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April 27, 2022

Karen Timberlake, Secretary-designee Wisconsin Department of Health Services 1 W. Wilson Street Madison, WI 53703

Dear Ms. Timberlake,

This letter is to protest, in the strongest possible terms, the <u>decision</u> of the State Department of Health Services (DHS) to rescind the "<u>Notice and Order</u>" that was filed by the Division of Quality Assurance on February 1, 2022, against ProHealth Care Regency Senior Community New Berlin, regarding the eviction of my mother, Elaine Benz, who as 97 at the time and is 98 now.

This action was taken in contradiction to the <u>findings of deficiencies</u> in the Division of Quality Assurance (DQA) inspector's report, dated November 8, 2021, and without any effort to truth-test the validity of the claims made by the Regency and its agents. Our family, which has highly relevant information and documentation regarding this matter, was never consulted.

DHS simply capitulated to the wishes of a violator that urged and perhaps pressured it to do so. It is a betrayal of my family and a dereliction of the department's duty under the law.

State administrative code <u>requires</u> facilities in the licensing category that includes the Regency to provide at least 30 days' advance notice before terminating the lease of a resident. In this case, we were given less than 24 hours of advance notice, despite the Regency's own assertion, in its belated <u>eviction notice</u>, that it had for some time been contemplating transitioning Elaine Benz to a new facility.

The Regency in this notice contends that Elaine Benz had come to need more than the 28 hours of care per week it was obligated to provide. The fact is that Elaine Benz has never needed or

received anywhere near 28 hours per week of care. She did not receive anywhere near this level of care before her illegal eviction and she has never needed or received this level of care since then, at her new facility. The Regency simply lied about this, and the Department of Health Services simply allowed itself to be lied to.

The Regency further contends that Elaine's condition constituted an emergency, obviating the need for advance notice. The state administrative code expressly states that an emergency "means an immediate and documented threat to the health or safety of the tenant or of others in the facility." The DQA inspector investigated and found that the Regency failed to provide "documented evidence of this threat or significant change in condition." The division imposed a nominal \$1,200 fine for this violation.

The DQA inspector also found that the Regency neglected to perform a required comprehensive assessment "with the active participation of the tenant and the tenant's legal representative." This was a correct and irrefutable finding, as nothing of the sort occurred. In response, DQA imposed an additional \$300 fine, bringing the total to \$1,500, which is far less than the actual costs to our family as a result of the Regency's actions.

The fact is that the Regency deliberately put our mother's life at risk because she had become a little more work than it cared to provide. And now DHS is signaling that it has no problem with this reprehensible and illegal conduct.

Worse, there is every reason to believe that Regency engaged in additional duplicity as a result of our decision to turn to the state for help. As soon as it learned that I had contacted the state about its failure to provide 30 days' advance notice, the Regency took steps to provide cover for its actions. We were suddenly told that Elaine Benz actually required 168 hours of direct care per week, meaning 24 hours per day, which would mean we would have to hire an around-the-clock care team to be with her, even when she slept. As I noted in the grievance I filed with the state on November 5, 2021:

"We believe that ProHealth Regency's claim that she needs extraordinary levels of care has been concocted because of the otherwise clear violation of law that the Regency committed in preventing her from coming home with less than 24-hour notice. We suspect it may be tied to the investigation started by the [Division] of Quality Assurance in response to my contacts."

But DHS has decided to let the Regency get away with it—sending a clear signal to the state's residents that complaining about plain violations of law committed by senior care providers can entail severe retributive consequences about which the state will do nothing.

Rather than do its duty to hold violators of the law accountable, DHS has given the Regency carte blanche to lie about its actions and inactions. The inspector's report includes, on page 8, this claim from the Regency: "10/03/2021- Staff talked to Tenant 1's family member about a change in condition that the tenant was having. Tenant 1 went from 1 person assist to 2 person assistance with transfers."

My sister, Diane Roth, the referenced family member, visits our mom almost every day. She has seen care staff get Elaine out of bed and into a wheelchair on countless occasions. She has never seen a two-person team conducting this transfer of Elaine Benz, who is able to stand and weighs less than 100 pounds. To this day, these transfers are accomplished at Elaine Benz's new facility by a single person, in some cases young women who weigh only slightly more.

As for the claim that the family was contacted on October 3, 2021, this is another outright lie that the Department of Health Services has accepted. October 3, 2021, was a Sunday, when administrative staff would not likely even be working. Moreover, no one from the Regency ever spoke to any member of our family regarding a change in our mother's condition prior to October 28, when we learned she would not be allowed to return home the following day. (The Regency did set up a meeting with Diane that never happened but did not say what it was about. Diane: "I thought they were going to say they were raising the rent.")

The Regency's claims that Elaine Benz's condition represented a medical emergency that required immediate dismissal are contradicted by a <u>letter from the insurance company Livanta</u> dated October 28, 2021, based on an assessment by "an independent, certified, licensed, practicing peer reviewer." It concluded: "The patient is medically stable. There is no documented evidence that continued skilled medical services are needed daily to maintain or prevent decline. There are no documented medical issues to support the need for daily skilled nursing care."

This letter is among the medical records that were provided to the state as part of this process, which I obtained through the exertions described below.

What has happened here is an egregious failure on the part of DHS to enforce state administrative code against an especially flagrant violator. You are making it clear that providers of care to the elderly can violate the state's rules with impunity. As such, the decision of the Department of Health Services to dismiss this case puts all of the state's most vulnerable residents at unnecessary risk.

In fact, our entire experience with the Department of Health Services with regard to the Regency's eviction of our mother points up serious and systemic flaws in the state's regulatory process, highlighting the need for fundamental reform, which is why I am sharing this letter with

various officials within DHS, the offices of the governor and attorney general, members of the legislature and representatives of the press.

## To recap:

The DQA inspector conducted a complaint investigation on November 8, 2021, and identified the above-referenced violations of state administrative code. Rather than act on this information in a way that might have prevented this illegal eviction and the trauma it caused, the division took no action until February 1, 2022, when it issued its two citations, long after Elaine was forced to spend 19 days in punishing isolation in a rehabilitation center in COVID-19 lockdown, where she was abandoned, as our family scrambled to find her a new place to live.

The citation issued on February 1, 2022, by Daniel Perron, Assisted Living Director, Bureau of Assisted Living Division of Quality Assurance, was addressed to Cherie Carty, the Regency's former New Berlin campus administrator, who left this position in May 2021. The DHS' own website correctly listed the name of the current campus administrator, Mara Henningsen, but Perron still got this wrong, suggesting his review of the case was cursory at best; moreover, he apparently made no effort to correct the record when I pointed out his mistake in an <a href="mailto:emailto:mailto:e

There is no reason to believe that, were it not for my inquiries, anyone from the Division of Quality Assurance would have ever notified my family that the Regency was appealing the citations it received and asking for a hearing. This information was then provided by DQA Policy Initiatives Advisor Patricia Benish, who has distinguished herself among her colleagues by performing her job duties in an exemplary manner.

Similarly, I learned of the dismissal of the citations against the Regency only because I made an inquiry regarding the status of the appeal to the Division of Hearings and Appeals. Initially I was provided with only an <u>Order of Dismissal</u>, dated April 21, 2022, which contained no information regarding the terms of the settlement. As a result of Benish's interventions, I was provided with a copy of the <u>Stipulated Dismissal</u>, containing signatures dated April 20, 2022. That document states, at point 8:

"Based on additional information provided with the appeal, before the case conference, during the case conference, and after the case conference, the Department agrees to rescind both tags [citations]." I asked Ashley Schmit, Legal Associate Supervisor for the Division of Hearings and Appeals, who sent this document, what "additional information" had been provided that prompted the state to dismiss the citations without so much as a hearing. In response, she sent a number of documents, most of which I already had and none of which explained what "additional information" was received. When I pointed this out, she <u>responded</u>: "There is nothing else available."

After contacting Benish, I was provided with a stack of medical records stamped as marked exhibits. I looked them over and sent this response: "Thank you. Just to check: This appears to be a batch of medical records stamped as marked exhibits. There is no document that outlines the reasons for terminating Elaine Benz's tenancy on an emergency basis, and no document that attempts to explain the relevance of these provided records. Is that correct?"

The DHS/DQA records custodian <u>replied</u>: "In response to your question in your email below, yes, you are correct."

That's right: DHS/DQA, by its own admission, does not have any record from the Regency that defends its actions or even attempts to explain the relevance of the records that it provided. If there is such a thing as malpractice in public office, this is it. The state agreed to absolve the Regency of all responsibility for violating state administrative code for what appears to be no reason at all.

I am, with this letter, demanding that someone with better judgment than whoever agreed to this dismissal step in and reverse it. What has happened here is an outrage, and it must not be allowed to stand.

Sincerely,

Bill Lueders