SUPREME COURT OF THE STATE OF NEW YORK
ALBANY COUNTY

THE PEOPLE OF THE STATE OF NEW YORK,
by ELIOT SPITZER, Attorney General
of the State of New York,

Plaintiff,

- against -

ANTHONY SALERNO, NRNH, INC.
d/b/a/ JENNIFER MATTHEW NURSING
and REHABILITATION CENTER, and H.C.F.A.
ASSOCIATES CORP. d/b/a HEALTHCARE
ASSOCIATES,

Defendants.

COMPLAINT

Index No. 42-06

Plaintiff, the People of the State of New York, by Eliot Spitzer, Attorney General of the State of New York, alleges upon information and belief:

INTRODUCTION

1. Jennifer Matthew Nursing and Rehabilitation Center ("Jennifer Matthew") is a for-profit nursing home located in Rochester, New York. The majority of the residents of the home are Medicaid recipients, and the full cost of their care is provided by the Medicaid program, a health care program for the poor which is funded by the federal, state and local governments. Since 2000, Medicaid has paid Jennifer Matthew approximately $20 million for providing this care.

2. New York law imposes on nursing homes a "special obligation" to care for their residents. To meet this obligation, homes are required to assure that each nursing home resident receives the care, treatments, diet, and health services that they need to

attain their "highest practicable level of well-being." Moreover, Jennifer Matthew has promoted itself to consumers as "providing the best quality services in a home-like atmosphere" and providing "a warm and caring environment."

3. In reality, for years Jennifer Matthew has systematically neglected its residents. While management abdicated its most basic responsibility, nursing staff members slept, socialized, watched movies, and left the building to go to church. Residents were denied basic and necessary medications, care, and treatments. They were left to lie for hours in their own urine and feces, they were moved dangerously and improperly, they did not receive all prescribed medications and treatments, they did not receive proper hydration and nutrition, and bedridden residents were not repositioned to prevent pressure sores and infections.

4. To hide the neglect, nursing staff routinely falsified patient records claiming that care had been provided when it had not. When the New York State Department of Health ("DOH") arrived for inspections, Jennifer Matthew would increase staffing and made sure required tasks were diligently performed. When DOH nonetheless found serious violations, the facility promised corrective measures, which were quickly abandoned.

5. In 2005, after DOH had cited the facility on multiple occasions for serious quality of care violations, the Medicaid Fraud Control Unit ("MFCU") of the Attorney General's office installed a secret camera in the room of a bedridden Jennifer Matthew's resident ("Patient A") with the consent of Patient A's family. This camera recorded

hundreds of instances of neglect and inadequate care. Moreover, the camera produced indisputable proof that the medical records prepared by Jennifer Matthew's staff were routinely falsified. About 20% of Jennifer Matthew's nursing staff was implicated in these falsifications.

6. As a result, four Jennifer Matthew aides and four nurses have pleaded guilty in Rochester City Court to criminal neglect and falsifying records, and are now cooperating in the ongoing investigation. (Similar charges are pending against six other former employees.) The cooperating witnesses report that Patient A's treatment was no isolated instance. Rather, it was symptomatic of a nursing home where neglect was the norm, and supervision was virtually non-existent.

7. Resident neglect at Jennifer Matthew has been a longstanding problem. Over the last three years, the New York State Department of Health ("DOH") has cited Jennifer Matthew for violating state regulations which are designed to assure that adequate care is provided to nursing home residents, and in three instances has found that the home placed its residents in "immediate jeopardy" of "serious injury, harm, impairment and death."

8. The State now seeks an order: (1) enjoining Defendants from neglecting residents at Jennifer Matthew and from falsifying care records; (2) directing Defendants to repay the Medicaid program for monies paid although services were not rendered; and (3) enjoining Defendants from providing health care services in New York State in connection with the Medicaid program.

VENUE

9. Venue is proper in this county pursuant to CPLR § 503.

PARTIES AND JURISDICTION

10. Plaintiff is the People of the State of New York, by Eliot Spitzer, Attorney General of the State of New York.

11. Defendant NRNH, INC. d/b/a JENNIFER MATTHEW NURSING and REHABILITATION CENTER ("Jennifer Matthew"), is a corporation organized under the laws of the State of New York, with its main facility in Rochester and its registered office at 1 Linden Place, Great Neck, Nassau County, New York. NRNH has owned and operated Jennifer Matthew since 1999.

12. Defendant ANTHONY SALERNO is the Chief Executive Officer of NRNH, Inc., and owner of 42.5% of its corporate stock, which he acquired in 1999. Salerno controls all of the other Defendants, and is actively involved in the management and operation of Jennifer Matthew. Salerno and the other shareholders of NRNH, Inc. are, in the same proportions, shareholders of a corporation that owns the real estate in which the facility operates.

13. Defendant H.C.F.A. ASSOCIATES CORP. d/b/a HEALTHCARE ASSOCIATES ("HCA") is a corporation organized under the laws of the State of New York, with its principal place of business at 24 Lohmaier Lane, Lake Katrine, New York. HCA is the alter-ego of Defendant Salerno, who is its sole owner. HCA is Defendant Salerno's vehicle for management of individual for-profit corporations operating nursing

homes, including Jennifer Matthew, in the "HCA Network." In Salerno's words, HCA is "a creature that exists to serve those members of the network ." It provides consulting services, negotiates group purchasing contracts, provides billing and other administrative support, and frequently guarantees equipment purchases and leases. HCA determines which of the facilities will pay HCA's overhead, and it shifts profits from some facilities to offset losses at other facilities. To provide incentives to HCA employees, Salerno has given them shares in some of the corporations in the HCA Network, including Jennifer Matthew. With rare exceptions, the homes in the HCA Network are owned by Salerno, a group of associated investors, and HCA employees.

14. From 2000 through the present, HCA supplied "consulting services" to Jennifer Matthew, and HCA's employees have been, since the acquisition of the facility, designated by Salerno as "resources" for the on-site management of the home. HCA, as Salerno's vehicle for carrying out his duties as the operator of the facility, has taken on the responsibility for assuring that Jennifer Matthew complies with applicable federal and state laws and regulations. Since 2000, Jennifer Matthew has paid HCA more than $785,000 for the "consulting" services.

THE JENNIFER MATTHEW NURSING HOME

15. Jennifer Matthew is located on Portland Avenue in Rochester, New York. It has three floors and contains 120 beds. A significant portion of its resident population requires assistance from staff to meet their basic needs. During 2005, care at Jennifer

Matthew was provided by approximately 50 Certified Nurse Assistants, 30 Licensed Practical Nurses, and 7 Registered Nurses.

16. New York law requires Jennifer Matthew to provide each resident with sufficient care and services to attain "the highest practicable physical, mental, and psychosocial well-being." 10 N.Y.C.R.R. §415.12. In addition, New York forbids any person from committing an "act of . . . neglect." Public Health Law § 2803-d(7). Neglect is defined as "failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care . . . including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living." 10 N.Y.C.R.R. §81.1 (c).

17. Jennifer Matthew has held itself out to the public in promotional materials as being "dedicated to providing the best quality services in a home-like atmosphere," and providing a "warm, caring environment." It has also claimed that its "professional experienced staff is committed to making your stay pleasant and as comfortable as possible," and that it provides "compassionate, qualified employees who provide a wide range of services to meet the individual needs of each resident."

18. Jennifer Matthew employs a variety of health care professionals: a physician (the Medical Director); a Nurse Practitioner; Registered Nurses; Licensed Practical Nurses; and Certified Nurse Assistants, also called "aides." Nurse Practitioners have the authority to order certain drugs and treatments. Only Registered Nurses can assess patients and perform certain specialized procedures; both Registered Nurses and

Licensed Practical Nurses) can dispense medications, provide treatments and supervise the delivery of care. Registered Nurses and Licensed Practical Nurses have diagnostic training; Certified Nurse Assistants do not. Most hands-on resident care is rendered by the aides, the least-trained and lowest-paid nursing staffers. Aides are often trained on-the-job and are responsible for time-consuming services such as feeding, bathing, dressing, toileting and transporting residents.

19. At Jennifer Matthew, Physicians and Nurse Practitioners are not routinely on duty. Registered Nurses are the principal care managers when acting as shift managers for the entire facility, and overall care supervisors as the facility's Director of Nursing and Assistant Director of Nursing. Care providers at Jennifer Matthew work one of three shifts: a day shift, an evening shift, or a night shift.

20. As mandated by state law, Jennifer Matthew, in conjunction with a physician, describes each resident's needs in a "Comprehensive Care Plan" ("Care Plan") 10 N.Y.C.R.R. §415.11 (c). The resident's Care Plan identifies health concerns and directs particular courses of treatment, specifying, among other things, medications, assisted movement, skin care, bowel and bladder care, and nutrition needs.

21. The staff executes the Care Plan for each resident pursuant to directions set forth in specific documents. Thus, "Doctors Orders" direct what medications, treatments and other care Registered Nurses and Licensed Practical Nurses are required to administer. Similarly, the duties that a Certified Nurse Assistant must perform for the resident are specified in a document called a "Resident Profile Kardex."

22. One of the most important commands on the Kardex is the direction to reposition bedridden residents. Because they are immobile, bedridden residents are at risk for developing pressure sores. Pressure sores can develop when blood supply to the skin is cut off for more than two to three hours, for example, by lying in a bed or sitting in a wheelchair. Left untreated, the dead skin can break open and become painfully, and fatally, infected. Care Plans for bedridden residents at Jennifer Matthew typically require residents to be repositioned every two hours.

23. At Jennifer Matthew, every staff member's identification card has a diagram called "the Wheel" printed on its back. The Wheel is designed to ensure that all immobile residents are repositioned on the same side at the same time. For example, the "Wheel" indicates that at 2:00 p.m., all immobile residents were to be turned on to their right side, while at 4:00 p.m., they were to be turned on to their left side. Thus, a supervisor can tell at a glance whether staff is doing its job.

24. The staff is required to accurately document what care is – and is not – delivered. Registered and Licensed Practical Nurses must record the medications they administer on a "Medication Administration Record" and the treatments they provide on a "Treatment Administration Record." Certified Nurse Assistants, in turn, must sign a "Certified Nurse Assistant Accountability Sheet" verifying that the aide has followed all the instructions in a resident's Kardex. New York law requires that these records be "complete" and "accurately documented." 10 N.Y.C.R.R. §415.22(a). As Defendant

Salerno has testified, "Everyone in this system knows you only document what you do. You never document what you don't."

DEFENDANTS' PERSISTENT ILLEGAL CONDUCT

The Neglect of Patient A

25. Patient A is a 70 year-old male, who suffers from dementia, type II diabetes and other ailments that have left him totally dependent on Jennifer Matthew's staff. He is bedridden, immobile, cannot communicate, and obtains all of his nutrition, medications and hydration through a feeding tube. His Care Plan mandated that he be turned and repositioned every two hours to prevent skin breakdown, pressure sores and limb contracture.

26. Patient A's family consented to the use of a hidden camera in his room. This video surveillance occurred from April 26, 2005 to June 3, 2005. The videotape, reviewed by a physician who is a specialist in geriatric medicine, revealed that Jennifer Matthew routinely violated Patient A's Care Plan, and neglected him day after day. For example:

a. He was not, even for one single day, turned and repositioned every two hours as required. Indeed, in one instance, he was not repositioned by any staff during 76 hours of continuous observation.

b. He was not given regular oral care, important for the prevention of infections.

c. He was not given adequate or timely incontinence care and was often left unchecked for extended periods.

d. He was not given adequate hydration or feeding.

e. He was not given adequate "range of motion" therapy (to prevent limb contracture).

f. He did not receive regular nebulizer treatments (to prevent pneumonia).

27. Jennifer Matthew's neglect of Patient A continued after specific warnings from the Attorney General's Office. In May 2005, MFCU informed Jennifer Matthew that Patient A was being neglected. In addition, MFCU investigators visited Patient A and requested copies of his patient chart. Even after this specific warning, the ongoing secret video surveillance disclosed that treatments mandated by the Care Plan were still being withheld, and that the neglect continued.

28. In addition to comparing the video to Patient A's Care Plan, investigators also compared it to the care records purporting to memorialize his actual care. The records repeatedly falsely reported that Patient A had been given treatments and care when, in fact, he had not. Indeed during a 39-day period, nurses and Certified Nurse Assistants made more than 300 false entries. These fabrications involved almost every aspect of Patient A's care, including false entries regarding turning and positioning, temperature and blood glucose readings, skin treatment, pneumonia-preventive nebulizer treatments, oral hygiene, incontinence care, and tube feeding.

29. The nursing staffers who made these false entries constituted approximately 20% of the nurses and aides employed by Jennifer Matthew. Defendant Salerno, the facility's Director of Nursing, its Administrator, and a consultant employed by HCA, have each admitted under oath that the treatment of Patient A constituted

neglect. Moreover, Salerno conceded "that if [the neglect] was true of [Patient A], then it had to be true elsewhere in the facility, and in fact that it had to be widespread."

Jennifer Matthew Employees Describe a Condition of Endemic Neglect

30. Eight licensed caregivers have now pleaded guilty to the crime of neglecting Patient A and falsifying his care records. Each is a cooperating witness in the ongoing investigation of Jennifer Matthew and its senior managements and owners. They report that the abuse and neglect of Jennifer Matthew residents extended far beyond Patient A, and was widespread and routine. Indeed, one cooperating witness observed that Patient A was "actually treated better" than some of the other residents because he had an attentive family. According to another, Jennifer Matthew was by far the "worst" nursing home she had ever worked in. All the cooperating defendants said that conditions at Jennifer Matthew were so bad that none would ever consider placing a loved one at the facility. These dire conditions were due to superficial and inadequate supervision, even in the face of repeated DOH findings that Jennifer Matthew was providing deficient and dangerous care.

31. The cooperating witnesses have described a longstanding supervisory abdication. Many had worked at other facilities where management took basic steps to ensure that work was being done – by checking care, by following the workers on their "rounds," by conducting spot-checks and surprise inspections, and by simply making sure each supervisor was responsible for the work of subordinates.

32. But at Jennifer Matthew there was little regular hands-on supervision. Consequently, aides and nurses would often take extended and unscheduled television, smoking, or social breaks, either on their own floor, or on another floor, away from the call bells of their residents. Some of the staff would sleep during the night shift. For example, one nurse habitually slept from 1 a.m. until 5 a.m. She would omit her medication rounds and tell aides to wake her up only if it was urgent. On the weekend day shift, in the morning, a group of aides would regularly watch a movie video. This group would work through their first round, and then skip their next rounds as they watched their film. One cooperating witness reported that the prevailing attitude at Jennifer Matthew was "not to do the work."

33. A common method of neglect was simply to skip one or more rounds of resident care each shift, rounds normally done every two hours. Thus, the first round might be done, the middle two rounds skipped, and the final round done. Residents would remain in their soiled garments and linen for the middle four to six hours. Residents would go unturned and unwashed. "Call bells" would be placed out of reach. One cooperating witness estimated that over 80% of the residents were neglected when it came to incontinence changing; at the beginning of her shift she routinely found bedridden residents soaked from head to foot in urine and covered with feces.

34. Similarly, staff regularly skipped residents' oral care, even though many residents needed swabbing with special prescription mouthwash to prevent dangerous infection.

35. Nurses failed to administer necessary medications or if they did, failed to do so promptly or properly. One nurse admitted that she "forgot" to provide medication and disposed of the unused medication by throwing it in the garbage, but falsely recorded that she had provided the medication. Even though required to do so at regular intervals, this same nurse admitted that she only gave a resident a nebulizer treatment when he was in "distress." Protocols necessary to assure the safe use of feeding tubes were routinely ignored.

36. Cooperating witnesses also reported neglect of Patient A and residents like him that eludes capture on video. One aide reported finding a pressure sore on Patient A and later observing his wound dressing grow "dirtier and dirtier." As an aide, she was not permitted to change the dressing, but the nurse's initials and date written on the dressing did not change over several days. She observed similar neglect of another resident's wound dressing.

37. In addition to being effectively absent as supervisors, management undermined those who were attempting to attend to the residents. Staff members were often faced on night shifts with insufficient supplies, particularly diapers, bed linen and towels. Aides were forced to use small blankets as adult diapers. After getting a bed bath, residents might be dried with a single small washcloth because no towels were available. Layers of bed linens could not be replaced after residents lost continence because sheets and pads had run out.

38. The mismanagement of supplies, as with other organizational failures, caused a chain of other problems. For example, when linen supplies were unavailable or delayed, residents could not be moved along to the next phase of their day. If supplies were scrounged from the rooms of other residents, then infection-control policy was violated. Due to delayed supplies, residents lying in their waste could not be cleaned, dressed, and moved to the dining room for meals, which would be cold by the time they arrived. Mobile residents, who were often suffering from Alzheimer's disease or other forms of dementia, would begin to get out of bed and wander around, causing more confusion and needing to be returned to their own room. Those persons actually attempting to do their work would fall farther behind.

The Evidence Shows Massive Supervisory Abdication

39. Neglect of this magnitude cannot escape managerial notice if there is even a minute supervisory presence. For example, the Jennifer Matthew facility is sufficiently small that it takes only about 15 minutes to walk into every resident room on each floor of the building. Thus, a 15-minute walk each shift would have instantly revealed the endemic violation of the Wheel system for repositioning residents.

40. The cooperating witnesses report that a supervisor could easily know whether a resident had been washed, could smell if a soiled resident had not been changed, and could tell instantly (from halitosis) if proper oral care was administered. One cooperating witness would often arrive for the morning shift and find pillows and

blankets left by sleeping staff members strewn around the facility dining room, easily noted by any supervisor.

41. One nurse, who had worked in the building for 25 years, recalled that former management promptly dealt with any aide who refused instruction from the nurses. Under Salerno's regime, however, she was reduced to "reminding" aides to do their basic tasks. Complaints to the nurse managers or shift supervisors had no effect, as the supervisor would often be socializing with non-working aides.

42. Indeed, cooperating aides report that their supervisors – nurses – told them to sign the Certified Nurse Assistant Accountability Sheets but were never told what to do if they did not complete all required care. To the contrary, aides were only told that they would be penalized by management unless they signed these records, and that they should sign the sheets "to get credit for their work." One cooperating witness reports that she was repeatedly asked by her supervisors to sign the "Meal Board," confirming residents' per-shift meal consumption, even though she was not on duty on the shifts.

43. Effective supervision by the Directors of Nursing or assistants was virtually non-existent. Night shift workers had difficulty recalling the name of the current Director of Nursing, or ever talking to or seeing her. Day and evening shift workers occasionally saw the Director of Nursing, but not conducting in-room inspections, and none could recall seeing her after 6 p.m. The Director of Nursing's subordinate would only be seen on the 3rd floor in emergencies or when State inspectors were present.

44. Workers also complained to top management without result. One aide recalled a phone call from the Director of Nursing, as being the only time she ever spoke directly to her. The aide took the opportunity to ask about a persistent supply shortage and to complain about the substandard efforts of other workers. She was told, in substance, "to worry about your own work, not others."

45. Indeed, Jennifer Matthew's Administrator has admitted in sworn testimony that there was a breakdown in reliable, consistent supervision of direct care staff.

46. In sum, at Jennifer Matthew, neglect was defined at each level of the operation. Certified Nurse Assistants neglected to perform basic tasks such as turning and repositioning residents. Nurses neglected to supervise Certified Nurse Assistants and neglected their residents. The Director of Nursing neglected to take even the most basic steps – walking a daily 15-minute beat through the facility – to check the employees' work.

DOH Has Repeatedly Sanctioned Jennifer Matthew for Deficient Care and Jennifer Matthew Has Repeatedly Failed To Fulfill Its Promises To Correct These Deficiencies

47. Jennifer Matthew's abandonment of its most basic responsibilities comes against a backdrop of repeated warnings from DOH, including findings that residents were in "immediate jeopardy." In 2003, 2004, and twice in 2005, DOH sanctioned Jennifer Matthew for significant quality of care "deficiencies," which are violations of

New York care regulations. Each "deficiency" finding was typically based upon multiple instances of the same violation.

48. Indeed, DOH sent the warnings directly to Salerno, as the facility operator with ultimate responsibility for Jennifer Matthew, describing the care deficiencies in detail. DOH has repeatedly cautioned Salerno that continued funding in both the Medicaid and Medicare programs required compliance with all federal program requirements which are binding on state operators of nursing homes.

The DOH Survey Process

49. Pursuant to state and federal law, DOH conducts on-site inspections of nursing homes called "surveys," which are usually conducted every 12 to15 months. Trained inspectors visit the facility, review records, observe resident care, and interview residents and staff members. Usually on-site for just a few days, the surveyors are unable to monitor every activity or review every record, and therefore use sampling methodology to review records of some, but not all, residents. Out of necessity, the DOH surveyors rely on the truth of the resident records, which are required by law to be kept accurately.

50. DOH then issues a report, which may include "a Statement of Deficiencies" and may require corrective action. If deficiencies are found, the facility must file a "Plan of Correction" for them. If DOH believes that the deficiencies are serious or may continue, it may order a "Directed Plan of Correction," which requires the facility to employ an outside consultant to provide an independent assessment of the facility's problems and to correct specific failings.

51. Cooperating witnesses have reported that DOH inspectors did not get a view of the real conditions at Jennifer Matthew. When management learned that a visit was likely – or that the DOH surveyors were actually on site – then, according to one worker, "people came out of the woodwork." Shifts that were missing aides and nurses were then fully or over-staffed. Supervisors made rounds hourly. The Director of Nursing would provide resident care and feed residents, and staff from the personnel department would be "on the floor" helping aides. Supplies were plentiful. When the DOH inspectors left, "then it would end." Thus the DOH surveys – based on inflated staffing levels and records now known to be false – reflect better conditions than the Jennifer Matthew norm.

The 2003 Survey

52. On April 30, 2003, a DOH survey of Jennifer Matthew found 25 deficiencies. On May 14, Defendant Salerno was informed of these deficiencies and that DOH had determined that the residents of Jennifer Matthew were in "immediate jeopardy" and that substandard quality of care had been identified. Salerno was informed that compliance with federal program requirements was necessary for continued participation in the Medicaid program. Further, Salerno was informed that a recommendation had been made to terminate the home from the Medicaid and Medicare programs within a week unless all "immediate jeopardy" deficiencies were corrected.

53. The "immediate jeopardy" determination in the 2003 Survey was based on a finding that a "hostile environment" existed at Jennifer Matthew. The survey found that

staff subjected residents to "pushing, shoving, punching, negative comments, intimidation, threats to withhold care" and sought to deter residents from using nurse call bells.

54. In one instance, DOH found that a resident was "punched . . . around the head" for using a nurse call bell. The next day the resident begged a Certified Nurse Assistant, who had been involved in the assault, not to hurt him. That night, three staff members "surrounded the resident's bed and asked the resident to identify which one of them had punched the resident." The resident was intimidated and stopped using the call bell. A month later, the resident fell out of bed and sustained a hip fracture while attempting to reach for dentures instead of using a call bell to summon assistance.

55. The 2003 Survey also found that Jennifer Matthew provided inadequate medical treatment. It found that in five sample cases Jennifer Matthew's staff had failed to follow doctor's orders. Further, it found that residents who had pressure sores had not received adequate treatment. Patient A was specifically identified in the 2003 Survey as one of the residents who received deficient care in this area.

56. The 2003 Survey also uncovered evidence that staff had falsified care records. One resident's treatment record indicated the resident had been taken out of bed three times in one day. A nurse manager admitted, however, that the record was false since the resident had not been out of bed even once that day.

57. Finally, the survey found that the care deficiencies were traceable to managerial failure. Jennifer Matthew had not "established and implemented policies to assure the effective management and operation of the facility."

58. As a result of the 2003 Survey, DOH required Jennifer Matthew to submit a "Directed Plan of Correction." DOH specifically focused on improving supervision, demanding remedial measures "to deliver consistent, reliable supervision of direct care staff on all shifts."

59. Defendant Salerno designated a senior employee of HCA (an RN who was also an owner of Jennifer Matthew and another HCA Network facility) to work as a "consultant" and bring the facility into compliance with the law.

60. Thereafter, Jennifer Matthew presented DOH with its Directed Plan of Correction. The facility promised to provide in-service training for all clinical staff, create a "skin team" to assess residents on a weekly basis, create a "tracking form" and to have the Director of Nursing conduct "chart audits" of at least five resident records per week to assure compliance with skin care policies. As to supervision, the Director of Nursing was to audit 20% of the resident population monthly to identify and immediately correct potential deficient practices. These audit findings were to be reported weekly to the Administrator, and monthly to the home's Quality Assurance Committee.

61. In sworn testimony, Salerno has admitted that even before the 2003 Survey, he knew he had a facility in crisis, and that "my team" had reported "we were culture in which residents are afraid, afraid of staff in my facility." Salerno acknowledges

that he "called it the four-alarm fire." According to Salerno, "something was terribly wrong and it had to be fixed."

The 2004 Survey

62. But Salerno and HCA failed to fix it. In January and February 2004, DOH inspectors returned to Jennifer Matthew. On March 8, 2004, DOH reported that it found 14 deficiencies, with six "repeat deficiencies" from the 2003 Survey, including findings regarding the prevention and treatment of pressure sores. DOH found instances of "substandard quality of care" that required "significant corrections" and, as a result, DOH required that a monitor be assigned to inspect the facility, that the facility employ a consultant to develop and implement an acceptable Directed Plan of Correction, and that the facility conduct staff training to address multiple areas of concern.

63. DOH found that in five of eleven sampled cases "residents reviewed for pressure sores did not receive the necessary treatment and services." DOH further reported that "baths and personal care, as well as turning and positioning [to prevent or heal pressure sores] are not done and toileting schedules are not followed." DOH surveyors identified deficiencies in the treatment of residents who had to be tube fed and failures to provide residents with proper hydration. Once again, the surveyors found problems with Jennifer Matthew care records. Specifically, the 2004 Survey cited "problems with staff not completing the fluid intake records," so no one could determine whether residents received necessary hydration.

64. As it had in 2003, DOH again found that the problem at Jennifer Matthew was poor management, that it lacked effective oversight mechanisms. DOH wrote that Jennifer Matthew lacked a "formal means to identify clinical and administrative problems, which in turn leads to issues not being identified and corrected as soon as possible." Jennifer Matthew's quality care controls were so poor that its administrator and Quality Assessment and Assurance Committee were cited for inability to independently identify any problems at the home. Indeed, DOH found that Jennifer Matthew's Quality Assessment and Assurance Committee did more harm than good; it was having a "negative impact" on residents.

65. In a new Directed Plan of Correction, Jennifer Matthew once again promised to correct its deficiencies. The plan, filed in March of 2004, included promises that the Director of Nursing would audit the care being given to ensure care delivery. For example, Jennifer Matthew promised that the Director of Nursing would conduct 20 chart audits weekly, visit at least five residents daily to check incontinence, and visit five residents daily to check turning and repositioning. These visits would ensure that residents were properly turned and repositioned to prevent pressure sores and that residents were receiving timely incontinence care. The 2004 Directed Plan promised that these audits would continue into the future. The 2004 Directed Plan assured DOH that the audit findings would be reported to Jennifer Matthew's Quality Assurance Committee "for the first three months and then quarterly thereafter for evaluation and follow up if indicated."

66. DOH accepted this Directed Plan of Correction. In May 2004, DOH revisited the facility and found the home to be in substantial compliance with state and federal requirements.

67. But just weeks later, Jennifer Matthew abandoned the audits – both the visits and the paper audits. Jennifer Matthew has admitted that it dropped the audits without notice to DOH. It contends that it did so because they were too burdensome on the newly-hired Director of Nursing. Salerno has admitted that "in hindsight" the visual inspections "should not have been changed."

68. In or around June 2004, Jennifer Matthew claims to have substituted a new auditing procedure – the "Daily Rounding Tool" which required two daily rounds by facility managers, at 10:00 a.m. and again at 2:00 p.m. (No rounds were scheduled under the new plan for the evening or night shifts.) The facility has produced no records to demonstrate that these daily rounds were regularly conducted. Indeed, one cooperating witness has reported that rounds were conducted diligently only around the time of a DOH visit, and trailed off quickly thereafter. Moreover, Jennifer Matthew assigned, among others, its billing manager and activities director to walk these rounds, not, for the most part, health care professionals. Not a single staff position was added to carry out these inspections. Jennifer Matthew's Administrator has admitted in sworn testimony this new procedure was inferior to the one that it replaced in detecting patient neglect.

69. The facility slid backwards. In January 2005, DOH again inspected Jennifer Matthew and identified twelve deficiencies – well above the state average. They

included violations regarding activities of daily living, staff treatment of residents, resident assessment, administration, quality of care, dietary services, physical environment, disregard of pharmacy recommendations, and medication irregularities.

70. One of the violations was predicated on the facility's failure to realize that a resident with a history of seizures and schizophrenia had wandered outside one night for at least four hours. His absence was only discovered when staff was notified by a nearby hospital. The DOH surveyors found no evidence that anyone at Jennifer Matthew even bothered to investigate why the staff was unaware that the resident had left the grounds.

71. A Directed Plan of Correction was again submitted by Defendants, once again promising to correct the facility's deficiencies.

72. Although the January 2005 Survey revealed 12 deficiencies, Jennifer Matthew nonetheless determined to formally abandon the 10:00 a.m and 2:00 p.m. "Daily Rounds." In its place, the facility instituted: (1) "grooming audits" in which staff were asked to assess each resident's hair, nails and other aspects of grooming on a periodic basis; and (2) "walking rounds" to be conducted by employees as part of their shift assignments. As the covert camera on Patient A demonstrated, these measures once again failed as a managerial tool.

The Summer 2005 Complaint Investigation

73. In July 2005, after a complaint investigation, DOH again found that Jennifer Matthew had placed its residents in "immediate jeopardy."

74. First, DOH found that Jennifer Matthew management "failed to implement the facility policy for heat emergencies during periods of extremely high temperatures and humidity." DOH determined that when temperatures in residents' rooms rose to between 86 and 90 degrees, staff failed to move residents out of their rooms and had not taken steps to prevent their dehydration. In one instance, staff kept an 82-year old man in his bed in direct sunlight when the room temperature was 96º F.

75. Second, DOH found that the facility had "failed to provide intervention to a resident experiencing a choking episode." An 81-year old resident appeared to choking in the dining room but staff did not provide emergency help such as the Heimlich Maneuver.

76. DOH directed Jennifer Matthew to correct these deficiencies. When Jennifer Matthew submitted a Plan of Correction in which it stated that it had installed air conditioners and would bring in a CPR trainer, the "immediate jeopardy" finding was lifted. Jennifer Matthew's is currently pursuing legal action to get this "immediate jeopardy" finding overturned.

MANAGEMENT'S VIEW

77. Management's response to the neglect documented by Patient A's video camera has been to blame the line workers, and to indict a "culture" among the aides at the facility. Indeed, tension between Salerno and his work force dates to his 1999 purchase of the facility, when NRNH and HCA required the existing staff to reapply for

their jobs, and terminated 36 of them. Within months, however, all of those employees were reinstated by a federal labor ruling and 25 returned. Despite that, Salerno did not increase supervision at the facility.

78. Salerno has repeatedly stated that he viewed Jennifer Matthew's workforce as in need of firm management, even characterizing the situation at the home as a "four-alarm fire." Moreover, as set forth above, DOH repeatedly faulted management, at one point going so far as noting that the Quality Assurance Committee was having a "negative impact." Yet, Salerno, HCA and NRNH repeatedly failed to take very simple steps that would likely have prevented the neglect recorded on the video of Patient A. They did not add supervisory positions, systematically audit tasks, or deploy any surveillance or monitoring technology. Nor did they even order a step that is largely cost-free: periodic presence of the Director of Nursing on the floors.

79. Just the opposite, NRNH and HCA dismantled the single managerial protocol that had resulted in their only "substantial compliance" survey since 2003. Jennifer Matthew unilaterally ended the March 2004 protocol under which the Director of Nursing was to audit incontinence care and turning and positioning for at least five residents daily and to review 20 additional charts, as had been promised under the 2004 Directed Plan of Correction. Indeed, it later abandoned even the new Administrator's own substituted "daily rounds" which were to be conducted by the billing manager and others.

80. In sum, faced with what was, in his own assessment, a difficult employee population to manage, Salerno made a series of choices that led to rampant patient neglect. He has testified that better auditing of resident care would have detected the widespread neglect. And he has estimated that even an extensive, dedicated, multi-person audit program would have required only approximately $250,000 in additional salaried positions per year.

81. Thus, despite instruction since 2003 "to deliver consistent, reliable supervision of direct care staff on all shifts," Defendants utterly failed to do so. In his sworn testimony, Salerno defended Jennifer Matthew by saying that "[S]upervision is delivered in the context of what's possible," and that he had tried to hire better supervisors.

JENNIFER MATTHEW'S SUBMISSION OF FALSE CLAIMS FOR MEDICAID REIMBURSEMENT

82. Jennifer Matthew is a registered Medicaid "Provider" with DOH, subject to the program regulations and a Medicaid Provider Agreement that explicitly makes those regulations the foundation of the relationship between the State and the provider. DOH regulations require that a Medicaid provider's claim for reimbursement from the State contain:

> a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . . and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false

> claims, statements or documents, or concealment of a material fact provided .
>
> 18 N.Y.C.R.R. §540.7(a)(8)

83. At all times relevant hereto, Jennifer Matthew, by its agents, obtained and attempted to obtain Medicaid payments from the State by means of claims submissions which included a certification that Jennifer Matthew had complied with all of the legal requirements for reimbursement. In particular, all Medicaid claims made by Jennifer Matthew were subject to a certification signed annually by an agent of Jennifer Matthew stating:

> I have reviewed these claims; I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized and done so in accordance with applicable federal and state laws and regulations . . . the amounts listed are due . . . ALL STATEMENTS, DATA AND INFORMATION TRANSMITTED ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT … I UNDERSTAND THAT MY SIGNATURE HEREON GUARANTEES THE ABOVE CERTIFICATION WILL APPLY TO ALL ELECTRONIC CLAIMS SUBMITTED, USING MY (OR THE ENTITY'S) MEDICAID PROVIDER IDENTIFICATION NUMBER. THIS CERTIFICATION REMAINS IN EFFECT AND APPLIES TO ALL CLAIMS UNTIL SUPERCEDED BY ANOTHER PROPERLY EXECUTED CERTIFICATION STATEMENT.

(emphasis in original).

84. As demonstrated by the Patient A video, the DOH surveys, and the cooperating witnesses, Jennifer Matthew did not in fact provide the "care, services and supplies" for which it claimed and received Medicaid funds, nor did it provide the services in accordance with applicable state and federal law and regulations.

85. Jennifer Matthew billed the Medicaid program for this neglectful care. During the 39-day period of the video surveillance, Medicaid paid Jennifer Matthew more than $396,000 to provide care to approximately 96 Medicaid patients, including Patient A. For Patient A's "care" during this period, the facility received approximately $6,000. From 2003 to mid-2005, Medicaid paid Jennifer Matthew over $10 million.

Executive Law Section 63(12)

86. Executive Law Section 63(12) provides that whenever any person engages in repeated fraudulent or illegal acts or otherwise demonstrates persistent fraud or illegality in the carrying on, conducting or transaction of business, the Attorney General may apply in the name of the People of the State of New York to the Supreme Court for an order enjoining the continuance of such business activity or of any fraudulent or illegal acts, directing restitution and damages and granting other relief.

87. The acts set forth herein, and the crimes charged against, and admitted by, Defendants' employees and agents, constitute violations of the Public Health Law and the Penal Law.

88. Defendants, through the management and employees of Jennifer Matthew, have repeatedly violated New York law and regulations relating to the operation of nursing homes in New York and the delivery of care to residents in those homes. Their employees also repeatedly engaged in fraudulent and criminal conduct. They have repeatedly neglected and abused Jennifer Matthew's residents and they have repeatedly falsified the business records of the home to cover-up this neglect and abuse. Defendants failed to supervise their employees to assure safe and appropriate care of residents and to ensure that medical and care supplies are adequate and they repeatedly deceived DOH as to the deficient care delivered and as to their efforts to remedy those deficiencies identified by DOH. Defendants also deceived prospective residents and their families asto the nature of conditions within Jennifer Matthew and the quality of care delivered in that facility.

89. Defendants repeatedly violated the following laws and regulations, among others, in their operation of Jennifer Matthew:

a) "Neglect" of residents by failing to "provide timely, consistent, safe, adequate and appropriate services, treatment, and/or care." 10 N.Y.C.R.R. § 81.1.

b) Failure to provide each resident with "the necessary care and services to attain or maintain the highest practicable physical, mental, and psycho-

social well-being, in accordance with the comprehensive assessment and plan of care." 10 N.Y.C.R.R. § 415.12.

c) Failure to provide "sufficient nursing staff" so that each resident "receives treatments, medications, diets and other health services in accordance with individual care plans." 10 N.Y.C.R.R. § 415.13.

d) Submission of false claims, statements, documents, and concealment of material fact in connection with claims for Medicaid reimbursement. 18 N.Y.C.R.R. §515.2(b)(1)(i)(a).

90. The acts of Defendants and Defendants' agents set forth in this Complaint further violate prohibitions on false and fraudulent claims for Medicaid reimbursement contained in Social Services Law §145-b and other federal and state statutes and regulations.

* * *

Accordingly, the conduct set forth in this Complaint represents repeated and persistent fraud and illegality in violation of New York and federal laws, rules and regulations.

FIRST CAUSE OF ACTION:
BREACH OF CONTRACT
BY DEFENDANT JENNIFER MATTHEW

91. Plaintiff repeats and realleges paragraphs 1 to 90 as if fully set forth herein.

92. By failing to provide the care and services to Medicaid recipients resident at Jennifer Matthew and false representing that it had provided care and services, in violation of the New York Public Health Law, New York Social Services Law, and rules and regulations promulgated thereunder, Jennifer Matthews breached its contractual obligations under its Medicaid Provider Agreement with the State of New York.

93. As a result of Jennifer Matthew's breach of contract the State of New York suffered damages in excess of $1,000,000, in an amount to be determined at trial.

SECOND CAUSE OF ACTION:
UNJUST ENRICHMENT

94. Plaintiff repeats and realleges paragraphs 1 to 90 as if fully set forth herein.

95. Defendants were not entitled to submit claims to Medicaid and receive payment for unauthorized services in violation of Medicaid program regulations.

96. By reason of the foregoing, Defendants have been unjustly enriched to the detriment of Plaintiff and are liable to Plaintiff in an amount to be determined at trial.

97. As a result of the failure to provide the care and services to Medicaid recipients resident at Jennifer Matthew, in violation of the New York Public Health Law,

New York Social Services Law, and rules and regulations promulgated thereunder, Jennifer Matthew received Medicaid reimbursement to which it was not entitled from 1999 to the present.

98. Defendant Jennifer Matthew's acts and practices alleged herein constitute a breach of its Medicaid Provider Agreement with the State. Jennifer Matthew overbilled, and DOH overpaid, an amount to be determined at trial, to which Jennifer Matthew was not entitled, and for which Jennifer Matthew is liable to the State.

THIRD CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW SECTION 63(12):
FRAUD

99. Plaintiff repeats and realleges paragraphs 1 to 90 as if fully set forth herein.

100. By engaging in the conduct as described above, Defendants repeatedly and persistently claimed and received moneys from Medicaid as reimbursement for residential health care services that had not been provided, and falsely claimed that such services had been provided to Medicaid recipients.

101. Defendants thereby engaged in repeated fraudulent acts and persistent fraud in the carrying on, conducting and transaction of business, in violation of Executive Law §63(12).

FOURTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW SECTION 63(12):
REPEATED VIOLATION OF THE PENAL LAW

102. Plaintiff repeats and realleges paragraphs 1 to 90 as if fully set forth herein.

103. By engaging in conduct as described above, Defendants' agents and employees repeatedly and persistently committed the crimes of Falsifying Business Records in the Second Degree in violation of Penal Law § 175.05(1) and Endangering the Welfare of an Incompetent or Physically Disabled Person in violation of Penal Law § 260.25.

104. Defendants thereby engaged in repeated fraudulent acts and persistent fraud and illegality in the carrying on, conducting and transaction of business, in violation of Executive Law §63(12).

FIFTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW SECTION 63(12):
REPEATED VIOLATION OF THE HEALTH LAWS

105. Plaintiff repeats and realleges paragraphs 1 to 90 as if fully set forth herein.

106. By engaging in conduct as described above, Defendants' agents and employees repeatedly and persistently committed the crime of Wilful Violation of Health Laws in violation of Public Health Law § 12-b(2), Public Health Law § 2803-d(7), and § 81.1, subdivision (c) of Title 10 of the New York Code of Rules and Regulations.

107. Defendants thereby engaged in repeated fraudulent acts and persistent fraud and illegality in the carrying on, conducting and transaction of business, in violation of Executive Law §63(12).

SIXTH CAUSE OF ACTION PURSUANT TO EXECUTIVE LAW SECTION 63(12): VIOLATION OF 18 N.Y.C.R.R. §515.2(b)(1)(i)(a)

108. Plaintiff repeats and realleges paragraphs 1 to 90 as if fully set forth herein.

109. New York State law provides that making false claims by submitting, or causing to be submitted, a claim or claims for unfurnished medical care, services or supplies constitutes the unacceptable practice of fraud or abuse. 18 N.Y.C.R.R. §515.2(b)(1)(i)(a).

110. By engaging in conduct as described above, Defendants engaged in repeated and persistent violation of 18 N.Y.C.R.R. §515.2(b)(1)(i)(a).

111. Defendants thereby engaged in repeated illegal acts and persistent fraud and illegality in the carrying on, conducting and transaction of business, in violation of Executive Law §63(12).

SEVENTH CAUSE OF ACTION PURSUANT TO EXECUTIVE LAW SECTION 63(12): VIOLATION OF 18 N.Y.C.R.R. §515.2(b)(2)(i)

112. Plaintiff repeats and realleges paragraphs 1 to 90 as if fully set forth herein.

113. New York State law provides that making false statements by making, or causing to be made any false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment, or for use in determining the right to payment, constitutes the unacceptable practice of fraud or abuse. 18 N.Y.C.R.R. §515.2(b)(2)(i).

114. By engaging in conduct as described above, Defendants engaged in repeated and persistent violation of 18 N.Y.C.R.R. §515.2(b)(2)(i).

115. Defendants thereby engaged in repeated illegal acts and persistent fraud and illegality in the carrying on, conducting and transaction of business, in violation of Executive Law §63(12).

EIGHTH CAUSE OF ACTION PURSUANT TO EXECUTIVE LAW SECTION 63(12): VIOLATION OF SOCIAL SERVICES LAW §145-b(1)

116. Plaintiff repeats and realleges paragraphs 1 to 90 as if fully set forth herein.

117. Social Services Law §145-b(1) declares it unlawful, knowingly by means of a false statement or representation, or by deliberate concealment of any material fact, or other fraudulent scheme or device, to attempt to obtain or to obtain payment from public funds for purported Medicaid services.

118. By engaging in conduct as described above, Defendants engaged in repeated and persistent violation of Social Services Law §145-b(1).

119. Defendants thereby engaged in repeated illegal acts and persistent fraud and illegality in the carrying on, conducting and transaction of business, in violation of Executive Law §63(12).

NINTH CAUSE OF ACTION PURSUANT TO EXECUTIVE LAW SECTION 63(12): VIOLATION OF THE FEDERAL FALSE CLAIMS ACT

120. Plaintiff repeats and realleges paragraphs 1 to 90 as if fully set forth herein.

121. Federal law provides for penalties to be imposed against any person who knowingly, or in deliberate ignorance or reckless disregard as to truth, makes or uses a false record or statement to obtain payment of a false claim for which the federal government provides any portion of the money which is claimed. 42 U.S.C. §3729(a)(2)(c).

122. By engaging in conduct as described above, Defendants engaged in repeated and persistent violation of the federal False Claims Act.

123. Defendants thereby engaged in repeated illegal acts and persistent fraud and illegality in the carrying on, conducting and transaction of business, in violation of Executive Law §63(12).

TENTH CAUSE OF ACTION PURSUANT TO EXECUTIVE LAW SECTION 63(12): VIOLATION OF 42 U.S.C. §1320a-7a

124. Plaintiff repeats and realleges paragraphs 1 to 90 as if fully set forth herein.

125. Federal law provides for civil monetary penalties when a person knowingly presents or causes to be presented a Medicaid claim to a state agency and it is determined that the person knows "or should know" that the service was not provided as claimed or that the claim was false or fraudulent. 42 U.S.C. §1320a-7a.

126. By engaging in conduct as described above, Defendants engaged in repeated and persistent violation of 42 U.S.C. §1320a-7a.

127. Defendants thereby engaged in repeated illegal acts and persistent fraud and illegality in the carrying on, conducting and transaction of business, in violation of Executive Law §63(12).

WHEREFORE, it is respectfully requested that the Court issue an Order and Judgment:

1. Permanently enjoining Defendants from operating the Jennifer Matthew Nursing and Rehabilitation Center and any other healthcare facility in New York State;

2. Permanently enjoining Defendants from further violation of healthcare regulations relating to the provision of nursing home services in New York;

3. Permanently enjoining Defendants from further engaging in fraudulent and illegal acts and practices relating to reimbursement by the New York Medicaid Program;

4. Directing Defendants to make full monetary restitution and pay damages to the State of New York in the amount of money received by Defendants from Medicaid in reimbursement of claims for nursing home services purportedly rendered from April 30, 2003 to the present;

5. Directing Defendants, under Section 145-b(2) of the Social Services Law, to pay damages equal to three times the money received by Defendant from Medicaid in reimbursement of claims for nursing home services purportedly rendered from April 30, 2003 to the present;

6. Directing Defendants, under Section 145-b(2) of the Social Services Law, to pay damages in the amount of $5,000 per instance of non-monetary false statements or representations relating to provision of Medicaid-reimbursed nursing home services purportedly rendered from April 30, 2003 to the present;

7. Directing Defendants to pay Plaintiff the costs of this proceeding; and

8. Granting to Plaintiff such other and further relief as the Court may deem just and proper.

Dated: Albany, New York
January 5, 2006

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