SUPREME COURT OF THE STATE OF NEW YORK
ORLEANS COUNTY

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

Petitioner,

Index No. _____

AFFIDAVIT OF MEDICAL ANALYST JENNIFER CRONKHITE, R.N.

-against-

COMPREHENSIVE AT ORLEANS LLC d/b/a THE VILLAGES OF ORLEANS HEALTH AND REHABILITATION CENTER, TELEGRAPH REALTY LLC, CHMS GROUP LLC, VILLAGES OF ORLEANS LLC, ML KIDS HOLDINGS LLC, BERNARD FUCHS, JOEL EDELSTEIN, ISRAEL FREUND, GERALD FUCHS, TOVA FUCHS, DAVID GAST, SAM HALPER, EPHRAM LAHASKY, BENJAMIN LANDA, JOSHUA FARKOVITS, TERESA LICHTSCHEIN, and DEBBIE KORNGUT,

Respondents.

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

Jennifer Cronkhite, being duly sworn, deposes and says:

1. I am a licensed Registered Nurse ("RN") employed as a Medical Analyst by the Office of the New York State Attorney General, Medicaid Fraud Control Unit ("MFCU"). I have been a Medical Analyst with MFCU for over six years and have participated in hundreds of investigations into activities of Medicaid providers, including nursing homes.

2. In my position as a MFCU Medical Analyst, among other duties and responsibilities, I review medical records maintained by healthcare providers, including nursing home resident charts, care plans and other facility records, along with records maintained by other healthcare providers treating nursing home residents, such as outside physicians and hospitals. I

also provide interpretation and support of medical concepts for other MFCU staff members and have assisted in identifying and explaining healthcare provider billing fraud throughout my career at MFCU.

3. Prior to being appointed as a Medical Analyst with MFCU, I began my work in the medical field as a Certified Nurse Aide ("CNA") and went on to become a licensed RN in 2002. I have held various positions in long-term care facilities throughout my career, including Staff Nurse, Unit Manager, Assistant Director of Nursing ("ADON"), and Director of Nursing ("DON"). While serving as an ADON and DON, I was required to ensure that the facility I worked for complied with all federal and New York State laws and regulations governing nursing homes. As such, I am familiar with these regulations through training and through my experience working in long-term care and at MFCU.

4. In my capacity as a Medical Analyst, I participated in MFCU's investigation of Comprehensive at Orleans LLC d/b/a The Villages of Orleans Health and Rehabilitation Center ("The Villages"). In support of this investigation, I have assisted with interviews of various staff and former staff of The Villages, reviewed voluminous records from The Villages and other medical providers, and spoken with MFCU Detectives, attorneys, and Auditor/Analysts about their findings relative to this facility. I have also consulted with other MFCU Medical Analysts about many of the findings and information contained within this Affidavit. This Affidavit is intended to summarize relevant findings pertinent to this investigation and does not set forth each and every fact known to me about this investigation.

OVERVIEW & BACKGROUND

5. This affidavit sets forth: (1) Analysis and conclusions drawn from information reviewed specific to this investigation of The Villages; followed by (2) relevant information with respect to the professional standard of care of nursing home residents, including applicable laws, and information about negative healthcare outcomes frequently experienced by nursing home residents who do not receive appropriate care.

6. To participate in Medicare and Medicaid, nursing homes such as The Villages, like all providers enrolled in government-funded healthcare programs, must comply with certain federal and state regulations. (*See* 42 CFR § 424.5; 10 NYCRR § 504.3; *see also* 42 USC § 1396r and 10 NYCRR § 415.1.) More detailed information about these regulations and their practical implications for nursing home residents is set forth in Section II of this Affidavit.

7. Generally, relevant state and federal statutes and regulations impose special obligations and comprehensive duties on nursing homes to provide all required care to nursing home residents, and prohibit the neglect, abuse and mistreatment of residents. *See* Verified Petition at ¶¶ 4-5; 21-23. For example, as a nursing home, The Villages is required by law to provide each resident with a care plan that includes "measurable objectives and timetables to meet each resident's medical, nursing and mental and psychosocial needs." (10 NYCRR § 415.11(c).) The Villages is also required to update and adapt care plans to account for residents' changes in medical conditions; to provide treatment in accordance with the care plan; and to provide sufficient staffing to ensure the care plan is followed. *Id*. State and federal statutes also require nursing homes to report suspected neglect, abuse, and mistreatment of residents. (*See* 42 USC § 1320b-25 and Public Health Law ("PHL") § 2803-d.)

I. Comprehensive at Orleans LLC d/b/a The Villages of Orleans Health and Rehabilitation Center Repeatedly and Persistently Neglected and Mistreated Residents.

8. As part of my involvement with the investigation of The Villages, I reviewed records and findings from MFCU's investigation of the facility from approximately January 1, 2015, to present ("Relevant Period"). Summaries of 15 resident records from The Villages are summarized below, in paragraphs 11 through 116.[1]

9. Based on my review, I was able to draw the following conclusions about the treatment of residents of The Villages received during the relevant time period:

(1) Some resident records do not contain a comprehensive care plan[2] at all;

(2) When care plans were created, they were often inadequate, incomplete, and/or violated multiple times;

(3) In many instances, The Villages staff did not update care plans to reflect major issues affecting resident care and safety, such as falls, severe wounds, and behavior risks;

(4) Medical records demonstrate numerous instances of missing documentation of care for crucial tasks such as monitoring of residents and providing medications to residents, indicating the care was not completed;

(5) The Villages staff often did not administer basic personal care to residents, such as assistance with feeding, transfers, bathing, toileting, personal care and providing physician ordered medication and therapy;

(6) The Villages did not provide proper monitoring of and care for residents' wounds;

[1] Given the highly sensitive nature of these medical records, Petitioner will make these documents available for *in camera* inspection, should the Court wish to review. Petitioner is also amenable to producing these documents to Respondents after entry of an appropriate protective order.

[2] As discussed further in paragraphs 107 through 109, below, all nursing home resident records must contain a care plan. The resident care plan is also known as the "Comprehensive Care Plan," and is intended to provide a complete picture of the resident and their needs, including specific information (problems, goals, and interventions) as to issues such as cardiac concerns, and fall risks. A resident record should also contain what is known as a "CNA Care Plan," also sometimes called a "closet" or "pocket" care plan, which is a smaller snapshot of resident issues that can be more readily referenced by staff.

(7) Medical records were often incomplete, and at times, The Villages staff did not prepare required internal incident reports and mandated reports to outside agencies concerning incidents and accidents;

(8) The Villages staff did not appropriately manage residents' medical conditions and prescriptions; and

(9) The Villages staff did not communicate vital health information to resident family members.

10. My analysis revealed these and numerous other deficiencies, omissions, and oversights on the part of The Villages, many of which resulted in an unacceptable loss of dignity for its residents. The sample of resident records summarized below uniformly reflect failures by The Villages to ensure that each nursing home resident in its care received the "adequate and appropriate medical care" needed to attain their "highest practicable physical, mental, and psychosocial well-being." (*See* 10 NYCRR § 415.12; PHL § 2803-c[3][e].) This failure is evident in both direct resident care deficiencies and general infection control procedures, or the lack thereof. In all cases, these residents' conditions deteriorated instead of improved during their stay at The Villages.

Resident 38's Suicide Risk Factors Were Ignored by The Villages.

11. Resident 38,[3] [redacted] female, was admitted to The Villages on [redacted]. She was admitted for rehabilitation of a left femur fracture. Resident 38's other diagnoses included multiple sclerosis, major depressive disorder, anxiety disorder and hypothyroidism.

12. Shortly after admission, Resident 38 began refusing medications and food. On [redacted], the social worker discussed medication and food refusals with Resident 38 and how her refusals were viewed as self-harm. On [redacted], she was scheduled for an outside consult with her surgeon to remove her hip staples. Her husband refused to allow her to go, stating

[3] To shield protected health information, Residents are referenced herein by numerical identifiers, rather than names. Residents' numerical identifiers are consistent throughout Petitioner's papers.

"My wife is dying." Resident 38's husband was also upset that staff continued to offer her meals. In Resident 38's records, it was noted that Resident 38's husband would frequently state that "it was time for [his wife] to die" and that he frequently closed her door while visiting, despite being educated by staff not to do these things.

13. The DON provided education that assisted suicide was illegal in New York and instructed the family that the staff would continue to provide meals. Resident 38 was screened by Hospice, per the family's request, but Hospice ultimately decided that Resident 38 was not an appropriate candidate because she was not exhibiting signs of being at end of life.

14. On [redacted], [redacted] a third-party psychology consultant service utilized by The Villages, completed a tele-psych visit with Resident 38, and determined that Resident 38 was high risk for self-harm. She was placed on 30-minute checks, her call bell with a cord was replaced with a tap bell, and she was to be provided with plastic silverware and plates for meals.

15. Nonetheless, on [redacted], Resident 38 was found without vital signs, having starved herself to death. A review of records intended to document the 30-minute checks of Resident 38 by staff indicated 19 missed checks on [redacted] and 138 missed checks between [redacted], and her death on [redacted]. Further, The Villages never had Resident 38 evaluated in the hospital after continued refusals of medication and food and numerous verbalizations of wanting to die, as would have been the appropriate intervention. There is also no evidence that The Villages addressed Resident 38's safety regarding her husband telling her "It is time to die," his repeated closing of Resident 38's door during visits, and his request not to offer her meals.

16. Finally, there is no evidence that the facility reported Resident 38's death, despite it being a reportable event per the New York State Department of Health ("DOH") Nursing Home Incident Reporting Manual. (*See* New York State Department of Health Nursing Home Incident Reporting Manual at 14, 18 [Aug. 2016].)

Resident 35 Suffered from Dangerous Seizures and Falls Because The Villages Did Not Provide Her with Required Medication and Attention.

17. Resident 35, a 45-year-old female, was admitted to The Villages from Highland Hospital on November 17, 2020, after a lengthy stay due to seizures. At age 29, Resident 35 was diagnosed with Neuronal Ceroid Lipofuscinosis ("NCL"), also sometimes called Kufs disease, a rare genetic disease. NCL is a disease that affects the nervous system. Signs and symptoms generally include dementia, vision loss and epilepsy. Both Resident 35's father and sister died from this disease. Resident 35's other diagnoses include epilepsy, agoraphobia, delusional disorder, speech disturbance, and dementia without behaviors.

18. Resident 35's mother was very active in her care at The Villages and has described having to attend to Resident 35's needs in terms of daily hygiene, feeding, maintenance of Resident 35's room, staff education, and scheduling and coordinating of Resident 35's medical care, because The Villages did not address these needs. (Affidavit of Donna Kelly ¶¶ 18-35). These basic and necessary tasks were absolutely the responsibility of The Villages' staff and should not have necessitated near-daily assistance from a family member.

19. Resident 35's experience with The Villages substandard care began immediately upon her admission. The day following her admission, Resident 35 experienced three seizures because The Villages' failed to have her anti-seizure medication available upon her admission.

20. A review of her Medication Administration Record ("MAR") for November 2020 indicates that Resident 35 did not receive any of her anti-seizure medications, including Ativan,

Keppra and Topamax, following her admission on November 17, 2020. The MAR indicates that her medications were not available from the pharmacy. There is no note indicating that staff contacted the pharmacy or the medical team to address the lack of medication upon admission, as would have been appropriate, given the severity of the situation.

21. Resident 35's records from Highland Hospital indicate that she suffered three seizures on the morning of November 18, 2020, after one dose of Ativan was missed. The hospital emergency department ("ED") note indicated that Resident 35 suffered the first seizure at The Villages, and two more seizures while under the care of Emergency Medical Services ("EMS"). The ED note also indicated that Resident 35 was less responsive to answering questions than she had been when she was discharged to The Villages just a day earlier. Resident 35 remained hospitalized until she was discharged back to The Villages on December 4, 2020.

22. Upon Resident 35's return to The Villages in December 2020, she began having falls related to self-transfers. Resident 35's falls from self-transferring occurred throughout January, February, March, and April 2021. For example, on January 5, 2021, Resident 35 was found in her bathroom on the floor bleeding from her head. On April 13, 2021, she was found in her room with a bloody nose. She was sent to the ED and was diagnosed with a nasal fracture.

23. Instead of addressing the root of the problem, and despite Resident 35 having a BIMS[4] score indicating that she was severely impaired (she was unable to understand health teaching), "health teaching" and "reminder signs" were a common intervention provided by The Villages for her falls. More appropriate interventions such as setting up a toileting schedule,

[4] A "BIMS" score as it is commonly referred to is a rating scale for cognitive impairment based on the "Brief Interview for Mental Status" Assessment. (Centers for Medicare & Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual at C1 - C6 [eff Oct. 1, 2019].)

moving Resident 35 to a more closely supervised area, and lowering her mattress were apparently not considered.

Resident 7 Died After Being Co-Habited with a Covid-19-Positive Roommate.

24. Resident 7, an 80-year-old female, was admitted to The Villages on March 24, 2020, from Medina Memorial Hospital. Resident 7 had been hospitalized briefly for dizziness and a fall at home, which had been attributed to dehydration. Her other diagnoses included Atrial Fibrillation, Diabetes Mellitus and Alzheimer's Disease. At the time of her admission to The Villages, Resident 7 had a Stage II[5] pressure sore on her left buttock.

25. A review of Resident 7's Treatment Administration Records ("TAR") indicates multiple blank areas, which were intended for documentation of the treatment to her left buttock Stage II pressure sore. There were no new measurements[6] in the medical record, nor any indication that the wound healed before discharge. Further, on April 13, 2020, the nursing notes indicate a new stage II pressure sore had been found on Resident 7's right big toe. A treatment was ordered on April 14 but was not started until the next day. The TAR reveals four blank areas of documentation for the treatment of her right big toe, suggesting treatment was not provided. There are no measurements or description of the toe wound in Resident 7's records, and the toe wound was never addressed in Resident 7's care plan.

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[5] As explained further in paragraphs 136 through 141 below, there are four stages used to categorize pressure injuries. There is an additional category of pressure sores which are referred to as "unstageable." Unstageable sores are serious as they are usually beneath compromised skin tissue and evaluators are unable to determine the severity of damage beneath the skin.

[6] Wounds such as pressure sores should be measured and "staged" weekly to evaluate whether the wound has improved or deteriorated. This weekly assessment allows for further interventions, such as treatment changes, new cushions or devices to offload pressure, and dietary changes to promote wound healing to be put in place. Further information about proper wound care is set forth below in paragraphs 139 through 141.

26. Resident 7 was discharged home on April 21, 2020, after having been exposed to her COVID-19-positive roommate at The Villages and having had a negative COVID-19 test on April 18, 2020. She was admitted to United Memorial Medical Center, Batavia ("UMMC") hospital four days after being discharged home and was found to be COVID-19 positive. She died on May 2, 2020, at another nursing facility. Resident 7's exposure to COVID-19 and subsequent death can be attributed, at least in part, to The Villages' shoddy infection control.

27. A nursing note which was entered on May 4, 2020, by then Director of Nursing Debra Donnelly ("DON Donnelly") indicates that on April 21, 2020, DON Donnelly educated Resident 7's husband that Resident 7 had been in "close contact" with a COVID-19-positive resident and Resident 7's husband chose to proceed with the discharge plan. According to the note, Resident 7's daughter was also notified of the close contact. It is questionable why such an entry was not made until several weeks after this resident's discharge and two days after this resident's death. It is also notable that Resident 7's family disputes the information in this entry, saying they were merely advised of an exposure to a COVID-19-positive resident. (Affidavit of Ondrea Pate ¶ 9.)

Resident 19 Was Subjected to Misuse of Seizure Medication.

28. Resident 19, a [redacted] male, was admitted to The Villages on [redacted], from UMMC Hospital. He had been hospitalized for increased seizure activity and lethargy. His other diagnoses included benign neoplasm of the brain, epilepsy, hypothyroidism, TBI, major depressive disorder and anxiety. Resident 19's seizures were described in outside medical records as: complex partial seizures (seizures that only affect one part of the brain).

29. To help manage his seizures, Resident 19 had an implanted device called a Vagal Nerve Stimulator (a device to treat focal or partial seizures that do not respond to medications by

delivering pulses or stimulation at regular intervals). There are no notations or orders in Resident 19's care plan indicating that doctors or staff at The Villages were monitoring this device or checking for any potential complications related to this device.

30. Resident 19's records also show that staff at The Villages failed to follow orders from Resident 19's physicians regarding the medications he was taking to treat and manage his seizures. First, following his admission to The Villages, Resident 19's medical marijuana was discontinued because "no dosing was provided from the hospital." There are no physician notes or other explanations from The Villages detailing the reason for discontinuing Resident 19's medical marijuana other than dosing issues. Second, Resident 19 was given Ativan as needed, or "PRN," for seizures. A review of his MAR noted, however, that he was given Ativan by nursing staff at The Villages when no seizure activity was documented and was not given Ativan at other times when seizure activity was documented.

31. A review of Resident 19's MAR and nursing notes regarding the use of Ativan from [redacted] 2020 through [redacted] 2021 reveals that he was given Ativan 26 times without any documentation of seizure activity. Misuse of Ativan predominately occurred in 2020. Meanwhile, there were multiple other seizures documented throughout the review period where, according to the MAR, Resident 19 was not given Ativan.

32. This pattern is significant because this patient was prescribed Ativan to address seizures, not anxiety, and Ativan was only to be administered when Resident 19 was having seizures. It appears from my review that inappropriate use of this medication may have been administered for "staff convenience," in that Resident 19 was a difficult resident for staff to care for and suffered from frequent falls, and Ativan likely kept him more sedentary. Such misuse of

a medication like Ativan violates a resident's right to be free from the use of chemical restraints and is contrary to applicable regulations.[7]

Resident 43's Wounds Were Not Attended to and Worsened While at The Villages.

33. Resident 43, a [redacted]-year-old male, was admitted to The Villages on [redacted] 2020, from Highland Hospital. Resident 43 had been hospitalized for a Clostridium Difficile infection. Resident 43 had a previous below-the-knee amputation to his left leg. His other diagnoses included COPD, morbid obesity, Type 2 Diabetes, and hypertension. Additionally, at the time of his admission to The Villages, Resident 43 had a scab on his left leg stump, and a Stage III pressure sore on his right buttock.

34. Importantly, a review of Resident 43's TAR from his time at The Villages indicates multiple missing wound assessments and treatments. The [redacted] 2020 TAR indicates that wound care for Resident 43's right buttock called for the wound to be cleansed daily with saline, for calcium alginate to be applied to the wound bed, and for the wound to be covered daily with a dry dressing. Nonetheless, it was noted that wound care did not start until [redacted] 2020, two days after Resident 43's admission. Thereafter, in [redacted] there are a total of seven blank areas of documentation for Resident 43's wound treatment. The treatment for his stump scab also did not start until [redacted] 2020. A clean dry dressing was to be applied to the scab daily, but there are five areas of blank documentation related to the stump in [redacted] records. Resident 43 was also ordered to have a stump shrinker always applied to his stump except when bathing. There are 11 blank areas of documentation related to the stump shrinker in [redacted] 2020.

35. A review of the [redacted] 2020 TAR indicates there were no changes in Resident 43's treatment. There are 14 blank areas of documentation noted for the treatment to his right

[7] *See* 10 NYCRR § 415.4; 42 CFR § 483.10(e)(1).

buttock. Although there is a nursing note dated [redacted] 2020, indicating that the scab on Resident 43's left stump was resolved, the treatment for this issue continued throughout [redacted] There are 13 blank areas of documentation related to treatment of the stump. Resident 43 was also supposed to have his stump shrinker throughout the month of [redacted], but there are 30 areas of blank documentation, and a nursing note dated [redacted] 2020, indicates that the stump shrinker was missing.

36. A review of the [redacted] 2021 TAR again indicates no changes in the wound treatment to Resident 43's right buttock and contains 16 blank areas of documentation. The treatment for his left stump also reportedly continued in [redacted], but there are 16 blank areas of documentation for that month, too.

37. A review of the [redacted] 2021 TAR indicated that Resident 43 missed one treatment the day before being sent to Rochester Regional Hospital ("RRH") on [redacted] 2021, for COVID-19 symptoms. Importantly, on [redacted] 2021, Resident 43 was seen by the wound care team at RRH. At that time, his right buttock wound measured substantially larger than when he was admitted to The Villages, and it was noted to have purulent drainage. This is a clear indication that Resident 43 failed to receive adequate wound care treatment while a resident at The Villages. Not only did his pressure sore fail to resolve during his nearly three months there, but it got substantially larger.

Resident 53 Did Not Receive the Assistance He Required to Eat Meals.

38. Resident 53, a 64-year-old male, was admitted to The Villages from Highland Hospital on December 21, 2020. His diagnoses included cerebral infarction with hemiparesis of the right side, epilepsy, dysphagia, and aphasia. He weighed 181.4 pounds on December 31, 2020, shortly after his admission.

39. A review of Resident 53's medical record indicates that he was weighed only twice while residing at The Villages. There are no dietary notes in his care plan. On January 21, 2021, a medical note indicated that Resident 53 could feed himself after set-up. However, he would experience left hand tremors halfway through meals and would require more assistance to complete each meal. His care plan failed to address nutrition, though, and a review of the aide documentation was noteworthy, as it contained more blank documentation than completed documentation. Given the absence of meal consumption documentation, little insight was available as to how well he was eating/drinking during his stay at The Villages. As of February 9, 2021, however, Resident 53 weighed 174.8 pounds, a loss of 6.6 pounds in little over a month.

40. While Resident 53's nursing notes indicate that he refused care at times, they also indicate that his wife had provided staff with a blue folder outlining how to provide care and how to handle refusals. Notably, Resident 53's care plan does not reflect refusals or his wife's suggestions. In fact, his records do not contain a CNA care plan at all, and documentation of Activities of Daily Living "ADL," such as transfers, ambulating, eating and bathing, is very poor, and does not reflect daily assistance requirements or refusals.

41. On February 11, 2021, Resident 53 was discharged from The Villages and transferred to St. Ann's Community, a Nursing Home in Rochester, N.Y., at his wife's request. At that time, he had lost another two pounds, and weighed 172.8 pounds (total weight loss of 8.6 pounds since the end of December 2020), indicating he could not possibly have been getting the proper assistance with meals that he needed at The Villages.

Resident 51 Was Subjected to Unreported and Unaddressed Falls, Abuse and Sexual Contact.

42. Resident 51, a [redacted]-year-old female, was admitted to The Villages on [redacted] 2018, from an assisted living facility. Her diagnoses included Alzheimer's, dementia, anxiety,

hypertension, and peripheral vascular disease. A review of her medical record reflects a notable lack of documentation, as well as repeated failures by the staff at The Villages to report and adequately address falls, allegations of physical abuse, and incidents of sexual conduct between Resident 51 and other residents.

43. On [redacted] 2020, a male resident was observed putting his hands down Resident 51's pants. While this incident was ultimately reported to DOH on [redacted] 2020, ACTS[8] information indicates that the same male resident had been found lying on top of Resident 51 in [redacted] of 2020, but there is no documentation of that incident in her medical record. A review of her care plan indicates that no interventions were put in place until the [redacted] 2020 incident. Once an intervention was finally put in place, the intervention was to keep Resident 51 away from the male resident. Monitoring of this intervention was to be recorded in the TAR, which is notable for multiple blank areas, indicating that the intervention was not monitored. Then, on [redacted] 2020, Resident 51 was observed hugging a male resident. The records fail to identify if this was the same male resident that she had a history of sexual encounters with, or whether any further interventions were implemented.

44. On [redacted] 2020, Resident 51 reported that a male staff member had slapped her. According to DOH ACTS information, this incident was never reported to the DOH as required by reporting guidelines. There is similarly no information regarding this incident in her medical record. Worse still, a subsequent DOH complaint was filed by another person indicating that the DON and the ADON knew about abuse to Resident 51, but never reported it.

[8] The ASPEN Complaints/Incidents Tracking System, commonly referred to as "ACTS", is used by DOH to record and track allegations and complaints related to Nursing Home regulated by CMS. Medicare State Operations Manual, § 5060 (eff Mar. 17, 2006).

45. Finally, a review of Resident 51's care plan indicates she was "at risk for falls" but despite multiple falls, her care plan was never updated to address her actual falls and to implement appropriate interventions to prevent additional falls.

46. On [redacted] 2020, Resident 51 was found with a laceration to the left side of her head of unknown origin. This incident is documented in her medical record. The nursing note indicates that there were also cuts to the left side of her chest. Her mental functioning was documented as "sluggish" and "off." The note indicates that neuro checks[9] were completed and continued, but there is no evidence of that in the medical record. This incident was not reported to DOH as required by reporting guidelines, though an internal incident report was completed.

47. On [redacted] 2020, Resident 51 had another unwitnessed fall in the hallway. She was noted to have a laceration to the bridge of her nose with some bleeding. This time, there was no internal incident report or DOH report, nor was there evidence that neuro checks were completed, despite Resident 51 having suffered facial injuries.

48. On [redacted] 2020, Resident 51 was found lying on the floor in the hallway, this time without injury. Again, on [redacted] 2021, Resident 51 had another fall without injuries. No incident report was prepared for either of these falls. The sheer amount of falls suffered by Resident 51 at The Villages is concerning, and reflects a lack of proper monitoring, overall care, and planning by The Villages' staff.

[9] A neurological exam or "neuro check" is completed after a resident fall in which they potentially or actually hit their head. They are completed to identify if the resident possibly suffered a head injury and requires further medical attention. Neuro checks consist of checking the resident's level of consciousness and orientation to person, place and time in comparison to the normal baseline, and a pupil check to ensure they react appropriately to light and grip strength.

Resident 17 Did Not Have a Care Plan and Was Not Appropriately Monitored by The Villages Staff; Resident Died.

49. Resident 17, an [redacted]-year-old female, was admitted to The Villages on [redacted] 2020, from an Assisted Living Facility. She was unable to be maintained at the assisted living facility due to advancing dementia. She also suffered from hypertension, and it was noted that, at the time of her admission to The Villages, she had been non-verbal for approximately 6-12 months. Shockingly, there is no comprehensive care plan at all in her medical record from The Villages. Her record overall reflects a significant lack of documentation.

50. On [redacted] 2020, Resident 17 had a documented fall from her wheelchair, hitting her head. A one centimeter raised bump was noted to the center of her forehead near her hairline. According to the nursing notes, an ice pack was applied, neuro checks were completed and continued. Other than the one note, however, there were no further documented neuro checks. No internal incident report appears to have been prepared documenting Resident 17's fall. The following day, Resident 17 was noted to have emesis (vomiting) after lunch. No further evaluation or monitoring was noted, however.

51. On [redacted] 2020, Resident 17 had another episode of emesis. No further notes, such as a description of the emesis, vital signs, staff monitoring, or issues with food or fluid intake, appear in her medical record until the following day when Resident 17 was found without vital signs at 6:51 a.m. The lack of documentation makes it impossible to determine the cause of Resident 17's death, whether Resident 17's falls contributed to her death, and whether her death was preventable. It also calls into question whether Resident 17 even received basic care during her short stay at The Villages or was just ignored.

Resident 8's COVID, UTI, and Broken Hip Went Undetected by The Villages.

52. Resident 8 was admitted to The Villages on October 24, 2019, at the age of 78, after her family found it difficult to manage her advancing dementia. Resident 8's diagnoses included anxiety, dementia, major depressive disorder and hypothyroidism.

53. According to Resident 8's records, she experienced multiple falls while a resident at The Villages. The first fall occurred on the day she was admitted. She was seen in the Emergency Department at Medina Memorial Hospital for a laceration to her nose and bruises. She was treated and returned to The Villages. Her next fall occurred on March 20, 2020, when she attempted to self-transfer. As a result of this fall, she experienced bruising on her back. And on May 8, 2020, during lunch, Resident 8 suffered her third fall. She was found lying in front of her wheelchair, complaining of left leg pain. The Villages doctor ordered x-rays and an orthopedic consult with the intention of treating Resident 8 in the facility. Resident 8's daughter, however, insisted that she be sent to the hospital for treatment. Upon admission to UMMC, it was noted that, in addition to a left hip fracture, Resident 8 was also suffering from COVID-19 and a UTI, which had apparently gone undetected, or ignored, at The Villages.

54. Resident 8's hip was surgically repaired, but her hospitalization was complicated by hypoxia and hyponatremia (low blood oxygen and sodium). On May 20, 2020, she started refusing any oral intake of food and fluids. After consultation with her daughter, the hospital physician instituted comfort measures, and Resident 8 died on May 23, 2020.

55. While at The Villages, Resident 8 was given several different medications to treat her dementia and major depressive disorder (MDD). According to Resident 8's medical record, as of January 1, 2020, she was noted to be on Prozac 20mg for MDD, Buspar 5mg twice daily for MDD, Namenda 10mg for dementia and Neudexta for dementia. In February of 2020, her Prozac

was increased due to weepiness. On March 25, her Prozac order was changed back to 20mg for seven days and then it was ordered to be discontinued. In a note from the previous day, the physician stated they would try Cymbalta for depression and pain issues. The Cymbalta was ordered to start at 20mg for seven days and then increase to 40mg. However, this order was not started until April 2, 2020, two days after Resident 8's Prozac had been discontinued. The increase in Cymbalta should have started seven days after the 20mg was started, which would have been April 8, 2020. The ordered increase did not start, however, until April 10. On May 1, 2020, it appears that Resident 8's Cymbalta was discontinued. There is no order in the records to discontinue the Cymbalta, however, a physician's note dated May 1, 2020, discussed "switching to Remeron," and it appears Remeron was started on May 1, 2020.

56. Resident 8's medication record is notable, because it demonstrates that The Villages' reaction to medication orders was not timely, causing potentially dangerous gaps in treatment. Additionally, in May 2020, Resident 8's Cymbalta was abruptly stopped. Prescribing information for Cymbalta recommends a gradual dose reduction rather than abrupt cessation to prevent or reduce adverse side effects, which can include dizziness, headaches, nausea, vomiting, paresthesia and anxiety. This is significant because Resident 8's fall, as a result of which she fractured her hip, and ultimately decompensated, occurred just seven days after the abrupt cessation of her Cymbalta.

Resident 34 Left The Villages Undetected and Was Found Walking Alone at Night Outside a Prison.

57. Resident 34 was admitted to The Villages on December 29, 2020, at the age of 59. He was admitted from Rochester General Hospital after it was deemed no longer safe for him to live alone after multiple behavior problems. His diagnoses included intellectual disability, hypothyroidism, epilepsy and dysphagia.

58. Upon admission, Resident 34 was noted to be sexually aggressive towards other male residents. On the date of his admission, he was found kneeling next to a male resident with the other resident's gown up. The following day, he was observed grabbing another male resident's genitals. Resident 34's sister informed the facility that he had previously been removed from day treatment programs due to sexually inappropriate behaviors. On January 7, 2021, Resident 34 was observed touching another resident inappropriately. And on March 7, 2021, he was sent to the ED for sexual aggression. He was care planned for sexual aggression on January 13, 2021, and behaviors related to sexual tendencies on January 7, 2021, but no incident reports regarding these incidents of resident-on-resident sexual abuse appear to have been prepared, and there is no evidence these incidents were reported to DOH as required by the guidelines in the Nursing Home Incident Reporting Manual. (*See* New York State Department of Health Nursing Home Incident Reporting Manual at 8-9 [Aug. 2016].)

59. Resident 34 was also noted to have exit seeking behaviors, and on January 31, 2021, the facility was notified by Albion Prison that Resident 34 was found walking near the prison. The facility investigation found that the door alarm had been shut off for a family member of another resident to drop off birthday gifts for that resident, and that Resident 34 had left the dementia unit sometime after 8:00 p.m. Resident 34 was not wearing a wander guard at that time, as would have been appropriate, given his history. Upon his return to the facility, a wander guard was placed on his right ankle. Oddly, however, his care plan was not updated to address his elopement risk until June 5, 2021.

60. Resident 34 also suffered numerous falls during his stay at The Villages. His falls were commonly related to self-transferring and sliding out of his bed to reach items. He was care

planned for falls on January 10, 2021. Nonetheless, on May 23, 2021, he suffered a fall with injury and was sent to the emergency department the next day due to increasing lethargy.

61. Finally, it was noted by Resident 34's sister that he suffered substantial weight loss while a resident at The Villages. According to Resident 34's sister, he lost approximately 38 pounds while he was a resident at The Villages. Resident 34's admission weight was 157.6 pounds. His weight in June was 140 pounds. That is an 11% weight loss and considered "severe," according to the Long-Term Care Survey Manual.[10] (*See* American Healthcare Association, The Long Term Care Survey, Phase 2 at p. 473.) The Speech Language Pathologist changed Resident 34's diet to puree with nectar thick liquids, and in July of 2021, it was noted that he suffered from increased difficulty swallowing and required suctioning of his puree diet due to choking. While the social worker documented that Resident 34's sister declined a feeding tube, and a nutrition care plan was initiated, CNA documentation is lacking, making it difficult to determine what his oral intake actually was. Ultimately, by September of 2021, Resident 34's weight had further declined to 121.5 pounds.

62. On September 15, 2021, he was sent out to Strong Memorial Hospital ("Strong"), where he remained until he died on January 26, 2022. Overall, Resident 34 severely declined during his time in The Villages. The Villages never appropriately assessed and planned for Resident 34's needs until after he was put in harm's way. It appears that The Villages was not fully equipped to meet Resident 34's many needs, and never fully provided treatment to keep him safe and improve his quality of life.

[10] The Long Term Care Survey Manual is published by American Health Care Association, and updated on a regular basis. It is commonly used as a reference source by nursing homes.

Resident 50 Was Clearly Neglected by The Villages and Was Rarely Showered.

63. Resident 50 was admitted to The Villages on December 17, 2020, at the age of 82, following a hospitalization for hemorrhagic cystitis. His diagnoses included diabetes, history of prostate cancer and dementia. According to his wife, while Resident 50 was a resident at The Villages he suffered substantial weight loss, bruising, and resident on resident abuse. She also noted that family notification of these issues was lacking. His wife further reported that on at least one occasion, he was naked during a FaceTime call with her. (Affidavit of Margarette Volkmar ¶¶ 7-22.)

64. Upon review of the medical record, Resident 50's height and weight were not recorded upon admission. His height was first recorded on March 31, 2021, at 73 inches. His first weight was recorded a month after his admission on January 18, 2021. His weight at that time was 247.8 pounds. He was weighed again on January 25, February 1, and February 15, 2021. His weight on February 15, 2021, was 237.5 pounds. He was weighed weekly starting March 15, 2021, after his reported weight dropped to 196.4 pounds. This is a 20% weight loss from his original weight on January 18, 2021. At the end of March and beginning of April 2021 it appears that Resident 50 gained a small amount of weight. However, his April 14, 2021 weight was 195.4 pounds. This represents a total 21.5% weight loss in three months and is considered by the Center for Medicare and Medicaid Services[11] ("CMS") as severe weight loss (greater than 7.5% weight loss in three months is considered severe). On April 1, 2021, the Interdisciplinary Care Team[12]

[11] Centers for Medicare and Medicaid Services, commonly referred to as CMS, is part of the U.S. Department of Health and Human Services ("HHS"). Among other things, CMS puts forth regulations and guidelines for medical providers, such as nursing homes, that treat Medicare and Medicaid patients. (Centers for Medicare & Medicaid Services, www.cms.gov [last accessed Oct. 13, 2022].)

[12] Nursing Homes are required to have IDT's made up of a physician, A registered nurse with responsibility for the resident, and other appropriate staff. (*See* 10 NYCRR § 415.11[c][2][ii].)

("IDT") met and reviewed Resident 50's weights. They apparently decided that staff had failed to subtract the weight of Resident 50's wheelchair and that his "appropriate" weight had been obtained March 15, 2021. However, the weight of the wheelchair was never even noted in the record.

65. Significantly, there are no notes completed by a registered dietician or diet tech in the medical record, as is required by regulation.[13] Resident 50's ADL documentation is severely lacking. There are numerous blank areas of documentation, and the medical record does not give any indication as to how well Resident 50 was eating and what level of assistance he required or received. Nutrition is not even addressed in his care plan, where it should have been a focus point, given his weight loss issues.

66. Resident 50 also appears to have had a problem with falls. According to nursing notes, his first fall was on the day of his admission. He was found by staff laying on the floor next to his bed. On December 28, 2020, he was again found on the floor next to his bed. Although no apparent injuries were documented, it was not documented that his family was notified of the fall, as they should have been. On January 16, 2021, Resident 50 was found on the floor in the bathroom without injury. Again, it was not documented that family was notified of this fall as they should have been.

67. On February 6, 2021, Resident 50 was again found on the floor in his room. A contusion to the right side of his forehead appeared later that day. He became more lethargic with increased confusion and drooling the next day. His wife was notified about the fall on February 7,

[13] Per 42 C.F.R § 483.60(a), a facility must employ sufficient staff with the appropriate competencies and skill sets to carry out functions of the food and nutrition services. 42 C.F.R. §483.60(a)(1) further states that a qualified dietician or other clinically qualified nutrition professional must be employed full time, part time or on a consultant basis.

but only, it appears, because he was sent to the ED for evaluation. He returned from the ED the same day. On March 4, 2021, he was found, once again, on the floor in his room without injuries.

68. While Resident 50's care plan notes that he is at risk for falls, despite the numerous falls documented in his record, The Villages did not establish a "fall care plan" to address the falls and did not implement any interventions to prevent further falls. Further, there are no Internal Incident reports for Resident 50. Incident reports should have been prepared for each of the four fall incidents described above, in order to properly document the events.

69. A review of Resident 50's TAR corroborates the issues with hygiene noted by his family members. His record indicates that he was not showered in the month of December 2020, only received two out of five showers in January 2021, and two out of four showers in February 2021. In March he received weekly showers, but in April 2021 he only received a shower the day he was discharged to another facility. A review of the aide documentation reveals frequent blank documentation, indicating he was not provided with care.

70. On April 14, 2021, Resident 50 was transferred to St. John's nursing home in Rochester, at the request of his wife. Upon admission, his weight was 193 pounds. and it was noted by the Registered Dietician that he was at risk for malnutrition. He was also noted to have several broken teeth and upper dentures. He was promptly seen by a dentist to address this. He was noted to have several bruises to his upper extremities, multiple cyst-like areas on his back and arms (that were determined to probably be sebaceous cysts by a mobile surgery unit) and a scabbed area on his right small toe. He was noted to have long fingernails and was noted to be scratching his lower back, buttocks and groin area. The note indicates that his buttocks and groin area were red, but not fungal in appearance. This assessment reflects that Resident 50 was clearly neglected while at The Villages.

71. Finally, Resident 50's record demonstrates further problems with The Villages timely documenting and reporting instances of resident abuse. A note created on March 10, 2021, documented an incident that occurred on January 28, 2021, in which Resident 50 slapped a female resident. A review of DOH records indicates that this resident-on-resident abuse was reported to DOH outside of the reporting guidelines. Additionally, Resident 50's family was not notified of this incident. Then, on March 3, 2021, Resident 50 was choked by another resident after touching his room door. This incident was also reported to DOH the following day, outside of the reporting guidelines. Once again, there are no notes indicating that Resident 50's family was notified of the incident either.

Resident 42's Basic Needs and Medical Concerns Were Ignored.

72. Resident 42 was admitted to The Villages from Strong Hospital on January 25, 2021, at the age of 67. Her records, and an interview conducted by MFCU with her friend, Laurel Harrington, highlighted issues with her care, including unavailability of facility staff, persistent failure to properly document issues related to Resident 42's care, and failure to properly address her pressure sores. According to Ms. Harrington, Resident 42 would text her when she couldn't find staff to help with obtaining water or toileting. (Affidavit of Harrington ¶ 14.)

73. Notably, Resident 42's chart from The Villages does not even contain a comprehensive care plan.

74. When Resident 42 was admitted to The Villages, she was not prescribed any medication for anxiety. She was started on Buspirone 5mg twice daily on January 23, 2021. There is no significant documentation outlining severe anxiety, as would support such a prescription. Upon admission, she experienced some confusion and was occasionally questioning her medications. Despite lack of significant documentation of anxiety, in April, her Buspirone was

increased to 10mg twice daily and Cymbalta was started for anxiety. There are no nursing notes indicating she was monitored for reduction in anxiety with the dose increase or whether she had any side effects.

75. A review of Resident 42's PRN (as-needed) medications indicates frequent administration of Tylenol and Zofran but reflects a lack of corresponding assessments related to conditions the PRN medication was used to treat. Zofran was ordered as needed on March 20, 2021 for nausea. Resident 42 was given Zofran almost daily after it was prescribed, including 18/30 days in April, 16/31 days in May, 13/30 days in June, and 5/13 days in July. There are, however, no assessments or root causes of her nausea documented in her records, nor is there any evidence that her frequent need for nausea medication was discussed with the doctor for further follow up to determine the cause of her illness.

76. Similarly, Resident 42 was given Tylenol for pain almost daily. Again, there is a lack of assessment and root cause of pain or documentation that non-pharmacological techniques were trialed to relieve the undescribed pain. She was also ordered Tramadol at the end of April, but that medication was rarely used. Resident 42 was also prescribed cough medication. She was given this medication almost daily. Assessments of her cough and lungs were lacking. There is also no evidence that the frequent use of this medication was discussed with the doctor.

77. Resident 42 was noted to be on 15-minute checks since her admission. There are noted blank areas of documentation in the administration records, indicating the checks were not completed, and there is no reason given for 15-minute safety checks. Again, Resident 42 did not have a care plan, so none of these issues were adequately addressed by The Villages.

78. According to nursing notes, when Resident 42 was originally admitted to The Villages, she had a Stage II pressure sore to her sacrum. Beginning on January 6, 2021, she was

seen weekly by Wound Healing Solutions ("WHS"), a third-party company hired by The Villages to consult as to wound treatment. WHS recommended a zinc-based ointment as a treatment for Resident 42's pressure sore. The ointment was ordered, but not until January 23, 2021 (18 days after the initial WHS assessment). WHS noted the wound healed on February 3, 2021, but the facility never discontinued the treatment for the pressure sore.

79. On June 24, 2021, WHS documented that Resident 42 had two re-opened areas on her sacrum, both of which were Stage III. WHS recommended calcium alginate covered with a dry clean dressing during this assessment. The facility did not order the new treatment until June 30, 2021, and did not start the new dressing until July 1. When WHS assessed the wound on July 7, it was noted that both wounds were deemed unstageable. There is no facility note in June indicating exactly when and how the open areas on Resident 42's sacrum were detected. There is also no care plan in her chart for any other interventions related to pressure sore prevention.

80. Medina Memorial Hospital records state that Resident 42 arrived on July 13, 2021, at 7:09 p.m., unresponsive, but with vital signs. After discussion with Ms. Harrington, the ED physician withdrew care and Resident 42 died at 8:05 p.m. The ED physician diagnosed Resident 42 with acute cardiopulmonary arrest secondary to respiratory failure.

81. Resident 42 weighed 66.8 pounds on admission to The Villages. Her weight remained stable until July 7, 2021, shortly before her death, when her weight dropped to 60.3 pounds.

82. Finally, as is the pattern with Resident 42's records from The Villages, documentation is also lacking from the time period leading up to Resident 42 being found unresponsive in her room on July 13, 2021, including a lack of documentation as to the nursing care, or lack thereof, she received before being sent to the hospital. The lack of documentation

combined with other factors, such as Resident 42's frequent use of anti-anxiety and PRN medications, raises serious questions as to whether she was suffering from a serious medical condition that was ignored by The Villages.

Resident 6's Severe Cardiac Concerns and Cardiac Medications Were Not Monitored and She Developed Gangrene at The Villages.

83. Resident 6, a [redacted]-year-old female, was admitted to The Villages on [redacted] 2021, from Rochester General Hospital ("RGH"). Resident 6 had a lengthy hospitalization prior to her admission to the Villages, having been admitted to RGH from [redacted] 2021, to [redacted] 2021, for respiratory failure, then transferred to the Long-Term Acute Care Hospital, on a diuretic drip, and returned to the acute hospital for worsening heart failure and hyponatremia. Resident 6 underwent a coronary artery bypass graft surgery on [redacted] 2021. She also suffered from peripheral vascular disease, sore of the right foot, diabetes, and chronic kidney disease.

84. At the time of her admission to The Villages, Resident 6 was ordered to wear a Zoll Life Vest. The life vest is a wearable cardioverter defibrillator. The vest detects and converts rapid life threatening cardiac arrythmias. The vest is only to be removed for showering and hygiene. There is no evidence this device was ordered upon her admission to The Villages. There is also no rationale for not ordering the life vest. Worse still, there is no care plan at all to address Resident 6's severe cardiac concerns.

85. Upon her admission to The Villages, Resident 6 was also prescribed Digoxin 62.5mcg, a medication used to treat heart failure. When someone is prescribed Digoxin, it is routinely ordered that the patient's pulse be taken before administering the medication, and that the medication not be administered if the patient's pulse is less than 60. A review of the orders from The Villages is notable for the complete lack of pulse monitoring or hold parameters. Patients with renal impairment, like Resident 6, are also at risk for Digoxin toxicity and require monitoring.

A review of Resident 6's orders from The Villages does not indicate that labs were ordered to be drawn until [redacted] 2021, despite the fact that, as early as [redacted], 2021, she began gagging with medications and meals, developed a poor appetite, and had difficulty swallowing medications and food.[14] Further, there is no evidence that Resident 6's change in condition was even discussed with a doctor. On [redacted] 2021, Resident 6 was sent to the ED at Unity Hospital ("Unity"). Upon evaluation at Unity, Resident 6's Digoxin level was far above the normal range, confirming she likely suffered from Digoxin toxicity. Unity determined Resident 6 needed a higher level of care and transferred her to RGH the same day.

86. Upon her original admission to The Villages on [redacted] 2021, the doctor noted that she had eschar (dead tissue) to the right heel and a clear bulla (large blister containing serous fluid) to the left heel. Despite this note, there is no nursing assessment or assessment from WHS regarding the wounds to her heels. On [redacted] 2021, an LPN noted that the 2nd, 3rd, and small toes on Resident 6's right foot were black. The DON indicated that the doctor was notified, but no orders are noted following that notification. Santyl was originally ordered for the heel wounds. That treatment was only completed 6/10 times. The treatment was changed to Dakin's solution on [redacted] 2021, the day Resident 6 was sent to Unity, and ultimately to RGH, where it was determined that she had gangrene and cellulitis. Importantly, Resident 6's care plan at The Villages did not address any of her wounds.

87. Finally, a review of the Unity and RGH medical records indicated that Resident 6 was noted to have large necrotic wounds on both her right and left thighs. The wound on the anterior of her left thigh measured 18cm x 4cm with surrounding erythema (redness). The right

[14] Signs and symptoms of digoxin toxicity include bradycardia, lack of appetite, nausea, and vomiting. (Digoxin Monograph for Professionals, https://www.drugs.com/monograph/digoxin.html [last accessed Oct. 13, 2022].)

anterior thigh wound measured 22cm x 5cm with surrounding erythema. There is no documentation indicating that these wounds were identified while Resident 6 was a resident at The Villages. Significantly, the hospital paperwork notes that The Villages failed to notice these thigh wounds.

88. Resident 6 remained at RGH from her re-admission on [redacted] 2021, until her death on [redacted] 2021. She suffered worsening infections and was eventually placed on a ventilator. She was unable to be removed from the ventilator and her family made the decision to pursue comfort care. She died on [redacted] 2021, after a compassionate wean from the ventilator.

Resident 22's Wounds Worsened at The Villages, and She Was Endangered by The Villages' Unsafe Decision to Discharge Her.

89. Resident 22, a 60-year-old female, was admitted to The Villages from Strong Hospital on January 19, 2022. Resident 22 had been admitted to the hospital from home after falling at home and following multiple prior hospitalizations due to chronic pain and falling. Resident 22 has a long history with chronic pain, depression and suicidal ideations. Her diagnosis includes anxiety, dermatopolymyostis, chronic pain, CREST syndrome, Sjogren syndrome, diabetes mellitus, depression, major depressive disorder, and opioid dependency. Resident 22's depression is noted to stem from her family dynamics and chronic pain. Her suicidal ideations have been present since she was a child. Strong psychiatry indicated that her suicidal ideations were not life threatening. It was determined due to her chronic conditions that Resident 22 would be appropriate for long term care.

90. Upon admission to The Villages, Resident 22 had a Stage II pressure sore to her sacrum. There are no admission nursing notes indicating the size or presence of the Stage II sore upon admission to the facility. WHS assessed the sore on her sacrum on January 24, 2022, 5 days

after admission. They noted that the sore was considered unstageable. WHS assessed the sacral sore weekly. On February 9, 2022, WHS recommended that the sore be cultured, but The Villages' physician declined to order the culture. The sore was eventually cultured on March 15, 2022 and found to be positive for Staph Aureus. Treatment with Bactrim was not started until March 22, 2022. Resident 22's sacral sore was cultured May 16, 2022 and found to be positive again with Staph Aureus. Bactrim was started the same day. The sore measurements decreased in size and the sore was staged as a Stage III on April 13, 2022.

91. On April 20, 2022, WHS noted that Resident 22's right hip was swollen and red. They recommended warm soaks. Warm soaks are not noted on the TAR or in the MD orders from The Villages. There is no indication in the nursing notes that nursing staff noted redness and swelling in the right hip area. On May 21, 2022, the TAR indicates the staff was cleaning the right hip with normal saline and covering it with a dry clean dressing. On May 27, 2022, a Villages NP recorded that Resident 22's right hip was swollen, red and draining. She ordered a stat culture and noted that Resident 22 may need hospitalization for IV antibiotics. The NP indicated Resident 22 scratches this area during antibiotic therapy. However, there is no noted antibiotic therapy for this area.

92. Resident 22 was sent to UMMC on May 28, 2022. and admitted for sepsis due to this sore. She required surgical removal of the abscess. She was discharged back to The Villages on June 10, 2022. WHS followed the hip incision until it was healed. A review of Resident 22's care plan from The Villages shows this sore was never addressed in the care plan, pre-hospitalization or post-hospitalization.

93. Resident 22's sacral pressure sore assessments were reinstated on June 15, 2022, after Resident 22's return from the hospital. The pressure sore was labeled unstageable and slightly

larger. Of note, there are multiple blank areas of documentation for the sacral pressure sore in Resident 22's medical record, indicating that the pressure sore was not properly cared for. A review of Resident 22's care plan does not indicate that she was turned and positioned, or encouraged to turn and position, as would have been the appropriate treatment.

94. Resident 22 had many falls. Most of her falls were caused by her self-transferring or rolling out of bed. None of these falls are noted in the medical records produced by The Villages. On April 30, 2022, May 1, 2022, May 14, 2022, and May 15, 2022, Resident 22 was noted to have hit her head. There is no evidence in the medical record that neuro checks were completed. An Internal Incident Report from May 1, 2022, indicates that Resident 22 was sent to a hospital ED with hip pain, and had hit her head. There is no documentation in the medical record regarding Resident 22's departure to the ED or return from the ED. The Internal report indicates that x-rays and CT scans were negative. On May 15, 2022, Resident 22 was sent to the ED after a fall. There is no documentation of her departure or documentation of the specific concern that sent her to the ED. There is a nursing note indicating that Resident 22 returned at 8:00 a.m. with a diagnosis of polypharmacy and fatigue. A review of her care plan indicates that she is care planned for risk of falls. However, there is no evidence that care plan interventions, such as patient education and additional staff monitoring, were initiated in response to the 11 falls she had from admission to July of 2022.

95. On July 19, 2022, a new CNA at The Villages was assigned to care for Resident 22 and others on her Canal View unit, during the night shift, from approximately 10:00 p.m. to 6:00 a.m. After Resident 22 made a complaint regarding the CNA, records obtained from The Villages revealed that The Villages had not completed the required background check for the CNA, and

that in the absence of a completed background check, the CNA had not been properly supervised, as required.[15]

96. Thereafter, on August 25, 2022, following the initiation of an outside investigation into Resident 22's complaint against said CNA, and an unrelated altercation between Resident 22 and a staff member of The Villages, Resident 22 and her boyfriend, Resident 57, were discharged by the Villages and driven to an apartment in Monroe County by a Villages staff member. This discharge was conducted in violation of discharge regulations[16] which set forth very specific requirements with respect to discharge notice, planning, and documentation. Furthermore, the discharge put Resident 22 at a serious health and safety risk, given Resident 22's documented physical and psychological challenges, combined with the fact that Resident 57 was known to have behavior problems.

97. A review of Resident 22's discharge records indicates that The Villages Social Worker, Sarah Woodin ("SW Woodin") documented she first met with Resident 22 to discuss discharge planning on August 2, 2022. The note indicates that the discharge plan would be to Resident 22's son's home because of falls and hospitalizations when she lived alone. On August 15, 2022, the social worker documented that Resident 22 wanted to discharge home with her boyfriend from the facility. The social worker indicated that her apartment was still available, and Resident 22 would be welcome to return. On August 22, 2022, SW Woodin documented that she met with Resident 22 to review the discharge plan and that referrals were made for therapy, aide services and nursing services. On August 25, 2022, the social worker documented that Resident

[15] 10 NYCRR § 402.4(a)(1) sets forth criminal background check requirements for prospective nursing home employees; and 10 NYCRR § 402.4(b)(2)(i) requires nursing homes to ensure that employees who have not undergone the required background check "do not have unsupervised physical contact with patients."
[16] *See* 10 NYCRR 415.3.

22 was discharged and SW Woodin helped her move to her apartment. This note indicates that the resident's daughter and son would be grocery shopping for her but does not reference any contact with Resident 22's family.

98. Resident 22 was not assessed by a doctor prior to her discharge, as is required. From a medical perspective, it was unsuitable for Resident 22 to be discharged as she had an open pressure sore on her tailbone. Furthermore, according to The Villages records, Resident 22's family members were never contacted by The Villages prior to her discharge, as is required. To make matters worse, it appears that The Villages did not notify Resident 22's family the day she was discharged, nor did they advise her family of the location to which she was being discharged.

99. In addition, between the initial discussion of discharge on August 2, 2022, and her discharge on August 25, 2022, there is no evidence that Resident 22 was evaluated to ensure she could safely administer her medication and manage her diabetes appropriately. Resident 22 also still had a Stage III pressure sore on her sacrum. There is no evidence that Resident 22 was assessed for her ability to independently care for this pressure sore. On August 1, 2022, and August 3, 2022, an NP from The Villages indicated that she had to complete teaching Resident 22 to be compliant with her insulin. The note indicates that Resident 22 had been refusing her insulin, causing increased blood sugars. Resident 22's record contains an entry from Dr. Madejski dated August 23, 2022, indicating that Resident 22 was stable to go home. There is no further discharge summary to review what medications were prescribed, what teaching was completed or what home care agencies were contacted. There is no documentation of family discussions as to what assistance they would provide, nor is there documentation that any family was notified of her discharge. There is also no care plan for review to indicate any discharge planning or teaching that was completed with Resident 22 or her family.

100. Upon Resident 22's discharge from The Villages, the facility was required to prepare a discharge summary including (1) a recapitulation of the resident's stay; (2) a final summary of the resident's status[17] that at the time of the discharge shall be available for release to authorized persons and agencies, with the consent of the resident or legal representative; and (3) a post-discharge plan of care that shall be developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment and assure that needed medical and supportive service have been arranged and are available to meet the identified needs of the resident. (*See* 10 NYCRR § 415.11[d][3].) This does not appear to have been prepared.

101. Clearly, Resident 22 was not in a sufficiently healthy condition or sufficiently prepared to be discharged, nor were the majority of the discharge regulations followed. Resident 22's clinical record is bereft of many of the conditions required before Resident 22 could be safely and appropriately discharged, and the facts and circumstances of her discharge combined with the inadequate discharge records demonstrate that Resident 22's discharge from The Villages was conducted contrary to applicable regulations and with disregard for Resident 22's health and safety.

Resident 40 Weighed Just 56lbs but Her Weight Was Not Monitored and Her Wounds and Basic Needs Were Ignored.

102. Resident 40, an 86-year-old female, was admitted to The Villages on September 30, 2021 from Medina Memorial Hospital ("Medina Hospital").[18] Resident 40 had been

[17] This summary is to include a comprehensive assessment of the resident regarding such things as medical status measurement, physical and mental functional status, special treatments or procedures, mental and psychosocial status, and drug therapy. (10 NYCRR§ 415.11[a][2].)
[18] Resident 40 was first admitted to The Villages in January of 2019 for rehabilitation. She was discharged home on February 25, 2019. Resident 40 was again admitted to The Villages for rehabilitation on October 2, 2020 and discharged home on November 2, 2020.

hospitalized at Medina Hospital for pelvic fractures and injuries to her buttock muscles after suffering a fall at home. According to Medina Hospital's discharge summary, Resident 40's other diagnoses included: dementia without behaviors; severe protein-calorie malnutrition; dysphagia; major depressive disorder; chronic atrial fibrillation; and compression fractures of T7-T8 vertebrae. Medina Hospital discharged Resident 40 with an order for Rivastigmine (Exelon) capsules daily for dementia. There are no other psychotropic medications or antidepressant medications noted on the discharge summary.

103. In the admission note dated October 2, 2021, Dr. Madejski noted that he may wish to place Resident 40 on an appetite stimulant but would wait a few days. On October 6, 2021, Dr. Madejski discontinued Resident 40's Exelon and started her on Remeron 7.5mg at bedtime. Remeron is an antidepressant medication that has a wanted side effect of increased appetite and weight gain. On November 2, 2021, Dr. Madejski increased Resident 40's Remeron to 15mg at bedtime. Despite this dosage increase, as of November 2, 2021, there had been no documentation regarding signs and symptoms of depression. Nor was Resident 40 even weighed until December 1, 2021, more than 60 days after her admission. Resident 40's first recorded weight at that time was 56lbs.

104. On May 19, 2022, there was a social worker note indicating that Resident 40 had threatened to slit her wrists. There are no corresponding nursing notes regarding this suicidal threat. There is no indication that Resident 40's family was notified regarding the suicidal threat. There was no incident report completed for the suicidal threat. Resident 40's care plan does not address that a suicidal threat was made. There was no increased monitoring or referral made to outside counseling.

105. On June 17, 2022, Resident 40 was started on Seroquel 25mg for psychosis. There is one NP note dated May 27, 2022 that indicated Resident 40 was experiencing confusion and thought her house was on fire. On June 16, 2022, Dr. Madejski entered a note that documented that Resident 40 was experiencing paranoia and anxiety, but did not provide further details. In my professional opinion, I would expect to see more than two notes indicating signs and symptoms indicative of psychosis over the approximately eight months between Resident 40's admission and initiation of the Seroquel, including notes entered by the nursing staff who provide daily care for Resident 40, if Resident 40 were in fact suffering from psychosis.

106. On July 21, 2022, a nursing note indicated that the NP saw Resident 40 for anxiety and hallucinations. A urine sample was obtained to rule out a UTI. A new order was received at that time to increase Resident 40's Seroquel to 50mg daily. The Seroquel 50mg was discontinued on October 20, 2022. There was no taper or reason for the discontinuation noted in the medical record. There is no evidence that Resident 40's family was notified of the medication addition, dose increase, or discontinuation. There is no added diagnosis of psychosis to Resident 40's diagnosis listing. Resident 40's care plan indicated that she received a psychotropic medication, but was never updated when the medication was discontinued.

107. On July 27, 2022, a referral was made for Deer Oakes Psychological Services ("Deer Oakes"). There is no indication in the record why a referral was made. Resident 40 was seen for the initial visit on August 12, 2022, but due to her positioning, the tele visit was difficult. She was seen again by Deer Oakes on August 26, 2022. The consulting psychologist noted that Resident 40 seemed depressed and withdrawn. The psychologist further noted that Resident 40's confusion and unclear thinking were likely symptoms of dementia, not psychosis.

108. Upon admission in September 2021, Resident 40 appeared to have no wounds present. For the entire review period (Sept. 30, 2021 to Oct. 24, 2022), there are multiple areas of missing documentation indicating that preventative wound care treatments were not completed each month. On June 21, 2021, there was an order placed on the TAR for turning and positioning every two hours. From the start of that order to when that order was discontinued on August 25, 2022, there are multiple blank areas of documentation indicating turning and positioning was not completed. On August 25, 2022, the order on the TAR changed to monitoring turning and positioning every two hours. There are multiple blank areas of documentation indicating that turning and positioning was not monitored.

109. On October 8, 2022, a new order for a dressing to Resident 40's right hip is noted in the nursing notes. There are no measurements or description of the hip wound – nor does the hip wound appear anywhere in the chart prior to this date. On October 22, 2022, the TAR indicated a treatment change to the wound on Resident 40's right glute. Again, there are no measurements or wound descriptions available for the wound.

110. I have reviewed the photographs provided by Resident 40's family to Detective Krzyskoski. Exhibit 7 to the Affidavit of Vicki Juckett ("Juckett Aff."), taken on October 3, 2022 (*see* Juckett Aff. ¶ 23), shows a wound to Resident 40's right hip. There is no dressing present near this wound in the photograph. Exhibit 7 further shows two photographs that appear to be closer pictures of the same wound. There is no dressing present on or near the wound. Exhibit 9 to the Juckett Aff. includes two photographs taken on October 8, 2022 (*see id*. ¶ 25). Both pictures appear to be a wound to Resident 40's right buttock. There appear to be 3 areas of redness, one area with an open area. These 2 pictures also do not indicate any dressing or treatment on this wound. The pictures indicate a heavily soaked adult brief.

111. A review of Resident 40's care plan did not show care planning for actual skin problems. Instead, Resident 40 was care planned as at risk for skin breakdown. Interventions included in this care plan are to turn and position her every 2 hours and to provide a position change when she is out of bed every 2 hours. There is no actual skin breakdown care plan initiated when open areas are noted. Upon admission a swallow evaluation was completed, and it was noted that Resident 40 required a pureed diet and to be kept upright 30-60 minutes after eating due to Gastroesophageal Reflux Disease (GERD). Her care plan indicated that she required extensive assistance with eating:

> EATING: Extensive Assistance. Straws approved.
> *Apply cervical collar per tolerance for meals and off directly after.
> 1.Provide optimal positioning with setup of one item at a time, verbal cues as necessary.
> 2. Alternate between pureed foods and thin liquids in small sips with an allowance of 10 sec or longer in between bites/sips
> 3. If patient is not engaging in her meal please encourage and provide an adequate amount of extensive assistance to improve her overall intake I.E hand over hand strategies or feeding.
> food in bowls
> aspiration precautions
> encourage upright posture for 60 minutes after meals.

112. There was no weight obtained for Resident 40 upon admission on September 30, 2021. There was no weight obtained until December 1, 2021 – more than 60 days after admission – at which time Resident 40's weight was 56lbs.[19] On December 1, 2021, a note from the dietician indicated she met with Resident 40 and offered food alternatives. The dietician suggested weighing Resident 40 weekly. According to the MAR, Resident 40 weighed 56lbs on December 16, 2021 and December 23, 2021 and then jumped to 68.6lbs on the 30th. Weekly weights continued in January 2022. On January 1, 2022 Resident 40's weight was 60.6lbs. That was also her recorded

[19] Of note, the weight obtained during Resident 40's 2020 rehab stay at The Villages was 81.6lbs.

weight on January 6 and January 12. In other words, The Villages recorded the exact same weight for Resident 40 on January 1, January 6, and January 12, 2021. Resident 40's weight increased almost 10lbs to 70.1lbs on January 20. Just 2 out of 4 weekly weights were obtained in February 2022. Resident 40's recorded weights for February 10 and February 24 were both 69.7lbs. In March, a monthly weight was obtained as 62.6lbs. Resident 40's weight further decreased in April of 2022. Her monthly weight was recorded as 61.2lbs. Weekly weights re-appeared on the MAR in May of 2022; however, weekly weights were not actually obtained. On May 5, 2022, Resident 40's weight was 59.2lbs. A month later on June 7, 2022, Resident 40's weight significantly increased to 70.2lbs. In July, the MAR indicated that weekly weights were not completed, however 2 weights were recorded in the weight summary, 69.3lbs on July 4 and 70.8lbs on July 14. In August of 2022 Resident 40's weight was 70.8lbs and 70.4lbs. In September of 2022, it was ordered that her weights be obtained every Monday, Wednesday, and Friday. By the end of September, Resident 40's weight was 56.6lbs. Her last weight obtained in this production was October 21, 2022 at 57.6lbs.

113. A review of photographs provided by the family to Detective Krzyskoski indicated that Resident 40 was involved in an accident. Exhibit 2 to the Juckett Aff., taken on October 1, 2021 (*see id*. ¶ 7), shows bruising to Resident 40's ankle. There were no accident or incident reports provided for review. There were no notations in the medical record of any accidents or incidents. There is no care plan indicating an accident or incident occurred.

114. Exhibit 8 to the Juckett Aff., taken on October 6, 2022 (*see id*. ¶ 6), shows Resident 40's tongue. There are white patchy spots on her tongue indicative of oral thrush. Oral thrush is a fungal infection of the mouth and can be caused by wearing dentures, taking antibiotics or steroids, and other oral conditions. Symptoms of oral thrush other than the obvious white patches are pain

with eating or swallowing and loss of taste. According to the family, they found and reported the oral thrush to staff. It was apparent that Resident 40 was not receiving assistance with oral hygiene. Resident 40 is care planned to wear dentures. Her care plan indicated that staff was supposed to remove and clean her dentures at night. She is also care planned for assistance with hygiene. A review of the aide documentation indicated numerous areas of blank documentation indicating that Resident 40 was not receiving assistance with her oral care. A review of her medical record indicated that she was only seen by a dentist one time since her September 2021 admission. This visit occurred on November 17, 2021. There were no assessments completed as Resident 40 lost weight to determine if her dentures continued to fit appropriately.

115. Resident 40 is care planned for extensive assistance for bathing and showering. A review of Resident 40's TARs indicates that, starting in December of 2021, Resident 40 was commonly only showered only 2 out of 4-5 times per month. Exhibit 14 to the Juckett Aff., taken during Detective Krzyskoski's November 2, 2022 visit (*see id*. ¶ 39), indicated caked old nystatin powder under Resident 40's breast. Again, the review of the aide documentation reveals numerous blank areas of documentation indicating bathing/showering was not completed routinely.

116. The family reported multiple issues with the delay of incontinent care. Resident 40's care plan indicated that she had been incontinent of urine since October 10, 2021. Upon admission, it appears by her care plan that Resident 40 was taken to the bathroom with assistance, however she was changed to total care for toileting October 14, 2022. Her care plan does not address bowel continence or incontinence. The earliest picture provided by the family is Exhibit 3 to the Juckett Aff., taken on October 5, 2021 (*see id*. ¶ 14), and it shows Resident 40's bottom reddened from being in a wet adult brief. Exhibit 9 to the Juckett Aff., taken on October 8, 2022 (*see id*. ¶ 25), shows Resident 40 laying on a urine-soaked incontinent pad. The aide documentation

reveals multiple blank areas of documentation indicating that Resident 40 did not receive timely and routine incontinent care.

II. Legal Duties of New York Nursing Home Owners to Protect Nursing Home Residents and Practical Implications for Nursing Home Residents.

117. The law views a nursing home as much as a resident's "home" as "a medical institution." (10 NYCRR § 415.1[1][a].) The rights of nursing home residents flow from the concept that a nursing home is their home.[20] Thus, New York 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 nursing home resident receives the care, treatment, diet, and health services that they need to attain their "highest practicable" level of well-being. (*See* 10 NYCRR § 415.12; 10 NYCRR § 415.3.)

118. Under New York law, each resident has the right to "adequate and appropriate medical care." (PHL § 2803-c[3][e]; 10 NYCRR § 415.3 42; and CFR § 483.25.)

119. To put the legal duties and accepted practices described below into context, it is important to note that for well over a decade, a greater proportion of the population in nursing homes like The Villages has become increasingly frail and has more acute care needs. Nursing homes, although perhaps seen in popular culture and facility advertising as places where people who are merely elderly choose to live, are, in fact, "Skilled Nursing Facilities" designated primarily for the care of people who are often completely dependent on the nursing home for their basic human needs and who have complex and significant medical needs.

[20] "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).

Resident Bill of Rights: The Law Requires Nursing Homes to Treat Residents with Dignity.

120. New York and federal laws 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 maintenance or enhancement of his or her quality of life. (*See* PHL § 2803-c[3]; 10 NYCRR § 415.12; and 42 CFR § 483.10[a][1].)

121. New York law requires nursing homes to provide each resident with the enumerated rights under the Residents Bill of Rights codified at PHL § 2803-c. (*See also* 10 NYCRR § 415.3.)

Nursing Homes Must Provide Care Plans and Documentation of Care.

122. As mandated by state law, nursing homes, in conjunction with a physician and other licensed healthcare professionals, are required to evaluate and describe each resident's needs in a comprehensive care plan ("care plan"). (10 NYCRR § 415.11[c]). The resident care plan identifies health concerns and directs particular courses of care and treatment, specifying, among other things, medications, assisted movement, skin care, bowel and bladder care, safety, psychological, and social and nutrition needs, in order to maintain the resident's highest level of function.

123. The staff at each New York nursing home is expected to execute the care plan for each resident. Thus, "Doctors Orders" direct what medications and treatments RNs and LPNs are required to administer, and the duties that Certified Nurse Aides ("CNAs") must perform.[21]

124. In any nursing home, staff are required to accurately document what care is – and is not – delivered, as well as report any decline in physical or mental function. RNs and LPNs must record the medications they administer on a "Medication Administration Record" ("MAR")

[21] It is an "unacceptable practice," vitiating a claim for Medicaid reimbursement, for a nursing home to fail to meet recognized standards in furnishing medical care, services or supplies under 18 NYCRR §515.2(b)(12).

and track 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," that they delivered care such as oral care, turning and positioning, range of motion, toileting, changing briefs, and other services as required by the resident's care plan. New York law requires that these records must be "complete" and "accurately documented." (10 NYCRR § 415.22[a].)

Definition of Neglect and the Duty to Report Neglect and Abuse.

125. Residents of New York's nursing homes are protected by law from acts of abuse, mistreatment, and neglect. (*See* PHL § 2803-d.) "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, therapies, sanitary clothing and surroundings, and activities of daily living." (10 NYCRR § 81.1[c].) Nursing home operators, employees, and administrators as well as RNs and LPNs are required to report to the New York State Department of Health (DOH) "suspected physical abuse, mistreatment or neglect of persons" if they have reasonable cause to believe that a resident has been physically abused, mistreated or neglected in the facility. PHL § 2803-d. The failure to report suspected abuse or neglect is a crime. (*See* PHL § 2803-d[7]; PHL § 12-b.)

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

126. New York law directs that nursing homes shall provide services by sufficient personnel on a 24-hour basis to deliver nursing care to all residents in accordance with resident care plans. (*See* 10 NYCRR § 415.13[a].) These requirements include the obligation for nursing homes to provide 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.

(*See* 10 NYCRR 415.13; *see also* 42 CFR § 483.35 [requiring that the facility "have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity[22] and diagnoses of the facility's resident population in accordance with the facility assessment required at 42 CFR §483.70[e]"]).

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

128. Staffing is sometimes measured in terms of "Hours per resident per day," also known as "HPRD." HPRD is the number of hours of care provided to each resident each day by nursing staff (RNs, LPNs/LVNs, CNAs/NAs), and is determined by dividing the total number of nursing staff hours worked by the total number of residents.[23] While HPRD is critical, sufficient staffing cannot simply be measured in numbers. Sufficient staffing also requires accounting for variables such as the type and severity of residents' medical conditions, and on the quality, training, experience and supervision of all levels of nursing home staff. (*See* 42 CFR §483.35.)

Direct Care Staff – Duties at Nursing Homes.

129. The direct caregivers in a nursing home are, in increasing order of training and formal education, CNAs, LPNs, and RNs. The bulk of the hands-on care that nursing home residents require as specified in each resident's care plan is carried out by the CNAs. CNAs are

[22] "Acuity" refers to the level of nursing care required in practice for each resident's particular health conditions.

[23] Medicare.gov, Staffing for nursing homes, www.medicare.gov/care-compare/resources/nursing-home/staffing [last accessed Oct. 13, 2022].

unlicensed New York State-certified individuals who perform non-medical services and supports for residents who need help with activities of daily living (ADL)[24], 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 primarily focus on medication administration, monitoring vital signs, and providing certain treatments.[25]

130. Sufficient RN staffing is also vital to a nursing home's ability to provide required care to its residents, as RNs primarily supervise LPNs and CNAs and focus on resident acute care needs, complex treatments, compliance with medical orders, communication with physicians and specialists, record keeping, and complex health assessments. RNs spend much of their time assessing any changes in residents' condition and conveying that information to physicians and then implementing any orders from the physicians, most commonly changes in medications or treatments, all of which are required to be documented in the resident's medical chart.

Nursing Home Administration.

131. 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).)

132. 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. The governing

[24] It is outside the scope of professional practice for a CNA to administer/pass medications and to perform wound care treatments. (*See* New York State Education Department, Career and Technical Education, Nurse Assisting (Nurse Aide), http://www.nysed.gov/career-technical-education/nurse-assisting-nurse-aide [last accessed Oct. 19, 2022].)

[25] *See* NYSED.gov, Office of the Professions, Practice Information, Frequently Asked Questions, http://www.op.nysed.gov/prof/nurse/nursepracticefaq.htm [last accessed Oct. 19, 2022].

body, among other things, is required to establish and implement policies regarding the management and operation of the facility, appoint the administrator, and be responsible for the operation of the facility. (*See* 10 NYCRR § 415.26[b]; *see also* 42 CFR § 483.70[d][1].)

133. 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]; *see also* 42 CFR § 483.70[h].) The medical care of each resident is required to 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].) Although all nursing homes are required to have a medical director on call, physicians are not routinely on-site around the clock at nursing homes.

134. The Director of Nursing (DON) or Director of Nursing Services ("DNS") – DONs or DNSs are responsible for leading and supervising RNs, LPNs, and CNAs in a nursing home. They are required to be registered professional nurses. (10 NYCRR § 415.13[b][2].) There are no regulations that define specific duties and responsibilities of a DON/DNS in a nursing home. Typically, the DON/DNS is responsible for supervising the nursing care received by residents and reports to the administrator.

The Dangers of Insufficient Staffing to Nursing Home Residents – Generally.

135. 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* Appropriate Nurse Staffing Levels for U.S. Nursing Homes – PMC [nih.gov].) Insufficient staffing occurs when a nursing home lacks sufficient direct care staff to provide its residents with the care that the law requires and that is

specified in the residents' care plans. Insufficient staffing at nursing homes is one of the most significant factors leading to resident neglect and abuse. Insufficient staffing leads to poor health outcomes and general poor care for each resident. As more specifically described below, when a nursing home is insufficiently staffed, residents are more likely to get injured by falling, to develop infections or pressure injuries, or to suffer from malnutrition and dehydration.

136. 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. Operating a nursing home with insufficient staffing, which includes insufficient supervision of staff, results in staff failing to provide care to residents. Insufficient staffing also results in staff providing poor care or an environment where residents are endangered as staff rush to complete their tasks before moving on to the next resident. As described below, when a nursing home has insufficient staff, staff fail to properly feed residents and to timely change residents' disposable briefs when they are wet or soiled.[26] Staff fail to "turn and position" residents, leaving their skin at risk for pressure injuries. They can also fail to note declines in medical conditions since observations are rushed, or not performed at all. Staff will fail to bathe or provide personal care to ensure residents' good 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 on to their next task.

137. When nursing homes operate with insufficient staffing, nursing homes inappropriately delegate essential aspects of resident care to residents' loved ones.[27] Even though

[26] In addition, many residents who wear disposable incontinence briefs require the assistance of multiple caregivers when they are changed. When there is insufficient staff on the unit, this can cause even more delay as the assigned caregiver must wait for an additional caregiver to become available.

[27] This concept broke down during the pandemic when, due to government regulations, visitors, including family members, were barred from visiting residents.

nursing homes are being paid to provide care and treatment to residents, resident families are left to fill the void of care and forced to provide fundamental care directly to residents themselves. For example, resident families often have no choice but to feed their loved ones, wash their clothes, and provide basic grooming.[28] Unfortunately, when a resident does not have family, or in situations where visitation is prohibited, like during peak times of the pandemic, residents do not have the safety net of a loved one's help and they are often left to suffer the indignities of poor care when there is not enough staff to provide them with adequate and appropriate care.

138. It is therefore crucial that nursing homes maintain safe staff-to-resident ratios based on each resident's acuity. Nursing homes that fail to employ sufficient staff place their residents at risk for serious injuries, and, when their staff are rushed and overworked, residents' concerning health conditions go unnoticed for prolonged periods of time, which can allow those conditions to progress into more significant health issues and even lead to death. Providing safe staff-to-resident ratios enables caregivers to provide required care and attention to each individual's needs. If one resident's care plan requires two caregivers to assist the resident with various activities, such as turning and positioning, transferring a resident to and from their bed/wheelchair, toileting, and feeding, the facility must assign sufficient staff to a unit to ensure its direct care staff are available and able to assist that resident with their needs. 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 requires 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 their own weight and needs the assistance of only one aide. Nursing homes

[28] I have been advised that this phenomenon in economic terms is known as "Cost Externalization." Cost externalizing is a socioeconomic term describing how a business maximizes its profits by off-loading indirect costs and forcing negative effects to a third party.

must also ensure that there is adequate RN supervision on the individual units to ensure that its staff are being attentive to and timely performing their assigned duties and providing care that complies with the residents' care plans. Staff who work under insufficient supervision too often, for the sake of expediency, provide care negligently, in violation of residents' care plans. RN supervision is essential on all units on all shifts, as licensed practical nurses cannot perform health assessments or other duties outside of their scope of practice.

139. Staff turnover is also an important factor in considering the qualities and abilities of staff to care for residents. According to CMS' analysis, "as the average staff turnover decreases, the overall star ratings for facilities increases, suggesting that lower turnover is associated with higher overall quality."[29] Additionally, "[f]acilities with lower nurse turnover may have more staff that are familiar with each resident's condition and may be more able to identify a resident's change in condition sooner. The facility may be able to implement a plan to avoid an adverse event, such as a fall, for a patient."[30]

Hazards Faced by Nursing Home Residents Exacerbated by Insufficient Staffing.

140. Injuries Caused by Incidents, Accidents, and Insufficient Staffing – Accidents and incidents, which are more frequent in nursing homes with insufficient staffing, are a leading cause of injury in the elderly. A nursing home must ensure that "the resident environment remains as free of accident hazards as is possible," and that "each 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 individual

[29] CMS.gov, To Advance Information on Quality of Care, *CMS Makes Nursing Home Staffing Data Available*, https://www.cms.gov/newsroom/press-releases/advance-information-quality-care-cms-makes-nursing-home-staffing-data-available [last accessed Oct. 13, 2022].
[30] (*Id.*)

resident 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. Accidents can result in injury, including fractures, contusions/bruises, burns, intracranial (head) injuries, loss of consciousness, and even death. A common avoidable accident in nursing homes is a fall, which is defined as an unplanned descent to the ground.

141. Every resident that is admitted to a nursing home is required to be screened for falls as part of their care plan. Conducting a comprehensive fall assessment and providing physical therapy ("PT") and occupational therapy ("OT") with goals and desired outcomes are essential aspects of nursing home care. Falls contribute to 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 the residents' overall physical and mental health.

142. Medications such a diuretics, narcotics, and psychotropic medications can lead to a high risk of falls. Restraints such as the inappropriate use of bed siderails lead to a high risk of falls with increased injury, as residents may attempt to climb over them rather than call for assistance. 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 each resident's care plan and ensure that there is sufficient staff to implement care plans to ensure the residents' safety.

143. Lack of Monitoring Causes Preventable Falls – Insufficient staffing to adequately monitor residents increases a resident's risk of falls. Evaluating the prevalence of falls and adding additional staff members to the nursing schedule, along with additional safety interventions, can contribute to a decrease in falls. When residents are being cared for by a nursing home, nursing homes must operate with sufficient staffing in all areas of the building (CNAs, LPNs, RNs, maintenance, housekeeping, Safety Committee, administration/department heads, supervision, Dietary, PT, OT and Activities) in order to prevent resident accidents and incidents that result from inadequate staffing, and to prevent the resulting adverse events and negative outcomes.

144. Insufficient staffing to timely answer call bells when residents need to use the toilet leads to increased risk of falls. When staff do not respond timely, or at all, residents are more likely to try to stand up, or get out of bed, and walk or otherwise move to the bathroom by themselves. Such residents often fall. Insufficient staff also increases the risk of falls and injury because it causes staff to provide improper care to residents, such as one aide alone transferring a resident from their bed to a wheelchair despite the resident's care plan requiring the assistance of two caregivers. Insufficient supervisory staff to oversee staff performing their job duties often results in 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, as discussed above, because staff is simply left to do too much due to lack of support from other staff.

145. A facility that is in disrepair or lacks sufficient maintenance staff to monitor the physical aspects of a facility or to repair equipment, including medical devices such as wheelchairs and lifts, can endanger residents. For example, lack of staff to perform temperature checks on the water systems for bathing can lead to resident burns from hot water. Residents who are forced to use broken wheelchairs, or wheelchairs that are missing parts like footrests, can injure themselves

or fall getting into, or out of, such wheelchairs. Insufficient dietary staff to perform temperature checks on meals or follow procedures of meal preparation (*e.g.,* for a resident who is at risk of choking) can also increase risks to and harm residents. Insufficient staff to perform safety rounds in which staff proactively monitor residents increases the risk of a resident sliding off their bed and onto the floor. In sum, there are a multitude of ways in which insufficient staffing adversely impacts resident care and health.

146. Dangers from Lack of Infection Control Protocols due to Insufficient Staffing – 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* 42 CFR § 483.80 and 10 NYCRR § 415.19.) A facility is required to have an infection control program pursuant to 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. *Id.* Nursing homes are required to isolate residents and properly sanitize and store all equipment to prevent the spread of infection. *Id.* 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. *Id*.

147. Infection Preventionist – Every nursing home in the United States must designate a qualified professional to serve as an infection preventionist ("IP"). Each nursing home must

employ one or more individuals who has "primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field" and who has "completed specialized training in infection prevention and control" as the IP who is responsible for the facility's infection control program. (42 CFR § 483.80[b].) The IP "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[c].)

148. As outlined in the Attorney General's January 2021 Report "Nursing Home Response to COVID-19 Pandemic" (the "Report"), NYS 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, too many nursing homes still: (1) failed to properly isolate COVID-19 residents when appropriate; (2) conducted lax employee COVID-19 screening that allowed positive cases into the facility; (3) demanded that sick employees continue working when symptomatic; and (4) failed to obtain, fit and train caregivers with personal protective equipment ("PPE"), thus, neglecting residents under NY law by failing "to provide timely, consistent, safe, adequate and appropriate services, treatment, and/or care …." (10 NYCRR § 81.1[c].) The Report found that lack of infection control put residents at increased 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 ratings.

149. There is, undoubtedly, a connection between insufficient staffing and poor infection control, because good 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 conduct the due diligence necessary to maintain proper infection control. For example, overburdened staff are

forced to move quickly from resident to resident and do not have time to comply with the methodical aspects of good infection control. Handwashing recommendations are to wash your hands for a minimum of 20 seconds before and after care. Donning and doffing PPE, including changing gloves properly after providing care to each resident, takes time to complete. When facilities are operated with insufficient staffing, these steps become overwhelming for staff whom the facility assigns to care for too many residents. When nursing homes are insufficiently staffed, staff are forced to choose between skipping steps required for sound infection control, shortening the recommended frequency and time frames of required steps, and/or failing to provide certain care completely to try to respond expediently to the care needs of as many residents as possible. When a nursing home operates with insufficient staffing, the facility often re-assigns designated infection control staff, like an IP, who would ordinarily oversee infection control practices and outbreaks in the facility, to instead help provide residents with basic required care. This diversion of focus by the IP prevents a facility from timely identifying resident infections, and results in untimely tracking and documentation of infection outbreaks. Timely identifying resident infections and tracking and documenting infection outbreaks are critical to combatting a communicable disease like COVID-19 in a medical facility.

150. Insufficient housekeeping personnel can affect resident health as well. High touch surfaces of a nursing home cannot be appropriately cleaned by already burdened staff, nor can all resident rooms and common rooms. Failure to appropriately clean rooms and surfaces increases the risk for infection transmission among residents and staff. When a nursing home operates with insufficient staffing, it too often either compels staff that may be sick themselves to come to work and potentially spread infection to residents and other staff members, or otherwise violates infection control protocols, disregarding the risk that its staff are sick and spreading infection.

Continued testing and screening of staff, residents and visitors is time consuming and nursing homes with insufficient staffing too often disregard such infection control protocols when their staff are faced with high resident caseloads. This exposes residents to increased risk of infection from within and outside of the facility.

151. Pressure Injuries – Pressure injuries, also known as pressure sores, pressure ulcers, or decubitus ulcers, are serious medical conditions, and, according to the CDC, one of the important measures of the quality of clinical care in nursing homes. Nursing homes are responsible for preventing pressure injuries and required to take precautions and provide care to prevent pressure injuries in the resident population. (*See* 42 CFR § 483.25[b] and 10 NYCRR § 415.12[c].) Pressure injuries, which may present as an open sore or ulcer, are wounds that develop on skin covering bony areas of the body when pressure on that area of the skin 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 side rails. However, the most common cause of pressure injuries in nursing home residents is the nursing home's failure to move a resident from a static position for an extended period of time. For example, when a resident is lying down in bed in one position for hours at a time and parts of the resident's body, e.g., heels, buttocks, back, hips, etc., are pressing down on the surface of the bed for an extended period, it can cause their skin to degrade. These injuries too often occur when a nursing home resident is bedridden, or continuously in a wheelchair, and the nursing home fails to provide necessary, very well-understood, and successful, preventative care to timely alleviate pressure on the skin of the resident's body that is in contact with the bed or wheelchair.

152. 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. Pressure injuries, which are almost always preventable and a sign of inadequate nursing home care and neglect, can lead to agonizing pain, bone infections, osteomyelitis, sepsis, and even death.

153. There are four stages used to categorize pressure injuries. There is an additional category of pressure injuries which are referred to as "unstageable." Unstageable injuries are serious as they are usually beneath compromised skin tissue and evaluators are unable to determine the severity of damage beneath the skin. A Stage I 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 II, III and IV 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 I pressure injury is defined as intact skin with non-blanchable redness of a localized area usually over a bony prominence. A Stage II 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. Slough is the dropping off of dead skin tissue from living tissue, after tissue has died. A Stage III 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. Slough may be present but does not obscure the depth of tissue loss. A Stage IV pressure injury is full thickness tissue loss, where the lost tissue includes all layers of skin, and exposed bone, tendon, or muscle is visible to the eye. Slough or eschar, which is necrotic/dead tissue that is dryer than slough and adheres to the wound bed, may be present on some parts of the wound bed. 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; it is a very severe condition.

154. To prevent pressure injuries in residents who lack sufficient ability to move their own bodies independently, nursing homes must frequently change the position of such residents' bodies (such as by rolling them from one side to the other, or from one side to their back), which is often referred to as "turning and positioning." Nursing homes must also appropriately use assistive devices such as gel cushions and air mattresses that induce some physical movement and reduce some of the pressure on the skin when they provide homes to residents who spend the bulk of their day either in a wheelchair or in bed. To prevent the development and worsening of pressure injuries, nursing homes must also provide regular skin integrity checks. By doing so, if a Stage I pressure injury does develop, treatment can be administered at the earliest moment to mitigate the likelihood that the injury progresses to Stage II or worse.

155. For context, the phrase "turn and position" or "turn and re-position" may seem to healthy persons to be a minor event; however, if a resident needs such "turning and positioning," it means that the person lacks the physical and/or cognitive ability to do almost all of the large and small adjustments that able-bodied humans do thousands of times of day. A person who needs "turning and positioning" cannot perform the movements necessary to move their own body as they lie in bed, to turn from their back to their side, or from one side to the other, to lift their heel, to sit up, or to lift their arms above their head. A person who needs to be turned and re-positioned is unable significantly to independently change the relationship of their body to clothing, bedding, and furniture. An able-bodied person who might describe significant discomfort as "I feel stiff, I have been looking at this computer for three hours without a break", "I slept badly and now my back is sore", or "my leg 'fell asleep' and I need to stretch," is still able to move their own body

to make the many micro-adjustments necessary to ameliorate their discomfort; a person who needs "turning and positioning" is unable to move their body to make those adjustments at any point of the day, and, as a result, their body remains in one position until another person assists to move their body to another position, relieving pressure on the skin that was in contact with the bed or chair.

156. Residents that are immobile can suffer from incontinence, poor nutrition and hydration, cognitive deficits, or medical conditions that affect blood flow such as diabetes and heart disease, and are more susceptible to developing pressure injuries. The risk of developing pressure injuries increases when nursing home staff fail to ensure residents receive and consume adequate food and water, and, as noted above, when staff fail to properly turn and re-position residents who require that care. Further, once a pressure injury has formed on a resident's body, poor nutrition and hydration can impede the body's ability to heal.

157. Malnutrition/Hydration/Dehydration/Weight Loss/Aspiration – 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 or 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. These conditions are often the result of neglect or mistreatment, and they can take an emotional and psychological toll on a resident, potentially causing a lack of motivation to participate in activities and lack of cooperation with their care plan.

158. 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 nursing home staffing plays a pivotal role in ensuring that a resident's proper nutritional needs are met. Many residents require

physical assistance and/or supervision while eating. Such assistance may include providing encouragement to continue eating, supervising to ensure the resident does not aspirate, or full-on feeding a resident who is disabled and unable to feed themselves. Essential supervision during mealtime includes 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 eat food properly. For example, a resident whose care plan requires precautions to minimize the risk of choking or aspiration – which is the condition in which food, liquids, saliva, or vomit is breathed into a person's airways – 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 safely fed by a caregiver. Staff members must be trained on how to provide the necessary supervision/assistance effectively to provide required care to such residents during mealtime. A nursing home that operates with insufficient staffing (whether by sheer numbers of direct care staff, insufficient supervisory staff, and/or staff that is incompetent or ineffectively trained), creates a risk that its residents will not be fed or provided hydration timely or at all, thereby resulting in malnutrition and weight loss that can, in turn, cause additional physical ailments and overall decline in health.

159. Medication Errors – Nursing homes that operate with insufficient staffing create a higher risk of errors in the administration of medication to their residents, as insufficient staffing adversely impacts a nurse's ability to give adequate care and attention to the task at hand when the nurse is responsible for administering medication to too many residents during a shift. Examples of medication errors include 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 and the nurse did not measure

the resident's vital signs appropriately, or at all. Significant medication errors can be dangerous to a resident's health and safety and even cause death. Federal and state laws require that nursing homes keep residents free from significant medication errors. (*See* 42 CFR § 483.45[f]10 NYCRR § 415.18.) Medication errors must be reported internally to the facility and to DOH. (*See* New York State Department of Health Nursing Home Incident Reporting Manual at 18 [Aug. 2016].) When a nursing home operates with insufficient staffing, it creates poor and stressful working conditions that place its nurses at greater risk of making transcription errors when receiving an order, and of making an error during the actual administration of medication when they are responsible for administering medication to an excessive number of residents. Individuals who are capable of independent living have the ability to identify their medication, accurately self-administer the dosage, and report to their physician any issues they perceive; in nursing homes, most residents find themselves in the exact opposite situation. The nurse is the person who must accurately dispense, evaluate, and report all aspects of the resident's medication needs.

160. In a practical sense, medication errors often occur in nursing homes 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's listed on the MAR; 2) preparing the medication and identifying the medication by looking at it; and 3) a final check that the label on the medication's container matches the MAR. Medication should not be prepared ahead of the scheduled time of administration to avoid an increased risk of medication errors. The nursing home is responsible for ensuring that nursing staff have time to administer medications

and that "the Five Rights" and the "Three-Check Process" are incorporated and detailed in their own policies and procedures. Similarly, if nurses are not adequately trained on the facility's policies and procedures when receiving an order or 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 for a resident's overall health.

161. Chemical and Physical Restraints – A resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience of staff. (*See* 42 CFR § 483.10[e][1]; 10 NYCRR 415.4.) "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. A "chemical restraint" is the inappropriate use of medication to restrict movement or suppress thought and/or free will. Psychotropic drugs frequently act as a chemical restraint by causing side effects such as lethargy, increased falls, abnormal involuntary movements, lack of socialization, and a decline in physical function. Minimizing these side effects while maintaining therapeutic effectiveness of the medication is imperative.

162. Each nursing home must develop and maintain a written policy prohibiting the use inappropriate restraints and detailing the limited circumstances when restraints may be used. The facility's policy 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. 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). The individual resident's medical record must include an order from an appropriate medical provider setting forth a rationale for use of the device or medication, potential underlying causes of the behavior, documented attempts at nonpharmacological interventions, potential risks and benefits of the device or medication, as discussed with the resident and/or the family, specific target behaviors and expected outcomes, and a plan of care. Ongoing evaluations for the continued use of the restraint must occur at least quarterly and more frequently as needed. 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.

163. Improper use of physical or chemical restraints can lead to life-threatening injuries and/or death. For example, many psychotropic medications are accompanied by an FDA "Black Box" warning and are contraindicated for residents diagnosed with dementia as they can increase their risk of death.[31] Other potential injuries can include a decline in physical function, muscle contractures, increased incidences of infection, development of pressure sores, falls and incontinence. There can also be cognitive effects, such as increased agitation, depression, and anxiety. Moreover, restraints can lead to a resident becoming emotionally withdrawn and cause

[31] The Food and Drug Administration (FDA) 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 substantially increase 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 still often administer antipsychotic drugs, sometimes without first seeking informed consent. (*See* Psychiatric News, American Psychiatric Association, Clinical & Research News, *FDA Extends Black-Box Warning to All Antipsychotics*, https://psychnews.psychiatryonline.org/doi/full/10.1176/pn.43.14.0001 [last accessed Oct. 14, 2022]; *see also* Drugwatch, Black Box Warnings, https://www.drugwatch.com/fda/black-box-warnings/ [last accessed Oct. 14, 2022].)

them to experience a decrease in their self-esteem and, in turn, 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, such as a resident becoming catatonic.

164. To adequately monitor residents whose care plan appropriately includes the use of restraints, a nursing home must operate with sufficient staffing. Often, a nursing home must increase direct care staffing to be able to perform the additional tasks that proper use of restraints for its residents requires. For example, 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. In addition, proper training and supervision of direct care staff is essential to minimizing unnecessary restraints. Caretakers must be trained on various interventions to utilize when a resident exhibits aggressive behavior (such as re-direction, de-escalation, and calming techniques like offering a snack, taking the resident for a walk, or offering recreation therapy) before seeking an order for physical or chemical restraints. Unfortunately, nursing homes that are understaffed too often use psychotropic medications to sedate residents to make them more docile to reduce the amount of staff time that is otherwise required to appropriately provide care for these residents. This unacceptable practice is less expensive for the nursing home than the cost of operating the nursing home with sufficient staffing to provide required, appropriate care.

165. Isolation and Depression – the Importance of Recreation for Residents – Residents of nursing homes with insufficient staffing are more likely to experience isolation and depression. This is because such nursing homes assign their direct care staff to provide care to too many residents, forcing them to triage, to allocate their limited time to providing care to the residents with the greatest needs, the most time-sensitive needs, or to the residents who are most able to

advocate for their own care needs. In extreme cases, where there is insufficient supervision, nursing home staff can use isolation to punish or mistreat residents, which causes fear of retribution among residents and/or their loved ones. Isolation can be a contributing factor to a diagnosis of depression in nursing home residents, which can 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 work, sleep, study, eat and enjoy life. Recreational therapy and other activity-based interventions are critical to improve a resident's overall physical health, cognition, and emotional well-being.

166. Nursing homes must provide, based on each resident's care plan, "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].) Research has consistently shown that loneliness and social isolation have a negative effect on physical and mental health, and they contribute to a higher mortality rate in older adults. (*See* Social isolation, loneliness in older people pose health risks / National Institute on Aging [nih.gov].) Prolonged loneliness and social isolation are associated with a wide range of physical, cognitive, and psychological health conditions, including 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 with dementia is higher than it is among the general population, and such residents may exhibit additional symptoms, such as delusions and hallucinations. Along with isolation and lack of recreational therapy, inconsistent and unfamiliar staffing, such as when there is high employee turnover in a nursing home due to

poor working conditions, or when owners hire agency staff to avoid paying the cost of employee fringe benefits, can also lead to feelings of distrust and loneliness for residents. Nursing homes with insufficient staffing frequently have high employee turnover.

167. 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 loneliness and social isolation. In fact, too many nursing homes often cut recreation therapy programs first from their budgets. In nursing homes with insufficient staffing, overworked staff are required to focus on resident physical needs and do not have the opportunity to spend time with each resident, much less provide recreational therapy to a resident. Residents deserve to be offered therapeutic activities to maintain and improve their physical and cognitive function. Recreational therapists work with the healthcare team to set attainable goals and develop an individualized plan of care. Recreation 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, trivia, social events, reminiscing activities, arts and crafts, sensory programs such as hand massage, and outings, including restaurants, ball games, and fishing trips. Research has shown that increased verbal activity improves self-esteem and results in decreased levels of depression. (*See* Exercise and Depression: Endorphins, Reducing Stress, and More [webmd.com].) Residents with a dementia diagnosis should have specialized small group programs or individual programs to provide the right amount of challenge and stimulation to help maintain current function, which, in turn, results in decreasing difficult behaviors. In sum, recreational therapy interventions make a tremendous difference in the outcomes of older adults in nursing homes.

168. Activities of Daily Living, Lack of Personal Care, and Loss of Dignity – Nursing home residents need assistance with Activities of Daily Living ("ADLs") and personal hygiene due to difficulty with mobility, cognitive processing, or other reasons. Quality of life and dignity are essential components of the standard of care in a nursing home. Proper hygiene and grooming are important aspects of maintaining good health and allowing a nursing home resident to maintain their dignity as a human being. A nursing home must provide care and services relating to a resident's 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 speech, language and other functional communication systems." (42 CFR § 483.24[b].) Federal and state law recognizes 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.) Under federal law, nursing homes are required to provide "the necessary services" to ensure that residents "maintain good nutrition, grooming, and personal and oral hygiene." (42 CFR § 483.24[a][2]*; see also* 10 NYCRR § 415.12[a].) Every ADL is critical to a resident's ability to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

169. Mobility / Ambulation - Mobility is critical to the overall health of nursing home residents, including to ensure that they maintain proper range of motion with their joints and limbs. Failure to keep a resident moving is known to cause functional decline and complications affecting the respiratory, cardiovascular, gastrointestinal, integumentary, musculoskeletal, and renal systems. Lack of mobility and ambulation can be especially devastating to an older adult when the aging process causes a more rapid decline in function and can potentially lead 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. The way to prevent this deterioration is through ambulation and passive or active range of motion on a regular daily schedule. Ambulation provides not only improved physical function, but also improved emotional and social well-being. The inability to ambulate puts limitations on social life, including limitations on visiting with friends or close relatives, limitations on religious expression, artistic expression, and increases the incidental encroachment of non-therapeutic solitude. The necessary range of motion activities vary from resident to resident based on their individual functional abilities. Some residents may need assistance in moving their limbs while lying in bed, while others may require assistance in walking certain 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 the residents or even to get them out of bed to ambulate.

170. Toileting - Urinary and fecal incontinence are co-morbid conditions affecting many nursing home residents. Toileting refers to assisting dependent residents with their waste elimination needs and can vary from assisting a resident to walk to the toilet in a bathroom, or a bedside commode, to assisting a resident with the use of a bedpan or urinal, or, for a more dependent or incontinent resident, to meeting their elimination needs with the use of adult diapers, 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 is also necessary to assist a resident to regain continence or contain incontinence when possible. Proper toileting is, of course, also central to an individual's sense of dignity and control. Failure to assist a resident with toileting can lead to a resident falling if the resident attempts to toilet themselves

without proper assistance. A resident who has basic cognition, but impaired mobility, will naturally wish to avoid the embarrassment and physical discomfort of incontinence, and may fall while attempting to get to a toilet by themselves, if they call for assistance and the nursing home fails to provide it on a timely basis, or at all.

171. A nursing home's failure to promptly change a resident's soiled adult diaper can cause severe health problems for the resident who is left sitting, or lying, in a soiled diaper. When nursing homes operate with insufficient staffing, direct care staff cannot timely respond to resident call bells, forcing residents to suffer excessive delays in receiving assistance with toileting. This, too often, results in continent residents holding their urine for excessive periods of time, in hopes that help will eventually come, which increases the risk of urinary tract infections and pressure injuries.

172. Dining - Dining, hydration, and a healthy diet is critical to ensure that a resident receives the nourishment required to maintain health. The level of assistance required by residents to eat varies greatly. Some residents may need to be fed by a caregiver, while others may only require encouragement to continue their meal or monitoring to prevent the risk of choking and aspiration. As described above, when nursing homes operate with staffing insufficient to meet the needs and acuity of their residents, their overburdened and/or under-supervised direct caregivers cannot allot sufficient time to properly assist all of their residents with dining. Any person who has fed a baby or toddler would recognize some of the challenges – the inability to lift and move a utensil to the mouth, or to do so accurately; the inability or difficulty to open packaging containing plastic silverware or food items; the need to cut the food to appropriate size for the person's chewing and swallowing ability to prevent choking; the need to observe and be alert for

choking or vomiting; and the need to encourage a reluctant (or depressed) person to consume sufficient quantities of food or liquids.

173. Communication - Communication is critical to avoid devastating isolation, as described above. When a nursing home fails to provide to a resident any of these critical aspects of life that are so easy for able-bodied people to take for granted, it deprives the person living in the nursing home of their dignity, and, eventually, potentially their will to live.

174. Hygiene – Nursing homes must maintain a resident's personal hygiene, including regular bathing and dental hygiene, to maintain their dignity and ensure that a resident attains or maintains the highest practicable physical, mental, and psychosocial well-being.

175. Bathing – Regular bathing is fundamental to maintaining an individual's physical and psychosocial well-being. Nursing homes should take individual preferences into account when determining how residents 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 assistance needed in bathing varies from one resident to the next. Some may only require assistance in getting to and from the bathroom, while others may be wholly dependent on their caregivers for bathing.

176. Dressing – Nursing home residents often need assistance with dressing, an ADL which 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.

177. 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 prevents hair from tangling and becoming matted. Regular nail care helps residents present a neat appearance, and also 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 gives residents dignity, preserves their dignity, and improves their self-esteem. When nursing homes operate with insufficient staffing, based on the needs and acuity of the residents, their direct caregivers are more likely to fail to properly groom their residents, thereby negatively impacting the residents' physical and psychosocial health.

178. Dental Hygiene - Dental hygiene is incredibly important to the overall health of a nursing home resident. Failure to maintain good dental hygiene has been linked to heart disease and other conditions, as well as overall mouth health. 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.) Nursing homes must operate with sufficient staffing to provide required care to brush their residents' teeth and to assist them with other good oral care. Nursing homes that operate with insufficient staffing increase the likelihood that their staff will fail to regularly brush their residents' teeth and otherwise provide good dental hygiene, thereby increasing the risk that their residents' teeth will decay, rot, develop infection, need to be extracted, and cause the residents to experience preventable pain, suffering and bad breath.

179. Property – 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, their 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 in geriatric care that nursing home residents suffering from cognitive deficits are prone to misplace their possessions, including by leaving them on unmade bedding. Caregiver staff who are assigned to provide care to too many residents are predictably rushed in performing overwhelming care duties and frequently discard a resident's personal property or otherwise fail to take adequate care to safeguard a resident's personal property when cleaning a resident's room or removing meal trays after meals. Too often when nursing homes operate with insufficient staffing, they fail to safeguard the residents' clothing that is critical to maintaining the residents' self-esteem and dignity. Insufficiently staffed nursing homes often "cut expenses" by failing to invest in sufficient staff to properly handle the important obligation of washing, folding, and returning clothing owned by their residents. Sadly, for the same reasons, when a resident loses their dentures or hearing aids in such nursing homes, residents, or their families, are often forced, out of necessity, to bear the cost of replacing those important items – even though it is the facility's responsibility to replace items lost or damaged by staff in the environment that is the residents' home. This is because the facility either does not replace them on a timely basis or at all, and during the time period that it takes to replace the item, the resident is forced to live in the nursing home without the benefit of the lost item. As a result, during the time that the resident is waiting for a replacement for the lost item, the resident is dressed in ill-fitting clothing or no clothing at all, is left unable to eat solid food because they need and lack dentures, or is left unable to hear properly or participate fully in conversations because they need and lack a hearing aid.

180. As part of their "special obligation" to residents "who depend upon the facility to meet (their) every basic human need," a nursing home must "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 § 415.1[a][1]; 42

CFR § 483.70 and 10 NYCRR § 415.26.) Nursing home residents suffer when a nursing home operator fails to operate a nursing home 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 force their direct care employees to work under poor and stressful conditions in which they are insufficiently supervised and forced 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 the nursing homes are legally and morally required to provide, and they cheat Medicaid and Medicare out of the care that they are reimbursed for providing yet fail to provide.

CONCLUSION

181. There can be no question that these residents, whose records I reviewed, did not receive "adequate and appropriate medical care" needed to attain their "highest practicable" level of well-being. As detailed above, the lack of documentation seen in virtually every resident's records, the failures to report falls, neglect, and abuse, the deterioration of residents, and the failure to take common-sense steps to ensure the health and well-being of vulnerable residents clearly demonstrate a pattern of direct care deficiencies at The Villages, that not only caused residents to fall short of their "highest practicable" level of well-being, but endangered them in nearly every conceivable way.

Jennifer Cronkhite, R.N.

Sworn to before me this
22nd day of November, 2022

Notary Public

Mary L Henry
NOTARY PUBLIC, STATE OF NEW YORK
Comm. No. 01HE6299052
Qualified in Erie County
My commision expires March 17, 2026

CERTIFICATION PURSUANT TO RULE 202.8-b

I, Soo-young Chang, an attorney duly admitted to practice law before the Courts of the State of New York, hereby certify that this Affidavit contains 23,654 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: New York, New York
November 23, 2022

Respectfully submitted,

Letitia James
Attorney General of the State of New York

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