STATE OF NEW MEXICO
COUNTY OF SANTA FE
FIRST JUDICIAL DISTRICT COURT

STATE OF NEW MEXICO ex rel.
HECTOR H. BALDERAS, ATTORNEY GENERAL,

Plaintiff,

v. D-101-CV-2014-02535

PREFERRED CARE, INC.; PREFERRED CARE PARTNERS MANAGEMENT GROUP LP; PCPM GP, LLC; THOMAS SCOTT; SF HEALTH FACILITIES, LP d/b/a CASA REAL; SF HEALTH FACILITIES – CASA REAL GP, LLC; GALLUP HEALTH FACILITIES LP d/b/a RED ROCKS CARE CENTER; GALLUP HEALTH FACILITIES GP, LLC; SF HEALTH FACILITIES, LP d/b/a SANTA FE CARE CENTER; SF HEALTH FACILITIES GP, LLC; PINNACLE HEALTH FACILITIES XXXIV, LP d/b/a SAGECREST NURSING AND REHABILITATION CENTER; PINNACLE HEALTH FACILITIES GP V, LLC; BLOOMFIELD HEALTH FACILITIES LP d/b/a BLOOMFIELD NURSING AND REHABILITATION CENTER; BLOOMFIELD HEALTH FACILITIES GP, LLC; ESPANOLA HEALTH FACILITIES, LP d/b/a ESPANOLA VALLEY NURSING AND REHABILITATION CENTER; ESPANOLA HEALTH FACILITIES GP, LLC; LORDSBURG HEALTH FACILITIES, LP d/b/a SUNSHINE HAVEN AT LORDSBURG; LORDSBURG HEALTH FACILITIES GP, LLC;

and

CATHEDRAL ROCK CORPORATION; CATHEDRAL ROCK MANAGEMENT LP; CATHEDRAL ROCK MANAGEMENT I, INC.; CATHEDRAL ROCK INVESTMENTS, INC.; C. KENT HARRINGTON; CASA REAL NURSING OPERATIONS LLC; RED ROCKS NURSING OPERATIONS LLC; SANTA FE NURSING OPERATIONS LLC; BLOOMFIELD NURSING OPERATIONS LLC; ESPANOLA VALLEY NURSING OPERATIONS LLC; SUNSHINE HAVEN NURSING OPERATIONS LLC; .

Defendants.

FIRST AMENDED COMPLAINT

The State of New Mexico ("the State"), by the Honorable Hector H. Balderas, Attorney General of the State of New Mexico, files this First Amended Complaint to recover damages and civil penalties arising from false and fraudulent statements, records, and claims submitted and caused to be submitted to the State by Defendants in violation of the New Mexico Fraud Against Taxpayers Act, §§ 44-9-1 to 44-9-14 NMSA 1978 ("FATA"), the New Mexico Medicaid Fraud Act, §§ 30-44-1 to 30-44-8 NMSA 1978 ("MFA"), and New Mexico common law, and to recover civil penalties and obtain injunctive and equitable relief arising from false or misleading statements made by Defendants to New Mexico consumers and unconscionable trade practices by Defendants in violation of the New Mexico Unfair Practices Act, §§ 57-12-1 to 57-12-26 NMSA 1978 ("UPA"). The State alleges as follows:

I. INTRODUCTION

1. Cathedral Rock Corporation, by and through its subsidiaries (collectively, "Cathedral Rock"), managed and operated ten skilled nursing facilities throughout New Mexico between approximately April 2007 and November 2012. During those years, Cathedral Rock Corporation was the subject of False Claims Act litigation and a federal Department of Justice investigation into Cathedral Rock's Missouri operations, which culminated in criminal felony plea bargains, a civil settlement, and the sale of Cathedral Rock's Missouri nursing homes to

another operator. Cathedral Rock sold its New Mexico nursing homes to Preferred Care, Inc. and its subsidiaries (collectively, "Preferred") in or around November 2012.

2. Today, Preferred manages and operates eleven nursing homes in New Mexico. These include Defendants Casa Real (Santa Fe, NM), Red Rocks Care Center (Gallup, NM), Santa Fe Care Center (Santa Fe, NM), Sagecrest Nursing and Rehabilitation Center (Las Cruces, NM), Bloomfield Nursing and Rehabilitation Center (Bloomfield, NM), Espanola Valley Nursing and Rehabilitation Center (Espanola, NM), and Sunshine Haven at Lordsburg (Lordsburg, NM), (collectively, "Defendant Nursing Facilities").

3. Since 2008, the Defendant Nursing Facilities have generated revenue in excess of $236 million from more than one million patient days – the sum of each day each resident stayed at the Defendant Nursing Facilities. By far, the largest purchasers of this nursing home care were the state and federal governments, paying for 78.8% of the total patient days through Medicare and Medicaid. The ability to generate this revenue hinged upon the Defendant Nursing Facilities' participation in the Medicare and Medicaid programs which, in turn, was contingent upon their promises to operate their facilities in compliance with federal and state law and regulations.

4. In addition to government funds, the Defendant Nursing Facilities derived substantial income from private payors – residents, their families, or their insurers. These consumers paid substantial amounts – ranging from around $115 to $250 daily – for each resident's nursing home care.

5. This case arises from Defendants' scheme to generate outsized revenues at the expense of the physical well-being of vulnerable nursing home residents through false representations to the State's Medicaid program and consumers about the level and quality of services they provided from July 1, 2007 to the present (the "Relevant Period").

6. Persons admitted to a nursing facility have limitations caused by physical deterioration, cognitive decline, the onset or exacerbation of an acute or chronic illness or condition, or other related factors. They need nursing care, medical treatment, and rehabilitation to maintain functional status, increase functional status, or live safely from day to day. Many such residents are elderly, disabled, confined to their beds or unable to rise from a bed or chair independently, and unable to groom, feed, toilet, or clean themselves. Consequently, many nursing home residents rely upon nursing home staff for not only skilled nursing care and treatment, but also essential primary care (herein "Basic Care") including:

(a) toileting assistance,

(b) incontinence care and changing of wet and soiled clothing and linen,

(c) assistance transferring to and from bed and wheelchair,

(d) assistance with dressing and personal hygiene,

(e) assistance with bathing,

(f) assistance with turning and repositioning residents in bed or chair,

(g) feeding assistance, and

(h) exercises/passive range of motion ("ROM") exercises.

7. Basic Care is primarily delivered by Certified Nursing Aides or "CNAs."

8. While the amount of Basic Care assistance needed may vary from resident to resident, and even from day to day for residents, Basic Care is included in the per diem cost of residency in the nursing home and billed at a fixed per diem rate.

9. Defendants limited the number of CNA staff on duty at the Defendant Nursing Facilities and rendered the facilities incapable of delivering the Basic Care that residents needed. While the intent may have been to control costs, the effect on resident care was dramatic. With the limited budgets for CNA staffing, the supply of CNA hours fell far short of the demand for care by the resident population.

10. The profound difference between the amount of services that Defendants promised and claimed to provide and the amount of services that the Defendant Nursing Facilities could have provided is at the heart of this case. During the Relevant Period the Facilities completed, certified, and submitted to the state and federal governments individualized date-specific assessments – known as a Minimum Data Set or "MDS" – of the Basic Care required by and provided to every resident. Using these MDS resident assessments and a widely-accepted industrial engineering simulation, the Office of the Attorney General ("OAG") was able to determine the minimum CNA time required to care for these residents. Using the Defendant Nursing Facilities' self-reported staffing data, the OAG then calculated the total CNA hours available in the Defendant Nursing Facilities to provide this care. In sum, the OAG determined (a) the care that Defendants certified was required and certified they provided in every resident assessment and the total labor time required to provide such care; (b) the maximum amount of care that could possibly be provided to these residents, given the available

CNA time; and (c) the amount of care that was omitted. The OAG found that during the Relevant Period, significant percentages of Basic Care have been omitted at the Defendant Nursing Facilities.

11. Interviews with residents' families and former employees, review of complaints received by the OAG, and analysis of survey results reported by the New Mexico Department of Health ("DOH") all confirm the chronic understaffing of the Defendant Nursing Facilities and their failure to provide the Basic Care services that they were paid to provide.

12. More specifically, CNA understaffing led to a pattern and practice of failing to provide Basic Care Services across the Defendant Nursing Facilities and throughout the Relevant Period. For example, the Defendant Nursing Facilities:

(a) Failed to regularly provide toileting, incontinence care, and basic hygiene care, leaving dependent residents in dirty diapers, dirty clothes, and dirty beds for hours at a time.

(b) Failed to timely respond to call lights rung by residents. Residents were left to soil themselves while waiting for assistance; others fell while attempting to walk to the bathroom unaided.

(c) Failed to re-position bed-bound and immobile residents; many residents remained in the same position for hours at a time, which can and sometimes did result in painful, infection-prone pressure sores.

(d) Failed to undertake ROM exercises – moving their joints and limbs, and assisting vulnerable residents who could walk or exercise. Without this assistance, residents lost mobility, rendering them even less independent.

(e) Failed to wash and bathe dependent residents.

(f) Failed to get dependent residents up, dressed, and out of bed.

(g) Failed to assist dependent residents with meals. Without help, some residents were unable to eat or drink in the time allotted, and some of them suffered weight loss and dehydration.

13. These tell-tale signs confirm that the Defendant Nursing Facilities did not provide the Basic Care that was required and paid for, and highlight the very human toll of understaffing. Defendants' staffing practices saved them the cost of labor, but cost residents their dignity and comfort, and jeopardized their safety. Residents and their families and former employees confirmed that because CNAs were not available: residents at the Defendant Nursing Facilities were left for long periods in their own urine and waste; were not cleaned, repositioned, or moved, resulting in infections, pressure sores, and loss of mobility; were deprived of food and water; and suffered falls. The failure to provide this care not only violated the law and the promises made by Defendants, it also degraded residents and increased their risk of serious negative health consequences.[1]

[1] Factors affecting the degree and nature of injury suffered by residents exposed to routine understaffing and core care omissions include: (a) the precise nature of the resident's dependency and length of exposure to care deprivation, (b) whether the resident received a proportionate or disproportionate share of the limited care, (c) whether certain types of Basic

14. In the course of their participation in Medicaid, the Defendant Nursing Facilities falsely certified their compliance with state and federal regulations that required them to provide the care needed by their resident populations. They submitted MDS assessments for their residents that falsely certified the level of care that was being provided and would be provided. And they billed for services that were not provided or were fundamentally worthless. Accordingly, the Defendant Nursing Facilities submitted thousands of false claims for Medicaid payments to the State.

15. The Defendant Nursing Facilities also engaged in deceptive and unconscionable conduct by charging private pay residents per diem rates without delivering the care that was promised or that was proportionate to the charges paid.

II. PARTIES, JURISDICTION, AND VENUE

16. Plaintiff Hector H. Balderas is the duly elected Attorney General of the State of New Mexico. The Attorney General has the statutory authority to enforce laws for the protection of the public. The Attorney General can act on behalf of the State in all actions when, in his judgment, the interests of the State require action. § 8-5-2(B) NMSA 1978.

17. Preferred Care, Inc. is a Delaware corporation, with headquarters at 5420 West Plano Parkway, Plano, Texas 75093. Preferred Care, Inc. indirectly owns and operates skilled nursing facilities throughout the State of New Mexico and does business in New Mexico through

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Care were routinely omitted for individual residents, (d) the individual resident's physiological capacity to withstand care deprivation, and (e) the extent to which the resident's diagnosis and chronic disease process mask omissions of care.

the actions of its agents, employees, staff, and others at its skilled nursing facilities in New Mexico. The residents of these skilled nursing facilities are New Mexico residents. At all times relevant, Preferred Care, Inc. has engaged in trade or commerce in New Mexico within the meaning of the UPA.

18. Defendant Preferred Care Partners Management Group, LP is a Texas limited partnership, with headquarters at 5420 West Plano Parkway, Plano, Texas 75093. Preferred Care Partners Management Group, LP exercises operational and managerial control over the skilled nursing facilities described in paragraphs 26, 29, 32, 35, 37, 40, and 43 of this Complaint, which are located throughout the State of New Mexico. Preferred Care Partners Management Group, LP does business in New Mexico through the actions of its agents, employees, staff, and others at its skilled nursing facilities in New Mexico. The residents of each of these skilled nursing facilities are New Mexico residents. At all times relevant, Preferred Care Partners Management Group, LP has engaged in trade or commerce in New Mexico within the meaning of the UPA.

19. Defendant PCPM GP, LLC is a Texas limited liability corporation with headquarters at 5420 West Plano Parkway, Plano, Texas 75093. PCPM GP, LLC is the general partner of Preferred Care Partners Management Group, LP, which indirectly owns and operates skilled nursing facilities throughout the State of New Mexico and does business in New Mexico through the actions of its agents, employees, staff, and others at its skilled nursing facilities in New Mexico. The residents of these skilled nursing facilities are New Mexico residents. At all times relevant, PCPM GP, LLC has engaged in trade or commerce in New Mexico within the meaning of the UPA.

20. Defendant Thomas Scott is an individual who resides in Texas. Thomas Scott is a limited partner of SF Health Facilities-Casa Real, LP, Espanola Health Facilities, LP, Gallup Health Facilities, LP, SF Health Facilities, LP, Lordsburg Health Facilities, LP, and Pinnacle Health Facilities XXXIV, LP. On information and belief, Scott also acts as a manager of the limited liability companies that act as general partners in each of these Defendant partnerships, giving him the right and the ability to exercise operational control over these entities.

21. Defendant Cathedral Rock Corporation is a Texas corporation with headquarters at 306 West 7th Street, Ste. 415, Fort Worth, Texas 76102. Cathedral Rock Corporation indirectly owned and operated the skilled nursing facilities described in paragraphs 28, 31, 34, 39, 42, and 45 of this Complaint, in the State of New Mexico, from the beginning of the Relevant Period to in or around November 2012, and did business in New Mexico through the actions of its agents, employees, staff, and others at its skilled nursing facilities in New Mexico. The residents of these skilled nursing facilities were New Mexico residents. At all times relevant, Cathedral Rock Corporation engaged in trade or commerce in New Mexico within the meaning of the UPA.

22. Defendant Cathedral Rock Management LP is a Texas limited partnership with headquarters at 306 West 7th Street, Ste. 415, Fort Worth, TX 76102. It managed the nursing facilities directly or indirectly held by Cathedral Rock Corporation and did business in New Mexico through the actions of its agents, employees, staff, and others at its skilled nursing facilities in New Mexico. The residents of these skilled nursing facilities are New Mexico

residents. At all times relevant, Cathedral Rock Management LP has engaged in trade or commerce in New Mexico within the meaning of the UPA.

23. Defendant Cathedral Rock Investments, Inc. is a Delaware corporation with headquarters at 306 West 7th Street, Ste. 415, Fort Worth, TX 76102. It is the limited partner of Cathedral Rock Management LP. Cathedral Rock Corporation owns 100% of Cathedral Rock Investments, Inc.

24. Defendant Cathedral Rock Management I, Inc. is a Delaware corporation with headquarters at 306 West 7th Street, Ste. 415, Fort Worth, TX 76102. It is the general partner of Cathedral Rock Management LP. Cathedral Rock Corporation owns 100% of Cathedral Rock Management I, Inc.

25. Defendant C. Kent Harrington is an individual who resides in Texas. He is and/or has been, during the Relevant Period, an officer and direct or indirect majority owner of the Cathedral Rock Corporation, Cathedral Rock Management LP, Cathedral Rock Management I, Inc., and Cathedral Rock Investments, Inc. (collectively, "the Cathedral Rock Defendants").

26. Defendant SF Health Facilities–Casa Real, LP is a Texas limited partnership, with headquarters at 5420 West Plano Parkway, Plano, Texas 75093. SF Health Facilities–Casa Real, LP has owned and operated a skilled nursing facility located at 1650 Galisteo Street, Santa Fe, New Mexico 87505 known as Casa Real, with the New Mexico Medicaid provider number[2] 73354872, from in or around November 2012 through the present. The residents of Casa Real

[2] A unique Medicaid provider number is assigned to each skilled nursing facility that is approved to participate in the Medicaid program.

are New Mexico residents. At all times relevant, SF Health Facilities–Casa Real, LP has engaged in trade or commerce in New Mexico within the meaning of the UPA.

27. Defendant SF Health Facilities – Casa Real GP, LLC is a Texas limited liability company, with headquarters at 5500 West Plano Parkway, Ste. 210, Plano, Texas 75093. SF Health Facilities – Casa Real GP, LLC is the general partner of SF Health Facilities–Casa Real, LP.

28. Defendant Casa Real Nursing Operations LLC is a Delaware limited liability company, with headquarters at 306 West 7th Street, Fort Worth, Texas 76102. Casa Real Nursing Operations LLC owned and operated a skilled nursing facility located at 1650 Galisteo Street, Santa Fe, New Mexico 87505 known as Casa Real, with the New Mexico Medicaid provider number 68500238, from at least the beginning of the Relevant Period to in or around November 2012. The residents of Casa Real were New Mexico residents. At all times relevant, Casa Real Nursing Operations LLC engaged in trade or commerce in New Mexico within the meaning of the UPA.

29. Defendant Gallup Health Facilities, L.P. is a Texas limited partnership, with headquarters at 5420 West Plano Parkway, Plano, Texas 75093. Gallup Health Facilities, L.P. has owned and operated a skilled nursing facility located at 3720 Church Rock Road, Gallup, New Mexico 87301 known as Red Rocks Care Center, with the New Mexico Medicaid provider number 58939725, from in or around November 2012 through the present. The residents of Red Rocks Care Center are New Mexico residents. At all times relevant, Gallup Health Facilities, L.P. has engaged in trade or commerce in New Mexico within the meaning of the UPA.

30. Defendant Gallup Health Facilities GP, LLC is a Texas limited liability company, with headquarters at 5500 West Plano Parkway, Ste. 210, Plano, Texas 75093. Gallup Health Facilities GP, LLC is the general partner of Gallup Health Facilities, L.P.

31. Defendant Red Rocks Nursing Operations LLC is a Delaware limited liability company, with headquarters at 306 West 7th Street, Fort Worth, Texas 76102. Red Rocks Nursing Operations LLC owned and operated a skilled nursing facility located at 3720 Church Rock Road, Gallup, New Mexico 87301 known as Red Rocks Care Center, with the New Mexico Medicaid provider number 96902256, from at least the beginning of the Relevant Period to in or around November 2012. The residents of Red Rocks Care Center were New Mexico residents. At all times relevant, Red Rocks Nursing Operations LLC engaged in trade or commerce in New Mexico within the meaning of the UPA.

32. Defendant SF Health Facilities, L.P. is a Texas limited partnership, with headquarters at 5420 West Plano Parkway, Plano, Texas 75093. SF Health Facilities, L.P. has owned and operated a skilled nursing facility located at 635 Harkle Road, Santa Fe, New Mexico 87505 known as Santa Fe Care Center, with the New Mexico Medicaid provider number 22757279, from in or around November 2012 through the present. The residents of Santa Fe Care Center are New Mexico residents. At all times relevant, SF Health Facilities, L.P. has engaged in trade or commerce in New Mexico within the meaning of the UPA.

33. Defendant SF Health Facilities GP, LLC is a Texas limited liability company, with headquarters at 5500 West Plano Parkway, Ste. 210, Plano, Texas 75093. SF Health Facilities GP, LLC is the general partner of SF Health Facilities, L.P.

34. Defendant Santa Fe Nursing Operations LLC is a Delaware limited liability company with headquarters at 306 West 7th Street, Fort Worth, Texas 76102. Santa Fe Nursing Operations LLC owned and operated a skilled nursing facility known as Santa Fe Care Center, with the New Mexico Medicaid provider number 96786825, from at least the beginning of the Relevant Period to in or around November 2012. The residents of Santa Fe Care Center were New Mexico residents. At all times relevant, Santa Fe Nursing Operations LLC engaged in trade or commerce in New Mexico within the meaning of the UPA.

35. Defendant Pinnacle Health Facilities XXXIV, L.P. is a Texas limited partnership, with headquarters at 5420 West Plano Parkway, Plano, Texas 75093. Pinnacle Health Facilities XXXIV, L.P. has owned and operated a skilled nursing facility located at 2029 Sagecrest Court, Las Cruces, New Mexico 88011 known as Sagecrest Nursing and Rehabilitation Center, with the New Mexico Medicaid provider number 99527561, from on or around July 11, 2011 through the present. The residents of Sagecrest Nursing and Rehabilitation Center are New Mexico residents. At all times relevant, Pinnacle Health Facilities XXXIV, L.P. has engaged in trade or commerce in New Mexico within the meaning of the UPA.

36. Defendant Pinnacle Health Facilities GP V, LLC is a Texas limited liability company, with headquarters at 5420 West Plano Parkway, Plano, Texas 75093. Pinnacle Health Facilities GP V, LLC is the general partner of Pinnacle Health Facilities XXXIV, L.P.

37. Defendant Bloomfield Health Facilities L.P. is a Texas limited partnership, with headquarters at 5420 West Plano Parkway, Ste. 210, Plano, Texas 75093. Bloomfield Health Facilities L.P. has owned and operated a skilled nursing facility located at 803 Hacienda Lane,

Bloomfield, New Mexico 87413 known as Bloomfield Nursing and Rehabilitation Center, with the New Mexico Medicaid provider number 27003221, from in or around November 2012 through the present. The residents of Bloomfield Nursing and Rehabilitation Center are New Mexico residents. At all times relevant, Bloomfield Health Facilities L.P. has engaged in trade or commerce in New Mexico within the meaning of the UPA.

38. Defendant Bloomfield Health Facilities GP, LLC is a Texas limited liability company, with headquarters at 5500 West Plano Parkway, Ste. 210, Plano, Texas 75093. Bloomfield Health Facilities GP, LLC is the general partner of Bloomfield Health Facilities L.P.

39. Defendant Bloomfield Nursing Operations LLC is a Delaware limited liability company, with headquarters at 306 West 7th Street, Fort Worth, Texas 76102. Bloomfield Nursing Operations LLC owned and operated a skilled nursing facility located at 803 Hacienda Lane, Bloomfield, New Mexico 87413 known as Bloomfield Nursing and Rehabilitation Center, with the New Mexico Medicaid provider number 34279024, from at least the beginning of the Relevant Period to in or around November 2012. The residents of Bloomfield Nursing and Rehabilitation Center were New Mexico residents. At all times relevant, Bloomfield Nursing Operations LLC engaged in trade or commerce in New Mexico within the meaning of the UPA.

40. Defendant Espanola Health Facilities, L.P. is a Texas limited partnership, with headquarters at 5420 West Plano Parkway, Plano, Texas 75093. Espanola Health Facilities, L.P. has owned and operated a skilled nursing facility located at 720 Hacienda Street, Espanola, New Mexico 87532 known as Espanola Valley Nursing and Rehabilitation Center, with the New Mexico Medicaid provider number 24280020, from in or around November 2012 through the

present. The residents of Espanola Valley Nursing and Rehabilitation Center are New Mexico residents. At all times relevant, Espanola Health Facilities, L.P. has engaged in trade or commerce in New Mexico within the meaning of the UPA.

41. Defendant Espanola Health Facilities GP, LLC is a Texas limited liability company, with headquarters at 5500 West Plano Parkway, Ste. 210, Plano, Texas 75093. Espanola Health Facilities GP, LLC is the general partner of Espanola Health Facilities, L.P.

42. Defendant Espanola Valley Nursing Operations LLC is a Delaware limited liability company, with headquarters at 306 West 7th Street, Fort Worth, Texas 76102. Espanola Valley Nursing Operations, LLC owned and operated a skilled nursing facility located at 720 Hacienda Street, Espanola, NM, 87532 known as Espanola Valley Nursing and Rehabilitation Center, with the New Mexico Medicaid provider number 03381536, from at least the beginning of the Relevant Period to in or around November 2012. The residents of Espanola Valley Nursing and Rehabilitation Center were New Mexico residents. At all times relevant, Espanola Valley Nursing Operations, LLC engaged in trade or commerce in New Mexico within the meaning of the UPA.

43. Defendant Lordsburg Health Facilities, L.P. is a Texas limited partnership, with headquarters at 5420 West Plano Parkway, Plano, Texas 75093. Lordsburg Health Facilities, L.P. has owned and operated a skilled nursing facility located at 603 Hadeco, Lordsburg, NM 88045 known as Sunshine Haven at Lordsburg, with the New Mexico Medicaid provider number 61553727, from in or around November 2012 through the present. The residents of Sunshine Haven at Lordsburg are New Mexico residents. At all times relevant, Lordsburg Health

Facilities, L.P. has engaged in trade or commerce in New Mexico within the meaning of the UPA.

44. Defendant Lordsburg Health Facilities GP, LLC is a Texas limited liability company, with headquarters at 5500 West Plano Parkway, Ste. 210, Plano, Texas 75093. Lordsburg Health Facilities GP, LLC is the general partner of Lordsburg Health Facilities, L.P.

45. Defendant Sunshine Haven Nursing Operations LLC is a Delaware limited liability company, with headquarters at 306 West 7th Street, Fort Worth, Texas 76102. Sunshine Haven Operations LLC owned and operated a skilled nursing facility located at 603 Hadeco, Lordsburg, New Mexico 88045 known as Sunshine Haven at Lordsburg, with the New Mexico Medicaid provider number 15978575, from at least the beginning of the Relevant Period to in or around November 2012. The residents of Sunshine Haven at Lordsburg were New Mexico residents. At all times relevant, Sunshine Haven Nursing Operations LLC engaged in trade or commerce in New Mexico within the meaning of the UPA.

46. Hereinafter, the skilled nursing facilities known as Casa Real, Red Rocks Care Center, Santa Fe Care Center, Sagecrest Nursing and Rehabilitation Center, Bloomfield Nursing and Rehabilitation Center, Espanola Valley Nursing and Rehabilitation Center, and Sunshine Haven at Lordsburg will be referred to collectively as the "Defendant Nursing Facilities."

47. As a court of general jurisdiction, this Court has jurisdiction over this matter and the parties.

48. For purposes of the general venue statute in New Mexico, the OAG resides in Santa Fe County. Venue in this judicial district is therefore proper pursuant to Section 38-3-1(A) NMSA 1978.

III. SUMMARY OF THE ALLEGATIONS

49. Defendants entered the business of caring for elderly, frail, and disabled persons voluntarily. They are for-profit companies that, upon information and belief, sought to participate in the Medicare and Medicaid programs because the federal and state governments are the biggest purchasers of nursing home services and most reliable payors of nursing home bills.

50. The Defendants voluntarily chose to participate in the New Mexico Medicaid program. Participation in the program, and payment for services provided to Medicaid recipients, is conditioned upon compliance with federal and state laws and regulations, which require that the Defendant Nursing Facilities provide, and have sufficient nursing staff to provide, the services necessary to meet the needs of each resident, as defined by their individualized assessments and required care plans.

51. Defendants made statements to residents and their families that deceived, may have deceived, or would tend to deceive or mislead residents and their families about the level of care available in the Defendant Nursing Facilities. These misleading statements were reinforced by regular billing statements that deceived, may have deceived, or would tend to deceive or mislead residents and their families about the level of care that was being delivered at the Defendant Nursing Facilities.

A. Ascertaining the Gap Between the Basic Care Needed and Required and the Basic Care Delivered

1. Quantifying the Cumulative Work Load at Each Defendant Nursing Facility

52. The Defendant Nursing Facilities were required to complete an individualized, date-specific Minimum Data Set or "MDS" assessment for every resident, evaluating the resident's functional capabilities to perform activities of daily life ("ADLs"), upon admission to the facility and again each quarter, or whenever a significant change in the resident's health or capabilities was observed. From the MDS, two pieces of information can be derived: the resident's level of dependence in each ADL and the level of assistance or Basic Care provided for each ADL. For illustrative purposes, an exemplar of *Section G* of the MDS is set forth below:

Section G Functional Status

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	3	3
B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	3	3
C. Walk in room - how resident walks between locations in his/her room	8	8
D. Walk in corridor - how resident walks in corridor on unit	8	8
E. Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	8	8
F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	8	8
G. Dressing - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	3	2
H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	1	2
I. Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	3	3
J. Personal hygiene - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	2	2

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code: 3

A. Self-performance

0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** during the entire period

Enter Code: 3

B. Support provided

(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

Exemplar: MDS 3.0 Section G

53. The Defendant Nursing Facilities were required to accurately assess and code each resident's level of dependency in Column 1 of the MDS. Column 2 captures the level of assistance and support the facility claimed was provided to each resident for each ADL. As the key in the upper right hand corner of the MDS form lays out, a resident's dependence and need for assistance ranges from "0" (the resident is independent and needs no staff assistance to perform the ADL) to "3" (the resident has minimal ability to perform the ADL and the nursing home provides two staff to assist him with it). A "2" in the second column indicates that the nursing home provides one staff person to assist with the particular ADL. An "8" is the MDS equivalent to "non-applicable"—the resident did not engage in that activity during the relevant time period. Thus, the *Section G* MDS exemplar above indicates the resident required (and was provided) the assistance of two nursing home staff members to reposition himself in his bed (Bed Mobility), to get in and out of bed (Transfer), and to use a toilet or bedpan (Toilet Use), and the assistance of one staff member for dressing, eating, and personal hygiene.

54. The Defendant Nursing Facilities certified the accuracy of the data within each MDS submitted for each of their residents.

55. The OAG obtained from the Centers for Medicare and Medicaid Services ("CMS") ADL data for every resident in the Defendant Nursing Facilities on the last day of each quarter for the period of 2008 to 2014.[3] Using the Defendant Nursing Facilities' certified-as-accurate MDSs, CMS captured all Basic Care coded in *Section G* as required by and provided to

[3] Whenever in this pleading the timeframe of 2008 to 2014 is used, such timeframe includes January 1, 2008 to December 31, 2014.

each resident, determined which residents required distinct combinations of this care, and classified each resident into one of seven recognized workload categories. Through extensive research, CMS has found that the Basic Care needs of virtually every nursing home resident and the corresponding labor burden imposed on staff can be classified into one of the following workload categories determined by the below combinations of Basic Care required:

RESIDENT CATEGORIES	WORKLOAD DESCRIPTION	BASIC CARE REQUIRED				
		Incontinence Care/Toileting Assistance	Repositioning Assistance	Eating Assistance	AM/ PM Hygiene	Exercise or ROM
1	Light	NO	NO	NO	NO	YES
2	Light	NO	NO	NO	YES	YES
3	Moderate	NO	NO	YES	YES	YES
4	Heavy	YES	YES	NO	YES	YES
5	Heaviest	YES	YES	YES	YES	YES
6	Moderate	YES	NO	NO	NO	YES
7	Heavy (Bedbound)	YES	YES	YES	YES	YES

Seven Workload Categories

56. By way of illustration, a Category 5 resident needs a combination of all 5 Basic Care services identified, and, therefore, is a heavy care resident.[4] A Category 1 resident, on the other hand, requires only range of motion assistance, and therefore is light care. As a consequence, the labor resources required to meet the Basic Care needs of a Category 5 resident

[4] It takes less time to care for a Category 7 (bedbound) resident than a Category 5 resident because of the differences in toileting and transfer assistance provided them. A bedbound resident typically does not get out of bed and merely has a diaper change. It is faster for staff to change a diaper than to take a resident to the restroom or help him with a bedpan.

are significantly greater than the resources required to meet the needs of a Category 1 resident. On the facility level, as the proportion of more dependent residents in a nursing home goes up, so does the workload and the number of staff required.

57. For example, the table below summarizes the resident category data that the OAG obtained from CMS for Casa Real on the last day of each quarter from December 31, 2012 to June 30, 2013:

RESIDENT CATEGORY DATA FOR CASA REAL						
	12/31/12 Capture Date		3/31/13 Capture Date		6/30/13 Capture Date	
RESIDENT CATEGORIES	**# of Residents**	**% of Residents**	**# of Residents**	**% of Residents**	**# of Residents**	**% of Residents**
1 (Light)	1	0.73%	0	0%	0	0%
2 (Light)	0	0%	0	0%	0	0%
3 (Moderate)	0	0%	0	0%	0	0%
4 (Heavy)	0	0%	0	0%	1	0.78%
5 (Heaviest)	97	70.83%	75	66.37%	92	71.32%
6 (Moderate)	0	0%	0	0%	0	0%
7 (Heavy)	39	28.47%	38	33.63%	36	27.92%

This table reveals that over 99% of the residents at Casa Real were distributed in the three heaviest workload categories (4, 5, and 7) during the listed quarters. A review of all the workload data compiled by CMS for each of these facilities from 2008 to 2014 reveals that the Defendant Nursing Facilities consistently had extremely high concentrations of heavy care residents (categories 4, 5, and 7). These heavy care residents require at least twice (and sometimes three times) as much care time as light care residents.

58. Each of the Basic Care services that make up the resident workload categories has been extensively observed and stopwatch-timed by scientists to determine the minimum, mode, and maximum times required to perform them. For example, scientists have determined based on thousands of observations of stopwatch-timed Basic Care services in nursing homes, that the simple act of turning and repositioning a resident requires a minimum of 2 minutes, a maximum of 5 minutes, and most often (the mode) 3.5 minutes to complete. However, in order to improve productivity and efficiency, the activity of turning is often combined with incontinence care (the changing of diapers, wet clothing, and linens). For those residents who are unable to control their bladders or bowel function, researchers have determined that the time required to perform the combined tasks of incontinence assistance and turning is a minimum of 3 minutes, a maximum of 8 minutes, and most often (the mode) 5.5 minutes to complete.[5] For residents who are able to use a toilet with assistance, researchers have established that the combined activity of toileting and repositioning requires a minimum of 5 minutes, a maximum of 10 minutes, and most often (the mode) 7.5 minutes to complete.

59. Utilizing these scientifically-established labor times and the minimum frequency each Basic Care service is required daily, the Defendant Nursing Facilities' resident category data can be converted on a quarterly basis into a workload score for each nursing home. The workload score is obtained by multiplying the total number of Basic Care services needed by

[5] *See* Marvin Feuerberg, Centers for Medicare and Medicaid Services and Health Care Financing Administration, Phase I Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, 14-10 (2000); and Phase II, Vol. 1, Table 3.5 at pp. 3-55 and 3-56 (2001).

every resident (within every category) in a nursing home by the average time required to perform such services and then dividing by the facility census.[6] This simple equation provides a blunt measurement of the average workload in each facility, but industrial engineering has long recognized that this formula significantly underestimates the total labor time actually required, because it does not take into account: (1) the variation in time required to complete each item, (2) staff travel time between residents and tasks, (3) time-bounded services that must be completed within a specific period of time and that cause congestion or "bottle-necking," (4) staff productivity rates – staff simply are not 100% efficient, (5) unexpected events that interrupt workflow, and (6) staff breaks. For this reason, the use of a more sophisticated industrial engineering tool—computer simulation—is required to precisely calculate the total amount of labor required to provide the Basic Care claimed in residents' MDSs.

60. Additionally, certain residents in a nursing home require two staff members to assist with their *Section G* core care. Obviously, two-person assists require more staff and labor resources, because instead of one staff member providing Basic Care, two staff members must both be available to simultaneously deliver the required Basic Care. Consequently, as the number of residents who require 2-person assists increases, the labor burden and the amount of labor time required also increase.

61. The OAG obtained from CMS data reflecting, on a quarterly basis from 2008 to 2014 for each facility population, the number and percentage of residents who the Defendant

[6] Dividing by the census allows for a comparison of the workload in different nursing homes, irrespective of their census levels.

Nursing Facilities claimed were provided two-person assists for each of the following Basic Care services: (a) toileting/incontinence care, (b) repositioning, (c) transferring, (d) personal hygiene, and (e) bathing/showering.

62. Taken together, the workload category and 2-person assist data derived from the Defendant Nursing Facilities' MDSs provided the OAG with an objective basis for calculating the work demands placed on the Defendant Nursing Facilities' CNAs.

2. Quantifying the Amount of Labor Time Available for Basic Care

63. As a condition of Medicaid participation, the Defendant Nursing Facilities compile and calculate the total number of staff hours worked, including hours worked by CNAs, during the 2-week pay period preceding the commencement of the facility's annual certification survey or follow-up recertification survey.[7]

64. The OAG used the staffing data reported by the Defendant Nursing Facilities to calculate the CNA labor supply, or number of CNA hours, available to each resident on a daily basis ("per patient day" or "PPD").[8] The OAG also used the Defendant Nursing Facilities' reported staffing data to determine the *maximum* amount of labor time available for providing these Basic Care services.

[7] The annual certification survey is an inspection conducted by the New Mexico Department of Health ("DOH").

[8] HPPD or PPD stands for "hours per patient day," and it measures the number of staff hours available for residents in a nursing home. Thus, a 2.2 CNA PPD means that, on average, staffing was sufficient to provide each resident with 2.2 hours of CNA attention during a 24-hour period.

3. Quantifying the Omissions of Care

65. The OAG compared the demand in the Defendant Nursing Facilities for Basic Care services to the supply of CNA hours available to provide that Basic Care. Quite basically, if residents require 250 hours of care each day, but a nursing facility only has enough CNAs to provide 125 hours of care, it will be unable to provide the care required. It is not physically or mathematically possible to provide 250 hours of care with 125 hours of staff time. Using a widely-accepted industrial engineering simulation that models the delivery of Basic Care services based on a facility's workload and CNA labor supply, the OAG was able to determine: (a) the quantity and percent of *Section G* Basic Care services that were physically and mathematically possible in each subject facility, (b) the total amount of labor time (resources) required to deliver the Basic Care that residents required and the Defendant Nursing Facilities claimed to provide, and (c) the quantity and percent of Basic Care services that were physically and mathematically impossible. The simulation platform that computed the above metrics is widely used by leading healthcare institutions, hospitals, and emergency rooms across the United States to quantify the care services that can and cannot be delivered by a defined number of staff.

66. The results of the simulation analysis of the Defendant Nursing Facilities (discussed in more detail below in Section IV) reveal a significant disparity between the CNA staffing hours required to provide the Basic Care services claimed by Defendants in the MDSs of residents and the actual staffing hours available.

67. The percentages of omitted *Section G* Basic Care set forth below demonstrate the gap between staffing capacity, which is dictated by the staffing levels Defendants set, and

resident workload in each Defendant Nursing Facility. The needs of residents for Basic Care routinely overwhelmed the limited staff at their facilities, making it physically and mathematically impossible for the Defendant Nursing Facilities to provide the Basic Care that was promised, required, and paid for by the State and consumers. The inability of the CNA staff to provide this Basic Care – and the need to increase staffing levels – were or should have been plainly evident to Defendants.

4. Eyewitness Confirmation of Basic Care Omissions

68. The pervasive understaffing and resulting omissions of care that the OAG has quantified are confirmed by the experiences of residents and former employees of the Defendant Nursing Facilities. Their eyewitness accounts include numerous observations and complaints of residents being left in their own waste for long periods, residents not receiving adequate baths or assistance with personal hygiene, residents waiting 20-30 minutes for responses to call-lights when they sought assistance, residents falling when they attempted to go to the bathroom on their own because no help was available, and residents not being able to get sufficient food or liquids because no one was available to help them.

69. State inspectors from the New Mexico Department of Health ("DOH") also found instances of omitted care. That any such deficiencies were noted by the inspectors is telling for four reasons. First, the inspectors' visits capture a snapshot of a moment in time, and not the year-round, round-the-clock conditions in these nursing facilities. Second, inspections are infrequent in number and limited in scope, usually relying on small samples of resident observations. Inspectors review a wide array of nursing home operations and therefore

generally do not have sufficient time to extensively observe the delivery of ADL care. Third, evidence suggests that the Defendant Nursing Facilities were aware of planned inspections and increased staffing in anticipation of them, enabling them to appear adequately staffed. In addition to calling in CNAs who were not scheduled to work, management and administrative staff helped with Basic Care when state inspectors were on-site. Fourth, pervasive omissions of Basic Care may not be obvious to state inspectors and even family members if they are only able to make short or sporadic visits.[9]

B. Defendants Improperly Billed for Care that Was Not Provided

70. By reason of their own data regarding staffing and resident needs, complaints made by residents and residents' family members, complaints made by their own employees, and state inspections, Defendants knew that their staffing practices compromised the delivery of Basic Care services. Despite this knowledge, Defendants failed to staff sufficiently to meet the needs of residents in the Defendant Nursing Facilities. At the same time, Defendants continued to submit (or caused to be submitted) claims to the State for Basic Care services they failed to provide. These false claims were supported by false certifications in MDS forms.

[9] The limitations of the survey process and the likelihood that surveys significantly understate care issues at nursing homes are well known and well documented. A study done by the United States Government Accountability Office ("GAO") in 2008 described widespread, nationwide patterns of state surveys failing to identify deficiencies; 70% of state surveys missed one or more deficiencies. The most frequently missed type of deficiency identified was poor quality of care, including things like failing to ensure proper nutrition and hydration and failing to prevent pressure sores. A 2009 study by the GAO identified several causes for this high level of deficiency understatement including the high number of survey tasks that surveyors were expected to complete, surveyors' inexperience with the survey methodology, and surveyor workforce shortages.

71. The New Mexico Medicaid program paid for the care provided at the Defendant Nursing Facilities. As a result of the Defendant Nursing Facilities' pattern and practice of failing to provide Basic Care in its facilities, the State paid Defendants for care that: (a) was not provided; (b) did not comply with applicable laws and regulations; (c) did not promote the maintenance or enhancement of the quality of life of the residents at the Defendant Nursing Facilities; (d) was of a quality that failed to meet professionally recognized standards of health care; and (e) was so deficient as to be worthless. Compliance with federal and state staffing requirements is material to the New Mexico Medicaid program's decision whether to pay for these services, and the Defendant Nursing Facilities' services fell so far short of what was required and billed, that the New Mexico Medicaid program would not have paid for it had it known of the extent of Defendants' understaffing and omissions of care.

72. The Defendant Nursing Facilities similarly misled private pay residents, their families, and their insurers. As a result of Defendants' pattern and practice of failing to provide Basic Care in its facilities, New Mexico consumers paid Defendants for services that fell short of the assurances made to attract patients to the facilities and, on information and belief, the representations made in the care plans and bills shared with consumers.

IV. OMISSIONS OF BASIC CARE AT SPECIFIC FACILITIES CAUSED BY UNDERSTAFFING

73. Based on its review of staffing and workload data, interviews with former

employees, residents, and resident families, complaints received by the OAG, and deficiencies[10] found by DOH, the OAG collected the following evidence of understaffing and omissions of care at the Defendant Nursing Facilities.

A. Omissions of Basic Care at Casa Real

74. The simulation analysis for Casa Real reveals that significant percentages of Basic Care required by residents and claimed to have been provided to them could not have been provided. For example:

Year & Quarter	**TOTAL PERCENT of Category 4, 5, & 7 Residents in Facility**	**WORKLOAD SCORE: based on MDS Section G CLAIMED STAFF SUPPORT**	**2 PERSON ASSIST AVERAGE** (Repositioning, Transferring, Toileting)	**CNA PPD (during Quarter)[11]**	**OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (No 2 Person Assist)**	**OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (With 2 Person Assist)**
2009 Q4	84.5%	139.64	21.99	2.02	34.7	43.2
2012 Q2	100%	148.82	14.90	2.28	29.7	35.8
2012 Q4	99.26%	148.15	10.40	1.94	40.4	44.5
2013 Q1	100%	147.34	11.78	2.00	38.0	42.7
2013 Q2	100%	148.93	18.49	1.96	39.9	47.0

[10] A "deficiency" is a citation that a nursing home receives from its state licensing agency – in New Mexico, DOH – for failing to meet certain standards and regulatory requirements under federal and state law, including the regulatory requirements of the Medicare and Medicaid programs.

[11] Beginning in the fourth quarter of 2012, the CNA PPDs included in the above table were based on Defendants' records. Prior to the fourth quarter of 2012, the CNA PPDs included in the above table were those reported by Defendants to CMS in Form CMS-671.

2013 Q3	100%	147.74	19.61	1.88	42.5	49.9
2013 Q4	98.33%	147.22	17.44	1.89	41.9	48.5
2014 Q1	98.30%	148.63	25.95	1.79	46.3	55.8
2014 Q2	98.16%	147.18	25.13	1.99	38.1	47.7
2014 Q3	98.03%	147.37	26.72	1.97	39.0	49.2
2014 Q4	96.28%	144.56	25.50	1.96	38.5	48.2

Industrial Engineering-Derived Basic Care Omissions

75. This analysis is supported by omissions of care described by witnesses who observed resident care firsthand at Casa Real.

76. Confidential Witness #1 is the son-in-law of a woman who resided at Casa Real from December 2007 to May 2010.

77. According to Confidential Witness #1:

(a) He and his wife visited her mother at different times during the day and her diaper was always dirty. His wife would take her mother to the bathroom and clean her. His wife would also change the bed linens, which often were soiled. His mother-in-law developed urinary tract infections while at the home.

(b) His mother-in-law developed pressure sores on her hip, back, and elbows during her last six months at the facility.

(c) He heard people calling out for help in the facility and no one answered them.

(d) His mother-in-law needed to have her food cut-up and required assistance in eating. Although this need was documented in her care plan, the care was not provided. His mother-in-law lost weight while at the facility.

(e) When he and his wife visited, his mother-in-law was dirty and unkempt. On one occasion, he and his wife visited in the morning and his mother-in-law had eggs on her face and clothes; when they returned to the facility in the evening, she was still in that condition. Confidential Witness #1's wife washed her mother's face and brushed her hair and teeth when she visited, as it otherwise was not done.

78. Confidential Witness #2 is the daughter of a resident who resided at Casa Real from April to June 2014. According to Confidential Witness #2:

(a) Her father walked with assistance into the facility in April 2014, after being hospitalized after a stroke, for rehabilitation. The plan was to increase his functional mobility and ability and for him to return home. Although her father could walk with supervision for short distances on admission to Casa Real, he required at least the assistance of one person for all Basic Care.

(b) She visited her father at least five times weekly and her sister usually visited once a week. During the first week at Casa Real, when the family visited, their father appeared relatively clean and fed and he offered no complaints. However, after the initial week at Casa Real, on every visit, she would find her father lying flat in bed and smelling bad, like he needed a bath, often with

complaints that he was hungry. She asked the nursing staff why her father had not been cleaned up and was told they were understaffed and had not gotten to him. When this happened again the next day, she could not stand seeing her father that way, so she got supplies and gave her father a bath herself and cleaned up his bed. She shaved him and made sure his teeth were brushed. Then she spoon fed him his dinner and by that time, the nursing staff was coming in with his evening medications.

(c) It became a pattern that she would come in every day just after she left work around 5:00 p.m. Her father was dirty and definitely had been left unattended for a long period of time by the time she arrived.

(d) She noticed that her father's roommate, a hospice patient, also had a daughter who came in every evening and bathed, groomed, and fed her father every time she visited. The roommate's daughter told her that unless hospice was in, her father would not be bathed, changed, or groomed. She took on these tasks every night.

(e) Because Confidential Witness #2 had not had an experience with having a loved one in long-term care, she assumed that, after the first week, it was up to the family to provide basic care needs as the facility was so obviously understaffed. She could not stand to see her father neglected, so providing his Basic Care became her life – stopping in before work to be sure he was

changed and ate breakfast and then coming back in at least five times a week in the evening.

(f) On the days she could not come in, her father was not cleaned up, shaved, given oral care, or fed. She clipped his nails, shaved him and brushed his teeth, and encouraged him to eat, spoon-feeding him to be sure he got some nutrients, in addition to bathing, changing, dressing, and providing ice water for her father regularly.

(g) She became fearful of missing visitation with her father, knowing that the understaffing at Casa Real would mean her father would not be cared for. She placed his toothbrush in a certain position and checked it for placement and wetness every time she was there, hoping that she would see signs that it had been used. It never was moved or wet unless she used it on her father.

(h) Her father fell multiple times, suffering lacerations and abrasions, when nobody answered the call light and he tried to get up on his own to go to the bathroom. The facility only called her once to report a fall with injuries, but her father told her about other falls and so did the roommate and his daughter, who witnessed them at times.

(i) Her father declined physically and mentally at Casa Real. He had therapy on some days, but the nursing staff never routinely exercised him. He began speaking less and less and lost weight as the daughter could not be there to assist during the day and supervise his eating.

(j) By the time of discharge in June 2014, her father was no longer able to walk. Her father was very stiff and contracted after being left in bed or in a wheelchair for two months at Casa Real. He had lost at least 23 pounds in 8 weeks. He was in constant pain and feared falling. The serious decline in his condition caused him to be hospitalized shortly after his discharge.

(k) Her father is now at a rehabilitation center in Albuquerque where the nursing staff actually do bathe, groom, shave, dress, toilet, feed, and encourage her father every day. He is slowly improving as a result of their care.

79. Confidential Witness #3 is the surviving spouse of a man who resided at both the Casa Real and Santa Fe Care Center facilities between August and December 2011. Her husband was partially paralyzed by a stroke and needed help with all aspects of ADLs. She witnessed constant understaffing problems that prevented the staff from attending to residents' basic needs.

80. According to Confidential Witness #3:

(a) Her husband was totally reliant on the CNAs for help with food and liquids. A day or two after his admission, Confidential Witness #3 arrived at the facility and found him sitting in his room with a tray in front of him and no one to help him eat. He was covered in Cream of Wheat and eggs because he apparently had attempted to feed himself. Based on her observation of this lack of sufficient care, and her observation that the facility did not have sufficient staffing, she did not believe the nursing home was capable of keeping him fed

and hydrated. Therefore, she came in daily in the mornings and evenings to help feed him herself and do other basic tasks for him.

(b) He lost a lot of weight during the course of his stay and suffered from dehydration. Casa Real staff left drinks for him on his tray, but he could not handle these on his own either, and staff did not provide enough help for him to drink the beverages. He became so dehydrated at one point that he required hospitalization.

81. Confidential Witness #31 is the mother of a man who lived at Casa Real between early January and early March 2013. Her son had suffered a stroke at a young age. After spending approximately two months in acute care hospital settings, he was sent to Casa Real for skilled nursing and rehabilitation. From the day he arrived, it was clear that the facility did not have enough staff to meet resident needs, including his. As a result, Confidential Witness #31 removed her son from the facility in March 2013 and elected to care for him at home, even though he initially required round-the-clock supervision and help.

82. According to Confidential Witness #31:

(a) On the day her son was transferred from the hospital to Casa Real, there was no staff available to help him settle in. He was left in a wheelchair in the hallway for one and a half hours; when he was finally provided with a room, there was no staff available to help him get into the bed or to get him a meal. He had not had lunch or dinner that day. The family ended up having to leave the facility to go in search of food for him.

(b) When Confidential Witness #31 rang the call-bell for help, she would wait typically 5 to 15 minutes for a response, after calling for help 3-4 times.

(c) Her son was continent but wore adult diapers while at the facility. Confidential Witness #31 recalls her son ringing his call-bell so that a CNA could help him to the bathroom and then soiling himself while waiting for a response. The family was able to assist him to get to the bathroom during their visits, but the staff did not assist him with this when the family was not present.

(d) The staff was unable to see to her son's grooming needs, so Confidential Witness #31 assisted him daily in brushing his teeth, combing his hair, and shaving. She relied upon the CNAs to help him shower, but they did not do so frequently enough to keep him clean. He often smelled. She frequently requested that the staff have him showered and ready before she took him to a doctor's appointment, but they did not.

(e) Although her son was supposed to be receiving physical therapy to help him regain the ability to walk with a cane after his stroke, Casa Real did not provide it. Instead, her son was heavily medicated and sat quietly in his wheelchair or slept for most of the day.

(f) Her son fell twice early during his stay at Casa Real: once while attempting to get out of his wheelchair and once when attempting to move from his chair to the bed.

83. Confidential Witness #4, a former CNA at Casa Real in 2007-2008, witnessed understaffing and serious omissions of care. She typically worked a daytime shift, from 7 a.m. to 7 p.m., but she often stayed as late as 10:30 p.m. because the facility was short-staffed. Over the course of her shift, she was responsible for taking vital signs, getting residents out of bed and ready for the day, making their beds, doing rounds, and taking residents to breakfast and lunch. She also showered 5-6 residents each shift, taking around 30-35 minutes each, so that this task alone took up roughly three hours of her shift.

84. According to Confidential Witness #4:

(a) CNAs were supposed to respond to call lights within five minutes, but residents usually waited 20-25 minutes for a response. Residents would get upset while waiting because they often were requesting help to get to a bathroom.

(b) Residents were supposed to be repositioned every two hours, but she regularly found residents who had not been repositioned for several hours. One female resident had a Stage IV pressure sore[12] on her tailbone that was so bad it required a wound vacuum.[13] The sore developed at Casa Real, and was caused, in this CNA's opinion, by the resident not being repositioned

[12] A Stage IV pressure sore is one that has advanced to the point where tissue loss exposes bone, tendon, or muscle.

[13] A wound vacuum is used to constantly pull drainage from the wound and encourage blood supply to the area to help new tissue grow.

frequently enough. The resident herself was aware that she was receiving inadequate care; she complained to Confidential Witness #4 that she was not being repositioned often enough.

(c) Incontinent residents were supposed to be changed every hour, but Confidential Witness #4 regularly found residents who had not been changed for several hours. For example, she recalled one incident when she discovered a resident had soiled himself badly – the urine had soaked through his clothing, and he had a ring of urine in his bed. On another occasion, she went to change a resident and found that under his new, clean pair of briefs, there was a completely soiled second pair of briefs. When she reported this to the charge nurse, the charge nurse explained that CNAs were too busy to do more.

85. Confidential Witness #5 was a registered nurse at Casa Real from 2005 to 2012. She typically worked the 3 p.m. to 11 p.m. shift on a unit with 22 residents and only one CNA. The CNA was responsible for repositioning residents, feeding residents, performing range of motion exercises, dressing and bathing residents, and providing incontinence care, but much of this care was omitted. Confidential Witness #5 emphasized that most of the CNAs she supervised were good workers and it was amazing what they were able to accomplish under the circumstances.

86. According to Confidential Witness #5:

(a) CNAs did not have time to reposition residents. They tried and wanted to, but there was not enough time.

(b) The only thing the CNAs could do was to keep changing people – they did not really have time to do much else. And yet, family members often complained that a resident was not changed frequently enough, and staff on the next shift would often complain that residents were soaked when they came in.

(c) Most of the residents under her care needed help eating, and there was never time to feed all the residents properly. She believes some residents experienced weight loss as a result, but management gave the residents dietary supplements rather than increase staffing.

(d) ROM exercises were seldom done and residents went a very long time without doing any activities.

(e) Management instructed staff to answer call lights promptly, but with so few staff, there was no way to respond to all of them.

(f) The management of Casa Real and Cathedral Rock were aware of the problems. For example, falls were common, because with such minimal staffing, the staff could not watch everyone. She filled out an incident report describing one fall and noted in the report that only she and one CNA were on duty at the time of the fall. The Director of Nursing got very angry at her for including this fact in the report. Confidential Witness #5 called Cathedral Rock CEO Kent Harrington, but he never responded. She reached others at Cathedral Rock and told them that the facility did not have adequate staffing; they promised to look into it, but, to her knowledge, nothing happened.

(g) Casa Real took steps to hide its typical conditions and staffing from DOH. The Cathedral Rock corporate office knew DOH surveyors were coming ahead of time and would conduct a preliminary survey in advance. They would reach full staffing levels for surveys by calling all of the CNAs in – even those who were not scheduled to work. The food even looked better during surveys.

87. Confidential Witness #6 worked as a CNA at Casa Real from 2011 to 2013. She frequently worked double-shifts and overtime because the facility was understaffed. She typically worked the overnight shift and was responsible for 20 residents, if not more. During that time she would check vital signs, shower residents, dress residents for bed, conduct rounds for repositioning and incontinence checks, wake residents, and dress them for breakfast.

88. According to Confidential Witness #6:

(a) Call lights were supposed to be answered as soon as possible, but multiple lights would go off at the same time and there would not be enough staff to respond. Some residents would tire of waiting for assistance, try to get up and then fall. The resulting injuries could have been prevented if more staff had been on duty.

(b) She frequently found that incontinent residents had not been changed for hours because the previous shift had not had time to get to it. She would walk into a room and smell feces or see feces coming out of their briefs.

(c) She performed ROM exercises when they were noted on a care plan, or when a resident requested help, but always felt very rushed when doing this because

she could hear call lights going off. As a result, these exercises were generally cut short.

89. Confidential Witness #7 worked as a CNA at Casa Real from May 2010 to January 2014. He worked both the daytime and evening shifts, as well as frequent overtime. Despite the overtime hours he and others worked to cover call-outs (when staff did not show up for work) and turnover, the facility always was understaffed. During his shifts, he and another CNA would be responsible for as many as 30 residents, and his responsibilities were taking vital signs, doing rounds to reposition and check incontinent residents, and feeding residents.

90. According to Confidential Witness #7:

(a) Call lights were supposed to be answered right away, but residents typically waited 15-30 minutes for a response when they needed something, like help transferring from the bed to a chair or a drink of water.

(b) Repositioning was supposed to happen every 2 hours, but he was only able to reposition residents every 3-4 hours.

(c) Confidential Witness #7 was expected to shower 3-4 residents during his evening shifts; showers were regularly skipped, however, because there simply was not enough time to do them.

(d) There were 5-6 falls each day at the facility. Many of these falls were preventable; residents would try to get up themselves if their call lights were not answered. If the facility had had more staff on duty, residents would have received more attention.

(e) He frequently complained to management about the understaffing problem, but nothing was done in response.

91. Confidential Witness #32 worked in the kitchen at Casa Real in 2014. He was responsible for preparing three meals a day and snacks for the residents at the facility. He observed that staffing levels were too low to provide adequate feeding assistance to residents.

92. According to Confidential Witness #32:

(a) The facility only had one, sometimes two, CNAs available to assist as many as 55 residents in the dining room. Many of the residents needed to be spoon-fed, and one or two CNAs could not do that for so many residents. Family members would come in to help residents eat because they knew there wasn't enough staff to help.

(b) The amount of food coming back to the kitchen uneaten was substantial – roughly 60-70%. This was not because the food was not good. It was because the residents were not getting fed.

(c) The only residents who ate well were those who could eat independently.

(d) The kitchen also prepared snacks for the residents, but the CNAs and nurses did not pass them out to the residents. The residents often complained about being hungry, but the trays came back full because they were sitting out on the counter instead of being distributed to residents.

(e) Residents and their family members complained frequently about conditions in Casa Real. Their biggest concerns were about residents being soiled all the

time and being hungry. They also complained about the facility not complying with special diets that some residents needed, like diabetic diets. The kitchen prepared the diabetic meals and put them out, but some of these residents needed to be spoon-fed, and there was no one there to help.

93. Nursing home inspectors have repeatedly found that Casa Real violated state and federal nursing home regulations by failing to provide Basic Care over the Relevant Period. For example:

(a) During a January 14, 2008 survey, inspectors found that Casa Real failed to maintain the psychosocial wellbeing of five of the eight residents examined by surveyors by not cleaning a resident after incontinent episodes and not giving scheduled showers. One resident told surveyors that staffing levels were a problem at night and that she is "soaking wet up to [her] waist in the morning." Three other residents had told one of the nurses at the facility that they had not been showered in more than a week. One of those residents told surveyors that it was upsetting not to receive the 2-3 showers per week she was supposed to receive. Facility records confirmed that showers were not being given as frequently as needed. Records showed, for example, that one resident did not receive a shower for ten days, and that another resident went ten days without a shower and then another 14 days before he received another one.

(b) During a February 17, 2010 survey, inspectors found that Casa Real failed to provide adequate oral/dental care to a resident. The resident's care plan

specified that caregivers were to offer and assist with oral/dental care after the resident woke up each day, after each meal daily, and before the resident went to sleep. The resident told surveyors that she only received assistance cleaning her teeth three nights per week.

(c) During an October 19, 2012 survey, inspectors found that Casa Real did not provide care that "maintains or enhances each resident's dignity and respect" for failing to provide adequate toileting assistance to a resident. The resident told the surveyor that when she called for toileting assistance, the CNA made fun of her and took so long to answer the call light that she "had no choice but to go in [her] pants."

(d) On April 12, 2013, inspectors found that Casa Real failed to have adequate care plans to meet the care needs for three of the six residents whose files inspectors reviewed. One resident, for example, had a very high risk of falls, but her care plan did not require preventative measures. Following a fall in which she sustained injuries, this resident was evaluated and found to also have a urinary tract infection and low sodium levels. Surveyors found that another resident's weight had declined significantly over a four-month period, from 161 pounds at admission to 119 pounds. The facility had not updated his care plan to address this weight loss or to prevent dehydration. The facility also lacked sufficient care plans for two additional residents to adequately address urinary incontinence issues. For example, the facility had determined that a

toileting schedule should be used to improve one resident's continence, but it had not implemented a toileting schedule.

(e) During a January 28, 2014 survey, inspectors examined the files of two residents who required repositioning to prevent pressure sores and found that records did not show that the required care had been provided. One resident's care plan specified that he be repositioned at least 8 to 12 times per day, but records for the two months prior to the survey showed that he was repositioned only once on 13 days, twice on 32 days, three times on 10 days, and not at all on two days.

(f) At a March 21, 2014 survey, inspectors found that Casa Real failed to prevent the development of pressure sores on one resident. The resident was at the facility following surgery to repair a broken hip. The transfer orders from the hospital specified that the resident must be repositioned every two hours. However, records showed no care was provided to prevent pressure sores, such as frequent turning or providing a special anti-pressure mattress. Ten days after being discharged from the hospital to Casa Real, the resident had developed pressure sores on both heels.

B. Omissions of Care at Red Rocks Care Center

94. The simulation analysis for Red Rocks Care Center reveals that significant percentages of Basic Care required by residents and claimed to have been provided to them were not provided. For example:

Year & Quarter	TOTAL PERCENT of Category 4, 5, & 7 Residents in Facility	WORKLOAD SCORE: based on MDS Section G CLAIMED STAFF SUPPORT	2 PERSON ASSIST AVERAGE (Repositioning, Transferring, Toileting)	CNA PPD (during Quarter)[14]	OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (No 2 Person Assist)	OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (With 2 Person Assist)
2010 Q3	99.17%	154.90	9.02	2.17	34.9	38.8
2011 Q3	96.26%	149.23	2.49	2.00	38.6	39.9
2012 Q3	98.15%	151.22	10.12	2.16	33.9	38.2
2012 Q4	98.73%	152.41	11.24	2.08	37.0	41.6
2013 Q1	100%	156.68	3.19	2.01	40.7	42.2
2013 Q2	100%	157.76	11.72	1.95	43.1	47.6
2013 Q3	98.85%	152.83	29.47	2.07	37.5	48.8
2013 Q4	98.23%	154.77	38.40	1.99	40.8	55.3
2014 Q1	98.59%	155.51	42.67	1.69	52.8	68.2
2014 Q2	97.61%	153.13	39.77	1.86	45.1	59.8
2014 Q3	97.54%	150.55	50.68	1.86	44.2	63.0
2014 Q4	97.45%	146.49	40.70	1.74	47.7	62.5

Industrial Engineering-Derived Basic Care Omissions

[14] Beginning in the fourth quarter of 2012, the CNA PPDs included in the above table were based on Defendants' records. Prior to the fourth quarter of 2012, the CNA PPDs included in the above table were those reported by Defendants to CMS in Form CMS-671.

95. This analysis is supported by omissions of care described by witnesses who observed resident care firsthand at Red Rocks Care Center.

96. Confidential Witness #8 is the wife of a resident who resided at Red Rocks Care Center from December 2012 to February 2013. Her husband was dependent on nursing home staff for: assistance with toileting; turning and repositioning; eating, bathing, grooming, and basic hygiene; dressing and getting in and out of bed; oral care; and ROM exercises. Because of her husband's condition, she depended upon Red Rocks Care Center to provide this Basic Care. She visited him every day, staying several hours.

97. Even though Red Rocks Care Center was being paid to provide Basic Care to her husband, she was forced to provide as much of this care as she possibly could during her visits because the nursing home could not or would not do so. According to Confidential Witness #8, the facility's lack of staff was a continuing problem resulting in the failure to provide her husband's needed care. Despite multiple complaints made by her to the director of nursing regarding her husband's lack of care, nothing changed. During her visits, she observed the following:

(a) Her husband and she routinely experienced long wait times for staff to respond to a call light request for assistance.

(b) Staff did not have or make time to assist her husband with eating or drinking. Further, they rarely entered his room to monitor the amount of his food or fluid intake. He was subsequently found by the hospital to be dehydrated and experienced significant weight loss.

(c) Her husband was left lying in the same position in bed because staff did not have time to turn and reposition him. This led to the development of a pressure sore on his coccyx.

(d) Due to the staff's ongoing failure to provide oral care to her husband and lack of basic hygiene, Confidential Witness #8 was required to provide this care.

98. Confidential Witness #9 is the daughter of a resident who resided at Red Rocks Care Center from October 2012 through July 2013. Her father was admitted to Red Rocks Care Center by the hospital because he needed round-the-clock skilled care. He was also completely dependent upon the nursing home staff for all ADLs.

99. According to Confidential Witness #9:

(a) Each day, she or a member of her family was required to spend many hours in the facility because the staff did not have time to provide him with: incontinence care; diaper changes; eating assistance; getting up, dressed, and out of bed; turning and repositioning; bathing; oral care; and grooming.

(b) When family was not present, her father was forced to wait long times before receiving any assistance with toileting, which not only resulted in him frequently soiling himself, but caused him profound embarrassment.

(c) Similarly, she discovered that her dad was left in bed by the staff unless the family insisted that the staff get him up and dressed. He would only get bathed if the family pushed for it. Because the staff would not clean him, the family

was frequently required to change his soiled clothes and linens, and to clean him.

(d) Staff rarely assisted him with eating, always depending on the family to provide this assistance.

(e) Although their father needed to be turned and repositioned while in bed, they never observed staff do this unless the family chased down a staff member and requested assistance.

(f) Rarely did staff enter the room for any reason during her visits and staff was difficult to find when she needed their assistance.

(g) Frequently, it took the staff an hour or more to answer call lights. Staff would often apologize, stating they were unable to respond because they were too busy.

(h) Because staff was short all the time, Confidential Witness #9 and her family complained to the administrator. Not only were their pleas for more help ignored, the failure by the nursing home to provide this Basic Care seemed to get even worse in 2013.

(i) Therefore, Confidential Witness #9 and her family pulled their father out of Red Rocks Care Center.

100. Confidential Witness #10 is the daughter of a resident at Red Rocks Care Center, who resided there from August to December 2012. Her mother was dependent upon the nursing

home staff for assistance with toileting, eating, turning and repositioning, getting up out of bed, bathing, dressing, and grooming.

101. Confidential Witness #10 experienced the following during her regular visits:

(a) Upon walking to her mother's room, there was a strong stench of urine and feces in the hallways.

(b) Although her mother was admitted to the nursing home with a bedsore, she was frequently found in bed and rarely turned and repositioned off of the existing wound area.

(c) Rarely did she observe staff enter the room to deliver any care to her mother.

(d) She and her mother encountered long waits when they attempted to get assistance by using the call light.

(e) She was upset by the overall lack of Basic Care delivered to her mother and complained to the nursing home about this.

(f) Due to the facility's failure to keep her mother clean, change the bandages on her bedsore, and provide her the basic assistance needed, Confidential Witness #10 moved her mother out of Red Rocks Care Center following the development of dehydration, weight loss, and the significant deterioration of her pressure sore.

102. Nursing home inspectors have repeatedly found that Red Rocks Care Center violated state and federal nursing home regulations by failing to provide Basic Care over the Relevant Period. For example:

(a) During a survey on May 16, 2008, inspectors found that Red Rocks Care Center failed to provide adequate care resulting in a resident acquiring a Stage IV pressure sore that went untreated for nineteen days. The resident's MDS specified that she was at high risk for development of pressure sores and that preventative care was needed, including turning and repositioning the resident every two hours. Despite this known high risk of pressure sores, the facility repeatedly failed to check the resident's skin for developing sores and the facility missed 19 of 23 opportunities to bathe the resident over a two month period. Staff subsequently noticed that pressure sores had developed, but they were not adequately assessed or treated. When the Director of Nursing learned that one pressure sore had increased in size from 2 cm to 4.5 cm, she "panicked and sent the resident out to the hospital." The surveyor noted that the resident died shortly thereafter.

(b) On July 24, 2009, inspectors found that the facility violated several different regulations relating to failures to provide Basic Care. In one case, surveyors observed a resident sitting in her wheelchair in her room. Her lips were dry and her water pitcher was sitting on the bedside dresser. The resident told the surveyor that she was thirsty and that staff did not routinely offer her water. The next day, the surveyor observed her again, and noted that her tongue and lips were dry and that she said she was thirsty. When offered her water pitcher, she took several large sips. The inspector spoke with the resident's niece later

that day, and the niece said that the resident was nearly blind and would not be able to see her water pitcher on the bedside dresser. Based on the resident's care plan, the inspector determined that the facility staff knew this resident was at risk for dehydration due to a medication she was taking, but that no plan was made for ensuring that the resident received adequate fluids.

(c) On August 16, 2010, inspectors found that Red Rocks Care Center failed to provide adequate passive range of motion assistance to a resident at risk for hand contractures (a condition in which the muscles of the hand become rigid and shortened, leading to a curling or clawing of the hand). Physician's orders in the resident's records instructed the facility to apply soft hand splints daily to maintain range of motion in the resident's right hand. However, the inspector observed the resident on five separate dates with no hand splints in place and observed that her hand was tightly clenched and severely contracted. Staff members told inspectors that splints were applied to the resident, but they were unable to find them when asked to do so.

(d) On September 28, 2011, inspectors found that Red Rocks Care Center failed to adequately assess and treat two residents with pressure sores. One of the residents had developed a pressure sore on his left heel within about two weeks of admission to the facility.

(e) During an annual licensure survey on June 13, 2014, inspectors found that the facility violated several different regulations relating to Basic Care. In one

example, surveyors noted that a resident's records indicated she had not received oral care for the 3.5 months preceding the survey and that another resident had not received a dental appointment. In another case, the inspector observed that two male residents were unshaven. Records for one of these residents showed no documentation of his having been shaved in the 2.5 months preceding the survey, and that he had received only five showers in April of that year, seven showers in May, and two showers in the first two weeks of June. The surveyor interviewed the other resident, and he said that he did not receive showers often enough, saying "[t]hey have a schedule to follow, so I pretty much have to do what they say." Facility records indicated he had refused showers, but he told the surveyor that the only time he had refused a shower was when he had a therapy appointment coming up. He also said he was embarrassed that he may have a body odor. The inspectors also found that the facility failed to "utilize trained staff and provide appropriate procedures to prevent a pressure ulcer[ ]" for yet another resident.

C. Omissions of Care at Santa Fe Care Center

103. The simulation analysis for Santa Fe Care Center reveals that significant percentages of Basic Care required by residents and claimed to have been provided to them could not have been provided. For example:

Year & Quarter	TOTAL PERCENT of Category 4, 5, & 7 Residents in Facility	WORKLOAD SCORE: based on MDS Section G CLAIMED STAFF SUPPORT	2 PERSON ASSIST AVERAGE (Repositioning, Transferring, Toileting)	CNA PPD Per Quarter[15]	OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (No 2 Person Assist)	OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (With 2 Person Assist)
2008 Q4	100%	158.10	24.34	1.51	62.0	70.0
2012 Q2	100%	149.06	9.82	2.68	20.4	24.6
2013 Q1	99.01%	148.64	17.43	2.08	35.7	42.6
2013 Q2	88.87%	143.27	13.99	2.06	34.6	40.2
2013 Q3	83.00%	136.93	15.77	2.24	26.8	33.3
2013 Q4	83.49%	139.56	13.04	2.11	31.7	37.0
2014 Q1	87.12%	142.67	22.79	1.97	37.5	46.2
2014 Q2	79.75%	126.96	14.77	2.13	26.8	32.9
2014 Q3	92.07%	138.99	18.15	2.11	31.5	38.7
2014 Q4	96.89%	141.55	15.29	2.07	33.6	39.8

Industrial Engineering-Derived Basic Care Omissions

104. This analysis is supported by omissions of care described by witnesses who observed resident care firsthand at Santa Fe Care Center.

[15] Beginning in the first quarter of 2013, the CNA PPDs included in the above table were based on Defendants' records. Prior to the first quarter of 2013, the CNA PPDs included in the above table were those reported by Defendants to CMS in Form CMS-671.

105. Confidential Witness #11 is the son of a resident of Santa Fe Care Center who resided there from March to October 2013 and needed assistance with all ADLs. He and his family frequently visited his mother, staying as long as 3 hours at a time. According to Confidential Witness #11:

(a) During his visits, rarely was staff observed to enter his mother's room. Rarely, if ever, did staff turn and reposition her – in bed or in her wheelchair. She developed two pressure sores.

(b) Food trays were put in her room and left there. She needed assistance to eat, but the staff never stayed to help her, so the family assisted her at the times they visited. Similarly, there was a water pitcher in her room, but the water would be warm and staff did not assist her with fluids.

(c) The lack of care was upsetting, and he made complaints to the administrator.

(d) In October 2013, while attempting to go to the bathroom alone, his mother fell. Three days later, she died.

106. Confidential Witness #12 was a resident of Santa Fe Care Center for two weeks from August to September 2014. The resident, who was incontinent, wheelchair-bound, and dependent on staff for Basic Care described her stay at Santa Fe as terrifying. The resident needed and was dependent on the nursing staff for assistance for the following bedside care: getting in and out of bed, turning and repositioning, toileting, bathing and showering, dressing, grooming, and range of motion. According to Confidential Witness #12:

(a) The staff in the facility was overwhelmed, with there often being 25 residents to 1 CNA.

(b) Confidential Witness #12 has a vivid memory of the staff's inability to answer call lights. She often activated the call light for help due to the fact she needed a diaper change. Frequently, she was left for an hour or more in a wet or soiled diaper. When her diaper was soiled with BM, she persistently rang her call light button asking for immediate help – it really did not seem to make a difference. She gave up on getting help if her diaper was only wet. When staffing was particularly low on a shift, the wait for a diaper change could be much longer.

(c) Grooming and hygiene were a continuing problem – she went 14 days without a shower and received only 2-3 bed baths despite her incontinence issues.

(d) Frequently she was left in bed during the day in her night clothes. The staff did not routinely come into her room.

(e) She was only repositioned, at most, once a shift while in bed, and staff did not perform routine 2-hour checks.

(f) She complained to the floor staff about the lack of care, but she did not want to complain too much as she was afraid of retaliation.

(g) Two weeks after admission to the nursing home, she went back to the hospital where she stayed until discharged to her own home.

107. Confidential Witness #13 is the son of a resident of Santa Fe Care Center who resided there from January 2013 to May 2014. His mother was dependent on the nursing staff for assistance with all ADLs. Confidential Witness #13 visited his mother every day. According to Confidential Witness #13:

(a) His mother spent most of her time in bed until he complained to staff.

(b) He frequently found his mother in need of grooming, hygiene, and oral care.

(c) There appeared to be one CNA available to assist roughly 30 residents.

(d) He described long waits when the call light was activated. Because of the lack of response, when he was visiting he would try to track down staff to assist.

(e) Turning and repositioning were not done. His mother developed a pressure sore on her coccyx. She also became dehydrated on several occasions.

(f) He complained to the administrator, but nothing changed.

108. Confidential Witness #14 is the sister of a resident of Santa Fe Care Center who lived in the nursing home from January to March 2013. Her brother was dependent on the nursing staff for assistance with: getting in and out of bed, toileting and incontinence care, bathing and showering, oral care, dressing, and eating (at the end of his stay). Confidential Witness #14 visited her brother every day. According to Confidential Witness #14:

(a) She frequently found her brother soaking wet with urine. This was a continuing issue.

(b) Grooming and hygiene were a constant problem; she frequently found her brother in need of grooming and hygiene. The nursing home only gave him

one shower each week. Because he was in need of basic hygiene, she would assist him with bed baths.

(c) The nursing was always understaffed, especially at night. She thought there was one CNA for about 30 residents.

(d) She always had to hunt for staff when her brother needed assistance. She even had to search for a nurse when her brother died.

(e) Towards the end of his stay, she was required to feed him most of the time because no staff was available.

(f) She complained to the administrator about the lack of care, insufficient staff, and call lights going off all down the hall with no one responding to them.

(g) Her brother's hand was dislocated and the staff never noticed it; she had to show the staff.

109. Confidential Witness #15 is the daughter of a resident of Santa Fe Care Center who was in this nursing home from October 2012 to October 2013. Her mother, who had Alzheimer's disease, was dependent upon the nursing home staff for assistance with all ADLs. She visited her mother in the nursing home at least two times a week.

110. According to Confidential Witness #15:

(a) When her mother was admitted to Santa Fe Care Center she wore underwear. However, within a week the nursing home placed a diaper on her and she no longer wore underwear from that point on.[16]

(b) Commonly, when she arrived at the facility, her mother would ask to go to the restroom. Often, she found her mother in soiled or wet clothing. Frequently, her mother had a strong odor and she discovered dried feces in her diaper.

(c) Her mother developed severe rashes on her buttocks from long periods of sitting in a soiled diaper. Although her mother had moderate control over her bladder function, she was forced to urinate on herself and in her diaper because there were too few staff members to assist her to the toilet.

(d) When she or her mother pushed the call light to request assistance, there was generally a long wait before anyone came. When staff did come, they told Confidential Witness #15 that many people required help and her mother would just have to wait.

111. Confidential Witness #16 is the daughter of a woman who resided at Santa Fe Care Center in November 2013. Her mother was admitted to the facility for a short-term rehabilitative stay. She needed assistance to get out of bed and was classified as a high risk for falls. Nevertheless, she was left unattended on the toilet and suffered a catastrophic fall that injured her jaw, cut her forehead, pushed in one of her eyes, and left her face bruised and red.

[16] Putting continent residents in diapers, which can be changed more quickly than assisting the resident to the bathroom and on the staff's schedule, can be a sign of understaffing.

She died the same day. Confidential Witness #16 does not know how long her mother laid on the floor of her bathroom after falling. Three family members had visited her mother on the day she fell and died; they found her in an upbeat mood, looking forward to being discharged soon.

112. According to Confidential Witness #16:

(a) She and her sister, or one of their brothers, visited their mother every day. She observed wait-times of 30 minutes for responses to call lights.

(b) Because at least one of the siblings visited daily, they assisted in taking care of their mother's care needs. They observed other patients sitting in their wheelchairs in the hallway for hours; the patients were tired and said that they wanted to return to their rooms, but no one came to assist them. The residents would ask Confidential Witness #16 and her sister for help.

113. Confidential Witness #33 was the daughter of a woman who resided at the Santa Fe Care Center from 2007 or 2008 until her death on January 16, 2015. At the time her mother entered Santa Fe Care Center, she had suffered significant brain damage and was unable to walk or move her arms, and therefore to feed or dress herself or use a toilet. Towards the final years, she was not able to easily communicate her needs. Her mother was 76 years old at the time of her death.

114. According to Confidential Witness #33:

(a) The facility always smelled like urine and feces; she thinks they were not attending to incontinence care.

(b) Her mother developed a number of urinary tract infections while at the facility. She had not been prone to these before. When Confidential Witness #33 visited, she often found her mother so wet with urine in her bed that it had soaked through to the bedding.

(c) Her mother needed assistance with her meals, as she was not able to swallow well. Confidential Witness #33 told a CNA that it was not a good idea to just leave a tray in front of her, because she might choke, and that she needed to be fed. She was also concerned about her mother being fed in the dining room however, because she did not see that they had any nurses available there to assist in the event that there was a choking incident.

(d) She could tell that some CNAs were too busy and were overwhelmed by their duties. Some of the CNAs told her that they were working extra hours.

(e) She was present one day when a state inspection was taking place. There was more staff that day than she had ever seen before, many of whom she did not recognize, and the nurses answered the call bells as soon as they rang. It was never like this before or after the inspection.

115. Confidential Witness #17, a former CNA who worked between 2010 and 2012 at both Santa Fe Care Center and Casa Real, described Santa Fe Care Center as filthy and terrible-smelling. He typically worked the 6 p.m. to 6:30 a.m. shift, and he was responsible for 25-32 totally dependent residents, on average. Over the course of his shift, he was responsible for waking residents up, getting them dressed, bathing residents, repositioning residents, providing

incontinence care, and doing rounds. He said that dressing residents alone took 15-20 minutes each.

116. According to Confidential Witness #17:

(a) He had to skip repositioning residents because he did not have enough time during his shift. Residents were supposed to be repositioned every two hours, but sometimes they were not repositioned for an entire shift. He recalled seeing pressure sores on residents. Many residents with pressure sores had to be sent to the hospital, and some of them never returned. He recalled one resident with a pressure sore on his tailbone that was so bad he could see through the layers of tissue and muscle.

(b) He never did ROM exercises with residents.

(c) Lack of staff forced the CNAs to shower male and female residents at the same time in a shower room where shower heads were only separated by curtains, which was humiliating for the residents because they were essentially showering together. When CNAs were showering residents, no CNAs would be on the floor. When he was really rushed, some residents would not receive a shower, and he would do his best to wash them in bed with a rag instead.

(d) Incontinence care also was rushed or omitted. Incontinent residents were supposed to be changed every two hours, but he usually could change residents only once per twelve-and-a-half hour shift. CNAs often doubled- or tripled-up on briefs because they knew they would not be able to get to the residents as

frequently as needed. He frequently found residents drenched in urine, and he would have to change everything – clothing and bedding.

(e) Residents usually had to wait thirty minutes for a response to their call light. Residents often tried to get up on their own because they waited too long for assistance to use the bathroom, and they would fall out of their beds and crawl to the hallways yelling for help. He recalled several falls at the facility, including ones that resulted in hip fractures.

(f) Confidential Witness #17 said that the CNAs frequently complained to management about the lack of adequate staffing, and were told that the facility did not have the budget to hire more staff.

117. Nursing home inspectors have repeatedly found that Santa Fe Care Center violated state and federal nursing home regulations by failing to provide Basic Care over the Relevant Period. For example:

(a) On June 5, 2008, inspectors found that staff repeatedly failed to assist a resident in getting to the bathroom. The DOH found that the resident rang her call bell a total of five times; staff told her to wait following the first four call bells and to go in her diaper after the fifth call bell. The resident told staff that she could use the bathroom, but that she just needed help getting to the bathroom. She tried to reach the bathroom on her own and fell.

(b) During another survey on December 4, 2009, inspectors found that the facility had failed to splint a resident's hand, a passive range of motion treatment to

address and prevent contractures. In an interview with surveyors, a family member of the resident said that she had been concerned that the resident would have skin problems because his hand had curled so much that his nails were rubbing against his palm.

(c) On May 15, 2012, inspectors found that the facility had failed to prepare care plans for two residents. One resident had no care plan, despite the fact that her MDS indicated she needed extensive assistance. The other resident was at the facility for two months before an initial care plan was prepared.

D. Omissions of Care at Sagecrest Nursing and Rehabilitation Center

118. The simulation analysis for Sagecrest Nursing and Rehabilitation Center ("Sagecrest") reveals that significant percentages of Basic Care required by residents and claimed to have been provided to them were not provided. For example:

Year & Quarter[17]	**TOTAL PERCENT of Category 4, 5, & 7 Residents in Facility**	**WORKLOAD SCORE: based on MDS Section G CLAIMED STAFF SUPPORT**	**2 PERSON ASSIST AVERAGE** (Repositioning, Transferring, Toileting)	**REPORTED CNA PPD (during Quarter)**	**OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (No 2 Person Assist)**	**OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (With 2 Person Assist)**
2012 Q3	98.98%	149.82	85.48	2.30	29.4	61.7
2013 Q2	98.88%	150.33	69.42	2.17	33.3	59.5
2014	95.05%	148.72	33.0	2.27	29.9	42.7

[17] The quarters included here are the ones from the Relevant Period for which data was available from CMS.

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Industrial Engineering-Derived Basic Care Omissions

119. This analysis is supported by omissions of care described by witnesses who observed resident care firsthand at Sagecrest.

120. Confidential Witness #18 is the wife of a resident of Sagecrest, who was in this nursing home for approximately 7 months from October 2013 to May 2014. This resident was visited by his wife or two children every day and sometimes several times a day. After suffering a stroke and being cared for by his family at home for several years, he was admitted to the Sagecrest facility because his medical needs and level of dependency were greater than the care the family could provide. While at Sagecrest, this resident required the assistance of 1-2 persons for all his Basic Care with the exception of eating. He could independently eat, but he required a mechanically altered diet and supervision by staff. According to Confidential Witness #18:

(a) When she arrived at the nursing home each day, she often found her husband in bed or parked in a wheelchair in his room with a foul-smelling, soaking wet or feces-soiled diaper. Frequently, when she walked into the room, he was calling out for help with his call light string out of his reach.

(b) He was never provided a routine bath except when either she or her children repeatedly insisted that staff bathe or shower him. More often than not, an initial request for a bath was met with the response that they did not have enough staff and would get to it when they had time.

(c) It was not unusual to observe on any given day other residents who needed to be bathed and cleaned. The smell of urine, feces, and body odor was overpowering upon walking down the hallway of the nursing home. The odor seemed to get worse over the weekends when the understaffing was even more noticeable.

(d) Due to the lack of staff, she and her family were forced to provide much of her husband's Basic Care. It was difficult to find staff to assist them. She experienced long delays when she used the call light to signal for help. Her husband repeatedly told her that staff became frustrated when he used the call light and discouraged him from doing so.

(e) Due to the lack of staff supervision, her husband fell several times suffering a black eye and bruising. Her husband's roommate verified that once when the resident had fallen, he had yelled out "HELP, HELP" for hours, despite the fact that the call light had been activated by the roommate immediately after the fall.

(f) Due to the stroke her husband suffered, he had problems with swallowing and required close supervision with meals. A meal monitoring "safe swallow" program was supposed to be in effect. However, the dining room where he ate was very poorly attended and supervised by staff, if at all.

(g) Confidential Witness #18 began to search for another facility that could provide for her husband's care. On May 30, 2014, she assisted her husband to

the dining room and left to finish making arrangements for his transfer out of Sagecrest. An hour after leaving the facility, Sagecrest called her and told her that her husband had choked to death.

121. Confidential Witness #19 is the court-appointed guardian of a Sagecrest resident who was in the facility from June 2012 to September 2014. She has been the court-appointed guardian for many other residents in this facility, so she has had many opportunities to observe the care delivery at this facility. According to Confidential Witness #19:

(a) She visited the resident initially every week to every 2 weeks, but in the last 2 months of resident's life, she visited several times a week.

(b) The resident had a history of stroke and head injury and was dependent upon the assistance of 1-2 persons for all ADLs. He spent most of his time either in bed or in a wheelchair. From July 2013 until his death in the facility, he was primarily bed-bound.

(c) It was clear that ADLs – especially bathing, grooming, incontinence checks, and meal assistance – were not being attended to by facility staff.

(d) The oral care was deplorable. This resident's mouth was bad. The resident really needed to see a dentist, and Confidential Witness #19 asked about getting a dentist to come in to the facility, but it was never addressed.

(e) Often, baths and showers were needed, but not provided, based on residents' smell and appearance.

(f) On weekends, staffing was particularly short. She would often visit Sunday at dinner time. The appearance of the residents and lack of available staff caused her to have serious concerns about the care.

(g) Confidential Witness #19 frequently complained to the director of nursing and other staff when she observed this poor care. While complaints and threats to call the State usually resulted in temporary corrective measures, the lack of Basic Care returned.

122. Confidential Witness #20 is the sister of a Sagecrest resident who was in the facility in April 2012. She visited her brother every day and tried to always be there for at least one meal. Her brother was wheelchair-bound and bed-bound, and he was dependent on the nursing staff for assistance with all ADLs. According to Confidential Witness #20:

(a) If his family had not been there every day, his needs for basic hygiene care, assistance with feeding, repositioning, and oral care would have been totally neglected.

(b) She observed during mealtimes there was not enough staff and they did not assist him in eating. When she was there to help him, her brother, who was a slow eater, would eat well. However, because the staff did not have or take the time to assist him, her brother suffered weight loss.

(c) She rarely saw staff come in to the room to perform routine care. Her brother was not turned and repositioned on a regular basis unless she repeatedly asked

staff to do so. Typically, attempts to get the staff to answer a call light were fruitless. Waits for a response were often long.

(d) In a 21-day period, her brother received a shave only once. She observed staff provide him oral care only once during 21 days. This was one of the many tasks left for her or her family.

123. Confidential Witnesses #21 and #22 are the son and daughter of a Sagecrest resident who was in the facility from November 2012 to April 2013. Confidential Witness #21 visited her mother three to five times weekly and Confidential Witness #22 (who is a retired RN) visited at least once a week. Their mother was also a retired RN. Although her mother was able to ambulate with a walker and minimal assistance initially on admission, within 3 months, she had lost this ability and became dependent on the nursing home staff for her ADLs.

124. According to Confidential Witnesses #21 and #22:

(a) There did not seem to be any routine scheduled incontinence or oral care, bathing, showers, or hydration rounds.

(b) Frequently, Confidential Witnesses #21 and #22 would find their mother lying in bed with a wet or dirty diaper on, usually with a strong urine and fecal smell to her body and to the room. Her hair was never combed and was frequently in need of washing.

(c) Confidential Witnesses #21 and #22 reported that they had to find help to get any of this Basic Care attended to, or do it themselves. They frequently had to get water or other liquids for their mother to drink.

(d) Oral care was never administered. Her mouth care had to be done by the family if it was to get done.

(e) Grooming and dressing were a problem. The family asked that their mother be put in pajamas at night so she would know it was bedtime, and to put on fresh clothing the next morning so she would know it was a new day. However, they knew this was not done when they would find her in the afternoon wearing the rumpled clothing that they had dressed her in the previous day before breakfast. This happened quite often.

(f) When they made efforts to get staff assistance, staff frequently responded that they would get to the resident as soon as they could. These responses were usually followed by long waits for assistance. It was not unusual to see call lights on up and down the hallway for an hour or more without being answered.

(g) The CNAs were not assisting with meals and encouraging their mother to eat. As a result, she lost 15-20 pounds while at this facility. The dining room was horrible. There was little supervision and assistance with eating or feeding. Residents would be helping other residents, rather than staff helping residents in the dining room. There might, at best, have been one staff person for 25-30 residents in the dining room.

(h) Finally, after giving the facility the benefit of the doubt for almost 5 months, they moved their mother out of state to a much better facility, where she thrived for a year with a much improved quality of life and care.

125. Confidential Witness #23 is the daughter of a Sagecrest resident who was in the facility from July to December 2013. She visited her mother every day. Her mother was wheelchair-bound. Although her mother could eat independently, she was dependent on the nursing staff for the following Basic Care: getting in and out of bed, turning and repositioning in bed and in a wheelchair, toileting, bathing and showering, oral care, dressing, and ROM exercises. According to Confidential Witness #23:

(a) It was rare to see nursing staff in her mother's room during Confidential Witness #23's many visits to the facility. Initially, the witness believed the facility was simply respecting their privacy. Soon, however, she realized the real reason for their lack of presence – short-staffing.

(b) Throughout her mother's stay, staff members were difficult to find when assistance was required. Call lights routinely took 30 minutes to 1 hour to be answered.

(c) Frequently, her mother was only bathed twice a week.

(d) Once her mother was left over an hour on a bed pan and suffered bruising as a result.

(e) Her mother spent most of the day and evening hours in her wheelchair. Often her mother would be left in her wheelchair in her room for extended periods of time without being repositioned or her body being moved.

(f) Her mother experienced weight loss at Sagecrest as a result of the staff not having the time to feed her and was hospitalized for dehydration.

(g) She complained to Sagecrest staff orally and in writing about the care her mother received.

126. Confidential Witness #34 is the wife of a man who resided at Sagecrest for a few weeks in 2014. Confidential Witness #34 had been taking care of her husband at home for many years, with assistance from home health care aides who provided periodic skilled nursing. In October 2014, she noticed a change in his behavior and took him to the hospital where it was determined that he had suffered a minor stroke. He was very alert mentally, but was admitted to Sagecrest for rehabilitation, with the intention of returning to his home once he had recovered his strength and mobility.

127. According to Confidential Witness #34:

(a) Her husband had had periodic difficulty with swallowing in the past and had been put on a soft, mechanically-altered diet at the hospital. Confidential Witness #34 therefore went to the nursing home for breakfast on his first morning in residence to see how he was handling meals. When she arrived, he was in his room and she was informed that he had already eaten, but that the staff had observed difficulties with swallowing and would have him assessed

by a speech therapist. Confidential Witness #34 noticed that her husband was not speaking and his face appeared tense, so she asked him to open his mouth; she found that both of his cheeks were stuffed with scrambled eggs and his dentures were not in. She realized that she could not trust the facility to monitor and assist with his meals and so she visited the nursing home daily, for at least one meal, to feed him herself.

(b) There was never enough staff on the floor. Her husband was continent of bowel, and could use a toilet if assisted in walking and managing his Foley bag. Every time she visited, she would ask if he had used the bathroom and the answer was always "no." When they rang the call-bell, no one came.

(c) Staff only offered her husband beverages at mealtimes – usually cranberry or apple juice. There was normally a pitcher of water in his room, but because the room was small, he was rarely able to maneuver his wheelchair around to reach the pitcher and pour himself a glass of water. She never saw a staff member offer him a beverage, other than the beverages served at mealtimes.

(d) For over a year when Confidential Witness #34 cared for her husband at home, he had an in-dwelling catheter. Confidential Witness #34 kept him very clean and made sure that his groin area was clean and dry. Soon after her husband arrived at Sagecrest, she noticed that he had developed skin problems in his groin because he was not kept clean.

(e) Her husband received physical therapy, and after a few weeks at Sagecrest his strength and coordination improved to the point where he was starting to walk with a walker. At this point, it was also time for his catheter to be replaced, and on Thursday and Friday of that week, Confidential Witness #34 reminded two of his nurses and the facility doctor that this needed to be done before the weekend, when she knew the facility would be understaffed and hectic. On Friday evening, during dinner, she noticed there was no urine in his Foley bag – a sign that something was wrong. She brought this to the attention of his nurse, who told her she would check it later that evening. Confidential Witness #34 waited, and the nurse returned later in the evening to remove and replace the catheter. Confidential Witness #34 then went home for the night.

(f) When she arrived at the facility the next morning, she found a nurse in her husband's room, attempting to attend to her husband, who was delirious and bleeding profusely from his penis. His bedding was covered in blood. Confidential Witness #34 told staff to call an ambulance; she is not sure whether they had already called one or not. Her husband received two blood transfusions at the hospital, but had lost a significant amount of blood. After three days in the hospital, he was transferred to hospice and died ten days later.[18]

[18] The placement of catheters is typically done by licensed nurses, not CNAs, and is considered to be part of the skilled nursing care provided by a facility, rather than Basic Care.

128. Confidential Witness #24 worked as a CNA at Sagecrest between 2010 and 2012. The facility was always understaffed, and, as a result, the CNAs were not able to fully care for the residents. In her opinion, both pressure sores and fall-related injuries that she observed were attributable to understaffing. She worked the overnight shift, 10:00 p.m. to 6:00 a.m., and was responsible, with another CNA, for as many as 30 residents. During her shift, she took residents' vital signs, did rounds to reposition and check incontinent residents, and woke and dressed residents for breakfast in the morning.

129. According to Confidential Witness #24:

(a) Residents were supposed to be repositioned and checked for incontinence every two hours, but this could only be done, at most, every three hours because there were so many residents to take care of. She frequently found residents who were soaking wet because the previous shift did not change them and because she was not able to change them frequently enough. Upon change of shift, she would get a report that all the residents had been checked and were fine. But when she started her rounds, she would find some residents so wet that the bed linens were saturated.

However, Basic Care does include conducting rounds to check in on residents regularly – typically every two hours – to reposition them and provide incontinence care. When CNAs are responsible for too many residents, however, they cannot complete rounds as frequently as required, and serious problems (like the one Confidential Witness #34's husband experienced) can go unnoticed and untreated for hours as a result.

(b) One particular resident required more frequent checks because of behavioral problems, and she was instructed to visit his room every 45 minutes. The extra time she devoted to him meant that other residents received less attention, even though they needed care and assistance.

(c) Residents complained about waiting a long time for responses to call lights and would be particularly upset when they were left in soiled or wet briefs.

130. Nursing home inspectors have found that Sagecrest violated state and federal nursing home regulations by failing to provide Basic Care over the Relevant Period. For example:

(a) During Sagecrest's annual licensure survey on June 13, 2014, inspectors found multiple violations of regulations relating directly to understaffing and failures of Basic Care. Inspectors cited the facility, among other things, for "fail[ing] to ensure sufficient staff were available to respond to resident needs." The inspectors' findings were based on an interview with family members of one resident who told the surveyor that it took 30-60 minutes for staff to answer the call light and an interview with a resident who told them that staff told her "No" when she asked for assistance using the toilet rather than a bedpan. An inspector also witnessed another resident waiting more than thirty minutes for a response to her call light, which she had used because she wanted to take a shower before her therapy appointment. The CNA assigned to assist her did not know the call light had gone off because he was busy helping another CNA

with other residents. The CNA was responsible for twelve residents on his shift.

(b) At the same June 2014 survey, inspectors found that Sagecrest failed to provide adequate supervision of residents to prevent accidents, following a choking incident at the facility the previous month. The resident was known to be at risk for choking. His physician ordered a special soft diet, and, according to the resident's MDS, the resident required supervision during meals with the physical assistance of one staff member. However, on May 30, 2014, the staff provided him with a hamburger and a cold cut sandwich instead of the soft diet, and a CNA left the meal tray with the resident and went to pass out more trays in the dining room. The resident choked on his food and died. Surveyors reviewed other instances of choking at the facility as part of this survey – including one that the surveyor personally witnessed – and concluded that the facility had failed to provide adequate assistance to these residents at meals, putting them at risk for choking.

E. Omissions of Care at Bloomfield Nursing and Rehabilitation Center

131. The simulation analysis for Bloomfield Nursing and Rehabilitation Center ("Bloomfield") reveals that significant percentages of Basic Care required by residents and claimed to have been provided to them were not provided. For example:

Year & Quarter[19]	**TOTAL PERCENT of Category 4, 5, & 7 Residents in Facility**	**WORKLOAD SCORE: based on MDS Section G CLAIMED STAFF SUPPORT**	**2 PERSON ASSIST AVERAGE** (Repositioning, Transferring, Toileting)	**REPORTED CNA PPD (during Quarter)**	**OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (No 2 Person Assist)**	**OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (With 2 Person Assist)**
2009 Q3	94.9%	148.83	25.32	1.97	39.5	49.2
2010 Q3	100%	153.40	17.62	2.05	38.3	45.2
2011 Q3	100%	152.64	13.01	2.20	33.3	38.6
2012 Q3	100%	148.43	10.99	2.25	30.4	35.1
2013 Q3	91.01%	144.87	43.22	2.32	27.3	44.0
2014 Q3	90.46%	141.30	39.1	2.34	25.5	40.7

Industrial Engineering-Derived Basic Care Omissions

132. This analysis is supported by omissions of care described by witnesses who observed resident care firsthand at Bloomfield.

133. Confidential Witness #35 is the son of a woman who resided at Bloomfield from October 2009 through November 2010. She went to Bloomfield after a fall for the purpose of physical therapy to gain strength for balance, skilled nursing related to diabetes and dialysis, and observation. At the time she was admitted to Bloomfield, she was 77 years old and capable of

[19] The quarters included here are the ones from the Relevant Period for which data was available from CMS.

walking, eating, drinking, using the toilet, bathing and dressing on her own, but she had early onset dementia.

134. Confidential Witness #35 visited his mother daily, and according to him:

(a) His mother deteriorated rapidly while at Bloomfield. Within six months of arriving, she needed assistance to use the bathroom, dress herself, and bathe herself.

(b) She did not receive adequate physical therapy or ROMs. When Confidential Witness #35 visited her on the weekends, they would go outside for walks, which she could manage with a walker. The walker was not made available to her daily by the facility. Instead, she remained sedentary in bed or her wheelchair. He repeatedly asked them to provide her with the walker, but was told that someone else was using it. When he insisted, they would go and retrieve it, but when he returned it was gone again. After living at the facility approximately 6 months, she was no longer able to use the walker.

(c) His mother was continent when she arrived at Bloomfield, but one day he arrived and found that she had soiled herself. The facility's response was to put her in adult diapers. She had never had any incontinence issues at home. She was quite capable of using the call bell and had no speech problems preventing her from alerting the staff that she needed assistance in getting to the bathroom; however, the response time was not fast enough for her to do so. Once he found her call button on the floor under the bed where she never

would have been able to reach it. He often would find his mother soiled; the odor was so strong that anyone standing within a few feet of her would have been able to smell both urine and feces.

(d) When his mother had been living at Bloomfield for approximately a year, she complained to him one day of lower back pain. He was a licensed massage therapist, so he tried massaging her back, but she told him to stop because it was too painful. Shortly afterwards, when she was at the hospital for a routine checkup regarding her dialysis, the hospital discovered that she had advanced pressure sores on her sacrum and heels. His mother died shortly after returning to Bloomfield.

135. Confidential Witness #36 is the wife of a man who resided at Bloomfield for a 6-week rehabilitation stay starting in September 2012, and then again for long-term care from mid-May 2013 to August 10, 2014, when he was 85 years old. Before re-entering Bloomfield in May 2013, he was alert and enjoying life; however, he had recently suffered a broken leg, was confined to a wheelchair, and required more physical assistance than his wife could provide at home. He also had suffered a stroke in 2006 and had aphasia as a result, so he was not always able to find the words he needed to communicate.

136. Confidential Witness #36 visited her husband daily. According to her:

(a) During her husband's stay in 2013 and 2014, there wasn't enough staff to care for the residents.

(b) Her husband needed assistance going to the bathroom, but staff was resistant to helping. Quite often, he would be soaked. From the moment she walked into the front door of the facility, she could smell the urine.

(c) Her husband did not get enough to drink. The majority of the time, the water jug in his room would be empty, and seemed like it had been empty for a long time. Staff seldom offered him water. They did come around with apple juice in the afternoons, but he did not like apple juice, and they offered no alternative.

(d) In August 2014, she visited her husband on a Sunday afternoon, which was after her usual visiting time, so she thinks staff was not expecting her. She found her husband lying in a pool of urine. He had been there so long that the bottom sheet was starting to dry; she could see a brown ring from drying urine. She was angry about this and concerned about a sore on her husband's foot, which she had previously warned the staff about. Her husband's condition seemed so bad that she called for an ambulance.

(e) Once her husband was at the hospital, doctors found that he was acutely anemic and bleeding internally, in his digestive tract. He required a transfusion of four units of blood and two units of plasma. She thinks the nursing home staff must have seen the blood in his stool, because they had to help him onto and off of the toilet, but they never said or did anything about it.

(f) Her husband's condition declined significantly while he was at Bloomfield. His weight declined rapidly from around 209 pounds in May or June of 2014 to 175 pounds when he arrived at the hospital in August 2014. His mental alertness declined as well. Sometimes he did not recognize his wife or his step-son. He did not enjoy television shows or football because he could not follow what was happening. The facility nurses told her that the decline was due to dementia and to the stroke he had in 2006, and that he would continue to decline quickly. She believed this at the time.

(g) However, after his treatment at the hospital in August 2014, he moved to another nursing home, where he received the basic care and assistance he needed. His condition improved. His speech has improved, and he was recently able to recognize a former co-worker who he had not seen in years, as well as his family again. He is now alert and enjoying life again.

137. Confidential Witness #25 a former CNA at Bloomfield in 2012, recalled that the facility was understaffed and that the CNAs were unable to give residents the care that they needed. He typically worked the 5 a.m. to 5 p.m. shift and usually was responsible for 14-18 residents suffering from dementia or otherwise requiring full assistance with their ADLs. In the time he had, he was responsible for doing rounds, putting residents to bed, getting residents up, taking residents to the dining hall and feeding them, taking vital signs, showering some residents, repositioning some residents, and providing incontinence care.

138. Confidential Witness #25 recalled omissions of care that resulted from understaffing. According to him:

(a) Residents were supposed to be checked and changed only three times over the course of a twelve hour shift. He frequently found residents who had not been changed for several hours, and he thought the CNAs were too busy to change the residents as often as required.

(b) Residents waited a long time to eat because of inadequate staffing.

(c) When he had to rush in providing care, the residents' hygiene was sacrificed – for example, they would sometimes not get their teeth brushed adequately.

F. Omissions of Care at Espanola Valley Nursing and Rehabilitation Center

139. The simulation analysis for Espanola Valley Nursing and Rehabilitation Center ("Espanola Valley") reveals that significant percentages of Basic Care required by residents and claimed to have been provided to them were not provided. For example:

Year & Quarter[20]	TOTAL PERCENT of Category 4, 5, & 7 Residents in Facility	WORKLOAD SCORE: based on MDS Section G CLAIMED STAFF SUPPORT	2 PERSON ASSIST AVERAGE (Repositioning, Transferring, Toileting)	REPORTED CNA PPD (during Quarter)	OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (No 2 Person Assist)	OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (With 2 Person Assist)
2009 Q2	97.4%	154.78	19.91	2.14	35.8	43.7
2010 Q2	93.24%	151.38	16.67	2.13	35.0	41.7
2011 Q2	100%	144.33	16.35	2.38	25.5	32.2
2012 Q3	100%	152.79	16.67	2.06	37.7	44.3
2013 Q3	93.31%	143.86	12.71	2.55	21.2	26.6

Industrial Engineering-Derived Basic Care Omissions

140. This analysis is supported by omissions of care described by witnesses who observed resident care firsthand at Espanola Valley.

141. Confidential Witness #26 a former CNA at Espanola Valley from 2011 to 2012, described constant understaffing and serious omissions of care. She typically worked the 2:00 p.m. to 10:00 p.m. shift and was responsible for 8-12 residents, and sometimes more if the facility was short-staffed. She was responsible for cleaning residents, taking them to dinner, getting them up and putting them to bed, making sure they were dry, doing rounds, assisting with

[20] The quarters included here are the ones from the Relevant Period for which data was available from CMS.

showers, and taking vital signs three times per shift for each resident. She never had enough time to do her work.

142. According to Confidential Witness #26:

(a) Residents sometimes received cold food because there were not enough CNAs to help them eat, so they had to wait a long time to be fed.

(b) She was not able to do ROM exercises with residents because she did not have time.

(c) Almost all of the residents for whom she cared were incontinent, and she frequently found residents who were soaked and had not been changed in hours.

(d) She saw several residents with open pressure sores.

(e) It took a long time for CNAs to respond to call lights because there was too much work for them to do.

(f) The CNAs at Espanola Valley frequently complained to the managers about the lack of staff, but they were told to manage with the staffing they had.

143. Confidential Witness #27 worked as a CNA at Espanola Valley in 2013. She worked during the daytime shifts and might be responsible for as many as 20 residents. Understaffing was a serious problem.

144. According to Confidential Witness #27:

(a) She was only able to reposition residents 2 or 3 times over the course of an 8 hour shift, and not 4 times, as was required and recorded. If she needed the

assistance of a second CNA to move or reposition a resident, she would wait 30-60 minutes for help. As a result, she would perform 2-person assists by herself. She feels lucky that no one (a resident or herself) was injured in the process.

(b) Incontinent residents were supposed to be checked and changed 4 times during a shift. She could not keep to that schedule.

(c) Residents needed assistance, encouragement, and time to eat. Staff was insufficient to provide that assistance. Residents did not have enough time to eat and their meals were often cold; clean-up in the dining room started an hour after meals commenced, whether or not the residents had eaten. Some residents took their meals in their rooms; she would see them sitting, alone, staring at their trays.

(d) Residents were generally showered once a week; sometimes a resident would be showered twice in one week.

145. Nursing home inspectors have repeatedly found that Espanola Valley violated state and federal nursing home regulations by failing to provide Basic Care over the Relevant Period. For example:

(a) During a survey on May 21, 2010, inspectors found that Espanola Valley failed to ensure that a resident did not develop a pressure sore. Upon admission to the facility, the resident had risk factors for development of pressure sores, including decreased circulation. Bloodwork done a month and a half after

admission showed a decreased level of Albumin, indicating prolonged malnutrition, another risk factor for the development of pressure sores. The resident developed a pressure sore on her bottom around six months later, which continued to worsen over the month preceding the survey inspection.

(b) On February 7, 2012, inspectors found that Espanola Valley violated several different regulations in the care of a resident who suffered an erosion of his catheter and severely infected wound on his penis that resulted in gangrene, necrotizing fasciitis (a flesh-eating bacterium), and partial amputation of the penis. The doctor who treated the resident told the DOH inspector that the resident's catheter was left in and the resident was left sitting all the time, so the catheter eroded inside of him, causing an infection of the entire penis. The resident's penis was partially amputated, leaving it a non-working organ.

(c) On August 15, 2012, inspectors found that Espanola Valley violated several different regulations by maintaining an unclean dining room and kitchen and failing to provide care in a way that promotes the residents' dignity. The inspector witnessed an evening meal and described a hot dining room infested with flies. CNAs began bringing residents to the dining room at 4:15 p.m. even though service did not begin until 5:30 p.m. CNAs poured apple juice into glasses without asking residents what they wanted to drink. Flies were everywhere, landing on the juice glasses; some residents tried to wave the flies away from their glasses. The surveyor witnessed similar conditions at

breakfast, noting a group of five residents sitting in the dining room alone. The inspector described: "[p]lates of scrambled eggs and toast were cold and flies all over the eggs and fruit juice while the residents sat there and stared at their food."

(d) On June 24, 2013, inspectors found that Espanola Valley failed to prevent neglect of a resident by not repositioning the resident, offering the resident toileting assistance, or conducting an accurate skin or bowel assessment of the resident, resulting in the development of a pressure sore on the resident's tailbone, subsequent infection, and eventual fecal impaction in the intestines.[21] The resident's care plan specified that he receive incontinence care and be repositioned every 2-3 hours. However, the surveyor found in a review of the resident's records that 17 times over four months the resident was not repositioned or offered toileting assistance for twelve or more hours and 14 times the resident was positioned on his back for 3.5 hours or more without repositioning. The resident was ultimately sent to the hospital with an infected pressure sore with full-thickness necrosis (dead tissue at all layers of the tissue/flesh), a severe fecal impaction in his intestines, and possible sepsis.

G. Omissions of Care at Sunshine Haven at Lordsburg

[21] A fecal impaction results from the failure to monitor the frequency and consistency of bowel movements. This condition can be fatal in the elderly and is often secondary to lack of proper hydration and the administration of narcotics.

146. The simulation analysis for Sunshine Haven at Lordsburg ("Sunshine Haven") reveals that significant percentages of Basic Care required by residents and claimed to have been provided to them were not provided. For example:

Year & Quarter[22]	**TOTAL PERCENT of Category 4, 5, & 7 Residents in Facility**	**WORKLOAD SCORE: based on MDS Section G CLAIMED STAFF SUPPORT**	**2 PERSON ASSIST AVERAGE** (Repositioning, Transferring, Toileting)	**REPORTED CNA PPD (during Quarter)**	**OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (No 2 Person Assist)**	**OMITTED PERCENT Section G CLAIMED STAFF SUPPORT TIME (With 2 Person Assist)**
2012 Q1	81.13%	132.65	12.02	1.79	41.0	45.4
2012 Q4	88.46%	132.48	9.84	1.96	34.4	38.4
2013 Q4	89.08%	147.89	33.3	1.67	51.2	63.1

Industrial Engineering-Derived Basic Care Omissions

147. This analysis is supported by omissions of care described by witnesses who observed resident care firsthand at Sunshine Haven.

148. Confidential Witness #28 worked as a CNA at Sunshine Haven in 2011 and 2012. She worked the night shift, 6:00 p.m. to 6:00 a.m., and was typically responsible for 20 residents. During her shift, she would: shower residents, put residents to bed, conduct repositioning and incontinence rounds, and wake and dress residents for breakfast.

149. According to Confidential Witness #28:

[22] The quarters included here are the ones from the Relevant Period for which data was available from CMS.

(a) Residents typically waited 20 minutes for a response to a call light.

(b) Confidential Witness #28 frequently found residents who had not been changed for several hours, both because CNAs on prior shifts did not change the residents and because she did not have time to change the residents frequently enough herself.

(c) When two CNAs were required to move or reposition a resident, she waited 20-30 minutes for an assist. Many CNAs used Hoyer lifts[23] on their own rather than wait and several suffered back and shoulder injuries as a result.

(d) The CNAs regularly complained to management about understaffing.

150. Confidential Witness #29, a former social worker at Sunshine Haven in 2013 and 2014, says that she frequently brought poor care and neglect to the attention of management, but administrators ignored her. According to her:

(a) Residents were rarely changed or bathed, and would sometimes be left in their chairs or in bed for hours.

(b) Call lights were constantly going off, and she would often respond to help the residents, even though it was not her job.

[23] A Hoyer lift is a device used to help lift residents and transfer them in and out of bed, and two CNAs are required to safely operate it. However, Hoyer lifts are sometimes used by CNAs alone when they cannot find another free CNA to assist due to understaffing.

(c) She found one resident who had been left on the toilet unattended for twenty minutes, and was very upset as a result. She constantly found residents in sheets that were soaked with urine or stained with feces.

(d) Residents complained that they were either not fed at all or were receiving cold food. Once, she observed that the CNAs left a tray in one resident's room and forgot to feed her. Confidential Witness #29 reported this incident to the administration, but nothing was done in response.

(e) Confidential Witness #29 also recalled observing falsification of records at Sunshine Haven. One day, a resident's daughter told the staff that the resident needed a bath. The CNA responsible for that resident said the resident had refused the bath, but when Confidential Witness #29 checked the records, she discovered that the CNA had recorded that she had bathed the resident.

151. Confidential Witness #30 worked as a CNA at Sunshine Haven in 2014. During that time, she observed regular omissions of care caused by chronic understaffing. She worked the daytime shift, 6:00 a.m. to 6:00 p.m. and during that time was responsible for 13 or 14 residents. Her shift responsibilities were: waking and dressing residents; taking them to the dining hall and feeding them breakfast and lunch; conducting rounds for repositioning, providing incontinence care, and checking vital signs; and assisting residents with showers. Her typical day was hectic; she did not have enough time to do her job correctly or even finish all of her work.

152. According to Confidential Witness #30:

(a) Residents were routinely left in their wheelchairs for several hours at a time.

(b) Confidential Witness #30 frequently found incontinent residents soaked with urine because they had not been checked or changed for hours.

(c) Confidential Witness #30 spent her day rushing from task to task and rushing through her tasks. The residents did not get the attention they needed and deserved. For example, if a resident needed something small that could wait, like a cup of coffee, she would never have time to get back to that request. She only had time to respond to the most urgent requests.

(d) CNAs regularly complained to management about understaffing, but management never seemed to make changes.

153. Nursing home inspectors have repeatedly found that Sunshine Haven violated state and federal nursing home regulations by failing to provide Basic Care over the Relevant Period. For example:

(a) On November 5, 2009, inspectors found that Sunshine Haven failed to arrange dental appointments for two residents pursuant to a doctor's orders. One resident had broken teeth and the other had "poor dental condition" with "red/swollen gums," suggesting inadequate dental hygiene and care was being provided at the facility.

(b) On December 12, 2012, inspectors found that Sunshine Haven failed to prevent the neglect of a resident who was found crawling naked on the floor one morning. The facility did not immediately seek medical treatment for her,

though the resident's daughter observed later that day that her arm looked broken and bruised; she was subsequently taken to the hospital and diagnosed with a fractured left arm and ribs. During an interview with surveyors, the director of nursing said she did not understand why no one had noticed the broken arm, given that the resident was supposed to be changed at least every two hours. On the same date, the facility received another deficiency for failing to prevent the development of two pressure sores on another resident. That resident was admitted to the facility without any pressure sores, and on the date of the survey – only a month later – had developed two Stage III pressure sores[24] on the right and left buttocks.

V. DEFENDANTS' FALSE CLAIMS FOR MEDICAID PAYMENTS

154. Medicaid is a joint federal-state program under Title XIX of the Social Security Act. The Medical Assistance Division of the Human Services Department ("HSD") administers the Medicaid program in New Mexico. Through Medicaid, New Mexico and the United States pay for nursing facilities for the disabled and those who meet certain income requirements.

155. Defendants chose to participate in the New Mexico Medicaid program to receive payments for care provided to dependent, disabled, and vulnerable residents of their nursing

[24] A Stage III pressure sore is one that has advanced to the point where skin in the affected area is eroded and subcutaneous fat may be visible, but bone, muscle and tendons are not exposed.

facilities. Since 2008, on average, at least 65% of the Defendant Nursing Facilities' resident population was covered by Medicaid.

A. Federal Requirements

156. As part of the Omnibus Reconciliation Act of 1987, Congress enacted the Nursing Home Reform Act, 42 U.S.C. §§ 1395i-3, 1396r ("NHRA"), which establishes minimum standards for nursing facilities participating in, and seeking funding from, the Medicaid and Medicare programs.

157. The Defendant Nursing Facilities are nursing facilities as defined by the NHRA. 42 U.S.C. § 1396r(a).

158. The NHRA mandates that nursing facilities "operate and provide services in compliance with all applicable Federal, State, and local laws and regulations . . . and with accepted professional standards and principles which apply to professionals providing services in such a facility." 42 U.S.C. § 1396r(d)(4)(A). Likewise, 42 U.S.C. § 1320c-5(a)(2) requires all health care providers, including nursing facilities, to ensure that all services for which they submit claims for Medicaid payment are "of a quality which meets professionally recognized standards of health care."

159. Under the NHRA, nursing home operators that participate in Medicaid or Medicare must conduct comprehensive clinical assessments of each nursing home resident's needs, which are reflected in the MDS. 42 C.F.R. § 483.20(b)-(c). The MDS documents and scores each resident's level of impairment or infirmity, forms the foundation of the resident's care plan, and defines the day-to-day services the resident needs. 42 C.F.R. § 483.20(b). Given

the MDS's importance to residents' assessment and care, various regulations ensure that an MDS accurately reflects each resident's status and needs – requiring that the MDS be signed and certified, and imposing penalties for falsifying an MDS. 42 C.F.R. § 483.20(g)-(k).

160. As explained in Section III above, the MDS allows the nursing home to catalog exactly which Basic Care services are required by its residents with great specificity, as well as the number of staff members who assist when assistance is needed.

161. Federal regulations require that all nursing homes have sufficient numbers of nursing staff, including CNAs, "to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care." 42 C.F.R. § 483.30(a). Further, every nursing home, as a condition of payment and participation in the Medicaid and Medicare program, must:

> provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) . . . licensed nurses; and (ii) [o]ther nursing personnel.

42 C.F.R. § 483.30(a)(1). "Other nursing personnel" includes CNAs, which are specifically included as "nurse aids" in 42 C.F.R. § 483.75(e)(1).

162. Thus, federal regulations make clear that: (a) a nursing home must provide sufficient nursing staff – including CNAs – to meet the needs documented in the MDS and care plans of its residents, and (b) the necessary level of staffing, therefore, depends upon the specific needs of and level of care required by the home's resident population.

B. State Requirements

163. Nursing homes that participate in New Mexico's Medicaid program are required to comply "with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the [Program Participation Agreement]." § 8.312.2.11 NMAC. Such compliance is not simply a condition of participation in the program, but also a condition of Medicaid payments. State regulations expressly condition Medicaid payments on nursing facilities' compliance with conditions of participation set out in the regulations, providing, "To be eligible for reimbursement, a provider must adhere to the provisions of the [Provider Participation Agreement] and all applicable statutes, regulations, and executive orders." § 8.312.2.10 NMAC.

164. All New Mexico nursing homes, whether or not they participate in Medicaid or Medicare, must be licensed as nursing homes under § 24-1-5(A) NMSA 1978 and are subject to all provisions of § 7.9.2 NMAC, which establishes minimum standards for nursing homes in New Mexico. § 7.9.2.2(B) NMAC. The Defendant Nursing Facilities are licensed as "nursing homes" under § 24-1-5(A) NMSA 1978.

165. State regulations require that within two weeks following admission, a written plan of care for the resident shall be developed based on the resident's history and assessments; that plan must be reviewed, evaluated, and updated quarterly or more often as needed, and substantially followed. § 7.9.2.47 NMAC. State regulations also separately provide that nursing facilities participating in the Medicaid and Medicare programs must complete an MDS for each resident. § 8.312.2.19 NMAC.

166. State regulations mandate that "[s]ervices for residents shall be provided on a continuing twenty-four (24) hour basis and shall maintain or improve physical, mental, and psychosocial well-being under plan of care developed by a physician or other licensed health professional and shall be reviewed and revised based on assessment." § 7.9.2.2(A) NMAC.

167. Specifically, state regulations provide, "each resident shall receive care based upon individual needs," including, among other things, assistance with proper hygiene; prevention of pressure sores; assistance with food or fluid intake; and other care to maintain current functioning and improve each resident's ability to carry out activities of daily living. § 7.9.2.42 NMAC.

168. The staffing levels needed to fulfill this mandate depend upon the specific care needs of the residents in the facility. State regulations require "[t]he assignment of the nursing personnel . . . shall be sufficient to meet each resident's needs and implement each resident's comprehensive care plan." § 7.9.2.51(F) NMAC.

169. Nursing facilities that participate in the Medicaid program also are additionally required to provide "[p]ersonal assistance services on a 24 hours a day, seven days a week basis. Personal assistance services are those services, other than professional nursing services, that are provided to [a resident] who, because of age, infirmity, physical or behavioral health limitations, requires assistance to accomplish the activities of daily living." § 8.312.2.12(D) NMAC. These personal assistance services include Basic Care.

170. Medicaid providers are only permitted to furnish services to Medicaid patients, and receive payment for furnishing those services, after executing a written Provider

Participation Agreement ("PPA") with the New Mexico Medicaid program. The PPA conditions payment of Medicaid claims on the prospective provider's certification that the provider will "abide by and be held to" all state and federal laws and regulations, including all applicable laws, regulations, and Medicaid program instructions. The certification is made under penalty of perjury.

171. New Mexico Medicaid providers submit claims to the State electronically through the Electronic Data Interchange ("EDI") program. Providers sign EDI Provider Participation Agreements in which they agreed to "comply with all applicable provisions of the Social Security Act, as amended; federal or state laws, regulations, and guidelines; and HSD rules." Providers also agree that they "will request payment only for those services . . . rendered personally by the Provider or rendered by qualified personnel under the Provider's direct and personal supervision."

172. On the MDS that is submitted for each Medicaid recipient quarterly, the provider is required to certify the accuracy and truth of the MDS assessment as a condition of payment:

> I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated the collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

State regulations and the Provider Participation Agreement make the submission of accurate MDSs a condition of payment for the State's Medicaid program.

173. The MDS moreover, is not simply a forward-looking document that describes projected needs. It also reflects the care that has been provided to date. The evaluation of the resident's needs for ADLs is based upon observations of the assistance provided in the preceding 7 days.

C. The False Claims

174. Under the New Mexico Medicaid program, providers are paid for services on the basis of pre-determined, fixed amounts. The State pays a facility set rates – called "per diem rates" – for each day that the facility provides care to a Medicaid resident.[25] The per diem rates include a resident's lodging, meals, and nursing care, but do not include additional, discrete services, like physical therapy, that the facility also may provide. The per diem rates are calculated every three years using the costs reported by the homes annually, which include: labor, rent, equipment, food, supplies, administration, and certain other expenses. §8.312.3.11(G) NMAC.

175. The Defendant Nursing Facilities signed Provider Participation Agreements.

176. The Defendant Nursing Facilities submitted claims for payment of per diem rates for each Medicaid recipient, generally on a monthly basis, over the Relevant Period. Each time the Defendants submitted a claim form, the UB-04, they certified that the "billing information

[25] There are two per diem rates: High NF (for residents who require substantial skilled nursing) and Low NF (for residents whose greatest needs involve unskilled nursing).

. . . [was] true, accurate and complete" and that they had not "knowingly . . . disregard[ed] or misrepresent[ed] or conceal[ed] material facts."

177. The Defendant Nursing Facilities submitted MDS forms, on a quarterly basis, in which they certified both the level of care needed by each resident and the level of care that they were providing to each resident.

178. Defendants' claims for per diem payments constitute false claims because:

(a) As set forth in Section IV above, the Defendant Nursing Facilities did not maintain staffing levels sufficient to provide the Basic Care required by their residents. The extent of omitted services was so great as to render the Basic Care unreasonable in quantity, unreasonable in duration, and professionally unacceptable. These omissions may be quantified and expressed as a percentage of care omitted on a daily basis. In submitting claims for payment of full per diem rates, when an unreasonable and measurable percentage of the services covered by the per diem rate were not rendered by them or under their supervision, the Defendant Nursing Facilities submitted false claims.

(b) Significant omissions of Basic Care did not promote the maintenance or enhancement of the quality of life of the residents at the Defendant Nursing Facilities. Indeed, these omissions compromised the quality of life of residents in terms of health, safety and dignity. As discussed in Section IV of this Complaint, significant percentages of Basic Care were not, and could not have been, provided to residents at the Defendant Nursing Facilities given the

substantial understaffing at these facilities. Because of inadequate staffing levels, residents were left for long periods in their own urine and waste, were not re-positioned and bathed, were deprived of food and liquids, and suffered falls when left without assistance to navigate their rooms and bathrooms. As such, the amount of the Basic Care actually provided by the Defendant Nursing Facilities failed to meet professionally recognized standards of health care and was so deficient as to be worthless. In submitting claims for payment of per diem rates when the services provided were worthless, the Defendant Nursing Facilities submitted false claims.

(c) The certifications set forth in the MDSs submitted to the government were false because the Defendant Nursing Facilities lacked sufficient staff to deliver the care described as necessary and appropriate on the MDS submissions, even as the Defendant Nursing Facilities certified that the care had been and would be provided and that the MDS would serve as a basis for reimbursements. The claims for payment of per diem rates predicated upon the Defendant Nursing Facilities' certification of MDSs as accurate were false.

(d) The certifications regarding statutory and regulatory compliance made in the Defendant Nursing Facilities' Provider Participation Agreements were false because the facilities did not comply with all state and federal regulations, including § 7.9.2.51 NMAC and § 8.313.2.12 NMAC. Because the Defendant Nursing Facilities did not maintain staffing levels sufficient to meet the needs

of their residents and omitted significant percentages of the Basic Care services in violation of state and federal regulations, the claims for payment of per diem rates predicated on their certification of statutory and regulatory compliance were false.

179. The federal and state regulations relating to quality of care discussed above are so integral to the services bargained for by New Mexico as to constitute conditions material to the New Mexico Medicaid program's payment for these services.

VI. DEFENDANTS' DECEPTIVE STATEMENTS TO PRIVATE PAYORS AND UNCONSCIONABLE CONDUCT

180. The Defendant Nursing Facilities also provided care to many residents who paid for all or part of their care out of pocket, through private insurance, or through the assignment of their social security benefits.

181. During the time period in which Cathedral Rock owned the Defendant Nursing Facilities, other than Sagecrest, residents at the Defendant Nursing Facilities who paid for their care with private funds were charged between $119.38 and $244.38 per day. This adds up to millions of dollars in revenue for the Defendant Nursing Facilities paid from consumers' private funds:

Defendant Nursing Facility	**Total Revenue From Private Pay Residents – 4/1/2007 – 10/31/2012**
Santa Fe Care Center	$4,088,039
Casa Real	$3,164,950
Espanola Valley Nursing and Rehabilitation	$2,551,202
Bloomfield Nursing and Rehabilitation	$656,470
Red Rocks Care Center	$705,000
Sunshine Haven at Lordsburg	$811,444[26]

182. During the time period in which Preferred owned the Defendant Nursing Facilities, residents at the Defendant Nursing Facilities who paid for their care with private funds were charged between $175 and $215 per day. This adds up to millions of dollars in revenue for the Defendant Nursing Facilities paid from consumers' private funds:

[26] Data from 2012 was not available for Sunshine Haven at Lordsburg, so this figure does not include revenue from 2012.

Defendant Nursing Facility	**Total Revenue From Private Pay Residents – 11/1/2012 – 12/31/2013**[27]
Santa Fe Care Center	$756,372
Casa Real	$1,057,899
Sagecrest Nursing and Rehabilitation	$609,976
Espanola Valley Nursing and Rehabilitation	$359,022
Bloomfield Nursing and Rehabilitation	$96,950
Red Rocks Care Center	$75,850
Sunshine Haven at Lordsburg	$369,775

183. On information and belief, each of the Defendant Nursing Facilities made statements to New Mexico consumers regarding the services provided and quality of care at their facilities that may have, tended to, or did deceive or mislead New Mexico consumers.

184. For example, the Defendant Nursing Facilities were required by federal and state regulations to devise a care plan for each resident based upon the needs of the resident identified in his or her MDS. On information and belief, the Defendant Nursing Facilities communicated these care plans to residents and their families, which may have, tended to, or did lead them to

[27] The total provided here for Sagecrest reflects total revenue from private pay residents from August 1, 2011 through December 31, 2013, because Preferred acquired this facility earlier than the other Defendant Nursing Facilities.

believe that the Facilities would deliver – and had the staff and resources to deliver – the care outlined in the plans. These representations were false or misleading.

185. The Defendant Nursing Facilities billed residents, their families, and insurers. Included in these bills, on information and belief, was a per diem charge – the daily rate for a resident's stay in the facility, which covered Basic Care. By charging the full per diem rate, even though the facilities lacked the staff to deliver the Basic Care needed, the facilities may have, tended to, or did deceive the recipients of these bills and led them to believe that the per diem charges assessed were based on and commensurate with the care provided.

186. Additionally, the Defendant Nursing Facilities make misrepresentations regarding the care they provide in marketing materials directed to consumers. For example:

(a) Bloomfield, Casa Real, Red Rocks, Sagecrest, and Sunshine Haven, five of the Defendant Nursing Facilities, each advertise on their websites to prospective residents that "[o]nce you arrive, a multidisciplinary team will be there to meet your every need."[28]

(b) Bloomfield, Casa Real, Red Rocks, Sagecrest, and Sunshine Haven, five of the Defendant Nursing Facilities, have language on their websites promising that at each of their nursing facilities, consumers "will find Respite Care which allows

[28] Welcome to Bloomfield Nursing and Rehabilitation (Dec. 1, 2014), http://www.bloomfieldnursing.com/; Welcome to CASA REAL (Dec. 1, 2014), http://www.casarealnursing.com/; Welcome to Red Rocks Care Center! (Dec. 1, 2014), www.redrockscarecenter.com; Welcome to Sagecrest Nursing & Rehabilitation Center (Dec. 1, 2014), www.sagecrestrehabilitation.com; Welcome to Sunshine Haven at Lordsburg! (Dec. 1, 2014), http://www.sunshinehavennursing.com/.

families time away without worry when [their] loved one needs 24 hour supervision."[29]

(c) On information and belief, each of the Defendant Nursing Facilities makes similar statements in marketing materials to consumers that may, tend to, or do deceive consumers. Uniform language appears on the websites of the Defendant Nursing Facilities, indicating that these websites – and, likely, other marketing materials – are authored and distributed by the parent entities of the Defendant Nursing Facilities. On information and belief, these types of misrepresentations to consumers are made uniformly across the Preferred Care chain of nursing homes in New Mexico.

187. The Defendant Nursing Facilities' trade practices also are, and have been throughout the Relevant Period, unconscionable, because the Defendant Nursing Facilities take advantage of the vulnerability and incapacity of their residents. Nursing home residents constitute a vulnerable population: they are elderly, ill, infirm, and often deteriorating. These residents often face the double burden of dependency and isolation. The Defendant Nursing Facilities accept these vulnerable residents for admission, conduct MDS assessments of each resident, and then knowingly fail to provide sufficient levels of staffing to provide the care

[29] About Us (Dec. 1, 2014), http://www.bloomfieldnursing.com/about-us/ ; Nursing Services (Oct. 16, 2014), http://casareal.newlifestylesforms.com/nursing-services/; Nursing Services (Dec. 1, 2014), http://www.redrockscarecenter.com/nursing-services/; About Us (Dec. 1, 2014), http://www.sagecrestrehabilitation.com/site/371/about_us.aspx; About Us (Dec. 1, 2014), http://www.sunshinehavennursing.com/about-sunshine-haven/.

required. Many nursing home residents require assistance with most or all of the ADLs. Once admitted, they lack the autonomy or ability to seek alternative care. Residents who are unable to get in and out of bed on their own, for example, have few options when the nursing home at which they are living fails to provide the care they need. Thus, residents cannot "vote with their feet," as consumers might in other contexts. Some residents are not even able to voice a complaint.

188. The Defendant Nursing Facilities also engage in, and have engaged in throughout the Relevant Period, substantively unconscionable trade practices by providing care that is so inadequate to meet the needs of residents that it results in a gross disparity between the value received by the residents for the services provided and the cost of the services. The Defendant Nursing Facilities have charged private pay residents, over the Relevant Period, rates that varied between $119.38 (at Espanola Valley in 2008) and $244.38 (at Red Rocks Care Center in 2009) per day for residence in a semi-private room, meals, and care. However, as alleged in greater detail herein, a significant percentage of the Basic Care that is needed by, promised to, and paid for by these residents is not provided, due to chronic understaffing, resulting in a gross disparity between the value they receive and the amount they pay.

VII. DEFENDANTS' KNOWING FAILURE TO PROVIDE ADEQUATE CNA STAFFING

189. Defendants knew that they were not meeting, and did not have sufficient CNA staff to meet, the Basic Care needs of their residents as mandated by state and federal laws and regulations. Defendants also knew that the services for which they billed Medicaid were not

rendered, not rendered as claimed, not compliant with law, or were so inadequate, deficient, or substandard as to be essentially worthless.

190. In 2004, the Institute of Medicine published guidelines for nursing home staffing. These guidelines were based upon computer simulations of nursing home operations that are similar to the simulation used by the OAG here. At a minimum, the Institute of Medicine recommends staffing at a level sufficient to provide 2.8 hours of CNA care per patient day.

191. Defendants had knowledge of both the Basic Care needs of their residents and of the staffing levels at the Defendant Nursing Facilities. Through the process of regularly completing the MDS forms for every resident, the Defendant Nursing Facilities assessed each resident and determined precisely what level of care was needed to adequately assist him or her with ADLs. The Defendant Nursing Facilities closely monitored their staffing levels, for regulatory and business purposes, at all times.

192. Defendants received complaints about omissions of Basic Care and understaffing from residents and their families, as described in Section IV above.

193. The Defendant Nursing Facilities received complaints about understaffing from their staff, as described in Section IV above.

194. For conduct occurring during the Relevant Period, the Defendant Nursing Facilities received repeated deficiencies related to failures of Basic Care in DOH surveys. They received these deficiencies despite, on information and belief, taking steps to increase staffing and prepare staff for surveys ahead of time – steps that would lead surveyors to believe levels of care provided were higher than they actually were during non-survey times.

195. For conduct occurring during the Relevant Period, former residents and their family members filed dozens of lawsuits against Defendants alleging that the Defendant Nursing Facilities failed to provide residents with proper care, resulting in serious injury and death.

196. On information and belief, Cathedral Rock and Preferred, as managers, were aware of these complaints, lawsuits, and deficiencies.

197. On information and belief, Cathedral Rock and Preferred, as managers, set or approved and closely watched labor costs and hours at the Defendant Nursing Facilities.

198. On information and belief, neither Cathedral Rock nor Preferred increased staffing or otherwise addressed the deficiencies in Basic Care at the Defendant Nursing Facilities, despite the fact that they were, or should have been, aware of these deficiencies and had the power, as managers of the Defendant Nursing Facilities, to correct them.

VIII. CATHEDRAL ROCK CORPORATION'S LIABILITY

199. Cathedral Rock Corporation, Cathedral Rock Management, LP, Cathedral Rock Management I, Inc., and Cathedral Rock Investments, Inc. (collectively "Cathedral Rock Parent Entities") and C. Kent Harrington are responsible for the actions and omissions of the Defendant Nursing Facilities from at least the beginning of the Relevant Period until on or around November 1, 2012 (hereafter referred to as the "Relevant Cathedral Rock Ownership Period"), when they sold the Defendant Nursing Facilities to Preferred Care, Inc.

200. Throughout the Relevant Cathedral Rock Ownership Period, C. Kent Harrington was employed as the president and chief executive officer of Cathedral Rock Corporation.

201. Throughout the Relevant Cathedral Rock Ownership Period, C. Kent Harrington was the majority stockholder in Cathedral Rock Corporation and owned approximately sixty-five percent (65%) of Cathedral Rock Corporation.

202. On information and belief, throughout the Relevant Cathedral Rock Ownership Period, C. Kent Harrington served as the president of Cathedral Rock Management I, Inc. as well as the president of each of the Defendant Nursing Facilities.

203. On information and belief, through the Relevant Cathedral Rock Ownership Period, Cathedral Rock Corporation, Cathedral Rock Management I, Inc., Cathedral Rock Investments, Inc., and the Defendant Nursing Facilities operated their financial affairs on a consolidated basis, including but not limited to, filing tax returns on a consolidated basis.

204. As the owners and operators of the Defendant Nursing Facilities, the Cathedral Rock Parent Entities and C. Kent Harrington exercised operational control over the activities of the Defendant Nursing Facilities. On information and belief, this control extended to day-to-day operational matters at the Defendant Nursing Facilities including: setting staffing levels and budgets for the facilities, issuing policies and procedures for key aspects of the facility operations, and preparing annual cost reports for HSD.

205. The profits of the Defendant Nursing Facilities were passed to the Cathedral Rock Parent Entities as several types of expenses: management fees or central office costs and operations support provided by related parties charged to the Defendant Nursing Facilities. Additionally, revenue of the Defendant Nursing Facilities flowed to the Cathedral Rock Parent Entities through payments for therapeutic services provided by related parties.

206. Nursing facilities are required to report the compensation received by their owners on their annual cost reports submitted to the State. While the owners of the Cathedral Rock Parent entities were not compensated directly by the nursing facilities, the Cathedral Rock Parent Entities charged these management fees and home office costs to the individual nursing facilities and then paid an unknown amount in compensation or profit to the owners at the corporate level. On information and belief, this system allowed the owners of the Cathedral Rock Parent Entities, including C. Kent Harrington, to derive profits from the individual nursing homes without being required to disclose to the State how much they were being paid.

207. The Defendant Nursing Facilities reported the following management fees and central office costs paid to related parties during the Relevant Cathedral Rock Ownership Period:

Nursing Facility	**Year**	**Management Fees Paid to Related Parties**
Casa Real	2007 (4/1/2007 – 12/31/2007)	$401,893
	2008	$599,910
	2009	$581,274
	2010	$411,188
	2011	$440,565
	2012 (through 10/31/12)	$470,541
	TOTAL	$2,905,371
Red Rocks Care Center	2007 (4/1/2007 – 12/31/2007)	$261,745
	2008	$401,566
	2009	$453,207
	2010	$291,108

	2011	$298,361
	2012 (through 10/31/12)	$306,958
	TOTAL	$2,012,945
Santa Fe Care Center	2007 (4/1/2007 – 12/31/2007)	$406,164
	2008	$515,264
	2009	$500,700
	2010	$368,952
	2011	$372,700
	2012 (through 10/31/12)	$398,209
	TOTAL	$2,561,989
Sunshine Haven at Lordsburg	2007 (4/1/2007 – 12/31/2007)	$165,560
	2008	$242,840
	2009	$239,228
	2010	$137,496
	2011	$173,256
	2012 (through 10/31/12)	$188,048
	TOTAL	$1,146,428
Espanola Valley Nursing and Rehabilitation	2007 (4/1/2007 – 12/31/2007)	$336,374
	2008	$488,055
	2009	$428,103
	2010	$302,101
	2011	$321,263
	2012 (through 10/31/12)	$348,671
	TOTAL	$2,224,567

Bloomfield Nursing and Rehabilitation	2007 (4/1/2007 – 12/31/2007)	$264,034
	2008	$393,287
	2009	$389,498
	2010	$289,206
	2011	$284,100
	2012 (through 10/31/12)	$305,732
	TOTAL	$1,925,857

208. On information and belief, the Cathedral Rock Parent Entities also received monies from the Defendant Nursing Facilities through transactions between the Defendant Nursing Facilities and other entities within the corporate family (called "related party transactions"). Cost report data show that during the relevant period, significant sums of money were paid by the Defendant Nursing Facilities to related parties for therapy services provided to residents:

Nursing Facility	Year	Therapy Expenses Paid to Related Parties
Casa Real	2010	$641,269
	2011	$802,638
	2012 (through 10/31/12)	$726,026
	TOTAL	$2,169,933
Red Rocks Care Center	2010	$535,805
	2011	$732,585
	2012 (through 10/31/12)	$547,155
	TOTAL	$1,815,545
Santa Fe Care Center	2010	$532,192
	2011	$730,197
	2012 (through 10/31/12)	$621,806
	TOTAL	$1,884,195
Sunshine Haven at Lordsburg	2010	$82,478
	2011	$234,175
	2012 (through 10/31/12)	$220,059
	TOTAL	$536,712
Espanola Valley Nursing and Rehabilitation	2010	$504,579
	2011	$651,096
	2012 (through 10/31/12)	$508,307

	TOTAL	$1,663,982
Bloomfield Nursing and Rehabilitation	2010	$558,980
	2011	$554,193
	2012 (through 10/31/12)	$470,378
	TOTAL	$1,583,551

These cost reports identify Defendant Cathedral Rock Corporation as the related party with which the facilities contracted.

209. On information and belief, the Defendant Nursing Facilities were undercapitalized throughout the Relevant Cathedral Rock Ownership Period, such that each facility did not operate as a freestanding entity. The Defendant Nursing Facilities held substantially less cash and available liquid assets during this time period than were necessary to run the facilities or that were actually available to the Defendant Nursing Facilities through inter-company accounts or transfers within the Cathedral Rock corporate family.

210. On information and belief, the Cathedral Rock Parent Entities caused the transfer of assets out of the Defendant Nursing Facilities during the Relevant Cathedral Rock Ownership Period to pay for corporate expenses that were unrelated to the operations of the individual Defendant Nursing Facilities: payments on loans taken out by the Cathedral Rock Parent Entities and C. Kent Harrington to pay government-imposed penalties related to the operation of Cathedral Rock nursing homes in Missouri.

211. The Cathedral Rock Parent Entities are liable for the acts and omissions of the Defendant Nursing Facilities during their period of ownership under an alter ego or agency theory of liability.

IX. PREFERRED CARE, INC.'S LIABILITY

212. Preferred Care, Inc., Preferred Care Partners Management Group LP, and PCPM GP, LLC (collectively "Preferred Parent Entities") are liable for the actions and omissions of the Defendant Nursing Facilities from in or around July 2011 through the present for Sagecrest, and from in or around November 2012 through the present for the other Defendant Nursing Facilities (hereafter referred to as the "Relevant Preferred Ownership Period").

213. The Preferred Parent Entities have directly or indirectly owned the Defendant Nursing Facilities since in or around November 2012, with the exception of Sagecrest Nursing and Rehabilitation, which they have directly or indirectly owned since in or around July 2011.

214. As the parent companies for the Defendant Nursing Facilities, the Preferred Care Parent Entities exercise operational control over the activities of the Defendant Nursing Facilities. On information and belief, this control extends to day-to-day operational matters at the Defendant Nursing Facilities including: setting or approving staffing levels and budgets for the facilities, drafting marketing materials, issuing policies and procedures for key aspects of the facility operations, and preparing annual cost reports for HSD.

215. On information and belief, the Preferred Parent Entities directed the Defendant Nursing Facilities to maximize revenue and profits at the Defendant Nursing Facilities by increasing resident census, maximizing billings for resident stays, and containing or cutting

costs. During Preferred Care's ownership, the Defendant Nursing Facilities were collecting the highest per diem rate paid by the State for the majority of their Medicaid residents' days.

(a) New Mexico has established two payment categories for Medicaid recipients staying in long-term care nursing facilities: high skilled nursing usage ("High NF") and low skilled nursing usage ("Low NF"). High NF resident days are reimbursed at significantly higher rates than Low NF resident days.

(b) During much of Cathedral Rock's ownership of the Defendant Nursing Facilities (other than Sagecrest), approximately 95% of the Facilities' Medicaid resident days were reimbursed at the Low NF rate; only 5% of the Medicaid days were reimbursed at the High NF rate. By contrast, the percentage of High NF Medicare and private pay days was generally 60% or higher.

(c) Between late 2011 and the end of 2012, when Preferred Care owned and was operating the Defendant Nursing Facilities, the percentage of Medicaid days reimbursed at the High NF rate grew from 5% to more than 60%; at 4 facilities, more than 70% of Medicaid days were reimbursed at the High NF rate. Over the same time period, however, the percentage of Medicare and private pay resident days reimbursed at the High NF rate stayed stable or went down.

(d) This growth in the percentage of High NF Medicaid days was substantial and occurred at the same time, across all of the Cathedral Rock facilities acquired by Preferred. Similar changes occurred at Sagecrest between 2012 and 2013.

Casa Real	**Medicaid**		**Medicare / Private Pay**	
	% High NF	**% Low NF**	**% High NF**	**% Low NF**
2007 *Apr-Dec Only	4.00%	96.00%	54.41%	45.59%
2008	5.40%	94.60%	61.90%	38.10%
2009	1.39%	98.61%	57.27%	42.73%
2010	2.34%	97.66%	66.65%	33.35%
2011	18.11%	81.89%	67.37%	32.63%
2012 *Nov - Dec Preferred	67.33%	32.67%	72.82%	27.18%
2013 *Preferred	60.84%	39.16%	51.29%	48.71%

Red Rocks Care Center	**Medicaid**		**Medicare / Private Pay**	
	% High NF	**% Low NF**	**% High NF**	**% Low NF**
2007 *Apr-Dec Only	4.55%	95.45%	97.52%	2.48%
2008	8.64%	91.36%	75.07%	24.93%
2009	0.73%	99.27%	61.24%	38.76%
2010	2.47%	97.53%	90.39%	9.61%
2011	27.76%	72.24%	90.89%	9.11%

2012 *Nov -Dec Preferred	80.40%	19.60%	87.77%	12.23%
2013 *Preferred	77.52%	22.48%	85.72%	14.28%

Santa Fe Care Center	**Medicaid**		**Medicare / Private Pay**	
	% High NF	**% Low NF**	**% High NF**	**% Low NF**
2007 *Apr-Dec Only	6.33%	93.67%	60.13%	39.87%
2008	4.60%	95.40%	62.46%	37.54%
2009	4.11%	95.89%	47.56%	52.44%
2010	4.54%	95.46%	70.47%	29.53%
2011	23.54%	76.46%	62.09%	37.91%
2012 *Nov - Dec Preferred	73.76%	26.24%	55.62%	44.38%
2013 *Preferred	69.76%	30.24%	52.47%	47.53%

Sagecrest	**Medicaid**		**Medicare / Private Pay**	
	% High NF	**% Low NF**	**% High NF**	**% Low NF**
2007	5.21%	94.79%	65.57%	34.43%
2008	1.61%	98.39%	65.92%	34.08%
2009	1.46%	98.54%	49.40%	50.60%
2010	11.78%	88.22%	51.94%	48.06%
2011 *Aug-Dec Preferred	11.41%	88.59%	52.40%	47.60%

2012 *Preferred	10.51%	89.49%	59.42%	40.58%
2013 *Preferred	63.29%	36.71%	64.42%	35.58%

Bloomfield	**Medicaid**		**Medicare / Private Pay**	
	% High NF	**% Low NF**	**% High NF**	**% Low NF**
2007 *Apr-Dec Only	11.40%	88.60%	90.23%	9.77%
2008	11.57%	88.43%	86.45%	13.55%
2009	8.23%	91.77%	75.85%	24.15%
2010	19.19%	80.81%	78.99%	21.01%
2011	23.84%	76.16%	95.41%	4.59%
2012 *Nov - Dec Preferred	58.81%	41.19%	90.53%	9.47%
2013 *Preferred	54.44%	45.56%	72.95%	27.05%

Espanola	**Medicaid**		**Medicare / Private Pay**	
	% High NF	**% Low NF**	**% High NF**	**% Low NF**
2007 *Apr-Dec Only	1.44%	98.56%	58.08%	41.92%
2008	2.48%	97.52%	65.12%	34.88%
2009	1.36%	98.64%	61.43%	38.57%
2010	6.23%	93.77%	65.02%	34.98%
2011	14.51%	85.49%	69.54%	30.46%

2012 *Nov - Dec Preferred	74.59%	25.41%	69.63%	30.37%
*2013 Preferred	68.55%	31.45%	37.88%	62.12%

Sunshine Haven	**Medicaid**		**Medicare / Private Pay**	
	% High NF	**% Low NF**	**% High NF**	**% Low NF**
2007 *Apr-Dec Only	3.23%	96.77%	57.62%	42.38%
2008	6.74%	93.26%	53.00%	47.00%
2009	3.98%	96.02%	36.27%	63.73%
2010	11.40%	88.60%	23.72%	76.28%
2011	12.94%	87.06%	68.98%	31.02%
2012 *Nov - Dec Preferred	72.28%	27.72%	65.08%	34.92%
2013 *Preferred	73.16%	26.84%	44.81%	55.19%

216. The profits of the Defendant Nursing Facilities have been passed to the Preferred Parent Entities as management fees charged to the Defendant Nursing Facilities. Additionally, revenue of the Defendant Nursing Facilities flowed to the Preferred Parent Entities through payments for therapeutic services provided by related parties.

217. The following management fees were reported by the Defendant Nursing Facilities in their cost reports that were, on information and belief, paid to entities with a direct or indirect ownership relationship to the Preferred Care Parent Entities:

Nursing Facility	Year	Additional Management Fees
Casa Real	2012 (11/1/2012 – 12/31/2012)	$98,132
	2013	$559,163
	TOTAL	$657,295
Red Rocks Care Center	2012 (11/1/2012 – 12/31/2012)	$65,881
	2013	$411,147
	TOTAL	$477,028
Santa Fe Care Center	2012 (11/1/2012 – 12/31/2012)	$89,366
	2013	$536,927
	TOTAL	$626,293
Sagecrest Nursing and Rehabilitation	2011 8/1/2011 – 12/31/2011)	$161,364
	2012	$425,167
	2013	$483,906
	TOTAL	$1,070,437
Sunshine Haven at Lordsburg	2012 (11/1/2012 – 12/31/2012)	$39,214
	2013	$242,226
	TOTAL	$281,440
Espanola Valley Nursing and Rehabilitation	2012 (11/1/2012 – 12/31/2012)	$71,597
	2013	$424,469
	TOTAL	$496,066

Bloomfield Nursing and Rehabilitation	2012 (11/1/2012 – 12/31/2012)	$59,776
	2013	$381,437
	TOTAL	$441,213

218. The Defendant Nursing Facilities also reported the following management fees and central office costs paid to related parties during the Relevant Preferred Ownership Period:

Nursing Facility	**Year**	**Management Fees Paid to Related Parties**
Casa Real	2012 (11/1/2012 – 12/31/2012)	$3,301
	2013	$22,298
	TOTAL	$25,599
Red Rocks Care Center	2012 (11/1/2012 – 12/31/2012)	$2,164
	2013	$15,053
	TOTAL	$17,217
Santa Fe Care Center	2012 (11/1/2012 – 12/31/2012)	$2,869
	2013	$20,229
	TOTAL	$23,098
Sagecrest Nursing and Rehabilitation	2012	$16,715
	2013	$16,052
	TOTAL	$32,767
Sunshine Haven at Lordsburg	2012 (11/1/2012 – 12/31/2012)	$1,450
	2013	$9,452
	TOTAL	$10,902

Espanola Valley Nursing and Rehabilitation	2012 (11/1/2012 – 12/31/2012)	$2,510
	2013	$15,874
	TOTAL	$18,384
Bloomfield Nursing and Rehabilitation	2012 (11/1/2012 – 12/31/2012)	$2,101
	2013	$14,847
	TOTAL	$16,948

219. On information and belief, the Preferred Parent Entities also received monies from the Defendant Nursing Facilities through transactions between the Defendant Nursing Facilities and other entities within the corporate family (called "related party transactions"). Cost report data show that during the relevant period, significant sums of money were paid by the Defendant Nursing Facilities to related parties for therapy services provided to residents:

Nursing Facility	**Year**	**Physical, Occupational, and Speech Therapy Expenses Paid to Related Parties**
Casa Real	2012 (11/1/2012 – 12/31/2012)	$139,565
	2013	$846,952
	TOTAL	$986,517
Red Rocks Care Center	2012 (11/1/2012 – 12/31/2012)	$91,299
	2013	$596,769
	TOTAL	$688,068

Santa Fe Care Center	2012 (11/1/2012 – 12/31/2012)	$121,363
	2013	$764,896
	TOTAL	$886,259
Sagecrest Nursing and Rehabilitation	2011 8/1/2011 – 12/31/2011)	$305,578
	2012	$972,839
	2013	$814,874
	TOTAL	$2,093,291
Sunshine Haven at Lordsburg	2012 (11/1/2012 – 12/31/2012)	$45,784
	2013	$234,787
	TOTAL	$280,571
Espanola Valley Nursing and Rehabilitation	2012 (11/1/2012 – 12/31/2012)	$93,282
	2013	$407,040
	TOTAL	$500,322
Bloomfield Nursing and Rehabilitation	2012 (11/1/2012 – 12/31/2012)	$61,266
	2013	$495,097
	TOTAL	$556,363

220. On information and belief, the Defendant Nursing Facilities are undercapitalized and have been throughout the Relevant Preferred Ownership Period, such that each facility does not operate as a freestanding entity. The Defendant Nursing Facilities hold substantially less cash and available liquid assets than are necessary to run the facilities or that are actually

available to the Defendant Nursing Facilities through inter-company accounts or transfers within the Preferred corporate family.

221. The Preferred Care Parent Entities are liable for the acts and omissions of the Defendant Nursing Facilities under an alter ego or agency theory of liability.

X. CLAIMS FOR RELIEF

A. Count I: Recovery of State Funds under the New Mexico Fraud Against Taxpayers Act, §§ 44-9-1 to 44-9-14 NMSA 1978

222. The State incorporates by reference the allegations contained in paragraphs 1 through 221 of this Complaint.

223. Defendants knowingly presented or caused to be presented to an employee, officer or agent of the State of New Mexico or to a contractor, grantee or other recipient of State funds, false or fraudulent claims for payment or approval by Medicaid in violation of the Fraud Against Taxpayers Act, § 44-9-3 NMSA 1978.

224. Defendants submitted claims to Medicaid even though they knew they failed to comply with State and federal laws and regulations material to payment requiring that skilled nursing facilities meet, and have sufficient nursing staff to meet, their residents' needs.

225. Defendants submitted claims for services that they knew were not rendered, not rendered as claimed, or were so deficient, inadequate, and/or substandard as to be worthless.

226. Pursuant to § 44-9-3 NMSA 1978, the State of New Mexico is entitled to damages in the amount of up to three times the amount of excess payments; a civil penalty of between $5,000 and $10,000 for each violation; payment of reasonable attorneys' fees, including

the fees of the Attorney General; and payment of the costs of the civil action brought to recover damages or penalties.

B. Count II: Recovery of Excess Medicaid Payments under the New Mexico Medicaid Fraud Act, §§ 30-44-1 to 30-44-8 NMSA 1978

227. The State incorporates by reference the allegations contained in paragraphs 1 through 221 of this Complaint.

228. The Defendant Nursing Facilities knowingly provided, with intent that a claim be relied upon for the expenditure of public money, care and services that were substantially inadequate when compared to generally recognized standards within the discipline or industry. § 30-44-7(A)(2)(b) NMSA 1978.

229. The Defendant Nursing Facilities presented or caused to be presented for allowance or payment with intent that a claim be relied upon for the expenditure of public money, false and/or fraudulent claims for furnishing care and services. § 30-44-7(A)(3) NMSA 1978.

230. The Defendants executed and conspired to execute a plan or action to defraud the New Mexico Medicaid program in connection with the delivery of or payment for health care benefits. § 30-44-7(A)(4)(a) NMSA 1978.

231. Pursuant to § 30-44-8 NMSA 1978, the State of New Mexico is entitled to a civil penalty in the amount of up to three times the amount of excess payments; a payment of interest on the amount of the excess payments at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to

the state; a civil penalty of up to $10,000 for each false or fraudulent claim submitted or representation made for providing treatment, services, or goods; and payment of legal fees and costs of the investigation and enforcement of the State's civil remedies.

C. Count III: Violations of the New Mexico Unfair Practices Act, §§ 57-12-1 to 57-12-26 NMSA 1978

232. The State incorporates by reference the allegations contained in paragraphs 1 through 221 of this Complaint.

233. The Defendant Nursing Facilities knowingly made representations to New Mexico consumers that they would provide the care required by their residents, which may have, tended to, or did deceive consumers in violation of the UPA, because the Defendant Nursing Facilities failed to provide a significant percentage of the care required by their residents. *See* § 57-12-2(D) NMSA 1978.

234. These false or misleading representations were made in connection with: care plans shared with residents that outlined the care that the Facilities promised to provide; billing statements that included a per diem charge leading recipients to believe that all services had been provided, and; the marketing and sale of skilled nursing services on Defendant Nursing Facilities' websites to New Mexico consumers who paid for skilled nursing care using private funds and, on information and belief, in their marketing and admissions materials, in the regular course of the Defendant Nursing Facilities' business.

235. These false or misleading representations were of the type that may, tend to, or do mislead New Mexico consumers and were particularly misleading to the elderly and infirm residents and their families, who often faced an urgent need for skilled long-term care.

236. The Defendant Nursing Facilities engaged in unconscionable trade practices in violation of the UPA, because they took advantage of the lack of knowledge, ability, experience, or capacity of New Mexico consumers to a grossly unfair degree. *See* § 57-12-2(E)(1) NMSA 1978.

237. The Defendant Nursing facilities engaged in unconscionable trade practices in violation of the UPA, because there was a gross disparity between the value of the Basic Care provided at the Defendant Nursing Facilities and the cost that the Defendant Nursing Facilities charged to New Mexico consumers. *See* § 57-12-2(E)(2) NMSA 1978.

238. The UPA empowers the Court to impose a civil penalty not exceeding $5,000 for each willful violation of the Act. The Defendants' violations of the UPA were willful, and the State therefore asks that the Court assess a civil penalty for each violation of the Act.

239. The State also seeks injunctive relief and restitution, as authorized under § 57-12-8 NMSA 1978, as a remedy for the violations of the UPA alleged herein, including disgorgement of the amount of unjust enrichment derived from Defendants' unlawful and unconscionable trade practices.

D. Count IV: Breach of Contract

240. The State incorporates by reference the allegations contained in paragraphs 1 through 221 of this Complaint.

241. The Defendant Nursing Facilities agreed to provide Medicaid-funded services to Medicaid-eligible New Mexicans in accordance with all applicable state and federal laws and regulations, and the regulations and standards of the New Mexico Medicaid Program. The Defendant Nursing Facilities, at all times material hereto, breached their Provider Participation Agreements by submitting billings for care not rendered, or for care rendered in a manner that was substantially inadequate when compared to generally recognized and legally mandated standards within the discipline or industry.

242. The New Mexico Medicaid program, at all times material hereto, has paid to the Defendant Nursing Facilities Medicaid program funds in reliance upon billings, supported by resident assessments or MDSs submitted by the Defendant Nursing Facilities. As a direct and proximate result of the Defendants' submission of billings for services not rendered, or rendered in a manner that was substantially inadequate when compared to generally recognized and legally mandated professional standards within the discipline or industry, the State has been damaged by the Defendant Nursing Facilities' breach of contract in an amount to be proven at trial.

243. The State is entitled to recover the value of all contracted services not performed, or improperly performed, in an amount to be proven at trial, together with costs of suit, attorneys' fees, interest, and such further relief as the Court deems proper.

E. Count V: Unjust Enrichment

244. The State incorporates by reference the allegations included in paragraphs 1 through 221 of this Complaint.

245. The Cathedral Rock Parent Entities and C. Kent Harrington were unjustly enriched through the actions of each of the Defendant Nursing Facilities, other than Sagecrest Nursing and Rehabilitation Center, throughout the Relevant Cathedral Rock Ownership Period. The Defendant Nursing Facilities, other than Sagecrest Nursing and Rehabilitation Center, submitted billings to the New Mexico Medicaid program for care not rendered or for care rendered in a manner that was substantially inadequate when compared to generally recognized and legally mandated standards within the discipline or industry. On information and belief, these nursing facilities acted at the direction of and under the control of the Cathedral Rock Parent Entities and C. Kent Harrington, and the profits wrongfully attained, at the State's expense, were transferred to Cathedral Rock and to C. Kent Harrington.

246. The Preferred Parent Entities and Thomas Scott were unjustly enriched through the Defendant Nursing Facilities' practices throughout the Relevant Preferred Ownership Period. The Defendant Nursing Facilities submitted billings to the New Mexico Medicaid program for care not rendered or for care rendered in a manner that was substantially inadequate when compared to generally recognized and legally mandated standards within the discipline or industry. On information and belief, these nursing facilities acted at the direction of and under the control of the Preferred Parent Entities and Thomas Scott, and the profits wrongfully

attained, at the State's expense, were transferred to the Preferred Parent Entities and Thomas Scott.

247. Defendants Cathedral Rock Parent Entities, C. Kent Harrington, Preferred Parent Entities, and Thomas Scott have been unjustly enriched at the expense of the New Mexico Medicaid program, and the State. This Court should find that Defendants Cathedral Rock Parent Entities, C. Kent Harrington, Preferred Parent Entities, and Thomas Scott have been unjustifiably enriched and order them to disgorge all monies received as a result of their unlawful actions.

248. Trial by Jury is demanded.

WHEREFORE, the State respectfully requests that the Court enter an order granting permanent injunctive relief prohibiting Defendants from engaging in the deceptive and unlawful conduct described herein, and enter judgment against the Defendants for the services not performed or improperly performed in an amount to be proven at trial, civil penalties, costs of suit, attorneys' fees, interest, and such other relief as the Court deems proper.

Dated: April 1, 2015

Respectfully submitted,

HECTOR H. BALDERAS
ATTORNEY GENERAL

By: /s/ Patricia Padrino Tucker

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