
City *State* *Zip*

Phone 850-892-2176

Email admin.Chautauqua@shccs.com

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☑ No

If yes, who? _____

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

10.11.18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** CRC Proposal 88

***Name** Gloryana Webb

Address 879 Usery Rd
Street
Chipley FL 32428
City *State* *Zip*

Phone 850-638-4654

Email ait.washington@signaturehealthcarellc.com

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☒ Yes ☐ No

If yes, who? Washington Rehabilitation and Nursing Center

Are you a registered lobbyist? ☐ Yes ☒ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Tenesia Pearson

Address 1017 Strong rd
Street

Phone 850-875-3711

Quincy Fl. 32351
City *State* *Zip*

Email tpearson@gchc.com

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☑ Yes ☐ No

If yes, who? River Chase Health & Rehab

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/2018
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Demetri Sapp

Address 1017 Strong Road
Street

Phone 1-850-875-3711

Quincy FL 32351
City *State* *Zip*

Email desapp@gchc.com

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☑ Yes ☐ No

If yes, who? Riverchase Health & Rehab

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1-11-18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Annie Bruce-Freeman

Address 1017 Strong Road
Street

Quincy Florida 32351
City *State* *Zip*

Phone 850-875-3711

Email guytonabellsouth.net

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☑ Yes ☐ No

If yes, who? Riverchase Health and Rehabilitation

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Damonica Dubose

Address 1017 Strong Rd.
Street
Quincy, FL 32351
City *State* *Zip*

Phone 850-875-3711

Email ddubose@gchc.com

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☑ Yes ☐ No

If yes, who? RiverChase Health & Rehab

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1-11-18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** DH Resident Rights

***Name** Kathy GALLIN

Address 379 NW Dogwood Terrace
Street
Lake City FL 32055
City *State* *Zip*

Phone 561-568-9067

Email kgallinesignaturehealthcare.com

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☒ Yes ☐ No

If yes, who? SIGNATURE HEALTHCARE

Are you a registered lobbyist? ☒ Yes ☐ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Bill of Rights

***Name** Kristen Tuten

Address 11056 S Jefferson St
Street

Phone 997-1800

Monticello FL 32344
City *State* *Zip*

Email Ktuten@gchc.com

***Speaking**: ☐ For ~~☒ Against~~ ☐ Information Only

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

not speaking

Are you representing someone other than yourself? ☒ Yes ☐ No

If yes, who? Gulf Coast Health Care

Are you a registered lobbyist? ☐ Yes ☒ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1-11-18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Bill of Rights

***Name** Cassandra McIntosh

Address 1654 South Jefferson St. Phone 997-1800
Street

Monticello Florida 32344 Email CMcIntosh@gchc.com
City *State* *Zip*

***Speaking**: ☐ For ☒ ~~Against~~ ☐ Information Only

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Not speaking

Are you representing someone other than yourself? ☐ Yes ☒ No

If yes, who? GCHC. (Gulf Coast Health Care

Are you a registered lobbyist? ☐ Yes ☒ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record. ***Required***

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Vicki Shepherd

Address 153 Old Still Rd. *Street*

Phone

Crawfordville *City* FL *State* 32327 *Zip*

Email

***Speaking:** ☐ For ☐ Against ☐ Information Only

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☑ Yes ☐ No

If yes, who? American Senior Alliance

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** _____

***Name** Tiwana Miller

Address 470 NW Haffye Drive (1656 S Jefferson Street) Monticello, Fla 32344 Phone 850-408-1402
Street
850 997-1800

Greenville, Florida 32331 Email TMiller@gcfhc.com
City *State* *Zip*

***Speaking**: ☐ For ☒ ~~Against~~ ☐ Information Only

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Not Speaking

Are you representing someone other than yourself? ☐ Yes ☒ No

If yes, who? _____

Are you a registered lobbyist? ☐ Yes ☒ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

***Topic** _____

Amendment Barcode (if applicable)

***Name** Monique Whetsel

Address 11656 S. Jefferson St
Street
Monticello FL 32344
City *State* *Zip*

Phone (850) 997-1802

Email TWhetsel@GCHC.com

***Speaking:** ☐ For ☒ Against ☐ Information Only

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Not Speaking

Are you representing someone other than yourself? ☐ Yes ☒ No

If yes, who? GCHC

Are you a registered lobbyist? ☐ Yes ☒ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record. ****Required***

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Bill of Rights

***Name** Rhad Fenelus

Address 1656 S. Jefferson st
Street

Phone 850 426 3638

Monticello FL 32344
City *State* *Zip*

Email rfenelus@gchc.com

***Speaking:** ☐ For ☒ ~~Against~~ ☐ Information Only

Not speaking

Waive Speaking: ☐ In Support ☑ ~~Against~~
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☑ ~~Yes~~ ☐ No

If yes, who? Gulf Coast Health Care

Are you a registered lobbyist? ☐ Yes ☑ ~~No~~

Are you an elected official or judge? ☐ Yes ☑ ~~No~~

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

Flight @ 4:15

4:30 ?

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1-11-19
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Residents Rights

***Name** Faye Haverlock

Address Okeechobee Health Care Facility
Street
16446 Hwy 441 N. Okeechobee, FL 34972
City *State* *Zip*

Phone 8637632226

Email fayeahaverlock@yahoo.com

***Speaking:** ☐ For ☒ Against ☐ Information Only

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☒ No

If yes, who? _____

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

5:35

CONSTITUTION REVISION COMMISSION
APPEARANCE RECORD

(Deliver completed form to Commission staff)

Jan. 11, 2018
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Bruce Duncan

Address 2255 Centerville Rd
Street

Tallahassee FL 32308
City *State* *Zip*

Phone (850) 298-6842

Email roostah2@yahoo.com

***Speaking:** ☐ For ☑ Against ☐ Information Only

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☐ Yes ☑ No

If yes, who? representing myself & Centre Pointe Health & Rehab

Are you a registered lobbyist? ☐ Yes ☑ No

Are you an elected official or judge? ☐ Yes ☑ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

1/11/18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Proposal 88

***Name** Douglas Mannheimer

Address 215 S. Monroe St. Suite 401 Phone 850 681 6810
Street

Tall, Fla 32301 Email dmannheimer@broadandcassel.com
City *State* *Zip*

***Speaking:** ☐ For ☒ Against ☐ Information Only

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☒ Yes ☐ No

If yes, who? Florida Health Care CISSH,

Are you a registered lobbyist? ☒ Yes ☐ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**

CONSTITUTION REVISION COMMISSION

APPEARANCE RECORD

(Deliver completed form to Commission staff)

5:40

1-11-18
Meeting Date

88
Proposal Number (if applicable)

Amendment Barcode (if applicable)

***Topic** Residents Rights

***Name** Conwell Hooper

Address 225 PEACHTREE ST NE, Suite 1430 South Tower Phone 404-425-2566
Street

ATLANTA, GA 30303 Email conwell@americanseniorsalliance.com
City *State* *Zip*

***Speaking:** ☐ For ☒ Against ☐ Information Only

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Are you representing someone other than yourself? ☑ Yes ☐ No

If yes, who? AMERICAN SENIOR ALLIANCE

Are you a registered lobbyist? ☐ Yes ☒ No

Are you an elected official or judge? ☐ Yes ☒ No

While the Commission encourages public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

Information submitted on this form is public record.

***Required**