Report on Investigation of Grand Rapids Home for Veterans

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I. Executive Summary

On February 23, 2016, Attorney General Bill Schuette, through his Health Care Fraud Division (HCFD), initiated his investigation into possible criminal conduct at the Grand Rapids Home for Veterans (GRHV). Schuette announced the investigation on May 25, 2016, and invited information from the public regarding the GRHV, resulting in dozens of calls expressing concerns and complaints, all of which were investigated.

The Health Care Fraud Division has completed the investigation of complaints against the GRHV. Schuette's comprehensive investigation was conducted over 13 months and included interviews of over 60 individuals, collection and review of over 1,000 pages of documents, and collaboration with the Michigan Office of the Auditor General (OAG), the GRHV, the Grand Rapids Police Department, the United States Department of Veterans Affairs (VA), and the Michigan State Budget Office's Office of Performance and Transformation and Internal Audit Services. Internal Audit Services investigated the GRHV's finances and reportedly found no evidence of malfeasance.

Schuette's investigation focused on concerns raised at legislative hearings, issues identified by the OAG and other agencies, and complaints reported directly to the Attorney General.

As a result of the investigation, felony charges have been filed against 11 care providers who worked at GRHV. Individuals charged include:

- Eric Anderson
- Jasmine Ferrer
- Cary Gerencer
- Sheryl Hillyer
- Lolitta Jackson
- Emina Kahriman
- Michelle Longmire
- Doris Penny
- Roconda Singleton
- Sequoyah Thomas
- Tyisha Toliver

Each of these defendants are alleged to have violated MCL 750.492a (falsifying medical record) when they falsely documented the completion of patient safety checks that were never actually performed.[1]

[1] A criminal charge is merely an allegation. Each of these defendants is presumed innocent until and unless proven guilty in court.

The OAG performed an audit of the GRHV that covered October 1, 2013 through August 31, 2015. The results of the audit were published on February 19, 2016. Residents of the GRHV, known as "members," include veterans and eligible spouses of veterans. The OAG's audit was performed in part to "assess the sufficiency of the Home's provision of member services," and found that the home was "not sufficient" in that regard. The audit resulted in the following "material condition" findings:

- Although staff members documented performing 100 percent of member room checks and 96 percent of fall alarm[2] checks on multiple sampled dates, video surveillance showed that only 43 percent of room checks and 33 percent of fall alarm checks were actually performed.
- Third-party, private staffing contractor J2S did not meet the home's staffing needs 81 percent of the time during four sampled months. Staffing shortages were as high as 22 staff per given day.
- The home did not properly administer nonnarcotic pharmaceuticals prescribed to members, causing insurance reimbursement inefficiencies and potential quality of care issues.
- The home did not establish adequate controls over nonnarcotic pharmaceuticals to ensure that they were properly accounted for and protected against loss and misuse.
- The home did not track, properly investigate, or respond to member complaints, including allegations of abuse and neglect.

In addition to the above material conditions, the OAG found four "reportable conditions" concerning development and implementation of member comprehensive care plans, billing of insurance companies for prescription medications, and collection of member assessments and disbursement of members' funds.

Following the OAG's audit, the Michigan Legislature held several public hearings regarding conditions, complaints, and remedial actions at the GRHV. Those hearings included testimony from a variety of individuals, including home administrators and staff and also friends and family of members.

[2] Fall alarms are mechanisms that alert staff that a vulnerable resident is out of bed and potentially at risk for falling.

II. The Grand Rapids Home for Veterans

The GRHV is one of two Michigan veterans' homes. The other is the D.J. Jacobetti Home for Veterans in Marquette. The homes provide domiciliary care and skilled nursing care for patients with post-traumatic stress, dementia and other chronic conditions, and care for those in need of end-of-life support.

Like many such homes in other states, the GRHV was founded as an "old soldiers' home" in the wake of the Civil War, in 1885, and predates the establishment of the VA by 45 years.

As of April 30, 2016, the GRHV had 450 nursing care beds and 100 domiciliary beds, with a census of 366 and 42 in each type of bed, respectively. In contrast, the Jacobetti home had a total census of 180 around the same time. Veterans and their families at the GRHV represent service in major conflicts as follows: 51 percent served in the Vietnam War; 12 percent served in World War II; 17 percent served in the Korean War; 17 percent served in the Cold War-era; and 3 percent served in the Gulf War.

According to the OAG, the GRHV expended $49.1 million in fiscal year 2015, with $14.5 million from state funding, $19.5 million from federal funding, and $15.1 million from member assessments and private donations. The Jacobetti home expended a total of $21.8 million in the same year.

Until recently, the two homes composed the Michigan Veteran Health System within the Michigan Veterans Affairs Agency (MVAA). Legislation signed by Governor Snyder on January 11, 2017 created the Michigan Veterans Facility Authority, a semi-autonomous agency within the Michigan Department of Military and Veterans Affairs, to oversee, improve, and expand residential facilities for veterans in Michigan.

III. GRHV Oversight

Until state legislation reorganizing state veterans' homes became effective on January 11, 2017, the homes were exclusively certified and audited by the U.S. Department of Veterans Affairs (VA), which conducted comprehensive annual "surveys," of the state-managed veterans' homes. Federal funding of state homes like the GRHV is contingent upon VA approval, pursuant to its annual surveys.

The VA's surveys of the GRHV from 2013 through 2016, as well as the Michigan OAG's performance audits of the home from 2013 and 2016, can be found online (at www.michiganveterans.com) under Veterans Homes–Administration and Public Documents–Grand Rapids Home for Veterans Public Documents.

IV. Role of the Attorney General

Attorney General Schuette's Health Care Fraud Division investigates and prosecutes criminal financial abuse and physical abuse and neglect of residents of board and care facilities[3] in Michigan. The Department of Attorney General does not provide regulatory oversight of these facilities, nor does the Attorney General have authority to make policy or staffing decisions regarding such facilities.

V. Michigan Protections for Vulnerable Veterans

Michigan law criminalizes reckless or intentional physical abuse and neglect of nursing home residents and vulnerable adults. The law defines vulnerable adults as persons 18 years of age or older who, because of their age or an illness or disability, lack the ability to live independently.

In order to successfully prosecute a charge of vulnerable adult abuse, the prosecution must prove beyond a reasonable doubt all of the following: that (1) the defendant's reckless or intentional act or failure to act (2) caused physical injury (3) to a person the defendant knew or should have known was a vulnerable adult.

[3] "Board and care facility" is defined as "a residential setting which received payment [from Medicaid] from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided: (i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant. (ii) A substantial amount of personal care services that assist residents with the activities of daily living...." 42 U.S.C. 1396b(q)(4)(B).

The applicable Michigan statute defines "reckless act or reckless failure to act" as "conduct that demonstrates a deliberate disregard of the likelihood that the natural tendency of the act or failure to act is to cause physical harm, serious physical harm, or serious mental harm." MCL 750.145m(p).

A lack of sufficient evidence as to any of those elements of a charge of vulnerable adult abuse will preclude prosecution and conviction.

Accordingly, the Attorney General's investigation of the GRHV was conducted for the purpose of determining whether sufficient evidence existed to warrant criminal charges for abuse of members of the home.

Michigan law also criminalizes embezzlement of money or property from vulnerable adults.

Depending upon the culpability of a suspect's conduct and the severity of injury, or the value of money or property embezzled, charges of physical and financial abuse involving vulnerable adults can be misdemeanors with potential jail time, or felonies that carry maximum potential sentences of up to 20 years in prison, and also fines.

VI. Summary of Complaints

Most of the complaints Attorney General Schuette investigated alleged abuse and neglect of veterans who lived in the GRHV.

Schuette solicited reports of neglect and abuse from the public and investigated over 35 complaints of mistreatment of members. At the outset of Schuette's investigation, five reported incidents were particularly concerning.

Thorough investigation of each of those complaints did not reveal sufficient evidence to support criminal charges at this time. The incidents were often not reported to the Attorney General by the injured members or eyewitnesses, but rather by third parties who were not witnesses or family members of the veterans involved.

When and if the veterans, eyewitnesses, and family members could be identified and interviewed, their accounts often did not match the allegations as originally reported to the AG, and did not support prosecution.

Two of the incidents had been investigated contemporaneously by Kent County authorities (identified below), who also declined to file charges. The AG's investigations of the five incidents are detailed below.

Member #1

Member #1 was allegedly left unattended in a courtyard and later found deceased. According to testimony by a concerned citizen at the legislative hearings, Member #1 was found "freezing outside…in a puddle of urine" with his wheelchair tipped over.[4]

Attorney General investigators interviewed Member #1's spouse, who reported that it was her understanding that her husband was outside smoking when his wheelchair tipped over and he experienced cardiac arrest and died. Although Member #1's spouse regarded his death as "suspicious," she did not elaborate upon her concerns.

Investigators also interviewed Member #1's sister, who confirmed that he died at the home during the summer, in late June of 2015. Member #1's sister said that she visited him weekly. She said that after she learned of her brother's death, she went to the home and spoke with several people regarding the circumstances of his death, including another member who said that he was with Member #1 at the time he died.

The other member reportedly said that very early in the morning (around 2:00 a.m.), he and Member #1 exited the home through a door that locked behind them to go outdoors and smoke, which they were free to do. The GRHV does not allow smoking indoors, but provides an outdoor smoking area available 24 hours a day. Member #1 and the other member did not go to the outdoor smoking area. The other member reportedly said that Member #1 tipped over in his wheelchair, and the other member was unable to assist Member #1, and also unable for several minutes to re-enter the home to get help. By the time the other member was able to obtain assistance, Member #1 had died.

The GRHV's records indicate that less than a month before he died, Member #1's medical diagnoses included congestive heart failure, chronic obstructive pulmonary disease, endstage renal disease requiring dialysis, aortic stenosis, bilateral lower leg amputations, and anemia. The death certificate states that Member #1 expired due to "cardiovascular disease."

The other member who allegedly was present when Member #1 died also passed away before Attorney General investigators interviewed him.

The home's incident report pertaining to Member #1's death indicates that the incident was "unobserved." The report states that Member #1 was "found by security outside the exit by the administrator's office," seated in his wheelchair and "hanging slumped forward," with the wheelchair's left front wheel off the sidewalk.

First responders were called, but member #1 reportedly was unresponsive at that time, in cardiac and respiratory arrest, and resuscitation efforts were not successful.

The incident report further states that Member #1 apparently exited the door by the administrator's office to smoke outside. He then called inside from his cell phone to report that he needed help, but did not state his location. Member #1 was located about 10 minutes later.

Member #1's wife was notified of his death within 45 minutes, according to the report.

Further documentation in Member #1's medical chart indicates that an autopsy was not performed, but the physician and medical examiner who reviewed the case concluded that Member #1 died due to a "cardiac event" related to his medical conditions and not as a result of being stuck in his wheelchair.

Despite the initial allegations from the legislative hearing testimony that Member #1 was left unattended outdoors in cold weather for a prolonged period of time, tipped over in his wheelchair and soiled with urine, the evidence obtained through investigation did not match those allegations.

Contrary to the suggestion that Member #1 died as a result of prolonged exposure to the elements under demeaning and dangerous circumstances, the evidence indicates that Member #1 died of cardiac arrest after going outdoors to smoke during the summer, and was found deceased by home staff shortly after calling for help.

It is unknown whether Member #1's cardiac event occurred before or after his wheelchair tipped over.

The totality of the evidence indicates that Member #1 died quickly and the fact that he was outdoors, where he was free to be, was not a factor.

At this time, there is insufficient evidence to establish a criminal act related to the death of Member #1.

[4] A video of legislative testimony given on March 10, 2016, can be found on the Michigan House of Representatives website. (www.house.mi.gov/MHRPublic/videoarchive.aspx)

Member #2

Member #2 had been deemed a fall risk, and for that reason often received one-to-one supervision from a staff member.

On August 23, 2015, Member #2 fell from his bed. According to the home's incident report, the fall was not observed.

After the fall, Member #2 was noted to be bleeding from his nose and complaining of knee pain, and was sent by ambulance to a local hospital emergency department.

The incident report further states that Member #2 was at risk for falls due to confusion and poor decision-making abilities, which had prompted an order for one-to-one care. However, at the time of his fall on August 23, Member #2 was not receiving such care.

Attorney General investigators interviewed GRHV Director of Nursing Paula Bixler and Nursing Supervisor Bette Barker, who was supervising the second shift on the day Member #2 fell.

Ms. Bixler said that per written GRHV policy, nursing supervisors like Ms. Barker had discretion to reassess one-to-one member care orders if a member had gone a long time without falling or was exhibiting improved balance, standing, or ability to reason. Both Ms. Bixler and Ms. Barker said that per the home's policy, staffing considerations also determined whether members received one-to-one care—if a shift or unit was short-staffed, the nursing supervisor had discretion to discontinue one-to-one care for certain members.

Neither witness could state with certainty the reason why Member #2 was not receiving such care at the time he fell, but Ms. Barker stated that she probably rescinded the order for one-to-one care for Member #2 during the second nursing shift on the day Member #2 fell, based upon the factors mentioned above. The member then fell during the third nursing shift.

Thus, the available evidence falls short of establishing that Member #2 was under an order for one-to-one care at the time he fell. A decision to temporarily discontinue such care was available and could have been made pursuant to a written GRHV policy.

While discontinuing necessary care for members based in part upon staffing shortages could be regarded as a substandard institutional practice, the evidence to date concerning the circumstances of this incident is not sufficient to prove beyond a reasonable doubt that Member #2's injuries were caused by intentional or reckless acts.

Member #3

Member #3 sustained a knee injury during transportation in a shower chair. Member #3 reported that he was being transported to the shower by a resident care aide, and the chair was too low, causing his feet to drag uncomfortably on the floor.

When Member #3 asked the aide to raise the chair, the aide indicated that he did not speak English and did not understand. Member #3 further stated that during the transport, his knee struck a door jamb. However, when interviewed by Attorney General investigators, Member #3 denied any apparent injury to his knee immediately following the incident, and also denied pain when using the knee immediately after the incident. It was later brought to his attention that the knee was bruised and swollen. Member #3 was taken to a hospital where x-rays revealed a leg fracture.

Member #3 commented that he did not believe the aide intentionally caused the injury. Rather, Member #3 attributed the injury to the aide's inability to understand English and poor job training.

The home's incident report also attributed the incident to lack of training. Specifically, the aide involved, who was a contract employee, had not been trained on how to properly operate the shower chair. As remedial action, a policy requiring additional training of all contract employees reportedly was instituted.

It is not clear that Member #3's leg fracture was the result of striking the door jamb, as he did not experience or exhibit symptoms immediately after that incident. Also, there is no evidence that the incident was due to intentional or reckless conduct. Rather, it appears to have been an accident due to inadequate training. There is insufficient evidence to support criminal charges at this time.

Member #4

Member #4, a dementia patient, died after being assaulted by another member with dementia. Allegedly, a delay in obtaining medical treatment for Member #4 following the assault contributed to his death.

The Grand Rapids Police Department investigated the incident involving Member #4 at the time it occurred, but Kent County declined to pursue charges. The alleged assailant has since died.

The Attorney General has not received sufficient evidence to believe the previous investigation was deficient or that the decision by Kent County authorities not to pursue criminal charges at that time was inappropriate.

Member #5

Member #5, suffering from dementia, was allegedly assaulted by a CNA who pushed him and caused him to fall, resulting in an arm fracture. This incident was partially captured by the video surveillance system in the home. The CNA involved was identified, as well as an eyewitness.

The Grand Rapids Police Department initially investigated this incident after being contacted by the family of Member #5. The investigation was reviewed by the Kent County Prosecutor who declined to issue criminal charges.

Attorney General investigators conducted significant additional investigation on this incident. The video was examined, all relevant witnesses were re-interviewed, and all prior reports were reviewed.

According to the eyewitness (a LPN), she had just finished training at the home and was assigned one-to-one care for Member #5. Member #5 entered an unoccupied room that did not belong to him and sat on the bed. Although he was not disturbing anyone, he refused to leave and return to his room. The LPN activated the call light for the room and the CNA responded. The CNA assisted Member #5 to his feet and, according to the eyewitness, placed her hands on his back and applied pressure to push him along. As Member #5 reached the doorway of the room, he fell into the hallway, breaking his arm. The eyewitness asserted Member #5 would not have fallen if the CNA had refrained from putting her hands on him.

The hallway video depicts the fall, but fails to capture any of the events leading up to the fall. The CNA consistently denied any sort of push and stated that Member #5 was known to shuffle and caught his feet as he moved out of the room.

Given various inconsistencies uncovered by Attorney General investigators, the lack of relevant video footage, and the insufficient proof of recklessness, the Attorney General at this time lacks evidence to disagree with the prior determination of the Kent County Prosecutor that no charges should be issued against the CNA or others related to the injury suffered by Member #5.

Other Reports and Complaints

Many people who reported complaints about the GRHV provided secondhand reports of member mistreatment and were not able to provide the names of the individuals involved. In such instances, the lack of specific information made further investigation difficult or impossible, because those involved could not be identified and interviewed, and incident reports could not be located.

For example, several complainants reported that members did not receive timely medical treatment after falling or being attacked by other members, but the complainants were not able to name the member or any witnesses.

An example of such a complaint concerned a veteran who died after falling and striking his head, but the complainant could not name the veteran or provide additional context. Other complainants generally alleged that members of the home died due to medical neglect, but were unable to provide details.

Many complaints involved general concerns about conditions or practices at the home, such as members being left in soiled clothes or beds for prolonged periods, receiving inadequate medical care for chronic conditions such as diabetes or bed sores, or falling due to inadequate monitoring and assistance.

While such systemic conditions, if true, were unacceptable, this information generally is insufficient to form a basis for criminal charges against specific individuals.

Many complaints did not involve allegations that rose to the level of reckless or intentional conduct causing physical injury, which are predicates to criminal abuse charges.

As noted, numerous individuals have been charged with falsely documenting that they performed room checks and fall alarm checks.

Several complainants reported that members' personal belongings went missing, including items such as jewelry, watches, dentures, and hearing aids.

In those cases, the complainants were unable to provide sufficient details to enable the AG to investigate further. The investigators had no way to determine whether the items were stolen by staff or other members, or simply misplaced.

In other instances, complainants or witnesses gave inconsistent and conflicting statements about alleged incidents, and their reports were deemed unreliable.

For example, one complainant initially reported being sexually assaulted in the home around 2009, but declined to discuss the incident in a subsequent interview.

In some cases, the members involved in an alleged incident had passed away, precluding further action.

In other cases, local law enforcement previously had investigated reported incidents and determined there was no basis for criminal charges, and there was no reason to believe their determinations were deficient or unreliable.

Multiple complaints concerned deaths of members, many of whom were very elderly, medically fragile, or present at the home because they were receiving end-of-life care. Over the past three years, an average of 112 members pass away at the home annually.

VII. Results

Schuette's investigation and the findings of the OAG resulted in felony charges against eleven former staff of the home, for allegedly falsifying medical records to cover up neglect of veterans.

The charges allege that the defendants documented performing regular, required safety checks on veterans under their care, but the defendants did not actually perform the checks.

Failure to perform regular checks on vulnerable residents of long-term care facilities, many of whom have serious illnesses, physical infirmities, and incontinence, can result in delayed treatment of acute medical conditions, residents laying in soiled beds for prolonged periods of time, and other unacceptable and dangerous circumstances, such as residents who have fallen and sustained bone fractures and head injuries going undiscovered for hours.

VIII. Legislative Response

In late 2016, the Michigan legislature passed a package of bills that Governor Snyder signed into law in early 2017. The bills create the Michigan Veterans Facility Authority, a semi-autonomous agency within the Michigan Department of Military and Veteran Affairs, which has the authority to issue bonds and operate, renovate, and construct veterans' homes in the state. According to an article by Gongwer News Service, the Michigan Department of Technology, Management and Budget has recommended replacing the GRHV and the Jacobetti home with new facilities on the same grounds as the existing facilities. Also according to the Gongwer article, a workgroup further recommended new homes in Detroit, the Flint/Saginaw/Bay City area, the Jackson/Battle Creek area, the northern Lower Peninsula, and southeast Michigan.

The legislative package recently signed by the governor also provides that the governing boards of the GRHV and Jacobetti homes must publish annual reports that include the "status" of the home, financial information and census and staffing metrics, and recommendations for improvement.

Also per the new laws, state veterans homes are now subject to state performance audits under various circumstances, including substandard federal reviews, or at the request of the legislature, or in the Auditor General's discretion.

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