# United States Senate

WASHINGTON, DC 20510

February 17, 2017

**VIA ELECTRONIC TRANSMISSION**

The Honorable Jeff Sessions
Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

Dear Attorney General Sessions:

On February 1, the Des Moines Register reported that a Le Mars, Iowa nursing home, "the Abbey," was "ordered closed" and required to pay $100,000 to the federal government under the False Claims Act because of "grossly substandard care" that was essentially "without value."[1] This is the same facility that failed to adequately respond to a patient that appeared to be dead and rather than calling for immediate help, the facility's nurse merely changed his sheets.[2] The Iowa Department of Inspections and Appeals has since revoked the facility's license.[3]

The report indicates that the federal government concluded that the facility would no longer be able to participate in Medicare and Medicaid and the U.S. Attorney's Office for the Northern District of Iowa said the level of care "was grossly substandard in multiple material ways."[4] For example, the Register notes that patients suffered skin conditions, broken bones and were also subject to unnecessary physical restraints.[5] In addition, the reporting found that patients were given unnecessary anti-psychotics in order to "decrease residents' needs" and that patients were given "inadequate nourishment and bathing and toileting care" resulting in emergency care.[6] Further, the Register reported earlier that the same facility owed the federal government more than $360,000 in fines.[7]

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[1] Tony Leys, "Le Mars nursing home shuttered amid allegations of 'grossly substandard care'," The Des Moines Register (Feb. 1, 2017). Available at http://www.desmoinesregister.com/story/news/health/2017/02/01/le-mars-nursing-home-shuttered-amid-allegations-grossly-substandard-care/97367836/

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Id.*

[7] *Id.*

This pattern of conduct is appalling and beyond words. A sign of our nation's strength is how well we treat our elderly population. Other than a fine and exclusion from Medicare and Medicaid, the reporting did not indicate what other steps the Justice Department took against the facility or its personnel for the conduct it engaged in. But, if the reporting is accurate, it is imperative the Justice Department explain what other steps it took to hold them accountable, if any. When patients are subjected to unwarranted physical restraints, are given medications just so that nurses don't have to provide care, and are not properly fed to the point where they need emergency care, the families of those affected deserve answers. Importantly, this facility was on a federal watch list for two years during the Obama Administration because of problems it faced with respect to care. Given that it was a problem-prone facility, the Justice Department, as well as other agencies, need to explain why such outrageous abuse of patients was allowed to occur and what steps will be taken to ensure that this misconduct will not go unpunished.

Accordingly, please answer the following:

1. When did the Justice Department begin its investigation into the facility? What caused it to begin the investigation?

2. Did the Justice Department coordinate with the Department of Health and Human Services and its Inspector General during the investigation?

3. Please explain how the Justice Department arrived at a $100,000 False Claims Act settlement and will the more than $360,000 in fines owed to CMS be paid separately?

4. How long did the facility provide services that were essentially "without value" and what amount of money would be required to be repaid to the taxpayer to wholly compensate for the subsidies provided during that period?

5. When a facility is on a federal nursing home watch list for questionable practices, what role does the Justice Department play in monitoring the conduct of the facility to ensure its patients are being properly treated in accordance with the law? For example, does the Justice Department regularly interface with other governmental agencies to stay updated on the conduct of the facility, its employees, and standards of patient care? Please explain.

6. Other than a fine and exclusion from federal programs, what other steps did the previous administration take to ensure that those engaging in the aforementioned conduct were held to account?

Thank you in advance for your cooperation with this request. Please number your responses according to their corresponding questions and respond no later than March 3, 2017. If you have questions, please contact Josh Flynn-Brown of Senator Grassley's Judiciary Committee staff at (202) 224-5225 and Danielle Janowski of Senator Ernst's staff at (202) 224-3254.

Sincerely,

Charles E. Grassley
Chairman
Committee on the Judiciary

Joni Ernst
United States Senator

Cc:

The Honorable Tom Price, Secretary of Health and Human Services

Mr. Patrick Conway, Acting Administrator of the Centers for Medicare & Medicaid Services