IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA
Acting by Attorney General
BRUCE R. BEEMER,

607 M.D. 2016

Plaintiff,

v.

GRANE HEALTHCARE CO.; ALTOONA CENTER FOR NURSING CARE LLC (d/b/a ALTOONA CENTER FOR NURSING CARE); EBENSBURG CARE CENTER LLC (d/b/a CAMBRIA CARE CENTER); COLONIAL PARK CARE CENTER LLC (d/b/a COLONIAL PARK CARE CENTER); HARMARVILLAGE CARE CENTER LLC (d/b/a HARMARVILLAGE CARE CENTER); HARMON HOUSE CARE CENTER LLC (d/b/a HARMON HOUSE CARE CENTER); HIGHLAND PARK CARE CENTER LLC (d/b/a HIGHLAND PARK CARE CENTER); KITTANNING CARE CENTER LLC (d/b/a KITTANNING CARE CENTER); LAURELWOOD CARE CENTER LLC (d/b/a LAURELWOOD CARE CENTER); PROVIDENCE CARE CENTER LLC (d/b/a PROVIDENCE CARE CENTER); RIVERSIDE NURSING CENTERS, INC. (d/b/a RIVERSIDE CARE CENTER); WOODHAVEN CARE CENTER LLC (d/b/a WOODHAVEN CARE CENTER),

JURY TRIAL DEMANDED

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) 232-7536

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JURY TRIAL DEMANDED

Defendants.

COMPLAINT AND PETITION FOR INJUNCTIVE RELIEF

AND NOW, comes the Commonwealth of Pennsylvania, acting by Attorney General Bruce Beemer, (hereinafter "the Commonwealth" or "OAG"), and brings

this action pursuant to the Unfair Trade Practices and Consumer Protection Law, 73 Pa.C.S. §§ 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 unjust enrichment.

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

I. INTRODUCTION

1. The Grane family of companies—including Defendant Grane Healthcare Co.—owns, operates, and manages twelve (12) skilled nursing

facilities[1] throughout the Commonwealth. These companies are referred to collectively herein as "Grane."

2. Grane's skilled nursing facilities in Pennsylvania include Defendants Altoona Center for Nursing Care (Altoona, PA); Cambria Care Center (Ebensburg, PA); Colonial Park Care Center (Harrisburg, PA); HarmarVillage Care Center (Cheswick, PA); Harmon House Care Center (Mount Pleasant, PA); Highland Park Care Center (Pittsburgh, PA); Kittanning Care Center (Kittanning, PA); LaurelWood Care Center (Johnstown, PA); Providence Care Center (Beaver Falls, PA); Riverside Care Center (McKeesport, PA); and Woodhaven Care Center (Monroeville, PA) (collectively, the "Grane 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.

4. 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.

[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."

5. Grane's facilities received significant revenue from private payors—residents, their families, and their insurers. These consumers paid substantial amounts—$256 per day, on average, from 2009 through 2014—for care in a semi-private room. On a monthly basis, these *per diem* payments can total, on average, over $7,680 for one resident.

6. Another significant source of revenue for Grane's facilities is the Pennsylvania Medical Assistance Program. Under the Commonwealth's Medical Assistance Program (Medicaid), Pennsylvania has paid the Grane's facilities $199 per day, on average, from 2009-2014 for each Medicaid resident's nursing home care. On a monthly basis the Commonwealth has been paying, on average, over $5,970 for each Medicaid resident.

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 Grane's facilities by promising that assistance is readily available to residents in their facilities, and that the facilities are well-staffed, with staffing levels set based on the acuity—the condition and care needs—of the residents.

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 Grane 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 Grane Facilities for reimbursement for resident care through the Pennsylvania Medical Assistance 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 Grane 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 Grane 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 Grane Facilities and review of survey results reported by the Pennsylvania Department of Health ("DOH") show that the Grane Facilities were chronically understaffed and failed to provide the Basic Care services they promised—and were paid—to provide.

15. Former employees 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 rushed;

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

(c) Incontinent residents were not checked and changed for hours at a time, and were left in wet and soiled clothing and bedding;

(d) Residents were woken at 5:00 a.m. or earlier to be showered and dressed for the day;

(e) Residents who required assistance with meals were not given enough time to eat, and were unable to finish their meals; and

(f) ROMs were rarely or ever done with residents, though CNAs were instructed to document that they had been done.

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

(a) Failing to provide adequate personal hygiene care to residents, such as providing oral care and cleaning hands and fingernails;

(b) Providing infrequent and inadequate showers to residents;

(c) Failing to provide range-of-motion exercises / restorative care to residents;

(d) Waking residents up during the night shift to get ready for the day, because of inadequate staffing on the day shift;

(e) Having inadequate staffing to adequately supervise residents to prevent harm or death;

(f) Failing to reposition residents frequently enough, and residents' development of serious pressure sores;

(g) Failing to provide timely assistance to the bathroom, resulting in residents urinating on themselves;

(h) Failing to provide timely incontinence care, resulting in residents waiting hours to have dirty diapers changed;

(i) Failing to provide adequate hydration to residents, resulting in severe dehydration and hospitalization; and

(j) Excessive and inappropriate use of physical and pharmacological restraints.

17. An analysis of the Grane Facilities' self-reported staffing numbers confirms that the conditions described by CNAs and in DOH surveys were chronic and widespread across the chain. Using census and labor data that Grane reported to the United States Centers for Medicare and Medicaid Services ("CMS"), the OAG estimates that approximately one-third or more of the Basic Care needed by residents at the Grane Facilities could not have been provided, given staffing levels, and was regularly omitted.

18. 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.

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. § 761.

III. PARTIES

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

22. Defendant Grane Healthcare Co. ("Grane Healthcare") is a Pennsylvania corporation regularly doing business in the Commonwealth of Pennsylvania. It has registered offices located at 7925 Hill Avenue, Pittsburgh, PA 15221 and 209 Sigma Drive, Pittsburgh, PA 15238-2826. Grane Healthcare exercises operational and managerial control over, and provides management services to, the Grane skilled nursing facilities described in paragraphs 23 - 33 of this Complaint, which are located throughout the Commonwealth of Pennsylvania. The residents of these skilled nursing facilities are Pennsylvania residents.

23. Defendant Altoona Center for Nursing Care LLC is a Pennsylvania limited liability company with a registered office located at 209 Sigma Drive, Pittsburgh, PA 15238-2826. Altoona Center for Nursing Care LLC owns and operates a skilled nursing facility known as Altoona Center for Nursing Care at 1020 Green Avenue, Altoona, PA, 16601-4623, with the Pennsylvania Medicaid provider number 0019284080001. The residents of Altoona Center for Nursing Care are Pennsylvania residents.

24. Defendant Ebensburg Care Center LLC is a Pennsylvania limited liability company with a registered office located at 209 Sigma Drive, Pittsburgh, PA 15238-2826. Ebensburg Care Center LLC has owned and operated a skilled nursing facility known as Cambria Care Center at 429 Manor Drive, Ebensburg, PA 15931-4917, with the Pennsylvania Medicaid provider number 1024037300001, since January 1, 2010. The residents of Cambria Care Center are Pennsylvania residents.

25. Defendant Colonial Park Care Center LLC is a Pennsylvania limited liability company with a registered office located at 209 Sigma Drive, Pittsburgh, PA 15238-2826. Colonial Park Care Center LLC owns and operates a skilled nursing facility known as Colonial Park Care Center at 800 King Russ Road, Harrisburg, PA 17109-5101, with the Pennsylvania Medicaid provider number

1009101610001. The residents of Colonial Park Care Center are Pennsylvania residents.

26. Defendant HarmarVillage Care Center LLC is a Pennsylvania limited liability company with a registered office located at 209 Sigma Drive, Pittsburgh, PA 15238-2826. HarmarVillage Care Center LLC owns and operates a skilled nursing facility known as HarmarVillage Care Center at 715 Freeport Road, Cheswick, PA 15024-1205, with the Pennsylvania Medicaid provider number 0018363060001. The residents of HarmarVillage Care Center are Pennsylvania residents.

27. Defendant Harmon House Care Center LLC is a Pennsylvania limited liability company with a registered office located at 209 Sigma Drive, Pittsburgh, PA 15238-2826. Harmon House Care Center LLC owns and operates a skilled nursing facility known as Harmon House Care Center at 601 South Church Street, Mount Pleasant, PA 15666-1703, with the Pennsylvania Medicaid provider number 0018363150001. The residents of Harmon House Care Center are Pennsylvania residents.

28. Defendant Highland Park Care Center LLC is a Pennsylvania limited liability company with a registered office located at 209 Sigma Drive, Pittsburgh, PA 15238-2826. Highland Park Care Center LLC owns and operates a skilled nursing facility known as Highland Park Care Center at 745 North Highland

Avenue, Pittsburgh, PA 15206-2526, with the Pennsylvania Medicaid provider number 0018557400001. The residents of Highland Park Care Center are Pennsylvania residents.

29. Defendant Kittanning Care Center LLC is a Pennsylvania limited liability company with a registered office located at 209 Sigma Drive, Pittsburgh, PA 15238-2826. Kittanning Care Center LLC owns and operates a skilled nursing facility known as Kittanning Care Center at 120 Kittanning Care Drive, Kittanning, PA 16201-4012, with the Pennsylvania Medicaid provider number 0018363240001. The residents of Kittanning Care Center are Pennsylvania residents.

30. Defendant LaurelWood Care Center LLC is a Pennsylvania limited liability company with a registered office located at 209 Sigma Drive, Pittsburgh, PA 15238-2826. LaurelWood Care Center LLC owns and operates a skilled nursing facility known as LaurelWood Care Center at 100 Woodmont Road, Johnstown, PA 15905-1342, with the Pennsylvania Medicaid provider number 1007294850003. The residents of LaurelWood Care Center are Pennsylvania residents.

31. Defendant Providence Care Center LLC is a Pennsylvania limited liability company with a registered office located at 209 Sigma Drive, Pittsburgh, PA 15238-2826. Providence Care Center LLC owns and operates a skilled nursing

facility known as Providence Care Center at 900 Third Avenue, P.O. Box 140, Beaver Falls, PA 15010-4613, with the Pennsylvania Medicaid provider number 0018363330001. The residents of Providence Care Center are Pennsylvania residents.

32. Defendant Riverside Nursing Centers, Inc. is a Pennsylvania corporation with registered offices located at 1500 Fifth Avenue, McKeesport, PA 15132-2483 and 209 Sigma Drive, Pittsburgh, PA 15238-2826. Riverside Nursing Centers, Inc. owns and operates a skilled nursing facility known as Riverside Care Center at 100 Eighth Avenue, McKeesport, PA 15132-2712, with the Pennsylvania Medicaid provider number 0010560920001. The residents of Riverside Care Center are Pennsylvania residents.

33. Defendant Woodhaven Care Center LLC is a Pennsylvania limited liability company with a registered office located at 209 Sigma Drive, Pittsburgh, PA 15238-2826. Woodhaven Care Center LLC owns and operates a skilled nursing facility known as Woodhaven Care Center at 2400 McGinley Road, Monroeville, PA 15146-3541, with the Pennsylvania Medicaid provider number 0018363510001. The residents of Woodhaven Care Center are Pennsylvania residents.

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

34. Skilled nursing care is expensive, and both the Commonwealth and Pennsylvania consumers spend significant sums of money on care at the Grane Facilities. However, due to the deceptive, misleading, and unfair conduct of the Defendants, residents did not receive the Basic Care that had been promised and paid for.

35. 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 Grane Facilities.

36. 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 average, at least 65% of the resident days in Grane Facilities are paid for by Medicaid; at some Grane Facilities, the percentage is above 80%.

37. Defendants have engaged in unfair and deceptive acts and practices towards Pennsylvania consumers and the Commonwealth by using a variety of materials 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 Grane Facilities.

A. Chain-wide Misrepresentations on Grane's Website

38. Grane Healthcare made deceptive and misleading representations on its website, which promised that the needs of residents at Grane's facilities would be met.

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

40. Defendants marketed Grane Healthcare and its facilities in Pennsylvania directly to Pennsylvania consumers, disseminating misrepresentations about the Basic Care provided at these facilities through the Grane Healthcare website.

41. For example, the Grane Healthcare website states that it implements a Quality Assurance Program at its facilities, which:

> Provide[s] for the patient's day-to-day comfort with 'back-to-basics' nursing care. This type of care, ***which is especially important to the chronically ill patient's feeling of well-being***, involves taking care of 'the little things' – answering the nurse-call bell promptly, giving shampoos and manicures, helping to wash up before dinner, or applying lipstick when company is visiting.

("Why Choose Us?," http://www.grane.com/about/why_choose_us.aspx (last visited Oct. 21, 2016) (*emphasis added*).)

42. The Grane Healthcare website also describes its facilities' staffing levels as "very high," and represents that staffing levels are set based on the needs of residents. It states:

> It's the people who make healthcare services and facilities exceptional! While the size of staff varies with the number of patients and their needs, each facility strives for ***a very high staff-to-patient ratio*** – higher than those mandated by the State of Pennsylvania. ***Staffing is provided based on patient acuity levels.***

("Specialty Care Services," http://www.grane.com/services/specialty_care_programs.aspx (last visited Oct. 21, 2016) (*emphasis added*).) In reality, the resident populations of Grane's facilities fall into the highest category of need, based on assessments of residents submitted to CMS. For the period of 2008-2014, 96% of the populations of Grane's skilled nursing facilities can be classified as having heavy care needs; 74% of Grane's residents over this time period were dependent on staff for assistance with every ADL. Yet, Grane's facilities have low staffing levels compared to other facilities nationwide. In 2015, nearly half of all Grane facilities were ranked "below average" or "much below average" under Medicare's Five-Star rating system; none received a ranking higher than "average." At present, two-thirds of Grane facilities are ranked "below average" or "much below average." As detailed below in Section VI, the Grane Facilities' staffing levels are far too low to meet the needs of the high-acuity residents they serve.

43. These marketing materials were deceptive and misleading, because they represented that Grane's skilled nursing facilities would provide care that was not, in fact, provided a significant percentage of the time at Grane's facilities due to understaffing. As detailed in Section VI below, the OAG's investigation has uncovered significant evidence of routine and serious omissions of Basic Care at the Grane Facilities named in this Complaint. Furthermore, based on an analysis of the staffing data reported by Grane's facilities, the OAG believes that this understaffing and these omissions of care represent a pattern and practice across the entire chain.

B. Facility-Level Misrepresentations

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

45. Defendants 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

46. The Grane Facilities misrepresent the staffing levels and quality of care that they provide through their facility-specific websites. Often, similar or identical misleading language appears across the websites of most or all of the Grane Facilities.

47. These websites represent that the Grane Facilities have adequate staff at the facilities to meet the needs of residents, saying, for example:

(a) "Assistance is readily available for residents who may need a little extra help with day-to-day tasks." (http://www.myaltoonacenterfornursingcare.com/photo/gallery.aspx#01 (last visited Oct. 21, 2016)).

(b) "Our knowledgeable and helpful staff are ready to assist you." (http://www.mycambriacarecenter.com/photo/index.aspx (last visited Oct. 21, 2016)).

(c) "Staff are always available to provide care – or even pop by for a chat." (http://www.myharmonhousecarecenter.com/photo/gallery.aspx#04 (last visited Oct. 21, 2016)).

(d) "Large nurses' stations accommodate increased staff and help them work effectively and efficiently."

(http://www.mycolonialparkcarecenter.com/photo/gallery.aspx#02 (last visited Oct. 21, 2016)).

(e) "Staff are ready to help residents with physical therapy as well as day-to-day needs."

(http://www.mywoodhavencarecenter.com/photo/index.aspx (last visited Oct. 21, 2016)).

(f) "Residents get to know each other, and enjoy delicious meals in our dining room."

(http://www.myprovidencecarecenter.com/photo/gallery.aspx#04 (last visited Oct. 21, 2016)).

48. Specifically, these facilities represent that their staffing levels are driven by patient needs and are "very high." For example, each of the Grane Facilities' websites contain language identical to the Grane Healthcare website—quoted in paragraph 42 above—stating that these facilities "strive[ ] for a very high staff-to-patient ratio" and that "[s]taffing is based on patient acuity levels."

49. These facilities also make specific, concrete representations regarding the types of care they will provide. Like the Grane Healthcare website (quoted in paragraph 41 above), the Grane facilities' websites state that this care includes "answering the nurse call bell promptly, giving shampoos and manicures, helping to wash up before dinner, or applying lipstick when company is visiting."

50. These marketing materials also omit 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 residents "enjoy delicious meals in our dining room." 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, or that residents who require assistance with meals are unable to finish eating because staff do not have enough time to assist them. These sites also represent that assistance with day-to-day tasks is "readily available," but they do not disclose the fact that staffing levels are so low that residents must often wake up at 5 a.m. or earlier to receive showers or to be cleaned and dressed for the day.

51. 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 the Grane Facilities.

2. Resident Assessments and Care Plans

52. On information and belief, the Grane Facilities made deceptive, misleading, and unfair representations in the resident care plans prepared for each resident, which itemized care that was not delivered.

53. 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

54. The Grane 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).

55. The Grane Facilities certified the accuracy of the data within each MDS submitted for each of their residents.

56. 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.

57. On information and belief, the Grane Facilities made representations to residents and/or their family members in resident care plans regarding the Basic Care that would be provided to them.

58. 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.

59. 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 Grane Facilities were not, in fact, delivered to residents.

3. Billing Statements

60. On information and belief, Grane Healthcare and the Grane Facilities reinforced these misleading statements and omissions with regular billing statements sent to insurers, to residents and/or their family members, and to the Commonwealth for payment of the per diem rate.

61. 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 Grane Facilities.

However, because of chronic understaffing, a significant percentage of this care was never provided to residents.

4. False Appearances During Commonwealth Surveys

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

63. The Grane 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 Grane 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

64. The Grane Facilities also misled the Commonwealth, through inaccurate or falsified resident care records, regarding the level of care they provided. As a result, CNAs recorded in resident care records that Basic Care had been provided, when in reality, they had not been able to provide this care.

65. The Grane 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

66. At the core of all of these deceptive and misleading statements was a basic promise to staff to acuity, provide prompt responses to call lights, to make assistance readily available, and to provide all of the Basic Care that each resident required, as often as the resident required it:

(a) Timely 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 each resident's care plan—to prevent 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 each resident's food is still hot, and for as long as it takes the resident to finish eating;

(f) Providing fluids and assisting residents who need help drinking;

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

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

67. Despite promising this care, the Defendants failed to provide adequate staffing levels at the Grane Facilities to provide this care as thoroughly and as frequently as needed. 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. GRANE'S MISREPRESENTATIONS TO THE PENNSYLVANIA MEDICAL ASSISTANCE PROGRAM

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

69. Defendants chose to participate in the Pennsylvania Medical Assistance Program to receive payments for care provided to dependent, disabled, and vulnerable residents of their nursing facilities. Since 2008, on average, at least 65% of the Grane Facilities' resident days were covered by Medicaid.

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

70. Pursuant to the Nursing Facility Provider Agreement that each of the Grane Facilities entered into with the Commonwealth, 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."

71. The Grane 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.

72. Pursuant to the Provider Agreement, each Grane Facility also agreed to abide by all regulations governing the Medical Assistance 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 Grane Facilities made detailed representations to the Commonwealth regarding the level of assistance that each resident needed—*and had been provided*—to complete each ADL.

73. 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 Grane Facilities submitted these reimbursement requests.

74. The Grane Facilities made misrepresentations to the Commonwealth by submitting claims for reimbursement under the Pennsylvania Medical Assistance 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. The Grane Facilities made further misrepresentations by submitting MDSs to the Commonwealth that contained misinformation regarding the level of care that had been provided to residents.

75. The Commonwealth relied upon the representations made in the MDS submissions from the Grane Facilities to determine each facility's per diem reimbursement rate under the Medical Assistance 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. The Commonwealth also relied upon the misleading claims submitted by the Grane Facilities for payment. Payments on these claims were made.

VI. OMISSIONS OF BASIC CARE AT THE GRANE FACILITIES

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

77. Each of the Grane Facilities has 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 the Grane Facilities due to understaffing.

78. The OAG collected the following evidence of chronic understaffing and routine omissions of Basic Care at the Grane Facilities.

A. Omissions of Care at Altoona Center for Nursing Care (Altoona, PA)

79. Confidential Witness #1 worked as a CNA at Altoona between 2009 and 2010. She usually worked the day shift (7 a.m. to 3 p.m.), but occasionally worked the night shift (11 p.m. to 7 a.m.). She was typically responsible for about

12-14 residents on the day shift, while night shift CNAs were responsible for 20 residents each.

80. According to Confidential Witness #1:

(a) Residents and their family members complained to the CNAs that the residents' call lights were not answered quickly enough. Residents waited, on average, around 30 minutes for a response to the call light.

(b) The residents were supposed to be repositioned every 2 hours, but Confidential Witness #1 was unable to reposition the residents this often. Residents and their family members complained to the CNAs that the residents were not getting repositioned frequently enough.

(c) She observed difficulties that CNAs had in finding a second CNA to assist with a Hoyer lift.[3] On one occasion, she waited an hour for assistance with a Hoyer lift. CNAs frequently used the Hoyer lifts on their own.

(d) Confidential Witness #1 frequently arrived at her shifts to find a resident who had not been provided incontinence care for hours or who had not had a bed bath. These residents were usually covered in urine. Confidential Witness #1 believed that the residents were not

[3] "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.

changed or bathed because the night shift had the lowest levels of staffing.

81. Confidential Witness #2 worked as a CNA at Altoona from 2003 to 2015. She usually worked the night shift (10 p.m. to 6 a.m.), but she sometimes worked other shifts. On the night shift, she was typically responsible for 30 residents.

82. According to Confidential Witness #2,

(a) She felt very rushed during her shifts, and she had to take short-cuts such as skipping taking the residents' vital signs. She was unable to complete her work due to lack of time.

(b) Confidential Witness #2 answered the call lights as soon as possible, but residents still had accidents (*i.e.*, urinated or defecated) because they waited too long.

(c) The facility's policy was that the residents were supposed to be repositioned every two (2) hours but Confidential Witness #2 only had time to reposition the residents three (3) times in an eight-hour shift.

(d) The facility's policy was that the residents were supposed to be changed every two (2) hours but Confidential Witness #2 could only change the residents three (3) times in an eight-hour shift due to lack of time. Every night, she observed residents who had not been

changed in several hours. For example, she frequently observed one resident, who was alert and oriented but unable to control her bowels, with dry feces caked on her genitals. Confidential Witness #2 complained to the nurse supervisor about this, but nothing came from her complaint.

(e) Residents at the facility often complained to staff and the resident council about low staffing and inadequate care. CNAs frequently "called out" (did not work their scheduled shifts) because they were very exhausted from working long shifts.

83. State inspectors from DOH also have found that Altoona violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During an abbreviated survey[4] on July 31, 2009, the facility received a deficiency for failing to provide ordered restorative nursing—care to help a resident with range of motion exercises.

(b) During an abbreviated survey on October 19, 2010, the facility received a deficiency when a CNA did not properly provide hygiene care after a resident used a bed pan.

[4] Abbreviated surveys are conducted by DOH, in between annual surveys, when DOH receives a complaint or a facility self-reports an incident (falls, elopements, *etc.*). These surveys focus on issues related to the complaint or incident, and they are not a comprehensive assessment of the facility.

(c) During an abbreviated survey on April 13, 2011, the facility received a deficiency because four residents' records showed their hair was not washed during their entire stays at the facility, which ranged from one week to two months in duration.

(d) During an abbreviated survey on May 13, 2015, the facility received a deficiency for failing to give eight residents showers on multiple occasions. CNAs told surveyors that they did not always have enough time to finish all of their care, and that at times, they are not able to provide all of their scheduled showers.

(e) During an abbreviated survey on November 7, 2015, the facility received a deficiency for failing to provide adequate hygiene care when a resident was seen with a dark brown substance underneath his fingernails on both hands.

84. DOH inspectors have also found deficiencies relating to Altoona's use of physical and pharmacological restraints:[5]

[5] Use of physical and pharmacological restraints can be an indication of inadequate staffing levels in a facility. Antipsychotic drugs can be used to sedate residents who would otherwise be agitated or more active, requiring more staff assistance. Alternative approaches to managing this behavior—such as paying attention to the resident or redirecting the resident's behavior—require the time and attention of staff. Reducing the use of physical restraints to prevent falls can also require increased levels of staff supervision. Federal regulations require skilled nursing facilities to ensure residents are free from unnecessary physical and pharmacological restraints.

(a) During the annual survey completed on February 6, 2008, the facility received a deficiency for using physical restraints on a resident for staff convenience.

(b) During an abbreviated survey on January 31, 2007, the facility received a deficiency for failing to follow a doctor's orders to discontinue psychoactive medications.

(c) During the annual survey completed March 5, 2015, the facility received a deficiency for overmedicating residents and not trying alternatives to medication before giving residents psychoactive medications.

B. Omissions of Care at Cambria Care Center (Ebensburg, PA)

85. Confidential Witness #3 worked as a CNA at Cambria Care Center from 2010 to 2014. She usually worked the 6:30 a.m. to 3:00 p.m. shift, and was supposed to be responsible for 6 residents each shift. However, the facility was frequently short-staffed, and when this occurred, she was responsible for 12-13 residents each shift.

86. According to Confidential Witness #3:

(a) Residents waited 20-25 minutes for a response to their call lights. The facility occasionally had consultants come to the facility to monitor the employees and see how they performed, and they observed the

same thing. Confidential Witness #3 encountered residents who were upset due to waiting for an answer to their call lights. For example, one resident, who was in the facility after having hip surgery, needed help going to the restroom and rang the call light for assistance. She waited so long for a response that she soiled herself and was very upset and embarrassed over the situation.

(b) Residents usually received cold food due to waiting to be fed. The plates came with lids to keep the food warm, but the food still got cold because it sat for a long time.

(c) CNAs were supposed to do ROMs on a daily basis, but there was not enough time to do them. The nurses told the CNAs that dressing the residents constituted ROMs and that they needed to chart that the ROMs were completed.

(d) Residents were supposed to be up and dressed before lunch, which was served around 11:30 a.m. However, some residents were left in their pajamas for the entire day because there was not enough time to dress all of the residents.

(e) The facility's policy was that the incontinent residents were supposed to have their briefs changed every two (2) hours. However, Confidential Witness #3 was able to change the residents only every

three (3) hours because she was responsible for so many residents. There were several incidents in which Confidential Witness #3 found residents who were soaking wet and required full bed changes.

(f) Right before the inspections, the facility was cleaned from top to bottom. Inspections occurred around the same time every year, so the facility knew when to expect the surveyors. Nurses and CNAs from other sbifts worked during inspections. Supervisors even went so far as to call some nurses while they were on vacation to have them come back to help during the inspections. Ordinarily, very few nurses were willing to help the CNAs with their work, but this changed and they were very willing to help out during inspections. There were two or three additional aides on the floor during inspections—they acted as floaters, helping out where needed and answering call lights.

(g) She sometimes accompanied residents off-site during her shifts, and while she was gone, the remaining CNAs on the floor had to care for additional residents. When she went offsite she could be away from the facility for as little as one hour to as much as an entire shift.

87. Confidential Witness #4 worked as a CNA at Cambria Care Center from 2012 to 2013. She usually worked the 3 p.m. to 11 p.m. shift, and was typically responsible for 13 residents during her shift.

88. According to Confidential Witness #4:

(a) She did not have enough time to finish her work and was very rushed throughout her day. The facility frequently "mandated" the CNAs—requiring them to stay for a second shift—about five minutes before their first shift ended.

(b) The facility's policy was that the residents were supposed to be repositioned every two (2) hours. Confidential Witness #4 was too busy to do this, however, and only repositioned the residents every three (3) hours.

(c) She occasionally did ROMs with the residents but did not do them as often as she would have liked because she did not have enough time. She spent about five minutes doing ROMs with the residents and felt rushed while doing them.

(d) She learned in her CNA training that incontinent residents were supposed to be changed every two (2) hours. She was usually able to do this, but there were also days where she was so busy that she was not able to change the residents at all. She frequently found residents who did not seem to have been changed in several hours. The CNAs on the previous shift told her that they were not able to change the residents either because they did not have enough time or because

there were not enough staff to find a second person to help with a Hoyer lift, and they were unable to change the resident alone.

(e) Everyone acted differently on inspection days. Office workers helped out on the floor and there was more staff working. The extra staff members were CNAs who usually worked on other shifts.

(f) CNAs routinely complained about the lack of staff, but supervisors would respond that they had "holes in their schedule and they were trying to fill them." The facility was still shorthanded, even after these complaints.

89. State inspectors from DOH also have found that Cambria violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During an abbreviated survey on March 26, 2010, the facility received a deficiency for failing to prevent and then treat pressure sores for two residents. One resident developed a Stage III sore[6] with bloody drainage. Inspectors observed during the survey that another resident with pressure sores on both buttocks was lying in a brief saturated with urine.

[6] Pressure sores are categorized as Stage I through Stage IV. A Stage III pressure sore is one in which the sore has extended down into the tissue below the skin, forming a small crater. Sometimes fat is exposed in Stage III pressure sores.

(b) During an abbreviated survey on April 6, 2010, the facility was given a deficiency for not giving residents showers according to their scheduled times and preferences. Residents were given bed baths instead of showers for at least two months.

(c) During an abbreviated survey on April 6, 2010, the facility was given a deficiency for not providing ordered range of motion exercises for a resident.

(d) During an abbreviated survey on May 20, 2010, the facility received a deficiency for failing to provide pressure sore and incontinence care to prevent pressure sores. Surveyors saw an incontinent resident with seeping open areas around her rectal area and buttocks. The facility had put in place no care plan to handle her incontinence-related skin breakdown.

(e) During the annual survey completed September 17, 2010, the facility received four deficiencies when residents developed new Stage II pressure sores and had pressure sores worsen to Stage III and Stage IV.[7] Care plans were not developed to prevent or promote healing for

[7] 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. A Stage III pressure sore is one in which the sore has extended down into the tissue below the skin, forming a small crater. A Stage IV pressure sore is one that has advanced to the point where there is large-scale tissue loss, exposing bone, tendon, or muscle.

weeks after the pressure sores were observed, and facility staff did not always follow pressure sore care plans.

(f) During an abbreviated survey on September 28, 2010, the facility received a deficiency for not providing adequate personal hygiene care. One resident was only showered four times in two months, instead of twice a week as requested. Another resident was showered only twice in a two month period. CNAs explained that residents were put onto a showering schedule at times when it was most convenient for staff, rather than taking into account resident preferences for the timing or frequency of showers.

(g) During an abbreviated survey on November 10, 2010, the facility received a deficiency for failing to perform range of motion exercises for three residents.

(h) During the annual survey completed March 4, 2011, the facility received a deficiency for failing to provide sufficient nursing staff to meet the needs of 57 residents on one unit. On one day, for example, only two CNAs were assigned to the unit. They were both assisting residents in the shower room when two other residents got in a fight resulting in a resident's death. The Director of Nursing said he did not have a system to determine the number of staff needed on each

unit but usually staffs with the following CNA to patient ratios: first floor 1:8, second through fourth floors 1:10 (dayshift) and 1:12 (evening shift). Inspectors found that facility managers did not consider resident needs and behaviors or the physical layout of the unit when determining staffing needs.

(i) During a revisit survey[8] on June 20, 2011, the facility received another deficiency for not providing sufficient nursing staff to meet the individual needs of each resident. The facility's Administrator told inspectors that CNA assignment records were destroyed daily, and therefore the facility could not provide staffing information. Surveyors concluded that the facility managers again failed to consider either the residents' needs and behaviors or the physical design of the nursing units when determining staffing needs.

(j) During an abbreviated survey on November 15, 2011, the facility was given a deficiency for failing to reposition a resident and provide a pressure-relieving cushion. The resident's pressure sore worsened and became three separate Stage III pressure sores.

[8] A revisit survey is done by DOH, after a facility receives one or more deficiencies and implements a plan of correction, so that DOH can assess whether the prior deficiencies have been adequately resolved.

(k) During the annual survey completed February 17, 2012, the facility received a deficiency for not respecting resident choices about rising times. For example, one resident was awakened at 6:00 a.m. by the night shift. Inspectors found that the night shift was required to get three residents up early to reduce the workload of the daylight staff.

(l) During the annual survey completed February 17, 2012, the facility received a deficiency for not ensuring resident safety in the bathroom. Incident reports showed a resident had fallen in her bathroom on two occasions trying to transfer herself to the toilet. Inspectors observed the resident sitting on the toilet unsupervised.

(m) During a July 20, 2012 survey, the facility received a deficiency for failing to provide adequate personal care. One resident was not bathed properly; surveyors saw a CNA neglect to rinse shampoo and soap from the resident's skin after bathing her. Another resident was not given proper oral care; he had dry lips and a yellow substance on his lips and tongue.

(n) During the annual survey completed April 17, 2014, the facility received a deficiency for failing to provide treatment and services to maintain a resident's mobility. The resident's mobility had declined, and her restorative walking program was discontinued.

90. DOH inspectors have also found deficiencies relating to Cambria's use of physical and pharmacological restraints:

(a) During the annual survey completed March 4, 2011, the facility received a deficiency for giving several residents anti-anxiety medication on multiple occasions without trying non-medication interventions, such as encouraging the residents to participate in activities or to express their feelings, or investigating whether pain could be the cause of a resident's agitation.

(b) During an abbreviated survey on November 4, 2011, the facility received a deficiency for overmedicating residents with anti-anxiety medication.

(c) During a licensure survey completed July 20, 2012, the facility received a deficiency for overmedicating a resident for staff convenience.

(d) During the annual survey completed May 9, 2013, the facility was given a deficiency for failing to develop care plans for eight residents for problems including, among others, physical restraint use.

(e) During a revisit survey on July 9, 2013, the facility received a deficiency for overmedicating residents for staff convenience.

C. Omissions of Care at Colonial Park Care Center (Harrisburg, PA)

91. Confidential Witness #5 worked as a CNA at Colonial Park Care Center from 2012 to 2013. She usually worked the 7 a.m. to 3 p.m. shift, and was typically responsible for 14 residents.

92. According to Confidential Witness #5:

(a) Residents waited 30 minutes to an hour for a response to the call lights and often complained about the wait times.

(b) The facility's policy was that the residents were supposed to be repositioned every two (2) hours but there was no way that the CNAs could do this; they were able to reposition the residents only every four (4) hours.

(c) CNAs waited 30-40 minutes when they needed the assistance of a second person to transfer a resident with a Hoyer lift. The CNAs used the Hoyer lifts by themselves often, because they were unable to find someone to assist.

(d) The residents were supposed to receive ROMs on a daily basis but there wasn't enough time. During the few times that Confidential Witness #5 did ROMs, she was interrupted by having to respond to call lights from other residents on the floor.

(e) The residents were supposed to be up and dressed between 7:45 a.m. and 8 a.m. for breakfast. Confidential Witness #5 was often unable to get the residents up and dressed on time. Some residents had to eat breakfast in their rooms and get dressed after breakfast.

93. State inspectors from DOH also have found that Colonial Park violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During an abbreviated survey on June 5, 2007, the facility received a deficiency for not providing incontinence care to two residents. One resident was left in her Geri chair for 4 hours and 40 minutes without being given incontinence care; she was incontinent of urine during that time. Another incontinent resident, totally dependent on staff for toileting, sat in a wheelchair for four hours without receiving toileting assistance; the resident was incontinent of urine during that time.

(b) During the annual survey completed September 26, 2008, the facility received a deficiency for failing to provide grooming, personal care, and oral hygiene to a resident. The resident's hair was bushy and sticking up all over her head, and she had dry, cracked lips that nearly stuck together when she tried to open her mouth. The resident's

family told inspectors that staff never combed her hair or gave her oral care.

(c) During an abbreviated survey on October 27, 2010, the facility received a deficiency for failing to keep residents hydrated after a resident who required extensive eating and drinking assistance was transferred to the ER and diagnosed with severe dehydration.

(d) During the annual survey completed March 29, 2012, the facility received a deficiency for neglect. A resident told surveyors that she asked for assistance to the bathroom, but was told to wait until the CNA had finished passing out meal trays. The resident could not wait and was incontinent in her bed.

(e) During a licensure survey completed September 28, 2012, the facility received a deficiency because an entire wing smelled of urine for the three days of the survey.

(f) Also during the September 28, 2012 survey, the facility received a deficiency for failing to provide passive range-of-motion assistance: applying an ordered palm guard to prevent loss of function in a resident's hand. Although the resident's record said that the palm guard was applied, surveyors observed that the resident was not wearing it over the two days of the survey.

(g) Also during the September 28, 2012 survey, the facility received a deficiency for failing to provide hygiene and personal care to a resident. Surveyors observed the resident wearing a dirty shirt inside out and stained sweatpants. His hair was not combed and looked dirty, and he had a strong body odor that could be smelled from five feet away. Although his care plan showed he was to be showered and shampooed twice weekly and his clothes changed daily, CNAs said they were unaware he needed that much help.

(h) Again during the September 28, 2012 survey, the facility received a deficiency for being unable to produce documentation that personal care was provided to residents. For example, one resident needed a cream applied twice a day, but there was no record of this being done for 19 days in the month of September. The same resident's record showed that the resident was not provided with a shower for 14 days in September, and that the resident's hair was not washed for nearly a month.

(i) During the October 31, 2013 survey, the facility was cited for failing to provide range-of-motion care. One resident required passive range of motion exercises to both legs, but the records reflected, and the Director of Nursing said, that this was never performed.

(j) Also during the October 31, 2013 survey, the facility was cited for failing to adequately supervise and prevent falls. Although a resident was known to be a fall risk and staff were required to stay with the resident while in the bathroom, the resident was left on the toilet unattended and fell on the bathroom floor.

(k) During the annual survey completed October 9, 2014, the facility received a deficiency for failing to complete a bladder assessment and develop a toileting schedule for a frequently incontinent resident.

(l) Also during the October 9, 2014 survey, the facility received a deficiency for failing to maintain accurate records regarding showers. According to records, one resident went 10 days without a shower, another went three months and 6 days without a shower, and another went one month and 11 days without a shower. None of the residents had documentation showing they had refused showers.

94. DOH inspectors have also found deficiencies relating to Colonial Park's use of physical and pharmacological restraints:

(a) During the annual survey completed October 4, 2007, the facility received a deficiency for overmedicating residents without monitoring or justification.

(b) During the annual survey completed October 31, 2013, the facility was given one deficiency for overmedicating two residents, and another deficiency for improper use of physical restraints on another resident.

(c) During an abbreviated survey on March 31, 2014, the facility received a deficiency for medicating a resident with potentially unnecessary anti-psychotic drugs without obtaining a psychiatric consult. Furthermore, no records in the resident's file indicated that staff members had monitored for or observed any psychotic behaviors from the resident.

(d) During an abbreviated survey on March 31, 2014, the facility received a deficiency for using a physical restraint on a resident to prevent falls instead of first trying different seating arrangements, more frequent repositioning, or a toileting schedule. There was also no care plan regarding how often staff were to check and release the seatbelt for repositioning or toileting.

D. Omissions of Care at HarmarVillage Care Center (Cheswick, PA)

95. Confidential Witness #6 worked as a CNA at HarmarVillage from 2009 or 2010 to 2011. She usually worked the 3 p.m. to 11 p.m. shift, and was typically responsible for 15 to 20 residents on a good day. On a day when the

facility was understaffed—which happened around three times per week—she was responsible for an entire hall, or around 30 residents.

96. According to Confidential Witness #6:

(a) The CNAs were the only employees who answered call lights, and residents waited 10-15 minutes for a response to their call lights. Residents were frequently upset or in distress due to waiting for a response to call lights. One resident had a port for dialysis that was attached to his stomach. One day the port came loose and cut a major artery, and the resident started bleeding profusely. The resident rang his call light but no one answered right away: Confidential Witness #6 was in the shower room, the other CNA was busy with a resident, and the nurse did not answer the call light. Confidential Witness #6 found the resident ten minutes later, and he had lost a substantial amount of blood. The resident was sent to the hospital.

(b) Residents were supposed to be repositioned every two (2) hours. Confidential Witness #6 was only able to reposition the residents twice during each eight-hour shift. Sometimes, she was so busy that she only repositioned the residents once during an eight-hour shift. Residents developed serious pressure sores at the facility.

(c) If Confidential Witness #6 needed assistance with repositioning a resident or with a Hoyer lift, she waited anywhere from 20-30 minutes. The CNAs frequently used the Hoyer lifts by themselves because they were unable to find assistance.

(d) Confidential Witness #6 felt very rushed while feeding the residents. Residents only ate about half of their meals because there was not enough time to feed them their entire meals. Residents sometimes received cold food due to waiting to be fed.

(e) The CNAs were responsible for doing ROMs with the residents but rarely had the time to do them. Confidential Witness #6 tried to do ROMs while changing the residents, but she was unable to spend more time than this on ROMs.

(f) The residents were supposed to be provided incontinence care every two hours. However, Confidential Witness #6 was so busy that she was usually only able to change the residents twice during an eight-hour shift.

(g) Confidential Witness #6 was present for a DOH inspection and witnessed administrative staff helping to pass out dinner trays. These staff members never helped out the rest of the time, however; the inspection day was the only time she had ever seen them. The week

of the inspection was nice, because the facility was fully-staffed; this did not happen most days.

97. State inspectors from DOH also have found that HarmarVillage violated state and federal nursing home regulations by failing to provide sufficient staffing for Basic Care. For example:

(a) During an abbreviated survey on January 3, 2011, the facility was given a deficiency for failing to provide enough assistance to prevent a fall. The resident needed assistance with all ADLs and frequent repositioning by two people. The resident fell to the floor when a CNA tried to reposition the resident without another person.

(b) During an abbreviated survey on August 30, 2011, the facility was given a deficiency for failing to report an allegation of neglect to the Department of Aging. A resident was injured while being transferred to the toilet. A CNA had tried to transfer the resident alone instead of with another person.

E. Omissions of Care at Harmon House Care Center (Mount Pleasant, PA)

98. Confidential Witness #7 worked as a CNA at Harmon House from 2008 to 2015. She usually worked the 7 a.m. to 3 p.m. shift, and was typically responsible for 15 to 16 residents.

99. According to Confidential Witness #7:

(a) Confidential Witness #7 worked at the facility for seven years. When she first started at the facility there was enough staff on duty. A few years after she started, managers started scheduling fewer staff members for each shift.

(b) Residents waited a long time for a response to their call lights—some told her that they waited 30 minutes for a response. Residents were often upset because they waited too long for a response to their call lights. Some residents soiled themselves while waiting for assistance. Other residents tried to get up on their own and fell.

(c) The CNAs felt very rushed while feeding the residents and often gave up on feeding the residents about halfway through the meal. When that happened, residents were not able to finish their meals and left the dining room hungry. Some of the residents also complained about receiving cold food.

(d) The CNAs were told by another staff member that getting the residents dressed and bathed counted as ROMs, so the CNAs charted that they did ROMs on a daily basis. However, she did not do any ROMs with residents other than dressing and bathing them.

(e) Confidential Witness #7 was able to get a few residents dressed before breakfast, but there was no way that she could get all of the residents

up and dressed in time. As a result, the majority of residents ate breakfast in their rooms because they were not allowed to eat in the dining room in their pajamas.

(f) She was supposed to shower 4-5 residents each shift, but it was only possible to shower 2 residents each shift. Residents only received showers once a week—not twice a week, which they were supposed to receive—because CNAs did not have enough time. If Confidential Witness #7 had to skip showering a resident, she gave the resident a bed bath instead. However, she did not have enough time to give them full bed baths, and only washed their underarms, face, hands, and genitals.

(g) The CNAs were supposed to provide incontinence care every two (2) hours, but she only had time to change the residents twice in an eight-hour shift: once after breakfast and once after lunch. Confidential Witness #7 often found residents who were soaking wet. Sometimes the residents were so soiled that she had to give them full showers in order to wash the feces and urine off.

(h) Falls occurred frequently at the facility. Many residents grew tired of waiting for assistance, tried to get up on their own, and fell.

(i) One time a resident eloped during the day shift, but the CNAs were too busy to notice. One of the evening shift CNAs noticed that the resident was missing and looked everywhere for the resident. The resident was eventually found at a police station near the facility.

(j) During inspections, there was much more help on the floor than usual, because the administrators came out of their offices and helped on the floor, doing things like passing meal trays and answering call lights. As soon as an inspector walked through the door, the receptionists would call the nurses to warn them, so the nurses knew that the inspectors were at the facility before they made it onto the floor.

100. Confidential Witness #8 worked as a CNA at Harmon House Care Center in 2010. She usually worked the 11 p.m. to 7 a.m. shift, and was typically responsible for 12 to 18 residents.

101. According to Confidential Witness #8:

(a) The CNAs were supposed to reposition residents every two (2) hours, but she was usually only able to reposition and change residents' diapers every three (3) hours because she was so busy.

(b) She had to start waking some residents at 4:00-4:30 a.m. to get them up and ready for dialysis appointments. When she woke residents at

4:30 a.m. she would have to rush to get them up and dressed, because there was not enough time.

(c) The overnight CNAs were also responsible for providing 10-12 residents with bed baths before their shift ended at 7 a.m. CNAs were not supposed to start waking residents until 5 a.m., but then they could not get the baths done and the dialysis patients up and ready in such a short time. She had to start very early—sometimes 1 or 2 a.m.—to provide bed baths to residents; otherwise, they would not have gotten bathed. She could not give good bed baths, and really get residents clean, because she had to rush through each bath.

(d) The residents usually had to wait between 10-15 minutes for a response to their call lights. Several residents would urinate or defecate on themselves while waiting to use the bathroom. Confidential Witness #8 would write up an incident report each time a resident would urinate on themselves while waiting for a call light. However, nothing was done in response to these reports.

(e) The residents were supposed to be repositioned every two (2) hours. Confidential Witness #8 was usually able to reposition residents only every three (3) hours, and occasionally could only reposition residents every four (4) hours.

(f) The residents were supposed to be changed every two (2) hours, but she only had time to change them every three (3) hours. Confidential Witness #8 routinely arrived to shifts and found residents who did not seem to have been changed for hours.

102. State inspectors from DOH also have found that Harmon House violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During an abbreviated survey on January 10, 2012, the facility received a deficiency for failing to supervise a resident. The resident was found outside, lying at the bottom of the stairs with his wheelchair caught halfway down the stairs.

(b) During the annual survey completed on September 5, 2014, the facility received a deficiency for failing to shower a resident who needed help with bathing. During an interview with a group of residents, they complained to surveyors that staff were not showering them as scheduled due to inadequate staffing. One resident's shower schedule showed that he had not been showered for an entire week.

103. DOH inspectors have also cited Harmon House for use of physical restraints. During the annual survey completed on September 9, 2010, the facility

received a deficiency for putting a resident in physical restraints without a medical reason.

F. Omissions of Care at Highland Park Care Center (Pittsburgh, PA)

104. Confidential Witness #9 worked as a CNA at Highland Park Care Center from 2013 to 2014. She usually worked the 11 p.m. to 7 a.m. shift, and was typically responsible for 20 residents per shift.

105. According to Confidential Witness #9:

(a) She did not have enough time to finish her work. She was the only CNA on her floor and was responsible for 20 residents.

(b) The call lights were supposed to be answered within two minutes, but the residents waited up to an hour for a response. Residents were constantly upset due to waiting too long for a response to the call lights.

(c) One resident was obese, and the CNAs had to use the Hoyer lift to get her up and down. CNAs did not respond to her call light in a timely fashion to help her to the bathroom, and the resident was required to wear briefs, which upset her very much.

(d) Another resident was once left on the toilet because a CNA forgot about him. The CNA on a previous shift had taken the resident to the bathroom, then left him to assist another resident who rang his call

light. The CNA forgot to check on the resident for the rest of her shift. Confidential Witness #9 found the resident sitting on the toilet when she arrived for her shift and went on rounds to check on the residents. She believes he had been there for a long time.

(e) The facility's policy was that the residents were supposed to be repositioned every two (2) hours. The residents were lucky if they were repositioned once during each eight-hour shift. On most days, the residents were not repositioned at all.

(f) The facility's policy was that the residents were supposed to be changed every two (2) hours. However, it was impossible to change 20 residents every two hours. Confidential Witness #9 was only able to change the residents two or three times during each eight-hour overnight shift.

(g) The nurses refused to help the CNAs use the Hoyer lifts. It was impossible to find another CNA to help because there were only two other CNAs in the entire building. The CNAs had no choice but to use the Hoyer lifts and reposition the residents by themselves.

(h) She fed three to four residents each shift and spent 15 to 45 minutes feeding each resident. Residents were often unable to eat all of their food because there was not enough time to feed them. Some of the

residents left the dining room hungry and yelled at the CNAs because they weren't able to finish their meals.

(i) Some of the residents chose to eat in their rooms. The CNAs did not have enough time to place these residents in their chairs to eat, and they had to eat in their bed at a 45 degree angle. Several of these residents threw up while eating because they couldn't digest their food properly while sitting at that angle. Other residents didn't want to eat because they did not want their stomachs to hurt after eating at an improper angle.

(j) She was required to dress and bathe four or five residents each morning. In order to have the residents up by 7 a.m., she started to get the residents up at 4:45 a.m. She occasionally had to dress the residents while they were still sleeping. The residents did not like to wake up that early, and many refused to get up or got angry when they were woken up. The remaining residents had to eat in their beds, and they were not provided with incontinence care and dressed until around 10 a.m. Residents' family members got upset when the residents were still unchanged and in bed when they arrived.

(k) There were several instances in which Confidential Witness #9 arrived to a shift and found a resident who hadn't been changed or

checked on in several hours. One day Confidential Witness #9 arrived to her shift and found a resident was sitting in a large puddle of urine. The resident had been lying in the urine for so long, her skin was stained yellow. Someone had removed the resident's catheter and forgotten to put it back in. The resident had not been checked on for hours, so the resident had not been fed, nor had her catheter been replaced.

(l) Falls occurred frequently at the facility. One night Confidential Witness #9 found a resident scooting around on the floor. The resident's call light had been activated, but then was turned off by another employee. When Confidential Witness #9 saw the resident on the floor, she realized that the other employee had not assisted the resident, and the resident had gotten up on her own and had fallen down. Confidential Witness #9 reported the incident to the nurse on duty, but the nurse did not send the resident out to the hospital.

(m) CNAs were responsible for cleaning during their shifts, which took away time from resident care.

(n) Inspections always happened around the same time each year, so the facility was ready for them. The facility was fully staffed on inspection days, with extra CNAs who usually worked other shifts,

which significantly increased the number of CNAs on the floor. Beginning in early June, the CNAs had to clean the entire building. The facility was filthy and the CNAs had to scrub vomit from the floors and walls, and wipe down picture frames. This additional cleaning took away time from the CNAs' other responsibilities; for example, they were only able to do two rounds at night instead of three, because they were cleaning. Before inspections took place, everything in the facility smelled like bleach.

106. Confidential Witness #10 worked as a CNA at Highland Park Care Center in 2011. She usually worked the 3 p.m. to 11 p.m. shift, and was typically responsible for 12 residents. However, the facility was short-staffed one to two days per week, and on those days, she would be assigned more residents.

107. According to Confidential Witness #10:

(a) When the facility was short-staffed, she would have to go from floor to floor and she got really behind. If she had to go from floor to floor she would not even know about call lights on the other floor. The wait for a response would be about 5-8 minutes if she were on the floor, 10-15 minutes if not.

(b) Some records were falsified. For example, if she took a short-cut by skipping a shower and, instead, giving a bed bath and putting down a new bed pad, she still had to write down that a shower was done.

(c) Records regarding ROMs were also falsified by her and by others. CNAs were told to do 15-30 minutes of ROMs with each resident each day, but most days she only had time to do 10 minutes. There was pressure to record more; they were told by the LPNs and/or the charge nurses to write down at least 20 minutes. This instruction conflicted with other instructions the CNAs received from managers not to stay any longer than 15 minutes with any one patient during rounds. Sometimes she didn't have time to do ROMs at all, in which case the nurse who was assigned to the same residents would tell her that the therapy staff would do ROMs with the residents, but she should write it down as complete in the resident records.

(d) Residents were supposed to be repositioned every two hours. Typically, she only had time to do this two or three times during each eight-hour shift, at the same time she was cleaning the residents. Confidential Witness #10 cared for three residents who required the assistance of two staff members to be safely repositioned. However,

she could not always find someone to help and would have to do it alone.

(e) Most residents needed to wear diapers and be regularly changed, because of their incontinence. However, there were around three residents who could have used the toilet if assisted, but she could not get to them fast enough.

(f) She was present for a DOH inspection. The facility was aware that the State was coming—charge nurses would tell the staff that the State was coming the next day. They also got more staff for inspection days. Sometimes, so many extra workers came on inspection days that facility managers would send some of them home.

108. State inspectors from DOH also have found that Highland Park violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During an abbreviated survey on July 27, 2011, the facility was given a deficiency for failing to provide nail care to several residents who had long, dirty fingernails.

(b) During the annual survey completed on September 18, 2014, the facility received a deficiency for failing to provide enough tubs and showers. Instead of the required ratio of one bathing fixture to 15

beds, the facility removed two tubs to use the area for storage, leaving the ratio at one fixture to 25 beds on two units.

G. Omissions of Care at Kittanning Care Center (Kittanning, PA)

109. Confidential Witness #11 worked as a CNA at Kittanning Care Center in 2015. She usually worked the 3 p.m. to 11 p.m. shift, and was typically responsible for 15 residents.

110. According to Confidential Witness #11:

(a) While she was working at the facility, she observed decreasing staffing levels and residents complaining frequently about not getting enough showers or attention from staff.

(b) If a resident was large and had to be lifted using a Hoyer lift, she gave him or her a bed bath instead of a shower, because putting the resident in a Hoyer lift, and then a shower chair, took up too much time.

(c) She was usually unable to take residents to the dining room on time because she was busy charting. She was frequently written-up for not getting the residents in the dining room on time. However, when she skipped charting, she also got written-up.

(d) The call lights were supposed to be answered within five minutes, but the residents complained that they waited for over 20 minutes for a response. On a daily basis, Confidential Witness #11 encountered

residents who were upset due to waiting for a response to their call lights. Residents got especially upset when they soiled themselves while waiting for assistance.

(e) A few of the residents had pressure sores, but many residents had "urine burn." "Urine burn" occurs when a resident sits in urine for too long, creating a red, painful rash. Some of the residents cried when they were changed because the burn was so bad. One resident had a burn that started from her brief and went down her leg. Residents had urine burn because they were not changed as often as needed.

(f) She sometimes saw CNAs try to feed a resident for ten minutes, then give up. When this occurred, Confidential Witness #11 tried to help the resident finish the meal. However, there were several incidents in which the residents did not get fed because the CNAs decided to stop feeding them before they were done eating. Residents also frequently received cold food due to waiting to be fed.

(g) CNAs were supposed to do ROMs with the residents on a daily basis. Confidential Witness #11 only did ROMs while undressing the residents and only spent a few minutes doing ROMs. She did not have time to do more than this.

(h) She often arrived to shifts and found residents who did not appear to have been changed in several hours. Sometimes when Confidential Witness #11 would put a resident in a lift, she would see feces and urine drop out of the resident's pants. When she asked the day shift CNAs why they didn't change the residents, they said that they were too busy.

(i) She was present for a DOH inspection that took place right after she received her CNA license. During the inspection, Confidential Witness #11 saw the Director of Nursing helping pass out trays and the nurses helping answer call lights. However, she did not see this on most days.

(j) The CNAs constantly complained about the lack of staff. The charge nurse's response was that the facility was holding a hiring event, or that a new CNA class was about to graduate. However, staffing levels never improved.

111. State inspectors from DOH also have found that Kittanning violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During an abbreviated survey on February 22, 2008, the facility received a deficiency for failing to provide the minimum required number of nursing hours for each resident on two separate days.

(b) During the annual survey completed on February 13, 2014, the facility received a deficiency for failing to report an injury during a mechanical lift transfer that sent a resident to the hospital.

H. Omissions of Care at LaurelWood Care Center (Johnstown, PA)

112. Confidential Witness #12 worked as a CNA at LaurelWood Care Center from 2008 to 2011. She usually worked the 7 a.m. to 3 p.m. shift, and was typically responsible for 15 residents.

113. According to Confidential Witness #12:

(a) Residents usually waited for about 15 minutes for an answer to the call lights. On a daily basis, she found residents who were upset due to waiting too long for a response to their call lights.

(b) The facility's policy was that the residents were supposed to be repositioned every two (2) hours. Confidential Witness #12 did not have enough time to reposition the residents this often, however, and was only able to reposition them about every four (4) hours. When she needed assistance with the Hoyer lift or with repositioning residents who required a two-person assist, she waited a long time for

help. As a result, she usually used the Hoyer lift by herself. She was unable to wait for help and had to get repositioning done.

(c) CNAs did ROMs with residents for a few minutes while bathing or showering them. However, Confidential Witness #12 rushed through ROMs and did not have enough time to give the residents the exercise that they needed.

(d) Only residents who had doctor's appointments would be dressed before breakfast. The remaining residents ate breakfast in their rooms and were not dressed until after breakfast.

(e) Confidential Witness #12 occasionally worked the night shift, and the night CNAs had to dress three or four residents before the day shift CNAs arrived. To get these residents dressed in time, Confidential Witness #12 had to wake the residents up at 4:30 a.m. The residents were not happy about getting woken up so early and got upset with the CNAs.

(f) Confidential Witness #12 was scheduled to shower two to three residents each shift, when she worked the day shift. However, she usually had to skip a shower, because there was not enough time.

(g) Approximately 90% of her residents were incontinent. The facility's policy was that the residents were supposed to be changed every two

hours, but the CNAs were only able to change the residents every three to four hours. On a daily basis, Confidential Witness #12 found residents who did not appear to have been changed in several hours. She frequently had to give residents complete bed baths because they were covered in feces and urine.

(h) During State inspections, the administrators and office workers came out of their offices to help out on the floor and pass trays out during meals. On a normal day, however, the administrators stayed in their offices.

(i) If a resident had to go off-site for an appointment, the supervisors pulled a CNA off the floor and had her accompany the resident off-site. This occurred frequently on the day shift. When this happened, other CNAs had to provide care to additional residents to cover for the CNA who had gone off-site. One time, Confidential Witness #12 left the facility at 9:15 a.m. and did not return until 3:15 p.m., which was after her shift ended. During that entire time there was only one CNA on the floor.

114. Confidential Witness #13 worked as a CNA at LaurelWood Care Center from 2013 to 2015. He worked the day shift (7 a.m. to 3 p.m.) and the evening shift (3 p.m. to 11 p.m.). If they were fully staffed, he was responsible for

8-10 residents during the day shift and 15-20 residents during the evening shift. However, the facility was frequently short-staffed, and when that happened, he was responsible for more residents.

115. According to Confidential Witness #13:

(a) The facility was usually short-staffed, and he was very rushed during these shifts.

(b) Residents waited up to 20 minutes for a response to their call lights. Confidential Witness #13 frequently found residents who were upset due to waiting for an answer to their call lights. Residents also complained about staff turning off their call lights but not coming back to provide assistance.

(c) Quite a few residents had pressure sores on their heels and buttocks, which developed because the residents were in the same position for too long.

(d) He usually stayed on the hall during meal times. He noticed that some CNAs took a tray into the room, and then took the tray out of the room 10 minutes later, and the trays were still full. If the residents were asleep, or did not eat right away, they missed their meals.

(e) The CNAs were supposed to do ROMs with residents and walk around the hallways at least once per shift. During the day shift,

Confidential Witness #13 spent about 5 minutes stretching the residents while getting them dressed, but only had enough time to walk with one or two residents on each shift. All of the residents needed to walk around the halls at least once each day, but there were not enough CNAs to walk with them. During the evening shift, Confidential Witness #13 did not have enough time to do ROMs with the residents at all.

(f) The residents were supposed to be up and dressed by breakfast. Breakfast was served anywhere from 7 a.m. to 8 a.m. Confidential Witness #13 was able to get five or six residents dressed by breakfast, and they ate in the dining room. However, the majority of residents ate breakfast in their rooms and got dressed after they finished breakfast.

(g) Residents were sometimes not well-groomed. CNAs rushed through showers, and residents still smelled bad after their showers. Sometimes CNAs did not wash the residents' faces, and they had food left on their faces from the day before.

(h) Some residents became incontinent while residing at the facility because they waited too long for assistance to go to the bathroom. Confidential Witness #13 was only able to change the incontinent

residents twice per shift because he was so busy, even though the facility's policy was that residents should be changed more frequently. Confidential Witness #13 constantly found residents who were soaking wet, sometimes with urine soaking through their blankets and sheets, and soiling their mattresses.

(i) Administrators knew when the inspectors were coming because they came around the same time every year. Once the inspectors walked through the door, staff would spread the word that the inspectors had arrived. The facility was very different from normal on inspection days. The hallways were clean, and there were additional CNAs on duty.

116. State inspectors from DOH also have found that LaurelWood violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During an abbreviated survey on August 30, 2007, the facility was given a deficiency for failing to bathe residents properly. While bathing two residents who needed help with personal hygiene, a CNA left visible soap residue on their skin and dried them without properly rinsing.

(b) Also during the August 30, 2007 survey, the facility was given a deficiency for failing to respect a resident's preference to get up and out of bed by 9:00 a.m. Inspectors observed that the resident was not gotten out of bed until just before 11:15 a.m.

(c) During an abbreviated survey on May 21, 2010, the facility received a deficiency for failing to prevent pressure sores due to incontinence. Staff were supposed to apply an ointment to a resident's buttocks and groin twice daily and as needed when incontinent. During the survey, the resident was incontinent of bowel and the CNA did not apply the ordered ointment.

(d) During the annual survey completed on August 4, 2011, the facility was given a deficiency for failing to notify a doctor of a change in condition in a resident. The resident had a fever for three days before staff informed the doctor. The doctor sent the resident to the hospital, where she was diagnosed with a UTI, possible pneumonia, a pressure sore, and dehydration.[9]

(e) During the annual survey completed August 6, 2015, the facility received a deficiency for failing to help a resident to eat. A resident who weighed 79.2 pounds needed extensive assistance with her meals.

[9] UTIs, pressure sores, and dehydration are conditions that are often caused by failures of Basic Care.

During the survey, inspectors observed that her meal tray was delivered to her room at 12:35 p.m., no staff tried to help her to eat, and the tray was removed at 3:07 p.m. without her eating any of the food. However, staff recorded that she had eaten 100% of her meal in the meal intake record. A CNA admitted the meal intake record was inaccurate.

117. DOH inspectors have also found deficiencies relating to LaurelWood's use of physical and pharmacological restraints:

(a) During an abbreviated survey on April 24, 2008, the facility received a deficiency for overmedication.

(b) During the annual survey completed July 23, 2009, the facility was given a deficiency for giving a resident anti-anxiety and anti-psychotic medications without justification for their use.

(c) During the annual survey completed July 31, 2014, the facility received a deficiency for failing to try to reduce the use of a physical restraint on a resident.

I. Omissions of Care at Providence Care Center (Beaver Falls, PA)

118. Confidential Witness #14 worked as a CNA at Providence Care Center from 2013 to 2015. She usually worked the 3 p.m. to 11 p.m. shift, and was typically responsible for 12-13 residents.

119. According to Confidential Witness #14:

(a) She did not have enough time to finish her work, because the facility was almost always short-staffed.

(b) The residents waited a long time for an answer to their call lights.

(c) The facility's policy was that the residents were supposed to be repositioned every two (2) hours. However, Confidential Witness #14 was usually only able to reposition residents twice per eight-hour shift due to the lack of staff. CNAs routinely used Hoyer lifts by themselves because it took too long to find another staff member to assist.

(d) Residents attached to feeding tubes often had bad pressure sores on their buttocks. The food in the feeding tubes led to loose bowels, and the skin on their buttocks became irritated from sitting in wet feces, because they were not changed often enough.

(e) CNAs were supposed to include ROMs in their care of residents, but they rarely did ROMs because they did not have enough time.

(f) Residents were put to bed before they wanted to go to bed. There was no one to help her after she fed the residents dinner, and it would have taken too long for her to put everyone to bed after dinner by herself,

so she put the immobile residents to bed before dinner and then fed them dinner in their rooms.

(g) The facility's policy was that the residents were to be checked for incontinence and changed, if needed, every hour or two. However, Confidential Witness #14 changed most of the residents only twice during each eight-hour shift and changed the heavy-wetters three times each shift. Confidential Witness #14 once arrived to her shift, and found that a resident who had thrown her brief onto the floor. The brief was drenched in urine, and the resident said that she took it off because she could not stand lying in it any longer.

(h) Inspections took place around the same time every year, and the administrators knew when to expect them. During inspections there were additional CNAs on duty who normally worked other shifts.

120. Confidential Witness #15 worked as a CNA at Providence Care Center from 2014 to 2015. She usually worked the 3 p.m. to 11 p.m. shift, and was typically responsible for 14-16 residents.

121. According to Confidential Witness #15:

(a) She often found residents who had urine soaked through their briefs and clothes, and required complete bed changes. The CNAs did not change the residents as often as needed because they did not have

enough time during their shifts. Some residents became incontinent while residing at the facility because they waited too long for assistance going to the bathroom.

(b) She felt rushed while undressing residents, and she did not have enough time to get residents completely washed up. Instead of giving the residents bed baths, she took a wet washcloth and cleaned off their faces, hands, and genitals.

(c) The CNAs tried to keep the residents well-groomed, but there was not enough time. She could tell from the appearance of the residents that they were not getting the care that they needed. Some of the residents smelled badly, so she knew that their showers had been skipped. Other residents had dirty faces because they had not been washed.

(d) In the mornings, the residents were supposed to be up and dressed by lunch, which was served between 11:00 a.m. and 11:30 a.m. The majority of the residents were not dressed in time for breakfast, so they had to eat breakfast in their rooms.

(e) She had four or five residents on each shift who needed complete assistance with eating, and she fed two residents simultaneously in order to save time. Some residents were unable to finish their meals, and a few of the residents did not get to eat at all because the CNAs

did not have time to feed them. This happened almost daily with certain residents who required more than 20-25 minutes of feeding assistance. Some of the residents ate in their rooms. The CNAs dropped off meal trays in their rooms, and if they did not finish their meals after 10 minutes, their trays were taken away. Sometimes the CNAs walked into the room with the trays and walked right out of the room because the CNAs didn't have time to feed the residents. If a CNA knew that a particular resident was known to eat only two bites every 20 minutes, for example, she would have to move on to the next task after trying to feed them. She saw some residents who withered away because they missed meals and were not fed properly.

(f) The nurses told the CNAs that it counted as ROMs when the residents lifted their hands above their heads while getting dressed. Thus, the CNAs charted that they did ROMs. A nursing supervisor informed the CNAs that they had to record a minimum of 15 minutes of ROMs per shift. There was no way to leave this section blank without getting a reprimand; it was understood that this must be done. However, the CNAs did not do any ROM exercises with the residents other than dressing them and undressing them, because there was not enough time.

(g) When CNAs complained about the inadequate staffing levels, administrators told them that they needed to learn how to work faster.

122. State inspectors from DOH also have found that Providence violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During an abbreviated survey on April 20, 2007, the facility received a deficiency for failing to assign enough staff to a resident. The resident's assessment showed the resident was totally dependent on two staff members for bed mobility, transfers, dressing, personal hygiene, and bathing. A CNA provided morning personal care without a second staff member, and the resident fell out of bed, fracturing a hip.

(b) During the annual survey completed August 22, 2008, the facility received a deficiency for failing to supervise and monitor residents to prevent falls. A CNA left a resident unattended in his wheelchair in the hallway after providing morning care. The resident rolled himself down a ramp and flipped the wheelchair. The resident's care plan showed that he needed extensive assistance with mobility and activities of daily living, and had fallen within the past 30 days.

(c) During an abbreviated survey on May 10, 2011, the facility was given a deficiency for failing to supervise a resident to prevent falls. The resident had fallen five times at the facility since his admission. He was left unattended after being taken to the shower room, and was seen rolling his wheelchair down a ramp, striking the elevator door frame and cutting his eyebrow.

123. DOH inspectors have also found deficiencies relating to Providence's use of physical and pharmacological restraints:

(a) During the annual survey on August 6, 2009, the facility received a deficiency for overmedicating a resident with psychoactive medication without an appropriate diagnosis or monitoring.

(b) During the annual survey completed on July 29, 2010, the facility received a deficiency for failing to try to reduce the use of physical restraints. Three residents were observed for three and a half hours without their restraints being released or the residents repositioned as required.

J. Omissions of Care at Riverside Care Center (McKeesport, PA)

124. Confidential Witness #16 worked as a CNA at Riverside Care Center from 2009 to 2012. He was a per diem employee and worked on whichever shift he was needed. He usually worked the overnight shift (11 p.m. to 7 a.m.) and

worked full time. On the overnight shift he was responsible for 20 residents. When he worked the daytime and evening shifts, he was responsible for at least 14 residents.

125. According to Confidential Witness #16:

(a) He rarely had enough time to finish his work and had to prioritize who he provided care to. The needy residents received more care than the more independent residents. Confidential Witness #16 felt badly about giving more attention to the needy residents, but had to use his limited time wisely.

(b) He learned in his CNA training that all employees are supposed to respond to the call lights. However, at Riverside, the CNAs were usually the only employees who answered the call lights. Residents usually waited about 10 minutes for a response, but if the CNAs were really busy, the residents had to wait about 40 minutes. Some residents complained about waiting too long for a response to their call lights.

(c) He learned in his CNA training that residents are supposed to be repositioned every two hours. However, it was too difficult to reposition 20 residents every two hours, so the residents were usually only repositioned every four to five hours. Confidential Witness #16

and the other CNAs used the Hoyer lifts by themselves because they were unable to wait for assistance. This was scary, because the CNAs are supposed to use the Hoyer lifts with at least one other person, otherwise the residents could get injured. However, there often was not another staff member who could help him.

(d) He learned in his CNA training that the residents should be changed every two (2) hours. However, he was only able to change the residents twice during each eight-hour shift; the workload was too heavy to change the residents more frequently. Several continent residents became incontinent due to waiting too long for assistance with using the restroom. On a daily basis, he found residents who were soaking wet.

(e) When he worked during mealtimes, he was responsible for feeding three or four residents who needed full assistance to eat and spent 15-20 minutes feeding each resident. The last resident to be fed usually received cold food. Confidential Witness #16 was rushed every time he fed the residents, and some of the residents did not respond well to being rushed. He sometimes noticed that some of the CNAs did not have enough time at meals, and some of the residents did not get fed.

(f) There was not enough time to do ROMs with the residents. Confidential Witness #16 charted that he did ROMs, but in actuality he showered and dressed the residents, and counted these tasks as ROMs. He was told he would get into trouble if he did not chart that he had done ROMs.

(g) When he worked the overnight shift, he had to get three residents up and dressed before the end of his shift. To get these residents ready for the day, he wiped down their underarms, faces, and genitals, and then got them dressed. In order to get these residents up and dressed before the end of his shift, he had to begin dressing residents at 5:30 a.m.

(h) Confidential Witness #16 was usually assigned to shower three residents each shift, but he frequently skipped showers because he did not have enough time to shower all the assigned residents.

(i) He was present for a few inspections, and on those days, the facility was fully-staffed with employees who usually worked other shifts. The office workers also helped out on the floor during inspections, but on normal days they would stay in their offices.

(j) Residents complained to the nursing staff about waiting too long for the call lights and assistance to the bathroom, and about feeling rushed

while eating. CNAs frequently complained to the Assistant Director of Nursing about the lack of staff. She said that she was trying to hire more people, but staffing levels did not improve. The lack of staff was the biggest problem at the facility. Absenteeism was a chronic issue, but the facility did not schedule more workers or call in more workers to compensate, so the facility was usually short-staffed.

126. Confidential Witness #17 worked as a CNA at Riverside Care Center from 2009 to 2012. She usually worked the 11 p.m. to 7 a.m. shift, and was typically responsible for 30 of the 60 residents on a unit. A couple of times she was by herself with all 60 residents.

127. According to Confidential Witness #17:

(a) When she and others complained to the management about the lack of staff, they got no response. Management staffed the overnight shift as if everyone was sleeping, but in reality some residents did not sleep through the night.

(b) She was only able to provide incontinence care and repositioning every four (4) hours, even though this was supposed to be done every two (2) hours. She told the Director of Nursing that they could not change the residents often enough with the number of staff that they had, but she only got in trouble for saying this. She worried about the

residents she had not had time to change, who were lying in their own feces.

(c) She was present for a few DOH inspections, which occurred during the daytime shift. She was told during her shift (the overnight shift) that she would be "mandated" to stay over for the day shift if they did not have enough staff for the inspection. Management knew the window of time when the State would arrive and made sure that there was enough staff during the window. Everyone from the office would also pitch in and help during inspections.

128. Confidential Witness #18 worked as a CNA at Riverside Care Center in 2014. She usually worked the 11 p.m. to 7 a.m. shift, and was supposed to be responsible for 10 residents. However, due to frequent absenteeism, she was usually responsible for 24 residents on her shift.

129. According to Confidential Witness #18:

(a) The facility was very understaffed, and CNAs were responsible for too many residents. Because of this, the residents did not receive adequate care.

(b) Residents had to wait a long time for a response to their call lights.

(c) Residents were supposed to be changed and repositioned every two (2) hours, which Confidential Witness #18 learned in her CNA

training program. However, she and the other CNAs were only able to change and reposition the residents every four (4) hours, because the CNAs were too busy to get to the residents more frequently. If Confidential Witness #18 needed assistance with a Hoyer lift or with repositioning a resident, she had to wait anywhere from 30 minutes to one hour. CNAs frequently used Hoyer lifts on their own because they were unable to wait for assistance.

(d) There were a few residents with pressure sores at the facility. Confidential Witness #18 remembered one resident who had a very bad pressure sore on his tail bone. The sore was so bad that she could see what appeared to be bone. Confidential Witness #18 had never seen a pressure sore that bad.

(e) She occasionally worked the day shift and the evening shift, and she helped feed the residents on these shifts. She spent about 25 minutes feeding each resident and felt very rushed. Residents often felt sick from eating too quickly, or they refused to eat because they did not want to be rushed. Residents often received cold food, due to waiting to be fed.

(f) CNAs were supposed to do ROMs with the residents, but there was not enough time, so they were usually skipped.

(g) Personal hygiene care was very rushed. Residents often got upset because they did not like feeling rushed while getting dressed. Showers were also often cut short, and residents were not fully washed, because there was not enough time.

(h) She was present for one inspection. During the inspection, everyone including the nurses and administrators helped out on the floor. The Administrator helped pass trays. On a normal day, however, the administrators did not help on the floor. Additionally, the facility was very clean on inspection day, although it was usually dirty. There was more staff working on inspection day than usual, and the residents received warm food.

(i) CNAs frequently complained to the administrators about the lack of staff, but they did nothing in response.

130. State inspectors from DOH also have found that Riverside violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During an abbreviated survey on October 3, 2007, the facility was given a deficiency because records did not reflect the incontinence care that a resident was supposed to receive. Staff were supposed to clean a resident's buttocks with cleansing lotion and apply skin cream

every shift and as needed after every incontinence episode and record doing so. However, the resident's record showed 13 blank spaces, where the care should have been recorded, and the resident had 33 episodes of diarrhea without any record of the ordered skin treatments. The resident was transferred to the hospital with extensive pressure sores and was in so much pain he was moaning when the area was examined.

(b) During the annual survey completed April 3, 2008, the facility received a deficiency for failing to respond to call lights in a reasonable time. Resident council meeting minutes from ten meetings included complaints that staff members were turning off call lights and not returning to actually perform care. Surveyors observed that it took 19 minutes for care to be provided after a call light was activated.

(c) During the annual survey completed March 27, 2009, the facility was given a deficiency for failing to resolve ongoing resident complaints. Two residents said they made multiple complaints about lack of care, but the facility staff never followed up with them or changed how care was provided. The Director of Nursing said the facility had not started a grievance log until recently before the survey.

(d) During the annual survey completed April 15, 2010, the facility received a deficiency for not providing personal care for a resident who hurt his hand because his nails were not trimmed and were long and jagged.

K. Omissions of Care at Woodhaven Care Center (Monroeville, PA)

131. Confidential Witness #19 worked as a CNA at Woodhaven Care Center from 2008 to 2009 and again from 2010 to 2011. In between these two periods of employment, he worked at the facility part time, as an agency CNA, while he was attending nursing school. He usually worked the 7 a.m. to 3 p.m. shift, but he was often required to stay on for mandatory overtime and work the 3 p.m. to 11 p.m. shift as well. When he first started working at the facility, when the facility was fully staffed, he would be assigned to six residents. When he came back to full-time work at the facility in 2010, staffing levels at the facility were lower. As time went on, the number of residents to whom he was assigned went up to 12, then to 20.

132. According to Confidential Witness #19:

(a) Sometimes he felt all he could do was make sure everyone ate and was washed up. Those were the two areas he would concentrate on when short-staffed. There was never enough time to complete all tasks. CNAs were responsible for cleaning resident rooms, but when

there was not enough time, he would have to leave the trays, laundry and trash in the rooms.

(b) The electronic tracker the facility used for resident care records would not allow for any blank entries and would not close unless filled out completely. There was no way to mark that something was not completed in the record. Supervisors would come around and remind the CNAs that all areas had to be completed in the records before they could leave.

(c) On a bad day, when they were short staffed (which was almost every day from 2010 – 2011), it could take as long as 20 minutes to respond to call lights. Nurses would turn off the call lights and tell residents that the CNAs would get back to them, but they did not provide assistance to residents themselves.

(d) He used the Hoyer lift alone many times, because he could not find someone to help.

(e) If a resident was a slow eater, his tray might be taken away before he was finished eating. For residents who required full feeding assistance, the CNA responsible for assisting them sometimes did not have time to finish.

(f) CNAs were told to do ROM exercises with residents, but he usually did not have time to do this. CNAs were told that they had to enter 15 minutes of ROMs – the "magic number" – into the record, no matter what. Because there was no way to enter that the ROMs were not done, he did so.

(g) There was not enough time to perform hygiene and personal care for residents, and Confidential Witness #19 sometimes had to give residents bed baths instead of showers due to lack of time.

(h) There was not enough time to provide proper incontinence care. Confidential Witness #19 would change all his assigned residents quickly at the beginning of his shift at 7 a.m., but would not be able to check residents for incontinence again until noon. Residents could be left soiled for several hours, especially around shift changes. The facility always smelled of human waste.

(i) He saw many residents with pressure sores while working at the facility.

(j) The facility knew that state inspectors were coming one week in advance and would get extra staff or force staff members from previous shifts to stay. Everything would be much better during the week of the inspection. The building did not smell bad, and the

inspectors did not get an accurate picture of how the facility actually looked and operated.

133. Confidential Witness #20 worked as a CNA at Woodhaven Care Center from 2011 to 2013. He worked the 7 a.m. to 3 p.m. shift during his first year at the facility, and he worked the 3 p.m. to 11 p.m. shift his second year at the facility. On both shifts, he was responsible for 16 residents when the facility was staffed normally, but was responsible for 20 when the facility was short staffed, which was more than once per week.

134. According to Confidential Witness #20:

(a) Residents and families complained of long waits for responses to call lights. Residents sometimes waited 15-30 minutes for a response.

(b) The facility's policy was that residents were to be repositioned every two (2) hours, unless the resident's doctor's order or care plan specified a different interval of time. If the facility was short-staffed, Confidential Witness #20 could only reposition residents every three (3) hours. He could not always find assistance to help reposition residents and sometimes resorted to using the Hoyer lift alone.

(c) CNAs were assigned to do ROM exercises and Restorative Assistance, which consisted of activities such as helping residents to

walk. Confidential Witness #20 only had time to do about half of what he was assigned for both ROMs and Restorative Assistance.

(d) Sometimes he did not have time to do assigned showers when the facility was short staffed. He still had to record in resident records that he had completed the showers, but he would tell the oncoming shift that he had not actually completed them. He does not know if they ever caught up on showers or not.

(e) When the facility was short staffed, and he was assigned to 20 residents, he could only check residents for incontinence every three (3) hours. They were supposed to be checked every two (2) hours.

(f) He was responsible for helping residents who needed assistance getting to the bathroom whenever they rang their call bells. Sometimes he could not get there in time, and residents would urinate or defecate on themselves.

(g) CNAs were required by both the Restorative Nurse and the Director of Staff Development to record in resident records that they had completed 15 minutes of ROMs with the resident, but about half the time, this was not actually done. However, per instructions, the CNAs recorded it anyway, which the Restorative Nurse and Director of Staff Development knew. The same rule applied for anything else that was

required on the resident's care plan; for example, CNAs had to record that a shower had been done, even if it was not. There was no way to record on the kiosk that a task had not been completed, other than to state that a resident refused.

(h) During the two DOH inspections that he was present for, management would help out on the floor, though they never did this normally. In addition, the facility would get some extra staff in to work on inspection days by having regular employees come in on their days off.

(i) Staff begged the facility managers to hire agency staff when they were short staffed, but the managers never would. Their response was that the facility was "on ratio"—meaning that it had the required State minimum ratio of staff to residents.

135. Confidential Witness #21 worked as a CNA at Woodhaven Care Center in 2014. She usually worked the 6:30 a.m. to 3:00 p.m. shift, and was typically responsible for 15-16 residents.

136. According to Confidential Witness #21:

(a) She never had time to finish her work because the facility was always understaffed. Residents suffered and did not receive proper care because the facility was never properly staffed.

(b) Residents usually waited more than 15 minutes for CNAs to respond to their call lights. They were frequently upset about the waits and did not understand why they had to wait so long for help.

(c) Although two people are supposed to use the Hoyer lift, the CNAs sometimes had to use the lift by themselves. It took too long to find help, and they needed to get the residents up as quickly as possible.

(d) In her CNA training, she learned that for residents who required assistance with eating, CNAs were supposed to look into the residents' eyes while feeding them, explain what they were being fed, and give them time to finish chewing. However, the CNAs were unable to do this because they were always in a rush.

(e) The CNAs were supposed to do ROMs with the residents every day and walk around the halls with them. The CNAs had no time to do this. Confidential Witness #21 only remembers a couple of times that she walked with the residents; when she did this, she fell behind on charting, and then got written up because she had to stay late to finish her charting after her shift.

(f) Hygiene was a serious problem at the facility. The CNAs were supposed to give each resident a bed bath before dressing them. However, the CNAs only had time to take a washcloth and wipe down

residents' faces and private areas. Another area of personal hygiene that was overlooked was shaving. CNAs did not have enough time to shave the residents, even though the residents wanted to be shaved. CNAs also did not have time to keep the residents' fingernails clean and trimmed.

(g) She found residents who were soaking wet every day, when she arrived for her shift in the morning. The overnight shift only had one CNA per hall and they were responsible for about 30 residents. These CNAs were only able to do rounds once each shift, at about 4 a.m., because they were so busy. By the time they finished their rounds, and the morning shift arrived, the first residents the overnight shift had changed were soaking wet.

(h) State inspectors were frequently at the facility to investigate falls. During inspections, the facility was very clean and fully-staffed. The facility administrators knew that an inspection was coming and told the CNAs to make sure the residents' rooms were clean and that everything was put away. The additional staff members who worked during inspections were CNAs who usually worked the other shifts.

(i) The CNAs frequently complained about the lack of staff, but the administrators told them that the facility was fully staffed, based on the census.

137. State inspectors from DOH also have found that Woodhaven violated state and federal nursing home regulations by failing to provide Basic Care. For example:

(a) During an abbreviated survey on August 7, 2009, the facility was given a deficiency for failing to provide enough staff to provide adequate care. At 11:00 a.m., surveyors noticed 14 residents still dressed in pajamas and in bed. A CNA said she was the only aide working with 24 residents because two CNAs called off work that day.

(b) During an abbreviated survey on April 16, 2010, the facility received two deficiencies for failing to investigate complaints of abuse: one regarding inadequate hygiene and another regarding inadequate incontinence care. In one of the incidents, a resident was incontinent while waiting for a response to his call light. A CNA was angry with the resident and told the resident he would have to sleep in his wheelchair if it happened again. The facility did not investigate the resident's complaint.

(c) During an abbreviated survey on March 30, 2011, the facility was given a deficiency because the facility failed to accommodate the needs of a blind resident. According to his care plan, CNAs were supposed to set up his meal tray and explain the location of items using the "clock method." Surveyors observed the resident eating applesauce, sauerkraut, and meat with his fingers without any assistance from staff. The resident said staff did not provide the assistance outlined in his care plan, and a CNA confirmed she did not know the "clock method."

(d) During the annual survey completed June 19, 2014, the facility received a deficiency for failing to resolve the grievances lodged at resident council meetings. Meeting minutes from several months showed resident complaints about slow responses to call bells and resident rooms and beds not being cleaned, and facility staff had not resolved these complaints.

VII. GRANE'S WILLFUL FAILURE TO PROVIDE ADEQUATE CNA STAFFING

138. 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.

139. Grane marketing materials are, on information and belief, generated and approved on a centralized basis by Grane Healthcare.

140. Bills for resident care are also generated by corporate-level employees at Grane Healthcare on behalf of the Grane Facilities.

141. Grane Healthcare exercises operational and managerial control over each of the Grane Facilities.

142. Because of the level of control it exerts over the Grane Facilities, Grane Healthcare also has the right to—and, on information and belief, actually does—monitor and manage key details of the Grane Facilities' day-to-day operations, as alleged in paragraphs 157-158 below, including the Grane Facilities' regulatory compliance.

143. Two of the Grane Facilities received deficiencies in DOH surveys for insufficient staffing. However, staffing levels in these facilities were not increased to appropriate levels following these deficiencies.

144. As a result, Grane Healthcare's managers knew or should have known that the CNA staffing levels at the Grane Facilities were far below what was required to provide the care that residents needed and that had been promised to them.

145. Additionally, upon information and belief, Grane Healthcare's managers were aware of the DOH survey deficiencies issued to the Grane Facilities relating to understaffing and omissions of Basic Care.

146. 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.

147. 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.

148. Both facility-level and corporate-level managers were or should have been aware that the raw staffing numbers at the Grane 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 Grane to CMS during the period 2009 through 2016, Grane's skilled nursing facilities provided,

on average, 2.04 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.

149. The Grane Facilities had the resources to pay for increased staffing levels—either increased payroll for regular employees or the cost of temporary staffing services. However, instead of providing adequate staffing to meet the needs of residents, they diverted significant amounts of profit each year to their owners in ways that made the facilities appear less profitable than they really were. For example, Grane Facilities entered into lease agreements with related companies (owned by the same owners) that owned the real property on which each facility was located, agreeing to pay in rent each year a particular base rent *plus any profit that the facility made over the year*. These agreements resulted in a significant transfer of assets—millions of dollars each year—from the Grane Facilities to the entities that owned the property which were, in turn, owned by the same people who owned the Grane Facilities. The transfers of assets through these lease agreements allowed the Grane Facilities to report little or no profit on cost reports submitted to the Pennsylvania Medical Assistance Program. In sum, a significant amount of the revenue received by the Grane Facilities—money paid by the Pennsylvania Medical Assistance Program and by Pennsylvania consumers for

resident care—was diverted out of the Grane Facilities, rather than used to pay for the staffing levels the facilities needed to provide adequate care to residents.

VIII. LIABILITY OF GRANE HEALTHCARE

150. Grane Healthcare is responsible for both its own conduct, as alleged herein, and for the actions and omissions of the Grane Facilities.

151. Grane Healthcare, the Grane Facilities, and related entities are a highly integrated family of companies, owned by a small group of individuals: David Graciano, Jeffrey Graciano, Richard Graciano, and Ross Nese ("Owners").

152. Some misrepresentations made to the Commonwealth and to Pennsylvania consumers, as alleged herein, were made, upon information and belief, directly by Grane Healthcare, such as the marketing information appearing at www.grane.com.

153. To the extent that other misrepresentations were made by employees of the individual Grane Facilities, Grane Healthcare is also responsible for this deceptive and misleading conduct under a theory of alter ego or agency theory of liability.

154. Grane Healthcare, like the Grane Facilities, is owned by the four individual Owners. Grane Healthcare is the entity identified as exercising operational/managerial control for each facility in Medicare records.

155. Although it purports to be an independent company, providing "consultation, advice and administrative support to independent providers of long-term care," and refers to the Grane Facilities as its "clients," Grane Healthcare exercises pervasive, day-to-day control over the operations of the Grane Facilities, to the advantage of their mutual owners.

156. Grane Healthcare, as the "home office" for each of the Grane Facilities receives funds designated as payments for management fees from the facilities. These payments total millions of dollars annually, across the Grane Facilities. For example, between 2008 and 2014, the following management fees were paid to Grane Healthcare by each of the Grane Facilities, according to their annual cost reports:

Facility	**Management Fees 2008-2014**
Altoona Center for Nursing Care	$4,371,260
Cambria Care Center	$7,276,294*
Colonial Park Care Center	$6,752,957
HarmarVillage Care Center	$6,455,732
Harmon House Care Center	$4,589,246
Highland Park Care Center	$4,605,329
Kittanning Care Center	$3,184,649
LaurelWood Care Center	$4,818,997
Providence Care Center	$6,212,484
Riverside Care Center	$4,079,261
Woodhaven Care Center	$4,010,337

*Cambria includes costs paid from 2010 – 2014. It was under other ownership from 2008-2009.

157. However, the relationship between each of the Grane Facilities and Grane Healthcare 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 Grane Facilities do not provide direction to or exercise any measure of control over the "services" provided to them by Grane Healthcare, nor do the Grane Facilities have any right or ability to decline to follow the directions or recommendations of Grane Healthcare, as a "client" would be able to do in a typical relationship with a consultant. Rather, Grane Healthcare exercises pervasive day-to-day control over its supposed "clients"—the Grane Facilities—at the direction of, and for the benefit of, their mutual owners. The Grane Facilities are then, in turn, required to pay Grane Healthcare for these "services."

158. On information and belief, Grane Healthcare exercises control over the Grane Facilities by:

(a) Hiring and training nursing staff;

(b) Sending nurse consultants to visit the facilities regularly and oversee the quality of resident care;

(c) Handling facilities' budgeting and accounting, including maintaining control over approval of facility staffing budgets;

(d) Providing facility policies and procedures;

(e) Preparing marketing materials; and

(f) Managing all aspects of the operations of the facilities.

159. Grane Healthcare also misrepresents the nature of its relationship with the "client facilities." It describes itself as a company that "provides consultation, advice and administrative support to independent providers of long-term care." ("About Us," http://www.grane.com/about/index.aspx (last visited Oct. 5, 2016).) However, the Grane Facilities are not, in any way, "independent." They are not independently owned, because the same people who own Grane Healthcare own each of the Grane Facilities. And they are not independently operated, because Grane Healthcare controls every aspect of their budget and operations.

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

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

161. The Grane Facilities and Grane Healthcare willfully made representations to Pennsylvania consumers that they would provide the Basic Care required by their residents when the Grane 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. Among other things, Grane:

(a) promised a level of services that they did not provide;

(b) stated that their staffing levels were based on resident acuity when they were not;

(c) characterized their staffing levels and ratings as "very high" when they were not;

(d) promised that assistance was readily available to residents when it was not;

(e) promised that they would provide and had provided services that they would not provide and had not provided.

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

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

(b) care plans that outlined the care that the Grane Facilities promised to provide and, on information and belief, were made available to or shared with residents and their family members; and

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

163. 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.

164. The Grane 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 Grane Facilities had provided, and would continue to provide, a level of care that was not provided.

165. The Grane 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.

166. 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.

167. 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: Unjust Enrichment

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

169. Grane Healthcare and the Grane Facilities were unjustly enriched through the actions of each of the Grane Facilities. The Grane 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 Grane Facilities for the per diem rates claimed on these billings. The Grane 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.

170. On information and belief, the Grane Facilities acted at the direction of, under the control of, and for the benefit of Grane Healthcare and their mutual owners, and profits wrongfully attained, at the Commonwealth's expense, were shared with Grane Healthcare through payment of management fees.

171. Grane Healthcare and the Grane Facilities have been unjustly enriched at the expense of the Pennsylvania Medical Assistance Program and the Commonwealth. This Court should find that Grane Healthcare and the Grane

Facilities 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 Grane Healthcare and the Grane Facilities unjustly enriched, and enter judgment against Grane Healthcare and the Grane Facilities in an amount equal to the monies received by them from the Pennsylvania Medical Assistance Program for Basic Care not rendered, 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,

BRUCE R. BEEMER
Attorney General

James A. Donahue, III
Executive Deputy Attorney General

Date: November 21, 2016

By: Thomas M. Devlin

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

COMMONWEALTH OF PENNSYLVANIA
Acting by Attorney General
BRUCE R. BEEMER,

Plaintiff,

v.

GRANE HEALTHCARE CO.; ALTOONA CENTER FOR NURSING CARE LLC (d/b/a ALTOONA CENTER FOR NURSING CARE); EBENSBURG CARE CENTER LLC (d/b/a CAMBRIA CARE CENTER); COLONIAL PARK CARE CENTER LLC (d/b/a COLONIAL PARK CARE CENTER); HARMARVILLAGE CARE CENTER LLC (d/b/a HARMARVILLAGE CARE CENTER); HARMON HOUSE CARE CENTER LLC (d/b/a HARMON HOUSE CARE CENTER); HIGHLAND PARK CARE CENTER LLC (d/b/a HIGHLAND PARK CARE CENTER); KITTANNING CARE CENTER LLC (d/b/a KITTANNING CARE CENTER); LAURELWOOD CARE CENTER LLC (d/b/a LAURELWOOD CARE CENTER); PROVIDENCE CARE CENTER LLC (d/b/a PROVIDENCE CARE CENTER); RIVERSIDE NURSING CENTERS, INC. (d/b/a RIVERSIDE CARE CENTER); WOODHAVEN CARE CENTER LLC (d/b/a WOODHAVEN CARE CENTER),

JURY TRIAL DEMANDED

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 Complaint And Petition For Injunctive Relief.* I hereby verify that the factual allegations contained in the attached 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: November 3, 2016

Rebecca M. Bloom

Rebecca M. Bloom
Consumer Protection Agent Supervisor
Health Care Section
Public Protection Division
Office of Attorney General