

### Table of Contents

[Buying and Selling Your HUD-Financed Long Term Care Project: Navigating the TPA Process](#)

Andrea Barach

[False Claims Act Developments for Providers](#)

Jason Edgcombe and Ted Lotchin

[Home and Community-Based Services: Seven Things You Need to Know](#)

Christy Tosh Crider, Danielle Trostorff, and Michael Shoptaw, Summer Associate

# Making a Difference

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## Beware! Long Term Care Class Actions are Coming

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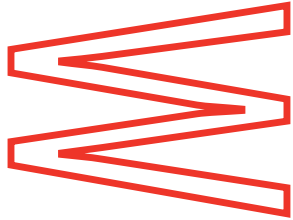
Long term care providers beware, class action suits are coming. Due to allegations of chronic understaffing, long term care providers are beginning to face massive class action lawsuits nationwide. The trend began in 2010, when Skilled Health Care settled a class action suit with more than 32,000 class members for around \$63 million. The settlement followed a jury award of \$671 million due to alleged chronic understaffing of 22 facilities. That got our attention.

Following suit, California plaintiff attorneys began filing class action suits under similar theories of chronic understaffing. Many of the California cases resulted in multi-million dollar settlements, something no long term care provider wants to face. For years this was a trend unique to California. However, times have changed. Class action chronic understaffing claims have begun to spread throughout the nation and have recently obtained a foothold in the South.

Less than a month ago, in *GGNSC Arkadelphia LLC v Lamb*, the Supreme Court of Arkansas certified a class action lawsuit against 12 nursing homes operated by Golden Living Centers in Arkansas. The certified class includes an astounding 3,400 past and present residents along with their family members. The plaintiffs allege that the practice of chronically understaffing the nursing homes breached the facilities' standard admission agreement, violated Arkansas' Long-Term Care Residents' Rights Act and violated Arkansas' Deceptive Trade Practices Act. Various officers, directors and administrators of Golden Living Centers were named in the suit in an individual capacity. There are two more similar class certifications pending in Arkansas.

The plaintiffs in *GGNSC Arkadelphia LLC v Lamb* and plaintiffs in California rely upon varying types of evidence to make their cases. Facilities' monthly staffing reports have been used to show a failure to meet state and federal minimum staffing requirements. Statements by employees, residents and residents' families that a facility has too few staff have been cited to support a finding of understaffing. Individual tales of residents soiling themselves, suffering repeated falls, being served cold food, etc., have been used by plaintiffs to paint a picture that all residents at a facility, or network of facilities, suffered through similar incidents. Inaccurate or missing chart entries have also been used to insinuate sub-par care. Plaintiffs argue that poor charting means that either a required task was not completed or an employee didn't have time to record it because the facility was understaffed. We have handled countless cases where plaintiffs have used imperfect charts to support their claims. Plaintiffs have argued, and some juries have agreed, that long term care providers pick "profits over people" by failing to staff a facility appropriately.

Continue on next page



## Table of Contents

[OSHA Concentrates its Health Care Facility Inspections on Key Areas, but Specific Requirements Remain Elusive](#)  
LeAnn Mynatt

[Time to Revisit Your Physician Relationships](#)  
Danielle Trostorff

[2015 Baker Donelson Long Term Care Webinar Series](#)

[In the Trenches](#)

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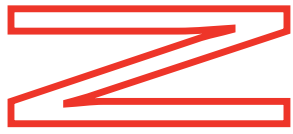
## Beware! Long Term Care Class Actions are Coming, *continued*

The evidence of understaffing has helped plaintiffs win compensatory damages, but it is punitive damages that keep long term care providers up at night. Punitive damages are often huge sums intended to deter an actor from engaging in the prohibited conduct. The Supreme Court of Appeals of West Virginia recently awarded a single wrongful death plaintiff \$32 million in punitive damages due to the facility's alleged chronic understaffing and pattern of much higher staffing ratios during state inspections. Those damages would be compounded in a class action lawsuit. Long term care providers should not wait until they are hit with a multi-million dollar lawsuit to take notice.

We have seen advertisements pop up in many jurisdictions seeking out plaintiffs who feel they have been "affected by understaffing." The potential exposure from these types of suits, particularly those of the class action variety, is massive. Long term care providers should take steps to prevent understaffing suits from occurring and be prepared to defend them if they arise. Here are a few tips:

- 1. Have a method to track that you are maintaining minimum staffing standards.** Ensure that each facility maintains the minimum staffing requirements, but be mindful that plaintiffs file suits even when minimums are met, with testimony that the basic needs of the residents were not being met. Plaintiffs build class actions by arguing that if there is not enough staff to meet one patient's needs, chances are several other patients are also not receiving adequate services. The minimum standards vary from state to state, so it is crucial your facilities know and adhere to state laws. Then, you must have a method to track those staffing patterns. That way you can identify and fix quickly any staffing issue.
- 2. Include an arbitration agreement in your admission packet.** Arbitration is an alternative to a jury trial where both parties agree to have a neutral third party decide their dispute rather than go through an extensive court proceeding. There is most often no right to appeal, so both parties get closure quickly with less cost. Arbitration agreements can also hinder class action lawsuits by removing members from the class or, in some cases, by blocking class certification entirely. Additionally, the U.S. Supreme Court has held that an arbitration agreement can include explicit provisions that forbid residents from joining a class or consolidated arbitration, further limiting providers' exposure. Enforceable arbitration clauses can significantly decrease exposure and litigation costs.
- 3. Train your staff on how to chart properly.** We have seen charting mistakes cost long term care providers millions of dollars. Plaintiffs will argue if it wasn't charted it didn't happen. Long term care providers should create clear charting guidelines and invest in training on proper charting. It is crucial to have professional charts that accurately reflect all the services provided to residents. This becomes critical when there is an injury or accident. If a jury hears an injury wasn't documented, they often assume the facility was trying to cover it up. Facility staff members are often very busy so it is understandable that they might hastily fill out a chart or forget to document some information. While understandable, it can be a costly mistake. The failure to do so can result in a lawsuit even in a case where a resident was well cared for.

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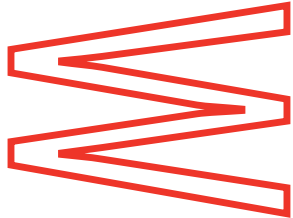
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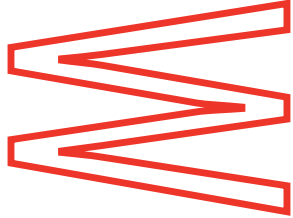
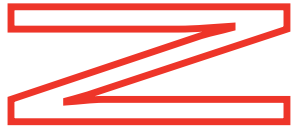
4. **Don't hire more staff on inspection days and for goodness sake don't send emails suggesting that.** Developing a pattern of hiring more staff for inspection days will imply to a judge and jury that every other day of the year you believe your facility is inadequately staffed. This is a bad inference to have. Everyone can understand wanting to put your best foot forward when being inspected. However, if you need more staff on inspection days to meet the state's standards, chances are you need more staff every other day of the year. Staffing records that reveal a pattern of only having higher standards on inspection days plays right into a plaintiff's argument that our facilities choose profits over people. And, whatever you do, don't send emails or distribute memos suggesting that practice.



5. **Respond to complaints regarding understaffing.** Residents and family members complain about understaffing for many reasons. Maybe a family member is having a bad day and wants to lash out. Maybe a resident forgot a nurse already stopped by twice that day. Or, maybe there is a legitimate issue with understaffing. It is important to document all complaints, investigate them thoroughly, and record the outcome. If the investigation reveals there was an issue with understaffing, fix it immediately. A lawsuit can go from manageable to disastrous if it is revealed a facility received several legitimate complaints about understaffing and did nothing to remedy the issue.

6. **Manage residents' and families' expectations about staffing levels.** Some lawsuits can be prevented by managing residents' and families' expectations. Many cases exist where family guilt is inappropriately directed towards caregivers. The reason for such guilt is unrealistic expectations. Long term care facilities do not provide a caregiver 24 hours a day for each resident. A good nursing home provides in the neighborhood of three hours of direct care to each resident each day. However, many families expect hospital-like care. Informing families and residents of the estimated hours the caregivers will and will not be with the resident is a good way to ensure everyone is on the same page about staffing.

7. **Don't advertise yourself as something you're not.** It is essential that you accurately advertise your services. In recent cases, plaintiffs have begun to allege deceptive trade practices. Long term care advertisements help set families' and residents' expectations. Claiming you can provide services you don't provide sets expectations too high, which will cause people to believe you are understaffed when you don't deliver the advertised services.



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## Buying and Selling Your HUD-Financed Long Term Care Project: Navigating the TPA Process

[Andrea Barach](#), 615.726.7321, [abarach@bakerdonelson.com](mailto:abarach@bakerdonelson.com)



So you have refinanced your long term care facility with Federal Housing Authority (FHA)-insured financing – a nonrecourse, 30-year (or longer) loan at an amazingly low fixed interest rate. Yes, the process may have been painful, but now you are enjoying that nice low debt service. So low, in fact, that your facility has never been more attractive in the marketplace. What’s next?

You recall that these loans are assumable, which is very unusual in the financing market today, and realize that you can sell your facility to a buyer who can assume your FHA-insured loan and free up equity for your next business adventure. In fact, the ability to pass along such a nice low interest loan may enhance the overall value you can receive in the sale.

Or, in the alternative, while your refinanced facility is doing well, perhaps you need to bring in a different management agent, or you are going through internal organizational changes with some principals departing and others joining your organization. You realize that you may need to go back to your FHA lender and HUD to get permission for your restructure, but may be a little unsure about the process.

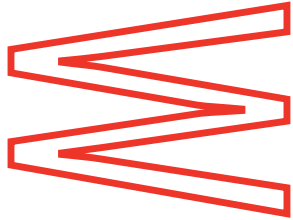
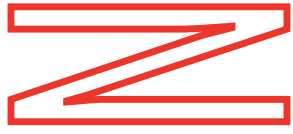
In yet another alternative, you realize that a sale-leaseback of your project to a REIT might be just the ticket to free up financial resources for the future. You would like to benefit from the value inherent in your low interest FHA-insured financing and you realize that the REIT could assume your existing great loan and those terms might support a higher valuation.

Any of these scenarios is possible by navigating the Transfer of Physical Assets (TPA) process, the HUD approval process for changes and assumptions of existing loans.

### What is a TPA?

- **Full TPA:** Transfer of title from the original borrower to a new entity – HUD underwrites the new borrower but not the project since it already has approved (and insured) the project as suitable for the 232 program in the initial closing.
- **Modified TPA:** Change of lessee, change of management agent, or change of controlling parties such as:
  - Transfer of more than 50 percent of a partnership (without causing partnership dissolution – if it is a dissolution, it is a Full TPA)
  - Addition or substitution of a managing, controlling or special member in an LLC

Continue on next page



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## Buying and Selling Your HUD-Financed Long Term Care Project: Navigating the TPA Process, *continued*

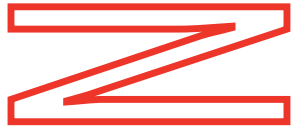
- Substitution of one or more general partners in a limited partnership (without causing partnership dissolution)
- Transfer of stock of the corporate general partner of a partnership where the transfer results in one owner of 50 percent of the stock, or the transfer results in change of control of the corporate general partner
- Transfer of stock in a corporate borrower which results in a change of more than 50 percent of the stock, or change in control of the borrower
- Transfer of beneficial interest in a passive trust that does not result in change in control of the property
- Change in control of the project's operating lessee or management agent
- Other transactions that result in changes of ownership in the second, third or even higher levels need to be reviewed with HUD to determine if the transaction requires a review.

A Full TPA will require a higher level of review than a Modified TPA. In any of these situations, however, you start the process by contacting your FHA lender that made the original loan and explaining the transaction.

### The Process

- Borrower contacts the FHA lender and starts the process. Some lenders require the deposit of a processing fee. Some lenders rely on the borrower and its counsel to prepare the bulk of the documents and assemble the packages, while other lenders will use their own counsel to a greater extent.
- Lender submits the application package to HUD, using a checklist with up to 45 items (not all will apply to any single transaction). Depending on the type of TPA, HUD collects a processing fee.
- HUD reviews the application. If either the loan or the project has been the focus of HUD concern on an ongoing basis, HUD is likely to use the TPA review process as a chance to correct outstanding issues and get the project back into compliance. HUD is particularly concerned if it sees what it deems "unworthy sellers" getting a big payday at a closing.
- HUD issues a Preliminary Approval Letter.
- Parties can close their transaction and have 45 working days to complete their transaction and submit copies of the final project documents, which must conform with the documents submitted in the initial application.
- HUD issues its Final Approval.

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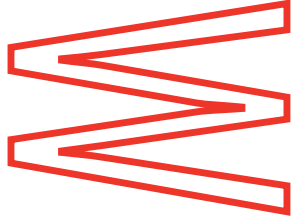
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## Buying and Selling Your HUD-Financed Long Term Care Project: Navigating the TPA Process, *continued*

### Ongoing Issues



- The new HUD Handbook requires that operating lessee be a single-purpose entity. This is a change from prior rules.
- If you have an operating lessee, it will need to execute the HUD operator documents on the new HUD forms, which impose a higher level of reporting requirements.
- Your contract for purchase needs to include a closing contingency for receipt of the Preliminary TPA approval before closing. It is very difficult to know how long to allow for the process. Unfortunately, TPA applications do not appear to enjoy a high priority with HUD and even some FHA lenders, perhaps due to the lower fees for TPA transactions as compared to new loans.
- Most purchase transactions will be for purchase prices that are larger, sometimes substantially larger, than the principal amount of the HUD-insured mortgage being assumed. At minimum, even if the project has not appreciated in value at all, there will be the same amount of equity that the seller provided when it closed its loan. More likely, the project will have increased in value and thus the amount of purchase price that the buyer must pay, above and beyond the amount of the HUD-insured mortgage being assumed, may be quite substantial. If the buyer wants to finance some of that additional purchase price with a note payable to the seller, the existing HUD rules about subordinate debt will apply, and those rules can be challenging to meet. It is important to recognize this issue at the front end while the deal is being structured by the parties, so that your closing is not delayed at the end when HUD objects to the form of seller financing.



In conclusion, TPA transactions are on the increase, and this trend will continue. If your transaction involves subordinate financing or seller financing, it is even more important to address these issues early, while your deal is being structured. In any event, if you can assemble an experienced team familiar with the TPA program requirements, the process will be easier overall, but the first ingredient for success is always a high level of patience and attention to detail.



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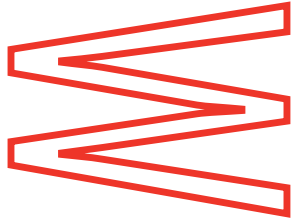
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## False Claims Act Developments for Providers

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[Ted Lotchin](#), 202.508.3490, [tlotchin@bakerdonelson.com](mailto:tlotchin@bakerdonelson.com)



In a pattern that has become all too familiar across the health care industry, fraud investigation and enforcement activity involving long term care providers continues to pick up steam:

- “Nursing Home Operator to Pay \$48 Million to Resolve Allegations That Six California Facilities Billed for Unnecessary Therapy”



- Therapy Provider “Agrees to Pay \$38 Million to Settle False Claims Act Allegations Relating to the Provision of Substandard Nursing Care and Medically Unnecessary Rehabilitation Therapy”

- “Florida Skilled Nursing Facility Agrees to Pay \$17 Million to Resolve False Claims Act Allegations”

Although the allegations behind each settlement may differ, these cases all demonstrate the government’s continued reliance on the Federal False Claims Act (FCA) to pursue claims of fraud and abuse against federal health care programs (FHCPS). From its humble beginnings as a means to protect the Union Army from unscrupulous defense contractors during the Civil War, the FCA has grown into a multi-billion dollar growth industry for both government enforcement agencies and private “qui tam” plaintiffs. Nowhere is this trend more evident than in the LTC industry.

Click [here](#) to read “False Claims Act Developments for Providers” in its entirety on McKnight’s.

*Ted Lotchin and Jason Edgecombe are featured guest columnists for McKnight’s for a four-part article series on the False Claims Act running June – September.*

## Home and Community-Based Services: Seven Things You Need to Know

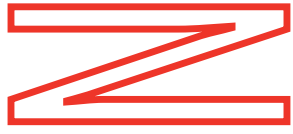
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Michael Shoptaw, Summer Associate

Few people have a strong understanding of home and community-based services (HCBS), how they work, how they came about and why they are important. There are a number of reasons why HCBS experts are few and far between. Put simply, administration of HCBS and its relation to Medicaid or Medicaid waiver funding is a convoluted area of the law. This article wades through the muddy waters in an attempt to explain some of the finer points of HCBS. Though just the tip of the iceberg, these are the seven things you need to know about HCBS.

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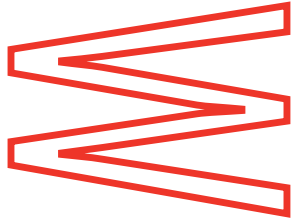
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## Home and Community-Based Services: Seven Things You Need to Know, *continued*



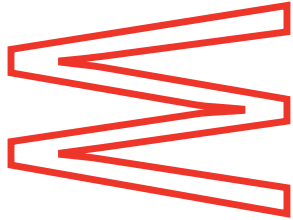
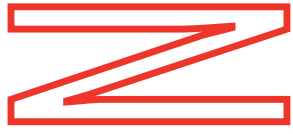
1. **HCBS serve a broad range of individuals with varying needs.** The HCBS programs target three groups – individuals who are aged and disabled or both, individuals with intellectual disabilities or developmental disabilities or both, and individuals with mental illnesses. HCBS programs allow individuals within these three target populations to receive a mix of services in their own home or community rather than in the traditional, institutional setting. Some of the services that HCBS individuals are able to receive are case management; habilitation which may include certain pre-vocational, supportive employment and certain special educational services; personal care and respite services; adult day care and adult day health services; day treatment or other partial hospitalization services; psychosocial rehabilitation services and clinic services for individuals with chronic mental illness; home delivered meals; home health aides; and homemaker services. Respiratory care is also a service available for ventilator-dependent individuals. States also have the option to provide other services approved by the Centers for Medicare & Medicaid Services (CMS) which are “effective and necessary to avoid institutionalization.”



2. **HCBS programs operate under one of three Medicaid or Medicaid waiver options.** There are three Medicaid authorities for HCBS: the 1915(c) HCBS Medicaid waiver program; the 1915(i) State Plan HCBS benefit option; and the 1915(k) Community First Choice (CFC) HCBS State Plan benefit option. The HCBS Medicaid waiver program became an option to State Medicaid agencies in 1983 when Congress approved section 1915(c) to the Social Security Act (SSA). This amendment to the SSA gave states the option to receive a waiver of Medicaid rules governing institutional care, and opened the door for individuals to receive treatment in the comfort of their own homes under the umbrella of Medicaid coverage. Today, [section 1915\(c\) waivers](#) are the largest Medicaid HCBS-related expenditures, with 47 states and the District of Columbia each operating at least one 1915(c) waiver. The section 1915(i) HCBS State Plan benefit option was added by Section 6086 of the Deficit Reduction Act of 2005 (DRA). The Affordable Care Act added the HCBS 1915(k) Community First Choice (CFC) State Plan benefit option and made amendments to the requirements defining and describing the State Plan Section 1915(i) HCBS benefit option.

3. **There is a trend away from institutional care and to HCBS.** Not surprisingly, many individuals need and want to receive care in the comfort of their own home or community rather than in an institutional setting. Enrollment in HCBS programs is growing, resulting in an increase in HCBS-related Medicaid expenditures. In 2002, HCBS accounted for 32 percent of Medicaid Long Term Services and Supports (LTSS) expenditures, totaling \$25.1 billion. By 2011, that figure had grown to 45 percent, totaling \$55.4 billion. This [HCBS growth](#) necessarily resulted in a 13 percent reduction in Medicaid LTSS expenditures on institution-based services over the same time, and growth in HCBS enrollment and expenditures does not appear to be slowing down soon.





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## Home and Community-Based Services: Seven Things You Need to Know, *continued*

### 4. HCBS are guided by the Americans with Disabilities Act (ADA) and the *Olmstead* decision.

Inclusion is the overarching theme behind the administration of HCBS, as evidenced by the adoption of the ADA in 1990 and subsequent Supreme Court decision in *Olmstead v. L.C.* in 1999. In passing the ADA, the federal government barred discrimination on the basis of disability in public services provided by state and local governments and by private entities. Nine years later in *Olmstead*, the Supreme Court held that “under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated.” In reaching its holding, the Supreme Court illuminated the exclusion concerns found in the ADA, dictating that “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” Furthermore, “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”

5. **The Centers for Medicare and Medicaid Services (CMS) recently changed the requirements of HCBS programs.** In 2014, CMS issued a final rule which, among other things, amended certain of the 1915(i) requirements and revised certain of the 1915(c) regulation requirements including providing States the option to combine target populations within one 1915(c) waiver, established requirements to enhance the quality of HCBS, included changes to the requirements for person-centered plans and processes, provided additional protections to participants and established what constitutes a home and community-based setting. The final rule requires CFCs to comply with the [HCBS setting requirements](#). All home and community-based settings must meet the following qualifications: “the setting is integrated in and supports full access to the greater community; is selected by the individual from among setting options; ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint; optimizes autonomy and independence in making life choices; and facilitates choice regarding services and who provides them; provides opportunities to seek employment and work in competitive integrated settings, and ensures the individual receives services in the community to the same degree of access as an individual not receiving HCBS.” In regard to provider-owned or controlled home and community-based residential settings, the requirements include: “the individual has a lease or other legally enforceable agreement providing similar protections; the individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit; the individual controls his/her own schedule including access to food at any time; the individual can have visitors at any time; and the setting is physically accessible to the individual.” In order to receive future Medicaid reimbursements for the administration of HCBS, States must align their existing and future HCBS programs with the final rule. CMS has required States to submit Transition Plans detailing how and when they expect to bring their 1915(c) HCBS waiver programs and 1915(i) HCBS State Plan benefit option into compliance with the final rule and modify service rates.



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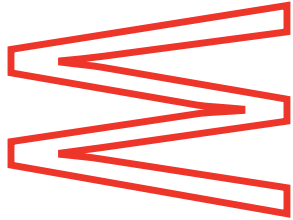
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## Home and Community-Based Services: Seven Things You Need to Know, *continued*



6. The Affordable Care Act (ACA) introduced a new State Plan Benefit option and the Innovation Center to encourage alternative payment and service delivery models while improving quality and outcomes. The ACA established the Community First Choice (CFC) State Plan benefit option to provide home- and community-based attendant care and personal care services and supports to individuals with disabilities and chronic conditions in conjunction with existing State plans. CFC gives States a six-percentage point increase in federal matching payments for service expenditures under [this option](#). The CMS final HCBS rule published last year also requires CFC to comply with the HCBS setting requirements. The ACA also created the Innovation Center, a body charged with creating and testing new payment and service delivery models that reduce HCBS expenditures without detracting from the quality of services. [CMS projects](#) that by the end of the fiscal year 2015, the cumulative obligations of the Innovation Center will approach \$5 billion, further highlighting the growing importance of HCBS and the need to discover cost-saving measures. The CMS final HCBS rule provides a five year approval and renewal period for certain of these Medicaid waivers and demonstration projects that serve dually eligible Medicare and Medicaid individuals.



7. The Medicaid expansion debate is incredibly important to the future of HCBS. States are finding it difficult to meet the growing demand for HCBS. While States do have separately-funded HCBS programs, Medicaid remains the primary payer for LTSS in the United States. The State Medicaid expansion option offered under the ACA could become an increasingly attractive option for States looking to supplement their LTSS programs. As qualified individuals remain on waiting lists for HCBS, States continue to juggle policy implications connected to Medicaid expansion. HCBS remain in limbo in many States, and there is no doubting that States accepting Medicaid expansion will see their already-growing HCBS enrollment continue to surge.

## OSHA Concentrates its Health Care Facility Inspections on Key Areas, but Specific Requirements Remain Elusive

[LeAnn Mynatt](#), 865.549.7206, [lmynatt@bakerdonelson.com](mailto:lmynatt@bakerdonelson.com)

On June 25, the U.S. Department of Labor’s Occupational Safety and Health Administration (OSHA) issued a [press release](#) outlining its focus areas for health care facility inspections. Musculoskeletal disorders (MSDs), blood-borne pathogens (BBPs), workplace violence, tuberculosis, and slips, trips and falls will be evaluated on *all* inspections of health care facilities. OSHA programs administered by states are required to follow suit. What’s hard to discern is what exactly is *changing* from current OSHA protocol.

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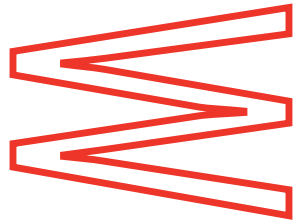
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## OSHA Concentrates its Health Care Facility Inspections on Key Areas, but Specific Requirements Remain Elusive, *continued*

In its [Inspection Guidance for Inpatient Healthcare Settings](#), OSHA reports that during a three-year period from 2012 to 2015, it conducted 1,100 inspections of nursing and residential care facilities, and issued 11 citations using its General Duty Clause provision related to MSD issues. OSHA addressed this issue in a [Self Assessment for Safe Patient Handling](#). Like MSDs, BBP is already a well-recognized hazard by the health care industry, and one of the most frequently issued citations. In its memo, OSHA directs its inspectors to evaluate compliance against the [Department of Health and Human Service’s guidance](#) for preventing the transmission of tuberculosis in health care settings, dated 2005. OSHA previously addressed workplace violence in the health care setting in its [Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers](#).



But, what is your facility *required* to do to comply with OSHA’s increased emphasis? Unfortunately, there’s no definitive answer. The links provided in this alert provide insight for the health care compliance specialist into what an inspector will be looking for, but may not provide definitive guidance on how to avoid a citation. OSHA’s press release appears to be more of the same, beating the drum to encourage companies to focus more attention on these common health care industry hazards.



## Time to Revisit Your Physician Relationships

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On June 9, 2015, the Department of Health and Human Services, Office of Inspector General issued a new Fraud Alert entitled “Physician Compensation Arrangements May Result in Significant Liability” (Alert) in the wake of 12 False Claims Act settlements involving physician compensation and medical director contracts.

On its tail, on June 16, 2015, the Department of Justice announced the largest False Claims Act settlement against a nursing home, *United States ex rel. Beaujon v. Hebrew Homes Health Network, Inc.*, et al., Case No. 12-20951 CIV (S.D. Fla.). The suit was brought by a whistleblower, the former CFO of a Miami nursing home which paid a record \$17 million to settle a case alleging a kickback scheme. The nursing home allegedly contracted with multiple medical directors, paying them thousands of dollars per month for phantom, undocumented services in return for referrals. The nursing home entered into a Corporate Integrity Agreement and agreed to alter its physician contracting policies.

This is a wake-up call for the health care industry. Even if one purpose of an agreement is to pay for referrals, it may run afoul of the anti-kickback statute and could lead to criminal and civil action under the False Claims Act, civil monetary penalties and exclusion from the Medicare and Medicaid programs.

*Continue on next page*



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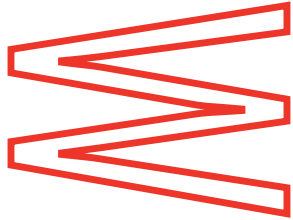


## Time to Revisit Your Physician Relationships, *continued*

This was also reminiscent of yet another case prosecuted in 2013 where a contracted physician medical director of a hospice, Eugene Goldman, was sentenced to 51 months in prison and excluded from participation in any federal health care program for conspiring to violate the anti-kickback law. The allegations were that the medical director contract gave the false impression that services were being rendered when in fact the majority of payments were for referrals.

The lessons learned include:

- Continue to be vigilant in your compliance efforts.
- Scrutinize physician contracts.
- Require job descriptions and duties.
- Require documentation of services rendered.
- Do not duplicate services.
- Routinely police the fair market value of services.



\* This schedule is subject to change.

## Join Us For Our Monthly Long Term Care Webinar Series\*

- 8.11.2015:** Are You Ready? What to Expect During an OCR HIPAA Investigation or Audit presented by [Gina Greenwood](#)
- 9.15.2015:** Ten Hot Topics in Labor and Employment presented by [Rusty Gray](#) and [Jenna Bedsole](#)
- 10.13.2015:** Disasters and Public Health Emergencies – Planning and Preparing for New and Emerging Risks presented by [Ted Lotchin](#) and [Jason Edgecombe](#)
- 11.10.2015:** Proper and Improper Use of Background Checks and Arrest Records presented by [Angie Davis](#)
- 12.15.2015:** Fraud and Abuse Compliance Program 101: Do You Have a Plan? presented by [Gina Greenwood](#)

To receive information about the webinar series or to register, email [rsvp@bakerdonelson.com](mailto:rsvp@bakerdonelson.com).



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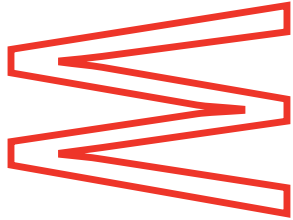
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## In the Trenches

[Rich Faulkner](#) will be featured in the webinar “Buying and Selling Long Term Care Facilities: Overcoming Complex Regulatory and Business Challenges” on Wednesday, August 26, 2015, 1:00 p.m. – 2:30 p.m. Eastern. To register, [click here](#) or call 1.800.926.7926 (ext. 10) and mention code “ZDFCT.”



Join [Christy Tosh Crider](#) at the 2015 Tennessee Health Care Association Annual Convention on Sunday, August 30, 3:00 – 4:00 p.m., for the panel program, “Responding to Unusual Events in Your Facility.” Fellow panelists include Nick Lamkin with Diversicare Healthcare Services and Kelly Thomas with Tennessee Health Management, Inc. The panel discussion will offer tips on how to investigate an unusual event, conduct interviews and develop an action plan. It will also address how to handle internal/ external communications, from talking to family members and the media to reporting up the chain of command.



[Christy Crider](#) was named to *Nashville Medical News* [2015 “Women to Watch.”](#)

[La’Verne Edney](#) was elected to the [American Board of Trial Advocates and to the National Black Lawyers – Top 100.](#)

[Caldwell Collins](#) received Baker Donelson’s [Work-Life Warrior Award.](#)

[Timothy M. Lupinacci](#) was inducted as a [Fellow of the American College of Bankruptcy.](#)

[J. Lane Crowder](#) joins [Baker Donelson’s Financial Services Transactions Group](#) as an attorney in the Chattanooga office. She represents banks and other financial institutions in HUD-insured loan transactions for multifamily and senior housing facilities.

[Quinn Carlson](#) and [Craig Conley](#) successfully represented a long term care facility in a three-day jury trial in June in Shelby County, Tennessee. The plaintiff was a nursing home resident who experienced a fall on a transportation van while being transferred from her wheelchair to a seat in the van. Through testimony from various witnesses, the defense team established that the Certified Nursing Assistant accompanying the plaintiff during the transport was not involved in the transfer despite the van driver’s testimony to the contrary. The jury awarded the plaintiff \$20,000 but allocated only 10 percent (\$2,000) of fault against the facility with the remaining 90 percent to the transportation company, which had settled with the plaintiff well in advance of trial.

[Claude Czaja](#), [Andrea Barach](#), [Rich Faulkner](#), [Kerry Henson](#), [Amy Mahone](#) and [Philip Whitaker](#) represented an owner/operator of senior living communities and a nursing and personal care company in an acquisition and related capital investment in a former county-owned nursing home in Tennessee. The nursing and personal care company became the tenant/operator while the owner/operator of senior living communities acquired the real estate.

[Amy Mahone](#), with assistance from [Rich Faulkner](#), represented an investment company in acquiring land for the construction of a new assisted living facility in Chattanooga.



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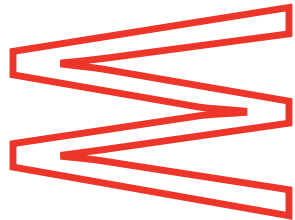
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## In the Trenches, *continued*

[Claude Czaja](#), [Rich Faulkner](#), [Tim Lupinacci](#), [Michaela Poizner](#) and [Philip Whitaker](#) represented an owner/operator of senior living communities in the successful eviction and assumption of operations of a highly-distressed nursing home located in Iowa. In a related transaction, the Firm represented the owner/operator of senior living communities in the acquisition and foreclosure of the former operator's accounts receivable note.



[Amy Mahone](#), with assistance from [Ken Beckman](#), [Christy Crider](#), [Rich Faulkner](#), [Tim Lupinacci](#), [Michaela Poizner](#) and [Clinton Sanko](#), assisted a health care provider in assuming the operation of eight skilled nursing facilities (SNFs) located in Arkansas. In addition, in October 2014, the Firm represented affiliates of the client in the consolidation of ownership in the company into its primary key principal. The client was glowing in its praise for Amy Mahone for helping them grow their skilled nursing portfolio from two facilities to 16 facilities in two years.



[Jim Levine](#), [John McGehee](#) and [Ross Schram](#) advised one of the nation's leading providers of FHA multifamily, affordable and health care financing in the March 2015 closing of a \$5.76 million loan for additions and upgrades to two facilities in Maryland. The loan was obtained through the U.S. Department of Housing and Urban Development's Section 241(a) program, which allows for secondary financing for the purpose of upgrading furnishings and/or for complete renovations and additions, in order to help meet demand in the local market. The loan allowed the owner to expand the property and add a new wing that will include 12 private skilled nursing rooms, a new dining room and 23 private assisted living rooms.

Baker Donelson recently closed the first three of a four-part corporate refinancing and loan consolidation transaction on behalf of a commercial lender and a financial institution in favor of a nursing home provider. The initial closing on April 15 involved a mortgage term loan, a non-HUD revolver and a cash flow loan totaling \$43.5 million with \$28.1 million in accordion features, all of which were cross-guaranteed and cross-collateralized. The parties are currently working to submit a package to HUD for the fourth loan, a HUD Revolver, valued at \$7.6 million with a \$1.9 million accordion feature. With 59 facilities, 54 borrowers, 51 leases and subleases, and 43 unaffiliated landlords, the deal boasted a 67-page execution document list and raised numerous and highly complex/nuanced lending questions, including those related to intercreditors, borrowing base eligibility and other health care principles. Commencing in February, the team consisted of [Evan Clark](#), [Austin Fleishour](#), [Casey Miley](#), [Elizabeth Sauer](#), [Teresa Beardsley](#), [Ken Beckman](#), [Kerry Henson](#), [Mary O'Kelley](#), [Jim Levine](#), [Mary Aronov](#), [Rich Faulkner](#), [Nelwyn Inman](#), [Lynn Landau](#) and [Michaela Poizner](#).

The Firm advised the mortgage lending entity of a comprehensive capital provider in the completion of an \$11.4 million HUD-insurance refinancing of a balance sheet bridge loan to complete two acquisitions for an owner/operator of senior living communities in Florida. With the Firm's assistance, the client was able to close the transaction in under 60 days, and was also able to provide financing for the full amount of the purchase option. The Firm also advised the client on the original balance sheet bridge loan. The Baker Donelson team assisting in the bridge and HUD loans included [Andrea Barach](#), [Rich Faulkner](#), [Marty Hartley](#), [Jim Levine](#), [Mary O'Kelley](#), [Ross Schram](#) and [Lynne White](#).

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