SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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

Petitioner,

Index No. _____/22

VERIFIED PETITION

- against -

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

Respondents.

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Petitioner, the People of the State of New York, by their Attorney General Letitia James ("Attorney General" or "Petitioner"), respectfully submits:

I. PRELIMINARY STATEMENT

1. Petitioner brings this Special Proceeding pursuant to Executive Law § 63(12) to expose the repeated and persistent fraud and illegality by Respondents Fulton Commons Care Center, Inc. ("Fulton Commons"), Moshe Kalter ("Kalter"), Aaron Fogel ("Fogel"), Frady Kalter, Esther Fogel, Mindy Steger, Sheindy Saffer, Chana Kanarek, Dovid Kalter, Yitzchok Kalter, Aryeh Kalter, Sheva Treff, Chaya Lieberman a/k/a Sara Lieberman, The New Fulton Commons Company LLC ("New Fulton"), Fulton Commons Realty Co., L.P. ("Fulton Realty LP"), Fulton

Commons Realty Co., Inc. ("Fulton Realty Inc."), The New Bridge View Company LLC ("New Bridge View"), Steven Weiss ("Weiss"), and Cathie Doyle ("Doyle"), the persons who control and/or exploit Fulton Commons, a 280-bed nursing home located at 60 Merrick Avenue in East Meadow, New York, and to bring transparency to the suffering their conduct has imposed upon the vulnerable, frail, elderly, and disabled individuals who call Fulton Commons their home. Most of the residents of Fulton Commons are supported by taxpayer-funded healthcare insurance programs, such as the New York State Medical Assistance Program ("Medicaid") and Medicare.

2. Petitioner seeks injunctive relief against the owners of Fulton Commons: Respondents Kalter, Fogel, Frady Kalter, Esther Fogel, Mindy Steger, Sheindy Saffer, Chana Kanarek, Dovid Kalter, Yitzchok Kalter, Aryeh Kalter, Sheva Treff, Chaya Lieberman a/k/a Sara Lieberman (collectively referred to hereinafter as "Respondent-owners"), its Comptroller, Respondent Weiss, its former administrator, Respondent Doyle, and related corporate vehicles Respondents Fulton Commons, New Fulton, Fulton Realty LP, Fulton Realty Inc., and New Bridge View (collectively referred to hereinafter as the "Corporate Respondents" or the "Fulton Commons Enterprise") to bring an end to the irreparable harm their schemes have already brought upon the residents of Fulton Commons through repeated and persistent illegality from at least as early as January 2018 through the present. This illegality includes, but is not limited to: (1) neglect, abuse, and mistreatment of Fulton Commons' residents who have suffered under Respondents Fulton Commons and Kalter—Fulton Commons' owner, operator, and governing body—and their agents, Respondents Weiss and Doyle; (2) chronic inadequate nursing staffing, and woefully deficient care, in violation of and with reckless disregard for the multitude of New York State and federal laws, rules, and regulations designed to protect the health, well-being, safety, and dignity of nursing home residents; and (3) flagrant violations of the laws that limit financial withdrawals

from nursing homes and require that Medicaid and Medicare payments be for actually-rendered services to residents.

3. The egregious failures in resident care that will be described herein are often the direct result of insufficient nursing staffing and supervision and are directly traceable to Respondents' repeated and persistent fraud and illegality in operating Fulton Commons with disregard for their legal duties, including: (1) Respondent Doyle and Fulton Commons' other high managerial agents' illegal actions to conceal pervasive resident neglect, abuse, and mistreatment from healthcare oversight agencies, the public, and residents and their family members, including acts leading to the felony indictment of Fulton Commons and its former Director of Nursing for covering up reports of sex offenses against residents; (2) Respondent-owners' fraudulent and unlawful conversion of over $16 million that should have been spent on improving resident care but was instead extracted through no-show jobs and other schemes implemented by Respondents Kalter and Weiss, utilizing the Fulton Commons Enterprise, in order to unjustly enrich Respondent-owners personally; and (3) the unlawful dereliction of nearly all responsibility by Respondent Kalter resulting in negligible oversight, if any, in the administration of Fulton Commons.

4. Petitioner further seeks restitution, disgorgement, and civil penalties from Respondent-owners and Corporate Respondents who have deprived the nursing home of government funds for their personal gain without regard for the nursing home's operational needs and duties to provide required care and staffing, and have "obtained, received, [and] converted" such monies "without right." (Executive Law § 63-c[1]; *see also* Executive Law § 63(12); CPLR 8303[a][6].) This practice of making payments from the nursing home to Respondents under the guise of pre-determined and self-negotiated "expenses" and other transfers of funds, as a priority

over, and without regard to, ensuring that the nursing home has used the public funds it receives to meet the nursing home's duty to provide required care to its residents, with sufficient staffing to render such care, is referred to herein as "up-front profit."

5. Respondents have been aware of serious and redressable problems at Fulton Commons for years through inspection reports and publicly-released ratings by federal and state health oversight agencies, resident family complaints made directly to the facility administration, and social media reviews made by former residents and/or their loved ones,[1] yet have refused to remedy the root cause of the residents' suffering. Through examinations under oath pursuant to Executive Law § 63(12) of Respondents Kalter, Weiss, and Doyle along with various Fulton Commons' employees and other high managerial agents; interviews of residents, their family members, and other employees of Fulton Commons; analyses of financial records and residents' medical records; and review of additional evidence as set forth in the accompanying affidavits and attorney affirmation, the Attorney General's findings reveal that long before the COVID-19 pandemic, Respondents operated the nursing home with inadequate staffing levels, implemented multiple fraudulent schemes to siphon off millions of healthcare dollars, and illegally prioritized profit for Respondent-owners and Corporate Respondents over the nursing home's legal duties to provide required resident care. This illegal conduct repeatedly caused neglect, abuse, mistreatment, and physical and emotional harm to the vulnerable people who lived in the nursing home, stripped them of their dignity, and created demoralizing working conditions for its staff. For these reasons, Petitioner respectfully submits that judicial intervention is warranted forthwith.

[1] *See* Affidavit of Medicaid Fraud Control Unit Detective John M. Tarpey ("Tarpey Aff.") at ¶¶ 89–98 ; *see also* Tarpey Aff. Ex. 6–13.

6. This Petition regrettably requires many pages of facts and over a dozen supporting affidavits to set forth Respondents' well-concealed fraudulent schemes, to identify their repeated and persistent violations of the many laws designed to protect nursing home residents, and to bring to light the stories of neglect and suffering experienced by many Fulton Commons residents. This comprehensive recitation warrants the injunctive relief sought to protect the many vulnerable people now living at Fulton Commons. In the pages that follow, the Court will find a multitude of factually supported accounts of the cruelties endured by Fulton Commons' residents under the charge of Respondents Fulton Commons, Kalter, Weiss, and Doyle. To illustrate just a few of those findings: residents sustaining grave injuries, including fractures, bruises, and face-disfiguring lacerations, due to inadequate supervision; horrific wounds and amputations; preventable harm from significant medication errors and the failure to render necessary treatments; preventable hospitalizations; and grossly inadequate nursing staffing. As a result of inadequate nursing staffing, residents: went unmonitored with their conditions unassessed; were left crying in pain for prolonged periods without assistance; were forced to sit in soiled briefs after failing to receive toileting assistance and/or incontinence care for hours; did not receive necessary assistance with basic grooming and hygiene; were not provided appropriate physical therapy services; lost mobility and independence; and suffered malnutrition and hunger from insufficient, inappropriate, and unpalatable nutrition. Specific examples of the harm caused to residents by inadequate staffing include: nursing staff standing by as a non-ambulatory resident suffering from dementia crawled on the floor; at least two unreported instances of sexual abuse by a licensed practical nurse who was nonetheless allowed continued access to vulnerable residents for approximately two years after the first unreported incident; feces on purportedly laundered clothes; non-existent infection control, including the corporate failure to heed guidance from the on-staff infection preventionist

along with interspersing COVID-19 infected residents with uninfected residents, leading to potentially preventable infections, serious illness, and deaths; falsification of a medical record to conceal inadequate treatment; and falsifying infection control training records to make it appear as though staff received required training when they had not. Also, this Verified Petition sets forth the Attorney General's findings as to Respondents' repeated and persistent financial fraud and illegalities, that: (a) Kalter and Fulton Commons submitted false certifications to the New York State Department of Health ("DOH") certifying compliance with Medicaid regulations and asserting that salaries were only paid to individuals who rendered care or services to the nursing home when in fact Kalter, facilitated by New Fulton, New Bridge View, and Weiss, caused Fulton Commons to pay salaries for no-show jobs to his eight adult children—Respondents Mindy Steger, Sheindy Saffer, Chana Kanarek, Dovid Kalter, Yitzchok Kalter, Aryeh Kalter, Sheva Treff, and Chaya Lieberman a/k/a Sara Lieberman (collectively referred to hereinafter as "Kalter-1% Owners); and (b) Kalter and Fogel converted millions of dollars in Medicaid and Medicare reimbursements paid to Fulton Commons for resident care by paying their other company, Fulton Realty LP, as landlord, grossly inflated purported rent—in fact, the highest percentage of rent to revenue of any Medicaid and Medicare-certified nursing home on Long Island in 2018 and 2020—and ultimately distributed these inflated funds to themselves. These verifiable accounts detail the abhorrent treatment of New York State's most vulnerable citizens, and the nursing home's repeated disregard of its legal duties to ensure sufficient staffing to provide required and necessary care—in service of Respondent-owners' avarice and their knowing dehumanization of the people living at Fulton Commons.

A. Respondents Fulton Commons, Kalter, Weiss, and Doyle Repeatedly Neglected, Abused, and Mistreated Fulton Commons' Vulnerable Residents, Failing to Provide Required Care

7. New York State law recognizes that a "license to operate a nursing home carries with it a special obligation to the residents who depend upon the facility to meet every basic human need" and that "[f]or the vast majority of residents, the residential health facility [or nursing home] is their last home." (10 NYCRR § 415.1[a][1].) As explained in the accompanying Affidavit of Medical Analyst Mary E. Conway, RN ("RN Conway Aff."), a primer on the care needs of nursing home residents:

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

(RN Conway Aff. at ¶ 6.)

8. At all relevant times, New York State law imposed on Fulton Commons, as a nursing home, a "special obligation . . . to assure the highest possible quality of care and most meaningful quality of life for all [its] residents" (10 NYCRR § 415.1[a]), and to ensure that its residents are provided with necessary care and services, including clinical care in accordance with each resident's individualized care plan, and sufficient staffing "to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." (10 NYCRR § 415.13; *see also* Public Health Law § 2803-c; 10 NYCRR § 415.1[a] [describing minimum standards for nursing homes]; 10 NYCRR § 415.3[f] [describing nursing home residents' rights to clinical care and treatment]; 10 NYCRR § 415.12 [describing required quality of care in nursing homes]; 10 NYCRR § 415.26 [describing required organization and administration of nursing homes]; 42 CFR

§ 483.25 [describing required quality of care in nursing homes]; 42 CFR § 483.35 [describing requirements for nursing services in nursing homes]; 42 CFR § 483.10 [describing nursing home residents' rights].) Respondents repeatedly violated these state and federal laws, amongst a myriad of others, which are discussed in depth below and in the accompanying Memorandum of Law.

9. Respondents Fulton Commons, Kalter, Weiss, and Doyle persistently insufficiently and inadequately staffed Fulton Commons, resulting in repeated neglect, abuse, and mistreatment of its residents in violation of Public Health Law §§ 2803-d(7), 2803-c(h), 10 NYCRR § 415.4(b), 42 CFR § 483.12, and 42 USC § 1320b-25. These Respondents: (i) failed to provide "timely, consistent, safe, adequate and appropriate services, treatment and/or care . . . including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living" (10 NYCRR § 81.1[c] [defining "neglect"]); (ii) failed to prevent "inappropriate physical contact . . . , which harms or is likely to harm the patient or resident" (10 NYCRR § 81.1[a] [defining "abuse"]); and (iii) caused "inappropriate use of medications, inappropriate isolation or inappropriate use of physical or chemical restraints" (10 NYCRR § 81.1[b] [defining "mistreatment"]).

10. Respondents Fulton Commons, Kalter, Weiss, and Doyle's persistent violations of their duties to Fulton Commons' residents began long before the COVID-19 pandemic.[2] The

[2] The Attorney General anticipates that Respondents will attempt to shield themselves from liability by asserting a defense under the short-lived COVID-19 emergency immunity statute, intended to protect the heroic healthcare workers who were forced to make difficult triage and treatment decisions under emergency circumstances. That law, New York Public Health Law §§ 3081–3082, enacted on March 7, 2020, was modified on August 3, 2020, to limit its scope to COVID-19 cases only, and then repealed, effective April 6, 2021. Respondents will fail to make out such a defense for the harms described herein during the COVID-19 crisis because they resulted from: (1) Respondents Fulton Commons, Kalter, Weiss, and Doyle's intentional and unlawful decisions made in contravention of New York State law and DOH infection control guidance, and (2) Respondents' implementation of financial and staffing decisions as part of a pre-

Attorney General's findings of repeated and persistent fraud and illegality at and by Fulton Commons, from as early as January 1, 2018, are detailed in the accompanying affidavits of 14 civilian witnesses (collectively referred to hereinafter as "Civilian Affs."), who were residents or family members of residents of Fulton Commons, as well as in the affidavits of Medicaid Fraud Control Unit ("MFCU") investigative staffers: Senior Auditor-Investigator Kristen Ronan ("Ronan Aff."), Detective John M. Tarpey, and Medical Analyst Mary E. Conway, and the Affirmation of Special Assistant Attorney General Prabhjot Sekhon ("Sekhon Aff.").

11. Fulton Commons' widespread neglect, abuse, and mistreatment of its vulnerable residents includes, but is not limited to, the following illustrative examples:

- **Amputee Repeatedly Neglected; Contracted Infection in Remaining Foot; Health Care Proxy Denied End-of-Life Visit**: Resident E.M.,[3] a then 86-year-old woman, was admitted to Fulton Commons in or around February 2015 for rehabilitation after losing a foot due to diabetes. She had a prosthetic leg and required assistance ambulating. E.M. was alert and oriented, and she had complained of insufficient staffing as far back as October 2017, stating that Respondent Doyle did not hire new certified nurse aides. She often had to ring her call bell, which was intended to allow her to communicate her need for care with staff members, for long periods of time; sometimes she was outright ignored, resulting in Fulton Commons' failure to administer doses of her medication and/or causing her to sit in soiled disposable briefs for extended periods of time. She complained that the food was "disgusting," and, on one occasion, reported being served a raw egg for breakfast. Fulton Commons staff inserted a port into E.M.'s arm for the administration of antibiotics despite her adamant insistence that the procedure not be performed. Furthermore, E.M.'s remaining foot became infected in January 2020, subsequently became gangrenous, and ultimately turned black. E.M. died at Fulton Commons on November 20, 2020. Her daughter-in-law, who was her healthcare proxy, was denied an end-of-life visit

existing business practice intended to extract funds from Fulton Commons without regard for laws requiring delivery of competent and quality care. Most pertinently, the acts and omissions of the Respondents, as shown herein, long predate the COVID-19 pandemic, and Respondent-owners' depredations continued throughout the COVID-19 pandemic until at least January 31, 2022, as detailed herein.

[3] To shield protected health information, residents are identified by the initials of their first and last names.

and was turned away at Fulton Commons' doorstep within 90 minutes of E.M.'s death. (*See* ¶¶ 82[iii], 83[i], 84[i], 85[i], 86[i], 87[iii], 93[i], 96[i] *infra*; *see also* Affidavit of Tami Milack ["Milack Aff."]).

- **Dementia Patient Unsupervised and Denied Basic Care**: Resident F.H. was admitted to Fulton Commons in May 2018 at the age of 87. He suffered from dementia,[4] was blind in his left eye, and was only able to see shadows out of his right eye. He required a wheelchair, wore disposable briefs, and used dentures, which were thrown away by Fulton Commons staff within weeks of his admission. Fulton Commons frequently lost F.H.'s clothing, resulting in him being left partially undressed on multiple occasions. In May 2019, F.H. sustained a significant laceration near his left eye, the origin of which Fulton Commons staff could not explain. In January or February 2020, staff failed to respond to F.H.'s cries when he was screaming in pain due to a recently-contracted urinary tract infection ("UTI").[5] (*See* ¶¶ 82[ii], 86[ii], 91 *infra*; *see also* Affidavit of Frank Hoerauf, Jr. ["Hoerauf Aff."].)

- **Dementia Patient Restrained and Unsupervised**: Resident S.K. suffered from dementia and was admitted to Fulton Commons in 2018, where she resided until her death in April 2020. S.K.'s son reported that Fulton Commons' staffing levels were always insufficient—generally, only one or two staff members supervised 30 residents. In or around October 2019, S.K. sustained a large circular bruise to her face near her left temple, which Fulton Commons staff was unable to explain. In January 2020, S.K.'s son arrived at Fulton Commons only to find his mother crawling on the lunchroom floor. Despite multiple staff members being present, none intervened; S.K.'s son had to lift her off the floor and place her back into her wheelchair himself. On another occasion, S.K.'s son witnessed her tied to her wheelchair with a piece of clothing. S.K.'s son did not complain about the lack of care to Fulton Commons as he feared that staff would retaliate against S.K. and provide even lower quality care. (*See* ¶¶ 81[i], 90[iii] *infra*; *see also* Affidavit of John Costa ["Costa Aff."].)

- **Blood Oxygen Depleted from Medication Error; Altered Records**: Resident W.V. was admitted to Fulton Commons on or about June 25, 2021, at the age of

[4] "Dementia" is not a specific disease; rather, it is a general term for the impaired ability to remember, think, or make decisions, which negatively impacts an individual's ability to function and carry out everyday activities. It is commonly seen in patients with Alzheimer's disease and other diseases with significant cognitive impairments. Of note, it does not connote violence or aggression in any way.

[5] As explained in the RN Conway Aff. at ¶¶ 80–82, 89, prevalence of UTIs within a nursing home suggests resident neglect, as they are indicative of residents experiencing excessive delays in receiving assistance with toileting, causing residents to hold their urine for lengthy periods of times.

81, for rehabilitation following a hospital stay. However, due to concerns about the inadequate and substandard care he received, W.V.'s family removed him from the facility within two weeks. He suffered from pulmonary fibrosis, a lung disease, and required supplemental oxygen at all times, as well as prednisone daily, to ensure safe blood oxygen levels. At the time of his admission, Fulton Commons failed to connect W.V. to an oxygen machine and had placed him in a room without a call bell. Upon his removal from Fulton Commons on July 8, 2021, W.V. was very ill, unable to stand, and had difficulty breathing. Thereafter, his family discovered Fulton Commons staff made a dangerous error in the administration of his prednisone by only administering one-third of his requisite dose. This led to his rehospitalization on July 12, 2021, for difficulty breathing and chest pains, and W.V. ultimately required a blood transfusion. When confronted with this grievous error, Fulton Commons' then Director of Nursing ("DON"), Carol Frawley, sent W.V.'s daughter a copy of hospital discharge paperwork that was blatantly falsified in an obvious attempt to shift the blame for the error onto the hospital and cover up Fulton Commons' indisputable neglect. Following this incident, W.V.'s health continued to deteriorate, and he ultimately died at St. Francis Hospital on February 2, 2022. (*See* ¶¶ 84[v], 92[ii] *infra*; *see also* Affidavit of Andrea Doherty ["Doherty Aff."].)

- **Stroke Patient Humiliated and Left on Floor While Attempting to get to Bathroom**: Resident D.L. was admitted to Fulton Commons on or about September 17, 2021, at the age of 53, with a history of strokes and expressive aphasia. He required assistance toileting as he had difficulty walking due to right-sided weakness. Nonetheless, staff regularly failed to timely respond to D.L.'s call bell, which eventually resulted in D.L. defecating on himself, and then being berated for doing so by the Fulton Commons aide assigned to provide him with care. Because of Fulton Commons' staff's demeaning and undignified response, D.L. became fearful of soiling himself; he subsequently fell twice while attempting to reach the bathroom unassisted following continued lengthy delays in staff response to his calls for assistance. On one of those occasions, he remained helpless on the floor for several hours before finally being discovered. Moreover, on October 19, 2021, a speech pathologist informed D.L.'s wife that he was groggy and slumped over in his chair—a change in his condition that a Fulton Commons registered nurse should have assessed but did not. At his wife's insistence, D.L. was sent to a hospital where he was diagnosed with a UTI—a condition that should have been discovered at the nursing home without a need for hospitalization.[5] (*See* ¶ 82[vii] *infra*; *see also* Affidavit of Felicia Lennon ["Lennon Aff."].)

- **Resident Deprived of Breathing Machine Became Comatose**: Resident C.B. was admitted to Fulton Commons in February 2021, at the age of 52, and suffered from elevated carbon dioxide ("CO2") levels and sleep apnea, a potentially serious sleep disorder where breathing repeatedly stops and starts while the patient is asleep. (*See* RN Conway Aff. at ¶ 107). However, following Fulton

Commons' failure to connect C.B. to a Bi-Pap[6] machine to help him breathe properly, he became comatose due to excessive CO2 levels and was transferred to the hospital within days of his admission. (*See* ¶ 84[iv] *infra*; *see also* Affidavit of Patricia Bernaerts ["Bernaerts Aff."].)

- **Fulton Commons Covered Up Multiple Infection Control Failures During the COVID-19 Pandemic**: Fulton Commons' administrator, Respondent Doyle, created a culture of cover-up and deceit at the facility, regularly prioritizing her self-interests and the facility's financial interests above the healthcare needs of the residents. This included issuing misleading robocalls to family members in the height of the first wave of the COVID-19 pandemic,[7] in which she claimed there was no COVID-19 in Fulton Commons, despite the facility actively treating residents for presumed COVID-19 infections. In line with these false robocalls, Doyle: (1) directed staff members not to discuss COVID-19 infections; (2) failed to report 45% of Fulton Commons' COVID-19 resident deaths to DOH—Fulton Commons reported to DOH only 40 out of 74 deaths of its residents who died from presumed and/or confirmed COVID-19; and (3) orchestrated a mass room shuffle during which Fulton Commons disregarded room cleaning infection control protocols on what Respondent Doyle believed was the eve of a DOH infection control inspection in order to protect Fulton Commons' financial and reputational interests by concealing the facility's repeated and persistent failure to cohort residents based on their COVID-19 status. (*See* ¶¶ 93, 112, 115–117, 120–122, 130, 178 *infra*.)

- **Fulton Commons and Former DON Carol Frawley Indicted for Intentionally Failing to Report Allegations of Sexual Abuse**: As detailed in ¶ 12 *infra*, Fulton Commons and former DON Frawley were indicted in November 2022 for repeatedly failing to report allegations of sexual abuse and allowing the accused nursing staff member to continue contact with residents, as follows:

    - In January 2022, DOH determined that Fulton Commons failed to report a resident's allegation of sexual abuse by a nursing staff member. A female resident told staff that a licensed practical nurse placed his hand in her disposable brief when not providing care. Fulton Commons failed to investigate or report this allegation to DOH and law enforcement as required by law, and dangerously permitted the accused staff member to continue working directly with Fulton Commons residents until a second complaint

[6] When required by their care plan, residents utilize a Bi-Pap machine to assist with proper breathing. A Bi-Pap machine includes a tube connected to a hard, plastic mask covering the resident's nose and mouth, through which the machine delivers high pressure air when the resident inhales, and a different amount of air pressure when the resident exhales. (*See* RN Conway Aff. at ¶ 107.)

[7] The first wave of the COVID-19 pandemic refers to the time period between March 1, 2020 and May 31, 2020.

was made against him a week later for exposing his genitalia to another resident. DOH found that Fulton Commons had an unlawful policy under which allegations of sexual abuse would not be reported to law enforcement unless another individual witnessed the incident, in violation of Public Health Law § 2803-d(7), 42 CFR § 483.12, and 42 USC § 1320b-25; instead, Fulton Commons treated such allegations as "grievances," which were handled by its social workers. (*See* ¶ 81[iii] *infra*.) This inexcusable failure to report sexual abuse placed its residents at further risk and resulted in DOH declaring that Fulton Commons was in "immediate jeopardy" ("IJ"), defined by DOH as immediate jeopardy to resident health or safety requiring immediate action (*see* Ronan Aff. at ¶ 103; *see also* Ronan Aff. Ex. 8); and

- On September 30, 2022, Fulton Commons reported to DOH that approximately two years earlier, yet another resident made sexual abuse allegations against the same employee. Although this incident had been promptly reported by the resident to her assigned caregivers, Fulton Commons did not report this allegation to DOH or law enforcement until after MFCU detectives starting interviewing witnesses to the January 2022 crimes. (*See* ¶ 81[iii] *infra*.)

- **Fulton Commons Downgraded to a 2-Star Facility and Added to the Special Focus Facility Program Candidacy List**: In April 2022, the Centers for Medicare and Medicaid Services ("CMS") lowered Fulton Commons' inflated Overall rating from 5-Stars (out of 5) to 2-Stars—a "BELOW AVERAGE" rating (detailed in ¶ 202 *infra*). CMS also placed Fulton Commons on the candidate list for its Special Focus Facility Program (defined in ¶ 136 *infra*). (*See* ¶ 138 *infra*.) Special Focus Facilities are the poorest performing nursing homes in the country.

Despite its failure to provide appropriate care to its existing residents, and in order to maximize its revenue, Fulton Commons continued to admit new residents into the facility and took affirmative steps to obstruct the discharge of certain other residents, as detailed in ¶ 96 *infra*.

12. **Indictment of Fulton Commons for Cover-up and Endangering**: On November 30, 2022, Nassau County Indictment No. 1454N-22 was unsealed, charging the following 13 counts in relation to the sexual abuse allegations referenced in ¶ 11 *supra*:

- Former Fulton Commons licensed practical nurse Daniel Persaud was charged with crimes arising from acts of sexual abuse that occurred on or about and between October 1, 2020 and November 26, 2020:

- One count of Endangering the Welfare of an Incompetent or Physically Disabled Person in the First Degree, in violation of Penal Law § 260.25, a class E Felony;
- One count of Endangering the Welfare of a Vulnerable Elderly Person, or an Incompetent or Physically Disabled Person in the Second Degree, in violation of Penal Law § 260.32(4), a class E Felony;
- One count of Forcible Touching, in violation of Penal Law § 130.52, a class A Misdemeanor;
- One count of Wilful Violation of Public Health Laws (Abuse), in violation of Public Health Law §§ 12-b(2), 2803-d(7), and 10 NYCRR § 81.1(a), an unclassified Misdemeanor; and
- One count of Sexual Abuse in the Third Degree, in violation of Penal Law § 130.55, a class B Misdemeanor.

- Former Fulton Commons DON Carol Frawley was charged with respect to: (1) her failure to prepare a facility investigation report, notify DOH, or notify law enforcement about a sexual abuse allegation against licensed practical nurse Daniel Persaud, occurring on or about and between October 1, 2020 and November 26, 2020; (2) her failure to report to DOH and law enforcement a sexual abuse allegation against licensed practical nurse Daniel Persaud, occurring on or about and between December 25, 2021 and January 2, 2022, and allowing Daniel Persaud to continue to care for Fulton Commons residents; (3) her creation of a false, undated entry on a Fulton Commons Incident Report regarding a resident of Fulton Commons; and (4) her failure to timely report an allegation of sexual abuse against licensed practical nurse Daniel Persaud and falsely stating to a DOH surveyor that she had not been made aware of the allegation until January 3, 2022, causing a false entry in DOH paperwork dated January 6, 2022:

  - Four counts of Falsifying Business Records in the First Degree, in violation of Penal Law § 175.10, a class E Felony;
  - Two counts of Wilful Violation of Public Health Laws, in violation of Public Health Law §§ 12-b(2), 2803-d(1), (3), (7), and 10 NYCRR § 81.1(a), an unclassified Misdemeanor; and
  - Two counts of Endangering the Welfare of an Incompetent or Physically Disabled Person in the First Degree, in violation of Penal Law § 260.25, a class E Felony.

- Fulton Commons was charged with crimes arising from: (1) Carol Frawley's failure to prepare a facility investigation report, notify DOH, or notify law enforcement about a sexual abuse allegation against licensed practical nurse Daniel Persaud, occurring on or about and between October 1, 2020 and November 26, 2020; (2) Carol Frawley's failure to report to DOH and law enforcement a sexual abuse allegation against licensed practical nurse Daniel Persaud, occurring on or about and between December 25, 2021 and January 2, 2022, and allowing Daniel Persaud to continue to care for Fulton Commons residents; (3) Carol Frawley's creation of a false, undated entry on a Fulton Commons Incident Report regarding a resident of Fulton Commons; and (4) Carol Frawley's failure to timely report an allegation of sexual abuse against licensed practical nurse Daniel Persaud and falsely stating to a DOH surveyor that she had not been made aware of the allegation until January 3, 2022, causing a false entry in DOH paperwork dated January 6, 2022:

- Four counts of Falsifying Business Records in the First Degree, in violation of Penal Law § 175.10, a class E Felony;
- Two counts of Wilful Violation of Public Health Laws, in violation of Public Health Law §§ 12-b(2), 2803-d(1), (3), (7), and 10 NYCRR § 81.1(a), an unclassified Misdemeanor; and
- Two counts of Endangering the Welfare of an Incompetent or Physically Disabled Person in the First Degree, in violation of Penal Law § 260.25, a class E Felony.

B. Fulton Commons' Resident Neglect was Directly Caused by its Failure to Provide Sufficient and Adequate Nursing Staff

13. Fulton Commons failed to adequately staff its nursing units with a sufficient amount of qualified and supervised caregivers, and thereby set up its overburdened staff to fail. (*See* RN Conway Aff. at ¶ 31.) Fulton Commons did so by putting staff in the impossible position of being assigned to provide care to too many residents, each of whom had an individualized care plan detailing their needs. Fulton Commons' staff's inability to complete their overwhelming tasks in the time allotted resulted in Fulton Commons neglecting numerous residents and ignoring their needs.

14. As the "governing body"[8] of Fulton Commons under the Public Health Law, Kalter was responsible for "the number and qualifications of staff members." (*See* 10 NYCRR § 415.26[b]). Nonetheless, despite the nursing home's consistently poor publicly-reported CMS staffing ratings of "BELOW AVERAGE" or "MUCH BELOW AVERAGE" since January 1, 2016, Kalter made no effort to ensure Fulton Commons maintained sufficient and adequate nursing staff on its units, and instead delegated this responsibility to Respondent Doyle—an administrator

[8] Each nursing home in New York State is required to have a "governing authority or operator" recognized by DOH that is "the party responsible for the operation" of the nursing home. (10 NYCRR § 600.9.) The "governing authority or operator" is also referred to in New York State regulations as the "governing body." (*See*, *e.g.*, 10 NYCRR § 415.27.) Fulton Commons and Kalter comprise Fulton Commons' governing body.

who, as discussed herein, habitually ignored her responsibility to safeguard the residents of the nursing home and regularly prioritized the financial interests of the Fulton Commons Enterprise above their welfare.

15. The Attorney General's January 2021 "Nursing Home Response to COVID-19 Pandemic" Report ("NH Report") established that the taking of substantial up-front profit from for-profit nursing homes with below-average staffing increased risks of harm to vulnerable residents. (*See* Ronan Aff. Ex. 6 at 23, 64.) The NH Report detailed that nursing homes that operated with CMS Staffing ratings that were "BELOW AVERAGE" or "MUCH BELOW AVERAGE" prior to the onset of the COVID-19 pandemic had higher death rates and put residents at increased risk of harm during the pandemic. (*Id.* at 23.) This was borne out at Fulton Commons, where 92 resident deaths occurred during the first wave of the COVID-19 pandemic—74 of which were related to COVID-19.

16. Despite the deaths of 92 Fulton Commons residents during that three-month period—including the 74 from COVID-19—Respondents continued their fraudulent and illegal conduct through at least October 2022. In other words, rather than expending enough money on resident care and staffing to comply with the nursing home's legal duties, Respondent-owners continued to prioritize their own financial interests over the residents' health and diverted millions of additional dollars to themselves in 2021 and 2022.

C. Respondent-Owners and Respondents Fulton Realty LP and Fulton Realty Inc.'s Unlawful Looting of Fulton Commons Resulted in Woefully Insufficient Staffing and Resident Neglect

17. The repeated and persistent neglect, abuse, and mistreatment of Fulton Commons residents could have been prevented if Fulton Commons had spent more money on resident care and staffing rather than transferring many millions of dollars in up-front profit to Respondent-

owners. Government payors reimbursed Fulton Commons more than sufficiently to staff its facility to provide requisite care to its residents. On its Cost Reports, Fulton Commons reported at least $105,834,966[9] in Medicaid and Medicare revenue for resident care between January 1, 2018 and December 31, 2021. (*See* Ronan Aff. at ¶ 93.) Yet, during the same period, Fulton Commons spent only $47,330,226 on direct resident care[10] while spending $34,473,105 on purported rent, of which $14,913,403 was diverted as up-front profit for Kalter, Fogel, Fulton Realty LP, and Fulton Realty Inc. and $1,056,990.79 as salaries paid to the Kalter-1% Owners for no-show jobs. (*Id*.)

18. Despite Respondents Fulton Commons, Kalter, Weiss, and Doyle's persistent violations of their legal duties to staff the nursing home sufficiently and to ensure the residents were provided with required care and services in compliance with the many laws detailed in ¶¶ 59–63 *infra,* from at least January 1, 2018 through January 31, 2022,[11] Respondents Kalter and Weiss concealed from DOH the funds they misappropriated from the nursing home and transferred

[9] While Fulton Commons received payments from taxpayer-funded Medicaid Managed Care Organizations, it failed to properly categorize any Medicaid Managed Care payments on its 2018, 2019, 2020, and 2021 Cost Reports to DOH, and these payments are not easily discernible from other payments (such as private insurance) in Fulton Commons' bank records; thus, any Medicaid Managed Care payments from 2018, 2019, 2020, and 2021 are not included in this amount. Importantly, Fulton Commons received significant funds from private payors as well. The legal duties of care under the Public Health Law apply to all nursing home residents regardless of payment source.

[10] Direct resident care refers to care rendered to residents by all nursing staff—registered professional nurses, licensed practical nurses, certified nurse aides, orderlies, and/or other assistants.

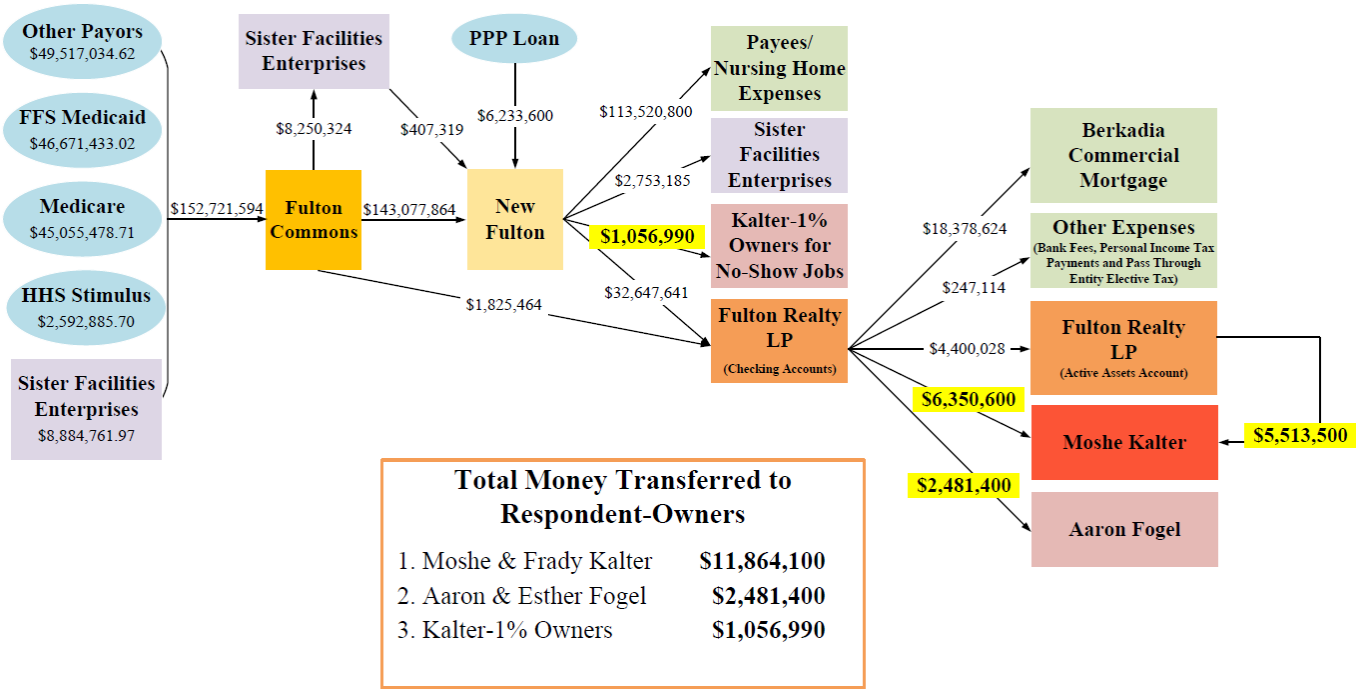
[11] While it is likely that the Kalter-1% Owners have continued to extract up-front profit from Fulton Commons through these sham salaries, Fulton Commons obstructed MFCU's investigation in this regard by rejecting a duly issued subpoena pursuant to Executive Law § 63(12) that demanded, inter alia, payroll records from February 1, 2022 through May 18, 2022. MFCU's subpoena, and Fulton Commons' unlawful rejection thereof, are attached the Sekhon Aff. as Exhibit 3. Notably, Respondent Fulton Commons rejected MFCU's subpoena in a detailed letter with attached exhibits. For brevity's sake, the exhibits are not included in Sekhon Aff. Ex. 3 but can be made available for the Court's review upon request.

to Respondent-owners through grossly inflated purported rent and sham salaries for no-show jobs. Through these illegal schemes, Respondent-owners funneled over $16 million from Fulton Commons to themselves and to Respondents Fulton Realty LP and Fulton Realty Inc. (as detailed in the chart below) in up-front profit, with no regard for whether the nursing home provided its residents with requisite care. The chart below summarizes this illegal conversion of over $16 million. (*See* Ronan Aff. at ¶ 72.)

Conversion	**2018**	**2019**	**2020**	**2021**	**January 2022**	**Total**
Excess Rent	$3,526,494.00	$4,422,281.00	$4,566,918.00	$2,397,710.00	Unable to determine	**$14,913,403.00**
Kalter-1% Owners' Salaries	$60,500.00	$170,295.03	$410,875.96	$415,319.80	$34,689.80	**$1,091,680.59**
Total	**$3,586,994.00**	**$4,592,576.03**	**$4,977,793.96**	**$2,813,029.80**	**$34,689.80**	**$16,005,083.59**

19. Moreover, while Respondents Fulton Realty LP and Respondent-owners fraudulently made their equity withdrawals from Fulton Commons appear to be bona fide business expenses, Respondents Fulton Commons and Kalter submitted false certifications to DOH attesting to the veracity of those "expenses." As depicted in the chart below, Fulton Commons' bank records reveal that the nursing home received over $94 million in healthcare revenue from government-funded sources (Medicaid, Medicare, and stimulus funds) between 2018 and 2021. (*See* Ronan Aff. at ¶ 47.) Of the almost $16 million converted during this four-year period, the Fulton Commons Enterprise surreptitiously and illegally transferred $15,402,490 (highlighted in yellow in the chart below) to Respondent-owners using their related-party operating company, New Fulton, as a conduit. Respondents New Bridge View and Weiss facilitated these fraudulent transactions. (*Id.*)

Fulton Commons Cash Flow Chart: Transfer of $15,402,490
to Respondent-Owners from Fulton Commons from 2018–2021



Notes:

*This sum is based on W-2 records, produced by Respondents Fulton Commons and New Fulton, reporting salaries paid to each of the eight Kalter-1% Owners by New Fulton.

1. Unless otherwise specified, all the chart totals other than those of the Sister Facilities Enterprises, as defined in ¶ 43 n.17 *infra*, are the net balances as determined from the analyses of the bank accounts.
2. This chart is not inclusive of every transaction in the accounts.
3. Some amounts are rounded down to the nearest dollar, which may affect the total balances.
4. The amounts transferred to Moshe Kalter and Aaron Fogel were transferred into joint bank accounts with their spouses, Frady Kalter and Esther Fogel, respectively.

20. Respondents' repeated and persistent fraudulent conduct continued through at least January 2022—when the Kalter-1% Owners illegally converted $34,689.80 in that one month through salaries received for no-show jobs. Additionally, in January 2022, Respondent Fulton Realty LP transferred $300,000 to Moshe Kalter and $200,000 to Aaron Fogel. In sum, of the more

than $16 million extracted through various corporate shells between January 1, 2018 and January 31, 2022, Respondent-owners ultimately received at least $15,937,180.59 into their own bank accounts. (*See* Ronan Aff. at ¶ 48.)

Respondent-Owners	**January 1, 2018 to January 31, 2022**
Moshe and Frady Kalter	$12,164,100.00
Aaron and Esther Fogel	$2,681,400.00
Kalter-1% Owners	$1,091,680.59
Total Amount Transferred to Respondent-Owners	**$15,937,180.59**

21. **Deceiving DOH and False Records**: Respondent-owners and Corporate Respondents' financial frauds and illegalities were not limited to looting Fulton Commons of funds meant for resident care through exploitative rent and no-show jobs. These Respondents further committed persistent and repeated fraud and illegality by deceiving DOH, through false statements and clandestine financial arrangements, as to their conversion of Fulton Commons' funds, in violation of laws that specifically limit extraction of assets and equity from nursing homes without DOH approval. (*See* Public Health Law §§ 2808[5][a], [c].) Yet, as discussed herein, between January 1, 2018 and December 31, 2021, Respondents Fulton Commons and Kalter repeatedly and persistently violated these statutory provisions by failing to accurately disclose the full extent of Respondent-owners' exorbitant and unlawful equity withdrawals totaling $11,576,151.53 and by failing to seek DOH approval before transferring these funds. (*See* ¶¶ 252–253 *infra*.)

22. By looting Fulton Commons while inadequately staffing the nursing home since well before the COVID-19 pandemic and through October 31, 2022, Respondents Fulton Commons, Kalter, Weiss, and Doyle repeatedly and persistently neglected, abused, and mistreated

Fulton Commons' residents, who were regularly forced to endure substandard care and indignities during their time at the nursing home, which for many of them were their final days. (*See* ¶¶ 80–96 *infra*.)

D. Respondent Moshe Kalter Was Derelict in His Responsibilities as Nursing Home Operator and Governing Body and Allowed an Unsupervised Administrator to Cover-Up Fulton Commons' Repeated Resident Neglect, Abuse, and Mistreatment

23. Respondent Kalter is a once-licensed nursing home administrator who has worked in the healthcare industry for more than 40 years (*see* Ronan Aff. Ex. 1 at 31–32) and has had an ownership interest in at least five New York State nursing home facilities. (*See* Ronan Aff. Ex. 1 at 39–44.) As such, he should be well-versed in the laws and regulations governing nursing homes. Moreover, as the owner, operator, and governing body of Fulton Commons, as discussed in ¶¶ 180–181 *infra*, Kalter was required to ensure that Fulton Commons met its obligations under state and federal laws, rules, and regulations. However, when Kalter was questioned under oath pursuant to Executive Law § 63(12), it was apparent that he only cared about "the numbers." (*See* Ronan Aff. Ex. 1 at 263.) This comports with the nursing home's abject failure to provide adequate care for its residents and Kalter's transfer of millions of Medicaid and Medicare dollars into his and other Respondent-owners' bank accounts.[12] (*Id.*; *see also* Ronan Aff. at ¶ 87.) Notably, Kalter's sole concerns were the resident census (how many beds were generating payment) and the bank account balance (*see* Ronan Aff. Ex. 1 at 263)—not the health, welfare, or safety of the thousands

[12] The Attorney General subpoenaed Kalter's tax returns and the financial statements of the Fulton Commons Enterprise and the Sister Facilities Enterprises pursuant to Executive Law § 63(12), and those Respondents, and their accounting firm, refused to comply. Upon motion to compel, these entities were ordered to comply by Hon. David T. Reilly, Nassau County Supreme Court on January 24, 2022. Respondents and their accounting firm filed an application for a stay and have appealed Justice Reilly's Order. The appeal is pending.

of vulnerable residents who depended on Fulton Commons for their basic human needs over the years.

24. Respondent Kalter shirked all his responsibilities under the law in the operation of Fulton Commons, shifting them instead to an administrator he failed to supervise. Although he was the owner, operator, and governing body of the nursing home, Kalter admitted that he had never spoken with Respondent Doyle, the employee who, from September 2016 to November 16, 2022 (*see* Tarpey Aff. Ex. 3 at 51; *see also* ¶ 57 *supra*), oversaw the care of thousands of residents treated in a facility that continues to make Kalter millions of dollars annually. (*See* Ronan Aff. Ex. 1 at 68, 73, 246.) In addition, as evidenced by his failure to draft or review Fulton Commons' policies and procedures (*id*. at 192), along with his failure to attend required quality assurance meetings or review quality assurance reports (*id*. at 198), Kalter paid no attention to the well-being of Fulton Commons' residents. His conduct reflects that he was not concerned with whether Fulton Commons rendered care that met its legal duties to people dependent on it for survival. Kalter was and still is a wholly absentee owner, operator, and governing body, who flouts the laws—laws that are in place to ensure the residents receive the care they deserve. (*See* Public Health Law § 2803-c; 10 NYCRR §§ 415.1[a][1]–[2]; 10 NYCRR § 415.3; 10 NYCRR § 415.12; 10 NYCRR § 415.13; 10 NYCRR § 415.26; 42 CFR § 483.10; 42 CFR § 483.25; 42 CFR § 483.35.)

25. Turning a blind eye to these laws and the need for an appropriate investment in direct care staffing, Kalter controlled the finances of Fulton Commons and its related parties as if they were his alter egos, engaging in repeated and persistent fraudulent conversion through self-dealing arrangements disguised as bona fide business expenses, i.e., by misappropriating millions of dollars through grossly inflated rent payments and providing no-show jobs to the Kalter-1% Owners.

26. Kalter's prioritization of his and his family members' financial interests over the nursing home's duties to provide care to its residents, and his corresponding failure to comply with his oversight duties at Fulton Commons, allowed Respondent Doyle to dupe DOH, CMS, the public, and, most importantly, current and prospective residents and their families, into believing Fulton Commons provided care reflective of a facility with a 5-Star Overall rating as of April 2019, as detailed more fully in ¶¶ 11–12 *supra* and ¶¶ 136–138, 145–147 *infra*. Lacking any accountability, Respondent Doyle orchestrated a multitude of cover-ups of her failures in running Fulton Commons, resulting in this inflated CMS rating. Notably, despite DOH's determination in January 2022 that Fulton Commons and Doyle's policy of covering up sexual abuse reports placed resident in immediate jeopardy, Kalter retained Doyle until November 2022.

E. Need for Injunctive Relief, Disgorgement, and Reform

27. Judicial intervention is required to enjoin Respondents' repeated and persistent fraudulent and illegal conduct and to protect Fulton Commons' vulnerable residents from continued neglect, abuse, and mistreatment. In addition to enjoining Respondents' persistent fraud and illegality in their operation of Fulton Commons, Petitioner also seeks restitution and disgorgement of the converted funds that Respondent-owners and Respondent Fulton Realty LP fraudulently transferred to themselves, while disregarding Fulton Commons' duty to ensure it provided sufficient staff to deliver required care to its residents. Respondent-owners and Fulton Realty LP retained these funds without right in violation of Executive Law § 63-c and have been unjustly enriched at the expense of New York State taxpayers and the Medicaid and Medicare Programs.

28. Petitioner also brings this Special Proceeding to bring transparency to the reality that much of the pain and indignity experienced by Fulton Commons' residents was preventable

and future suffering can be averted if Respondents stop—voluntarily or by Court order—illegally converting millions of dollars in Medicaid and Medicare funds as up-front profit, and instead enable Fulton Commons to retain and spend necessary funds to improve resident care, hire and retain sufficient numbers of qualified and adequately-supervised staff, and comply with applicable laws designed to ensure nursing homes protect, rather than exploit, residents.

29. As an illustration (but by no means the only expenditure needed to remedy this troubled facility), if Respondents Kalter and Fulton Realty LP had limited Fulton Commons "rent" expenditures to $8.85 million instead of the actual $9.85 million extracted in 2020, Fulton Commons could have spent that $1 million on staffing. Specifically, that $1 million would fund an additional $3,571.42 per bed to provide about 23,675 additional hours of direct care to the residents of the nursing home, including 2,525 registered professional nurse ("RN") hours, 4,785 licensed practical nurse ("LPN") hours, and 16,365 certified nurse aide ("CNA") hours. (*See* Ronan Aff. at ¶¶ 90–94.) Had Respondents Kalter and Fulton Realty LP done so, the Fulton Commons Enterprise would have still received more than $3.5 million in 2020. (*See* ¶ 213 *infra*.) Despite the ease of this relatively modest extra expenditure on staffing, and even after so many Fulton Commons residents died during the first wave of the COVID-19 pandemic when its shoe-string staffing model collapsed and its direct caregivers risked their lives working under poor conditions, Respondents Fulton Commons, Kalter, Weiss, and Doyle continued to operate the nursing home with "BELOW AVERAGE" Overall Staffing and RN Staffing levels.

30. Petitioner requests that this Court put a stop to this tragedy and hold the Respondents accountable, both retroactively and going forward. Accordingly, for the reasons stated herein, the Attorney General respectfully asks the Court to promptly issue an order, inter alia: (1) permanently enjoining Respondents from engaging in the illegal, fraudulent, and deceitful

conduct alleged herein, including further violations of state and federal nursing home laws, and fraudulent and illegal acts and practices relating to reimbursement by the New York State Medicaid Program; (2) appointing a financial monitor to oversee Fulton Commons' financial operations, to ensure that Respondent-owners are not paid for no-show jobs, and to ensure that Respondent-owners are not paid distributions and Fulton Realty LP is not paid any amount of rent until *after* residents are provided with the care that they need and are entitled to by law— including adequate staffing to provide that care; (3) appointing a healthcare monitor to oversee Fulton Commons' healthcare operations; (4) enjoining Fulton Commons from accepting any admissions of new residents until such time as Fulton Commons meets its obligations to ensure sufficient care and nursing staffing for all existing residents and any new residents; and (5) ordering restitution, disgorgement, and costs against Respondent-owners and Corporate Respondents, except Fulton Commons, pursuant to Executive Law § 63(12) and Executive Law § 63-c, which authorize the Attorney General to recover public monies wrongfully had or received, and common law unjust enrichment.

II. JURISDICTION AND VENUE

31. Since the 1970s, when widespread nursing home fraud and abuse were exposed, the Medicaid Fraud Control Unit of the Office of the Attorney General of the State of New York (the "State") has been tasked with investigating and prosecuting healthcare providers and associated persons engaged in civil and criminal fraud against the Medicaid and Medicare Programs to protect the state's vulnerable nursing home residents from neglect, abuse, mistreatment, and exploitation through civil and criminal prosecutions. The investigation leading to this Special Proceeding was undertaken pursuant to the well-established authority vested in the Attorney General by the Executive Law, New York State Medicaid rules and regulations, and

MFCU's federal grant of authority from the Office of the Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") to investigate and prosecute provider fraud and nursing home resident neglect, abuse, and mistreatment. (*See* Executive Law § 63[12]; 42 USC § 1396b[q]; 42 CFR §§ 1007.11[a][2], [b].) HHS-OIG has authorized MFCU to recover Medicare funds in this proceeding pursuant to 42 USC § 1396b(q)(3).

32. Executive Law § 63(12) empowers the Attorney General to bring a Special Proceeding for permanent injunctive relief, restitution, and damages whenever a person or business engages in "repeated" or "persistent fraud or illegality."[13] (Executive Law § 63[12] ["[w]henever any person shall engage in repeated fraudulent or illegal acts . . . the attorney general may apply . . . on notice of five days" for relief].) A Special Proceeding as authorized under Executive Law § 63(12) is "as plenary as an action, culminating in a judgment, but is brought on with the ease, speed, and economy of a mere motion." (Siegel & Connors, N.Y. Practice § 547 at 1054 [6th ed. 2018].)

33. A Special Proceeding goes directly to the merits. The Court is required to make a summary determination upon the pleadings, papers, and admissions to the extent that no triable issues of fact are raised. (*See* CPLR 409.) To the extent factual issues are raised, they must be tried

[13] Executive Law § 63(12) defines "fraud" and "fraudulent" conduct broadly to include "any device, scheme or artifice to defraud and any deception, misrepresentation, concealment, suppression, false pretense, false promise or unconscionable contractual provisions." "[I]llegality" includes the "continuance or carrying on of any fraudulent or illegal act or conduct." (*Id.*) A violation of any state, federal, or local law constitutes "illegality" within the meaning of Executive Law § 63(12) and is actionable thereunder when persistent or repeated. (*See State v Princess Prestige*, 42 NY2d 104, 107 [1977]; *see also People v Empyre Inground Pools, Inc.*, 227 AD2d 731, 733 [3d Dept 1996]; *Lefkowitz v E.F.G. Baby Products*, 40 AD2d 364, 367 [3d Dept 1973]; *State v Mgmt. Transition Res.*, 115 Misc 2d 489, 490–491 [Sup Ct, NY County 1982] [career counseling service that operated as an employment agency without a license and improperly took up-front fees violated Executive Law § 63[12] prohibition on illegality].)

"forthwith." (CPLR 410.) It is the very purpose of a Special Proceeding to provide a summary remedy.

34. The Attorney General is also empowered under the Tweed Law to investigate the misappropriation and misuse of any government funds. (*See* Executive Law § 63-c; *see also Cuomo v Ferran*, 77 AD3d 698, 701–702 [2nd Dept 2010]; *State of New York v Franklin Nursing Home*, 65 AD2d 788, 788–789 [2nd Dept 1978] [Attorney General on behalf of the state may recover Medicaid overpayments].)

35. Further, Public Health Law § 2801-c provides that, "upon request of the [Commissioner of Health], the attorney general shall maintain an action in the supreme court in the name of the people of the state to enjoin any" violation or threatened violation of the provisions of Article 28 of the Public Health Law, or any DOH regulations promulgated thereunder."[14] Pursuant to Public Health Law § 2801-c, the New York State Commissioner of Health has specifically requested that the Attorney General seek injunctive relief in this action, in addition to any other remedies available by law. (*See* Sekhon Aff. Ex. 1.)

36. Venue is proper in this county pursuant to CPLR 503.

III. PARTIES

A. Petitioner

37. Letitia James is the Attorney General of the State of New York, and as such, she is authorized on behalf of the People of the State of New York to enjoin and seek restitution and disgorgement for repeated or persistent fraudulent or illegal practices in the conduct of a business

[14] Article 28 of the Public Law Health governs residential health care facilities, such as Fulton Commons. (*See* Public Health Law § 2800, *et seq.*)

pursuant to Executive Law § 63(12) and to recover government funds "without right obtained" pursuant to Executive Law § 63-c.

Corporate Respondents – the Fulton Commons Enterprise

38. At all times relevant hereto, Fulton Commons was a for-profit corporation organized in 2001 under the laws of the State of New York and located at 60 Merrick Avenue in East Meadow, New York, operating a 280-bed skilled nursing facility pursuant to 10 NYCRR § 415.2(k), and is enrolled as a provider of services to Medicaid and Medicare recipients. The facility has seven units, with 40 beds on each unit. (*See* Tarpey Aff. Ex. 3 at 76.) Since 2018, Fulton Commons has been owned by Respondents Moshe Kalter (42%); Aaron Fogel (30%); Frady Kalter (10%); Esther Fogel (10%); Mindy Steger (1%); Sheindy Saffer (1%); Chana Kanarek (1%); Dovid Kalter (1%); Yitzchok Kalter (1%); Aryeh Kalter (1%); Sheva Treff (1%); and Chaya Lieberman a/k/a Sara Lieberman (1%).

39. At all times relevant hereto, New Fulton was a limited liability company organized under the laws of the State of New York and located at 143-10 20th Avenue in Whitestone, New York. New Fulton was responsible for providing payroll, contracting, and procurement services to Fulton Commons. At all times relevant hereto, Fulton Commons transferred the majority of its revenue to New Fulton, which, in turn, paid all of Fulton Commons' purported expenses. New Fulton was owned by Moshe Kalter (90%) and Frady Kalter (10%).

40. At all times relevant hereto, Fulton Realty LP was a for-profit corporation organized under the laws of the State of New York and located at 60 Merrick Avenue in East Meadow, New York. Fulton Realty LP was and remains the 100% owner of the real property located at 60 Merrick Avenue in East Meadow, New York, and was and still is the landlord of Fulton Commons. At all times relevant hereto, no written lease existed between Fulton Realty LP

and Fulton Commons. Fulton Realty LP was and still is owned by Moshe Kalter (58%), Aaron Fogel (40%), and Fulton Realty Inc. (2%).

41. At all times relevant hereto, Fulton Realty Inc. was and remains a for-profit corporation organized under the laws of the State of New York and located at 60 Merrick Avenue in East Meadow, New York. Fulton Realty Inc. was and remains a 2% owner of Fulton Realty LP. Kalter was and still is the President of Fulton Realty Inc., and at all relevant times hereto, distributions for its 2% ownership stake in Fulton Realty LP were paid to Kalter.

42. At all times relevant hereto, New Bridge View was and remains a for-profit corporation organized under the laws of the State of New York and located at 143-10 20th Avenue in Whitestone, New York. At all times relevant hereto, New Bridge View was the centralized business office for the Sister Facilities, as defined in ¶ 43 *infra*, which provided bookkeeping services to New Fulton and Fulton Commons, and was and remains the employer of Respondent Weiss. New Bridge View was and still is owned by Moshe Kalter (90%), and Frady Kalter is its Vice President.

B. Individual Respondents

43. Respondent Moshe Kalter resides in Kings County, New York, and was at all times relevant hereto: (1) an operator of Fulton Commons pursuant to Public Health Law § 2801-a; (2) an owner of Fulton Commons (42%),[15] Fulton Realty LP (58%),[16] New Fulton (90%), and New Bridge View (90%); (3) President of Fulton Realty Inc.; and (4) an operator and owner of three

[15] Prior to 2018, Kalter was a 50% owner of Fulton Commons. In or around 2018, Kalter transferred each of his eight adult children a 1% ownership interest in Fulton Commons, thereby reducing his ownership percentage to 42%. (*See* Ronan Aff. Ex. 1 at 98–102.)

[16] At all relevant times hereto, Kalter received 60% of any and all distributions from Fulton Realty LP, which is inclusive of Fulton Realty Inc.'s 2% share.

other nursing homes: Bridge View Nursing Home, Inc., Mayfair Care Center, Inc., and Midway Nursing Home, Inc. (collectively referred to hereinafter as "the Sister Facilities").[17] Kalter controlled and still controls the Fulton Commons Enterprise and the Sister Facilities Enterprises. Since 2005, Kalter has signed the annual Certification by Operator for Fulton Commons as required by 10 NYCRR § 86-2.6—falsely attesting since as early as 2018 that all of Fulton Commons' reported statements were true and that all expenses "were incurred to provide patient care in the facility." (Ronan Aff. Ex. 4.)

44. Respondent Aaron Fogel is Kalter's brother-in-law, resides in Israel, and at all times relevant hereto was an owner of Fulton Commons (30%) and Fulton Realty LP (40%).

45. Respondent Frady Kalter is Aaron Fogel's sister and the wife of Moshe Kalter, with whom she resides in Kings County, New York, and at all times relevant hereto was an owner of Fulton Commons (10%) and New Fulton (10%), and Vice President of New Bridge View.

46. Respondent Esther Fogel is the wife of Aaron Fogel, with whom she resides in Israel, and at all times relevant hereto was a 10% owner of Fulton Commons.

47. Respondent Mindy Steger is a daughter of Moshe and Frady Kalter, resides in Ocean County, New Jersey, and at all times relevant hereto was a 1% owner of Fulton Commons.

48. Respondent Sheindy Saffer is a daughter of Moshe and Frady Kalter, resides in Ocean County, New Jersey, and at all times relevant hereto was a 1% owner of Fulton Commons.

49. Respondent Chana Kanarek is a daughter of Moshe and Frady Kalter, resides in Ocean County, New Jersey, and at all times relevant hereto was a 1% owner of Fulton Commons.

[17] The Sister Facilities each have a business model similar to Fulton Commons with related operating companies. Collectively, the Sister Facilities and their related parties will be referred to herein as the "Sister Facilities Enterprises." (*See* Ronan Aff. at ¶ 41.)

50. Respondent Dovid Kalter is a son of Moshe and Frady Kalter, resides in Ocean County, New Jersey, and at all times relevant hereto was a 1% owner of Fulton Commons.

51. Respondent Yitzchok Kalter is a son of Moshe and Frady Kalter, resides in Ocean County, New Jersey, and at all times relevant hereto was a 1% owner of Fulton Commons.

52. Respondent Aryeh Kalter is a son of Moshe and Frady Kalter, resides in Ocean County, New Jersey, and at all times relevant hereto was a 1% owner of Fulton Commons.

53. Respondent Sheva Treff is a daughter of Moshe and Frady Kalter, resides in Ocean County, New Jersey, and at all times relevant hereto was a 1% owner of Fulton Commons.

54. Respondent Chaya Lieberman a/k/a Sara Lieberman is a daughter of Moshe and Frady Kalter, resides in Ocean County, New Jersey, and at all times relevant hereto was a 1% owner of Fulton Commons.

55. Respondent-owners each have an ownership interest in at least one, if not all, of the Sister Facilities. (*See* Ronan Aff. at ¶ 43.)

56. Respondent Steven Weiss is a nephew of Moshe Kalter and Frady Kalter, resides in Kings County, New York, and all times relevant hereto was the Comptroller of Fulton Commons, New Fulton, Fulton Realty LP, and New Bridge View.

57. Respondent Cathie Doyle resides in Suffolk County, New York, and at all times relevant hereto was the Licensed Administrator of Fulton Commons. According to information recently provided to the Attorney General, Respondent Doyle's employment at Fulton Commons ended on November 16, 2022.

IV. LAWS PROTECTING NURSING HOME RESIDENTS FROM NEGLECT, ABUSE, AND MISTREATMENT AND PROHIBITING MISUSE OF HEALTHCARE FUNDS

58. The New York State and federal statutes and regulations relevant to this Special Proceeding are contained in, inter alia, the Public Health Law, Social Services Law, and Title 42 of the United States Code. Specifically, the Public Health Law and its related regulations govern nursing home care, ownership, and financial disclosures. The Social Services Law and its related regulations govern claims under the Medicaid Program. Finally, Title 42 of the United States Code and its related regulations provide federal requirements for nursing homes, many of which are mirrored by the state regulations contained in the Public Health Law. These laws and regulations place clear requirements on Fulton Commons to deliver quality healthcare to its residents, which Respondents Fulton Commons, Kalter, Weiss, and Doyle failed to do, thereby necessitating both injunctive relief and disgorgement pursuant to the Executive Law and common law unjust enrichment.

59. Article 28 of the Public Health Law sets forth requirements imposed on nursing homes, as well as their owners, operators, and managers. As detailed herein, Fulton Commons, Respondent-owners, Weiss, and Doyle violated numerous provisions of Article 28, including:

- **Public Health Law § 2803-c**: Nursing home residents' rights.
    - **Public Health Law § 2803-c(2)**: Requires that every nursing home adopt "a statement of the rights and responsibilities of the patients who are receiving care in such facilities, and shall treat such patients in accordance with the provisions of such statement." This is also known as the "Patient's Bill of Rights."
    - **Public Health Law § 2803-c(3)(e)**: Every patient shall have the right to receive adequate and appropriate medical care, to be fully informed of his or her medical condition and proposed treatment unless medically contraindicated, and to refuse medication and treatment after being fully informed.
    - **Public Health Law § 2803-c(g)**: Every patient shall have the right to receive courteous, fair, and respectful care and treatment.

- **Public Health Law § 2803-c(h)**: Every patient shall be free from mental and physical abuse and from physical and chemical restraints.

- **Public Health Law § 2803-d**: Requires that the facility and almost all staffers report to DOH whenever there is "reasonable cause to believe that a person receiving care or services in a residential health care facility has been abused, mistreated, neglected or subjected to the misappropriation of property by other than a person receiving care or services in the facility."

- **Public Health Law § 2808(5)**: Asset and equity transfers from nursing homes.

  - **Public Health Law § 2808(5)(a)**: Limitations on the withdrawal of funds from nursing homes that would create or increase a negative net worth position without the approval of DOH.

  - **Public Health Law § 2808(5)(c)**: Limitations on the withdrawal of funds from nursing homes without the approval of DOH, referred to herein as "the 3% Rule."

60. Regulations of DOH adopted under Article 28 of the Public Health Law and codified in Title 10 of the New York Codes, Rules and Regulations that were violated by Fulton Commons, Respondent-owners, Weiss, and Doyle include:

- **10 NYCRR § 86-2.6**: Certification of Cost Report by Operator.

- **10 NYCRR § 400.19(b)(1)**: Forbidding withdrawal of equity and/or transfer of assets without DOH approval where "such a withdrawal would create or increase a negative net worth position for the facility or occur when the facility is in a negative net worth position."

- **10 NYCRR § 415.3**: Resident Bill of Rights.

  - **10 NYCRR § 415.3(a)**: Requirement that nursing homes "ensure that all residents are afforded their right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration and privacy in treatment and care for personal needs, and communication with and access to persons and services inside and outside the facility."

  - **10 NYCRR § 415.3(f)(1)(i)**: Requirement that nursing homes provide "adequate and appropriate medical care" and fully inform each resident of their "total health status."

  - **10 NYCRR § 415.3(f)(1)(iv)**: Requirement that each resident "be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being."

- **10 NYCRR § 415.3(f)(2)(ii)**: Requirement that each resident be consulted with immediately if competent, and the resident's physician and designated representative be notified within 24 hours when there is an accident involving the resident that results in injury requiring professional intervention; a significant improvement or decline in the resident's physical, mental, or psychosocial status in accordance with generally accepted standards of care and service; or a need to alter treatment significantly.

- **10 NYCRR § 415.4**: Requirement that nursing homes "provide each resident with considerate and respectful care designed to promote the resident's independence and dignity in the least restrictive environment . . . ."

  - **10 NYCRR § 415.4(a)**: Requirement that nursing homes ensure their residents are free from chemical restraints (psychotropic medications administered for discipline or convenience and not required to treat a resident's medical condition) and physical restraints (unless used for the health and safety of the resident and required by the resident's care plan).

  - **10 NYCRR § 415.4(b)**: Requirement that nursing homes develop and implement written policies and procedures prohibiting neglect, abuse, or mistreatment of their residents and misappropriation of resident property.

- **10 NYCRR § 415.5**: Requirement that nursing homes care for their residents in a manner and environment that promotes quality of life.

  - **10 NYCRR § 415.5(a)**: Requirement that nursing homes care for their residents in a manner that promotes dignity.

  - **10 NYCRR § 415.5(f)(1)**: Requirement that nursing homes offer each resident activities that meet the physical, mental, and psychosocial well-being of that resident and "promote and maintain the resident's sense of usefulness . . . , make his or her life more meaningful, stimulate and support the desire to use his or her physical and mental capabilities to the fullest extent and enable the resident to maintain a sense of usefulness and self-respect."

  - **10 NYCRR § 415.5(h)**: Requirement that nursing homes provide a safe, clean, comfortable, sanitary, and orderly environment.

- **10 NYCRR § 415.11**: Requirement that nursing homes conduct comprehensive assessments of each resident's capability of performing daily life functions upon admission and periodically thereafter.

- **10 NYCRR § 415.12**: Requirement that "[e]ach resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care . . . ."

- **10 NYCRR § 415.12(c)**: Requirement that nursing homes ensure that residents who are admitted without pressure injuries do not develop such injuries unless they were unavoidable despite reasonable efforts to prevent them and, further, that residents with pressure injuries receive necessary treatment.

- **10 NYCRR § 415.12(d)**: Requirement that nursing homes ensure that residents who are incontinent receive the necessary treatment and services to prevent UTIs.

- **10 NYCRR § 415.12(h)**: Requirement that nursing homes provide each resident with adequate supervision to prevent accidents.

- **10 NYCRR § 415.12(i)**: Requirement that nursing homes ensure that residents maintain acceptable parameters of nutritional status and receive therapeutic diets when there is a nutritional problem.

- **10 NYCRR § 415.13**: Requirement that nursing homes "have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual care plans." Further, the facility must ensure that its residents receive "treatments, medications, diets and other health services in accordance with individual care plans."

  - **10 NYCRR § 415.13(a)(1)**: Requirement that nursing homes "provide services by sufficient numbers" of various "personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans," including RNs, LPNs, CNAs, and other nursing personnel.

- **10 NYCRR § 415.14**: Requirement that nursing homes "provide each resident with a nourishing, palatable well-balanced diet that meets the daily nutritional and special dietary needs of each resident."

- **10 NYCRR § 415.15**: Requirement that nursing homes "develop and implement medical services to meet the needs of its residents."

- **10 NYCRR § 415.18**: Requirement that nursing homes "provide pharmaceutical services" and acquire, receive, dispense, and administer "all drugs and biologicals required to meet the needs of each resident."

- **10 NYCRR § 415.19**: Requirement that nursing homes "establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection."

- **10 NYCRR § 415.26**: Requirement that nursing homes are administered in a manner enabling them to effectively and efficiently utilize their resources to attain or maintain their residents' "highest practicable physical, mental, and psychosocial well-being."

- **10 NYCRR § 415.26(b)**: Requirement that nursing homes "have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility."

- **10 NYCRR § 415.26(c)**: Requirement that nursing homes "employ on a full time, part time or consultant basis a sufficient number of professional staff members who are educated, oriented and qualified . . . to assure the health, safety, proper care and treatment of the residents."

- **10 NYCRR § 415.26(h)(7)**: Requirement that nursing homes and their governing bodies seek DOH approval prior to making any withdrawal of funds from the facility that would create or increase a negative net worth position.

- **10 NYCRR § 415.26(i)(1)(ii)**: Requirement that nursing homes "accept and retain only those . . . residents for whom [they] can provide adequate care."

- **10 NYCRR § 415.27**: Requirement that nursing homes establish and maintain a quality assessment and assurance program that reviews "activities of all nursing home programs and services to enhance the quality of life and resident care and treatment."

- **10 NYCRR § 415.29**: Requirement that nursing homes be "designed, constructed, equipped and maintained to provide a safe, healthy, functional, sanitary and comfortable environment for residents, personnel and the public."

- **10 NYCRR § 600.9**: Establishing that the governing authority or operator is the party responsible for the operation of a nursing home.

- **10 NYCRR § 702.4**: Requirement that nursing homes report certain infection control data to DOH.

61. As a Medicaid participant, Respondents Fulton Commons, Kalter, Weiss, and Doyle also violated the following similar federal statutes under Title 42 of the United States Code ("USC") and Title 42 of the Code of Federal Regulations ("CFR") that were promulgated by HHS for the protection of nursing home residents:

- **42 USC § 1320b-25**: Requirement that nursing homes report crimes occurring within the facility to law enforcement.

- **42 CFR § 483.10**: Requirement that nursing homes treat residents with respect and dignity, provide all services in care plans, and keep residents free from restraints.

- **42 CFR § 483.12**: Requirement that residents be free from neglect, abuse, misappropriation of property, and exploitation.

- **42 CFR § 483.20**: Requirement that nursing homes develop personalized care plans and assess and review them periodically.

- **42 CFR § 483.24**: Requirement that nursing homes provide necessary care and services "to attain or maintain the highest practicable physical, mental and psychosocial well-being" of each resident and ensure that residents' abilities to do activities of daily living do not diminish unnecessarily; further requiring that nursing homes provide services for grooming, good nutrition, and hygiene.

- **42 CFR § 483.25**: Requirement that nursing homes ensure residents receive treatment and care in accordance with professional standards, care plans, and resident choice.

    - **42 CFR § 483.25(b)(1)**: Requirement that residents receive care to prevent pressure injuries and do not develop pressure injuries unless the resident's clinical condition demonstrates they were unavoidable.

    - **42 CFR § 483.25(b)(2)**: Requirement that nursing homes ensure residents receive proper treatment to maintain good foot health, including foot care and treatment to prevent complications from the resident's medical condition.

- **42 CFR § 483.35**: Requirement that nursing homes "have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment . . . ."

- **42 CFR § 483.45**: Requirement that nursing homes provide residents with pharmaceutical services, including the administration of routine and emergency drugs, to meet their individual needs.

- **42 CFR § 483.55**: Requirement that nursing homes "assist residents in obtaining routine and 24-hour emergency dental care."

- **42 CFR § 483.60**: Requirement that nursing homes "provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident"; employ sufficient staff for food and nutrition services; and that staff must possess appropriate competencies for care plans.

- **42 CFR § 483.70(d)**: Requirement that nursing homes have a governing body "that is legally responsible for establishing and implementing policies regarding the management and operation of the facility."

- **42 CFR § 483.80(a)(1)**: Requirement that nursing homes' infection control and prevention programs include a system for preventing, identifying, reporting, investigating, and controlling infection.

- **42 CFR § 483.80(b)**: Requirement that nursing homes designate at least one individual as the infection preventionist, who is responsible for the facility's infection control program.

62. Respondent Fulton Commons also violated Education Law § 6512, which prohibits the unauthorized practice of "any profession in which a license is a prerequisite," or the aiding and abetting of such unlicensed practice.

63. Respondents also violated the following Medicaid financial regulations that are promulgated under the Social Services Law, necessitating injunctive relief, disgorgement, and damages under Executive Law § 63(12), Executive Law § 63-c, and/or the equitable remedy of unjust enrichment:

- **18 NYCRR § 504.6(d):** A provider may only submit claims for services provided in compliance with Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State.
- **18 NYCRR § 515.2(b)**: Unacceptable Practices constituting fraud and abuse of the Medicaid Program, including:
    - **18 NYCRR § 515.2(b)(1)**: Submitting or causing to be submitted false claims for unfurnished medical care, services, or supplies;
    - **18 NYCRR § 515.2(b)(2)**: Making, or causing to be made any false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment, or for using in determining the right to payment;
    - **18 NYCRR § 515.2(b)(4)**: Converting a medical assistance payment, or any part of such payment, to a use or benefit other than for the use and benefit intended by the medical assistance program; and
    - **18 NYCRR § 515.2(b)(12)**: Furnishing medical care, services, or supplies that fail to meet professionally recognized standards for health care.

V. ATTORNEY GENERAL'S FINDINGS OF FACTS

64. As the result of an investigation conducted pursuant to Executive Law §63(12), the Attorney General has taken proof and made a determination as to the relevant facts concerning repeated and persistent fraud and illegality by Respondents, which includes: (1) compromising the

safety, health, and well-being of the residents of Fulton Commons; and (2) wrongfully converting Medicaid and Medicare funds for their personal enrichment. The Attorney General finds that Respondents have violated New York State and federal law as follows.

A. Fulton Commons is Funded by Government Healthcare Dollars

65. Medicaid is a joint state and federal program, which is primarily funded by New York State and federal taxpayer monies. The Medicaid Program provides no-cost medical services and goods to eligible needy persons. Individuals must meet defined disability or income thresholds to be eligible for Medicaid.

66. In New York State, Medicaid providers such as nursing homes are reimbursed either on a fee-for-service basis ("FFS"), through which healthcare providers bill the state directly for Medicaid services, or through claims submitted to Medicaid Managed Care Organizations, which manage funds and coverage on behalf of the state. In order to obtain authorization from DOH to enroll in the Medicaid Program, providers agree to comply with its governing laws, rules, and regulations.

67. Providers may only submit Medicaid claims for reimbursement for services provided in compliance with 18 NYCRR § 504.6(d).

68. Medicare is a health care insurance program for elderly individuals, which is funded by federal taxpayers.

69. All of Fulton Commons' residents are vulnerable, elderly and/or disabled individuals. Many of its residents are Medicaid and/or Medicare beneficiaries, and their care is paid for by state and federal taxpayers.

70. Fulton Commons reported more than $105,834,966 in revenue from Medicaid (FFS) and Medicare from January 1, 2018 to December 31, 2021, for the alleged provision of critical care to its residents. (*See* Ronan Aff. at ¶ 93.)

B. Respondents Fulton Commons, Kalter, Weiss, and Doyle Repeatedly and Persistently Violated Residents' Rights Through Repeated Neglect, Abuse, and Mistreatment

71. Respondents' repeated and persistent violations of laws, rules, and regulations through the Fulton Commons Enterprise continues to result in systemic and pervasive resident neglect, abuse, and mistreatment, and thus warrants expeditious injunctive relief through this Special Proceeding to protect Fulton Commons' current and prospective residents.

72. As previously detailed in ¶ 8 *supra*, at all relevant times, New York State law imposed on Fulton Commons a "special obligation" to care for its residents, including by providing each resident with the care, treatment, diet, and health services needed to attain their "highest practicable" level of well-being whilst promoting quality of life and dignity. (10 NYCRR §§ 415.1[a][1]–[2], 415.5, 415.13, 415.26.)

73. Left completely unchecked by Respondent Kalter, the nursing home's operator and governing body, Respondents Fulton Commons, Weiss, and Doyle repeatedly and persistently neglected, abused, and mistreated Fulton Commons' vulnerable residents since as early as January 2018 , as detailed below, and failed to comply with state and federal regulations designed to protect and promote the well-being of nursing home residents. All the while, Respondents Fulton Commons and Kalter simultaneously submitted fraudulent claims to the Medicaid and Medicare Programs and accepted significant taxpayer dollars intended for the provision of necessary resident care.

1. Between January 2019 and March 2022, DOH Cited Fulton Commons Multiple Times for Violations of State and Federal Law for Deficiencies that Harmed and/or Increased Risks to Residents

74. Between January 4, 2019 and March 31, 2022, DOH sanctioned Fulton Commons 12 times for violations of state and federal nursing home laws, rules, and regulations. (*See* Ronan Aff. at ¶ 95.) Nine of these citations were categorized as standard health citations, with two of the nine relating to actual harm or immediate jeopardy. (*Id*. at ¶ 96.) The remaining three citations were categorized as standard life safety code citations. (*Id*. at ¶ 97.)

75. On January 4, 2019, DOH conducted an on-site survey and cited Fulton Commons for five deficiencies. Notably, DOH found that Fulton Commons failed to: (1) implement a resident's comprehensive care plan by offering the resident a straw with meals despite the resident's care plan prohibiting straws due to a risk of aspiration; (2) review and revise one resident's care plan for seven months, despite the resident having had three assessments during that period; and (3) ensure that food was stored and handled in accordance with professional standards for food service safety, in that: (i) a CNA served food that she touched with her bare hands to two residents; and (ii) Fulton Commons' dairy walk-in freezer regularly failed to maintain a freezing temperature, and a dietary supervisor took no steps to correct the issue despite being on notice. (*Id*. at ¶ 98; *see also* Ronan Aff. Ex. 9.)

76. On July 30, 2019, DOH conducted an on-site survey and cited Fulton Commons for failing to ensure that the environment remained secure and free of accidents and that residents were adequately supervised. Specifically, a resident with severely impaired cognition and at moderate risk for elopement exited the facility through Fulton Commons' perimeter exit door, which failed to alarm. The resident's elopement went unnoticed by Fulton Commons staff for

several minutes. The resident was found more than an hour later, nearly half a mile away. (*See* Ronan Aff. at ¶ 99; *see also* Ronan Aff. Ex. 10.)

77. On May 15, 2020, during the first wave of the COVID-19 pandemic, DOH conducted an on-site survey and cited Fulton Commons for failing to maintain an infection control program to prevent the development and transmission of communicable disease and infection. (*See* Ronan Aff. at ¶ 100; *see also* Ronan Aff. Ex. 11.) Specifically: (1) a housekeeper failed to appropriately wear PPE while cleaning a room in Fulton Commons' COVID-19 designated unit; and (2) a CNA failed to wash her hands between transporting two different residents to their rooms. (*See* Ronan Aff. at ¶ 100; *see also* Ronan Aff. Ex. 11.)

78. On July 28, 2021, DOH conducted an on-site survey and cited Fulton Commons for failing to ensure residents were free from significant medication errors. (*See* Ronan Aff. at ¶ 102; *see also* Ronan Aff. Ex. 13.) Upon information and belief, this citation relates to former Fulton Commons resident W.V., who was hospitalized and received a blood transfusion after Fulton Commons staff failed to administer the proper dosage of medication necessary for W.V. to maintain safe blood oxygen/hemoglobin levels. (*See* ¶ 84[v] *infra*; *see also* Doherty Aff.; Ronan Aff. at ¶ 102.)

79. Moreover, on January 10, 2022, DOH conducted an on-site survey and determined Fulton Commons was in IJ based upon three deficiencies. (*See* Ronan Aff. at ¶¶ 103–105; *see also* Ronan Aff. Ex. 14.) One such deficiency was that Fulton Commons "failed to ensure its residents were free from abuse and neglect" following the nursing home's failure to report an allegation of sexual abuse, and for allowing the accused LPN to continue to provide care to residents. (*Id.*; *see also* ¶ 11 *supra,* ¶ 81[iii] *infra*.) Ultimately, Fulton Commons was criminally indicted for this failure, as detailed in ¶ 12 *supra*.

2. Fulton Commons Repeatedly and Persistently Neglected, Abused, and Mistreated its Residents from 2018 through at Least January 2022, in Violation of a Myriad of State and Federal Laws, Including Public Health Law § 2803-d(7)

80. Neglect, abuse, and mistreatment, as defined by 10 NYCRR § 81.1, are violations of law subject to penalties pursuant to Public Health Law § 2803-d(7). Fulton Commons repeatedly and persistently neglected, abused, and mistreated its residents by failing to provide necessary and appropriate services, as detailed herein. Included in ¶¶ 86, 87, and 90–91 *infra*, are certain images depicting Fulton Commons' resident neglect, which may be disturbing to some readers.

81. In violation of Public Health Law §§ 2803-c(h), 2803-d(7), 10 NYCRR § 415.4(b), 42 CFR § 483.12, and 42 USC § 1320b-25, Fulton Commons repeatedly abused and mistreated its residents and failed to report these acts of neglect, abuse, or mistreatment to law enforcement.

i. Fulton Commons staff mistreated Resident S.K. by physically restraining her, in violation of Public Health Law § 2803-d(7). (*See also* 10 NYCRR § 81.1[b]). Specifically, on one occasion prior to the COVID-19 pandemic, S.K.'s son arrived at Fulton Commons and discovered that his mother had been unlawfully tied to her wheelchair with clothing. (*See* Costa Aff. at ¶ 10.)

ii. Fulton Commons staff mistreated Resident G.G., an 87-year-old man who resided at Fulton Commons from April 28, 2020 until May 17, 2020, by chemically restraining him, in violation of Public Health Law § 2803-d(7). (*See also* 10 NYCRR § 81.1[b]). After viewing a video taken from a FaceTime call depicting Fulton Commons staff unsuccessfully attempting to wake G.G., his daughter expressed concerns for her father's well-being to the facility. His daughter was informed that G.G. was on several strong medications, including Ativan (a sedative), Seroquel (an antipsychotic), Neurontin (an anticonvulsant), and Melatonin (a natural sleep aid). G.G.'s daughter accused Fulton Commons of chemically restraining him—resulting in a Fulton Commons physician reducing the dosages of, or altogether discontinuing, all four of these medications. (*See* Affidavit of Nancy Fletcher ["Fletcher Aff."].)

iii. In November 2022, Fulton Commons and former DON Carol Frawley were criminally indicted for repeatedly failing to report allegations of sexual abuse to DOH and law enforcement and allowing the accused LPN to continue providing care, thereby endangering Fulton Commons residents.

a. As noted in ¶ 81[iii] *infra*, DOH determined that Fulton Commons placed its residents in immediate jeopardy of "abuse," which is "inappropriate physical contact with a . . . resident . . . , which harms or is likely to harm" the resident. (10 NYCRR § 81.1[a]; *see also* Ronan Aff. Ex. 14.)

1. On December 25, 2021, a female resident with intact cognition reported to an RN Supervisor that an LPN inappropriately touched her vaginal area by placing his hand in her brief when not rendering care. Nonetheless, that LPN was permitted to continue working at the facility and allowed to provide resident care, in violation of 10 NYCRR § 415.4(b)(1). Consistent with Fulton Commons' culture of covering up wrongdoing, the incident was not reported to law enforcement or DOH—in contravention of the nursing home's legally prescribed duties. (*See* Public Health Law § 2803-d[7]; 10 NYCRR § 415.4[b][1][iii]; 42 USC § 1320b-25.)

2. Subsequently, on January 3, 2022, a second resident reported that on January 2, 2022, the same LPN exposed his genitalia to the resident and stated, "If you help me, I'll help you." (Ronan Aff. Ex. 14.) Once again, in violation of its legal duty, Fulton Commons failed to report this incident to law enforcement. (*See* Public Health Law § 2803-d[7]; 10 NYCRR § 415.4[b][1][iii]; 42 USC § 1320b-25.)

3. Fulton Commons treated both incidents as "grievances"[18] rather than incidents of abuse, in accordance with Fulton Commons' shocking and dangerous policy. (*See* Ronan Aff. Ex. 14.) The failure to comport with the law is particularly egregious as 10 NYCRR § 415.1 makes clear that New York State's nursing home regulations' specific, detailed requirements are grounded in "a firm belief that experience has proven the specific practice to be necessary in all cases to assure the high quality of care [expected of] nursing homes . . . ." (10 NYCRR § 415.1[a][4].) Prohibiting and reporting neglect, abuse, and mistreatment is one of those specific requirements (*see* 10 NYCRR § 415.4[b][1]–[2]; *see also* Public Health Law § 2803-d[7]) due to the inherent danger they pose to nursing home residents.

4. DOH held Fulton Commons in IJ until February 24, 2022, when they approved a Fulton Commons Plan of Correction for systemic changes to its policies and procedures, including requiring that all allegations of sexual abuse be handled as accidents/incidents necessitating an immediate investigation and reporting to DOH and local law enforcement when appropriate. (*See* Ronan Aff. Ex. 14.)

[18] A "grievance" is typically a lower-level complaint that is handled by a nursing home social worker. In contrast, an allegation of sexual assault or abuse should be treated as an incident requiring an investigation by the facility and a report to DOH and law enforcement. (*See* RN Conway Aff at ¶¶ 109–110.)

b. Moreover, on September 30, 2022, Fulton Commons notified DOH that the facility failed to report an incident of sexual abuse that occurred two years prior involving the same LPN who was the subject of the January 2022 IJ. Specifically, Fulton Commons reported that a female resident alleged that this male LPN grabbed her left breast. Although the resident promptly reported this incident to her assigned CNA and to another LPN, this sexual abuse allegation was not reported by Fulton Commons to DOH or law enforcement for approximately two years.

82. In violation of Public Health Law § 2803-c(g), 10 NYCRR §§ 415.5, 415.12(d), and 42 CFR §§ 483.10, 483.24, Fulton Commons repeatedly and persistently neglected its residents by failing to answer their cries for help or provide them with timely toileting and incontinence care, thereby harming their physical and mental well-being.

i. Fulton Commons' records documented that over 30 residents were treated for UTIs during the three-month period between March 1, 2020 and May 31, 2020. Prevalence of UTIs within a nursing home is an indicator of resident neglect, as UTI's frequently develop when residents experience excessive delays in receiving assistance with toileting, causing residents to hold their urine for lengthy periods of time. (*Id.*) Notably, Fulton Commons staff euphemistically reported that during this time, residents who required assistance with walking to the restroom "might not have gotten such assistance . . . as often as [they] would have liked." (Tarpey Aff. at ¶ 14; *see also* RN Conway Aff. at ¶¶ 77–78, 87.)

ii. Resident F.H. was on a FaceTime call with his son just prior to the COVID-19 lock-down during which F.H. was screaming out in pain from a UTI, but no staff responded. His son immediately called the nurse's station, located mere feet from F.H.'s room, and the Fulton Commons staff member blatantly lied and claimed F.H. was resting comfortably.[19] (*See* Hoerauf Aff. at ¶ 15.)

iii. Resident E.M. sent her family text messages as early as 2017 complaining that "[Respondent Doyle] now doesn't hire any new aides" and that "[n]o aides saves money less people get good service." Thereafter, E.M. sent a text message dated April 15, 2018, reporting that no aides were working the night before and no one assisted her in changing her disposable brief. (*See* Milack Aff. at ¶ 6.)

[19] Notably, Fulton Commons unlawfully obstructed MFCU's attempts to obtain and review F.H.'s medical records through its improper and baseless rejection of a lawfully issued Executive Law § 63(12) subpoena that demanded such records. That subpoena is attached to the Sekhon Aff. as Exhibit 3 along with Respondent Fulton Commons' documented unjustifiable rejection. Accordingly, Respondents should now be precluded from presenting contrary interpretations of F.H.'s treatment based on the undisclosed records.

iv. Fulton Commons staff repeatedly neglected Resident V.T. during his stay from September 2018 until his death on March 30, 2020, by failing to timely assist him in using the toilet and/or changing his disposable brief. V.T.'s daughter was frequently forced to try to find someone to help him with toileting, assistance that Fulton Commons was obligated yet failed to provide. Notably, V.T. contracted several UTIs while at Fulton Commons. (*See* Affidavit of Rosemary Gregus ["Gregus Aff."] at ¶ 9; *see also* RN Conway Aff. at ¶¶ 81, 89.)

v. Fulton Commons staff routinely failed to timely change Resident E.B.'s disposable briefs during her stay at the facility from January 2016 until her death on February 18, 2021. E.B. regularly complained to her daughter that Fulton Commons staff members failed to timely respond to her call bell when she needed assistance in changing her soiled disposable briefs. On one such occasion during the COVID-19 lock-down, Fulton Commons failed to change E.B.'s soiled disposable brief for approximately 15 hours—spanning two shifts—which caused her to suffer a skin breakdown. (*See* Affidavit of Kristen Traina ["Traina Aff."] at ¶ 7; *see also* ¶ 82[i] *infra* [staff members euphemistically reported residents were not changed "as often as [they] would have liked]."]

vi. Fulton Commons staff regularly failed to promptly respond to Resident P.C.'s call bell during her stay between July and October 2021, even though P.C. had a hip injury that required Fulton Commons to assist her with walking to and from the bathroom when she needed to use the toilet. (*See* Affidavit of Emma Cruz ["Cruz Aff."] at ¶ 6.)

vii. Fulton Commons staff regularly failed to timely respond to requests for help from Resident D.L. D.L. resided at Fulton Commons between September 2021 and February 2022 and required assistance ambulating, or otherwise transporting, to the bathroom due to weakness on the right-side of his body. Fulton Commons' failure to timely respond to his requests caused him to suffer a loss of dignity and to experience multiple falls. (*See* Lennon Aff.)

a. On or about October 11, 2021, Fulton Commons staff failed to promptly respond to D.L.'s call bell for assistance to reach the bathroom. The delay in Fulton Commons' response led to D.L. defecating on himself, resulting in a loss of dignity. When a CNA finally responded, she yelled at D.L. and told him she would not clean him up. (*Id*. at ¶ 11.)

b. On or about October 13, 2021, Fulton Commons staff once again failed to timely respond to D.L. ringing the call bell for assistance to reach the bathroom. Fearful of getting yelled at again by Fulton Commons staff if he accidentally urinated or defecated on himself, D.L. attempted to walk to the bathroom himself and fell. (*Id*. at ¶ 12.)

c. Unsurprisingly, D.L. developed a UTI in October 2021. Specifically, on or about October 19, 2021, a speech pathologist informed D.L.'s wife that D.L. appeared confused and groggy. His wife insisted that D.L. be sent to a

hospital, where it was discovered that he was suffering from a UTI. (*Id*. at 14.)

d. Despite D.L.'s UTI diagnosis days earlier, on or about October 24, 2021, Fulton Commons staff yet again failed to promptly respond to his call bell. Due to Fulton Commons' unresponsiveness, D.L. attempted to walk to the bathroom himself and fell to the floor. D.L. waited helplessly on the floor for five hours until a staff member finally arrived at his room and assisted him. (*Id*. at ¶ 15.)

83. In violation of 10 NYCRR §§ 415.12(i), 415.13, and 415.14 and 42 CFR §§ 483.24 and 483.60, Fulton Commons repeatedly and persistently neglected its residents by failing to provide adequate and safe nutrition.

i. In a text message dated August 29, 2018, Resident E.M. reported that, in lieu of a hard-boiled egg, she was given a raw egg for breakfast, and was told by her caregivers that all the residents were given the same. Moreover, in a text message dated December 20, 2018, E.M. complained that the food was "disgusting," that she "had no lunch again today," and that she "pretty soon . . . will be down to one hundred pounds." (*See* Milack Aff. at ¶ 8.)

ii. Resident Ezekiel Sachs, a 73-year-old man who resided at Fulton Commons from April 25, 2020 to May 8, 2020, reported that, despite being admitted to Fulton Commons from a Coronary Care Unit, the facility failed to provide him with a heart-healthy diet, which resulted in an elevated, unhealthy cholesterol level of 259. Following Sachs' discharge from Fulton Commons, he placed himself on a heart-healthy diet, which brought his cholesterol level down to within normal range. (*See* Affidavit of Ezekiel Sachs ["Sachs Aff."] at ¶ 13.)

iii. Moreover, Fulton Commons routinely provided scant meals that were insufficient for Resident Sachs to maintain his weight. Other residents were similarly left to go hungry, and there was at least one occasion where Sachs' roommate took some oatmeal from Sachs' tray because he was hungry due to the lack of food provided to him by Fulton Commons. (*Id*. at ¶ 12.)

iv. Finally, as detailed in ¶ 75 *supra* and in Ronan Aff. Ex. 9, on January 4, 2019, DOH cited Fulton Commons for:

a. Increasing a resident's risk of aspiration by failing to follow their individual care plan for dining;

b. The unsanitary provision of food to two residents; and

c. The failure to follow food-safety storage requirements.

84. In violation of 10 NYCRR §§ 415.13 and 415.18 and 42 CFR § 483.45, Fulton Commons repeatedly and persistently neglected its residents by failing to administer necessary medications and treatments to meet the needs of each resident.

i. In a text message dated May 19, 2018, Resident E.M. reported that she did not receive her eye drops or Tylenol, despite having called for the nurse multiple times. Moreover, in a text message dated July 18, 2018, E.M. told a family member that she was experiencing bleeding when she used the bathroom but never received an antibiotic. (*See* Milack Aff. at ¶ 12.)

ii. Although Resident Sachs was prescribed medication for a fungal rash following his admission on April 25, 2020, he never received this medication—despite requesting it from the CNAs, desk nurse, and facility doctor. (*See* Sachs Aff. at ¶ 11.)

iii. Due to a constant barrage of staff in and out of Resident Sachs' room, he became sleep-deprived and asked Fulton Commons for over-the-counter sleep aids such as Melatonin or Benadryl. Despite his requests, Fulton Commons did not provide him with any sleep aids during his two-week stay. (*Id*. at ¶ 17.)

iv. Resident C.B. was admitted to Fulton Commons at the age of 52 in February 2021 but was hospitalized within a week due to Fulton Commons' failure to provide necessary medical treatment, which resulted in a dangerous decline in his condition. As previously detailed in ¶ 8 *supra,* Fulton Commons failed to connect C.B. to a Bi-Pap machine, thereby causing C.B., who was lucid and able to communicate, to significantly deteriorate and become delusional and comatose.[20] C.B. required a Bi-Pap machine to breathe correctly and to prevent excessive CO2 levels from developing in his body. Absent the Bi-Pap machine, elevated CO2 levels could affect C.B.'s brain and heart and lead to his death. Fulton Commons failed to connect C.B. to a Bi-Pap machine until his last day at the facility, leaving him disconnected for several days. On that final day, C.B.'s mother spoke to him and discovered that he was hallucinating. That same day, Fulton Commons staff informed C.B.'s mother that he was comatose. C.B. was hospitalized, and his oxygen levels were discovered to be in the 70th percentile. Following his transfer to the hospital, C.B.'s condition improved dramatically. (*See* Bernaerts Aff.; *see also* RN Conway Aff. at ¶ 107.)

[20] Notably, Fulton Commons unlawfully obstructed MFCU's attempts to obtain and review Resident C.B.'s medical records by its improper and baseless rejection of a lawfully issued Executive Law § 63(12) subpoena that demanded such records. That subpoena is attached to the Sekhon Aff. as Exhibit 3 along with Respondents' documented unjustifiable rejection. Accordingly, Respondents should now be precluded from presenting contrary interpretations of C.B.'s treatment based on the undisclosed records.

v. Resident W.V., an 81-year-old man, resided at Fulton Commons from June 25, 2021 to July 8, 2021, following a hospital stay. Fulton Commons failed to provide multiple, necessary services to W.V. and falsified facility records in an effort to conceal these failures. (*See* Doherty Aff.)

a. Although W.V. required the administration of supplemental oxygen 24 hours per day to breathe comfortably, Fulton Commons failed to connect him to his oxygen machine upon admission. W.V.'s daughter arrived for a visit the day after W.V.'s admission and found him without supplemental oxygen and without access to a call bell. As detailed in ¶ 8 *supra*, W.V.'s daughter felt compelled to pay an aide to stay overnight with W.V. to ensure he remained connected to his oxygen machine. (Doherty Aff. at ¶¶ 7, 10.)

b. Following W.V.'s removal from Fulton Commons by his family due to his deteriorating condition, it was discovered that Fulton Commons failed to give W.V. his required dosage of prednisone—medication he needed as treatment for pulmonary fibrosis and maintenance of safe blood oxygen/hemoglobin levels. (*Id*. at ¶¶ 6, 11–12.)

c. Prior to being prescribed prednisone, W.V. underwent 18 blood transfusions in a six-month period. (*Id*. at ¶ 6.)

d. Fulton Commons staff failed to correctly transcribe W.V.'s dosage of prednisone, documenting a 5 mg dosage despite the hospital discharge paperwork directing a 15 mg dosage, as depicted in ¶ 84(v)(f) *infra*. As a result, Fulton Commons staff administered 5 mg of prednisone, one-third of his required dosage, to W.V. for the entirety of his stay. (*See* Doherty Aff. at ¶¶ 6, 12.)

e. Following discovery of this alarming medication error and a further deterioration in W.V.'s condition that included difficulty breathing and chest pains, his family called 911 and W.V. was admitted to a hospital, where it was determined that his hemoglobin levels were strikingly low, necessitating a blood transfusion. (*Id*. at ¶¶ 13–14.) Regrettably, W.V.'s condition nonetheless continued to deteriorate, and he subsequently died on February 2, 2022. (*Id*. at ¶ 20.)

f. When W.V.'s daughter contacted Fulton Commons to notify them of their error, Fulton Commons' then DON, Carol Frawley, denied any culpability. DON Frawley produced to W.V.'s daughter a copy of the hospital discharge paperwork purportedly received by Fulton Commons from the hospital, but which Fulton Commons had clearly altered in a poor attempt to falsely make it appear that the hospital discharged W.V. with a 5 mg dose for prednisone instead of a 15 mg dose. (*Id*. at ¶¶ 16–19.) The true hospital discharge entry, and Fulton Commons' poorly altered copy of it, are both depicted below, with the image of the true version of the entry appearing on top.

predniSONE 5 mg oral tablet
--15 milligram(s) by mouth once a day
Indication: ILD

predniSONE 5 mg oral tablet
--15 milligram(s) by mouth once a day
Indication: ILD

85. In violation of Public Health Law § 2803-c, Fulton Commons violated Resident E.M.'s rights by conducting a medical procedure that she was vehemently opposed to undergoing.

i. Specifically, despite Resident E.M. clearly expressing to her family members that she was opposed to the insertion of a port in her arm for intravenous medication administration, Fulton Commons performed the procedure in July 2020. When E.M.'s daughter-in-law and healthcare proxy was advised that the port was successfully inserted into E.M.'s arm on or about July 15, 2020, she confronted Fulton Commons staff with E.M.'s express wishes in the past. In response, she was told that E.M. made her own choice. (*See* Milack Aff. at ¶ 13.)

86. In violation of 10 NYCRR §§ 415.5(a), (h) and 42 CFR § 483.10, Fulton Commons repeatedly neglected its residents by failing to provide necessary and adequate laundry services, including by failing to safeguard their clothing and allowing them to remain partially unclothed, resulting in a loss of a dignity.

i. In March 2020, Resident E.M. informed her family via text message that her clothes were not being laundered and that she was compelled to wash her own socks because she was running out of clean ones. Moreover, as discussed in ¶ 11 *supra*, when her daughter-in-law picked up E.M.'s purportedly laundered clothing, it was covered in feces. (*See* Milack Aff. at ¶ 9.)

ii. On several occasions during Resident F.H.'s stay at Fulton Commons from May 2018 until his death on July 25, 2020, his son arrived at the facility and found F.H. in various states of undress (as depicted below), sometimes not wearing any pants and sometimes dressed in nothing but a hospital gown, because his clothing often disappeared from his room. (*See* Hoerauf Aff. at ¶ 12.)

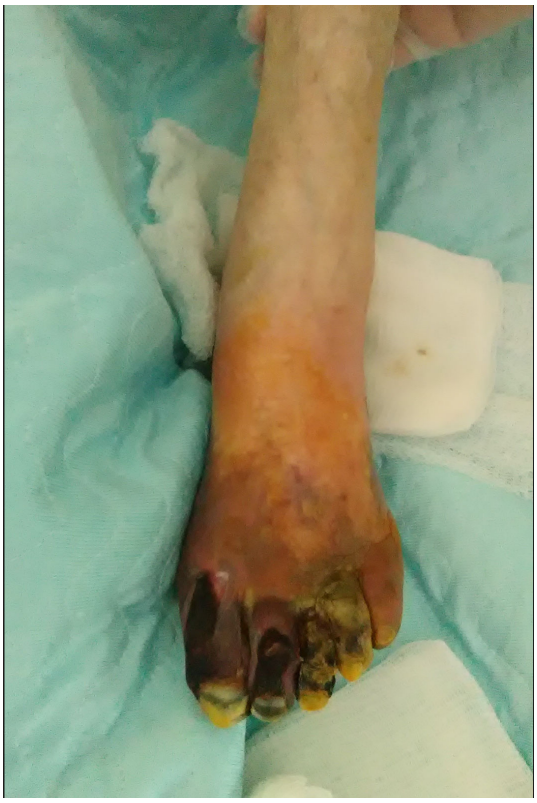
87. In violation of 10 NYCRR §§ 415.3(f)(1)(i), (iv), (2)(ii) and 415.12(c) and 42 CFR §§ 483.25(b)(1), (2), Fulton Commons repeatedly and persistently neglected its residents by failing to: (1) provide proper foot care and treatment; (2) prevent facility-acquired pressure injuries; and (3) provide adequate wound care to said injuries, including by failing to transfer residents suffering from significant wounds to the hospital for appropriate care. As noted in the RN Conway Aff. at ¶ 55, nursing home-acquired pressure injuries "are often preventable and a sign of inadequate nursing home care."

i. Resident M.M. resided at Fulton Commons from November 2018 until her death on September 2, 2020. During the COVID-19 lock-down,[21] M.M.'s daughter was notified that M.M. had developed pressure injuries on her buttocks and left leg. (*See* Affidavit of Willistene Williams ["Williams Aff."] at ¶ 9.) The development

[21] The COVID-19 lock-down refers to the period of time from March 13, 2020 through the summer of 2020, when DOH directed all nursing homes in New York State to halt visitation, except in limited circumstances such as end-of-life visits. (*See* Ronan Aff. Ex. 15.) The end of the lock-down cannot be stated definitively, as many nursing facilities reopened for short periods of time and then shut down again due to COVID-19 cases among the residents and staff.

of pressure injuries is indicative of Fulton Commons' staff failing to provide necessary and appropriate care, including turning and positioning M.M. (*See* Conway Aff. at ¶¶ 54–55, 58.)

ii. Diabetic resident A.C. resided at Fulton Commons from 2018 until approximately June 11, 2020. Throughout her stay, Fulton Commons failed to provide A.C. with adequate wound care. Specifically, A.C. was noted to have two necrotic[22] toes on her left foot, and physician's orders from as early as December 2019 directed Fulton Commons staff to monitor A.C.'s great toe and fourth toe for signs and symptoms of infection. Although photographs taken on or about June 11, 2020 (one of which is depicted below), revealed that A.C.'s second and third toes were also gangrenous[23] and necrotic, Fulton Commons records failed to document these wounds or detail any treatment to these areas. Moreover, it was not until on or about June 15, 2020, that A.C. was transferred to St. Francis Hospital, where her lower left leg was amputated up to the knee due to the gangrene infection. (*See* RN Conway Aff. at ¶¶ 90–92; *see also* Affidavit of Walter Crevoiserat at ¶ 14.)



[22] Necrosis is the death of a portion of tissue in the body that occurs when there is not enough blood supplied to the area. (*See* RN Conway Aff. at ¶ 56 n.10.)

[23] Gangrene refers to a large area of necrosis. (*See* RN Conway Aff. at ¶ 90 n.15.)

iii. Although Resident E.M. developed a foot infection in January 2020 following the removal of an ingrown toenail by a Fulton Commons podiatrist, her daughter-in-law and health care proxy was not notified by a doctor about that condition until approximately 11 months later. Her daughter-in-law learned of the infection directly from E.M., who sent photographs she took of her black, gangrenous foot—two of which are pictured below—to her family members. In various text messages to her family, E.M. reported suffering from substantial pain, which she at one point stated was "by far the absolute wors[t] [pain]" she had ever experienced in her life. In a text message dated June 14, 2020, E.M. reported to her family that a nurse told her that her foot was ready to fall off. More than once, E.M. expressed to her family that she hoped "God would be good to [her] and take [her] before it falls off." Despite a doctor advising E.M. on August 12, 2020, that "the infection will probably kill [her]," no one contacted her family until a week before E.M.'s death in November 2020, when her daughter-in-law and healthcare proxy was informed that if E.M.'s foot was not amputated, E.M. would die. (*See* Milack Aff. at ¶¶ 14–15.) Although E.M. expressed opposition to the amputation, Fulton Commons failed to notify her healthcare proxy prior to the wound's fatal progression.

88. In violation of 10 NYCRR § 415.5 and 42 CFR §§ 483.10 and 483.24, Fulton Commons repeatedly and persistently neglected its residents by failing to provide necessary grooming and hygiene care.

i. Fulton Commons staff neglected Resident F.H. over the course of his stay from May 2018 until his death in July 2020 by failing to regularly trim his fingernails or hair. On at least one occasion, F.H. left a voicemail for his son and reported that his hair had grown so long that it was down past his eyes and that he needed his son to trim his hair. (*See* Hoerauf Aff. at ¶ 11.)

ii. Fulton Commons neglected Resident A.C. by failing to regularly shower her in June 2020. (*See* RN Conway Aff. at ¶ 92.)

89. In violation of 10 NYCRR § 415.12(a)(3) and 42 CFR §§ 483.24 and 483.55, Fulton Commons repeatedly and persistently neglected its residents by failing to provide necessary oral and dental care.

i. Within weeks of his admission to Fulton Commons, staff members threw out Resident F.H.'s dentures and failed to obtain replacements for over a month and a half, forcing him to eat and speak without any dentures for that time period. (*See* Hoerauf Aff. at ¶ 2.)

ii. Fulton Commons staff failed to provide appropriate oral care to Resident J.C., who resided at Fulton Commons from August 2021 until December 23, 2021. As a result, her daughter frequently provided some of this care, removing J.C.'s dentures and cleaning out the food particles herself. (*See* Mejia Aff. at ¶¶ 5, 9; *see also* ¶ 154 *infra*.)

90. In violation of 10 NYCRR §§ 415.5(h), 415.12(h), and 415.29, Fulton Commons repeatedly and persistently neglected its residents by failing to provide adequate and necessary supervision.

i. As detailed in ¶ 76 *supra*, DOH cited Fulton Commons on July 30, 2019, for failing to adequately supervise its residents following the elopement of a resident with severely impaired cognition. (*See* Ronan Aff. Ex. 10.)

ii. The son of a Fulton Commons resident, who lived at the facility from 2017 until her death in 2019, reported witnessing a resident crawling on the floor. When he commented on this to a staff member, the Fulton Commons staff member replied, "It's okay." (*See* Tarpey Aff. at ¶¶ 19–20.)

iii. On one occasion prior to the COVID-19 pandemic, Resident S.K.'s son discovered her crawling on the lunchroom floor. Despite Fulton Commons staff being present, none assisted her or took any steps to get her off the floor. (*See* Costa Aff. at 9.)

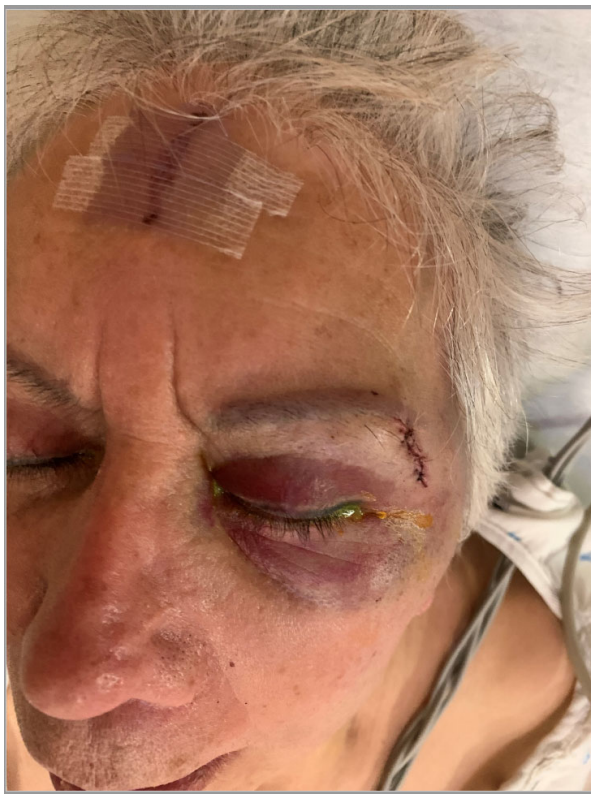
iv. Resident G.G. was admitted to the facility at the end of April 2020 for rehabilitation services following a fall, but Fulton Commons failed to adequately supervise him during his less than three-week stay. His daughter was informed that G.G. had fallen out of bed 12 times in a 24-hour period. G.G. was never transported to a hospital for an evaluation after these falls. (*See* Fletcher Aff. at ¶ 14.)

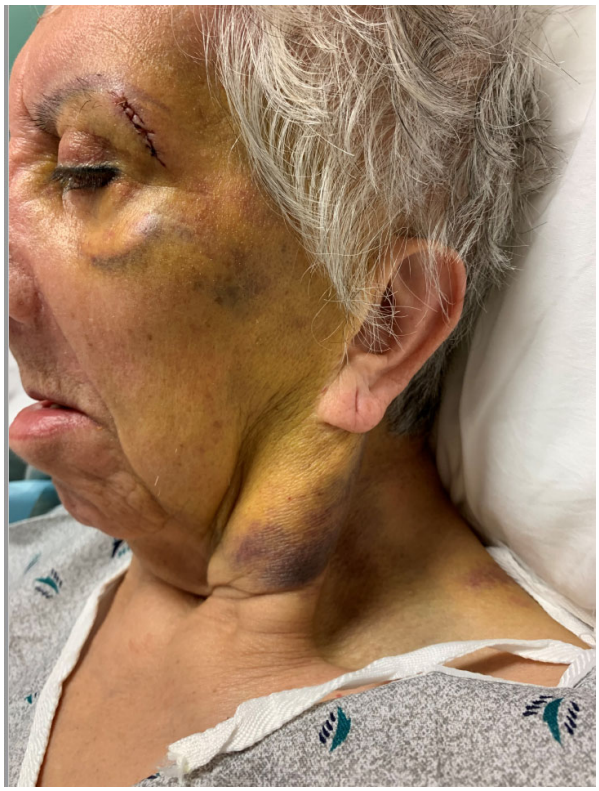
v. Fulton Commons failed to appropriately supervise residents suffering from dementia who were housed on units with residents who did not share that diagnosis. Within an hour of her admission to a non-dementia unit at Fulton Commons on or about July 22, 2021, a resident diagnosed with dementia entered Resident P.C.'s room and told her he was going to "take care of her," causing P.C. to become distraught and call 911. Her daughter-in-law reported that although their family convinced Fulton Commons to switch P.C.'s room, she slept in P.C.'s new room that night to provide reassurance. Two weeks later, the same resident entered P.C.'s new room and began rifling through her drawers. (*See* Cruz Aff. at ¶ 4.)

vi. Resident J.C. suffered from dementia but resided on a non-dementia unit on the third floor for three weeks starting in the middle of August 2021. Despite J.C.'s dementia diagnosis, Fulton Commons staff failed to monitor her

appropriately, allowing her to walk unsupervised through the doors of her unit and down the stairs, almost to the first floor. (*See* Mejia Aff. at ¶ 7.)

vii. On December 15, 2021, Resident J.C. suffered a fall and sustained a laceration to her forehead that was treated at the hospital. When she returned to Fulton Commons, J.C. was supposed to be checked every 15 minutes to ensure her safety. Nonetheless, staff members failed to supervise J.C. and, as a result, she suffered another fall, which required a second hospitalization. J.C.'s daughter met her at the hospital, at which point she discovered J.C. "was not herself." J.C.'s injuries (pictured below) included a laceration to her left eyebrow, significant swelling to her eye and face, and bleeding from her nose. Doctors told J.C.'s daughter that her mother was suffering from a brain bleed, broken cheek bone, broken eye socket, and broken jaw. J.C., who stopped talking and walking following this fall, never recovered from these injuries. J.C. died in February 2022. (*Id*. at ¶¶ 13–19.)





viii. Resident S.K. resided at Fulton Commons from August 2018 until her death on April 10, 2020, at the age of 75. On one occasion in October 2019, S.K.'s son visited her and discovered a circular bruise on the left side of her temple, as pictured below. Fulton Commons staff could not explain the origin of S.K.'s injury. (*See* Costa Aff. at ¶ 8.)

91. In violation of 10 NYCRR §§ 415.5(h), 415.12(h), and 415.29, Fulton Commons repeatedly and persistently neglected its residents by failing to maintain a safe environment free from hazards.

i. On May 21, 2019, Resident F.H.'s son visited him at Fulton Commons and was shocked to discover a gash on F.H.'s face that encompassed areas above and below his left eye, as pictured below. Fulton Commons staff could not explain how these injuries occurred, but F.H.'s son noticed that his father's dresser was missing a drawer and had protruding exposed screws; F.H.'s son believed his father fell into it. (*See* Hoerauf Aff. at ¶¶ 9, 14; *see also* RN Conway Aff. at ¶ 41.)

ii. Similarly, following F.H.'s death on July 25, 2020, his son discovered a bruise on F.H.'s shoulder. Fulton Commons staff could not explain the origin of this injury. (*See* Hoerauf Aff. at ¶ 18.)

92. In violation of 10 NYCRR §§ 415.5(h) and 415.29, Fulton Commons repeatedly and persistently neglected its residents by failing to provide a clean and sanitary environment.

i. Throughout Resident M.M.'s stay at Fulton Commons from November 21, 2018 until her death on September 2, 2020, her "room was perpetually filthy with dust accumulating under her bed, and her bathroom not being cleaned." Similarly, the dining room was always dirty, with food on the floor. (*See* Williams Aff. at ¶ 6.)

ii. Upon Resident W.V.'s admission to Fulton Commons on June 25, 2021, his daughter found that W.V.'s first room was dirty with exposed ductwork and lacked a call bell. Following her complaint, W.V. was moved to what his daughter was told was the "nicest" room, yet it also lacked a call bell and was significantly dusty and dirty. (*See* Doherty Aff. at ¶¶ 7–8.)

93. In violation of 10 NYCRR §§ 415.3(f)(1)(i), (iv), (2)(ii), Fulton Commons denied family members the right to know their loved ones' total health status and denied its residents the right to end-of-life visits from their loved ones. (*See* RN Conway Aff. at ¶¶ 15, 96–99.)

i. Fulton Commons callously denied Resident E.M.'s family the right to an end-of-life visit less than two hours before E.M.'s death. After being informed by a doctor, "[t]his is the end," E.M.'s daughter-in-law and healthcare proxy went to Fulton Commons on November 20, 2020, at approximately 11 a.m. to see E.M. for an end-of-life visit. Rather than allow this visit, Fulton Commons turned E.M.'s daughter-in-law away at the door and told her that E.M.'s condition was not serious enough to warrant a visit. At 12:22 p.m., E.M.'s daughter-in-law sent an email to Fulton Commons DON Frawley seeking permission to visit E.M. Eight minutes later, she received a call from Fulton Commons that E.M. had died. (*See* Milack Aff. at ¶¶ 15–16.)

ii. Fulton Commons failed to properly convey Resident S.K.'s medical condition to her son. On or about March 15, 2020, Fulton Commons' administrator, Respondent Doyle, told S.K.'s son that his mother had a fever for which she was receiving medication. However, her son received contradictory information from other Fulton Commons staff on his mother's unit, who claimed that she was fine. (*See* Costa Aff. at ¶ 13.)

iii. Fulton Commons robbed Resident V.T.'s daughter of the right to make an informed medical decision as to her father's care. When V.T. developed a fever on March 27, 2020, his daughter questioned whether it could be

COVID-19. Fulton Commons RN Elfa Llorente[24] falsely implied to V.T.'s daughter that V.T. probably did not have COVID-19. It was not until after his death that V.T.'s daughter learned that V.T. had been treated with COVID-19 protocols. (*See* Gregus Aff. at ¶¶ 11–19.) Notably, Llorente testified under oath that she never told any family members that their loved ones may have been infected with COVID-19, or that they were being treated as presumed COVID-19 positive, because Doyle gave a directive that there was no COVID-19 in the building. (*See* Ronan Aff. Ex. 19 at 116–118.)

iv. Fulton Commons failed to provide Resident G.G.'s family with accurate information regarding his medical condition. G.G.'s daughter was regularly told by staff on the day shift that G.G. was doing fine and eating, while the staff on the night shift contradicted this and told her that her father was not doing well. Specifically, on May 17, 2020, at approximately 2 p.m., G.G.'s daughter was told that he was stable and participating in activities. Less than five hours later, Fulton Commons staff informed G.G.'s daughter that his oxygen levels were critically low, he was unresponsive, and severely declining. G.G.'s daughter demanded her father be sent to the hospital, where she was told by a doctor that G.G.'s lungs were full of fluid; his blood levels were toxic; he had a collapsed lung; he was septic, dehydrated, and malnourished; and his kidneys had shut down. G.G., who was only supposed to be at Fulton Commons for 29 days for rehabilitation following a fall, was admitted to hospice after less than three weeks at Fulton Commons, and subsequently died on June 18, 2020. (*See* Fletcher Aff. at ¶¶ 13, 20–23.)

v. As detailed in ¶¶ 120–122 *infra*, from as early as March 12, 2020 through at least April 9, 2020, Doyle sent family members multiple false and misleading robocalls denying the existence of COVID-19 in the building, despite multiple residents being treated for and dying from COVID-19 symptoms. This denied family members the right to know their loved ones' total health status and to make informed medical decisions regarding their care.

94. In violation of Education Law § 6512, 10 NYCRR § 415.5, and 42 CFR § 483.24, Fulton Commons repeatedly and persistently neglected its residents by failing to provide necessary and appropriate ambulation and range of motion exercises, resulting in their functional decline. "Lack of mobility and ambulation can be especially devastating to an older adult as the aging process causes a more rapid decline in function and potentially leads to 'contracture' . . . . [which]

[24] In sworn testimony pursuant to Executive Law § 63(12), RN Elfa Llorente acknowledged that she was the charge nurse of Unit 3 West, where V.T. resided.

causes the joints to shorten and become very stiff . . . lead[ing] to permanent disability." (RN Conway Aff. at ¶ 78.)

i. Resident E.B. was often left lying in bed for days at a time by Fulton Commons staff members, necessitating her daughter to ask staff to move E.B. into a wheelchair. (*See* Traina Aff. at ¶ 7.) Nursing homes must frequently turn and position residents in order to prevent development and/or worsening of pressure injuries. (*See* RN Conway Aff. at ¶¶ 57–58.)

ii. Fulton Commons' neglect of Resident M.M. during the COVID-19 lock-down resulted in significant deterioration of her condition. Specifically, in a matter of months, M.M. became frail, and her leg became severely contracted (*see* Williams Aff. at ¶¶ 9–10), which is indicative of Fulton Commons failing to turn and position M.M. or provide her with range of motion exercises (*see* RN Conway Aff. at ¶ 78.) When M.M. died on September 2, 2020, her leg was so contracted that she could not even lay straight in her casket. (*See* Williams Aff. at ¶ 12.)

iii. Although the sole basis for Resident Sachs' stay at Fulton Commons from April 25, 2020 to May 8, 2020, was for rehabilitation following a hospitalization, Fulton Commons failed to provide meaningful rehabilitation services throughout his stay during the first wave of the COVID-19 pandemic and kept him confined to his room but for a few minutes per day of walking in the hallway. Further, Sachs' "physical therapy" was improperly provided by an occupational therapist, in violation of Education Law § 6512, and consisted only of 15–20 minutes of exercise per day. This prolonged, forced inactivity resulted in a deterioration in his physical condition, which only improved following his discharge from Fulton Commons. (*See* Sachs Aff. at ¶¶ 14–16.)

95. In violation of 10 NYCRR § 415.5(f), Fulton Commons repeatedly and persistently neglected its residents by failing to consider their emotional well-being or provide sufficient mental stimulation and activities.

i. Following E.B.'s roommate's death during the first wave of the COVID-19 pandemic, Fulton Commons left her roommate's corpse in E.B.'s room for several hours, with only a curtain separating them. (*See* Traina Aff. at ¶ 10; *see also* RN Conway Aff. at ¶ 95 n.19 [general nursing home practice dictates that, when a resident dies in their room in the facility, the living roommate is separated from the corpse].)

ii. Because Fulton Commons offered limited recreation, during her stay between approximately July 22, 2021 and October 29, 2021, Resident P.C. spent most of her day sitting in bed. Moreover, P.C.'s television had few channels, and

some of those channels displayed static and were unwatchable. (*See* Cruz Aff. at ¶ 7.)

96. In violation of Public Health Law § 2803-c and 10 NYCRR § 415.26(i)(1)(ii), Fulton Commons repeatedly and persistently neglected its residents by preventing them from being discharged, in order to maintain its census and corresponding revenue stream, despite its continued failure to provide adequate and necessary care.

i. On July 16, 2020, when Resident E.M.'s healthcare proxy expressed her desire to transfer E.M. to a different facility, Respondent Doyle insisted that E.M. was very happy at Fulton Commons. This directly contradicted a myriad of text messages that E.M. sent to her family in which she went so far as to say that she would "rather be confined to a jail cell" than continue to reside at Fulton Commons. (Milack Aff. at ¶ 10.)

ii. Fulton Commons prevented Resident Sachs from discharging himself from the facility on May 2, 2020, and ordered him back into his room. Despite telling Sachs that a discharge planner would meet with him to release him on May 4, 2020, Fulton Commons failed to make any efforts to facilitate his discharge. Sachs was so dismayed that he ultimately contacted an attorney to secure his release. Sachs left Fulton Commons on May 8, 2020, without a discharge plan. Yet again, Fulton Commons staff attempted to prevent him from leaving, compelling Sachs to threaten to call 911 and have staff charged with assault if they touched him. (*See* Sachs Aff. at ¶¶ 18–20.)

3. The COVID-19 Pandemic Compounded the Pre-Existing Systemic Resident Neglect at Fulton Commons

97. The disturbing resident neglect at Fulton Commons was only exacerbated by the COVID-19 pandemic. Since March 2020, infection control measures (such as halting visitation and changing and/or disinfecting personal protective equipment ["PPE"] between caring for each resident) increased the burden on already overworked direct caregivers who lacked sufficient time to provide each resident with necessary and dignified care. Nearly all of Fulton Commons' clinical employees who testified under oath pursuant to Executive Law § 63(12), including former DON Frawley, the former infection preventionist, and two RN managers, admitted and acknowledged that Fulton Commons committed rampant infection control violations during the first wave of the

COVID-19 pandemic, thereby neglecting and endangering its residents. (*See* Ronan Aff. at ¶ 131; *see also* Ronan Aff. Ex. 23 at 129–130, 142, 146–147, 152, 220; Ronan Aff. Ex. 20 at 77, 80, 210–211, 214, 227; Ronan Aff. Ex. 19 at 223; Ronan Aff. Ex. 21 at 43, 76; Tarpey Aff. Ex. 1 at 77, 249.)

4. Fulton Commons Engaged in Multiple Systemic Infection Control Failures Throughout the First Wave of the COVID-19 Pandemic, in Violation of 10 NYCRR § 415.19 and 42 CFR § 483.80, Thereby Neglecting its Residents and Putting Them at Increased Risk of Serious Illness and/or Death

98. State and federal regulations require nursing homes to have an infection prevention and control program in order to provide a "safe, sanitary, and comfortable environment . . . and to help prevent the development and transmission of disease and infection." (10 NYCRR § 415.19; *see also* 42 CFR § 483.80.) While the COVID-19 pandemic presented novel challenges to the medical community and the world at large, Fulton Commons failed to take even the most basic measures to protect its residents and utterly disregarded infection control policies and procedures and DOH guidance during the peak of the pandemic, thereby increasing the risk to its residents and staff of infection by the COVID-19 virus, serious illness, and/or death.

a. Fulton Commons Sidelined its Infection Preventionist During the First Wave of the COVID-19 Pandemic and Failed to Implement an Appropriate Infection Control Program, in Violation of 10 NYCRR § 415.19 and 42 CFR §§ 483.80(a), (b), Thereby Endangering its Residents

99. Fulton Commons failed to properly utilize its infection preventionist ("IP") during the first wave of the COVID-19 pandemic, which led to its inevitable failure to appropriately implement an infection control program, as required under 10 NYCRR § 415.19 and 42 CFR § 483.80(a). By law, Fulton Commons was and is required to designate a qualified professional who

has completed specialized training in infection prevention and control to serve as their IP and be responsible for Fulton Commons' infection control program. (*See* 42 CFR § 483.80[b]; *see also* RN Conway Aff. at ¶ 50.) Although Fulton Commons designated Marise Jean-Baptiste, an RN with specialized training in infection control and prevention, as the facility's IP in 2019 while Doyle was administrator (*see* Tarpey Aff. Ex. 1 at 25), Respondent Doyle intentionally sidelined the IP at the height of the first wave of the COVID-19 pandemic by inexcusably excluding her from all infection control decisions and ignoring her suggestions on how to contain the spread of COVID-19 in the facility. (*See* Tarpey Aff. at ¶¶ 42–47; *see also* Tarpey Aff. Ex. 1 at 25, 43–46.)

100. On February 6, 2020, DOH warned all nursing homes to "be ready and equipped to promptly screen, and where appropriate, to isolate, further evaluate, and correctly manage patients presenting to their facility with the potential of being infected with [COVID-19] and to notify appropriate public health authorities of the patient's potential status."[25] These responsibilities fall on a nursing home's infection preventionist—a position that is required to be filled by federal law. (*See* 42 CFR § 483.80[b].) Despite DOH's warning, Fulton Commons took no appreciable steps to prepare for the looming COVID-19 pandemic. In fact, although Jean-Baptiste was serving as one of Fulton Commons' Assistant Directors of Nursing and as the IP at the time of this warning and nominally remained in those roles through mid-June 2020, Respondent Doyle blanketly rejected her infection control suggestions and excluded her from infection control discussions. (*See* Tarpey Aff. at ¶¶ 43–44.) Despite having no medical training (*see* Tarpey Aff. Ex. 3 at 48–50), Doyle ignored Jean-Baptiste, an RN with over twenty years of experience, and denied her the authority to implement the infection control protocols she knew were necessary. (*See* Tarpey Aff.

[25] DOH, https://coronavirus.health.ny.gov/system/files/documents/2020/03/2020-02-06_ppe_shortage_dal.pdf (last accessed December 12, 2022).

Ex. 1 at 149–151.) For instance, when questioned under oath pursuant to Executive Law § 63(12), Jean-Baptiste acknowledged that Fulton Commons neglected and endangered its residents by failing to cohort residents based on their COVID-19 status during the first wave of the pandemic. (*See* Tarpey Aff. at ¶¶ 42–46; *see also* Tarpey Aff. Ex. 1 at 21, 35, 55–62, 166–168, 246, 249.)

101. Testimony taken during the course of MFCU's investigation demonstrates why an IP is essential in a nursing home—especially during a deadly pandemic. Jean-Baptiste testified that she was aware of various infection control measures that Fulton Commons should have taken to curb the spread of COVID-19, but Doyle refused to implement any of her suggestions. When questioned about the steps Fulton Commons failed to take to minimize the risks to residents, Jean-Baptiste testified, "It's not because I didn't know what to do, it's just I was not allowed to do what I was supposed to do." (Tarpey Aff. Ex. 1 at 176.)

102. Moreover, despite Doyle making the infection control decisions at Fulton Commons, she testified that she was not aware of various CMS infection control guidance issued during the first wave of the COVID-19 pandemic. Specifically, Doyle claimed that she was unaware of CMS Guidance issued on March 4, 2020 ("March 4th CMS Guidance"), requiring cohorting of nursing home residents based on COVID-19 status, and making it clear that nursing homes could only accept COVID-19 positive patients that were still considered contagious if they were capable of following the guidance from the Centers for Disease Control and Prevention ("CDC") for transmission-based precautions. (*See* Tarpey Aff. Ex. 3 at 485–489.) Doyle also claimed she was never made aware of any guidance regarding when a facility should and should not accept a COVID-19 resident. (*Id.* at 489.) In contrast, former IP Jean-Baptiste testified that she was very familiar with the March 4th CMS Guidance that laid out these guidelines. (*See* Tarpey Aff. Ex. 1 at 105–110.) Notably, the March 4th CMS Guidance was consistent with New York

State's long-standing regulation requiring that nursing homes only admit and retain those residents for whom they can provide adequate care.[26] (*See* 10 NYCRR § 415.26[i][1][ii].)

103. Although Doyle testified that Fulton Commons maintained infection control compliance for all residents throughout the first wave of the pandemic (*see* Tarpey Aff. Ex. 3 at 521), her illogical and self-serving testimony lacked credibility—particularly in light of former IP Jean-Baptiste's testimony (corroborated by various facility records, including Doyle's own emails, and testimony from numerous Fulton Commons staff members) that Fulton Commons' actions throughout the first wave of the pandemic endangered and neglected its residents. (*See* Tarpey Aff. Ex. 1 at 246, 249; *see also* Ronan Aff. Ex. 19 at 73, 223.)

104. By intentionally excluding Jean-Baptiste from infection control discussions and refusing to implement any of her suggestions, Fulton Commons and Doyle essentially operated the nursing home without an IP throughout the first wave of the COVID-19 pandemic and failed to establish and maintain an adequate infection control program, in violation of 10 NYCRR § 415.19 and 42 CFR § 483.80, which increased the risk of infection to all of Fulton Commons' residents, including the 74 residents who died from COVID-19-related causes in these three months.

[26] The first documented case of COVID-19 among Fulton Commons residents occurred as early as the middle of March 2020 (*see* Ronan Aff. Ex. 23 at 79), before it admitted its first COVID-19-positive patient from a hospital at the end of March 2020. (*See* Tarpey Aff. Ex. 3 at 181.) This admission itself was in violation of the Governor's Executive Order that nursing homes should admit COVID-19-positive residents if they were able to care for them, as well as for their existing residents. (*See* ¶ 102 *infra*; *see also* 10 NYCRR § 415.26[i][1][ii]; Tarpey Aff. Ex. 3, at 124–125.) Fulton Commons would have arguably been equipped to take on new admissions of COVID-19-positive residents if the facility properly cohorted its residents, which it did not do. (*See* ¶¶ 100, 102, 108–112 *infra*.)

b. Lack of Infection Control Signage Increased Risk of Spreading COVID-19 to Residents and Staff

105. Fulton Commons failed to display proper infection control signage within the facility during the first wave of the COVID-19 pandemic. Specifically, a Fulton Commons housekeeping staff member testified that proper infection control protocol required that any rooms housing suspected and/or presumed COVID-19 residents should have been designated with infection control signage and bins. Importantly, failure to display infection control signage and utilize infection control bins could have resulted in housekeeping staff spreading COVID-19 infection throughout the facility. (*See* Ronan Aff. Ex. 24 at 119.) Nonetheless, despite Fulton Commons' records establishing that presumed COVID-19 residents were interspersed throughout the facility during the first wave of the pandemic, this staff member was never made aware that any such residents were residing on non-COVID units. (*Id*. at 78–79.)

106. The utilization of proper signage throughout the facility would have been a cost-effective and simple way to curb the spread of COVID-19 by alerting residents and staff that a particular resident was COVID-positive or presumed COVID-positive. It would have taken minimal effort to obtain and hang infection control signage; yet, Fulton Commons failed to take even these simple measures to protect its residents and staff and reduce the spread of infection, which likely contributed to 74 residents dying of presumed or confirmed COVID-19 in a three-month period, as discussed in ¶ 118 *infra*.

107. Significantly, on or about April 7, 2020, the daughter of recently-deceased Resident H.G. went to Fulton Commons to see her father's body upon learning of his death. During her visit, she observed that there was no infection control signage on her father's door (*see* Tarpey Aff. at ¶ 69), despite the fact that Fulton Commons was treating him with COVID-19 protocols immediately prior to his death. (*See* Ronan Aff. at ¶¶ 119–121; *see also* Tarpey Aff. at ¶ 72.)

H.G.'s death certificate ultimately listed COVID-19 pneumonia as contributing to his cause of death. (*See* Ronan Aff. Ex. 16; *see also* Ronan Aff. at ¶ 119.)

c. Fulton Commons' Failure to Cohort Residents by their COVID-19 Status Increased Risk of Spreading COVID-19

108. Fulton Commons failed to cohort residents by their COVID-19 status during the first wave of the pandemic in direct violation of DOH guidance issued March 13, 2020 ("March 13th Guidance") and March 21, 2020 ("March 21st Guidance"). The March 13th Guidance required that nursing homes isolate suspected or confirmed COVID-19 residents in a separate room with the door closed. (*See* Ronan Aff. Ex. 15.) The March 21st Guidance specifically directed Long Island nursing homes, such as Fulton Commons, to presume all residents with any febrile acute respiratory illness, or clusters of acute respiratory illness, to be COVID-19 positive. (*See* Ronan Aff. Ex. 18.)

109. Specifically, as detailed in the Ronan Aff. at ¶¶ 118–121, at the end of March 2020, Fulton Commons moved a non-COVID resident into a room with Resident H.G., discussed in ¶ 107 *supra*, who was being treated for COVID-19 symptoms. The non-COVID resident was moved into that room to fill the recently-vacated bed of H.G.'s roommate, who was presumptively COVID-19 positive for several days and died earlier that day. Housing the non-COVID resident in the same room as symptomatic Resident H.G. was a gross deviation from infection control protocols and thus constituted neglect. (*See* RN Conway Aff. at ¶ 49.) This failure to cohort residents based on their COVID-19 status increased residents' risk of infection, serious illness, and/or death. (*Id.*)

110. Fulton Commons designated Unit 1 East as the "COVID-19 unit" by the end of March 2020, but this was a designation in name only. Fulton Commons inexcusably failed to properly utilize this unit and continued to commingle residents regardless of COVID-19 status.

Non-COVID-19 residents were regularly admitted onto 1 East, while some COVID-19-positive residents were admitted onto other units throughout the building. (*See* Ronan Aff. at ¶¶ 124–127.) Although former DON Frawley initially testified under oath that Fulton Commons did not admit COVID-19 residents onto units other than 1 East during the pandemic, she later retracted her testimony when confronted with facility records that directly contradicted her claim. (*See* Ronan Aff. Ex. 23 at 56–59, 110–111, 113, 115, 150–152, 174, 178, 180, 200, 202, 207–208, 212–213, 219.)

111. Specifically, between April 17, 2020 and April 29, 2020, Fulton Commons admitted at least six COVID-19-positive residents onto non-COVID units, and seven non-COVID residents onto Unit 1 East. (*See* Ronan Aff. at ¶¶ 124, 126.) This violation of infection control protocols unnecessarily increased the risk of spreading COVID-19 to Fulton Commons' non-COVID-19 residents, thereby endangering their lives, as admitted by former DON Frawley. (*See* Ronan Aff. Ex. 23 at 142; *see also* RN Conway Aff. at ¶ 105.)

112. Notably, Fulton Commons and Doyle were aware that the failure to cohort residents based on their COVID-19 status violated basic infection control practices and DOH guidance. This knowledge is evidenced by the fact that Doyle instituted a mass room-shuffle of residents based on their COVID-19 status on May 1, 2020—the eve of a DOH infection control survey. Despite Doyle's nonsensical testimony to the contrary, this room-shuffle was clearly effectuated to give DOH the false impression that Fulton Commons had been complying with the March 13th Guidance that required cohorting of residents based on their COVID-19 status. (*See* ¶¶ 130–131 *infra*.) Although former DON Frawley initially denied any knowledge of these room transfers, she ultimately admitted that Doyle orchestrated this room-shuffle, which she believed to be connected to the impending DOH survey. (*See* Ronan Aff. Ex. 23 at 176–181, 189–196.) This conduct reflects

that Fulton Commons and Doyle did not actually care about protecting the nursing home's residents' health or well-being; rather, they cared only about putting on a facade that they did, in order to protect Fulton Commons' financial and reputational interests.

d. Fulton Commons' Failure to Assign Dedicated Staff to Care for COVID-19 Residents Increased Risk to Non-COVID Residents

113. Furthermore, Fulton Commons failed to follow the explicit March 13th Guidance to cohort residents with dedicated caregivers and stop floating staff between units. Disregarding the health and well-being of its vulnerable residents, Fulton Commons failed to assign dedicated caregivers to its presumed and/or confirmed COVID-19 residents. In fact, multiple Fulton Commons employees testified under oath that CNAs were providing care to both COVID-19 and non-COVID-19 residents on the same shift (*see* Ronan Aff. Ex. 19 at 160, 168–169; *see also* Ronan Aff. Ex. 20 at 221–222, 224), and that caregivers continued to be floated throughout the building (*see* Ronan Aff. Ex. 21 at 73, 75–76) despite the March 13th Guidance and March 20th Guidance directing nursing homes to halt such practices. (*See* Ronan Aff. Exs. 15, 18; *see also* Ronan Aff. at ¶¶ 123–128.)

114. Although former DON Frawley testified that in response to the pandemic, Fulton Commons stopped floating caregivers between units (*see* Ronan Aff. Ex. 23 at 97–98) and asserted that "the team that was on 1 East was the team that remained on 1 East" (*id*. at 116), her claims are contradicted by other Fulton Commons staff members. Specifically, another Fulton Commons staff member testified that, as a floater, they worked as a direct caregiver on Unit 1 East as well other units in the building, sometimes on the same day. (*See* Ronan Aff. at ¶ 128; *see also* Ronan Aff. Ex. 21 at 73, 75–76.)

e. Fulton Commons Deaths Quadrupled Between March 1, 2020 and May 31, 2020, Compared to the Same Time Period in 2019

115. The New York State Death Registry reflects that 154 residents died at Fulton Commons in 2020, which is nearly double the 79 resident deaths that occurred in 2019. Strikingly, 92 of the 154 residents who died at Fulton Commons in 2020 died in the three-month period between March 1, 2020 and May 31, 2020. (*See* Ronan Aff. at ¶ 113.) Comparatively, between March 1, 2019 and May 31, 2019, only 24 Fulton Commons residents died. (*Id*.)

116. As discussed more fully in ¶ 118 *infra*, MFCU's analysis of Fulton Commons and DOH records revealed that Fulton Commons underreported its COVID-19 deaths by 45% (34 out of 74 deaths) in 2020 in its reports to DOH. However, if Fulton Commons were to claim now that its reported COVID-19 death count of 40 residents was accurate, then it would be admitting that 114 of its residents died in 2020 from causes unrelated to COVID-19, which is a 35-person increase from its 79 deaths in 2019. These 35 additional resident deaths in 2020 from causes unrelated to COVID-19, compared to resident deaths in 2019, would reflect a 44% increase in non-COVID-19 resident deaths in 2020. (*See* Ronan Aff. at ¶ 117.) Such a substantial increase in non-COVID-19 resident deaths in 2020 can only be attributed to Fulton Commons' neglect, abuse, and mistreatment of its residents.

5. Fulton Commons and Doyle Engaged in a Massive and Dangerous Fraudulent Scheme to Cover Up COVID-19 Infections, Deaths, and Fulton Commons' Poor Performance

117. Following their sidelining of IP Jean-Baptiste, Respondents Fulton Commons and Doyle engaged in a massive, coordinated scheme to conceal the nursing home's poor infection control performance, which likely led to the decimation of its census from presumed COVID-19 infections, as reflected in ¶ 112 *supra* and ¶¶ 130–135 and 178 *infra*. During the first wave of the

pandemic, Respondent Doyle directed and orchestrated this fraudulent scheme by intentionally: (1) underreporting COVID-19 resident deaths to DOH (*see* ¶¶ 118–119 *infra*); (2) disregarding clear DOH infection control guidance (*see* ¶ 98 *supra* and ¶¶ 108, 112, 132, 184, 196 *supra*); (3) repeatedly sending false robocalls to family members denying there was COVID-19 in Fulton Commons (*see* ¶¶ 120–122 *infra*); (4) falsely announcing to staff that there was no COVID-19 in the building (*see* ¶¶ 123 *infra*); (5) directing staff to refrain from informing family members that their loved ones had suspected or presumed COVID-19 (*see* ¶¶ 93, 124–125 *infra*); (6) resisting testing residents for COVID-19 (*see* ¶¶ 126–129 *infra*); and (7) failing to cohort residents based on their COVID-19 status until she anticipated that DOH would be arriving the next day to conduct an infection control survey (*see* ¶¶ 130–132 *infra*).

a. In Violation of 10 NYCRR § 702.4, Fulton Commons Intentionally Underreported by 45% its COVID-19 Deaths to DOH as Part of its Fraudulent Scheme to Conceal its Poor Performance

118. Fulton Commons was required to report all COVID-19 deaths to DOH via the Health Electronic Response Data System ("HERDS"). (*See* RN Conway Aff. at ¶ 100; *see also* 10 NYCRR § 702.4.) Fulton Commons' business records revealed that during the first wave of the COVID-19 pandemic, Fulton Commons knowingly underreported its COVID-19 deaths to DOH by as much as 45%. (*See* RN Conway Aff. at ¶¶ 100–104; *see also* Ronan Aff at ¶¶ 114–116.) Specifically, Fulton Commons' HERDS submissions, entered by either Respondent Doyle or former DON Frawley (*see* Tarpey Aff. Ex. 3 at 571), reflect that only 40 residents were reported to have died of either presumed or confirmed COVID-19, when in fact Fulton Commons' records reflect that 74 Fulton Commons residents died of presumed or confirmed COVID-19. (*See* RN Conway Aff. at ¶¶ 100–104; *see also* Ronan Aff at ¶¶ 114–115.) Even when one-third of the

residents on a single unit died over a 72-hour period in the height of the pandemic (12 or 13 residents out of 35 or 36 total on the unit) (*see* Tarpey Aff. Ex. 5 at 427, 452), only one was reported to DOH as a COVID-19 death—and that resident was only reported as such because they tested positive for COVID-19 at a local hospital after being transferred to same at their family's insistence. (*Id*. at 129, 450–457.) Thus, Fulton Commons failed to report 34 COVID-19 resident deaths. (*See* RN Conway Aff. at ¶¶ 100–104.)

119. Consistent with Fulton Commons' culture of cover-up and deceit, Fulton Commons and Doyle systematically and intentionally underreported these deaths to DOH, skewing data that was publicly released by DOH. This allowed Fulton Commons to avoid public scrutiny of its poor performance and high COVID-19 death count, including from residents' family members, who may have chosen to remove their loved ones from the facility had they known the true extent of the risks to the residents' health, safety, and well-being. Fulton Commons' fraudulent conduct prioritized the financial interests of Respondent-owners, enabling the facility to retain its existing residents and admit new ones, thereby increasing its revenue and ability to deliver more up-front profit to Respondent-owners and Fulton Realty LP, to the detriment of vulnerable residents.

b. In Violation of 10 NYCRR §§ 415.3(f)(1)(i), (2)(ii), Fulton Commons and Doyle Sent Misleading Robocalls to Residents' Family Members, Falsely Denying the Existence of COVID-19 in the Building

120. In a similarly deceitful scheme, despite Fulton Commons' active treatment of multiple residents throughout the facility for COVID-19 symptoms, Respondent Doyle sent numerous false "robocalls" to residents' family members, denying the existence of COVID-19 infections at Fulton Commons. Respondent Doyle began sending these false and misleading robocalls on March 12, 2020, and continued to send robocalls through at least March 24, 2020, in which she falsely asserted, "we have no suspected or confirmed cases of COVID-19 in the

facility." (*See* Ronan Aff. at ¶¶ 137–140.) This was patently false as at least five residents had died of presumed COVID-19 by that date. (*Id*. at ¶ 138.) Of those five residents, four were listed on an internal Fulton Commons document titled, "Residents with COVID-19 List," and three were ultimately reported to DOH as suspected COVID-19 deaths. (*Id*. at ¶ 139.) Additionally, former DON Frawley admitted under oath that Fulton Commons' first COVID-19 case was in mid-March, further establishing the falsity of Doyle's assertions that there was no COVID-19 in the building at that time. (*See* Ronan Aff. Ex. 23 at 80, 87, 91.)

121. It was not until a robocall made on April 9, 2020, that Doyle conceded, "We are tracking approximately 21 residents at the time for symptoms that could or could not be related to COVID"—although this, too, was misleading; internal Fulton Commons records revealed that 34 residents *had already died* of suspected COVID-19 by that date. (*See* Ronan Aff. at ¶ 140.) Of those 34 residents, 26 were included on the "Residents with COVID-19 List," three of the residents ultimately had COVID-19 listed as a contributing factor on their death certificates, and Fulton Commons ultimately reported 24 of those deaths to DOH as COVID-19 deaths. (*Id*.)

122. During her examination under oath pursuant to Executive Law § 63(12), when confronted with the fact that her recorded robocalls repeatedly gave false information to residents' families, Respondent Doyle doubled down on her false statements. She callously claimed that it was appropriate to tell family members that Fulton Commons "continue[d] to have no Coronavirus cases"—despite residents being treating for and dying of presumed COVID-19—as the residents with suspected COVID-19 had died prior to the dates of her calls and they therefore no longer counted as active cases within the facility. (*See* Tarpey Aff. Ex. 3 at 610–611.) Doyle used the fact that Fulton Commons did not test for COVID-19 to support her false assertion that there were no cases of COVID-19 in the building. (*Id*.) Notably, Doyle's untenable claim that Fulton Commons'

lack of testing of residents for COVID-19 justified her repeated false statements to families utterly ignores the March 21st Guidance that clearly required, ". . . ANY febrile acute respiratory illness or clusters of acute respiratory illness (whether febrile or not) in [nursing homes] and [acute care facilities] in . . . Long Island . . . should be **presumed** to be COVID-19 unless diagnostic testing revealed otherwise." (*See* Ronan Aff. Ex. 18 [emphasis in original].)

c. Doyle Falsely Directed Staff That Fulton Commons was a "COVID-Free Facility"

123. In addition to sending out false and misleading robocalls to residents' family members, Respondent Doyle also broadcast announcements on the facility's overhead system to staff and residents stating that Fulton Commons was a "COVID-free facility." (*See* Tarpey Aff. at ¶ 39.) Further, Doyle admonished Fulton Commons staff not to discuss COVID-19 with anyone outside the facility. (*See* Ronan Aff. Ex. 21 at 115–116). According to Fulton Commons staff, Respondent Doyle issued a "directive" that Fulton Commons did not have cases of COVID-19 in the facility. (*See* Tarpey Aff. at ¶ 39; *see also* Ronan Aff. Ex. 19 at 116.)

124. As detailed in ¶ 93(iii) *supra*, RN Llorente testified under oath that due to Doyle's directive that there was no COVID-19 in the building, she never informed any family members that their loved ones were being treated as presumed COVID-19 positive—a direct violation of 10 NYCRR §§ 415.3(f)(1)(i), (iv), (2)(ii).

125. By repeatedly falsely asserting that there was no COVID-19 in the building despite treating residents for COVID-19 symptoms and by causing Fulton Commons staff to mislead residents' family members as to their loved one's total health status, Doyle denied residents' families the right to make informed medical decisions regarding their loved ones' care and to be apprised of their total health status. (*See* 10 NYCRR §§ 415.3[f][1][i], [iv], [2][ii].)

d. Despite Fulton Commons' Infection Preventionist's Recommendations, Respondent Doyle Refused to Test Residents for COVID-19 and Later Resisted DOH's Efforts to Test at Fulton Commons

126. Fulton Commons and Doyle made no effort to test residents for COVID-19 during the first wave of the COVID-19 pandemic (*see* Tarpey Aff. Ex. 3 at 416–417, 429–430, 494–495), despite multiple staff members urging that Fulton Commons do so, including IP Jean-Baptiste, who testified under oath that she recommended testing residents to Respondent Doyle but was rebuffed. (*See* Tarpey Aff. at ¶ 44; *see also* Tarpey Aff. Ex. 1 at 56.) Another RN at Fulton Commons testified under oath that she voiced her concerns to Respondent Doyle but Doyle "did not want to test residents because that was the directive of DOH or of Governor Cuomo." (Ronan Aff. Ex. 19 at 91; *see also* Tarpey Aff. at ¶ 41.) In fact, this excuse is inconsistent with the March 21st Guidance, which directed that Long Island nursing homes should not *await* test results prior to implementing infection control protocols, and that any resident exhibiting COVID-19 symptoms should be presumed positive. (*See* Ronan Aff. Ex. 18.)

127. While Doyle denied that IP Jean-Baptiste recommended testing for Fulton Commons' residents (*see* Tarpey Aff. Ex. 3 at 432–433; *see also* Tarpey Aff. at ¶ 52), Doyle's own emails to DOH made clear her determination to refrain from testing Fulton Commons' residents for COVID-19 for as long as she could. (*See* Tarpey Aff. at ¶¶ 53–54.)

128. In fact, Fulton Commons residents were not tested for COVID-19 until June 2020, when DOH required it and sent representatives to the facility to conduct those tests; even then, testing was not completed without resistance from Doyle. (Tarpey Aff. at ¶ 47; *see also* Tarpey Aff. Ex. 2.) This testing was done after 74 residents had died of presumed or confirmed COVID-19 between March 1, 2020 and May 31, 2020. (*See* ¶ 118 *supra*.) Yet, in January 2021, Doyle incredibly testified under oath that testing residents for COVID-19 would not have been helpful,

nor would it have saved lives during the first wave of the pandemic. (*See* Tarpey Aff. Ex. 3 at 425–426.)

129. Doyle's testimony is obviously self-serving and not credible: Doyle, who possesses no medical background and yet ignored the advice of medical professionals, was the only Fulton Commons staff member to testify to such an absurdity. As explained by IP Jean-Baptiste, testing residents would have provided a baseline and made it easier to cohort residents based on their COVID-19 status and contain the infection, thereby decreasing the risk of spreading the infection throughout the facility and preventing further serious illness and/or death. (*See* Tarpey Aff. Ex. 1 at 56–57.) Further, former DON Frawley conceded that lives could have been saved if Fulton Commons had tested for COVID-19. (*See* Ronan Aff. Ex 23 at 95.)

e. Fulton Commons and Doyle Neglected Residents and Further Increased Risk of Infection by Orchestrating Mass Room Transfers on the Eve of a DOH Infection Control Survey to Conceal Their Failure to Cohort Residents

130. In line with her persistent cover-up of resident neglect, abuse, and mistreatment, when Respondent Doyle surmised on May 1, 2020, that a DOH on-site infection control inspection would likely occur the following day, she immediately moved a large number of residents from their original rooms to different rooms to hide that Fulton Commons had been violating basic infection control protocols, including failing to properly cohort residents based on their COVID-19 status. (*See* Ronan Aff. Ex. 23 at 195.) In rushing these mass room transfers over the course of a single afternoon, Fulton Commons failed to safeguard its residents and staff, engaged in rampant infection control violations, and increased the risk of infection to residents and staff, as explained below. (*See* Ronan Aff. at ¶¶ 132–136.)

131. Respondent Doyle assured Respondent Weiss that she would "do everything in [her] power to have [DOH] go with no findings." (Ronan Aff. Ex. 22 at 1; *see also* Ronan Aff. at ¶ 130.) To carry out this promise, Doyle directed 19 resident room transfers on May 1, 2020. Four COVID-positive residents previously housed on non-COVID units were moved onto Unit 1 East, the designated COVID-19 unit. (*See* Ronan Aff. at ¶ 132.) Even more alarming, 15 residents who had been admitted to Fulton Commons without a COVID-19 diagnosis but whom Fulton Commons had nonetheless housed on 1 East (where they were regularly cared for by staff members also providing care to COVID-19 positive residents) were moved off Unit 1 East and scattered throughout the facility without first being tested to confirm their COVID-19 status. (*Id.*; *see also* Tarpey Aff. at ¶¶ 47, 52–57.)

132. Moreover, in an attempt to cover up its disregard of DOH guidance and to give the false impression to DOH that Fulton Commons had been properly cohorting residents, Fulton Commons and Doyle failed to follow basic infection control procedures required to complete these room transfers safely. Fulton Commons and Doyle's dangerous conduct included failing to "terminally clean" the recently-vacated rooms. (*See* Ronan Aff. at ¶¶ 133–134.)

133. Terminal cleaning of a room after a resident is discharged or moved and before a new resident is moved into that room is an essential component of proper infection control at all times. (*See* Conway Aff. at ¶ 48.) It is especially critical during a pandemic when infectious disease is widespread among people living in a nursing home. (*Id.*) A Fulton Commons housekeeping staff member testified that terminal cleaning involves:

> [A] complete clean[ing] of [a resident's] room, chang[ing] curtains . . . . tak[ing] everything out of that room . . . disinfect[ing] that room completely and then put[ting] it back together . . . . tak[ing] the mattress off the bed . . . disinfect[ing] everything. The bottom of the bed, the top of the bed, the mattress . . . . us[ing] bleach . . . . everything is more or less bleached down . . . because you want to

> try to disinfect everything in that room *because we don't know what else somebody might have had.*

(Ronan Aff. Ex. 24 at 55–59 [emphasis added].)

134. Doyle admitted during her examination that no resident should be moved into a room that has not been terminally cleaned. (*See* Tarpey Aff. Ex. 3 at 452–454.) This is in line with state and federal laws requiring facilities to "establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission or disease and infection." (10 NYCRR § 415.19; *see also* 10 NYCRR § 415.5[h], 42 CFR § 483.80[a].)

135. When Respondent Doyle believed a DOH survey was imminent, she and Fulton Commons prioritized the nursing home's financial interest in avoiding thousands of dollars per violation of infection control protocols over the welfare of the residents. (*See* ¶ 178 *infra.*) They also blatantly disregarded the residents' health and welfare by moving four COVID-positive residents into rooms that had been vacated earlier that same day without terminally cleaning the rooms, thereby placing those residents at risk of contracting other infections or communicable diseases. (*See* Ronan Aff. at ¶¶ 133–134.) In further violation of basic infection control procedures, Fulton Commons also failed to terminally clean seven other resident rooms vacated on May 1, 2020, prior to moving other residents into those rooms in the ensuing weeks. (*Id*. at 134.)

6. CMS Designated Fulton Commons as a Candidate for its Special Focus Facility Program Due to Serious Quality Concerns

136. In April 2022, CMS designated Fulton Commons as a candidate for its SFF program. The SFF program was designed to ensure that designated facilities—those with a history of "serious quality issues"—address "underlying systemic problems that give rise to repeated

cycles of serious deficiencies, which pose risks to residents' health and safety."[27] CMS publicizes the list of nursing homes that are designated as special focus facilities as well as nursing homes that are candidates for the SFF program to help people make informed decisions about where to obtain nursing home care for themselves or their loved ones. (*Id.*)

137. CMS identifies nursing homes for the SFF program based on the number of deficiencies and the scope and severity of DOH citations, which are then converted into points. The facilities with the most points in each state, or in other words the worst nursing homes in each state, then become candidates for the SFF program.[27]

138. Notably, Fulton Commons was placed on the SFF candidate list following its receipt of an IJ citation from DOH in January 2022, when DOH discovered that Fulton Commons had covered up an allegation of sexual abuse of a resident. (*See* ¶¶ 11–12, 81[iii] *supra*). It is unsurprising that Fulton Commons, with its persistent pattern of neglect, abuse, and mistreatment, and its culture of covering up such problems, has been (and remains) an SFF candidate for eight months.

C. Respondents Fulton Commons, Kalter, Weiss, and Doyle Repeatedly and Persistently Unlawfully Operated Fulton Commons with Insufficient and Unqualified Staff, in Violation of 10 NYCRR §§ 415.13 and 415.26(c), as well as 42 CFR § 483.35, Resulting in the Appalling Neglect, Abuse, and Mistreatment of Fulton Commons' Residents

139. As explained in the RN Conway Aff., the failure to sufficiently staff a nursing home puts direct caregivers "into the impossible position" of having to care for too many residents during a given shift. (*See* RN Conway Aff. at ¶ 31.) This inevitably contributes to the endangerment of residents, as RN Conway states:

[27] CMS, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/SFFList.pdf [last accessed Dec. 4, 2022].

> The adequacy of a nursing home's staffing is the measure most closely linked to the quality of care residents receive in nursing homes. . . . Insufficient staffing is one of the most significant factors leading to resident neglect, abuse, and mistreatment.

(*Id*. at 30.)

140. State law mandates that New York nursing homes limit admissions to those residents for whom they can provide adequate care. (*See* 10 NYCRR § 415.26[i][1][ii].) Adequate care requires that "each resident receives [the] treatments, medications, diets and other health services in accordance with individual care plans" necessary to "attain or maintain the highest practicable physical, mental, and psychosocial well-being." (10 NYCRR § 415.13; *see also* RN Conway Aff. at ¶¶ 12–13.)

141. Under the law, Fulton Commons is required to provide its residents with necessary and appropriate care from a variety of health care professionals, including nursing staff—RNs, LPNs, and CNAs. (*See* 10 NYCRR§ 415.13; *see also* RN Conway Aff. at ¶ 22.) Most hands-on resident care is rendered by CNAs, typically the lowest paid of the nursing staff. (*See* RN Conway Aff. at ¶ 22.) CNAs are responsible for time-consuming but essential custodial services for residents in accordance with their individual care plans, such as feeding; assisting with personal hygiene, including bathing and dressing; toileting; and positioning, transferring, and transporting residents. (*Id*.) LPNs are primarily responsible for medication administration, monitoring vital signs, providing certain treatments within their scope of practice, and supervising CNAs. (*Id*.) RNs have the broadest scope of practice and provide the highest level of patient care. They typically focus on monitoring the health of residents to ensure they get proper care, addressing residents' acute care needs, performing complex treatments, ensuring compliance with medical orders, communicating with physicians and specialists, interacting with residents' families to report changes in condition, record-keeping, and completing complex health assessments. (*Id*.) Health

assessments include comprehensive assessments of residents' conditions when they are admitted to a nursing home, as well as any changes in their conditions thereafter. (*Id.*)

142. Of utmost importance, in addition to all of their direct resident care responsibilities, RNs are also responsible for supervising and training LPNs and CNAs to ensure they are performing their duties competently and diligently. (*Id.*) Adequate RN supervision on each unit is essential to guarantee nursing staff are properly and timely performing their assigned duties in compliance with residents' individual care plans. (*Id.* at ¶ 33.) When a nursing home lacks sufficient RN supervision, overworked and overburdened direct caregivers often provide care negligently, causing unnecessary suffering to the residents. (*Id.*)

143. From January 1, 2018 through January 31, 2022, Respondents Fulton Commons, Kalter, Weiss, and Doyle violated their duties under 10 NYCRR § 415.13 and 42 CFR § 483.35 to staff Fulton Commons sufficiently to provide necessary, appropriate, and dignified care to Fulton Commons' residents, while the facility fraudulently and illegally funneled millions of dollars to Respondent-owners and Fulton Realty LP. Maximizing Respondent-owners and Fulton Realty LP's up-front profit, Respondents intentionally maintained a business model that set direct care staff up to fail by operating with insufficient numbers of nursing staff, including supervising RNs, to meet the residents' care needs, despite receiving more than sufficient government funds to do so. Of the $105,834,966 that Fulton Commons reported in revenue from government-funded programs for the care of its residents from January 1, 2018 through December 31, 2021, Fulton Commons spent $47,330,226 on direct resident care and transferred $15,970,393.79 to Respondent-owners and Fulton Realty LP for their own financial gain.

144. Moreover, during the same period, Fulton Commons boosted its revenue by illegally continuing to admit residents for whom they could not provide adequate care, in violation

of 10 NYCRR § 415.26(i)(1)(ii), as evidenced by the pervasive neglect, abuse, and mistreatment of residents, many of whom were reliant upon staff for their survival. (*See* ¶¶ 71–81 *supra*; *see also* Ronan Aff. at ¶ 89.)

1. Respondents Fulton Commons, Kalter, and Doyle Were on Notice of Their Failure to Provide Sufficient Staffing Due to Consistently Substandard CMS Ratings

145. CMS publicly issues nursing home ratings via the "Care Compare" website.[28] Each Medicare-certified nursing home in the country has an Overall rating, which is based upon its performance in three areas, for which separate ratings are also issued: (1) Health Inspections; (2) Nursing Staffing; and (3) Quality Measures. (*See* Ronan Aff. at ¶ 73.) CMS created the Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily. (*Id.*) The ratings are based on official inspections and required facility-reported data, including but not limited to the data contained in payroll-based journal ("PBJ") records,[29] which are maintained by CMS. Importantly, these ratings are not matters of consumer opinion. CMS issues nursing staffing ratings based on ratios of total numbers of staffing hours for each direct care category relative to the number of residents in the nursing home. CMS includes both RN Staffing and Overall Staffing ratings, and the ratios are expressed as star ratings, with the lowest rating of 1-Star signifying the lowest number of staff per resident, and the highest rating of 5-Stars signifying the highest number.

146. CMS consistently rated Fulton Commons' Overall Staffing and RN Staffing levels at 2-Stars, which is "BELOW AVERAGE," or at 1-Star, which is "MUCH BELOW AVERAGE,"

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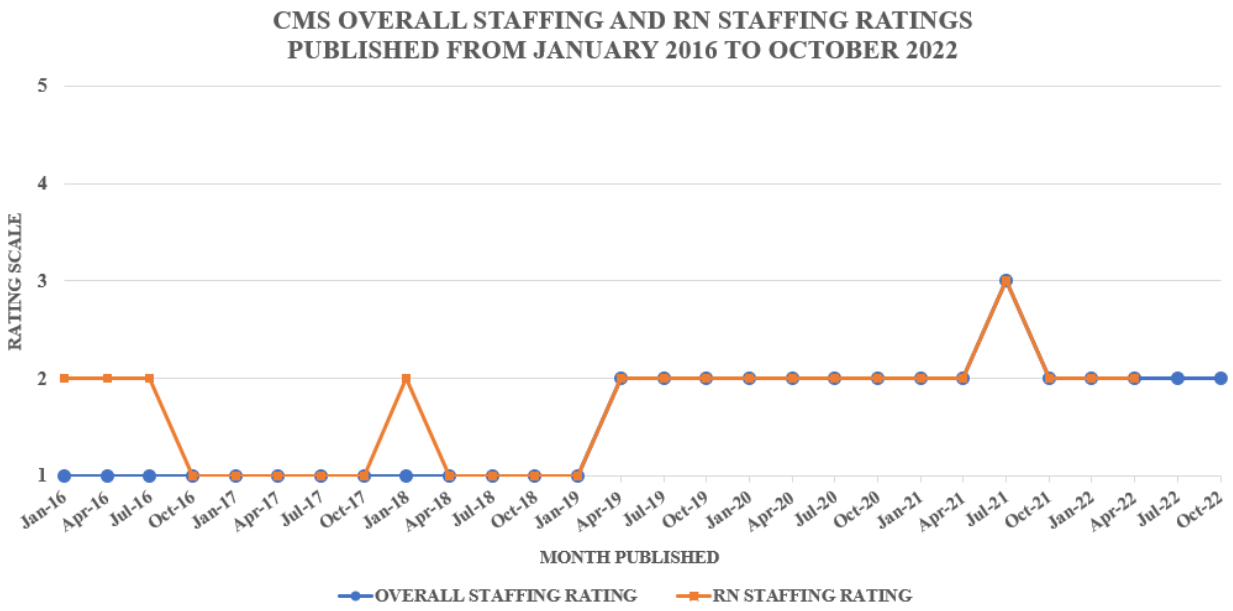
[28] The "Care Compare" website may be accessed at https://www.medicare.gov/care-compare/.

[29] The self-reported PBJ data includes nursing staff hours—the number of hours staff are paid to work each day, aggregated by staff reporting category.

from January 1, 2016 to October 31, 2022, with the single exception of the quarter beginning July 1, 2021, when it was rated at 3-Stars, or "AVERAGE," as reflected in the chart below.[30] (*See* Ronan Aff. at ¶ 74.)



147. Respondents knew, or should have known, that Fulton Commons had insufficient staffing levels because of these publicly-released CMS star ratings. Yet, Respondents Fulton Commons, Kalter, Weiss, and Doyle failed to address the evident detrimental effects of insufficient staffing on residents and continued to operate with insufficient staffing, in violation of 10 NYCRR § 415.13 and 42 CFR § 483.35. Despite Fulton Commons' consistent "BELOW AVERAGE" 2-Star Overall Staffing and RN Staffing ratings, the nursing home admitted 546 residents in 2019 while maintaining an average census of 271 residents. Similarly, in 2020, Fulton Commons

[30] At all times relevant hereto, CMS's staffing ratings were based on PBJ data reported by nursing homes from two quarters earlier, i.e., CMS's staffing ratings for July 1, 2021 through September 30, 2021, are based on PBJ data from January 1, 2021 through March 31, 2021. (*See* Ronan Aff. at ¶ 73.) The ratings for other facilities owned by various Respondents can also be found in the online CMS system.

admitted 762 residents despite these consistent "BELOW AVERAGE" ratings while maintaining an average census of 210 residents. (*See* Ronan Aff. at ¶ 89.)

2. Intentionally Low Staffing Made it Impossible for Fulton Commons Nursing Staff to Complete All of Their Caregiving Responsibilities

148. When a nursing home operates with insufficient nursing staffing, the effects on its staff and residents and their families are widespread and pervasive. Nursing homes that operate with insufficient staffing force their direct care employees into the impossible position of trying "beat the clock" to provide required care to too many residents, and inevitably residents' needs are unmet. (*See* RN Conway Aff. at ¶ 77.)

149. At Fulton Commons, the effect of insufficient nursing staffing is evidenced by its systemic resident neglect, to wit: medication errors; the failure to timely administer medications and necessary treatments; the failure to provide basic custodial care, e.g., toileting and assisting with grooming; the failure to assess resident conditions; the failure to follow infection control protocols; and unnecessary and avoidable hospitalizations. (*See* ¶¶ 11, 14–16 *supra*.)

150. Multiple Fulton Commons employees reported that even before the COVID-19 pandemic, the nursing home routinely operated with staffing shortages and relied on its already overworked staff to take on extra shifts or hours to fill the gaps. (*See* Tarpey Aff. at ¶ 13.) The COVID-19 pandemic exposed and exacerbated these staffing shortages, causing Fulton Commons' low staffing model to collapse. This resulted in staff checking in on residents only twice during an eight-hour shift. (*Id*. at ¶ 14.) Despite direct caregivers complaining to their superiors that they could not complete all the tasks assigned to them each shift, Respondents did not increase staffing levels (*id*. at ¶ 15), nor is there any evidence that they even contemplated doing so. In fact, Doyle's emails reflect that Fulton Commons considered laying off staff in June

2020. (*See* Sekhon Aff. Ex. 2.) Meanwhile, residents suffered, and Respondent-owners and Fulton Realty LP continued to extract and convert millions of dollars from Fulton Commons from 2020 through 2022.

151. Notably, Fulton Commons has maintained deficient staffing levels, as evidenced by their CMS Overall Staffing and RN Staffing ratings, through at least October 2022. (*See* ¶ 146 *supra*.) Specifically, during the weekend of March 25–27, 2022, there were so few CNAs on one unit that staff reported being unable to take a lunch or 15-minute break because doing so would result in residents not receiving necessary care. (*See* Tarpey Aff. at ¶ 18.) Fulton Commons staff further reported that there were times when, due to other responsibilities, there was only one CNA on the floor, rendering it difficult to provide adequate care. (*Id*.) These staffing insufficiencies placed undue physical and mental burdens on nursing staff and forced them to forgo their own basic needs. These burdens made nursing staff more prone to ignoring the needs of residents and/or treating residents in a disrespectful and undignified manner.

3. Fulton Commons Repeatedly and Persistently Unlawfully Externalized Staffing Costs to Residents' Family Members

152. Respondents Fulton Commons, Kalter, Weiss, and Doyle's repeated and persistent illegal operation of Fulton Commons with insufficient staffing improperly externalized—shifted—Fulton Commons' staff's duties onto residents' families, who were forced to step in and fill the void. Residents' family members did so either by providing the care their family members needed themselves, or by paying staff members for care out of pocket—in both cases, providing or paying for care that Fulton Commons was already being paid to provide by, inter alia, Medicaid and Medicare.

153. Multiple family members of residents personally witnessed insufficient nursing staffing at Fulton Commons. Some family members reported seeing merely one or two staff members attempting to provide care to as many as 30 residents. (*See* Costa Aff. at ¶ 4; Gregus Aff. at ¶ 9; Lennon Aff. at ¶ 10.) As detailed in ¶ 84(v)(a) *supra*, some family members paid for one-to-one caregivers to ensure their loved one's safety; others were forced to search for Fulton Commons staff members to assist their loved ones when call bells went unanswered.

154. Fulton Commons operated with staffing levels so deficient that residents' family members themselves regularly provided basic custodial care to their loved ones, including trimming fingernails, cutting hair, assisting with oral hygiene (such as cleaning dentures), and feeding and drinking. This personal care, which Fulton Commons was required by law to provide to its residents to maintain their health and dignity, would have gone unprovided had the family members not assumed the role of staff and completed these tasks themselves. Examples of this unlawful externalization of care to residents' families include:

i. As detailed in ¶ 88(i) *supra*, Fulton Commons staff routinely failed to cut F.H.'s fingernails or trim his hair, thereby shifting these responsibilities onto his son. (*See* Hoerauf Aff. at ¶¶ 2, 11.)

ii. As detailed in ¶ 90(iii) *supra*, Fulton Commons staff members failed to intervene or assist Resident S.K., who suffered from dementia, while she was crawling on the lunchroom floor, resulting in her son finding her in this undignified condition, compelling him to lift her off the floor himself. (*See* Costa Aff. at ¶¶ 2, 9.)

iii. As detailed in ¶ 89(ii) *supra*, Fulton Commons failed to provide appropriate and sufficient oral care and grooming to Resident J.C., forcing her daughter to clean her dentures and cut her fingernails. (*See* Affidavit of Diana Mejia ["Mejia Aff."] at ¶¶ 5, 9.)

155. Similarly, by operating Fulton Commons with chronic insufficient staffing levels, Fulton Commons, Kalter, Weiss, and Doyle repeatedly and persistently illegally externalized Fulton Commons' staffing costs to third-party family members who were compelled to pay

frequent tips to incentivize staff to prioritize their loved ones' needs, or hire private caregivers, to ensure that their relatives would receive the required care. Family members had to do so because they witnessed that Fulton Commons operated with such insufficient staffing levels that staff were regularly unable to provide all required care to their assigned residents. Examples of Fulton Commons' repeated and persistent illegality in failing to operate with sufficient staffing, and its unlawful externalization of costs of care to residents' families include:

i. The son of a former resident paid staff hundreds of dollars per month when he realized his mother was not receiving necessary care, including physical therapy. This resulted in some improvement in her care. (*See* Tarpey Aff. at ¶¶ 21–22.)

ii. The daughter of Resident V.P. reported tipping staff, first around the holidays, but then more regularly. V.P.'s daughter reported that Fulton Commons staff began soliciting "tips" by informing her that they had provided "special" care to her mother. Such tips became so frequent that this witness felt she was going to end up "in the poorhouse." (*Id*. at ¶¶ 22, 31.)

iii. As detailed in ¶ 84(v)(a) *supra,* Resident W.V.'s daughter hired a one-to-one caregiver to ensure her father remained connected to his oxygen machine. (*See* Doherty Aff. at ¶ 10.)

iv. Resident F.H.'s son regularly paid Fulton Commons aides in the hopes of obtaining improved care for his father. (*See* Hoerauf Aff. at ¶ 13.)

156. Sadly, residents are often neglected if they do not have family members or other loved ones to fill the void created by insufficient staffing. (*See* RN Conway Aff. at ¶ 36.) Residents are also neglected during times when visitation is prohibited, such as at the height of the COVID-19 pandemic, because their family members can no longer visit and provide care, or tip staff for, their relatives' care. (*Id*.)

4. Fulton Commons Sidelined and Ignored its Infection Preventionist During the First Wave of the COVID-19 Pandemic, Thereby Failing to Appropriately Staff the Position, in Violation of 10 NYCRR § 415.19 and 42 CFR § 483.80(a), (b)

157. As detailed in ¶¶ 99–104 *supra*, Fulton Commons sidelined its IP in the height of the COVID-19 pandemic and ignored her infection control recommendations, effectively leaving that position unstaffed in violation of federal law. (*See* 42 CFR § 483.80[b].) There is no excuse for Fulton Commons and Doyle ignoring their designated IP, let alone at the onset of a deadly pandemic. By intentionally excluding IP Jean-Baptiste from discussions regarding infection control policies and measures in the facility during the pandemic, Fulton Commons and Doyle demonstrated an intentional disregard for the health, safety, and well-being of its residents.

5. Fulton Commons Repeatedly and Persistently Illegally Failed to Provide its Staff with Infection Control Training, in Violation of 10 NYCRR § 415.19 and 42 CFR §§ 483.80(a) and 483.35, and Falsified a Record to Hide This Failure

158. "There is undoubtedly a connection between insufficient staffing and infection control as proper infection control practices take staff time to complete." (RN Conway Aff. at ¶ 52.) Good infection control practices include properly training staff to ensure infection control protocols are understood and followed. Typically, nursing homes assign dedicated RNs to provide training to LPNs and CNAs through orientation and ongoing in-service lessons. (*Id*. at ¶ 33.) When a nursing home operates with insufficient RN staffing, its RNs do not have enough time during their shifts to perform resident assessments, supervisory tasks, and/or training functions effectively, and residents often suffer from neglect as a result. (*Id*.)

159. Fulton Commons repeatedly and persistently engaged in illegal and fraudulent conduct by failing to provide its staff with adequate and proper training, commonly referred to as

"in-services," related to COVID-19 infection control procedures and PPE, and by falsely documenting that Fulton Commons provided staff with such training.

160. Staff at Fulton Commons reported that they received inadequate training regarding COVID-19 infection control in violation of 10 NYCRR § 415.19 and 42 CFR §§ 483.80(a), 483.35. In fact, some staff did not receive any in-services concerning COVID-19 infection control, including PPE donning and doffing procedures and contact and droplet precautions until *after* a DOH on-site focused infection control survey on May 4, 2020 (*see* Ronan Aff. Ex. 21 at 54, 68–69), by which time 72 Fulton Commons residents had already died of presumed or confirmed COVID-19. (*See* Ronan Aff. at ¶ 136.) This failure to provide required training and in-services is consistent with DOH's findings that Fulton Commons had multiple infection control deficiencies. (*See* ¶ 77 *supra*; *see also* Ronan Aff. Ex. 11.) DOH's findings required Fulton Commons to properly train its staff members as part of a Plan of Correction. (*See* Ronan Aff. Ex. 11.)

161. Two Fulton Commons staff members reported not receiving in-services concerning COVID-19, even though both staff members admitted to signing in-service sign-in sheets at the request and/or direction of their supervisors. (*See* Ronan Aff. Ex. 19 at 49–51, 54; *see* RN Conway Aff. at ¶ 35.) In other words, the staff members' supervisors caused them to falsely claim that they had been trained. As explained by RN Conway, "[r]equiring nursing home staff to falsely document that they received in-service training that was not in fact given is not only illegal as a falsification of business records, but also endangers residents." (RN Conway Aff. at ¶ 35.)

162. Fulton Commons' failure to provide necessary training to its direct caregivers while requiring them to falsify training records is another example of Fulton Commons' brazen culture of deceit in concealing its persistent neglect, abuse, and mistreatment of its vulnerable residents. Despite Fulton Commons' legal duty to provide adequate and effective training to ensure its staff

follow infection control protocols and procedures, Fulton Commons failed to comply with the law, thereby placing its vulnerable residents at increased risk of infection, serious illness, and/or death (*see* 10 NYCRR § 415.19; *see also* 42 CFR §§ 483.80[a], 483.35) and then directed staff members to break the law by falsifying documents to cover up Fulton Commons' violations of its duties.

6. Fulton Commons Repeatedly and Persistently Failed to Meet Evidence-Backed Staffing Levels Below Which Quality of Care is Compromised

163. As evident from Fulton Commons' CMS Overall Staffing and RN Staffing ratings of either "MUCH BELOW AVERAGE" or "BELOW AVERAGE" for all but one quarter since at least January 1, 2016,[31] Fulton Commons had woefully deficient staffing, to the detriment of its residents. As reflected by the findings of the Attorney General's investigation, and supported by the CMS study described below, Respondents' business decisions to inadequately staff the nursing home contributed to avoidable neglect, abuse, and mistreatment.

164. In 2001, CMS released a landmark report on nursing home staffing based on a study mandated by Congress. The CMS study entitled, "*Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*," concluded that there was "strong evidence" to "support the relationship between increases in nurse staffing ratios and avoidance of critical quality of care problems."[32] While the 2001 CMS report stopped short of making specific policy recommendations, it identified 4.1 hours of total direct care nursing time for long-stay populations, expressed in terms of nursing

[31] The exception to this consistently deficient pattern is the third quarter of 2021, when both of Fulton Commons' CMS staffing ratings were "AVERAGE" before dropping again to "BELOW AVERAGE." As detailed in ¶ 146 n.30 *supra*, the third quarter of 2021 rating was based on PBJ data from January through March 2021.

[32] Marvin Feuerberg, *Centers for Medicare & Medicaid Services (CMS) Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report,* Baltimore, MD: CMS; 2001. (*See* Sekhon Aff. Ex. 7).

hours per resident day ("HPRD"),[33] as the staffing threshold "below which quality of care was compromised." (*Id* at 5.) CMS noted that the closer a nursing home gets to 4.1 HPRD, equating to four hours and six minutes, the greater the improvements in quality care. (*Id*.) The 4.1 HPRD consists of 2.8 HPRD (equating to 2 hours and 48 minutes) from CNAs and 1.3 HPRD (equating to 1 hour and 18 minutes) for licensed nursing staff, which are RNs and LPNs, and specifically includes .75 HPRD (equating to 45 minutes) from RNs. Importantly, the study adjusted these numbers for populations with lower "acuity,"[34] finding that quality of care diminished in these populations when RN HPRD decreased below .55 hours (equating to 33 minutes). (*Id*.)

165. A number of researchers and nursing organizations have endorsed 4.1 HPRD as the minimum staffing level needed for nursing homes to improve resident outcomes in terms of lower mortality rates, fewer pressure injuries, less restraint use, decreased infections, less pain, improved activities of daily living, less weight loss, less dehydration, less improper and/or excessive use of antipsychotics, reduced emergency room visits, and fewer rehospitalizations.[35] These experts also recommend that nursing homes provide more than 4.1 HPRD to residents with higher acuity.

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[33] HPRD is calculated by dividing the total hours worked each day by nursing staff (RNs, LPNs, and CNAs) by the number of residents in the facility on the same day.

[34] "Acuity" refers to the level of nursing care required for each resident's particular health conditions." (RN Conway Aff. at ¶ 39.)

[35] *See* Charlene Harrington, et al., *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, June 29, 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/ (last accessed Dec. 5, 2022) (hereinafter the "Harrington Article") citing American Nurses' Association ("ANA"), *Nursing Staffing Requirements to Meet the Demands of Today's Long Term Care Consumer, Recommendations from the Coalition of Geriatric Nursing Organizations (CGNO)*, Position Statement Nov. 12, 2014, https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/nursing-staffing-requirements-to-meet-the-demands-of-todays-long-term-care-consumer).

166. The Harrington article, published after the end of the first wave of the COVID-19 pandemic, noted that "[d]uring the coronavirus pandemic in 2020, the importance of adequate nursing home staffing [became] even more critical in protecting the health and safety of residents."[36]

167. As explained in ¶ 173 *infra*, between January 2019 and June 2022 Fulton Commons' nursing HPRD was lower than the CMS study's target upper level of 4.1 HPRD in every month except one, May 2020, when the staffing level was artificially and temporarily inflated by the large number of resident deaths from COVID-19 in the first wave of the pandemic.

7. Fulton Commons Falsely Reported its RN Staffing Hours to CMS

168. Fulton Commons self-reported false staffing data to CMS. Specifically, in its PBJ data, Fulton Commons failed to distinguish the hours worked by RNs performing direct care from the hours worked by RNs with strictly administrative duties, as required by CMS. (*See* Ronan Aff. at ¶ 79.) Accordingly, any analysis of Fulton Commons' HPRD using the PBJ data is necessarily inflated because it includes both administrative and direct care RNs. This renders it impossible to accurately calculate Fulton Commons' HPRD levels as Fulton Commons' failure to demarcate its administrative RNs from its direct care RNs conceals its actual lower level of RN direct care staffing.

[36] Harrington Article, at p. 1, *citing* Stockman, F; Richtel, M; Ivory, D; Smith, M.; *They're Death Pits: Virus Claims at Least 7,000 Lives in U.S. Nursing Homes*, The New York Times, Apr. 17, 2020, https://www.nytimes.com/2020/04/17/us/coronavirus-nursing-homes.html; Rau, J.; Almendrala, A.; *COVID-Plagued California Nursing Homes Often Had Problems in Past*, Kaiser Health News, May 4, 2020, https://khn.org/news/covid-plagued-california-nursing-homes-often-had-problems-in-past/; Mathews, A.W.; Fuller, A.; De Avila, J.; *Thinly Staffed Nursing Homes Face Challenges in Pandemic*, Wall Street Journal, May 1, 2020, https://www.wsj.com/articles/thinly-staffed-nursing-homes-face-challenges-in-pandemic-11588343407.)

8. Fulton Commons Had Insufficient Nursing Staff Levels from January 2020 to January 2022 and Would Have Failed to Meet State and Federal Overall Quantitative Staffing Guidelines Were it Not for Fulton Commons' High Number of COVID-19 Deaths

169. As explained in ¶¶ 60–61 *supra*, New York State has a qualitative nursing staff requirement that directs nursing homes to operate with sufficient staff for each of their residents to "attain or maintain the highest practicable physical, mental, and psychosocial well-being," as dictated by their care plans and other qualitative standards. (*See* 10 NYCRR § 415.13; *see also* RN Conway Aff. at ¶¶ 11–12.) In addition to this long-standing minimum qualitative standard, New York State recently enacted Public Health Law § 2895-b(3), effective April 1, 2022, which sets forth a quantitatively expressed minimum of 3.5 HPRD (or 3 hours and 30 minutes) for nursing home staffing, of which no less than 1.1 hours (1 hour 6 minutes) must be furnished by a licensed nurse (RNs and/or LPNs). Although New York State nursing homes are now statutorily prohibited from operating below this staffing level, they must still meet the requirement under 10 NYCRR § 415.13 that they operate with sufficient staff to provide adequate care for each of their residents—even if the staffing level needed to meet the latter legal requirement is higher than 3.5 HPRD.

170. Fulton Commons failed to meet the minimum qualitative nursing staffing standard by failing to provide sufficient, quality staff—including supervisory staff—to ensure the residents' needs were met, as illustrated by the findings of neglect, abuse, and mistreatment herein (and the concealment thereof), and Fulton Commons would have also failed to meet the minimum quantitative standard of 3.5 HPRD had its census not dropped sharply after many residents died from COVID-19, as explained in ¶ 167 *supra*.

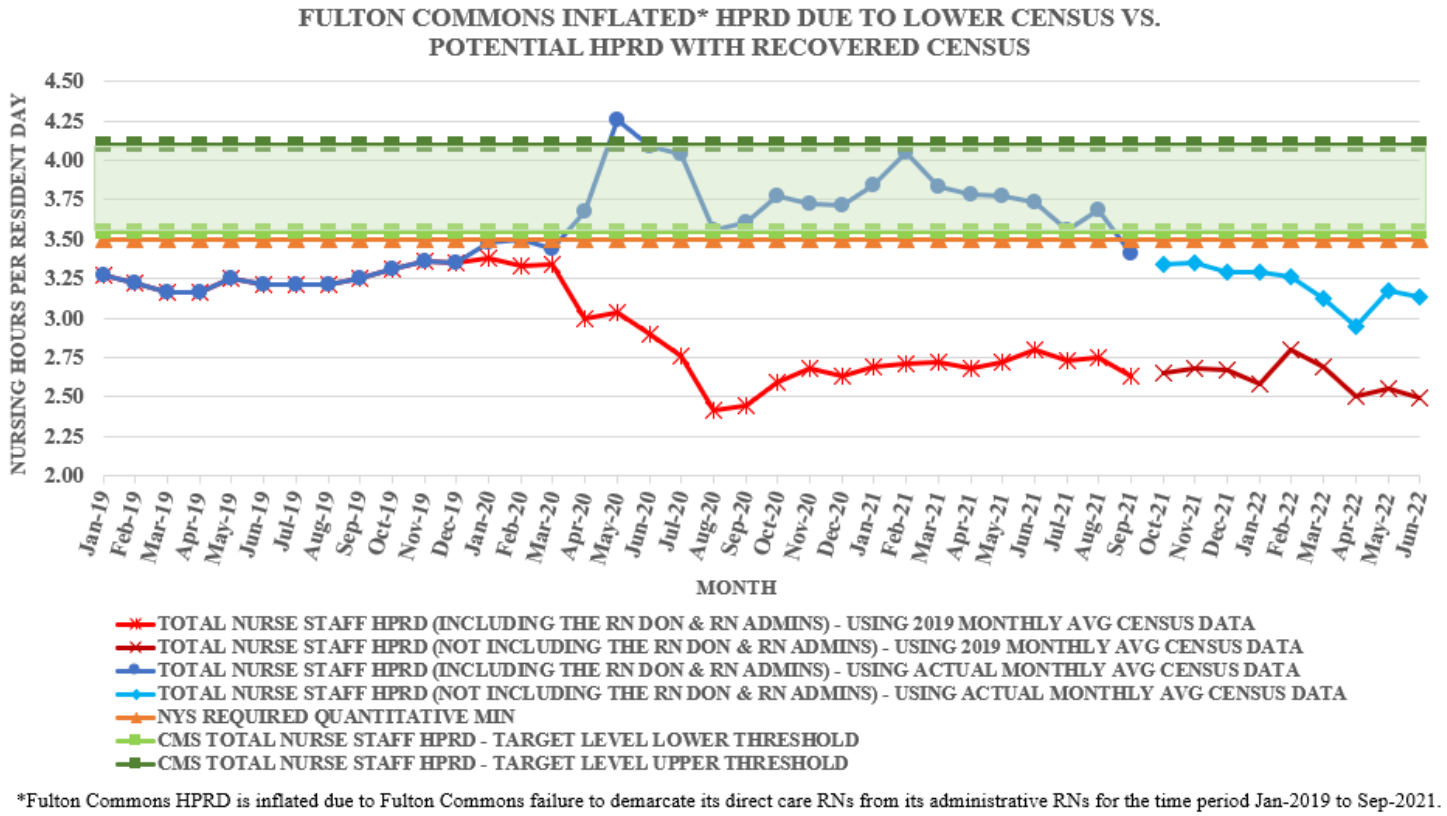
171. Importantly, Fulton Commons also unlawfully obstructed MFCU's attempts to conduct an analysis of its actual staffing levels, including its RN staffing levels, for the period of

February 1, 2020 through May 18, 2022. Fulton Commons improperly and baselessly rejected a lawfully issued Executive Law § 63(12) subpoena that demanded Fulton Commons' staffing records. (*See* Sekhon Aff. Ex. 3; *see also* Ronan Aff. at ¶ 76.) As a result of Fulton Commons' obstruction, MFCU was denied the opportunity to determine Fulton Commons' true RN staffing levels and HPRD between February and May 2022. That subpoena, which is attached to the Sekhon Aff. as Exhibit 3 along with Respondent Fulton Commons' documented unjustifiable rejection, required production of staffing records for the relevant period. Accordingly, Respondents should now be precluded from arguing that they had sufficient RN staffing during this period based on any previously undisclosed records.

172. Fulton Commons' HPRD, based on its inaccurate self-reported PBJ records, is depicted in the chart below—though this illustration is not reflective of its true HPRD, as it is hampered by the nursing home's false report of its RN data to CMS. (*See* ¶ 168 *supra*.) Nonetheless, even using Fulton Commons' defective self-reported data, its monthly average nursing HPRD in 2019 was consistently below the 4.1 target HPRD ratio found by CMS to maximize avoidance of quality-of-care issues and was even below the 3.5 HPRD now required by Public Health Law § 2895-b(3).

173. The chart below utilizes Fulton Commons' self-reported RN data and its average census from January 2019 through June 2022. The dark blue line with circles represents Fulton Commons' HPRD based on the conflated, and therefore inflated, RN staffing data from January 2019 through September 2021, using its actual census data. The bright blue line with diamonds represents Fulton Commons' HPRD from October 2021 through June 2022 (after the nursing home stopped conflating its direct care RNs and its administrative RNs in its self-reported PBJ data), using its actual census data. The bright red line with asterisks represents what Fulton Commons'

inflated HPRD would have been from January 2019 through September 2021, if its census had not plummeted due to its 74 COVID-19 resident deaths during the first wave of the pandemic. The dark red line demarcated with the letter "x" represents what Fulton Commons' HPRD would have been from October 2021 to June 2022, if its census had recovered to what it was during the same months (October to June) in 2019. These lines are then compared to the NYS quantitative minimum of 3.5 HPRD (expressed as the orange line with triangles), and the CMS study target level range of 3.55–4.1 HPRD (expressed as the green shaded area). Between January 2020 and June 2022 (with the exception of May 2020 when Fulton Commons' census dropped significantly due to COVID-19 resident deaths), the inflated nursing HPRD consistently remained lower than the target staffing upper level of 4.1 HPRD found by CMS to limit quality-of-care issues. The precipitous drop in resident census allowed Fulton Commons to meet the New York State quantitative minimum of 3.5 HPRD that went into effect on April 1, 2022. (Ronan Aff. at ¶¶ 82–83.) However, if Fulton Commons' census had recovered to that which it was in 2019, its staffing levels would have pitifully failed to even approach that staffing minimum (which itself is not an exhaustive requirement). (*Id*. at ¶ 85.) Indeed, Fulton Commons had an average census of 234 in February 2022, indicating that Fulton Commons continued to admit residents despite being unable to adequately care for them. (*Id*.) Notably, Fulton Commons' average census once again decreased in the Spring of 2022, likely due to its placement on CMS's SFF program candidacy list and its "BELOW AVERAGE" Overall Rating. (*See* ¶¶ 136–138, 145 *supra*.)

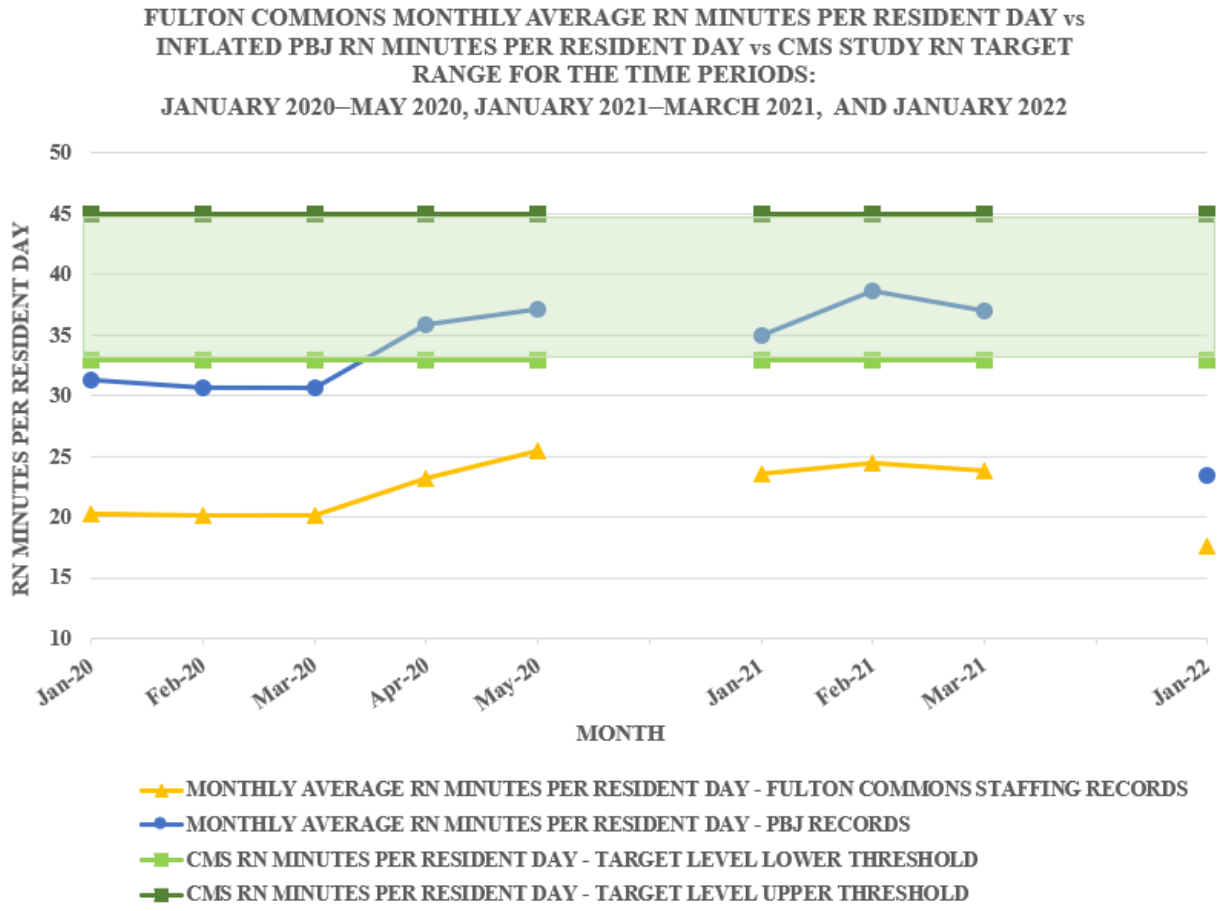


*Fulton Commons HPRD is inflated due to Fulton Commons failure to demarcate its direct care RNs from its administrative RNs for the time period Jan-2019 to Sep-2021.

174. Fulton Commons' failure to sufficiently staff its units includes its failure to employ enough RNs, who are essential to ensuring that residents receive adequate care. MFCU conducted a targeted review of Fulton Commons' internal staffing records for the periods: (1) January 2020 to May 2020; (2) January 2021 to March 2021; and (3) January 2022. MFCU found that Fulton Commons consistently failed to provide adequate RN staffing, because its RN staffing failed to meet the 2001 CMS study RN target range of 33 to 45 minutes per resident per day. (*See* Ronan Aff. at ¶¶ 76–80.) In order to understand the amount by which Fulton Commons inflated its self-reported PBJ data, MFCU compared the RN HPRD based on the PBJ data to the RN HPRD based on the facility's internal records.

175. This analysis is shown in the following chart, with the CMS range shaded in green, the actual RN staffing level in yellow with triangles, and the falsely inflated RN staffing level per

the PBJ data in blue circles.[37] This illustration makes abundantly clear the effect of Fulton Commons' improper reporting: Fulton Commons' conflated data would have one believe that the facility's RN staffing met the CMS study target range five out of the nine months reviewed, whereas their internal records reveal the nursing home was disgracefully understaffed with RNs each of those nine months.

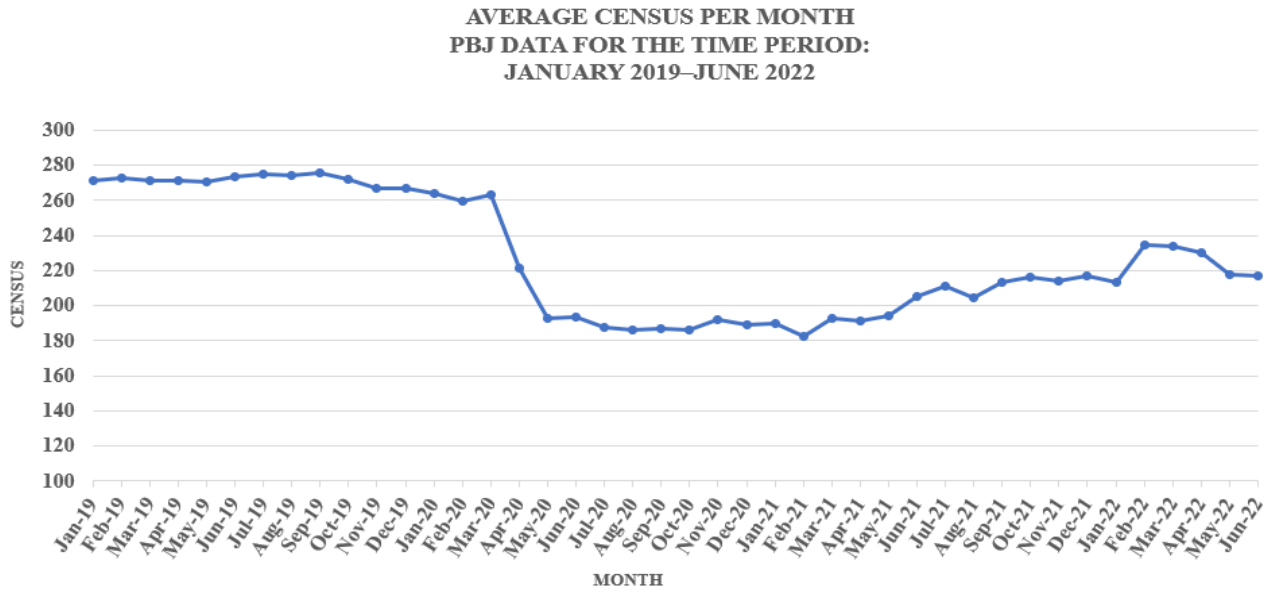


176. Importantly, although the graph in ¶ 175 reflects an increase in RN minutes per resident in April and May 2020, this is not a result of hiring more staff, but rather due to numerous

[37] Although Fulton Commons' January 2022 PBJ data does separately report direct care RNs, MFCU had no choice but to include all RNs (direct care, administrative, and DON) into its analysis of that month as well for the sake of continuity.

resident deaths, which caused the resident census to plunge during the first wave of the COVID-19 pandemic.

177. One-third of Fulton Commons' residents died between March 1, 2020 and May 31, 2020. Specifically, 92 Fulton Commons residents died in those three months—nearly four times as many deaths as occurred during the corresponding period in 2019, as discussed in ¶ 115 *supra*. (*See also* Ronan Aff. at ¶¶ 80, 113.) The following graph shows the changes in Fulton Commons' census between January 2019 and June 2022. (*See* Ronan Aff. at ¶ 85.)



9. Respondents Fulton Commons, Kalter, Weiss, and Doyle Operated the Nursing Home to Reduce Expenses and Maximize Revenue, Resulting in Increased Risk of Harm to Fulton Commons' Residents

178. Maintaining substandard staffing levels was not the only way in which Respondents Fulton Commons, Kalter, Weiss, and Doyle attempted to minimize expenses. The desire to reduce expenses was evident in Doyle's emails and testimony during an examination under oath pursuant to Executive Law § 63(12). Specifically in an email dated Friday, May 1, 2020, Doyle advised Respondent Weiss that she expected that a DOH survey team would be arriving imminently to

conduct an infection control survey and assured him that she would do whatever was in her power to prevent any findings. (*See* Ronan Aff. Ex. 22.) Furthermore, in her testimony, Doyle admitted that she was aware that DOH was fining nursing homes $2,000 per violation. (*See* Tarpey Aff. Ex. 3 at 313–314.) As detailed in ¶ 131 *supra*, Fulton Commons' records reveal that following Doyle's assurance to Weiss, Fulton Commons implemented a mass room transfer involving 19 residents whom the facility had failed to cohort based on their COVID-19 status. (*See* Ronan Aff. at ¶¶ 129–133; *see also* ¶¶ 130–132 *infra*.)

179. Similarly, Doyle's emails further evince that the desire to maximize revenue was the driving force behind the discussion of the assignment of certain diagnosis codes to residents, even when not applicable. Diagnosis codes are reported in a Minimum Data Set ("MDS") to DOH and CMS, which use the information to calculate the rate of reimbursement the nursing home receives from Medicaid and/or Medicare for each resident. In an April 9, 2020, email exchange with Fulton Commons' medical director, Dr. Olaf Butchma (who also served as an attending physician for one unit), Doyle reminded him of Fulton Commons' expenses when asking him to accept the MDS coordinator's advice regarding a medical diagnosis for a specific resident in order to maximize revenue. (*See* Tarpey Aff. Ex. 3 at 373–380.) This email chain further reflects Dr. Butchma's pushback and objection to conduct that would result in his incarceration. *(Id.)*[38]

Doyle at 9:42 a.m.:	PLEASE try and do as [Larisa, the MDS coordinator] asks because with 34 empty beds, tons of overtime and all the other Covid expenses, we are losing money by the day. She knows what she is doing to make sure we get paid the maximum amount and by code. Pretty please, Dr. B – I really need your help and cooperation.
Butchma at 9:46 a.m.:	Sounds good . . . . No tension. I can give the best honest diagnosis I can but change as more info available. Just that she

[38] Although Doyle testified under oath regarding this email chain, her testimony is self-serving and not credible because it contradicts the documentary evidence. (*See* Tarpey Aff. Ex. 3 at 384–397.)

	cornered me 6am in lot. I said right now mr [REDACTED] has UTI/sepsis. She said how about acute bronchitis instead. I'm aggressive in assisting mds everywhere. So long as I'm not writing fiction
Doyle at 9:47 a.m.:	How do we know he has UTI?
Butchma at 10:04 a.m.:	[Status post] catheter pus blood sediment . . . . clinical acumen
Doyle at 10:09 a.m.:	Ok thanks. Larisa is the BEST MDS person I have ever worked with, so if you could play nicer on the sandbox it would be appreciated.
Butchma at 10:17 a.m.:	I support you . . . and Larisa 100% . . . . wanna not be quarantined 3-5 years though

180. Notably, although Doyle wrote that the facility was "losing money by the day," Respondent-owners and Fulton Realty LP extracted $ 4,977,793.96 in up-front profit in 2020. (*See* ¶ 18 *supra*.)

D. "Just the Numbers": Respondent Kalter, Owner, Operator, and Governing Body of Fulton Commons, Failed to Meet His Legal Responsibility to Provide Adequate Care, Focusing Only on the Nursing Home's Revenue and His Extraction of Up-Front Profit

181. Kalter had specific legal obligations as a nursing home owner, operator, and governing body in New York State, which he repeatedly and persistently disregarded, with often disastrous results to residents as described herein. These distressing accounts of neglect, abuse, and mistreatment were entirely predictable given Respondent Kalter's singular focus on Respondent-owners' extraction of up-front profit from the nursing home at the expense of its residents.

182. In New York State, proposed nursing home owners undergo a lengthy approval process conducted by the New York State Public Health and Health Planning Council ("PHHPC"). (*See* Public Health Law §§ 2801-a[1], [4].) DOH administers the application process for PHHPC approval, which includes the requirement that applicants submit a "Certificate of Need" ("CON").

As part of the CON application, PHHPC considers: (1) the character, competence, and standing in the community of the proposed operator/owner, and (2) the financial resources of the proposed operator. (*See* Public Health Law § 2801-a[3].) If PHHPC approves the application, DOH grants an operating certificate.

183. On October 18, 2001, DOH granted an operating certificate to Fulton Commons (*see* Ronan Aff. Ex. 2), which was and is controlled by Kalter, its largest percentage owner and President. (*See* Ronan Aff. at ¶¶ 27, 38.) As the President of Fulton Commons, Respondent Kalter is the "governing authority or operator" of Fulton Commons and "the party responsible for the operation of Fulton Commons." (10 NYCRR §§ 600.9[a], [b][3].)

184. The Attorney General's investigation unequivocally established that, even though 12 individuals (Respondent-owners) have an ownership interest in Fulton Commons (*see* Ronan Aff. at ¶ 3), Kalter was and remains the only "operator" of the facility, in that, at all times relevant herein, he exercised control over Fulton Commons as follows:

- Kalter was the only owner charged with decision-making at Fulton Commons, and he made all decisions without consulting the other owners. (*See* Ronan Aff. Ex. 1 at 87; *see also* Tarpey Aff. Ex. 3 at 63.)
- Kalter was the only owner who "render[ed] services to Fulton Commons." (*See* Ronan Aff. Ex. 1 at 107.)
- Kalter was the only owner with whom Respondent Weiss, Comptroller of the Fulton Commons Enterprise and the Sister Facilities Enterprises, and who served as the liaison between Kalter and Doyle, communicated during the entire course of Respondents' repeated and persistent illegal and fraudulent conduct described herein. (*See* Ronan Aff. Ex. 7 at 67, 74, 87.)
- Kalter, alone, determined whether Respondent-owners received a distribution. (*See* Ronan Aff. Ex. 1 at 61–62.)
- Kalter set the salaries for his adult children, the Respondent Kalter-1% Owners, by which they were paid over $1 million for no-show jobs between January 1, 2018 and January 31, 2022. (*See* Ronan Aff. Ex. 1 at 88.)

- Kalter "negotiated" Fulton Commons' "rent" with himself—setting the terms of the unwritten lease agreement and amount of "rent" Fulton Commons paid to related-party landlord Fulton Realty LP, a company he also controlled. (*See* Ronan Aff. Ex. 1 at 56, 170.)

- Kalter certified Fulton Commons' annual Cost Reports—which he knew were submitted to DOH—as the "operator," pursuant to 10 NYCRR § 86-2.6. (*See* Ronan Aff. at ¶¶ 18–19, 63–65; *see also* Ronan Aff. Ex. 4.)

- Since as early as 2005, Kalter executed annual DOH certifications ("Certification Statement for Provider Billing Medicaid") on behalf of Fulton Commons as required of nursing home operators. (*See* Ronan Aff. at ¶ 141; *see also* Ronan Aff. Ex. 2.)

- On May 15, 2020, Kalter executed an Administrator/Operator's Certification of Compliance relating to Fulton Commons' compliance with COVID-19 Executive Orders and DOH guidance. (*See* Sekhon Aff. Ex. 4)

- Kalter was the signatory on every bank account in the Fulton Commons Enterprise, including but not limited to the Fulton Commons' Operating Accounts.[39] (*See* Ronan Aff. at ¶ 46; *see also* Ronan Aff. Ex. 1 at 170.)

185. As operator of Fulton Commons, Kalter was and remains responsible for, inter alia: (1) ensuring that Fulton Commons provided the care, staffing, nursing supervision, services, and supplies that met the standards established by DOH in its regulations and in other state and federal laws; (2) safeguarding Fulton Commons' residents' rights; and (3) promoting the social, physical, and mental well-being of Fulton Commons' residents. (*See* 10 NYCRR § 415.1[a]; 42 CFR § 483.35; 10 NYCRR § 415.3; 42 CFR § 483.10[d][2]; 10 NYCRR § 415.11[c]; 10 NYCRR § 415.12; 10 NYCRR §§ 415.13[a]–[d]; 42 CFR § 483.25; 10 NYCRR § 415.22[a]; 10 NYCRR § 415.26; 42 CFR §§ 483.10[a][1], [2]; 18 NYCRR § 515.2[b][12].)

186. As a nursing home, Fulton Commons is required to have a "governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility." (10 NYCRR

[39] His wife, Respondent Frady Kalter, was the only other signatory on any of these accounts.

§ 415.26[b]; *see also* 42 CFR § 483.70[d]; Ronan Aff. at ¶¶ 16–17.) Kalter unequivocally testified regarding the existence of any governing body at Fulton Commons, "I am the governing body . . . it's just me." (*See* Ronan Aff. Ex. 1 at 75–76; *see also* Ronan Aff. at 27.)

187. As the governing body, Kalter was responsible for, inter alia: (1) appointing an administrator who functions in accordance with the provisions of 10 NYCRR § 415.26(a); (2) determining and establishing written policies consistent with the stated purposes of the facility, the program of services provided, its physical structure and equipment, the number and qualifications of staff members, and their job classifications and descriptions; (3) the operation of the facility; and (4) compliance with all provisions of the nursing home regulations promulgated by DOH. (*See* 10 NYCRR § 415.26[b]; *see also* 42 CFR § 483.70[d].)

188. As the governing body, Kalter was also required to be a member of Fulton Commons' mandatory quality assurance and performance improvement ("QAPI") committee, which was required to meet at least four times per year in order "to oversee the effectiveness of monitoring, assessing and problem-solving activities" for purposes of initiating "quality improvement[s] . . . designed to advance the quality of life, care and services in the facility." (10 NYCRR § 415.27[c][2].)

1. Respondent Kalter Was Entirely Derelict in His Obligations as Operator and Governing Body of Fulton Commons in Flagrant Violation of the Law

189. Kalter repeatedly and persistently ignored all the obligations the law imposed on him as the operator and governing body of Fulton Commons, leaving Doyle in control of nearly all decisions at the facility. (*See* Ronan Aff. Ex. 1 at 238, 241, 245; *see also* Ronan Aff. Ex. 7 at 47, 49, 67, 73; Tarpey Aff. Ex. 3 at 54, 121.) By his own admission, Kalter did not ". . . operate

[Fulton Commons] at this point on a day-to-day basis. [He left it] to the people in charge of the facility to make decisions on what's important and what's not." (Ronan Aff. Ex. 1 at 71.)

190. With his operating and ownership interest in Fulton Commons, Kalter was the individual responsible for directing the management and policies of Fulton Commons, yet he never "had discussions with anybody at Fulton Commons in relation to anything," never set foot inside the facility, nor did he have "personal knowledge of anything that's going on in the nursing home." (*Id*. at 250, 298.) In fact, Kalter preposterously testified that it would be a violation of the chain of command for him to have direct communication with Fulton Commons staff members even if it were necessary to determine whether the facility was in compliance with DOH directives. (*Id*. at 298.)

191. In violation of 10 NYCRR § 415.26(b)(1), Kalter was seemingly uninvolved in the hiring of Doyle. (*See* Ronan Aff. Ex. 1 at 67–68; *see also* Ronan Aff. Ex. 7 at 44–45; Tarpey Aff. Ex. 3 at 53, 63.) In fact, in the six years Doyle served as Fulton Commons' administrator, Kalter neither met with nor communicated in any manner with her. (*See* Ronan Aff. Ex. 1 at 68, 73, 246; Tarpey Aff. Ex. 3 at 63.) Further, when confronted with the names of Fulton Commons' two prior administrators, Kalter testified that he did not recognize those names and that he did not recall that those individuals were the prior administrators. (*See* Ronan Aff. Ex. 1 at 74–75.)

192. Moreover, in direct violation of 10 NYCRR § 415.26(b)(2), Kalter has never been involved in the creation or implementation of Fulton Commons' policies and procedures (*id.* at 239; *see also* Tarpey Aff. Ex. 3 at 148–149), nor was he aware of who was responsible for creating them. (*See* Ronan Aff. Ex. 1 at 239.) In fact, Kalter has never consulted on, written, reviewed, revised nor approved any policies or procedures for Fulton Commons. (*Id.*)

193. Kalter's utter disregard of his duties left Doyle completely unchecked and enabled her to enact shocking and illegal policies at Fulton Commons that endangered residents. One of the most egregious examples is Fulton Commons' policy to treat all unwitnessed allegations of sexual abuse of its residents as grievances to be handled internally instead of as allegations of abuse, thereby circumventing the obligation to report such allegations to law enforcement under Public Health Law §§ 12-b(2), 2803-d, and 42 USC § 1320b-25. (*See* Ronan Aff. at ¶¶ 105–106; *see also* Ronan Aff. Ex. 14; ¶¶ 11–12, 81[iii] *infra*.)

194. In further violation of 10 NYCRR § 415.26(b)(2), Kalter played no role in ensuring Fulton Commons maintained sufficient staffing levels (*see* Ronan Aff. Ex. 1 at 118–119), and instead Kalter delegated these responsibilities to the administrator. (*See* Tarpey Aff. Ex. 3 at 54; *see also* Ronan Aff. Ex. 1 at 119–121; Ronan Aff. Ex. 7 at 101–102, 273–274.) Even worse, Kalter had zero involvement in decision-making at Fulton Commons and never "directed a certain action to be taken" at the facility. (Ronan Aff. Ex. 1 at 74.)

195. Indeed, at Fulton Commons, Doyle "[was] in charge, she [was] the boss." (Ronan Aff. Ex. 7 at 47.) In violation of 10 NYCRR § 415.26(b)(3), Doyle made and/or delegated all operational decisions at Fulton Commons without any input from Kalter—the governing body. (*See* Tarpey Aff. Ex. 3 at 148–149; *see also* Ronan Aff. Ex. 1 at 121; Ronan Aff. Ex. 7 at 55, 73.)

196. As a result of Kalter's complete and utter failure to participate in the operation of Fulton Commons and ensure it was meeting its duties, Doyle's authority to operate the nursing home was left entirely unchecked, in direct contravention of 10 NYCRR §§ 415.26(b)(3) and 600.9, and 42 CFR §§ 483.70(d)(2)(ii)–(iii). Even when required to certify to DOH, under penalty of law, that Fulton Commons was in compliance with various COVID-19-related DOH directives and Executive Orders, Kalter—in reckless disregard for the truth—took no affirmative steps to

ensure the nursing home's compliance and signed the certification in sole reliance upon Doyle's willingness to execute the document herself. (*See* Ronan Aff. Ex. 1 at 295–299; *see also* Sekhon Aff. Ex. 4.)

197. In delegating all authority to Doyle, Respondent Kalter created an end-run around the PHHPC process. Doyle was responsible for nearly every aspect of the nursing home's operations, yet she avoided the scrutiny imposed upon nursing home owners and operators by the PHHPC process, which is designed to protect the residents by ensuring that the person with decision-making authority is of sound character and judgment. Accordingly, Kalter's repeated and persistent dereliction of authority—in violation of 10 NYCRR § 415.26 and 42 CFR § 483.70(d)—completely nullified the operating certificate process and undermined the principles behind the above nursing home regulations.

198. Further exacerbating Doyle's lack of supervision, as the only member of the governing body, Kalter abjectly failed to participate in the QAPI process. The QAPI regulation is designed to ensure that each nursing home "establish and maintain a coordinated quality assessment and assurance program which integrates the review activities of all nursing home programs and services to enhance the quality of life and resident care and treatment." (10 NYCRR § 415.27.) QAPI is a means by which nursing homes can identify quality deficiencies and correct them internally. Put simply, the QAPI regulation aims to ensure that nursing homes meet their "special obligation" to each and every resident.

199. In violation of 10 NYCRR § 415.27, Kalter repeatedly and persistently failed to attend or participate in any QAPI meetings. (*See* Ronan Aff. Ex. 1 at 117; *see also* Tarpey Aff. Ex. 3 at 358.) Although the QAPI committee is required to include the administrator, the DON, a physician designated by the facility, and a member of the governing body (*see* 10 NYCRR §

415.27[b][1]), Kalter never met with or spoke to Doyle, former DON Frawley, or Dr. Butchma. (*See* Ronan Aff. Ex. 1 at 76.) Notably, Weiss, the liaison between Kalter and Doyle, was not even aware of the existence of a QAPI committee at Fulton Commons. (*See* Ronan Aff. Ex. 7 at 47, 98.)

200. To compound matters, Kalter was unaware that QAPI reports existed, and did not seek or receive the requisite quarterly reports of the committee's "activities, findings and recommendations." (10 NYCRR § 415.27[c][6]; *see also* Ronan Aff. Ex. 1 at 118; Ronan Aff. Ex. 7 at 99.)

201. Kalter's absence from QAPI meetings is unsurprising, given his utter disregard for ensuring the health, safety, and well-being of Fulton Commons' residents. In fact, the extent of Kalter's involvement in Fulton Commons was limited to only two considerations: its daily census and bank account balances. (*See* Ronan Aff. at ¶ 87; *see also* Ronan Aff. Ex. 1 at 122.)

202. Kalter's failure to provide any oversight as the operator and governing body allowed Doyle to conceal Fulton Commons' neglect, abuse, and mistreatment of its residents and dupe DOH, CMS, the general public, and most importantly, residents and their families, into believing Fulton Commons was a 5-Star facility.[40] Lacking any accountability, Doyle orchestrated a multitude of cover-ups of her failures in running Fulton Commons—including the wanton neglect of residents—until January 2022, when sexual abuse allegations came to light and Fulton Commons was rightfully downgraded to the 2-Star ("BELOW AVERAGE") facility it always was

[40] As of April 2019, Fulton Commons had an inflated CMS 5-Star Overall facility rating, despite its 2-Star Staffing rating. This Overall facility rating did not change until after DOH's discovery of Fulton Commons and Doyle's intentional cover-up of, and failure to report, the sexual abuse allegations involving an LPN in January 2022 detailed in ¶¶ 11–12 and 81 (iii), *supra*. Following DOH's citation and IJ finding, CMS corrected Fulton Commons' Overall facility rating and downgraded it to 2-Stars.

and placed on CMS's SFF candidacy list in April 2022. (*See* Ronan Aff. at ¶¶ 104–107; *see also* ¶¶ 136–138 *supra*.)

203. Despite the numerous obligations imposed on him as both the nursing home's operator and governing body to ensure that the home meets the needs of its residents, Kalter callously did nothing other than review how many bodies were in beds, which ultimately determined how much revenue—including Medicaid and Medicare dollars—was paid to Fulton Commons. When asked what was important to him in reviewing the census, Kalter responded, "Just the numbers." (Ronan Aff. Ex. 1 at 263.)

E. Respondent-Owners, Fulton Realty LP, and Fulton Realty Inc. Converted Millions in Government Funds Through Self-Dealing Financial Arrangements Disguised as Bona Fide Business Expenses

204. While Kalter repeatedly and persistently disregarded his duty to ensure Fulton Commons provided required care to its residents, he exercised sufficient control over the nursing home's operations to illegally deprive it of millions of dollars received from Medicaid and Medicare for resident care. Respondent-owners repeatedly and persistently converted these funds in violation of regulations that prohibited conversion, required equity disclosures to DOH, and limited undisclosed equity withdrawals from nursing homes, through multiple fraudulent schemes, as follows:

- Kalter caused Fulton Commons to enter into a collusive verbal "lease" with Respondent Fulton Realty LP, thereby requiring Fulton Commons to pay excessively inflated "rent," which included illegal, disguised, pass-through distributions from Fulton Commons to Kalter and Fogel, and therefore was far above any commercially reasonable amount. (*See* ¶¶ 205–212 *infra*; *see also* Ronan Aff. at ¶ 49.)

- Kalter caused Fulton Commons to transfer money to Respondent-owners' other business investments, including the Sister Facilities Enterprises, under the guise of loans, for no business purpose that benefitted Fulton Commons and without repayment terms. (*See* ¶¶ 226–228; *see also* Ronan Aff. at ¶¶ 60–62.)

- Kalter caused Fulton Commons to pay over $1 million in fraudulent salaries to Respondent Kalter-1% Owners for no-show jobs that Kalter also falsely reported on the nursing home's Cost Reports were paid for services rendered to the facility. Kalter did this to disguise illegal distributions from Fulton Commons to its minority share owners as bona fide business expenses. (*See* ¶¶ 229 – 237 *infra*; *see also* Ronan Aff. at ¶¶ 50, 55–59, 66, 71–72.)

Through these fraudulent schemes, Respondent-owners illegally converted more than $16 million from Fulton Commons between January 1, 2018 and January 31, 2022.

1. Kalter Caused Fulton Commons to Enter into a Collusive and Fraudulent Real Estate Arrangement with Fulton Realty LP, Depriving the Nursing Home of Crucial Funds for Resident Care

205. Kalter is not only an owner and operator of Fulton Commons but is also the principal owner of Fulton Realty LP, its related-party landlord. (*See* Ronan Aff. at ¶¶ 4, 39, 42, 44.) Through his control of both entities, Kalter set the terms of an unwritten self-dealing "lease" and repeatedly and persistently caused Fulton Commons to pay Fulton Realty LP exorbitant "rent" that he padded to include significant up-front profit for his and Fogel's personal gain,[41] without ensuring the nursing home was complying with its duties to provide required care.[42] (*Id*. at ¶¶ 39, 49–54.)

206. Though Kalter testified that Fulton Commons' annual purported rent was determined, in part, by what "the landlord [Fulton Realty LP] and the tenant [Fulton Commons] decide[d] [was] fair market value" (Ronan Aff. Ex. 1 at 140–141), the amount of "rent" was not fair nor representative of any market; rather, it was significantly higher than the landlord's real

[41] As 40% owner of Fulton Realty LP, Respondent Aaron Fogel also benefited significantly from this inflated rent.

[42] Kalter accomplished this fraudulent and illegal conversion using New Fulton, which is essentially a pass-through corporation to which Fulton Commons transferred most of its assets; New Fulton made the inflated rent payments to Fulton Realty LP on behalf of Fulton Commons. (*See* Ronan Aff. at ¶¶ 5, 49, 52.)

property expenses. Kalter testified that Fulton Commons' rent was based on property expenses, along with fair market value considerations, which purportedly included Fulton Realty LP's mortgage, "the bed size, the campus size, quality of the home, age of the home, profitability of the home, so on and so forth." (*See* Ronan Aff. Ex. 1 at 142.) However, as the principal owner of Fulton Realty LP and owner, operator, and governing body of Fulton Commons, Kalter alone determined what the nursing home paid to its landlord, i.e., what Kalter paid to himself, under the guise of rent. (*See* Ronan Aff. Ex. 1 at 156; *see also* Ronan Aff. at ¶ 49.)

207. No written lease existed between Fulton Realty LP and Fulton Commons since at least 2018, if ever. (*See* Ronan Aff. Ex. 1 at 156; *see also* Ronan Aff. at ¶ 49.) However, Kalter determined the arrangement between Fulton Commons and Fulton Realty LP would be a "triple-net lease," meaning that Kalter saddled Fulton Commons with the obligation to pay its related-party landlord not just rent, but also all utilities along with expenses of the property, including real estate taxes, building insurance, and maintenance. (*See* Ronan Aff. Ex. 1 at 157.)

208. In a clear attempt to fraudulently and illegally conceal his personal enrichment at the expense of Fulton Commons' residents, Kalter set the facility's "rent" at an amount far above fair market value in order to regularly extract up-front profit from Fulton Commons under the pretext of legitimate expenses. (*See* Ronan Aff. at ¶¶ 49–54, 66–69, 72, 93.)

209. Further, between 2018 and 2020, Kalter increased Fulton Commons' "rent" on an annual basis, regardless of Fulton Commons' revenue, pursuant to a supposed escalator clause of the verbal lease that existed only in Kalter's mind. (*See* Ronan Aff. at ¶ 49; *see also* Ronan Aff. Ex. 1 at 156.) Kalter raised Fulton Commons' "rent" by close to $1.5 million between 2018, when Fulton Commons paid over $8.3 million in inflated rent, and 2020, when Fulton Commons paid close to $10 million in inflated rent. Kalter increased Fulton Commons' "rent" by almost 18%,

despite a 16.79% decrease in Fulton Commons' total operating revenue for the corresponding period. (*See* Ronan Aff. at ¶¶ 49–54.)

210. In 2021, commensurate with a substantial decrease in operating revenue, likely caused by a dip in the facility's census (*see* Ronan Aff. ¶¶ 50–54, 85), Fulton Commons' rent decreased to $7,156,909 (*id.* at ¶¶ 50, 52.) However, as explained in ¶ 220 *infra*, Kalter ensured that Fulton Commons still paid extremely inflated rent in 2021, which was to his and Fogel's ultimate personal benefit as the two individual owners of Fulton Realty LP. (*Id*. at 52.) All the while, Kalter callously neglected his duties as operator, failed to ensure Fulton Commons was complying with its legal duties to provide required care to its residents, and failed to ensure that it was adequately staffed to deliver that care, resulting in resident neglect, suffering, and death without dignity.

211. The chart below depicts how exorbitantly inflated Fulton Commons' annual rent to revenue ratio was due to Kalter's fraudulent rent scheme in comparison to the average rent to revenue ratio of nursing homes in New York State ("NYS"). The columns indicate how much of Fulton Commons' revenue went to rent each year from 2018 to 2021, based on data reported in its Cost Reports, in comparison to the state average.

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Fulton Commons' Rent to Revenue Ratio vs. NYS Average Rent to Revenue Ratio				
Fulton Commons	**2018**	**2019**	**2020**	**2021**
Rent	$8,368,098	$9,096,302	$9,851,796	$7,156,909
Total Operating Revenue	$38,619,853	$40,638,641	$32,134,075	$29,953,410
Fulton Commons Rent to Revenue Ratio	**21.66%**	**22.38%**	**30.65%**	**23.89%**
NYS Average Total Rent to Revenue Ratio	**8.65%**	**See Footnote[43]**	**10.62%**	**See Footnote[43]**

212. As illustrated in the chart above, Kalter caused Fulton Commons' rent to revenue ratio, 21.66% in 2018 and 30.65% in 2020, to significantly exceed the corresponding NYS nursing home average rent to revenue ratios of 8.65% and 10.62%, respectively. This means that Fulton Commons' rent to revenue ratio surpassed the state average by over 13% in 2018 and 20% in 2020 and was the highest out of all Medicaid and Medicare-certified nursing homes on Long Island that reported a rental expense on their Cost Report. (*See* Ronan Aff. at ¶ 50.) In fact, Fulton Commons rent to revenue ratio in 2018 was the tenth highest out of all 351 such nursing homes in the state, and fourth highest out of all 379 such nursing homes in 2020. (*Id.*) This is particularly disturbing given that the state averages are already artificially inflated because many for-profit nursing home

[43] The NYS average rent to revenue ratio for 2019 could not be calculated as DOH did not publicly release the 2019 Cost Report data for all nursing homes in the state. In addition, the NYS average rent to revenue ratio for 2021 was not calculated by the time of this filing as the 2021 Cost Reports were only released in September 2022.

owners, like Kalter cause their facilities to pay inflated rent to themselves, their family members, or other individuals they favor.

a. Respondent Kalter Caused Fulton Commons to Pay Exorbitant "Rent" in Order to Extract Money While Obscuring the Profitability of the Nursing Home

213. Kalter forced Fulton Commons to pay astronomically high "rent" that greatly exceeded Fulton Realty LP's property costs in order to maximize up-front profit taken by disguising it as a bona fide business expense. To illustrate the economic reality of this fraudulent scheme, the chart below shows Fulton Commons' excess rent—actual rent charged minus Fulton Realty LP's total property expenses—between 2018 and 2021. The rows in the chart below compare Fulton Commons' rent, Fulton Realty LP's bona fide third-party property expenses (as described in ¶ 214 *infra*), excess rent, and the percentage by which Fulton Commons' rent exceeded Fulton Realty LP's property expenses. Each column represents the value of the corresponding category for the years 2018 through 2021. The data in the chart illustrates the audacity of the fraudulent rent scheme: Kalter required Fulton Commons to pay its related-party landlord amounts that shockingly exceeded the landlord's property expenses by over 42%, 48%, 46% and 33% in 2018, 2019, 2020, and 2021, respectively, netting Fulton Realty LP over $3.5 million, $4.4 million, $4.5 million, and $2.3 million in those years, respectively. This excess rent constituted a mark-up of the property expenses by as much as 94.61% in 2019, and even 86.41% in 2020—despite the COVID-19 pandemic. (*See* Ronan Aff. at ¶ 53.)

Fulton Commons' Excess Rent vs. Fulton Commons Overall Rent				
	2018	**2019**	**2020**	**2021**
Fulton Commons' Rent	$8,368,098	$9,096,302	$9,851,796	$7,156,909
Fulton Realty LP's Property Expenses	($4,841,604)	($4,674,021)	($5,284,878)	($4,759,199)
Excess Rent	**$3,526,494**	**$4,422,281**	**$4,566,918**	**$2,397,710**
% of Fulton Commons' Excess Rent to Fulton Commons Rent	42.14%	48.61%	46.35%	33.50%
Source: 2018 through 2021 Cost Reports				

214. At all relevant times herein, Fulton Realty LP made bona fide third-party monthly mortgage payments (including the amortization and interest) and escrow payments (including real estate taxes, property insurance, and mortgage insurance). (*See* Ronan Aff. at ¶¶ 49–54.) These annual property expenses, as depicted in the chart in ¶ 213 *supra*, ranged from a low of $4,674,021 in 2019 to a high of $5,284,878 in 2020. (*Id*.)

215. However, Kalter required Fulton Commons to pay annual purported rent that far exceeded these bona fide third-party property expenses by no less than 33.5% or $2,397,710 in 2021 and by as much as 48.61% or $4,422,281 in 2019. (*Id*. at 52.) This excess rent was nothing more than pure profit for Kalter and Fogel. Fulton Realty LP did not have any employees, nor did it occupy a physical office space; further, Fulton Realty LP did not utilize the services of legitimate management or consulting companies.[44] Thus, Fulton Commons' purported rent was padded so far beyond what was necessary to pay Fulton Realty LP's actual property expenses that it could not have any purpose other than to surreptitiously and illegally transfer millions of dollars, which Medicaid and Medicare paid for resident care at Fulton Commons, directly into Kalter and Fogel's pockets.

[44] Although Fulton Realty LP reported management fees on their financial statements, these were self-serving fees paid to Kalter for no legitimate services. (*See* Ronan Aff. Ex. 1 at 159.)

216. Furthering the Fulton Commons Enterprise and Respondent-owners' deception, Fulton Realty LP's expenses[45] as reported on Fulton Commons' Cost Reports for 2018 through 2021 include annual purported management fees to Kalter in the amounts of $3,255,000; $3,428,000; $489,000; and $970,000, respectively. (*See* Ronan Aff. at ¶ 51; *see also* Ronan Aff. Ex. 1 at 159–162, 165.) These sham management fees ranged from a low of nearly 10% of Fulton Realty LP's total expenses (property expenses and management fees) in 2020 to a high of more than 40% of its total expenses in 2019. (*See* Ronan Aff. at ¶ 51.) Incredibly, Kalter claimed that Fulton Realty LP, which he controlled, paid these "management fees" to compensate him partially for "the work he [did] for Fulton Realty LP," which he admitted was limited to the one-time "acquisition" of the mortgaged real property and "part[ially] for just having [the real property]." (Ronan Aff. Ex. 1 at 163.)

217. In short, Kalter simply took the money for himself. Kalter did nothing other than fraudulently charge Fulton Commons this exorbitant amount in rent solely to funnel up-front profit to himself and Fogel disguised as a bona fide business expense. He did so in a blatant attempt to circumvent the rules regarding equity withdrawals and/or asset transfers from nursing homes, as discussed in ¶¶ 244–253 *infra*. In fact, Kalter admitted as much when he explained that Fulton Commons has not provided ownership with a distribution in a few years because "there are restrictions on distributions from nursing homes." (Ronan Aff. Ex. 1 at 61–64.)

[45] Expenses on the Cost Report include both bona fide third-party property expenses as described in ¶¶ 51–52, 69 and "management fees."

b. Kalter and Fogel Fraudulently and Illegally Took Fulton Commons' Excess "Rent" as Distributions and Disbursements from Fulton Realty LP

218. Kalter repeatedly and persistently committed fraud and illegalities by converting Medicaid and Medicare funds from Fulton Commons that were paid to the facility so that it could comply with its legal duties to provide the nursing home's residents with requisite care. These converted funds should have been used to: increase staffing levels and/or pay overburdened staff higher wages; hire and retain competent employees, including RNs; and/or improve the facility's physical plant and equipment. (*See e.g.*, Public Health Law § 2803-c; 10 NYCRR §§ 415.1[a][1]–[2]; 10 NYCRR § 415.3; 10 NYCRR § 415.12; 10 NYCRR § 415.13; 10 NYCRR § 415.26; 42 CFR § 483.10; 42 CFR § 483.25; 42 CFR § 483.35.)

219. In addition to funneling more than $8 million in pure profit to Kalter between 2018 and 2021 as "management fees," compensation for his one-time acquisition of the property, Respondent Fulton Realty LP, with the assistance of Respondent Weiss, also paid distributions to owners Kalter and Fogel that resulted in their illegal conversion of millions of dollars more in government funds. (*See* Ronan Aff. at ¶¶ 51, 69; *see also* Ronan Aff. Ex. 7 at 141.)

220. Kalter alone determined whether and when distributions would be paid by any of the Corporate Respondents, including Fulton Realty LP, and if so, the amount of the distributions. (*See* Ronan Aff. Ex. 1 at 172.) Between January 1, 2018 and January 31, 2022, Kalter paid himself an additional $4,022,100 (of which at least $3,722,100 was classified as distributions) from Fulton Realty LP. (*See* Ronan Aff. at ¶ 69.) Through their fraudulent rent scheme, from January 1, 2018 through December 31, 2021, Respondents Fulton Realty LP, Fulton Realty Inc., Kalter, and Fogel converted over $14.9 million paid for resident care while disguising it as rent payments. Of that $14.9 million, Kalter personally received and converted $12.1 million from Fulton Realty LP in

the form of purported management fees and distributions, while Respondent Fogel received and converted $2.68 million in distributions from Fulton Realty LP. (*See* Ronan Aff. at ¶ 48.)

221. The payment of distributions from Fulton Realty LP was an end-run around the 3% Rule. (*See* Public Health Law § 2808[5][c].) These distributions were merely up-front profit extracted from the nursing home through the fraudulent rent scheme in order to hide Respondent-owners' secret profiteering and to evade seeking permission from DOH to withdraw significantly more than 3% of Fulton Commons' equity. (*Id*.) Moreover, this deceit enabled Kalter to minimize Fulton Commons' reported profit on its Cost Report, as the inflated rent payments were reported as an expense as opposed to a distribution.

c. Respondent Kalter Caused Fulton Commons to Violate the Negative Equity Rule in 2020 as a Result of Exorbitant Inflated Rent

222. Fulton Commons' grossly inflated "rent" served not only to enrich Kalter and Fogel, but in 2020, it also caused Fulton Commons to end the year with negative equity in violation of Public Health Law § 2808(5)(a) and 10 NYCRR §§ 400.19(b)(1) and 415.26(h)(7), both of which disallow a governing body from reducing a facility's equity to the extent that it creates "a negative net worth by means of a withdrawal" without seeking prior DOH approval. (*See* Ronan Aff. at ¶¶ 54, 68.) Withdrawal in this context is defined as: "(a) any payment of cash or transfer of other assets by a facility directly or indirectly to or for the benefit of its operator or owner; and (b) any liability or contingent liability incurred within any period of 12 consecutive months by a facility or its operator by reason of a mortgage, lease . . . or other transaction relating to such facility that exceeds, in the aggregate, $25,000." (10 NYCRR § 415.26[h][7][i].)

223. Fulton Commons' 2020 Statement of Changes in Fund Balances on its 2020 Cost Report indicates that Fulton Commons had a positive balance of $1,687,858 at the start of 2020.

(*See* Ronan Aff. at ¶ 54.) Fulton Commons' operating revenue decreased by more than $8.5 million in 2020, such that Fulton Commons' 2020 operating expenses exceeded its operating revenue by more than $6 million as enumerated in Fulton Commons' 2020 Statement of Revenues and Expenses. (*See* Ronan Aff. at ¶ 54.) This delta between the 2020 operating revenue and expenses was offset by Fulton Commons' receipt of COVID Stimulus Funds, following which Fulton Commons nonetheless still incurred a net loss of close to $3.9 million in 2020. (*Id.*) When combined with Fulton Commons' starting balance of $1.6 million, this net loss of $3.9 million left Fulton Commons with a negative equity balance of $2,163,601 at the end of 2020. (*Id.*)

224. Fulton Commons' 2020 operating expenses included Fulton Commons' 2020 rent of $9,851,796, which, as discussed in ¶¶ 213–217 *supra*, Kalter inflated by more than $4.5 million. (*Id.*) Accordingly, had Kalter lowered the facility's rent to cover just the property expenses, Fulton Commons would have ended the year with positive equity as required by New York State law.

225. Consequently, by repeatedly and persistently fraudulently and illegally requiring Fulton Commons to pay exorbitantly inflated "rent," Kalter caused Fulton Commons to have negative equity in violation of the law.

2. Respondent Kalter Drained Fulton Commons of Nearly $9 Million to Benefit Respondent-Owners' Other Businesses

226. As detailed in Fulton Commons' 2018 through 2021 Cost Reports, during those years, Kalter caused Fulton Commons to be owed a net amount of nearly $9 million from Respondent-owners' other business investments, including, but not limited to, the Sister Facilities Enterprises, for no legitimate business purpose. (*See* Ronan Aff. at ¶¶ 60–62.) Kalter historically treated Fulton Commons as his alter ego, causing Fulton Commons to repeatedly and persistently transfer funds to other companies he controlled, thereby disregarding its corporate form and using its assets to fund his other business interests.

227. Kalter repeatedly and persistently caused the transfer of nursing home funds between and among the Sister Facilities Enterprises to cover expenses when one of the Sister Facilities was short on cash. (*See* Ronan Aff. at ¶¶ 60–62; *see also* Ronan Aff. Ex. 1 at 194–206.) Kalter caused the entities he controlled to make these purported loans without any written agreements or terms, which is evidence that Kalter disregarded these corporate forms and instead used them as his alter ego. (*See* Ronan Aff. at ¶¶ 60–62; *see also* Ronan Aff. Ex. 4.)

228. These interest-free loans, used to cover other facilities' costs, served Kalter's financial interests and deprived Fulton Commons of millions of dollars of operating funds. Rather than permitting Fulton Commons to utilize these government funds for their intended purpose, to provide legally required resident care, Kalter illegally transferred these funds out of Fulton Commons to benefit his other investments at the expense of Fulton Commons' residents.

3. Respondent Kalter-1% Owners Converted More than $1 Million from Fulton Commons Through No-Show Jobs

229. Kalter also engaged in a fraudulent and illegal no-show job scheme for the benefit of his adult children, Respondent Kalter-1% Owners. This scheme was implemented by Respondents New Bridge View and Weiss, who were responsible for issuing the checks for these no-show jobs as part of their bookkeeping duties on behalf of New Fulton. (*See* Ronan Aff. Ex. 7 at 78–85.) As explained in ¶ 43 n.15 *supra*, in 2018, Kalter transferred a 1% ownership interest in Fulton Commons to each of his eight adult children—Mindy Steger, Sheindy Saffer, Chana Kanarek, Dovid Kalter, Yitzchok Kalter, Aryeh Kalter, Sheva Treff, and Chaya Lieberman a/k/a Sara Lieberman. The Kalter-1% Owners each own a nominal percentage of Fulton Commons and the Sister Facilities. (*See* Ronan Aff. at ¶ 3, 43.) The Kalter-1% Owners made no investments to purchase their ownership interests, which were gifted to them by Kalter at a time when he believed one of them might take over "the business, the operations from [him]." (Ronan Aff. Ex. 1 at 102.)

230. Counsel for Respondents objected to the Attorney General's intention to issue subpoenas for the testimony of the Kalter-1% Owners, to whom Kalter funneled over $1 million in Medicaid and Medicare funds as salaries for no-show jobs. Specifically, in a letter dated April 6, 2022, attached to the Sekhon Aff. as Exhibit 6, Respondents' counsel stated, ". . . (e) none of the [Kalter-1% Owners] have any decision-making role or otherwise, in the clinical aspects, business aspects or bookkeeping aspects of Fulton Commons (or any of the related businesses); (f) all of the [Kalter-1% Owners] live in . . . New Jersey, and each, solely in their capacity as 1% equity owner of Fulton Commons, is issued checks or wires from a company related to Fulton Commons; (g) payments issued to the [Kalter-1% Owners] are solely on account of their 'owner' interest in Fulton Commons." The letter further states: "*The [Kalter-1% Owners] are neither directors, officers nor employees of Fulton Commons*, and I am advised *that they provide no work or services for Fulton Commons*, they are not under control of Fulton Commons, they have never traveled to New York for any purpose related to Fulton Commons (or any of its related companies), and they have no involvement with Fulton Commons' clinical operations, bookkeeping operations or business operations." (Emphasis added.)

231. In addition to handing the Kalter-1% Owners a nominal percentage of Fulton Commons' ownership, beginning in 2018 through at least January 2022, Kalter also fraudulently caused Fulton Commons to make false entries in its books and records to justify his transfer of over $1 million from the New Fulton payroll to his eight adult children through "no-show" jobs. (*See* Ronan Aff. at ¶¶ 48, 55–59.) Despite providing no services to the nursing home, in order to give the false impression that the Kalter-1% Owners were actually employees of Fulton Commons, Kalter caused each of their names to be assigned to a particular department within the facility, for

a sham employment position, to be paid a "salary," and to receive fraudulent yearly W-2 statements as if they had worked as an employee. (*Id*. at ¶ 57.)

232. Specifically, when asked about funds paid from Fulton Commons to its owners, Kalter testified that his eight adult children received "salaries" in exchange for rendering no services:

> Q. When the [Kalter-1% Owners] receive . . . compensation . . . is it compensation for services rendered to Fulton Commons or something else?
>
> A. It's just compensation as owners. We don't render any services to Fulton Commons.
>
> Q. What services do [the Kalter-1% Owners] render on behalf of Fulton or any of the other [S]ister [F]acilities, and by that I mean do they do work for any facility in this system?
>
> A. They don't render any services to any of these facilities.

(Ronan Aff. Ex. 1 at 106–107.)

233. Kalter's testimony also reflects that the amounts Fulton Commons paid to the Kalter-1% Owners for their no-show jobs were dictated by Kalter's whims and were in no way tied to ownership percentage or any work performed for Fulton Commons:

> Q. Do all the owners at Fulton Commons receive the same amount of compensation?
>
> A. I don't think so.
>
> Q. And you set the compensation amounts for the ownership, correct?
>
> A. As we stated, yes.
>
> Q. And that compensation varies year to year?
>
> A. Yes.
>
> Q. And what is this variation in year to year compensation based on, is it tied to a specific metric?

A. No.

Q. Is it tied to an owner's ownership percentage?

A. No.

Q. If you can describe the metric used or the method used to determine compensation, who would that be?

A. There is no method, that's just what I decide to give them.

(Ronan Aff. Ex. 1 at 107–108.)

234. Kalter's fraudulent and illegal conduct in orchestrating the eight no-show jobs demonstrates his disregard for the forms of the corporate entities he controls and his use of them as his alter egos. Specifically, he exercised control over Fulton Commons, its related-party New Fulton, their agents—including New Bridge View and Weiss—and books and records to effect the repeated and persistent fraudulent and illegal payment of the "salaries" to his eight adult children for no-show jobs.

235. Accordingly, for the period January 1, 2018 through January 31, 2022, through Kalter's fraudulent and illegal no-show jobs scheme, Respondent Kalter-1% Owners illegally and fraudulently converted at least $1,091,680.59 from Fulton Commons disguised as "salaries" paid to them for the provision of services to the facility and its residents, when in reality these were the distribution of up-front profit to certain Respondent-owners—distributions issued while Fulton Commons was violating its legal duties to provide required care and staffing to its residents. (*See* Ronan Aff. at ¶ 70.)

236. Kalter's intentional disregard of the 3% Rule is demonstrated by his illegal no-show job scheme, which was a vehicle to transfer disguised distributions to the Kalter-1% Owners. When asked if he had taken any distributions from any of his nursing homes in the last five years, he testified, "I don't remember, but probably not." (Ronan Aff. Ex. 1 at 61.) In fact, his testimony

reflects that he had stopped taking *undisguised* distributions due to the laws restricting equity withdrawals and asset transfers from nursing homes absent DOH approval:

> Q. Are there plans currently or in the future to take a distribution?
>
> A. No.
>
> Q. And just for my own clarity, the decision to not take a distribution, what would that be based on?
>
> A. It wouldn't be based on anything. We just don't really take distributions from the nursing home.
>
> Q. But am I correct in understanding that approach has changed over time?
>
> A. Possibly, but I don't remember when.
>
> Q. And what I am trying to drive at is why distributions may have been taken in the past but aren't taken anymore. I am wondering if context has changed or the facts have changed or your methods for arriving at that decision has changed?
>
> A. I believe that law has changed.
>
> Q. And what was your understanding of that?
>
> A. There are restrictions on distributions from nursing homes.

(Ronan Aff. Ex. 1 at 63–64.)

237. Kalter's conduct reflects an awareness of Public Health Law § 2808(5), the New York State law designed to protect nursing home residents from unscrupulous operators who would withdraw excessive funds for their own profit while failing to provide adequate care. Despite this awareness, Kalter repeatedly and persistently disregarded this law, just as he disregarded the laws requiring nursing home operators to provide required care and staffing.

F. Respondent Kalter Caused Fulton Commons to File False and Misleading Cost Reports by Falsely Certifying that Expenses with No Legitimate Business Purpose Were Incurred to Provide Patient Care in the Facility

238. In order to conceal the Kalter-1% Owners' repeated and persistent conversion of more than $1 million of up-front profit from Fulton Commons through the no-show jobs scheme, Kalter caused Fulton Commons to file false annual Cost Reports from 2018 to 2021, in violation of its obligations under 10 NYCRR Part 86-2, which sets forth rules regarding cost reporting and rate certifications for nursing homes.

239. As operator of Fulton Commons, Kalter was responsible for ensuring that Fulton Commons complied with its annual obligation to file accurate Cost Reports with DOH. (*See* 10 NYCRR § 86-2.6; *see also* Ronan Aff. at ¶ 18.)

240. In order to file a Cost Report with DOH, the facility's operator must electronically sign the Operator's Certification, which contains the following two statements:

Certification Statement

> Misrepresentation or falsification of any information contained on this form may be punishable by fine and/or imprisonment under New York State Law and Federal Law.

Certification of Operator:

> I also certify that all salary and non-salary expenses presented in the RHCF-4 [Cost Report] (with the exception of those expenses attributable to Research, Physicians Offices and other Rentals, Gift Shop, Public Restaurant, Fund Raising and Sold Services) considering the adjustments contained in the Part II and the recoveries of expenses detailed in Exhibit I of the Part IV *were incurred to provide patient care in the facility.*

(Ronan Aff. Ex. 4 [emphasis added]; *see also* Ronan Aff. at ¶ 18.)

241. The operator must further certify that the report is "true and complete." (*See* Ronan Aff. Ex. 4; *see also* Ronan Aff. at ¶¶ 18, 65.)

242. Kalter falsely certified that the salaries paid to the Kalter-1% Owners "were incurred to provide patient care in the facility" (*see* Ronan Aff. at ¶ 64; *see also* Ronan Aff. Ex. 4), even though the Kalter-1% Owners never provided any services to Fulton Commons (*see* ¶ 230 *supra)* and were instead paid improper and illegal distributions disguised as salaries for no-show jobs.

243. By including the salaries paid to the Kalter-1% Owners in Fulton Commons' annual Cost Reports, Kalter repeatedly and persistently caused Fulton Commons to make false and misleading statements in the years 2018 through 2021 in violation of its obligations under 10 NYCRR Part 86-2. (*See* Ronan Aff. at ¶ 64; *see also* Ronan Aff. Ex. 4.) In addition, during these years, Kalter repeatedly and persistently falsely certified—by submitting to DOH the above-quoted Certification of Operator—that Fulton Commons' Cost Reports were "true and complete." (*See* Ronan Aff. at ¶ 65; *see also* Ronan Aff. Ex. 4.)

G. Respondent Kalter Repeatedly and Persistently Committed Fraud and Illegalities by Violating Equity Disclosure and Withdrawal Limits for Nursing Home Owners

244. Kalter also repeatedly and persistently violated the 3% Rule in order to conceal Respondent-owners and Fulton Realty LP's repeated and persistent conversion of millions of dollars of up-front profit taken from Fulton Commons, while disregarding Fulton Commons' special obligation to its residents. (*See* Public Health Law § 2808[5][c]; *Brightonian Nursing Home v Daines*, 21 NY3d 570, 575, 577–578 [2013].)

245. New York State law prohibits certain nursing homes, including Fulton Commons, from "withdraw[ing] equity or transfer[ring] assets which in the aggregate exceed three percent of such facility's total reported annual revenue for patient care services" without prior written approval from DOH. (*See* Public Health Law § 2808[5][c].)

246. The definition of withdrawals of equity or asset transfers is broad and specifically includes the following: "(i) any transfer of a facility's cash or other assets directly or indirectly to or for the benefit of its operator . . . (iii) any liability incurred within any period of time required for financial reporting in accordance with [10 NYCRR] Part 86 . . . by a facility or its operator by reason of a mortgage, lease, borrowing or other transaction relating to such a facility that exceeds, in the aggregate, $50,000 . . . and (v) payment to the operator or owner of a salary in excess of the maximum amount allowed for reimbursement purposes by the Department of Health." (10 NYCRR § 400.19[a][3].)

247. Between 2018 and 2021, Fulton Commons routinely engaged in transactions—namely, the payment of excess rent, as discussed in ¶¶ 213–221 *supra*, and the payment of salaries for no-show jobs, as discussed in ¶¶ 229–237 *supra*—that qualified as equity withdrawals or asset transfers in excess of the 3% withdrawal threshold. Yet, in another pattern of repeated fraud and illegality, Kalter never once gave DOH notice of, nor obtained approval for, these transactions. As a result, he violated the equity withdrawal and/or asset transfer limits every single year from 2018 through 2021.

248. Namely, as early as 2018 through at least 2021, Fulton Commons paid $14,902,698 through a fraudulent and illegal rent scheme in which it paid exorbitant rent to Fulton Realty LP in order to disguise Respondents Kalter, Fogel, and Fulton Realty Inc.'s profits. (*See* Ronan Aff. at ¶¶ 49–54.) As explained in ¶ 215 *supra*, Fulton Commons' excess rent was nothing more than a distribution paid to Kalter (individually, and on behalf of Fulton Realty Inc.) and Fogel disguised as a bona fide business expense. Thus, Kalter orchestrated this transfer of Fulton Commons' cash for the direct or indirect benefit of himself as the majority and controlling owner of Fulton Realty LP. (*See* 10 NYCRR § 400.19[a][3][i].)

249. Alternatively, these excess rent payments can also be categorized as a withdrawal of equity pursuant to a liability incurred by Fulton Commons as a result of a lease, despite the fact that there was no written lease between Fulton Commons and Fulton Realty LP. (*See* 10 NYCRR § 400.19[a][3][iii].)

250. Of the $14,902,698 Fulton Commons paid to Fulton Realty LP in excess rent, Kalter transferred over $8 million to himself in illegal and fraudulent management fees. Additionally, Kalter took over $4 million in illegal and fraudulent distributions from the $14,902,698 paid by Fulton Commons to Fulton Realty LP in excess rent, and Respondent Fogel took more than $2 million in such distributions. (*See* ¶ 220 *supra*.)

251. The Kalter-1% Owners' "salaries" were payments to owners of salaries in excess of the maximum amount allowed for reimbursement purposes by DOH. (*See* 10 NYCRR § 400.19[a][3][v].) Salaries to owners are permitted as expenses only when the owners render services to the facility. As previously established in ¶ 230 *supra*, the Kalter-1% Owners did not provide a single service to Fulton Commons, and therefore, their "salaries" were illegal and fraudulent equity withdrawals and/or asset transfers.

252. The chart below illustrates that Fulton Commons withdrew equity and/or transferred assets in excess of 3% for the years 2018 through 2021 based upon the previous years' total reported revenue. The rows on the left show: (1) Fulton Commons' total operating revenue; (2) 3% of the prior year's operating revenue; (3) Fulton Commons' excess rent, as discussed in ¶¶ 213–221 *supra*; (4) the Kalter-1% Owner salaries; (5) equity withdrawal and/or asset transfers in excess of 3%; and (6) the percentage of equity withdrawal and/or asset transfers above 3%. Each column represents the value of the corresponding category for the years 2018 through 2021.

Equity Withdrawals/Asset Transfers from Fulton Commons in Excess of 3%					
	2018	**2019**	**2020**	**2021**	**Total**
Fulton Commons' Prior Year's Total Operating Revenue (Cost Report)	$35,082,173.00	$38,619,853.00	$40,638,641.00	$32,134,075.00	$146,474,742.00
3% of Fulton Commons' Prior Year's Operating Revenue	**$1,052,465.19**	**$1,158,595.59**	**$1,219,159.23**	**$964,022.25**	**$4,394,242.26**
Excess Rent	$3,526,494.00	$4,422,281.00	$4,566,918.00	$2,397,710.00	$14,913,403.00
Kalter-1% Owners Salaries	$60,500.00	$170,295.03	$410,875.96	$415,319.80	$1,056,990.79
Total Equity Withdrawals/Asset Transfers	**$3,586,994.00**	**$4,592,576.03**	**$4,977,793.96**	**$2,813,029.80**	**$15,970,393.79**
Equity Withdrawals/Asset Transfers in Excess of 3%	**$2,534,528.81**	**$3,433,980.44**	**$3,758,634.73**	**$1,849,007.55**	**$11,576,151.53**
Percentage of Equity Withdrawals/Asset Transfers in Excess of 3%	**7.22%**	**8.89%**	**9.24%**	**5.75%**	–

253. As depicted in the chart above, Fulton Commons withdrew $2,534,528.81, $3,433,980.44, $3,758,634.73, and $1,849,007.55 in the years 2018 through 2021, respectively, in excess of 3% of the previous year's total operating revenue as reported on Fulton Commons' corresponding Cost Reports. (*See* Ronan Aff. at ¶ 66.) Respondents executed these equity withdrawals and/or asset transfers without the requisite approval of DOH. (*Id*. at ¶ 67.)

H. Respondent Kalter Repeatedly and Persistently Violated Conditions of Participation in the Medicaid Program in His Operation of Fulton Commons and Submitted False Certifications on Behalf of Fulton Commons to DOH

254. Fulton Commons is a registered "Provider" with DOH, subject to program regulations as well as a Medicaid Provider Agreement, which explicitly makes the New York State Medicaid regulations the foundation of the relationship between the state and the provider. (*See* Ronan Aff. at ¶ 26.)

255. Kalter repeatedly and persistently violated 18 NYCRR § 515.2(b) by his conduct in the operation of Fulton Commons. 18 NYCRR § 515.2(b) requires that a provider submit claims only for services provided in compliance with NYCRR Title 18. (*See* 18 NYCRR §§ 515.5[a]–[b].)

256. By their conduct in the operation of Fulton Commons, Kalter, and the other Respondent-owners repeatedly and persistently committed multiple violations of 18 NYCRR § 515.2, which prohibits as an "unacceptable practice":

> (b)(1) False claims. (i) Submitting, or causing to be submitted, a claim or claims for:
>
> (a) Unfurnished medical care, services or supplies.
>
> (b)(2) False statements. (i) Making, or causing to be made any false, fictitious, or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment, or for use in determining the right to payment.
>
> (b)(4) Conversion. Converting a medical assistance payment, or any part of such payment, to a use or benefit other than for the use intended by the medical assistance program.
>
> (b)(12) Failure to meet recognized standards. Furnishing medical care, services or supplies that fail to meet professionally recognized standards for health care . . . .

257. In addition, by his unlawful conduct in the operation of Fulton Commons, Kalter repeatedly and persistently violated regulatory requirements by submitting false Certification Statements for Provider Billing Medicaid to DOH. Kalter's Certification Statements falsely stated, in pertinent part:

> I (or the entity) have furnished or caused to be furnished the care, services, and supplies itemized *and done so in accordance with applicable federal and state laws and regulations* . . . .
>
> * * *
>
> In submitting claims under this agreement I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Health and the Office of the Medicaid Inspector General as set forth in statute or title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including eMedNY Provider Manuals and other official bulletins of the Department . . . .

(Ronan Aff. Ex. 2 [emphasis added].)

I. If Respondents Took Even $1 Million Less in Converted Up-Front Profits, They Could Have Increased Fulton Commons' Nursing Care Hours to Provide Vital Care to its Vulnerable Residents

258. The neglect, abuse, and mistreatment of Fulton Commons' residents, caused in large part by its chronic staffing deficiencies, could have been entirely avoided if the facility, Respondent-owners, Weiss, and Doyle properly utilized the revenue Fulton Commons received from Medicaid and Medicare to hire and retain a sufficient number of qualified staff, including RN supervisors. As detailed in ¶ 29 *supra*, if Fulton Commons had left just $1 million more for staffing expenses in 2020—when 154 residents died—it would have been able to provide an additional 23,675 hours of direct care to its residents. Fulton Commons, Respondent-owners, Weiss, and Doyle could have easily provided that additional care if Fulton Realty LP and Kalter had decreased the exorbitant rent charged to Fulton Commons and eliminated the Kalter-1% Owners' salaries for no-show jobs.

259. The chart below illustrates how many additional hours of direct care Fulton Commons could have provided to its residents in 2018, 2019, 2020, and 2021 if the Kalter-1%

Owners' annual salaries in the corresponding years had been directed to legitimate direct care nursing staffing. (*See* Ronan Aff. at ¶ 94.)

Additional Direct Care Hours That Could Have Been Paid for With the Kalter-1% Owners' Annual Aggregate Wages				
	2018	**2019**	**2020**	**2021**
Kalter-1% Owners Total Wages	$60,500.00	$170,295.03	$410,875.96	$415,319.80
RN Hours	111	218	1,037	615
LPN Hours	322	910	1,966	1,857
CNA Hours	1,113	3,086	6,724	5,047
Total Additional Hours of Direct Care	**1,546**	**4,214**	**9,727**	**7,519**

AS AND FOR THE FIRST CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED FRAUDULENT ACTS AND/OR PERSISTENT FRAUD
As against Corporate Respondents, Respondent-Owners, and Respondent Weiss

260. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

261. Executive Law § 63(12) authorizes the Attorney General to seek injunctive and other relief whenever an individual or entity engages in repeated fraudulent acts and/or demonstrates persistent fraud in the carrying on, conducting, or transaction of business.

262. Executive Law § 63(12) defines fraud and fraudulent conduct broadly to include "any device, scheme or artifice to defraud and any deception, misrepresentation, concealment,

suppression, false pretense, false promise or unconscionable contractual provisions." Corporate Respondents and Respondent-owners, through Respondent Weiss and their other agents and employees, repeatedly engaged in fraudulent acts and/or demonstrated persistent fraud by converting $16,005,083.59 in up-front profit from Medicaid and Medicare funds that Fulton Commons received for resident care.

263. Corporate Respondents, Respondent-owners, and Respondent Weiss thereby engaged in repeated fraudulent acts and/or demonstrated persistent fraud in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE SECOND CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED FRAUDULENT ACTS AND/OR PERSISTENT FRAUD
As against Corporate Respondents and Respondents Kalter, Fogel, and Weiss

264. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

265. Executive Law § 63(12) authorizes the Attorney General to seek injunctive and other relief whenever an individual or entity engages in repeated fraudulent acts and/or demonstrates persistent fraud in the carrying on, conducting, or transaction of business.

266. Executive Law § 63(12) defines fraud and fraudulent conduct broadly to include "any device, scheme or artifice to defraud and any deception, misrepresentation, concealment, suppression, false pretense, false promise or unconscionable contractual provisions." Corporate Respondents and Respondents Kalter and Fogel, through Respondent Weiss and their other agents and employees, repeatedly engaged in fraudulent acts and/or demonstrated persistent fraud by entering into a collusive and self-dealing lease agreement obligating Fulton Commons to pay artificially high rent to related-party Fulton Realty LP.

267. Corporate Respondents and Respondents Kalter, Fogel, and Weiss thereby engaged in repeated fraudulent acts and/or demonstrated persistent fraud in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE THIRD CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED FRAUDULENT ACTS AND/OR PERSISTENT FRAUD
As Against Respondents Fulton Commons and Kalter

268. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

269. Executive Law § 63(12) authorizes the Attorney General to seek injunctive and other relief whenever an individual or entity engages in repeated fraudulent acts and/or demonstrates persistent fraud in the carrying on, conducting, or transaction of business.

270. Executive Law § 63(12) defines fraud and fraudulent conduct broadly to include "any device, scheme or artifice to defraud and any deception, misrepresentation, concealment, suppression, false pretense, false promise or unconscionable contractual provisions." Respondents Fulton Commons and Kalter, through their agents and employees, repeatedly committed fraudulent acts and/or demonstrated persistent fraud by, to wit:

i. Failing to seek approval from DOH prior to withdrawing equity and/or transferring assets from Fulton Commons in excess of the disclosure threshold, in violation of Public Health Law § 2808(5)(c);

ii. Failing to seek approval from DOH prior to withdrawing equity and/or transferring assets from Fulton Commons that created a negative net worth position, in violation of Public Health Law § 2808(5)(a) and 10 NYCRR §§ 400.19(b)(1) and 415.26(h)(7);

iii. Preparing, filing, and/or causing to be filed false and/or misleading Cost Reports, on behalf of or for Fulton Commons, with DOH that falsely designated equity withdrawals and/or asset transfers to Respondent Kalter-1% Owners for no-show jobs as salaries and falsely asserted that such purported salaries were incurred to provide patient care at Fulton Commons;

iv. Submitting false Certification Statements for Provider Billing Medicaid to DOH in which Kalter falsely attested that the Medicaid Claims submitted by Fulton Commons were for care and services actually furnished and performed in accordance with applicable laws.

271. Respondents Fulton Commons and Kalter thereby engaged in repeated fraudulent acts and/or demonstrated persistent fraud in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE FOURTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED FRAUDULENT ACTS AND/OR PERSISTENT FRAUD
As Against Respondents Fulton Commons, Kalter, Weiss, and Doyle

272. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

273. Executive Law § 63(12) authorizes the Attorney General to seek injunctive and other relief whenever an individual or entity engages in in repeated fraudulent acts and/or demonstrates persistent fraud in the carrying on, conducting, or transaction of business.

274. Executive Law § 63(12) defines fraud and fraudulent conduct broadly to include "any device, scheme or artifice to defraud and any deception, misrepresentation, concealment, suppression, false pretense, false promise or unconscionable contractual provisions." Respondents

Fulton Commons, Kalter, Weiss, and Doyle, through their agents and employees, repeatedly engaged in fraudulent acts and/or demonstrated persistent fraud by, to wit:

i. Repeatedly deceiving DOH about the deficient care delivered at Fulton Commons; and

ii. Repeatedly deceiving current and prospective residents and their families as to the conditions within Fulton Commons and the quality of care delivered in the facility.

275. Respondents Fulton Commons, Kalter, Weiss, and Doyle thereby repeatedly engaged in fraudulent acts and/or demonstrated persistent fraud in the carrying on, conducting, and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE FIFTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED ILLEGAL ACTS AND/OR PERSISTENT ILLEGALITY
As against Respondents Fulton Commons, Kalter, Weiss, and Doyle

276. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

277. Executive Law § 63(12) authorizes the Attorney General to seek injunctive and other relief whenever an individual or entity engages in repeated illegal acts and/or demonstrates persistent illegality.

278. A violation of any state, federal, or local law constitutes "illegality" within the meaning of Executive Law § 63(12) and is actionable thereunder when persistent or repeated. Respondents Fulton Commons, Kalter, Weiss, and Doyle, through their agents and employees, including but not limited to former DON Frawley, repeatedly engaged in illegal acts and/or demonstrated persistent illegality in the carrying on, conducting, or transaction of business in

violation of Executive Law § 63(12), by failing to comply with their legal obligations to provide Fulton Commons' residents the care required under state and federal law, to wit, by failing to:

1. Maintain sufficient numbers of nursing staff with the appropriate competencies and skill sets to provide nursing and related services "to assure . . . the well-being of each resident," in violation of 42 CFR § 483.35.
2. Maintain sufficient personnel on a 24-hour basis to provide nursing care to all residents in accordance with each resident's needs as set forth in the care plan that Fulton Commons is required to develop, in violation of 10 NYCRR § 415.13(a);
3. Limit resident admissions, and "accept and retain only those nursing home residents for whom [they] can provide adequate care . . . ," in violation of 10 NYCRR § 415.26;
4. Timely administer treatments, medications, diets, and other health services, in violation of 10 NYCRR § 415.13;
5. Fulfill each resident's right to "adequate and appropriate medical care," in violation of 10 NYCRR § 415.3 and Public Health Law §§ 2803-c(2) and (3)(e);
6. Ensure that "all residents are afforded their right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration, and privacy in treatment and care for personal needs, and communication with and access to persons and services inside and outside

the facility," as required by 10 NYCRR § 415.3(a) and 42 CFR § 483.10(a);

7. Fully inform each resident "in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being," as required by 10 NYCRR § 415.3(f)(1)(iv);

8. Consult with the resident immediately if the resident is competent, and notify the resident's physician and designated representative within 24 hours when there is an accident involving the resident that results in injury requiring professional intervention; a significant improvement or decline in the resident's physical, mental, or psychosocial status in accordance with generally accepted standards of care and services, or a need to alter treatment significantly, as required by 10 NYCRR § 415.3(f)(2)(ii) and 42 CFR § 483.10(g)(14)(i);

9. Assure that each resident is free from any psychotropic drug administered for purposes of discipline or convenience, and not required to treat the resident's medical conditions or symptoms, as required by 10 NYCRR § 415.4(a)(1), Public Health Law § 2803-c(h), and 42 CFR § 483.10(e)(1);

10. Develop and implement written policies and procedures prohibiting neglect, abuse, or mistreatment of Fulton Commons residents, and report any alleged violations of the same to DOH, as required by 10 NYCRR § 415.4(b), Public Health Law §§ 12-b and 2803-d, 42 USC § 1320b-25, and 42 CFR § 483.12;

11. Care for Fulton Commons' residents in a manner and environment promoting quality of life and dignity, as required by 10 NYCRR § 415.5;

12. Offer activities that meet the physical, mental, and psychosocial well-being of each resident and "promote and maintain the resident's sense of usefulness . . . , make his or her life more meaningful, stimulate and support the desire to use his or her physical and mental capabilities to the fullest extent and enable the resident to maintain a sense of usefulness and self-respect," as required by 10 NYCRR § 415.5(f)(1);

13. Maintain a safe, healthy, functional, sanitary, and comfortable environment for residents, as required by 10 NYCRR §§ 415.5(h) and 415.29;

14. Create comprehensive and timely care plans, provide services in accordance with comprehensive care plans and revise care plans as necessary to assure the continued accuracy of a resident's health assessment, as required by 10 NYCRR §§ 415.11(a)–(c) and 42 CFR § 483.20;

15. Acquire, receive, dispense, and administer "all drugs and biologicals required to meet the needs of each resident," as required by 10 NYCRR § 415.18 and 42 CFR § 483.45;

16. Maintain an effective infection control program designed to provide a safe, sanitary, and comfortable environment, in violation of 10 NYCRR § 415.19 and 42 CFR § 483.80;

17. Have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility, as required by 10 NYCRR § 415.26(b) and 42 CFR § 483.70(d);

18. Ensure that at least one member of the governing body of Fulton Commons participates in the quality assessment and assurance committee, as required by 10 NYCRR § 415.27;

19. Provide the necessary quality of care and services to attain and maintain the "highest practicable physical, mental, and psychosocial well-being," of each resident, including but not limited to failing to ensure that the residents' activities of daily living "do not diminish," as required by 10 NYCRR § 415.12;

20. Ensure that "a resident who is incontinent of bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible," as required by 10 NYCRR § 415.12(d)(1);

21. Provide "appropriate treatment and services to maintain or improve [residents'] abilities," as required by 10 NYCRR § 415.12(a)(2);

22. Ensure "a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene," as required by 10 NYCRR § 415.12(a)(3) and 42 CFR §§ 483.24(b) and 483.55;

23. Ensure that (1) any resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable despite every reasonable effort to prevent them; and (2) any resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, as required by 10 NYCRR § 415.12(c) and 42 CFR § 483.25(b);

24. Ensure that residents receive proper treatment and care to maintain good foot health, including providing foot care and treatment to prevent complications from the resident's medical condition, as required by 42 CFR § 483.25(b)(2);

25. Ensure that each "resident maintains acceptable parameters of nutritional status, such as body and weight and protein levels . . . and receives a therapeutic diet when there is a nutritional problem," as required by 10 NYCRR § 415.12(i);

26. Provide "each resident with sufficient fluid intake to maintain proper hydration and health," as required by 10 NYCRR § 415.12(j);

27. Provide "each resident with a nourishing, palatable, well-balanced and medically appropriate diet that meets residents' daily nutritional and special dietary needs[,] . . . employ sufficient competent staff to carry out the functions of the dietary service[,] . . . provide assistance with eating and special eating equipment and utensils for residents who need them[,]

. . . [and] store, prepare, distribute and serve food under sanitary conditions," as required by 10 NYCRR § 415.14 and 42 CFR § 483.60;

28. Ensure that all "residents are free of any significant medication errors," as required by 10 NYCRR § 415.12(m)(2);

29. Ensure that "each resident receives adequate supervision . . . to prevent accidents," as required by 10 NYCRR § 415.12(h)(2);

30. Develop and implement medical services to meet the needs of its residents, as required by 10 NYCRR § 415.15;

31. Employ a sufficient number of professional staff members who are educated, oriented and qualified, as required by 10 NYCRR § 415.26(c);

32. Retain responsibility of the operation of the nursing home as the governing body or operator, as required by 10 NYCRR § 600.9;

33. Report accurate infection control data to DOH, as required by 10 NYCRR § 702.4;

34. Protect and promote the rights of each resident; treat each resident in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality; and provide equal access to quality care regardless of diagnosis, severity of condition, or payment source, as required by 42 CFR § 483.10(a);

35. Ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, as required by 42 CFR § 483.25;

36. Develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life, as required by 42 CFR § 483.75;

37. Provide courteous, fair, and respectful care and treatment to each resident, in violation of Public Health Law §§ 2803-c(2) and (3)(g); and

38. Ensure that only licensed individuals within a profession in which a license is a prerequisite practice in such profession, in violation of Education Law § 6512.

279. Respondents Fulton Commons, Kalter, Weiss, and Doyle thereby engaged in repeated illegal acts and/or demonstrated persistent illegality in the carrying on, conducting and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE SIXTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED ILLEGAL ACTS AND/OR PERSISTENT ILLEGALITY
As against All Respondents

280. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

281. Executive Law § 63(12) authorizes the Attorney General to seek injunctive and other relief whenever an individual or entity engages in repeated illegal acts and/or demonstrates persistent illegality.

282. A violation of any state, federal, or local law constitutes "illegality" within the meaning of Executive Law § 63(12) and is actionable thereunder when persistent or repeated.

283. Respondents' repeated and persistent violations of the Public Health Law, the Social Services Law, and the federal Social Security Act and its Medicare regulatory counterparts are all actionable under Executive Law § 63(12).

284. Respondents repeatedly, through their agents and employees, engaged in illegal acts and/or demonstrated persistent illegality in the carrying on, conducting or transaction of business in violation of Executive Law § 63(12) by, to wit:

i. Failing to seek approval from DOH prior to withdrawing equity and/or transferring of assets from Fulton Commons in excess of the disclosure thresholds, in violation of Public Health Law § 2808(5)(c);

ii. Failing to seek approval from DOH prior to withdrawing equity and/or transferring assets from Fulton Commons that created a negative net worth position, in violation of Public Health Law § 2808(5)(a) and 10 NYCRR §§ 400.19(b)(1) and 415.26(h)(7);

iii. Preparing, filing, and/or causing to be filed false Cost Reports, on behalf of or for Fulton Commons, with DOH that failed to disclose that expenses with no legitimate business purpose were incurred by Fulton Commons, in violation of 10 NYCRR Part 86-2;

iv. Submitting an incorrect or improper claim, causing such a claim to be submitted, and/or receiving payment for such claim, in violation of 18 NYCRR § 518.3(a); and

v. Committing unacceptable practices under the Medicaid Program, to wit:

1. Submitting or causing to be submitted false claims for unfurnished medical care, services, or supplies, in violation of 18 NYCRR § 515.2(b)(1)(i)(a);

2. Making, or causing to be made any false, fictitious, or fraudulent statement or misrepresentation of material fact in claiming a medical

assistance payment, or for using in determining the right to payment, in violation of 18 NYCRR § 515.2(b)(2);

3. Converting a medical assistance payment, or any part of such payment, to a use or benefit other than for the use and benefit intended by the Medicaid Program, in violation of 18 NYCRR § 515.2(b)(4); and
4. Furnishing medical care, services, or supplies that fail to meet professionally recognized standards for health care, in violation of 10 NYCRR § 515.2(b)(12).

285. Respondents are also liable for violation of federal Medicare payment statutes and regulations, including 42 USC § 1320a-7k(d), which defines an overpayment as "any funds that a person receives or retains under subchapter XVIII or XIX [of the Social Security Act] to which the person, after applicable reconciliation, is not entitled" and requires that overpayments of Medicare funds be repaid within 60 days.

286. Respondents thereby engaged in repeated illegal acts and/or demonstrated persistent illegality in the carrying on, conducting and transaction of business, in violation of Executive Law § 63(12).

AS AND FOR THE SEVENTH CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63-c
MISAPPROPRIATION OF PUBLIC FUNDS
As Against Corporate Respondents, Respondent-Owners, and Respondent Weiss

287. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

288. Corporate Respondents, Respondent-owners, and Respondent Weiss obtained, received, converted, or disposed of funds, either directly or indirectly, from the Medicaid Program to which they were not entitled, as alleged in the foregoing paragraphs of this Verified Petition.

289. The acts and practices of Corporate Respondents, Respondent-owners, and Respondent Weiss complained of herein constitute a misappropriation of public property, in violation of the Tweed Law, Executive Law § 63-c. By reason of the foregoing, the State is entitled to restitution from Corporate Respondents and Respondent-owners in an amount to be determined by the Court at a hearing, but no less than $16,005,083.59.

AS AND FOR THE EIGHTH CAUSE OF ACTION
PURSUANT TO COMMON LAW UNJUST ENRICHMENT
As Against Respondents Fulton Commons, Fulton Realty LP, Fulton Realty Inc., and Respondent-Owners

290. The State repeats and realleges the foregoing paragraphs of this Verified Petition as if fully set forth herein.

291. Respondents Fulton Commons, Fulton Realty LP, Fulton Realty Inc., and Respondent-owners are not entitled to receive or retain payment from the Medicaid and Medicare Programs for the services purportedly rendered by Fulton Commons because those payments were not in conformance with applicable laws and regulations.

292. By reason of the foregoing, Respondents Fulton Commons, Fulton Realty LP, Fulton Realty Inc., and Respondent-owners have been unjustly enriched to the detriment of the

Medicaid and Medicare Programs and it is against equity and good conscience to permit them to retain the payments they received under these Programs.

293. Respondents Fulton Commons, Fulton Realty LP, Fulton Realty Inc., and Respondent-owners are therefore liable to the State in an amount to be determined by the Court at a hearing, but no less than $11,565,447, which is the amount identified to date that Respondent-owners unlawfully received from Medicaid and Medicare funds between January 1, 2018 and December 31, 2021, in violation of Public Health Law § 2808(5)(c).

REQUEST FOR RELIEF

WHEREFORE, Petitioner respectfully requests that this Court grant relief pursuant to Public Health Law § 2801-c, Executive Law § 63(12), Executive Law § 63-c, 42 USC § 1396b(q)(3), and common law unjust enrichment against Respondents as set forth below by issuing an Order and Judgment immediately:

A. Declaring that:

1. Corporate Respondents, Respondent-owners, and Respondent Weiss engaged in repeated and persistent fraud in their conversion, and/or facilitation thereof, of Respondent Fulton Commons' Medicaid and Medicare reimbursement payments for the use of Respondents Fulton Realty LP, Fulton Realty Inc., and Respondent-owners, in violation of Executive Law § 63(12);

2. Corporate Respondents and Respondents Kalter, Fogel, and Weiss engaged in and/or facilitated repeated and persistent fraud through their use of a self-dealing unwritten lease agreement between Respondents Fulton Commons and Fulton Realty LP, in violation of Executive Law § 63(12);

3. Respondents Fulton Commons and Kalter engaged in repeated and persistent fraud by: (i) failing to seek DOH approval for withdrawals of equity and/or transfers of assets from Fulton Commons in excess of the disclosure thresholds found in Public Health Law § 2808(5)(c); (ii) failing to seek approval from DOH before withdrawals of equity and/or transfers of assets from Fulton Commons that created a negative net worth position, in violation of Public Health Law § 2808(5)(a), 10 NYCRR §§ 400.19(b)(1) and 415.26(h)(7); (iii) preparing, filing, and/or causing to be filed false and/or misleading Cost Reports, on behalf of or for Fulton Commons, with DOH that falsely designated equity distributions and/or asset transfers to Respondents Mindy Steger, Sheindy Saffer, Chana Kanarek, Dovid Kalter, Yitzchok Kalter, Aryeh Kalter, Sheva Treff, and Chaya Lieberman a/k/a Sara Lieberman, as salaries for no-show jobs, and falsely asserted that such purported salaries were incurred to provide patient care at Respondent Fulton Commons; and (iv) submitting false Certification Statements for Provider Billing Medicaid to DOH in which Kalter falsely attested that the Medicaid Claims submitted by Fulton Commons were for care and services actually furnished and performed in accordance with applicable laws, all in violation of Executive Law § 63(12);

4. Respondents Fulton Commons, Kalter, Weiss, and Doyle engaged in persistent and repeated fraud by repeatedly deceiving DOH and current and prospective residents and their families as to the nature of the conditions

within Fulton Commons and the quality of care delivered in that facility, in violation of Executive Law § 63(12);

5. Respondents Fulton Commons, Kalter, Weiss, and Doyle engaged in repeated and persistent illegality in their operation of Fulton Commons by virtue of their failure to deliver adequate care to residents of Fulton Commons, contrary to the regulations set forth in ¶ 278 *supra*, all in violation of Executive Law § 63(12);

6. Respondents engaged in repeated and persistent illegality in the operation of Fulton Commons in their failures to refrain from engaging in unacceptable practices under the Medicaid Program and failures to adhere to the laws and regulations set forth in ¶¶ 284–285 *supra*, all in violation of Executive Law § 63(12);

7. Corporate Respondents, Respondent-owners, and Respondent Weiss misappropriated public property, which they without right obtained, received, converted, and/or disposed of, in violation of Executive Law § 63-c; and

8. Respondents Fulton Commons, Fulton Realty LP, Fulton Realty Inc., and Respondent-owners were unjustly enriched at the expense of the Medicaid and Medicare Programs, by receiving and retaining payments from said Programs for services that were purportedly rendered by Fulton Commons, but which were not performed in conformance with applicable laws and regulations, and it is against equity and good conscience to permit them to retain the payments they received under the Programs.

B. Permanently enjoining:

1. Respondents from engaging in the illegal, fraudulent, and deceptive practices alleged herein;

2. Respondents from making self-dealing payments, loans, and other transfers of excessive value to themselves and related entities;

3. Respondents Fulton Commons, Kalter, Weiss, and Doyle from further violation of state and federal healthcare laws and regulations relating to nursing home services in New York State;

3. Respondents Fulton Commons, Respondent-owners, Weiss, and Doyle from further engaging in fraudulent and illegal acts and practices relating to reimbursement by the New York State Medicaid Program; and

4. Respondent Fulton Commons from accepting any admissions of new residents unless and until Fulton Commons' operator provides a signed certification, endorsed by a qualified independent licensed clinician, to the Attorney General certifying that the operator has met their obligation to operate Fulton Commons with sufficient staffing to provide necessary care for all existing residents, and that Fulton Commons' staffing levels after any admissions of new residents will continue to meet the levels deemed necessary by the qualified independent licensed clinician, but no less than the 3.5 HPRD required by Public Health Law § 2895-b(3).

C. Directing Respondent-owners and Corporate Respondents, except Fulton Commons, to pay restitution to the State;

D. Appointing a financial monitor to oversee Respondent Fulton Commons' financial operations, with plenary powers of visitation and inspection, and specific authority to: (i) approve and withhold payments, including any payments to any Respondent or related person or entity; and (ii) ensure that Fulton Commons ceases collusive and self-dealing payments, loans, and other transfers of value to other Respondents;

E. Appointing an independent healthcare monitor to oversee Fulton Commons' healthcare operations and ensure that Fulton Commons improves healthcare outcomes for its residents;

F. Directing Respondents Fulton Commons, Respondent-owners, and Weiss to provide the independent healthcare monitor with real-time 24-hour per day remote access, every day of each year, to all of Fulton Commons' Electronic Medical Records ("EMR") systems for its residents, and to grant the highest level network permissions and credentials for all such EMR systems to the independent healthcare monitor in order to enable viewing of all edits made at any time to any records by any user, person, and/or system administrator;

G. Directing that Respondents Fulton Realty LP, Fulton Realty Inc., and Respondent-owners fully account for and disgorge all monies wrongfully received, as identified in the Ronan Aff. at ¶ 72 and enumerated in ¶ 18 *supra*, as a result of their fraudulent and illegal conversion and retention of substantial public funds paid as Medicaid and Medicare reimbursement to Respondent Fulton Commons for resident care that Fulton Commons failed to provide, and directing those Respondents to return said monies within 15 days to the Attorney General's Medicaid Fraud Control Unit, for return to the Medicaid and Medicare Programs;

H. Requiring the establishment of a governing body for Fulton Commons, comprised of multiple members, including the operator or their agent, the independent healthcare monitor, and the independent financial monitor; and requiring that the majority of the members of the governing body are not owners of Fulton Commons or their related persons;

I. Requiring the operator and the independent healthcare monitor, as members of the governing body, to participate in QAPI meetings;

J. Directing Corporate Respondents, except Fulton Commons, and Respondent-owners to pay for the expenses of the monitors appointed hereunder;

K. Directing Respondent Fulton Commons to remove Dr. Olaf Butchma from the position of Medical Director and to replace him with a qualified physician, approved by the independent healthcare monitor;

L. Directing all Respondents, except Fulton Commons, to pay civil penalties to the State;

M. Directing all Respondents, except Fulton Commons, to pay statutory penalties in the amount of $2,000 pursuant to CPLR 8303(a)(6) for violations of the Public Health Law, Social Services Law, and Medicaid Program rules;

N. Directing all Respondents, except Fulton Commons, to reimburse the State for the costs of this investigation;

O. Directing all Respondents, except Fulton Commons, to pay pre- and post-judgment interest at the rate of 9% pursuant to CPLR 5001, 5003, and 5004;

P. Directing each Respondent to notify Petitioner of any change to Respondents' addresses within five days of such change; and

Q. Granting Petitioner such other and further relief as this Court deems just and proper.

Dated: New York, New York
December 13, 2022

LETITIA JAMES

Attorney General of the State of New York

By: Amy Held

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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

Petitioner,

- against -

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

Respondents.

Index No.: _____

VERIFICATION

Amy Held, an attorney duly admitted to practice before the Courts of the State of New York, affirms the following under penalty of perjury:

I am the Director of the New York State Attorney General's Medicaid Fraud Control Unit, of Counsel to Attorney General of the State of New York Letitia James, attorney for Petitioners in this action. I am acquainted with the facts set forth in the foregoing Verified Petition, based on my review of the files of the Medicaid Fraud Control Unit and information provided by Special Assistant Attorneys General, auditor-investigators, detectives, and medical analysts participating in the investigation of this matter, and said Petition is true to my knowledge, except as to matters which were therein stated to be upon information and belief, as to those matters I believe them to be true. The reason I make this Verification is that Petitioner, State of New York, is a body politic.

Dated: New York, New York
December 13, 2022

Amy Held
_____
AMY HELD