IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA
Acting by Attorney General.
KATHLEEN KANE,

Plaintiff,

v.

GOLDEN GATE NATIONAL SENIOR CARE LLC; GGNSC Holdings LLC; GGNSC Administrative Services LLC; GGNSC Clinical Services LLC; GGNSC Equity Holdings LLC; GGNSC Harrisburg LP; GGNSC Harrisburg GP, LLC; GGNSC Camp Hill III LP; GGNSC Camp Hill III GP, LLC; GGNSC Clarion LP; GGNSC Clarion GP, LLC; GGNSC Doylestown LP; GGNSC Doylestown GP, LLC; GGNSC Wilkes-Barre East Mountain LP; GGNSC Wilkes-Barre East Mountain GP, LLC; GGNSC Gettysburg LP; GGNSC Gettysburg GP, LLC; GGNSC Altoona Hillview LP; GGNSC Altoona Hillview GP, LLC; GGNSC Lancaster LP; GGNSC Lancaster GP, LLC; GGNSC Lansdale LP; GGNSC Lansdale GP, LLC; GGNSC Sunbury LP; GGNSC Sunbury GP, LLC; GGNSC Monroeville LP; GGNSC Monroeville GP, LLC; GGNSC Mt. Lebanon LP; GGNSC Mt. Lebanon GP, LLC; GGNSC Murrysville LP; GGNSC Murrysville GP, LLC; GGNSC Phoenixville II LP; GGNSC Phoenixville II GP, LLC; GGNSC Mount Penn LP; GGNSC Mount Penn GP, LLC; GGNSC Rosemont LP; GGNSC Rosemont GP, LLC; GGNSC Scranton LP; GGNSC Scranton GP, LLC; GGNSC Shippenville LP; GGNSC Shippenville GP, LLC; GGNSC Philadelphia LP; GGNSC Philadelphia GP, LLC; GGNSC Wilkes-Barre II LP; GGNSC Wilkes-Barre II GP, LLC; GGNSC Tunkhannock LP; GGNSC Tunkhannock GP, LLC; GGNSC Uniontown LP; GGNSC Uniontown GP, LLC; GGNSC Erie Western Reserve LP; GGNSC Erie Western Reserve GP, LLC; GGNSC Camp Hill West Shore LP; GGNSC Camp Hill West

JURY TRIAL DEMANDED

336 M.D. 2015

Shore GP, LLC; GGNSC Pottsville LP;
GGNSC Pottsville GP, LLC,

Defendants.

NOTICE TO DEFEND

You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within thirty (30) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW. THIS OFFICE CAN PROVIDE YOU WITH INFORMATION ABOUT HIRING A LAWYER.

IF YOU CANNOT AFFORD TO HIRE A LAWYER, THIS OFFICE MAY BE ABLE TO PROVIDE YOU WITH INFORMATION ABOUT AGENCIES THAT MAY OFFER LEGAL SERVICES TO ELIGIBLE PERSONS AT A REDUCED FEE OR NO FEE.

MidPenn Legal Services, Inc.
213-A North Front Street
Harrisburg, PA 17101
(717) 232-0581

or

Dauphin County Lawyer Referral Service
Dauphin County Bar Association
213 North Front Street
Harrisburg, PA 17101
(717) 238-7536

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GOLDEN GATE NATIONAL SENIOR CARE LLC; GGNSC Holdings LLC; GGNSC Administrative Services LLC; GGNSC Clinical Services LLC; GGNSC Equity Holdings LLC; GGNSC Harrisburg LP; GGNSC Harrisburg GP, LLC; GGNSC Camp Hill III LP; GGNSC Camp Hill III GP, LLC; GGNSC Clarion LP; GGNSC Clarion GP, LLC; GGNSC Doylestown LP; GGNSC Doylestown GP, LLC; GGNSC Wilkes-Barre East Mountain LP; GGNSC Wilkes-Barre East Mountain GP, LLC; GGNSC Gettysburg LP; GGNSC Gettysburg GP, LLC; GGNSC Altoona Hillview LP; GGNSC Altoona Hillview GP, LLC; GGNSC Lancaster LP; GGNSC Lancaster GP, LLC; GGNSC Lansdale LP; GGNSC Lansdale GP, LLC; GGNSC Sunbury LP; GGNSC Sunbury GP, LLC; GGNSC Monroeville LP; GGNSC Monroeville GP, LLC; GGNSC Mt. Lebanon LP; GGNSC Mt. Lebanon GP, LLC; GGNSC Murrysville LP; GGNSC Murrysville GP, LLC; GGNSC Phoenixville II LP; GGNSC Phoenixville II GP, LLC; GGNSC Mount Penn LP; GGNSC Mount Penn GP, LLC; GGNSC Rosemont LP; GGNSC Rosemont GP, LLC; GGNSC Scranton LP; GGNSC Scranton GP, LLC; GGNSC Shippenville LP; GGNSC Shippenville GP, LLC; GGNSC Philadelphia LP; GGNSC Philadelphia GP, LLC; GGNSC Wilkes-Barre II LP; GGNSC Wilkes-Barre II GP, LLC; GGNSC Tunkhannock LP; GGNSC Tunkhannock GP, LLC; GGNSC Uniontown LP; GGNSC Uniontown GP, LLC; GGNSC Erie Western Reserve LP; GGNSC Erie

JURY TRIAL DEMANDED

336 M.D. 2015

Western Reserve GP, LLC; GGNSC Camp Hill West Shore LP; GGNSC Camp Hill West Shore GP, LLC; GGNSC Pottsville LP; GGNSC Pottsville GP, LLC,

Defendants.

AMENDED COMPLAINT AND PETITION FOR INJUNCTIVE RELIEF

AND NOW, comes the Commonwealth of Pennsylvania, acting by Attorney General Kathleen Kane, (hereinafter "the Commonwealth" or "OAG"), and brings this action pursuant to the Unfair Trade Practices and Consumer Protection Law, 73 Pa.C.S.A. §§ 201-1 – 201-9.3 (hereinafter "Consumer Protection Law"), to restrain unfair or deceptive acts or practices in the conduct of any trade or commerce declared unlawful by Section 201-3 of the Consumer Protection Law, and to recover civil penalties, restitution and restoration for the Commonwealth and Pennsylvania consumers, and costs of this action.

The Consumer Protection Law authorizes the Attorney General to bring an action in the name of the Commonwealth of Pennsylvania, to restrain by temporary and permanent injunction, unfair or deceptive acts or practices in the conduct of any trade or commerce declared unlawful by Section 201-3 of the Consumer Protection Law. 73 P.S. § 201-3.

The Commonwealth Attorneys Act authorizes the Attorney General to bring an action on behalf of the Commonwealth and its agencies, 71 P.S. § 732-204, including common law claims for breach of contract and unjust enrichment.

In support of this action, the Commonwealth represents the following:

I. INTRODUCTION

1. Golden Gate National Senior Care LLC, by and through its subsidiaries, does business under the brand name "Golden Living" and manages and operates 36 skilled nursing

facilities throughout the Commonwealth.[1] Golden Gate National Senior Care LLC and its subsidiaries are referred to collectively herein as "Golden Living."

2. The Golden Living facilities located in Pennsylvania include Defendants Golden LivingCenter – Blue Ridge Mountain (Harrisburg, PA); Golden LivingCenter – Camp Hill (Camp Hill, PA); Golden LivingCenter – Clarion (Clarion, PA); Golden LivingCenter – Doylestown (Doylestown, PA); Golden LivingCenter – East Mountain (Wilkes-Barre, PA); Golden LivingCenter – Gettysburg (Gettysburg, PA); Golden LivingCenter – Hillview (Altoona, PA); Golden LivingCenter – Lancaster (Lancaster, PA); Golden LivingCenter – Lansdale (Lansdale, PA); Golden LivingCenter – Mansion (Sunbury, PA); Golden LivingCenter – Monroeville (Monroeville, PA); Golden LivingCenter – Mt. Lebanon (Pittsburgh, PA); Golden LivingCenter – Murrysville (Murrysville, PA); Golden LivingCenter – Phoenixville (Phoenixville, PA); Golden LivingCenter – Reading (Reading, PA); Golden LivingCenter – Rosemont (Rosemont, PA); Golden LivingCenter – Scranton (Scranton, PA); Golden LivingCenter – Shippenville (Shippenville, PA); Golden LivingCenter – Stenton (Philadelphia, PA); Golden LivingCenter – Summit (Wilkes Barre, PA); Golden LivingCenter – Tunkhannock (Tunkhannock, PA); Golden LivingCenter – Uniontown (Uniontown, PA); Golden LivingCenter – Western Reserve (Erie, PA); Golden LivingCenter – West Shore (Camp Hill, PA); and Golden LivingCenter – York Terrace (Pottsville, PA) (collectively, the "Golden Living Facilities").

3. At all relevant times, Defendants were engaged in trade and commerce in the Commonwealth within the meaning of Pennsylvania's Unfair Trade Practices and Consumer Protection Law.

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[1] Herein, "skilled nursing facilities" means residential facilities that provide skilled nursing, rehabilitation, and long-term care. Sometimes such facilities are referred to as "long-term care facilities" or "nursing homes."

4. The Golden Living Facilities received significant revenue from private payors – residents, their families, and their insurers. These consumers paid substantial amounts – $241 per day, on average, from 2008 through 2013 – for each resident's nursing home care. On a monthly basis, these per diem payments can total, on average, over $7,000 for one resident.

5. The Golden Living Facilities also received significant revenue from the Pennsylvania Medical Assistance Program. Under the Commonwealth's Medical Assistance Program (Medicaid), Pennsylvania has paid the Golden Living Facilities $188 per day, on average, from 2008 through 2013 for each Medicaid resident's nursing home care. On a monthly basis, the Commonwealth has been paying, on average, over $5,800 for each Medicaid resident.

6. This case arises from Defendants' deceptive and misleading representations to consumers and the Commonwealth about the level of services they provided to vulnerable, elderly nursing home residents and Defendants' pervasive, chain-wide practice of billing consumers and the Commonwealth for services not provided.

7. Individuals who reside in skilled nursing facilities typically require a mix of skilled nursing services and assistance with ordinary daily activities. These residents often face limitations caused by illness, disability, physical deterioration due to old age, dementia or other cognitive decline, or other diseases and conditions. Many of these residents are elderly. Many residents are confined to their beds or wheelchairs, and they require assistance to move around, to reposition themselves to avoid pressure sores, to groom themselves, to get to the bathroom, and to eat and drink. Many residents are incontinent, and they must be frequently checked on and changed to stay clean and dry. Consequently, many residents require not only skilled nursing care from nursing staff, but also assistance with activities of daily living ("ADLs"), including:

(a) assistance using the bathroom;

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

(c) assistance safely transferring between a bed and wheelchair;

(d) assistance with grooming, dressing, bathing, and oral care;

(e) repositioning in their beds or wheelchairs;

(f) assistance eating and drinking; and

(g) assistance and supervision performing active / passive range of motion exercises ("ROMs").

8. Assistance with ADLs (herein "Basic Care") is not skilled nursing. It is primarily delivered by Certified Nurse Aides or "CNAs."

9. While the amount of Basic Care assistance may vary from resident to resident, Basic Care is included in the daily charge for residency in the nursing home, which is billed at a fixed *per diem* rate.

10. Defendants marketed the Golden Living Facilities by promising to meet residents' needs, to keep them clean and comfortable, and to provide food and water at any time. These statements were false, deceptive, and misleading. Notwithstanding these representations, the Golden Living Facilities were so understaffed that residents were thirsty, hungry, dirty and unkempt, and found that when they tried to summon help, no one was available to meet their most basic needs, like escorting them to a toilet or refilling a water glass.

11. Defendants also engaged in deceptive, misleading, and unfair practices by representing to consumers, insurers, and the Commonwealth that the Basic Care needed by

residents of the Golden Living Facilities – as documented in each resident's care assessments and care plans – was, in fact, provided to those residents when it was not.

12. Defendants made deceptive, misleading, and unfair statements to the Commonwealth in making requests by or on behalf of the Golden Living Facilities for reimbursement for resident care through the Pennsylvania Medicaid program. On information and belief, Defendants likewise made deceptive, misleading, and unfair statements to consumers and insurers through regular billing statements for care provided to private-pay residents.

13. Despite making these representations that the promised care had been, and would be, provided to residents, Defendants limited the number of CNA staff on duty at the Golden Living Facilities and rendered the facilities incapable of delivering the Basic Care that residents needed. The effect on resident care was dramatic. With the limited levels of CNA staffing, the supply of CNA hours at the Golden Living Facilities fell far short of the demand for care by their resident populations and a significant percentage of the Basic Care that was promised to, and paid for by, consumers, insurers, and the Commonwealth, was never provided.

14. Interviews with former employees of the Golden Living Facilities, interviews with family members of residents, and review of survey results reported by the Pennsylvania Department of Health ("DOH") show that the Golden Living Facilities were chronically understaffed and failed to provide the Basic Care services they promised – and were paid – to provide.

15. Former employees and residents' family members described workloads that routinely could not be completed by the CNA staff on duty. They described CNAs routinely cutting corners in the delivery of care and record-keeping:

a) Showers were skipped, or reduced to bed-baths in which only a resident's face, underarms and genitals would be wiped off;

b) Repositioning did not happen every two hours, as needed, but instead was stretched to intervals of three and four hours, or longer;

c) Incontinent residents were left in wet and soiled clothing and bedding;

d) Residents were woken before 5:00 a.m. to be washed and dressed for breakfast.

16. Findings from DOH surveys also demonstrate omissions of Basic Care resulting from understaffing. Surveyors cited the Golden Living Facilities with deficiencies when they observed:

a) residents struggling to feed themselves or staring helplessly at their dinner trays while waiting for help – sometimes for the entire meal;

b) internal records reflecting repeated and unaddressed complaints about long waits for staff to respond to call-lights;

c) pressure sores that were undetected until noticeably advanced, and no evidence that CNAs were checking residents for pressure sores;

d) bad smells – urine and feces – permeating the common areas of the facility;

e) residents woken in the middle of the night, washed and partially dressed, and then put back to bed, or dressed and left sleeping in their wheelchairs, to

lessen the amount of work needed to prepare everyone for breakfast in the morning.

17. An analysis of the Golden Living Facilities' self-reported staffing numbers confirms that the conditions described by CNAs, residents' family members, and DOH surveyors were chronic and widespread across the chain in Pennsylvania. Using census and labor data that Golden Living reported to the United States Centers for Medicare and Medicaid Services ("CMS"), the OAG estimates that on average, across the chain, approximately one-third or more of the Basic Care needed by residents was regularly omitted.

18. Defendants' staffing practices cost residents their dignity and comfort, and jeopardized their health and safety. The failure to provide this required Basic Care not only fell short of the promises made by Defendants and violated the Consumer Protection Law, it also degraded residents and increased their risk of serious negative health consequences. When CNAs fail to promptly respond to call lights, residents frequently soil themselves or fall when attempting to get up and help themselves to the bathroom. When CNAs provide rushed or inadequate bathing and personal care – or no personal care at all – residents appear unkempt and smell bad, which can be isolating and embarrassing to them. When CNAs fail to reposition residents as frequently as required, residents can develop pressure sores. These and other shortcomings in Basic Care result in a loss of dignity, mobility and function, and comfort for these residents, many of whom are in their last months of life.

19. Through their deceptive, misleading, and unfair acts and omissions, the Defendants misled the Commonwealth and consumers into believing that the Basic Care needs of residents would be and were being met. This conduct gives rise to the claims alleged herein for violations of the Consumer Protection Law and common law.

II. JURISDICTION

20. This Court has jurisdiction over this action pursuant to 42 Pa.C.S.A. § 761.

III. PARTIES

21. Plaintiff is the Commonwealth of Pennsylvania, acting by Attorney General Kathleen Kane, with offices located at 14th Floor, Strawberry Square, Harrisburg, Dauphin County, Pennsylvania 17120.

22. Defendant GGNSC Holdings LLC is a Delaware limited liability company, with principal places of business at 7160 Dallas Parkway, Suite 400, Plano, Texas 75024 and 1000 Fianna Way, Fort Smith, Arkansas 72919. GGNSC Holdings LLC indirectly owns and operates skilled nursing facilities throughout the Commonwealth of Pennsylvania – including the Golden Living Facilities – and does business in Pennsylvania through the actions of its agents, employees, staff, and others at its skilled nursing facilities in Pennsylvania. The residents of these skilled nursing facilities are Pennsylvania residents. At all times relevant, GGNSC Holdings LLC has engaged in trade or commerce directly or indirectly affecting the people of the Commonwealth.

23. Golden Gate National Senior Care LLC is a Delaware limited liability company, with principal places of business at 7160 Dallas Parkway, Suite 400, Plano, Texas 75024 and 1000 Fianna Way, Fort Smith, Arkansas 72919. Golden Gate National Senior Care LLC, operating under the brand name "Golden Living," indirectly owns and operates skilled nursing facilities located throughout the Commonwealth of Pennsylvania – including the Golden Living Facilities – and does business in Pennsylvania through the actions of its agents, employees, staff, and others at the Golden Living Facilities. The residents of these skilled nursing facilities are residents of Pennsylvania. At all times relevant, Golden Gate National Senior Care LLC has engaged in trade or commerce directly or indirectly affecting the people of the Commonwealth.

24. Defendant GGNSC Administrative Services LLC is a Delaware limited liability company, with a principal place of business at 1000 Fianna Way, Fort Smith, Arkansas 72919. GGNSC Administrative Services LLC exercises operational and managerial control over the Golden Living Facilities, which are located throughout the Commonwealth of Pennsylvania. GGNSC Administrative Services LLC does business in Pennsylvania through the actions of its agents, employees, staff, and others at these skilled nursing facilities in Pennsylvania. The residents of each of these skilled nursing facilities are Pennsylvania residents. At all times relevant, GGNSC Administrative Services LLC has engaged in trade or commerce directly or indirectly affecting the people of the Commonwealth.

25. Defendant GGNSC Clinical Services LLC is a Delaware limited liability company, with a principal place of business at 1000 Fianna Way, Fort Smith, Arkansas 72919. GGNSC Clinical Services LLC exercises operational and managerial control over the Golden Living Facilities, which are located throughout the Commonwealth of Pennsylvania. GGNSC Clinical Services LLC does business in Pennsylvania through the actions of its agents, employees, staff, and others at these skilled nursing facilities in Pennsylvania. The residents of these skilled nursing facilities are Pennsylvania residents. At all times relevant, GGNSC Clinical Services LLC has engaged in trade or commerce directly or indirectly affecting the people of the Commonwealth.

26. Defendant GGNSC Equity Holdings LLC is a Delaware limited liability company, with a principal place of business at 1000 Fianna Way, Fort Smith, Arkansas 72919. GGNSC Equity Holdings, LLC is a general partner of GGNSC Wilkes-Barre II LP, GGNSC Phoenixville II LP, and GGNSC Camp Hill III LP. On information and belief, it also holds a controlling ownership interest in the Golden Living Facilities.

27. Defendant GGNSC Harrisburg LP is a Delaware limited partnership, with a principal place of business at 3625 N. Progress Avenue, Harrisburg, PA 17110. At all times relevant, GGNSC Harrisburg LP owned and operated a skilled nursing facility located at 3625 N. Progress Avenue, Harrisburg, PA 17110, known as Golden LivingCenter – Blue Ridge Mountain, with the Pennsylvania Medicaid provider number 1015529140001. The residents of Golden LivingCenter – Blue Ridge Mountain are Pennsylvania residents.

28. Defendant GGNSC Harrisburg GP, LLC is a Delaware limited liability company, with a principal place of business at 3625 N. Progress Avenue, Harrisburg, PA 17110. GGNSC Harrisburg GP, LLC is the general partner of GGNSC Harrisburg LP.

29. Defendant GGNSC Camp Hill III LP is a Delaware limited partnership with a principal place of business at 46 Erford Road, Camp Hill, PA 17011. GGNSC Camp Hill III LP owns and operates a skilled nursing facility located at 46 Erford Road, Camp Hill, PA 17011, known as Golden LivingCenter – Camp Hill, with the Pennsylvania Medicaid provider number 1015530900001. The residents of Golden LivingCenter – Camp Hill are Pennsylvania residents.

30. Defendant GGNSC Camp Hill III GP, LLC is a Delaware limited liability company, with a principal place of business at 46 Erford Road, Camp Hill, PA 17011. GGNSC Camp Hill III GP, LLC is a general partner of GGNSC Camp Hill III LP.

31. Defendant GGNSC Clarion LP is a Delaware limited partnership with a principal place of business at 999 Heidrick Street, Clarion, PA 16214. GGNSC Clarion LP owns and operates a skilled nursing facility located at 999 Heidrick Street, Clarion, PA 16214, known as Golden LivingCenter – Clarion, with the Pennsylvania Medicaid provider number 1015489850001. The residents of Golden LivingCenter – Clarion are Pennsylvania residents.

32. Defendant GGNSC Clarion GP, LLC is a Delaware limited liability company, with a principal place of business at 999 Heidrick Street, Clarion, PA 16214. GGNSC Clarion GP, LLC is the general partner of GGNSC Clarion LP.

33. Defendant GGNSC Doylestown LP is a Delaware limited partnership with a principal place of business at 432 Maple Avenue, Doylestown, PA 18901. GGNSC Doylestown LP owns and operates a skilled nursing facility located at 432 Maple Avenue, Doylestown, PA 18901, known as Golden LivingCenter – Doylestown, with the Pennsylvania Medicaid provider number 1015552280001. The residents of Golden LivingCenter – Doylestown are Pennsylvania residents.

34. Defendant GGNSC Doylestown GP, LLC is a Delaware limited liability company, with a principal place of business at 432 Maple Avenue, Doylestown, PA 18901. GGNSC Doylestown GP, LLC is the general partner of GGNSC Doylestown LP.

35. Defendant GGNSC Wilkes-Barre East Mountain LP is a Delaware limited partnership with a principal place of business at 101 East Mountain Boulevard, Wilkes-Barre, PA 18702. GGNSC Wilkes-Barre East Mountain LP owns and operates a skilled nursing facility located at 101 East Mountain Boulevard, Wilkes-Barre, PA 18702, known as Golden LivingCenter – East Mountain, with the Pennsylvania Medicaid provider number 1015491310001. The residents of Golden LivingCenter – East Mountain are Pennsylvania residents.

36. Defendant GGNSC Wilkes-Barre East Mountain GP, LLC is a Delaware limited liability company, with a principal place of business at 101 East Mountain Boulevard, Wilkes-Barre, PA 18702. GGNSC Wilkes-Barre East Mountain GP, LLC is the general partner of GGNSC Wilkes-Barre East Mountain LP.

37. Defendant GGNSC Gettysburg LP is a Delaware limited partnership with a principal place of business at 741 Chambersburg Road, Gettysburg, PA 17325. GGNSC Gettysburg LP owns and operates a skilled nursing facility located at 741 Chambersburg Road, Gettysburg, PA 17325, known as Golden LivingCenter – Gettysburg, with the Pennsylvania Medicaid provider number 1015528160001. The residents of Golden LivingCenter – Gettysburg are Pennsylvania residents.

38. Defendant GGNSC Gettysburg GP, LLC is a Delaware limited liability company, with a principal place of business at 741 Chambersburg Road, Gettysburg, PA 17325. GGNSC Gettysburg GP, LLC is the general partner of GGNSC Gettysburg LP.

39. Defendant GGNSC Altoona Hillview LP is a Delaware limited partnership with a principal place of business at 700 S. Cayuga Avenue, Altoona, PA 16602. GGNSC Altoona Hillview LP owns and operates a skilled nursing facility located at 700 S. Cayuga Avenue, Altoona, PA 16602, known as Golden LivingCenter – Hillview, with the Pennsylvania Medicaid provider number 1015520930001. The residents of Golden LivingCenter – Hillview are Pennsylvania residents.

40. Defendant GGNSC Altoona Hillview GP, LLC is a Delaware limited liability company, with a principal place of business at 700 S. Cayuga Avenue, Altoona, PA 16602. GGNSC Altoona Hillview GP, LLC is the general partner of GGNSC Altoona Hillview LP.

41. Defendant GGNSC Lancaster LP is a Delaware limited partnership with a principal place of business at 425 North Duke Street, Lancaster, PA 17602. GGNSC Lancaster LP owns and operates a skilled nursing facility located at 425 North Duke Street, Lancaster, PA 17602, known as Golden LivingCenter – Lancaster, with the Pennsylvania Medicaid provider

number 1015519170001. The residents of Golden LivingCenter – Lancaster are Pennsylvania residents.

42. Defendant GGNSC Lancaster GP, LLC is a Delaware limited liability company, with a principal place of business at 425 North Duke Street, Lancaster, PA 17602. GGNSC Lancaster GP, LLC is the general partner of GGNSC Lancaster LP.

43. Defendant GGNSC Lansdale LP is a Delaware limited partnership with a principal place of business at 25 West Fifth Street, Lansdale, PA 19446. GGNSC Lansdale LP owns and operates a skilled nursing facility located at 25 West Fifth Street, Lansdale, PA 19446, known as Golden LivingCenter – Lansdale, with the Pennsylvania Medicaid provider number 1015524500001. The residents of Golden LivingCenter – Lansdale are Pennsylvania residents.

44. Defendant GGNSC Lansdale GP, LLC is a Delaware limited liability company, with a principal place of business at 25 West Fifth Street, Lansdale, PA 19446. GGNSC Lansdale GP, LLC is the general partner of GGNSC Lansdale LP.

45. Defendant GGNSC Sunbury LP is a Delaware limited partnership with a principal place of business at 1040-52 Market Street, Sunbury, PA 17801. GGNSC Sunbury LP owns and operates a skilled nursing facility located at 1040-52 Market Street, Sunbury, PA 17801, known as Golden LivingCenter – Mansion, with the Pennsylvania Medicaid provider number 1015585330001. The residents of Golden LivingCenter – Mansion are Pennsylvania residents.

46. Defendant GGNSC Sunbury GP, LLC is a Delaware limited liability company, with a principal place of business at 1040-52 Market Street, Sunbury, PA 17801. GGNSC Sunbury GP, LLC is the general partner of GGNSC Sunbury LP.

47. Defendant GGNSC Monroeville LP is a Delaware limited partnership with a principal place of business at 4142 Monroeville Boulevard, Monroeville, PA 15146. GGNSC

Monroeville LP owns and operates a skilled nursing facility located at 4142 Monroeville Boulevard, Monroeville, PA 15146, known as Golden LivingCenter – Monroeville, with the Pennsylvania Medicaid provider number 1015498100001. The residents of Golden LivingCenter – Monroeville are Pennsylvania residents.

48. Defendant GGNSC Monroeville GP, LLC is a Delaware limited liability company, with a principal place of business at 4142 Monroeville Boulevard, Monroeville, PA 15146. GGNSC Monroeville GP, LLC is the general partner of GGNSC Monroeville LP.

49. Defendant GGNSC Mt. Lebanon LP is a Delaware limited partnership with a principal place of business at 350 Old Gilkeson Road, Pittsburgh, PA 15228. GGNSC Mt. Lebanon LP owns and operates a skilled nursing facility located at 350 Old Gilkeson Road, Pittsburgh, PA 15228, known as Golden LivingCenter – Mt. Lebanon, with the Pennsylvania Medicaid provider number 1015499550001. The residents of Golden LivingCenter – Mt. Lebanon are Pennsylvania residents.

50. Defendant GGNSC Mt. Lebanon GP, LLC is a Delaware limited liability company, with a principal place of business at 350 Old Gilkeson Road, Mount Lebanon, PA 15228. GGNSC Mt. Lebanon GP, LLC is the general partner of GGNSC Mt. Lebanon LP.

51. Defendant GGNSC Murrysville LP is a Delaware limited partnership with a principal place of business at 3300 Logan Ferry Road, Murrysville, PA 15668. GGNSC Murrysville LP owns and operates a skilled nursing facility located at 3300 Logan Ferry Road, Murrysville, PA 15668, known as Golden LivingCenter – Murrysville, with the Pennsylvania Medicaid provider number 1015509560001. The residents of Golden LivingCenter – Murrysville are Pennsylvania residents.

52. Defendant GGNSC Murrysville GP, LLC is a Delaware limited liability company, with a principal place of business at 3300 Logan Ferry Road, Murrysville, PA 15668. GGNSC Murrysville GP, LLC is the general partner of GGNSC Murrysville LP.

53. Defendant GGNSC Phoenixville II LP is a Delaware limited partnership with a principal place of business at 833 South Main Street, Phoenixville, PA 19460. GGNSC Phoenixville II LP owns and operates a skilled nursing facility located at 833 South Main Street, Phoenixville, PA 19460, known as Golden LivingCenter – Phoenixville, with the Pennsylvania Medicaid provider number 1015547300001. The residents of Golden LivingCenter – Phoenixville are Pennsylvania residents.

54. Defendant GGNSC Phoenixville II GP, LLC is a Delaware limited liability company, with a principal place of business at 833 South Main Street, Phoenixville, PA 19460. GGNSC Phoenixville II GP, LLC is a general partner of GGNSC Phoenixville II LP.

55. Defendant GGNSC Mount Penn LP is a Delaware limited partnership with a principal place of business at 21 Fairlane Road, Reading, PA 19606. GGNSC Mount Penn LP owns and operates a skilled nursing facility located at 21 Fairlane Road, Reading, PA 19606, known as Golden LivingCenter – Reading, with the Pennsylvania Medicaid provider number 1015513720001. The residents of Golden LivingCenter – Reading are Pennsylvania residents.

56. Defendant GGNSC Mount Penn GP, LLC is a Delaware limited liability company, with a principal place of business at 21 Fairlane Road, Reading, PA 19606. GGNSC Mount Penn GP, LLC is the general partner of GGNSC Mount Penn LP.

57. Defendant GGNSC Rosemont LP is a Delaware limited partnership with a principal place of business at 35 Rosemont Avenue, Rosemont, PA 19010. GGNSC Rosemont LP owns and operates a skilled nursing facility located at 35 Rosemont Avenue, Rosemont, PA

19010, known as Golden LivingCenter – Rosemont, with the Pennsylvania Medicaid provider number 1015549280001. The residents of Golden LivingCenter – Rosemont are Pennsylvania residents.

58. Defendant GGNSC Rosemont GP, LLC is a Delaware limited liability company, with a principal place of business at 35 Rosemont Avenue, Rosemont, PA 19010. GGNSC Rosemont GP, LLC is the general partner of GGNSC Rosemont LP.

59. Defendant GGNSC Scranton LP is a Delaware limited partnership with a principal place of business at 824 Adams Avenue, Scranton, PA 18510. GGNSC Scranton LP owns and operates a skilled nursing facility located at 824 Adams Avenue, Scranton, PA 18510, known as Golden LivingCenter – Scranton, with the Pennsylvania Medicaid provider number 1015515410001. The residents of Golden LivingCenter – Scranton are Pennsylvania residents.

60. Defendant GGNSC Scranton GP, LLC is a Delaware limited liability company, with a principal place of business at 824 Adams Avenue, Scranton, PA 18510. GGNSC Scranton GP, LLC is the general partner of GGNSC Scranton LP.

61. Defendant GGNSC Shippenville LP is a Delaware limited partnership with a principal place of business at 21158 Paint Boulevard, Shippenville, PA 16254. GGNSC Shippenville LP owns and operates a skilled nursing facility located at 21158 Paint Boulevard, Shippenville, PA 16254, known as Golden LivingCenter – Shippenville, with the Pennsylvania Medicaid provider number 1015581300001. The residents of Golden LivingCenter – Shippenville are Pennsylvania residents.

62. Defendant GGNSC Shippenville GP, LLC is a Delaware limited liability company, with a principal place of business at 21158 Paint Boulevard, Shippenville, PA 16254. GGNSC Shippenville GP, LLC is the general partner of GGNSC Shippenville LP.

63. Defendant GGNSC Philadelphia LP is a Delaware limited partnership with a principal place of business at 7310 Stenton Avenue, Philadelphia, PA 19150. GGNSC Philadelphia LP owns and operates a skilled nursing facility located at 7310 Stenton Avenue, Philadelphia, PA 19150, known as Golden LivingCenter – Stenton, with the Pennsylvania Medicaid provider number 1015550590001. The residents of Golden LivingCenter – Stenton are Pennsylvania residents.

64. Defendant GGNSC Philadelphia GP, LLC is a Delaware limited liability company, with a principal place of business at 7310 Stenton Avenue, Philadelphia, PA 19150. GGNSC Philadelphia GP, LLC is the general partner of GGNSC Philadelphia LP.

65. Defendant GGNSC Wilkes-Barre II LP is a Delaware limited partnership with a principal place of business at 50 N. Pennsylvania Avenue, Wilkes Barre, PA 18701. GGNSC Wilkes Barre II LP owns and operates a skilled nursing facility located at 50 N. Pennsylvania Avenue, Wilkes Barre, PA 18701, known as Golden LivingCenter – Summit, with the Pennsylvania Medicaid provider number 1015586130001. The residents of Golden LivingCenter – Summit are Pennsylvania residents.

66. Defendant GGNSC Wilkes-Barre II GP, LLC is a Delaware limited liability company, with a principal place of business at 50 N. Pennsylvania Avenue, Wilkes Barre, PA 18701. GGNSC Wilkes-Barre II GP, LLC is a general partner of GGNSC Wilkes-Barre II LP.

67. Defendant GGNSC Tunkhannock LP is a Delaware limited partnership with a principal place of business at 30 Virginia Drive, Tunkhannock, PA 18657. GGNSC Tunkhannock LP owns and operates a skilled nursing facility located at 30 Virginia Drive, Tunkhannock, PA 18657, known as Golden LivingCenter – Tunkhannock, with the Pennsylvania

Medicaid provider number 1015486900001. The residents of Golden LivingCenter – Tunkhannock are Pennsylvania residents.

68. Defendant GGNSC Tunkhannock GP, LLC is a Delaware limited liability company, with a principal place of business at 30 Virginia Drive, Tunkhannock, PA 18657. GGNSC Tunkhannock GP, LLC is the general partner of GGNSC Tunkhannock LP.

69. Defendant GGNSC Uniontown LP is a Delaware limited partnership with a principal place of business at 129 Franklin Avenue, Uniontown, PA 15401. GGNSC Uniontown LP owns and operates a skilled nursing facility located at 129 Franklin Avenue, Uniontown, PA 15401, known as Golden LivingCenter – Uniontown, with the Pennsylvania Medicaid provider number 1015582930001. The residents of Golden LivingCenter – Uniontown are Pennsylvania residents.

70. Defendant GGNSC Uniontown GP, LLC is a Delaware limited liability company, with a principal place of business at 129 Franklin Avenue, Uniontown, PA 15401. GGNSC Uniontown GP, LLC is the general partner of GGNSC Uniontown LP.

71. Defendant GGNSC Erie Western Reserve LP is a Delaware limited partnership with a principal place of business at 1521 West 54th Street, Erie, PA 16509. GGNSC Erie Western Reserve LP owns and operates a skilled nursing facility located at 1521 West 54th Street, Erie, PA 16509, known as Golden LivingCenter – Western Reserve, with the Pennsylvania Medicaid provider number 1015518640001. The residents of Golden LivingCenter – Western Reserve are Pennsylvania residents.

72. Defendant GGNSC Erie Western Reserve GP, LLC is a Delaware limited liability company, with a principal place of business at 1521 West 54th Street, Erie, PA 16509. GGNSC Erie Western Reserve GP, LLC is the general partner of GGNSC Erie Western Reserve LP.

73. Defendant GGNSC Camp Hill West Shore LP is a Delaware limited partnership with a principal place of business at 770 Poplar Church Road, Camp Hill, PA 17011. GGNSC Camp Hill West Shore LP owns and operates a skilled nursing facility located at 770 Poplar Church Road, Camp Hill, PA 17011, known as Golden LivingCenter – West Shore, with the Pennsylvania Medicaid provider number 1015531520001. The residents of Golden LivingCenter – West Shore are Pennsylvania residents.

74. Defendant GGNSC Camp Hill West Shore GP, LLC is a Delaware limited liability company, with a principal place of business at 770 Poplar Church Road, Camp Hill, PA 17011. GGNSC Camp Hill West Shore GP, LLC is the general partner of GGNSC Camp Hill West Shore LP.

75. Defendant GGNSC Pottsville LP is a Delaware limited partnership with a principal place of business at 2401 West Market Street, Pottsville, PA 17901. GGNSC Pottsville LP owns and operates a skilled nursing facility located at 2401 West Market Street, Pottsville, PA 17901, known as Golden LivingCenter – York Terrace, with the Pennsylvania Medicaid provider number 1015585060001. The residents of Golden LivingCenter – York Terrace are Pennsylvania residents.

76. Defendant GGNSC Pottsville GP, LLC is a Delaware limited liability company, with a principal place of business at 2401 West Market Street, Pottsville, PA 17901. GGNSC Pottsville GP, LLC is the general partner of GGNSC Pottsville LP.

IV. GOLDEN LIVING'S DECEPTIVE, MISLEADING, AND UNFAIR CONDUCT TOWARDS THE COMMONWEALTH AND CONSUMERS

77. For many Pennsylvanians, nursing home costs will deplete their savings and wipe out their assets. For such nursing home residents, the costs are substantial and they often

represent their final consumer expenditures. A significant number of Pennsylvania consumers have paid out of pocket for care at the Golden Living Facilities.

78. The Commonwealth is also a significant purchaser of nursing home services. For example, in 2013, the Commonwealth contributed 46% of the total revenue received by all Pennsylvania nursing homes statewide through Medicaid. On information and belief, at least 50% of the resident days in Golden Living Facilities are paid for by Medicaid; at some Golden Living Facilities, the percentage is above 80%.

79. Defendants have engaged in unfair and deceptive acts and practices towards Pennsylvania consumers and the Commonwealth by using a variety of media to convey misleading representations about the nature and quantity of services provided in their homes. These include misrepresentations made on a chain-wide basis at the corporate level of the company, as well as misrepresentations made by the individual Golden Living Facilities.

A. Chain-wide Misrepresentations in Golden Living Marketing Materials

80. Golden Living made deceptive and misleading representations in its chain-wide marketing materials, including brochures and other written marketing materials, which promised that residents' needs would be met.

81. Misrepresentations and omissions in these marketing materials have created a likelihood of confusion and misunderstanding among consumers.

82. Defendants marketed the Golden Living company and its skilled nursing facilities in Pennsylvania directly to Pennsylvania consumers, disseminating brochures, Web sites, videos, advertisements, and other information containing misrepresentations about the Basic Care provided at these facilities. On information and belief, printed marketing materials were also distributed to hospitals and hospital staff that made referrals to nursing homes.

83. The following are examples of the misrepresentations made in Defendants' marketing materials:

a) "We have licensed nurses and nursing assistants available to provide nursing care and help with activities of daily living (ADLs). Whatever your needs are, we have the clinical staff to meet those needs."

b) "Snacks and beverages of various types and consistencies are available at any time from your nurse or nursing assistant."

c) "A container of fresh ice water is put right next to your bed every day, and your nursing assistant will be glad to refill or refresh it for you."

d) "Clean linens are provided for you on a regular basis, so you do not need to bring your own."

e) "Providing exceptional dining is important to us. Not only do we want to meet your nutritional needs, but we want to exceed your expectations by offering a high level of service, delicious food and an overall pleasurable dining experience. Dining in the LivingCenter is all about choice. With a variety of flavors, an attractive environment and plenty of pleasant conversation, we hope the experience will nourish both your body and your soul, so please join us. We have a seat reserved for you in our dining room!"

84. These marketing materials also represented that the dignity and function of residents was important to the company, and that Golden Living's skilled nursing facilities

would create and implement care plans to help residents improve their physical function and ability to perform the activities of daily living. For example:

a) "[W]e believe that respecting your individuality and dignity is of utmost importance."

b) "A restorative plan of care is developed to reflect the resident's goals and is designed to improve wellness and function. The goal is to maintain optimal physical, mental and psychosocial functioning."

c) "We work with an interdisciplinary team to assess issues and nursing care that can enhance the resident's psychological adaptation to a decrease in function, increase levels of performance in daily living activities, and prevent complications associated with inactivity."

d) "Our goal is to help you restore strength and confidence so you feel like yourself again and can get back to enjoying life the way you should. That's The Golden Difference."

85. These marketing materials were deceptive and misleading, because they represented that Golden Living's skilled nursing facilities would provide care that was not, in fact, provided a significant percentage of the time at many of Golden Living's Pennsylvania facilities due to understaffing.

86. These marketing materials also omitted information that would be material to consumers. These materials do not disclose that residents will experience long waits for care, or that they will frequently not receive care as often as needed or requested. These materials represent, for example, that dining at the Golden LivingCenters will "nourish both your body and

your soul," and that dining is offered "[w]ith a variety of flavors, an attractive environment and plenty of pleasant conversation." However, these materials omit the fact that many residents habitually eat at least some meals – such as breakfast – alone in their rooms because their facility lacks sufficient staff to get them up and ready in time to have breakfast in the dining room. Nor do the materials state that residents often have to wait so long for assistance eating that their food is cold by the time they eat it. These marketing materials also state that "clean linens are provided...on a regular basis." However, they do not disclose that clean linens are often not provided as frequently as needed, or that residents may wait hours for linens soiled with urine or feces to be changed. Through these omissions of material facts, the Defendants create a false impression of the services provided at Golden Living's skilled nursing facilities.

87. The statements and omissions in these marketing materials were deceptive and misleading, because significant percentages of the Basic Care promised were not, in fact, delivered to residents at many or all of Golden Living's skilled nursing facilities in Pennsylvania. As detailed in Section VI below, the OAG's investigation has uncovered significant evidence of routine and serious omissions of Basic Care at the Golden Living Facilities named in this Complaint. Furthermore, based on an analysis of the staffing data reported by all of Golden Living's skilled nursing facilities in Pennsylvania, the OAG believes that this understaffing and these omissions of care represent a pattern and practice across the entire Golden Living chain in Pennsylvania.

B. Facility-level Misrepresentations

88. On information and belief, the individual Golden Living Facilities made deceptive, misleading, and unfair misrepresentations to the Commonwealth and to consumers regarding the care they provided in marketing materials, resident assessments and care plans, and bills, creating a likelihood of confusion and misunderstanding.

89. Defendants have further misled the Commonwealth in two additional ways: by misrepresenting during annual inspections the number and type of employees who provide Basic Care and by falsifying resident records to cover up omissions of care.

1. Marketing Materials

90. On information and belief, the Golden Living Facilities relied on and benefited from the marketing materials described in section IV(A) above and, in some cases, distributed marketing materials prepared on their behalf by the Golden Living corporate offices.

2. Resident Assessments and Care Plans

91. The Golden Living Facilities made deceptive, misleading, and unfair representations in the resident care plans prepared for each resident, which itemized care that was not delivered, and outlined schedules for delivering care that were not followed.

92. Under federal and state law, nursing homes are required to complete a resident assessment, known as a Minimum Data Set or MDS, for each resident within 14 days of his arrival at the facility. The MDS is an individualized, date-specific assessment of each resident's needs; it must be updated each quarter while the resident is at the facility, or whenever a significant change in the resident's health or capabilities is observed. Among other things, the MDS evaluates each resident's functional capabilities to perform activities of daily living ("ADLs"). The MDS is based on actual observations of resident care provided over a seven-day period, not a prospective assessment of what care a resident will need. It describes the actual assistance the facility provided and will provide going forward, and that the resident received. The MDS reflects, for each ADL, whether the resident could complete the ADL independently, required assistance (supervision only, limited assistance, or extensive assistance), or was totally dependent on staff. If the resident required assistance with a particular ADL, the MDS also reflects whether the resident needed set-up help only, the assistance of one staff member, or the

assistance of two staff members:

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0110. Activities of Daily Living (ADL) Assistance
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent; exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example: three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time.

Coding:

Activity Occurred 3 or More Times

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

Activity Occurred 2 or Fewer Times

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

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification.

Coding:

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

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

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

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

Enter Code ☐

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

Enter Code ☐

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

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding:
0. **Steady at all times**
1. **Not steady, but able to stabilize without human assistance**
2. **Not steady, only able to stabilize with human assistance**
8. **Activity did not occur**

↓ Enter Codes in Boxes

☐ **A. Moving from seated to standing position**

☐ **B. Walking** (with assistive device if used)

☐ **C. Turning around** and facing the opposite direction while walking

☐ **D. Moving on and off toilet**

☐ **E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

Coding:
0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

↓ Enter Codes in Boxes

☐ **A. Upper extremity** (shoulder, elbow, wrist, hand)

☐ **B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

☐ **A. Cane/crutch**

☐ **B. Walker**

☐ **C. Wheelchair** (manual or electric)

☐ **D. Limb prosthesis**

☐ **Z. None of the above** were used

G0900. Functional Rehabilitation Potential

Complete only if A0310A = 01

Enter Code ☐

A. Resident believes he or she is capable of increased independence in at least some ADLs
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐

B. Direct care staff believe resident is capable of increased independence in at least some ADLs
0. **No**
1. **Yes**

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93. The Golden Living Facilities were required to accurately assess and code each resident's level of dependency in Column 1 of the MDS. Column 2 captures the level of

assistance and support the facility claimed was provided to each resident for each ADL. As the key in the upper right hand corner of the MDS form lays out, a resident's dependence and need for assistance ranges from "0" (the resident is independent and needs no staff assistance to perform the ADL) to "3" (the resident has minimal ability to perform the ADL and the nursing home provides two staff to assist him with it). An "8" is the MDS equivalent to "non-applicable"—the resident did not engage in that activity during the relevant time period. Thus, *Section G* of each MDS indicates the level of assistance that a resident required (and was provided) to reposition himself in his bed (Bed mobility), to get in and out of bed (Transfer), to use a toilet or bedpan (Toilet use), to eat and drink, (Eating), to dress (Dressing), and to attend to personal hygiene (Personal hygiene).

94. The Golden Living Facilities certified the accuracy of the data within each MDS submitted for each of their residents.

95. The MDS is then used to develop a care plan for each resident, which outlines exactly what care is needed and how and when it will be delivered. The development of a care plan for each resident is also required under state and federal law.

96. The Golden Living Facilities made representations to residents and/or their family members in resident care plans regarding the Basic Care that would be provided to them. As Defendants explain in their own marketing materials:

> A "care plan" is the part of your medical record that directs the type of care you need and how that care will be provided.
>
> When you first move in, assessments are conducted to learn your specific needs. These assessments involve your direct-care needs (clinical needs) and your psychological needs in the LivingCenter social setting (psychosocial needs). Your personal and individual care plan is then developed to take care of those needs.
>
> You, your loved ones and your "care team" will sit down together (called a "care coordination meeting"), usually within 72 hours of

> admission, and review what the assessments say, including what you can do for yourself and what you may need assistance with. Your care team will consist of key members of our staff, like the nurses, social worker, dietitian, etc. In effect, the care plan you develop together becomes your personal "road map for success."

97. On information and belief, each resident's care plan was detailed and specific regarding what Basic Care would be provided to the resident; for types of care required repeatedly throughout the day, like repositioning, these care plans specified how frequently the care would be provided.

98. The promises and representations made in these assessments and care plans were deceptive and misleading, because significant percentages of the Basic Care deemed necessary for each resident and promised by the Golden Living Facilities were not, in fact, delivered to residents.

3. Billing Statements

99. On information and belief, these misleading statements and omissions were reinforced by regular billing statements sent to insurers, to residents and/or their family members, and to the Commonwealth for payment of the per diem rate.

100. These billing statements were deceptive and misleading because they led consumers, insurers, and the Commonwealth to believe that the care for which they were being charged had actually been provided by the Golden Living Facilities. However, because of chronic understaffing, a significant percentage of this care was never provided to residents.

4. False Appearances During Commonwealth Surveys

101. The Golden Living Facilities further deceived the Commonwealth regarding the true conditions and level of care they provided by increasing staffing levels on the floor at the Golden Living Facilities during survey inspections conducted by DOH.

102. The Golden Living Facilities increased staffing levels in two ways: by bringing in more CNAs than were regularly scheduled and by using office and administrative staff to provide direct care to residents during surveys to create the impression that staffing levels were adequate to meet residents' Basic Care needs. In reality, when DOH surveyors were not at the Golden Living Facilities, staffing levels went back down to normal levels and office and administrative staff rarely or never provided direct care to residents.

5. False Records

103. The Golden Living Facilities also misled the Commonwealth regarding the level of care provided at the Golden Living Facilities through inaccurate or falsified resident care records. Managers at the Golden Living Facilities placed significant pressure on CNAs to not leave any tasks blank in the resident care records, in some cases, directly instructing that records be falsified. As a result, CNAs recorded that Basic Care had been provided, when in reality, they had not been able to provide this care.

104. The Golden Living Facilities knew or should have known that their records were not accurate, because it was impossible to deliver all of the care needed by their residents with the level of staffing available to provide such care.

C. The Level of Care that Was Promised

105. At the core of all of these deceptive and misleading statements was a basic promise – to provide all of the Basic Care that each resident required, as often as the resident required it:

a) Assistance getting to the bathroom when the resident needed to go, for residents who were continent;

b) Incontinence care for residents who were incontinent, to keep them clean and dry;

c) Repositioning residents every two hours – or as frequently as required in their care plans – to avoid pressure sores;

d) Responding to call lights in a timely manner to provide, for example, assistance getting to the bathroom, a snack or beverage, or assistance cleaning a resident after an incontinence episode;

e) Assistance eating and drinking at meals, while residents' food is still hot;

f) Range of motion exercises, as specified in each resident's care plan, to avoid loss of mobility;

g) Thorough bathing and personal hygiene assistance, including regular bed baths and showers, oral care, nail care, shaving, and dressing.

106. Despite promising this care, the Defendants failed to provide adequate staffing levels at the Golden Living Facilities to provide this care as thoroughly and as frequently as needed.

107. Defendants made these representations at the same time that they were attempting to build their census and profitability by recruiting more residents and more clinically complex – *i.e.*, sicker and needier – residents. Moreover, Defendants made these representations with the knowledge that they were not staffed to meet residents' needs, as demonstrated by the changes in their staffing practices for annual surveys and their record-keeping practices.

V. GOLDEN LIVING'S BREACH OF ITS CONTRACT WITH THE COMMONWEALTH

108. The Pennsylvania Department of Human Services ("DHS")[2] administers the Medicaid program in Pennsylvania. Through Medicaid, Pennsylvania and the United States pay for nursing facility care for the disabled and those who meet certain income requirements.

109. Defendants chose to participate in the Pennsylvania Medicaid program to receive payments for care provided to dependent, disabled, and vulnerable residents of their nursing facilities. Since 2008, on average, at least 50% of the Golden Living Facilities' resident populations were covered by Medicaid.

110. Pursuant to the Nursing Facility Provider Agreement that each of Golden Living's facilities in Pennsylvania entered into with the Commonwealth (appended as Exhibit A), the submission of a claim constitutes a "certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated."

111. The Golden Living Facilities submitted claims for reimbursement to the Commonwealth on a regular basis, seeking payment for the per diem charges for each day that each medical assistance resident resided at the facility. The per diem charge includes Basic Care.

112. Pursuant to the Provider Agreement, each Golden Living Facility also agreed to abide by all regulations governing the Medicaid program. These regulations include a requirement that they complete and submit a Minimum Data Set ("MDS") for each resident. The MDS is based on actual observations of resident care provided over a seven-day period, and memorializes care that has been provided and is anticipated. Thus, when completing and submitting the MDS for each resident, the Golden Living Facilities made detailed representations

[2] DHS is formerly the Pennsylvania Department of Public Welfare.

to the Commonwealth regarding the level of assistance that each resident needed – *and had been provided* – to complete each ADL.

113. Much of the Basic Care that was purportedly provided as part of the per diem rate was, in fact, not provided to the residents for whom the Golden Living Facilities submitted these reimbursement requests.

114. The Golden Living Facilities breached their agreements with the Commonwealth by submitting claims for reimbursement under the Pennsylvania Medicaid Program, certifying that the services claimed had been provided, despite the fact that significant percentages of the Basic Care that comprise part of the per diem reimbursement rates were not provided.

115. The Commonwealth relied upon the representations made in the MDS submissions from the Golden Living Facilities to determine each facility's per diem reimbursement rate under the Medicaid program. Facilities received a higher per diem rate if their MDS submissions reflected that a higher level of assistance with ADLs was provided to residents.

VI. OMISSIONS OF BASIC CARE AT THE GOLDEN LIVING FACILITIES

116. In its investigation, the OAG examined, among other things, the staffing levels self-reported by the Golden Living Facilities to the Commonwealth and the federal Centers for Medicare and Medicaid Services ("CMS") during annual licensure surveys, interviewed former employees and family members of residents of the Golden Living Facilities, and analyzed deficiencies received by the Golden Living Facilities during surveys by DOH.

117. Many of the Golden Living Facilities have been cited by DOH with multiple deficiencies for failing to provide Basic Care. These deficiencies were found despite consistent efforts by the facilities to anticipate DOH surveys and to materially improve staffing levels, conditions, and levels of care at the facilities when DOH surveyors were on-site. Based on its

investigation, the OAG has concluded that these are not individual, isolated incidents. Rather, they are merely the tip of the iceberg – incidents that reflect chronic problems with care across all of Golden Living's facilities in Pennsylvania, due to understaffing.

118. The OAG collected the following evidence of chronic understaffing and routine omissions of Basic Care at the Golden Living Facilities:

A. Omissions of Care at Golden LivingCenter – Blue Ridge Mountain

119. Confidential Witness #1 worked as a CNA at Blue Ridge Mountain from 2012 to 2014. He usually worked the 7 a.m. to 3 p.m. shift or the 3 p.m. to 11 p.m. shift, and he was typically responsible for 15 residents.

120. According to Confidential Witness #1:

(a) Ninety percent of the residents were incontinent. He regularly observed residents who were only changed twice per shift. One time, he arrived for his shift and found each of the residents completely saturated in urine, with rashes around their genital areas.

(b) Residents were supposed to receive two showers per week. But several times a month, the CNAs were so busy they had to skip giving showers.

(c) Residents were supposed to be dressed by 8 a.m. for breakfast. However, the CNAs only had time to dress four residents before breakfast; they chose these residents at random. The rest of the residents had to eat in their rooms and get dressed after breakfast. By the time all the residents were dressed, it was usually around 11 a.m. – time for lunch.

(d) According to facility managers, dressing the residents and brushing their teeth counted as range of motion exercises ("ROMs"). Confidential Witness #1 charted these activities as ROMs. Some residents' care plans

specified that they be taken for walks. However, the CNAs did not have enough time to take the residents on walks, other than walking them to and from the bathroom.

(e) Staff was supposed to answer resident call lights within 6 minutes. However, residents complained that they waited 20-30 minutes for a response, and they were frequently upset about waiting too long.

(f) On DOH inspection days, the facility had additional staff members from other shifts working. Additionally, office workers and administrators helped out on the floor and in the dining room. On any ordinary day, the administrators and office employees never left their offices.

121. Inspectors from DOH also have found that Blue Ridge Mountain violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On August 13, 2009, the facility received a deficiency when a DOH surveyor observed an LPN failing to assist a resident who needed assistance transferring from his wheelchair to the toilet. The resident told the LPN that he needed to go to the bathroom, and she told him to "go ahead." The resident then attempted to transfer from the wheelchair to the toilet unassisted. When asked by the surveyor whether the resident required assistance, the LPN responded that "his [CNA] is coming, she'll help him."

(b) On July 27, 2012, the facility received a deficiency for failing to provide treatment and services to prevent decrease in range of motion for three residents. For one of those residents, for example, a physician had ordered

a restorative ambulation program, pursuant to which the resident was to be assisted with walking to meals. However, starting two days after this program was put into place, the resident's records gave no indication that the program was being performed. In an interview with the surveyor, the resident stated that staff does not help him walk to meals; he goes in his wheelchair.

(c) On July 27, 2012, the facility received another deficiency for failing to provide residents with a clean and home-like environment, due to a strong odor in the main entrance and lobby of the facility present throughout the survey period.

(d) On July 2, 2013, the facility received a deficiency for failing to timely and effectively resolve resident concerns regarding response times to call lights. Residents had voiced concerns regarding untimely call light responses during all shifts at Resident Council Meetings[3] in January, April, May, and June of 2013. When a surveyor conducted interviews with residents, they stated that call light response time continues to be delayed and that they are left wet for extended periods of time – up to 5 hours. The residents also explained to the surveyor that they believe the facility is short-staffed.

[3] A Resident Council is a group of residents who meet regularly with facility staff and represent resident interests and concerns. These meetings provide a forum for residents to communicate problems to facility staff, and they provide facility staff the opportunity to update residents on efforts made to resolve their concerns. Facilities are required to keep minutes of these meetings, which can be reviewed by surveyors during inspections.

(e) On August 22, 2013, the facility received fourteen deficiencies, including two relating to Basic Care. These deficiencies covered a range of issues. One of these deficiencies was based on the surveyor's conclusion that the facility failed to provide adequate staffing to maintain the highest practicable wellbeing of each resident, as determined by resident assessments and care plans. The surveyor found, based on minutes from Resident Council Meetings, that call lights were not answered in a timely fashion during all shifts, that resident chair and bed alarms (that signal a risk of fall or elopement) were not responded to in a timely fashion, and that rooms were not cleaned and trash was not emptied. At the same survey, the facility received a deficiency for failing to ensure that nursing personnel were not assigned to housekeeping duties that made them unavailable for direct care, based on findings that CNAs were responsible for cleaning resident wheelchairs, and that the facility was too short-staffed to provide adequate incontinence care. In yet another deficiency from this survey, DOH found that the facility was not implementing restorative ambulation programs for residents that had been ordered by their physicians.

(f) On April 18, 2014, DOH conducted an abbreviated survey[4] in response to a complaint, and the facility received a deficiency for failing to provide

[4] Abbreviated surveys are typically conducted by DOH in response to one or more complaints received about a facility or incidents that the facility was required to self-report to DOH, such as falls or elopements. The scope of an abbreviated survey is much narrower than an annual licensure survey. Surveyors typically focus on investigating the complaints or incidents

adequate bathing for two residents. Both residents were assessed by the facility as being totally dependent on staff for bathing, and both had missed scheduled showers on several occasions.

(g) On May 14, 2014, DOH conducted another abbreviated survey in response to several complaints. The facility received a deficiency for failing to promptly act upon resident and family member concerns regarding facility staffing levels and slow responses to call lights.

(h) At an annual licensure survey[5] concluding on July 17, 2014, the facility received thirty-seven deficiencies, including eight relating to Basic Care. One of these deficiencies related to a resident who was observed by the surveyor on several occasions throughout the survey with a urinal half or completely full of urine sitting on his dresser. The resident explained to the surveyor that he needed two urinals, because facility staff members do not empty his urinals and they get full. The facility received another deficiency for failing to provide assistance with the activities of daily living for a resident. The surveyor found that this resident's MDS assessment reflected that she needed the supervision and assistance of one staff member for eating. However, the surveyor observed the resident on two occasions during the survey with her meal but with no staff assistance. The surveyor observed the resident attempting to eat without assistance,

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that triggered the survey, though a facility can be cited for other violations that the surveyor notices while on-site.

[5] A licensure survey is a comprehensive, multi-day inspection that DOH surveyors conduct, on roughly an annual basis, that is required for the facility to maintain its license to operate in the Commonwealth and to participate in the Medicaid and Medicare programs.

resulting in her spilling her food and beverage. At one meal, the resident was given her meal at 12:15 p.m., but was observed by the surveyor thirty minutes later with 90% of her food remaining on the plate. She was the only resident in the dining room at this point, and she was still attempting to feed herself lunch – using the wrong end of the fork and spilling food off her plate.

(i) When DOH conducted a re-visit on October 2, 2014 to determine whether the facility had remedied the deficiencies from the July survey, the facility received five more deficiencies. One of these deficiencies was based on the facility's failure to develop appropriate care plans for residents. One resident was incontinent of urine and wore a diaper, but his care plan included no plan for addressing his urinary incontinence. Another resident's records indicated he had received wound care for pressure sores, but he had no care plan addressing risk of pressure sores.

(j) At an abbreviated survey on January 20, 2015, conducted in response to a complaint, the facility received a deficiency due to call lights not being within reach of three residents.

122. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Blue Ridge Mountain are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Blue Ridge Mountain's self-reported staffing data.

B. Omissions of Care at Golden LivingCenter – Camp Hill

123. Confidential Witness #2 worked as a CNA at Camp Hill from 2012 to 2013. She usually worked the 7 a.m. to 3 p.m. shift, and she was typically responsible for 11-12 residents.

124. According to Confidential Witness #2:

(a) The residents were supposed to receive bed baths and be dressed for breakfast by 8 a.m. However, this was virtually impossible, because Confidential Witness #2 had 12 residents to get up and dressed in only one hour. She estimates it would have taken 25 minutes or more to properly bathe and dress each resident. The residents who required full feeding assistance had to eat in the dining room, so she got them dressed and ready first. The rest of the residents ate in their rooms, and she dressed them after breakfast.

(b) She also had to cut corners when getting the residents ready for the day. Instead of giving them a full bed bath, she took a wash cloth and washed their faces, genital areas, and backsides. There was not enough time to give full bed baths, brush their teeth, or put lotion on their skin.

(c) Incontinent residents were supposed to be checked on and, if needed, changed every 2 hours. Confidential Witness #2 does not think that the other CNAs were able to do this as frequently as required, because she constantly found residents who were soaking wet and had not been changed in several hours. The facility was also usually short on briefs. When this occurred, the Confidential Witness #2 had to go looking for briefs to change residents. This took up a lot of time, and she was already short on time.

(d) CNAs frequently went off-site with residents for several hours to accompany them to appointments. When this happened, the floor would

be short a CNA, and the other CNAs would have to take on additional residents.

(e) On DOH inspection days, all of the office workers helped out on the floor. The facility also had additional staff come in on inspection days – usually part-time staff members.

125. Inspectors from DOH also have found that Camp Hill violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) The facility received a deficiency on March 18, 2008 for failing to implement care plans to avoid and/or heal pressure sores for two residents. The facility received another deficiency on this date because a resident was observed without his call light button within reach. This resident had a history of falling out of bed – three times within two months – and facility documentation indicated that this resident should be encouraged to use his call light to ask for assistance.

(b) On March 8, 2012, the facility received a deficiency for failing to provide care for residents in a manner and environment that maintains residents' dignity. In an interview with one resident, the surveyor learned that the resident had recently waited over an hour for a response to her call bell. When staff did come to her room to turn her call bell off, they asked what she wanted. She told them she needed to go to the bathroom, and staff members then said they would get someone to help. However, they took too long to return and she had an accident in bed. The resident said this

had happened numerous times, and that these accidents were very embarrassing to her.

(c) On March 6, 2014, the facility received a deficiency based on the fact that a resident's records showed no documentation that fall prevention measures had been taken, despite physician orders that this be done.

(d) On July 17, 2014, the facility received a deficiency based on a resident's pressure sore. A skin breakdown had first been documented in the resident's records in April, but records showed no assessments or documentation of the wound for the following month. By June 2, the wound was a Stage II pressure ulcer,[6] 1.5 cm long. A week later, the wound had increased in size to 5 cm long. The resident's care plan had not been revised to address the pressure sore as of the date of the survey in July 2014.

126. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Camp Hill are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Camp Hill's self-reported staffing data.

C. Omissions of Care at Golden LivingCenter – Clarion

127. Confidential Witness #3 is the daughter of a woman who resided at Clarion for over seven years.

128. According to Confidential Witness #3:

(a) Unless she was sick, she visited her mother daily, and she provided much of her mother's Basic Care. She dressed her mother every day so that she

[6] A Stage II pressure sore is one that has progressed to the point where the outer layer of skin and part of the underlying layer of skin has been damaged or lost.

could check her body for any marks. She combed her mother's hair. Staff members sometimes gave her mother food that she could not eat, because of her meal restrictions, and Confidential Witness #3 would march down to the kitchen and get what she needed to feed her mother. Her mother always ate better when she was there to help.

(b) Confidential Witness #3 does not think staff members repositioned her mother often enough. She was supposed to be in the wheelchair for only two hours per day and turned in bed every hour. However, Confidential Witness #3's visits lasted about three hours, and she never saw anyone come in to reposition her mother during that time. Her mother got some really bad pressure sores while living at Clarion.

(c) The CNAs on the day shift were very experienced and caring, and Confidential Witness #3 had no problems with them. However, there were fewer people available to help during the 3 p.m. to 11 p.m. shift. During the day shift, there were extra people around who could pitch in with resident care if needed, like the person who ordered the supplies. The CNAs were rougher with her mother during the evening shift, and the care was not good. Sometimes her mother would call her at night to complain that she had been waiting for one hour for a response to a call bell. Confidential Witness #3 would have to call the facility herself, and then someone would go check on her mother.

(d) She feels badly for the residents who do not have family members looking out for them. For example, she remembers one resident who fell asleep in

the bathroom, and because no one checked on her, she was in there for an hour.

(e) Confidential Witness #3 recently missed some visits because she had the flu. During that time, her mother received improper care. Her mother was supposed to be kept at a 45 degree angle while in bed because she was at risk of choking. However, this was not done, and she choked on her vomit and got pneumonia. She was hospitalized in intensive care on a ventilator and later died.

129. Inspectors from DOH have also found that Clarion violated state and federal nursing home regulations by failing to provide Basic Care and failing to keep accurate records. For example:

(a) During an annual licensure survey completed on January 7, 2011, inspectors found that a resident's clinical record was filled out inaccurately. On December 6, 2010, despite the fact that the resident was in the hospital and not in the facility at the times noted, staff had initialed that the following services were provided: (1) an air cushion was applied to the resident's wheelchair on the 3-11 p.m. shift; (2) catheter care was provided at 2 p.m. and 8 p.m.; (3) side rails were up to enable the resident to turn and reposition during the evening and night hours; (4) mechanical lift was used to transfer the resident on 3-11 p.m. shift; (5) the resident was sitting in a wheelchair from 2-4 p.m.; (6) the resident was out of bed to use a motorized wheelchair on 3-11 p.m. shift; (7) two caregivers were required to provide care and a trapeze for bed mobility was used on 3-11

p.m. and 11 p.m.-7 a. m. shifts; and (8) a wedge was used for positioning the resident in bed during the 3-11 p.m. shift.

(b) The facility received a deficiency during a complaint survey on March 22, 2011 for failing to address residents' grievances regarding being left alone in the bathroom. Resident Council Minutes for meetings held in January, February, and March of 2011, identified a grievance of having to wait too long for assistance after having been assisted to the toilet. Each month the issue was listed under "old business" and marked as not resolved. There was no indication that the residents' grievances were acted upon.

(c) Clarion also received a deficiency on March 22, 2011, because the facility failed to assist a resident with an ordered restorative eating program: a program designed to restore the resident's independence and function. The resident was to be supervised, correctly positioned and encouraged in eating methods. Surveyors noticed the resident alone in bed with a breakfast tray. Orange liquid was spilled around resident's mouth, neck and down the front of the resident's gown. The resident was coughing and had a flushed face and watery eyes, yet no staff attended to the resident while the surveyor was observing from 9:20 a.m. through 9:30 a.m.

(d) A Registered Nurse ("RN") told surveyors during a complaint survey on November 1, 2011, that night shift CNAs at Clarion are each assigned five residents to awaken, dress, and bathe or shower before the end of their shift. CNAs confirmed that they needed to begin this process by 5:00 a.m. to accomplish this and that most of the residents were confused and

unhappy to be awakened and bathed that early. Residents were observed at 5:30 a.m. dressed and asleep in their chairs in their rooms or in their wheelchairs in the corridor.

130. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Clarion are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Clarion's self-reported staffing data.

D. Omissions of Care at Golden LivingCenter – Doylestown

131. Confidential Witnesses #20 and #21 are the son and daughter of a man who resided at Doylestown for over four months in 2013. Confidential Witness #20 visited every couple of weeks, and Confidential Witness #21 visited twice per week, during which times they were able to observe their father's condition and the care he was receiving.

132. According to Confidential Witnesses #20 and #21:

(a) Their father was overmedicated for his first few weeks there, and he was often nonresponsive and "out of it."

(b) During the first few weeks, the facility sent him to his dialysis appointments without getting him dressed for the day—he was wearing his gown and socks only, and they transported him on a gurney rather than a wheelchair.

(c) The facility did not provide adequate grooming. Confidential Witness #21 is an experienced CNA herself, so she shaved her father and clipped his nails.

(d) Their father was placed in diapers because the bathroom in his room was very small, and there was not enough room for him, a staff member, and his wheelchair. However, Confidential Witness #21 feels that they should

have found another way to toilet him—either using a public bathroom or a toilet in the shower room.

(e) During a meeting, the Director of Nursing reviewed his care records with Confidential Witness #20. The records showed that his father had eaten all of his lunch at 2:30 p.m. on a particular day. This was impossible, because his father had been at dialysis that day, so he had not eaten lunch at Doylestown, and Doylestown staff could not have known how much he ate at lunch. Despite the dialysis center having requested it, the facility did not send a packed lunch with him to dialysis. For the first 2-3 weeks he was there, he likely got no lunch at all because of this.

(f) The facility's staffing seemed low to Confidential Witness #21. The CNAs always seemed to be very busy, and there did not seem to be enough nurses. She looked for the staffing ratio, but she could never find it posted.

133. Confidential Witness #22 is the daughter of a woman who resided at Doylestown for about a year between 2014 and 2015. She usually visited her mother 2-3 times per week, during which time she was able to observe her mother's condition and the care she was receiving.

134. According to Confidential Witness #22:

(a) Her mother went through a 6-8 week period of time after a shoulder injury in which she needed more assistance with personal care than usual, including assistance with dressing, bathing, and cutting her food. During this time period, staff was not getting her dressed, and she would remain

in her pajamas all day for days in a row. Her hair was matted because no one would brush it for her. No one helped her get dressed for bed in the evenings.

(b) Facility staff did not bring her water every day, though they would bring it if she requested it.

(c) She waited a half hour or longer for a response to a call light. Sometimes nurses responded to the call light but would not help her—they would tell her she had to wait for a CNA to come. Then she had to wait longer for the CNA to come.

(d) She was allowed to shower only once per week. When she was having breathing problems, she would not want to shower. Staff would record this as a refusal of the shower, and she would have to wait until her next scheduled shower day to receive a shower. Staff would not reschedule her shower. As a result, there were times when she went two weeks or more without receiving a shower. When she was well enough to do so, she would give herself a sponge bath in between showers. However, staff did not do this for her.

135. Inspectors from DOH have also found that Doylestown violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On August 1, 2008, the facility received a deficiency for failing to provide adequate supervision to prevent falls. A cognitively impaired resident, who needed help walking and toileting, was found on the floor of her bathroom after she attempted to toilet herself without assistance. To

prevent further falls in the bathroom, staff was supposed to stay by the door of the bathroom to supervise while the resident was using the toilet. However, the resident fell again in the bathroom, when the CNA who had taken her to the bathroom left her unattended while he gathered supplies.

(b) On September 3, 2009, the facility received a deficiency for failing to ensure that ordered safety measures were followed for several residents to prevent injuries and falls. One resident had swallowing difficulty and was not to have straws. On two occasions the resident was seen with a water carafe and straw accessible. Another resident was to wear elbow protectors to prevent further skin tears. The resident was observed not wearing elbow protectors several times throughout the survey. That resident, plus two other residents, were at risk for falls, but the facility had not taken the required precautions to prevent additional falls.

(c) The facility received another deficiency on September 3, 2009 for failing to provide timely assistance with eating. Staff were supposed to encourage a resident to eat and drink, to help improve a Stage IV sacral pressure sore. The resident's lunch tray was placed on the over-the-bed table in her room at 12:45 p.m. on one day of the survey. Thirty-five minutes later, staff were collecting the lunch trays and noticed she had not received any assistance with her meal. Only then did a CNA help feed the resident.

(d) The facility was given another deficiency on September 3, 2009 for failing to provide an ordered restorative ambulation program daily. CNAs were

supposed to offer and document the daily restorative program. There was no documented evidence to show that staff offered the restorative ambulation program during May and July 2009.

(e) On August 26, 2010, the facility received a deficiency for failing to promote dignity in dining for two residents. One resident was dependent on staff for all activities of daily living and needed to be fed all meals. The resident was seen in the dining room on August 23, 2010, from 12:05 p.m. – 12:30 p.m., watching other residents eat. The resident called out, "hungry." The following day the resident was seen watching other residents for fourteen minutes, becoming restless and wanting to eat lunch. Another resident's care plan instructed staff to redirect and approach the resident calmly whenever she displayed anxiety. The resident was seen seated in her wheelchair in the dining room calling out for fifteen minutes, asking for "help" and for "someone to talk to me." Surveyors saw several staff enter the dining room, but they did not attempt to calmly approach and reassure the resident. The facility received another deficiency for failing to provide adaptive equipment during meals. One resident required a sippy cup with a straw for drinking. The resident was seen at breakfast and lunch on two days without a sippy cup. There was also ice water in the resident's room in a large Styrofoam container, rather than a sippy cup.

(f) On October 18, 2010, the facility received a deficiency for failing to ensure that interventions and supervision were in place to prevent a

cognitively impaired resident from leaving the building without staff knowing. The resident was confused and unaware of his surroundings. On the evening of October 16, 2010, a nurse documented that the resident went down to the first floor of the facility for an activity. After the activity was over, the resident was found outside the building by a staff member. The following day, the resident was found on other floors of the facility looking for his room, not knowing where he was or where he was going. Surveyors found that the facility had not adequately supervised the resident to prevent the resident from wandering and leaving the facility unattended.

(g) On September 12, 2011, the facility was given a deficiency because surveyors noticed an offensive musty urine odor. The facility received another deficiency for failing to serve food at palatable temperatures. One resident told surveyors that hot foods were often served cold at breakfast. Surveyors tasted breakfast food and said it was lukewarm to taste.

(h) On August 17, 2012, the facility was given a deficiency for failing to provide adaptive equipment to assist residents to eat. One resident's care plan directed staff to provide the resident with an adaptive scoop plate at all meals to assist the resident in eating his meal. A CNA served the resident lunch and left his room, but did not give him a scoop plate or assistance with eating his meal. The resident tried to eat his lunch from 12:46 p.m. through 1:05 p.m., but had a difficult time placing food on his

utensils, and some spilled onto his over-the-bed table. At one point, the resident ate his turkey casserole with his hands.

(i) The facility received another deficiency on August 17, 2012 for failing to provide range of motion exercises to two residents. One resident's care plan and therapy notes reflected, in early July 2012, that the resident had decreased range of motion and that a goal for his care was to maintain range of motion. Surveyors interviewed the resident on August 16, 2012, and he said that both legs were stiff and no one was providing range of motion exercises. The resident was in bed with both knees flexed. Another resident was supposed to wear a palm guard twenty-three hours per day, but it was applied only sporadically.

(j) On July 12, 2013, the facility received a deficiency for not following physician's orders. One resident was supposed to have a pressure redistribution cushion when he was seated in his wheelchair and TED stockings on his legs throughout the day. Staff had documented that the resident had a cushion and TED stockings in place, but surveyors observed the resident without these items on several occasions throughout the survey. Another resident was also observed several times without an ordered pressure redistribution cushion in place while she was seated in her wheelchair.

(k) The facility received another deficiency on July 12, 2013 for failing to ensure that assistance was provided to a resident during a meal. The resident had no teeth and required assistance and supervision with eating.

On July 9, 2013, at 11:30 a.m., surveyors observed the resident in bed, eyes closed, with her breakfast untouched in front of her. Breakfast had been delivered at approximately 8:15 a.m. At 12:50 p.m., surveyors observed the resident in bed eating lunch with her fingers. Her utensils were still wrapped in a bag, lids had not been removed from a beverage container or the dessert, and the resident was not positioned correctly for eating in bed.

136. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Doylestown are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Doylestown's self-reported staffing data.

E. Omissions of Care at Golden LivingCenter – East Mountain

137. Confidential Witness #23 is the daughter of a woman who resided at East Mountain for one month in 2013. She visited her mother at least once each day for several hours, during which time she was able to observe her mother's condition and the care being provided to her.

138. According to Confidential Witness #23:

(a) Her mother needed help bathing, getting dressed and getting to the bathroom when she first arrived at East Mountain. However, she became ill shortly after arriving, and she could no longer do anything on her own. After becoming sick, she could no longer walk, and she needed to use a bedpan.

(b) After she fell ill, both she and Confidential Witness #23 asked that she be transferred to the hospital or seen by a doctor, but nursing staff refused.

Nursing staff told them that the illness was all in her head, and they had a psychiatrist see her and prescribe her anti-depressants.

(c) She became so weak she could not leave her bed. Staff brought food to her, but she was too sick to eat anything, and she threw up what she did eat. Staff did not try to help her eat or to figure out why she could not keep anything down. She lost weight.

(d) Her mother could no longer get to the bathroom, so she needed staff to bring her a bedpan. However, she had to wait a long time for staff to respond to a call light—usually 20 minutes or more. She complained that she was left on her bedpan sometimes for as long as an hour. She was often upset about this and cried when Confidential Witness #23 came to visit her. Confidential Witness #23 and her sister sometimes had to help her off the bedpan instead of waiting for a staff member to come.

(e) Confidential Witness #23 does not believe her mother was ever repositioned. Her mother never mentioned being moved, and she was always in the same position when Confidential Witness #23 visited.

(f) Once her mother began throwing up blood, the facility finally transferred her to the hospital for treatment, where she was diagnosed with a stomach illness that could have been easily managed with proper treatment. However, after having her condition decline so far, she never recovered. She remained bedridden until she passed away 6 months later.

139. Confidential Witness #24 is the sister of a man who resided at East Mountain for two months in 2015. She usually visited him every day after work and earlier in the day on weekends, during which time she could observe his condition and the care he was receiving.

140. According to Confidential Witness #24:

(a) Her brother needed assistance with bathing, dressing, oral care, and getting to the bathroom.

(b) It took a long time for staff to respond to call lights—always more than 5 minutes, and often more than 10-12 minutes. She frequently saw call lights from other residents on in the hallways for long periods of time.

(c) He was showered once or twice per week. She does not know whether staff did anything to clean him in between showers.

(d) A few times, when she came to visit, he was dressed for bed already at 4:30 p.m. He did not want to be dressed for bed so early, but the CNAs went ahead and dressed him for bed while they were helping him to the bathroom.

(e) Even though her brother was not incontinent, he needed help getting to the bathroom. The facility put him in diapers. They never explained to her why they did this. He would ring for help and then wait, and sometimes he would have an incontinent episode as a result.

(f) She had meetings with the Administrator of the facility several times to discuss problems with her brother's care. Things would improve for a few days, but then they went back to the same level of care as before.

141. Inspectors from DOH have also found that East Mountain violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On June 8, 2007, the facility received a deficiency for failing to provide adequate supervision and implement measures designed to prevent falls and injuries. One resident fell during a shower and fractured his right hip because the CNAs failed to transfer him using a mechanical lift, as had been ordered by his physician. Another resident fell and fractured his nose after removing a Velcro restraint belt, which had happened several times before, but the facility had not developed an alternative way to keep the resident in the wheelchair. Another resident fell, broke his right hip, and was hospitalized. When the resident returned from the hospital, additional precautions were ordered. The precautions were not implemented, and the resident fell again.

(b) On July 3, 2008, the facility received another deficiency for failing to implement effective safety interventions and provide sufficient supervision for three residents who were at risk for falls.

(c) On June 5, 2009, the facility received a deficiency for failing to provide care needed to promote a resident's dignity. The resident's care plan showed she was to be toileted before and after meals, at bedtime, and as requested. While sitting in the dining room, the resident attempted to stand. A CNA told her to sit back down. The resident said she needed to go to the bathroom, but the CNA replied that there was no one available to take her to the bathroom.

(d) On June 13, 2013, the facility was given a deficiency for failing to consistently implement pressure sore prevention measures. Two residents were ordered to have both heels elevated off their mattresses to prevent pressure sores. Surveyors observed both residents in bed on two occasions without their heels elevated and without devices present to elevate their heels. One of the residents told surveyors that it was very infrequent for staff to elevate his heels off the mattress.

(e) The facility received another deficiency on June 13, 2013 for failing to provide a dependent resident with the necessary assistance with meals to maintain good nutrition. Surveyors observed the resident at mealtime attempting to find her spoon (which was under her napkin). The resident also tried to reach for her coffee, which was out of reach. She then tried to feed herself with her butter knife. No staff assistance was provided to the resident, although another resident who was seated next to her tried to help her find her spoon.

(f) On June 11, 2015, the facility was given a deficiency for failing to provide adequate supervision to prevent a resident from eloping. The resident had a history of falls and erratic behaviors. Staff did not observe her between 11:40 p.m., when they returned her to her wheelchair after she had gotten up, and 12:25 a.m., when staff saw her wheelchair was empty. She was found sitting on a curb next to a parked car outside of the building. DOH found that the facility had not provided adequate supervision or safety measures to this resident to prevent this elopement from occurring.

142. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at East Mountain are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of East Mountain's self-reported staffing data.

F. Omissions of Care at Golden LivingCenter – Gettysburg

143. Confidential Witness #4 worked as a Licensed Practical Nurse ("LPN") at Gettysburg from 2010 to 2013 and 2014 to 2015. She served as a charge nurse and oversaw the work of the CNAs at the facility.

144. According to Confidential Witness #4:

(a) The facility routinely had staffing so low that one CNA was responsible for 24 residents; this happened around half the time. The facility counted nurses who worked in office jobs – not on the floor, helping residents – to meet the minimum PPD requirement.[7]

(b) Resident assessments were not accurate. For example, she was told not to document any resident as being independent in their assessments; managers told her that there was no such thing as an independent care resident. Nursing records were also inaccurate. She was also told to document Stage IV pressure sores as being Stage I.[8]

(c) During meals, there were no CNAs on the floor to assist all of the residents who remained in their rooms for meals. The CNAs would not

[7] Pennsylvania regulations specify that skilled nursing facilities must provide adequate staffing to meet the needs of residents, and that staffing levels may not drop below a minimum of 2.7 hours of direct care per patient day ("PPD").

[8] A Stage I pressure sore is the beginning stage of the sore – the skin remains unbroken, but may appear reddened and be tender to the touch. A Stage IV pressure sore, in contrast, is one that has advanced to the point where there is large-scale tissue loss, exposing bone, tendon, or muscle.

make it back to the floor in time to give the residents any drinks, so they had to eat their meals without anything to drink. Confidential Witness #4 saw signs of dehydration in residents, but she could not prove this, because the facility did not record the amount of fluids provided to residents.

(d) She never saw CNAs do ROMs, but she saw the CNAs record that they had in resident care records. She doesn't know how they could possibly have had time to do ROMs. She remembers one resident who reported that CNAs had never done any ROMs with her. The CNA who was responsible for that resident had been told that the resident could do ROMs on her own, so the CNA was just supposed to mark in the ADL book that ROMs had been done.

(e) Residents waited over an hour for help to the bathroom on a daily basis. This was usually because the CNAs or Confidential Witness #4 had to wait a long time for a second person to come help when a resident's care plan required a two-person assist.

(f) When the facility's survey window came up – meaning that they expected a DOH survey soon – managers would be running around trying to fix everything and put on a good show. When inspectors were there, the administration would come out onto the floor, pass out meal trays, serve food to the residents, and answer call lights. The rest of the time, they never came out of their offices.

145. Inspectors from DOH have also found that Gettysburg violated state and federal nursing home regulations by failing to provide Basic Care and failing to keep accurate records. For example:

(a) Surveyors noticed on March 4, 2008 that the facility failed to provide necessary care and services to prevent the development and promote healing of pressure sores. Weekly skin assessments for a resident at risk for pressure ulcers were skipped for four weeks, from January 24 - February 19, 2008, when a CNA found blood on the resident's sheets and a large piece of skin hanging from his left heel. The resident was diagnosed with a Stage II pressure ulcer.

(b) Surveyors conducting a complaint survey on October 3, 2013 observed fecal matter on toilet seats in three resident bathrooms.

(c) During an annual licensure survey at Gettysburg on October 24, 2013, the facility was given a deficiency for recording that a resident had zero falls from the date of the previous Minimum Data Set (MDS) assessment (July 19, 2013), when the resident had 11 falls during that time period. Another resident's records were also inconsistent – the resident's MDS said the resident did not have a toileting program, when the resident's clinical record indicated there was a toileting program in place.

(d) The facility also received a deficiency on October 24, 2013, for failing to complete post-fall investigations for two residents. One resident's bed and chair alarms were to be checked every shift because the resident was at risk for falls and the alarms were interventions put in place to alert staff to

resident movement. This resident fell 22 times between December 2012 and October 2013. Resident records showed the bed and chair alarms were not documented as checked on 16 days in January 2013, and 7 days in February 2013. The facility did not provide documentation for March 2013 and June 2013. There was no documentation that the alarms were checked as ordered.

146. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Gettysburg are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Gettysburg's self-reported staffing data.

G. Omissions of Care at Golden LivingCenter – Hillview

147. Confidential Witness #5 worked as a CNA at Hillview from 2009 to 2012. She usually worked the 3 p.m. to 11 p.m. shift. She worked on a wing with around 34 residents. There were supposed to be three CNAs on the wing, but often there were only two, so she would be responsible for more than 15 residents.

148. According to Confidential Witness #5:

(a) They had less than three hours to get all the residents ready for bed. They were not supposed to put residents to bed before 8 p.m., but they had to have everyone in bed by 10:55 p.m. in time for the next shift. She really tried to do everything by the book, but she just could not, because she had too many people to care for.

(b) To get everything done, she had to cut corners. She would leave residents alone on the toilet, instructing them to ring the call bell when they were done, so she could go help someone else. She would lift people herself, rather than using the mechanical lift like she was supposed to in some

cases. She sometimes had to skip giving showers to residents, giving them bed baths instead.

(c) A couple of times per week, some residents did not eat because no one was there to help feed them.

(d) The facility put some residents in diapers, even though they were continent and did not need them. Other residents were incontinent, and they were not changed as frequently as they should have been. Residents often smelled like urine. Quite a few times, Confidential Witness #5 came in for her shift and residents were soaked in urine – their clothes and sheets.

(e) The facility knew ahead of time when DOH was coming for a survey. Confidential Witness #5 was there for two surveys. Beforehand, the Assistant Director of Nursing went around the facility to alert employees that DOH was coming and to tell them what they had to do during the survey, such as clean the facility and keep all the bedsheets perfect. Facility managers – including the Director of Nursing and the Executive Director – were out on the floor helping with resident care before and during the survey. When the surveyors were not there, these managers were never out on the floor.

149. Inspectors from DOH also have found that Hillview violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) The facility received a deficiency on July 17, 2008 for failing to provide care in a manner and environment that promoted each resident's dignity.

Residents told the surveyor that staff woke them up during the night, bathed them, dressed their upper bodies, and put them back into bed, and the residents were upset about this practice. The surveyor visited the facility at 5 a.m. one morning and observed nine residents – all confused and dependent upon staff for ADLs, according to their assessments. These residents were asleep in bed wearing their shirts or blouses. The surveyor interviewed several members of the nursing staff and confirmed that these residents had been awakened between 3 a.m. and 5 a.m., bathed, dressed in their shirts or blouses, and put back into bed.

(b) On the same date, the facility also received a deficiency for failing to utilize a pressure-relieving device to prevent pressure sores while documenting in the resident's records that the device had been used. The resident was supposed to wear an elbow protector to prevent skin breakdowns. CNAs recorded that the elbow protector had been applied every shift for the past week, during which time the surveyor observed the resident three times without the protector. The resident told the surveyor that staff had lost the elbow protector the prior week while bathing her, and her right elbow was reddened and very sore to the touch.

(c) The facility received a deficiency on August 6, 2008 for failing to provide adequate incontinence care. A resident was incontinent with diarrhea and had pushed her call bell button around 8:45 a.m. There was also a wash basin on the bedside table containing vomit. A staff member had responded to the call bell and told the resident she would return to clean

her up, but no one assisted the resident until 9:38 a.m. While waiting for assistance to arrive, the resident told the surveyor that she was very uncomfortable sitting in the feces, and she was concerned about the length of time she was left sitting in the feces because she had previously had a urinary tract infection. When examined later in the day, the resident was found to have redness on her buttocks.

(d) On December 15, 2010, the facility received a deficiency for failing to provide personal care in a manner that promoted each resident's dignity. Surveyors found that six of the eight residents reviewed had multiple areas of dried food on their clothing, blankets, and wheelchairs. The facility received another deficiency that day for failing to provide oral care to a resident. Mouth care was supposed to be provided after meals and as needed throughout the day. The surveyor observed the resident several times throughout the day, and each time, the resident had a dried white substance at the corners of her mouth and edges of her lips.

(e) On May 20, 2014, the facility received a deficiency for failing to ensure that transfers of residents were completed with the appropriate amount of assistance to prevent accidents. A resident's most recent assessment indicated that she required the assistance of two staff members for transfers and toileting. However, surveyors observed a CNA transferring the resident from her wheelchair to the toilet without the assistance of a second staff member.

(f) On the same date, the facility also received a deficiency for failing to keep complete and accurate clinical records. An examination of several resident charts found that nursing staff did not document that pressure sore prevention/healing measures or a scheduled toileting program were provided, as ordered, for one resident, nor that pressure-reducing and skin care measures or assistance with drinking were provided, as ordered, for another resident.

150. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Hillview are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Hillview's self-reported staffing data.

H. Omissions of Care at Golden LivingCenter – Lancaster

151. Confidential Witness #25 is the ex-wife of a man who resided at Lancaster for two months in 2012. She visited him at least twice per week, usually staying a few hours, during which time she was able to observe his condition and the care he received.

152. According to Confidential Witness #25:

(a) Because of his medical condition, he had trouble controlling all voluntary muscle movement, so he was totally dependent on staff for all activities of daily living.

(b) In particular, his condition put him at risk of choking if he did not receive adequate eating assistance. However, the facility rarely did this. She frequently observed him eating alone, without his food being cut up, as it was supposed to be. He was never supposed to eat unsupervised, but she sometimes found him eating alone in his room. Once, she came into his room and saw him lying in bed with his meal tray at the foot of his bed –

out of reach. It was impossible for him to get to the food. She thinks staff would have just taken the food away at the end of the meal if she had not been there. She never saw staff members help him eat. She complained repeatedly to staff at the facility, but nothing improved.

(c) He also needed to have his teeth brushed after meals to remove any food left in his mouth after he ate. Otherwise, he was at risk for inhaling the remaining food left behind in his teeth. She repeatedly asked staff to do this, and they said that they would. However, when she checked his mouth after meals, it was clear his teeth were not being brushed.

(d) He did not have enough assistance to get water and drink it while at Lancaster. Typically, nursing staff did not bring water unless a family member requested it, and staff did not check to see if he had water. On the few occasions when he did have water, no one came in to see if he needed help drinking it, which he did. He could not pick up anything on his own, so he was unable to drink unless someone helped him.

(e) Staff said they bathed him twice per week, but he always smelled bad. He had dermatitis on his face, and he seemed very dirty. Confidential Witness #25 also frequently observed that he was sitting in a wet diaper for a long time.

(f) The family made the decision to move him to a different facility because the care was so bad. On his last day there, Lancaster was being inspected by DOH. Everything was different. The facility was cleaner and smelled better, there were more staff there, and they were more attentive and

provided better care. There were at least five people helping residents in the dining hall, when normally there was only one person helping. Staff was friendly and attentive, cutting his food for him and helping him eat. They also finally provided him with a scoop bowl that day – a special utensil that allowed him to feed himself even with his limited muscular control. He was supposed to have had the scoop bowl the entire time he was at Lancaster; he did not receive it until the day DOH arrived for the inspection.

153. Inspectors from DOH have also found that Lancaster violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On February 27, 2007, the facility received a deficiency because the surveyors observed a urine odor and brown stains in the bathrooms. The facility was also cited because a resident was not showered between January 10 and February 22, 2007. Lancaster also failed to meet the minimum required nursing care hours for nine of the fourteen days reviewed.

(b) On February 8, 2008, the facility received a deficiency because a resident had long and dirty fingernails. The facility also failed to document and treat pressure sores on three residents.

(c) On February 27, 2009, the facility received a deficiency for not serving food at appropriate temperatures and for not putting call lights within reach of six residents.

(d) On April 23, 2009, the facility received a deficiency for continuing to serve food at incorrect temperatures, and for not following a resident's drinking safety plan by providing a sippy cup.

(e) On February 24, 2010, the facility received a deficiency when two residents fell. One resident rolled out of bed during morning care and broke a leg. Another resident fell out of bed during incontinence care that had been provided by one CNA, rather than two CNAs, as required by the resident's care plan; the facility was also cited for not reporting the incident to DOH as neglect, as required.

(f) On March 7, 2011, the facility received a deficiency for several issues: a resident fell in the bathroom after being left alone; staff did not assist residents with eating on three occasions; and the facility failed to treat and prevent pressure sores after initial signs of redness.

(g) On March 14, 2011, the facility received a deficiency when a resident fell after being transferred to and from a wheelchair and bed by one staff member, rather than the required two. The facility also failed to report the incident of neglect to DOH, as required.

(h) On February 7, 2012, the facility was given a deficiency for serving food late to residents who needed help eating. While the residents waited, other residents were eating around them. The facility also received a deficiency for not giving a resident a special drinking cup. Another deficiency was given because a restorative nursing program for passive range of motion was not provided to a resident.

(i) On March 5, 2013, the facility received a deficiency for failing to respect a resident's dignity regarding his need for incontinence care. The resident told a nurse that he needed to be changed. However, the nurse continued to sit at the nurse's station and did not provide assistance, and the resident waited twelve minutes for his CNA to return from break before being changed.

(j) On September 17, 2013, the facility received a deficiency because a resident had two pressure ulcers - one that was acquired at the facility and another that had worsened at the facility.

(k) On December 12, 2014, the facility received a deficiency for failing to adequately supervise a resident after a resident was found by the resident's daughter at a local YMCA before anyone at the facility noticed the resident was gone.

154. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Lancaster are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Lancaster's self-reported staffing data.

I. Omissions of Care at Golden LivingCenter – Lansdale

155. Confidential Witness #6 worked as a CNA at Lansdale from 2007 to 2008. She usually worked the 7 a.m. to 3 p.m. shift, and she was typically responsible for around 15 residents. All of these residents required total care – assistance with all of their ADLs.

156. According to Confidential Witness #6:

(a) She had only an hour and a half to get all the residents up and dressed before breakfast, but this was not enough time. The residents who required full feeding assistance had to be up and dressed, because they had

to eat in the dining room. The CNAs would then randomly choose four other residents to get up and dressed for breakfast. The rest of the residents had to eat in their rooms and wait until after breakfast to get dressed. It was usually lunchtime before all the residents were dressed for the day. She also had to rush through morning care, so she sometimes had to skip oral care because she did not have enough time.

(b) There were not enough CNAs to feed the residents who needed assistance eating. Residents frequently got cold food because they had to wait to be fed. CNAs had to rush when feeding them, so residents were sometimes unable to finish their meals and left the dining room hungry.

(c) There were several residents who were unable to touch their call lights or to communicate their needs. They often were ignored, because they did not directly ask for help. The CNAs did the best they could, but they had too many residents and not enough help.

(d) Residents were supposed to be repositioned every 2 hours, but it was less frequent than that. Several of the residents had pressure sores, some of them open wounds that smelled like rotten flesh.

(e) The majority of the residents were incontinent, and they were also supposed to be changed every 2 hours. However, they were usually only changed once or twice per 8-hour shift, because there was not enough time. On a daily basis, she found residents who were soaking wet and had not been changed for hours; their wheelchairs would be saturated with urine.

(f) Very few of the nurses helped with Basic Care. They were supposed to respond to call lights, but they refused. Instead, they would tell the CNAs that a resident's call light had gone off. The nurses also refused to change the residents' colostomy bags – a nurse responsibility – and made the CNAs do it instead.

(g) On days when DOH was conducting a survey, everyone helped out on the floor and helped clean the building. The facility was also fully staffed on inspection days. Inspection days were very stressful, because everyone was running around trying to clean the building. If the facility had been cleaned on a daily basis and regularly been fully-staffed, inspection days would not have been this stressful.

157. Inspectors from DOH also have found that Lansdale violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On January 30, 2009, the facility received a deficiency for failing to feed a resident who required extensive assistance with eating. The surveyor observed the resident attempting to eat a meal of pureed meat, sauerkraut, and potatoes without assistance, licking the food in the bowl, using her hands to scoop food from the plate, and attempting to lick and scoop food off the table when it fell onto the table. Throughout the meal, staff members never attempted to feed the resident, assist her with eating, or provide her with utensils to use.

(b) On February 4, 2011, the facility received a deficiency for failing to provide adequate personal care to two residents, both of whom required

significant assistance. One resident was observed with a heavy beard growth and long, soiled fingernails. He told surveyors that he wanted to be shaved and to have nail grooming completed. The other resident was observed with a heavy beard growth, and he told surveyors that he preferred to be clean shaven.

(c) On October 23, 2012, the facility received a deficiency for failing to follow a resident's shower schedule. Surveyors found that the resident had received only one shower in a 5-week period.

(d) On February 7, 2013, the facility received a deficiency for failing to provide restorative nursing services – walking residents – per the instruction of physicians. The surveyor interviewed several CNAs and learned that they were often unable to provide restorative services due to insufficient staffing.

(e) At a survey on July 2, 2014, the facility received a deficiency for failing to provide appropriate services to maintain or improve bladder function for four residents. Surveyors found that the facility had no residents on bladder retraining programs, despite having several residents who were good candidates for bladder retraining to improve continence. Surveyors also found, in a review of resident records, that some residents had experienced a decline in ability to control their bladders.

158. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Lansdale are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Lansdale's self-reported staffing data.

J. Omissions of Care at Golden LivingCenter – Mansion

159. Confidential Witness #26 is the son of a woman who resided at Mansion between 2010 and 2015. He visited his mother weekly, during which time he was able to observe her condition and the care she was receiving.

160. According to Confidential Witness #26:

(a) His mother was more self-sufficient at the beginning of her stay, but needed some assistance due to dementia. Her condition declined, and she was soon dependent on staff for assistance with all activities of daily living.

(b) She was left lying in bed all day, much of the time. Sometimes he visited around 10:30 a.m. and his mother was still in bed and not dressed for the day. When she left Mansion in 2015, she had serious pressure sores on her back.

(c) Her hands were so contracted that her nails were embedded in her palms, and she could not hold anything. Confidential Witness #26 thinks this happened because she did not receive range of motion exercises. She could not feed herself due to this limitation. Because staff rarely got her up for the day, she was given meals in her room. Confidential Witness #26's father tried to make sure he was there every day to feed her, but they never saw any staff members come in to assist her with her meals. She lost a lot of weight while at the facility. She usually had a Styrofoam cup of water next to her bed, but she could not grasp it or drink from it herself, and he never saw anyone help her drink.

(d) Within a year after she entered the facility, she needed help to the bathroom, and staff started putting her in diapers because they did not want to help her. When he visited, her diapers were often soaked. Sometimes, she would be lying in a soaked diaper, with her shirt pulled halfway up and no pants on. He often had to go find a nurse to change her, and they waited 20-30 minutes after asking before someone came in to change her. She developed urinary tract infections while staying at the facility.

(e) She was not cleaned or groomed well. Her hair was usually a mess, she did not have her glasses on, and her dentures were not in. Staff did not clean her dentures, and they got very dirty. Confidential Witness #26 thinks she was showered approximately once every two weeks. She often smelled of urine.

161. Inspectors from DOH have also found that Mansion violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On June 6, 2008, the facility received a deficiency when a double amputee was left on a bedpan for three hours. Staff said the previous shift had not told them he was still on the bedpan. He told surveyors it was a physically uncomfortable situation.

(b) On June 6, 2008, the facility also received a deficiency for not answering call bells in a timely manner. Surveyors observed a resident activate his call bell. A registered nurse assessment coordinator, two LPNs, and a CNA heard the call bell, but no one answered it until ten minutes after the

resident activated it. The resident told surveyors he had rung the call bell because he needed help getting back into bed. A surveyor also observed a resident waiting 12 minutes for a response to a call bell, during which time the Assistant Director of Nursing, social services director, an LPN, and a CNA were nearby but did not check on the resident. One resident tried to get out of her wheelchair unassisted while waiting. Another resident rang her call bell, and was ignored by staff until 12 minutes after it was activated. A resident told surveyors she often waits a long time for staff to answer call bells. She waited in the bathroom once for 40 minutes, until a staff member assisted her off the toilet.

(c) On July 24, 2009, the facility received a deficiency for not providing adequate incontinence care. One resident's care plan did not include several needed measures to promote continence even though the resident was assessed as a fair candidate for restorative bladder training. The resident was repeatedly diagnosed with urinary tract infections. She told surveyors that, when they have time, staff sometimes try to toilet her before she has an incontinent episode, but that they are usually busy. The resident's buttocks were "excoriated (abrasion/skin erosion resulting from persistent exposure of perineal skin to urine and/or feces)." The resident was in a great deal of pain from a dime-sized bleeding area on her buttocks.

(d) On June 4, 2010, the facility received a deficiency for failing to provide safety interventions to prevent falls. Two residents had fallen, and

surveyors found that fall prevention measures had not been implemented for them. They also observed that another resident's fall prevention measures were not in place in the bathroom; the resident said staff had removed them about a year before. The facility received a separate deficiency for falsely documenting that these interventions were in place.

(e) On July 15, 2011, the facility again received a deficiency for not providing safety interventions to prevent falls. One resident fell after ordered fall prevention measures were not taken. Another resident was supposed to be helped by two staff members to use the bathroom because he was unsteady during toilet use. However, he fell when he was taken to the bathroom by only one CNA. Another resident's care plan ordered two people to help with transfers and toileting, and that a chair sensor be on her chair to alert staff to her attempts to rise and walk alone. She was found on her bathroom floor bleeding from her head. Staff had left her in the bathroom unattended.

(f) On July 12, 2013, the facility received a deficiency for not providing restorative nursing care. A resident's care plan showed she was to wear a hand splint for four hours twice per day, and an anti-contracture boot at all times in bed. Her treatment record showed that staff applied the splint four times per day, for 10-15 minutes per application, and the boot three times per day, for 10-15 minutes per application. Surveyors saw the resident in bed, but her splint and boot were sitting on her wheelchair.

162. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Mansion are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Mansion's self-reported staffing data.

K. Omissions of Care at Golden LivingCenter – Monroeville

163. Confidential Witness #7 worked as a CNA at Monroeville from 2009 to 2011. She usually worked the 3 p.m. to 11 p.m. shift, and she was usually responsible for 15-18 residents.

164. According to Confidential Witness #7:

(a) Residents got upset because their call lights were not answered fast enough. Some would become incontinent while waiting for the call light to be answered. Others would try to go to the bathroom or get into bed by themselves and would fall.

(b) Facility policy was for residents to be repositioned every 2 hours. She saw residents waiting longer than 2 hours to be repositioned; some were repositioned every 3-4 hours during the shift, if at all. She would see residents lying in the same position at 6 p.m. as they had been at 3 p.m.

(c) Residents sometimes missed meals because there was no one available to feed them. CNAs would sometimes take trays to the residents' rooms and leave them there, without helping the residents eat. She thinks this happened a few times a week. Other residents received their meals and assistance eating, but they had to wait to be fed. Residents were also left incontinent during meal time, because the CNA who was assigned to assist residents with toileting would not answer call lights.

(d) Some of the residents were continent, but they were forced to wear diapers anyway. She remembers one resident who was continent, but who took medication that caused her to need the bathroom frequently. The other CNAs told Confidential Witness #7 that this resident had to wear a diaper, rather than her underwear, because she went to the bathroom too often. If residents were sick and had diarrhea, CNAs would put them in diapers instead of taking them to the bathroom, even if they were continent. Some were left for a long time in soiled diapers.

(e) Confidential Witness #7 always knew that DOH was coming for a survey before they arrived. On days when surveyors were there, there were more people working than usual, and she was able to get help with her tasks from her coworkers and supervisors. The building was also clean on inspection days.

165. Confidential Witness #8 worked as a CNA at Monroeville from 2011 to 2013. She usually worked the 3 p.m. to 11 p.m. shift and was responsible for 12-13 residents when the facility was fully-staffed. However, the facility was usually short-staffed, and when this happened, she was responsible for 16-17 residents.

166. According to Confidential Witness #8:

(a) Monroeville was usually short-staffed, and she did not have enough time to finish her work.

(b) The CNAs were supposed to reposition residents every 2 hours. However, the CNAs were usually only able to reposition residents once per 8-hour

shift because they were too busy. A number of residents at the facility had pressure sores – some of them were wide, open wounds.

(c) Staff members were supposed to respond to resident call lights within 3 minutes. However, in reality, residents frequently waited at least 30 minutes for a response. Residents had to wait even longer if they needed the assistance of two staff members. One time, a resident who needed a two-person assist rang his call light. Confidential Witness #8 responded, but she had to wait an hour until another CNA was available to help her with the resident.

(d) The CNAs were very rushed when feeding the residents who required full eating assistance. These residents did not get enough to eat at meals because the CNAs did not have enough time to finish feeding them.

(e) The CNAs were supposed to do ROMs on a daily basis with residents. However, they rarely had time to do so. Confidential Witness #8 was only able to do ROMs a few times a week. Several of her residents were supposed to be walked up and down the hall each day, but she only had time to walk them to the bathroom and back.

(f) Incontinent residents were supposed to be checked and changed every 2 hours, but there was not enough time to do this. Residents were usually changed only twice per 8-hour shift, but sometimes they were not changed at all during a shift. The residents who were more vocal and outspoken got changed more frequently than the residents who were not able to communicate.

(g) On DOH inspection days, the administrators helped out on the floor. But once the inspectors left, the administrators went back into their offices and stayed there.

167. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Monroeville are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Monroeville's self-reported staffing data.

L. Omissions of Care at Golden LivingCenter – Mt. Lebanon

168. Confidential Witness #9 worked as a CNA at Mt. Lebanon from 2007 to 2009 and in 2011. She usually worked the overnight shift, from 11 p.m. to 7 a.m. When she worked at the facility in 2011, they had decreased their staffing levels since her prior employment there, and she was typically responsible for 24 residents.

169. According to Confidential Witness #9:

(a) There was not enough time to do all of her assigned tasks when she was responsible for 24 residents. Management would say that the residents were just sleeping on the night shift, but this was not true. Many residents had Alzheimer's or dementia and did not sleep. The work was non-stop all night.

(b) Residents were supposed to be repositioned every 2 hours, but she was only able to reposition them three times in an 8-hour shift.

(c) Most of the residents were incontinent. She sometimes arrived for her shift to find residents reeking because the staff on the previous shift had not changed them.

(d) She had to get at least 3 residents up, give them bed baths, and get them dressed for the day before her shift ended at 7 a.m. It took at least 30

minutes to care for each resident, so she had to start waking residents up at 5 a.m. Sometimes she did not have enough time to give bed baths, so instead she would take a washrag and just clean the residents' faces, underarms, genital areas and bottoms.

(e) The facility always knew when a DOH survey was coming. They would increase staffing on inspection days by bringing in staff who usually worked other shifts. Managers would put up a sign-up sheet in the facility for staff members to sign up to work on inspection days. They also sometimes mandated that CNAs work a double-shift when they thought an inspection was coming.

170. Inspectors from DOH also have found that Mt. Lebanon violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) The facility received a deficiency on May 13, 2011 for having a musty urine odor on the first floor nursing unit. The musty odor was confirmed by several residents and a resident family member.

(b) On August 11, 2011, the facility received a deficiency due to a resident being transferred (for example, from bed to wheelchair) with the assistance of only one CNA, when assessments and physician orders indicated the assistance of two CNAs was required. This practice put resident at a risk of injury and actually resulted in the injury of the resident.

171. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Mt. Lebanon are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Mt. Lebanon's self-reported staffing data.

M. Omissions of Care at Golden LivingCenter – Murrysville

172. Confidential Witness #27 is the daughter of a woman who resided at Murrysville from 2011 to 2013. She visited her mother every day, both before work and in the evening for 2-3 hours, as well as on the weekends, during which time she was able to observe her mother's condition and the care she was receiving. She did not visit as often when her mother first came to the facility, but she started visiting more often because she became concerned that her mother was not getting the care she needed.

173. According to Confidential Witness #27:

(a) Her mother needed help with all activities of daily living during most of her stay. At first, she could eat on her own, but then her breathing got worse and it was hard for her to eat.

(b) She was continent when she arrived at the facility, but she was not able to get enough assistance going to the bathroom. If Confidential Witness #27 was not there visiting, her mother would usually wait around 2 hours, but sometimes waited as long as 4 hours, for a response to her call light. The facility later put her in diapers because it was easier for them. Sometimes, when Confidential Witness #27 visited in the evenings, her mother's diaper would be saturated with urine and feces.

(c) Her mother always seemed to be in the same position when she visited, so she did not think repositioning was being done. After her mother developed a pressure sore, Confidential Witness #27 purchased a gel

pressure sore mattress to relieve the pressure on her mother's skin. Her mother later got sick and had to be sent to the hospital for a few days, and Confidential Witness #27 discovered at that time that the gel mattress was soaked and had fungus growing on it from material leaking from her feeding tube and urine and feces from her diaper. It had to be thrown away. After her mother returned from the hospital, she had to sleep on a regular mattress for 8 months until the facility got her a new gel mattress, during which time she acquired a terrible pressure ulcer on her tailbone that she had until she died. By the time she died, the pressure sore was so serious that you could see down to the bone.

(d) Confidential Witness #27 provided nearly all of her mother's bathing and grooming herself, because her mother was fragile and needed to be handled gently. Facility staff were supposed to shower her every three days, but they did not always get to her, so Confidential Witness #27 would perform the shower herself. Confidential Witness #27 also sometimes gave her sponge baths.

(e) Staff did not walk her mother or provide any range-of-motion exercises, and she became bedridden soon after she stopped receiving physical therapy.

(f) Staffing levels seemed very low to her. She only ever saw one or two CNAs at the facility, and she sometimes talked to CNAs in the evenings who were there alone with 20-30 residents.

(g) She complained to supervisors at the facility about problems with her mother's care. However, nothing changed after complaining. When she complained about slow responses to call bells, they would say her mother was just confused and that the light had only been on for 5 minutes, but this was not true.

174. Confidential Witness #28 resided at Murrysville for around two months in 2015. She was recovering from a broken femur and needed help with bathing, dressing, toileting, and getting around.

175. According to Confidential Witness #28:

(a) The CNAs were too busy to give her bed baths or to get her up and dressed for the day, so the occupational therapy staff often helped out. However, on the days when the CNAs had to help her, she had to wait until much later in the day—more like 2 p.m.—before she was cleaned and dressed for the day. She would have preferred to take a shower, but she needed the assistance of two staff members, and there were never two staff members available to help.

(b) She waited 15 minutes or more for a response to her call light, sometimes waiting as long as an hour.

(c) She could get to the bathroom with assistance, but there was not enough staff to get her to the toilet in time, so she had to use a bedpan. She also had to wait for a long time after calling for the bedpan. Sometimes she urinated on herself while waiting, and this was embarrassing. During a period of time when she was taking a medication that caused her to urinate

frequently, staff would place a diaper underneath her, without fastening it around her properly, in case no one came to help her in time.

(d) She had to ask to be repositioned. She could move herself during the day, but at night, she was tired and afraid of falling, so she would call for assistance. She usually waited an hour for someone to come assist her.

(e) A State DOH inspection occurred while she was there. She heard a page over the PA system for a certain "doctor," but she knew this was a bogus page, because the CNAs said that the State was in the building when they heard it. She noticed that the call light response times improved while the State was there.

176. Inspectors from DOH have also found that Murrysville violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On March 13, 2014, the facility received a deficiency for failing to serve food at palatable temperatures. The November 2013, December 2013, and March 2014 resident council meeting minutes revealed that residents complained about food being served cold, and residents told surveyors that hot foods were being served cold. Surveyors observed that lunch tray service took around 45 minutes between the food leaving the kitchen and the last tray being passed.

(b) On February 26, 2015, the facility received a deficiency for not providing fingernail care to two residents. One resident's fingernails were excessively long with ragged edges and a brown substance underneath. During an interview at 2:02 p.m. on one day of the survey, the resident's

CNA confirmed she had not yet provided morning care to the resident. Another resident was seen with excessively long, dirty fingernails. The resident complained to surveyors that his/her fingernails were too long and in need of care.

177. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Murrysville are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Murrysville's self-reported staffing data.

N. Omissions of Care at Golden LivingCenter – Phoenixville

178. Confidential Witness #10 worked as a CNA at Phoenixville from 2009 to 2014. She usually worked the 3 p.m. to 11 p.m. shift, and she was typically responsible for 13 residents when the facility was fully staffed. However, the facility was frequently short-staffed, and then she was responsible for 18-19 residents.

179. According to Confidential Witness #10:

(a) CNAs were too busy to reposition residents every 2 hours, like they were supposed to. Confidential Witness #10 repositioned residents 2-3 times per 8-hour shift, depending on how busy she was.

(b) She was responsible for assisting residents with changing their clothes for bed. When the facility was short-staffed, she had to rush with this task. The result was that the more independent residents – who could have changed themselves with assistance – were not able to do so. The CNAs could change them more quickly than they could change themselves, so that is what they did when there was not enough time. However, this took away the residents' independence.

(c) The CNAs did not have enough time to check the incontinent residents and, if needed, change them every two hours, as required by Golden Living policy. Instead, they checked and changed them 2-3 times per 8-hour shift. Confidential Witness #10 frequently found residents who were soaking wet, covered in feces, or had puddles of urine under their wheelchairs.

(d) The facility was frequently short on briefs. When this happened, the CNAs had to go to different floors looking for more briefs. This took up additional time, when the CNAs were already rushed.

(e) The CNAs frequently complained to administrators about the lack of staff. But the administrators said they were staffing according to the census. Sometimes they even sent CNAs home if they thought there were too many staff on duty.

180. Inspectors from DOH also have found that Phoenixville violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) The facility received a deficiency on August 27, 2009 for failing to dress and groom residents in a dignified manner. The surveyor observed one resident's fingernails to be long and unclean. Two other residents had their stomachs exposed. Another resident was lying on his bed in full view of the hallway dressed in only a shirt and incontinence briefs.

(b) The facility received another deficiency on the same date for repeatedly failing to apply a protective cream to the perineal areas of several residents on each shift and after each incontinence episode over numerous days, as

directed by their physician orders. Records also reflected that regular skin assessments were not performed for one of these residents.

(c) On January 2, 2013, the facility received a deficiency for failing to investigate an incident of neglect. An evening shift CNA had found a resident soaked through to the mattress with urine, according to the nurse's notes. However, no steps had been taken to investigate this allegation of neglect.

(d) On September 11, 2014, the facility received a deficiency for failing to provide a restorative program – assistance ambulating with a rolling walker – as ordered by a physician for a resident. Records showed that the resident did not receive this care on 14 of the scheduled days in June, 18 of the scheduled days in July, or 4 of the scheduled days in August.

181. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Phoenixville are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Phoenixville's self-reported staffing data.

O. Omissions of Care at Golden LivingCenter – Reading

182. Inspectors from DOH have found that Reading violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On May 11, 2007, the facility received a deficiency for failing to ensure food was served at appropriate temperatures. Based on resident council meeting minutes and resident interviews, there was an ongoing concern that hot breakfast foods were served cold. Residents also told surveyors that soup was often cold. Surveyors observed that during breakfast, service began at 7:40 a.m., and the last tray was passed at 8:50 a.m.

Surveyors tasted the food, finding that the eggs, hot cereal, and toast were lukewarm or cold to taste.

(b) On May 13, 2010, the facility was given a deficiency for failing to provide proper staff assistance and supervision to one resident identified as a fall risk, and for failing to implement safety measures for two residents to prevent skin injuries and elopement. One resident was not provided assistance by two people as ordered for all transfers and care. A CNA did not follow the care plan and took the resident to the bathroom by herself. The resident fell, breaking her leg, and was admitted to the hospital. The facility did not follow elopement protocol with another resident known to exhibit wandering behavior. Staff also failed to ensure that ordered geri-sleeves and Geri-legs to prevent skin tears were applied to another resident. The resident was to wear them at all times, but needed extensive staff assistance with dressing and personal hygiene. Surveyors saw the resident without the Geri-sleeves and Geri-legs on multiple occasions over the course of the survey.

(c) The facility received another deficiency on May 13, 2010 for failing to develop comprehensive care plans. One resident was assessed as needing a restraint to prevent him from getting up on his own and walking. His current care plan did not include a restraint. Another resident known to be at risk of falling and elopement had no care plan in place to adequately provide supervision. Another resident's initial assessment on January 12, 2010, showed a need for urinary incontinence to be addressed in the care

plan. As of May 11, 2010, the facility had not developed a care plan for urinary incontinence. The facility received a separate deficiency for not addressing this resident's incontinence even though the resident was a fair candidate for a restorative bladder program when first assessed.

(d) On June 10, 2011, the facility received a deficiency for failing to provide personal care and grooming in a manner that enhanced residents' dignity. One resident's fingernails were long, jagged, yellowed, and dirty. The resident's thumbnails were at least a half inch above the skin. The resident had a significant amount of facial hair that was dirty. Another resident was seen by surveyors sitting in her reclining chair in a corridor for three hours wearing a shirt stained with fruit punch from breakfast.

(e) On July 27, 2012, the facility was given a deficiency for failing to adequately supervise two residents at risk for falls, and for failing to follow safety interventions for another resident. One resident's care plan included a number of fall precautions as of February 2012, including moving his room closer to the nurses' station for increased supervision. However, the resident had ten falls from February 6, 2012, to July 24, 2012, when the resident sustained an injury that required a trip to the emergency room. The staff had still not moved the resident's room closer to the nurses' station for increased supervision. Another resident was admitted with a history of falls. The care plan specified several fall-prevention measures. However, the resident fell sixteen times between admission to the facility on March 13, 2012, and the date of the survey

(July 27, 2012). Surveyors found that the precautions specified in the care plan had not been consistently taken. On May 26, 2012, the resident fell and hit his head after asking a CNA for help repositioning and being told to "wait a minute."

(f) On June 7, 2013, the facility received a deficiency for failing to thoroughly investigate falls to ensure that safety interventions were functioning and for failing to evaluate the need for increased supervision for two residents. One of these residents fell four times between December 16, 2012, and March 5, 2013.

(g) On June 18, 2015, the facility received a number of deficiencies relating to failures to provide adequate Basic Care, including:

- Not ensuring that care plans were revised in a timely manner to reflect four residents' current needs, including Basic Care needs. For example, one resident's care plan showed the resident was to receive a mechanical soft diet, needed assistance with walking, and was receiving physical therapy, occupational therapy, speech therapy, and psychiatric services. The resident had not received these services for an extended period of time, could only handle a pureed diet, and had not been able to walk since at least November 2014;

- Failing to keep accurate and complete clinical records. One resident's CNA records were missing documentation regarding safety devices and measures, urinary incontinence care, skin care,

and meal supervision. Additionally, staff erroneously documented that there were two fall mats in place when there was only one, that there was an air mattress on the bed when there was not, and that incontinence checks were done every two hours when, in reality, incontinence care was provided only every three hours;

- Failing to implement safety measures to prevent falls and skin injuries for three residents;

- Failing to thoroughly assess and provide care to residents to maintain as much bladder function as possible. Three residents were frequently incontinent of urine, but the facility could not demonstrate that bladder assessments had been completed for months, and no interventions had been developed or implemented;

- Failing to follow physician and therapist orders to help with range of motion. Staff did not apply and remove hand splints at the correct times;

- Failing to assist two residents with eating. Staff served one resident lunch without using the ordered lip plate and lidded mug. The resident also had visible food spillage on the front of her clothing. Staff did not assist another resident to drink from her lidded cup, even though she had upper extremity limitations in range of motion.

183. The omissions of Basic Care documented in DOH deficiencies at Reading are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Reading's self-reported staffing data.

P. Omissions of Care at Golden LivingCenter – Rosemont

184. Confidential Witness #29 is the sister of a woman who has resided at Rosemont from late 2014 through the present. She visits her sister at least twice a week, during which time she is able to observe her sister's condition and the care that she receives.

185. According to Confidential Witness #29:

(a) Her sister needs assistance with bathing, dressing, getting around, performing personal hygiene, and getting to the bathroom. She could walk with the assistance of a person when she entered the facility, but her mobility has declined significantly since then.

(b) She has attended several care plan meetings with facility staff, where they explained what care would be provided to her sister. However, the facility does not provide the care described in the care plan.

(c) Staff rarely respond to the call light, so instead, her sister yells out when she needs help. Staff members get to her when they can, and she often waits a long time. She often tries to do things on her own, because she is waiting so long, and she has suffered several falls as a result.

(d) Her sister wears diapers, and it seems like everyone in the facility wears diapers as well. Her sister can get to the bathroom with assistance, but staff members do not come and help her in time. A nurse once proposed that she be given toileting assistance every 2 hours as a measure to prevent her falls. However, this does not seem to be happening. She also gets

upset because she has to wait a long time for staff to change her when she has an accident. There is often an overpowering smell of urine and stool from her diaper. Many times, her clothes are soaking wet as well, because she is sitting in her wheelchair in a wet diaper.

(e) Her sister only receives beverages at mealtimes. There is no cup or pitcher of water in her room at other times of the day. She is able to eat on her own, without assistance, but there are sometimes only two staff members on the entire floor during mealtimes. Sometimes no staff members are available to assist residents who need help eating their meals.

(f) Her sister often appears to be overmedicated when Confidential Witness #29 visits. She has arrived to the facility for a visit on several occasions and found her sister drooling and slouched over, with her eyes fluttering. This is not her sister's normal baseline condition. She believes that they overmedicate her sister so that staff members do not have to provide her with care.

186. Inspectors from DOH have also found that Rosemont violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On June 4, 2010, the facility received a deficiency because a care plan had never been developed to address a resident's incontinence. The resident was not being monitored, nor was a plan being developed to promote continence. The staff were aware of his incontinence but were not consistent in meeting his needs.

(b) On August 9, 2010, the facility received a deficiency for failing to supervise residents. Two residents with a history of wandering left the building; the police department called forty minutes after they were last seen to inform the facility that they had been found on the street five blocks away. One of the residents had to be admitted to the hospital for loss of consciousness.

(c) On April 26, 2012, the facility received a deficiency because a resident's fingernails had not been trimmed as requested by the resident.

(d) On April 11, 2014, the facility received a deficiency for failing to provide special eating equipment and utensils to residents who need them.

187. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Rosemont are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Rosemont's self-reported staffing data.

Q. Omissions of Care at Golden LivingCenter – Scranton

188. Confidential Witness #30 is the son of a woman who resided at Scranton from 2013 to 2015. Sometimes he was able to visit a couple of times each week; other times, there may have been a few weeks between visits. He visited at varying times of the day and stayed around an hour at each visit, during which time he was able to observe his mother's condition and the care being provided to her.

189. According to Confidential Witness #30:

(a) His mother was wheelchair-bound and unable to communicate, and she needed assistance with all activities of daily living.

(b) When Confidential Witness #30 visited, his mother was always in the day room, with around 6 to 10 residents. CNAs would come in and out of the

room periodically. His mother was usually sitting alone, by the window. She did not have water available to her in the day room. Even if there was a pitcher of water in the day room, she would not have been able to use it to refill her cup. Sometimes, when he arrived for a visit, she would be chewing on an empty plastic cup.

(c) His mother was often not kept clean. Her wheelchair, Velcro belts, and clothes were often caked with food and crumbs. Her hair was often greasy and unclean.

(d) When she was wearing her dentures, they were filthy. Eventually, staff members left her dentures out of her mouth. After that, her food had to be pureed. At meal times, CNAs would puree her food, put it in a cup, and leave the cup in her hand. She would put the cup to her mouth to try to drink it, but much of the food would run down her front onto her clothes and wheelchair. She also received nutrient drinks to help make up for missing nutrients, but she needed help drinking these as well. Confidential Witness #30 does not think CNAs always stayed with his mother throughout her meal, because there were too few staff on duty to help her. He worries that she did not get enough food. She lost over thirty pounds during her two years at the facility.

(e) His mother was supposed to receive oxygen 24 hours per day. Several times, when he visited, he would discover that her oxygen tanks were empty. Later, the facility started using an oxygen machine, which could run constantly without the need for tanks. However, he noticed several

times that the machine's filters were filthy. It was easy to clean the filters, but apparently this was not done. Once, when he visited, he found his mother chewing on the oxygen machine's electrical cord. It was not plugged in at the time, so she was not in danger of electrocution, but this also meant she was not receiving oxygen.

190. Confidential Witness #31 is the daughter of a woman who has resided at Scranton from 2013 to the present. She visited 3-4 times per week in the beginning, and she now visits weekly. She usually visits for 2-3 hours in the evenings, and she is able to observe her mother's condition and the care she receives.

191. According to Confidential Witness #31:

(a) Her mother needs assistance with bathing, dressing, and getting to the bathroom. She could walk independently and go to the bathroom independently when she entered the facility, but now she is wheelchair-bound and has been placed in a diaper. She is not incontinent—she can use the bathroom if someone assists her—but she has been in diapers for several months.

(b) The facility does not seem clean when Confidential Witness #31 visits. There is a strong odor throughout the facility. She has complained to the DOH about the cleanliness of the facility before, and the facility was spotless for a couple of weeks after their investigation. However, soon afterwards, it went back to the same unclean state as before.

(c) Her mother is a fall risk and has fallen a number of times while at Scranton. However, staff do not consistently implement her fall

precautions. She is supposed to have an alarm clipped to her shirt, but it is not clipped on half the time. The alarm on her wheelchair is often switched off or has the batteries hanging out of it. At least one time, when she visited, the floor mat next to her bed was not there, and she had to ask for it to be put back in place.

(d) Her mother is not provided with water at night. She could drink a glass of water on her own, without needing help, but there is no pitcher of water available to her at night.

(e) Confidential Witness #31 never sees staff provide assistance to residents with eating their meals, even when they need assistance. She sees staff place meal trays in front of residents, provide no assistance to help them eat, then come back later and take the trays away even though the residents have been unable to eat. She has seen this at least a couple of times per month since her mother has been staying there. She has never observed staff assisting residents at mealtime in the dining hall.

(f) She has observed call lights on for up to three hours, on occasion, without a response from staff.

(g) Confidential Witness #31 does not believe her mother ever received any walking exercises or assistance walking with a walker. She could ambulate on her own when she was admitted, but she has declined, and she is now wheelchair-bound.

(h) Her mother's appearance is usually not tidy when she visits. She sometimes has stuff on her face or crumbs on her clothes, her shirt is dirty,

and her nails are dirty underneath. Her dentures are not brushed or cared for. She is supposed to be showered twice per week, but this is not enough; Confidential Witness #31's sister used to come in and give her mother extra showers, but the facility will not allow this anymore.

(i) Her mother often suffers injuries—bruises, gashes on her head, and black eyes—which the facility says are the result of falls. She does not understand why her mother falls so much, and she has repeatedly asked Golden Living to provide physical therapy to her mother to address this. Recently, her mother hurt her ankle, and it was swollen and turning dark red. Confidential Witness #31 asked staff to seek treatment, but they said it was not an infection. Her mother did not receive treatment until Confidential Witness #31's sister—who works at a hospital where the Golden Living doctor also works—contacted the doctor directly to get assistance. Confidential Witness #31 is sometimes afraid to leave her mother there, because of the injuries she has sustained.

192. Inspectors from DOH have also found that Scranton violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On October 26, 2007, the facility received several deficiencies. The facility was cited for not providing sufficient nursing staff, which was demonstrated by several incidents. One resident was supposed to be supervised and helped at breakfast, but was seen by surveyors alone in his room eating breakfast. The facility did not assist two residents with personal hygiene; one had long fingernails that left indentations on the

palm of his left hand. Another resident fell out of bed during incontinence care. A CNA turned the resident on her side, removed her soiled brief, turned to throw it away and left the resident on her side; the resident fell out of bed and hit her head on the floor, bruising her forehead and left eye, and had to go to the emergency room. Further investigation showed that the facility had not provided the number of staff this resident needed for bed care and bed mobility, which was the direct cause of her fall from the bed.

(b) The facility received another deficiency on October 26, 2007 for not devising a repositioning and care plan to prevent skin breakdown for a resident.

(c) On February 22, 2008, the facility received a deficiency for failing to maintain adequate grooming, hygiene, and a dignified personal appearance. The surveyors discovered that the resident did not receive a shower or tub bath twice weekly, even though it was facility policy.

(d) On May 15, 2008, the facility received a deficiency for failing to consistently provide range of motion exercises for two residents. The facility also received a deficiency for failing to provide adequate staff supervision to prevent a resident from falling even though she was known to repeatedly go to the bathroom alone.

(e) On July 11, 2008, the facility was given a deficiency for not providing adequate personal hygiene and grooming services for three residents. Two

residents were seen with dirty, long, and jagged fingernails, and the third resident was observed with facial hair on her chin.

(f) On July 11, 2008, the facility received a deficiency for not consistently providing pressure-reducing measures. CNAs were supposed to use heel pillows for a resident when she was in bed and put the resident on a pressure-reducing cushion when out of bed. Surveyors saw the resident in her wheelchair in the dining room without the cushion in place.

(g) On November 14, 2008, the facility was given a deficiency for failing to consistently provide a resident with planned pressure reducing measures and skin protection devices. Throughout the survey, the resident was either in his bed or wheelchair without his ordered elbow protectors, and his mattress was not programmed to the correct setting based on the resident's weight. The facility received another deficiency because a resident's toileting schedule was not being followed. The resident was supposed to be offered the toilet or a bedpan before breakfast, midmorning, before lunch, mid-afternoon, after dinner, 11 p.m., 12 a.m., and every two hours through 6 a.m. if awake and upon request. Surveyors saw the resident on November 12, 2008, between 10:30 a.m. and 12:40 p.m., and on November 13, 2008, between 9:45 a.m. and 12:40 p.m. The resident was not offered toileting during these times. The DON confirmed that the resident was not being toileted as scheduled.

(h) On November 14, 2008, the facility received a deficiency for not adequately supervising a resident to prevent a fall for one resident and

failed to implement an identified safety intervention for another. Both residents had a history of falls and were known to be fall risks. The first resident had been identified as a fall risk and had a history of falls during the late evening and early morning hours. There was no evidence that the facility provided sufficient supervision during those time periods, when CNAs were responding to call lights or making rounds, to prevent falls. As a result, the resident was without direct supervision in the dining room during the early morning hours of October 8, 2008, and fell, sustaining serious injury. The other resident had a history of falls and his care plan was updated to ensure he was not left alone in his Geri Chair.[9] Surveyors observed him on multiple occasions alone in his room seated in his Geri Chair.

(i) On October 2, 2009, the facility was given a deficiency for failing to provide adequate supervision to a resident at risk for repeated falls, relying instead solely on alarms to prevent falls.

(j) On April 20, 2010, the facility received a deficiency because a resident was not fed or dressed. The resident's lunch tray was left uncovered for over an hour after it was delivered at 12:15 p.m., and he had not been helped to eat it. He was not yet dressed for the day, as of 1:07 p.m. A CNA who was collecting trays noticed that the resident was sleeping in his hospital gown and his uncovered meal tray was untouched. She said he ate better when he was up, dressed, and in the dining room, so she dressed

[9] A "Geri Chair" is a geriatric recliner – a reclining chair on wheels often used by elderly or mobility-limited residents.

him and took him to the dining room at 1:15 p.m. The meal tray was not reheated, nor was a new meal tray gotten for the resident.

(k) On October 22, 2010, the facility was given a deficiency for failing to adequately train CNAs to perform ROM exercise programs. CNAs said they did not feel comfortable doing restorative tasks because they were not trained to do so and could not demonstrate competency in restorative nursing as required, and a resident was losing the use of both legs because the restorative nursing program exercises were not done on a daily basis. The facility received another deficiency when one resident was seen without ordered hand splints. The facility also received a deficiency for not providing safety measures and enough staff supervision to prevent repeated falls and injuries for two residents.

(l) On December 20, 2012, the facility received a deficiency because there was no documentation to show that toileting was being offered to a resident. The facility was also missing documentation of the rationale behind the resident's toileting schedule to ensure incontinence care coincided with the resident's bladder habits and was timed at intervals to prevent incontinent episodes. The facility received another deficiency when a resident's repositioning records showed that staff did not document repositioning on 57 occasions in October 2012, 59 occasions in November 2012, and 19 occasions in December 2012. There was no evidence to suggest staff had repositioned the resident at those times. Another resident's records were missing 65 occasions of repositioning.

Another resident's CNA records were missing documentation on several occasions that the resident's side rails for repositioning were in place, bed alarm was in place when in bed, chair clip alarm was in place when in her wheelchair, pressure-reducing cushion was on her chair, pressure redistribution mattress was used, protective barrier cream was applied after every incontinent episode, or non-skid socks were placed on her feet at all times.

(m) On May 7, 2013, the facility received a deficiency for not maintaining a clean environment, leaving residents at risk of infection. A urine collection device was seen on top of a toilet shared by three residents. The toilet in another resident bathroom was soiled with feces in and around the bowl, and a pair of used gloves was on the floor.

(n) On November 1, 2013, the facility received a deficiency for not following planned pressure sore interventions, including using a pressure-reducing wheelchair cushion, repositioning every two hours, and a pressure reducing mattress. The wheelchair cushion was to be checked for proper inflation. The resident's family reported that the staff was not checking the cushion or repositioning the resident when he was uncomfortable, nor were they using the "communication book" consistently. The resident does not speak, and uses a special "communication book/board" to convey his needs and symptoms. A CNA told surveyors she did not know how to use the "communication book."

193. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Scranton are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Scranton's self-reported staffing data.

R. Omissions of Care at Golden LivingCenter – Shippenville

194. Confidential Witness #32 is the daughter-in-law of a man who resided at Shippenville on and off for several years, including the full year prior to his death in 2014. She and her family visited him at least twice per week for most of that year, during which time she was able to observe his condition and the care that he received. For the last week and a half of his life, her family provided around-the-clock care for him.

195. According to Confidential Witness #32:

(a) Her father-in-law needed assistance with all activities of daily living.

(b) He was unable to dress himself, and whenever they visited, he was always in the same clothes. On nearly every visit, she and her husband cleaned him and changed his clothes.

(c) He could have used the bathroom with assistance from staff, but instead they gave him urine bottles to use in his bed. Most of the time, he had two or three completely full urine bottles sitting on his dresser when they came to visit. The facility started putting him in diapers as well, later in his stay. When they visited, he was often soaked from his mid-chest down to his toes, indicating to them that he had been lying in wet briefs for a long time.

(d) There was rarely water in his room. The facility gave him a mug with a lid, but it was usually empty. Confidential Witness #32's husband would go get ice for his father when they visited and found the mug empty.

(e) She does not think the facility ever showered her father-in-law; they just gave him sponge baths every two weeks or so. He did not seem clean when they visited. His face and ears were dirty, and he had build-up on his skin. Family members had to cut his nails for him. Staff members did not clean his dentures properly, brushing them while they were still in his mouth.

(f) When he was nearing the end of his life, the family decided to provide much of his care themselves. Confidential Witness #32's sister was an experienced CNA, and she came in to assist them. When she took his dentures out to clean them, they saw that the build-up of material in his mouth was terrible. It was a half-inch thick, and the smell was so bad that everyone in the room gagged. When they bathed him, big clumps of dirty material would come off of him, and the smell was terrible. She does not think facility staff had even been wiping him down prior to that.

196. Confidential Witness #33 is the daughter of a man who resided at Shippenville for three months in 2014. She and her family members visited him nearly every day, for many hours per day, during which time they were able to observe his condition and the care that was provided to him.

197. According to Confidential Witness #33:

(a) Her father suffered from a degenerative disease and needed assistance with all activities of daily living.

(b) After observing how deficient the care was during his first two weeks at the facility, Confidential Witness #33 and her mother and sister

determined that a family member needed to be present at the facility constantly to make sure he was cared for. Among the three of them, they were able to make sure that someone was there with him several hours each day.

(c) Family members provided essentially all of his Basic Care: washing his face, shaving him, using a washcloth to clean his back and arms, cutting his hair and nails, and applying deodorant. Confidential Witness #33 went to the linen room herself to get supplies so she could change him into a clean gown and change his towels and pillow cases. Family members were not able to take him to the toilet, however. For most of his stay, he could stand with assistance, but not walk. Even standing became more difficult, and he needed to be moved with a Hoyer lift. The family felt they should not be operating the lift. Thus, they relied on staff for this.

(d) On a handful of days, no one from the family was able to visit. When they arrived the next day, they found that he was not shaved, his teeth had not been brushed, his hair had not been brushed, and his face was not washed. Confidential Witness #33 does not believe the facility provided any Basic Care on the days when they did not come in and do it themselves.

(e) Because of his condition, her father had good days and bad days. On good days, he could say when he needed to go to the bathroom, and his family could use the call bell to seek assistance from staff to take him. However, they had to wait so long for a staff member to respond to the call bell, he often became incontinent.

(f) On average, they waited around 30 minutes for staff to respond to the call bell. However, sometimes they waited as long as an hour. They usually went out to look for a staff member after waiting for 10 minutes or more, but they typically had to wait even after finding someone until that person was available.

(g) Family members also made sure he had water to drink, because staff never came in to see if he needed water. Family members fed him his meals at lunch and dinner once his condition declined and he could no longer eat on his own. They got him Ensure supplement drinks when he had not eaten well. Staff did not help with any of these things.

198. Inspectors from DOH have also found that Shippenville violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On August 8, 2008, the facility received a deficiency for waking residents up during the 11 p.m. – 7 a.m. shift to perform skin assessments. Residents had complained during Resident Council meetings and directly to surveyors about being awakened in the middle of the night.

(b) On July 19, 2013, the facility received a deficiency for failing to reassess a resident after a significant decline. The resident declined from limited to extensive assistance with eating, urinary function declined from occasionally incontinent to frequently incontinent, and the resident had a change in his/her range of motion. The facility received another deficiency for failing to complete bowel and bladder assessments to try to help maintain or improve continence. Two residents' assessment forms

were incomplete and did not indicate how the facility would develop a plan to treat the levels of incontinence.

(c) On June 6, 2014, the facility received a deficiency for failing to provide proper hygiene care for a resident with an indwelling urinary catheter. Staff was to provide care to clean around the resident's catheter every shift: cleansing the perineum with soap and warm water, taking care to wash from front to back, cleansing well at the catheter insertion area, and rinsing. Surveyors observed a CNA apply a "no-rinse" soap to a warm wash cloth and intermittently wipe from back to front, putting the resident at risk of a urinary tract infection.

(d) The facility received another deficiency on June 6, 2014 for not providing planned restorative nursing. A resident was supposed to wear a splint on the right hand after morning care for four hours, then staff was to move the splint to the left hand for four hours, with the process repeating. Surveyors saw resident in bed at various times without the splint applied on either hand, as ordered.

199. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Shippenville are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Shippenville's self-reported staffing data.

S. Omissions of Care at Golden LivingCenter – Stenton

200. Confidential Witness #11 worked as a CNA at Stenton from 2004 to 2010. She usually worked the daytime shift, from 7 a.m. to 3 p.m., and she was typically responsible for 11-12 residents. However, when the facility was short-staffed, which happened frequently, she was responsible for as many as 15 residents on that shift.

201. According to Confidential Witness #11:

(a) She was supposed to have all the residents up and ready in time for breakfast by 8 a.m. However, this was impossible, because she had so many residents to take care of. Residents had to eat breakfast in their rooms in their pajamas, instead of going to the dining room for breakfast.

(b) CNAs were expected to dress each resident in 10 minutes, but in reality, it took about 30 minutes to dress each one. Because the CNAs were so rushed when getting the residents dressed, their clothing sometimes didn't match, or the CNAs did not have time to put residents' socks on. Confidential Witness #11 was not able to get all the residents up and dressed for the day until around 2 p.m. each day.

(c) Stenton was constantly short on supplies – typically briefs and soap. When the facility was short on briefs, CNAs would have to go looking for briefs that would fit their residents in other rooms and on other halls.

(d) Residents usually had to wait around 20 minutes for a response to a call light. Confidential Witness #11 often found residents in distress because they had activated their call lights and waited too long for a response. She remembers one incident when she responded to a call light, and the resident was very upset because she had waited too long and had gone to the bathroom on herself.

(e) It was very difficult to reposition residents every two hours, as she was trained to do. Confidential Witness #11 and other CNAs frequently used

Hoyer lifts[10] to reposition residents by themselves, even though they were supposed to get a second person to help, because they were not able to wait for help. Confidential Witness #11 occasionally found residents who did not seem to have been repositioned or checked on for an entire shift.

202. Confidential Witness #12 worked as a CNA at Stenton from 2009 to 2011. She usually worked the 7 a.m. to 3 p.m. shift, and she was responsible for 13-16 residents.

203. According to Confidential Witness #12:

(a) She did not have enough time to finish everything she was supposed to finish. There was no time to chat with a resident or even wish them a happy birthday. She once got in trouble for spending 15 minutes with one resident; the administrator told her this was too much time to spend. Confidential Witness #12 felt that because many residents were in their last days, they needed more comfort than this.

(b) She was supposed to reposition residents every two hours, but she was not able to do this. Heavy residents who required two CNAs to reposition them would only be moved once, if at all, during a shift. Other residents were moved, at most, twice per shift. She remembers residents getting pressure sores.

(c) Most of her residents were incontinent. According to facility policy, these residents were supposed to be changed every hour and a half, but Confidential Witness #12 was not able to change them that often; she

[10] "Hoyer lifts" are devices used to lift and transfer residents in and out of bed. They must be operated by two people to be safely used. However, CNAs sometimes use Hoyer lifts by themselves when another CNA is not available to assist, risking injury to themselves and to residents.

thinks they may have waited as long as 5 hours between changes. There were several times when she found residents who had not been changed for an entire shift. Once, during a day shift, a CNA found a resident at 11 a.m. who had not been changed since 1 a.m. – the resident was lying in a soiled diaper for 10 hours.

(d) She wrote down in resident records that she finished tasks she did not really finish. She was not told to do this, but she and the other CNAs lived in fear of the administrator. They would be written up if they did not finish all their work, but there was no way they could finish everything.

(e) DOH inspections happened around the same time every year, and the facility knew when they were coming. The facility would get more staff for the inspection, and the nurses would help out more than usual on the floor.

204. Confidential Witness #13 worked as a CNA at Stenton from 2009 to 2012. He usually worked the 7 a.m. to 3 p.m. shift and the 3 p.m. to 11 p.m. shift, and he was responsible for 13-15 residents on both shifts. He sometimes worked the overnight shift (11 p.m. to 7 a.m.), and he was responsible for as many as 23 residents on that shift.

205. According to Confidential Witness #13:

(a) He was supposed to get the residents up and dressed by 8 a.m., but this was impossible. There was no way to get 13-15 residents up and dressed in one hour. Instead, he got the residents who needed assistance eating up and dressed, and took them to the dining room. The rest of the residents

had to eat breakfast in their rooms. The residents were usually all up and dressed by 10:30 a.m.

(b) Confidential Witness #13 regularly found residents saturated in urine because they had not been changed in hours. This usually happened when he arrived in the morning, because there was not enough staff on the overnight shift to change the residents.

(c) The facility was routinely short on supplies – mainly shampoo, wash cloths, and diapers. When they were short on shampoo, CNAs would use soap to wash the residents' hair. When they were short on wash cloths, the CNAs would rip towels or sheets apart to make wash cloths. When they were short on diapers, the CNAs would look for diapers to borrow from other residents to fill the gaps, or place extra linens underneath the residents for extra padding. One day, in 2012, the facility had only one box of diapers (containing 24 diapers) for 94 residents. DOH came to investigate a few days later, but by then, the facility had enough supplies.

(d) CNAs frequently went off-site with residents for appointments, and they would be gone for 1-4 hours. When this happened, the facility did not place an additional CNA on the floor, so the CNAs who remained had to care for even more residents than usual.

(e) Administrators knew ahead of time when a DOH inspection was about to take place. They would hold a meeting right before each inspection and say that they had heard the facility would be inspected in a few days, and that the staff should get the facility clean. On inspection days, everything

was clean and perfect, everyone was helpful, and supplies were fully stocked. The Administrator would even put out new socks for the residents. There were also more staff on duty on inspection days. The facility would bring in CNAs who were part-time or who usually worked other shifts. Because everyone helped out on inspection days, the CNAs would only have to be responsible for about 7-8 residents each.

206. Inspectors from DOH have also found that Stenton violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During the annual licensure survey completed on September 26, 2008, a resident who was totally dependent upon staff for hygiene and bathing was not clean shaven over the three days that surveyors were at Stenton.

(b) On October 23, 2008, during a survey in response to an incident, Stenton received a deficiency for failing to adequately supervise a resident who was identified as a risk for falling, and who sustained a fracture and required surgery after falling when left unattended in a bathroom. The resident required extensive assistance with transferring, walking, dressing, hygiene, and incontinence care. The resident was to receive incontinence care every two hours and as needed, and a mechanical lift and the assistance of two staff members were required when transferring this resident.

(c) Stenton was given a deficiency during a complaint survey on June 8, 2009, for failing to maintain hygiene and dignity of residents. During a tour of the facility, two residents told surveyors they were upset because bed

sheets were being used instead of incontinence briefs because no briefs were available. Surveyors looked in the rooms of seven residents who used incontinence products, and none was available. The supply room only had one pack each of the three sizes of briefs. An employee said that those were the only briefs in the facility until the next delivery day.

(d) During the annual licensure survey on September 20, 2011, the facility received a deficiency for failing to provide adequate eating assistance. A resident requiring one-on-one assistance with eating and a specific eating method was observed with his tray of food between 12:30 and 1:00 p.m., but with no assistance.

(e) On November 17, 2011, surveyors conducted a survey in response to two complaints and a revisit for deficiencies found during the annual licensure survey on September 20, 2011. Several deficiencies were found, including the failure to provide an adequate number of bath towels to residents on all living areas. The first floor nursing unit only had six large bath towels for 42 residents; the second floor nursing unit only had five large bath towels available for 52 residents. A laundry aide showed the surveyor a bath towel that had been cut in half and was being used to dry residents. Several CNAs told surveyors that the bath towel supply had been an ongoing issue for several weeks and that residents had not been able to get showers because bath towels were not available. Nine residents were interviewed and were frustrated that they were not able to receive showers

on scheduled shower days and that they had to use wash cloths to dry themselves.

(f) The facility received a deficiency on November 29, 2012 due to a resident elopement that went unnoticed for hours. A resident went missing from Stenton on October 6, 2012. The Director of Nursing was interviewed during this survey and was unsure of the times, but believed that the resident left the facility at 10:00 a.m. on October 6, and it was not until a family member called the facility at 4:00 p.m. that they learned the resident had left the facility.

207. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Stenton are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Stenton's self-reported staffing data.

T. Omissions of Care at Golden LivingCenter – Summit

208. Inspectors from DOH have found that Summit violated state and federal nursing home regulations by failing to provide Basic Care and failing to keep accurate records. For example:

(a) During the annual licensure survey completed May 2, 2008, Summit received deficiencies for dehydration of residents and late delivery of meals and drinks. The dietitian and administrator told surveyors that meals were not served consistently as scheduled, and not within 15 minutes of the posted meal times. A resident told surveyors that he was not always provided with ice water, nor did he receive cranberry juice at breakfast as ordered by his physician to prevent urinary tract infections. The medication administration record said the resident had been provided

with cranberry juice at each meal, but surveyors noted that there was no evidence to indicate the resident actually received and consumed cranberry juice.

(b) Surveyors found on a complaint survey on March 12, 2009 that Summit had failed to ensure that each resident received the appropriate treatment and services to restore as much normal bladder function as possible. A resident, prior to admission to the facility, used the toilet and was continent of both bowel and bladder. After surgery for leg amputations, a Foley catheter was used for a while, and then discontinued. The resident told surveyors she feels embarrassed when the staff changes her briefs because she cannot get to the bathroom without the assistance of two staff members now and is frequently incontinent. Surveyors found that there was no evidence that after the Foley catheter was removed that any efforts were made to restore as much normal bladder function as possible through bladder retraining. Another resident, who required assistance of two staff members for toileting, was incontinent of urine occasionally, but was a candidate for a bladder retraining program to restore as much bladder function as possible. However, no such program had ever been implemented for this resident.

(c) The facility was cited again on April 23, 2009 for failing to correct these deficiencies from the March 12 survey and for the unjustified use of a catheter for a third resident.

(d) The April 23, 2009 survey also revealed failure to implement pressure sore interventions at Summit. A resident with a Stage II pressure sore and who required extensive assistance with mobility and repositioning was to be repositioned at least every two hours, per facility policy and the resident's individual care plan. A CNA noticed a small open area on the resident's buttocks on March 20, 2009, but the pressure sore was not described in any nurse's notes on the following days. The resident's repositioning documentation showed that on March 20, 2009, from 1:30 p.m. – 5:00 p.m., the resident was not repositioned off her back. Summit was given a deficiency based on the inconsistencies in the resident's record and the failure to follow protocol to prevent pressure sores.

(e) Eight of the ten residents interviewed during the annual licensure and complaint survey completed on May 28, 2010 said that it is not uncommon to wait in excess of 10 minutes for assistance to be provided. One resident said that staff frequently will respond to her call bell, turn it off, say they will come back to help but do not come back. Another resident said she doesn't bother to use her call bell during certain times of the day (*i.e.*, change of shift, morning showers, meal times) because in her experience, it is not answered and assistance is not provided promptly. Untimely response to call bells was a topic of discussion at several Resident Council meetings: December 4, 2009; January 4, 2010; March 26, 2010; and May 7, 2010.

(f) During the survey on May 28, 2010, Summit was again given a deficiency for failing to restore bladder function. A resident's records contained conflicting notes and assessment conclusions regarding a toileting schedule. They contained no indication that the resident's bladder incontinence was tracked to see if there was a pattern of incontinence, and there were no individualized interventions put in place to maintain or restore this resident's bladder function.

(g) During a visit to the facility for a complaint on March 31, 2011, at 2:00 p.m., a surveyor observed a call bell light was lit and audibly sounding throughout the corridors. Five minutes later, the bell was still sounding. An RN and two LPNs were nearby, within hearing distance of the call bell alarm. The call bell continued to ring for a further 15 minutes, when a central supply employee went into the resident's room and came back to tell the nurses that the resident was requesting a bed pan. It was then that one of the nurses left the nurse station to assist the resident with the request for a bedpan, approximately 20 minutes after first observing the resident's call light. The surveyor interviewed the resident at 2:30 p.m. and the resident said, "It always seems long for someone to come when you need the bedpan."

(h) During an annual licensure survey on April 15, 2011, the facility received a deficiency for failing to maintain accurate resident records. One resident's clinical record showed that computerized nursing progress notes were identical, word for word, on thirteen different occasions between

September and October 2010. Documented blood pressures were identical at the same time for three days in September 2010, even though the Medication Administration Record for the same dates and times showed different blood pressures. A different resident's record also repeated the same wording in multiple nursing entries. A third resident's records contained a detailed record of how many times the resident had voided on several dates; however, this resident was unable to void due to the removal of both the resident's kidneys.

(i) An inspector, while on a complaint survey on March 25, 2013, found that a resident's family member had filed a grievance stating that during his visit, the resident was left in a wet and soiled brief. Another grievance stated that a resident's bed sheets were covered with dried feces and there was a strong smell of urine. The surveyor found that the facility had not addressed this grievance, nor fully resolved the concerns of the family member.

(j) Summit was given a deficiency during an annual licensure survey and complaint survey on April 5, 2013 for not addressing the residents' grievances about call bell responses. Resident Council meeting minutes held from October 2012 through March 2013 showed residents complaining about call bells not being answered and staff refusing to provide care unless they were assigned to the particular resident. The facility responses to these meeting minutes did not resolve the problems. November 2012's meeting minutes showed five out of eleven residents at

the meeting said residents wait too long for call bells to be answered. Surveyors interviewed seven residents, all of whom said they often wait for thirty minutes or more for call bells to be answered. Two reported they have had incontinent accidents waiting for call bells to be answered. One said she often uses the bathroom unassisted because she has to wait too long for the call bell to be answered. Four residents said that staff had walked by their rooms when the call bells were sounding, and told residents they were too busy to help residents who were not assigned to their care. One resident said she had waited more than thirty minutes for her call bell to be answered, and on one occasion she waited for over an hour.

(k) The facility received another deficiency during this survey for failing to document that Basic Care had been provided. One resident was to receive passive ROM exercises twice a day, but the restorative nursing record for January 2013 showed the resident did not receive the exercises on the 3 p.m. to 11 p.m. shift for the entire month. The resident did not receive the exercises twice a day the entire month of February, and most of the month of March. Another resident's record was missing documentation that restorative ambulation was provided on three shifts, or that the resident was repositioned every two hours, as required. Records showed that repositioning had not been performed on 17 occasions throughout March 2013. Yet another resident's record showed he was to be turned and

repositioned every two hours, but on fourteen occasions in March, it was not documented as completed.

(l) The facility received another deficiency relating to slow responses to call bells during the annual licensure survey completed on May 15, 2014. Resident Council meeting minutes and grievances from several months in 2013 and 2014 showed that call bells were not being answered in a timely manner, especially in the afternoon hours, and Summit had not addressed the problem. Call bell audits were not performed consistently. One resident interviewed said that two days after he was admitted, he experienced an incontinence episode and rang his call bell. Staff answered the call bell and said they would be right back to help him, but the staff member did not return for an hour. After he filed a grievance, he did not hear anything from the facility regarding his complaint.

209. The omissions of Basic Care documented in DOH deficiencies at Summit are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Summit's self-reported staffing data.

U. Omissions of Care at Golden LivingCenter – Tunkhannock

210. Confidential Witness #14 worked as a CNA at Tunkhannock from 2009 to 2010. She usually worked the 7 a.m. to 3 p.m. shift. She typically was responsible for 10-12 residents, but she often was responsible for as many as 17 residents.

211. According to Confidential Witness #14:

(a) After she arrived for her shift each day, she was supposed to get 6 – 7 residents up and ready to go to the dining area for breakfast in one hour. This meant bathing, changing, dressing, and toileting each resident in ten

minutes. Often, residents' bedding was soaked with urine and also had to be changed when she arrived for her shift. It was very difficult to get all of this done, and she frequently had to feed residents in their rooms because she did not have enough time to get them ready to go to the dining room. She was also unable to do a good job getting residents ready for the day. For example, sometimes she skipped oral care in the morning. She did not have time to provide care properly.

(b) She was supposed to reposition residents every two hours, but there was not enough time to do it that often. She also skipped ROM exercises due to not having enough time. She was told to count getting the residents dressed as ROM exercises, so this is what she did.

(c) Management knew when DOH surveyors were coming. Employees with office jobs would come out of their offices and help on the floor on inspection days. In her opinion, the State did not get an accurate picture of real life at the facility.

212. Confidential Witness #15 worked as a CNA at Tunkhannock from 2011 to 2014. She usually worked the 6 a.m. to 2 p.m. shift, and she was frequently responsible for as many as 18 residents. All of these residents required total care.

213. According to Confidential Witness #15:

(a) She had only an hour and a half in the morning to dress all of her residents. First, she dressed the residents who required assistance eating, because they had to eat in the dining room. Next, she would pick other residents to dress before breakfast so they could eat in the dining room.

She was only able to dress around 9 residents before breakfast, and the rest of the residents were not dressed until after breakfast. These residents had to eat breakfast in their rooms, unless they were at risk of choking, in which case they would eat in the dining room without being dressed for the day.

(b) Approximately ninety percent of her residents were incontinent, and the CNAs were supposed to check them every hour to see if they needed to be changed. She frequently found residents who were soaking wet and needed a complete bed change. This usually happened at the shift change. Most of these residents had not been changed in a long time; Confidential Witness #15 could tell this because the urine on the bed was cold.

(c) The facility was often short on supplies – especially briefs. When this happened, and there were not enough briefs in one resident's room, Confidential Witness #15 had to search for residents with the same size briefs so she could borrow from their rooms. This took up extra time.

(d) Residents' call lights were supposed to be answered in 1-2 minutes. However, residents usually waited 10-20 minutes for a response. Residents were frequently upset about waiting too long, but there were too many residents for the CNAs to care for to get to them more quickly.

(e) CNAs frequently went off-site with residents to accompany them to appointments. When this happened, the floor was down a CNA, and the other CNAs had to take on additional residents. Sometimes, CNAs were gone for an entire shift.

(f) Resident charts were not very accurate. CNAs got in trouble if they left the charts blank, so she and the other CNAs would just check off information about the residents to get the charting finished. She estimates she was able to accurately chart only about 50% of the time.

(g) On days when DOH inspections took place, everything was perfect. All of the managers and administrators helped out on the floor. There were also additional staff members working on inspection days. Confidential Witness #15 thought these additional staff members were CNAs who usually worked other shifts and agency CNAs who were hired for the day so the facility would appear to have enough staff on duty.

214. Inspectors from DOH have also found that Tunkhannock violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On March 25, 2008, the facility received a deficiency for failing to consistently implement pressure-relieving devices for three residents who were at risk of developing pressure sores. Each of these residents' care plans or physician orders specified that certain pressure-relieving devices be applied regularly, but resident records did not show that these measures had been consistently taken.

(b) The facility received a deficiency on September 4, 2008 for failing to adequately manage a resident's incontinence and to restore or maintain her bladder function. The resident had been evaluated and was found to be a good candidate for a toileting program, but the evaluation process was never completed and the program was never implemented.

(c) The facility received a deficiency on November 25, 2008 for failing to address repeated resident concerns about slow responses to call lights. Resident Council meeting minutes from September, October, and November of that year included concerns about slow responses to call lights. One resident complained of ringing the call bell for two hours after lunch, seeking assistance getting back into bed.

(d) On April 29, 2010, at a survey conducted by DOH in response to a complaint, the facility received a deficiency for failing to maintain adequate hygiene and grooming for 9 residents dependent on staff for personal grooming assistance. The surveyor observed the residents' fingernails to be long and jagged.

(e) The facility received a deficiency on July 21, 2010 for failing to adequately address resident and family member concerns about slow response times to call bells. Residents complained that they waited in excess of thirty minutes for a response at times. Some residents also complained that staff would answer a call bell, would say they would return, but then would not do so, or that staff members placed call bells out of reach of the residents.

(f) The facility received a deficiency on October 14, 2011 for failing to adequately groom residents. Two residents were found to have long, dirty fingernails.

(g) On August 6, 2014, the facility received a deficiency for failing to specify in a resident's care plan that she required the assistance of two staff members for repositioning.

215. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Tunkhannock are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Tunkhannock's self-reported staffing data.

V. Omissions of Care at Golden LivingCenter – Uniontown

216. Confidential Witness #34 is the daughter of a woman who lived at Uniontown from 2011 to 2013. She visited her mother daily, during which time she was able to observe her mother's condition and the care she received.

217. According to Confidential Witness #34:

(a) Her mother was at Uniontown for rehabilitation after she broke her hip. She could not walk, so she needed assistance from staff with getting to the bathroom, bathing and dressing, and getting around.

(b) Her mother waited up to 45 minutes or longer for a response to her call light, and she often became upset because she waited so long.

(c) She was able to use the bathroom if someone assisted her. However, she started having accidents while waiting for assistance to the bathroom, and staff began putting her in diapers. She was constantly getting urinary tract infections, and Confidential Witness #34 could tell her mother was often sitting in soiled diapers.

(d) Sometimes, when Confidential Witness #34 visited around 10 a.m., her mother still would not be dressed for the day.

(e) Her mother sat in a chair all day next to her bed, or sometimes staff left her in bed all day. Confidential Witness #34 does not think they repositioned her regularly. She had a pressure sore when she entered the facility, and she still had it when she left the facility two years later.

218. Confidential Witness #35 resided at Uniontown for one month in 2014.

219. According to Confidential Witness #35:

(a) She came to Uniontown after suffering strokes, and she needed assistance with many activities of daily living, including bathing, dressing, grooming, oral care, toileting, and walking.

(b) She had a catheter, but she was able to use the bathroom for bowel movements. However, the CNAs did not want to take her to the bathroom, especially at night, when there was usually only one person for the whole wing of 30-40 rooms. She was supposed to have two people assist her, but it was hard for the CNAs to find a second person to help. They always tried to get her to take herself to the bathroom using her walker, or to use the bedpan. However, the bedpan was very painful for her, and she was unable to go to the bathroom while on it. And although she had a walker, no one ever taught her how to use it, and the left side of her body was very shaky.

(c) The first night she was there, a CNA left her on the toilet but never came back when she called for her using the call bell. When no one responded to the call bell, she finally stood up herself and tried to lean out the door to

call for help. Two other staff members did finally come in response to that and helped her.

(d) She received physical therapy while she was at Uniontown, but staff did not do any range-of-motion exercises with her outside of that.

(e) The assistance she got with grooming was inadequate. Her nails were done only once in the month that she was there. Her armpits were only shaved once. Once or twice, she got two baths a week, but the rest of the time she got one bath and one sponge bath per week. She went one whole week without receiving a bath at all. She had her boyfriend wash her face for her and help her dress for bed.

220. Inspectors from DOH have also found that Uniontown violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On June 13, 2008, the facility was given a deficiency for failing to maintain a safe, clean, and homelike environment in both of two shower rooms. One toilet chair had brown stains, and another had dark yellow liquid in the pot. The base of a toilet had a crack, which was surrounded by a brown stain.

(b) On June 11, 2009, the facility was given a deficiency for not incorporating range of motion exercises into resident care plans. Two residents had limited range of motion, though their assessments and care plans did not reflect it or plan to correct it.

(c) On May 25, 2012, the facility received a deficiency for failing to maintain an effective call bell/light system. Surveyors saw that there was no visual way for staff to know a resident was calling.

(d) On June 27, 2013, the facility received a deficiency for failing to provide assistance with meals. The facility had failed to incorporate nutritional and occupational assessments into resident care plans to ensure that needed mealtime assistance would be provided. One resident had a physician's order not to use straws because of a risk of aspiration. A CNA and the Assistant Director of Nursing told surveyors that the resident used straws all the time. Another resident was unable to handle cups and other utensils without spilling due to shakiness and hand tremors from Parkinson's. The resident's assessment reflected his need for extensive assistance with eating, but his care plan did not reflect this need nor did he receive the assistance he needed. A surveyor observed the resident in bed attempting to self-feed; the resident's clothing protector was covered with breakfast food. The resident asked the surveyor for help positioning a coffee cup and spilled the coffee.

221. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Uniontown are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Uniontown's self-reported staffing data.

W. Omissions of Care at Golden LivingCenter – Western Reserve

222. Confidential Witness #16 is the wife of a man who resided at Western Reserve for two weeks in 2010. She visited her husband daily and spent most of the day with him.

223. According to Confidential Witness #16:

(a) Her husband was completely ignored by staff members. When he first entered the facility, he could sit up on his own and use his walker to go to the bathroom. Over two weeks at the facility, however, his condition declined dramatically.

(b) Staff placed his water on his nightstand, out of reach. She regularly filled his water pitcher for him when she visited, because he was so thirsty. By the end of his two weeks at the facility, his urine had turned brown in color.

(c) Staff brought in his food tray at meal times, placed it at the other side of the room, and left it there. At first, he could get the food on his own. But as his condition declined, Confidential Witness #16 had to start feeding him breakfast and lunch, because no staff member helped. At dinnertime, Confidential Witness #16 went home to care for their pets, then returned to the facility after dinner. Upon her return, she would find her husband's dinner uneaten and cold, sitting across the room from her husband, because he could not feed himself and no staff member came to feed him. After she saw this for a few days, she started cooking him dinner at home, bringing it in, and feeding it to him, so he could have a warm dinner.

(d) Her husband needed help getting dressed and undressed. Because no one assisted him, Confidential Witness #16 tried to dress him in the mornings and undress him in the evenings. However, after a few days, she realized she could not do this by herself. After that, her husband was left in his dressing gown day and night.

(e) His call light was not within his reach. When he needed something, Confidential Witness #16 would ring the call light for him. They would wait up to 30 minutes for a response. She eventually got fed up and went to the nurse's station to get help. The staff said they were all busy, but they would get to him as soon as they could.

(f) After her husband was at Western Reserve for about two weeks, Confidential Witness #16 came to visit one day and saw him being loaded onto an ambulance to go to the emergency room. Facility staff told her he needed immediate medical attention. At the hospital, they learned that he had urinary sepsis, was severely dehydrated, and had suffered a drug overdose.

224. Confidential Witness #17 is the daughter-in-law of a woman who resided at Western Reserve from 2009 until her death in 2011. She spent the first year on the rehabilitation floor, but she was subsequently moved to the long-term care floor, where the care was much worse. Confidential Witness #17 and her husband visited once or twice each week, and other family members visited several additional times each week.

225. According to Confidential Witness #17:

(a) Her mother-in-law was neglected and ignored.

(b) One day, she and her husband went to the facility to visit and saw that her mother-in-law's mouth and teeth were dirty, and she did not appear to have had her teeth brushed in some time. She was also very thirsty.

(c) Her mother-in-law needed assistance getting dressed for the day. One time, she visited and noticed that her mother-in-law was wearing the same

clothes that she had been wearing during a visit two weeks prior. She checked with other family members who had visited during the two-week period, and they all said that she was wearing the same outfit when they saw her. They became concerned that she had been left in the same clothing for two weeks.

(d) They did not know how often her mother-in-law received showers, but she was always dirty and unkempt looking. She looked as if her hair had not been brushed for days.

(e) Her mother-in-law was able to feed herself. However, staff never took her to the dining room for meals, so she ate alone in her room. She began to eat less and less, and she lost around 50 pounds from the date she was admitted to Western Reserve to the date she died.

(f) When her mother-in-law entered the facility, she was completely continent. However, after she was moved to the long-term care floor, she started wearing diapers. She asked her why she was wearing diapers, and her mother-in-law said she did not know, because she could still use the bathroom.

(g) After her mother-in-law moved to the long-term care floor, staff ignored her. She sat in a geriatric chair all day, and staff never walked or repositioned her.

226. Inspectors from DOH have also found that Western Reserve violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) Western Reserve received a deficiency during a complaint survey on July 9, 2008, for failing to provide hygiene care. As of a complaint survey conducted on July 9, 2008, a resident's bathing records showed the resident had not received a shower since July 2. The resident told the surveyor that a shower had been scheduled for July 4, but it still had not happened.

(b) On October 17, 2008, Western Reserve received a deficiency for failing to restore or maintain bladder function. A resident was assessed as usually continent of bladder in July 2008, and in September had become frequently incontinent. In September the resident was determined to be a good candidate for a bladder retraining program to improve bladder function and reduce incontinent episodes. As of the annual licensure survey at Western Reserve completed on October 17, 2008, a bladder retraining program had not been started.

(c) Western Reserve received a deficiency at a survey on September 25, 2009 for failing to provide restorative nursing program interventions for eating for four residents. A resident's records included a restorative dining program to help try to restore eating independence. Surveyors noted that CNAs feeding four residents were either not aware of or did not comply with the residents' individual eating plans.

(d) The facility received a deficiency on May 7, 2010 for lack of hydration care. While conducting a complaint survey, the inspector observed several residents from 9:30 a.m. to 10:45 a.m. without access to water. Four

residents had no water at the bedside; two residents had water on a table away from the bed, where they were unable to independently reach the water. One resident told the inspector, "They don't take care of me at all."

(e) Western Reserve received a deficiency for failing to provide incontinence care during an annual licensure survey on October 7, 2010. The surveyor heard a resident's call bell sounding at 9:00 a.m. At 9:16 a.m., a CNA entered the resident's room and provided a blanket, but told him he would have to wait for the CNA assigned to him to provide incontinence care. At 9:45 a.m., incontinence care had still not been provided. When interviewed by the surveyor at that time, the resident said, "I'm still wet," 45 minutes after pressing his call bell.

(f) The facility received a deficiency on January 12, 2011 for failing to provide care to restore bladder function. A resident was assessed to be a good candidate for a restorative program for bladder control over several months in 2010, but the plan to increase bladder function was never made. During a survey conducted in response to two complaints, surveyors noted that from 9:45 a.m. through 1:40 p.m. on January 11, 2011, the resident was not assisted to the toilet or provided with incontinence care during the four hours of observation.

227. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at Western Reserve are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of Western Reserve's self-reported staffing data.

X. Omissions of Care at Golden LivingCenter – West Shore

228. Confidential Witness #36 is the daughter of a woman who resided at West Shore for three months in 2014. She visited her mother daily, so she was able to observe her mother's condition and the care she received. She dropped her father off in the mornings so he could stay with her mother all day, and she rejoined them in the afternoons and evenings for several hours.

229. According to Confidential Witness #36:

(a) Her mother suffered from dementia and needed assistance with all activities of daily living, including bathing, dressing, grooming, brushing her teeth, and going to the toilet. She spent 2-3 weeks in the short-term care / therapy unit of the facility, and was then moved to the long-term care unit for the remainder of her stay.

(b) Her condition declined significantly over her three-month stay at the facility. When she entered West Shore, she was a feisty woman who could walk with a small cane. Within a month after entering the facility, she was confined to a wheelchair, and by the time she left, she rarely moved or spoke.

(c) Confidential Witness #36 and her father provided much of her mother's care, including helping her eat, helping her to the bathroom, clipping her fingernails, and making sure she had clean clothes. Her father spent the whole day with her mother each day; she visited for several hours in the afternoons and evenings.

(d) She ate in her room and needed assistance with her meals. However, CNAs sometimes forgot to drop off her meal tray, and they did not provide her with assistance eating. Instead, Confidential Witness #36 and

her father always helped feed her. She believes that if they had not done this, her mother would not have gotten fed.

(e) Staff frequently said her mother was refusing showers, and they once went five weeks without showering her. Confidential Witness #36 does not believe her mother refused showers for five weeks straight. She was supposed to receive a bed bath every day. However, in the long-term care unit of the facility, she was lucky to receive bed baths three times per week.

(f) Facility staff never brushed her mother's teeth. She and her father purposefully noted the position of the toothpaste and toothbrush, so they could tell they never moved in between their visits.

(g) Confidential Witness #36 and her father never saw staff reposition her mother. She just sat in her wheelchair all day.

(h) Her mother had to wait at least a half hour for a response to her call bell. The wait was longer during mealtimes, because only one CNA stayed on the hall. She could have gone to the bathroom with assistance, but she always waited too long for anyone to come. When Confidential Witness #36's father was there, he would help her to the bathroom. But she was often wet when he arrived in the mornings, so he knew she was not being helped or changed when he was not there.

230. Confidential Witness #37 is the sister of a man who resided at West Shore for around two years between 2011 and 2013. She usually visited the facility 3-4 times per week for

several hours, during which time she was able to observe her brother's condition and the care he received.

231. According to Confidential Witness #37:

(a) Her brother suffers from "locked in syndrome," a condition that causes him to be paralyzed and unable to speak, although he is fully aware and can communicate by pointing to letters on a chart. He requires assistance with all activities of daily living.

(b) When he was admitted to the facility, staff told her that he would be kept near the nurse's station to be monitored at all times, that he would be taken out of bed every day and receive lots of attention, and that he would receive the oral care and bathing that he needed. These things did not happen.

(c) His room was frequently dirty, with the handrails and frame of his bed covered in feces, dried food from his feeding tube on the floor, and his roommate's bed pan full of urine.

(d) Confidential Witness #37 frequently found her brother wearing a hospital gown when she came to visit, despite the fact that she brought him clothing and asked staff to dress him. During her visits, she would have to find a CNA and ask that they dress him. She does not think he was dressed at all on days when she did not visit.

(e) The facility did not bathe him frequently enough. He told Confidential Witness #37, using his communication board, that he was not being bathed, and she thinks he got one or two showers per month. He always

appeared dirty, with ear wax coming out of his ears, dried food caked up around his feeding tube, and mucus, skin flakes, and other debris in his beard. He had a beard because facility staff did not shave him, even though she purchased an electric razor and asked them to. His fingernails were always dirty, and the facility did not cut them. Once, she complained to the Administrator that her brother's nails were too long, and the Administrator told her that clipping his nails and shaving him were Confidential Witness #37's responsibilities.

(f) Her brother needed to have his mouth swabbed several times per day, because his mouth is constantly dry because he does not eat and drink like most people. However, staff did not do this. He often had material caked around his mouth, and his teeth declined while he was at the facility. He had to have six teeth extracted after he left West Shore.

(g) Every time she visited her brother, his diaper was full—sometimes so full that feces leaked out of it. She always had to ask for a staff member to come change him. She also frequently saw other residents at the facility with wet spots on their pants, and the residents' wheelchairs in the dining room and activities room often had fresh puddles of urine on them.

(h) CNAs frequently failed to put her brother's glasses on. The only two things he could do for enjoyment were visiting with guests and watching TV, and he could not watch TV without his glasses.

(i) Her brother's physical and mental condition declined significantly while he was at West Shore. After many hospitalizations, she was eventually

able to move him to a different nursing home, and with better care, he has significantly improved.

232. Inspectors from DOH have also found that West Shore violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) On February 29, 2008, the facility received a deficiency for failing to reposition a resident. The resident's records had dozens of missing entries documenting repositioning. The resident told surveyors that staff did not turn her every two hours unless she asked them to.

(b) On July 10, 2008, the facility received a deficiency for failing to treat residents with dignity. One resident rang her call bell at 9:30 a.m.; a CNA responded to her room at 11:40 a.m., laid the resident on her bed, removed the covers without pulling the privacy curtain and left the room again until 11:55 a.m. The resident later activated her call light again, because she needed to be changed. A CNA came to her room to ask the resident what she wanted for lunch, but said she could not provide care while passing lunch trays. She did not assist the resident with incontinence care until an hour later.

(c) On September 12, 2008, the facility was given a deficiency for failing to adequately supervise residents. A resident who needed the assistance of two CNAs for care was receiving care in bed from only one CNA, and fell out of bed, face down, with injuries to nose and hips.

(d) On November 13, 2009, the facility received a deficiency for failing to prevent a decrease in range of motion for one resident. The resident was

supposed to wear a splint on her left ankle to prevent further decline in range of motion and help her to walk. Surveyors observed the resident several times throughout the survey without the ankle splint.

(e) The facility received another deficiency on November 13, 2009 for failing to document repositioning. A resident was supposed to be repositioned every two hours, for toileting, meals, and supervised activities every shift. The resident's records for September 2009 did not have repositioning documented for the 7 a.m. – 3 p.m. shift for 10 out of 30 days, and no documentation of repositioning whatsoever for the other two shifts. For October and November 2009, there was no documentation of repositioning at all.

(f) On February 23, 2010, the facility received a deficiency for failing to develop an updated care plan for a resident who experienced a significant decline in bowel and bladder continence. The resident's care plan for January and February 2010 did not include urinary incontinence as a problem area, nor were any interventions planned to address the decline in the resident's continence.

(g) On October 21, 2010, the facility was given a deficiency for failing to ensure that call bells were accessible to six residents. Three residents' call bells were lying on the floor beside their beds, one resident's call bell was behind her pillow, and two residents' call bell cords were wrapped around the side rail of their beds. Three of the residents told the surveyors they

did typically use their call bells, but they could not reach their call bells at that time.

(h) On January 20, 2011, the facility received a deficiency for failing to keep a resident safe. A resident on Hospice care with end stage dementia was left by a CNA in the dining room in her wheelchair near a heater for over two hours. The resident was sent to the emergency room, where she was treated for first and second degree burns.

(i) On May 15, 2013, the facility received a deficiency for not providing adequate supervision to prevent accidents. A resident who was a fall and elopement risk was "found off unit" on at least one occasion and fell five times between October 20, 2012 and April 12, 2013. The resident was to be closely supervised and kept in view at high risk times, such as change of shift. On April 12, 2013, around the change of shift at 3 p.m., another resident reported to the nurse that the resident was lying on the ground outside her window. The resident was found outside, face down, bleeding from her face.

(j) On May 15, 2013, the facility received another deficiency for not treating residents with dignity by providing personal grooming services. Two female residents had thick facial hair above their mouths and under their chins. The Clinical Director said the residents are groomed twice per week on shower days, but CNAs should remove facial hair immediately.

(k) On January 22, 2014, the facility received a deficiency for failing to provide oral care to one resident and apply TED hose (compression socks

which help relieve leg and foot pain and promote blood circulation) to another. A resident was to receive mouth care every shift, but there was no documentation of mouth care having been provided on 14 shifts in December 2013, and 11 shifts between January 1 and 22, 2014. The resident was also to use a lip plate with all meals, but there was no documentation of its use for 13 meals in December 2013, and 11 meals between January 1 and 22, 2014. Another resident had physician's orders to wear TED hose all day, applied in the morning and removed in the evening. Surveyors saw the resident during the survey between 11:30 a.m. and 1:30 p.m. not wearing the TED hose. A CNA assigned to the resident told surveyors she did not know why he did not have them on, nor did she know where they were or if he had more than one pair.

(l) On September 11, 2014, the facility was given a deficiency for not providing showers to a resident who needed staff assistance. The resident was supposed to have a shower twice a week and was totally dependent on staff for bathing. The bathing report showed the resident had only been given a shower on three days between August 12, 2014 and September 11, 2014. The facility could not explain why she was not showered regularly.

233. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at West Shore are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of West Shore's self-reported staffing data.

Y. Omissions of Care at Golden LivingCenter – York Terrace

234. Confidential Witness #18 worked as a CNA at York Terrace from 2007 to 2011. She started on the 3 p.m. – 11 p.m. shift, but later moved to the 7 a.m. to 3 p.m. shift. She was typically assigned to care for 15 residents.

235. According to Confidential Witness #18:

(a) Some CNAs never changed residents' diapers, and residents frequently went without being changed for an entire shift or were changed just once a day. Confidential Witness #18 tried her best to get to the residents as often as she could, but she was usually only able to change them once a shift. She was just too busy and there were too many residents.

(b) She cut corners on dressing and bathing by only doing a quick wipe down of the resident. Some CNAs would only dress residents and do no washing at all. The CNAs had to cut corners or they would never get their work done. Residents were supposed to get showers twice a week, but sometimes there was no time for showers. This occurred a lot on the 3 p.m. to 11 p.m. shift, because they were often short staffed on that shift.

(c) Some residents had to wait a long time to get fed, and the food would be cold by the time the CNAs got to them. CNAs handed out ice water in the morning, but sometimes they could not get around to doing a refill later in the shift. She remembers a few residents who got dehydrated and needed treatment.

(d) Resident records were not always accurate. Managers would tell the CNAs to write down that they had provided care even if it was not done.

Additionally, when residents fell, the nurses didn't always chart what happened or report it like they were supposed to.

(e) Managers knew when DOH inspections were coming, and they would rush to make sure everything was set for the inspection. They also got extra staff for inspection days. In her opinion, the facility should have had this level of staff all of the time.

236. Confidential Witness #19 worked as a CNA at York Terrace from 2012 to 2014. She usually worked the overnight shift, from 11 p.m. to 7 a.m., and she was typically responsible for 21-22 residents.

237. According to Confidential Witness #19:

(a) She did not have enough time to finish her work because there was not enough staff.

(b) Confidential Witness #19 did not do ROMs with the residents because there was not enough time, but she charted that she did. CNAs were told to chart that they did ROMs with residents, because the Director of Nursing said that lifting the residents' arms and legs while dressing them constituted ROMs.

(c) She had to give showers to 2-3 residents during her shift. The CNAs were told that they had 15 minutes to shower residents. However, even when she rushed through showers, it took her 20-25 minutes, and then she spent at least an additional 10 minutes dressing the residents. She was sometimes unable to provide residents with oral care, and she always had to skip putting skin cream on their bodies after their showers. She had to

start waking residents up around 4:30 a.m. to begin showers so that she could get everything done before her shift ended at 7 a.m.

(d) Call lights were supposed to be answered within two minutes, but CNAs were usually too busy to get to them on time, so residents had to wait up to 30 minutes for a response. A few residents' family members started staying overnight with the residents to time how long it took to get a response to the call lights. When the administrators found out about this, they told the CNAs to answer call lights from the residents whose family members were present first, no matter what they needed, and then answer the rest of the call lights.

(e) Residents who were aware of their surroundings and who could communicate received better care than the residents who could not communicate, because they could complain to their family members, who complained to the administrator.

238. Inspectors from DOH have also found that York Terrace violated state and federal nursing home regulations by failing to provide Basic Care and failing to keep accurate records. For example:

(a) During an annual licensure survey completed on October 2, 2008, surveyors found two deficiencies related to Basic Care. One resident was supposed to have splints to prevent further range of motion decline. The resident's record said they were applied, but surveyors observed that the resident did not have them on during the documented days and times. Another resident was also seen without physician-ordered splints.

(b) York Terrace received a second deficiency at this survey for not following a resident's feeding plan. The resident was supposed to be put in a wheelchair for meals, and have extensive supervision and instruction. Surveyors saw the resident in her room in bed, and saw an aide leave the resident's breakfast tray on her table and leave the room. Twenty minutes later, the resident was picking at her food with her fingers but was unable to feed herself. She said, "I am hungry but can't do it."

(c) During the annual licensure survey of October 21, 2010, York Terrace received a deficiency for failing to help residents maintain range of motion. Splints were supposed to be applied every morning to prevent contractures. Surveyors observed the resident throughout the morning without splints.

(d) York Terrace received a deficiency for failing to develop a comprehensive care plan during the annual licensure survey completed on September 27, 2013. Surveyors found there was no plan in place for a resident admitted with incontinence and with a history of falls.

239. The omissions of Basic Care described by witnesses and documented in DOH deficiencies at York Terrace are, on information and belief, representative of typical conditions at this facility, based on the OAG's analysis of York Terrace's self-reported staffing data.

VII. GOLDEN LIVING'S WILLFUL FAILURE TO PROVIDE ADEQUATE CNA STAFFING

240. Defendants' deceptive and misleading conduct – as alleged herein – is part of a willful, calculated effort to recruit residents and secure payments for their care while not providing the staffing necessary to meet their needs.

241. Golden Living marketing materials are, on information and belief, generated and approved on a centralized basis by managers at the highest levels of the company.

242. Bills for resident care are also generated by corporate-level employees on behalf of the Golden Living Facilities.

243. Because of their ownership of and ability to control the Golden Living Facilities, the corporate-level managers also had the right to – and, on information and belief, actually did – monitor and manage key details of the Golden Living Facilities' operations, such as monitoring daily census levels, controlling facility budgets, and monitoring DOH survey results.

244. As a result, these corporate-level managers knew or should have known that the CNA staffing levels at the Golden Living Facilities were far below what was required to provide the care that residents needed and that had been promised to them.

245. Facility-level managers were also aware that CNA staffing levels at their facilities were well below what was required to provide the care that residents needed and that had been promised to them. They were physically present on-site, and were therefore able to personally observe conditions at the facilities. Furthermore, CNAs routinely complained to managers about inadequate staffing.

246. The conduct of facility-level managers during DOH surveys also demonstrates their awareness that the facilities were inadequately staffed. They increased staffing levels and/or personally assisted with Basic Care during DOH surveys. Had ordinary staffing levels been adequate, these additional measures would not have been needed when DOH inspectors were on-site.

247. Both facility-level and corporate-level managers were or should have been aware that the raw staffing numbers at the Golden Living Facilities were inadequate to meet the needs

of residents. The Institute of Medicine – the health arm of the National Academy of Sciences – has recommended that skilled nursing facilities provide a minimum of 2.8 hours of CNA care per patient day ("PPD") to provide Basic Care to residents. According to the labor data reported by Golden Living to CMS during the period 2008 through 2014, all Golden Living facilities in Pennsylvania provided, on average, 1.86 hours of CNA care per patient day. These CNA staffing levels consistently fall well below the Institute of Medicine's recommended minimum, often falling short by as much as one hour of care per patient day.

VIII. LIABILITY OF GOLDEN LIVING PARENT ENTITIES

248. GGNSC Holdings LLC, Golden Gate National Senior Care LLC, GGNSC Clinical Services LLC, and GGNSC Administrative Services LLC (hereinafter the "Golden Living Parent Entities") are responsible for both their own conduct, as alleged herein, and for the actions and omissions of the Golden Living Facilities.

249. GGNSC Holdings LLC (doing business under the name, and referred to herein as, "Golden Horizons") and its direct and indirect subsidiaries are a highly integrated family of companies. Operating under the brand name "Golden Living," Golden Horizons operates more than 300 skilled nursing facilities in 21 states, including the Golden Living Facilities at issue in this case.

250. Many of the misrepresentations made to the Commonwealth and to Pennsylvania consumers, as alleged herein, were made, upon information and belief, directly by one or more of the Golden Living Parent Entities. For example:

(a) Brochures and other marketing materials disseminated at www.goldenliving.com.

(b) Reimbursement requests submitted to the Commonwealth for the per diem rate for residents in the Medical Assistance Program.

251. To the extent that other misrepresentations were made by employees of the individual Golden Living Facilities, the Golden Living Parent Entities are also responsible for this deceptive and misleading conduct under a theory of alter ego or vicarious liability. The Golden Living Parent Entities are also responsible for the Golden Living Facilities' breach of their Nursing Facility Provider Agreements with the Commonwealth under a theory of alter ego or vicarious liability.

252. Golden Horizons directly or indirectly owns each of the other Golden Living Parent Entities as well as each of the Golden Living Facilities.

253. On information and belief, Golden Horizons exercises pervasive, day-to-day control over the operations of the Golden Living Facilities through the actions of its other subsidiaries, the other Golden Living Parent Entities.

254. Golden Gate National Senior Care LLC (doing business under the name, "Golden Living") is owned by Golden Horizons. It provides administrative services to the Golden Living Facilities and is the recipient of significant sums of money from the Golden Living Facilities each year in exchange for these services. For example, between 2008 and 2013, the following sums of money were paid by several Golden Living Facilities to Golden Gate National Senior Care LLC in "Home Office" administrative costs:

Facility	**Payments 2008-2013**
Clarion	$256,484
Gettysburg	$278,370
Lancaster	$344,308
Scranton	$334,850
Stenton	$254,364
Summit	$322,005
Tunkhannock	$336,402
Western Reserve	$363,303

On information and belief, similar amounts were paid in "Home Office" administrative costs to Golden Gate National Senior Care LLC by Golden Living's other skilled nursing facilities in Pennsylvania.

255. GGNSC Clinical Services, LLC is, in turn, owned by Golden Living (which, as noted above, is owned by Golden Horizons). It provides administrative, nursing-related, dietary-related, and social service-related services to the Golden Living Facilities and is the recipient of significant sums of money from the Golden Living Facilities each year. For example, between 2008 and 2013, the following sums of money were paid by several Golden Living Facilities to GGNSC Clinical Services, LLC in administrative, nursing-related, dietary-related, and social service-related costs:

Facility	**Payments 2008-2013**
Clarion	$349,972
Gettysburg	$367,715
Lancaster	$475,350
Scranton	$452,612
Stenton	$356,370
Summit	$442,096
Tunkhannock	$484,087
Western Reserve	$475,624

On information and belief, similar amounts were paid in administrative, nursing-related, dietary-related, and social service-related costs to GGNSC Clinical Services, LLC by Golden Living's other skilled nursing facilities in Pennsylvania.

256. GGNSC Administrative Services LLC (doing business under the name, and referred to herein as, "Golden Ventures") is owned by Golden Horizons. It provides administrative services to the Golden Living Facilities, including compiling and submitting each facility's required Medical Assistance Program cost report to the Commonwealth and compiling

and submitting claims for reimbursement for resident care under the Medical Assistance Program. It is also the recipient of significant sums of money from the Golden Living Facilities each year. For example, between 2008 and 2013, the following sums of money were paid by several Golden Living Facilities to Golden Ventures in administrative costs:

Facility	**Payments 2008-2013**
Clarion	$2,019,195
Gettysburg	$2,178,601
Lancaster	$2,696,142
Scranton	$2,589,868
Stenton	$1,986,053
Summit	$2,514,990
Tunkhannock	$2,624,782
Western Reserve	$2,825,330

On information and belief, similar administrative costs were paid to Golden Ventures by Golden Living's other skilled nursing facilities in Pennsylvania.

257. However, the relationship between each of the Golden Living Facilities and Golden Gate National Senior Care LLC, GGNSC Clinical Services LLC, and Golden Ventures is not a typical arm's length relationship, in which one business contracts with another to provide services at its direction. On information and belief, the Golden Living Facilities do not provide direction to or exercise any measure of control over Golden Gate National Senior Care LLC, GGNSC Clinical Services LLC, or Golden Ventures, nor do the Golden Living Facilities direct the services that these entities provide to them. Rather, these Golden Living Parent Entities exercise pervasive day-to-day control over the Golden Living Facilities – at the direction of the ultimate parent company, Golden Horizons. The Golden Living Facilities are then, in turn, required to pay each of these Golden Living Parent Entities for these services.

258. The Golden Living Parent Entities exercise control over the Golden Living Facilities by, for example:

(a) Restricting the ability of the Golden Living Facilities' managers to increase staffing levels;

(b) Supervising – and in some cases, overriding – the personnel decisions of the Golden Living Facilities;

(c) Visiting facilities, observing care, and enforcing corporate-level policies;

(d) Preparing and submitting requests for reimbursement and required cost reports under the Medical Assistance Program in Pennsylvania;

(e) Creating and implementing company-wide policies and incentive programs;

(f) Requiring centralized reporting of key data points – such as daily reporting of census information – from the Golden Living Facilities to the Golden Living Parent Entities;

(g) Maintaining a company-wide Customer Compliance Hotline for residents to call if they have raised a concern with facility staff but still feel that their concern has not been addressed to their satisfaction.

259. Payments made by the Golden Living Facilities to the Golden Living Parent Entities also provide one mechanism by which the significant profits of the Golden Living Facilities are siphoned out of the facilities and transferred to Golden Horizons and likely, ultimately, to the ultimate owner of the company: Fillmore Capital Partners.

260. The Golden Living Facilities are enormously profitable. For example, the following is a summary, by year, of the net revenue and profit or loss reported to the Commonwealth by several of Golden Living's facilities in Pennsylvania from 2008 – 2013:

Nursing Home	**Year**	**Net Revenue**	**Profit or (Loss)**
Clarion	2008	$5,183,579	($28,651)

	2009	$5,745,112	$270,781
	2010	$6,514,627	$564,068
	2011	$6,875,169	$922,100
	2012	$6,157,217	$59,575
	2013	$5,863,177	($111,109)
	TOTAL	**$36,338,881**	**$1,676,764**
Gettysburg	2008	$7,794,720	$559,256
	2009	$8,650,685	$980,313
	2010	$8,732,576	$787,138
	2011	$8,736,378	$559,198
	2012	$8,460,002	$431,568
	2013	$8,141,098	($59,473)
	TOTAL	**$50,515,459**	**$3,258,000**
Kinzua	2008	$7,387,142	$943,912
	2009	$8,324,437	$1,796,902
	2010	$8,378,299	$1,550,617
	2011	$8,841,806	$1,514,866
	2012	$8,780,292	$1,295,242
	2013	$8,365,833	$1,083,473
	TOTAL	**$50,077,809**	**$8,185,012**
Lancaster	2008	$8,940,558	$798,359
	2009	$9,172,379	$807,100
	2010	$10,652,070	$1,638,621
	2011	$10,853,278	$1,074,698
	2012	$10,524,233	$126,326
	2013	$10,036,734	($946,396)
	TOTAL	**$60,179,252**	**$3,498,708**
Scranton	2008	$10,801,522	$1,295,149
	2009	$10,179,529	$1,101,442
	2010	$10,015,457	$407,041
	2011	$10,841,845	$498,180
	2012	$9,914,985	($162,039)
	2013	$10,171,814	($47,126)
	TOTAL	**$61,925,152**	**$3,092,647**
Stenton	2008	$8,549,500	$1,530,798
	2009	$9,273,245	$1,515,048
	2010	$9,857,329	$1,661,734
	2011	$10,622,990	$2,019,566
	2012	$8,726,671	$847,594
	2013	$8,152,110	($556,572)

	TOTAL	**$55,181,845**	**$7,018,168**
Summit	2008	$9,422,514	$898,345
	2009	$9,035,250	$519,192
	2010	$10,189,757	$1,053,269
	2011	$9,903,447	$712,450
	2012	$9,875,811	$309,321
	2013	$9,295,822	$296,959
	TOTAL	**$57,722,601**	**$3,789,536**
Tunkhannock	2008	$9,954,592	$1,556,995
	2009	$9,654,008	$1,038,996
	2010	$9,458,369	$506,132
	2011	$9,985,253	$677,410
	2012	$10,251,448	$708,938
	2013	$10,322,771	$963,111
	TOTAL	**$59,626,441**	**$5,451,582**
Western Reserve	2008	$11,153,732	$1,555,422
	2009	$11,821,071	$1,849,452
	2010	$10,931,919	$1,053,707
	2011	$11,680,940	$1,329,914
	2012	$11,240,769	$838,815
	2013	$11,207,095	$867,853
	TOTAL	**$68,035,526**	**$7,495,163**
William Penn	2008	$9,742,491	$1,887,746
	2009	$9,870,170	$1,779,599
	2010	$10,280,767	$1,708,994
	2011	$11,064,088	$1,874,094
	2012	$11,369,979	$1,469,276
	2013	$11,595,490	$1,694,914
	TOTAL	**$63,922,985**	**$10,414,623**

These figures reflect the profits as stated in annual cost reports submitted by the facilities to the Commonwealth. However, these calculations of profit do not take into account certain adjustments made to the reported expenses in these cost reports. On information and belief, each facility's true profitability is significantly higher – as much as double the reported profits.

261. Despite these large profits, each facility's cash balance at year-end is trivial. This fact, in combination with other transactions recorded on the balance sheets in these cost reports, indicates that significant resources are often transferred out of these facilities.

262. On information and belief, these transfers of resources out of the facilities increased in the years 2011 through 2013 – at roughly the same time that many of the facilities began reporting lower profits than they had in previous years. On information and belief, these lower reported profits do not actually reflect a decrease in the profitability of these facilities. Rather, they reflect an increase in the use of accounting mechanisms to transfer assets – such as accounts receivable – out of the facilities and into the hands of the Golden Living Parent Entities and/or their investors.

263. On information and belief, no consideration was provided by the Golden Living Parent Entities in exchange for these transfers of assets out of the Golden Living Facilities.

264. In addition to siphoning assets out of the Golden Living Facilities, the Golden Living Parent Entities also failed to respect the corporate boundaries of their subsidiaries in other ways. For example, the Golden Living Facilities do not own the real property at which their facilities are located, but according to the cost reports they submit to the Commonwealth, they pay the real estate taxes for these properties and record depreciation on their balance sheet for these properties.

IX. CLAIMS FOR RELIEF

A. Count I: Violations of the Unfair Trade Practices and Consumer Protection Law, 73 P.S. §§ 201-1-201.9.3

265. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs as if fully set forth herein at length.

266. The Golden Living Facilities and Golden Living Parent Entities willfully made representations to Pennsylvania consumers that they would provide the Basic Care required by their residents when the Golden Living Facilities did not, as a matter of practice, provide staff adequate to meet the needs of their residents and did, in fact, fail to provide a significant percentage of the care required by their residents.

267. These deceptive, misleading, and unfair representations were made in:

(a) marketing of skilled nursing services on Defendants' websites to Pennsylvania consumers;

(b) marketing materials;

(c) care plans shared with residents that outlined the care that the Facilities promised to provide; and

(d) billing statements that included a per diem charge leading recipients to believe that all services had been provided.

268. These deceptive, misleading, and unfair representations were of the type that would create a likelihood of confusion or misunderstanding for Pennsylvania consumers and were particularly misleading to the elderly and infirm residents and their families, who often faced an urgent need for skilled long-term care.

269. The Golden Living Facilities additionally made deceptive and misleading representations to the Commonwealth in the Minimum Data Sets (MDSs) that were submitted to the Commonwealth on a quarterly basis (or more frequently) for each resident covered by Medicaid and monthly billing statements submitted for Medicaid payments. These MDSs and billing statements created the impression that the Golden Living Facilities had provided, and would continue to provide, a level of care that was not provided.

270. The Golden Living Facilities' deceptive, misleading, and unfair statements and practices are in violation of:

(a) 73 P.S. § 201-2(4)(v), which prohibits representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits or quantities that they do not have;

(b) 73 P.S. § 201-2(4)(ix), which prohibits advertising goods or services with intent not to sell them as advertised;

(c) 73 P.S. § 201-2(4)(x), which prohibits advertising goods or services with intent not to supply reasonably expectable public demand, unless the advertisement discloses a limitation of quantity; and

(d) 73 P.S. § 201-2(4)(xxi), which prohibits engaging in any other fraudulent or deceptive conduct which creates a likelihood of confusion or misunderstanding.

271. The Consumer Protection Law empowers the Court to impose a civil penalty not exceeding $1,000 for each willful violation of the Act and a penalty not exceeding $3,000 for each violation where the victim is sixty years of age or older. The Commonwealth therefore asks that the Court assess a civil penalty for each violation of the Act.

272. The Commonwealth also seeks injunctive relief and restitution or restoration, as authorized under § 73-201-4 and § 73-201-4.1, including monies which were paid by consumers and the Commonwealth in the form of per diem payments and acquired by Defendants by means of the alleged violations of the Consumer Protection Law.

WHEREFORE, the Commonwealth respectfully requests that the Court enter an order granting permanent injunctive relief prohibiting Defendants from engaging in the

deceptive and unlawful conduct described herein, and enter judgment against the Defendants for the services not performed or improperly performed in an amount to be proven at trial, restitution, restoration, civil penalties, costs of suit, attorneys' fees, interest, and such other relief as the Court deems proper.

B. Count II: Breach of Contract

273. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs as if fully set forth herein at length.

274. The Golden Living Facilities agreed to provide Medicaid-funded services to Medicaid-eligible Pennsylvanians in accordance with all applicable state and federal laws and regulations, and the regulations and standards of the Pennsylvania Medical Assistance Program. Under the express terms of the Nursing Facility Provider Agreements, the Golden Living Facilities agreed to bill the Commonwealth only for services provided.

275. The Golden Living Facilities, at all times material hereto, breached their Nursing Facility Provider Agreements by submitting billings for care not rendered, or for care rendered in a manner that was substantially inadequate when compared to generally recognized and legally mandated standards within the discipline or industry.

276. As a direct and proximate result of the Defendants' submission of billings for services not rendered, or rendered in a manner that was substantially inadequate when compared to generally recognized and legally mandated professional standards within the discipline or industry, the Commonwealth has been damaged by the Golden Living Facilities' breach of contract in an amount to be proven at trial.

277. The Commonwealth is entitled to recover the value of all contracted services not performed, or improperly performed, under the Nursing Facility Provider Agreement, in an

amount to be proven at trial, together with costs of suit, attorneys' fees, interest, and such further relief as the Court deems proper.

WHEREFORE, the Commonwealth respectfully requests that the Court enter an order declaring the Golden Living Facilities in breach of their contracts with the Commonwealth, and enter judgment against the Defendants for the services not performed or improperly performed in an amount to be proven at trial, interest, and such other relief as the Court deems proper.

C. Count III: Unjust Enrichment

278. The Commonwealth incorporates by reference the allegations included in the preceding paragraphs as if fully set forth herein at length.

279. The Golden Living Parent Entities and GGNSC Equity Holdings LLC were unjustly enriched through the actions of each of the Golden Living Facilities. The Golden Living Facilities submitted billings to the Pennsylvania Medical Assistance Program for care not rendered or for care rendered in a manner that was substantially inadequate when compared to generally recognized and legally mandated standards within the discipline or industry. The Commonwealth reimbursed the Golden Living Facilities for the per diem rates claimed on these billings. The Golden Living Facilities did not, however, provide all of the care that should have been covered under the per diem rate and thereby benefited from receipt of the Commonwealth's payments.

280. On information and belief, the Golden Living Facilities acted at the direction of, under the control of, and for the benefit of the Golden Living Parent Entities and GGNSC Equity Holdings LLC, and profits wrongfully attained, at the Commonwealth's expense, were transferred to the Golden Living Parent Entities and GGNSC Equity Holdings LLC.

281. The Golden Living Parent Entities and GGNSC Equity Holdings LLC have been unjustly enriched at the expense of the Pennsylvania Medical Assistance Program and the Commonwealth. This Court should find that the Golden Living Parent Entities and GGNSC Equity Holdings LLC have been unjustifiably enriched and order them to disgorge all monies received as a result of their unlawful actions.

WHEREFORE, the Commonwealth respectfully requests that the Court enter an order declaring the Golden Living Parent Entities and GGNSC Equity Holdings LLC unjustly enriched, and enter judgment against the Golden Living Parent Entities and GGNSC Equity Holdings LLC in an amount equal to the monies received by them from the Golden Living Facilities, interest, and such other relief as the Court deems proper.

Demand for Jury Trial

The OAG demands trial by jury in this action of all issues so triable.

Respectfully Submitted,

KATHLEEN G. KANE
Attorney General

Bruce R. Beemer
First Deputy Attorney General

James A. Donahue, III
Executive Deputy Attorney General

Date: September 8, 2015

By: Thomas M. Devlin

Thomas M. Devlin
Chief Deputy Attorney General
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Public Protection Division
Office of Attorney General
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EXHIBIT A

10552914_0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program, and

Whereas Beverly Healthcare - Blue Ridge Mountain, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Blue Ridge Mountain
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Harrisburg GP LLC (General Partner of GGNSC Harrisburg LP)
Title

Signature

10154884-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Cambridge Springs, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Cambridge Springs
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Cambridge Springs GP LLC (General Partner of GGNSC Cambridge Springs LP)
Title

Signature

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Cambridge Springs Rehabilitation & Nursing Center, LLC, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 01/01/2010 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Cambridge Springs Rehabilitation & Nursing Center, LLC
Nursing Facility Name

Auth. Member
Title

12/31/09
Date

Signature

15

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LONG TERM LIVING
BUREAU OF PROVIDER SUPPORT

SPECIAL PROVIDER AGREEMENT

WHEREAS, the Department of Public Welfare administers the Pennsylvania Medical Assistance Program; and

WHEREAS, pursuant to 55 Pa. Code § 1101.43(b)(3), when nursing facility providers change owners, the new owner may not be enrolled as a provider until the conditions in the regulations are complied with; and

WHEREAS, an application for enrollment has been made by the below-signing applicant; and

WHEREAS, the below-signing applicant is the new owner of a nursing facility which was an enrolled provider prior to the change in ownership; and

WHEREAS, the below-signing applicant wishes to enroll in the Medical Assistance Program prior to the former owner meeting the condition of 55 Pa. Code § 1101.43(b) (3) (iii); and

WHEREAS, the Department of Public Welfare is willing to permit such an exception to its regulations in consideration of the new and former owner entering into this agreement; and

WHEREAS, the former owner and the below-signing applicant wish to enter into this agreement in order to finalize the transfer as between them and as necessary consideration to their bargain;

NOW, THEREFORE, in consideration of the foregoing and of the following, the parties agree and witness that:

1. The Department of Public Welfare shall not consider 55 Pa. Code §1101.43(b)(3)(iii) in determining whether the below-signing applicant is eligible for enrollment as a provider; however, all other regulatory criteria will continue to be applicable and the Department may, in its discretion, refuse to enroll the below-signing applicant.

2. The below-signing applicant warrants that it is seeking the enrollment of one specific licensed nursing facility

3. The below-signing applicant hereby expressly assumes any and all liability and rights of former owner with respect to overpayments made to the former owner by the Department for services to Medical Assistance residents; however, the former owner shall continue to have the duty to maintain documents, provide access to documents, and file cost reports, with respect

to its period of ownership, and shall remain liable for any penalties, damages, or fines for any abuse or misconduct during such periods; and the Department shall remit any underpayments only to the order of the former owner.

4. The former owner shall hold the below-signing applicant harmless from any liability assumed in Paragraph 3, above, including the costs of litigation, and it shall have the right to control the defense against any liability which the Department seeks to impose on the below-signing applicant as to periods of operation by the former owner.

5. The below-signing applicant shall have the right to offset against any debt due from it to the former owner the amount of any liability, including any costs of litigation incurred by it because of the former owner's unreasonable failure to defend, as a result of Paragraph 3, above.

6. All audit reports and settlements issued hereafter shall be sent by the Department of Public Welfare to the below-signing applicant at its latest address of record with the Division of Provider Services, if and only if it is in fact enrolled as a provider.

WHERETO, the parties agree this 1st day of January, 2010

GGNSC Cambridge Springs GP LLC, on behalf of GGNSC Cambridge Springs LP

Golden Living Center - Cambridge Springs
Name of Facility (current/former name)

Former Owner Signature

Holly A. Rasmussen-Jones, Secretary
Printed Name/Title of Former Owner

Cambridge Springs Rehabilitation & Nursing Center
New Name of Facility (if applicable)

Cambridge Springs Rehabilitation & Nursing Center, LLC
Name of Applicant/Legal Entity

Signature of Applicant (new owner)

Nathan Syra Asst Member
Printed Name/Title of Applicant (new owner)

Office of Long Term Living Representative
Bureau of Provider Support

Revised 4/09

10/553090-0021

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Camp Hill, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Camp Hill
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Camp Hill III GP LLC (General Partner of GGNSC Camp Hill III LP)
Title

Signature

10154895S-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Canonsburg, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Canonsburg
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Canonsburg GP LLC (General Partner of GGNSC Canonsburg LP)
Title

Signature

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Clarion, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Clarion
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Clarion GP LLC (General Partner of GGNSC Clarion LP)
Title

Signature

10/555228-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Doylestown Manor, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Doylestown Manor
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Doylestown GP LLC (General Partner of GGNSC Doylestown LP)
Title

Signature

10154913/- 0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - East Mountain, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1 That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

(b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

(c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - East Mountain
Nursing Facility Name

4/27/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Wilkes-Barre East Mountain GP LLC (General Partner of GGNSC Wilkes-Barre East Mountain LP)
Title

Signature

10154953A-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Erie (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Erie
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Erie II GP LLC (General Partner of GGNSC Erie II LP)
Title

Signature

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Golden LivingCenter - Walnut Creek, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

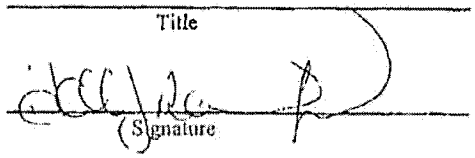
   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 11/23/2009 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Golden LivingCenter - Walnut Creek	Secretary
Nursing Facility Name	Title
12/02/2009	
Date	(Signature)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LONG TERM LIVING
BUREAU OF PROVIDER SUPPORT

SPECIAL PROVIDER AGREEMENT

WHEREAS, the Department of Public Welfare administers the Pennsylvania Medical Assistance Program; and

WHEREAS, pursuant to 55 Pa. Code § 1101.43(b)(3), when nursing facility providers change owners, the new owner may not be enrolled as a provider until the conditions in the regulations are complied with; and

WHEREAS, an application for enrollment has been made by the below-signing applicant; and

WHEREAS, the below-signing applicant is the new owner of a nursing facility which was an enrolled provider prior to the change in ownership; and

WHEREAS, the below-signing applicant wishes to enroll in the Medical Assistance Program prior to the former owner meeting the condition of 55 Pa. Code § 1101.43(b) (3) (iii); and

WHEREAS, the Department of Public Welfare is willing to permit such an exception to its regulations in consideration of the new and former owner entering into this agreement; and

WHEREAS, the former owner and the below-signing applicant wish to enter into this agreement in order to finalize the transfer as between them and as necessary consideration to their bargain;

NOW, THEREFORE, in consideration of the foregoing and of the following, the parties agree and witness that:

1. The Department of Public Welfare shall not consider 55 Pa. Code §1101.43(b)(3)(iii) in determining whether the below-signing applicant is eligible for enrollment as a provider; however, all other regulatory criteria will continue to be applicable and the Department may, in its discretion, refuse to enroll the below-signing applicant.

2. The below-signing applicant warrants that it is seeking the enrollment of one specific licensed nursing facility

3. The below-signing applicant hereby expressly assumes any and all liability and rights of former owner with respect to overpayments made to the former owner by the Department for services to Medical Assistance residents; however, the former owner shall continue to have the duty to maintain documents, provide access to documents, and file cost reports, with respect

to its period of ownership, and shall remain liable for any penalties, damages, or fines for any abuse or misconduct during such periods; and the Department shall remit any underpayments only to the order of the former owner.

4. The former owner shall hold the below-signing applicant harmless from any liability assumed in Paragraph 3, above, including the costs of litigation, and it shall have the right to control the defense against any liability which the Department seeks to impose on the below-signing applicant as to periods of operation by the former owner.

5. The below-signing applicant shall have the right to offset against any debt due from it to the former owner the amount of any liability, including any costs of litigation incurred by it because of the former owner's unreasonable failure to defend, as a result of Paragraph 3, above.

6. All audit reports and settlements issued hereafter shall be sent by the Department of Public Welfare to the below-signing applicant at its latest address of record with the Division of Provider Services, if and only if it is in fact enrolled as a provider.

WHERETO, the parties agree this 16th day of December, 20 09

Golden LivingCenter - Erie
Name of Facility (current/former name)

Former Owner Signature

Holly Rasmussen-Jones, Secretary
Printed Name/Title of Former Owner

Golden LivingCenter - Walnut Creek
New Name of Facility (if applicable)

Erie Operating LLC
Name of Applicant/Legal Entity

Signature of Applicant (new owner)

Holly Rasmussen-Jones, Secretary
Printed Name/Title of Applicant (new owner)

Office of Long Term Living - Representative
Bureau of Provider Support

Revised 4/09

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Gettysburg, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Gettysburg
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Gettysburg GP LLC (General Partner of GGNSC Gettysburg LP)
Title

Signature

10155750-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Halda, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Halda
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Hastings GP LLC (General Partner of GGNSC Hastings LP)
Title

Signature

/0155 2093 – 0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Hillview, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Hillview
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Altoona Hillview GP LLC (General Partner of GGNSC Altoona Hillview LP)
Title

Signature

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program, and

Whereas Beverly Manor of Lancaster, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Manor of Lancaster
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Lancaster GP LLC (General Partner of GGNSC Lancaster LP)
Title

Signature

10/552450-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Lansdale, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Lansdale
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Lansdale GP LLC (General Partner of GGNSC Lansdale LP)
Title

Signature

10/558533 - 0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Manslon Nursing and Convalescent Home, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Mansion Nursing and Convalescent Home
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Sunbury GP LLC (General Partner of GGNSC Sunbury LP)
Title

Signature

10/558023-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program, and

Whereas Beverly Healthcare - Meyersdale, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Meyersdale
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Meyersdale GP LLC (General Partner of GGNSC Meyersdale LP)
Title

Signature

10454981 0-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Monroeville, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Monroeville
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Monroeville GP LLC (General Partner of GGNSC Monroeville LP)
Title

Signature

10154955-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Mt. Lebanon, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Mt. Lebanon
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Mt. Lebanon GP LLC (General Partner of GGNSC Mt. Lebanon LP)
Title

Signature

10/550956-001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Murrysville, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Murrysville
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Murrysville GP LLC (General Partner of GGNSC Murrysville LP)
Title

Signature

10155126 05 - 6601

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Oakmont, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06, and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Oakmont
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Oakmont GP LLC (General Partner of GGNSC Oakmont LP)
Title

Signature

10287693-0001

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF LONG TERM LIVING
BUREAU OF PROVIDER SUPPORT

SPECIAL PROVIDER AGREEMENT

WHEREAS, the Department of Public Welfare administers the Pennsylvania Medical Assistance Program; and

WHEREAS, pursuant to 55 Pa. Code § 1101.43(b)(3), when nursing facility providers change owners, the new owner may not be enrolled as a provider until the conditions in the regulations are complied with; and

WHEREAS, an application for enrollment has been made by the below-signing applicant; and

WHEREAS, the below-signing applicant is the new owner of a nursing facility which was an enrolled provider prior to the change in ownership; and

WHEREAS, the below-signing applicant wishes to enroll in the Medical Assistance Program prior to the former owner meeting the condition of 55 Pa. Code § 1101.43(b) (3) (iii); and

WHEREAS, the Department of Public Welfare is willing to permit such an exception to its regulations in consideration of the new and former owner entering into this agreement; and

WHEREAS, the former owner and the below-signing applicant wish to enter into this agreement in order to finalize the transfer as between them and as necessary consideration to their bargain;

NOW, THEREFORE, in consideration of the foregoing and of the following, the parties agree and witness that:

1. The Department of Public Welfare shall not consider 55 Pa. Code §1101.43(b)(3)(iii) in determining whether the below-signing applicant is eligible for enrollment as a provider; however, all other regulatory criteria will continue to be applicable and the Department may, in its discretion, refuse to enroll the below-signing applicant.

2. The below-signing applicant warrants that it is seeking the enrollment of one specific licensed nursing facility

3. The below-signing applicant hereby expressly assumes any and all liability and rights of former owner with respect to overpayments made to the former owner by the Department for services to Medical Assistance residents; however, the former owner shall continue to have the duty to maintain documents, provide access to documents, and file cost reports, with respect

1028716793-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Oakmont Center for Nursing & Rehabilitation, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 03-01-14 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Oakmont Center for Nursing & Rehabilitation
Nursing Facility Name

Authorized member.
Title

1/24/2013
Date

Signature

15

10155318 - 0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Oil City, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Oil City
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Oil City GP LLC (General Partner of GGNSC Oil City LP)
Title

Signature

101554730-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program, and

Whereas Beverly Healthcare - Phoenixville, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Phoenixville
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Phoenixville II GP LLC (General Partner of GGNSC Phoenixville II LP)
Title

Signature

101551372 - 0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Reading, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare- Reading
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Mount Penn GP LLC (General Partner of GGNSC Mount Penn LP)
Title

Signature

10155151A - 0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Richland, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Richland
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Johnstown GP LLC (General Partner of GGNSC Johnstown LP)
Title

Signature

101554928-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program, and

Whereas Beverly Healthcare - Rosemont, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Rosemont
Nursing Facility Name

4/3/06
Date

Vice President and Secretary, on behalf of GGNSC Rosemont GP LLC (General Partner of GGNSC Rosemont LP)
Title

Signature

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Scranton, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Scranton
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Scranton GP LLC (General Partner of GGNSC Scranton LP)
Title

Signature

101558130 - 0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Shippenville, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Shippenville
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Shippenville GP LLC (General Partner of GGNSC Shippenville LP)
Title

Signature

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Stenton, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Stenton
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Philadelphia GP LLC (General Partner of GGNSC Philadelphia LP)
Title

Signature

10155597-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Stroud, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Stroud
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC East Stroudsburg GP LLC (General Partner of GGNSC East Stroudsburg LP)
Title

Signature

1015586013-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Summit Health Care Center, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Summit Health Care Center
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Wilkes-Barre II GP LLC (General Partner of GGNSC Wilkes-Barre II LP)
Title

Signature

101558186-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program, and

Whereas Beverly Healthcare - Titusville, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Titusville
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Titusville GP LLC (General Partner of GGNSC Titusville LP)
Title

Signature

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Tunkhannock GP LLC (General Partner of GGNSC Tunkhannock LP)
Title

Signature

10155829 3-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Uniontown, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Uniontown
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Uniontown GP LLC (General Partner of GGNSC Uniontown LP)
Title

Signature

10155180D -0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Waynesburg, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Waynesburg
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Waynesburg GP LLC (General Partner of GGNSC Waynesburg LP)
Title

Signature

10/5584435.001
(Central)

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program, and

Whereas Beverly Healthcare - Warren, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Warren
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Warren II GP LLC (General Partner of GGNSC Warren II LP)
Title

Signature

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

LONG TERM CARE
PROVIDER SERVICES

P.O. BOX 8025
HARRISBURG, PENNSYLVANIA 17105-8025

717-772-2571
www.dpw.state.pa.us/omap

CERTIFIED MAIL: 7099 3400 0012 4367 4102

December 24, 2007

Ms. Cheryl Gruber
Administrator
Golden LivingCenter-Central
121 Central Avenue
Warren, Pennsylvania 16365

PROMISe No.: 1015584350001
Medicare No.: 39-5924
LSCU NO.: 2304-02

Dear Ms. Gruber:

On December 18, 2007, we received notification from the Department of Health, Division of Nursing Care Facilities that your facility consisting of 46 beds voluntarily closed on November 14, 2007.

Therefore, effective November 14, 2007, the Medical Assistance Provider Agreement issued to your facility is null and void.

In addition, effective November 14, 2007, you may no longer receive payments under the Medical Assistance Program for nursing care and services provided to medical assistance residents.

If there are any questions, please contact Kim Luciano at 717-772-2571.

Sincerely,

Bonnie L Rose
Director

BLR/KRL/crb

bcc: Mr. Bordner
Mr. Pezzuti
Mr. Williamson
Ms. Rose
Ms. Nolen
Ms. Rowe
Ms. Weidman
Ms. Lay
Ms. Luciano
Ms. Chavez/M&S
Warren CAO-MA Nsg. Hm. Supvsr.
File

Ltr. 18

10155186A-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - Western Reserve (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare, and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - Western Reserve
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Erie Western Reserve GP LLC (General Partner of GGNSC Erie Western Reserve LP)
Title

Signature

10/553/52-0001

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas West Shore Health and Rehabilitation Center, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

West Shore Health and Rehabilitation Center
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Camp Hill West Shore GP LLC (General Partner of GGNSC Camp Hill West Shore LP)
Title

Signature

1015585O6 -000 1

NURSING FACILITY PROVIDER AGREEMENT

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas Beverly Healthcare - York Terrace, (hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.

   (b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding payments the Facility has claimed.

   (c) To provide such information as may otherwise be required by state or federal law.

3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on 04/01/06 and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

Beverly Healthcare - York Terrace
Nursing Facility Name

4/3/06
Date

Vice President and Assistant Secretary, on behalf of GGNSC Pottsville GP LLC (General Partner of GGNSC Pottsville LP)
Title

Signature

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA
Acting by Attorney General.
KATHLEEN KANE,

Plaintiff,

v.

GOLDEN GATE NATIONAL SENIOR CARE LLC; GGNSC Holdings LLC; GGNSC Administrative Services LLC; GGNSC Clinical Services LLC; GGNSC Equity Holdings LLC; GGNSC Harrisburg LP; GGNSC Harrisburg GP, LLC; GGNSC Camp Hill III LP; GGNSC Camp Hill III GP, LLC; GGNSC Clarion LP; GGNSC Clarion GP, LLC; GGNSC Doylestown LP; GGNSC Doylestown GP, LLC; GGNSC Wilkes-Barre East Mountain LP; GGNSC Wilkes-Barre East Mountain GP, LLC; GGNSC Gettysburg LP; GGNSC Gettysburg GP, LLC; GGNSC Altoona Hillview LP; GGNSC Altoona Hillview GP, LLC; GGNSC Lancaster LP; GGNSC Lancaster GP, LLC; GGNSC Lansdale LP; GGNSC Lansdale GP, LLC; GGNSC Sunbury LP; GGNSC Sunbury GP, LLC; GGNSC Monroeville LP; GGNSC Monroeville GP, LLC; GGNSC Mt. Lebanon LP; GGNSC Mt. Lebanon GP, LLC; GGNSC Murrysville LP; GGNSC Murrysville GP, LLC; GGNSC Phoenixville II LP; GGNSC Phoenixville II GP, LLC; GGNSC Mount Penn LP; GGNSC Mount Penn GP, LLC; GGNSC Rosemont LP; GGNSC Rosemont GP, LLC; GGNSC Scranton LP; GGNSC Scranton GP, LLC; GGNSC Shippenville LP; GGNSC Shippenville GP, LLC; GGNSC Philadelphia LP; GGNSC Philadelphia GP, LLC; GGNSC Wilkes-Barre II LP; GGNSC Wilkes-Barre II GP, LLC; GGNSC Tunkhannock LP; GGNSC Tunkhannock GP, LLC; GGNSC Uniontown LP; GGNSC Uniontown GP, LLC; GGNSC Erie Western Reserve LP; GGNSC Erie Western Reserve GP, LLC; GGNSC Camp Hill West Shore LP; GGNSC Camp Hill West Shore GP, LLC; GGNSC Pottsville LP; GGNSC Pottsville GP, LLC,

Defendants.

VERIFICATION

I, Rebecca M. Bloom, Consumer Protection Agent Supervisor of the Commonwealth of Pennsylvania, Office of Attorney General, Health Care Section, have reviewed the attached *Commonwealth's Amended Complaint And Petition For Injunctive Relief.* I hereby verify that the factual allegations contained in the attached Amended Complaint are true and correct to the best of my knowledge, information, and belief. However, the language and style of averments is provided by legal counsel. I make this verification subject to the penalties under 18 Pa. C.S. §4904 relating to unsworn falsification to authorities.

Dated: September 8, 2015

Rebecca M. Bloom

Rebecca M. Bloom
Consumer Protection Agent Supervisor
Health Care Section
Public Protection Division
Office of Attorney General

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA
Acting by Attorney General.
KATHLEEN KANE,

Plaintiff,

v.

GOLDEN GATE NATIONAL SENIOR CARE LLC; GGNSC Holdings LLC; GGNSC Administrative Services LLC; GGNSC Clinical Services LLC; GGNSC Equity Holdings LLC; GGNSC Harrisburg LP; GGNSC Harrisburg GP, LLC; GGNSC Camp Hill III LP; GGNSC Camp Hill III GP, LLC; GGNSC Clarion LP; GGNSC Clarion GP, LLC; GGNSC Doylestown LP; GGNSC Doylestown GP, LLC; GGNSC Wilkes-Barre East Mountain LP; GGNSC Wilkes-Barre East Mountain GP, LLC; GGNSC Gettysburg LP; GGNSC Gettysburg GP, LLC; GGNSC Altoona Hillview LP; GGNSC Altoona Hillview GP, LLC; GGNSC Lancaster LP; GGNSC Lancaster GP, LLC; GGNSC Lansdale LP; GGNSC Lansdale GP, LLC; GGNSC Sunbury LP; GGNSC Sunbury GP, LLC; GGNSC Monroeville LP; GGNSC Monroeville GP, LLC; GGNSC Mt. Lebanon LP; GGNSC Mt. Lebanon GP, LLC; GGNSC Murrysville LP; GGNSC Murrysville GP, LLC; GGNSC Phoenixville II LP; GGNSC Phoenixville II GP, LLC; GGNSC Mount Penn LP; GGNSC Mount Penn GP, LLC; GGNSC Rosemont LP; GGNSC Rosemont GP, LLC; GGNSC Scranton LP; GGNSC Scranton GP, LLC; GGNSC Shippenville LP; GGNSC Shippenville GP, LLC; GGNSC Philadelphia LP; GGNSC Philadelphia GP, LLC; GGNSC Wilkes-Barre II LP; GGNSC Wilkes-Barre II GP, LLC; GGNSC Tunkhannock LP; GGNSC Tunkhannock GP, LLC; GGNSC Uniontown LP; GGNSC Uniontown GP, LLC; GGNSC Erie Western Reserve LP; GGNSC Erie Western Reserve GP, LLC; GGNSC Camp Hill West Shore LP; GGNSC Camp Hill West Shore GP, LLC; GGNSC Pottsville LP; GGNSC Pottsville GP, LLC,

Defendants.

VERIFICATION

I, Maryann E. Walsh, Senior Civil Investigator of the Commonwealth of Pennsylvania, Office of Attorney General, Antitrust Section, have reviewed the attached *Commonwealth's Amended Complaint And Petition For Injunctive Relief.* I hereby verify that the factual allegations contained in the attached Amended Complaint are true and correct to the best of my knowledge, information, and belief. However, the language and style of the averments is provided by legal counsel. I make this verification subject to the penalties under 18 Pa. C.S. § 4904 relating to unsworn falsification to authorities.

Dated: September 8, 2015

Maryann E. Walsh
Senior Civil Investigator
Antitrust Section
Public Protection Division
Office of Attorney General

CERTIFICATE OF SERVICE

I hereby certify that on September __8__, 2015, I did cause to be served a true and correct copy of the *Commonwealth's Amended Complaint And Petition For Injunctive Relief* upon the following respondents service method via email as set forth below:

Christopher John Mauro
Email: christopher.mauro@dechert.com
Dechert, LLP
504 South 12th Street
Philadelphia, PA 19147

Laura Morrison Kessler
Email: laura.kessler@dechert.com
Dechert, LLP
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Philadelphia, PA 19103

Thomas H. Lee, II, Esquire
Email: Thomas.lee@dechert.com
Dechert, LLP
Cira Centre
2929 Arch Street
Philadelphia, PA 19104-2808

Dated: September __8__, 2015

Linda S. Sitlinger, Secretary