SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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PEOPLE OF THE STATE OF NEW YORK by LETITIA JAMES, Attorney General of the State of New York,

Petitioner,

-against-

AFFIDAVIT OF MARY E. CONWAY, R.N.

FULTON COMMONS CARE CENTER, INC.; MOSHE KALTER; AARON FOGEL; FRADY KALTER; ESTHER FOGEL; MINDY STEGER; SHEINDY SAFFER; CHANA KANAREK; DOVID KALTER; YITZCHOK KALTER; ARYEH KALTER; SHEVA TREFF; CHAYA LIEBERMAN A/K/A SARA LIEBERMAN; THE NEW FULTON COMMONS COMPANY LLC; FULTON COMMONS REALTY CO., L.P.; FULTON COMMONS REALTY CO., INC.; THE NEW BRIDGE VIEW COMPANY LLC; STEVEN WEISS; and CATHIE DOYLE,

Respondents.

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State of New York)
) ss.:
County of Nassau)

Mary E. Conway, being duly sworn, deposes and says:

1. I am a Registered Professional Nurse ("RN") employed as a Medical Analyst by the New York State Office of the Attorney General, Medicaid Fraud Control Unit ("MFCU"). I have been a Medical Analyst with MFCU for six years and have participated in multiple investigations into activities of Medicaid providers, including nursing homes. I am part of the MFCU team investigating resident neglect and Medicaid provider fraud at Fulton Commons Care Center, Inc. ("Fulton Commons"), a 280-bed nursing home, located at 60 Merrick Avenue in East Meadow, New York.

2. The facts stated hereafter are based both upon my personal knowledge and upon information and belief. The sources of this information and basis for this belief are specified herein. Because this Affidavit is being submitted for the limited purpose of supporting the Verified Petition, I have not included details of every aspect of the investigation.

3. I have been licensed as an RN since 1997. Prior to being hired as a Medical Analyst with MFCU, I practiced as an RN in a long-term care setting and a subacute facility, both commonly referred to as a nursing home. My duties and responsibilities included performing comprehensive nursing assessments (including risk assessments) of new admissions on long term and cardiac subacute units; medication order verifications; making entries into the electronic medical record ("EMR") systems; medication and treatment administration, including complex treatments such as replacing gastric tubes and performing vacuum-assisted wound closures; conducting safety rounds, daily resident assessments, and incident/accident assessments; providing patient-centered care; supervising Certified Nurse Aides ("CNAs") and Licensed Practice Nurses ("LPNs") to ensure they were performing their duties effectively and appropriately; establishing communication and building rapport with residents and their families; and reviewing discharge information with residents and their families to provide instructions for taking care of the residents' medical needs at home. I was also involved with the Suffolk County Community College Preceptor Program for Leadership and Management, which involved making rounds with student-nurses, writing daily reports regarding patients, drafting patient assessments, and communicating with staff members to build cohesive quality work environments. Lastly, as a Nursing Supervisor, I implemented new policies and procedures and oversaw the delivery of care to residents. Prior to becoming an RN, I worked first as a CNA and then as an LPN in nursing homes. In total, I worked in the nursing home industry for approximately 35 years.

4. In the course of my duties as a Medical Analyst at MFCU, I review medical records maintained by healthcare providers, including nursing home resident charts and/or EMR and other facility records. In addition, I compare such records to those maintained by other treating healthcare providers, such as community-based physician records and hospitals. I analyze data collection and review trends in the nursing home industry to assist in the improvement of quality-of-care issues that are discovered. I also interpret and provide support for medical concepts to other MFCU staff members.

5. In the body of this Affidavit, in consultation with other MFCU Medical Analysts, I set forth some key concepts relating to the care of nursing home residents, including applicable laws and regulations. These concepts are explained below and include: (1) Residents' Increased Frailty and Medicaid Provider Duties (p. 4); (2) Legal Duties of New York Nursing Home Operators to Care for Residents (pp. 4–9); and (3) Nursing Home Administration and Governance (pp. 9–10). I also describe the negative healthcare outcomes frequently experienced by nursing home residents who do not receive appropriate care in the section titled: Dangers of Insufficient Staffing to Nursing Home Residents (pp. 11–40). Finally, I describe how Fulton Commons failed to meet its obligations and neglected its residents in the following sections: (1) Fulton Commons Neglected Residents (pp. 40–41); (2) Fulton Commons' Urinary Tract Infection ("UTI") Treatment Rates Suggest Resident Neglect (p. 41); (3) Fulton Commons Neglected Resident A.C. (pp. 41–43); (4) Fulton Commons Neglected Resident E.B. (pp. 43–44); (5) Fulton Commons Denied Residents the Ability to Make Informed Decisions, and Misled Family Members (pp. 44–45); (6) Fulton Commons' Records Reflect That Fulton Commons Underreported its Presumed COVID-19 Deaths by Over 45% (pp. 45–47); (7) Fulton Commons Increased Risk to Residents by Failing to Cohort Residents by COVID-19 Status, Despite Having a Designated COVID-19

Unit (pp. 48); (8) Fulton Commons Neglected Resident C.B. by Failing to Provide Necessary Medical Treatment (pp. 48–49); and (9) Fulton Commons Increased Risk to its Residents by Having an Unlawful Policy that Treated Sexual Abuse Allegations as Grievances (pp. 49–50).

I. Nursing Home Residents' Increased Frailty and Medicaid Provider Duties

6. For well over a decade, a greater proportion of the nursing home population has become increasingly frail, with greater acute care needs, and more comorbidities. Although nursing homes are perhaps seen in popular culture and facility advertising as places where elderly people go to live and participate in recreational activities, they are in fact "Skilled Nursing Facilities" that primarily provide subacute care to people who are very much dependent on nursing home staff for their complex medical and basic human needs.

7. To participate in the New York State Medical Assistance Program ("Medicaid") and Medicare, nursing homes—like all providers enrolled in government-funded healthcare programs—must comply with state and federal rules, regulations, and laws. (*See* 10 NYCRR § 504.3; *see also* 10 NYCRR § 415.1; 42 CFR § 424.5; 42 USC § 1396r.)

II. Legal Duties of New York Nursing Home Operators to Provide Required Care to Residents

8. As detailed below, state and federal statutes and regulations impose obligations and comprehensive duties on nursing homes and their operators to provide all required and necessary care to, and prohibit the neglect, abuse, and mistreatment of, nursing home residents. State and federal statutes also require nursing homes and their employees to report suspected neglect, abuse, and mistreatment of residents. (*See* 42 USC § 1320b-25; *see also* Public Health Law § 2803-d.)

9. The law views a nursing home as a resident's "home" as much as "a medical institution." (10 NYCRR § 415.1[a][5].) The rights of nursing home residents flow from the

concept that a nursing home is their home.[1] Thus, New York State law imposes on operators of nursing homes a "special obligation" to care for their residents and to meet every basic human need. (10 NYCRR § 415.1[a][1].) To meet this obligation, nursing homes are required to ensure that each resident receives the care, treatment, diet, and health services that they need to "attain or maintain their highest practicable physical, mental and psychosocial well-being." (10 NYCRR § 415.12.)

A. The Resident Care Plan

10. As mandated by New York State law, nursing homes, in conjunction with a physician, are required to evaluate and describe the needs of each resident in a comprehensive care plan ("care plan"). (*See* 10 NYCRR § 415.11[c]; *see also* 42 CFR § 483.25.) The resident care plan identifies health concerns and directs courses of care and treatment, specifying, among other things, medications, assisted movement, skin care, bowel and bladder care, and psychological, social, and nutritional needs. Thus, "Physician's Orders" direct what medication and treatments RNs and LPNs are required to administer, and the care plan directs the responsibilities of the interdisciplinary team, which includes the duties that CNAs must perform. Nursing homes are required to ensure residents receive care and treatment in accordance with their individualized care plans as well as general professional standards of practice. (*See* 42 CFR § 483.25.) In fact, failing to meet recognized standards in furnishing medical care, services, or supplies is an "unacceptable

[1] "The facility shall provide: (1) a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible; (2) housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior; (3) clean bed and bath linens that are in good condition; (4) comfortable and safe temperature levels; and (5) for the maintenance of comfortable sound levels." (10 NYCRR § 415.5[h].)

practice" under the Medicaid Program pursuant to 18 NYCRR § 515.2(b)(12), vitiating any claim for reimbursement.

B. Nursing Homes Must Have Sufficient Caregiver Staff to Care for Each Resident

11. The law requires that nursing homes provide services by sufficient personnel on a 24-hour basis to meet the care needs of each of their residents in accordance with their individualized care plans. (*See* 10 NYCRR § 415.13.) This requirement includes the obligation for nursing homes to "have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." (10 NYCRR § 415.13; *see also* 42 CFR § 483.35.)

12. To ensure they operate with sufficient resources to provide required resident care, nursing homes must limit admissions and "accept and retain only those . . . residents for whom [they] can provide adequate care." (10 NYCRR § 415.26[i][1][ii].)

C. Resident Bill of Rights: The Law Requires Nursing Homes to Treat Residents with Dignity and to Provide Appropriate Medical Care

13. Under state and federal law, each resident has the right to "adequate and appropriate medical care." (Public Health Law § 2803-c[3][e]; *see also* 10 NYCRR § 415.10; 42 CFR § 483.10[d][2].) State and federal law also require nursing homes to treat each resident with courtesy, respect, and dignity, and to care for each resident in a manner and in an environment that promotes the maintenance or enhancement of his or her quality of life. (*See* Public Health Law § 2803-c[3]; *see also* 10 NYCRR § 415.3; 42 CFR § 483.10[a][1].)

14. Moreover, state law requires that nursing homes provide each resident with the rights enumerated under the Residents' Bill of Rights, codified at Public Health Law § 2803-c. (*See also* 10 NYCRR § 415.3.)

15. Under the Residents' Bill of Rights, each nursing home resident has the right to be "fully informed of his or her medical condition and proposed treatment." (Public Health Law § 2803-c[e]; *see also* 10 NYCRR § 415.3[f][1][i].) Moreover, residents have the right to "be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being." (10 NYCRR § 415.3[f][iv].)

D. Nursing Homes Are Required to Document Resident Care They Provide

16. In any nursing home, staff are required to accurately document what care is—and is not—delivered. RNs and LPNs must record the medications they administer on a "Medication Administration Record" ("MAR") and track the treatments they provide on a "Treatment Administration Record" ("TAR"). CNAs must also document in an appropriate medical record, often referred to as a "CNA Accountability Log" or "Resident Kardex," what care they delivered, such as oral care, turning and positioning,[2] range of motion, toileting, changing briefs, and other services as required by the resident's care plan. New York State law requires that these records must be "complete [and] accurately documented." (10 NYCRR § 415.22[a][1]–[2].)

E. Definitions of Neglect, Abuse, and Mistreatment and the Duty to Report

17. Residents of New York State nursing homes are protected by law from acts of neglect, abuse, and mistreatment. (*See* Public Health Law § 2803-d[7].)

18. "Neglect" is defined as the "failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care . . . including but not limited to: nutrition, medication,

[2] "Turning and positioning" is the act of changing the body position of a resident who is unable to do so on their own, such as by rolling them from one side to the other or from one side to their back.

therapies, sanitary clothing and surroundings, and activities of daily living." (10 NYCRR § 81.1[c].)

19. "Abuse" is defined as "inappropriate physical contact with a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility, which harms or is likely to harm the patient or resident." (10 NYCRR § 81.1[a].)

20. "Mistreatment" is defined as "inappropriate use of medications, inappropriate isolation or inappropriate use of physical or chemical restraints on or of a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility." (10 NYCRR § 81.1[b].)

21. Nursing home operators, administrators, and employees (including RNs, LPNs, and CNAs) are required to file a report with the New York State Department of Health ("DOH") if they have reasonable cause to believe that a resident has been neglected, abused, or mistreated in the facility. (Public Health Law § 2803-d[1].) The willful failure to report suspected neglect, abuse, or mistreatment is a crime. (*See* Public Health Law §§ 12-b; 2803-d[7].)

F. Duties of Direct Care Staff in Nursing Homes

22. The direct caregivers in a nursing home are, in increased order of training and formal education: CNAs, LPNs, and RNs. CNAs carry out the bulk of the hands-on care required by nursing home residents, as specified in their individualized care plans. They assist residents with activities of daily living ("ADLs"), such as ambulation, transfers to/from bed, feeding, hygiene, toileting, bathing, dressing, bed cleaning and adjustments, turning and positioning of immobile patients, and other care and comfort. LPNs supervise CNAs and primarily focus on medication administration, monitoring vital signs, and providing certain treatments. RNs primarily supervise LPNs and CNAs to ensure they are performing their duties competently and diligently,

and monitor the residents' health to ensure they receive proper care. RN responsibilities further include addressing residents' acute care needs, performing complex treatments, ensuring compliance with medical orders, communicating with physicians and specialists, interacting with residents' families to report changes in condition, keeping records, and conducting complex health assessments, which include a comprehensive assessment upon admission. RNs spend much of their time assessing changes in their residents' conditions (whether unexplained or due to a fall or other incident and/or injury), conveying that information to physicians, and then implementing physicians' orders (most commonly, changes in medications or treatments), all of which must be documented in the residents' medical charts.

23. Although all nursing homes are required to have a medical director on call, physicians are not typically on-site around the clock.

III. Nursing Home Administration and Governance

24. The Administrator: Nursing homes operate under the supervision of a licensed administrator, who is required to manage the facility and recognize "that the institution exists to serve the interests and the needs of the residents." (10 NYCRR § 415.26[a][1]; *see also* 42 CFR § 483.70[d][2][ii].)

25. The Governing Body: Nursing homes are required to have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility, appointing the administrator, and the overall operation of the facility. (*See* 10 NYCRR § 415.26[b].)

26. The Medical Director: A nursing home is required to designate a full-time or part-time physician to serve as medical director. The medical director is responsible for implementing resident medical care policies and coordinating physician services and medical care in the facility.

(*See* 10 NYCRR § 415.15[a].) The medical care of each resident must be "supervised by a physician who assumes the principal obligation and responsibility to manage the resident's medical condition and who agrees to visit the resident as often as necessary to address resident medical care needs." (10 NYCRR § 415.15[b][1][i].)

27. The Director of Nursing ("DON") or Director of Nursing Services ("DNS"): Each nursing home is required to designate an RN as their DON or DNS on a full-time basis. (*See* 10 NYCRR § 415.13[b][2].) There are no regulations that define the duties and responsibilities of a DON/DNS in a nursing home, but the DON/DNS is typically responsible for leading and supervising the RNs, LPNs, and CNAs; ensuring necessary nursing care received by residents; ensuring that staff comply with all rules, regulations, and laws governing nursing homes; and reporting to the administrator.

28. Minimum Data Set ("MDS") Coordinator: Nursing homes typically have an MDS Coordinator who is responsible for comprehensive assessments of residents to determine functional capabilities and identify health problems. An important aspect of these assessments includes the appropriate coding of residents' diagnoses and clinical needs to ensure receipt of proper reimbursement for resident care. MDS assessments are conducted within days of a resident's admission, then at regular intervals as directed by DOH and the Centers for Medicare & Medicaid Services ("CMS"), and whenever there is a significant change in a resident's condition.

IV. The Dangers of Insufficient Staffing to Nursing Home Residents

29. As part of its "special obligation" to residents "who depend upon the facility to meet [their] every basic human need" (10 NYCRR § 415.1[a][1]), a nursing home must "have sufficient nursing staff to provide nursing and related services" (10 NYCRR § 415.13) and "shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or

maintain the highest practicable physical, mental, and psychosocial well-being of each resident." (10 NYCRR § 415.26; *see also* 42 CFR § 483.70.)

30. The adequacy of a nursing home's staffing is the measure most closely linked to the quality of care residents receive in nursing homes. (*See* Charlene Harrington, et al., *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, June 29, 2020, Health Serv. Insights, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/ [last accessed Dec. 5, 2022]; *see also* Marvin Feuerberg, *CMS Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report*, Baltimore, MD: CMS; 2001 [identifying minimum nurse staffing thresholds for "avoidance of crucial quality of care problems"].) Insufficient staffing occurs when a nursing home lacks sufficient direct care staff to provide its residents with the care specified in their individual care plans and required under the law. Insufficient staffing is one of the most significant factors leading to nursing home resident neglect, abuse, and mistreatment. When there is insufficient staffing, residents are more likely to get injured by falling, or can suffer from malnutrition, dehydration, or pressure injuries, as more specifically described below.

31. When a nursing home fails to sufficiently staff its residential units, the nursing home puts its caregivers into the impossible position of being assigned to provide too many services to too many residents during the caregiver's shift. Operating a nursing home with insufficient staffing—which includes insufficient RN supervisory staff—results in staff failing to provide care to residents. Insufficient staffing also results in resident neglect or substandard care, or creates an environment where residents are endangered as staff rush to complete their tasks before moving onto the next resident. As described below, when a nursing home has insufficient staff, caregivers fail to timely change residents' wet or soiled disposable briefs.[3] Staff fail to turn

[3] In addition, many residents who wear disposable briefs require the assistance of multiple caregivers when they are changed in order to be safely turned and positioned. Insufficient staff on

and position residents, increasing their risk of developing pressure injuries. Staff also fail to bathe or provide personal care necessary to ensure residents' proper hygiene and dignity. Moreover, residents who rely on their caregivers to feed them do not receive adequate nutrition or hydration as caregivers disregard care plans and rush through meals to move onto their next task.

32. Unsurprisingly, insufficient staffing and poor working conditions often result in nurses and other direct caregivers leaving their jobs, which only worsens the nursing home's staffing levels. This was exacerbated during the COVID-19 pandemic, when a disturbingly high number of nurses quit their jobs due to fear of losing their licenses if they made a mistake—which was more likely to occur as a result of working under poor conditions including insufficient staffing, low pay, and/or nursing staff being "burned out" as a result of their employers repeatedly mandating or assigning extra shifts to fill in the gaps caused by lack of staff.

A. Insufficient Supervisory RN Staffing Results in Neglect of Residents

33. Operating a nursing home with insufficient RN supervisory staff often results in resident neglect. Typically, nursing homes assign dedicated RNs to train LPNs and CNAs through orientation and ongoing "in-service" lessons. In addition, as part of their responsibility to ensure LPNs and CNAs are performing their resident care duties diligently and competently, RNs on the unit are responsible for providing their subordinates with any "on-the-job" training necessary. Nursing homes must ensure that they operate with adequate RN supervisory staff on the individual units to guarantee that staff are trained effectively and are timely completing their assigned duties, which includes providing care in compliance with the residents' care plans. When a nursing home fails to ensure sufficient RN supervision on the units, staff are more prone to providing care

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the unit can delay residents' receiving this assistance as the assigned caregiver must wait for an additional staff member to become available.

negligently and in violation of residents' care plans for the sake of expediency. In addition, RN supervision is essential on all units on all shifts, as LPNs cannot legally perform health assessments or other duties outside of their scope of practice. Accordingly, when a nursing home operates with insufficient RN staffing, its RNs lack adequate time during their shifts to provide effective supervision and training or perform resident assessments, which often results in resident neglect.

34. Training is an essential component to RNs' duties and responsibilities. If CNAs and LPNs are not trained effectively, they are more likely to provide negligent and/or insufficient resident care. Moreover, failing to effectively train staff in infection control protocols can lead to the spread of infectious disease within a facility, placing all residents (and staff) at risk of infection. Accordingly, a nursing home's failure to effectively train its staff gravely endangers its residents.

35. In this regard, I have reviewed excerpts of the transcript of an Executive Law § 63(12) examination of a Fulton Commons employee, whose full name and identity are known to me.[4] In their testimony, this confidential employee reported that they were required to place their signature on a sign-in sheet for an in-service that was not actually given, and that they felt they had to do so to avoid being harassed by the administration. Requiring nursing home staff to falsely document that they received in-service training that was not in fact given is not only illegal as a falsification of business records, but also endangers residents.

B. Nursing Homes Operating with Insufficient Staffing Externalize Costs to Family Members Who Tip, Pay for Private Care, or Directly Provide Necessary Care

36. Nursing homes are paid to provide essential care and treatment to residents, which includes custodial care, such as grooming and oral and nail care. Despite receiving payment for

[4] The transcript of this testimony is not attached hereto, as the witness expressed fear of retaliation from Fulton Commons' administration, however it will be made available to the Court for an *in camera* inspection upon request.

providing such care, when nursing homes operate with insufficient staffing, residents' family members are often compelled to fill the void and provide fundamental care to residents themselves.[5] Rather than watch their loved ones languish as they await for an overburdened staff member to become available, residents' families often feel bound to feed their loved ones, wash their clothes, and provide basic grooming. Unfortunately, when a resident does not have family or other loved ones to help or are in situations where visitation is prohibited, like during the first wave of the COVID-19 pandemic,[6] they lack the safety net of outside help and are left to suffer the indignities of neglect stemming from insufficient staff.

37. In addition, when nursing homes operate with insufficient staff—including insufficient RN supervisory staff—residents' families often feel compelled to either tip staff members in an effort to prevent their loved ones from being neglected or hire private caregivers to provide necessary care that the nursing home is required to yet fails to provide. Families of nursing home residents who resort to paying tips to nursing home staff often do so in the hope that overworked staff will prioritize the care of their loved one over another resident.

38. The law requires nursing homes to operate with sufficient staffing. (*See* 10 NYCRR 415.13.) By enrolling in the Medicaid Program, a nursing home agrees to accept Medicaid funds as payment in full for care, services, and supplies rendered. (*See* 18 NYCRR § 504.3[c].) It is inappropriate for nursing home owners to underpay direct care staff, thereby creating an environment where staff may be tempted to accept or even solicit tips from residents or their loved

[5] This concept, known as the externalization of costs, effectively stopped during the COVID-19 pandemic when government regulations barred visitors, including family members, from visiting residents to protect them from COVID-19 infection. However, rather than hiring more staff to provide the care that families were compelled to provide, many nursing homes simply failed to provide required care.

[6] As referenced herein, the first wave of the COVID-19 pandemic refers to the time period of March 1, 2020 through May 31, 2020.

ones—an act that should be prohibited under a nursing home's written policy and procedures. Tipping creates a two-tier system of inequality that discriminates against those residents who do not have family support or the economic means to tip. Prohibiting tipping prevents the nursing home operator from externalizing the cost of staffing its facility to others while retaining the revenue from residents' admissions.

C. Sufficient Staffing Requires Assessment of Resident Acuity to Prevent Neglect

39. It is crucial that nursing homes maintain safe staff-to-resident ratios based on each resident's "acuity." "Acuity" refers to the level of nursing care required for each resident's particular health conditions. If a resident's care plan requires two caregivers to assist the resident with various activities, such as turning and positioning, transferring to and from their bed/wheelchair, toileting, and feeding, the facility must assign sufficient staff to that resident's unit to ensure the necessary caregivers will be available to timely assist the resident when required. Nursing homes must also consider how long various activities take for the individual residents when determining appropriate staffing levels. For example, a resident who is wholly dependent on staff for movement and needs the assistance of two or more caregivers with a mechanical lift requires more time to get out of bed than a resident who can bear his/her own weight and needs the assistance of only one aide. Nursing homes that fail to employ sufficient staff to meet the individual needs of the residents place their residents at risk for serious injuries. Moreover, when staff members are rushed and overworked, residents' health conditions go unnoticed for prolonged periods of time, causing those conditions to progress into more significant issues that may lead to hospitalizations and, occasionally, death. Nursing homes that operate with safe staff-to-resident ratios enable caregivers to provide required care and attention to each individual's needs.

D. Insufficient Nursing Home Staffing Creates and Exacerbates Many Hazards Faced by Residents

40. Nursing homes must operate with sufficient staffing in all areas of the building (CNAs, LPNs, RNs, maintenance, safety committee, administration/department heads, supervision, dietary, physical therapy ("PT"), occupational therapy ("OT"), and activities) in order to prevent resident accidents and incidents, and to prevent the resulting adverse events and negative outcomes. Below is just a sampling of the many ways in which nursing homes operating with insufficient staff adversely impact their residents' care and health.

1. Insufficient Staffing Increases the Risk of Injuries from Accidents and Incidents

41. Accidents and incidents, a leading cause of injury in the elderly, are more prevalent in nursing homes that are insufficiently staffed. Nursing homes must ensure that "[t]he resident environment remains as free of accident hazards as is possible," and that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents." (42 CFR § 483.25[d].) An avoidable accident is one that occurs because the facility failed to either: (1) identify environmental hazards and an individual resident's risk of an accident (including the need for supervision); (2) analyze the hazards and risks; (3) implement interventions, including adequate supervision, consistent with the resident's individual needs and current standards of practice to reduce the risk of an accident; or (4) monitor the effectiveness of the interventions and modify them as necessary. (*See State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities* [rev. 208, Oct. 21, 2022], https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf at 297 [last accessed Dec. 1, 2022] [hereinafter the "State Operations Manual"]). Accidents can result in various injuries, including

fractures, contusions/bruises, burns, and intracranial (head) injuries, and can even lead to death. Falls are amongst the most common avoidable accidents in a nursing home.

42. Every resident admitted to a nursing home is required to be screened for falls as part of their care plan. (*Id*. at 233.) Conducting a comprehensive fall assessment and providing PT and OT with established goals and desired outcomes are essential aspects of nursing home care. Falls can result in injury, loss of independence, decreased mobility, hospitalization, and premature death. Lack of ambulation, nursing rehabilitation, PT, and OT leads to increased risk of falls. On the other hand, performing these services allows residents to increase their mobility and agility, and improves their overall physical and mental health.

43. Medications such as diuretics, narcotics, and psychotropic medications[7] increase a resident's risk of falls, as they can adversely affect a resident's gross motor skills. Restraints, such as the inappropriate use of bed siderails, increase a resident's risk of falls with injury, as residents may attempt to climb over them rather than call for assistance (or wait for assistance when caregivers fail to respond to call bells in a timely manner). Diagnoses such as Parkinson's disease, conditions that cause dementia such as Alzheimer's disease, arthritis, vertigo, and movement disorders all increase the risk of falls due to their effect on a resident's motor skills. Accordingly, nursing homes are required to consider these conditions as part of a resident's care plan and ensure that there is sufficient staff on the unit to implement the care plan and ensure the resident's safety.

44. Lack of Monitoring Causes Preventable Falls. Insufficient staff on the unit to adequately monitor residents increases the residents' risk of falls. For instance, insufficient staffing to perform safety rounds in order to proactively monitor residents increases the risk of a resident sliding off their bed and onto the floor. To help decrease the incidence of falls, nursing homes

[7] A psychotropic medication is a drug that affects the brain and nervous system, thereby impacting behavior, mood, thoughts, or perception.

should evaluate the prevalence of falls and add interventions to the safety prevention program, such as adding additional staff members to the schedule. **(***See* Mary T. Hoffman, et al., *Decreasing the incidence of falls in the nursing home in a cost-conscious environment: a pilot study,* Journal of Post-Acute and Long-Term Care Medicine, March 1, 2003, https://www.jamda.com/article/S1525-8610(04)70282-0/fulltext [last accessed Dec.4, 2022].)

45. Falls from Unanswered Call Bells by Residents Seeking Help with Toileting. Insufficient staff to timely answer call bells leads to an increased risk of falls, as residents who need assistance to use the bathroom but do not timely receive a response to their request for help are more likely to attempt to stand up, get out of bed, and try to walk or otherwise ambulate to the toilet themselves, often resulting in a fall. Insufficient staff to help residents carry out other ADLs also increases the risk of falls and injury, as it often leads to improper resident care, such as an aide transferring a resident from their bed to a wheelchair alone despite the resident's care plan requiring the assistance of two caregivers. Insufficient RN supervisory staff to oversee LPNs and CNAs performing their duties increases the risk of resident neglect and mistreatment by direct care staff who fail to provide required care to residents, either due to inadequate or poor training, inattentiveness, or staff simply providing substandard care due to lack of support from their colleagues.

46. Facility and Equipment Disrepair Can Cause Injury. Nursing homes that are in disrepair, have equipment in disrepair, or lack sufficient maintenance staff to monitor the physical aspects of a facility or to repair equipment, including medical devices such as wheelchairs and lifts, endanger their residents. For example, lack of staff to perform temperature checks on the water systems for bathing can lead to resident burns from hot water, and lack of maintenance staff to repair broken furniture can lead to residents injuring themselves on exposed screws or nails. In

addition, residents can injure themselves or fall getting into or out of a broken wheelchair or a wheelchair that is missing parts, such as footrests.

2. Insufficient Staffing Increases the Risk of Infection Due to Inadequate Infection Control Protocols

47. Infection prevention and control is a critical aspect of basic nursing home care. Nursing homes are expected to take all reasonable steps to avoid the transmission of disease, and never was that obligation more important than during the COVID-19 pandemic. Nursing home infection control regulations require every nursing home to maintain an infection control program with policies designed to provide a safe, sanitary, and comfortable environment in which residents vulnerable to infection reside (and their health care providers work). (*See* 10 NYCRR § 415.19; *see also* 42 CFR § 483.80.) A facility is required to have an infection control program in which the facility: (1) investigates, controls, and takes action to prevent infections in the facility; (2) determines what procedures, such as isolation, should be utilized for an individual resident to prevent continued transmission of a disease; and (3) maintains a record of incidence and corrective actions related to infections. (*See* 10 NYCRR § 415.19[a]; *see also* 42 CFR § 483.80[a].) Nursing homes are required to isolate residents when their infection control programs dictate that isolation is necessary, and properly sanitize and store all equipment to prevent the spread of infection. (*See* 10 NYCRR § 415.19[b].) Facilities are also required to mandate basic infection control practices, including ensuring that staff wash their hands after each direct resident contact and properly handle and store linens. (*See* 10 NYCRR §§ 415.19[b]–[c]; *see also* 42 CFR § 483.80[e].)

48. Important Infection Control Protocols Include Terminal Cleaning. Terminal cleaning refers to a nursing home's thorough cleaning of a room between room changes, new admissions, or discharges. It includes fully cleaning and disinfecting all surfaces in a room, including floors, mattresses, and curtains, as well as patient care equipment. Terminal cleaning

helps reduce the number of microorganisms and prevents the spread of germs, providing the resident with a sanitary and safe space. If a resident's room is not thoroughly sanitized before they are moved into the room, they are at a higher risk to contract a communicable or transmissible illness. Placing a resident in a room that has not been terminally cleaned is a gross violation of infection control protocols and constitutes neglect.

49. Important Infection Control Measures Include Ensuring Safe Room Assignments. When nursing homes admit new residents, or transfer residents from one room to another, they must consider whether the new assignment would place the resident's health at risk. Placing an uninfected resident into a room with an individual exhibiting symptoms of a communicable or transmissible illness would place the uninfected resident at risk for contracting that illness. Placing uninfected residents into rooms with residents exhibiting symptoms indicative of infections such as COVID-19 is a gross deviation of infection control protocols, especially if there are other rooms available; would increase residents' risk of infection, serious illness and/or death; and constitutes neglect.

50. Infection Preventionist. Under federal law, nursing homes are required to designate at least one individual who has "primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field[s]" and who has "completed specialized training in infection prevention and control" as their infection preventionist ("IP"). (42 CFR § 483.80[b].) The IP is responsible for the facility's infection control program and "must be a member of the facility's quality assessment and assurance committee and report to the committee . . . on a regular basis." (42 CFR § 483.80[b]–[c].)

51. Insufficient Staffing Leads to Infection Control Failures. As outlined in the Attorney General's January 2021 Report "Nursing Home Response to COVID-19 Pandemic"

("NH Report") (available at https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf [last accessed Dec.4, 2022]), DOH, CMS, and the U.S. Centers for Disease Control ("CDC") issued guidance to nursing homes to ensure proper infection control measures to protect residents from COVID-19. Despite pre-existing protocols, best practices, regulations, and further guidance, many nursing homes violated infection control protocols by: (1) failing to properly isolate COVID-19 residents when appropriate; (2) conducting lax employee COVID-19 screening that allowed positive cases into the facility; (3) demanding that sick employees continue working even when symptomatic; and (4) failing to obtain, fit, and train caregivers with personal protective equipment ("PPE"). Thus, those nursing homes neglected residents under New York State law by failing "to provide timely, consistent, safe, adequate and appropriate services, treatment, and/or care to a patient or resident of a residential health care facility." (10 NYCRR § 81.1[c].) The NH Report found that lack of infection control put residents at increased risk of harm, and that nursing homes that entered the pandemic with low CMS staffing ratings had higher COVID-19 fatality rates than facilities with higher CMS staffing ratings. (*See* NH Report at 17–21; 23.)

52. There is undoubtedly a connection between insufficient staffing and infection control as proper infection control practices take staff time to complete. When a nursing home fails to invest in sufficient staff, there are simply not enough staff on duty to maintain proper infection control. Overburdened staff are forced to move quickly from resident to resident and do not have time to comply with the methodical, time-consuming aspects of proper infection control, such as washing hands for a minimum of 20 seconds before and after care, donning and doffing PPE, and changing gloves properly after providing care to each resident. These steps become overwhelming for staff when they are assigned to care for too many residents, and they are thus forced to choose between violating infection control protocols—either by shortening the frequency and/or time

frames of necessary steps or skipping them altogether—or neglecting their residents, by failing to provide certain care altogether or providing poor care in an effort to try to respond expediently to the needs of as many residents as possible. Additionally, a nursing home operating with insufficient staffing is more likely to reassign designated infection control staff, like an IP, to help provide residents with basic required care. This forced diversion of the IP's focus would prevent a facility from timely identifying resident infections and result in untimely tracking and documentation of outbreaks. Timely identifying resident infections and tracking and documenting outbreaks are critical to combatting a communicable disease like COVID-19 in a medical or nursing home facility.

53. Insufficient staffing in the housekeeping department affects resident health as well. High touch surfaces of a nursing home cannot be appropriately cleaned by overburdened staff, nor can all resident rooms and common areas. Rooms requiring terminal cleaning may not be adequately cleaned or cleaned at all. Failure to appropriately clean rooms and surfaces increases the risk for infection transmission among residents and staff. Nursing homes operating with insufficient staffing may compel staff that are sick themselves to come to work, disregarding the risk that its staff may spread infection to residents or other staff members within the facility. In the age of COVID-19, continued testing and screening of staff, residents, and visitors is time-consuming, and insufficiently staffed nursing homes are more prone to disregard such infection control protocols, exposing residents to increased risk of infection from within and outside of the facility.

3. Insufficient Staffing Results in Increased Pressure Injuries

54. Pressure injuries, also known as pressure sores, pressure ulcers, or decubitus ulcers, are serious medical conditions and, according to the CDC, one of the most important measures of

the quality of clinical care and safety in nursing homes. (*See* Eunice Park-Lee et al., *Pressure Ulcers Among Nursing Home Residents: United States, 2004*, CDC, Feb. 2009, https://www.cdc.gov/nchs/products/databriefs/db14.htm [last accessed Dec. 4, 2022].) Nursing homes are responsible for preventing pressure injuries and are required to take precautions and provide appropriate care to prevent pressure injuries among the resident population. (*See* 10 NYCRR § 415.12[c]; *see also* 42 CFR § 483.25[b][1].) Pressure injuries, which may present as open ulcers, are wounds that develop on the skin covering bony areas of the body when pressure on that area cuts off blood supply for more than two to three hours. Pressure injuries can result from multiple sources, including misplaced or long-term use of devices, such as a wheelchair, braces, or bed siderails. However, in nursing homes, the most common cause of pressure injuries is staff failure to move a resident from a static position for an extended period of time. Leaving a resident lying in bed in one position for hours at a time with parts of their body—*e.g.*, heels, buttocks, back, hips, etc.—pressing down on the surface of the bed for an extended period can cause the skin to degrade. These injuries often occur when a nursing home resident is bedridden or continuously in a wheelchair, and staff fail to provide necessary, well-understood, and successful preventative care to timely alleviate pressure from the part of the resident's skin that is in contact with the bed or wheelchair.

55. While some people use the phrase "bed sores" to describe such injuries, "bed sore" is not a medical term and fails to convey the serious and painful nature of a pressure injury. A "bed sore" or a "pressure sore" is not at all the sort of minor ache and pain that a healthy person with a blister or sore elbow would experience. Facility-acquired pressure injuries, which are often

preventable and a sign of inadequate nursing home care, can lead to agonizing pain, bone infections, osteomyelitis,[8] sepsis,[9] and death.

56. There are four possible stages of pressure injuries. A Stage 1 pressure injury is a closed wound, meaning that the resident's skin is covering all parts of the body that are normally protected by skin. Stage 2, 3, and 4 pressure injuries are usually open wounds, meaning that portions of the resident's body that are normally covered by skin are exposed to open air or bandages, if such are placed over the wound. Under federal guidelines, a Stage 1 pressure injury is defined as "intact skin with a localized area of non-blanchable erythema." (State Operations Manual at 297.) A Stage 2 pressure injury is partial thickness loss of dermis (the inner layer of the two main layers of skin) presenting as a shallow open ulcer with a red or pink wound bed, without slough. (*Id*.) Slough is non-viable yellow, tan, gray, green, or brown tissue that may be adherent to the base of the wound or present in clumps throughout the wound bed. (*Id*. at 296.) A Stage 3 pressure injury is full thickness tissue loss, where the lost tissue extends past the two layers of skin, and where the subcutaneous fat may be visible, but bone, tendon or muscle is not visible. (*Id*. at 297.) Slough may be present but does not obscure the depth of tissue loss. (*Id*.) A Stage 4 pressure injury is full thickness tissue loss, where the lost tissue includes all layers of skin, and exposed bone, tendon, or muscle is clearly visible. (*Id*.) Slough, or eschar, which is necrotic[10] tissue that is dryer than slough and adheres to the wound bed, may be present on some parts of the wound bed.

[8] Osteomyelitis is inflammation or swelling that occurs in the bone. It can result from an infection anywhere in the body that spreads to the bone. Osteomyelitis is a serious condition that requires immediate medical treatment.

[9] Sepsis is the body's life-threatening response to an infection, which can lead to tissue damage, organ failure, and death.

[10] Necrosis is the death of a portion of tissue in the body that occurs when there is not enough blood supplied to the area.

(*Id*.) In addition, an "unstageable pressure injury" is one where the extent of the injury cannot be determined due to non-removable dressings/devices, coverage of the wound bed by slough and/or eschar, or because it is a deep-tissue injury (*id*. at 297–298); contrary to the implication of the word "unstageable" to a layperson, it is a very severe condition.

57. To prevent pressure injuries in residents who lack the ability to sufficiently move their own bodies independently, nursing homes must frequently turn and position such residents. Nursing homes must also appropriately use assistive devices, such as gel cushions and air mattresses, to reduce some of the pressure on the skin for residents who spend the bulk of their day in a wheelchair or bed. To prevent the development and/or worsening of pressure injuries, nursing homes must also conduct regular skin integrity checks. By doing so, if a Stage 1 pressure injury does develop, treatment can be administered upon early onset, mitigating the likelihood of the injury progressing to Stage 2 or worse.

58. Notably, although the phrase "turn and position" may sound like a relatively minor event, it plays an important role in preventing pressure injuries. Certain residents that require such turning and positioning may lack the physical and/or cognitive ability to perform the large and small adjustments necessary to meaningfully move their own bodies—to turn from their backs to their sides or from one side to the other in bed, to lift their heels, to sit up, or to lift their arms above their heads. Residents who need turning and positioning are not able to perform the position changes themselves, therefore they cannot relieve pressure from the skin that was in contact with the bed or chair. Turning and positioning helps to increase the blood flow to pressure prone areas and supports the wound healing process.

59. Residents who are immobile or suffer from incontinence, poor nutrition, dehydration, cognitive deficits, or medical conditions that affect blood flow—such as diabetes and

heart disease—are more susceptible to developing pressure injuries. Accordingly, the risk of developing pressure injuries increases when nursing home staff fail to ensure residents receive and consume adequate food and water. Similarly, once a pressure injury has formed on a resident's body, poor nutrition and/or poor hydration impede the body's ability to heal.

4. Insufficient Staffing Increases the Risk of Resident Malnutrition, Dehydration, Weight Loss, and Aspiration

60. Providing food and fluids to a nursing home resident is essential to sustain the resident's life, health, and well-being, and to promote healing. Malnutrition and dehydration—the lack of appropriate and adequate food and fluids—can lead to a host of physical issues, including weakness, infections, delirium, cardiac arrhythmia, and overall deterioration of the body. They can also take an emotional and psychological toll on a resident, causing a lack of motivation to participate in activities or lack of cooperation with their care plan. Malnutrition and dehydration are often the result of neglect or mistreatment.

61. A nursing home must ensure that a resident "maintains acceptable parameters of nutritional status, . . . is offered sufficient fluid intake to maintain proper hydration and health[,] and . . . is offered a therapeutic diet." (42 CFR § 483.25[g].) Sufficient dietary staff are necessary to perform temperature checks on meals and follow meal preparation procedures to decrease the risk of harm to residents. Sufficient nursing home staffing plays a pivotal role in ensuring that a resident's nutritional needs are met. Many residents require supervision and/or physical assistance while eating. Such assistance may include providing encouragement to continue eating, supervision to ensure the resident does not aspirate,[11] or full-on feeding of a resident who is disabled and unable to feed themselves. Essential supervision during mealtimes includes

[11] Aspiration is the condition in which food, liquids, saliva, or vomit is breathed into a person's airways.

monitoring food trays, supervising distribution of meals, ensuring compliance with residents' individual diets, and ensuring that residents are in a place where they can safely and properly consume food. For example, a resident whose care plan requires precautions to minimize the risk of choking or aspiration must be supervised during mealtimes to ensure their safety. A resident who suffers from Parkinson's disease or another neurological disorder may need to be fed by a caregiver. Nursing homes must train staff members on how to effectively provide the necessary supervision and/or assistance to such residents during mealtime. A nursing home operating with inadequate staffing (whether by sheer number of direct care or RN supervisory staff and/or a lack of competent or effectively trained staff), increases the risk that its residents will not be properly fed or hydrated, thereby leading to malnutrition, dehydration, and weight loss. Operating with inadequate staffing also increases the residents' risks of aspiration, choking, pneumonia, and death.

5. Insufficient Staffing Increases the Risk of Medication Errors

62. Individuals living independently typically have the ability to identify their medication, accurately self-administer the proper dosage, and report to their physician any issues they perceive. However, in nursing homes, most residents are reliant upon the nurse (LPN or RN) to accurately administer, evaluate, and report all aspects of the resident's medication needs.

63. Nursing homes operating with insufficient staffing increase the risk of errors in the administration of medications to their residents. Namely, insufficient and/or inadequate staffing creates stressful working conditions that increase the risk of nurses committing medication errors, as a nurse's ability to give adequate time and attention to the task at hand is impeded by the overwhelming responsibility of administering medication to too many residents during a shift. Medication errors include incorrectly transcribing new medication orders, administering the wrong medication to a resident, administering medication in an amount other than what is prescribed, or

administering medicine when it is medically inappropriate to do so based on the resident's vital signs (or when the resident's vital signs were not measured appropriately, or at all).

64. Significant medication errors can be dangerous to a resident's health and safety and even cause death. State and federal law require that nursing homes keep residents free from significant medication errors, and any such errors must be reported both internally to the facility as well as to DOH. (*See* 10 NYCRR §§ 405.17, 415.12[m][2]; *see also* 42 CFR § 483.45[f].)

65. In nursing homes, medication errors often occur as omissions (medications were ordered but not administered), lack of authorization (no physician's order), or an administration outside of the "Five Rights," which are the "right": (1) patient, (2) time, (3) medication, (4) dosage (either amount or form, such as tablet rather than liquid), and (5) route (method of administration). Nurses are also required to complete the "Three-Check Process," which entails: (1) matching the label on the medication's container to what is listed on the resident's MAR; (2) preparing the medication and identifying the medication by looking at it; and (3) conducting a second and final check to ensure that the label on the medication's container matches the resident's MAR. To minimize the risk of medication errors, medication should not be prepared ahead of the scheduled time of administration. The nursing home is responsible for ensuring that nursing staff have adequate time to administer medications and that "the Five Rights" and the "Three-Check Process" are incorporated into their own policies and procedures. If nurses are not adequately trained regarding the facility's policies and procedures when receiving an order, or are overwhelmed with the responsibility to care for the basic needs of too many residents, there could be a delay or error in the transcription and ultimate administration of that medication. Receiving medication that should not have been administered, or failing to receive a timely, proper dose of a medication that should have been administered, could have serious implications on a resident's overall health.

6. Insufficient Staffing Can Result in Nursing Homes Unlawfully Utilizing Chemical and Physical Restraints on Residents

66. Understaffing nursing homes increases the risk of staff members inappropriately and illegally using psychotropic medications to sedate residents to make them more docile and reduce the amount of time that staff would otherwise be required to spend appropriately providing care for these residents.

67. A resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience of staff. (*See* 10 NYCRR § 415.4[a][1]); *see also* Public Health Law § 2803-c[h]; 42 CFR § 483.10[e][1].) "Physical restraints" include leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions, lap trays, or any other physical device that: (1) a resident cannot easily remove, and (2) restricts the resident's movement. (*See* State Operations Manual at 340; *see also* 10 NYCRR § 415.4[a][2].) A "chemical restraint" is the inappropriate use of medication to restrict movement or suppress thought and/or free will. (*See* State Operations Manual at 125–126; *see also* 10 NYCRR § 415.4[a][1].) Psychotropic drugs frequently act as chemical restraints by causing side effects such as lethargy, increased falls, abnormal involuntary movements, lack of socialization, and a decline in physical function. If psychotropic drugs are ordered, it is imperative that nursing homes take steps to minimize these side effects while maintaining the therapeutic effectiveness of the medication.

68. Each nursing home must develop and maintain a written policy prohibiting the use of inappropriate restraints and detailing the limited circumstances in which restraints may be used. (*See* 10 NYCRR § 415.4[a][7].) The facility's policies and procedures must include considerations for the risk of physical and cognitive decline as a result of restraints and ensure that measures are in place to minimize any such decline. (*See* 10 NYCRR § 415.4[a][2].) If any type of restraint is deemed appropriate, the facility must ensure that the least restrictive device is implemented for the

least amount of time and that ongoing evaluations occur to reduce the need for the device (including tapering a resident from a chemical restraint-medication). (*Id*.; *see also* State Operations Manual at 125–128.) The individual resident's medical record must include an order from an appropriate medical provider, a rationale for use of the device or medication, potential underlying causes of the behavior, documented attempts at non-pharmacological interventions, potential risks and benefits of the device or medication as discussed with the resident and/or the resident's family, specific target behaviors and expected outcomes, and a plan of care. (*See* State Operations Manual at 125–128.) Ongoing evaluations for the continued use of the restraint must occur at least quarterly and more frequently if warranted. (*Id*. at 573.) If psychotropic medications are prescribed to treat behavioral symptoms, the symptoms must be clearly documented and a scheduled gradual dose reduction must be attempted to ensure that the resident is receiving the lowest possible dose of the medication for the shortest period of time. (*Id*. at 125–128.)

69. Improper use of physical or chemical restraints can lead to life-threatening injuries and/or death. For example, improper use of side rails for a resident with impaired cognition and poor safety awareness can trap a resident who attempts to exit the bed without the necessary assistance of staff and cause death by asphyxiation. Similarly, many psychotropic medications are accompanied by a "black box" warning that they are contraindicated for residents diagnosed with dementia as they can increase their risk of death.[12] Other potential injuries can include a decline in physical function, muscle contractures (*see* ¶ 78 below), increased incidence of infections,

[12] The Food and Drug Administration ("FDA") has required manufacturers to place the strongest caution, known as a "black box warning," on the packaging of many psychotropic drugs to advise against the medicines' use in patients suffering from dementia. According to the FDA, such drugs almost double the risk of death and have never been approved as safe or effective for treating symptoms of dementia. Despite the warning and in violation of federal regulations, nursing homes often administer antipsychotic drugs, sometimes without first seeking informed consent.

development of pressure injuries, falls, and incontinence. There may also be cognitive effects, such as increased agitation, depression, and anxiety. Restraints can lead to a resident becoming emotionally withdrawn and cause them to experience a decrease in their self-esteem and, in turn, a decrease in their quality of life. Chemical restraints have the potential to include all of the above adverse effects, as well as toxic effects of the medication and other health conditions, and can also result in a resident becoming catatonic.[13]

70. Adequately monitoring and caring for residents whose care plans include the use of restraints requires additional caregiver duties. Accordingly, nursing homes must often increase direct care staffing to be able to perform these additional tasks. Specifically, physical restraints have release periods, during which the various restraints are required to be removed for a certain length of time at regular intervals. Similarly, chemical restraints often coincide with a resident being deemed a fall risk, which, in turn, requires increased monitoring. These additional caregiver duties cannot adequately be performed without sufficient direct care staff in the facility. Moreover, proper training and supervision of direct care staff are essential components of minimizing unnecessary restraints. Caretakers must be trained on various interventions to utilize when a resident exhibits aggressive behavior (such as redirection, de-escalation, and calming techniques like offering a snack, taking the resident for a walk, or offering recreational therapy) before seeking an order for physical or chemical restraints. Nursing homes operating with insufficient or inadequate staffing increase the risk of caregivers inappropriately and unlawfully physically or chemically restraining their residents.

[13] Catatonia is a group of symptoms characterized by abnormal movements, immobility, lack of speech, abnormal behaviors, and withdrawal.

7. Insufficient Staffing Increases the Risks of Resident Isolation and Depression

71. Residents of nursing homes that are insufficiently staffed are more likely to suffer from isolation and depression due to beleaguered direct care staff being forced to triage—allocating their limited time to provide care to the residents with the greatest or most time-sensitive needs, or to the residents most capable of advocating for themselves. In extreme cases, this can result in nursing home staff improperly and illegally using isolation to punish or mistreat residents. In addition, insufficiently staffed nursing homes frequently have inconsistent and unfamiliar staffing due to high employee turnover or the nursing homes' use of agency staff to avoid paying the cost of employee fringe benefits, thereby exacerbating residents' feelings of distrust and loneliness. Isolation can be a contributing factor to depression, which can, in turn, cause a loss of interest in normal daily activities, a feeling of hopelessness, a lack of productivity, lower self-esteem, and an overall feeling of inadequacy that interferes with the ability to sleep, eat, and enjoy life.

72. Research has consistently shown that loneliness and social isolation negatively impact physical and mental health and contribute to a higher mortality rate in older adults. (*See National Institute on Aging: Social isolation, loneliness in older people pose health risks*, National Institute on Aging, April 23, 2019, https://www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks [last accessed Dec. 4, 2022].) Prolonged loneliness and social isolation are associated with a wide range of physical, cognitive, and psychological health conditions, which can lead to cardiovascular disease, hypertension, obesity, depression, substance abuse, suicidal ideation and suicide attempts, cognitive decline, progression of dementia, stroke, and premature death. The rate of depressive symptoms among nursing home residents suffering

from dementia is higher than it is among the general population, and such residents may exhibit additional symptoms, such as delusions and hallucinations.

73. Recreational therapy and other activity-based interventions are critical to combat the severe risks associated with isolation and to improve a resident's overall physical health, cognition, and emotional well-being. Nursing homes must provide "an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community." (42 CFR § 483.24[c]; *see also* 10 NYCRR § 415.5[f].) Further, the program must "promote and maintain the resident[s'] sense of usefulness . . . [and] make [their] life more meaningful . . . ." (*See* 10 NYCRR § 415.5[f].)

74. Recreational therapists work with the healthcare team to set attainable goals and develop individualized plans of care. Recreational therapists offer outcome-based therapeutic programs in small groups or one-to-one sessions for older adults with a variety of mental and physical conditions. Therapeutic recreation interventions or activities can include such things as physical games, cognitive games such as cards and trivia, social events, reminiscing activities, arts and crafts, sensory programs such as hand massage, and outings, including to restaurants or sporting events, and fishing trips. Residents with a dementia diagnosis should have specialized small group programs or individual programs to provide the appropriate amount of challenge and stimulation to help maintain current function, which, in turn, results in a decrease of difficult behaviors. Recreational therapy interventions make a tremendous difference in the outcomes of older adults in nursing homes.

75. Despite loneliness and social isolation being among the most fixable risk factors for mortality and morbidity, nursing homes too rarely prioritize providing care that addresses these serious issues. In fact, when cutting expenses, many nursing homes first cut recreational therapy programs from their budgets. In nursing homes that are insufficiently staffed, overworked caregivers are required to focus on residents' physical needs and have little, if any, opportunity to spend time with each resident, much less provide recreational therapy. Residents deserve therapeutic activities to maintain and improve their physical and cognitive function.

8. Insufficient Staffing Leads to Less Assistance with Activities of Daily Living and Personal Care and Leads to Loss of Dignity

76. Many nursing home residents need assistance with ADLs and personal hygiene due to, *inter alia*, difficulty with mobility or cognitive processing. Nursing homes are required to treat residents with dignity and in a manner that promotes the maintenance and enhancement of each resident's quality of life. (*See* Public Health Law § 2803-c[3]; *see also* 10 NYCRR § 415.3; 42 CFR § 483.10[a][1].) State and federal laws recognize that "quality of life is a fundamental principle that applies to all care and services provided to facility residents." (42 CFR § 483.24*; see also* 10 NYCRR § 415.5.) Thus, the law requires that nursing homes provide residents with care and services relating to their ADLs, which include: (1) "Hygiene - bathing, dressing, grooming and oral care," (2) "Mobility - transfer and ambulation, including walking," (3) "Elimination - toileting," (4) "Dining - eating, including meals and snacks," and (5) "Communication, including (i) [s]peech, (ii) [l]anguage, [and] (iii) [o]ther functional communication systems." (42 CFR § 483.24[b]; *see also* 10 NYCRR 415.12[a].) Undoubtedly, proper hygiene and grooming are important aspects of maintaining good health and dignity and are critical to a resident "attaining or maintaining their highest practicable physical, mental, and psychosocial well-being." (10 NYCRR § 415.12.) Accordingly, under both state and federal law, nursing homes are required to

provide residents with "the necessary services to maintain good nutrition, grooming, and personal and oral hygiene." (10 NYCRR § 415.12[a][3]; *see also* 42 CFR § 483.24[a][2].)

77. Nursing home residents suffer when a nursing home fails to operate with sufficient staff to provide the required care and services to assist residents with all of their ADLs, consistent with state and federal law. Nursing homes that operate with insufficient staffing regularly direct their caregivers to work under poor and stressful conditions, forcing them to try to "beat the clock" to provide required care to too many residents. In so doing, such nursing homes deprive residents of the care and services that they are legally required to provide and defraud Medicaid and Medicare by accepting reimbursement for care that residents did not wholly receive.

78. Mobility and Ambulation. Mobility is critical to the overall health of nursing home residents. This includes ensuring that residents maintain proper range of motion in their joints and limbs. Failure to keep a resident moving is known to cause functional decline and complications affecting the respiratory, cardiovascular, gastrointestinal, integumentary (skin, nails, hair, and glands), musculoskeletal, and renal systems. Lack of mobility and ambulation can be especially devastating to an older adult as the aging process causes a more rapid decline in function and potentially leads to contracture, which is the abnormal shortening of muscle tissue, rendering the muscle highly resistant to stretching. Contracture causes the joints to shorten and become very stiff, which can lead to permanent disability. This deterioration can be prevented through ambulation and passive or active range of motion on a regular daily schedule. Ambulation leads to not only improved physical function, but also improved emotional and social well-being. A lack of the ability to ambulate puts limitations on social life—including limitations on visiting with friends or close relatives, religious expressions, and artistic expressions—and increases solitude.

79. The range of motion activities necessary vary from resident to resident based on their individual functional abilities. Some residents may need assistance with moving their limbs while lying in bed, while others may require assistance with walking particular distances a certain number of times each day. When facilities fail to adequately staff their units based on the needs and acuity of the residents, staff members are more likely to rush through their tasks and fail to provide the necessary range of motion activities to residents or even get them out of bed to ambulate.

80. Toileting. Urinary and fecal incontinence are comorbid conditions affecting many nursing home residents. Toileting refers to assisting dependent residents with their waste elimination needs, which can vary from assisting a resident to walk to the bathroom to assisting a resident with the use of a bedpan or urinal, or, for a more dependent or incontinent resident, meeting their elimination needs with the use of disposable briefs, incontinence pads, or urinary catheters. Proper toileting is critical to the overall health of a nursing home resident, as failure to toilet is linked to serious health outcomes. Proper toileting, or bowel and bladder training, is also necessary to assist a resident in regaining continence or containing incontinence when possible. Proper toileting is also central to an individual's sense of dignity and control. When staff fail to timely respond to call bells, residents with basic cognition, but impaired mobility, may attempt to reach the toilet without the necessary caregiver assistance to avoid physical discomfort and/or embarrassment, placing them at risk for falls.

81. A nursing home's failure to promptly change a resident's soiled disposable brief can cause severe health problems, such as skin breakdowns that lead to pressure injuries. Moreover, forcing residents to suffer excessive delays in receiving assistance with toileting often

results in continent residents holding their urine for excessive periods of time, in hopes that staff will eventually respond, which increases the risk of UTIs and pressure injuries.

82. Dining. Dining, hydration, and a healthy diet are critical to ensuring residents receive the nourishment required to maintain health. The level of assistance required by residents to eat varies greatly. Some residents may have difficulty with or be entirely unable to lift and/or move a utensil to their mouth, open packaging containing plastic silverware or food items, or cut the food to appropriate size for their chewing and swallowing abilities to prevent choking. Other residents may only require encouragement to continue eating their meal and/or consume sufficient quantities of foods or liquids, or monitoring to prevent the risk of choking, aspiration, and vomiting. As described in ¶ 61 above, when nursing homes operate with insufficient staffing to meet the needs and acuity of their residents, their overburdened and/or unsupervised direct caregivers cannot allot sufficient time to properly assist all of their residents with dining safely.

83. Communication. Communication is critical to avoid devastating isolation, which, as described in ¶¶ 73–74 above, negatively impacts mental health and contributes to an increased mortality rate in older adults. Research has shown that increased verbal activity improves self-esteem and results in decreased levels of depression. (*See, e.g.*, Sunghee H. Tak et al., *Activity Engagement: Perspectives from Nursing Home Residents with Dementia*, Educational Gerontology, Mar 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4256713/ [last accessed Dec. 4, 2022].)

84. Hygiene. Nursing homes must maintain each resident's personal hygiene, such as regular bathing and dental hygiene, to maintain their dignity and ensure that they "attain or maintain the highest practicable physical, mental, and psychosocial well-being." (10 NYCRR § 415.12.)

Bathing. Regular bathing is fundamental to maintaining an individual's physical and psychosocial well-being. Nursing homes should take each resident's individual preferences into account when determining how they should be bathed—whether receiving showers, full baths, sponge baths, etc. Not only does bathing remove dirt and bacteria and promote blood circulation, but it also plays a vital role in maintaining a resident's overall self-esteem and self-image. Like all ADLs, the level of bathing assistance needed varies from one resident to the next. Some may only require assistance with getting to and from the shower room, while others may be wholly dependent on their caregivers for bathing.

Dressing. Many nursing home residents need assistance with dressing, an ADL that requires significant dexterity and hand-eye coordination. Though seemingly mundane, getting dressed is a daily activity that significantly impacts a resident's psychosocial welfare. Nursing homes that operate with insufficient staffing also increase the risk that a resident needing assistance with dressing will grow frustrated when forced to wait and fall while attempting to get dressed independently.

Grooming. Grooming, which includes hair care and nail care, is also essential to maintaining a resident's health, dignity, and self-esteem. Regularly brushing a resident's hair not only impacts their self-image, but also prevents hair from tangling and becoming matted. Regular nail care helps residents present a neat appearance and prevents residents from accidentally injuring themselves by scratching themselves, or from getting dirt and/or bacteria stuck under their nails. Assistance with these basic ADLs maintains residents' dignity and improves their self-esteem. Nursing homes operating with insufficient staffing to provide required care to their residents based on their unique needs and acuity increase

the risk of caregivers failing to properly groom residents, thereby negatively impacting residents' physical and psychosocial health.

Dental Hygiene**.** Dental hygiene is incredibly important to the overall health of a nursing home resident. Failure to maintain proper dental hygiene has been linked to heart disease and other medical conditions. Nursing homes must assist residents with routine dental care and provide emergency dental services to meet the needs of each resident. (*See* 42 CFR § 483.55; *see also* 10 NYCRR § 415.12.) Nursing homes must operate with sufficient staffing to provide required oral care to residents. Insufficiently staffed nursing homes increase the likelihood of their staff failing to regularly brush residents' teeth and/or otherwise provide appropriate dental hygiene, thereby increasing the risk that residents' teeth will decay, rot, develop infection, need to be extracted, and cause preventable pain and suffering.

9. Insufficient Staffing Increases the Risk of Loss of Residents' Property

85. Nursing home residents have the right to retain and use personal possessions, including furnishings and clothing. (*See* 42 CFR § 483.10[e][2].) When nursing homes operate with insufficient staffing, residents' personal belongings, including important medical devices such as dentures and hearing aids, are frequently discarded or lost within the facility. It is well known among those caring for the geriatric population that nursing home residents suffering from cognitive deficits are prone to misplace their possessions, including by leaving them on food trays or unmade bedding. Caregivers who are assigned to provide care to too many residents are predictably rushed in performing overwhelming care duties and frequently discard residents' personal property, or otherwise fail to adequately safeguard residents' personal property, when cleaning residents' rooms or removing trays after meals. Moreover, nursing homes operating with

insufficient staffing often fail to safeguard residents' clothing, depriving residents of a key aspect of their self-esteem and dignity. Some nursing homes cut expenses by failing to invest in sufficient staff to properly handle the important obligations of labeling, washing, folding, and returning clothing to their residents.

86. Sadly, when a resident's clothing, dentures, or hearing aids are lost or damaged, residents or their families are often forced, out of necessity, to bear the cost of replacing those crucial items—even though it is the facility's responsibility to replace them. During the time that it takes to obtain a replacement, the resident is forced to live without the benefit of the lost item, *e.g.*, a resident whose clothing was lost is forced to wear ill-fitting clothing, someone else's clothing, or no clothing at all; a resident whose dentures were misplaced is left unable to chew properly or even at all; and a resident whose hearing aid was lost is left hearing-impaired and unable to participate fully in conversations.

V. Fulton Commons Neglected Residents

87. MFCU has established that Fulton Commons neglected its residents—in large part by operating the facility with dangerously low and/or inadequate staffing, violated basic infection control principles, and dramatically underreported resident deaths from COVID-19 to DOH.

88. Since in or about March 2020, I have reviewed various medical records in order to conduct several analyses including, but not limited to, that of Fulton Commons' infection control program and treatment and reporting of COVID-19 confirmed and/or suspected residents, as detailed at length in ¶¶ 93–106 below. These records include various resident charts as well as Fulton Commons' 24-hour Daily Reports ("24-hr reports").[14] 24-hr reports are a tool for inter-shift

[14] The voluminous medical records detailed herein are not included as exhibits in an effort to avoid disclosure of HIPAA protected information. However, they will be available for an *in camera* review upon request of the Court.

communication used by nursing staff to convey snapshots of significant events and changes in residents' conditions from off-going to oncoming staff. More specifically, the Fulton Commons' 24-hr reports reviewed also included certain interventions and treatments put into place for residents.

A. Fulton Commons' UTI Treatment Rates Suggest Resident Neglect

89. Importantly, my review of Fulton Commons' 24-hr reports indicated that over 30 residents were treated for UTIs during the first wave of the COVID-19 pandemic—the three-month period from March 1, 2020 through May 31, 2020. As detailed above in ¶ 81, the prevalence of UTIs within a nursing home is indicative of neglect, as continent residents are often forced to hold their urine for excessive periods of time when staff fail to timely respond to their call bells.

B. Fulton Commons Neglected Resident A.C.

90. In connection with MFCU's investigation, I reviewed the medical records of Fulton Commons resident A.C. My review of those records revealed that A.C. had a history of peripheral vascular disease and diabetes and was admitted to Fulton Commons in 2018 with vascular wounds. A.C. was transferred to St. Francis Hospital on June 15, 2020, because Fulton Commons could no longer provide requisite care for her leg. At St. Francis Hospital, A.C.'s left lower leg was amputated secondary to gangrene infection.[15] Sometime thereafter, A.C. regrettably died. I have reviewed a photograph, attached to the Affidavit of Walter Crevoiserat, which purportedly depicts A.C.'s left foot at the time of her admission to St. Francis Hospital. My review of that photograph shows that A.C.'s second, third, fourth and great toe were gangrenous and necrotic.

[15] Gangrene refers to large areas of tissue that died due to lack of blood supply.

91. My review of A.C.'s medical records revealed that A.C.'s care plan documented a chronic vascular ulcer to her left heel. In addition, A.C. had facility-acquired[16] pressure injuries to the left buttock and sacral region,[17] and a vascular ulcer to the left knee. Lastly, A.C.'s left foot, great toe, and fourth toe were necrotic. A.C.'s medical records indicate that there were physician's orders from as early as December 18, 2019 through her discharge from the facility on June 15 2020, for staff to monitor A.C.'s left great toe and fourth toe for signs and symptoms of infection. Fulton Commons' care plan and wound notes did not describe or document any wounds to A.C.'s left third and second toes at any point during her stay at the facility. Further, Fulton Common's treatment administration records failed to document any monitoring of infection of her left third and second toes at any point during her stay. A wound care note dated May 29, 2020, indicated that A.C. was assessed by the wound doctor two days earlier, on May 27, 2020, and that there was no change to her left heel, but that all other wounds and her overall status had worsened.[18] Nonetheless, Resident A.C. was not transferred to St. Francis Hospital until June 15, 2020—19 days after this assessment. This reflects the neglect of resident A.C. In my professional opinion, Fulton Commons should have monitored and addressed A.C.'s entire left foot, including her second and third toes. If Fulton Commons had communicated the risks versus the benefits of advanced care at a hospital to A.C. and her family, and if A.C. had been sent to the hospital at an earlier date, it is possible that a lesser amputation (such as that of the toes or part of the foot) may

[16] Facility-acquired pressure injuries are those that develop while the resident lived in the nursing home.

[17] The sacral region of the body is the portion of the spine between the lower back and tailbone.

[18] Like all other Fulton Commons wound records relating to A.C., this treatment note also failed to mention A.C.'s second and third toes of her left foot.

have prevented the infection from spreading, and ultimately prevented the loss of her entire lower leg.

92. In addition, a limited review of A.C.'s medical records from June 2020 disclosed that Fulton Commons failed to provide A.C. with regular showers, a basic human need, which is indicative of neglect. Per these medical records, A.C. was supposed to be showered twice per week, on Mondays and Thursdays. However, Fulton Commons' records document that she was not showered at all for the two-week period from June 1, 2020 to June 14, 2020.

C. Fulton Commons Neglected Resident E.B.

93. In connection with MFCU's investigation, I also reviewed Resident E.B.'s medical records, including "Nurse's Notes." A handwritten entry by Fulton Commons' former DON Carol Frawley, dated April 25, 2020, at approximately 10:00 a.m., states, "As per instructed [sic] by administrator who spoke to resident's daughter . . . a face mask was given to the resident. [Respondent Cathie] Doyle Administrator explained to daughter that [E.B.'s] roommate did not pass away from the COVID virus but was happy to accommodate her request." Notably, I reviewed 24-hr reports related to E.B.'s roommate, which reveal that E.B.'s roommate should have been presumed COVID-19 positive, as detailed below.

94. My review of the 24-hr reports determined that E.B.'s roommate exhibited symptoms consistent with COVID-19, including an elevated temperature, beginning on or about March 27, 2020. COVID-19 treatment protocols were initiated on March 28, 2020, and E.B.'s roommate was given cough suppressant, IV fluids, and Zithromax. E.B.'s roommate died at Fulton Commons towards the end of April 2020. Although Fulton Commons had a designated COVID-19 unit, Fulton Commons' 24-hr reports revealed that E.B.'s roommate was neither isolated nor moved to the COVID-19 unit—despite DOH Guidance issued on March 21, 2020, that required

that symptomatic residents in nursing homes on Long Island be presumed COVID-19 positive and isolated from other residents. (*See* Affidavit of Senior Auditor-Investigator Kristen Ronan ["Ronan Aff."] Ex. 18; *see also* Ronan Aff. Ex. 15.)

95. As detailed in the accompanying Affidavit of Kristen Traina ("Traina Aff."), E.B.'s daughter, E.B.'s roommate's corpse was left in her mother's room for several hours after their death.[19] Moreover, although Fulton Commons' records reveal that E.B. developed a cough in April 2020, prior to her roommate's death, E.B. was neither tested for COVID-19, nor was she isolated. (*See* Traina Aff. at ¶ 11.) E.B. ultimately tested positive for COVID-19 antibodies on or about May 18, 2020, and died on February 18, 2021.

D. Fulton Commons Denied Residents the Ability to Make Informed Medical Decisions and Misled Family Members

96. As detailed above, each nursing home resident has the right to be "fully informed . . . of his or her total health status, including but not limited to, his or her medical condition including diagnosis, prognosis and treatment plan." (10 NYCRR § 415.3[f][1][i].) Moreover, residents have the right to "be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being." (10 NYCRR § 415.3[f][1][iv].)

97. I have reviewed excerpts of the transcript of the Executive Law § 63(12) examination of Latasha Waller, Fulton Commons RN Unit Manager on COVID Unit 1 East, taken on September 30, 2020, which is attached to the Ronan Aff. as Exhibit 20. RN Waller testified that non-COVID residents were not made aware that the aides providing them with direct care were

[19] General nursing home practice dictates that, when a resident dies in their room in the facility, the living roommate should be removed from the room into another area of the facility. Alternatively, the deceased's body can be moved from the room and temporarily placed in a collection area, where no one can see the body.

also caring for COVID-positive residents on the same shift. (*See* Ex. 20 at 241–244.) Knowing the risk of infection posed by a caregiver is necessary for a resident to be "fully informed . . . about care or treatment" affecting the resident's well-being. (10 NYCRR § 415.3[f][1][iv].)

98. I have also reviewed excerpts of the transcript of the Executive Law § 63(12) examination of Elfa Llorente, the Fulton Commons RN Unit Manager on non-COVID Unit 3 West, taken on October 19, 2020, which is attached to the Ronan Aff. as Exhibit 19. RN Llorente testified that she never disclosed to residents' family members that their loved ones were being treated with COVID-19 protocols or that they were under suspicion or presumed to be infected with COVID-19. Llorente explained that she did not disclose this information because she understood this was what Respondent Doyle, Fulton Commons' administrator, wanted staff to do. (*See* Ronan Aff. Ex. 19 at 116, 121–122.)

99. RN Llorente further acknowledged in her testimony that she only disclosed to family members their loved one's individual symptoms and the treatment put into place, and that a layperson would not have understood from that information that a resident was suspected or presumed to be infected with COVID-19. (*See* Ronan Aff. Ex. 19 at 114–115.) The failure to properly convey this information denied residents and their healthcare proxies of the right to be fully informed of residents' total health statuses.

E. Fulton Commons' Records Reflect That Fulton Commons Underreported Its Presumed COVID-19 Deaths to DOH

100. MFCU determined that Fulton Commons underreported the number of its COVID-19 resident deaths during the three-month period of the peak of the first wave of the pandemic in 2020 in its Health Electronic Response Data System ("HERDS") submissions to DOH. Specifically, Fulton Commons failed to report at least 34 presumed COVID-19 resident deaths in

its HERDS submissions. Though the facility's HERDS submissions reflect 40[20] residents died of either suspected or confirmed COVID-19, MFCU's review of Fulton Commons' records determined that, in fact, at least 74 of its residents died of suspected or confirmed COVID-19. Specifically, MFCU determined that an additional 34 residents, including Resident E.B.'s roommate (discussed above in ¶¶ 93–94), should have been reported as presumed COVID-19 deaths.

101. I reviewed Fulton Commons' 24-hr reports to determine which residents began exhibiting certain symptoms, such as fevers and respiratory issues, that could be indicative of COVID-19, what treatment was initiated for those residents, and which of those residents should have been presumed to have COVID-19 based on applicable DOH and CMS guidance at the time as well as Fulton Commons' own protocols. Specifically, DOH Guidance dated March 21, 2020, directed that nursing homes on Long Island (which includes Fulton Commons), presume that any febrile acute respiratory illness (or any cluster[21] of respiratory illness, irrespective of fever) is COVID-19 absent a negative COVID-19 test.

102. I, along with MFCU auditor-investigators, conducted a review of the 24-hr reports; resident death certificates; Fulton Commons' Admission, Discharge and Transfer records; and Fulton Commons' facility protocol lists, and determined that during the time period of March 1, 2020 through May 31, 2020, a total of 90 resident deaths had occurred at Fulton Commons, and an additional two residents died at the hospital.

103. I also reviewed the HERDS reports Fulton Commons submitted to DOH, various evolving fever protocols initiated by Fulton Commons throughout the first wave of the pandemic

[20] This number excludes a living resident that Fulton Commons mistakenly reported as deceased.

[21] Per the National Institute of Health, a cluster is defined as two or more cases associated with the same location, group, or event around the same time.

(attached to the Ronan Aff. as Exhibit 17), records of residents exhibiting signs and symptoms of COVID-19, and records of residents that were admitted from hospitals with a COVID-19 diagnosis. Fever protocols were initiated by Fulton Commons nursing staff when residents exhibited symptoms of fever, cough, shortness of breath, general malaise, and/or sore throat. Fulton Commons' earliest fever protocol, which was undated, consisted of intravenous fluids, antibiotics such as Zithromax and/or Rocephin, lab work, chest x-rays, urine cultures, and oxygen as needed.[22] (*See* Ronan Aff. Ex. 17.) These protocols were updated based on the availability of medications. Fulton Commons' protocol dated March 30, 2020, specifically mandated that any resident with a temperature of 100° or above should obtain diagnostic testing of a chest x-ray, labs, urine culture, and a baseline EKG. (*Id*.) After these diagnostics were completed, a regimen of Plaquenil (Hydroxychloroquine), Zithromax, Zinc, and Vitamin C were to be initiated. (*Id*.) From March 1, 2020 through May 31, 2020, a total of 146 residents exhibited signs of COVID-19, including a fever of 100° or above. These 146 residents were spread throughout the facility, on all units and all floors.

104. Out of the 92 total Fulton Commons deaths during the three-month time period of March 1, 2020 and May 31, 2020, MFCU determined that six residents were confirmed COVID-19 deaths, and an additional 68 residents should have been presumed COVID-19 deaths. As discussed above, Fulton Commons only reported 34[23] presumed and six confirmed COVID-19 resident deaths to DOH via its HERDS reports. Accordingly, Fulton Commons underreported its presumed COVID-19 resident deaths by 45% (34 deaths).

[22] I reviewed Fulton Commons' nursing department protocols, including various protocols put into place during the COVID-19 pandemic. I determined that this undated protocol was the earliest based on my review of the 24-hr reports, which documented that this was the protocol used for the first residents that exhibited COVID-19 symptoms.

[23] This number excludes a living resident that Fulton Commons mistakenly reported as dead.

F. Fulton Commons Increased Risk to its Residents by Failing to Cohort Residents by COVID Status, Despite Having a Designated COVID-19 Unit

105. MFCU examined admissions records, which indicated that, despite establishing Unit 1 East as Fulton Commons' COVID-19 unit by the end of March 2020, Fulton Commons continued to admit COVID-19-positive residents onto non-COVID units. (*See* Ronan Aff. at ¶ 124.) In addition, Fulton Commons continued to admit non-COVID residents onto its designated COVID unit, 1 East. (*Id*. at ¶ 126.) These actions constitute violations of infection control protocols that increased risks to residents.

106. Moreover, despite intermingling COVID-positive and non-COVID residents throughout the building, Fulton Commons failed to institute separate staffing teams to care for residents based on their COVID-19 status. (*Id*. at ¶¶ 124, 126–127.) This failure was not only a gross deviation from basic infection control principles, but also violated DOH Guidance dated March 13, 2020, which required nursing homes with COVID-19 residents to establish separate staffing teams for non-COVID and COVID-positive residents. (*See* Ronan Aff. Ex. 15.)

G. Fulton Commons Neglected Resident C.B. by Failing to Provide Necessary Medical Treatment

107. I have reviewed the Affidavit of Patricia Bernaerts, mother of Resident C.B., in which she reported that Fulton Commons failed to provide Resident C.B. with a Bi-Pap machine, despite the device being medically prescribed to treat C.B.'s sleep apnea. Sleep apnea is a condition in which an individual's breathing stops and restarts many times while asleep, which may prevent their body from receiving adequate oxygen. Left untreated, sleep apnea may lead to serious health problems, such as high blood pressure and heart trouble. One method of treatment for sleep apnea is a Bi-Pap machine, which is a medically prescribed non-invasive ventilation therapy that helps to improve air exchange in the lungs. It assists in opening up the lungs, thereby improving the level of oxygen in the blood. Additionally, Bi-Pap machines are utilized to decrease the blood's carbon

dioxide (CO2) levels. An individual with sleep apnea and elevated CO2 levels who is deprived of required mechanical ventilation can suffer detrimental health effects. The availability of functional equipment, the use of such equipment, and sufficient and competent staffing are vital for these necessary therapies/treatments to occur. By accepting Resident C.B., who, as reported by Patricia Bernaerts, required a Bi-Pap machine, and failing to provide that necessary therapy, Fulton Commons neglected Resident C.B.

H. Fulton Commons Increased Risk to its Residents by Having an Unlawful Policy that Treated Sexual Abuse Allegations as Grievances

108. I have reviewed the results of a DOH survey of Fulton Commons conducted on January 10, 2022, in which Fulton Commons was cited for: (1) failing to ensure its residents were free from abuse and neglect; (2) failing to report two allegations of sexual abuse to law enforcement; and (2) failing to ensure that two allegations of sexual abuse were thoroughly investigated and reported to DOH within five working days. (*See* Ronan Aff. Ex. 14.) This survey determined that the two allegations of sexual assault were improperly treated as "grievances," rather than incidents of abuse, pursuant to facility policy. (*Id*.)

109. Such a facility policy is unlawful and endangers residents. A grievance is a complaint, either from a family member of a resident, or from a resident themself, for minor issues, such as, *inter alia*, missing clothes or not getting along with a roommate. Generally, grievances are sent to the social work department for ensuing investigation and resolution.

110. Conversely, allegations of neglect, abuse, and mistreatment require a report to DOH, as detailed in ¶ 8 above. (*See* 42 USC § 1320b-25; *see also* Public Health Law § 2803-d.) When there is an allegation of sexual assault, the facility should immediately remove the subject, notify law enforcement and DOH within twenty-four hours, and initiate an internal investigation to rule out abuse. (*See* 42 CFR § 483.12[b].) Nursing homes must report to DOH any incident that

contains one of the following elements: non-consensual sexual intrusion or penetration, touching intimate body parts or the clothing covering intimate body parts, examination or treatment of the resident for other than bona fide medical purposes, or observation or photographs of another person's intimate body parts. (*See Nursing Home Incident Reporting Manual* [August 2016], https://www.health.ny.gov/professionals/nursing_home_administrator/docs/incident_reporting_manual.pdf at 8 [last accessed Dec. 4, 2022].)

111. Accordingly, as detailed above, Fulton Commons neglected its residents by failing to report allegations of sexual abuse to DOH and unlawfully treating them as grievances; failing to cohort residents based on their COVID-19 status during the height of the first wave of the pandemic and failing to assign dedicated caregivers to COVID-positive and COVID-negative residents; failing to provide certain residents with necessary medical treatments and/or therapies; failing to fully inform residents and their family members regarding their total health statuses; and underreporting its presumed COVID-19 deaths.

WHEREFORE, based upon the foregoing, I respectfully request that the Court grant the relief requested in the Verified Petition.

Mary E. Conway, R.N.

Sworn to before me this
6th day of December, 2022

Notary Public

JOHN M TARPEY
NOTARY PUBLIC, STATE OF NEW YORK
NO. 01TA6327981
QUALIFIED IN NASSAU COUNTY
MY COMMISSION EXPIRES JUL 20, 2023

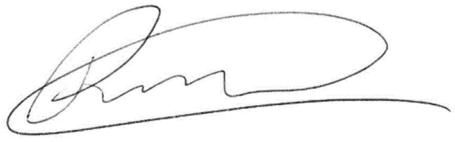
CERTIFICATION PURSUANT TO RULE 202.8-b

I, Prabhjot Sekhon, an attorney duly admitted to practice law before the Courts of the State of New York, hereby certify that this Affidavit contains 15,308 words, excluding the parts of the Affidavit explicitly exempted by Rule, and that Petitioner's request for permission to file an oversize submission as provided in Rule 202.8-b(f) is forthcoming.

Dated: Hauppauge, New York
December 12, 2022

Respectfully submitted,
Letitia James
Attorney General of the State of New York

By:



Prabhjot Sekhon
Special Assistant Attorney General
Office of the Attorney General
Medicaid Fraud Control Unit
300 Motor Parkway, Suite 210
Hauppauge, New York 11788
Prabhjot.Sekhon@ag.ny.gov