SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORLEANS

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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. _____

VERIFIED PETITION

- against -

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

Respondents.

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

PRELIMINARY STATEMENT

1. Comprehensive at Orleans LLC d/b/a The Villages of Orleans Health and Rehabilitation Center ("The Villages") is a for-profit 120-bed nursing home located at 14012 Route 31 in the Village of Albion, County of Orleans, State of New York, which is home[1] to over 100 vulnerable, frail, elderly, or disabled individuals, most of whom are Medicaid and/or Medicare beneficiaries whose care is funded by New York and federal taxpayers.

[1] "For the vast majority of residents, the residential health care facility is their last home," and its residents "depend upon the facility to meet every basic human need." (10 NYCRR § 415.1[a][1].)

2. Petitioner brings this proceeding pursuant to, *inter alia*, Executive Law § 63(12) against Respondents to seek injunctive relief to expose and stop the persistent fraud and illegality of the persons who have operated, owned, and controlled The Villages, and to seek restitution, disgorgement, rescission, civil penalties, and costs against any person that has engaged in or otherwise demonstrated repeated illegal and/or fraudulent acts, including: (1) repeated neglect and inhumane mistreatment of The Villages' residents who have suffered while in Respondents' charge; and (2) a long history of insufficient and unqualified staffing and poor quality of care in violation and in reckless disregard of numerous New York State rules, regulations, and laws, including the Tweed Law, Executive Law § 63-c, which authorizes the Attorney General to recover public monies "without right obtained, received, converted, or disposed of." Petitioner also brings this special proceeding to bring transparency to the reality that much of the human pain, actual harm, and humiliation experienced by the individuals who have lived at The Villages was preventable and can be prevented in the future. As detailed herein, Respondents did not provide The Villages' residents with even the most basic care and necessities, such as hygiene, prescribed medications, meals, phones, and hot water, and created conditions wherein those who lived at The Villages routinely sat unattended in dirty adult diapers for hours on end; suffered from unnecessary physical and mental decline; were deprived of essential medical treatment; suffered from pressure sores, infections, and other preventable ailments; and were forced to live in a dilapidated facility, despite receipt of tens of millions of dollars in government reimbursement.

3. The Villages' egregious history of insufficient and unqualified staffing and poor quality of care is directly traceable to Respondents' unconscionable conversion of millions of dollars in "up-front profit" taken from The Villages. In flagrant disregard of their legal duties, from January 1, 2015 to the present, Respondents took either directly or through related-party

transactions, over $18.6 million from The Villages that should have been spent on ensuring adequate resident care, but was instead used by Respondents to unnecessarily and unjustly enrich themselves at the expense of The Villages' residents.

4. At all relevant times, New York law has imposed on The Villages, as a nursing home facility, and those who own, operate, and control it, a "special obligation" to care for its residents; and to ensure that the facility has sufficient staffing "to assure the highest practicable quality of life" for each resident and to provide its residents with the necessary "care and services," including clinical care, in accordance with each resident's individualized care plan. (*See* 10 NYCRR § 415.1[a] [nursing homes – minimum standards]; 10 NYCRR § 415.3[f] [right to clinical care and treatment]; 10 NYCRR § 415.12 [quality of care]; 10 NYCRR § 415.13 [nursing services]; *see also* 42 CFR § 483.25 [quality of care]; 42 CFR § 483.35 [nursing services]; 42 CFR § 483.10 [resident rights]; PHL § 2803-c(3) ["Patient's Bill of Rights"].) Respondents repeatedly violated these regulations during the relevant time period.

5. Furthermore, Respondents repeatedly committed acts of neglect against residents of The Villages in violation of Public Health Law § 2803-d(7). (*See* 10 NYCRR § 81.1[c] [defining "neglect" as "failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care . . . including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living"].)

6. Through the interviews of residents and employees of The Villages, analysis of medical records of residents, and additional evidence as set forth in the accompanying affidavits, the Attorney General's findings demonstrate that Respondents repeatedly prioritized their personal profit over The Villages' duty to provide required resident care and required staffing, thereby causing physical and emotional harm to vulnerable people who lived at the nursing home, and

stripping them of their dignity. Neglect and mistreatment at The Villages includes the following illustrative, but not exhaustive, examples:

- **Suicidal Patient Ignored to Death:** A woman known as Resident 38[2] was admitted to The Villages in early 2020, for rehabilitation of a fractured left femur. Shortly after admission, Resident 38 began refusing medications and food, and spoke of wanting to die. An outside psychology consultant determined that Resident 38 was at high risk for self-harm and ordered checks on her condition every 30 minutes. Nonetheless, The Villages repeatedly failed to monitor Resident 38 and she was found dead 20 days later. The Villages failed to report Resident 38's death to the New York State Department of Health as required. (Affidavit of Medical Analyst Jennifer Cronkhite, R.N. ["Medical Analyst Aff."] ¶¶ 11-16.)

- **Delayed Wound Treatment, Unexplained Doping and Death:** Resident 42 was admitted to The Villages on January 6, 2021, with a Stage II pressure sore near the base of her spine, but it was not treated for the first time until 18 days later.[3] By June 24, Resident 42 suffered from two Stage III pressure sores. A specialty wound care consultant recommended a treatment regime, yet The Villages did not order this new treatment until nearly a week later, and did not provide a new dressing until July 1. When the consultant re-assessed Resident 42's wounds on July 7, both wounds had deteriorated to "unstageable." Additionally, The Villages gave Resident 42 psychotropic medication, purportedly for "severe anxiety," a diagnosis which cannot be found in Resident 42's medical records. Resident 42 was also frequently given medications for nausea, cough, and pain, without documented clinical need. Resident 42 was found unresponsive on July 13, and her records are silent as to what care, if any, she was provided before being sent to the hospital, where she died on July 13, 2021, from acute cardiopulmonary arrest secondary to respiratory failure. Staff at The Villages failed to notify Resident 42's healthcare proxy that she was sent to the hospital. (Medical Analyst Aff. ¶¶ 72-82.)

- **Mother of Resident Teaches Seizure Care to Nursing Staff:** Resident 35 suffers from a rare genetic disorder and had three seizures upon admission to The

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

[3] There are four stages used to categorize pressure sores, plus an additional category of pressure sores which are referred to as "unstageable." A Stage II pressure sore involves a partial thickness loss of dermis (the inner layer of the two main layers of skin) presenting as a shallow open ulcer with a red or pink wound bed, without slough (a mass of dead tissue separating from the ulcer). Stage III pressure sores involve full-thickness skin loss potentially extending into the subcutaneous tissue layer. An unstageable sore is where there is full thickness tissue loss in which actual depth of the sore is completely obscured by wet or dry necrotic (dead) tissue in the wound bed. It is a very serious condition. (*See* Medical Analyst Aff. ¶¶ 151-156.)

Villages in November 2020 because The Villages failed to timely obtain and administer her anti-seizure medication as ordered, after which she was rushed to the hospital where she stayed for over two weeks. After discharge back to The Villages, Resident 35 suffered numerous falls resulting in bruising, bleeding, and tooth injury. Resident 35 frequently soiled herself because staff did not promptly respond to her call bell, and because she was unable to get to the bathroom without assistance. In April 2022, a Detective from the Attorney General's Medicaid Fraud Control Unit observed that staff did not help Resident 35 eat despite orders in her care plan requiring that Resident 35 be properly positioned to eat safely, monitored to prevent choking, and assisted with utensils and guiding food into her mouth. The Villages' staff were so ill-trained that Resident 35's mother posted seizure instructions on the wall of Resident 35's room after seeing Resident 35 suffer a seizure while staff did not know what to do. Resident 35's mother spent months trying to arrange a transfer to a different facility. Those efforts were finally successful in April 2022. Resident 35 currently resides at the new facility. (Affidavit of Detective Jaimie Krzyskoski ["Detective Aff."] ¶¶ 221-226; Medical Analyst Aff. ¶¶ 17-23; Affidavit of Donna Kelly ["Kelly Aff."] ¶¶ 9, 14, 18-20, 22, 37-47.)

- **Amputee Sits in Urine, Awaiting Medication:** Resident 43 was admitted to The Villages in late 2020 after a leg amputation in order to regain enough strength to use a prosthetic leg and live independently. During his three-month stay at The Villages, Resident 43 had few physical therapy sessions, which he described as "laughable." In the Physical Therapy room, he was left to sit without exercise. Due to his amputation, Resident 43's care plan called for two staffers to assist him with cleaning himself, but staff frequently failed to timely change his adult diaper and, as a result, he often sat in a puddle of his own urine for hours. When interviewed in March 2022, Resident 43 was living at a different facility and reported he was "making great progress." He stated that if he had received proper treatment and care at The Villages, he "would be back home by now." (Detective Aff. ¶¶ 175-194; Medical Analyst Aff. ¶¶ 33-37.)

- **"Wouldn't put a dog in Villages":** Resident 50 arrived at The Villages in December 2020 for rehabilitation after knee surgery. During a video call, Resident 50's wife saw he was lying in bed with only a diaper on, atop a rubber mat, without sheets or blankets. Resident 50's wife found bruises on his head, face, and arms, yet The Villages did not notify her about or explain these injuries. At The Villages, Resident 50 became "a stranger" to his wife, and "could not communicate verbally." After his wife transferred Resident 50 to a different facility, he was able to eat, talk, and laugh again. Resident 50's wife now holds that she "wouldn't put a dog in Villages." Resident 50 passed away in November 2021 from COVID-19. (Affidavit of Margarette Volkmar ["Volkmar Aff."] ¶¶ 7-27.)

7. Respondents' persistent violations of their duty to care for The Villages' residents began long before the COVID-19 pandemic, and continue to the present.[4] Almost immediately after Respondents took control of The Villages in January 2015, The Villages' Five Star quality ratings plummeted, becoming among the worst in the State. In May 2020, the New York State Department of Health ("DOH") declared The Villages to be in "Immediate Jeopardy" for violating COVID-19 protocols, causing or likely causing, "serious injury, harm, impairment, or death to a resident."[5] (*See* 42 CFR § 488.301 [defining "Immediate Jeopardy"].) Less than a year later, in March 2021, the U.S. Centers for Medicare and Medicaid Services ("CMS") designated The Villages as a Special Focus Facility, a designation reserved for the poorest performing nursing homes in the country.[6] As shown below, the Attorney General's Medicaid Fraud Control Unit ("MFCU") has determined that The Villages' egregious mistreatment of residents continues to date and has seemingly not been deterred by Petitioner's investigation, and other repeated notifications of deficiencies, including DOH surveys, consultant reports, news media reports, and resident family complaints.

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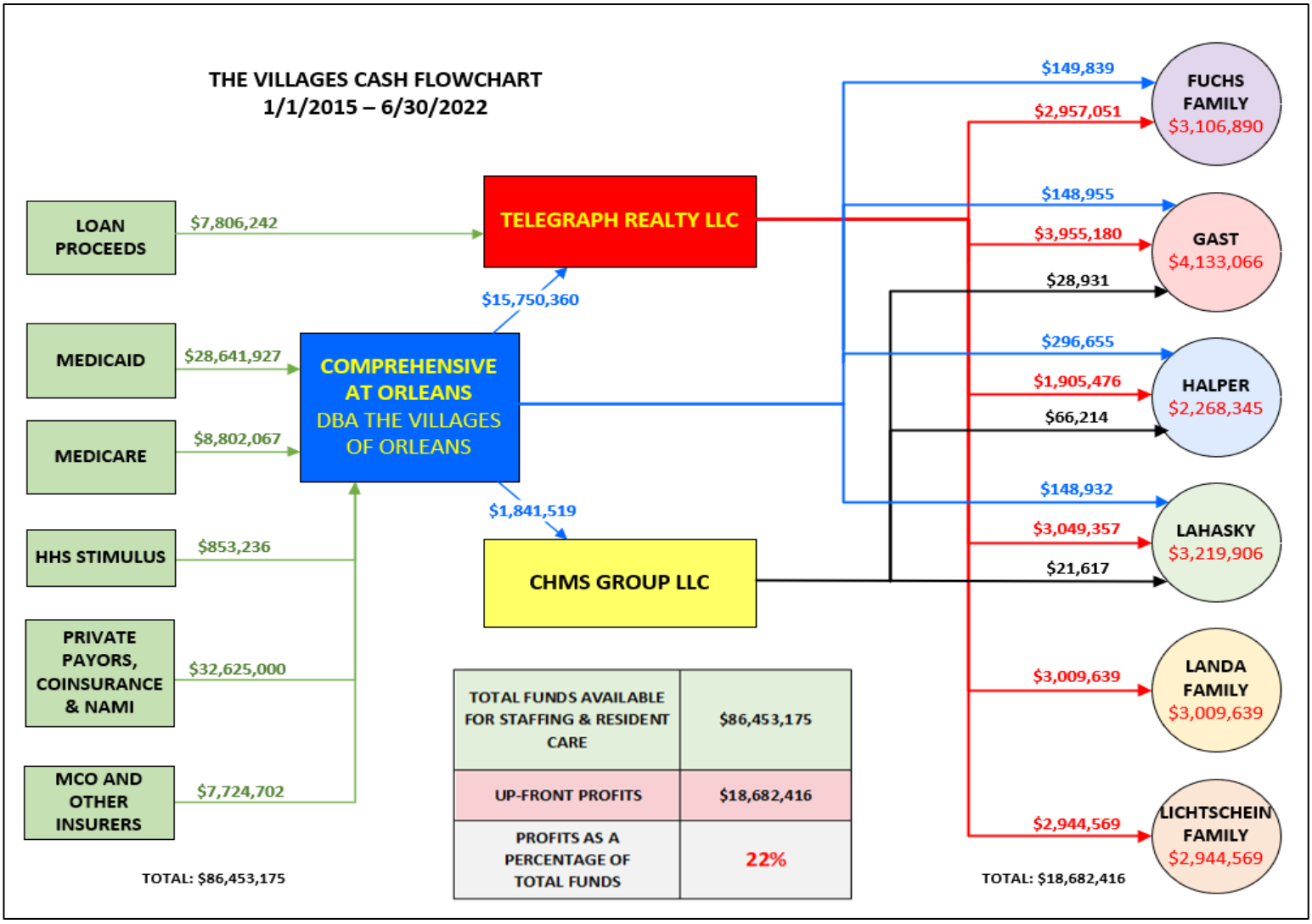
[4] The Attorney General anticipates that the Respondents will cynically attempt to shield themselves by asserting a defense under the short-lived COVID-19 emergency immunity statute intended to protect the heroic healthcare workers who had to make difficult triage and treatment decisions under emergency circumstances. That law, Public Health Law §§ 3081-82, was enacted on March 7, 2020, modified on August 3, 2020, to limit its scope to COVID-19 cases only, and 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 the harms were entirely the result of unrelated financial decisions carried out as part of a pre-existing and on-going scheme to extract funds from the nursing home facility without regard to professional standards and regulatory requirements related to the delivery of competent, quality care. More importantly, the acts and omissions of Respondents, as shown herein, long predate the COVID-19 pandemic and their depredations and looting have continued after the expiration of the declaration of emergency.

[5] Less than 2% of nursing home facilities in New York State received an Immediate Jeopardy finding in 2020.

[6] As of November 2021, only three out of 613 facilities in New York State were designated as Special Focus Facilities.

8. Neglect and mistreatment of The Villages' residents could have been prevented by Respondents' appropriate investment in resident care and staffing. Instead, as the below cash flow chart illustrates, the funds paid to The Villages and Respondents' real property holding company, Telegraph Realty LLC ("Telegraph"), including tens of millions of dollars in taxpayer funds to provide healthcare to vulnerable residents, flowed from The Villages' and Telegraph's bank accounts to Respondents' bank accounts, resulting in over $18.6 million in "up-front profit." Critically, Respondents did not re-invest these funds to improve the building, operations or quality of life and care for residents at The Villages. Respondents' looting of The Villages began well before the onset of the COVID-19 pandemic. Of the over $18.6 million in "up-front profit" shown below, Respondents took over $10 million before 2020 – leaving the facility in a precarious position to face the COVID-19 pandemic. Respondents achieved this through, among other things, causing The Villages to pay an outsized portion of its annual revenue to Telegraph in the form of inflated "rent" payments, dwarfing the percentage of revenue allocated to rent at similarly situated facilities. Moreover, this looting of The Villages' funds continues to the present day, while residents at The Villages continue to suffer.



NEED FOR INJUNCTIVE RELIEF, RESTITUTION, DISGORGEMENT, RESCISSION, CIVIL PENALTIES, COSTS, AND REFORM

9. To protect The Villages' vulnerable residents, judicial intervention is required now to enjoin Respondents' persistent fraudulent and illegal conduct. In addition to enjoining Respondents' persistent fraud and illegality in their operation of The Villages, Petitioner also seeks restitution and disgorgement of the illegally converted funds that Respondents fraudulently transferred to themselves, while disregarding and violating The Villages' duty under state and federal regulations to provide required care to, and staffing for, its residents. Respondents retained

the Medicaid funds without right under Executive Law § 63-c, and violated federal law with respect to Medicare funds. The Attorney General's MFCU may recover Medicare funds diverted in connection with schemes to defraud the New York State Medicaid Program upon approval of the United States Department of Health and Human Services, Office of the Inspector General ("HHS OIG"). (*See* 42 USC § 1396b[q][3].) HHS OIG has authorized MFCU to recover Medicare funds in this proceeding pursuant to 42 USC § 1396b(q)(3). (Affirmation of Special Assistant Attorney General Soo-young Chang ["SAAG Aff."] ¶ 5.)

10. Public Health Law § 2801-c further 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.[7] Pursuant to Public Health Law § 2801-c, the Commissioner of Health has specifically requested that the Attorney General seek such injunctive relief in this action, in addition to any other remedies available by law. (*Id*. ¶ 6, Ex. 40.)

11. Respondents' fraudulent and illegal conduct is detailed throughout this Petition and the accompanying affidavits. Petitioner recognizes that this Petition and supporting documents are voluminous but respectfully submits that the length and breadth of this Petition are justified by the scope of the findings, which are vast and necessary to convey the toll of Respondents' actions and the urgent need for reform. As shown, the Attorney General's finding that The Villages' residents suffered harm and neglect due to Respondents' repeated decisions to funnel millions of dollars out

[7] Article 28 of the Public Law Health governs residential health care facilities such as The Villages. (*See* PHL § 2800, *et seq.*)

of the facility is supported by the facility's CMS ratings,[8] which dropped in every category after Respondents took control of The Villages, ranking it among the worst in the state (*see* pp. 29-32). Yet, while these objective metrics provide insight into The Villages' functioning, they cannot tell the whole story. Other instances of harm and neglect included failure to: (1) follow resident care plans, meaning that The Villages failed to appropriately monitor residents at risk for suicide and safely supervise and assist residents to prevent falls (*see* pp. 33-40); (2) manage physician-ordered medications and monitor medical conditions, for example failing to obtain one resident's seizure medications and schedule a biopsy for another (*see* pp. 40-44); (3) provide proper nutritional support and weight monitoring, leading one resident to lose 60 pounds in three months (*see* pp. 44-48); (4) provide proper wound care, causing residents to develop gangrene and other dangerous infections (*see* pp. 49-53); (5) meet basic care needs, leaving residents unattended in dirty adult diapers (*see* pp. 53-59); (6) complete and maintain accurate medical records (*see* pp. 59-61); and (7) communicate vital health information to families and loved ones, all simultaneous with Respondents' constant drive to admit new residents into The Villages for more revenue (*see* pp. 61-72). The Villages' residents were further endangered by Respondents' failure during the pandemic to ensure proper infection control, including The Villages' delayed and secretive response to COVID-19 infections, pressure on staff to work while sick, and failure to provide adequate health screening (*see* pp. 72-80). DOH surveys and citations, along with third-party consultant evaluations, further echoed these findings and put Respondents on notice of regulatory violations and resident endangerment (*see* pp. 80-93).

[8] CMS publishes nursing home ratings for each nursing home in the country based on required data reported by the facility and on official inspections in the categories of Health Inspections, Staffing, Quality Measures, and overall ratings. (*See* CMS Care Compare, https://www.medicare.gov/care-compare/ [last accessed Nov. 14, 2022].) (Affidavit of Auditor-Investigator Milan Shah ¶ 51.)

12. Moreover, The Villages intentionally maintained chronically inadequate staffing levels in order to maximize Respondents' profits, and pressured or forced staff to: (1) perform work outside the scope of their qualifications; (2) work without adequate support from other personnel; and (3) work under substandard conditions, all while being paid low wages (*see* pp. 93-106). Indeed, Petitioner recognizes that Respondents will likely argue that the allegations herein are the result of negligent and lazy direct care staff. To the contrary, however, Petitioner's extensive investigation found that the Respondents themselves are responsible for egregious conditions at The Villages, including through their intentional and reckless decision to deprive healthcare workers of the resources and supervision needed to succeed.

13. Respondents' fraudulent conduct included a scheme to hide the facility's true owners and operators from DOH, and to hide the true nature of The Villages' lease agreement with Telegraph. The lease agreement is the vehicle through which Respondents funnel money from The Villages to themselves to create automatic profits, prior to ensuring that The Villages expends sufficient funds on staffing and resident care to meet its legal duties (*see* pp. 123-28). The practice of making payments from the nursing home to Respondents in 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 uses the public funds it receives to meet the nursing home's duty to provide required care, with sufficient staffing to render such care, to its residents is referred to herein as "Up-Front Profit."

14. Through this Petition, Petitioner requests that the Court put a stop to this tragedy and hold the Respondents accountable. Accordingly, for the reasons stated herein, the Attorney General respectfully asks the Court to issue promptly an Order, *inter alia*: (1) permanently enjoining Respondents from engaging in the illegal, fraudulent, and deceptive conduct alleged

herein, including further violation of state and federal nursing home regulations, and fraudulent and illegal acts and practices relating to reimbursement by the New York State Medicaid Program; (2) appointing a receiver and financial monitor to oversee The Villages' financial operations and a healthcare monitor to oversee The Villages' healthcare operations; (3) enjoining The Villages from accepting any admissions of new residents until such time as The Villages meets its obligations to ensure sufficient care and staffing for all existing residents and any new residents; (4) directing Respondents to fully account for and disgorge all monies wrongfully received; and (5) removing Respondents Gast, Halper, and Lahasky immediately and permanently from any role at The Villages and any related entity.

JURISDICTION, VENUE, AND REGULATORY FRAMEWORK

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

16. The Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General of the State of New York is responsible for investigating and prosecuting healthcare providers and associated persons engaged in civil and criminal fraud against the Medicaid and Medicare Programs and for protecting the State's vulnerable nursing home residents from exploitation, abuse, and neglect by providers. The investigation leading to this proceeding was undertaken pursuant to the well-established authority vested in the Office of the Attorney General ("OAG") by the Executive Law, New York Medicaid rules and regulations, and MFCU's federal grant of authority under the Social Security Act and its Medicaid and Medicare Program regulations to investigate and prosecute provider fraud and nursing home resident abuse and neglect. (*See* Exec. Law § 63[12]; 42 USC 1396b[q]; 42 CFR §§ 1007.11[a][2], [b].)

17. 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 fraudulent or illegal acts" or "persistent fraud or illegality."[9] (*See* Exec. Law § 63[12] ["Whenever 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].)

18. 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, then they must be tried "forthwith." (CPLR 410.) It is the very purpose of a special proceeding to provide a summary remedy.

19. Further, the Attorney General is empowered under the Tweed Law to investigate the misappropriation and misuse of any government funds. (*See* Exec. Law § 63-c; *see also Cuomo v. Ferran*, 77 AD3d 698, 701-02 [2d Dept 2010]; *State of New York v Franklin Nursing Home*, 65

[9] 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]; *People v. Empyre Inground Pools, Inc.*, 227 AD2d 731, 733 [3d Dept 1996]; *Lefkowitz v. E.F.G. Baby Products*, 40 AD2d 364 [3d Dept 1973]; *State v. Mgmt. Transition Res.*, 115 Misc 2d 489 [Sup Ct, New York 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].)

AD2d 788, 788-89 [2d Dept 1978] [Attorney General on behalf of State may recover Medicaid overpayments].)

APPLICABLE REGULATIONS

20. Medicaid is a joint state and federal program designed to provide medical care to those who would not otherwise be able to afford it. It is primarily funded by New York State and federal funds. Medicare is a federally funded program that provides medical care for the elderly and disabled. To participate in Medicare and Medicaid, nursing homes such as The Villages, like all providers enrolled in government-funded healthcare programs, must obtain authorization from DOH and must agree to comply with certain federal and state regulations. (*See* 42 CFR § 424.5; 10 NYCRR § 504.3; *see also* 42 USC § 1396r; 10 NYCRR § 415.1.)

21. In New York, Public Health Law § 2803 empowers DOH to adopt and amend rules and regulations, which are codified at 10 NYCRR §§ 410-415, along with a system of penalties for continuing violations of said rules and regulations. (*See* PHL § 2803[6].) Nursing homes within New York State receiving Medicare and Medicaid funds are also required to comply with federal nursing home regulations, which are predominately set forth in The Federal Nursing Home Reform Act, at 42 CFR § 483, as amended.

22. 18 NYCRR § 504.6(d) further requires that healthcare providers, including nursing homes, submit Medicaid claims for reimbursement only for services provided, in compliance with Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State.

PARTIES

Petitioner

23. 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 investigate, to apply for an injunction, and to seek restitution for repeated or persistent fraudulent or illegal practices in the

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

Corporate Respondents

The Villages – the Nursing Home Facility

24. At all relevant times herein, Comprehensive at Orleans LLC, doing business as The Villages of Orleans Health and Rehabilitation Center, was and still is a domestic limited liability company formed in February 2014 under the laws of the State of New York with offices at 14012 Route 31, Albion, New York. Comprehensive at Orleans LLC owned, operated, managed, directed, administered, and/or assumed responsibility for the 120-bed nursing home facility named The Villages of Orleans Health and Rehabilitation Center, located at the same address, 14012 Route 31, Albion, New York, at all relevant times since 2015.

25. Respondent Bernard Fuchs is the sole approved and official owner and operator of The Villages, and has been so since Respondents purchased the facility from Orleans County in 2015. However, as set forth below, numerous other Respondents in fact exercise management authority and control over The Villages and benefit financially from The Villages.

Telegraph Realty – the Real Property Holding Company

26. At all relevant times herein, Telegraph Realty LLC was and still is a domestic limited liability company formed in January 2014 under the laws of the State of New York, with offices for the transaction of business located at 14012 Route 31, Albion, New York. Telegraph acquired The Villages' real property from Orleans County effective January 1, 2015, owns the real property where The Villages is located, and was formed for that purpose. In total, The Villages and Telegraph paid Orleans County $7.8 million to purchase the facility's real property and business assets. (Affidavit of Auditor-Investigator Milan Shah ["Auditor Aff"] ¶ 9.) The Villages

is a party to a self-dealing and predatory lease agreement pursuant to which The Villages has paid "rent" to Telegraph since 2015. (*See id*. ¶¶ 179, 215-219.) Telegraph owns no other properties and the "rent" payments from The Villages are its sole significant source of revenue. (*See* SAAG Aff., Ex.1 at 79:18 – 80:24.)

27. At all relevant times since on or about 2015, Telegraph's members have been as follows: Bernard Fuchs (3.32%), Joel Edelstein (3.32%), Israel Freund (3.32%), Gerald Fuchs (3.32%), Tova Fuchs (3.32%); Villages of Orleans LLC (entity controlled by David Gast) (20.99%); Sam Halper (12.33%); Ephram Lahasky (16.6%); Benjamin Landa (16.6%); Teresa Lichtschein (7.5%), and Debbie Korngut (9.16%).[10] (Auditor Aff. ¶ 10.)

CHMS Group – the Management Company

28. At all relevant times herein, CHMS Group LLC ("CHMS Group"), was and still is a domestic limited liability company formed in January 2015 under the laws of the State of New York, with offices for the transaction of business located at 600 Broadway, Lynbrook, New York. CHMS Group provides so-called "administrative services" to The Villages, including purchasing, accounting, insurance billing, and payroll services. At all relevant times herein, CHMS Group's members have been as follows: David Gast (33.33%), Sam Halper (33.34%), and Ephram Lahasky (33.33%). Sam Halper is CHMS Group's managing member. (*Id*. ¶¶ 13-14.)

Villages of Orleans LLC – the Pass-Through Entity

29. At all relevant times herein, Villages of Orleans LLC ("Gast LLC") was and still is a domestic limited liability company formed in March 2015 under the laws of the State of New

[10] Pursuant to Telegraph's 2014 Operating Agreement, the members of Telegraph were David Gast (25%), Ephram Lahasky (37.5%), and Joshua Farkovits (37.5%). In 2015, Respondents executed the Amended Operating Agreement establishing the ownership composition set forth above. (Auditor Aff. ¶¶ 10-11.)

York, with offices for the transaction of business located at 14012 Route 31, Albion, New York 14411. Gast LLC has a 20.99% ownership interest in Respondent Telegraph. (*Id*. ¶ 10.) Respondent David Gast controls Gast LLC. (*Id*. ¶¶ 17-20.)

ML Kids Holding LLC – the Holding Company

30. At all relevant times herein, ML Kids Holdings LLC ("Lahasky LLC") was and still is a limited liability company formed in 2018 under the laws of the State of Delaware, with offices for the transaction of business located in Lawrence, New York. During the relevant period, Lahasky LLC received over $1.5 million in cash distributions from Telegraph. Respondent Lahasky controls Lahasky LLC. (*Id*. ¶¶ 21-22, 183 n.49.)

Individual Respondents

31. The Individual Respondents[11] are the individuals who own, control, and financially benefit from the Respondent entities that operate The Villages. As detailed herein, Respondents Bernard Fuchs, David Gast, Sam Halper, and Ephram Lahasky are the individuals who control The Villages' operations and finances. As individuals with a financial interest in Telegraph, the other Individual Respondents colluded with these controlling Respondents to siphon taxpayer funds out of the facility and away from residents for their own personal profit.

Fuchs Family Group

32. Respondent Bernard Fuchs ("Fuchs") resides in Nassau County, New York. At all relevant times, by virtue of his 100% ownership of The Villages, Bernard Fuchs was responsible for: (a) ensuring that The Villages provided the required supervision, care, and services to its residents that met the standards imposed by New York State, as established by DOH; (b) assuring

[11] As used herein, "Individual Respondents" means Bernard Fuchs, Joel Edelstein, Israel Freund, Gerald Fuchs, Tova Fuchs, David Gast, Sam Halper, Ephram Lahasky, Benjamin Landa, Joshua Farkovits, Teresa Lichtschein, and Debbie Korngut.

the protection of The Villages' residents' rights; and (c) promoting the social, physical, and mental well-being of The Villages' residents. (*See* 10 NYCRR § 415.1[a][1]-[2] [describing the "special obligation" of New York's residential health care facilities to "assure the highest practicable quality of life" for each individual resident].) Fuchs is a member (3.32%) of Respondent Telegraph. As of 2020, Fuchs' estimated net worth was approximately $43.89 million. (Auditor Aff. ¶¶ 23-24.) Under examination by OAG, Fuchs testified that he has ownership shares in eight additional nursing homes in New York State, and in 12 nursing homes in the state of Kentucky. (SAAG Aff., Ex. 2 at 12:1 – 15:4.)

33. Respondent Joel Edelstein ("Edelstein") resides in Nassau County, New York, and has been a member (3.32%) of Respondent Telegraph at all relevant times since 2015. Upon information and belief, Edelstein is Respondent Fuchs' son-in-law. (Auditor Aff. ¶ 25.)

34. Respondent Israel Freund ("Freund") resides in Kings County, New York, and has been a member (3.32%) of Respondent Telegraph at all relevant times since 2015. Upon information and belief, Freund is Respondent Fuchs' son-in-law. (*Id*. ¶ 26.)

35. Respondent Gerald Fuchs ("G. Fuchs") resides in Nassau County, New York, and has been a member (3.32%) of Respondent Telegraph at all relevant times since 2015. Upon information and belief, G. Fuchs is Respondent Fuchs' son. (*Id*. ¶ 27.)

36. Respondent Tova Fuchs ("T. Fuchs") resides in Nassau County, New York, and has been a member (3.32%) of Respondent Telegraph at all relevant times since 2015. Upon information and belief, T. Fuchs is Respondent Fuchs' daughter-in-law. (*Id*. ¶ 28.)

37. Together, members of the Fuchs family own 16.6% of Telegraph.

David Gast

38. Respondent David Gast ("Gast") resides in Nassau County, New York. At all relevant times, by virtue of his managerial involvement at The Villages, Gast was responsible for: (a) ensuring that The Villages provided sufficient supervision, care, and services to its residents that met the standards imposed by New York State, as established by DOH; (b) assuring the protection of The Villages' residents' rights; and (c) promoting the social, physical, and mental well-being of The Villages' residents. (*See* 10 NYCRR § 415.1[a][1]-[2].) Gast controls Gast LLC, a pass-through entity that holds a 20.99% ownership interest in Respondent Telegraph; and is a member (33.3%) of Respondent CHMS Group. As of 2020, Gast's estimated net worth was approximately $22.19 million. (Auditor Aff. ¶ 30.) Gast testified that, in addition to The Villages, he owns one other nursing home in Western New York, and more than 40 nursing homes outside of New York State. He also owns a share of Diversicare, a company that owns over 60 nursing homes throughout the country. In total, Gast has an ownership share in more than 100 nursing homes. (SAAG Aff., Ex. 1 at 18:5 – 21:18.)

Sam Halper

39. Respondent Sam Halper ("Halper") resides in Miami-Dade County, Florida. At all relevant times, by virtue of his managerial involvement at The Villages, Sam Halper was responsible for: (a) ensuring that The Villages provided sufficient supervision, care, and services to its residents that met the standards imposed by New York State, as established by DOH; (b) assuring the protection of The Villages' residents' rights; and (c) promoting the social, physical, and mental well-being of The Villages' residents. (*See* 10 NYCRR § 415.1[a][1]-[2].) Halper is also a 12.33% member of Respondent Telegraph; and is the managing member (33.4%) of Respondent CHMS Group. (Auditor Aff. ¶ 31.) Respondent Halper is under federal indictment in

the United States District Court for the Western District of Pennsylvania for crimes relating to the submission of false reports to the Commonwealth of Pennsylvania and the U.S. Department of Health and Human Services, intended to cover up deficient levels of care and staffing at two Pennsylvania nursing homes. (*See* SAAG Aff., Ex. 3.) As of 2020, Halper's estimated net worth was approximately $22.89 million. (Auditor Aff. ¶ 32.)

Ephram Lahasky

40. Respondent Ephram Lahasky a/k/a "Mordy Lahasky" ("Lahasky") resides in Nassau County, New York. At all relevant times, by virtue of his managerial involvement at The Villages, Lahasky was responsible for: (a) ensuring that The Villages provided sufficient supervision, care, and services to its residents that met the standards imposed by New York State, as established by DOH; (b) assuring the protection of The Villages' residents' rights; and (c) promoting the social, physical, and mental well-being of The Villages' residents. (*See* 10 NYCRR § 415.1[a][1]-[2].) Lahasky is a member (16.6%) of Respondent Telegraph; and is a member (33.3%) of Respondent CHMS Group. As of 2020, Lahasky's estimated net worth was approximately $72.74 million. (Auditor Aff. ¶¶ 33-34). Lahasky testified that he owns three nursing homes in New York State and several hundred nursing homes outside of New York State, including approximately 65 homes via his ownership interest in Diversicare. He believes himself to be the "largest [nursing home] operator in Pennsylvania," with approximately 70 facilities. (SAAG Aff., Ex. 4 at 16:11 – 17:19.)

Landa Family Group

41. Respondent Benjamin Landa ("Landa") resides in Nassau County, New York, and has been a member (16.66%) of Respondent Telegraph at all relevant times since 2015. As of

December 2016, Landa's estimated net worth was approximately $308.06 million. (Auditor Aff. ¶ 35.)

42. Respondent Joshua Farkovits ("Farkovits") resides in Israel. Prior to 2015, Joshua Farkovits was a member (37.5%) of Respondent Telegraph.[12] Upon information and belief, Farkovits is the son-in-law of Respondent Benjamin Landa. As of 2017, Farkovits' estimated net worth was approximately $22 million. (*Id*. ¶¶ 36-38.)

43. Together, members of the Landa family group own 16.66% of Telegraph.

Lichtschein Family Group

44. Respondent Teresa Lichtschein ("Lichtschein") resides in Kings County, New York, and has been a member (7.5%) of Respondent Telegraph at all relevant times since 2015. (*Id*. ¶ 40.)

45. Respondent Debbie Korngut ("Korngut") resides in Ocean County, New Jersey, and has been a member (9.16%) of Respondent Telegraph at all relevant times since 2015. Upon information and belief, Korngut is the daughter-in-law of Lichtschein. (*Id*. ¶ 41.)

46. Together, the Lichtschein family group owns 16.66% of Telegraph.

ATTORNEY GENERAL'S FINDINGS OF FACT

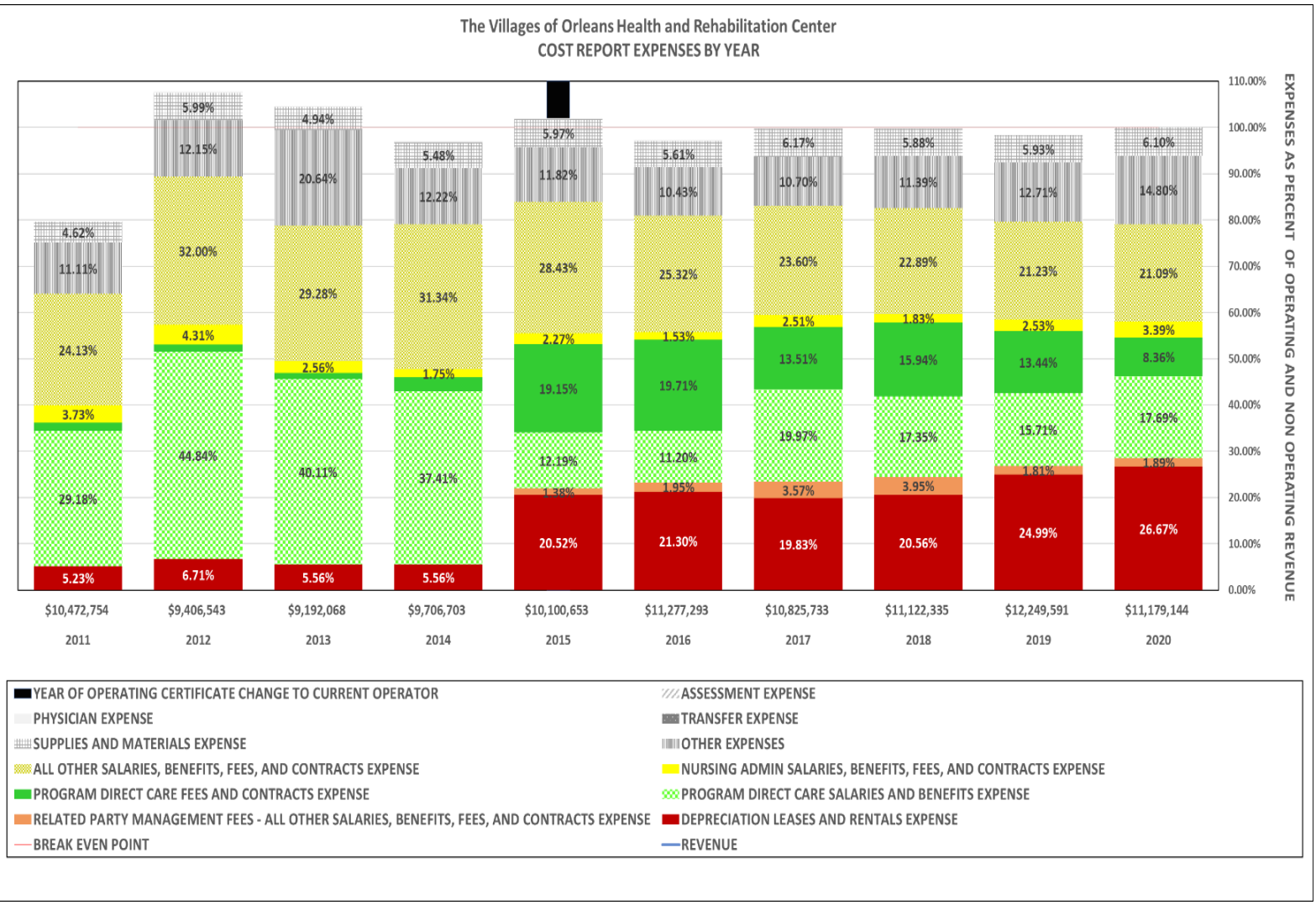
47. According to The Villages' Medicaid Cost Reports,[13] from 2015 through 2021, The Villages reported total net revenue from the New York State Medicaid Program of approximately

[12] Although no longer an official member of Telegraph per the company's Amended Operating Agreement, Farkovits continues to receive distributions from Telegraph as if he owns an approximately 8% share (*i.e.*, one-half of his father-in-law, Benjamin Landa's, share). (Auditor Aff. ¶ 37.)

[13] Pursuant to 10 NYCRR § 86-2.2, nursing home providers are required to submit complete and accurate annual financial and statistical reports ("Medicaid Cost Reports") to DOH. These reports include revenues, expenses, assets, liabilities, and statistical data. The data is used by DOH to develop Medicaid rates, assist in the formulation of reimbursement methodologies, and analyze trends. (Auditor Aff. ¶ 220.)

$48.67 million and total net revenue from the Medicare Program of approximately $10.58 million. (*Id*. ¶¶ 171-72.) As a condition of receipt for these funds, The Villages was obligated to follow applicable laws and regulations ensuring that it provided sufficient care and staffing to protect its vulnerable residents. As detailed below, Respondents chose to siphon millions out of the facility for their own personal profit, leaving the facility with insufficient resources to safely care for its residents.

48. MFCU further found that Respondents encouraged a false impression that Medicaid reimbursement rates are too low to enable profit. The chart below was created from data in the Medicaid Cost Reports that The Villages filed with DOH from 2015 to 2020 (and that Orleans County filed in previous years) and reflects that Respondents manipulated The Villages' expenses, including through related-party transactions, to ensure that its reported expenses and revenue netted out to almost even in 2015 through 2020. This careful orchestration of its financial operations creates the false impression that The Villages is an unprofitable investment. To the contrary, those who control it have extracted millions of dollars each year in "up-front profit" through related-party transactions – principally causing The Villages to pay "rent" to Telegraph well in-excess of fair market value, causing The Villages to pay over $2 million in purported "management" fees and other payments to related parties, and using the facility as collateral to secure and cash in on multi-million dollar loans that provided no benefit for the residents. (*See id*. ¶¶ 179-99.)



I. Respondents Gast, Halper, and Lahasky Are De-Facto Owners of The Villages and Abdicated Their Responsibility to Provide Adequate Care; Other Respondents Contributed Nothing and Made Millions.

49. Respondents falsely listed Bernard Fuchs as 100% owner of The Villages in submissions to DOH and on corporate organizing documents in an intentional scheme to mislead DOH about the identities of the individuals who planned to, and did in fact, exercise control over The Villages from day one – all in an effort to evade DOH scrutiny and fast track licensing. In reality, Fuchs played the role of a silent, minority partner, with little inclination or authority to

interfere in The Villages' operations. In fact, under examination by OAG, Fuchs testified that he has never even visited the facility. (SAAG Aff., Ex. 2 at 134:13 – 15; *see also id.*, Ex. 5 at 79:9 – 14 [The Villages' Administrator testifying that he has never spoken to Fuchs although his name "sounds familiar"].) On the other hand, Respondents Gast, Halper, and Lahasky saw themselves as the "Three Musketeers," sharing authority over and responsibility for finances, staffing, budgeting, and high-level decision making at The Villages. (*Id.*, Ex. 4 at 40:3 – 42:19.)

A. Respondent David Gast in Fact Owns, Manages, and Controls The Villages.

50. Evidence shows that, despite the fact that Respondent Gast was not disclosed to DOH as an owner/operator, or approved as such, Gast owned, managed, and operated The Villages through the exercise of decision making authority. For example, in 2015, Gast executed a contract on behalf of The Villages to retain a medical laboratory to perform laboratory testing services for residents. Gast signed this contract as a "member" of The Villages. (Auditor Aff., Ex. 18 at 8.)

51. Similarly, in 2016, Gast executed a contract on behalf of The Villages to retain a staffing agency to provide nursing staff. Gast signed this contract as a "member" of The Villages. (*Id.*, Ex. 19 at 3.)

52. Gast is a signatory for The Villages' checking account with The Private Bank. This is the account where the New York State Medicaid Program and the Medicare Program sent millions of dollars in electronic funds transfers ("EFTs") as reimbursement for patient care.[14] (*Id.* ¶ 7.) Yet again, Gast signed the signature card for this account as a "member" of The Villages. (*Id.*, Ex. 2 at 1.)

[14] Bernard Fuchs, The Villages' sole "official" (but in fact nominal) owner per submissions to DOH and corporate organizing documents, is not a signatory on this critical account, and testified that he did not know it existed. (*See* Auditor Aff. ¶ 7; SAAG Aff., Ex. 2 at 86:23 – 25.)

53. As detailed below, emails and testimony from staff confirm that Respondent Gast performed a high-level managerial role at The Villages. Testimony from certain individuals further reinforces Respondent Gast's control. For example, Gast testified that the Regional Administrator responsible for overseeing The Villages and another local facility reports to him, as well as Halper and Lahasky. (SAAG Aff., Ex. 1 at 218:24 – 219:16.) Lahasky also testified that Gast played an operational role at The Villages. (*Id*., Ex. 4 at 41:9 – 42:19.) Jason Teitelbaum, Administrator at The Villages, referred to Gast, Halper, and Lahasky as "operators" of The Villages. (*Id*., Ex. 5 at 284:13-17.)

B. Respondent Sam Halper in Fact Owns, Manages, and Controls The Villages.

54. Respondent Halper, like Respondent Gast, exercised de-facto control over The Villages, despite not being disclosed to DOH as an owner/operator or approved as such. For example, in 2015, Halper signed a contract to retain a radiology provider to perform portable radiology services at The Villages. Halper signed this agreement as the "CEO" of The Villages. (Auditor Aff., Ex. 20 at 5.)

55. In 2015, 2016, and 2017, Sam Halper executed annual Medicaid Cost Report Certifications on behalf of The Villages. (*Id*., Ex. 67.)

56. Sam Halper is a signatory for The Villages' checking account at The Private Bank (the account that received tens of millions in Medicaid and Medicare EFTs). (*Id*., Ex. 2 at 2.)

57. As detailed below, emails and testimony from staff reflect that Halper performed a high-level managerial role at The Villages. For example, in April 2020, Halper decided not to offer COVID-19 hazard pay for social workers at The Villages. (*See* SAAG Aff., Ex. 6.) Testimony from certain individuals further confirms that Halper exercised de facto control at The Villages. For example, Fuchs testified that Halper "was on the ground. He was the one that was in the

facility, operating the facility, resident care, all that." (*Id.*, Ex. 2 at 96:13-16.) Administrator Jason Teitelbaum testified that if there was an issue at The Villages on "an operational level," he would contact Sam Halper. (*Id.*, Ex. 5 at 32:15-18; *see also id.* at 39:16 – 40:6 [testifying that he would contact Sam Halper if there was a question, problem, concern or complaint with "the building or anything in the facility" and "in the event there were issues with the operation day-to-day"] and 284:13-17 [referring to Halper, Gast, and Lahasky as "operators" of The Villages].) Administrator Teitelbaum also testified that Halper personally asked him to become the Administrator at The Villages. (*Id.*, Ex. 5 at 75:3-13.)

C. Respondent Ephram Lahasky in Fact Owns, Manages, and Controls The Villages.

58. Respondent Lahasky exercised de facto control over The Villages, despite not being disclosed as an owner/operator to DOH, or approved as such, and despite the fact that he testified that he "can't manage . . . a falafel stand." (*Id.*, Ex. 4 at 196:22-23.) For example, in 2014, Lahasky executed the Purchase and Sale Agreement with Orleans County Health Facilities Corporation as an "authorized member" on behalf of The Villages.[15] Lahasky further personally guaranteed payment of the $7.8 million purchase price. (Auditor Aff., Ex. 4 at 35, 38.)

59. In 2014, Lahasky held himself out to the U.S. Internal Revenue Service ("IRS") as sole member of The Villages, according to an IRS letter addressed to Lahasky and issuing an employer identification number to The Villages. (*Id.*, Ex. 21.)

60. Additionally, Lahasky executed The Villages' 2015 Medicaid Billing Certification, an attestation expressly reserved for partners, officers, or directors of the provider. (*Id.*, Ex. 22.)

[15] Further illustrating the illusory separation between The Villages and Telegraph, Lahasky signed the Purchase and Sale Agreement on behalf of Telegraph as well. (Auditor Aff., Ex. 4 at 35.)

61. Along with Gast and Halper, Lahasky is a signatory for The Villages' checking account at The Private Bank. Lahasky signed the signature card as a "member" of The Villages. (*See id.*, Ex. 2 at 1.) Lahasky is also a signatory for The Villages' checking account at Five Star Bank, which received tens of millions of dollars in resident private pay and individual contributions towards the cost of Medicaid care. (*Id.* ¶ 177.) Lahasky signed the signature card for this account as the "Secretary" of The Villages. (*Id.*, Ex. 3 at 3.)

62. As detailed below, emails and testimony from staff reflect that Lahasky performed a high-level managerial role at The Villages. For example, staff testified that Lahasky exerted pressure to increase admissions at The Villages until all 120 beds were full. (*See* ¶ 156, *infra*.) Bernard Fuchs testified that Lahasky was at the "top of the pyramid," responsible for handling lease agreements, bank accounts, and managing operations at The Villages. (SAAG Aff., Ex. 2 at 96:21 – 97:1.) Jason Teitelbaum, Administrator at The Villages, referred to Lahasky, Gast, and Halper as "operators" of The Villages. (*Id.*, Ex. 5 at 284:13-17.)

D. Respondents Edelstein, Freund, G. Fuchs, T. Fuchs, Landa, Farkovits, Lichtschein, and Korngut Get Money for Nothing.

63. Respondents Edelstein, Freund, G. Fuchs, T. Fuchs, Landa, Farkovits, Lichtschein, and Korngut made money while abdicating their duties to the residents of The Villages. During the period January 2015 through June 2022:

- Respondent Edelstein made over $589,000 from The Villages and Telegraph, although he contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent Freund made over $598,000 from The Villages and Telegraph, although he contributed nothing and failed to prevent the abuse and neglect described herein;

- Respondent G. Fuchs made over $589,000 from The Villages and Telegraph, although he contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent T. Fuchs made over $589,000 from The Villages and Telegraph, although she contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent Landa made over $1.49 million from The Villages and Telegraph, although he contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent Farkovits made over $1.5 million from The Villages and Telegraph, although he contributed nothing and failed to prevent the abuse and neglect described herein;
- Respondent Lichtschein made over $1.36 million from The Villages and Telegraph, although she contributed nothing and failed to prevent the abuse and neglect described herein; and
- Respondent Korngut made over $1.58 million from The Villages and Telegraph, although she contributed nothing and failed to prevent the abuse and neglect described herein.

(*See* Auditor Aff. ¶¶ 183, 186, 190.)

II. Respondents' Decision to Funnel Money Out of the Facility Causes The Villages' Residents to Suffer Harm and Neglect.

64. In numerous ways, many of which are set forth in this Petition, and all of which were preventable, Respondents persistently and illegally violated a litany of laws and regulations, including sections of 10 NYCRR § 415 that impose many obligations on nursing home operators

to provide vulnerable residents with care to meet their needs in what for the vast majority of nursing home residents will be their "last home." (10 NYCRR § 415.1[a][1].)

A. After Respondents Took Control of The Villages, Its CMS Nursing Home Ratings Dropped in Every Category and Its Specific Quality Measures Became Among the Worst in the State.

65. CMS publishes nursing home ratings in the following categories: 1) Health Inspections; 2) Staffing; 3) Quality Measures; and 4) Overall ratings for each nursing home in the country. These ratings are published on the CMS "Care Compare" website.[16] CMS created this Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily. The ratings are based on required data reported by the facility and on official inspections; the ratings are not matters of consumer opinion. (Auditor Aff. ¶ 51.)

66. CMS rates each nursing facility on a scale of 1 to 5 stars. CMS designates a 1-Star rating to mean "MUCH BELOW AVERAGE," a 2-Star rating to mean "BELOW AVERAGE," a 3-Star rating to mean "AVERAGE," a 4-Star rating to mean "ABOVE AVERAGE," and a 5-Star rating to mean "MUCH ABOVE AVERAGE." (*Id.* ¶ 52.)

67. **"One Star" Overall Rating:** The CMS Overall rating is based on the Health Inspection, Staffing, and Quality Measures ratings. The Villages' CMS star ratings declined in every category when Respondents took control of The Villages from Orleans County in January 2015. (*Id.* ¶ 53.)

68. Prior to Respondents' ownership and operation, in October 2014, CMS gave The Villages an Overall rating of 3-Stars. In February 2015, CMS decreased the Overall rating to 2-Stars. In April 2015, CMS decreased the Overall rating to 1-Star. The Villages languished at a 1-

[16] *See* CMS Care Compare, https://www.medicare.gov/care-compare/ (last accessed Nov. 17, 2022)

Star Overall rating until March 2021, at which point The Villages was designated as a Special Focus Facility ("SFF") by CMS. (*Id*. ¶¶ 54-57.) The SFF program addresses facilities that have: "[m]ore problems than other nursing homes (about twice the average number of deficiencies);" "more serious problems than other nursing homes (including harm or injury experienced by residents);" and "[a] pattern of serious problems that has persisted over a long period of time (as measured over approximately three years before the date the nursing home was first put on the SFF list)."[17] The program is intended to address facilities with a history of "yoyo," or "in and out" compliance.[18] While designated as an SFF facility, The Villages was not rated by CMS, per rule. On or around April 2022, CMS removed The Villages from the SFF list. As of November 1, 2022, The Villages' Overall rating was 1-Star. (*Id*. ¶¶ 98-100.)

69. **"One Star" Staffing:** The Villages' "Staffing" rating dropped to 1-Star under Respondents' ownership and operation, the lowest possible level, where it currently remains. (*See id*. ¶¶ 64-70, 100.)

70. **"One Star" Health Inspections:** The Villages' "Health Inspections" ratings dropped to 1-Star under Respondents' ownership and operation, the lowest possible level, where it currently remains. (*See id*. ¶¶ 58-63, 100.)

71. **Abysmal Quality Measures:** The Villages maintained a 3-Star Quality Measures rating from November 2020 until March 2021, which meant it was in approximately the bottom 20% of all New York nursing homes that participate in Medicaid or Medicare. (*See id*. ¶¶ 71-81.) The Villages' currently has a 2-Star Quality Measures rating, which is even worse. (*Id*. ¶ 100.)

[17] CMS, Special Focus Facility Program, at 1, available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFFList.pdf (last accessed Nov. 17, 2022).
[18] *See id*.

72. During the relevant period, CMS utilized 15 quality measures ("QMs") to calculate the Quality Measures Star rating. These QMs address a broad range of function and health status indicators. CMS assigned points for each QM based on clinical data self-reported by the nursing home. The Villages' residents were consistently at a much higher risk of injury and poor care than at other nursing homes in New York State, specifically:

- The Villages' residents consistently suffered more falls with major injuries than in other nursing homes in New York State (*see id*. ¶¶ 83-84);
- More Villages' residents suffered pressure sores than at other nursing homes (*see id*. ¶ 85);
- The Villages consistently scored in the bottom 10% (in some years in the bottom 5%) for the QM that captures percentage of short-stay residents with pressure sores that are new or whose existing pressure sores worsened during their stay in the SNF, including unstageable sores (*see id*. ¶ 86);
- The Villages used antipsychotic medications significantly more often than other nursing homes (*see id*. ¶¶ 87-89);[19]
- The Villages' residents visited the emergency room significantly more often than residents in other nursing homes (*see id*. ¶¶ 90-91);

[19] 10 NYCRR § 415.4(a) (as well as federal regulation) prohibits unjustified use of physical and chemical restraints, including psychotropic drugs. As explained in the Medical Analyst Affidavit, psychotropic drugs frequently act as a chemical restraint by causing side effects such as lethargy, increased falls, abnormal involuntary movements, lack of socialization, and a decline in physical function. Improper use of such restraints can lead to life-threatening injuries and/or death. Moreover, restraints can lead to a resident becoming emotionally withdrawn and cause them to experience a decrease in their self-esteem and, in turn, their quality of life. (*See* Medical Analyst Aff. ¶¶ 161-64.)

- The Villages' residents were re-admitted to the hospital significantly more often than residents at other nursing homes. In 2019 and 2021, The Villages scored in the bottom 10% in New York State for this QM (*see id*. ¶ 92);
- The Villages had fewer successful discharges to the community than most other nursing homes in New York State (*see id*. ¶ 93); and
- Residents' ability to perform activities of daily living (*e.g.*, bathing, walking, toileting, transferring, dressing) and move independently worsened at The Villages (*see id*. ¶¶ 94-95).

73. Asked whether he was aware of these and other abysmal QMs at The Villages, Respondent Halper refused to answer and asserted his right against self-incrimination under the Fifth Amendment of the United States Constitution and the New York State Constitution, stating "I plead the Fifth." (SAAG Aff., Ex. 7 at 80:2 – 81:17.)

74. These dismal ratings were more than just numbers. Through interviews with residents and family members; examinations of front-line staff, managers, and executives; extensive review of documents, including emails, text messages, patient charts, and regulatory deficiencies; and data analyses, MFCU established a pattern of Respondents' systemic understaffing and cost cutting at The Villages, which caused physical and emotional harm to vulnerable residents, stripped residents of their dignity, and enabled Respondents to profit enormously from their ownership of the facility and its related companies.

B. The Villages Does Not Create, Follow, and Update Residents' Care Plans, Leading to Resident Harm, Accidents, and Injuries.

75. Per professional standards and regulatory requirements, "care plans" are the essential game plan for understanding and caring for a nursing home resident. MFCU found significant evidence that The Villages failed to create comprehensive and timely plans of care,

failed to follow residents' plans of care, and that care plans were not updated with vital health and safety information identifying resident care needs, in violation of 10 NYCRR § 415.11(a)-(c), as well as federal regulatory requirements.[20] (*See* Medical Analyst Aff. ¶ 9.) These violations resulted in physical and emotional harm to residents and stripped them of their right to dignity, in violation of numerous additional regulations including 10 NYCRR § 415.3(f) and 10 NYCRR § 415.12. (*See id*. ¶¶ 9-10, 122-124.)

76. On March 18, 2020, Randi Rushing ("SW Rushing"), a Social Worker at The Villages, emailed then Director of Nursing, Debra Donnelly[21] ("DON Donnelly"), then Assistant Director of Nursing Kathy Howard[22] ("DON Howard") and then Administrator Steve Hefter[23] ("Admin Hefter") regarding outdated care plans and low staffing issues. Specifically, SW Rushing wrote:

> Can someone please update Rosie's care plan, there is a focus for pressure injury that's from 2018. I am not bothering Tonya [Tonya Zambito, RN] with it as she's been running around ragged all week and has other tasks that take priority. Clearly the nurses are just signing off on them and not actually reviewing and updating. If we could get them to come to the care plans and review with us as a team then these things will be cause [sic] and updated. Deb, I know you have spoken to them about attending but when they are short staffed and your unit managers end up on carts for days at a time they don't have time to be updating care plans or signing off on them let alone attending the review. Without nursing present at our care plan

[20]According to 10 NYCRR § 415.11(a)-(c), a nursing home facility is required, among other things, to (i) include in its care plans "measurable objectives and timetables to meet each resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment," (ii) revise care plans as often as necessary to assure the continued accuracy of a resident's health assessment, and (iii) provide services in accordance with a resident's comprehensive care plan.

[21] Debra Donnelly began working at The Villages in 2007 and served as The Villages' Director of Nursing ("DON") from approximately September 2015 to June 22, 2020, when she was terminated. (*See* SAAG Aff., Ex. 13 at 16:4-5; 29:10-22; 182:5-8.)

[22] Kathleen "Kathy" Howard, current DON at The Villages, was The Villages' Assistant Director of Nursing ("ADON") from approximately 2020 to January 2021, when she was promoted to DON (*See* SAAG Aff., Ex. 9 at 105:2-12.)

[23] Steve Hefter ("Admin Hefter") was the Administrator of The Villages from approximately February 2020 to approximately June 2020 (*See* SAAG Aff., Ex. 5 at 74:2-14.)

> reviews I am not updating any nursing focuses, goals or interventions as I was specifically told not [to] touch nursing sections of care plans. It makes it very difficult to give families accurate information when we are reviewing a care plan that has stuff on it from 2-3 years ago.

(SAAG Aff., Ex. 8.)

77. Former DON Karrie Mikits[24] ("DON Mikits") testified that when she started working at The Villages in June 2020, she had concerns that resident care plans were incomplete and inaccurate, and that care plan meetings were not being conducted at The Villages. (*Id.*, Ex. 9 at 248:9-13.) Similarly, CNA Logan White ("CNA White") testified that care plans "wouldn't ever be updated or accurate" because The Villages "never kept up with it;" or, even if a care plan existed on paper, staff couldn't access it because "there wouldn't be any copies out for people to have."[25] (*Id.*, Ex. 39 at 81:5-21.)

78. Resident 22 had at least 11 falls during her first six months at The Villages, yet there is no evidence that care plan interventions were initiated in response to her falls. Several of these falls resulted in trips to the emergency room, but The Villages did not appropriately document the cause of the falls or what, if any, follow-up was done after most of the falls. For example, although Resident 22 hit her head multiple times, there is no indication neuro checks were conducted.[26] (Medical Analyst Aff. ¶ 94.)

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[24] Karrie Mikits was The Villages' Director of Nursing ("DON") from approximately June 2020 to January 2021 when she was terminated. Mikits began as DON upon the termination of prior Villages' DON Debra Donnelly. (SAAG Aff., Ex. 9 at 33:16-19; 37:7-14; 44:24 – 45:19.)

[25] CNA White worked off and on at the facility from 2013 to April 2021. (SAAG Aff., Ex. 39 at 41:18-23.)

[26] A neurological exam or "neuro check" is completed after a resident fall in which they potentially or actually hit their head. They are completed to identify if the resident possibly suffered a head injury and requires further medical attention. Neuro checks consist of checking the resident's level of consciousness and orientation to person, place and time in comparison to the normal baseline, and a pupil check to ensure they react appropriately to light and grip strength. (Medical Analyst Aff. ¶ 46 n9.)

79. This lack of care planning and updating care plans had serious implications for residents of The Villages:

- Resident 22 had an abscess on her hip so severe that it required hospitalization. This resident did not have a care plan to address this condition prior to hospitalization, nor did her care plan contain information as to how to care for this wound when Resident 22 returned to The Villages from the hospital, leading to persistent issues with the wound. (*Id*. ¶ 92.)
- Resident 34 left the facility undetected and was found walking alone near a prison gate at night; his care plan was not updated to address his elopement risk until approximately four months after that incident. (*Id*. ¶ 59.)
- Resident 53 frequently refused care from staff. His wife provided The Villages with instructions on how to administer care in the face of such refusals but the information was never put into the resident's care plan, and apparently not utilized in the resident's care. (*Id*. ¶ 40.)

80. Existing care plans were disregarded, even under the most precarious circumstances. For example, the care plan of Resident 38, who was clearly at risk for suicide, required regular 30-minute checks, but Resident 38's record lacked documentation that staff were actually conducting regular checks. For example, MFCU identified 138 missing checks during the one-week period before Resident 38's death in early 2020. After Resident 38 died, The Villages failed to notify DOH of a potential suicide, as is required by law. (*Id*. ¶¶ 14-16.)

81. The Villages staff failed to follow Resident 35's plan of care so significantly that her mother placed information about Resident 35's medical conditions, and instructions and information as to how to properly care for Resident 35 on the walls of her room, including call

light reminders, dates of medical visits, and instructions on what to do when Resident 35 experienced a seizure. (Kelly Aff. ¶¶ 19-20.)

82. Shortly after RN Tonya Zambito[27] ("RN Zambito") returned to work at The Villages on January 5, 2022, she noticed residents were not getting physical therapy and occupational therapy services as ordered. She stated she was "flabbergasted" that the physical therapy department never came down any of The Villages' hallways to work with the residents, but that she knows the therapy department is billing services for five days a week for many residents. However, the resident never goes down to the therapy room. (Detective Aff. ¶¶ 148-153, Ex. H.)

83. MFCU's investigation uncovered that many of The Villages' residents suffered from frequent and avoidable accidents and injuries as a result of Respondents' decisions to chronically understaff the facility—leaving The Villages with insufficient staff to safely supervise and assist residents in transport, as called for in their care plans.

84. Former CNA Dylan Miller ("CNA Miller"), a CNA at The Villages from 2010 through early 2019, testified that he filled out more accident and incident reports[28] as time went on at The Villages, because staffing levels were low and the facility was admitting "hard-to-place residents that we may not have been the best equipped to deal with." (SAAG Aff., Ex. 10 at 145:4-11.) When asked whether he recalls any incidents that occurred at The Villages because of the low

[27] RN Zambito worked on and off at the facility between approximately August 2018 to August 2022, and held various supervisory and non-supervisory positions. (Detective Aff. ¶¶ 125-126.)

[28] New York State regulations mandate that nursing homes create and maintain accident and incident records, including "a clear description of every accident and any other incident involving behavior of a resident or staff member that poses a threat to a resident or staff member, the resident's version of the accident or incident unless the resident objects or is unable to give a report due to his/her medical condition, names of individuals involved and a description of medical and other services provided, by whom such are provided, and the steps taken to prevent recurrence." (*See* 10 NYCRR § 415.30[f].)

staffing levels, CNA Miller testified, "Oh, numerous, numerous, falls," and he described that residents would be sitting in "soaking wet pants," because it could take two people to toilet somebody but if "an LPN went for lunch," and there was not enough staff to assist, they would "have to put them on the stand machine . . . and while that's going on, somebody else is falling out of their wheelchair because there is no eyes on anybody." (*Id.* at 112:13-23.)

85. CNA Miller testified that Resident 2 suffered from multiple falls because of understaffing at The Villages:

> She had Alzheimer's, but she was very high functioning. She would help the activities aides, you know, kind of run activities with the other residents. Like if they were playing ball, she'd go and get the ball and bring it back. There were numerous times that she had fallen and just kept hitting her head, head injury after head injury because of short-staff. And I remember talking to the other employees saying, you know, I can guarantee there is a correlation between when she is falling and how much staff we have on the ground. By the end of it, you know, she was bedridden. She couldn't speak. She just gargled, and it was horrible to see that, you know, somebody that came from, you know, who was so high functioning. And of course the disease would have taken its toll but there is just no way to keep an eye on her, you know.

(*Id.* at 115:25 – 116:22.) Molly Brown ("CNA Brown"), a CNA at The Villages intermittently from 2016 through 2018, also testified that Resident 2 was permanently injured because of understaffing at The Villages. According to CNA Brown, Resident 2:

> was on [the] dementia [unit] and she used to wander around all the time and because staffing was so low she kept falling and falling and falling until one day she fell and just cracked her head open and she was never the same again . . . Pretty much any fall in that building is because of staffing. I can guarantee you if you pull up every single fall in that building and the staffing levels, it's because there was not enough staff in that building.

(*Id.*, Ex. 11 at 36:17 – 37:5.)

86. CNA Miller testified about the time that he accidentally dropped a resident out of bed who was supposed to be a two-person assist, but that according to CNA Miller he was one of only two people working on the dementia unit so he had to move the resident himself. He testified

that he attempted to move an aggressive patient who had "basically not been changed for God knows how long" onto a Hoyer lift,[29] and that:

> [W]e're so short-staffed and we have 30 people to get up. So I went in there. He became combative. I had to change the entire bed . . . And I went to roll him over to put the sling under him and he was pushing back and pushing back and I said, 'you got to roll over, I am trying to'—but he was severely demented and aggressive as well. And he just finally let go and he accidentally went over the other side of the bed and he hit his face on the recliner which was horrible.

(*Id*., Ex. 10 at 114:10-23.)

87. CNA Miller also testified that he was encouraged by his supervising nurse, Michelle Neal ("LPN Neal"), to move residents by himself even when a two-person lift was required, which is a violation of the resident's care plan and 10 NYCRR § 415.12(a) (activities of daily living) and 10 NYCRR § 415.13(a) (sufficient staff). According to CNA Miller, LPN Neal told him that other CNAs didn't have issues using the machines on their own, and she asked CNA Miller, "what's wrong with you? You're a man. You can get these people up by yourself." (*Id.* at 100:9 – 101:11.)

88. CNA White testified that Resident 30, whose care plan called for assistance with toileting, was forced to try and use the bathroom herself one morning because The Villages did not have any staff available to help her. According to CNA White, Resident 30 "fell and obliterated her face" while trying to use the bathroom and "was in the hospital for a little while as a result of us not having enough staff." (*Id*., Ex. 39 at 67:12 – 68:15.)

89. When a resident suffers from an accident or injury, the resident must be assessed and proper protocol for such resident is to revise their care plan to address the injury and attempt to prevent a recurrence. Although numerous residents of The Villages, including Resident 35,

[29] A Hoyer lift is a mobility tool to assist residents that cannot bear weight move from surface to surface or bed to wheelchair and vice versa.

Resident 22, Resident 50, and others, fell frequently, The Villages made no revisions to those residents' care plans to address and prevent falls, in violation of 10 NYCRR § 415.11(c). (*See, e.g.*, Medical Analyst Aff. ¶¶ 23, 68, 94; Affidavit of Cynthia Delaura ["Delaura Aff."] ¶¶ 8, 11; Kelly Aff. ¶¶ 14, 25-26; Affidavit of Susan Fuller ["Fuller Aff."] ¶¶ 16, 19, 21, 22, 24, 26, 27, 34.)

90. On July 19, 2022, a new CNA at The Villages was assigned to care for Resident 22 and others on her unit. After Resident 22 made a complaint regarding the CNA, records obtained from The Villages revealed that The Villages had not completed the required background check for the CNA as required by 10 NYCRR § 402.4(a)(1), and that in the absence of a completed background check, the CNA had not been properly supervised, as required by New York State regulations. (*See* 10 NYCRR § 402.4[b][2][i]; Detective Aff. ¶ 199; Medical Analyst Aff. ¶ 95.)

91. Thereafter, on August 25, 2022, following the initiation of an outside investigation into Resident 22's complaint against said CNA, and an unrelated altercation between Resident 22 and a staff member of The Villages, Resident 22 and her boyfriend, Resident 57, were discharged by The Villages and driven to an apartment in Monroe County by a Villages staff member. This discharge was conducted in violation of discharge regulations which set forth very specific requirements with respect to discharge notice, planning, and documentation. (*See* 10 NYCRR §§ 415.3 & 415.11[d][3].) Furthermore, the discharge put Resident 22 at a serious health and safety risk, given that Resident 22 had documented physical and psychological challenges, which included an open pressure sore on her tailbone, and difficulties managing her diabetes and medications, and her boyfriend was known by staff of The Villages to have behavior problems. Notably, Resident 22's records from The Villages do not indicate that any discharge planning or teaching was completed, nor do her records include documentation that any family was notified of her discharge. Resident 22 was not in a sufficiently healthy condition or sufficiently

prepared to be discharged. This was further evidenced by the poor condition of Resident 22's home, which was cold and void of food when Det. Krzyskoski visited her on August 29, 2022, and by the fact that Resident 22 reported having been subjected to physical abuse by Resident 57 following her discharge and was re-hospitalized shortly thereafter due to her underlying medical conditions. (*See* Detective Aff. ¶¶ 203-215; Medical Analyst Aff. ¶¶ 96-101.)

92. Asked whether he was aware of The Villages failure to follow proper care planning protocols, Respondent Halper stated, 'I plead the Fifth." (SAAG Aff., Ex. 7 at 67:6-9.)

C. Staff at The Villages Do Not Provide Residents with Adequate Medical Care.

93. Although they were required to develop and implement medical services to meet resident needs, Respondents provided residents of The Villages with inadequate medical treatment and violated residents' rights to "adequate and appropriate medical care," by taking money for themselves, rather than hiring a qualified medical and interdisciplinary team for The Villages with enough staff to attend to basic resident healthcare needs. (*See* 10 NYCRR § 415.15 [medical services]; 10 NYCRR § 415.3[f][2][ii] [right to clinical care and treatment]; 42 CFR § 483.10 [resident rights].)

94. Leann Sample ("CNA Sample"), a CNA at The Villages off-and-on from 2012 through June 2021, testified that she saw incidents of resident abuse and neglect at The Villages. According to CNA Sample:

> [R]esidents weren't getting their medications. They weren't being turned and positioned. They were being left in their own feces and urine for hours on end. They weren't getting fed. There would be times where I would come in to my shift or I would pick up a shift and they would still have their food trays in front of them that were completely full and the resident specifically was supposed to be fed because they couldn't feed themselves and the tray would be full. So the resident didn't get fed. This would be 45 minutes after the meal and nobody would be feeding them. They were being left in bed and not being brought down to meals when they were supposed to be fed so they would get skipped right over. They were not getting the right medications or getting no medications at all.

(SAAG Aff., Ex. 12 at 53:18 – 54:11.)

95. Former Villages' resident, Resident 43, who was a diabetic, recounted one day when he could feel his blood sugar dipping, and pressed his call light for help. When an aide at The Villages eventually arrived at his room, the aide told Resident 43 he would have to wait for help, and that the aide "didn't care" if Resident 43's sugar went low. Resident 43 was frequently forced to wait long periods of time for his medication to be administered, even when he was in severe pain. (Detective Aff. ¶¶ 181-182.)

96. The Villages also often ignored and/or failed to follow-through on crucial medical orders, creating hazardous conditions for its residents. (Medical Analyst Aff. ¶ 9.) For example, at the time of Resident 6's admission to The Villages, she was ordered to wear a Zoll Life Vest, a wearable cardioverter defibrillator, which detects and converts rapid life threatening cardiac arrythmias. There is no evidence this device was obtained as ordered upon Resident 6's admission to The Villages, nor is there explanation as to why it was not obtained as ordered. Worse still, there was no care plan at all for Resident 6's cardiac concerns. (*Id*. ¶ 84.)

97. Similarly, when Resident 19 was admitted to The Villages, he had an implanted device called a Vagal Nerve Stimulator (a device to treat focal or partial seizures that do not respond to medications by delivering pulses or stimulation at regular intervals). There are no notations or orders in Resident 19's care plan indicating that doctors or staff at The Villages ever monitored this device or any potential complications related to this device. (*Id*. ¶ 29.)

1. The Villages Does Not Adequately Manage Prescription Medications, Endangering Residents.

98. The Villages did not have Resident 35's ordered seizure medications available upon her admission, in violation of 10 NYCRR § 415.13, which requires the timely administration of

medications. (Kelly Aff. ¶ 10.) The day following her admission, she had three seizures, and had to be transferred to the emergency room. (Medical Analyst Aff. ¶ 19.) Records indicate that her medications were not available from the pharmacy, but there is no indication that staff contacted the pharmacy or the medical team to address the lack of medication upon admission. (*Id*. ¶ 20.) The ER note indicates that Resident 35 was less responsive to answering questions than she had been when she was discharged to The Villages just a day earlier. (*Id*. ¶ 21.) Resident 35's mother, Donna Kelly, was not notified of the seizures by The Villages, and found out through a phone call from the hospital. (Kelly Aff. ¶ 10.)

99. While at The Villages, Resident 8 was given several different medications to treat her dementia and depressive disorder. (Medical Analyst Aff. ¶ 55.) Resident 8's medication record demonstrates that The Villages failed to timely carry out physician medication orders, causing gaps in treatment, and danger to patients. (*Id*. ¶ 56.) Additionally, at one point, Resident 8's depression medication was abruptly stopped, as opposed to a gradual dose reduction recommended in the prescribing information to prevent or reduce adverse side effects, like dizziness, headaches, nausea, vomiting, paresthesia, and anxiety. Just seven days after the abrupt cessation of this drug, Resident 8 fell, fractured her hip, and ultimately decompensated. (*Id*.)

2. The Villages' Staff Does Not Monitor Medical Conditions and Carry Out Necessary Medical Tests.

100. Staff levels were so inadequate that physician-ordered testing and samples were either lost, delayed, or never performed, in violation of 10 NYCRR § 415.13 and 10 NYCRR § 415.20, which require (i) the timely administration of health services and (ii) that laboratory services meet the needs of the nursing home residents, respectively. Stephen Dioguardi ("LPN Dioguardi"), an LPN who has worked at The Villages since at least early 2020, stated that many residents suffered because samples were not picked up and processed by the lab or samples

appeared to have gone missing, and that it was a "big problem." (Detective Aff. ¶¶ 69-71.) LPN Dioguardi gave the specific example of Resident 37, who went untreated for an infection after two urine samples that were supposed to have been taken were never processed, because the first sample was not picked up and the second sample was not officially ordered. LPN Dioguardi finally obtained a doctor's order for a third urine sample test to be completed, and an infection was detected. (*Id*. ¶¶ 71-72.) Resident 37 suffered due to an avoidable delay in treatment.

101. Another resident, Resident 45, was diagnosed with stomach cancer while at The Villages when The Villages' Medical Director, Dr. Madejski, found a mass on Resident 45's stomach. Melissa Olles ("LPN Olles"), an LPN at The Villages, stated that Dr. Madejski directed LPN Neal to schedule a biopsy for the mass on Resident 45's stomach. LPN Olles states LPN Neal left her job at The Villages and never scheduled a biopsy for Resident 45, and that approximately three months later, Resident 45 died. She states Resident 45's condition progressed quickly and that the cause of Resident 45's death was "natural cause from cancer." LPN Olles thinks "he died because of delay in care." (*Id*. ¶¶ 113-114.)

102. Upon her admission to The Villages from the hospital, Resident 6 was prescribed a medication used to treat heart failure. The medication required routine pulse checks and additional monitoring for patients with renal impairment, such as Resident 6. The Villages did not order pulse monitoring, nor did The Villages order monitoring lab work for Resident 6 until 11 days after her admission, despite the fact that, as early as eight days after her admission, she began having signs of toxicity from the medication (like gagging and difficulty swallowing). Further, there is no evidence that Resident 6's change in condition was ever communicated to a doctor, as required. On the same day The Villages finally ordered lab work, Resident 6 was readmitted to the hospital

emergency department, where she was found to be suffering from toxicity from the heart medication. (Medical Analyst Aff. ¶ 85.)

103. Witness Rebecca Lockwood explained that during her husband Resident 53's first week at The Villages, his neurologist ordered a bloodwork panel, and then had to put in a second order for the bloodwork panel because The Villages never carried out the first order. The Villages' Medical Director also ordered bloodwork for Resident 53 that was never carried out. Rebecca Lockwood states that, to her knowledge, no bloodwork was ever completed, despite her multiple requests. (Affidavit of Rebecca Lockwood ["Lockwood Aff."] ¶ 12.)

3. The Villages Failed to Provide Proper Nutritional Support and Weight Monitoring, Endangering Residents' Health Before, During, and After COVID-19.

104. Pursuant to 10 NYCRR § 415.14, The Villages is required to provide each resident with a nourishing, palatable, well-balanced and medically appropriate diet, 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. (*See also* 10 NYCRR § 415.12[i] [requiring nursing home facility to ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels and receives a therapeutic diet when there is a nutritional problem].)

105. Due to grossly inadequate staffing levels, The Villages' residents were not properly fed, nor was their weight monitored to detect and respond to malnutrition. The Attorney General's investigation documented numerous instances where The Villages failed to properly assist residents with their nutritional needs, including Resident 35 and Resident 40 pictured below.

(Detective Aff. ¶¶ 224-226, 230-232.)

106. Both proper feeding practice and monitoring and proper weighing technique require sufficient staffing with sufficient time. Asked whether he was aware of dietary issues at The Villages such as insufficient staff to assist residents with eating, Respondent Halper stated, "I plead the Fifth." (SAAG Aff., Ex. 7 at 64:25 – 65:3.)

107. According to witness Rebecca Lockwood, due to her husband Resident 53's aspiration issues, he was never to be fed lying down. However, many times when she would FaceTime him at The Villages, she observed that he was being fed while lying down in his bed. When she voiced her concerns to the nursing aides, they said they were uncomfortable moving

him because he required a two-person assist and there was not enough staff at The Villages to move him out of his bed. (Lockwood Aff. ¶ 24.)

108. Lockwood also said that when Resident 53 was eventually transferred from The Villages to a different facility, he was found to be hypotensive, anemic, malnourished, and, according to his lab work, had low albumin (liver protein) levels. (*Id*. ¶ 32.)

109. Other residents of The Villages also suffered dangerous weight loss. (*See* Medical Analyst Aff. ¶¶ 41, 61, 64, 112.) Resident 50's medical record contains no notes whatsoever from a dietician or dietary aid, despite a weight loss of 60 pounds in approximately three months—representing approximately 20% of Resident 50's total body weight. (*Id*. ¶¶ 64-65.) Resident 50's wife, Margarette Volkmar, requested his weight records and dietician's information from The Villages, but never received them. (Volkmar Aff. ¶ 34.) She further stated that, although she sought answers, no one from The Villages was able to explain the cause of Resident 50's dramatic weight loss. (*Id.* ¶ 22.)

110. Similarly, according to witness Darlene Stevens, her brother, Resident 34, weighed 167 pounds when he was admitted to The Villages, but dropped to 129 pounds over the nine months he resided there. (Affidavit of Darlene Stevens ["Stevens Aff."] ¶ 10.) She noticed Resident 34 was often choking and aspirating on his food. (*Id*.)

111. Feeding the residents became "tricky" according to former RN Zambito. She stressed her frustration when it came to critical staffing levels and the lack of help from The Villages' administration. RN Zambito stated the lack of help caused neglect to residents who needed assistance with eating. She stated that residents' food intake would have been better if there was more help available. She stressed if residents received more assistance from staff when eating, they would eat more. However, RN Zambito stated that the staff was unable to spend enough time

with each resident due to staffing issues, thus leading to patterns of frequent weight loss. (Detective Aff. ¶¶ 136-137.)

112. Sheila Fernandez ("CNA Fernandez"), a CNA who worked on and off at The Villages between 2018 and spring 2020, said that when The Villages was short-staffed, one CNA sometimes had to feed seven or eight dementia residents. If a resident was losing or gaining weight, it was never documented, and staff could only tell by looking at them or if their clothes fit differently. (*Id*. ¶¶ 14, 22.)

113. CNA Miller testified that The Villages' administration knew that understaffing meant that certain residents were not given appropriate assistance to eat their meals.

> I'm sure they were aware of it . . . They knew the staffing issues that were going on. You know, you can't expect one or two people to be able to complete all these tasks, you know, for 30 people on a unit, you know . . . As I have said before, they set you up for failure.

(SAAG Aff., Ex. 10 at 153:14 – 155:3.)

114. CNA Miller also testified that the food quality and quantity diminished after Respondents purchased The Villages:

> I remember one evening shift residents were served maybe three French fries and something that was supposed to be ribs or something like that. It was like some kind of processed meat patty. I asked them, I said, 'how come these guys are only getting three French fries?' And they said, 'we don't have enough to go around so we're trying to ration that out and split it up.'

(*Id.* at 53:23 – 55:15.)

4. The Villages Did Not Provide Appropriate Wound Care to Residents, Endangering Residents' Health Before, During, and After COVID-19.

115. The Villages failed to properly address and treat residents' pressure sores in violation of numerous regulations, including 10 NYCRR § 415.12(c) and 42 CFR § 483.25(b).[30] (*See* Medical Analyst Aff. ¶¶ 9, 151-156.) For instance, when Resident 6 was admitted to The Villages, The Villages' physician noted that she had a large blister and some other injury to the right heel. However, no nursing or wound assessment was documented, and it was not until approximately one week later, when a nurse noted that her toes on her other foot were black, that treatment was ordered. The treatment was administered only six of the ten times it was ordered, and Resident 6 had to be re-admitted to the hospital for gangrene and cellulitis. At the hospital, it was noted that Resident 6 had large wounds on her right and left thigh which The Villages had failed to notice or treat. Resident 6 never recovered after hospitalization and died several months later. (*Id*. ¶¶ 86-88.)

116. Resident 42 was admitted to The Villages with a Stage II pressure sore to her sacrum. She had a wound assessment upon her admission, but treatment was not ordered for 18 days. Approximately five months later, Resident 42 had two re-opened areas on her sacrum, both staged as Stage III (Stage III is a deterioration from Stage II). The facility did not revise the treatment until six days later, and did not initiate the new treatment until the following day. When the wounds were re-assessed on the first day of treatment, both had worsened and were deemed

[30] 10 NYCRR§ 415.12(c) requires a nursing home facility to ensure that "(1) a 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) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."

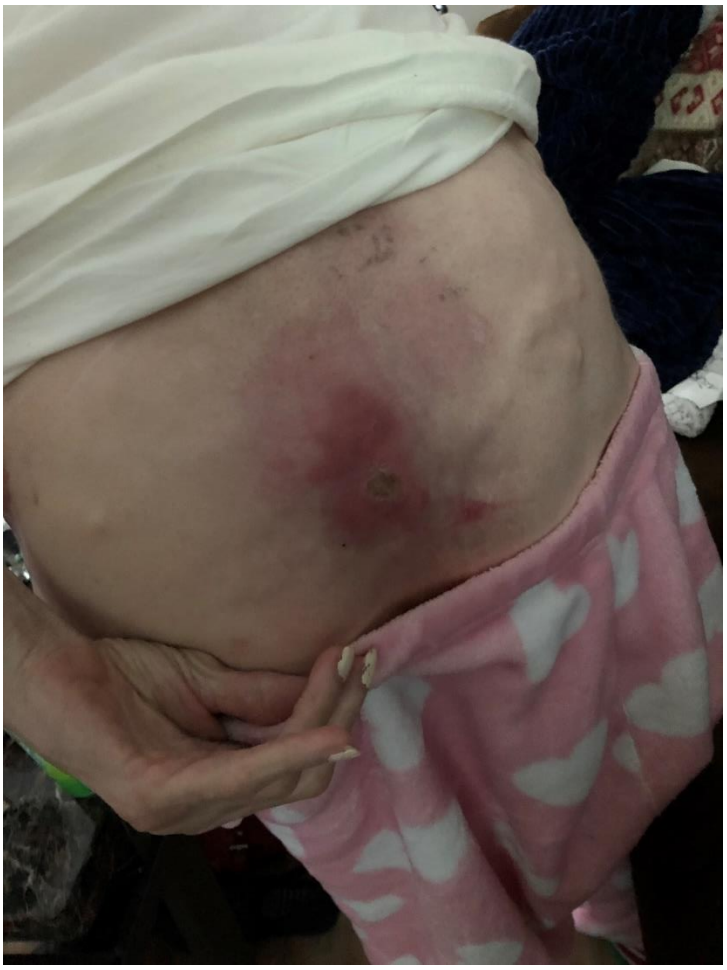
"unstageable." There was no care plan in Resident 42's chart for any other interventions related to pressure sore prevention. (*Id*. ¶¶ 78-79.)

117. Resident 43, an amputee and a diabetic, was admitted to The Villages with a scab on his leg stump and a Stage III pressure sore on his buttock. His records reflect multiple missed wound treatments and assessments, and wound care and treatment for his scab did not begin until two days after his admission to The Villages. Resident 43 did not receive treatment for his wounds as often as prescribed, and a device that was to be worn on his stump went missing for at least 30 days. Resident 43 was eventually re-admitted to the hospital for COVID-19 symptoms, and it was determined that his pressure sore had grown in size during his three-month stay at The Villages, and developed drainage which had not been present before. (*Id*. ¶¶ 33-37.) During his residency at The Villages, Resident 43 stated that the staff never once measured his wounds, and the pressure sore on his buttock progressively deteriorated. Due to being diabetic, Resident 43 needed to use the restroom frequently. He stated that he would press his call light, and it took staff so long to respond that he was usually "sitting in a puddle of urine when they arrived." He was worried about his pressure sores as he was often sitting in his "own urine and feces with only a barrier cream covering [his] wounds." (Detective Aff. ¶ 179-180.)

118. Resident 22 was admitted to Villages with a Stage II pressure sore to her sacrum, but when it was assessed five days after her admission, it was deemed to be "unstageable." Several weeks later, Wound Healing Solutions ("WHS"), an outside company that assisted with wound care at The Villages, recommended the sore be cultured, but The Villages did not order a culture for over a month, at which time the culture was positive for staph aureus, a dangerous infection. Treatment was not started for yet another week. The sore was cultured again several months later and was again positive for staph aureus. Approximately six months after her admission to The

Villages, a hospital reassessed the wound and found that it was "unstageable" (*i.e.*, the same severity documented five days after admission). Resident 22's medical record from The Villages reflects lack of treatment for her wounds, and her care plan did not call for turning and positioning to assist in healing the pressure sore. (Medical Analyst Aff. ¶¶ 90-93.)

119. In addition, in April 2022, WHS noted that Resident 22's right hip was swollen and red. They recommended warm soaks, but this was never indicated on The Villages' treatment notes or doctors' orders, and nursing staff did not even note redness and swelling in the right hip area. Approximately five weeks later, Resident 22's right hip was noted to be swollen, red and draining, and a culture was ordered. Resident 22 was sent to the hospital the next day, where she was admitted for sepsis due to this wound. She required surgical removal of the abscess and was later transferred back to The Villages. In June 2022, an additional pressure sore on Resident 22's sacral area was recorded as being unstageable. Documentation indicates the sore was not properly cared for. Even upon her discharge in August 2022, Resident 22 continued to suffer from this pressure sore, as depicted below, and she was discharged contrary to regulations. (*Id*. ¶¶ 91-101.)



(*Id*.; Detective Aff. ¶ 204, Ex. T.)

120. RN Zambito stated that resident wounds did in fact get worse due to low staffing at The Villages and that CNAs rather than LPNs or RNs performed wound treatments. (Detective Aff. ¶ 135.) Such care is outside the scope of professional practice for CNAs and in every instance should have been performed by LPNs or RNs. (Medical Analyst Aff. ¶ 129 n.24.)

121. Respondent Sam Halper knew from his review of CMS quality data that residents at The Villages were suffering from a high number of pressure sores but only cared about how it affected The Villages' CMS star rating, not the pain and suffering the residents experienced. On December 8, 2020, Halper emailed then Villages Director of Nursing, DON Mikits, and Regional

Administrator, Jason Teitelbaum ("Admin Teitelbaum"),[31] "3 residents got 11 wounds in house?" DON Mikits responded, " . . . No, it is actually 7 . . ." Halper replied on December 11, 2020, "Thanks. Are these all stageable wounds that would be counted against the medicare [sic] quality measure as part of the facility star rating? It looks like alot [sic] of wounds, especially with current census." DON Mikits replied, "It is an extreme amount of wounds I agree. All of those wounds are the stageable wounds that do count against our quality measures. I wish I could say it would get better." Respondent Halper did not reply. (SAAG Aff., Ex. 14.)

122. Asked whether he was aware that low staffing at The Villages led to poor outcomes for resident pressure sores, Halper stated, "I plead the Fifth." (*Id*., Ex. 7 at 109:13-17.)

D. The Villages Did Not Provide Even Basic Care to Residents Before, During, and After the COVID-19 Pandemic, Endangering Residents' Health, Dignity, and Well Being.

123. In addition to living in an environment in which their health was at risk due to inadequate staffing, residents at The Villages suffered the indignity of having even their most basic care needs ignored. Residents' basic hygiene needs, such as showers, nail care, and changing clothes, went unperformed and undocumented due to lack of sufficient staffing, in violation of numerous regulations including 10 NYCRR § 415.12(a)(3) and 10 NYCRR § 415.12(i).[32] Respondents also persistently violated 10 NYCRR § 415.12(a)(1), which requires nursing homes to provide care and services to its residents for the following activities of daily living: (1) Hygiene

[31] Jason Teitelbaum was The Villages Administrator from approximately June 2020 to November 2020. He has functioned as a Regional Administrator overseeing The Villages since approximately November 2020. (SAAG Aff., Ex. 74 at 74:5-14; 33:11-18.)

[32] 10 NYCRR § 415.12(a)(3) requires a nursing home facility to ensure that "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." 10 NYCRR § 415.12(i) requires a nursing home to ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels and receives a therapeutic diet when there is a nutritional problem.

- bathing, dressing, grooming, and oral care; (2) Mobility - transfer and ambulation, including walking; (3) Elimination - toileting; and (4) Dining - eating, including meals and snacks. (*See also* 42 CFR § 483.24(b) [requiring facility to provide care and services relating to a resident's activities of daily living, including bathing, dressing, grooming, oral care, transfer and ambulation, walking, toileting, eating and communication].)

124. The Villages' residents often went weeks without showers. (*See* Affidavit of Christine Sevor ["Sevor Aff."] ¶ 18; Medical Analyst Aff. ¶¶ 9, 69, 115.) According to witness Christine Sevor, in early 2022, her husband Resident 12's nails were not cut for several months and, as a consequence, his nails became very thick and very long. (*See* Sevor Aff. ¶ 19.) He also did not see a podiatrist for a period of approximately six months. (*Id.*)

125. Witness Margarette Volkmar stated that she had to repeatedly ask The Villages' staff to cut her husband Resident 50's hair (which had grown past his shoulders) and fingernails and bathe him. (Volkmar Aff. ¶ 8.) Resident 50's medical record indicates he received only seven showers in the 17 weeks between December 17, 2020 and April 14, 2021. (Medical Analyst Aff. ¶ 69.)

126. According to former Villages resident, Resident 43, he only had one shower in the approximately three months he was at The Villages and had to have sponge baths. (Detective Aff. ¶ 180.)

127. Witness Darlene Stevens stated that her brother, Resident 34, never received a bath during his entire residency at The Villages. (Stevens Aff. ¶ 17.) She described an instance when The Villages transported Resident 34 to a medical appointment, and she met him there to find that he was "absolutely filthy" and without his shoes and glasses. (*Id*. ¶ 16.)

128. CNA Miller and CNA Brown both testified to seeing Resident 21 with an injury to his hand and maggots falling out of it. According to CNA Brown, the maggot incident occurred in 2016. CNA Brown explained that Resident 21 had very long nails that punctured his skin and because his hand was clenched into a fist, with his fingers curled into themselves, The Villages failed to ensure that staff cleaned the wound. (SAAG Aff., Ex. 10 at 56:3 – 57:20; *id.*, Ex. 11 at 85:14 – 86:18.)

129. Interviews with other staff members confirm these horrors. Dawn Moore ("RN Moore") is an RN who has worked at The Villages since approximately January 2020. RN Moore stated that due to lack of staff, there was no time to shower the residents in the morning at the end of her overnight shift. (Detective Aff. ¶ 82.) CNA Sample similarly testified that during her employment at The Villages, there was not enough staff to give residents showers. (SAAG Aff., Ex. 12 at 58:22 – 59:13, 59:24 – 60:21, 61:21-25.) CNA White testified that she reported low staffing issues to DOH because residents were not getting showers. (*Id*., Ex. 39 at 111:2-13.) CNA White reported this issue anonymously because she feared "backlash" and testified, "when you're a continuous voice that is speaking out against certain stuff they kind of . . . be mean to you and make it so you want to leave pretty much." (*Id.* at 111:14 – 112:7.)

130. Due to short-staffing, RN Zambito stated that residents' general needs, such as feeding and bathing, were neglected. She said there were days when a CNA would go into a resident's room only once, possibly two times per day to provide basic care. (Detective Aff. ¶ 132.)

131. RN Zambito also stated that staff members voiced their concerns to her about the lack of care residents were receiving. She stated that staff members came to her and reported that residents were in the same clothes, soiled with "piss and shit," still in bed from the day before.

(Detective Aff. ¶ 133.) On some occasions, residents were left in bed for 24 hours straight. (*Id*. ¶ 22.)

132. The harm to residents only became more acute during the height of the COVID-19 pandemic. For example, Glennis Poole ("CNA Poole"), a CNA who worked part-time on the evening shift at The Villages during the spring of 2020, stated that she was concerned that there was no 2:00 p.m.-10:00 p.m. staff on May 3, 2020 at The Villages. When she came in at 10:00 p.m. that day, a resident on the Canal View unit still had on the same clothes from when Poole left at 6:00 a.m. the day before, and another resident had been in the same chair all day. (Detective Aff. ¶ 98.)

133. Even after visitation resumed at The Villages, witness Donna Kelly, mother of Villages Resident 35, went to The Villages almost daily and had to clean her daughter's room and bathroom, change her daughter's linens and bed pads, and change her daughter's clothes, because it was "hit or miss" if The Villages would complete these tasks. Kelly also purchased antibacterial soap for her daughter's room. (Kelly Aff. ¶ 21.)

134. Resident 35 also required assistance to use the bathroom, and often pressed her call light for assistance. Frequently, The Villages' staff members did not answer her call light, which caused Resident 35 to soil herself in urine. Because it took so long to get help, Resident 35 often tried to get out of her wheelchair by herself and get to the bathroom, which was dangerous due to her limited mobility. Resident 35 had a special alarm on her wheelchair to alert staff when she tried to get out of her wheelchair on her own yet there were times that she tried to get out of her wheelchair, activating the alarm, but no staff members came to assist her or to check on her. (*Id*. ¶ 22.)

135. Due to his disability, Resident 12 requires assistance to go to the bathroom. According to his wife, witness Christine Sevor, he rarely gets this assistance at The Villages. (Sevor Aff. ¶ 11.) He rings his call light when he needs to use the restroom, but staff rarely respond in a timely manner. (*Id*.) The staff's repeated failure to timely respond to Resident 12's request for assistance to use the bathroom has resulted in Resident 12 needing to wear pull-up adult diapers, which he finds degrading. (*Id*.)

136. After having suffered a stroke, Resident 53 was unable to use the restroom on his own. He required assistance to use a urinal or a bed pan but, instead, was placed in an adult diaper by The Villages and his calls for assistance were rarely, if ever, answered. Within four to five weeks of transferring to a different facility, Resident 53 became continent and was able to use the restroom on his own. (Lockwood Aff ¶ 36.)

137. Witness Vicki Juckett reports that her mother, Resident 40, has been a resident of The Villages since September 2021 and that from day one The Villages has been inattentive to Resident 40's requests for help with toileting, which means Resident 40 often sits or lays for long periods of time in soiled clothes and bedding (Affidavit of Vicki Juckett ¶¶ 9-12). Witness Juckett further reports that she frequently arrives at The Villages to visit her mother and finds Resident 40 sitting in the hallway in a soiled adult diaper or in bed in a wet brief surrounded by wet linens (*Id*.). As recently as November 2, 2022, MFCU Detective Jaimie Krzyskoski witnessed over several hours the effects of The Villages' deficient staffing on this resident. Specifically, Detective Krzyskoski observed Resident 40 in an adult diaper heavily saturated with urine, which had soaked the bandage over her pressure sore, and leaked onto the bed pad. Although staff entered Resident 40's room during this time, they did not offer to change her adult diaper, bandages, or linens. MFCU Detective Krzyskoski took the following photograph:

(Detective Aff. ¶ 237, Ex. BB.)

138. According to witness Laurel Harrington, a close friend and healthcare proxy of Resident 42, Resident 42 sent over 1,000 text messages to Harrington asking for basic necessities, like help using the restroom and to receive food and water. She often received texts from Resident 42 stating things like, "I've been lying in a dirty diaper for hours," or "I just need a glass of water." Resident 42 was unable to complete these tasks on her own and repeatedly was unable to get The Villages' staff to complete them for her. (Affidavit of Laurel Harrington ["Harrington Aff."] ¶ 14.)

139. CNA White testified about an occasion when she found Resident 46 physically tied to a recliner with a bedsheet "in a big, huge knot . . . so tight to the point that we had to cut the sheet with the scissors to even get the sheet off of him." (SAAG Aff., Ex. 39 at 65:4 – 67:8.)

140. Asked whether he was aware of DOH findings that The Villages did not have enough staff to bathe and toilet residents, Respondent Halper stated, "I plead the Fifth." (*Id*., Ex. 7 at 82:13-19.)

E. Respondents Do Not Create and Maintain Necessary and Accurate Documentation.

141. At all times, The Villages was required to maintain "complete" and "accurately documented" records detailing what care its staff did and did not deliver to residents. (10 NYCRR § 415.22[a].) This includes a complete record of medications administered, vital signs checked, treatments administered, and completion by CNAs verifying that they delivered care in accordance with the resident's care plan. (*See* 10 NYCRR § 415.22[f].) By diverting the resources needed to run the facility and care for the residents that lived there, Respondents set up The Villages' employees to fail, and encouraged a culture where employees maintained unreliable, incomplete, non-compliant, and falsified health documentation and hid true conditions at The Villages from DOH.

142. CNA Brown testified that The Villages' staff constantly violated their documentation requirements. CNAs did not look at care plans on a daily basis because they did not have time to do it and "there was no point" looking at them because care plans were not properly updated. (SAAG Aff., Ex. 11 at 71:11-23, 73:12 – 74:24.) CNA Brown further testified that The Villages' Electronic Medical Records entries, known as PointClickCare ("PCC") entries, were falsified because CNAs did not have time to enter information in the computers. According to CNA Brown,

> it got to a point where we just weren't doing our computer work because we were so short-staffed, and this [PointClickCare] was literally the only in-service we ever had, and Deb Donnelly told us to our faces we have to get the computer work done no matter what. And then I asked her specifically, what if the person is a two assist and I don't have another person to put them in bed and it's just me, and she said,

> ‘you still have to put them down as a two assist because you’d be going against care plan and you will get in trouble.’

(*Id.* at 77:2 – 78:9.)

143. CNA Fernandez stated that documentation was falsely filled out by nurses, especially when CNAs, including her, performed treatments and passed medication, which was supposed to be done by nurses. The nurses would falsely document that they administered the treatment or passed the medication to the resident. (Detective Aff. ¶ 23.)

144. Between July 2019 and September 2019, LPN Olles assisted the facility transition from paper documents to electronic files using PCC. LPN Olles trained staff members on how to use the system in its entirety. Once the facility fully transitioned to PCC, LPN Olles discovered numerous PCC reports that were missing significant resident care information including nursing notes, doctor orders, and errors involving treatment and medication administration. (*Id*. ¶ 101.) She stated, “I would see something happen on a unit and then I’d go back to PCC, and it wouldn’t be documented there.” LPN Olles began running reports daily and noticed certain staff members were deleting and “striking” out notes in PCC, including several whom she said were “notorious” for making changes to resident records in PCC. (*Id*. ¶¶ 102-103.)

145. LPN Olles further stated that a certain LPN would often not follow up on a doctor’s order and then delete it in PCC to cover it up. After going to former DON Donnelly numerous times with her complaints, LPN Olles said DON Donnelly took away LPN Olles’ credentials for PCC, and she was unable to run reports and could no longer see what care was or was not being provided to residents. (*Id*. ¶¶ 104-110.) That is, LPN Olles was punished for reporting illegal documentation practices.

146. The Villages’ staff failed to document other significant medical incidents as well. The medical record for Resident 17 indicates she fell and hit her head on in late 2020, that a neuro

check was completed, and that further neuro checks would be continued. There is no record of any additional neuro checks. This same resident's record has a note indicating she vomited one month later, and then no further notes, other than that she was found without vital signs (dead) the next day. (Medical Analyst Aff. ¶¶ 50-51.)

147. Similarly, Resident 42's medical record is void of any meaningful documentation for the time period leading up to her being found unresponsive and sent to the hospital where she died. Resident 42's medical record indicated she was to be on 15-minute checks, but there was no reason given for the 15-minute checks, no care plan regarding the 15-minute checks, and often no record that the checks were completed. (*Id*. ¶¶ 77, 82.)

148. The high managers of The Villages were also not ashamed to falsify documentation. On September 14, 2020 and September 15, 2020, DON Mikits joked with Social Worker Sarah Woodin ("SW Woodin") in a text message: "What I left out is how great we are at making up policies on the fly! Lol and maybe a care plan or two" and "I faked policies all week! Lol Google saves the day!" Similarly, on September 10, 2020, DON Mikits texted SW Woodin about falsifying a resident's incident/accident report: "U rock. I'm gonna say I interviewed u k. Lol and u said that . . . he came in blah blah blah." (Detective Aff. ¶¶ 159-160.)

149. Asked whether The Villages had ongoing issues with maintaining medical documentation, Respondent Halper stated, "I plead the Fifth." (SAAG Aff., Ex. 7 at 75:23-25.)

F. The Villages Deceived DOH as to Resident Incidents and Facility Conditions.

150. In its investigation, MFCU found a troubling culture of cover up in numerous areas of operation at The Villages, including a failure to report required events to DOH and last-minute whitewashing of conditions at the facility before DOH visits.

151. MFCU found multiple instances in which The Villages' leadership did not report incidents to DOH as required, or reported them late. These include a failure to report a probable resident suicide (Medical Analyst Aff. ¶ 16), a resident-on resident assault (*id*. ¶ 71), and resident-to-resident sexual incidents (*Id*. ¶¶ 43, 58), in violation of PHL § 2803-d, which provides for mandatory reporting of abuse, mistreatment, neglect, and misappropriation of property.

152. DOH survey teams comprised of health care professionals are tasked with unannounced inspections (also known as surveys) of nursing home facilities in the state to ensure quality of care and building safety, among other concerns.[33] However, MFCU found evidence that The Villages had advance warning of inspections by DOH and covered up conditions to try to meet surveyors' approval.

153. A month after The Villages' first COVID-19 case, LPN Fairbanks described one morning (April 29, 2020) that DON Donnelly unexpectedly came in to work at 5:30 a.m., an unusual hour for DON Donnelly to arrive, and brought out new PPE supplies and collected all of the used gowns that had been hanging on the units. In a text to MFCU Detective Krzyskoski on April 29, 2020, LPN Fairbanks wrote: "The Director of Nursing Deb Donnelly came in early to be sure to put out new packages of PPE and brief the employees on infection control and isolation policies and what the DOH may ask . . . and that we need to use common sense when answering." LPN Fairbanks also wrote, "I took this as a threat, that if we answer truthfully we may lose our job." The night before (April 28, 2020), "[t]he Director had night shift put up isolation signs . . . and other protection measures that should have been done over a month ago." (Detective Aff. ¶¶

[33] *See* New York State Department of Health, About Nursing Home Inspections, https://profiles.health.ny.gov/nursing_home/pages/about_inspections (last accessed Oct. 25, 2022).

33-35, Ex. B.) Later that morning, personnel from DOH arrived at the facility to conduct a survey. (*Id*. ¶ 34; *see also* Auditor Aff., Ex. 66.)

154. In sum, this culture of deceit and cover-up created an environment ripe for neglect. (*See* 10 NYCRR § 81.1[c] [defining "neglect" as failure to provide "timely, consistent, safe, adequate and appropriate services, treatment and/or care. . . including but not limited to: nutrition medication, therapies, sanitary clothing and surroundings, and activities of daily living"].)

G. Respondents Continued to Pressure Staff to Admit New Residents Despite Knowing The Villages Did Not Provide for Residents' Basic Needs.

155. Respondents persistently violated 10 NYCRR § 415.26(i)(1)(ii), which requires that nursing homes limit new admissions, and "accept and retain only those nursing home residents for whom [the nursing home] can provide adequate care." To the contrary, Respondents increased revenue by seeking more admissions without regard for The Villages' inability to care for its current residents, let alone new ones. The increased revenue was necessary to ensure ongoing exorbitant cash transfers to Respondents in the form of purported "rent" payments.

156. Multiple sources confirm Respondents' desire to keep beds full in order to increase revenue, no matter the human cost and potential harm to residents. DON Donnelly testified that after the facility became The Villages in 2015, there was pressure from Respondents Halper and Lahasky to increase the number of residents at the facility until all 120 beds were full. (SAAG Aff., Ex. 13 at 156:6 – 157:6.) DON Donnelly testified that in 2017 or 2018, Kim Brueckner ("Brueckner"), who handled admissions, sought DON Donnelly's input about potential new residents, but that stopped after DON Donnelly advised against certain admissions. According to DON Donnelly, "it got to the point where corporate office got involved and said that [Brueckner] was not to ask me any longer whether or not these people were appropriate for admission. She was just to admit them." (*Id.* at 149:15 – 152:6.)

157. Former Villages Environmental Services Director Elijah Howard ("E. Howard") testified that he was concerned about residents at The Villages and he knew:

> that we couldn't take care of the people the way that we should have, but then they kept on bringing them in. There's nothing that I could do about that part. It's above my pay grade. So yeah, I was really concerned. It became – people would ask me you can't take care of what you have now and now they want more people in . . . .

(*Id*., Ex. 15 at 191:21 – 192:12.)

158. DON Mikits also testified that she and Brueckner were pressured by the Administrator, Eric Flugel[34] ("Admin Flugel"), to admit everyone to The Villages. (*Id*., Ex. 9 at 103:20 – 104:12.) Email from Respondent Halper to Respondent Gast and others confirms this laser focus on filling beds, without concern for resident welfare. On January 21, 2020, Halper emailed regarding an empty resident room at The Villages, writing, "Kevin/Jason can you get the room fixed? I didn't know theres [sic] a room offline there but now we cant [sic] fill up." (*Id*., Ex. 16.)

159. DON Mikits testified that she had concerns about The Villages admitting new residents because inexperienced staff at The Villages could not properly care for new admissions. According to DON Mikits, "We didn't have the staff to accommodate our growing need and quite honestly, the place was running a mess. So let's get it straightened out before we start throwing people in here to just take care of willy-nilly." (*Id*., Ex. 9 at 105:9-23.) DON Mikits said that she spoke with Admin Teitelbaum and Admin Flugel on a "regular basis . . [a]nd like everything else that you speak to anyone there about, you would get a better response if you just looked at the wall and carried on a conversation with it." (*Id.* at 105:24 – 106:7.)

[34] Eric Flugel was the Director of Rehabilitation at Villages from approximately March 2017 to October 2020, when he was promoted to facility Administrator. He is currently the Administrator of The Villages.

160. Similarly, CNA Sample testified that when the facility became The Villages,

> it just turned into whoever we can take, we're going to take. We're going to take people from group homes. We will take people from a prison. We will take people from four states over. They just don't care. Now they are taking people from drug facilities or halfway houses or -- they are just taking people from all over. Drug rehab centers -- they are bringing people in from drug rehab centers. So at this point -- and they are all mixed together. You don't know what you're going to get, who you're going to get or how these people are going to react to you or anything in all honestly. It's just -- it's very hard to go from, you know, they are putting them in rooms with each other that -- these people should not be in the same rooms with each other. If you know a guy is going to scream and holler and kick the walls and spit in peoples' faces, you're not going to put him into a room with somebody that can't defend themselves or someone that's laying in bed and can't move or pick up their arms because they are contracted. This is -- that's what goes on there. So they are literally just taking people to take them.

(*Id*., Ex. 12 at 109:18 – 110:20.)

161. CNA Brown testified that she was concerned The Villages admitted residents it could not care for, especially extremely overweight residents whose needs could not be met because of the broken Hoyer lifts, and psychiatric patients who displayed aggressive behavior, which was "dumb" in a facility that was usually short-staffed, because CNAs were not trained on how to handle these residents and the psychiatric residents often required one-on-one care at all times. (*Id*., Ex. 11 at 94:12 – 96:3.) Kelly Daigler ("CNA Daigler") worked as a CNA at The Villages off and on for twenty years, from 1998 through 2006, and again from 2010 through 2018, and three months between 2018 through December 2020. CNA Daigler testified that she became concerned that The Villages was admitting residents it could not care for starting in 2017 and that she was never concerned about the kinds of residents admitted to the facility when it was county-owned. (*Id*., Ex. 17 at 24:3 – 24:11.) She testified that The Villages "would take any type of people. We had – like near the end when I was there, we had people that should have been in drug and alcohol rehab, but they were bringing them there. One guy had just been released from prison." (*Id.* at 23:14 – 24:2.)

162. As detailed in the Auditor Affidavit, MFCU's analysis of staff timecards and resident admission records further confirms that The Villages continued admissions in the run up to COVID-19 despite dangerously low staffing levels. (*See* Auditor Aff. ¶¶ 148-157.)

163. Pressure to increase The Villages' census continued even when staff pointed out the numerous staffing and process issues that needed to be addressed at The Villages in September 2020. For example, Toni Dimas ("Dimas"), The Villages' MDS[35] coordinator, emailed Michelle Romeo[36] on September 1, 2020, about management "pushing to increase our census" although there were numerous other pressing tasks she needed to perform. (SAAG Aff., Ex. 18.)

164. In October 2020, The Villages continued to admit new residents despite concerns from staff. In an email dated October 27, 2020, DON Mikits replied to an email from Brueckner regarding three new admissions planned for that day. DON Mikits wrote, "Damnit the staff is threatening to kill me!!! Thanks though, we need our numbers up! . . . LOL" (*Id*., Ex. 19.) In a text message exchange from December 22, 2020 between DON Mikits and SW Woodin, DON Mikits and SW Woodin discussed management's attempt to increase the census at The Villages. SW Woodin wrote, "They need to stop with all these admissions!! No one is caught up from last weeks. It's getting way to [sic] crazy!! All the room changes on top of 3 admissions in a day a few times a week. We need staff before more admissions." (Detective Aff. ¶ 173, Ex. R.)

165. In a January 3, 2021 text message discussion following a resident's death from a suspected illegal drug overdose, SW Woodin wrote to DON Mikits, "We need to stop getting these

[35] MDS (Minimum Data Sets) assessment is a federally-mandated process used to evaluate patients in Medicaid- and Medicare-certified nursing homes. Assessments are conducted by trained nursing home clinicians upon admission and discharge, as well as at other regular intervals and when there is a significant change in the status of a patient.

[36] Michelle Romeo is a clinical reimbursement consultant who oversaw the MDS assessments for The Villages' residents. (*See* SAAG Aff., Ex. 38.)

prisoners. They need to stop admitting anyone and everyone. That's frustrating. I know it's not Kim [sic] fault. I feel bad for her because they are hounding her to fill beds, not worrying about not having staff, nor trained staff to deal with addicts." (*Id.* ¶ 172, Ex. Q.)

166. Then, despite The Villages' SFF designation in March 2021, and in continuing disregard for the residents' well-being, The Villages continued to prioritize increasing its revenue by pushing to admit new residents. For example, on April 13, 2021, Admin Teitelbaum emailed Brueckner asking, "census goal to break 100 this week??" Brueckner replied, "Absolutely, we have one new admit today and one set up for tomorrow. I am working on others as well." (SAAG Aff., Ex. 20.)

167. Respondent Lahasky admitted that census is a "big deal" to him, and he closely monitors census at all of the over 150 nursing homes he owns:

> There is always a drive to keep census high, you know. In a way, it's like a hotel. You don't want empty beds, you don't want vacancies. Your costs are – a lot of it is static. If you're running at 50 or you're running at 120, a lot of the costs don't change so you always want to have – not always but, you know, it's a big deal to keep the census up which is why that's a report I look at.

But Respondent Lahasky also testified that he doesn't concern himself with the appropriateness of new admits to the facility and looks at census from "afar." (*Id.*, Ex. 4 at 231:21 – 232:17; 254:16 – 256:8.)

168. Joshua Farkovits similarly testified that Telegraph's business is analogous to a landlord leasing its property to a "La Quinta" hotel. (*Id.*, Ex. 21 at 78:20 – 79:11.) Of course, unlike a short-stay hotel, nursing home residents "depend upon the facility to meet every basic human need" and the nursing home has a "special obligation" to care for its residents. (10 NYCRR § 415.1[a].)

169. Asked whether there was a repeated push to increase census to boost profitability at The Villages, Respondent Halper stated, "I plead the Fifth." (*Id*., Ex. 7 at 66:7-10.)

H. The Villages Does Not Communicate Vital Health Information to Family Members, and Makes It Difficult for Residents to Communicate with Their Families.

170. Lacking sufficient staff to provide basic care due to Respondents' profiteering, The Villages certainly lacked staff to provide timely and accurate information to resident's representatives, as required by 42 CFR § 483.10(g)(14). (*See* 42 CFR § 483.10[g][14] [requiring the facility to immediately inform the resident's representative[s] when there is an accident involving the resident that "results in injury and has the potential for requiring physician intervention"; "a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment significantly"; "a decision to transfer or discharge the resident from the facility"; and "a change in room or roommate assignment"].) Family members of The Villages' residents frequently had difficulty getting vital health information about their loved ones, either because there simply was not the staff to keep track of issues and communicate them as appropriate under the law, or staff lacked accountability to management to treat the residents and their families with the respect they deserved.

171. Witness Donna Kelly stated that her daughter, Resident 35, fell many times at The Villages, resulting in fractures, black eyes, and bruising. (Kelly Aff. ¶ 25.) Sometimes Kelly was notified about the falls, but other times she was not. (*Id.*) The Villages ignored Kelly's request to move Resident 35's mattress to the floor to avoid falls. (*Id*.) Donna Kelly recalled one day when she went to The Villages after having been notified that Resident 35 fell, to find that Resident 35's tooth had gone through her lip, and Resident 35 was covered in blood that had not been cleaned up by The Villages' staff. (*Id.* ¶ 26.)

172. According to witness Ondrea Pate, when her mother was discharged from The Villages on April 21, 2020, DON Donnelly gave her incomplete information as to her mother's exposure to COVID-19 and did not alert her as to the facility's COVID-19 outbreak. (Pate Aff. ¶¶ 9, 12.) Failure to "notify family members or next of kin if any resident tests positive for COVID-19, or if any resident suffers a COVID-19 related death, within 24 hours of such positive test result or death" is a violation of Executive Order No. 202.18. (SAAG Aff., Ex. 23.) Upon discharge, Resident 7 told her daughter that Resident 7's roommate at The Villages had tested positive, and that the facility had kept Resident 7 in the same room with her roommate for four days following her roommate's positive test result. (Affidavit of Ondrea Pate ["Pate Aff."] ¶ 11.) Resident 7 later died from COVID-19. Yet, thirteen days after Resident 7's discharge and two days after Resident 7's death, DON Donnelly entered a retroactive nursing note in Resident 7's resident record reflecting that on the day of discharge, DON Donnelly educated Resident 7's husband that Resident 7 had been in "close contact" with a COVID-19 positive resident and Resident 7's husband chose to proceed with the discharge plan. According to the note, Resident 7's daughter was also notified of the close contact. (Medical Analyst Aff. ¶ 27.)

173. According to witness Rebecca Lockwood, when her husband, Resident 53, left the hospital to be transported to The Villages in December 2020, she was told by then DON Mikits that someone from The Villages would contact her after he arrived at the facility so that she could provide The Villages with her husband's medical history. (Lockwood Aff. ¶ 9.) She never received an arrival notice, became worried that her husband did not arrive safely to The Villages, and began calling the facility. (*Id*.) She called The Villages numerous times, but no one answered the phone. She had to call the Ombudsman (a N.Y. State employee assigned to advocate for nursing home

residents and mediate disputes)[37] who was able to get in touch with a nurse at The Villages, who then called Lockwood and told her that she did not have time to make calls to family members. (*Id*. ¶ 10.)

174. The only way Lockwood could contact her husband, Resident 53, at The Villages was by calling the nurse's station. (*Id*. ¶ 19.) Due to his tremors, Resident 53 could not open his iPad without assistance. (*Id.*) There were many times when Lockwood attempted to set up such video visits, but The Villages' staff would not even answer the phone for many hours. (*Id*.) She often had difficulty contacting The Villages, as no one on the staff had their voicemail set up, and she was unable to leave messages. (*Id*. ¶ 23.) She sent "countless" emails to Admin Flugel, SW Woodin, Occupational Therapist Assistant LeeAnna SanFilippo ("OTA SanFilippo"), and DON Howard, but rarely, if ever, received a response. (*Id*.)

175. Witness Donna Kelly also recounted that she was unable to get in touch with staff at The Villages via phone because they claimed to be in meetings or did not have voicemail set up. (Kelly Aff. ¶ 27.) In 2021, her daughter, Resident 35, was admitted to the hospital, after experiencing two grand mal seizures at The Villages. She was supposed to be released back to The Villages the following day. That day, Kelly called The Villages numerous times to see if her daughter had arrived. She was unable to get in touch with anyone at The Villages and drove over an hour from the Rochester area to The Villages to see if her daughter had arrived. (*Id*. ¶ 28.) When she arrived, she was told by the medical van transporter that her daughter was not at The Villages. (*Id*.) She later found out that her daughter had been transferred to Strong Memorial Hospital in Rochester, New York, because the hospital tried to call The Villages, but could not get in touch with anyone at the facility. (*Id*.)

[37] *See* N.Y. Elder Law § 218.

176. Witness Cynthia Delaura relayed that her mother, Resident 8, fell the first day she arrived at The Villages in October 2019, and then fell two additional times at The Villages. (Delaura Aff. ¶¶ 8, 11.) Delaura was never notified by The Villages as to one of the falls, which occurred on May 8, 2020, and only learned of it because she called The Villages to check on her mother. (*Id*. ¶ 11.) On this day, when Delaura called The Villages, a CNA told her The Villages doctor wanted Resident 8 to stay at The Villages and that Resident 8 did not need to go to the hospital. Instead, Delaura took her mother to the hospital, where it was determined she had broken her hip during the fall and required surgery. According to Delaura, while her mother was at The Villages, between October 2019 and May 2020, Delaura tried calling to talk to the Director of Nursing or the Administrator approximately ten times and was never able to reach either of them. She left voicemails each time but did not receive return calls. (*Id*. ¶ 14.)

177. In addition, The Villages' residents and families had to rely on The Villages' staff to facilitate communication, because they did not have access to adequate avenues of communication with their loved ones. In contravention of 10 NYCRR § 415.3(e)(3), residents at The Villages did not have regular access to private telephones to call their loved ones – resident rooms at The Villages did not have telephones, available phones in the hallway were scarce, were not private, and could not be accessed by many residents, and the facility did not have reliable cell phone service. (Detective Aff. ¶ 229.)

178. Witness Darlene Stevens testified that when her brother, Resident 34, was first admitted to The Villages in late December 2020, she was able to FaceTime with him once per week, but that quickly changed. (Stevens Aff. ¶ 11.) It became very difficult to get in contact with anyone at The Villages. She would constantly call to try to speak with a nurse, CNA, or anyone

she could get a hold of, but no one answered the phones in any section of the facility. She went days without any communication. (*Id*.)

179. Witness Laurel Harrington stated that while her friend, Resident 42, was a resident of The Villages, between January 2021 and July 2021, it was difficult to contact anyone at The Villages, and no one answered the phones. She complained about this to the facility administrator, Admin Flugel, at least twice. She left several messages for The Villages' Director of Nursing and did not receive a return call. When she wanted to get information to Resident 42, Harrington was forced to route hand delivered messages through the billing office. (Harrington Aff. ¶ 15.)

180. Finally, shortly before Resident 42's death, in July 2021, Harrington received a call from the hospital alerting her to Resident 42's condition. Although Harrington was the healthcare proxy for Resident 42, The Villages did not contact Harrington to tell her Resident 42 had been sent to the hospital, where she died. (*Id*. ¶ 22.)

I. Respondents' Failure to Ensure Proper Infection Control Procedures During the COVID-19 Pandemic Endangered The Villages' Residents and Staff.

181. The intentional short-staffing model used by Respondents snapped when the COVID-19 pandemic increased the demands on staff and required more time and attention to avoid spreading infection. But just as disturbing is that The Villages did not have a proper infection control policy at any time before the COVID-19 pandemic and made no efforts to create a policy in early 2020, even after the Department of Health warned all Article 28 facilities on February 6, 2020, to "be ready and equipped to promptly screen, and where appropriate, to isolate, further evaluate, and correctly manage patients" presenting to their facility the potential of being infected with COVID-19. (SAAG Aff., Ex. 24.)

1. The Villages' Delayed and Secretive Response to COVID-19 Infection Control Protocols Likely Caused Higher Deaths at the Facility.

182. MFCU found that management at The Villages attempted to keep COVID-19 infections secret, and either delayed or failed to cohort symptomatic residents, observe proper sanitation protocols, and follow even the most basic infection control procedures during the height of the COVID-19 pandemic, in violation of 10 NYCRR § 415.19, likely causing a greater number of deaths at the facility. (*See id.* [requiring nursing home facilities to establish an infection control program, prevent the spread of infection by implementing numerous safeguard measures, and report increased infections and communicable diseases to the appropriate government agencies]; *see also* 42 CFR § 483.80 [same under federal law].) For example, The Villages did not have an Infection Preventionist as required by 42 CFR § 483.80(b) and (c). (SAAG Aff., Ex. 13 at 107:5 – 109:11.)

183. Mary Fairbanks ("LPN Fairbanks"), an LPN who has worked at The Villages off and on since approximately 2013, stated the facility's first case of the COVID-19 virus was known on March 30, 2020. The man who tested positive was sent to the hospital that day. According to LPN Fairbanks, his chart documented that he had a fever three days prior to being tested. This first case was treated as "a big secret," and for the next three weeks, despite the initial DOH warning and multiple updates from DOH and CDC dating back to early February, the facility did not do anything to avoid the spread of the virus. LPN Fairbanks told DON Donnelly that they needed to lock down a unit for residents that tested positive to avoid the spread, but DON Donnelly ignored her concerns. Other employees also expressed their concerns to DON Donnelly, but their concerns were similarly ignored. (Detective Aff. ¶ 29.) Likewise, The Villages never informed the staffing agency it used that there were positive cases of COVID-19 at the facility and that there was a lack of N95 masks for agency employees. (*Id*. ¶ 62.)

184. LPN Fairbanks also stated that The Villages did not respond quickly to the COVID-19 outbreak, and that staff were floating from positive residents' to negative residents' rooms because they were so short-staffed. (*Id*. ¶ 24.) It wasn't until April 28, 2020, one day before a DOH visit for which The Villages had advance warning, that DON Donnelly instructed LPN Fairbanks to put up isolation signs throughout the facility. This was a month after the first COVID-19 positive resident in the facility. (*Id*. ¶ 33.)

185. According to CNA Poole, the Canal View and Garden View units were housing positive and negative residents together. Meanwhile, every resident on the Orchard View unit was positive except for one resident that was also a "wanderer." CNA Poole did not know why the administration was keeping the only negative resident on a full positive hall. (*Id*. ¶ 99.) RN Zambito also stated that the facility mixed COVID-19 positive employees with COVID-19 negative residents, and mixed COVID-19 positive residents with COVID-19 negative residents. (*Id*. ¶ 143.)

186. Hope Albone ("CNA Albone") is a part-time CNA, who has worked at The Villages since at least March 2020. CNA Albone stated that as of April 20, 2020, residents were still able to socialize outside of their rooms on the Canal View unit, despite positive cases of COVID-19 on the unit. All units at The Villages had residents that had tested positive for COVID-19 as of that date. The facility, nonetheless, began moving patients from other units to Orchard View, which has a total of 24 beds, and where there were 18 residents that had tested positive for COVID-19. (*Id*. ¶ 44.) Susan Nashburn ("Nashburn"), an Activities Aide at The Villages from approximately mid-March 2020 to early April 2020, also gave examples of the cross-contamination taking place at the facility. On April 25, 2020, she observed, together in one room, resident "A," who had tested

negative for COVID-19, and resident "B," who had tested positive. Meanwhile, the curtain dividing the room was wide open. (*Id*. ¶ 53.)

187. Nashburn stated that residents were being moved in and out of rooms without them being properly sanitized due to the lack of staff. (*Id*. ¶ 49.)

188. A husband and wife on the dementia unit who both tested positive for COVID-19 were able to wander the halls while positive due to low staffing; there was usually only one aide for that entire unit. (*Id*.)

2. Staff Were Working While Sick with COVID-19.

189. In addition to the above infection control failures, The Villages staff were working while sick with COVID-19, in violation of 10 NYCRR § 415.19(b)(3).[38]

190. Nashburn stated there were aides that had elevated temperatures but were allowed to continue working. An agency employee allegedly came back to work after travelling and complained that she did not feel well several days after her return, but was told to go back to work even though she was not feeling well. That employee ended up testing positive for COVID-19. The policy that was dictated to Nashburn "per the owner Jason," was that if an employee had a temperature upon arriving to work, the employee was to go outside for one hour then come back inside and take their temperature again. (*Id*. ¶ 55.)

191. According to witness Susan Fuller, after repeated delays and unreasonable hurdles, her parents, Resident 54 and Resident 39, were finally allowed to room together, only to contract COVID-19 and die a few days apart. (Fuller Aff. ¶¶ 10-13, 35.) RN Zambito stated that various

[38] Per 10 NYCRR § 415.19(b)(3), a facility "shall prohibit persons . . . known to have a communicable disease . . . from direct contact with residents or their food, if direct contact will transmit the disease."

staff members, including those that were COVID-19 positive, went in and out of their room during the outbreak. (Detective Aff. ¶ 147.)

192. Jake Hebdon, a local funeral home director, entered The Villages to remove bodies on numerous occasions in April and May 2020. Hebdon stated that the facility was very understaffed and that he thought about complaining but did not know who to go to. Hebdon further stated that while at The Villages he removed a dead resident whose body had been left in their room together with a roommate who was coughing loudly. Hebdon also observed nurses cross-contaminating COVID-19 negative and positive residents. (*Id*. ¶¶ 218-220.)

3. The Villages Has No Staff to Monitor Visitors or Perform Temperature Checks.

193. The Villages also failed to screen employees and visitors for signs of illness.

194. According to LPN Fairbanks, as of late April 2020, the facility screened employees before they came into work but only up until 8:30 p.m. After 8:30 p.m., employees had to take their own temperature and no one monitored that. (*Id*. ¶ 39.)

195. According to Orleans County Coroner Scott Schmidt, when he arrived at The Villages in April 2020 to remove a body, no one at the facility took his temperature or otherwise screened him for COVID-19. Schmidt further observed that a resident's body had been left in their room without a sheet or cloth covering the face (in contravention of normal protocol) and noted that a roommate was being wheeled out of the room by a staff member. When the resident asked why she was being moved, the staff member responded, "because your roommate died." Schmidt also stated that he was aware of at least one staff member working after testing positive for COVID-19. (*Id*. ¶¶ 216-217.)

196. During one of her visits with her brother at The Villages, after in-person visitation resumed, Darlene Stevens recounted that she was able to walk right into the facility, sign herself

in and take her own temperature, walk through the facility, and walk into the dining room in the dementia unit before seeing a single staff member. When she arrived in the dining room, she observed one CNA attempting to feed at least ten residents. (Stevens Aff. ¶ 15.)

197. According to witness Donna Kelly, in spring 2021, no one at The Villages monitored those who entered the facility. No one was present with a sign-in sheet or to take the visitors' temperatures. (Kelly Aff. ¶ 16.) Indeed, as recently as April 20, 2022, and despite The Villages' mandates to the contrary, MFCU Detective Jaimie Krzyskoski visited The Villages and upon arrival at 11:00 a.m., entered the first set of doors to the facility where there was a phone on the wall to use to call reception to open the second set of doors. She called three times with no answer. After five minutes, two staff members walked by and opened the door for her, without asking her why she was there. She walked through the entrance; there was no reception staff, no sign-in book or thermometer. She had no idea where to go and walked down a few hallways until she found a staff member who was able to give her directions to a resident's room. (Detective Aff. ¶ 222.)

4. Respondents Failed to Provide The Villages' Staff With Adequate PPE.

198. In addition to The Villages' failure to adhere to even basic infection control protocols, despite being aware of the dangers of the COVID-19 pandemic, Respondents failed to provide sufficient personal protective equipment ("PPE") for The Villages' staff, and The Villages' management hoarded and rationed it instead of dispensing it appropriately. According to LPN Dioguardi, in the "beginning" of the pandemic, there was no PPE gear because DON Donnelly had it "locked up." Dioguardi believed that the outbreak of the virus at The Villages happened so rapidly because of the lack of PPE and because there was not enough staff to contain the residents appropriately. (*Id*. ¶ 65.)

199. LPN Fairbanks stated that cross-contamination and lack of adequate PPE were huge concerns in the facility. Numerous staff reported having to reuse disposable gowns creating a risk of cross-contamination. (*See, e.g.*, *id*. ¶¶ 30, 37, 45-46, 52, 66, 86, Ex. C.)

200. Witnesses stated that prior to a DOH inspection on April 29, 2020, only some gowns were available for staff as they were put out "sporadically." Gowns were left on the doors of rooms of Covid-19 positive residents to be used by any aides entering the room. The gowns were reused by staff on every shift. When DOH came to inspect the facility, however, DON Donnelly claimed she never told the aides to reuse the gowns. (*Id*. ¶ 86.) Mike Estela ("PTA Estela") is a Physical Therapy Assistant who has worked at The Villages since at least January 2020. PTA Estela stated that when DOH showed up for a "surprise visit," on April 29, 2020, the facility must have had a few days' notice because they provided staff with PPE gear when DOH came. (*Id*. ¶ 92.)

201. Despite having taken millions of dollars out of The Villages during its first five years of operation, Respondents left the staff and the residents to bear the cost of their "up-front" profit-taking. Nashburn stated that she had to work one-on-one as an Activities Aide with COVID-19 positive patients, but DON Donnelly refused to give her and two other Activities Aides PPE gear. She was only provided a regular mask to wear and was told it only lasted 30 minutes. When everything "came to a peak," DON Donnelly provided her with an N95 mask, but she was directed to re-use it, and DON Donnelly told her to put it in the dryer every day to kill the germs. (*Id*. ¶ 51.) At one point, Nashburn said that every resident on the Orchard View unit was positive for the COVID-19 virus. Employees were directed to "gown up" and then hang the gown inside the resident's room on their closet door to be reused. Nashburn asked DON Donnelly for her own gown and DON Donnelly told her she could not pass them out "willy nilly," and that they were

only for those "on the front line," despite Nashburn interacting closely with COVID-19-positive residents. Ultimately, the Activities Director obtained three gowns for the three Activities Aides, but they had to wear the same gown every day. The gowns became visibly soiled and had to be thrown out. After that, the Activities Aides began just wearing a regular sleeping gown over their clothes when tending to residents. (*Id*. ¶ 52.)

202. In April 2020, an agency aide asked LPN Fairbanks for a mask and LPN Fairbanks had to call DON Donnelly to get one. DON Donnelly told her that the aide could only have a surgical mask because she did not have any N95 masks and the aide "didn't need one." (*Id*. ¶ 30.)

203. RN Zambito voiced her concerns to DON Donnelly and the facility administrator, however, they continued to keep the PPE under lock and key. RN Zambito stated that the administrator attempted to get more PPE from "corporate" but was "unsuccessful." (*Id*. ¶ 144.)

204. Even as late as December 2020, The Villages' staff were forced to ask management for basic PPE to protect themselves from infection. In a group text message on December 16, 2020, that included many managerial employees of The Villages, including Brueckner, Admin Flugel, SW Woodin, E. Howard, DON Howard, and OTA SanFilippo, DON Howard wrote, "We need more surgical masks for the residents. None in the main PPE room." (*Id.* ¶ 163, Ex. L.)

205. RN Moore stated that staff did not have appropriate PPE gear until after DOH came in for an inspection. Prior to the DOH visit, RN Moore's husband donated eight boxes of N95 masks from his employer. RN Moore brought in the eight boxes of N95 masks and DON Donnelly locked them all up in her office. RN Moore's husband was able to get a few more boxes, so she kept them in her car and passed them out to staff members herself. (*Id*. ¶ 85.)

206. PTA Estela stated that he eventually purchased his own Tyvek plastic suit and sprayed it down and hung it to dry every night. He also purchased his own painter's mask. (*Id*. ¶ 91.)

III. DOH Inspections Dating Back to 2015 Show Respondents' Disregard for Resident Welfare – DOH Issues Multiple Citations to The Villages.

207. The findings of DOH surveys and inspections since 2015 demonstrate Respondents' disregard for the care and well-being of The Villages' residents, and a troubling inadequacy of staffing levels—despite evidence that The Villages and Respondents had notice when DOH surveyors were coming. Indeed, COVID-19 was not the cause of the woes for The Villages, it was simply the point of total failure for Respondents' "up-front profit" model. Each of the findings in the surveys below were communicated to one or more of the Individual Respondents, all of whom were obligated to The Villages' residents and none of whom made any meaningful effort or expenditure to resolve the well-documented problems at The Villages. Each of the surveys below reflect merely a sampling of residents and operations at The Villages, as DOH surveyors do not inspect every person and situation at a facility, and the findings below are illustrative, rather than an exhaustive list of DOH's deficiency findings.

208. In a survey completed on July 31, 2015, just seven months after Respondents took over operation of The Villages, a DOH surveyor observed mold on food items and other areas of the walk-in cooler; storage of undated, outdated, unlabeled, and uncovered food items; suboptimal temperatures in the cooler; soiled floors; flies; dirty and wet pans stored for use; and bearded dietary staff who were not wearing beard covers during meal preparation in the kitchen. The surveyor further observed a refrigerator labeled "Resident's [sic] refrigerator" that "smelled of rotten food" and contained undated and severely outdated items. Villages' staff members did not

know who among them was responsible for cleaning the residents' refrigerator. (Auditor Aff. ¶ 101, Ex. 23.)

209. On October 13, 2015, a DOH surveyor found that The Villages failed to notify the facility's physicians and a resident's family in an instance where the resident ran a fever for an extended period and experienced difficulty swallowing. The surveyor additionally observed that the same resident did not receive a wound consultation for a worsening pressure sore as ordered by The Villages' physician. (*Id*. ¶ 102, Ex. 24.)

210. In DOH's annual survey of The Villages completed on April 25, 2016, DOH surveyors observed multiple deficiencies, including deficiencies involving dignity and respect of the individual, failure to develop and implement comprehensive care plans, and failure of qualified persons at The Villages to provide services per residents' care plans. As examples, surveyors observed the following: (1) lack of timely assistance to residents during meals; (2) failure to update a resident's care plan to address the use of an anticoagulant (medications used to prevent blood from clotting) medication, including monitoring for signs of bleeding; (3) failure to revise residents' care plans for the increased level of assistance required to eat, for a change in dosage of a psychotropic medication and the need for increased assistance to eat, for the development of a urinary tract infection (UTI), and for the physical aggressiveness of a resident towards other residents and staff; (4) CNAs did not wash hands or change gloves after providing incontinence care; (5) failure to provide a right palm guard, per a resident's care plan, to prevent worsening contractures from occurring for a resident with a splint application; and (6) resident at risk for aspiration (taking foreign matter into the lungs) because resident was not positioned in a manner that was conducive for eating or swallowing and was coughing and choking intermittently throughout meals. During the same inspection, the DOH surveyor observed that residents reviewed

for pressure sores had a seven-day delay in the initiation of treatment, there was no evidence of a proper weekly RN wound assessment, and preventative wound care measures were not in place as ordered in a resident's care plan. (*Id*. ¶ 103, Ex. 25.)

211. In a survey completed on June 22, 2017, DOH surveyors confirmed that staff at The Villages did not follow the care plan of a resident who had a history of starting fights with other residents. Specifically, The Villages failed to provide one to one supervision of that resident when out of bed, per the resident's care plan. Because of The Villages' failure to follow the resident's care plan, the resident wandered undetected to another unit, striking another resident three times in the chest before staff intervened. (*Id*. ¶ 104, Ex. 26.)

212. In a survey completed on July 12, 2017, a DOH surveyor observed that The Villages did not properly screen employees for abuse through the New York State Nurses Aide Registry. The surveyor further observed that The Villages did not ensure that a resident with a pressure sore received the necessary treatment and services to promote healing because The Villages did not complete wound treatment as ordered by the physician. (*Id*. ¶ 105, Ex. 27.)

213. In an inspection completed on February 21, 2018, after a complaint was filed on February 13, 2018, DOH surveyors found that nursing staff at The Villages failed to notify the medical doctor of a "change in condition" of a resident. That innocuous sounding "change in condition" was the fact that the resident experienced abdominal distension with multiple episodes of vomiting, rectal bleeding, weakness, and abnormal vital signs, and had died before the resident could be transported to the hospital. In addition, the surveyor found no evidence that The Villages notified the resident's physician of a skin condition or completed a proper assessment of the condition, and that nursing staff applied a skin treatment without the physician ordering such treatment. (*Id*. ¶ 106, Ex. 28.)

214. In DOH's annual survey completed on November 16, 2018, DOH surveyors cited The Villages for, among other things: (1) failing to promote self-determination because residents were not given the choice of how often they wanted to shower (specifically, the opportunity to shower more than once a week); (2) failing to maintain a clean, comfortable, homelike environment because hot water was not being provided for bathing and bathroom facilities were not properly cleaned and maintained; (3) failing to properly develop care plans to address residents' behavioral issues and use of psychotropic medications; (4) failing to provide CPAP treatment as ordered by the doctor and failing to repair a broken CPAP machine, and (5) failing to remove an employee from duties involving direct care in accordance with the DOH criminal history record check process. (*Id*. ¶ 107, Ex. 29.)

215. On April 2, 2019, approximately one year before the COVID-19 pandemic, DOH conducted an inspection in response to a complaint filed on January 18, 2019. Surveyors observed that The Villages did not have sufficient staff to complete 15 showers, to monitor the dining room, to assist residents with their toileting needs and to properly feed 11 residents. (*Id*. ¶ 108, Ex. 30.)

216. As part of this inspection, DOH surveyors interviewed numerous CNAs who stated that The Villages is often short-staffed and residents suffer as a result:

- "I worked on Canal View today and I did not get any of my showers done. There were four residents that didn't receive them. I worked as hard as I could, but I just could not do the showers. I was the only CNA over there, we were short staffed. We are short staffed a lot of the times."
- "I am the only CNA on Orchard View today. I was not able to get the showers done today. I had three residents scheduled to have showers done today. We are short staffed today. Also, I was not able to toilet Resident #1 every two to three hours

today and I just got to him and he was incontinent. Normally if I am able to toilet him as scheduled he is not incontinent."

- "I was not able to complete any of my showers today on Garden View. There were three residents scheduled to be showered, that I was not able to get done. Residents' hair didn't get done either. I was the only aide over there, we are very short staffed today. I had my nurse help me with the two assists. We are short staffed quite often."
- "I was not able to get all my work done today because we were short staffed. I was not able to get any of my showers done today I had five showers scheduled for today. There are thirty residents for only two aides and five showers over here on Autumn View North today. I didn't even take a lunch today. They are normally short staffed, Sometimes we have two CNAs on each unit and on a rare occasion three. When we have three aides, those are the days we will do nails and hair."

(*Id*. ¶ 109, Ex. 30.)

217. Also on April 2, 2019, DOH surveyors observed a resident whose care plan called for supervision while eating due to aspiration risk, and who had been ordered a puree/ honey thick liquid diet, take a sandwich from another resident's meal tray and eat it. An LPN in the dining room stated "[t]his isn't the first time he has done this. He often grabs at things . . . I wasn't watching him because I was busy passing other resident's [sic] trays because we are short staffed today." (*Id*. ¶ 110, Ex. 30.)

218. In the Statement of Deficiencies, DOH surveyors further noted that several residents at The Villages "had an odor" because they had not been bathed. (*Id*. ¶ 111, Ex. 30.)

219. On April 2, 2019, DOH surveyors further found that all five units in the facility did not have sufficient staff and failed to meet The Villages' Facility Assessment.[39] DOH also reviewed The Villages' Daily Staffing Worksheets from March 1, 2019 through March 31, 2019 and found the following: (1) Day shift CNA levels per the Facility Assessment were not met for eight out of the 31 days; (2) Evening shift CNA levels per the Facility Assessment were not met six out of the 31 days; (3) Night shift CNA levels per the Facility Assessment were not met 19 out of the 31 days; (4) Day and Evening shift LPN levels per the Facility Assessment were not met two out of the 31 days; and (5) Night shift LPN levels per the Facility Assessment were not met 14 out of the 31 days. (*Id*. ¶ 112, Ex. 30.)

220. In an abbreviated survey completed on July 9, 2019, surveyors again found The Villages did not have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. DOH found that The Villages did not meet the minimum standards they set for nursing services staff as documented in the Villages' Facility Assessment Tool and did not meet the minimum standards set for CNAs as documented in the facility's Critical Staffing Plan. Through review of staffing "Worksheets," as well as observations and interviews, DOH found numerous incidents of insufficient staffing levels in June and July 2019, substantiating a finding of federal deficiency for insufficient nursing staff. (*Id*. ¶ 113, Ex. 31.)

221. On May 9, 2020, DOH conducted an on-site survey at The Villages resulting in an "Immediate Jeopardy" finding due to infection control violations. Immediate Jeopardy means "a

[39] The Facility Assessment Tool is an internal Villages' document prescribing necessary staffing levels "to ensure residents needs are practicably met." (Auditor Aff., Ex. 45 at 7.)

situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (42 CFR § 488.301.) Among other things, the surveyor found that The Villages "failed to protect asymptomatic non-COVID-19 residents" after observing multiple staff members who were not wearing proper PPE or observing proper hand hygiene while providing care to residents. (Auditor Aff. ¶ 114, Ex. 32.)

222. DOH surveyors further observed CNAs and LPNs exiting a COVID-19 positive room and entering COVID-19 negative rooms while serving breakfast trays, assisting with trays, and providing care without PPE and completing proper hand hygiene. Surveyors also observed that PPE was not readily accessible to staff and that residents under investigation for COVID-19 were not placed on droplet precaution. (*Id*. ¶ 115, Ex. 32.)

223. Surveyors further observed that The Villages did not notify the responsible party when a resident tested positive for COVID-19 and did not provide timely notification to the responsible party when the resident developed symptoms of COVID-19. (*Id*. ¶ 116, Ex. 32.)

224. Due to the serious nature of The Villages' noncompliance with applicable nursing home infection control requirements, The Villages was fined for violating PHL § 2803(4), 10 NYCRR §§ 415.3(f)(2)(ii)(b) and 415.3(f)(2)(ii)(c), 415.19(a)(1), 415.19(a)(2), 415.19(b)(1) and Governor's Executive Order 202.11. (*Id*. ¶ 117, Ex. 33.)

225. In an inspection completed on August 12, 2020, DOH surveyors found that the Villages failed to perform criminal history record checks for prospective employees. Specifically, the facility did not initiate the background check process in a timely manner for one of six new/prospective employees reviewed for compliance with the DOH Criminal History Record Check ("CHRC") process. The facility did not-submit fingerprints in a timely manner for two of six new/prospective employees reviewed for compliance with the CHRC process. Additionally,

one employee of six prospective employees viewed for supervision pending the results of criminal history record checks did not have evidence of weekly supervision as required. (*Id*. ¶ 118, Ex. 34.)

226. On December 17, 2020, DOH again conducted an on-site survey resulting in deficiencies because The Villages failed to establish and maintain an infection control program under which it investigates, controls, and takes action to prevent infections in the facility. The Villages failed to require all staff to be checked for COVID-19 symptoms, including a temperature check at the start of each shift and every 12 hours while on duty pursuant to DOH's directives. The Villages also failed to perform weekly testing of three staff for COVID-19 and to ensure that facility staff wore proper PPE when conducting COVID-19 swabbing. (*Id*. ¶ 119, Ex. 35.)

227. On February 3, 2021, DOH found The Villages civilly liable for repeat violations of 10 NYCRR § 415.4(b)(1)(i) for permitting sexual abuse of residents, and failure to ensure that allegations of abuse are reported within two hours after the allegation is made. (*Id*. ¶ 120, Ex. 36.) Specifically, in an inspection completed on September 24, 2019, in response to a complaint made on September 10, 2019, DOH surveyors found that The Villages failed to report to DOH an allegation of sexual abuse perpetrated by a male resident against a female resident within two hours of the allegation, but instead reported the alleged incident more than 24 hours after receiving the allegation. (*Id*. ¶ 121, Ex. 37.) A February 26, 2020 DOH survey found that The Villages failed to timely investigate an incident of alleged sexual abuse. DOH surveyors found that an LPN did not report an alleged sexual abuse of a resident to the supervisor the night she was informed of the alleged incident. The Administrator in turn did not report the allegation to DOH until the day after he was informed of the alleged sexual abuse. Additionally, the facility failed to ensure that the alleged perpetrator no longer had access to the resident victim's room, even after the resident requested that the facility prohibit visitation. (*Id*. ¶ 122, Ex. 38.) Again, in a survey completed on

August 11, 2020, in response to a complaint filed on July 16, 2020, DOH surveyors found that two residents who lacked the ability to consent to sexual activity engaged in such activity with one another and, per facility policy, The Villages did not evaluate the two residents for capacity to consent after the activity occurred. Furthermore, The Villages did not report this incident to DOH within two hours of learning about this abuse allegation. (*Id*. ¶ 123, Ex. 39.)

228. In a survey completed on April 26, 2021, DOH surveyors again found that The Villages failed to timely investigate and report abuse and neglect allegations to DOH. The surveyors further found that a care plan was not developed for the use of anticoagulant medication and antipsychotic medication for certain residents, meaning that staff did not know how to guide their care for safety, interventions, and side effects of medications. During that same survey, surveyors found that one resident received Haldol[40] without a physician's order and another resident did not receive lab work per the physician's order. Surveyors also found that the facility failed to provide a resident who was fed by enteral means with nutritional assessments and weight monitoring to ensure that the resident's nutritional needs were being met. (*Id*. ¶ 124, Ex. 40.)

229. In that same survey completed on April 26, 2021, DOH surveyors found that the facility did not conduct annual Legionella culture sampling and analysis, despite the fact that in its annual inspection completed on November 16, 2018, DOH found that The Villages did not complete a Legionella sampling, and in a Recertification survey completed on September 14, 2020, DOH again found that The Villages did not conduct a complete Legionella risk assessment and did not have a water management plan in place to reduce the risk of growth and spread of Legionella. (*Id*. ¶ 125, Ex. 40.)

[40] Haldol is an antipsychotic medication used to treat Schizophrenia, among other conditions.

230. In an inspection completed on October 25, 2021, after complaints were filed in June and July of that year, DOH surveyors observed that The Villages failed to ensure each resident received adequate supervision and assistance with devices to prevent accidents. Surveyors observed a resident transferred by staff without the use of a gait belt,[41] which created an accident hazard. Surveyors also found that The Villages did not honor residents' wishes regarding life-sustaining treatment as set forth in those residents' advanced directives. (*Id*. ¶ 126, Ex. 41.)

IV. Multiple Consultants Warned Respondents Prior to COVID-19 That The Villages was "At Risk" and Respondents Ignored Them.

231. In 2019, The Villages' lender, Housing and Healthcare Finance, LLC, commissioned an "on-site risk management assessment" performed by Quality In-cite, LLC ("In-cite") in connection with Respondents' efforts to secure a mortgage re-financing. The assessment aimed to review the overall clinical, regulatory and operational performance of The Villages. In making its assessment, In-cite relied on "operator reports," three years of survey history, CMS Five-Star Rating information available on the CMS/Data.gov web sites, and on-site interviews with "facility leadership." In-cite's analysis, as reflected in its On-Site Risk Management Assessment, dated March 15, 2019 ("2019 In-cite Report"), found The Villages to be "At Risk." The report emphasized that The Villages had, on average, more life safety survey deficiencies[42] from DOH than the average for New York nursing homes in 2016, 2017 and 2018; 16 repeat citations in numerous categories including multiple violations pertaining to (i) services not provided by qualified personnel; (ii) services and treatment not provided to prevent and/or heal pressure sores (ulcers); (iii) failure to supervise to prevent accidents; (iv) incomplete and

[41] A gait belt is a device used to help safely assist residents with sitting and standing.
[42] Life safety surveys include evaluation of factors such as fire alarms, sprinkler systems, evacuation plans, and electrical hazards.

inaccurate clinical records; and (v) failure to properly release and/or maintain residents' medical and non-medical status. (*Id*. ¶ 127, Ex. 42.) These deficiencies are in violation of numerous regulations including 10 NYCRR § 415.26(c) (requiring a nursing home to employ qualified professional staff members), 10 NYCRR § 415.13 (requiring nursing home to timely administer treatments, medications, diets, and other health services), 10 NYCRR § 415.3 (requiring nursing home to fulfill each resident's right to "adequate and appropriate medical care"), 10 NYCRR § 415.12(c) (requiring nursing home to prevent avoidable sores from developing and provide necessary treatment and services to promote the healing, prevent infection and prevent new pressure sores from developing), 10 NYCRR § 415.12(h)(2) (requiring nursing home to provide adequate assistance and supervision to residents to prevent accidents) and 10 NYCRR §§ 415.22(a) (requiring nursing home to maintain complete, accurately documented, readily accessible and systematically organized clinical records) and (c) (requiring nursing home to safeguard clinical record information against loss, destruction, or unauthorized use).

232. The 2019 In-cite Report also made specific recommendations designed to ensure The Villages provided proper care to residents, including: (1) implementation of a formalized Performance Improvement Plan with appropriate monitoring tools to decrease the percentage of weight loss, wounds, antipsychotics, and anxiolytic/hypnotics among residents; (2) address root causes to "mitigate repeat life safety deficiencies;" (3) establish regional/corporate oversight and review policies and procedures on an annual basis; (4) adhere to The Villages' QAPI plan policy; (5) develop a formal survey for both short-term and long-term residents, and review results of those surveys during QAPI meetings and develop action plans as appropriate to address areas of concern; (6) consider a comprehensive weekly risk meeting to review those residents that are triggering in high risk care areas to ensure resident condition is reviewed, and documentation, care

plans, interventions, notifications, and orders are appropriate and implemented; and (7) obtain informed consents from residents and/or responsible parties prior to utilizing psychotropic medications. (*Id*. ¶ 128, Ex. 42.) Failure to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life is a violation of 42 CFR § 483.75(f).

233. The 2019 In-cite Report also confirmed serious and chronic understaffing at The Villages, and made the following staffing recommendations: (1) review staffing levels and conduct an analysis of resident acuity and dependency to ensure staffing is appropriate to meet the needs of the residents; (2) implement formalized staffing improvement plans; (3) add a full-time Staff Development Coordinator to oversee training and in-servicing of staff; (4) enroll Activity Director in a required certification course, and confirm whether the Dietary Manager completed their required Certified Dietary Manager course; and initiate regional/corporate support visits and to review MDS assessments to ensure accuracy given that The Villages' MDS nurse had no prior experience in completing MDS assessments. (*Id*. ¶ 129, Ex. 42.)

234. Asked whether The Villages implemented these and other recommendations included in the 2019 In-Cite Report, Respondent Halper stated, "I plead the Fifth." (SAAG Aff., Ex. 7 at 90:23 – 91:1.)

235. The abject failure of Respondents to care for The Villages' residents by making any of the improvements recommended by the 2019 In-Cite Report is underscored by nearly identical findings made by another consultant. In May 2020, The Villages hired another third-party healthcare consulting company, Polaris Health, LLC, d/b/a Polaris Group ("Polaris"), to provide Respondents with a risk management assessment report in connection with their mortgage re-financing efforts. Like In-cite, a Polaris consultant also found that The Villages lacked appropriate

systems to monitor and adhere to regulatory standards and provide proper care to residents. Specifically, after three days of visiting The Villages in June 2020, a Polaris consultant found that The Villages scored as "high risk," which is the highest risk rating available, for 15 total care areas: pharmacy/medication management, nutrition/hydration, skin wound/pressure sore, complex care management, incident risk management/ADLs, infection control, change of condition, Minimum Data Set ("MDS") assessments, care planning, elopement risk, behavior/dementia/trauma management, pain management, bowel/bladder, Quality Assurance/Performance Improvement ("QAPI")[43] and medical records. (*Id.* ¶ 130, Ex. 43.) Per the Polaris report, a score of "high risk" indicates a "pattern of breakdown in implementation with or without negative outcome." (*Id.* ¶ 131, Ex. 43.)

236. Significantly, and further illustrative of the culture of cover-up at The Villages, the Polaris consultant was unable to assess The Villages in the category of "Abuse Reporting/Dignity" and assigned a finding of "NA" in this category because the new DON and Administrator could not, in June 2020, "readily locate any recent reports or investigations." (*Id.* ¶ 132, Ex. 43.) Notably, The Villages also failed to produce a significant number of "Accident and Incident Reports and Internal Investigation reports" from January 1, 2020 forward, in response to a March 1, 2021 subpoena issued by MFCU to The Villages. Moreover, it took The Villages over five months to respond to MFCU's repeated requests for the documents, at which point, The Villages claimed they had recently "discovered" that those reports are "missing." (*Id.*, Ex. 44.) Specifically, DON

[43] "QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving. (*See* QAPI Description and Background, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition [last accessed on Oct. 4, 2022].)

Kathy Howard submitted a sworn statement, signed on August 13, 2021, describing that "[a]fter receiving the subpoena," they "discovered" that the accident and incident reports dated January 2020 through June 2020 were "missing." (*Id.*) Those reports and investigations, and the proper maintenance of such reports, are required by law. (*See* 10 NYCRR § 415.30[f] [requiring nursing home facilities to maintain accident and incident records necessary to permit the production of such records "immediately upon request"].)

237. In sum, Respondents ignored their own consultants' findings that they were placing residents "at risk," rather than using the reports as a springboard for corrections and improvements to benefit residents of The Villages, or as a means to bring The Villages into compliance with applicable Laws, Regulations, and professional standards.

V. Respondents Intentionally Maintain The Villages at Chronically Inadequate Staffing Levels, Without Regard for Resident Harm.

238. As soon as they acquired The Villages in 2015, Respondents cut staffing to unacceptable levels in order to cut costs and increase their revenue siphoning and profit-taking. For example, CNA Miller testified that staffing levels at the facility when it was county-owned were adequate. However, after the facility became The Villages in 2015, Respondents informed staff that each unit "could run" with only two aides, which increased each aide's assignment from having eight or ten residents to care for to up to fifteen residents. (SAAG Aff., Ex. 10 at 90:12 – 91:17.) CNA White similarly testified that staffing levels were not an issue when she began working at the facility in 2014, but that staffing levels became an issue "[a]fter [the facility] switched hands." (*Id*., Ex. 39 at 71:24 – 72:1.) White, who was paid hourly as a CNA at the facility when it was county-owned in 2013 and after it became The Villages in 2015, also testified that her hourly rate was cut after the facility "switched hands" and that "a lot of the reason a lot of people left" is because the new owners cut the staff's pay. (*Id*. at 18:9-18.)

239. Respondents' avarice-motivated pattern of paper-thin staffing persists to this day, resulting in a dangerous and undignified environment for The Villages' residents.

240. As a consequence of these actions, Respondents persistently violated 42 CFR § 483.35, which mandates that nursing homes must have sufficient numbers of nursing staff with "the appropriate competencies and skills sets" to provide nursing and related services "to assure . . . the well-being of each resident." (*See* 42 CFR § 483.35 [emphasis added]; *see also* 42 CFR § 483.70[e] [requiring a nursing home facility to include, in its facility assessment, the staff competencies necessary to provide the level and types of care "required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present*"* within the nursing home facility].)

241. Respondents further persistently violated 10 NYCRR § 415.13(a)(1), which mandates that nursing homes must maintain "sufficient . . . personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans." (10 NYCRR § 415.13[a][1] [emphasis added]; *see* 42 CFR § 483.25 [requiring that "the facility must 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"].)

A. The Villages Forces CNAs to Perform Work They Are Not Licensed or Qualified to Perform.

242. Numerous witnesses inform MFCU that CNAs were, and continue to be, forced to perform work they were not licensed or qualified to perform because of persistent inadequate staffing of LPNs and RNs. (*See* 10 NYCRR § 415.13[c][1] [defining CNAs' functions as "including, but not limited to, safety, comfort, personal hygiene or resident protection services . . ."]; Medical Analyst Aff. ¶ 129 n.24.) For instance, CNA Sample testified that because of short-staffing, she performed functions that were outside of her job responsibilities as a CNA, and that

nurses expected her to perform certain treatments that should have been administered by a nurse, including treating pressure sores, skin tears, changing a Foley or urostomy bag,[44] and packing wounds. According to CNA Sample, when she told nurses that she should not be providing these treatments, the nurses replied that they were too busy to do those tasks. (SAAG Aff., Ex. 12 at 45:3-23.)

243. CNA Brown also testified that she was asked to perform functions outside of her job description as a CNA. She said that nurses asked her "more than a dozen" times to pass medications to residents because the nurses were impatient and did not have a good rapport with the residents, whom they barely spent time with. CNA Brown agreed to pass the medications and provide skin treatments, even though she did not feel comfortable doing so, because she feared retaliation from the nurses. (*Id*., Ex. 11 at 32:18 – 34:21; *see also* Detective Aff. ¶¶ 49, 134-135.)

244. As a CNA, Fernandez stated that she had many responsibilities, including getting residents dressed, fixing their hair, washing and toileting them, getting them up for breakfast, and any other activities related to daily living. While employed at The Villages, CNA Fernandez was also forced to perform many functions that were not a part of her job description: she performed wound treatments, replaced band aids, and passed medications to residents, all tasks that are supposed to be performed by a licensed nurse, and which are beyond the scope of professional practice of a CNA employed in a long-term care facility. (Detective Aff. ¶ 18; Medical Analyst Aff. ¶ 129 n.24.)

245. On one occasion in 2020, CNA Fernandez stated that she and another CNA from The Villages, Lindsay Wilston ("CNA Wilston") were the only two aides working on the dementia

[44] A Foley bag is used to collect urine drained from the bladder.

unit.[45] No nurse was assigned to the dementia unit, and, in fact, there was only one nurse for the entire building, who had to place residents' pills in individual cups and directed CNA Fernandez and CNA Wilston to administer the medications to the residents at breakfast. The nurse then documented the completed medication pass as if the nurse had personally distributed the medications. (Detective Aff. ¶ 19.) CNA Fernandez stated that she and other CNAs complained to the full-time nurses and DON Donnelly, however their complaints were ignored. (*Id*. ¶ 20.)

B. Witnesses Told MFCU That There Were Times When The Villages Was Dangerously Understaffed.

246. CNA Miller testified that, "[t]here were days that there was just one aide per floor. Overnight shift was especially bad . . . There may have been four or five people in the entire building staff-wise in a 120-bed capacity. So there is just no way to keep people safe and clean and you can't do your job." (SAAG Aff., Ex. 10 at 90:12 – 91:17.)

247. CNA Albone said the staffing at The Villages is "awful." She recalled that on March 28, 2020, she was the only CNA in the entire building for 120 residents, and remembers telling "Jason" from corporate that if the State came in that weekend, that the facility would be "flagged," and that Jason did not seem concerned because the facility "knows when the State comes in to do checks." (Detective Aff. ¶¶ 41-42.) A photo taken by CNA Albone of the staff schedule for April 20, 2020 likewise tells a disheartening story: only one RN, "M Fairbanks," scheduled on the dementia and rehabilitation unit alone, and one RN with two medication carts

[45] Indeed, CNA Fernandez stated that staffing at The Villages was "not consistent." She noted that for a unit to be fully staffed it must have four CNAs, however she recalls times where there was one CNA working both the dementia and rehabilitation unit alone. On more than one occasion, she worked the dementia unit by herself with no nurse and had to take care of 30 residents. (Detective Aff. ¶ 17.)

scheduled for Canal View and Garden View. Albone is the only CNA on the schedule for both Canal View and Garden View. Further, there is only one CNA on Orchard View. (*Id*. ¶ 46, Ex. C.)

248. Lucy Bucknan, an LPN who worked at The Villages through a staffing agency from approximately June 2019 to April 2020, stated that The Villages was always short-staffed, and residents were not getting the proper care they deserved. She would often have two medication carts to pass medication to the dementia and rehabilitation units by herself. (*Id*. ¶ 59.)

249. The risk to The Villages' residents became even more acute as the COVID-19 pandemic reached the facility. For example, on two days in April 2020, due to lack of staff, LPN Fairbanks supervised three halls of the facility alone, and also had to handle the medication cart/medication pass for an additional unit (Orchard).[46] She also had to go over to the physical rehabilitation unit to check on a resident, and then had to go to the Dementia care unit because Resident 51 fell and cracked their head and was bleeding. Resident 51 died following this incident. (*Id*. ¶ 31.)

250. During the spring of 2020, staffing was so inadequate that the physical therapy staff sometimes assisted the overnight nursing staff with postmortem care. (*Id*. ¶ 80.) PTA Estela confirmed that staffing was so short that he, a physical therapist, helped with room changes and postmortem care, a job that CNAs typically perform. Postmortem care included cleaning the bodies, including hair and teeth, putting on clean clothes and clean briefs, covering the face with a towel, and wrapping the body in a sheet. (*Id*. ¶ 90.)

251. RN Moore stated that on the weekend of May 23, 2020, during the day shift, one nurse called out and another nurse was a "no call no show." This left one nurse for the entire

[46] The Villages is divided into the following units: Autumn South (12 short-term rehab beds); Autumn North (30 locked dementia beds); Garden View (27 long-term care beds); Orchard View (24 long-term care beds); and Canal View (27 long-term care beds).

building. The following Monday, RN Moore worked 10:00 p.m. to 6:00 a.m. and was the only nurse on three units. The following day, RN Moore stayed after her shift was supposed to end at 6:00 a.m. and worked until 12:30 p.m. because there was no other nurse. LPN Dioguardi worked two units by himself. DON Donnelly was in the building, but did not come out of her office. (*Id*. ¶¶ 75-76.)

252. For RN Moore's shift on May 28, 2020, she was the only nurse for the entire building, which she said was "overwhelming." RN Moore said that one of the most difficult responsibilities for her was keeping up with daily tasks. It was too hard to change the residents, make rounds every two hours and pass medications. If there was time, RN Moore stated she would try to assist the CNAs with rounds after she passed medications. On one occasion, staffing was so short that she placed a resident that required 15-minute checks in a wheelchair and pushed him around with her while she passed medications. (*Id*. ¶¶ 75, 81.)

253. CNA Daigler described the staffing levels at The Villages as "poor." She said incidents occurred when she was the only aide in the dementia unit with no other staff member, including no medication nurse. She described a fistfight that broke out just after breakfast one day in November 2020 between two residents in the dementia unit. CNA Daigler said she could not prevent it because she could not pay attention to all of the residents in the dementia unit—25 to 30 residents—while responding to resident assistance call lights and doing other things. CNA Daigler testified that she was the only CNA assisting 30 residents "at least once a week or more" and that she left The Villages in December 2020 because, "I just couldn't do it anymore. It broke my nursing spirit. I just had to break away." (SAAG Aff., Ex. 17 at 42:21 – 43:17; 49:17 – 51:14.)

254. DON Mikits frequently texted with other employees about the dire staffing levels at The Villages.

- On November 7, 2020, CNA Wilston texted DON Mikits: "Jill never showed. Katie left. Stephen is the only nurse in the building . . . We have one LPN and one CNA that will be here within the hour and that's all we can get." (Detective Aff. ¶ 164, Ex. M.)
- On November 7, 2020, CNA Wilston sent a screenshot to DON Mikits of a Facebook message sent from CNA Wilston to Office Assistant/Scheduler Brittany Roberts, stating, "Karrie said its too short staffed and we need as much help as possible to have you come in and help." Roberts responded, "Ok it's not my fault if 2 CNAs didn't call in and a ton of CNAs up and left!!!!!" Roberts further wrote, "I'm not a slave for this building." (*Id*. ¶ 165, Ex. M.)
- On November 7, 2020, CNA Wilston sent a screenshot to DON Mikits of a text message sent by a resident of The Villages stating, "We have no nurse and no meds here tonight. Please see if you can get us help." (*Id*. ¶ 166, Ex. M.)
- On November 8, 2020, CNA Wilston texted DON Mikits that Admin Flugel was aware of low staffing and did nothing. CNA Wilston wrote, "Eric knew we had no staff yesterday when he was here. I pointed out the schedule to him yesterday. And he did nothing, and now we have all these call ins because everyone is fed up." (*Id*. ¶ 169, Ex. N.)
- On November 13, 2020, DON Mikits and CNA Wilston discussed low staffing, and CNA Wilston sent a photo of the schedule and wrote, "We have to work down the halls by ourselves ON TOP OF training the new girls!" (*Id*. ¶ 170, Ex. O.)

- On December 20, 2020, CNA Wilston texted DON Mikits again with a photo of the staffing schedule, and wrote, "Hey. We have critical staffing. 4-5 CNAs called in. Katie has called everyone and she can't get ahold of anyone." (*Id.* ¶ 171, Ex. P.)

255. DON Mikits testified that appropriate staffing levels at The Villages were "few and far between. For The Villages there was one time that I had to go in there and work with just me and -- I don't even know if there was an aide. It was just me with, I want to say, 60 patients" during an afternoon shift, so DON Mikits had to text everyone and the department heads came in and helped pass trays. (SAAG Aff., Ex. 9 at 100:15 – 101:11.)

256. Instead of hiring additional staff and increasing pay rates, Respondents resorted to scare tactics, pressure, and bullying to keep staff working. CNA Fernandez reported that she was frequently bullied to stay past her shift and would be ordered to stay because the next shift was late and understaffed. She stated that tardiness for all shifts was a big issue at the facility, including many no-call no-shows. On April 13, 2020, CNA Fernandez's last day at The Villages, she walked out at 2:30 p.m. because her relief never showed up at 2:00 p.m. as scheduled. This was CNA Fernandez's last day working at The Villages. (Detective Aff. ¶ 25.)

257. LPN Fairbanks recalled that she was "begged" to come in to work the evening of April 29, 2020, and the Administrator "Steve" offered to give her $100, rather than the $50 that DON Donnelly was regularly giving out to employees that pick up additional shifts to help address staffing shortages. (*Id.* ¶ 36.)

C. Respondents Rely on Ineffective Temporary Staff as a Stopgap Measure.

258. Full-time staff got no relief from some agency workers. CNA Sample testified:

> I mean, they were being -- some of them were being yelled at or they were -- aides were being aggressive with them. I ended up going to court a couple of years ago because of an agency aide smacking a resident. They were bringing people in that weren't, the agency

> aides that they weren't doing their jobs so they were sitting in residents [sic] rooms hiding, playing on their phone.

(SAAG Aff., Ex. 12 at 53:8 – 54:21.)

259. RN Moore said that "Re-lo" is a term that stands for "Relocation." The facility was using re-lo aides and nurses that came from Alabama, Louisiana, Georgia, and West Virginia to work at the facility in the early months of the pandemic. The re-lo staff was housed in apartments in Brockport, NY; they lived rent-free and were given a food allotment. RN Moore stated that the re-lo staff were unprofessional, but could get away with all of it because the facility was so short-staffed. (Detective Aff. ¶ 77.)

260. CNA Sample testified that staffing levels became an issue at the facility after it became The Villages. She testified that The Villages did not replace full-time staff with more full-time staff. Instead, they hired agency staff, who were unreliable. (SAAG Aff., Ex. 12 at 20:19 – 21:10.)

261. MFCU's analysis of The Villages' Medicaid Cost Reports confirms that The Villages increasingly utilized short-term agency staff instead of hiring full-time direct-care employees, who receive benefits not provided to agency staff. Specifically, during the period of County ownership and operation (2012-2014), the facility employed, on average, 7.37 Full Time Equivalent ("FTE") RNs, 26.73 FTE LPNs, and 53.43 FTE Aides, Orderlies, and Assistants. On the other hand, during the period of Respondents' ownership and operation from 2015-2021, The Villages employed, on average, 2.38 FTE RNs, 13.64 FTE LPNs, and 25.32 FTE Aides, Orderlies, and Assistants. This decrease represents an approximately 68% drop in FTE RN employees, a 49% drop in FTE LPN employees, and a 53% drop in FTE Aide, Orderly, and Assistant employees. (Auditor Aff. ¶¶ 135-36.)

262. MFCU similarly found that agency staffing averaged just 7.31% of total annual direct-care staff wages during the period of time up and until 2015 when the facility was owned and operated by Orleans County. On the other hand, from January 2015 through 2021 when Respondents owned and operated the facility, agency staff averaged, astoundingly, over 51% of total annual direct care staff wages. (*Id*. ¶ 137.)

263. Although the data alone speaks to the extent of Respondents' profiteering, it does not tell the full story. "Agency" staff are temporary workers, but the residents are not "temporary" – the nursing home, under the law, is their home. Thus, when temporary workers are the norm, the residents do not receive care from knowledgeable staffers who know them as individuals and who can interpret and solve healthcare problems and communicate effectively with known patients, known colleagues, and known physicians. (*See* Medical Analyst Aff. ¶¶ 139, 166)

D. Instead of Hiring Sufficient Staff, Respondents Rely on a Scheme of Low Pay for Overworked Staff and Refuse to Hire Replacements or Pay the Bills – "You Could Make More Money at Subway."

264. To maintain the "up-front profit" model Respondents relied on to enrich themselves, MFCU found that Respondents refused to increase pay rates to maintain or attract staff, failed to pay staff what they were owed, worked employees to "burn out" levels, and failed to fill important vacancies.

265. Multiple former employees described how Respondents failed to increase pay rates or provide other benefits. Environmental Services Director E. Howard testified that The Villages could have kept qualified CNAs and nurses by paying them more money. "Raise that pay scale, especially where we are . . . They have a nursing home 10 miles to the east, nursing home 15 miles to the south, 15 miles to the west of them and north of them is the lake. So there's like you're

trapped. The only way you can get people to come out to that remote area is to pay." (SAAG Aff., Ex. 15 at 203:13 – 204:1.)

266. The Villages could have recruited and retained staff had they offered contractually guaranteed sign-on bonuses and raised wages. According to CNA Miller:

> We were arguing for a while to do 'pay by experience' and that fell on deaf ears for a long time. I don't know if they're doing it now, but that was one of the things that we wanted to discuss with Sam [Halper], at least early on. We got told that when staffing becomes an issue, which it did, that they'd revisit it. As far as I know, that wasn't revisited during the time I was there that I recall but that was something that we thought would remedy part of it. They were starting people off at such a low wage you could make -- we always joked you could make more at Subway than taking care of people . . . .

(*Id*., Ex. 10 at 108:3 – 109:6.)

267. According to DON Donnelly, if The Villages paid its staff more money, the staffing problems would improve. (*Id*., Ex. 13 at 78:11-14.) CNA Daigler also testified that The Villages could easily hire and retain more staff if the facility paid higher wages, the raises "Comprehensive" offered were "minute," and that in all of her time at The Villages, she never received a bonus. CNA Daigler further testified that she would still be working at The Villages if she was paid more, "at least up to $15.50 an hour." (*Id*., Ex. 17 at 46:17-20, 49:6-16, 64:16-23.)

268. Further compounding the situation, Respondents failed to ensure staff were paid what they were owed and the local union president had to file several grievances about The Villages not properly paying overtime. (*Id*., Ex. 10 at 75:9 – 76:23.)

269. CNA Sample testified that she was mandated to work double shifts at The Villages approximately two or three times a month and that she did not recall ever being mandated to work a double shift in the two years that she worked for the facility when it was county-owned. CNA Sample also testified that she had problems getting paid for the double shifts that she worked at The Villages and that "nobody offered raises. Nobody offered anything. There was nothing to get

people to want to stay [at The Villages]." (*Id*., Ex. 12 at 67:11 – 68:25.) CNA Sample further testified that when Respondents took over The Villages, "paychecks were getting messed up. More people started leaving because of that. I actually left because of that at one point. I don't remember exactly when, but I did leave. They did owe me $200 in overtime that I never received . . . close to every paycheck, something was wrong with it." (*Id*., Ex. 12 at 21:10 – 21:17.)

270. E. Howard testified that when he quit his job at The Villages in June 2021 as the Director of Environmental Services, he was the head of housekeeping, maintenance, and repairs, and that the "owners," "without a doubt" could have kept him from burning out had they paid him more, gotten him a larger staff, and shown more appreciation for his work. At the time that E. Howard resigned in June 2021, he was making less than $50,000 a year. (*Id*., Ex. 15 at 197:2 – 198:8.)

271. DON Donnelly further testified that she threatened to quit in 2018 or 2019 "because the job responsibilities that were being put on me were too much for one person to handle . . . Staffing was diminishing and it became my responsibility to find people to work in this building. I would ask for ads to be put in the paper, they'd say they were in, we'd search the papers, there were no ads." (*Id.*, Ex. 13 at 45:4-17.)

272. Data analysis confirms The Villages churned through employees at an astonishingly high rate. As part of this investigation, MFCU analyzed personnel data contained in Medicaid Cost Reports to measure annual turnover rates for employees at 24 low-performing nursing home facilities in New York State, including The Villages. MFCU found that The Villages had the highest employee turnover rate in 2019 (182.14%) and 2020 (220.95%) out of all 24 facilities measured. The Villages' turnover rate was even higher in 2021 – 296.84%. (Auditor Aff. ¶¶ 138-40.)

273. Despite his awareness of The Villages' dire staffing needs,[47] Respondent Halper ignored DON Donnelly's requests to get staff hired for important vacancies, and instead wanted her to handle it all. DON Donnelly testified that she recommended that more staff be hired "all of the time." She testified, "I'd go to the administrator because in all reality it was his job to let the owners know what I was needing. So we -- we needed an educator, we needed an infection control person, we needed an ADON [Assistant Director of Nursing]. I went a while without an ADON." According to DON Donnelly, she did not have an ADON for about a year-and-a-half, from 2017 to 2019. The Villages never hired an Infection Preventionist; instead, Admin Teitelbaum or Respondent Halper told her that the ADON would assume this role. (SAAG Aff., Ex. 13 at 107:5 – 109:11.) DON Donnelly also testified that she was concerned when The Villages did not hire an Educator or Quality Assurance Coordinator. She spoke with Respondent Halper about her concerns. She does not remember his exact response but "their answers were always myself or the ADON should do whatever they don't replace." DON Donnelly told Respondent Halper that she had enough responsibilities and did not know how she would fit it all in. (*Id*. at 174:8 – 177:4.)

E. COVID-19 Hit While Respondent Halper Negotiated for Discounts.

274. Other staff implored management at The Villages to hire additional full-time staff. On February 20, 2020, Tara Cline, who was the staff Scheduler for The Villages, emailed Admin Teitelbaum, Respondent Halper, Administrator Brian Reader[48] ("Admin Reader"), and others asking for a new hire of a full-time RN. Admin Teitelbaum pushed back on hiring a new RN,

[47] *See* January 22, 2020, email from Tara Cline to leadership, including Respondent Halper, requesting at least four additional relocation nursing staff due to no-shows, refusals to work double-shifts, drug use among staff, and mental health issues. Respondent Halper seemingly dismisses Cline's request. (SAAG Aff., Ex. 26.)

[48] Brian Reader was The Villages' Administrator from approximately February 2017 to March 2020.

insisting that "we need to further discuss this position before we bring her on." Cline replied, in part, that the "agency is not covering, last night we had 3 nurses and Deb had to pay a bonus for 2 people to stay over. It is impossible for the RN to be on the cart, and has been on 2 at a time with doing orders and admissions." (*Id.*, Ex. 27.) On February 28, 2020, Cline emailed numerous individuals, including Admin Reader and ADON Kathy Howard re: "LPN needs," seeking full-time LPNs and writing, "estimated need through end of May, but of course they can stay on if they want as we always need LPN's [sic]." (*Id.*, Ex. 22.)

275. Even when the COVID-19 pandemic laid bare Respondents' routine, crisis-level staffing methods, Respondents did little to change staffing and in many instances, refused to pay more. Emails demonstrate that in March 2020, as COVID-19 was about to sweep the facility nearly two months after DOH and CDC warnings, Respondents refused an increase in wage rates. Karlyn Pellman of Nursefinders emailed Cline, copying The Villages' DON and Administrator, explaining "I may have an easier time finding LPNs to come help your facility out if you were to put Crisis Rates in place." (*Id.*, Ex. 29.) Respondents waited until at least April 2020—two months after DOH and CDC warnings—before they agreed to hazard pay or pick-up bonuses for some staff. (*Id.*, Exs. 30-31.) However, even then, Respondent Halper refused to offer hazard pay to social workers. (*Id.*, Ex. 6.)

276. Even on April 24, 2020, staffing agency Medical Staffing Network emailed DON Donnelly and Admin Hefter stating that the agency cannot send staff to The Villages until a past-due account over 60 days late was paid. Admin Hefter forwarded this email to Respondent Halper and others at CHMS Group, including Yaron Garcia. Garcia replied, copying Respondent Halper, "I'm just confirming w/management how much we can send out right now. Are they withholding

staffing?" (*Id.*, Ex. 32.) Around the same time, in April and May 2020, The Villages transferred over $315,000 in profits to Telegraph. (Auditor Aff. ¶ 180.)

277. Instead of following industry norms of offering competitive wage rates and increasing pay to attract more staff during the COVID-19 crisis to care for The Villages' residents, in May 2020, Respondent Halper tried to bargain with nurse staffing agencies. In an email dated May 15, 2020, Respondent Halper emailed Admin Teitelbaum, Admin Hefter, and Kayla Cohen of Western Pa Consult,[49] asking if they could negotiate lower hourly rates with Med-Core Agency, an agency from which they were seeking temporary staff. (SAAG Aff., Ex. 33.) Respondent Halper's disregard for staff recruitment and retention amplified The Villages' staffing issues in May 2020. On May 26, 2020, DON Donnelly emailed Admin Teitelbaum, Admin Hefter, Sam Dubin (of Western Pa Consult) and Office Assistant/ Scheduler Brittany Roberts, regarding staffing:

> We need help here. I have 1 LPN here & 1 RN who stayed to help from night shift. Tonya, RN, out sick, Michelle, Katy both LPN out sick, Kathy, ADON out sick; none can return till test negative. S Gross took a leave as she has not seen here [sic] children in 2 months; it was a leave or she is quitting. I am doing my best to hold it together here, but I cannot be a med pass nurse and do what is required of me as DON; HERDS, swabbing, A&I's, Skin team, and filling roll of SW as both SW are out. Dr. Madejski says the building is filthy & Tammy from housekeeping says she has spoken to the housekeepers but they don't do their jobs. Eli is also out & waiting to test negative. The agenc[ies] are sending us no one other than the few (3) regulars we have. Brittany is sending needs out daily to agencies with no results.

(SAAG Aff., Ex. 34.)

278. DON Donnelly's plea fell on deaf ears. The staffing agency that Respondent Halper tried to bargain with for lower rates while residents were dying from COVID-19 stopped taking

[49]Certain individuals who appear to do work on behalf of The Villages claim to work for a company known as Western Pa Consult. Little detail as to the corporate structure and ownership of Western Pa Consult is available, but Admin Teitelbaum testified that he is employed by Western Pa Consult and that he reports to Respondent Halper. (SAAG Aff., Ex. 5 at 24:21 – 32:10.)

and returning The Villages' Scheduler's phone calls. On May 28, 2020, The Villages' Office Assistant/Scheduler Brittany Roberts emailed Admin Teitelbaum, copying DON Donnelly and Admin Hefter:

> I know you are all very busy however we are in a desperate spot for nurses and we need help. I don't know what to do . . . 5 nurses to cover every day, 3 shifts . . . I sent an email to every single agency stating we desperately need nurses, I tried calling Beth from med-cor and every time it goes to voicemail. I don't know what to do. Stephen, Jen and Alexandria work every single day, usually doubles. I have no one left to ask and I'm not getting anything from agency.

(*Id*., Ex. 35)

279. DON Donnelly testified that staffing agencies did not get paid on time and that she would forward emails from the agencies regarding unpaid bills to Respondents Halper, Lahasky, and Gast. (*Id*., Ex. 13 at 98:1 – 99:4.)

F. The Villages Provided Its Residents With Far Fewer Hours of Nursing Care Than the State Average, Leading to a Dangerous Environment for Residents Before and During the Pandemic.

280. The above testimonial and documentary evidence is consistent with MFCU's quantitative analysis. Hours per resident day (or "HPRD") refers to the hours of daily care that staff members provide to each resident of the nursing home. This measure is calculated by adding up the total number of hours worked by nursing staff and dividing it by the number of resident-days during the reporting period. (Auditor Aff. ¶ 142.) As detailed in the Auditor Affidavit, MFCU found that The Villages provided its residents, on average, with just 0.13 RN HPRD (7.8 minutes) during the period 2017 to 2021, whereas the New York State average for the same period was 0.45 RN HPRD (27 minutes). In other words, The Villages provided its residents with approximately 71% fewer hours of RN care than the state average. Similarly, as detailed in the Auditor Affidavit, during the period 2017 to 2021, the Villages provided its residents with fewer Total Nursing Care (RN, LPN, & CNA) HPRD than the state average. (*Id*. ¶ 143.)

281. As described by the testimony of staffers at The Villages, not only do such staffing ratios deprive residents of required care, but such conditions demoralize and defeat the staffers who need their paychecks but do not have enough colleagues.

282. The Villages' own policy documents demonstrate the egregiousness of Respondents' paper-thin staffing levels. During the course of the investigation, The Villages produced a document to MFCU labeled "Facility Assessment Tool" (last updated March 1, 2020), which lists the level of staff required to care for the residents on a per shift basis, and reflects that it was reviewed by the facility's QAPI committee and The Villages' executives on a regular basis. MFCU compared this assessment tool against actual staff shift data, or "punch card" data, for the period January 1, 2020 to June 11, 2020, and found that The Villages routinely failed to meet its own required staffing levels.[50] Specifically, as depicted below, MFCU found that approximately 223 out of 489 total CNA shifts (46%) were below the assessment ratio. As to nurse staffing, MFCU found that approximately 184 out of 489 total nurse shifts (38%) were below the assessment ratio.[51] (*See id*. ¶¶ 148-57.)

[50] MFCU's analysis was limited to the period January 1, 2020 to June 11, 2020 because this is the period for which data was readily available. (*See* Auditor Aff. ¶ 154 n.44.)

[51] As to LPNs, The Villages assessed itself as needing approximately one LPN for every 23 residents for day and evening shifts (115 residents to 5 LPNs), and approximately one LPN for every 29 residents during night shifts (115 residents to 4 LPNs). As to CNAs, The Villages assessed itself as needing approximately one CNA per 12 residents for day and evening shifts (115 residents to 10 CNAs), and approximately one CNA per 19 residents for night shifts (115 residents to 6 CNAs). (Auditor Aff. ¶¶ 151-52.)

Month of Admission	POSITION	% of Monthly Shifts below Level
JANUARY 2020	CNA	33%
	NURSE	20%
FEBRUARY 2020	CNA	45%
	NURSE	43%
MARCH 2020	CNA	57%
	NURSE	46%
APRIL 2020	CNA	67%
	NURSE	49%
MAY 2020	CNA	34%
	NURSE	28%
JUNE 2020 (6/1-6/11)	CNA	24%
	NURSE	45%

283. To further contextualize these egregiously low staffing levels, MFCU calculates that if Respondents paid themselves just $360,000 less in 2020, The Villages could have provided over 15,000 additional hours of direct care to residents in that year during the first wave of the COVID-19 pandemic.[52] (*Id*. ¶ 207.)

284. Skeleton staffing at The Villages also led to a dangerous environment for residents – including numerous instances where the same high-acuity residents suffered accidents again and again. This trend pre-dated COVID-19 and continued through the pandemic.

285. MFCU reviewed resident files, including accident and incident reports and progress notes for the period January 1, 2020, to June 11, 2020, and found dozens of examples of resident injuries that were preventable with adequate staffing levels. (*See* Medical Analyst Aff. ¶¶ 143 -

[52] As discussed below, $360,000 is 10% of the $3,600,000 in loan proceeds that Respondents paid themselves in 2020.

145.) Of course, the examples are limited to those occurrences that were appropriately documented – and do not include accidents that were not properly documented or not otherwise produced.

286. MFCU identified approximately 39 accidents and incidents at The Villages in January 2020 alone. Approximately five residents were involved in multiple incidents in that month. For example, Resident 49 fell off his bed on January 6, and The Villages' staff found Resident 49 on the floor on three separate occasions on January 8, 9, and 10. Nursing notes reflect that Resident 49 suffered a hematoma in connection with the January 10 fall. As depicted in the chart above, in January 2020, 33% of CNA shifts and 20% of nurse shifts at The Villages were below the assessment staffing levels. (Auditor Aff. ¶ 160.)

287. MFCU identified approximately 40 accidents and incidents in February 2020. Approximately 11 residents were involved in multiple incidents in that month. For example, Resident 58 fell on February 18, 19, and 23, and The Villages' staff found Resident 58 on the bathroom floor on February 11 and 20. 45% of CNA shifts and 43% of nurse shifts at The Villages were below the assessment staffing levels in February 2020. (*Id*. ¶ 161.)

288. MFCU identified approximately 49 accidents and incidents in March 2020. Approximately nine residents were involved in multiple incidents that month. For example, Resident 19 fell twice that month, and The Villages' staff found him on the floor on three separate occasions. Nursing notes reflect that Resident 19 suffered a bleeding head injury on one of those occasions. In March 2020, 57% of CNA shifts and 46% of nurse shifts at The Villages were below the assessment staffing level. (*Id*. ¶ 162.)

289. MFCU identified approximately 48 accidents and incidents in April 2020. Approximately nine residents were involved in multiple incidents that month, including Resident 19 (discussed above) who was involved in 10 separate incidents during this single month. For

example, The Villages' staff discovered Resident 19 on the floor seven times in April, including during one evening when The Villages' staff found Resident 19 on the floor of his room with feces smeared around him. Resident 19 further suffered an additional two falls another date in April, one of which resulted in a bleeding head injury. 67% of CNA shifts and 49% of nurse shifts at The Villages were below the assessment staffing level in April 2020. (*Id*. ¶ 163.)

290. MFCU identified approximately 43 accidents and incidents in May 2020. Approximately six residents were involved in multiple incidents in that month. For example, Resident 19 (discussed above) fell or was found on the floor on 13 separate occasions in May 2020. Also in May 2020, Resident 59 fell in the bathroom on three separate occasions, including on May 23 and 25 when Resident 59 suffered head lacerations. 34% of CNA shifts and 28% of nurse shifts at The Villages were below the assessment staffing level in May 2020. (*Id*. ¶ 164.)

VI. Respondents Cut Costs and Fail to Maintain The Villages' Physical Property—"It's A Disgusting Place."

291. MFCU's investigation found that Respondents failed to maintain a clean and safe physical environment at The Villages for residents and staff, in violation of 10 NYCRR § 415.5(h) and 10 NYCRR § 415.29. (*See id.* [requiring a nursing home facility to provide, among other things, "a safe, clean, comfortable and homelike environment," "housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior," and "comfortable and safe temperature levels"].) Evidence acquired by MFCU demonstrates unsanitary conditions such as dirt, mold, and insects in the facility, routinely broken medical and HVAC equipment, and inadequate levels of cleaning and hygiene supplies.

292. CNA Sample testified that conditions at the facility were "good" when it was county-owned, but when Respondents purchased The Villages it became a "disgusting place":

> [W]e had no air conditioning. We had no briefs or Depends. We had no washcloths to clean the residents with. The soaps were locked up because they said we were using too much.[53] They took all of our powders away because they said that it was too expensive and we were wasting it. They took everything that was a hygiene product and locked it up and we had to ask for it. If a resident needed it, we were supposed to go and ask if they could bring some down to us and 90 percent of the time somebody was too busy to bring it for us. We were bringing our own soaps in to make sure that everyone had soap. The closet doors are coming off. The drawers in their room are busted. I actually had a toilet burst on me on the rehab unit while there was a resident in the bathroom with me. As I was walking him out, a ceiling fell on a nurse and then like two weeks later he was fired. There was black mold everywhere. There is holes in the walls. There is bugs everywhere in the building, ants[54] everywhere. There's food caked all over everything. The floors, the tables, the wheelchairs do not get cleaned. It's a disgusting place.

(SAAG Aff., Ex. 12 at 29:7 – 31:11.)[55]

293. Photos taken by a family member of a resident in May 2020 and posted on Facebook likewise show rusted doorframes, peeling paint, missing ceiling tiles, and cracked flooring, among other concerns, at The Villages.

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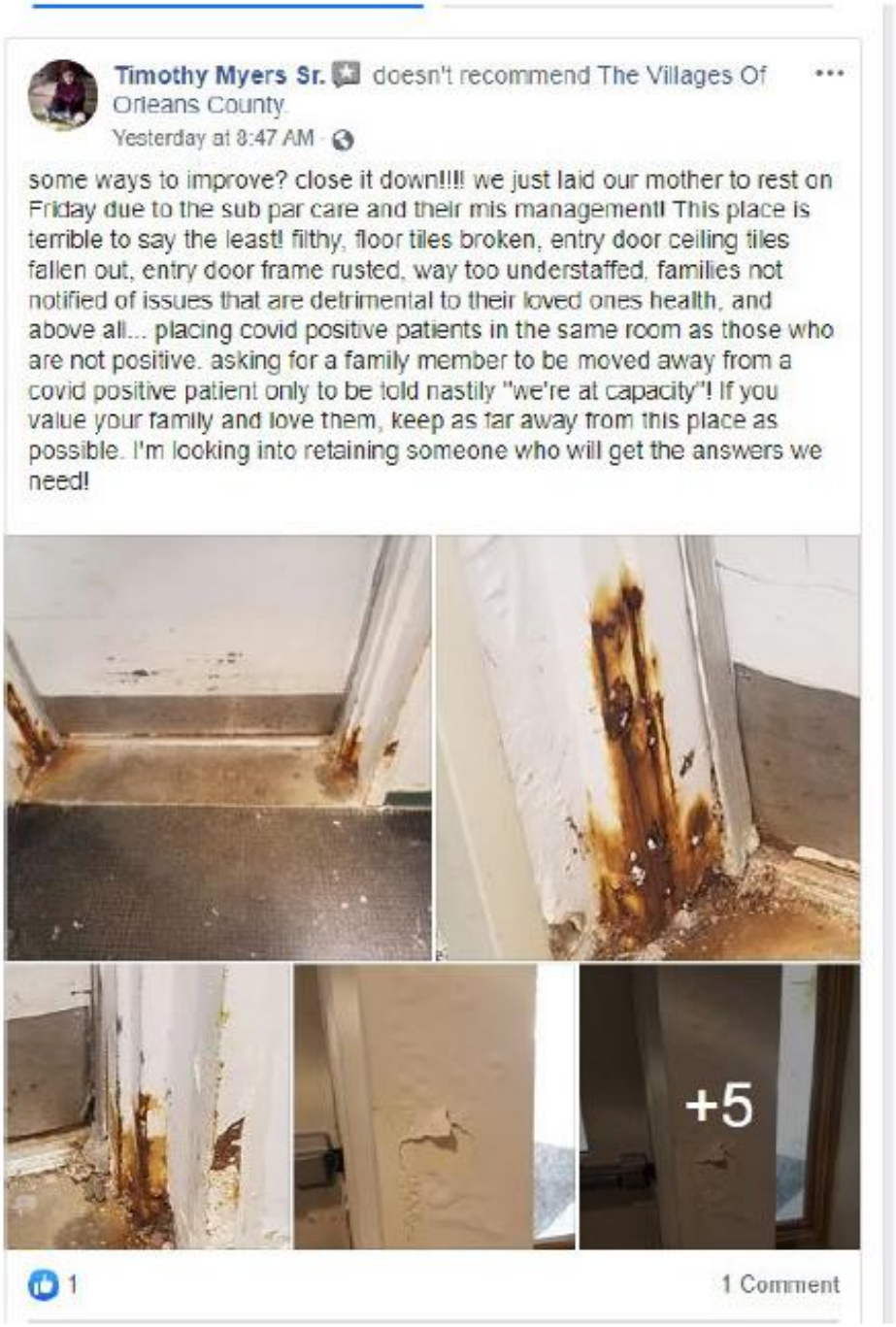
[53] CNA Daigler also testified that soaps, personal products, and incontinent products were hard to access at The Villages because they were locked up. She testified that on several occasions, before 2020, The Villages did not have the soaps and personal products that she needed because they ran out. Daigler was not surprised when she heard that The Villages ran out of these products because "I could see how everything was going downhill . . . in the last part when I was there, you could just tell how everything started going down from the people scheduling. You had to double-check your paychecks to make sure they were right. When they started bringing in the relocated workers is when it really got bad." (SAAG Aff., Ex. 17 at 40:7 – 41:17.)

[54] In a group text message from December 10, 2020 between DON Mikits, Brueckner, Admin Flugel, SW Woodin, E. Howard, DON Howard, and OTA SanFilippo, Brueckner wrote, "Room 202 is ready but has ant problem." To which Admin Flugel responded not with a solution, but with a temporary cover up: "Eli, can it be vacuumed, wiped down? Maybe some food missed?" (Detective Aff. ¶ 162, Ex. K.)

[55] CNA Sample testified that hygiene products had to be locked up because "the owners" thought that staff went through too much of it too quickly. She testified that she complained every day to the DON or administrator about not having access to certain hygiene products, and that she overheard a colleague complain to Respondent Halper when he was in The Villages. When CNA Sample complained to DON Donnelly, DON Donnelly replied that she was trying to talk to the owners but they were not listening to her. CNA Sample also testified to hearing DON Donnelly speak to Respondent Halper a few times "about getting things taken care of in the facility as far as making it better and they kept dismissing her." (SAAG Aff., Ex. 12 at 33:5 – 34:22.)



(Detective Aff. ¶¶ 244-245, Ex. EE.)

294. CNA Miller testified that because Respondents did not hire maintenance workers to replace retiring maintenance workers, repairs were not made at The Villages in a timely manner. (SAAG Aff., Ex. 10 at 47: 22 – 50:18.)

295. E. Howard testified that in or around 2018 and 2019, six part-time housekeeping employees quit, leaving him with only 12 housekeeping employees. E. Howard asked Respondent Halper to replace the six employees who quit, but Respondent Halper pushed back and ultimately agreed to hire only two additional housekeeping staff, as opposed to replacing all six who quit. (*Id*., Ex. 15 at 77:25 – 79:5.) E. Howard also testified that owners of The Villages did not invest enough money in the maintenance department, which consisted of only one employee for the entire 90,000 square foot facility, and that The Villages did not have a maintenance employee with the skill level necessary for the job. His request to hire additional maintenance workers was to no avail. E. Howard testified that he thinks that Respondent Halper did not want to pay someone with the skill level needed to do the job because "we never got anybody." (*Id*. at 67:5 – 69:2.)

296. Problems with equipment were "a big issue" at The Villages. RN Moore stated that there should always be one Hoyer lift for each hall, but there were frequently issues with them. DON Donnelly told RN Moore that the people above her did not want to spend money to make repairs, saying the owners did not help DON Donnelly with repairing or replacing any of the large equipment that was needed for resident care. (Detective Aff. ¶ 83.) Indeed, on September 3, 2020, CNA Wilston and DON Mikits exchanged texts:

> Wilston: So, we don't have a working hoyer machine. Haven't all day. So now Resident 52 is stuck in his recliner and we have no way to put him in bed.
>
> Mikits: Where is the charger?
>
> Wilston: Someone broke it. Ripped it from the wall and the piece that goes into the hoyer broke off.

(*Id*. ¶ 161, Ex. J.) Without working Hoyer lifts, residents who require two-person assists in their plan of care cannot be moved, such as Resident 52, to whom CNA Wilston referred.

297. CNA Sample testified that the air conditioning at The Villages worked off-and-on for the last five years that she worked there, and that every time the air conditioning broke, they would "stick big old industrial fans in the halls and hope for the best." (SAAG Aff., Ex. 12 at 40:14 – 41:12.) CNA Brown also testified that in the two years that she worked at The Villages, the air conditioning was broken "[a] lot. Like, I am going to guess at least five [times]." (*Id*., Ex. 11 at 29:24 – 31:4.) As evidence of some of the HVAC problems, CNA Brown provided a photograph, taken on June 30, 2018, showing that the thermometer located near the dining room of the residential halls read 80 degrees Fahrenheit. Describing the photo, CNA Brown stated "[t]his was one of the hot days in the building when the ac didn't work. It was so hot and humid in the building we had to put wet towel [sic] around our necks." (Detective Aff. ¶ 174, Ex. S.) CNA Miller also testified that CNAs were unable to give residents showers or baths on numerous occasions because there was no hot water. Instead, CNAs were expected to take water basins up to the kitchenette, microwave the water, and use that water to bathe residents. (SAAG Aff., Ex. 10 at 51:25 – 52:13.)

298. CNA White testified that repairs were made on a timely basis, usually "that day or the next," when the facility was county-owned. However, under new ownership, when the facility became The Villages, repairs were not made on a timely basis. CNA White testified that, for example, lifts "never got fixed," "lights would go out and they would be out for days," and most televisions did not work. (*Id*., Ex. 39 at 42:8 – 43:8.)

299. CNA Miller testified that the facility was less clean when it was run by Respondents, compared to when it was a county-owned facility, because The Villages had difficulty maintaining housekeeping and kitchen staff. (*Id*., Ex. 10 at 37:2-17.)

300. E. Howard testified that "there was always a complaint" about deep cleans not getting done at The Villages but it was because the nursing was so short-staffed that they were not

getting residents up and out of bed in time to allow housekeeping to do deep cleans. E. Howard also testified that the nursing staff's tardiness and unexcused absences affected everybody (*e.g.*, dietary, housekeeping, laundry, etc.) because it threw everyone's schedules off. (*Id.*, Ex. 15 at 80:25 – 88:24.)

301. CNA Fernandez summarized the letter complaint she and CNA Wilston sent to Admin Reader detailing their complaints about lack of staff, the shower room flooding, water underneath the shower tiles that were lifting up, mold on the bathroom walls, and the fact that the stand-lift in the shower room never worked. Admin Reader told CNA Fernandez and CNA Wilston that he would take care of their concerns, but subsequently relayed that he was "yelled at" by DON Donnelly when he raised them with her. (Detective Aff. ¶ 21.)

302. CNA White testified that when the facility was owned by the county, it did not have a pest problem. But when the facility became The Villages, pests became an issue. For example,

> the dementia room shower room had rotted so bad that there were these like – I don't know what kind of bugs they were, to be honest with you – crawling all over the dementia bathroom just from like water leakage and mold . . . there was a period in time where we couldn't use the shower room because it was so filthy disgusting that we would complain every day . . . I would say by 2018, 2019 that's when it got really, really bad.

(SAAG Aff., Ex. 39 at 44:9 – 45:11.)

303. Additionally, as set forth in the Auditor Affidavit, DOH surveyors issued numerous citations to The Villages for repeat building code deficiencies from 2015 forward. (*See* Auditor. Aff. ¶¶ 165-170.)

VII. From 2015 through June 2022, Respondents Siphoned Over $18.6 Million From The Villages, a Profit of Nearly 22% From a Primarily Government-Funded Facility.

304. Since purchasing The Villages in 2015, Respondents secretly siphoned millions of dollars from the nursing home, leaving behind insufficient financial resources to safely provide care for residents. Respondents' looting of The Villages has taken on many forms:

- First, since 2015, through a self-dealing and predatory lease agreement, Respondents have forced the Villages to pay exorbitant "rent," the majority of which has gone into Respondents' pockets by way of their real estate pass-through entity, Telegraph;
- Second, Respondents obtained and cashed-in on a sequence of overvalued mortgages, secured by The Villages and its steady flow of resident admissions and government claims. Respondents have since taken significant portions of the loan proceeds as profit, rather than reinvesting the loan proceeds into the facility. Per the lease agreement, The Villages, rather than Respondents or Telegraph, was, and is, obligated to make the mortgage payments out of its operating accounts, to the detriment of residents; and
- Third, Respondents Gast, Halper and Lahasky extracted purported management fees through CHMS Group, and transferred funds to themselves directly from The Villages' operating account.

305. Respondents did not seek written permission from DOH to transfer any of these assets at any time during the period from 2015 through 2021, in violation of Public Health Law § 2808(5)(c), which requires nursing home operators to obtain written permission from DOH prior to withdrawing equity or transferring assets in excess of 3% of a nursing home's annual revenue for patient care for the prior year. (*See* PHL § 2808[5][c]; 10 NYCRR § 400.19 [defining

"withdrawal" to include "any transfer of a facility's cash or other assets directly or indirectly for the benefit of its operator" and "any liability incurred . . . by a facility or its operator by reason of a mortgage, lease, borrowing or other transaction relating to such facility that exceeds, in the aggregate, $50,000"].)[56]

A. Respondents Extracted Undisclosed Profit Through So-Called "Rent."

306. Since on or about 2015, The Villages has been a party to a lease agreement[57] with Telegraph Realty. The operative lease agreement, which appears to be still in effect, provides that The Villages shall pay rent to Telegraph in the amount of: (a) monthly debt service[58] on the mortgage; (b) $50,000 per month; *plus* (c) "profits of up to One Million ($1,000,000) Dollars per annum." (Auditor Aff., Ex. 50 § 2.1.)

307. The lease between The Villages and Telegraph is also triple net, meaning it is a lease agreement whereby the tenant (*i.e.*, The Villages) is obligated to pay all the expenses of the property, including real estate taxes, building insurance, and maintenance, in addition to the cost of rent and utilities.[59] (*See id*.) As set forth in more detail below, this predatory operative lease agreement varies significantly from the sham lease agreement provided by Respondents to DOH in support of their 2014 application for permission to run The Villages.

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[56] *See also Brightonian v. Daines*, 21 NY3d 570, 575, 577-78 (2013) (holding that PHL § 2808[5][c] is constitutional and not a violation of substantive due process).

[57] The operative lease agreement, which is undated but states that it became effective in 2015, was purportedly signed off on by Respondent Fuchs on behalf of The Villages, and by Respondent Lahasky, on behalf of Telegraph. Fuchs is also a member of Telegraph Realty, as are several of his children and/or their spouses.

[58] "Debt service" refers to the total payments required to actually satisfy a debt obligation or loan, including principal, interest, and any associated fees.

[59] In contrast, in standard commercial lease agreements, some or all of these payments are typically the responsibility of the landlord.

308. Under this operative lease agreement, between January 1, 2015 and June 30, 2022, Respondents forced The Villages to pay $15,750,360 as "rent" for The Villages' use of the real estate owned by Respondents through Telegraph. (*Id*. ¶ 179.) These excessive payments were anything but fair, did not follow the market, and provided no value to The Villages.

309. During the same period, Respondents took that "rent" as profit and paid themselves $9,826,936 directly from Telegraph, labeled with notations such as "Orleans Salary" and "Telegraph Monthly Distribution." (*Id*. ¶ 183.) Respondents also sent Telegraph payments of $67,910 in April 2020 and $249,930 in May 2020—during the peak of the first wave of the COVID-19 pandemic, and at the same time that staffing agencies were refusing to send much-needed nursing staff to The Villages because Respondents were not paying their agency bills (*see* ¶ 276, *supra*). (Auditor Aff. ¶ 180.)

310. As detailed in the Auditor Affidavit, using the amounts reported by nursing home facilities on Medicaid Cost Reports, MFCU determined that The Villages' rent to revenue ratio in 2020 was 124.1% greater than the average rent to revenue ratio for all New York State for-profit nursing homes. MFCU further determined that, in 2018, The Villages' rent to revenue ratio was the highest out of all 24 nursing home facilities in the Finger Lakes economic region. (*Id*. ¶¶ 181-182.)

311. Respondents never sought permission from DOH to transfer these inflated "rent" payments to themselves, in violation of PHL § 2808(5)(c).

B. Respondents' Mortgage Scheme Saddles The Villages With Outsized Debt to Bolster Respondents' Profit and Boost Equity in Property Investment, at No Benefit to Residents.

312. On or around January 2015, The Villages and Telegraph obtained a $6,300,000 mortgage loan from The Private Bank to finance their $7,800,000 purchase of the facility and real property from Orleans County Health Facilities Corporation. (*Id*. ¶ 184.)

313. Respondents quickly re-financed The Villages' mortgage at nearly double the initial purchase price. To wit, in January 2017, just two years after obtaining the purchase loan, Respondents obtained a $15,000,000 loan from The Private Bank to refinance the original mortgage—a loan almost twice the size of the 2015 sale. (*Id*. ¶ 185.)

314. Respondents immediately took out more than $4,000,000 of the mortgage proceeds as a cash distribution.[60] Not a penny of this distribution went to resident care, but the loan was paid by the facility almost entirely through funds brought in from government revenue. At the same time, Respondents accrued equity in the real estate. (*See id*. ¶¶ 186-87.)

315. In December 2020, Telegraph refinanced the facility and the real estate yet again, this time through the U.S. Department of Housing and Urban Development ("HUD") for the total sum of $14,541,000. (*Id*. ¶ 188.) The same month, Respondents withdrew as profit an additional $3,600,000 in loan proceeds from the 2017 re-financing which they had been required to set aside in a blocked account prior to the HUD refinance.[61] Respondents did not reinvest these additional

[60] Specifically, on or around January 30, 2017, at the direction of Respondent Lahasky, the title company associated with the refinancing wired approximately $4,106,242 in loan proceeds to Telegraph. The following day, Telegraph paid approximately $4,394,338 to the Individual Respondents. (*See* Auditor Aff. ¶ 186.)

[61] Specifically, on December 11, 2020, the day of the HUD closing, Respondents released $3,700,000 plus accrued interest from the blocked account and transferred it to Telegraph. Telegraph then transferred $3,600,000 to the Individual Respondents, with remarks including "HUD Distribution." (Auditor Aff. ¶¶ 189-90.)

loan proceeds into the facility, and instead took millions of dollars in refinanced loan proceeds out of Telegraph as profit distribution. (*Id*. ¶¶ 189-91.)

316. Meanwhile, through the above-referenced predatory lease agreement, Respondents caused The Villages, rather than Telegraph, to repay the inflated mortgage principal, and interest on that principal, out of its operating account. This scheme has resulted in extremely high expenses for The Villages with no benefit to the operation of The Villages or the care of its residents.

317. Furthermore, Respondents have never sought DOH permission to saddle the facility with these inflated mortgage debts, in violation of Public Health Law § 2808(5)(c). Respondents simply pocketed the cash from the inflated loans, while the struggling facility was and remains obligated to cover the monthly loan payments to the bank.

C. Respondents Paid Themselves "Management Fees" from CHMS Group and Salaries Directly from The Villages, yet Delivered Nothing for Residents.

318. In addition to the above looting schemes, Respondents also took profit distributions from the management fees The Villages paid to CHMS Group, and took salaries directly from The Villages itself, while running the facility into the ground, harming residents, and extracting as much profit as possible.

319. MFCU's analysis of The Villages' bank records shows that, from January 1, 2015, to January 31, 2021, The Villages paid approximately $1,534,856 to CHMS Group as purported management fees. (*Id*. ¶ 193.) CHMS Group also received payments from other nursing homes owned and/or controlled by Respondents. During the same period, Respondent Gast received $440,274 from CHMS Group, Respondent Halper received $1,007,662 from CHMS Group, and Respondent Lahasky received $328,973 from CHMS Group. (*See id*. ¶¶ 195-96.) Employing a

weighted average approach, MFCU found that approximately $116,761 in these revenue distributions are attributable to payments by The Villages.[62]

320. Respondents Fuchs, Gast, Halper, and Lahasky likewise drew funds directly from The Villages' operating account. According to bank records, during the period January 1, 2015, through June 30, 2022, Respondents paid themselves $744,380 including transactions labeled "Orleans salary." (*Id*. ¶ 197.)

VIII. Respondents Made Affirmative Misrepresentations to DOH to Hide Pattern of Looting.

321. In order to shield themselves from nursing home regulators and protect their illegal looting, Respondents lied to DOH on multiple required disclosures. From day one, Respondents misrepresented who owned and controlled The Villages, and submitted deliberately misleading documentation to support ownership. Respondents likewise submitted a sham lease agreement which failed to disclose the true nature of their profit taking, and have annually misrepresented to DOH that all The Villages' expenses were incurred to provide patient care in the facility.

A. DOH-Approved Owner, Bernard Fuchs, Is A "Straw Man" Owner, While Respondents Gast, Halper, and Lahasky Actually Control The Villages.

322. Under New York law, The Villages was required to submit a Certificate of Need ("CON") application seeking DOH approval to assume operation of The Villages from the facility's former operator, Orleans County. Public Health Law § 2801-a requires that a CON application must include, *inter alia*, "information as to the character, competence and standing in the community of every individual and entity of the applicant and specify the identity of every

[62] The Villages' $1,534,856 management fee represents 6.57% of the total deposits to CHMS Group, as apportioned across all of Respondents' nursing homes. Using this percentage, OAG calculated $116,761 as 6.57% of Respondents' total profits pulled from CHMS Group across all homes. (Auditor Aff. ¶¶ 195-96.)

nursing home in which each of those individuals and entities is, or in the preceding seven years has held a controlling interest or has been a controlling person, principal stockholder or principal member; and the nature of that interest."[63] (PHL § 2801-a.)

323. Per the statute, DOH "shall not" approve an applicant "unless it finds that each individual and entity, in relation to ownership of a nursing home located in the United States, for at least the previous seven years, demonstrated satisfactory character, competence and standing in the community and the nursing home provided a consistently high level of care." (*Id*.) At a minimum, the "consistently high level of care" inquiry includes consideration of CMS ratings, repeated or severe violations of federal and state nursing home regulations, licensure revocations, and involuntary termination from the Medicare or Medicaid Program. (*Id*.) Further, the statute is clear that bootstrapping new owners is not allowed – individuals that seek to acquire ownership shares after the operator entity is formally approved must themselves go through DOH approval. (*Id*.)

324. On or around March 31, 2014, Respondents submitted The Villages' CON application, dated March 19, 2014, to DOH ("2014 CON Application"). (Auditor Aff., Ex. 51) The 2014 CON Application states that Bernard Fuchs is the sole member and 100% owner of The Villages. (*Id*. at 5.) As such, Schedule 2 of the 2014 CON application provides information about Fuchs' ownership of other nursing homes, as well as information about his education, experience, and assets. As to other nursing homes, according to Schedule 2, Fuchs disclosed ownership interests in three facilities in New York State and none outside the State. (*Id*., Ex. 52 at 3-4.)

[63] "[E]very individual and entity of the applicant" includes, *inter alia*, individuals who direct management or policies of the applicant and individuals with a greater than 10% ownership interest in the applicant. (PHL § 2801-a.)

325. There is no question that the representation of Fuchs as sole owner was a sham designed to mislead DOH. As set forth throughout this Petition, Respondents Gast, Halper, and Lahasky control, and have always controlled, The Villages. However, Respondents Gast, Halper, and Lahasky did not disclose their authority and involvement to DOH, the agency responsible for vetting proposed nursing home operators according to statute. Instead, to avoid scrutiny and seamlessly acquire a CON, Respondents Fuchs, Gast, Halper, and Lahasky carried out a scheme to name Fuchs as the 100% owner of The Villages on corporate organizing documents and in formal submissions to DOH, despite the fact that Fuchs never intended to (and never did) meaningfully contribute to managing or controlling The Villages – nor was Fuchs ever the only (or even majority) investor, as would be consistent with a 100% ownership stake.

326. Fuchs testified that in early 2014, Lahasky approached him with an investment opportunity to acquire a minority share in The Villages, along with other partners including Respondents Gast and Halper. As to the 2014 CON Application, Lahasky told Fuchs "there's too many partners involved. It will take a very long time to get the CON approval and [the county] wants to close very quickly, so is it okay if we use your name as a 100 percent and then we will file applications to change the ownership accordingly the way it's supposed to be." Fuchs agreed. (SAAG Aff., Ex. 2 at 18:8-16.)

327. According to Fuchs, he believes he was listed as 100% owner of the Villages on the CON application because he "didn't own any real homes at that point yet, so I had a very good clean record as a businessman and not any issues with the Department of Health so it would go quickly." (*Id*. at 76:3-18.)

328. Lahasky testified similarly, stating "we asked Mr. Fuchs if he would mind being the only one on the operations for the purpose of just having a faster application. You know, if you

put on everybody, then the State comes back with a million questions and this and that, so we asked him just if you mind being the only person on the operations and he said okay." (*Id*., Ex. 4 at 44:16-45:3.) Lahasky testified that Fuchs was asked to do this because he was "best suited," and later conceded that it was likely because Fuchs owned only a few nursing homes. (*Id*. at 44:13 – 45:25.)

329. In reality, Fuchs was a "silent investor" who never took on any responsibility for resident care or finances at The Villages, while Gast, Halper, and Lahasky controlled operations from the outset. (*Id*., Ex. 2 at 77:20-23.)

B. Respondents' 2016 CON Application Further Demonstrates Their Scheme to Mislead DOH.

330. On or around January 28, 2016, The Villages submitted a new CON application to DOH, signed by Respondent Fuchs, seeking approval to modify Fuchs' share in The Villages (from 100% to 3.32%) and expand ownership of The Villages to include Joel Edelstein (3.32%), Israel Freund (3.32%), Gerald Fuchs (3.32%), Tova Fuchs (3.32%), David Gast (20.99%), Sam Halper (12.33%), Ephram Lahasky (16.66%), Joshua Farkovits (16.66%), Teresa Lichtschein (7.5%), and Debbie Korngut (9.16%). (*Id*., Ex. 54). This ownership composition substantially accords with the Individual Respondents' actual shares of Telegraph.

331. DOH made various inquiries in response to the application, including asking for very specific information about the proposed new owners, their ownership interests in certain facilities, explanations for poor performance at various facilities in and out of state, and turnaround plans for said facilities. (*Id*., Ex. 55.) DOH further asked Respondents Lahasky, Farkovits, and Gast to certify that they had no "current or past operational ownership" in The Villages. (*Id.*)

332. The Villages did not respond to these multiple inquiries. As a consequence, on or around February 28, 2018, DOH deemed the application abandoned, and Respondent Fuchs

remained the sole owner of The Villages, even though he remained completely uninvolved in The Villages and had never even been there. (*Id*., Ex. 56.)

333. Further compounding the complete lack of transparency regarding who was actually responsible for decisions at The Villages, Fuchs testified that he did not know until "years later" during the COVID-19 pandemic—when Lahasky requested that Fuchs attend a call with the OAG—that the application to amend The Villages' management structure was not approved by DOH and that he was therefore still 100% owner. (SAAG Aff., Ex. 2 at 46:17 – 47:19.) Fuchs testified that Lahasky was "not honest with [him] regarding this ownership situation" and claimed he was "very surprised and upset" to find out that he, Fuchs, had a 100% ownership interest in The Villages when "from day one" the ownership interest was supposed to be divided among numerous partners, including Respondents Gast, Halper and Lahasky. (*Id*. at 53:18 – 22, 78:3 – 11.) Fuchs testified that he "should have checked with an attorney what I can do at that point legally" after he learned that he remained the 100% owner, but that he "just said [to Respondent Lahasky], Mordy, please. I beg you, fix the facility." (*Id*. at 134:23 – 135:8.)

C. Respondents Concealed Profits Under The Villages' Lease Agreement From DOH.

334. In addition to misrepresentations about the true ownership in The Villages, Respondents submitted a sham lease agreement for approval to DOH in support of the 2014 CON application.

335. As a condition of approval for the 2014 CON Application, DOH required The Villages to submit "an executed lease agreement that is acceptable to the Department of Health." (Auditor Aff., Ex. 57 at 4.) To satisfy this condition, The Villages submitted a 10-year term lease agreement with Telegraph which provides, *inter alia*, that The Villages will pay rent to Telegraph

in the amount of: (a) monthly debt service on the mortgage;[64] and (b) $50,000 per month.[65] (*Id*, Ex. 49 § 2.1; *see also id*., Ex. 58 at 6.)

336. After DOH approved the CON, however, Respondents effectuated the operative lease agreement – which calls for payments of an additional up to $1,000,000 in profit per annum. Since that time, the Villages has followed the operative lease agreement in practice, and even exceeded the payments provided for therein. For example, based on information reported on The Villages' 2020 Medicaid Cost Report, debt service on the mortgage for 2020 plus $600,000 ($50,000/ month) amounted to $1,213,998. Nonetheless, The Villages reported $2,655,527 in rental expenses to Telegraph that year – approximately $1.4 million more than what was owed according to the first lease and $400,000 more than what was owed according to the operative lease agreement. (Auditor Aff. ¶ 219.)

D. Respondents Falsely Certified Medicaid Cost Reports.

337. Respondents also routinely misrepresented in their annual Medicaid Cost Reports that the facility's expenses went to patient care.

338. Pursuant to 10 NYCRR § 86-2.2, nursing home providers are required to file complete and accurate annual financial and statistical reports (Medicaid Cost Reports) to DOH. These reports include revenues, expenses, assets, liabilities, and statistical data. The data is used

[64] The debt service amount disclosed was prior to Respondents' mortgage refinancing scheme which significantly increased the amount of the debt service owed by The Villages. The Villages did not receive permission from DOH to take on this additional debt obligation.

[65] Notably, Respondents represented to DOH that Telegraph's members were Respondents Gast, Lahasky, and Farkovits – and DOH approved the 2014 CON Application under the impression that these Respondents "are not associated with the proposed member of the operations." (Auditor Aff., Ex. 58 at 6.) Respondents did not advise DOH that Fuchs and his family members intended to join Telegraph.

by DOH to develop Medicaid rates, assist in the formulation of reimbursement methodologies, and analyze trends. (Auditor Aff. ¶ 220.)

339. Together with the annual Medicaid Cost Report, nursing home operators are required to submit the following certification to DOH:

> 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.

(*Id*. ¶ 221) (emphasis added.)

340. As set forth above, Respondents secretly siphoned funds out of the facility for their own personal use by disguising large profit distributions as "rent" payments on Medicaid Cost Reports and other financial documents. In so doing, Respondents falsely certified that such payments were expenses "incurred to provide patient care" in violation of New York law.

IX. Respondents Flagrantly Disregarded Their Obligations to Assure The Villages Was in Compliance With State and Federal Laws by Failing to Have a Defined Governing Body.

341. At all relevant times, The Villages was required to adopt and implement an effective compliance program to address activities including: "billing, payments, medical necessity and quality of care, governance, mandatory reporting, credentialing, and other risk areas that are or should with due diligence be identified by the provider." (*See* 19 NYCRR § 521.3 [compliance program required provider duties].) The compliance program was required to implement written policies and procedures for The Villages regarding: training, reporting, communication, discipline, retaliation, and other areas of great importance. (*See* 19 NYCRR § 521.3[b] and [c].)

342. Among the "minimum standards" for nursing homes called for by 10 NYCRR § 415.26 is the requirement that a nursing home be administered "in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." (*Id*.)

343. 10 NYCRR § 415.26(b) specifies that the nursing home shall "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." Federal law imposes the same requirement. (*See also* 42 CFR § 483.70[d].) Among other tasks, the governing body is responsible for appointing an administrator; determining and establishing written policies as to the program of services provided, the physical structure and equipment of the facility, and the number and qualifications of staff; operating the facility; providing and arranging for services for residents and staff in accordance with applicable regulations; compliance; and addressing resident complaints. (*See* 10 NYCRR § 415.26[b]; *see also* 42 CFR § 483.70[d].)

344. According to 10 NYCRR § 415.2(g), governing body is further defined as the policy-making body of a government agency, the board of directors or trustees of a corporation or the proprietor or proprietors of a proprietary nursing home to which the department has issued an Operating Certificate.

345. Since 2015, Bernard Fuchs is the sole individual to whom an Operating Certificate has been issued in connection with The Villages. All pertinent testimony and documentation reflects that Bernard Fuchs does not perform any of the functions required of a governing body. (*See, e.g.*, SAAG Aff., Ex. 2 at 77:20-23.) In July 2020, in response to a request from MFCU for identification of the members of The Villages' governing body, the facility's attorney responded:

"The person responsible for establishing and implementing policies regarding the management and operation of the facility was and is the Administrator. *Please be advised that I have been informed that the functional Governing Body during the applicable period of time was Brian Reader and Jason Teitelbaum, and then Steve Hefter and Jason Teitelbaum as they were responsible for the establishment and implementations of policies and procedures and for the QAPI program.* They did not, however, have the function of ensuring a licensed nursing home administrator. That function belonged to Mr. Fuchs who delegated same to consultants. As you are aware, Jason Teitelbaum is the current LNHA." (SAAG Aff., Ex. 36) (emphasis added.) The "functional Governing Body" cannot be a facility's administrator. Pursuant to 10 NYCRR § 415.26(a)(4)(i) and 42 CFR § 483.70(d)(2)(iii), the administrator reports to and is accountable to the governing body.

346. Additionally, in response to MFCU's follow-up request for supporting documentation, the facility's attorney asserted that The Villages does not have a Board of Directors or a formal Governing Body. Instead, according to the facility attorney, administrators, owners and an outside consultant are responsible for reviewing policies and procedures and ensuring that a licensed administrator is employed at the facility. The attorney further asserted that The Villages administrators, owners and outside consultants do not hold monthly meetings but they do communicate with one another to fulfill the functions of a Governing Body. The attorney stated he would provide additional documentation as to the arrangement, but none was provided to MFCU. (*Id*.) In March 2022, MFCU requested the "[n]ames and contact information of each individual and entity responsible for setting policies and adopting and enforcing rules and regulations for health care and safety of the residents in the Facility, from January 1, 2019, through the present." The facility's response included the names of seven individuals, all of whom have

served as facility administrators or Directors of Nursing: Brian Reader, Steve Hefter, Jason Teitelbaum, Eric Flugel, Debra Donnelly, Karrie Mikits, and Kathleen Howard. (*Id*., Ex. 37.) This further demonstrates that the facility never had a governing body as required by New York law, and that The Villages continues to operate in flagrant violation of 10 NYCRR § 415.26(b), and in such a way that neither the owner, nor the other individuals who receive significant financial benefit from the facility accept responsibility for The Villages, its employees, and its residents. Respondents are the first in line to collect siphoned monies but run for the exits when asked who legally governs the facility.

347. Respondent Lahasky testified, "I don't even know what a governing body is." He further testified that he is not familiar with the regulations that require nursing homes to have a governing body and that, "[t]he administrator usually sets policies." (SAAG Aff., Ex. 4 at 58:18 – 61:19.)

348. To further confuse the issue, The Villages pays fees to a management company known as CHMS Group. Respondent Gast testified that CHMS Group provided "consulting" services to The Villages. (*Id*., Ex. 1 at 25:13 – 16) In other words, the same Individual Respondents who control The Villages also have a financial and controlling interest in CHMS Group, the facility's management company.

349. In another confusing addition, certain individuals who appear to do work on behalf of The Villages claim to work for a company known as Western Pa Consult. Little detail as to the corporate structure and ownership of Western Pa Consult is available, but Admin Teitelbaum testified that he is employed by Western Pa Consult and that he reports to Respondent Halper. (*Id*., Ex. 5 at 24:21 – 32:10.) According to The Villages, employees of Western Pa Consultant provide

services to The Villages. Those services are paid for by CHMS Group "on behalf of" The Villages. (*Id*., Ex. 37.)

350. Respondents' decision to ignore its compliance obligations is also apparent in staff correspondence, which reflects a lack of understanding of and adherence with uniform policies and procedures and applicable legal obligations. This is further underscored by staff's frequent use of text messages between personal telephones to discuss The Villages' residents and the facility's business. For example, on September 14, 2020 and September 15, 2020, DON Mikits joked with SW Woodin: "What I left out is how great we are at making up policies on the fly! Lol and maybe a care plan or two" and "I faked policies all week! Lol Google saves the day!" Similarly, on September 10, 2020, DON Mikits texted SW Woodin about falsifying a resident's incident/accident report: "U rock. I'm gonna say I interviewed u k. Lol and u said that… he came in blah blah blah." (Detective Aff. ¶¶ 159-160, Exs. H-I.)

351. DON Mikits was advised by Admin Teitelbaum not to use official facility e-mail to discuss important issues and problems, and to instead use Signal, an encrypted messaging application that does not store or retain messages in a central location, allowing users to easily destroy messages. DON Mikits testified that Teitelbaum advised her to use the Signal App which "self-destructs" because "the government" was watching their e-mails. (SAAG Aff., Ex. 9 at 252:9 – 253:7.) DON Donnelly testified that she was advised by Admin Teitelbaum not to put information about accidents, injuries, and other important events at The Villages in e-mail or text messages and to convey such information via telephone call. (*Id*., Ex. 13 at 188:1 – 189:21.)

352. Furthermore, Respondents did not comply with Quality Assessment and Assurance Program requirements intended to allow for review of facility programs and "enhance the quality of life and resident care and treatment." (*See* 10 NYCRR § 415.27.) As part of this requirement,

The Villages was directed to establish a Quality Assessment and Assurance Committee comprised of "at least one member of the governing body who is not otherwise affiliated with the nursing home in an employment or contractual capacity," in addition to the facility's administrator, director of nursing, physician, and three additional staff members. The Medical Director or his designee was required to attend such meetings at least on a quarterly basis. (*See* 10 NYCRR § 415.27; 42 CFR 483.75[g][2].)

353. The Villages provided MFCU with attendance sheets from 27 QAPI meetings held at The Villages from March 2018 to July 2021. The Medical Director, Dr. Madejski, appears on the attendance sheet for only two of those meetings, in violation of 42 CFR § 483.75(g) and 10 NYCRR § 415.27(b). Neither Bernard Fuchs nor any other designated "governing body" member appears on any of the attendance sheets provided by the Villages, in violation of 10 NYCRR § 415.27(b)(4). (Auditor Aff. ¶ 226.)

X. Respondent Sam Halper, Currently Under Federal Indictment, Is Unfit to Operate The Villages and Must Be Removed.

354. On August 5, 2022, an Indictment was filed in the U.S. District Court for the Western District of Pennsylvania, charging Respondent Halper; Comprehensive Healthcare Management Services, LLC, d/b/a Brighton Rehabilitation and Wellness Center[66]("Brighton"); Mt. Lebanon Operations, LLC, d/b/a Mount Lebanon Rehabilitation and Wellness Center[67] ("Mt. Lebanon"); and four other individuals, with various crimes. (SAAG Aff., Ex. 3.)

355. Specifically, Respondent Halper was charged with:

[66] Brighton is a skilled nursing facility located in Beaver, PA. Its owners include Respondents Joel Edelstein, Israel Freund, Gerald Fuchs, Tova Fuchs, Sam Halper, Ephram Lahasky, Joshua Farkovits, and Lahasky LLC. (Auditor Aff. ¶ 227.)

[67] Mt. Lebanon is a skilled nursing facility located in Pittsburgh, PA. Its owners include Respondents Sam Halper, David Gast, and Ephram Lahasky. (Auditor Aff. ¶ 228.)

- Conspiring to defraud the United States, in violation of Title 18, United States Code, Section 371, and Making a False Statement in a Healthcare Matter, in violation of Title 18, United States Code, Section 1035(2), in that through his management of Brighton, Halper and others knew the facility was understaffed, understood the impact low staffing had on the facility's residents, and conspired to provide false information and documentation as to facility staffing during surveys to make it appear that staffing was higher than it actually was, and to make it appear as though staffing met acceptable state and federal guidelines; and
- Conspiracy to Commit Healthcare Fraud, in violation of Title 18, United States Code, Section 1349, in that Halper, along with Michelle Romeo and Johnna Haller falsified information submitted to CMS, intended to fraudulently inflate reimbursement paid for resident care, including MDS data regarding medical condition, nursing care and therapy needs, and status of residents at "CHMS Facilities" in Pennsylvania. For example, Halper and others are accused of instructing administrators to unnecessarily delay discharge of residents, and to create orders and visits that would raise reimbursement rates without regard to residents' actual medical needs.

(*Id*.)

356. As the individual responsible for operations at The Villages, Halper's role at The Villages is analogous to his role at Brighton and Mt. Lebanon. Halper is aware of factors affecting The Villages' Medicare and Medicaid reimbursement rates, and Michelle Romeo oversaw the MDS assessments for The Villages' residents. (*See, e.g.*, *id*., Ex. 38.)

357. On September 1, 2022, Sam Halper had the opportunity to testify and explain his conduct regarding The Villages pursuant to a subpoena issued under Executive Law § 63(12). Notably, Halper declined to respond to every single inquiry other than his name and present location, and instead invoked his right against self-incrimination on all topics of inquiry, including specifically as to his ownership and control of The Villages, whether he and his co-Respondents caused The Villages to properly deliver healthcare to residents, whether he and his co-Respondents and others deceived the Department of Health, and the source and conversion of the funds received by The Villages, Telegraph, and other Respondents.

XI. Respondents Refuse to Improve Conditions for Residents.

358. Respondents have been aware of serious and redressable problems at The Villages for years through, among other avenues, DOH surveys, consultant reports, news media reports, resident family complaints, and, dating back to the spring of 2020, Petitioner's investigation, which involved telephone interviews with Individual Respondents, document requests, and multiple examinations under oath. Nonetheless, Respondents have refused to remedy the root cause of the residents' suffering: Respondents' continued operation of the nursing home with insufficient staffing while Respondents continue to take exorbitant "up-front profit" from The Villages, depriving it of funds needed to deliver required resident care and disregarding many state and federal laws designed to protect residents. Even as recently as November 2022, Petitioner's investigation found that residents at The Villages continue to be neglected and mistreated, and staffing remains inadequate. (Detective Aff. ¶¶ 230-238.) For all of these reasons, Petitioner respectfully submits that judicial intervention is warranted.

AS AND FOR THE FIRST CAUSE OF ACTION
PURSUANT TO EXECUTIVE LAW § 63(12):
REPEATED AND PERSISTENT FRAUD
As against All Respondents

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

360. Executive Law § 63(12) authorizes the New York Attorney General to seek injunctive and other equitable relief whenever an individual or entity engages in repeated or persistent fraudulent conduct. 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."

361. Respondents, through their agents and employees, repeatedly and persistently committed fraud by engaging in the above-described scheme to convert millions of dollars in "up front profit" from Medicaid and Medicare funds that The Villages received as reimbursement for services purportedly rendered by The Villages that did not conform with applicable laws and regulations, including refraining from engaging in unacceptable practices, in violation of 18 NYCRR § 515.2;

362. Respondents thereby engaged in repeated and 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 AND PERSISTENT FRAUD
As against All Respondents

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

364. Executive Law § 63(12) authorizes the New York Attorney General to seek injunctive and other equitable relief whenever an individual or entity engages in repeated or persistent fraudulent conduct. 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."

365. Respondents, through their agents and employees, repeatedly and persistently committed fraud by:

a. Entering into complex real estate transactions, including but not limited to, collusive and/or self-dealing lease agreements obligating The Villages to pay artificially high rent and to pay additional interest;

b. Entering into a mortgage scheme to saddle The Villages with debt while bolstering their profits and equity holdings, at no benefit to residents; and

c. Engaging in unacceptable practices, in violation of 18 NYCRR § 515.2.

366. Respondents thereby engaged in repeated and 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 AND PERSISTENT FRAUD

As against Comprehensive at Orleans, LLC d/b/a The Villages of Orleans Health and Rehabilitation Center, CHMS Group, LLC, Villages of Orleans LLC, ML Kids Holdings LLC, Bernard Fuchs, David Gast, Sam Halper, Ephram Lahasky

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

368. Executive Law § 63(12) authorizes the New York Attorney General to seek injunctive and other equitable relief whenever an individual or entity engages in repeated or persistent fraudulent conduct. 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."

369. Respondents, through their agents and employees, repeatedly and persistently committed fraud by:

a. Failing to seek approval from DOH for withdrawals and transfers from The Villages in excess of the disclosure thresholds as set forth in Public Health Law § 2808(5)(c);

b. Preparing, filing, and/or causing to be filed with DOH false cost reports that failed to disclose and/or misrepresented the amounts of money certified to have been spent on resident care, in violation of 10 NYCRR § 86-2.2;

c. Preparing, filing, and/or causing to be filed with DOH false and/or misleading documents concerning an application for a Certificate of Need, on behalf of The Villages; and

d. Engaging in unacceptable practices, in violation of 18 NYCRR § 515.2.

370. Respondents thereby engaged in repeated and 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 AND PERSISTENT ILLEGALITY

As against Comprehensive at Orleans, LLC d/b/a The Villages of Orleans Health and Rehabilitation Center, CHMS Group, LLC, Villages of Orleans LLC, Bernard Fuchs, David Gast, Sam Halper, Ephram Lahasky

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

372. Executive Law § 63(12) authorizes the New York Attorney General to seek injunctive and other equitable relief whenever an individual or entity engages in repeated or

persistent illegal acts and/or illegality. 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.

373. Respondents, through their agents and employees, repeatedly and persistently committed illegalities by failing to comply with their legal obligations to provide The Villages' residents the care required under New York law and federal regulations by failing to:

a. Fulfill each resident's right to adequate and appropriate medical care, as required by 10 NYCRR § 415.3 and PHL § 2803-c;

b. Provide regular access to the private use of a telephone, as required by 10 NYCRR § 415.3(e);

c. 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 which 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 and a need to alter treatment significantly as required by 10 NYCRR § 415.3(f)(2)(ii);

d. Assure that the 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);

e. Provide a safe, clean, comfortable and homelike environment, housekeeping and maintenance services necessary to maintain a sanitary, orderly and

comfortable interior and comfortable and safe temperature levels, as required by 10 NYCRR § 415.5(h);

f. Create comprehensive and timely care plans, provide services in accordance with comprehensive care plans, revise care plans as necessary to assure the continued accuracy of a resident's health assessment, and prepare a discharge summary as required by 10 NYCRR § 415.11(a)-(d) and 42 CFR § 483.70(e);

g. 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-(a)(1);

h. 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);

i. Ensure that (1) a 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) a resident having 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);

j. Provide adequate assistance and supervision to residents to prevent accidents, as required by 10 NYCRR § 415.12(h)(2);

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

l. Timely administer treatments, medications, diets, and other health services, as required by 10 NYCRR § 415.13;

m. 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 a comprehensive care plan that The Villages is required to develop, as required by 10 NYCRR § 415.13(a);

n. 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;

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

p. Maintain an effective infection control program designed to provide a safe, sanitary, and comfortable environment, as required by 10 NYCRR § 415.19 and 42 CFR § 483.80;

q. Ensure that laboratory services meet the needs of the nursing home residents, including by failing to ensure the quality and timeliness of such services, as required by 10 NYCRR § 415.20;

r. Maintain clinical records for each resident in accordance with accepted professional standards, as required by 10 NYCRR § 415.22;

s. Have an administrator that reports to the facility's governing body at regular intervals, as required by 10 NYCRR § 415.26(a)(4)(i) and 42 CFR § 483.70(d)(2)(iii);

t. 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);

u. Employ on a full-time, part-time or consultant basis a sufficient number of professional staff members who are educated, oriented and qualified, as required by 10 NYCRR § 415.26(c);

v. Limit resident admissions, and accept and retain only those nursing home residents for whom they can provide adequate care, as required by 10 NYCRR § 415.26(i)(1)(ii);

w. Maintain a quality assessment and assurance committee consisting of at least the administrator or his or her designee, the director of nursing services, a physician designated by the facility, one member of the governing body who is not otherwise affiliated with the nursing home in an employment or contractual capacity, and three other members of the facility's staff, as required by 10 NYCRR § 415.27(b);

x. Maintain a safe, healthy, functional, sanitary, and comfortable environment for residents, as required by 10 NYCRR § 415.29;

y. Maintain accident and incident records necessary to permit the production of such records immediately upon request, as required by 10 NYCRR § 415.30(f);

z. Protect and promote the rights of the 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);

aa. Inform the resident, consult with the resident's physician, and notify the resident representative(s) when there is a change in condition, including accident, discharge, change of room, etc., as required by 42 CFR § 483.10(g)(14)(i);

bb. Provide care and services relating to a resident's activities of daily living, including bathing, dressing, grooming, oral care, transfer and ambulation, walking, toileting, eating and communication, as required by 42 CFR § 483.24(b);

cc. 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;

dd. 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, as required by 42 CFR § 483.35;

ee. Ensure that an ongoing QAPI program is defined, implemented, and maintained, including during transitions in leadership and staffing; and that the

QAPI program is adequately resourced, identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents, takes corrective actions to address gaps in systems, and sets clear expectations around safety, quality, rights, choice, and respect, as required by 42 CFR § 483.75(f);

ff. Maintain a quality assessment and assurance committee, as required by 42 CFR § 483.75(g);

gg. Provide adequate and appropriate medical care to each resident, as required by PHL § 2803-c(3)(e);

hh. Provide courteous, fair, and respectful care and treatment to each resident, as required by PHL § 2803-c(3)(g); and

ii. Prevent and report abuses of persons receiving care or services in The Villages, as required by PHL § 2803-d.

374. Respondents thereby engaged in repeated or persistent illegality 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 AND PERSISTENT ILLEGALITY

As against Comprehensive at Orleans, LLC d/b/a The Villages of Orleans Health and Rehabilitation Center, CHMS Group, LLC, Villages of Orleans LLC, ML Kids Holdings LLC, Bernard Fuchs, David Gast, Sam Halper, Ephram Lahasky

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

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

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

378. Respondents, directly and through their agents and their employees, repeatedly and persistently committed illegalities by failing to comply with their legal obligations to provide The Villages' residents the care required under New York and federal laws, to wit, by failing to:

a. Refrain from engaging in unacceptable practices, pursuant to 18 NYCRR § 515.2;

b. Seek approval from DOH for withdrawals and transfers from The Villages in excess of the disclosure thresholds, in violation of 10 NYCRR § 400.19(b)(1) and PHL § 2808(5)(c);

c. Refrain from submitting an incorrect or improper claim, or refrain from causing such claim to be submitted, or refrain from receiving payment for the incorrect or improper claim, in violation of 18 NYCRR § 518.3(a); and

d. File complete and accurate annual financial and statistical reports (Medicaid Cost Reports) to DOH, in violation of 10 NYCRR § 86-2.2.

379. Respondents are also liable for violation of federal Medicare payment statutes and regulations, including 42 USC § 1320a-7k, which defines an overpayment as "any funds that a person receives or retains under title 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.

380. Respondents thereby engaged in repeated or 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:
MISAPPROPRIATION OF PUBLIC FUNDS
PURSUANT TO EXECUTIVE LAW § 63-c
As against All Respondents

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

382. Respondents obtained, received, converted, or disposed of funds, either directly or indirectly, from the Medicaid and Medicare Programs to which they were not entitled, as alleged in the foregoing paragraphs of this Verified Petition.

383. The acts and practices of Respondents 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 the Respondents in an amount to be determined by the Court.

AS AND FOR THE SEVENTH CAUSE OF ACTION
PURSUANT TO COMMON LAW UNJUST ENRICHMENT
As against All Respondents

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

385. Respondents are not entitled to receive or retain payment from the Medicaid and Medicare Programs for the services purportedly rendered by The Villages, as they were not in conformance with applicable laws and regulations.

386. By reason of the foregoing, Respondents 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 the Programs.

387. Respondents are therefore liable to the State in an amount to be determined by the Court for funds unlawfully received from the Medicaid and Medicare Programs.

REQUEST FOR RELIEF

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

A. Declaring that:

1. Respondents engaged in repeated and persistent fraud in their up-front conversion of The Villages' Medicaid and Medicare reimbursement payments for their own use, in violation of Executive Law § 63(12);

2. Respondents engaged in repeated and persistent fraud through the use of self-dealing lease agreements with The Villages and through a scheme to use a mortgage loan to further profit off of The Villages, and by engaging in other unacceptable practices, in violation of Executive Law § 63(12);

3. Respondents engaged in repeated and persistent fraud by failing to seek DOH approval for withdrawals and transfers from The Villages, preparing, filing, and/or causing to be filed with DOH false cost reports and false and/or misleading documents concerning an application for a Certificate of Need, and by engaging in other unacceptable practices, in violation of Executive Law § 63(12);

4. Respondents repeatedly and persistently engaged in illegality in the operation of The Villages in its failure to deliver adequate care to residents

of The Villages, contrary to the regulations set forth in paragraphs 373a-373ii above, all in violation of Executive Law § 63(12);

5. Respondents repeatedly and persistently engaged in illegality in the operation of The Villages in its failures to refrain from engaging in unacceptable practices and failures to adhere to the laws and regulations set forth in paragraphs378a-d, all in violation of Executive Law § 63(12);

6. Respondents obtained, received, converted, or disposed of funds, either directly or indirectly, from the Medicaid and Medicare Programs to which they were not entitled, in violation of the Tweed Law, Executive Law § 63-c; and

7. Respondents were unjustly enriched to the detriment of the Medicaid and Medicare Programs by receiving and retaining payments from said Programs for services which were purportedly rendered by The Villages, but which were not performed in conformance with applicable laws and regulations.

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 the Respondents and related entities;

3. Respondents from further violation of state and federal regulations relating to nursing home services;

4. Respondents from further engaging in fraudulent and illegal acts and practices relating to reimbursement by the New York State Medicaid Program;

5. Respondent The Villages from accepting any admissions of new residents unless and until Respondent Fuchs provides a signed certification, endorsed by a qualified licensed clinician, to the Attorney General certifying that Fuchs has met his obligation to operate The Villages by ensuring sufficient care and staffing for all existing residents and for any potential new residents; and

6. Respondents Halper, Gast, and Lahasky from further serving or having any role at The Villages and any related entity;

C. Directing all Respondents to pay restitution to the State;

D. Directing that each Respondent fully account for and disgorge all monies wrongfully received as a result of Respondents' fraudulent and illegal conversion and retention of substantial public funds paid as Medicaid and Medicare reimbursement to The Villages for resident care that The Villages failed to provide, and to return said monies within 15 days to the Attorney General's Medicaid Fraud Control Unit, for return to the Medicaid and Medicare Programs;

E. Appointing a receiver and financial monitor to oversee The Villages' financial operations, with plenary powers of visitation and inspection, and specific authority to approve and withhold payments, including any payments to any Respondent or related person or entity;

F. Appointing an independent healthcare monitor to oversee The Villages' healthcare operations and ensure that The Villages improves healthcare outcomes for the residents;

G. Directing the Respondents to provide the independent healthcare monitor with real-time 24-hour/day remote access, every day of each year, to all of The Villages' 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 systems administrator;

H. Directing all Respondents except The Villages to pay for the expenses of the receivers and monitors appointed hereunder;

I. Directing Respondents to pay civil penalties to the State, including in accordance with CPLR 8303(a)(6), for violations of the Public Health Law, Social Services Law, and Medicaid payment rules;

J. Directing all Respondents except The Villages to reimburse the State and the United States for the costs of this investigation;

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

L. Directing each Respondent to pay post-judgment interest at the statutory rate of 9% per annum pursuant to CPLR §§ 5003-5004; and

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

Dated: New York, New York
November 29, 2022

LETITIA JAMES
Attorney General of the State of New York

By: 

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Counsel for New York

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ORLEANS

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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. _____

VERIFICATION

- against -

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

Respondents.

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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 Petition, based on my review of the files of the Medicaid Fraud Control Unit and information provided by Special Assistant Attorneys General and auditors and investigators 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
November 29, 2022

Amy Held
AMY HELD