ORIGINAL

Dkt #1

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA *EX REL.* AMANDA HODGE and JENNIFER MINSHELL AS CO-RELATORS; STATE OF NEW YORK *EX REL.* AMANDA HODGE and JENNIFER MINSHELL AS CO-RELATORS, Plaintiffs, v. CENTER FOR DISABILITY SERVICES HOLDING CORPORATION D/B/A ST. MARGARET'S CENTER; CENTER FOR DISABILITY SERVICES, INC.; and GREGORY SORRENTINO, Defendants.	§	Civil Action No. 1:22-CV-0004 (LEK/DJS) **RELATORS' COMPLAINT AND DEMAND FOR JURY TRIAL** FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2) DO NOT ENTER INTO PACER DO NOT ENTER IN CM/ECF DO NOT PLACE IN PRESS BOX

FALSE CLAIMS ACT COMPLAINT AND DEMAND FOR JURY TRIAL

I. PRELIMINARY STATEMENT

1. This is an action by Amanda Hodge and Jennifer Minshell (collectively, "Relators"), on behalf of the United States of America and the State of New York, against Center for Disability Services Holding Corporation D/B/A St. Margaret's Center ("SMC"), Center for Disability Services, Inc. ("CFDS"), and Gregory Sorrentino (collectively, "Defendants") to recover damages and civil penalties under the federal False Claims Act ("FCA"), 31 U.S.C. § 3729 *et seq*., and the New York False Claims Act, State Finance Law, Art. XIII § 187-194.

2. As more fully alleged herein, this action arises out of the Defendants' fraudulent practices and fraudulent submissions which caused Medicare and the New York Medicaid program to pay for services that did not occur as Defendants reported them to have occurred and as they were required to perform under regulations.

3. Specifically, Defendants knowingly and purposefully underreported harm and injuries to the patients, as set forth herein. Defendants made or caused to be made false statements in the Certification and Survey Provider Enhanced Reports ("CASPER") submitted to Centers for Medicare & Medicaid Services ("CMS") and the Health Electronic Response Data System ("HERDS") report submitted to the New York State Department of Health ("NYSDOH").

4. Defendants knowingly and purposefully underreported the number of SMC patients impacted by the different quality measure conditions (including pressure ulcers, falls and falls with major injury, excess weight loss, and increased help with Activities of Daily Living ("ADL")) in the CASPER to avoid alerting the government about the substandard care rendered at SMC.

5. Additionally, Defendants knowingly and purposefully reported to NYSDOH an inflated number of staff that were working at SMC on any given day on the HERDS report to hide the fact that SMC was and is severely understaffed and unable to adequately care for its patients

and their particular needs and requirements. The lack of staff is the cause of the substandard care rendered at SMC, resulting in patient falls, wounds, contractures, injuries, and infections.

6. All the while, Defendants submitted claims for the substandard services and received payment from Medicare and New York Medicaid, which payments would not have been made if Medicare and New York Medicaid were aware of the fraud.

7. CMS created the Five-Star Quality Rating System to assess the conditions in a nursing home and to help consumers select a nursing home. The star rating is based on health inspections, staffing, and quality measures listed on the CASPER. NYSDOH also utilizes the star rating system. Reporting true and correct information on the CASPER and HERDS report would have negatively impacted SMC's star rating. Defendants engaged in the practices described herein to maintain SMC's star rating and attract future patients.

8. Relator Minshell first observed the wrongdoing described herein as early as 2014. The wrongdoing became more apparent in 2018 when she assumed a supervisory role and had increased contact with Defendant SMC's management. The wrongdoing has been ongoing since before the Covid-19 pandemic but has been exacerbated by the pandemic.

II. JURISDICTION AND VENUE

9. This action arises under the FCA, 31 U.S.C. § 3729 et *seq*. This Court has jurisdiction over this case pursuant to 31 U.S.C. §§ 3732(a) and 3730(b). This court also has jurisdiction pursuant to 28 U.S.C. § 1345 and 28 U.S.C. § 1331. Supplemental jurisdiction for Counts IV through IV arises under 28 U.S.C. § 1367 because these claims are so related to the federal claims that together they form part of the same case or controversy under Article III of the U.S. Constitution.

10. At all times material to this Complaint, Defendants regularly conducted substantial business within the State of New York, maintained permanent employees and offices in New York, and made and are making significant revenue within New York. Defendants are thus subject to personal jurisdiction in New York.

11. Venue is proper in the Albany courthouse of this district pursuant to 31 U.S.C. § 3732(a) because the Defendants SMC and CFDS are located in Albany, Albany County in the Northern District of New York.

III. FILING UNDER SEAL

12. Under the FCA, this Complaint is to be filed in camera and remain under seal for a period of at least sixty days and shall not be served on Defendants until the Court so orders.

13. As required by the FCA and relevant state statutes, Relators voluntarily submitted, prior to the filing of this Complaint, a confidential pre-filing disclosure statement (subject to the attorney-client, work product and common-interest privileges) to the governments of the United States and the State of New York containing materials, evidence, and information in their possession pertaining to the allegations contained in this Complaint.

IV. PARTIES

14. The real parties in interest as Plaintiffs are the United States of America and the State of New York.

A. Relator Amanda Hodge

15. Relator Amanda Hodge ("Relator Hodge") is a resident of the State of New York. She is a Practical Nurse licensed in New York. She started working at SMC as a Licensed Practical

Nurse ("LPN") in February 2015. She became a house supervisor[1] in 2020, then a floating charge nurse, and was promoted to charge nurse for the North and West units in April 2021.

B. Relator Jennifer Minshell

16. Relator Jennifer Minshell ("Relator Minshell") is a resident of the State of New York. She is a Practical Nurse licensed in New York and Massachusetts. Relator Minshell started working at SMC as an LPN in August 2012. She started filling in as a house supervisor in 2018. She was then promoted to charge nurse for the North and West units in April 2020. Finally, she was promoted to Nursing Admissions Director in August 2021.

C. Defendant Center for Disability Services Holding Corporation D/B/A St. Margaret's Center ("SMC")

17. Defendant Center for Disability Services Holding Corporation D/B/A St. Margaret's Center ("SMC") is a New York charitable corporation. Its principal place of business is at 27 Hackett Blvd, Albany, NY 12208. Its service of process address is 314 South Manning Blvd., Albany, NY, United States, 12208, which is also the principal place of business of Defendant CFDS. SMC's NPI number is 1972663508.

18. SMC is a 94-bed skilled nursing facility with a pediatric ventilation unit. It offers 24-hour long term intensive skilled nursing to medically fragile infants, children, and young adults. SMC specializes in long-term care, but also serves short-term stay and respite patients.[2] *See* https://www.cfdsny.org/st-margarets-center. SMC accepts resident-patients from premature babies to individuals 47 years old. Due to the severity of patients' conditions, their plans of care often require 24-hour one-on-one care, with some individuals requiring two-on-one care for certain daily living needs, such as bathing. Many patients are non-verbal, have extreme cognitive

[1] An industry term meaning supervisor of all the staff in house.
[2] Respite care provides short-term relief for primary caregivers.

limitations, cannot ambulate, lack manual dexterity, and receive sustenance through feed tubes because they are incapable of chewing or swallowing food.

19. Maria Kansas Devine, M.D. was the Chief Executive Officer ("CEO") and is the Chief Medical Officer of SMC. Defendant Gregory Sorrentino is the CEO, President, and Acting Administrator at SMC. Catherine ("Cathy") Welcome is Administrator-in-training at SMC under the direction and supervision of Defendant Sorrentino.

D. Defendant Center for Disability Services, Inc. ("CFDS")

20. Defendant Center for Disability Services, Inc. ("CFDS") is a New York charitable corporation. Its principal place of business is at 314 South Manning Blvd., Albany, NY 12208. Its service of process address is the same. *See* https://www.cfdsny.org/contact-us.

21. CFDS is the parent company of Defendant SMC. CFDS oversees Defendant SMC, the Clover Patch preschool and camp, the Prospect Center, the Kevin G. Langan school, the Down Syndrome Aim High Resource Center, and the Center Health Care. *See* https://www.cfdsny.org/about-us.

22. Gregory Sorrentino is the President and CEO of CFDS. From 1993 to 2018, he was the Chief Operating Officer and Chief Financial Officer of CFDS. *See* https://www.cfdsny.org/about-us/board-directors; *see also* https://www.cfdsny.org/about-us/board-directors/governing-board-directors. Maria Kansas Devine, M.D. is the Chief Medical Officer at Defendant CFDS. *See* https://www.cfdsny.org/center-health-care/providers.

E. Defendant Gregory Sorrentino

23. Defendant Gregory Sorrentino ("Defendant Sorrentino") is a resident of the State of New York. He is the CEO, President, and Acting Administrator of Defendant SMC and makes decisions on how the facility should operate. He is also the President and CEO of Defendant CFDS.

V. RELEVANT LAW

A. The False Claims Act

i. The Federal False Claims Act

24. The False Claims Act provides, in pertinent part, that any person who:

> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; [or]...
>
> (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.

31 U.S.C. § 3729(a)(1).

25. A person who violations the FCA is liable to the United States Government for a civil penalty of not less than $11,665 and not more than $23,331, plus three times the amount of damages which the Government sustains because of the act of that person. *Id.*[3]

26. For purposes of the False Claims Act,

> (1) the terms "knowing" and "knowingly"
>
> > (A) mean that a person, with respect to information – (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information; and
> > (B) require no proof of specific intent to defraud.

31 U.S.C. § 3729(b).

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[3] Pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by Section 701 of the Bipartisan Budget Act of 2015, Public Law 114-74 (Nov. 2, 2015), 28 U.S.C. 2461 note, and 28 CFR § 85.5, the False Claims Act civil penalties were adjusted to $11,665-$23,331 for penalties assessed after June 19, 2020. *See* 85 FR 37004.

ii. The New York False Claims Act

27. The New York False Claims Act provides liability for any person who:

> (a) knowingly presents, or causes to be presented a false or fraudulent claim for payment or approval;
>
> (b) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> (c) conspires to commit a violation of paragraph (a), (b), (d), (e), (f) or (g) of this subdivision;
>
> (d) has possession, custody, or control of property or money used, or to be used, by the state or a local government and knowingly delivers, or causes to be delivered, less than all of that money or property;
>
> (e) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the state or a local government and, intending to defraud the state or a local government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
>
> (f) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a local government knowing that the officer or employee violates a provision of law when selling or pledging such property;
>
> (g) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or a local government; or
>
> (h) knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a local government, or conspires to do the same.

NY State Finance Law, Art. XIII § 189.

28. Violators shall be liable to the state or a local government, as applicable, for a civil penalty of $6,000-$12,000, as adjusted to be equal to the civil penalty allowed under the federal False Claims Act, 31 U.S.C. sec. 3729, et *seq.*, as amended, as adjusted for inflation by the Federal

Civil Penalties Inflation Adjustment Act of 1990, as amended (28 U.S.C. 2461 note; Pub. L. No. 101-410), plus three times the amount of all damages. *Id.*

29. Under the NY FCA, the terms "knowing and knowingly"

(a) means that a person, with respect to information:

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(b) require no proof of specific intent to defraud, provided, however that acts occurring by mistake or as a result of mere negligence are not covered by this article.

Id. at § 188(3).

B. The Medicare Program

30. Congress established the Medicare Program in 1965 to provide health insurance coverage for people age 65 or older and for people with certain disabilities or afflictions. *See* 42 U.S.C. §§ 426, 426A. Medicare Part A generally covers inpatient hospital services, home health and hospice care, and skilled nursing and rehabilitation care.

31. The Medicare program is divided into four "parts" that cover different services. Medicare Part A generally covers inpatient hospital services, home health and hospice care, and skilled nursing and rehabilitation care.

32. Subject to certain conditions, Medicare Part A covers up to 100 days of care in a skilled nursing facility ("SNF") for a benefit period (*i.e.*, spell of illness) following a hospital stay. 42 U.S.C. § 1395d(a)(2)(A); 42 C.F.R. § 409.61(b), (c).

33. Among the conditions that Medicare imposes on its Part A SNF benefit are that: (1) the patient requires skilled nursing care or skilled rehabilitation services (or both) on a daily basis, (2) the daily skilled services must be services that, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis, and (3) the services are provided to address a condition for which the patient received treatment during a hospital stay or that arose while the patient was receiving care in a skilled nursing facility (for a condition treated during the hospital stay). 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b).

34. To be considered "skilled," a service must be "so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel." 42 C.F.R. § 409.32(a).

35. Medicare Part A covers only those services that are "reasonable and necessary for the diagnosis or treatment of illness or injury." *See* 42 U.S.C. § 1395y(a)(1)(A). Services or supplies are considered medically necessary "if they meet the standards of good medical practice and are: proper and needed for the diagnosis or treatment of the beneficiary's medical condition; furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition; and not mainly for the convenience of the beneficiary, provider, or supplier." *See* Centers for Medicare & Medicaid Services, Items and Services That Are Not Covered Under the Medicare Program, ICN 906765, January 2015.

36. In order to make it possible to assess whether services are reasonable and necessary, and therefore eligible for reimbursement, Medicare rules require proper and complete documentation of the services rendered to beneficiaries. In particular, the Medicare statute provides that:

> no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due

> such provider under this part for the period with respect to which the amounts are being paid or any prior period.

42 U.S.C. § 1395g(a).

C. CMS requirements for nursing homes

37. Nursing homes submit the CASPER to CMS monthly. The CASPER contains data compiled to demonstrate a facility's performance and quality of care. The CASPER is generated from Minimum Data Set ("MDS") data. Four types of CASPER are available: Facility Characteristics Report, Facility Quality Measures Report, Resident Level Quality Measure Report, and MDS Submission Statistics Report. The Facility Characteristics Report provides demographic data on a specific facility compared against state and national averages. The Facility Quality Measures Report provides facility-wide data on 15 quality measures[4] (pressure ulcers, physical restraints, falls, falls with major injury, antianxiety/hypnotic, behavior symptoms affecting others, depression symptoms, urinary tract infections, catheter insertions and left in bladder, lost bowel and bladder control, weight loss, increased ADL help, worsened ability to move independently for long-term care residents; anti-psychotic medications for short-term and long-term stay residents; and improvement in function for short-term stay residents). The Resident Level Quality Measure Report shows which residents triggered a quality measure condition. The MDS Submission Statistics report provides an overall report of MDS batch submission, the number of records processed, the number rejected, and the number accepted.

38. Quality Measures data is also available to the public as part of the Nursing Home Quality Initiative ("NHQI") to help consumers make informed decisions about the quality of care

[4] These measures have changed over the years. For example, residents' reported pain level is no longer reported as one of the quality measures. *See* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-20-02-NH.pdf.

in nursing facilities.[5] The data can be accessed on Medicare's Care Compare website.[6] This website features a quality rating system that gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have much above average quality and nursing homes with 1 star are considered to have quality much below average. There is one Overall 5-star rating for each nursing home, and a separate rating for health inspections, staffing, and quality measures.[7]

39. Health inspection measures are based on outcomes from state health inspections. Ratings for the health inspections domain are based on the number, scope, and severity of deficiencies identified during the three most recent annual inspection surveys, as well as substantiated findings from the most recent 36 months of complaint investigations and focused infection control surveys. All deficiency findings are weighted by scope and severity. The health inspections rating also takes into account the number of revisits required to ensure that deficiencies identified during health inspection surveys have been corrected.[8]

40. Staffing measures are based on nursing home staffing levels. Ratings for the staffing domain are based on two measures: 1) Registered nurse (RN) hours per resident per day; and 2) total nurse (the sum of RN, licensed practical nurse (LPN), and nurse aide) hours per resident per day. Other types of nursing home staff, such as clerical or housekeeping staff, are not included in the staffing rating calculation. The staffing measures are derived from data submitted each quarter through the Payroll-Based Journal System, along with daily resident census derived from Minimum Data Set, Version 3.0 (MDS 3.0) assessments, and are case-mix adjusted based on

[5] https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf
[6] https://www.medicare.gov/care-compare/
[7] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS
[8] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf

the distribution of MDS 3.0 assessments by Resource Utilization Groups, version IV (RUG-IV groups). In addition to the overall staffing rating, a separate rating for Registered Nurse ("RN") staffing is also reported. Table A1 in the Appendix of *Design for Care Compare Nursing Home Five-Star Quality Rating System* shows the case-mix nursing minutes by RUG-IV group and nursing staff type. [9]

41. Quality Measures are based on MDS and claims-based quality measures. Ratings for the quality measures are based on performance on 15 of the quality measures that are currently posted on the Care Compare website, including pressure ulcers, falls with major injury, weight loss, and increased help with daily activities. Not all of the quality measures that are reported on Care Compare are included in the rating calculations. Table A2 in the Appendix of *Design for Care Compare Nursing Home Five-Star Quality Rating System* shows ranges for point values for each quality measure. In addition to an overall quality of resident care rating, separate ratings for the quality of resident care for short-stay residents and long-stay residents are also reported. [10]

42. Facilities may see a change in their overall rating for a number of reasons. Since the overall rating is based on three individual domains, a change in any one of the domains can affect the overall rating. Any new data for a nursing home could potentially change a star rating domain. Data for the MDS-based quality measures and the claims-based hospitalization and emergency department visit measures are updated quarterly, and the quality measures rating is updated at the same time. The updates typically occur in January, April, July, and October at the time of the Care Compare website refresh. Changes in the quality measures may change the star ratings. Payroll-Based Journal System staffing data are reported quarterly, so new staffing

[9] *Id.*
[10] *Id.*

measures and ratings are calculated and posted quarterly. Changes in a nursing home's staffing measure or rating may be due to differences in the number of hours submitted for staff, changes in the daily census, or changes in the resident case-mix from the previous quarter. Additionally, the audit process may lead to a change in the staffing rating for a facility. Events that could change the health inspection score include: a new health inspection; new complaint deficiencies; new focused infection control survey deficiencies; a second, third, or fourth revisit; resolution of Informal Dispute Resolutions (IDR) or Independent Informal Dispute Resolutions (IIDR) resulting in changes to the scope and/or severity of deficiencies; the "aging" of complaint and focused infection control survey deficiencies; and a nursing home newly qualifies for the abuse icon or no longer qualifies for the abuse icon. Health inspection data will be included as soon as they become part of the CMS database.[11]

D. The New York Medicaid Program

43. Authorized under Title XIX of the Social Security Act, Medicaid is a means-tested individual and state entitlement program jointly financed by states and the federal government. To be eligible for the New York Medicaid program, individuals must meet certain income, resource, age, or disability requirements.[12]

44. The New York Medicaid program uses the case mix index ("CMI") payment system for the purposes of reimbursement. The CMI is now calculated using an average of all Medicaid assessments for a six-month period.[13] SMC's 2021 daily reimbursement rate for adult patients is $595.70 and for pediatric patients is $724.73.[14]

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[11] *Id.*

[12] https://www.health.ny.gov/health_care/medicaid/

[13] https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/2021/docs/2021-07-01_dal.pdf

[14] https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/

45. As part of the NHQI, New York's Medicaid program distributes to nursing homes $50 million yearly based on quality measures, compliance with reporting, and avoidable hospital use. This is done to incentivize nursing homes across New York to improve the quality of care for their residents, and to reward homes for quality based on their performance.[15] The Five Star Health Inspections rating and other elements of the rating system are used to determine distributions under this program. The NHQI 2020 score is worth a maximum 90 points. The 65 points allotted for quality are distributed evenly for all quality measures. The NHQI includes 13 quality measures with each measure being worth a maximum of five points. The 13 quality measures include pressure ulcers, falls with major injuries, weight loss, and increased help with ADLs.[16]

46. Due to the Covid-19 pandemic, nursing homes in New York must report daily to the NYSDOH, through the HERDS reporting system, the number of staff working in the facility, the number of staff and patients affected by the pandemic, and their Covid-19 supplies.

E. The Nursing Home Reform Act of 1987

47. The Nursing Home Reform Act of 1987 ("NHRA"), 42 U.S.C. § 1395i–3, sets the federal quality standards for nursing homes.

48. The NHRA requires skilled nursing facilities to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

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15 https://www.health.ny.gov/health_care/medicaid/redesign/nursing_home_quality_initiative.htm; https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/nhqp/docs/2018-11-20_dear_admin.pdf

16 https://www.health.ny.gov/health_care/medicaid/redesign/nhqi/2020/methodology.htm

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

42 U.S.C. § 1395i–3(b)(2).

49. The NHRA also requires skilled nursing facilities to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

(iii) uses an instrument which is specified by the State under subsection (e)(5); and

(iv) includes the identification of medical problems.

Id. at § 1395i–3(b)(3)(A).

50. Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment. *Id.* at § 1395i–3(b)(3)(B).

51. To the extent needed to fulfill all plans of care described in paragraph (2), a skilled nursing facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for the provision of—

(i) nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

(vi) routine and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality. Nothing in clause (vi) shall be construed as requiring a facility to provide or arrange for dental services described in that clause without additional charge. *Id.* at § 1395i–3(b)(4)(A).

52. Services must be provided by qualified persons in accordance with each resident's written plan of care. *Id.* at § 1395i–3(b)(4)(B).

53. Subject to certain exceptions, a skilled nursing facility must provide 24-hour licensed nursing service which is sufficient to meet nursing needs of its residents and must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. *Id.* at § 1395i–3(b)(4)(C)(i).

F. National Nursing Home Initiative

54. In March 2020, the Department of Justice (DOJ") launched the National Nursing Home Initiative to pursue nursing homes that provide grossly substandard care. During its launch, DOJ identified several issues of concern, including inadequate staffing, hygiene and infection control protocols, inadequate nourishment of residents, withholding pain medication, and use of physical or chemical restraints. *See* https://www.justice.gov/opa/pr/department-justice-launches-national-nursing-home-initiative.

IV. DEFENDANTS' WRONGDOING

55. Defendants knowingly underreported in the CASPER the number of SMC patients impacted by the different quality measure conditions (including pressure ulcers, falls and falls with major injury, excess weight loss, and decreased Activities of Daily Living ("ADL")) to avoid alerting the government about the substandard care rendered at SMC. SMC's MDS Coordinator (Nicole Rogers, RN), Administrator (presently, Catherine Welcome,[17] and formerly, Jule

[17] Catherine Welcome is Administrator-in-training under the direction and supervision of Acting Administrator, Defendant Greg Sorrentino. Her LinkedIn profile shows that she has worked as

Kovacs),[18] or Director of Nursing (Siranoush Bagramian, RN) completed and submitted the CASPER quarterly. Additionally, Defendants knowingly inflated the number of staff working at SMC on any given day on the HERDS report to hide the fact that SMC is severely understaffed and unable to adequately care for its patients. SMC's Administrator completes and submits the HERDS report. The lack of staff has caused and substantially contributed to the substandard care rendered at SMC, resulting in patient falls, wounds, contractures, injuries, infections, and other harm, while billing Medicare and Medicaid for those substandard and valueless services.

56. SMC has an overall 3/5 star rating with CMS. Broken down by category, SMC has a 4/5 star rating for quality of resident care, 3/5 for staffing, and 2/5 for health inspections.[19] Reporting true and correct information on the CASPER and HERDS report would have negatively impacted SMC's star rating. Defendants engaged in the practices described herein to avoid alerting the government about the substandard care rendered and SMC and to maintain SMC's star rating and attract future patients.

57. The CASPER is generated from MDS data. On July 19, 2021, Defendant Sorrentino certified to NYSDOH that SMC's MDS data is complete and accurate.

A. Defendants' false statements regarding quality measures in the CASPER

i. Pressure ulcers

SMC's Director of Program Operations since 2011. Relators have observed that Ms. Welcome was responsible for quality assurance before assuming her new position as Administrator-in-training.

[18] According to his LinkedIn profile, Mr. Kovacs assumed the role of Administrator in June 2017. Mr. Kovacs left his employment at SMC in or about April 2021. Before Mr. Kovacs, Beth Barnes was SMC's Administrator.

[19] https://www.medicare.gov/care-compare/details/nursing-home/335830?id=46b94143-679e-48cc-85d3-c9eb74926c24&city=Albany&state=NY&zipcode=

58. Defendants knowingly underreported in the CASPER the number of pressure ulcers that SMC patients suffered each month. Below are seven examples of months in which Defendants underreported the number of pressure ulcers.

a) For the month of September 2020, Defendants reported that two patients suffered from pressure ulcers. The reported patients were Patient 1 (a Medicaid patient) and Patient 2 (a Medicaid patient). Internal SMC records show that at least two additional patients also suffered from pressure ulcers that month. The additional patients were Patient 3 (a Medicaid patient) and Patient 4 (a Medicaid patient).

b) For the month of November 2020, Defendants reported that one patient suffered from pressure ulcers. The reported patient was Patient 2 (a Medicaid patient). Internal SMC records show that at least two additional patients also suffered from pressure ulcers that month. The additional patients were Patient 5 (a Medicaid patient) and Patient 6 (a Medicaid patient).

c) For the month of March 2021, Defendants reported that two patients suffered from pressure ulcers. The reported patients were Patient 7 (a Medicaid patient) and Patient 1 (a Medicaid patient). Internal SMC records show that at least five additional patients also suffered from pressure ulcers that month. The additional patients were Patient 8 (a Medicaid patient), Patient 5 (a Medicaid patient), Patient 9 (a Medicaid patient), Patient 4 (a Medicaid patient), and Patient 10 (a NYS Medical Indemnity Fund patient)

d) For the month of May 2021, Defendants reported that one patient suffered from pressure ulcers. The reported patient was Patient 1 (a Medicaid patient). Internal SMC show that at least six additional patients also suffered from pressure ulcers

that month. The additional patients were Patient 11 (a Medicaid patient), Patient 12 (a CDPHP Medicaid patient), Patient 13 (a Medicaid patient), Patient 14 (a Medicaid patient), Patient 4 (a Medicaid patient), and Patient 15 (a Medicaid patient).

e) For the month of June 2021, Defendants reported that one patient suffered from pressure ulcers. The reported patient was Patient 1 (a Medicaid patient). Internal SMC records show that at least three additional patients also suffered from pressure ulcers that month. The additional patients were Patient 16 (a Medicaid patient), Patient 17 (a Medicaid patient), and Patient 18 (a Medicaid patient).

f) For the months of July and August 2021, Defendants reported that no patients suffered from pressure ulcers. Internal SMC records show that at least two patients suffered from pressure ulcers in July and August. The patients were Patient 19 (a Medicaid patient) and Patient 20 (then, a Medicare patient; now, a Medicaid patient).

ii. Weight loss

59. Defendants knowingly underreported in the CASPER the number of SMC patients who experienced significant weight loss each month. The *Weight and Vitals Exceptions* report shows specific examples of patients who lost significant weight between January and July 2021. Below are five examples from this report.

a) Patient 21, a Medicaid patient, weighed 113 lbs. on January 8, 2021. This patient weighed 98 lbs. on March 15, 2021. This patient lost 15 lbs. in two months. Yet, this was not reported on the January, February, or March 2021 CASPER.

b) Patient 22, a Medicaid patient, weighed 105.2 lbs. on January 5, 2021. This patient weighed 94.6 lbs. on June 27, 2021. This patient lost 10.6 lbs. in five months. Yet, this was not reported on the January, February, March, May, June, or July 2021 CASPER.

c) Patient 8, a Medicaid patient, weighed 115.8 lbs. on January 8, 2021. This patient weighed 111.8 lbs. on May 5, 2021. This patient lost 4 lbs. in four months. Yet, this was not reported in the January, February, March, or May 2021 CASPER.

d) Patient 5, a Medicaid patient, weighed 131.8 lbs. on February 10, 2021. This patient weighed 122.0 lbs. on June 8, 2021. This patient lost 9.8 lbs. in four months. Yet, this was not reported in the February, March, May, June, or July 2021 CASPER.

e) Patient 23, a Medicaid patient, weighed 77.4 lbs. on June 10, 2021. This patient weighed 68.0 lbs. on July 6, 2021. This patient lost 9.4 lbs. in less than one month. Yet, this was not reported in the June or July 2021 CASPER.

60. Jamie Coburn, the facility's nutritionist, asks the nursing staff to re-weigh the patients again and again when this report shows the patients have experienced significant weight loss, until she is satisfied with the weight reported.

iii. Adverse effects of severe isolation and little interaction including a decline in ADLs

61. On January 19, 2021, Stacey Sano (s_sano@cfdsny.org), Director of Rehabilitation Services at SMC, sent an email to SMC's then Administrator, Jule Kovacs, and nursing department staff, including Relator Minshell (byrnes@cfdsny.org), describing declines in various patients' ADLs because of the isolation they each experienced during the Covid-19 pandemic. Patients often quarantined in their room to avoid the spread of the virus. Ms. Sano wrote:

> "Obviously all the residents and staff have been affected by the limited interaction and isolation over the past few months, but we have a number of residents that are displaying behaviors that seem directly related to being stuck in their rooms for extended periods of time with decreased stimulation. We were hoping to have some sort of meeting to discuss options to help provide meaningful interaction and time out of cribs/chairs, especially when they are not able to come out of rooms. Another issue is these behaviors are not often documented but seen regularly by therapy, activities and aides."

62. Ms. Sano then listed 17 patients, by unit, who have experienced the problems she described above. On the January 2021 CASPER, SMC reported that five patients needed increased help with ADLs. SMC did not report that the following twelve patients listed in Ms. Sano's email also needed increased help with ADLs: Patient 22 (a Medicaid patient); Patient 24 (a Medicaid patient); Patient 25 (a Medicaid patient); Patient 26 (a Medicaid patient); Patient 27 (a Medicaid patient); Patient 28 (a Medicaid patient); Patient 29 (a Medicaid patient); Patient 30 (a Medicaid patient); Patient 31 (a Vermont Medicaid patient); Patient 32 (a Medicaid patient); Patient 33 (a Medicaid patient); Patient 34 (a Medicaid patient).

63. Two of SMC's patients have expressed suicidal ideations at various points while in Covid-19 isolation. Patient 22 (a Medicaid patient) has stated "I want to die! I want to die!" and is now being treated by a psychiatrist. Patient 25 (a Medicaid patient) has pulled off the ventilation tubes and has been sent out to Albany Medical Center for treatment. These are recent developments for these two patients.

B. Defendants' false statements in the HERDS report relating to staffing levels

64. SMC undergoes quarterly and yearly facility-wide assessment of its patient population and the resources it needs to care for its residents. This is known as Quality Assurance and Performance Improvement ("QAPI") assessment. SMC's latest annual QAPI occurred in March 2021. Part 3 of the QAPI report provides information on the staff census needed to properly care for the patients in each unit during each shift. SMC is organized into different patient units:

the North unit houses the young adult population, the South unit houses toddlers and pre-teenagers, the New South unit houses pre-teenagers through teenagers, the West unit houses young adults and teenagers, the East units house Ped C, residents on ventilation, and respite residents. SMC operates in three shifts: 7 a.m. to 3 p.m., 3 p.m. to 11 p.m., and 11 p.m. to 7 a.m.

65. According to the QAPI report, the North unit requires two nurses during the day and one nurse overnight, and 2-3 Certified Nursing Assistants ("CNAs") during the day and afternoon shifts and two CNAs overnight. The South unit and New South unit each require one nurse at all times and share 3-4 CNAs during the day and afternoon shifts and 2-3 CNAs overnight. The West unit requires one nurse at all times and 2-3 CNAs during the day shift, 3 CNAs during the afternoon shift, and 2 CNAs overnight. The East units require 2 RNs, 1 LPN, or 1 RN and 2 LPNs, and two respiratory therapists at all times as well as 3 CNAs during the day and afternoon shifts and 2 CNAs overnight. In total, SMC requires 20-23 patient care staff during the day shift, 21-22 patient care staff during the afternoon shift, and 17-18 patient care staff overnight to properly care for its patients. In other words, SMC requires a minimum of 58 and a maximum of 63 patient care staff daily.

66. In reality, SMC is continually understaffed. For example, only 48 nursing staff worked on December 3, 2021. Only 47 nursing staff worked on October 18, 2021. Only 50 nursing staff worked on October 17, 2021. Only 52 nursing staff worked on October 16, 2021. Only 53 nursing staff were scheduled to work on June 29, 2021. Only 54 nursing staff were scheduled to work on June 12, 2021. Only 53 nursing staff were scheduled to work on April 28, 2021. Being understaffed affects the amount of time each nursing personnel spends with individual patients because but there is fewer staff available in each unit to render the level of care required by each patient. Therefore, patients do not receive the level of care they need.

67. Defendants knowingly inflated the number of staff reported on the HERDS reports to hide this problem. The HERDS report requires SMC to report the number of staff who worked at the facility the previous day. SMC uses the Kronos system to track employee schedules and hours worked. The Kronos reports show the true number of all staff (including nursing, therapy, clerical, kitchen, and housekeeping staff) who work at SMC on any given day. The nursing department comprises the majority of SMC's staff. Reporting inflated numbers on the HERDS report suggests that SMC has more nursing and direct patient care staff on any given day than it does in reality.

68. Below are four examples of days when SMC reported inflated staff numbers on the HERDS report:

a) On July 23, 2020, SMC reported on the HERDS report that 137 individuals worked at the facility on July 22, 2020. The Kronos report shows that only 63 individuals worked at SMC on July 22, 2020.

b) On May 22, 2021, SMC reported on the HERDS report that 155 individuals worked at the facility on May 21, 2021. The Kronos report shows that only 99 individuals worked at SMC on May 21, 2021.

c) On October 20, 2021, SMC reported on the HERDS report that 148 individuals worked at the facility on October 19, 2021. The Kronos report shows that only 111 individuals worked at SMC on October 19, 2021. The daily schedule shows that 52 nursing staff worked at SMC on October 19, 2021.

d) On December 2, 2021, SMC reported on the HERDS report that 155 individuals worked at the facility on December 1, 2021. The Kronos report shows that only

about 100 individuals worked at SMC on December 1, 2021. The daily schedule shows that only 54 nursing staff worked at SMC on December 1, 2021.

69. Ruth Keneston (SMC's Manager of Human Resources and Operations) and Catherine Welcome (Administrator-in-training) have access to the data SMC submits through the Payroll-Based Journal System, which shows staffing information reported to CMS.

C. Evidence of Defendants' knowledge of SMC's false reporting and purposeful understaffing to increase profits by lowering the labor burden

70. Every facility like SMC is required to have a named administrator, whose responsibility is to assure compliance with regulations and that the plan of care for each patient is carried out. Catherine Welcome is the Administrator-in-training at SMC making some of the decisions. However, she is practicing under Defendant Sorrentino, Acting Administrator of SMC, as she has not yet obtained her administrator license and has little experience. Relators have observed that Defendant Sorrentino spends little time at SMC – he is only there a couple hours a week to attend meetings.[20] Defendant Sorrentino knows that the facility is extremely short staffed, a fact that has caused harm to many of the patients, as set forth herein. Yet SMC continues to bill New York Medicaid and Medicare for the highest reimbursements – averaging about $720/day per patient but sometimes as much as $1,400/day per patient – and has received those payments.

71. SMC's management is aware of the understaffing issue the facility faces but has not fixed, or seriously attempted to fix, the problem. Since being promoted to Nursing Admissions Director in August 2021, Relator Minshell meets with Defendant Sorrentino on a weekly basis to discuss new patient admissions. These "admission meetings" are scheduled on Mondays or

[20] He attends a weekly "admissions meeting" with Relator Minshell and Ms. Welcome and another meeting with Jen McDonald, Head of Finance/Business at SMC.

Thursdays.[21] She has observed that Defendant Sorrentino prioritizes increasing SMC's revenue over patient care. Despite Relator's repeated complaints that SMC is severely understaffed and cannot adequately care for its existing patients, Defendant Sorrentino has not taken serious action to hire new nursing staff and continues to admit new patients.

72. SMC has admitted seven new patients between August 2021 and December 3, 2021. SMC is a 94-bed facility, including two respite beds. As of December 8, 2021, 86 of the 92 long- and short-term beds are occupied, and three beds are on hold for pending patient admissions. Five beds are empty, including the two beds reserved for respite patients.

73. Relators have offered to attend job fairs and suggested that SMC post signs that it is hiring, but SMC's management has not agreed to either option. Relators also know that their colleagues have referred friends to apply to SMC, but the friends who applied did not receive a call back or an interview. For example, Nicole Rogers (SMC's MDS Coordinator) knows of several CNAs from Baptist Nursing and Rehabilitation Center in Scotia, NY who applied to SMC, but SMC would not offer them prevailing wages, so they were not interested in the position.

74. Furthermore, SMC is losing employees because it removed incentives. When Defendant Sorrentino assumed control in or about 2018, SMC removed ventilation unit pay incentives for the day shift (an additional $4/hour for LPNs and $8/hour for RNs if working on the ventilation unit), removed double-time pay and time-and-a-half pay for working extra shifts, and restricted the alternative shift pick-up incentives ($50 per shift for CNAs, $100 per shift for LPNs, and $150 per shift for RNs when working an extra shift) to times of emergency. SMC also does not offer competitive pay and denies raises. Heather Ewell has worked as an LPN at SMC for

[21] These meetings initially took place on Mondays from 3 p.m. to 4 p.m. On or about October 2021, these meetings were rescheduled to Thursdays. However, these meetings were cancelled the last several weeks. The last meeting Relator Minshell attended was in mid-November 2021.

almost five years. She is leaving her employment at SMC in December 2021 because she was denied a raise on her fifth-year employment anniversary.

75. In addition, the Departmental Income Statement shows that SMC budgeted only $56 annually for staff recruitment.

76. Hiring additional staff would increase expenses, but not necessarily revenue as SMC is operating at near-capacity, and Defendant Sorrentino has made an executive decision not to correct the understaffing problem that SMC is facing.

77. Richard Lilkas is an LPN and house supervisor at SMC and has been vocal about the dangers and increasing risks at SMC due to the severe staff shortages. He sent an email to Defendant Sorrentino, Catherine Welcome, Siranoush Bagramian (Director of Nursing) and Ruth Keneston (Manager of Human Resources and Operations) voicing his concerns. He subsequently met with Defendant Sorrentino and the three individuals in late October 2021 to discuss his concerns. On December 17, 2021, Relator Minshell sent a text message to Mr. Lilkas about his conversations with Defendant Sorrentino regarding the understaffing problem and the resulting harm to the patients. She wrote:

> **Relator Minshell:** "Hey my friend, So [sic] I am going to approach Greg and Cathy about these admissions and how unsafe we are with no staff and we really need to stop. I know you had a similar conversation with Greg and I wanted to see how it went to prepare myself and how to say it"
>
> **Mr. Lilkas:** "We have a culture of short staffing not safety or making these kids life better."
>
> **Relator Minshell:** "True. We've been running short and unsafe even prior to covid [sic]. I just wanted to know Gregs [sic] response to you about it, so I know how I should approach"

Mr. Lilkas: "They don't understand how fast these kids can go South, and it's not like an adult Nursing home where the residents are DNR, these are someone's kids and especially on South New South, we have 6 which require constant respiratory intervention, and are ½ mile away from any RT [respiratory therapist] support!"

Relator Minshell: "…What did Greg say to you when you brought these things to his attention so I can prepare myself."

Mr. Lilkas: "And we have ambulatory kids, one nurse on the floor doesn't cut it, while the treatment nurse is on North, he said they had a plan , [sic] but Nurses continue to leave or go per diem, and a lot more are talking about leaving."

Relator Minshell: "…I don't understand why he doesn't care we have no staff and wount [sic] stop admissions"

Mr. Lilkas: "They are not about the kids they are about $$$$, Sue Waters [former Director of Nursing] used to say if you're not about the kids you have no business being here. … They basically let [Patient 35] die , [sic] I sent her out 5 minutes after I got there at 11 p , [sic] CNA aid she was like that all day and no one even put eyes on her, she died 2 hours after I sent her out her mother barely even made it there before she died"

Relator Minshell: "I remember that. These kids are suffering, the staff is traumatized. Everyone shouldn't feel like It's going into a battle field [sic] every time they come to work. They are well aware of the open positions, the pressure sores, broken bones, declines in status, traumatized staff, Massive amounts of OT (like the 6 day 12 hrs stretch you just did) to try to do what we can for these kids. I'm sorry for all of you, things have been so bad and keep getting worse and no one cares to rescue these kids or staff. Ive [sic] talked

to management till my face turned blue, but I'm going to be direct to Greg. I need to before another child dies and we carry that guilt too."

78. The patient Mr. Lilkas referenced in the text message is Patient 35. She had not been feeling well for a couple of days and Mr. Lilkas sent her to Albany Medical Center on or about April 23, 2020, while she was in respiratory distress. The patient passed away a few hours later. SMC was short staffed then and the patient did not receive the care she needed. Mr. Lilkas reported the occurrence to Relator Minshell as she was charge nurse of the unit at the time. Mr. Lilkas reported that "no one has looked at her for almost nine hours."

79. On November 26, 2021, Relator Minshell had a phone conversation with Ashley Saunders who was the Acting House Supervisor on Thanksgiving Eve into Thanksgiving Day about the staffing issues at SMC. Ms. Saunders was scheduled to work 11 p.m. to 7 a.m. but SMC was so understaffed that she came in to work again at 8 p.m. to 7 a.m. the evening of November 25th into the morning of November 26th. Ms. Saunders called the Director of Nursing, Siranoush Bagramian, RN, as well as the on-call RN Nursing Administration, Dennisha Kownack, RN, but both refused to come in.

80. In early December 2021, SMC's nursing staff was planning a walk-out because they refused to continue working at SMC under current conditions. Only 54 nursing staff worked on December 1st and 48 nursing staff on December 3rd, 2021.

81. While on a phone call with NYSDOH on December 14, 2021, Siranoush Bagramian, Director of Nursing stated that SMC is not as understaffed as some of the other facilities. After the call, Ms. Bagramian explained: "We're not that bad compared to other facilities. We are not violating any rights of anyone. … 20 patients per nurse is not the end of the world. 40 is not the end of the world." SMC is a specialty care facility for medically fragile infants,

children, and young adults. SMC's patients are of a higher level of acuity than nursing home patients generally.

82. The subject of the call with NYSDOH was, in part, a recent incident which occurred at SMC. Patient 36 had a code blue emergency on December 13, 2021. He had a seizure that caused him to aspirate, which altered his breathing. He was not breathing when the code was called but he did have a pulse. SMC staff were not able to render proper care because they could not find the supplies they needed, such as a backboard and an Oxygen tank.

D. Known understaffing resulting in substandard patient care and patient injuries and harm

i. Serious Falls and Broken Bones

83. Due to insufficient staffing, patients at SMC, including young children, regularly sustain serious and life-threatening injuries. Many serious injuries go unreported to the New York State, with SMC's management requiring that all incidents be reported solely to facility management, who make the final decision whether to report. Relators have observed that many serious incidents are not reported to the State unless a patient is sent to Albany Medical Center, where medical records would also document the incident. Below are six examples of patient falls and injuries.

a) Patient 28 is a three-year-old Medicaid patient with significant mental and physical disabilities caused by nonaccidental subdural hematomas when she was nine months of age. She experiences respiratory failure, seizures, dysphagia, and has limited cognitive function, among other serious conditions. She is 1:1 assist, which means one staff member must be with the patient at all times. This patient has regularly fallen from her crib at SMC, including two times within a 24-hour period. The crib is about 3 feet high. Her falls are directly attributable to the insufficient

staffing at SMC and impede any hope she has at improving her condition. In one instance, on or around May 13, 2020, Ms. Hodge arrived at work at 7:00 a.m. and learned that this patient had fallen from her crib at 10:00 p.m. the previous night and was injured. No staff at SMC had called the patient's family, the on-call nurse, or a doctor. While this patient should have been sent to the hospital immediately as she could have had a concussion, she was only sent after Relator Hodge called for an ambulance.

b) Patient 37 is a five-year-old Fidelis patient with Down syndrome, a congenital heart defect, and an extremely limited ability to communicate. Despite his plan of care requiring one-on-one supervision since his admission to SMC, within two weeks of admission, on or around March 24, 2021, he was sent to the hospital via ambulance when a wheelchair scale weighing approximately 150 pounds fell on his head while he was unattended. The nursing notes in his medical chart are contradictory regarding supervision, with the nurse assigned to his care for that day claiming he was supervising this patient and the other nurse claiming they found him alone in his chair, crying hysterically. The March 2021 CASPER does not list this patient under "falls" or "falls with major injury."

c) Patient 8 is a 26-year-old Medicaid patient with spastic quadriplegic cerebral palsy, gastroesophageal reflux disease without esophagitis, expressive language disorder, and neuromuscular sclerosis, among other conditions. He is not independently mobile and requires assistance with all daily living activities. On September 10, 2019, Relator Minshell found this patient in bed in his room moaning and in discomfort. He was later taken to the hospital where it was determined that his

femur was broken in two places. The origin of the break was never determined, as no report related to an incident causing the break had been reported. He was physically incapable of causing the break himself due to his lack of mobility. The September 2019 CASPER does not list this patient under "falls" or "falls with major injury".

d) Patient 8 was discovered with a broken leg again on December 10, 2021, by the day shift staff. He is a two-person assist but only one staff member documented working with the patient the night before the injury was discovered. This is the second femur break for this patient. As described above, he was previously injured in September 2019.

e) Patient 38 is a 36-year-old Medicaid patient with shaken infant syndrome, profound intellectual disabilities, and epilepsy. On December 29, 2019, Richard Lilkas, LPN, created an internal note describing his encounter with the patient. Mr. Lilkas "discovered a cut over the residents [sic] right eyebrow and what appeared to be blood on the corner of the wall." The patient was sent to the emergency room per the nurse's recommendation. The December 2019 CASPER does not list this patient under "falls" or "falls with major injury".

f) Patient 34, a Medicaid patient, fell out of her bed during the early morning of December 20, 2021. She was sent to the hospital hours later in severe pain with a possible broken arm. She has a displaced distal humerus fracture. SMC was understaffed on December 20, 2021. Only 53 nursing staff worked that day.

ii. Pressure Ulcers

84. Relators regularly observe that immobile patients at SMC do not have their positions in bed changed, are not moved out of their beds, and do not have their tracheotomy ties changed and/or adjusted, as required by their plans of care. As a result, patients develop stage 2 and stage 3 pressure ulcers, which become infected. SMC staff are directed not to report pressure ulcers to the State of New York and facility management take the position that newly found pressure ulcers did not originate at SMC. Below are several examples of patients with pressure ulcers.

a) Patient 19 is a 24-year-old Medicaid patient with quadriplegia, microcephaly, chronic respiratory failure, and profound intellectual disabilities, among other conditions. Only two months after he received a tracheotomy tube, around November 2020, one of SMC's staff discovered this patient had a stage 3 pressure ulcer under his tracheotomy tie. The facility's wound nurse, Nicole Rogers, RN (she is also SMC's MDS Coordinator and Infection Control Nurse) reported she had not seen the pressure ulcer and it was never reported to State of New York. The wound nurse has since reported that this patient's pressure ulcer has healed. Pictures taken on August 28, 2021 show that the pressure ulcer had not healed and had developed a fungal infection.

b) Patient 15 is an 11-year-old Medicaid patient with a traumatic intracerebral hemorrhage and no verbal or motor skills. A picture taken on May 25, 2021 shows a pressure ulcer discovered by Relator Hodge. This is the second pressure ulcer found by staff on this patient in approximately a six-month period. Neither pressure ulcer has been reported to State of New York.

iii. Hygiene and Infections

85. Due to lack of staffing at SMC, patients' dressings and diapers are not timely changed and patients go weeks without being showered or bathed, resulting in infections. Relators regularly encounter patients who have not been changed for 12- to 24- hours and have soiled both their diapers and the absorbent material in their beds. When they are able to, both Relators sign the fresh diapers they dress patients in to confirm that the patients were not changed in the 12-hour period between their shifts. Below are several examples of this.

a) Pictures taken on September 20, 2021 show Patient 19, a Medicaid patient, with infected or unclean gastrostomy-jejunostomy ("G/J") tubes, which are common among SMC patients. All children with G/J tubes have standing physician orders to clean the site with soap and water at least twice daily as well as applying split gauze around the site to keep it clean and dry and reduce friction. This regularly does not occur, resulting in pain, discomfort, and infection for patients at SMC. This patient who was found with dry bile and extremely irritated skin near his G/J tube. The pictures also show this patient's fungal infections from not being bathed. After being released from the hospital on August 23, 2021, this patient had not been showered as of September 15, 2021, despite being the only patient with his own bathroom and shower. The pictures show a fungal infection on this patient's thigh and an untreated fungal rash growing on this patient's foot.

b) Relator Hodge observed soiled tracheotomy ties on Patient 5, a Medicaid patient, on August 5, 2021. This patient has meningitis leading to encephalitis, with no intentional movement or ability to speak. As with all patients with tracheotomy ties, the patient's plan of care requires that her tracheotomy ties are changed at least twice per day. In some cases, Relators write their initials on newly applied

tracheotomy ties, diapers, and similar dressings, showing that they had not been changed since their last shift, approximately a 12-hour period. Changes are required as often as every two hours under patients' plans of care, but the facility is so understaffed that this is impossible.

c) Patient 12 is a 13-year-old CDPHP Medicaid patient with paraplegia, spina bifida, cerebral palsy, limited movement, limited cognition, who cannot articulate appropriately for his age. A note by social services dated May 26, 2021 at 10:53 a.m. shows that this patient had not been bathed for seven weeks. This patient suffered an in-line sepsis infection as a result of the unhygienic conditions he was subjected to at SMC.

d) Patient 23 is a 19-year-old Medicaid patient who lacks intentional movement, is nonverbal, and is completely dependent on staff for all care. Relator Hodge found this patient laying in a pool of liquid feces in and around the patient's bed on or about November 21, 2019. Relator Hodge estimates the patient had been laying in these conditions for approximately four hours due to staffing issues.

iii. Contractures

86. In part due to the understaffing problems, SMC patients do not participate in needed range of motion activities. The nursing department does not have enough time to perform range of motion activities. This has resulted in patients developing contractures. Below are two examples of this.

a) Patient 21 is a Medicare and Medicaid patient. The patient has resided at SMC most of her life. Pictures taken on September 23, 2021 show that the patient has

developed contractures on her arms, hands, fingers, ankles, and spine (including neck). The patient does not have the necessary bracing she should be wearing.

b) Pictures taken on September 20, 2021 show that Patient 19, a Medicaid patient, has developed contractures in his arms, fingers, and ankles.

iv. Other Life-threatening Situations

87. Patient 3 is a Medicaid patient. His plan of care requires a BiPap at all times while he in bed or asleep. Pictures show this patient's mask was put on upside down, choking him. The patient is non-verbal and does not have the manual dexterity to pull the mask off. Relator Hodge found the patient with his mask upside down when his Oxygen alarm triggered due to low blood-oxygenation levels.

88. Patient 39 is a two-year-old Medicaid patient with hypertension, tracheostomy, and who is gastrostomy-tube dependent. Relator Hodge discovered this patient unattended, presenting multiple risks of death. The patient could choke from the seatbelt if she slid too far down in the bouncer and could easily suffocate from being in the bouncer with a tracheotomy tube. Bouncers should only be used if an aide or a nurse is in the immediate vicinity. Around 2012, a child died at SMC while left unattended like Patient 39. Relators do not recall that patient's name.

COUNT I: FALSE OR FRAUDULENT CLAIMS
31 U.S.C. Sec. 3729(a)(1)(A)

89. Relators repeat and re-allege each allegation in each of the preceding paragraphs as if fully set forth herein.

90. During the period 2018 to the present day, Defendants knowingly or in deliberate ignorance or reckless disregard of the truth presented or caused to be presented false or fraudulent claims for payment or approval, in violation of the False Claims Act, 31 U.S.C. Sec. 3729(a)(1)(A). Specifically, Defendants presented or caused to be presented claims for payment to Medicare and

Medicaid for medically substandard services at SMC which derived from the fraud and caused harm to the patients. Medicare and Medicaid, unaware of the substandard services and the patient harm, paid for these claims.

91. By virtue of the false or fraudulent claims Defendants knowingly presented or caused to be presented, the United States has suffered actual damages in an amount to be proven at trial. The United States is entitled to recover treble damages plus a civil monetary penalty for each and every false claim.

COUNT II: FALSE STATEMENTS MATERIAL TO FALSE CLAIMS
31 U.S.C. Sec. 3729(a)(1)(B)

92. Relators repeat and re-allege each allegation in each of the preceding paragraphs as if fully set forth herein.

93. During the period 2018 to the present day, Defendants knowingly or in deliberate ignorance or reckless disregard of the truth made, used or caused to be made or used, false records or statements material to false or fraudulent claims, in violation of the False Claims Act, 31 U.S.C. Sec. 3729(a)(1)(B).

94. Defendants knowingly and purposefully underreported harm and injuries to the patients as set forth herein. Defendants made or caused to be made false statements in the CASPER submitted to CMS and the HERDS report submitted to NYSDOH. The government relied on those false statements and paid the fraudulent claims. The misrepresentations were material as the term is defined in the False Claims Act and interpreted by the courts.

95. By virtue of the false records or statements Defendants made, used or caused to be made or used, the United States has suffered actual damages in an amount to be proven at trial. The United States is entitled to recover treble damages plus a civil monetary penalty for each and every false claim.

COUNT III: REVERSE FALSE CLAIMS ACT
31 U.S.C. Sec. 3729(a)(1)(G)

96. Relators repeat and re-allege each allegation in each of the preceding paragraphs as if fully set forth herein.

97. During the period 2018 to the present day, Defendants made and used or caused to be made or used false records or statements material to an obligation to pay or transmit money to the United States, or knowingly concealed, avoided, or decreased an obligation to pay or transmit money to the United States. Defendants knowingly underreported harm and injuries to the patients as set forth herein. Defendants made or caused to be made false statements in the CASPER submitted to CMS and the HERDS report submitted to NYSDOH to avoid alerting the government to the substandard services rendered at SMC, and continued to submit claims to, and collect reimbursement from, Medicare and Medicaid for the substandard services rendered at SMC.

98. Such false records or statements or knowing concealment, avoidance or decrease of an obligation to pay or transmit money to the United States were made or done knowingly, as defined in 31 U.S.C. § 3729(b)(1). Failure to return any overpayment such as the claims on which Defendants received any overpayment from Medicare or Medicaid constitutes a reverse false claim under 31 U.S.C. § 3729(a)(1)(G) of the False Claims Act.

99. By virtue of Defendants' conduct, the United States has suffered actual damages in an amount to be proven at trial. The United States is entitled to recover treble damages plus a civil monetary penalty for each and every false claim.

COUNT IV: FALSE OR FRAUDULENT CLAIMS
NY State Finance Law, Art. XIII § 189(1)(a)

100. Relators repeat and re-allege each allegation in each of the preceding paragraphs as if fully set forth herein.

101. During the period 2018 to the present day, Defendants knowingly or in deliberate ignorance or reckless disregard of the truth presented or caused to be presented false or fraudulent claims for payment or approval in violation of the New York False Claims Act, State Finance Law, Art. XIII § 189(1)(a). Specifically, Defendants submitted claims for payment to the New York Medicaid for substandard services at SMC which derived from the fraud and caused harm to the patients. New York Medicaid, unaware of the substandard services and patient harm, paid for these claims.

102. By virtue of the false or fraudulent claims Defendants knowingly presented or caused to be presented, the State of New York has suffered actual damages in an amount to be proven at trial. The State of New York is entitled to recover treble damages plus a civil monetary penalty for each and every false claim.

COUNT V: FALSE STATEMENTS MATERIAL TO FALSE CLAIMS
NY State Finance Law, Art. XIII § 189(1)(b)

103. Relators repeat and re-allege each allegation in each of the preceding paragraphs as if fully set forth herein.

104. During the period 2018 to the present day, Defendants knowingly or in deliberate ignorance or reckless disregard of the truth made, used or caused to be made or used, false records or statements material to false or fraudulent claims, in violation of the New York False Claims Act, State Finance Law, Art. XIII § 189(1)(b).

105. Defendants knowingly and purposefully underreported harm and injuries to the patients as set forth herein. Defendants made or caused to be made false statements in the CASPER submitted to CMS and the HERDS report submitted to NYSDOH. The State of New York relied on those statements and paid the fraudulent claims. The misrepresentations were material as the term is defined in the New York False Claims Act and interpreted by the courts.

106. By virtue of the false records or statements Defendants made, used or caused to be made or used, the State of New York has suffered actual damages in an amount to be proven at trial. The State of New York is entitled to recover treble damages plus a civil monetary penalty for each and every false claim.

COUNT VI: REVERSE FALSE CLAIMS
NY State Finance Law, Art. XIII §§ 189(1)(g) and 189(1)(h)

107. Relators repeat and re-allege each allegation in each of the preceding paragraphs as if fully set forth herein.

108. During the period 2018 to the present day, Defendants made and used or caused to be made or used false records or statements material to an obligation to pay or transmit money to the State of New York or knowingly concealed, avoided, or decreased an obligation to pay or transmit money to the State of New York. Defendants knowingly underreported harm and injuries to the patients as set forth herein. Defendants made or caused to be made false statements in the CASPER submitted to CMS and the HERDS report submitted to NYSDOH to avoid alerting the government to the substandard services rendered at SMC, and continued to submit claims to, and collect reimbursement from, New York Medicaid for the substandard services rendered at SMC.

109. Such false records or statements or knowing concealment, avoidance or decrease of an obligation to pay or transmit money to the State of New York were made or done knowingly, as defined in State Finance Law, Art. XIII § 188(3). Failure to return any overpayment such as the claims on which Defendants received any overpayment from the New York Medicaid program constitutes a reverse false claim under Art. XIII §§ 189(1)(g) and (h) of the New York False Claims Act.

110. By virtue of Defendants' conduct, the State of New York has suffered actual damages in an amount to be proven at trial. The State of New York is entitled to recover treble damages plus a civil monetary penalty for each and every false claim.

PRAYER FOR RELIEF

WHEREFORE, Relators demand and pray that judgment be entered in favor of the United States, the State of New York, and Relators as follows:

1. On Counts I, II, and III, enter judgment holding the Defendants jointly and severally liable for the maximum civil penalties permitted for each violation of the federal False Claims Act committed by the Defendants;
2. On Counts I, II, and III, enter a judgment against the Defendants jointly and severally for three times the amount of damages sustained by the United States of America because of the acts of the Defendants;
3. On Counts IV, V, and VI, enter judgment holding the Defendants jointly and severally liable for the maximum civil penalties permitted for each violation of the New York False Claims act as pled herein;
4. On Counts IV, V, and VI, enter judgment against the Defendants jointly and severally for the damages sustained by the State of New York because of the acts of the Defendants described herein, multiplied, as permitted under the New York False Claims Act;
5. Award the Relators a percentage of the proceeds of the action in accordance with 31 U.S.C. § 3730;
6. Award the Relators a percentage of the proceeds of recoveries under the New York False Claims Act;
7. Award the Relators their costs and reasonable attorneys' fees and costs for prosecuting

this action; and

8. All other relief as may be required or authorized by law in the interest of justice.

DEMAND FOR JURY TRIAL

Relators, on behalf of themselves, the United States, and the State of New York, demand a jury trial on all claims alleged herein.

Dated: January 3, 2022

Respectfully submitted,

Relators Amanda Hodge and Jennifer Minshell by their Counsel

Robert W. Sadowski
New York Bar # 2023794
Robert W. Sadowski PLLC
800 Third Avenue, 28th Floor
New York, NY 10022
Tel: 646-503-5341
rsadowski@robertwsadowski.com

Jeffrey A. Newman, Esq.
Massachusetts BBO # 370450
Newman & Shapiro
One Story Terrace
Marblehead, Ma. 01945
Tel: 978-880-4758
Fax: 781-639-8688
jnewman@newmanshapiro.com
jeffrey.newman1@gmail.com
Pro Hac Vice to be filed