SCR

47

SENATE COMMITTEE REPORT

FIRST COMMITTEE OF REFERRAL

Date of 4-7-88 5-DAY NOTICE
IN ACCORDANCE WITH UNIFORM RULE 23

FURTHER: HESS
FINANCE

**FISCAL NOTE(S) ATTACHED ✓ **
IN ACCORDANCE WITH AS 24.08.035
(see below)

2/11/88 DATE TURNED INTO OFFICE 4-19-88

Mr. President:

State Affairs Committee considered SCR 47

operation of Pioneers' Homes

and recommended:

[ ] replace with CS ______ [] same title
[] new title

[ ] attached amendment(s) and

[X] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to ______

[ ] letter of intent adopted and attached

** Committee [X] attached or [ ] adopted fiscal note(s)
[X] zero [ ] fiscal impact

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

W. Hurley - No Rec.

Chairman signature and recommendation

[ ] Committee Backup Attached

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION : SCR 47
PUBLISH DATE : 2-11-88

FISCAL NOTE

REQUEST:

Revision Date:
Title : Relating to the operation of Pioneers' Homes
Sponsor : Kerttula
Requestor :

Agency Affected :
BRU :
Components :

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Prepared by : Senate State Affairs Committee
Phone : 465-4522
Division :
Date :
Approved by Senator Mitch Abood
Date : 4-13-88
Agency : Senate State Affairs Committee

Distribution (by preparer) :
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

SCR-47

Nursing home faces loss of license over patient deaths

A corporately owned Mountain View, Calif., nursing home is facing the possible loss of its license after state health inspectors turned up evidence suggesting that poor nursing care contributed to the deaths of five patients at the facility during the past seven months.

In November, Julia Sanitarium also was fined $226,850 for 22 violations of health care rules.

One death involves the demise of a woman for whom an ambulance allegedly was not summoned for 45 minutes after the patient first exhibited symptoms of heart failure. In a second death, for 26 minutes staff allegedly delayed calling paramedics to assist a woman dying of

> Three deaths involved patients who expired after developing numerous serious bedsores.

pneumonia. The three other deaths involved patients who expired after developing numerous serious bedsores.

The nursing home is owned by Beverly Enterprises of Pasadena, Calif., the same corporation that owns Beverly Manor convalescent hospital in Los Gatos, which health officials fined $233,000 this fall for four patient deaths.

A state health official said California nursing home regulators in San Jose plan to recommend that the home's Medicaid and Medicare contracts be canceled. Mary Louise Mock, administrator of the California Dept. of Health Services' licensing office in San Jose, said her office already was taking steps to revoke the license of Beverly Manor in Los Gatos.

AMONG THOSE whose deaths are under investigation is Edith Hyde Sears, 81, of Santa Barbara. She died June 14 at Kaiser Hospital in Santa Clara after experiencing a heart attack at Julia. Nursing notes on June 1 described her condition as "alert, coherent, and oriented." On June 12, notes indicated she had vomited by 8:15 p.m. and began calling for nurses. Seventy-five minutes later, she reported chest pains and shortness of breath. When her physician was contacted, he ordered her transferred to an acute-care hospital. Ten minutes after her arrival she experienced cardiac arrest and died two days later.

Investigator Karen White reported, "More than 45 minutes passed from the time the patient exhibited classic symptoms of acute myocardial infarction until the ambulance was called."

THE WOMAN'S DEATH, health officials claimed, occurred as a direct, proximate cause of inadequate care. That poor care was a contributing factor in four other deaths, reports indicated.

A second incident involved 63-year-old Virginia Glissmeyer of Santa Cruz, who died May 10 of pneumonia at Kaiser Hospital in Santa Clara after showing signs of lung problems from May 1 to May 9 while at the nursing home.

White reported, "The facility staff failed to inform the attending [staff] physician of [high] temperatures in a patient with a known history of pneumonia, failed to report green oral secretions and the development of two decubitus ulcers (bed sores)."

Moreover, White indicated that 26 minutes had passed before paramedics were called after the patient's physician

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Ants found on patients led to citations by regulators

Continued from facing page

was notified that she was ill.

The three deaths allegedly related to bedsores involved nursing staff who failed to properly treat the sores or to notify the patients' physicians of changes in their conditions.

THOSE PATIENTS were Nettie Gill, 85, of San Jose, who died Sept. 25 at Julia; Elmer Neville, 83, of Campbell, who died Oct. 20 at another nursing home where he had been transferred; and Charles Kemmerer, 72, who died Sept. 25 at Kaiser Hospital in Santa Clara.

A state investigator said the nursing home accepts a lot of terminal patients,

> A nursing home spokeswoman claimed that citations involved incidents that had occurred before management changes were put in place.

but that none of the three was in this category.

Alleged problems at the facility were uncovered when health officials sent a seven-member investigative team into the sanitarium in October, after acquiring from anonymous sources a 31-item list of complaints. On the team were nurses, one of them with acute care experience, as well as a pharmacist and two auditors. The team spent two weeks at the home.

AMONG THE ALLEGED events that triggered citations was one involving an 85-year-old female patient who was discovered with ants all over her body. Another citation sprang from an incident in which a nursing employe alleged he suctioned ants from a breathing tube inserted in a 29-year-old comatose patient.

The facility also was fined for three incidents in which nurses reportedly calculated medicine dosages incorrectly and administered up to 7½ times the maximum amount of morphine prescribed for a patient. Fortunately, the high dose was not a fatal level.

Julia also was cited for:

- Neglecting to provide a wheelchair and oxygen as prescribed by a physician for a 22-year-old female auto crash victim.
- Failing to train staff promptly on safety procedures after a car accident victim fell 2½ feet from a lift while being moved from a whirlpool bath.
- Neglecting to report a high temperature, rash, and odorous throat secretions in a spinal-cord-injured patient.
- Neglecting to notify physicians when four patients lost six to 19 pounds each within a 30-day period.

A SPOKESWOMAN for Beverly Enterprises acknowledged that the quality of the homes' care had deteriorated during a period when the management of the home was supervised from Rockville, Md.

Diane McCarthy, director of communications for Beverly's western headquarters in Fresno, emphasized that actions connected with deaths had occurred before management tightened controls on the facility July 1 and provided more expert help for the staff of the facility. She said the company had uncovered shortcomings and had transferred supervisory control to Beverly's Fresno Western Divi-

Continued on next page

No more nursing homes for big chain

State cracks down on Beverly Enterprises for its many violations

by Alex Tizon
Times East bureau

Beveny Enterprises, the nation's largest nursing-home chain — recently under fire for having several substandard facilities in the area — will not be allowed to buy any more nursing homes in Washington, according to a state official.

The Pasadena, Calif., company has compiled too long a list of problems in its short history in the state, said Mike Wills, director of rates and licensing for adult services at the Department of Social and Health Services.

"They've acquired too many homes too fast — and we're not going to let them buy any more," Wills said.

Nearly all of Beverly's 33 nursing homes in Washington were purchased in the past three years. In the past eight months, seven of those homes have been fined or threatened with disciplinary action because of substandard conditions.

Fines levied against Beverly-owned nursing homes — totaling $6,800 since last summer — account for more than half of the total fines levied against all nursing homes in the state in that period.

In the latest development, Renton Terrace Nursing Center in Renton was cited last week for deficiencies in food preparation and nursing care. Violations included serving residents poor-quality food, inadequate staff hygiene and allowing residents to sit in urine-drenched wheelchairs.

The center has until Sept. 26 to correct the problems or risk losing its Medicare and Medicaid certification. That would, in effect, close it down, since most of its 147 residents receive Medicare or Medicaid.

Bellevue Terrace Nursing Center in Bellevue — which, with 235 beds, is one of the state's largest nursing homes — faces the same risk. That center was purchased by Beverly Enterprises in 1985.

An order to stop admitting new patients was imposed last month on the Bellevue center after a routine DSHS inspection turned up a long list of violations, including negligent patient care, inadequate documentation of drug dispensing, unsanitary kitchens and bathrooms and the presence of cockroaches.

DSHS officials completed a second inspection of Bellevue Terrace yesterday to see if the center had corrected the deficiencies. The results are to be announced later this week.

Frank Occhiuto, Bellevue Ter-

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State cracks down

BEVERLY

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race administrator, said the latest inspection went smoothly, with DSHS officials acknowledging "significant progress" in correcting deficiencies.

Occhiuto said he is confident the state will not strip the Bellevue center of its Medicare and Medicaid certification, and that the order to stop admitting new patients will be lifted within a month.

Other Beverly-owned nursing homes that in the past year have been fined or threatened with disciplinary action for substandard conditions are Olympic Crest Convalescent Center near Des Moines, Sherwood Nursing Center in Tacoma, Sunny Haven Convalescent Center in Sunnyside, Evergreen Terrace Nursing Center in Mount Vernon and Lilac City Convalescent Center in Spokane.

Wills said he is concerned the Beverly-owned nursing homes that have not been cited with deficiencies may soon follow with poor evaluations, because they are all under the same management.

"I'm wondering about the others," Wills said. "How many more are going to come in with bad reports? Part of my concern is that I don't know how wide and how deep the problem is."

But if nationwide reports are an indication, Wills said, the problem is indeed wide and deep: "Beverly nursing homes have had serious problems in California, they've been banned in Maine, they've had serious problems in Michigan. . . . They've had problems all over."

Beverly Enterprises operates about 1,200 nursing-home facilities in the United States and is the nation's largest nursing-home chain. The company owns more than 10 percent of the nearly 300 nursing homes in Washington state alone, offering about 4,000 beds statewide.

Beverly spokeswoman Diane McCarthy said the company is having problems in Washington because it purchased too many homes in a short period and it could not upgrade all of them at the same time. McCarthy said many of the deficiencies now being cited were inherited.

"We made a lot of acquisitions too quickly, and many of the facilities needed a tremendous amount of attention," McCarthy said. "We weren't completely aware of how bad the problems were when we bought some of them."

Wills said he doesn't buy McCarthy's contention that deficiencies were inherited. He said Bellevue Terrace, Renton Terrace, Sherwood Terrace and Olympic Crest nursing homes met all standards in the two years preceding Beverly's purchase of them.

Wills said new regulations enabling DSHS to levy stiffer fines may force Beverly Enterprises to spend more time and money keeping up its facilities.

The new regulations, which went into effect in the middle of August, empower DSHS officials to levy fines of up to $3,000 a day for any one violation. The department could triple that figure if the violation is repeated within a year. The old laws allowed only fines of up to $1,000 per violation.

But Wills said that despite the more stringent penalties, "I'm not going to feel real confident about Beverly Enterprises until they take full responsibility and blame for what they're doing."

Renton nursing home violates state, federal laws

By DAVID DANELSKI
Staff Reporter

A Renton nursing home has been cited for violating state and federal laws for not properly caring for its patients.

The facility, Renton Terrace Nursing Center, 80 S.W. Second St., is owned by Beverly Enterprises, which has faced disciplinary action at seven other nursing homes it owns in the state.

The Renton facility did not meet "dietary services" conditions required for state licensing and federal certification for the Medicaid and Medicare programs, said Mike Wills, director of the state nursing home licensing division.

Food-related problems at the 147-bed facility included diabetic patients who were served improper diets, an unsanitary kitchen, poor hygiene of kitchen staff, poor quality of food and food storage methods that could allow spoilage, said Sharon Morrison, the division's nursing home survey manager.

Moreover, a 102-page state report, she said, based on inspections done Aug. 4 to 7, said that urine puddles were observed under the chairs of three patients in the dining room and that another patient sat in a urine-soaked wheelchair in a hallway.

"The dining room smelled of urine," Morrison said.

These reports add to the troubles of Beverly Enterprises, the nation's largest nursing care company, which owns 1,200 nursing homes.

Of the company's 33 homes in Washington, the Renton facility is the eighth to face disciplinary action in the 14 months. Since July 1986, seven homes owned by Beverly in the state have been fined $6,800, a lion's share of all fines — $11,075 — levied against nursing homes in the state.

Morrison said the Renton nursing home must correct its deficiencies by Sept. 26 or the state will recommend that to federal government that it be shut down. Also at that point, she said, the state will decide what fines, if any, will be levied against the nursing home.

Diane McCarthy, spokeswoman for Beverly Enterprises, said Monday that the nursing home is correcting its problems.

"Most of the issues were dietary," said McCarthy, interviewed by telephone from Beverly's Sacramento, Calif., office. "We put people and systems in to ensure the necessary corrections are made."

Additionally, the corporation hired a new vice president to oversee its Washington facilities and increased its staff of consultants in the state from three to seven.

Asked about the conditions, McCarthy replied that the company had staffing problems brought on by rapid growth.

"We made a number of acquisitions that took more energy than we anticipated," she said. Problems, she added, have been compounded by a shortage of nurses and nursing aides.

Wills said the Beverly started buying nursing homes in the state in 1981 and had a relatively few problems through 1985. But that changed when the company purchased more homes in the last year and half.

"I think they over-extended themselves," Wills said. "They just can't manage all of those homes.

"When you have eight homes with all those deficiencies, all of them may be flawed. That's the concern."

Morrison said 70 percent of residents interviewed randomly at Renton Terrace complained that they don't like the food because it was bland and over-cooked.

Inspectors revealed that diabetic patients and those requiring pureed food not given proper diets, Morrison said. Diabetics, for example, were fed potatoes one day which put their caloric intake over their daily limit.

"If these patients are on insulin, it makes a difference," Morrison said. "It creates a problem."

As for poor food quality, she said, residents were served grade B potatoes that were bruised and frost damaged. Additionally, residents were served chicken burned on the outside and undercooked on the inside.

Poor sanitary conditions in the kitchen include soiled water left in a mixing bowl; dirty carts used to bring to residents food in their rooms; a dishwasher that did not remove food stuck on plates and utensils; a dirty meat cutter, floors, walls, floors and ceiling that were not cleaned; food debris that had accumulated around the perimeter of the floor; spilled food in a storage room; and dried blood from meat on the floor of a walk-in cooler.

Kitchen workers would often handle food with their hands when utensils should have been used, Morrison said.

Additionally, leftover food was not dated to be either frozen or discarded.

Strike against drug firm unresolved

By BRUCE ROMMEL
Staff Reporter

A strike against Northwestern Drug Co. of Auburn remained unresolved Monday when federal labor officials were unable to count more than half the ballots in a decertification election to determine whether the Teamsters will continue to represent company employ-ees

Fire . . .

Continued from page A1

steep slope just behind the home of Charles and Rikki Birge.

"I was kind of surprised," Braeden said. "There wasn't any neighbors anywhere around. Just me."

He yelled for his mother to call 911, grabbed a garden hose from in front of the Birge home, and went around back and began hosing down the house and tall dried grass nearby.

"I was barefoot at the time," he said. "I hosed the area down, then my feet started getting hot, and I saw I was standing on some hot coals."

He also saw a good example of the effect of the summer drought

Wayne Kier, shift commander for District 44, later said Braeden's action was "the main factor" in preventing the spread of the fire to the home. The district will recognize Braeden's actions with a commendation, said Fire Chief Bob Tankersly.

The apparent cause of the fire was children playing with matches.

Braeden, who will be a senior this fall at Auburn High School, said after graduation he plans on going to college to seek a degree in architecture.

Correction

Problems in nursing home chain alarm state

As violations mount, Beverly promises that care will improve

By Pete McConnell
P-I Reporter

Clarence B. Leen, an 85-year-old man with degenerative arthritis, developed bed sores on his spine, right foot and left elbow in the 14 months he spent at a Los Gatos, Calif., nursing home owned by Beverly Enterprises.

He eventually developed pneumonia and died Aug. 13, 1985, 12 days after he was moved to a hospital.

For Beverly, the nation's largest nursing home chain and 36th largest employer, the death was one of nine that California officials attributed to poor care in Beverly-owned facilities that year.

And while no deaths have been linked to deficiencies in Beverly nursing homes in Washington, the state Department of Social and Health Services is troubled by the company's checkered track record here.

Beverly's nursing homes have run up a disproportionate number of problems in Washington, according to state inspection records.

Washington has 298 nursing homes in this state and Beverly owns 33 of them — 11 percent.

Yet 26 percent of the homes in the state threatened with losing their Medicaid contracts because of various deficiencies were Beverly homes, according to state records from July 1986 to July 1987.

And since July 1986, facilities owned by Beverly have been fined $6,800 because of deficiencies. The fines, assessed primarily because of inadequate patient care and unsanitary conditions, are more than half the total, $11,075, levied against all nursing homes in the state during the same period, the records reveal.

"Is it a trend? I don't know," said Mike Wills, director of the state nursing home division under the Department of Social and Health Services. "But it looks pretty scary to me."

Nursing home ownership in Washington state

Name	Facilities	Beds
Beverly Enterprises Pasadena, Calif.	33	4,002
Hillhaven Corp. Tacoma Wash.	11	1,330
Pleasant Valley Camarillo, Calif.	9	869
Regency Care Centers Issaquah, Wash.	8	769
Quad C Convalescent Centers Tacoma, Wash.	7	563
Washington state total	298	28,997

SOURCE: State Department of Social and Health Services, 1987

DUANE HOFFMANN/P-I

In California, authorities cited Beverly for 60 health and safety violations and alleged that deficiencies in care led to the deaths of nine elderly patients who were in Beverly homes in 1985.

Beverly officials have denied that poor care caused the deaths of the patients. Contending that the charges could not be proven, Beverly officials nevertheless entered into a strict compliance agreement with the state and kept the controversy out of the courts.

Admitting they have paid a price for rapid expansion, Beverly officials this year started a major restructuring program that included reducing the number of homes the firm buys each year and placing greater emphasis on providing quality care.

"We have a lot going on and I think there will be steady progress," said Beverly spokeswoman Diane McCarthy.

The nursing home chain established a strong presence in the state when it bought 30 homes from 1984 through 1986. (It sold five homes this year.)

But the homes started to run into compliance problems last year, according to state inspection records.

The records for homes bought by Beverly show:

■ Bellevue Terrace Nursing Center in Bellevue was banned by the state last month from accepting new patients. State officials discovered that the acting administrator at the time of the survey was operating without a license since November 1986. Other problems included dirty bedpans, linen utensils and the presence of cockroaches.

The home has until tomorrow to correct the deficiencies or fa

See BEVERLY Page B3

inspection. One patient had feces on his long johns and was covered with flies. An order to ban new patients was lifted in December when the home came into compliance.

"It appears to me the track record has gotten substantially worse under Beverly's management," Wills said. "Olympic Crest, Sherwood Terrace and Bellevue Terrace did not have bad surveys in the immediate years they were under a different administration."

Because of the large number of patients who receive Medicaid, the state can virtually close down a nursing home by transferring its Medicaid patients to another facility.

Beverly officials said a series of changes are in the works to help improve the company's image.

The chain recently opened a training center for nurses' aides in Vancouver, Wash., and other centers are tentatively planned in the Seattle, Tacoma-Olympia and Pasco areas, said Janis E. Tietjen, Beverly's new vice president in charge of Washington operations.

The aides will receive special training in nursing care and won't be allowed to work in Beverly homes until they complete the two- to three-week program. Moreover, the training center is designed to attract new applicants during a time of a critical nursing shortage.

Also, Beverly has established its own quarterly inspection program to help identify and correct deficiencies in nursing homes before the state intervenes. The company has made key personnel changes in the corporate structure in this state and has added more consultants to help develop care plans.

Nationally, the company that was founded as a partnership in 1963 has opened a training center in Atlanta in a move to provide better care, said Beverly spokeswoman McCarthy.

But for some critics, Beverly's change in direction typifies a company that reacts to potential disaster rather than having the foresight to prevent it.

"We felt we were getting a franchise-quality operation — not very bad homes and not very good homes but very predictable," said Wills.

"We knew they had deep pockets and would at least bring some standardization here. I thought it would work out.

"I'm encouraged by the fact that they are hemmed in and won't acquire any more facilities. Now they will be forced to manage them. But I will believe it when I see it."

McCarthy denied that the company is suffering from a corporate-wide nursing care problem.

"A good facility is only as good as the management we have in that facility," she said. "The company's priority is to provide quality patient care first. There are times when you are going to have an excellent person in an administrative position, and times when that person isn't able to do the job."

Tietjen's job is to ensure that Beverly homes attract and keep quality employees.

She also has ordered that each Beverly nursing home have resident and family councils. The family councils, composed of patients' relatives, would monitor nursing home activities and be allowed to take their concerns to top corporate management.

Nevertheless, the publicity surrounding Beverly has prompted some states, including Washing-

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Maine nixes Beverly expansion; chain pulls out

Health officials in Maine recommended that Beverly Enterprises Inc. not be allowed to purchase two homes in that state, following a finding that the company "was not fit, willing, and able" to operate the homes in accordance with Maine health laws.

The Maine recommendation was based on a 600-page review of the health care record at nursing homes owned by Beverly in seven states, recently released in response to a request from *American Medical News.*

The survey conducted by the Maine Dept. of Human Services Division of Project Review covered five states in which there were nursing homes operated by Beverly's Heritage Division, which was managing a number of homes in New England. The survey also covered Texas and Colorado, where Beverly has large concentrations of nursing homes. Analysts examined health care records for Beverly homes for 1985 and 1986.

After the recommendation, Beverly decided to pull out of the Maine market entirely.

The survey found that the Commonwealth of Massachusetts in 1985 prohibited Beverly from expanding operations in its state until June, 1986, because of patient care problems at five Massachusetts homes in 1984 and 1985. The problems have since been corrected, but Beverly has been able to obtain only provisional licenses to operate seven Massachusetts facilities the corporation purchased in 1985, the analysts said.

Officials from the Massachusetts Dept. of Public Health told Maine officials that the commonwealth also temporarily stopped Medicaid payments to one of Beverly's Massachusetts homes and banned new admissions to another.

IN PENNSYLVANIA, where Beverly managed 39 nursing facilities, one was cited more than 20 times for having an inadequate nursing staff in 1985 and 1986, the analysis said. Staffing problems jeopardized the Fayette Health Center license, Maine officials reported, and the nursing home was granted only a provisional operating license. A second Beverly facility in Pennsylvania also sustained repeated citations for staffing and physical plant problems, Maine analysts said.

In Connecticut, where Beverly operated five homes, each facility was cited at least four times in 1985 and 1986 for failing to meet nursing standards, the analysis said. Those standards, said Maine officials, ensure that nursing home operators provide enough "nursing personnel to meet the patients' needs." During 1985 and 1986, four out of the five Connecticut nursing homes were cited for infection control violations.

Maryland health officials provided data showing that each of Beverly's six nursing homes in the state were cited four to 23 times during 1985 and 1986. Sixty-one of the violations involved inadequate staffing of the facilities. Two of Beverly's Maryland nursing homes were found to have problems with infection control because cockroaches were observed at nursing stations and in utility rooms, the Maine analysts found.

New Hampshire health officials told the Maine analysts that inadequate staffing and problems with infection control and the physical plant were discovered in inspections at two facilities Beverly managed in the state from 1985 to 1986.

BEVERLY ENTERPRISES had 139 nursing homes equipped with 15,440 beds in Texas. Nurse staffing, physicial plant deficiencies, and inadequate infection control proved to be problems in 34 of Beverly's Texas facilities, the Maine analysts found. Twenty-four times in 1985 and 1986, Texas Beverly homes had government funds withheld for health violations. Eight homes lost contracts to operate as Medicaid facilities, Texas health officials reported to the Maine analysts.

Beverly controlled 692 beds in Colorado. In 1986, Colorado Dept. of Health officials granted licenses for Beverly to operate three nursing homes near Denver only when the corporation agreed to provide adequate nursing staff for its Colorado facilities, according to the Maine survey. The corporation also agreed to pay the Colorado health department for any additional monitoring that would be required to ensure that the company operated its nursing homes in Colorado safely, Maine analysts found.

Maine officials concluded, "Because of the nature and widespread frequency of violations of federal and state regulations at Beverly Enterprises' existing facilities, and said violations presenting an unacceptable risk to patients," the company was "not fit, willing, and able to provide the proposed services in conformity with the standards of care as required" by Maine health laws.

Robert Van Tuyle, chairman of the board of Beverly Enterprises, said his company's operations throughout the United States had been affected by a lack of qualified nursing home staff. "Staffing is proving to be a serious problem," said Van Tuyle.

BUT VAN TUYLE accused Maine health analysts of manipulating statistics on Beverly's performance to make the chain look bad. He complained that the Maine analysts had merely tallied the alleged health care deficiencies of Beverly facilities without comparing these tallies with similar statistics for other nursing homes in the same states.

"They do not have comparable data, Van Tuyle said.

Commenting on specific allegatio about Beverly's health care record Maryland, Van Tuyle said, "Any facil can be cited . . . if the intent is to cite. W deal with several hundred regulations each of these instances [of inspections health personnel]. It is impossible to ha them all in tune at the same time."

Further comment about specific alleg tions, however, was "pointless," V Tuyle said. "You seem as a group to committed to negative journalism. long as you're emphasizing the negati comments are inappropriate."

Van Tuyle said, however, that many the problems cited by health officials porting to the Maine analysts had si been corrected. —Phyllis Gap

ıMA backs

ıntinued from preceding page

nce." At the same time, the Associa-ın has "an equally serious interest" in ısuring that medical and policy deci-ɔns adequately protect the public from eventable exposure to the human im-ıunodeficiency virus (HIV).

Because the AMA is "vitally con-erned" that the public be fully informed bout the modes of transmission of AIDS, ıe AMA brief pointed to the "extensive nedical information currently available ɔn the non-transmission of AIDS based ɔn casual contact."

Reviewing research findings on the non-transmissibility of HIV in various set-tings, the AMA brief noted that medical and public health authorities have con-cluded that the "wholesale segregation of AIDS patients is entirely unjustified."

Noting that attorneys for the school board had argued that Chalk might trans-mit opportunistic infections to his stu-... said "there is no evi-

see him" speaking and signing.

In other school cases, where the risk of transmission might be greater, courts have granted injunctions ordering that children be admitted to regular class-rooms on the grounds that the transmis-sion risk is negligible, the AMA noted.

"Numerous and extensive studies have been conducted to determine whether there is any appreciable risk of transmis-sion through casual contact in school, the workplace, and at home," the AMA wrote. "After intensive study and blood testing of the subjects, not a single case of transmission of the AIDS virus, much less development of the actual disease, has been documented. The probability of harm, therefore, is not substantial." Ac-cordingly, the brief concluded, Chalk is "qualified to resume his teaching position because he poses an insufficient risk of transmission to his students."

—Sari Slaver

Nursing home chain drops operations in five states

Beverly Enterprises Inc., the nation's largest nursing home chain, has with-drawn its operations from five states since January of this year. In two of these states, the 120,000-bed nursing home chain acted after encountering opposi-tion based on charges that the chain has a poor record of patient care.

"We are making no effort to operate in Maine, and we have withdrawn from Wy-oming, Montana, Colorado, and New Mexico, although we had pending plans to expand there," said Robert Van Tuyle, chairman of the board of Beverly Enter-prises.

Van Tuyle denied any connection be-tween Beverly's actions and charges of poor patient care that have plagued the chain in some states. However, Beverly encountered opposition in both Maine and Montana before its decision to curtail its activities in those states.

The company is currently barred from expanding operations in California. Since May, 1986, the California Dept. of Health Services has refused to grant operating licenses to the chain's new enterprises, citing allegations of patient care problems at existing Beverly-owned nursing homes in the state (*AMN*, July 25, 1986).

IN MAINE, Beverly had proposed to purchase and operate Marchalin Nursing Home in Milbridge and Market Square

rsing Home in South Paris. However, ıine health officials recommended ıinst allowing these sales. Beverly offi-ls responded by requesting a hearing the decision. But the company with-·w that petition in March, after Maine icials produced a 600-page analysis :ical of the health care record of Bever- Enterprises nursing homes in seven tes. Last month , when Beverly's man-ement contract for the Marchalin facili- expired, the company ceased its oper-ons in Maine.

Beverly also had obtained state permis-ın to start construction on a nursing me in Helena, Mont. But two non-ofit nursing homes appealed the state's cision, arguing that Beverly should not . allowed to expand in Montana be-use the corporation had a poor patient re record in other states. The Court of Fifth Judicial District of the State of ontana, in Boulder, ordered the state to reconsider its decision. Soon afterward, Beverly withdrew an application to construct the new nursing home in Helena and sold two other nursing homes it had owned in the state. Both of these facilities had a good record of patient care, according to Montana health officials.

Health officials in Wyoming confirmed that Beverly ceased operations in the state last month. Abandoning Wyoming operations meant giving up a management contract at a nursing home in Wyoming's central ranching district and giving up certificates obtained to construct three new long-term-care facilities in the western region of the state. Construction was halted on a planned facility in Evanston, and the partially built facility was sold to HMU Management, said Charlie Simineo, survey coordinator for the Wyoming Dept. of Health's section on licensing and certification. Officials in Wyoming said that Beverly has had no patient care problems in the state.

In January, 1987, Beverly sold four nursing homes in New Mexico. The corporation had suffered staffing problems at two of these facilities, which were located near rural Indian reservations and far from a concentrated pool of labor, said Sue Morris, a spokeswoman for the state's Dept. of Health and Environment. But the corporation apparently did not encounter any opposition to its expansion in New Mexico.

In two of the states, Beverly withdrew after facing opposition.

Colorado health officials were unavailable for comment.

Van Tuyle told *AMN* that the decision to curtail operations in all five states came because the corporation had been unable to acquire at least 1,000 nursing home beds per state.

"Unless we get 1,000 beds, we find it impossible to operate in a particular state. We no longer operate in a number of states because of the inability to get what we consider an adequate number of facilities," he said.

He added that the corporation had been unable to find nursing homes it could purchase. "People wouldn't sell to us," Van Tuyle said, adding that there was no connection between this unwillingness to sell and controversy surrounding Beverly's health care record. "People were just looking for the best price."

—Phyllis Gapen

Gapen is a free-lance writer based in Houston.

Nursing home chain pays big fine, avoids sanctions

Beverly Enterprises, the largest nursing home chain in the nation, paid $600,000 in fines Oct. 16 to ward off California Dept. of Health sanctions brought against the chain because of alleged negligence leading to the deaths of nine patients at three of its homes.

Faced with November administrative hearings to revoke the licenses of Beverly Manor in Los Gatos, Julia Convalescent Hospital in Mountain View, and Beverly Manor in Santa Cruz, the giant nursing home company agreed to stiff terms that allow the existing homes to continue operating and seven others to open.

Reform law aided authorities.—page 57

Under the terms of the agreement, the licenses of the three Northern California nursing homes were revoked, but the three facilities are allowed to operate for the next four years on probation.

In a pyrrhic victory for Beverly, state officials agreed to grant provisional licenses to seven new Beverly facilities, which had been held up pending the outcome of the administrative hearing, but stipulated that the Pasadena-based corporation would license no new nursing homes for the next 14 months.

That provision prevents the corporation from taking on new business in the state, but allows the company to begin operating three new nursing homes it had built in the state and four others it had purchased but had been unable to license after making a $20-million investment.

The price of the settlement included a stipulation that all of Beverly's California skilled nursing facilities, which serve bedridden patients, will be monitored during

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the next 26 months to determine whether they equal or exceed the average statewide performance record of similar, non-Beverly facilities. If Beverly fails to perform as well as other operators, the probationary licenses of Julia, Beverly Manor in Los Gatos, and Beverly Manor in Santa Cruz will be revoked, and the provisional licenses granted to its seven new homes will expire.

Kenneth Kizer, MD, state health director, said the settlement should send a clear signal to other nursing homes that poor quality care will not be tolerated by his department. He added that the fine paid by Beverly was the largest ever levied against a nursing home operator in California.

The corporation, which collects $1 billion a year in revenues from the operations of more than 1,200 nursing homes in 46 states, agreed to pay 75 cents on the dollar for $885,400 in fines levied against the three troubled Northern California nursing homes and five others in the Los Angeles area.

BEVERLY'S PRESIDENT, David Banks, said the corporation settled because "we decided that it made more sense to try to work hand-in-hand with the state than go through this procedure [the administrative hearing to revoke licenses]. Tempers had gotten out of line on both sides, and that does not make for us moving ahead. We felt that it was better to work with them than against."

Banks added, "We felt that it was more important to give attention to patient care than to worry about fighting our adversaries. We don't think we should be in an adversarial role with any state, and so we decided to settle."

Banks said his firm admitted no wrongdoing as part of the settlement, and other company officials have denied that the corporation neglected patients at its Northern California homes. Beverly officials also have insisted that state officials could not prove their case against Julia, Beverly Manor in Los Gatos, and Julia Convalescent.

But Paul Keller, chief of field operations for the state health department, said, "There was never any doubt on anybody's mind on the state's side that we couldn't go to an administrative hearing and prove up our revocation actions against these three Beverly facilities. We were not negotiating from a position of weakness."

Keller said that the state's decision to settle was partly motivated by a shortage of nursing homes in Northern California and in other communities where Beverly had built new but unlicensed facilities.

ONE OF THE concessions Beverly made to state health officials was the payment of $7,500 in fines for operating three of its new facilities — Summerfield Convalescent Hospital in Santa Rosa, Healdsburg Convalescent Hospital in Healdsburg, and Ukiah Convalescent Hospital in Ukia — without a license. The health department recently had sued the corporation for operating these newly purchased facilities without first obtaining licenses, but Beverly had contended it was merely "managing" the homes for the previous owner while the sales transaction was being completed.

Beverly has agreed to turn over future proposed management contracts to state health officials before taking over operations at any other California nursing homes. The provision is important because the corporation acts as a manager of many nursing homes, in addition to those it owns.

Beverly also promised to "provide all resources, including staffing and supplies, to assure that patient care does not fall below the [health department's] standards and to implement business practices and budgetary practices that do not impede this goal" in its California homes.

—Phyllis Gapen

Gapen is a free-lance writer based in Houston.

Fine settlement involves other Beverly homes

When the nation's largest nursing home operator, Beverly Enterprises Inc., settled, for $600,000, nearly $900,000 in fines against its California homes recently, the glare of public scrutiny was on three of its northern California homes. But Beverly facilities in other parts of the state also were involved in the settlement.

In Los Angeles, Beverly Manor Convalescent Hospital in Panorama City was fined $5,000 for allegedly permitting a patient's thigh to be broken while untrained employes were changing linen on the bedfast woman's special bed in September, 1986. The home also received a $10,000 fine for an incident involving an elderly patient who allegedly was struck in the face by an orderly in October, 1985.

The chain received a $25,000 fine for allegedly allowing an unattended, retarded patient with a history of seizures to drown in a bathtub at Lynwood Care Center last December.

A $5,000 fine was levied for alleged failure to treat a urinary tract infection or give sufficient insulin to a diabetic patient who fell into a coma after an eight-day stay at Beverly Manor Convalescent Hospital in Glendale in October, 1985.

At Beverly Manor in West Covina, the corporation incurred a $10,000 fine in March, 1985, for allegedly failing to monitor and treat a woman who developed a bedsore that extended to the bone. When hospitalized, the woman was treated for blood poisoning arising from the infected skin ulcer. She died nine days after the home discharged her to the hospital.

In the $600,000 settlement, Beverly paid 75% of each of the Los Angeles fines, some $48,750. The total fines were $65,000 from that region.

David Banks, president of Beverly Enterprises, declined to comment on the fines being paid in Los Angeles.

Beverly faced earlier probe of California operations

Beverly Enterprises, which has agreed to pay heavy penalties in order to resolve a string of problems with the California Dept. of Health Services, has been in trouble with the state of California before.

Twelve years ago, Beverly was the object of a headline-making investigation prompted by the deaths of nine patients in four nursing homes. The nursing home chain's operations were probed first by the *Sacramento Bee* and then by California's health department and at least five other agencies.

But those inquiries fizzled out — an outcome far different from that of the latest clash between the state and the Beverly chain. Observers say that California's 1985 nursing home reform act, which created special inspection teams, may have made the difference between investigations that went nowhere 12 years ago and the record settlement just negotiated by state health officials.

IN 1973, Pasadena-based Beverly Enterprises operated 63 California nursing homes and was experiencing a fiscal crisis. Until that time, the worst criticisms of Beverly had come from regulators who gave the company mixed reviews for the care it provided to the large population of elderly poor in its care. Some thought the chain did an average job compared to the independently owned homes in the state. Other regulators who talked to John Berthelson, an investigative reporter for the *Sacramento Bee*, said they saw the company's operations as "spotty."

But Berthelson's investigative series painted a more negative portrait of the Beverly chain. The taxpayers who footed the bills for California nursing home patients in the 1970s were shocked by allegations that patients in Beverly-owned homes were suffering because of short staffing, rapid turnover of nurse's aides, and malfunctioning equipment, and that aggressive, mentally ill patients were mixed with the frail elderly. Among the accusations made in 1973 were that there had been three suspicious patient deaths in a Beverly-owned home in Azusa, two at a home the company owned in Modesto, three at a facility in Carmichael, and one at a Beverly-owned facility in Los Gatos.

One charge brought against the chain was that a man who was unable to swallow had strangled after a nurse at a Beverly home poured water down his throat, and a suction machine malfunctioned. That death occurred at Beverly Manor of Los Gatos, the same home state officials last year fined some $246,000 for violations involving the deaths of three elderly patients whose bedsores were allegedly treated inadequately.

The deaths at the Azusa facility, Edgewood Convalescent Center, were allegedly caused by food poisoning, a charge later disputed by the Food and Drug Administration, which found that staff at the facility had prepared the food properly. This home was still owned by Beverly in August, 1985, when it was fined $10,000 for failing to ensure that a patient who had allegedly been sexually abused was seen by a physician until four days after the incident.

IN 1973, a northern California sheriff came forward with an allegation that a patient had been beaten to death at Beverly's Carmichael home. This accusation prompted Berthelson's investigative series and a round of official investigations, including a criminal investigation of deaths at the Carmichael facility. But in 1974, Chief Deputy District Attorney Geoffrey Burroughs held a press conference to announce that there was insufficient evidence on which to base criminal charges against the home. At the press conference, Burroughs angrily urged other state agencies to continue the investigation he had begun.

Burroughs did not delve into why the evidence at his disposal was inadequate to support criminal charges. However, officials from the California Attorney General's Office recently explained that, prior to 1985, the state often had great difficulty proving its cases against nursing homes. The reason: Poorly trained inspectors often failed to gather sufficiently detailed information.

This problem was addressed in June, 1974, in a state health department draft report titled "Proposed Methodology for the Identification and Prevention of Unusual Occurrences in Skilled Nursing Facilities." Prompted by the allegations concerning the Beverly-owned homes, this 1974 report was critical of the state's mechanisms for regulation of nursing homes and included a series of recommendations. Among them was a proposal to add registered nurses to the inspection teams that were expected to document instances of abuse and neglect. Another was that nursing homes be required to report unusual occurrences to the state department of health within 24 hours. Yet another recommendation was that the performance of corporately owned nursing home chains should be measured against that of independently operated facilities.

But that 1974 report was never published. It became public only recently, when a copy was obtained by *AMN*.

One of two investigators who produced the report recently told *AMN* that the report was "squelched." The former investigator said, "It was disgusting. I wasn't privy to any discussions of the report at higher levels [in the state health department] but it was clear they didn't want to do anything. Nobody wanted to come out front because the findings made the department of health look bad." This investigator also claimed that the nursing home industry influenced the decision to suppress the report.

NONE OF THE recommendations in the 1974 draft report were acted upon at the time, and the report disappeared

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Beverly faced earlier probe

Continued from preceding page
from view. Current administrators in California's Dept. of Health Services were unaware that the report had ever been produced.

A decade passed before the California Health Facilities Commission did — as had been recommended in the 1974 report — compare the Beverly chain with independently owned facilities in California.

The commission found that, among the homes Beverly was then operating in the state, more homes had received Class A citations (for life-threatening conditions) than among facilities outside of the control of big corporations. In 1983, 11% of Beverly homes were said to pose threats to life, compared to 7% of other noncorporate homes.

In the mid-1980s, the climate of opinion toward the nursing home industry in California had begun to change. Growing awareness of problems in the industry led to the passage of reform legislation in 1985. Among the provisions of this new legislation: Nursing homes must report unusual occurrences to the state department of health within 24 hours, as was originally recommended in the 1974 report.

The 1985 legislation also creates special investigative teams that include not only a registered nurse but also an auditor trained to spot Medicaid fraud and any pharmacy, dietary, or medical consultant who may also be needed. Whereas planned inspections were the norm before the reform legislation was enacted, the special teams are allowed to make surprise inspections at homes in the state. Directed by supervisors with two-to-three years of experience inspecting nursing homes, the teams have unlimited time to inspect the facilities they enter. When they find evidence that a patient has died from neglect or abuse, a medical consultant is called in to review medical records.

Regulators may now also fine facilities up to $25,000 per incident for instances of abuse and neglect, compared to penalties up to $5,000 before the legislation was enacted. Under the new legislation, nursing home operators are also subject to heavy fines for negligent care that leads to patient deaths, falsification of medical records, or repeated violations of health rules.

OBSERVERS INITIALLY questioned whether the state would be able to collect the full fines it levied against nursing homes, pointing out that another nursing home chain operating in California had, in 1984, been negotiating to pay 20 cents on the dollar for some $75,000 in fines and, in 1985, had settled another $65,000 in fines for 55 cents on the dollar.

But Paul Keller, chief of field operations for California's health department, pointed out that the state was recently able to settle some $885,000 in fines against Beverly for 75 cents on the dollar. One key reason the state is now able to crack down on operators charged with nursing home abuses, he said, is that its accusations are now well-documented. And that is thanks to the special investigative teams.

Said Keller, "The teams develop documentation of the problems — physical evidence, testimony, photos, declarations, whatever it takes to build the best possible case."

Said the investigator who helped to write the long-suppressed 1974 report on California's nursing home industry: "Naturally if you have people who are trained medically, they're going to be looking at how the care is actually rendered, and that will provide evidence in a case."

—Phyllis Capen

Capen is a Houston-based free-lance writer.

State refuses licenses

Chain's expansion plans stymied

Exclusive

Expansion of the nation's largest nursing home chain has come to a standstill in California in the wake of state action to close three of the chain's 93 nursing homes in that state. In two of these homes, negligent care allegedly led to nine patient deaths, and the state now contends that the chain cannot be relied upon to meet health standards either in homes it already operates or in the facilities it had planned to open.

With revenues of more than $1 billion a year, Beverly Enterprises of Pasadena, Calif., controls more than 100,000 nursing home beds nationwide, and the expansion-minded company has been eyeing California's 10.7% population of persons older than 65 as a prime source of new business for the next decade.

Thus Beverly Enterprises recently built two nursing homes in California and purchased four more, and had plans to open a home health agency branch office in the state soon.

But these plans have been grinding to a halt since May — when, as *AMN* has learned exclusively, the regional offices of the California Dept. of Health Services (CDHS) began refusing to grant operating licenses to the chain's new enterprises.

The reason for the CDHS decisions: allegations of serious patient-care problems at three Beverly-owned nursing homes in Northern California.

BASED ON THESE allegations, Attorney General John K. Van de Kamp recently initiated action to revoke the licenses of Beverly Manor of Los Gatos, Julia Convalescent Hospital in Mountain View, and Beverly Manor in Santa Cruz, all owned by Beverly. If Van de Kamp prevails in administrative proceedings before the State Dept. of Health Services, each of the homes also will be suspended from the state Medicaid program, and offi-

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State seeks license revocation of fourth nursing home

The state of California, which currently is seeking to revoke the licenses of three nursing homes belonging to Beverly Enterprises of Pasadena, also is seeking revocation of the license of a fourth nursing home in the state — West Park Convalescent Hospital in San Jose.

West Park's owner is ARA Enterprises Inc. of Philadelphia, the third largest nursing home chain in the country, with some 31,000 beds. Last year, ARA was barred from licensing any more nursing homes in California until May of this year. Before signing agreements to manage any more homes, ARA also was required to obtain approval from state health officials.

ARA is now under fire from the attorney general's office for allegedly understaffing ARA West Park, failing to maintain equipment in working order, and failing to provide adequate patient care to patients at the 166-bed skilled nursing facility.

In the accusation filed against ARA, California Attorney General John K. Van de Kamp cites instances of patient neglect dating from February, 1983, to July, 1984, which involved problems ranging from failing to isolate a patient with a staphylococcus infection to failing to give medication for a heart condition.

State health officials also contend that patients at West Park were not properly groomed. During an inspection in September, 1984, 21 people allegedly were discovered in bed at 3 p.m., 31 patients had long or dirty fingernails, 13 people had sharp toenails, and eight people had excessive facial hair.

Cathy Daigle, a spokesman for ARA in Houston, Texas, said the company "obviously doesn't like" the state's pending revocation action against West Park and indicated that ARA will fight the revocation proceeding. She said that ARA had corrected problems uncovered at West Park and that the company would "continue to run the facility, ensuring we have proper care."

West Park "is now running well, and from our perspective we cannot understand the state's action to revoke the license," Daigle said.

In other action involving the West Park facility, federal health officials recently decertified the nursing home, as well as a second Northern California nursing home owned by ARA, Cypress Convalescent Hospital in Pleasant Hill. Daigle said that the company has gone to court to force the federal government to reinstate Medicare and Medicaid payments to the West Park nursing home.

Nursing home chain's expansion stymied

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cials who administered and managed the facilities may be barred from California's nursing home industry.

But it is of perhaps even greater import for the giant nursing home chain that the CDHS has begun to balk at licensing new Beverly Enterprises facilities. A total of seven Beverly facilities are stalled or about to be stalled because of the CDHS.

In May and June, the CDHS denied licenses for Beverly to operate the Ukiah Convalescent Hospital in Ukiah, Summerfield Convalescent Hospital in Santa Rosa, Healdsburg Convalescent Center in Healdsburg, and Palm Terrace Health Care Center in Laguna Hills, all of which Beverly recently acquired; a new home health agency branch office in San Jose; and one nursing home Beverly has just built, Rancho Mirage near San Bernadino. And in Ridgecrest, Calif., Beverly has completed a new 99-bed skilled nursing facility, but there is "every indication the state health agency will deny an application for licensure," said Paul Keller, chief of the field operations branch of the CHSD licensing division.

Diane McCarthy, a spokesperson for Beverly Enterprises, questioned the methods regulators are using against the chain. "Obviously it is not something we feel is equitable," McCarthy said. It is not proper for the state to hold up licensure of Beverly's new facilities pending a decision on whether to revoke the licenses of three others, she explained.

But Hank Schoenlein a CDHS official who supervises health facilities in a vast region of Northern California, countered that health watchdogs are "following a policy whereby the licensee applying for additional acquisitions of facilities is going to have to demonstrate its ability to comply with California health laws and regulations."

As a result, when an applicant for a California license has had a license revoked or is threatened with loss of a license, Schoenlein said, that applicant is going to have problems obtaining licenses to operate other nursing homes. "We are looking at the compliance record of already existing licensed facilities" operated by the applicant, he said. "Where we have pending revocation actions, an applicant is going to have a very difficult time getting a license because the ability to comply with laws and regulations has not been demonstrated."

Schoenein went on to say, "What we've seen in the South Bay area causes us serious concern. These actions are being taken due to the serious violations of the health and safety code and department regulations governing skilled nursing facilities run by Beverly. Because of these violations the department has determined that Beverly has not provided satisfactory evidence of its ability to comply with the statutes and regulations of the state of California related to the operation of skilled nursing facilities."

THE MOST SERIOUS violations alleged against Beverly involve the deaths of nine patients, four at Beverly Manor of Los Gatos and five at Julia Convalescent Hospital (*AMN*, Jan. 17, 1986).

In Los Gatos, one patient, identified as Margaret R., died from shock on July 8, 1985. She died in a hospital where she was being treated for infected decubitus ulcers on her right hip, right leg, left thigh, left buttock, and tailbone. Nursing notes indicate that the nursing home did not tell her physician about several of the sores for weeks. When the physician ordered draining ulcers to be cultured for infective organisms, nursing home staff failed to follow through, Attorney General Van de Kamp's accusation against the facility states.

Deficiencies in care at the Los Gatos facility also allegedly led to the death, on July 10, 1985, of William Bronson, a San Jose man who suffered from congestive heart failure. Although he coughed up bloody sputum for three days, nursing home staff allegedly failed to report his condition to a physician. When he experienced a sudden drop in blood pressure, increased pulse rate, and labored breathing, nurses allegedly waited 22 minutes to transfer him to a hospital next to the nursing home.

Another patient, Clarence L., died Aug. 13, 1985, almost 14 months after being admitted to Los Gatos because of severe degenerative arthritis. The 120-pound man subsequently developed bedsores on his spine, right foot, and left elbow and an open sore on his penis. The accusation filed by the attorney general contends that the facility repeatedly failed to develop a plan to adequately treat these sores and that the man developed a 101 degree (F) temperature on Aug. 1, 1985, and had to be transferred to a hospital. Diagnosed with "possibly urinary source of pneumonia," he died 12 days later.

HARRIET M., admitted to Los Gatos June 19, 1985, with fragile but unbroken skin, suffered from diabetes mellitus, hypertension, peripheral vascular insufficiency, and senile dementia, and had experienced a cerebral vascular accident. State officials contend that the woman developed a sore on her heel that progressed to a 5-cm X 5-cm necrotic ulcer before her physician was notified. Moreover, the attorney general alleges, Los Gatos staff failed to monitor the woman's blood sugar for the entire month of July, 1985.

Harriet M. died Aug. 12, 1985, in an acute care hospital to which she was transferred upon becoming weak and unresponsive. Documents filed by the attorney general attribute her death to gram-negative sepsis, "with acute pyelonephritis or decubitus ulcers listed as portals of entry."

At Julia Convalescent Hospital, the attorney general contends, a patient waited 45 minutes after exhibiting symptoms of heart failure before staff called an ambulance. Another negligent death allegedly resulted when staff for 26 minutes failed to call paramedics to assist a woman dying of penumonia. The three other deaths involved patients who had developed numerous, serious bedsores.

The attorney general also is attempting to revoke the license of Beverly Manor in Santa Cruz, which was given $65,000 in fines in June; the nursing home was given a class A citation for an incident that threatened the life of a patient, state health officials said and McCarthy confirmed.

The attorney general also reportedly is considering whether to attempt to revoke the license of another Bay Area nursing home owned by Beverly — the Beverly Manor Convalescent Hospital in Live Oak, which in June received 11 citations and $67,000 in fines for care that allegedly led to the death of a 93-year-old woman.

BEVERLY ENTERPRISES is taking the position that problems at the facilities that are the object of the attorney general's action already have been corrected, and that as a result, the state no longer has grounds for the revocation proceedings.

"At this point in time we're delivering excellent patient care," McCarthy said. "Revoking a license in an existing operation is supposed to be for the purpose of protecting any patients that might have harm come to them as a result of being in the home. On follow-up surveys, state inspectors have to be able to say that people are in jeopardy. On follow-up surveys (at Beverly homes of which the licenses are now threatened) we have done very, very well. Technically, (the state) should not be allowed to consider revoking our licenses."

But San Francisco Deputy State Attorney General Jan Sherwood said, "The law doesn't say, 'If you clean up your act, all is forgiven.' " A violator, she said, "is still subject to a penalty for having violated the law."

Sherwood also noted, "The fact that Beverly cleaned up problems is some evidence of its ability to correct a problem, but the health department has some concern about Beverly's ability to prevent the problem from happening in the first place. It's the responsibility of the licensee to always run a clean nursing home."

BEVERLY OFFICIALS have vowed to go to court, if necessary, to fight license revocations at their California facilities, and they have engaged the prestigious San Francisco law firm of Pillsbury, Madison, and Sutro to plead their cause. The corporation "is working on doing everything we can to see to it that" that no revocations are imposed, McCarthy said.

However, should Beverly lose its licenses to operate in Los Gatos, Mountain View, and Santa Cruz, a four-tiered appeals process remains open to the company. In California, the decision of an independent hearing officer sitting in an administrative revocation proceeding before the CDHS may be appealed to the department's director.

Beyond that, decisions of the health department also may be appealed to a California superior court, and beyond that to the California Court of Appeals. The state's Supreme Court is the final arbiter, but it hears appeals only if it chooses to do so.

—Phyllis Gapen

Gapen is a free-lance writer living in Houston.

State stiffens stance on nursing homes

Armed with tough new laws giving regulators greater powers, California is moving more aggressively in its battle against nursing home abuse and neglect.

The state's new tactics include inspecting homes without prior warning and levying fines up to $25,000 per incident. The state has already forced the closure of two facilities since the spring, when the state legislature passed landmark nursing home reform legislation.

Penalties up to $5,000 per incident and planned inspections were the norm before California Governor George Deukmejian signed a package of nursing home reform bills giving regulators authority to levy heavy fines for negligent care that leads to patient deaths, falsification of medical records, or repeated violations of health rules.

As a result of the new laws, the California State Dept. of Health Services has recently levied the largest fines in its history — including a record $197,000 fine against Beverly Manor of Los Gatos, a home owned by Beverly Enterprises, Inc., of Pasadena, Calif. That sum is almost $35,000 more than all fines levied against 82 of the California homes operated by Beverly Enterprises in 1981 and 1982.

But some observers question whether the state will be able to exercise the full measure of its new powers. Nursing home operators and reformers alike warn that the state may never collect the full fines it levies against nursing homes.

HISTORICALLY, CALIFORNIA has had difficulty collecting the full fines assessed against nursing homes accused of violations. One reason is that nursing home operators have the right to appeal decisions of the Dept. of Health Services — first to a hearing officer and then to the courts — and most do.

In addition, it has often been difficult for the state to prove the charges it makes against nursing homes. "There are often mitigating factors on the side of the facility," said Susan Bertken, an attorney for the Dept. of Health Services. "Nursing home inspectors sometimes fail to substantiate their cases. Maybe the evaluator was lax in writing up the citation."

Given the small size of the fines California used to impose on nursing homes — a mere $4,000, for example, on a charge of negligence that cost a patient a leg — there was little point in the state's pursuing these cases to the trial stage. "It takes very little time for us to spend more on legal fees and attorneys' time than we are going to get back in penalties," Bertken said.

Thus, traditionally, the state has been willing to offer a lesser fine to a nursing home rather than go to court. "I can't remember a citation going all the way to trial," Bertken said.

UNDER CALIFORNIA'S new law, specially trained inspection teams are uncov-

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California acts to combat nursing home abuses

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ering abuses that carry higher fines than in the past, and this may provide greater incentives for the state to take its nursing home cases to court.

The pattern thus far, however, is that the state continues to be willing to settle out of court — but it may be collecting a greater percentage of its fines than it previously obtained.

For example, ARA Living Centers, the Houston-based owner of a national chain of nursing homes, received some $65,000 in fines for a wide variety of incidents that allegedly occurred in nursing homes it owned or managed in California from 1980 to 1984. Recently ARA settled these fines by paying 55 cents on the dollar, or $35,695.

But in 1984, said Santa Rosa, Calif., personal injury lawyer Patrick Grattan, ARA was negotiating to settle $75,000 in fines against troubled California homes for 20 cents on the dollar, with an admission that the fines were justified.

Viewed from an historical perspective, therefore, the recent ARA settlement is "quite high," Bertken said.

Even more telling were regulators' curbs on ARA's expansion in California. The state will not allow the chain to license any more facilities in California until next May and is insisting that it gain approval from state officials before signing any more contracts to manage nursing homes in the state.

Moreover, the state revoked the license of Driftwood Convalescent Center of Santa Rosa, formerly operated by ARA, which incurred fines of considerably more than $10,000 in 1983 and 1984 for alleged violations that included failure to give patients medications that had been ordered for them; walls smeared with feces; patients left lying in their own wastes; linen shortages that forced patients to lie on torn, wrinkled plastic sheets; and failure to obtain and record patients' vital signs.

The state placed the license of ARA's Driftwood Convalescent Center in Torrance on probation for two years because of problems allegedly found at the home between 1980 and 1983. In one instance, the facility allegedly failed to provide appropriate care for a patient who lost 20 pounds in an 18-day period in 1980 when as few as two nurse assistants were caring for 75 patients at night.

Finally, the state dismissed with prejudice actions to lift the licenses of Good Hope Convalescent Hospital, which ARA no longer manages, and the former Laurelwood Convalescent Center in Los Angeles. Under ARA's management in 1982, Good Hope officials allegedly failed to notify a physician that an orderly had struck a blind patient so hard that blood began to flow from the man's ear. Problems at Laurelwood, now called Prestige Convalescent Hospital, involved a patient who allegedly sustained third-degree burns when a heat pack was used incorrectly, as well as the rapid decline of a patient with an open, pus-filled decubitus ulcer on her right foot, whose temperature was not monitored for a week.

BY NO MEANS all observers are happy with the way the state is enforcing the new laws, however.

Watchdog groups critical of the Dept. of Health Services contend that the state is not doing enough to collect the stiff fines levied under the new nursing home law.

For example, critics report that nursing homes in a five-county area of northern California, where the state is aggressively enforcing the new law, have been fined more than $1 million since the new law took effect, on charges of neglect that allegedly led to the deaths of 10 patients and the prostitution, rape, and brain damage of three others. Yet these nursing homes have so far paid less than $30,000 of the fines levied against them.

Meanwhile, spokesmen for the nursing home industry contend that the Dept. of Health Services is levying excessive fines in response to the intense pressure it has been under from its critics.

"This is a testing time in California with these reform actions," said Kathy Daigle, an executive with ARA, which recently reorganized its division responsible for the operation of nursing homes. "The Dept. of Health Services feels the need to prove it is taking a more aggressive stand with nursing homes."

She said that, before the new legislation, only 5% of all fines levied against nursing homes were on charges of negligence leading to patient deaths — the category for which the highest fines are assessed. These severe penalties are more common now, she said. "But they have been inappropriately placed at the higher level."

She predicted that, because the fines are now too high, they will be lowered by the courts if the nursing homes are forced to take them to trial.

DAIGLE ALSO criticized the process whereby health department officials in charge of licensing and inspection also act as hearing officers when fines are initially appealed. That process represents a conflict of interest, in which an official is both "the collector of fines and the trier of facts," she said — adding that, prior to 1985, only 30-40% of fines appealed to hearing officers were reduced or dismissed.

—Phyllis Gapen

Phyllis Gapen is a free-lance writer who divides her time between Washington, D.C., and Houston.

California officials continue crackdown on health violations in nursing homes

Two proprietary chains cited by state defend overall quality of care offered

Three nursing homes in northern California racked up record fines in recent weeks as the state's health department continued its crackdown on facilities rendering poor quality care.

Since August, three homes operated by Beverly Enterprises and ARA Services Inc. have been hit with more than $250,000 in fines in the Golden State. California health officials have cited them for health code violations that allegedly contributed to the deaths of five elderly patients.

The two chains are the largest nursing home companies in the United States, with control over more than 10% of the country's long-term care beds.

A Los Gatos home owned by the 100,000-bed Pasadena-based Beverly Enterprises has just been slapped with the largest fine ever imposed by the state on a California convalescent center. The $197,000 fine imposed on Beverly Manor Convalescent Hospital, a 73-bed facility south of San Francisco, was issued by the California Dept. of Health Services, which penalized the home for inadequate care by issuing 10 citations against it late last month. Two of the citations were $25,000 "AA" violations for life-threatening conditions, the most severe the department can issue.

Penalties came in the wake of the deaths of three nursing home patients in July and August: 65-year-old William Bronson and two unnamed patients, one an 84-year-old man and the other an 80-year-old woman.

COUNTING these latest violations, the home has been hit with 12 citations totaling $233,000 in fines since Aug. 8.

Beverly's competitor, ARA Services Inc., which controls more than 32,000 beds in 12 states, also received heavy fines in August.

ARA's recent troubles stem from problems at Skyline Convalescent Hospital in San Jose and at Driftwood Convalescent Hospital in Salinas, the community that houses California's famed Cannery Row.

Western Medical Enterprises, ARA's West Coast division, incurred a total of $20,000 in Class "A" fines at the facilities because two of its elderly charges died allegedly when nurses failed to respond properly to emergencies.

Driftwood, a 99-bed facility, was fined $10,000 Aug. 6 for the death of an unnamed 82-year-old man. State health officials allege that the man died of a heart attack Aug. 6 after a nurse discovered him on a bathroom floor. Although an ambulance was called, proper cardiopul-

Continued on page 28

California continues crackdown on nursing homes

Continued from page 2

monary resuscitation techniques allegedly were not implemented rapidly enough to save the man's life, and he died at a local hospital to which he eventually was transferred.

Skyline, a 227-bed facility, was issued a Class "A" citation and a $10,000 fine for the death of an unnamed 85-year-old woman Jan. 15. The state alleges that the woman was not attended properly by a physician even though she suffered from a blood clot that louged in her leg. State investigators said that although the nursing home contacted a physician when the woman was found cold and mottled, she went without a physician's care for more than eight hours before being transferred to a hospital where she died.

PROBLEMS CITED at Beverly Manor in Los Gatos are so serious, said the state Dept. of Health Services director, Kenneth [illegible] that the home could lose its lic[illegible]ell as its certification for fed[illegible] health care programs. Ki[illegible]ative team already has rec[illegible] that the federal government [illegible]s Medicare and Medicaid agre[illegible]ents with the home.

Violations involve deficiencies in care that allegedly led to the July 10 death of William Bronson, a San Jose man who suffered from congestive health failure and was being given oxygen to sustain his life. State investigators said that the elderly man coughed up bloody sputum July 5, 6, and 7, but a nurse failed to report the bloody nature of the liquid when a physician was contacted.

On July 10 at 1:30 p.m., Bronson experienced a sharp drop in blood pressure, an increase in pulse rate, and labored breathing, but nurses waited 22 minutes to transfer him to a hospital next door. He died at 2:35 p.m.

The state alleged in its citation that "a direct proximate cause of the death of the patient" was the failure of the nursing home staff to recognize the severity of Bronson's condition and to act immediately to transfer him to a hospital.

"The patient's diagnosis (of congestive heart failure) does not excuse inadequate nursing care," the citation said.

In response to the citations, ARA's manager of public relations, Cathy Rubenstone, said the company "holds in each of these cases that we provided adequate care." ARA has the option of protesting the fines the state has imposed, and Rubenstone suggested that the company might do so. "We routinely contest fines," she said in an interview.

ON AUG. 8, the Beverly home received "AA" and "A" citations related to the death of an unnamed 80-year-old woman who allegedly died of blood poisoning that resulted from infection in numerous large bed sores.

Although the staff of the home diligently logged the progress of the sores over two weeks into large, festering wounds, the state charged that no one had notified the woman's physician or adequately treated the sores.

Among other "A" citations that brought the home a total of $197,000 in fines last August were the alleged failure to:

- Prevent the development of bedsores on the skin of a woman with diabetes who had to be transferred to an acute care hospital Aug. 5; monitor her blood sugar weekly as ordered by her physician; and notify the physician promptly of changes in her condition.
- Re-evaluate the plan of care for an amputee whose weight dropped from 92 to 76 pounds from Feb. 26 to June 21.
- Notify a physician about a patient with a pacemaker whose daily pulse rate varied wildly.
- Rectify a situation wherein a nurse-call device was beyond the reach of a 99-year-old blind patient with so much mucous in her mouth that her breathing was impaired.
- Prevent the development of skin ulcers in a paraplegic woman as well as provide the special bed and mattress her physician ordered to prevent sores from forming, and deal with her diminishing appetite.
- Review patient care plans.
- Provide prescribed therapeutic diets.
- Assist patients in eating.
- Provide proper skin care for incontinent patients.
- Notify physicians promptly of changes in the condition of their patients.

A SPOKESWOMAN for Beverly, Diane McCarthy, said the corporation "is not concerned because of citations or fines. We're the largest operator of nursing homes in the country and we didn't get that way by offering anything but excellent quality of care in general. Our primary concern now is to get in there and make sure nothing like this ever happens again."

Carla Framiglio, supervisor in the San Jose licensing office of the state Dept. of Health Services, said Beverly Manor had brought in a number of consultants and undertaken a complete reassessment of the conditions of every patient since the state undertook its investigation.

"Most of the home's quite ill patients have now been discharged to other Beverly facilities or to acute care hospitals," said the state health department's district administrator, Mary Louise Mock.

Framiglio and Mock work out of the health department's San Jose licensing office, an entity that acts as an overseer for nursing homes in Santa Clara, Santa Cruz, Monterey, and San Benito counties. Since the first of the year, the office has levied more than $1 million in fines and recommended the closure of several facilities. Two additional ARA facilities near San Jose are facing the loss of their licenses because of the actions of the office. They are ARA-Westpark in San Jose and Driftwood Convalescent Center in Santa Rosa.

In 1983, Driftwood was cited for 83 non-life-threatening conditions. In 1983 and 1984, 39 complaints against ARA-Westpark resulted in the issuance of two Class "A" and 11 Class "B" citations. Three of the citations were for insufficiently staffing Westpark with nurses, one was for failing to notify a physician of a change in the condition of a patient, and another was for failing to implement adequate infection control procedures.

Corporately owned nursing homes are not the only facilities under fire in California. Bethany Convalescent Hospital in San Jose, one of a small group of homes run by the National Benevolent Assn. Health Services Corp., was fined $15,000 recently in incidents involving patient deaths (*AMN*, Sept. 6, 1985). Northlake Convalescent Hospital in San Jose, owned by Youmans Convalescent Hospitals Inc., was cited for the deaths of two elderly women patients from dehydration and untreated urinary tract infections. That facility has been closed, as have several others.

IN COMPARING Beverly Manor to Northlake, Framiglio said, "The findings of our investigation indicate that the nursing care situation was far worse than it was in our investigation at Northlake Convalescent Hospital."

Framiglio made no comparisons among such chain-operated homes and the recently cited Brommer Manor in Santa Cruz, a facility fined $3,000 and given an "A" citation Aug. 9 because of alleged rough handling of a patient.

At the 38-bed Brommer facility, an elderly woman allegedly sustained a bruised knee, a cut eyebrow, and a broken arm while a nurse's aid was turning her to change a dressing.

The citation marked the third Class "A" penalty issued against Brommer since the beginning of the year. On May 29, the facility was fined $10,000 after a woman patient fell and broke her hip for the fifth time in five months. State investigator Beverly Craig said, "There was no plan of care to prevent the patient from falling [even] after all of the [other] documented falls."

Brommer also was fined $1,000 Feb. 14 after a woman patient sustained a fractured leg when a nurse's aide was putting her to bed. The patient allegedly told investigator Barbara Johnson that the aide had dragged her to the bed even though she had protested, and that her leg was broken when it became entangled in a side rail on the bed.

—Phyllis Gapen

Gapen is a Washington, D.C.-based free-lance writer specializing in medical and health topics.

Wrongful death suit is filed against nursing-home operator

by Jim Simon
Times staff reporter

Beverly Enterprises, under fire from politicians and state social-service officials for violations at several of its nursing homes around the state, now has legal problems to add to its woes.

A wrongful death suit has been filed against Beverly in Pierce County Superior Court in connection with an 89-year-old woman who, attorneys allege, died from injuries sustained at a Tacoma nursing home owned by the company.

The suit alleges that Florence Gamache died from improper care she received at the Sherwood Terrace Nursing Center.

According to the lawsuit, Gamache suffered a broken leg and bruises on her head, face, arms and neck while under Sherwood's care on June 14. Two weeks later, while still under treatment from those injuries, she developed pneumonia and died.

Sean Briggs, the attorney who filed the suit on behalf of Gamache's family, said Sherwood officials never offered an explanation of what caused the death.

"The family entrusted her to Beverly Enterprises for care, and now they're left without an explanation for why she died," said Briggs.

Briggs said Gamache lived at Sherwood for several years. She had been bedridden for some time because of a stroke and a broken hip, he said.

Beverly officials were unavailable for comment on the lawsuit.

The state House Health Committee was scheduled to hold a hearing today in Olympia to discuss problems at the 33 homes owned by Beverly in Washington. The committee chairman, Rep. Dennis Braddock of Bellingham, has warned Beverly to improve its operations or face the threat of a state takeover.

Sherwood is one of eight facilities owned by Beverly — the largest nursing-home operator in the nation and the state — that have been cited by state Department of Social and Health Service inspectors for improper practices this year. Several of those homes have been barred from accepting new patients.

Gamache's death was investigated by the state Medicaid Fraud Unit and Tacoma police, according to Curtis Edwards of the fraud unit.

Edwards said nursing-home inspectors referred the Gamache case to his office because of possible patient abuse or criminal violations.

He said Sherwood officials claimed Gamache was injured when she fell while being moved by a nursing-home employee. But Edwards said the bruises on Gamache's face did not appear consistent with a fall.

However, Tacoma police say they are no longer investigating the death.

"We found no evidence of criminal intent to inflict bodily harm," said Chris Taylor, Tacoma police spokesman. He added that police responsibility under state law doesn't extend to investigating possible neglect.

Sherwood was cited twice in June by DSHS investigators for improperly transferring Gamache from her bed to her wheelchair, said Rodney Atkins of the nursing-home complaint division.

Atkins said Gamache's care plan called for the woman to be transferred with the help of two nurses aides, but only one aide was used on at least two occasions. Inspectors found Gamache suffered "skin tears," bruises on her forehead and a thigh problem that was later diagnosed as a fracture.

But Atkins said DSHS investigators do not have evidence directly linking the injuries cited in the lawsuit to the two incidents where Gamache was improperly transferred.

Last February, the DSHS nursing-home division put a temporary ban on admission of new patients at Sherwood and fined the home $600 because of sanitation violations. The ban was later lifted after those problems were corrected.

Judge recommends revoking nursing home license

A California administrative law judge has recommended revoking the license of a corporately owned nursing home in San Jose for allegedly understaffing the facility, providing inadequate care, and failing to maintain medical equipment in working order during a period in 1983 and 1984.

In a hearing before the state's Dept. of Health Services, administrative law judge Ruth S. Astle advised health officials to revoke the license of the former West Park Convalescent Hospital, a home owned by Western Medical Enterprises, a division of ARA Services Inc. of Philadelphia, the nation's third largest nursing home chain.

But in her decision, which is not binding on the health department, Astle also took into account improvements ARA had made at the home since the February, 1983, to July, 1984, period and recommended that the revocation action be stayed.

Mary Louise Mock, a district administrator for the health department, said nursing home regulators now were weighing whether to accept the judge's recommendation or to simply revoke the license of the 166-bed facility.

A decision from health officials is expected before the end of the year, said Cathy Daigle, a spokesman for ARA Living Centers.

The patient care problems that prompted health officials to seek revocation of the home's license ranged from failing to note the signs of a diabetic crisis to neglecting to isolate a patient with a *Staphylococcus* infection. They also included broken bed rails, urine odors, poor recordkeeping, and failure to help patients with meals.

Since then, Astle said, the chain has fired an "incompetent" nurse at the facility, hired a new administrator, increased formerly inadequate staffing, and taken steps to ensure that the physical plant is operating properly. The name of the nursing home also has been changed to Winchester Living Center.

Daigle, who is based in Houston, said that Astle "had made a personal visit to the facility" where she found that "the new administrator at the facility had taken care of any problems that [illegible] exist. We are hopeful that when the Dept. of Health reviews her findings it will concur with her decision and that we will continue operating the facility. We think that things are going very well there."

ARA'S CLOSE CORPORATE competitor in California, Beverly Enterprises, also is weighing the future of one of its nursing homes in Northern California.

Beverly Manor Convalescent Hospital in Los Altos, a 152-bed facility serving bedridden patients, was fined $33,800 in November and given one class A and two class B citations.

A citation filed by the California Dept. of Health Services alleges that an 89-year-old man with a history of falls sustained an injury in an accident at the home in October and will have to have his left eye removed as a result.

Inspectors cited this facility because the man allegedly had not been afforded procedures that would have prevented him from falling from his bed or wheelchair.

The facility was fined $30,000 because of allegedly poor care that led to the injury and $800 for failing to report the man's injury to health officials.

Charges that a demented 87-year-old woman had sustained bloody skin tears that were not reported to her physician also produced a $3,000 class B fine for the facility.

Beverly Enterprises Vice President Jack MacDonald said the corporation's health care consultants are "reviewing the events surrounding the incidents that have been cited" and engaging in discussions with state officials about the alleged impending loss of a patient's eye. "It would be inappropriate to comment further on specific details of the allegations noted in the citations," MacDonald said. "We have undertaken a full review of the facility. We are very concerned and interested in seeing that the care and services in the facility are of the highest quality."

—Phyllis Gapen

Gapen is a free-lance writer living in Houston.

In California

Beverly sues for nursing home licenses

Beverly Enterprises, the nation's largest nursing home chain, is suing the California Dept. of Health Services over the agency's unwillingness to license seven facilities the chain wants to operate in the state.

The health department is currently attempting to revoke the licenses of three nursing homes already being operated by Beverly in Northern California — Beverly Manor in Los Gatos, Julia Convalescent Hospital in Mountain View, and Beverly Manor in Santa Cruz, with total annual revenues of about $9 million. In its lawsuit, filed in superior court in San Francisco, the corporation is seeking an injunction to prevent the health department from refusing to license its new facilities as long as revocation action is pending against existing ones. The corporation contends that the health department is attempting to coerce it into a settlement of the dispute over the existing facilities.

State regulators contend that the deaths of nine elderly patients in the three Beverly facilities were related to improper care, a charge that is flatly denied by Beverly's chairman, Robert Van Tuyle. Corporate officials contend the allegations cannot be proven in court.

The corporation, with annual revenues of more than $1 billion and $20 million invested in its new California facilities, filed its suit Aug. 19, after rejecting a state offer to settle the revocation actions against the three existing facilities.

In August, the state offered to stay revocation actions against the three homes for three years if corporate officials agreed to forgo an administrative hearing protesting the revocation action, paid $393,825 of $459,350 in fines against Julia and Beverly Manor in Los Gatos, and accepted provisional licenses for all three facilities as well as its new state facilities. Moreover, state officials insisted that they would henceforth rate the performance of the Beverly chain against other nursing homes in the state. Beverly's failure to perform as well as other operators, the regulators said, would lead to the revocation of licenses for Julia, Beverly Manor in Los Gatos, and Beverly Manor in Santa Cruz; refusal to license any new Beverly facilities for 12 months, and expiration of provisional licenses.

In court papers, attorneys for Beverly complained that state officials were coercing the corporation to give up its constitutional right to a Nov. 3 hearing on the revocation actions, taking improper punitive actions against homes that had rectified patient care problems, and thwarting the chain's ability to do business in the state. A hearing on these issues is scheduled for Sept. 25.

At stake in the suit is the fate of the three existing homes as well as four homes recently purchased by Beverly and two homes the chain recently built. Beverly recently bought Summerfield Convalescent Hospital in Santa Rosa, Healdsburg Convalescent Hospital in Healdsburg, Ukiah Convalescent Hospital in Ukiah, and Palm Terrace Health Care Center in Laguna Hills. The corporation recently built Rancho Mirage Health Care Center in Rancho Mirage and another, apparently unnamed, facility in Ridgecrest.

Beverly officials assert that state officials should explain what the company must do to obtain licenses for its new facilities. But Hank Schoenlein, a regional official for the California of Dept. of Health Services, said the state has already addressed that issue. Regulators told the corporation it must comply with state health requirements if it expects to operate new enterprises.

"Everyone who applies to license a health facility in California is evaluated in terms of compliance with the laws and regulations of the state," Schoenlein said. "Issuing a license is not a routine matter. Considerable time and effort is being spent evaluating an application. Among other things, we look at the compliance record of applicants who have licenses at other facilities."

Beverly Corporate Vice President and General Counsel Bob Palmmerville said he was not certain "what the state was trying to do" in its recent actions involving his company. "We only know that they're not behaving in a proper manner when they try to force us into a settlement. We call this case our 'tying case,' because the state is attempting to tie issuance of license on activities unrelated to the nursing home. The state even denied our license for a home health agency."

As the dispute between the Beverly chain and the state continue, homes owned by the chain in California have received additional citations from the state health department.

In August, Beverly Manor of Santa Cruz was issued a $30,000 citation for allegedly failing to consult a doctor when an elderly woman with a history of breathing problems exhibited lung problems for more than four hours; she was transferred to an acute care hospital only at the insistence of her daughter, said state health officials. Hospital personnel found the woman had fluid in her lungs.

Also in August, Beverly of Los Altos was given a $30,000 citation involving the death of a 76-year-old heart patient who had lost 21.1 pounds in a 13-day stay at the home.

—Phyllis Gapen

Gapen is a free-lance writer living in Houston.

Nursing home is fined $5,000 over death

A San Jose, Calif., nursing home has become the fifth nursing home in the area to be fined by the state since July in incidents involving patient deaths.

Following an investigation by the state Dept. of Health Services, Bethany Convalescent Hospital was fined $5,000 for an incident involving a 69-year-old woman patient who fell out of bed and died two days later, the *San Jose Mercury News* reported.

State investigators said that the patient was admitted July 11, and that the nurse's notes from the first night recommended restraints because the woman tried to get out of bed. On July 12, a physician's order for postural restraints was obtained, but that night the woman was found by a nurse on the floor by the foot of the bed.

She was promptly moved to a hospital, where she was diagnosed with a broken hip and arm, but she died before treatment could be begun. The coroner's office attributed the death to arteriosclerosis, aggravated by the fall.

The state investigator's report asserted that there was "no evidence that the physician's order to use [postural] supports was implemented on the night of July 12-13."

The same home also was fined $10,000 recently as the result of a fall by another patient, a 72-year-old woman who broke her left hip. The woman told investigators that the nurse's aide who helped her up after she fell did not immediately report the fall and warned the woman not to tell anyone, lest the aide be fired.

PUBLIC OPINION MESSAGE

DEAR: SENATOR ABOOD

NAME: CAROLYN N. TURNER
TITLE:
ADDRESS: 120 KATLIAN ST.
CITY: SITKA, AK ZIP: 99835
PHONE: 747-6846
BILL NO: SCR 47
SUBJECT: OPERATION OF PIONEERS' HOMES
MESSAGE: I'M OPPOSED TO THE PRIVATE SECTOR RUNNING THE PIONEERS HOME. I SUPPORT THE STATES CURRENT PROGRAM. PLEASE DO NOT CHANGE THE PRESENT SYSTEM.

POMID: 12143335
DATE: 02/25/88
TIME: 14:33:35
LIONAME: SITKA LIO

COPIES:	REPRESENTATIVE	SENATORS
	GRUSSENDORF	ELIASON
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		JONES
		KERTTULA
		BINKLEY
		DUNCAN
		HALFORD
		ZHAROFF
		FAIKS

RECEIVED
FEB 29 1988

PUBLIC OPINION MESSAGE

DEAR: SENATOR ABOOD

NAME: EVERITT CALHOUN
TITLE:
ADDRESS: 120 KATLIAN ST.
CITY: SITKA, AK ZIP: 99835
PHONE: 747-6896
BILL NO: SCR 47
SUBJECT: OPERATION OF PIONEERS' HOMES
MESSAGE: I FAVOR SENATOR KERTTULA'S RESOLUTION. THE GOVERNOR CAN FIND OTHER WAYS TO ECONOMIZE THAN THE WELFARE OF THE ELDERLY. THE CARE NOW GIVEN IS SECOND TO NONE. KEEP IT THAT WAY. PRIVATE MANAGEMENT WOULD HAVE TO CUT CORNERS TO MAKE A PROFIT, AND THAT WOULD JEOPARDIZE THE WELFARE OF THE RESIDENTS. EVERITT CALHOUN, RESIDENT, SITKA PIONEER HOME

POMID: 12122107
DATE: 02/24/88
TIME: 12:21:07
LIONAME: SITKA LIO

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		KERTTULA
		BINKLEY
		DUNCAN
		HALFORD
		ZHAROFF
		FAIKS

RECEIVED
FEB 25 1988

PUBLIC OPINION MESSAGE

DEAR: SENATOR A0000

NAME: ORVILLE R. WHEAT
TITLE: SITKA PIONEERS HOME
ADDRESS: [redacted]
CITY: [redacted] ZIP: 99835
PHONE: N/R-
BILL NO: SCR 47
SUBJECT: [redacted]
MESSAGE: I ASK YOU TO SUPPORT SCR 47. TO CONTRACT OUT PIONEERS HOMES TO THE PRIVATE SECTOR WOULD LOWER OUR STANDARD OF LIVING.

POMID: 12151122
DATE: 02/23/88
TIME: 15:11:22
LIONAME: SITKA LIO

COPIES:

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GRUSSENDORF	ELIASON
	FANNING
	HENSLEY
	JOSEPHSON
	UEHLING

RECEIVED
FEB 25 1988

Joan Pope
Sitka Pioneers' Home
120 Katlian St.
Sitka, Alaska
99835

2/22/88

RECEIVED
FEB 25 1988

Senator Abood
Senate State Affairs Committee
Pouch V.
Juneau, Alaska 99811

Dear Senator Abood,

Please support Senator Kerttula's resolution SCR 47 relating to the Pioneers' Homes. I agree with this resolution as a resident of the Sitka Pioneers' Home. I am against the privatization of any Pioneers' Home.

Thank you,

Joan Pope

Sitka Alaska
Feb 22, 1988

RECEIVED
FEB 25 1988

Senator Mitch Abood
Juneau Alaska

Dear Chairman Abood.

I would like for you to use your Voting Power to help pass the SCR 47 that Senator Kerttula has recommend.

I am very much in favor of the way our administration is being carried on instead of Private contract.

I urge you to try & help our Pioneers I think they could be more happy with out the Private Contract

To keep our Jobs in Alaska Private Contractors usually comes from out of states.

Yours Truly

Mr. Mrs Ira Leon & Ofalm Roberts
120 Kallam St.
% Pioneer Home
Sitka Alaska
99835

RECEIVED
FEB 24 1988

2/21/88

Senator Mitch Abood
Chairman
Senate Affairs Committee
Pouch V,
Juneau, Alaska 99811

Dear Senator Abood:

Please support Senate Concurrent Resolution No 47. relating to the operation of the Pioneer Homes.

Alaska has earned a fine reputation in its treatment of its Pioneers that it would be most unfortunate to make a change in administration from the present status to the private sector. In other states where programs, similar to that of the Pioneer Homes, which have been established under the private sector the results have been far from satisfactory.

I will be grateful for your support.

Sincerely yours,

Helen Hartigan

RECEIVED
FEB 24 1988

ALBERT J. BROOKMAN, SR.
[illegible] ST.
SITKA, AK [illegible]

I

Senator Mitch Abood — Feb. 18, 1988
Chairman Senate State Affairs Comm.
Alaska State Senate, Juneau, Alaska
Reference to Senate Concurrent Res. #SCR47.

Dear Senator Abood :-

There was a lot of concern and indignation when the Residents of Sitka Pioneer's Home found out that the ~~Legislature~~ proposes to let the management of Juneau Pioneer's Home out on contract instead of being operated by the Dept. of Administration as all Pioneer's Homes have been operated since the first one was built.

We will be grateful to you and all the other State affairs committee members if you will reccomend a "do pass" ~~to Sen. Kertula's Senate Bill S.C.R. #47.~~

Sincerely,
Al Brookman Sr

2-22-88

Senator Fitch Abood Chairman
State Affairs Committee
Po Box √
Juneau Alaska. 99811

RECEIVED
FEB 24 1988

Dear Senator Abood,

I personally am asking you to urge passage of SCR 47. I am also asking as President of the Presidents Council at the Ketchikan Pioneers Home, on behalf of the residents.

We made a choice to come, to live here at Pioneer's Home because we could afford to live here And the level of care was known to be good. We are, as a group, afraid this may change if the State loses complete Control. Most of us in this home are over 70, a good Many past 88 and we are not able to make a change at this time in our lives. We Ask you to help prevent the administering of these homes going out of State Control.

Respectfully
Flora Nygard
President Ketchikan Pioneer Home
Resident Council