medications were "borrowed." (Trial Tr. Vol. 11 (T. Edwards) at 1594.) "Borrowing," however, was not always possible, because it required a "donor" resident who had the appropriate medication in the appropriate dosage. (Trial Tr. Vol. 12 (Brunner) at 1818-19, 1832-32; Trial Tr. Vol. 14 (Lee) at 2284.) When "borrowing" was not possible, residents did not receive their medications. (Trial Tr. Vol. 12 (Brunner) at 1818-19, 1832-32; Trial Tr. Vol. 14 (Lee) at 2284.)

268. Barbara Lynch's mother lived in Mt. Berry from approximately 2004 until the home closed. (Trial Tr. Vol. 10 (Testimony of Barbara Lynch) at 1518-19.) When Ms. Lynch's mother first moved into Mt. Berry, Ms. Lynch was satisfied with the care that her mother received. (Id. at 1519.) Ms. Lynch testified that, before the home closed, it

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suffered from large staff turnover, the dumpster was full, and the home "didn't have water and then the laundries didn't work." (Id. at 1520-21.) At that time, Ms. Lynch saw that her mother was not receiving her medication. (Id. at 1521-22.) Mrs. Lynch visited her mother frequently, and she found her mother's pills on her bed or on the floor. (Id. at 1521.) According to Ms. Lynch, at that point, it had become difficult to find a nurse or CNA in the home, but Mrs. Lynch would find one and would report that her mother was not receiving her medication properly. (Id. at 1521-22.) Ms. Lynch testified that her reports and complaints had no effect. (Id. at 1521.)

11. Staff Shortages

269. Nursing homes must have sufficient nursing staff to care for their residents. (Trial Tr. Vol. 2 (Mauldin) at 143-

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45; 42 U.S.C. § 1396r(a)(4)(A)(i); 42 C.F.R. § 483.30.)

a. Mt. Berry

270. Ms. Stanley testified that she was "uncomfortable" with the cuts in staffing that Defendant wanted her to make. (Trial Tr. Vol. 1 (Stanley) at 42.) Staff quit because of the payroll problems, and Ms. Stanley testified that it was difficult to recruit new staff because the community knew about the difficulties with payroll and people did not want to work at the facilities. (Id. at 12.) According to Ms. Stanley, at times, staffing was short because employees left to race to the bank to try to cash their paychecks. (Id. at 79.) Ms. Stanley and other witnesses testified that staff members were pulled from their regular jobs to take laundry to the laundromat or to shop for food and supplies for the residents. (Id. at 34; Trial Tr. Vol. 2 (Knowles) at 300, 306-

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07, 312-13; Trial Tr. Vol. 9 (Grant) at 1362.)

271. Ms. Stanley's successor, Ms. Greenway, testified that she received multiple complaints from family members about staffing levels in the nursing home. (Trial Tr. Vol. 6 (Greenway) at 872.) According to Ms. Greenway, Mt. Berry had a smaller nursing staff than it needed, but Defendant pressured Ms. Greenway to reduce the nursing staff. (Id. at 882-83; Gov't Ex. 594.) Ms. Greenway testified that payroll problems, including bouncing paychecks, delayed paychecks, and lapses of insurance coverage, as well as the nursing staff's fears about the consequences of the shortages in the nursing home, and Mt. Berry's inability to advertise for new employees to replace those who were leaving, made it impossible for Ms. Greenway to maintain the staffing level that she thought was necessary to provide

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quality care to her residents. (Trail Tr. Vol. 6 (Greenway) at 843-44, 850, 856, 958; Gov't Exs. 471, 800, 809, 811, 812.) According to Ms. Greenway, at times during her tenure, she could not maintain the staff levels needed to provide adequate care to the residents. (Trial Tr. Vol. 6 (Greenway) at 907.)

272. Carolyn Williams was a restorative aid under Ms. Greenway; however, she testified that, because of staff shortages, she actually spent all of her time working as a CNA and never worked as a therapist. (Trial Tr. Vol. 15 (Testimony of Carolyn Williams) at 2518-2522.)

273. Barbara Lynch, whose mother lived in Mt. Berry for approximately three years before the nursing home closed, testified that, during Mt. Berry's final months, it did not have enough staff "to care properly for everybody that

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was there." (Trial Tr. Vol. 10 (Lynch) at 1522.) According to Ms. Lynch, Mt. Berry did not have sufficient staff to feed her mother, and she stated that, at times, she could not find a nurse or a CNA." (Id. at 1521.) Ms. Lynch testified: "They lost lots of the help because they were not getting paid, and it was just a sad situation. I mean, the ones that tried was doing the best they could. And like I said, it was just sad, sad." (Id. at 1520.)

274. Kenneth Hinkley testified that his mother-in-law did not receive physical therapy prescribed for her while she was at Mt. Berry, because Mt. Berry did not have a physical therapist. (Trial Tr. Vol. 5 (Hinkley) at 756-57.)

275. In 2005, Laverne Burrell, the payroll manager for FHG, moved her mother to Mt. Berry. (Trial Tr. Vol. 9 (Burrell) at 1264-65.) Ms. Burrell testified that, during the

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following year, the Mt. Berry administrator and some CNAs warned Ms. Burrell that they could not care for her mother as they did when her mother first arrived at Mt. Berry. (Id.) According to Ms. Burrell, those individuals warned her to move her mother to another nursing home, and she did so. (Id.)

b. Moran Lake

276. Witnesses testified that staffing was also a problem at Moran Lake. (Trial Tr. Vol. 11 (T. Edwards) at 1591-93; Trial Tr. Vol. 16 (Terhune) at 2618, 2640.) Tammy Edwards testified that, because of payroll problems, employees would not come to work. (Trial Tr. Vol. 11 (T. Edwards) at 1591.) As a result, Ms. Edwards, the charge nurse, did not have sufficient staff to take care of the residents on her wing. (Id.) Ms. Edwards testified that she

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should have had two CNAs on her floor, but, at times, she had only one CNA to care for forty-four to forty-eight residents. (Id. at 1591-92; Trial Tr. Vol. 15 (Cox) at 2445 (testifying that resident complained of staff turnover); Trial Tr. Vol. 16 (Terhune) at 2618, 2640 (stating that Moran Lake had good people, but just did not have enough between September 2006 and April 2007); Gov't Ex. 354.)

c. Wildwood

277. Ms. Grant testified that she used "creative staffing" in the fall of 2006, including scheduling employees to work long shifts and substantial overtime, to make it appear to state surveyors that Wildwood had sufficient staffing "on paper," but that she knew she was "wearing out what little staff" she had. (Trial Tr. Vol. 9 (Grant) at 1337; Gov't Ex. 831.9.) Sonya Brunner, an LPN, testified that this

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technique did not provide for sufficient staffing in the home, noting that, "[j]ust because it's [staffing] posted on this schedule does not mean those people were present." (Trial Tr. Vol. 12 (Brunner) at 1865.)

278. Tonia Hamilton, a family member, testified that Wildwood did not have not enough CNAs to do all of the work. (Trial Tr. Vol. 4 (Hamilton) at 667.) Ms. Hamilton acknowledged the staffing posted on the schedule always met the state requirement, but stated that she never saw as many staff members on duty as were posted on the schedule. (Id. at 668.)

279. Ms. Grant further testified that she moved residents out of their rooms and consolidated them in wings, in part because of clinical staffing shortages. (Trial Tr. Vol. 9 (Grant) at 1343-45; Gov't Ex. 831.23.) Ms. Gaulin, the

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ombudsman, testified that residents became upset after being moved, and that, as a result of consolidating the residents into certain wings, residents who were at risk of wandering out of the nursing home were moved to unlocked, unsecured wings. (Trial Tr. Vol. 12 (Gaulin) at 1909.)

280. Witnesses testified that, to cut costs, Wildwood sent its nursing staff home early, leaving the nursing home short-staffed on night shifts, with too few CNAs to care for the residents properly. (Trial Tr. Vol. 12 (Brunner) at 1822-23, (Collins) at 1887; Browning Dep. at 21-22.)

281. Although short staffing was the family members' chief complaint, Ms. Brunner testified that employees were not permitted to acknowledge the insufficient number of staff members verbally, even though the short staffing

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situation was obvious. (Trial Tr. Vol. 12 (Brunner) at 1814, 1854. Ms. Brunner stated:

> We did not have adequate staff. . . . employee-to-patient ratio, we did not always have. And as for the supplies, we didn't always have the supplies. That was one of the chief complaints of family members that's coming in, "Y'all shorthanded today?" And that was one of the things that we were not allowed to verbalize.
>
> No, you're not -- we were programmed "You're never shorthanded. You're never short-staffed." If you have two CNAs on the floor with a ratio -- with a unit census of 45, and you have two CNAs on the unit and a family member says, "Y'all short today?" You were never to say, "Yes, we short, but we'll get to them." You're never to say you're short employee wise.

(Id. at 1854; see also Trial Tr. Vol. 13 (Gaulin) at 1919 (addressing staff shortages); Gov't Ex. 361.37 (indicating that complaints about staffing shortages increased in March 2007); Browning Dep. at 22 (stating that short staffing at

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Wildwood at nights made residents wait longer for help and to be changed).)

282. Wildwood experienced frequent employee absenteeism because of payroll problems and other issues. (Trial Tr. Vol. 9 (Grant) at 1337, 1358; Trial Tr. Vol. 3 (Free) at 400 (describing how call lights went unanswered as employees raced to the bank to try to cash paychecks).) Ms. Free stated that she was constantly worried about having enough staff to take care of her residents. (Trial Tr. Vol. 3 (Free) at 404.)

283. In July 2007, when Barbara Chal became the administrator at Wildwood, she found that she could not keep sufficient staff at the nursing home because of its payroll problems and many other problems. (Trial Tr. Vol. 16 (Chal) at 2682.) Ms. Chal learned that the staff would

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not work for free. (Id.) Ms. Chal resigned on August 3, 2007, because Wildwood could not providing the care and services required to meet its residents' needs. (Id. at 2677-78; Gov't Exs. 361.47, 1104.) Ms. Chal testified that, under Defendant's management, Wildwood did not provide its residents with a safe environment or with balanced, nutritional meals. (Trial Tr. Vol. 16 (Chal) at 2678.)

12. Urine-soaked Residents

284. A nursing home is supposed to check, and, if necessary, to change, its incontinent nursing home residents at least every two hours. (Trial Tr. Vol. 12 (Brunner) at 1814.) Staff must turn residents who cannot turn themselves every two hours. (Id. (Collins) at 1868-69.) Those two-hour changes and turns are important to the residents' health, hygiene, dignity, and overall well-being.

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(Trial Tr. Vol. 12 (Brunner) at 1815-16, (Collins) at 1868-69; Trial Tr. Vol. 16 (Testimony of Pamela Davis) at 2590.) Ms. Brunner testified that regularly changing and turning the residents is "part of taking care of people." (Trial Tr. Vol. 12 (Brunner) at 1815-16.)

285. Witnesses Tonia Hamilton, Lurette McPherson and Hazel Evans visited Ms. Evans' mother, a resident of Wildwood, daily. Those witnesses testified that, "[m]any, many times" they found Ms. Evans' mother "soaking wet with urine from head to toe." (Trial Tr. Vol. 4 (Hamilton) at 668; Evans Dep. at 19-20.) Ms. McPherson testified that, approximately five times, she found her grandmother caked in dried feces. (Trial Tr. Vol. 4 (McPherson) at 692.) On another occasion, Ms. Evans found that her mother had been lying in her own feces for so long that the feces had

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thoroughly dried and caked to her skin. (Evans Dep. at 18-19.) According to Ms. Evans, she found her mother soaked in urine once out of every three or four visits. (Id. at 20.) Ms. Evans further testified that it was "an everyday occurrence" to see Wildwood residents soaking wet, with pools of urine beneath their chairs or wheelchairs. (Id. at 20, 23.)

286. Reba Usher's mother's roommate at Wildwood wet her bed often, and her soaked mattress continually emitted a "very horrible" odor. (Trial Tr. Vol. 12 (Usher) at 1778-79.) According to Ms. Usher, her mother's room reeked of urine the entire time that she lived in Wildwood. (Id. at 1778-79.)

287. According to Ms. Brunner, because of Wildwood's short staffing situation, it was impossible for the staff to

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check, change, and turn residents every two hours. (Trial Tr. Vol. 12 (Brunner) at 1815-16.) Specifically, Ms. Brunner testified:

> Q: When you have a -- when you have a short -- when you don't have as many CNAs as you need, can everybody get turned every two hours?
>
> A. No. You'd try, but it's a hit-and-miss situation. I mean, you try, but no.

(Id. at 1815.)

288. Ms. Brunner also testified that residents at Wildwood went longer than two hours between changes because the nursing staff had to conserve diapers and other supplies. (Trial Tr. Vol. 12 (Brunner) at 1814.) According to Ms. Brunner, "when we had no supplies and had to bring diapers from home or purchase your own supplies . . . [i]f someone urinated a small amount and that diaper indicator

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was just wet a little bit, that diaper was not coming off right then." (Id. at 1814.)

289. Kenneth Hinkley testified that he began bringing diapers when he visited his mother-in-law at Mt. Berry "[b]ecause she wasn't being changed." (Trial Tr. Vol. 5 (Hinkley) at .) Caren Kelley testified that she would find that her mother's bed was wet, and that she often could not find clean linens to change her mother's bed. (Trial Tr. Vol. 10 (Kelley) at 1504-05.) Carolyn Williams, a CNA at Mt. Berry, testified that the staff shortages made it impossible to change the residents every two hours. (Trial Tr. Vol. 16 (Williams) at 2523.)

290. Linda Dodson testified that, while her brother resided at Moran Lake, she often found him sitting in his wheelchair soaking wet with urine. (Trial Tr. Vol. 10

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(Dodson) at 1530.) On several occasions, Ms. Dodson found that her brother was not wearing a diaper, and when she asked the nursing staff why, they told her that the nursing home had no diapers in his size. (Id.) Ms. Dodson testified that, on three occasions, she turned her brother's bed down for him and discovered that his bed was wet with urine beneath the dry cover. (Id.) On other occasions, Ms. Dodson found that her brother had not been cleaned and that he had feces on his hands, his legs, and under his fingernails. (Id. at 1530-31.)

291. From September 2006 until April 2007, Lynn Terhune's father, Morris Ellison, lived at Moran Lake. (Trial Tr. Vol. 16 (Terhune) at 2617.) Ms. Terhune visited her father several days a week, and she testified that, on approximately forty percent of her visits, she found her

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father lying in a urine-soaked bed. (Id. at 2623-24.) Ms. Terhune also found her father in soiled, unchanged diapers. (Id. at 2624-25.) Ms. Terhune testified that her friend tipped a staff member twenty dollars to encourage him to check on Mr. Ellison, but that the staff was too small to keep Mr. Ellison and his room clean. (Id. at 2618, 2624.) Ms. Terhune said Mr. Ellison liked the staff members, "but there just wasn't enough people to go around to do what needed to be done." (Id. at 2624.)

292. The short staffing problem became more severe on paydays, when employees raced to the bank or stood in line to cash their checks at the money van. (Trial Tr. Vol. 14 (Fuqua) at 2145, 2185, (Lee) at 2281-82.) According to witness Stephanie Lee, on those occasions, residents would have to wait "a couple more hours" to be changed or fed.

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(Id. (Lee) at 2281-82.)

13. Medical Directors

293. Medicare and Medicaid require nursing homes to have a physician as a medical director. 42 C.F.R. § 483.75(i); (Trial Tr. Vol. 2 (Mauldin) at 162-64.) The medical director is responsible for implementing resident care policies and coordinating medical care in the nursing home. 42 C.F.R. § 483.75(i).

294. From 1999 until May 2005, Dr. Keith Hannay served as the medical director at Moran Lake and Mt. Berry. (Trial Tr. Vol. 10 (Hannay) at 1425-27; Gov't Ex. 1233.) Effective May 4, 2005, Floyd Medical Center terminated its agreements with FHG that permitted Dr. Hannay to serve as the medical director for Mt. Berry and Moran Lake. (Trial Tr. Vol. 10 (Hannay) at 1427; Gov't Exs. 1232 & 1233.) Dr.

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Hannay recalled that Floyd Medical Center terminated the agreements because Defendant had not paid the $1,000 per month medical director fee in several months and the nursing homes had no medical malpractice insurance for their medical director. (Trial Tr. Vol. 10 (Hannay) at 1426-28; Gov't Exs. 1232 & 1233.)

295. After Dr. Hannay left , the nursing homes were without a medical director until Dr. Evans was hired. (Trial Tr. Vol. 5 (Greenway) at 782-84.) Dr. Evans later left his medical director position because of nonpayment, and no evidence indicates that Defendant ever found a replacement. (Id.)

14. Equipment and Services

a. Monitoring Blood Sugar

296. Frances Browning testified that, while she lived at

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Wildwood from 2005 until September 2007, she let the nursing staff use her personal blood sugar testing device because the staff did not have one. (Browning Dep. at 15-17.) According to Ms. Browning, on many nights, she went the different wings in the home begging the residents for blood sugar testing strips because the nursing staff had none. (Id.) Ms. Browning testified that her attempts to obtain testing strips for the nurses to use were "quite often" unsuccessful. (Id.) Specifically, Ms. Browning testified, "I'd go down [the halls] almost every night and probably three out of four I was unsuccessful." (Id. at 16.) According to Ms. Browning, this situation continued for the entire time that she lived in Wildwood. (Id.)

b. Nebulizers

297. Nebulizers are devices that are used to

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administer medication in the form of a mist inhaled into the lungs of patients with respiratory illnesses. (Trial Tr. Vol. 11 (T. Edwards) at 1593.) Each patient should have his or her own nebulizer. (Id.) Allowing different patients to use the same nebulizer is unsanitary and creates a risk of infection. (Id.) According to witness Tammy Edwards, Moran Lake had many residents with respiratory illnesses, some of whom needed to use a nebulizer four times a day. (Id.) The nursing staff, however, had only one nebulizer, and the staff used the same nebulizer on all of the patients, because the nursing staff "had to do what [it] had to do." (Id.)

c. Beds

298. The nursing homes had problems with beds. (Trial Tr. Vol. 4 (Prince) at 606; Trial Tr. Vol. 7 (Herrington)

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at 1054-55; Trial Tr. Vol. 10 (Peyton) at 1550-51; Trial Tr. Vol. 14 (Fuqua) at 2149-50, (Lee) 2290, 2301; Trial Tr. Vol. 15 (Zackary) at 2381.) The hand-cranking mechanisms on many of the beds did not work, and staff used cinder blocks to prop up and position the beds. (Trial Tr. Vol. 7 (Herrington) at 1054-55; Trial Tr. Vol. 14 (Fuqua) at 2149-50, (Lee) at 2290.) Moran Lake had no bariatric beds for heavy residents. (Trial Tr. Vol. 14 (Lee) at 2301.) When Pete Peyton's mother needed a low bed, Mt. Berry staff built her a cage-like frame with a mattress lying on top of hard plastic pipes. (Trial Tr. Vol. 10 (Peyton) at 1550-51; Gov't Ex. 628.) The "bed" promptly fell apart when staff tried to move it. (Trial Tr. Vol. 10 (Peyton) at 1552.)

299. At Wildwood, many of the mattresses were so worn out and discolored that the staff covered them "with

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sheets and stuff" to hide the stains and to help bolster the mattresses. (Trial Tr. Vol. 12 (Brunner) at 1858.) Wildwood had no bed-to-chair devices to help residents get in and out of their beds. (Id at 1858.) Wildwood had few turning aids, such as foam blocks used to position a resident who needs help maintaining a position. (Id.) According to Ms. Brunner, the Wildwood staff lacked many necessities for caring for the residents. (Id.)

d. Emergency Supplies

300. Nursing homes must have a seventy-two-hour supply of food for emergencies. (Trial Tr. Vol. 17 (Goldsmith) at 2800.) Nursing homes also must have water available or must have a contract with a company that will provide the home with water in an emergency. (Id. at 2800.) Nursing homes also must have an emergency supply of

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medication. (Id.)

301. At Moran Lake, the kitchen staff sometimes had to use the emergency food supply to make it through routine days because Defendant failed to pay the food supplier. (Trial Tr. Vol. 11 (Testimony of Larrious Williamson) at 1581, 1584.)

302. Ms. Greenway testified that Mt. Berry had no emergency water supply because Defendant did not pay the supplier. (Trial Tr. Vol. 5 (Greenway) at 798.)

303. Wildwood eventually could not maintain the required emergency medical supply stock because the staff had to use the emergency supplies when they ran out of daily supplies. (Trial Tr. Vol. 9 (Grant) at 1352; Trial Tr. Vol. 12 (Brunner) at 1829.)

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e. Alarms

304. At Moran Lake, some residents were ambulatory or could wheel around the nursing home. As a result, someone had to stand at the door "for hours at a time" to block residents from leaving when the door alarm did not work. (Trial Tr. Vol. 3 (Knowles) at 295; Trial Tr. Vol. 14 (Fuqua) at 2150-51; Trial Tr. Vol. 16 (Young) at 2574-75.) According to witness Christie Fuqua, residents occasionally left through a door, and staff had to bring the residents back to the nursing home. (Trial Tr. Vol. 14 (Fuqua) at 2170.)

305. Ms. Fuqua also testified that fall alarms that were worn by residents who were prone to fall did not work, staff could not repair many of the alarms, and that Moran Lake could not buy new fall alarms because Defendant would not pay for those. (Trial Tr. Vol. 14 (Fuqua) at 2151-52.)

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306. The fire alarm monitoring service at Moran Lake and Mt. Berry was terminated because Defendant failed to pay for it. (Trial Tr. Vol. 1 (Stanley) at 32; Trial Tr. Vol. 2 (Knowles) at 295; Trial Tr. Vol. 5 (Greenway) at 798.)

307. When Southeast Georgia Health Systems took over Wildwood in September 2007, Dennis Johnson inspected the condition of the nursing home and found that the interior fire sprinkler system was not connected to anything. (Trial Tr. Vol. 13 (Johnson) at 2044-45.)

f. Transportation for Treatment

308. Ms. Knowles continually notified Defendant that the non-emergency transport service for Moran Lake was not being paid. (Trial Tr. Vol. 3 (Knowles) at 299; Gov't Ex. 487.) The nursing home pulled staff members from their regular jobs on the floor and had them use their personal

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cars to take residents to doctor's appointments and other non-emergency visits. (Id. at 300, 306-07.)

309. In June 2006, Ms. Greenway notified Defendant that the transport service for Mt. Berry's Medicare Part A patients was not being paid. (Trial Tr. Vol. 6 (Greenway) at 832; Gov't Exs. 790, 811.) The following month, Ms. Greenway informed Defendant: "I am having problems admitting [residents] because of the inability to get transport for Medicare Part A residents." (Trial Tr. Vol. 6 (Greenway) at 860; Gov't Ex. 519.) By late October 2006, Defendant was $5,000 behind on payments to Redmond Regional's non-emergency transport service, which had already agreed to cut its bill by fifty percent. (Trial Tr. Vol. 6 (Greenway) at 868; Gov't Ex. 552.) Because of the unpaid bills, Mt. Berry residents who could not be transported to the hospital in an

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automobile had to be transported in an emergency ambulance. (Trial Tr. Vol. 6 (Greenway) at 961.)

310. Winifred Herrington's aunt was a dialysis patient at Wildwood, and Medicaid paid Wildwood to provide her with transportation from the nursing home to the dialysis clinic. (Trial Tr. Vol. 7 (Herrington) at 1050-52.) On many occasions, Ms. Herrington's aunt missed dialysis because the transportation company refused to service Wildwood due to unpaid bills. (Id.) According to Ms. Herrington, that problem continued even after Wildwood changed transportation companies. (Id. at 1052.)

g. Ice

311. Providing residents with ice chips is important for helping the residents maintain hydration. (Trial Tr. Vol. 12 (Brunner) at 1810.) The vendor that supplied the ice

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machine at Wildwood frequently disconnected the machine for lack of payment, and staff had to leave the nursing home to buy ice. (Trial Tr. Vol. 9 (Grant) at 1339; Trial Tr. Vol. 12 (Brunner) at 1809; see also Trial Tr. Vol. 7 (Herrington) at 1044-45 (stating that nurses sometimes had to go out and buy ice).) Even when the ice machine worked, employees were reluctant to use it because it was full of mold. (Trial Tr. Vol. 12 (Brunner) at 1809.)

312. By August 2006, the only working ice maker in Wildwood was inaccessible because it was in a wing of the home that the state had closed because of the leaking roof. (Trial Tr. Vol. 16 (Chal) at 2667-68.)

15. No Evacuation Plan

313. The Georgia Emergency Management Agency ("GEMA") required Wildwood to have a hurricane

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evacuation plan. (Trial Tr. Vol. 16 (Chal) at 2661-62, 2667; Gov't Exs. 1091, 1098.) GEMA also required Wildwood to have a contract in place with an ambulance company to transport the residents under the evacuation plan. (Trial Tr. Vol. 16 (Chal) at 2661-62.) The only ambulance provider in Brunswick, however, refused to do business with Defendant because of unpaid bills. (Id. at 2662; Gov't Ex. 1091.) Wildwood never had an evacuation plan during Barbara Chal's tenure as administrator. (Trial Tr. Vol. 16 (Chal) at 2662, 2667.) Ms. Chal served as Wildwood's administrator during hurricane season. (Id.)

16. Weight Loss

314. Weight loss is a "sentinel event" in a nursing home because it can indicate that a resident is developing, or has, serious underlying medical problems. (Trial Tr. Vol.

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2 (Mauldin) at 160; Trial Tr. Vol. 10 (Hannay) at 1451.) Weight loss and malnutrition make nursing home residents "more susceptible to disease, infection, and aggravate[] the chronic illnesses that they already have." (Trial Tr. Vol. 15 (Cox) at 2441.) Nursing homes must keep track of their residents' weights, and must investigate when a resident loses five percent or more of his or her body weight during a one-month period. (Trial Tr. Vol. 10 (Hannay) at 1451.)

a. Moran Lake and Mt. Berry

315. As previously noted, Dr. Hannay served as the medical director for Moran Lake and Mt. Berry from 1999 until May 2005, and, even after he left that position, he continued to see many residents of the nursing homes as his patients until the homes closed in July 2007. (Trial Tr. Vol. 10 (Hannay) at 1422-23, 1425-28; Gov't Ex. 1233.) Dr.

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Hannay usually spent one day of every week at each home. (Trial Tr. Vol. 10 (Hannay) at 1448.) According to Dr. Hannay, the Moran Lake and Mt. Berry residents' weight loss was constantly brought to his attention. (Id. at 1451.) Dr. Hannay had two nurse practitioners who monitored the residents, and both became concerned about the residents' weight loss. (Id. at 1451.) Dr. Hannay also became concerned about his patients' weight loss, and he reported that concern to the state. (Id. at 1447-50; Gov't Ex. 1237.) In a May 2007 letter, Dr. Hannay reported that, at Mt. Berry and Moran Lake, "we are experiencing unnecessary weight losses that herald even bigger problems in the future." (Gov't Ex. 1237.) Dr. Hannay has specialized in long-term care since 1984, and he observed that the residents' weight loss at Moran Lake and Mt. Berry "was out of proportion to

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what we would, typically, expect." (Trial Tr. Vol. 10 (Hannay) at 1468.)[1]

316. In mid-May 2007, Melissa Hickman, Consultant Dietician for Moran Lake, wrote a letter voicing concerns about weight loss because residents were not receiving their nutritional supplements and the home had an inadequate food budget. (Gov't Ex. 355.) Although employees bought food for the residents during food shortages, the employees could not buy the quantity and types of foods and supplements necessary to prevent weight loss among residents. (Trial Tr. Vol. 14 (Lee) at

[1]Dr. Hannay has treated patients in nursing homes since 1984, and he has served as the medical director of several nursing homes. (Trial Tr. Vol. 10 (Hannay) at 1450.) Other than the complaints that Dr. Hannay filed about Moran Lake and Mt. Berry between 2005 and 2007, Dr. Hannay has never found it necessary to file complaints with the state about the operation of any nursing homes. (Id.)

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317. Tatum Zackary, a CNA at Moran Lake, observed that the residents who could not afford to "eat out of the vending machines" suffered weight loss because the small portions they were served at meals were "maybe enough to feed a two-year-old." (Trial Tr. Vol. 15 (Zackary) at 2383, 2390-91.) According to Ms. Zackary, the residents who gained weight ate snack food from the vending machines or received food from family members. (Id. at 2390-91.)

318. Dr. Hannay noted that some of the residents at Moran Lake ate large amounts of snack food from the vending machines. (Trial Tr. Vol. 10 (Hannay) at 1469-70.) The vendor who stocked the vending machines at Moran Lake told Dr. Hannay that he had to fill the machines two or three times per week because the residents ate "huge

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amounts from the vending machines." (Id.) According to Dr. Hannay, the residents who ate large amounts of snack food from the vending machines tended to weigh more, and lost less weight than, the residents who did not eat large quantities of snack food from the vending machines. (Id.)

319. When Mattie Cox inspected Moran Lake on May 16, 2007, her initial scan of the nursing home's records led her to believe that the residents' weights were stable. (Trial Tr. Vol. 15 (Cox) at 2327, 2439.) In a later review of Moran Lake's records, however, Ms. Cox found that some residents had lost weight, and she notified ORS about her finding. (Id. at 2439; Gov't Ex. 355.)

b. Recording Weight Loss

320. According to Ylaunda Dixon, when she served as the record CNA at Mt. Berry, she recorded that "a lot of the

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residents was losing a whole bunch of weight." (Trial Tr. Vol. 10 (Dixon) at 1564.) Ms. Dixon noted that the weight loss occurred when the nursing home was serving the residents half-size portions of food at meals, and when nutritional supplements and therapeutic diets were not available. (Id. at 1562-64.) According to Ms. Dixon, after the residents "started losing so much weight," the nursing staff met with their supervisor, Barbara Hamilton. (Id. at 1564.) Ms. Dixon testified that Ms. Hamilton, her supervisor, instructed the staff to stop recording the residents' weight loss "per George Houser." (Id.)

c. Unavailability of the Residents' Records

321. Defendant failed to preserve at least some of his residents' medical records. (Trial Tr. Vol. 16 (Rotti) at 2542-

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46; Gov't Exs. 2001 & 2002.) After Defendant, as custodian of FHG's records, received a subpoena for the residents' records on March 22, 2010, he moved to quash the subpoena and stopped paying rent for the storage unit where those records were stored. (Trial Tr. Vol. 16 (Rotti) at 2542-2546; Gov't Exs. 2001 & 2002.) After Defendant failed to pay the storage facility's rent for three months, it sold the contents of his storage unit on August 4, 2010, pursuant to its policy, and the purchaser discarded all the paperwork and records that Defendant had stored. (Trial Tr. Vol. 16 (Rotti) at 2542-45, 2547.) In December 2010, Defendant's newly appointed defense counsel investigated the whereabouts of records that would have been responsive to the subpoena, and learned that the storage company had auctioned the records the preceding August.

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(Id. at 2547.)

322. On March 25, 2010, a few days after the issuance of the subpoena for the residents' medical records, a police investigator in Rome recovered some of the records of a former Mt. Berry resident. (Trial Tr. Vol. 16 (Rotti) at 2545-47; Gov't Ex. 696a.) The investigator found the records in a pile of trash strewn on the curb in front of the FHG offices. (Trial Tr. Vol. 16 (Rotti) at 2545.) On March 26, 2010, an FBI agent sifted through that trash pile and found, among other things, a FHG check. (Id. at 2546-47; Gov't Ex. 696a.)

d. Equipment Problems

323. Mt. Berry had no sling to use to weigh residents in wheelchairs. (Trial Tr. Vol. 6 (Greenway) at 833.) When Anggie Chandler arrived at Mt. Berry in late March 2007,

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she discovered that the scales used to weigh residents did not work properly. (Trial Tr. Vol. 14 (Chandler) at 2324.) According to Ms. Chandler, the malfunction made it impossible to conduct accurate assessments of the residents' health and weight. (Id. at 2338.)

324. Wildwood had no scale to weigh the obese residents. (Trial Tr. Vol. 9 (Grant) at 1350-51; Gov't Ex. 831.33.)

17. Events After Transfer

a. Cedar Springs Healthcare

325. In June 2007, approximately twenty-one Moran Lake and Mt. Berry residents were transferred to the Cedar Springs Healthcare nursing home in Cedartown, Georgia. (Trial Tr. Vol. 13 (Davis) at 2577-78.) The residents appeared to be unkempt. (Id. at 2580.) Pam Davis, the

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administrator at Cedar Springs Healthcare, did not know the residents' weight histories because the residents' medical records were not transferred with the residents. (Id. at 2591.) Davis was never able to obtain the residents' records. (Id. at 2592-93.)

326. When the residents arrived at Cedar Springs Healthcare, they all complained of hunger. (Trial Tr. Vol. 16 (Davis) at 2580.) Ms. Davis testified: "They were just all very hungry and they wanted something to eat. And there for a few weeks we couldn't seem to get them, you know, enough to eat because they did seem to be very hungry." (Id. at 2581.)

327. Many former Moran Lake residents hoarded food. (Trial Tr. Vol. 16 (Davis) at 2581-82.) Ms. Davis recalled that the residents would put a biscuit or a piece of cake in

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their pockets "for later because they said they were afraid they wouldn't have any supper." (Id. at 2581.) Some residents would eat half of the food on their plates and attempt to take the other half back to their rooms to eat later. (Id. at 2582.) According to Ms. Davis, this type of food hoarding is unusual in a nursing home. (Id.) Ms. Davis recalled that it took two to three weeks for the residents to become convinced that they would receive full meals and snacks regularly, and that they did not have to hoard food in their rooms. (Id.) One resident told Ms. Davis, "I just can't believe that I can ask for a snack and I have it anytime I want." (Id. at 2582-83.) Most of the residents steadily gained weight during their first three to four months in Cedar Springs Healthcare. (Id. at 2583-85; Gov't Ex. 794.)

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b. Reliable Health and Rehab at Lakewood

328. Michelle Prince served as the administrator at Moran Lake from 2002, when it was a Sunbridge facility, until November 2003, a few months after Defendant took over the management of Moran Lake. (Trial Tr. Vol. 4 (Prince) at 599-600.) Ms. Prince testified that she resigned because she felt that Defendant's conduct was putting her administrator's license at risk. (Id. at 607.) After Ms. Prince left Moran Lake, she went to work in another Sunbridge facility, and, in March 2007, she became the administrator of the Reliable Health and Rehab nursing home in Atlanta. (Id. at 598-600.)

329. In June 2007, approximately fifteen Moran Lake residents were transferred to Reliable Health and Rehab.

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(Id. at 607-08.) Ms. Prince recalled that the residents were unkempt. (Id. at 608.) The residents also hoarded food. (Id. at 608.) Ms. Prince recalled that the residents hid food in their purses or wheelchairs, and when staff asked why, the residents said that they wanted food for later. (Id. at 608, 619.)

330. Ms. Prince recognized several of the residents from her time as administrator at Moran Lake, and she observed that the residents had suffered "significant" or "noticeable" weight loss. (Trial Tr. Vol. 4 (Prince) at 608-09, 621-22.) Ms. Prince obtained the medical records for the residents who came to her nursing home. (Id. at 621-22.) According to Ms. Prince, the records revealed that some residents had lost more than five percent of their body weight within the preceding thirty days, which constitutes

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"significant" weight loss under the applicable regulations. (Id. at 621-22.) Ms. Prince could not recall how many of the residents met the regulatory standard for "significant" weight loss, but testified that the residents said "they hadn't eaten, they didn't get a lot of food, that they had been hungry, and they were grateful to have hot meals." (Id. at 621-22.)

c. Waycross Health & Rehabilitation Center

331. In September 2007, Utrena Grant, an RN, went to Wildwood to bring eleven residents back to Waycross Health & Rehabilitation Center, the nursing home where she worked. (Trial Tr. Vol. 13 (Testimony of Utrena Grant) at 2004-05.) When Ms. Grant arrived at Wildwood, she saw that very few Wildwood staff members were still working at the home, and that she could count the staff members on

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one hand. (Id. at 2005.) According to Ms. Grant, the residents were hoarding food. (Id. at 2006-07.) Ms. Grant also testified that the residents were extremely unkempt and heavily soiled. (Id. at 2007, 2011.) Ms. Grant could not obtain the residents' medical records, which significantly limited her nursing home's ability to assess and diagnose the new residents. (Id. at 2007.)

d. Sears Nursing Home

332. Joyia Williams, a CNA at Sears Manor Nursing Home in Brunswick, worked at Wildwood on the last two nights it was open. (Trial Tr. Vol. 16 (Testimony of Joyia Williams) at 2643-44.) When Ms. Williams arrived at Wildwood, the nurses and CNAs expressed a great need for nursing supplies. (Id. at 2644-45.) On both nights that Ms. Williams worked at Wildwood, she went to the nursing

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home, made a list of needed supplies, went back to Sears Manor to get the supplies, and then returned to Wildwood with the supplies. (Id. at 2644-45, 2651.) According to Ms. Williams, Wildwood was sparsely staffed, and it did not have enough staff or supplies to take care of the residents. (Id. at 2645.) Ms. Williams testified that all of the residents were dirty, in need of immediate attention, and in need of being changed, cleaned and bathed. (Id. at 2646-47.)

18. Actual Resident Harm

333. Witnesses testified that nursing supply shortages, staff shortages, payroll problems, lack of regular lab work, inability to provide residents with their prescribed medications, last-minute bill paying, frequent changing of vendors, and Defendant's practice of not addressing problems until state surveyors threatened to fine him,

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created an atmosphere of chaos in which some residents endured actual harm. (Trial Tr. Vol. 3 (Free) at 411; Trial Tr. Vol. 6 (Greenway) at 856; Trial Tr. Vol. 14 (Fuqua) at 2184-88.) Ms. Fuqua testified that residents were not checked, changed, or turned in a timely manner and were not taken to meals in a timely manner because the staff was preoccupied with shortages, workloads and bouncing paychecks and unable to focus on their jobs. (Trial Tr. Vol. 14 (Fuqua) at 2188.) According to Ms. Fuqua, the nursing homes were reluctant to fire poorly performing employees, or employees who left work to rush to the bank to try to cash their paychecks, because the nursing homes could not hire anyone else. (Id.) Another witness testified that employees were embarrassed to reveal where they worked. (Trial Tr. Vol. 11 (Landers) at 1737.) Tammy Edwards testified that

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the staff at Moran Lake did not understand how the state could let the nursing home operate, because it was obvious that the residents were cold and hungry. (Trial Tr. Vol. 11 (Edwards) at 1611.) Staff members at Mt. Berry reported their nursing home to the state in hopes that the state would remove Defendant from managing the nursing home. (Trial Tr. Vol. 15 (Testimony of Carolyn Williams) at 2523-24.)

334. Dr. Hannay testified:

> [Y]ou've got to realize, here's a patient in a nursing home, which is not where most people want to be. You're thinking this is -- "I'm not going to get better," you're fearful. You're in the setting that you want to get better, and you're getting a diet that's inadequate in protein. You become fatigued because of that. I mean, you know, our antibodies that we use to fight infections are protein derivatives. So if you've got an inadequate diet of protein, eventually, you get tired, fatigued, despondent. Some get hopeless, perhaps clinical depression. And just you're already worried about this happening, and now it's happening and,

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> eventually, it cascades into a higher use of drugs to help the depression. They may get pneumonia because of the inability to fight infection. It's one of those times when the harm that we see from this, you can't connect all the dots because it's two months from Point A to Point Z, or wherever. But, you know there's been this decline in function.

(Trial Tr. Vol. 10 (Hannay) at 1435-36.)

335. CNA Tatum Zackary testified that when the Moran Lake nursing staff had no gauze or tape to treat bedsores properly, the staff left sores open and uncovered for more than one or two days at a time. (Trial Tr. Vol. 15 (Zackary) at 2382, 2399.) As a result, those residents had to lie on open sores for days at a time, during which time the sores could become contaminated with feces or urine. (Id. at 2399.) Moreover, flies are drawn to open wounds and can lay eggs in the wounds, which, in turn, can lead to an infestation of maggots. (Trial Tr. Vol. 13 (Wells) at 2081-

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82.) An untreated bed sore "escalates" and becomes larger and deeper. (Trial Tr. Vol. 12 (Brunner) at 1817.) Witnesses testified that residents with open bedsores suffered harm as a direct result of the supply shortage. (Trial Tr. Vol. 4 (McPherson) at 692 (stating her grandmother's skin would be split open with no ointment or dressing); Trial Tr. Vol. 5 (Hinkley) at 753-54 (testifying his mother-in-law's bedsore was untreated at Mt. Berry and eventually ate down to her bone, causing her great pain); Trial Tr. Vol. 10 (Dodson) at 1527-29 (stating her brother's severe pressure sore on his heel was not properly treated at Moran Lake); Browning Dep. at 15 (testifying that untreated pressure sores would break down and bleed because Wildwood rarely had zinc ointment needed to treat them); Trial Tr. Vol. 14 (Lee) at 2302 (stating residents did

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not receive adequate or "proper care that they should have" because of food and supply shortages), (Chandler) 2338 (stating residents must wait for care if staff members have to leave nursing home to buy supplies or food); Trial Tr. Vol. 15 (Zackary) at 2384-85 (testifying that residents did not receive adequate care because of food and supply shortages); Trial Tr. Vol. 15 (Cox) at 2437 (stating that Moran Lake staff did not have enough supplies and equipment to provide quality care and Medicaid was not getting what it paid for when it paid Defendant's claims).

336. Residents could not be checked, changed and, if necessary, turned every two hours because of staffing shortages and the staff's need to conserve diapers and other supplies. (Trial Tr. Vol. 12 (Brunner) at 1814; Trial Tr. Vol. 14 (Lee) at 2281-82; Trial Tr. Vol. 15 (Williams) at

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2522-23; Browning Dep. at 22 (stating that short staffing at Wildwood at nights made residents wait longer for help and to be changed); Trial Tr. Vol. 6 (Greenway) at 907 (testifying that, at times, Ms. Greenway could not maintain the staff required to provide adequate care to the residents).

a. Moran Lake

337. From September 2006 until early April 2007, Morris Ellison lived at Moran Lake, and his autopsy shows that he suffered severe malnutrition, dehydration, and muscle wasting while he lived in that home. (Trial Tr. Vol. 14 (Testimony of Brian Frist, M.D.) at 2234-35, 2239-2242, 2244-45, 2256; Trial Tr. Vol. 16 (Terhune) at 2617; Gov't Exs. 944 & 949.1.)

338. On April 7, 2007, Mr. Ellison fell and broke his hip, and he was admitted to Floyd Medical Center. (Trial Tr.

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Vol. 14 (Frist) at 2230-33; Trial Tr. Vol. 17 (Collins) at 2764.) On April 13, Mr. Ellison was transferred to a hospice facility, and he died four days later. (Trial Tr. Vol. 14 (Frist) at 2230-33; Trial Tr. Vol. 17 (Collins) at 2764, 2771.) Mr. Ellison was eighty-two years old when he died. (Trial Tr. Vol. 14 (Frist) at 2267.) Dr. Brian Frist, the Chief Medical Examiner of Cobb County, conducted an autopsy on Ellison on April 18, 2007, the day after his death. (Id. at 2230-33; Gov't Exs. 944 & 949.1.)

339. Records from the Fifth Avenue nursing home indicate that Ellison weighed 127 pounds in September 2006. (Trial Tr. Vol. 17 (Collins) at 2764.) When Mr. Ellison died, he was five feet, eight inches tall and weighed approximately 100 pounds. (Trial Tr. Vol. 14 (Frist) at 2235.) Dr. Frist estimated Mr. Ellison's death, in

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accordance with the standard practice at the Cobb County Medical Examiner's Office. (Id. at 2246, 2260.) The Cobb County Medical Examiner's Office does not have scales capable of weighing entire bodies. (Id.) Testimony about Moran Lake records indicates that Mr. Ellison weighed 148 pounds in February 2007, two months before he died. (Trial Tr. Vol. 17 (Collins) at 2764.)

340. The autopsy photos reflect that Mr. Ellison had extreme muscle wasting, bulbous knees, very little flesh or tissue between his feet, and highly visible hip joints. (Trial Tr. Vol. 14 (Frist) at 2234-35, 2239-2242, 2244-45, 2256; Gov't Ex. 949.1.) Dr. Frist acknowledged that muscle wasting occurs as humans age. (Trial Tr. Vol. 14 (Frist) at 2235.) Dr. Frist also acknowledged that he did not conduct the tests that could determine to what degree Mr. Ellison

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suffered from malnutrition and dehydration before he died. (Id. at 2247.) According to Dr. Frist, however, Mr. Ellison's muscle wasting was so extreme that "the pictures speak for themselves." (Id.; Gov't Ex. 949.1.)

341. Defendant's expert, Dr. Kim Collins, testified that there was no evidence that Mr. Ellison was malnourished or suffered from muscle wasting. (Trial Tr. Vol. 17 (Collins) at 2767.) Dr. Collins testified that the Moran Lake records indicated that Ellison weighed 148 pounds two months before he died. (Id. at 2768.) When the Court asked Dr. Collins to comment about Mr. Ellison's weight in light of an autopsy photograph, Dr. Collins refused, stating that she did not want to guess. (Id.)

342. Another Moran Lake resident was dropped to the floor because the lift failed mechanically and the CNA who

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was operating it was working without any help because of the short staffing issue. (Trial Tr. Vol. 14 (Fuqua) at 2163-64, 2176-77.) The resident eventually died, and Christie Fuqua, the assistant director of nursing, testified that she could not rule out the connection between the resident being dropped and her death, because she was not a doctor. (Id. at 2176-77.)

b. Mt. Berry

343. In November 2006, a Mt. Berry resident had to be hospitalized, "hopefully to prevent any more damage to him." (Trial Tr. Vol. 6 (Greenway) at 869-71; Gov't Exs. 563, 565.) The resident had to be hospitalized because he had a renal disease and needed to have the ammonia levels in his blood monitored closely and regularly. (Trial Tr. Vol. 6 (Greenway) at 869-71; Gov't Ex. 563, 565.)

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Monitoring ammonia levels is very important when caring for residents with renal disease. (Gov't Ex. 563.) Mt. Berry, however, could not monitor the ammonia levels in the resident's blood, because it had no laboratory testing service in November 2006. (Trial Tr. Vol. 6 (Greenway) at 869-71; Gov't Ex. 563, 565.) Ms. Greenway testified that the resident developed renal failure as a result of Defendant's failure to provide basic laboratory testing services for his residents, and that the resident had to be hospitalized. (Trial Tr. Vol. 6 (Greenway) at 953.)

344. FHG Maintenance Supervisor Jerry Chisolm's grandmother lived in Mt. Berry. (Trial Tr. Vol. 4 (J. Chisolm) at 557-59.) According to Mr. Chisolm, his grandmother had her mandible removed while she lived in Mt. Berry, and she never received the speech therapy that she was supposed

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to receive. (Id. at 557-58.) Mr. Chisolm testified that, while his grandmother lived in Mt. Berry, she fell twice and broke her hip, and that she died after the second fall. (Id.)

345. Anggie Chandler, who served as the administrator at Mt. Berry from March through July 2007, testified that the food served at Mt. Berry during that time period was worthless because the portions were too small. (Trial Tr. Vol. 14 (Chandler) at 2306-08, 2334-36.)

c. Wildwood

346. As previously noted, Joyia Williams, a CNA at Sears Manor Nursing Home in Brunswick, worked at Wildwood in September 2007, during the last two nights that the nursing home remained open. (Trial Tr. Vol. 16 (Williams) at 2643-44.) Ms. Williams found that the residents were dirty and needed to be changed, cleaned,

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and bathed. (Id. at 2646-47.) Ms. Williams testified that she found one resident, an elderly woman, lying in her bed, covered from her neck to her feet in small black bugs. (Id. at 2647.) Ms. Williams recalled that the woman's eyes were matted completely shut from lack of care. (Id.) Ms. Williams testified that she washed the woman's face until the woman could open her eyes, but that she could not determine how long the woman's eyes had been matted shut. (Id.)

347. In early July 2007, Connie Petty, a resident at Wildwood, slipped and fell two separate times in water that leaked into her room. (Trial Tr. Vol. 12 (Gaulin) at 1926-27; Gov't Ex. 361.41.) Water leaking from a water pipe penetrated a wall and pooled on the floor in Ms. Petty's room. (Trial Tr. Vol. 13 (Gaulin) at 1926-27; Gov't Ex.

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361.41.) On July 2, 2007, Ms. Petty fell for the first time. (Gov't Ex. 361.41.) Although Ms. Petty reported her fall, staff did nothing. (Trial Tr. Vol. 13 (Gaulin) at 1926-27; Gov't Ex. 361.41.) On the next day, July 3, 2007, Ms. Petty fell a second time, fracturing the fibula in her left leg. (Trial Tr. Vol. 12 (Gaulin) at 1926-27; Gov't Ex. 361.41.) According to Ms. Gaulin, the ombudsman, the Wildwood staff moved Ms. Petty to another room after her second fall. (Trial Tr. Vol. 13 (Gaulin) at 1926-27; Gov't Ex. 361.41.)

348. A fire occurred in one resident's room at Wildwood after a water leak soaked the exposed wiring that connected the air conditioning unit in the resident's room to the power source. (Trial Tr. Vol. 9 (Patrick) at 1275.)

349. In late April 2007, Ervin Simmons complained to the state that his uncle's groin area became badly infected

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after Wildwood staff failed to provide proper care. (Gov't Ex. 361.39.) Mr. Simmons' uncle, Oliver Dixon, had been hospitalized on March 1, 2007 with a urinary tract infection. (Id.) The hospital treated Mr. Dixon, inserted a urinary catheter, and returned him Wildwood that same day with orders that his catheter be changed every month and as needed. (Id.) The nursing notes for Mr. Dixon showed that on April 19, 2007, a CNA told a nurse that she was concerned about the appearance of Mr. Dixon's penis. (Id.) Mr. Dixon's physician referred the situation to a urologist, who saw Mr. Dixon three times and had a different catheter inserted on May 3, 2007. (Id.) An investigation revealed that, from March 1, 2007 to May 3, 2007, Mr. Dixon's catheter was never changed, and no evidence indicated that Mr. Dixon had ever received any routine catheter care. (Id.)

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350. From May 2006 until July 2007, Winifred Herrington's aunt, Mrs. Campbell, lived in Wildwood. (Trial Tr. Vol. 7 (Herrington) at 1031.) During that time period, Ms. Campbell developed pneumonia twice. (Id. at 1036-37.) Ms. Herrington testified that Ms. Campbell's doctor attributed the second case of pneumonia to the fact that the shower room was heated, but the hallway and Ms. Campbell's room had no heat, and the temperature changes aggravated a cold Ms. Campbell had until it developed into pneumonia. (Id.) Ms. Campbell also developed bed sores because she was not turned properly. (Id. at 1044.) Further, Ms. Campbell missed dialysis appointments because Defendant failed to pay the service that transported Wildwood residents to the dialysis clinic. (Id. at 1050-53.) In approximately July 2007, Ms. Campbell

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was hospitalized for dehydration and because she did not have enough food at Wildwood. (Id. at 1048-49.) During that hospital stay, a doctor who was treating Ms. Campbell for ear discomfort removed a roach that was burrowing deeply into her ear. (Id.) Finally, as previously noted, a saturated ceiling tile fell on the foot of Ms. Campbell's roommate's bed immediately after the roommate had moved to the head of her bed. (Id. at 1046.)

351. Edna Walker lived in Wildwood from July to October 2005 and again from February 2006 until the nursing home closed. (Trial Tr. Vol. 4 (Hamilton) at 660; Evans Dep. at 6-7.) During Ms. Walker's second stay in Wildwood, she was hospitalized for two weeks because of dehydration. (Evans Dep. at 16-18.)

352. When Ms. Chal came to Wildwood in July 2007,

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she found that she could not keep sufficient staff at the nursing home because of its payroll problems and many other problems. (Trial Tr. Vol. 16 (Chal) at 2681-82.) Ms. Chal testified that she resigned on August 3, 2007 because Wildwood was incapable of providing the care and services needed to meet the needs of the residents. (Id. at 2677-78; Gov't Exs. 361.47, 1104.) According to Ms. Chal, under Defendant's management, Wildwood did not provide residents with a safe environment or balanced, nutritional meals. (Trial Tr. Vol. 16 (Chal) at 2678.)

19. Defendant's Responsibility for Residents

353. On May 23, 2007, surveyors placed Moran Lake and Mt. Berry in immediate jeopardy. (Gov't Exs. 292, 306.) On June 15, 2007, both facilities were terminated from the programs. (Gov't Exs. 134, 361_10.) For most of August

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and September 2007, surveyors placed Wildwood in immediate jeopardy, and Wildwood was in immediate jeopardy on September 13, 2007, when it was terminated. (Trial Tr. Vol. 16 (Chal) at 2680-83, 2694-95; Gov't Exs. 136, 323-28.) The termination letter for each nursing home contained a notice that Medicare and Medicaid payments for services rendered to residents would continue for a thirty-day period from the date of termination in order to facilitate the orderly transfer of the residents. (Trial Tr. Vol. 14 (Chandler) at 2320-21; Gov't Exs. 134, 136, 361_10.)

354. Defendant submitted claims and received payments that were supposed to be for services rendered to the residents until June 30, 2007 for Mt. Berry residents, until July 5, 2007 for Moran Lake residents, and until September 7, 2007 for Wildwood residents. (Trial Tr. Vol.

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9 (Cannon) at 1310-11; Gov't Exs. 254, 254a, 134, 136, 361_10.) When ORS began monitoring the homes, state surveyors came to the homes and observed their operation; however, the state did not insert a management team or assume responsibility for operating the homes and caring for the residents. (Trial Tr. Vol. 14 (Chandler) at 2316-18, 2321-22; Trial Tr. Vol. 16 (Chal) at 2680-81.) Ms. Chandler testified that she remained the administrator at Mt. Berry throughout the monitoring, that the FHG nursing staff still cared for the residents, and that FHG still billed Medicare and Medicaid as long as each resident remained in the homes. (Trial Tr. Vol. 14 (Chandler) at 2316-18, 2321-22.) Ms. Chal stated that she the FHG staff remained responsible for the Wildwood residents until the last resident was removed from the nursing home. (Trial Tr. Vol. 16

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(Chal) at 2680-81.) Surveyor Mattie Cox testified, even if surveyors are monitoring a nursing home, the owner and staff of the facility are responsible for providing care to the residents. (Trial Tr. Vol. 15 (Cox) at 2442-43.) According to Defendant's own expert, in such a situation, the provider is the one receiving payment and, consequently, is responsible for providing care. (Trial Tr. Vol. 17 (Goldsmith) at 2865-66.)

355. No evidence indicates that anyone other than Houser and FHG received payment or was responsible for the residents' care until the residents were transferred to new homes. The evidence, however, indicates that Defendant did not pay the Moran Lake and Wildwood employees for the last four weeks that the employees worked. (Trial Tr. Vol. 11 (Edwards) at 1598-99; Trial Tr.

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Vol. 14 (Lee) at 2280-2283, (Chandler) 2338-39.) Joyia Williams testified that, although she came to Wildwood to work just before the nursing home closed, she received pay for that work from her own nursing home, not from Defendant. (Trial Tr. Vol. 16 (Williams) at 2651.) According to one witness, many FHG employees sued Defendant for pay that they never received, and, although Defendant promised the court that he would pay the employees, Defendant never did so. (Trial Tr. Vol. 14 (Lee) at 2280-2283.)

20. Food

356. Medicare and Medicaid providers must give their residents nourishing, palatable, well-balanced diets that meet the daily nutritional and special dietary needs of each resident. (Trial Tr. Vol. 2 (Mauldin) at 159-161, 168-174);

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42 U.S.C. § 1396r(a)(4)(iv); 42 C.F.R. §§ 483.25(i) & 483.35. A nursing home provider must ensure that residents maintain "acceptable parameters of nutritional status," such as body weight and protein levels. (Trial Tr. Vol. 2 (Mauldin) at 159-161); 42 C.F.R. § 425(i)(1). Ms. Mauldin testified that a nursing home cannot serve the same meal to every resident, because some or many residents may be diabetics, on dialysis, require caloric modifications, or have heightened protein needs, different hydration requirements, or difficulty chewing. (Trial Tr. Vol. 2 (Mauldin) at 159-161); 42 C.F.R. § 483.35. The regulations require that residents receive three full meals per day, as well as nutritional snacks, including a snack at bedtime. 42 C.F.R. § 483.35(f)(1), (2) & (3). According to Ms. Mauldin, snacks are especially important for diabetics,

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but also help all residents sleep through the night. (Trial Tr. Vol. 2 (Mauldin) at 170-74.)

357. Ms. Mauldin testified that nursing homes must post their menus in advance and, unless an emergency intervenes, should serve the meals that are on the menus. (Trial Tr. Vol. 2 (Mauldin) at 169-170.) According to Ms. Mauldin, doing so benefits the residents, because many residents look forward to meals. (Id. at 169.) Ms. Mauldin also noted that menus serve as a planning device and help nursing homes order the food and supplies necessary to provide nutritious, well-balanced meals that meet all of the residents' special needs. (Id. at 169-70.)

358. Defendant's own expert acknowledged that a Medicare and Medicaid provider cannot rely on his employees, residents, or residents' family members to

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provide the residents with meals and snacks that the law requires. (Trial Tr. Vol. 17 (Goldsmith) at 2881.) Mattie Cox of Medicaid stated:

> [W]e're paying a provider that signed a contract with Medicaid, and it was issued a Medicaid provider number that had nothing to do with staff. We pay according to provider number. Staff do not have a contract with Medicaid. It's the provider or the owner of that nursing home. So we do have concerns if staff are paying for services that we're paying an individual who has a prior number and has the contract with Medicaid.

(Trial Tr. Vol. 15 (Cox) at 2460.)

359. In his provider applications and in each claim for payment, a Medicare and Medicaid provider certifies and represents that he has provided the residents with meals and snacks that met the daily nutritional and special dietary needs of each resident. (Trial Tr. Vol. 17 (Goldsmith) at 2881; Trial Tr. Vol. 2 (Mauldin) at 159-161, 168-174; 42

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C.F.R. §§ 483.25(i) & 483.35.)

a. Inadequate Meals

360. During the time period relevant to this action, residents at Moran Lake, Mt. Berry, and Wildwood often received nutritionally inadequate meals with exceedingly small portions, no extra portions or "seconds" and often, little or no milk. (Trial Tr. Vol. 1 (Stanley) at 14-17, 42, 72-73 (addressing Mt. Berry); Trial Tr. Vol. 3 (Knowles) at 358, (Free) 408-412, 437 (discussing Wildwood), (Glymph) at 456-57; Trial Tr. Vol. 4 (Hamilton) at 665, 670 (addressing Wildwood); Trial Tr. Vol. 7 (Herrington) at 1038-42 (same); Trial Tr. Vol. 9 (Patrick) at 1277 (same), (Grant) 1374 (same); Trial Tr. Vol. 10 (Kelley) at 1499-1509 (discussing Mt. Berry), (Dodson) 1533 (addressing Moran Lake), (Dixon) 1562-64 (discussing Mt. Berry); Trial Tr. Vol. 11

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(Williamson) at 1581-82 (addressing Moran Lake), (Edwards) 1594-95, 1600 (same), (Landers) 1735 (same); Trial Tr. Vol. 12 (Usher) at 1783, 1793 (discussing Wildwood), (Gaulin) 1897-98, 1905-14 (same); Trial Tr. Vol. 14 (Fuqua) at 2181 (addressing Moran Lake), (Thomas) 2194-95, 2212-14, 2222-23 (same), (Lee) 2285-87, 2290-91 (same); Trial Tr. Vol. 15 (Zackary) at 2383-84 (same), (Cox) 2439 (same), (Williams) 2534 (discussing Mt. Berry); Trial Tr. Vol. 16 (Chal) at 2663, 2666-69, 2691-94 (addressing Wildwood), (Garrett) 2700-2701 (discussing Moran Lake); Browning Dep. at 10-11, 20 (addressing Wildwood); Gov't Exs. 355; 361.33, 361.37, 361.46, 1091, 1092, 1097, 1099.)

b. No Dietary Supplements

361. Residents with special dietary needs often did not receive protein shakes, other dietary supplements, or

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required therapeutic meals. (Trial Tr. Vol. 1 (Stanley) at 15; Trial Tr. Vol. 2 (Knowles) Tr. at 290, 324-25; Trial Tr. Vol. 3 (Free) at 411; Trial Tr. Vol. 4 (Hamilton) at 665, Trial Tr. Vol. 5 (Testimony of Tamara Primus) at 740, 748; Trial Tr. Vol. 6 (Greenway) at 859, 926; Trial Tr. Vol. 7 (Herrington) at 1063-64; Trial Tr. Vol. 10 (Hannay) at 1433-36, (Kelley) 1499, (Dixon) 1564; Trial Tr. Vol. 11 (Williamson) at 1581, (T. Edwards) 1600-01; Trial Tr. Vol. 12 (Gaulin) at 1906, 1915-16; Trial Tr. Vol. 14 (Fuqua) at 2179-81, (Lee) 2285-87; Trial Tr. Vol. 15 (Zackary) at 2383-84; 2397; Trial Tr. Vol. 16 (Terhune) at 2619-20.) On May 15, 2007, Melissa Hickman, Consultant Dietician for Moran Lake, wrote a letter expressing concern about weight loss because residents were not receiving their nutritional supplements and Moran Lake had an inadequate food budget. (Gov't Ex.

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355.)

c. Snacks

362. Residents of Defendant's three nursing homes often did not receive snacks. (Trial Tr. Vol. 11 (T. Edwards) at 1600; Trial Tr. Vol. 14 (Fuqua) at 2181, (Lee) 2285-86; Trial Tr. Vol. 15 (Zackary) at 2383, (Williams) at 2533-34; Browning Dep. at 11; Gov't Ex. 361.30.)

d. Therapeutic Diets

363. Witnesses testified that, due to food shortages and irregular food supplies, the nursing homes could not follow their posted menus or provide therapeutic diets. (Trial Tr. Vol 2 (Knowles) at 290, 324-25; Trial Tr. Vol. 3 (Knowles) at 358, (Free) 410-11; Trial Tr. Vol. 4 (Hamilton) at 665; Trial Tr. Vol. 5 (Primus) at 740, 748; Trial Tr. Vol. 6 (Greenway) at 859; Trial Tr. Vol. 9 (Grant) at 1374; Trial Tr.

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Vol. 10 (Dixon) at 1564; Trial Tr. Vol. 11 (Williamson) at 1579-83; Trial Tr. Vol. 12 (Gaulin) at 1915; Trial Tr. Vol. 14 (Fuqua) at 2178; Trial Tr. Vol. 15 (Zackary) at 2397, (Cox) 2438.)

e. Worthless Dietary Services

364. Ms. Chandler, who served as the administrator at Mt. Berry from late March 2007 until its closure, testified that the food service that Mt. Berry provided to the residents during the last month of her tenure was "worthless" because the portions were so small. (Trial Tr. Vol. 14 (Chandler) at 2334-36.) Ms. Chandler did not remember whether residents ever received any snacks or whether residents with special dietary needs received therapeutic diets. (Id.)

365. Ms. Stanley, who served as the administrator at Mt. Berry from January 2000 until January 2005, testified

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that, under Defendant's management, both the quality and the quantity of food served to the residents "was not of a standard appropriate for the residents." (Trial Tr. Vol. 1 (Stanley) at 5, 72-73.)

366. Ms. Free, who served as the administrator of Wildwood from August 2003 to July 2005, testified: "Lots of times we didn't have milk to offer [the residents], which was very important because, you know, being elderly, they need their nutrients. Of course, we were more careful, too, of the portions we were giving because we knew we were short of food. . . . We were very careful to not put any more than we had to, at least try to meet the regulation, but there were times when we didn't because there wasn't enough food." (Trial Tr. Vol. 3 (Free) at 394, 408-412, 437.)

367. In late January 2007, Christie Glymph inspected

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Moran Lake and observed that the nursing home served residents only three of the nine items listed on the menu. (Trial Tr. Vol. 3 (Glymph) at 456-57.)

368. Edna Walker, Tonia Hamilton's and Lurette McPherson's grandmother, lived in Wildwood from July to October 2005 and again from February 2006 until the home closed. (Trial Tr. Vol. 4 (Hamilton) at 660; Evans Dep. at 6-7.) Ms. Hamilton visited Ms. Walker three times a week. (Trial Tr. Vol. 4 (Hamilton) at 661.) At least one family member visited Mrs. Walker nearly every day. (Trial Tr. Vol. 4 (Hamilton) at 661, (McPherson) 691; Evans Dep. at 8-9.) Ms. Hamilton testified that, during Mrs. Walker's second stay in Wildwood, the quality of the food deteriorated, stating, "you may see a piece of chicken and green beans or potatoes to where it looked like slop you would feed your

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pigs. And you never seen the meat. And if you did, it was pureed, and most of it looked like Brunswick stew. You couldn't tell what you were eating." (Trial Tr. Vol. 4 (Hamilton) at 665.) Ms. Hamilton testified, "When it got so bad to where you couldn't recognize the food, we brought Grandma [Ms. Walker] food. We started bringing a lot of food in, actually. We would bring in food for the other residents because we couldn't set there and feed Grandma and not feed the roommate or not feed Johnny or Mary, or whoever, was sitting at the table in the community room with her." (Id. at 670.) Although Ms. Walker was a diabetic with special dietary needs, Ms. Hamilton stated, "it [did not] matter what her needs were or what the next person's needs, they all got the same. Whether you were a diabetic or not a diabetic, you had the same food on your plate that

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the person next to you had." (Id. at 665.) Although Ms. Hamilton complained to the state about Ms. Walker's treatment, she saw nothing change after she filed her complaint. (Id. at 659, 670-673; Gov't Ex. 628b.)

369. One day in 2007, Ms. Walker received a ham sandwich with green spoiled ham, one and one-half green beans, and approximately five French fries for lunch. (Trial Tr. Vol. 4 (McPherson) at 694-96; Evans Dep. at 26-27; Gov't Ex. 628a.) Ms. McPherson testified that she photographed the sandwich, and that she also showed the sandwich to a county commissioner, who said that he would not have fed it to his dog. (Trial Tr. Vol. 4 (McPherson) at 694-96; Gov't Ex. 628a.) Ms. Walker's roommate, Mary, also received a green ham sandwich that day. (Trial Tr. Vol. 4 (McPherson) at 696; Gov't Ex. 628a.)

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370. Winifred Herrington visited her aunt in Wildwood daily from May 2006 until August 2007. (Trial Tr. Vol. 7 (Herrington) at 1031, 1042.) Ms. Herrington testified taht she never saw her aunt served a full, balanced meal. (Id. at 1039-40.) On one occasion, her aunt, who was on dialysis, received only white rice and white bread for lunch, which was far too starchy a meal for a dialysis patient. (Id. at 1038-39.) On some occasions, her aunt received vegetables but no meat, such as green beans and saltine crackers, or, at other times, received only a hot dog. (Id. at 1039-40.) Many residents told Mrs. Herrington, "we can't eat this garbage." (Id. at 1041.) Ms. Herrington testified that the food often was prepared poorly or was inedible. (Id. at 1040-41.) According to Ms. Herrington, the unbalanced and inedible meals remained a problem during the entire

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time that her aunt lived in Wildwood. (Id. at 1039-40.) When Ms. Herrington asked Wildwood's dietician about the meals, the dietician stated that she had to serve what she had, which was especially difficult when the food truck did not make deliveries. (Id. at 1039-40.) Ms. Herrington testified that her aunt saved some of her food, out of fear that she would not receive anything to eat later, and that her aunt did not receive the protein shakes that she needed as part of her therapeutic diet. (Id. at 1038-40, 1063-64.)

371. Danny Patrick, a maintenance man at Wildwood, sometimes helped feed residents, and testified that he was concerned about the small portions the residents received. (Trial Tr. Vol. 9 (Patrick) at 1277.) Mr. Patrick testified that, if the kitchen staff made bologna sandwiches, each resident received half of a sandwich. (Id.) Mr. Patrick noted that,

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although he was puzzled as to how the nursing home could split a single egg, the kitchen staff split one egg between two residents' plates. (Id. at 1277.)

372. Dr. Hannay testified that, because of food shortages, he once saw Moran Lake residents served "a piece of salami and a piece of bread for breakfast." (Trial Tr. Vol. 10 (Hannay) at 1434-35.) When Dr. Hannay went to the kitchen to complain, the staff told him: "This is all we've got . . . the pantry is empty. There is nothing else to feed these people." (Id. at 1435.)

373. From 2003 until July 4, 2007, Caren Kelley's mother lived in Moran Lake. (Trial Tr. Vol. 10 (Kelley) at 1497.) According to Ms. Kelley, in late 2006, her mother began calling her almost daily, complaining, "I'm starving" and "they're not feeding us good." (Id. at 1499.) Ms. Kelley

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stated that her mother wanted more food, and that her mother was not a picky eater. (Id. at 1499-50.) According to Ms. Kelley, during the last six months of her mother's stay at Moran Lake, her mother's calls progressed from: "'I'm hungry' to 'We're starving. Can't you bring me something to eat.' It just hurt your heart to think that your mother was starving, you know. So I tried to keep her some little snacks in her drawer, and then it became she wanted a sandwich. She wanted something, as she would say, substantial to eat." (Id. at 1508-09.)

374. In late October 2006, Wildwood residents complained to Ombudsman Kathy Gaulin about the quantity and quality of the food served at Wildwood. (Trial Tr. Vol. 12 (Gaulin) at 1905-06; Gov't Ex. 361.33.) Several residents complained about the quality of the food, and

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reported that they had received very small portions during the past few days. (Trial Tr. Vol. 12 (Gaulin) at 1905-06; Gov't Ex. 361.33.) When the residents complained about the small portions, staff told them that "the [food] truck had not come." (Trial Tr. Vol. 12 (Gaulin) at 1905-06; Gov't Ex. 361.33.) Residents reported that they did not receive eggs for breakfast, and said that they received "a scoop of mashed potatoes and rice," but no meat for lunch and dinner. (Trial Tr. Vol. 12 (Gaulin) at 1905-06; Gov't Ex. 361.33.) Ms. Gaulin testified: "[A] lot of them [the residents] were frightened. A lot of them were angry and frightened. They were paying – a couple of them said, "I'm paying a lot of money to stay here, and I can't even get a decent meal.'" (Trial Tr. Vol. 12 (Gaulin) at 1906.)

375. Between 2004 and 2007, Ms. Gaulin visited

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Wildwood frequently. (Trial Tr. Vol. 12 (Gaulin) at 1890-91.) During the last two years that Wildwood was open, Ms. Gauilin visited almost weekly. (Id. at 1891.) Residents complained to Ms. Gaulin about food every week. (Id. at 1898.) Ms. Gaulin testified that, based on what she saw and experienced, the food served to Wildwood residents was "pretty disgusting." (Id. at 1897.) According to Ms. Gaulin:

> It wasn't warm. The residents complained it wasn't hot enough. It was mushy; everything was mushy. You couldn't identify the vegetables because they were so mushy. You couldn't tell if it was a pea or a squash or a zucchini. It was just a lot – several times observed potatoes and rice. Lots of starch, lots of macaroni, mushy macaroni. Not al dente. Just not a lot of meat. And when they did serve meat, it was always left because they couldn't chew it or it was chicken wings with very little meat that someone with dentures or someone with poor, you know, skills couldn't get that meat off of that chicken.

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(Id. at 1897-98.) Ms. Gaulin saw the dinner served at Wildwood on March 22, 2007, and she gave the following description:

> Chicken pie. That's, once again, the breaded vegetables. That was one of those deals where you couldn't tell what the vegetable was. It was some kind of a vegetable, but you couldn't really identify it. And the residents didn't eat it. 75 percent of them didn't eat it. It all went back on to the cart. Dessert, some of them received peaches, some did not. There was plenty of it, but they weren't eating it. So in this case it wasn't the quantity, it was the quality at this point.

(Id. at 1914; Gov't Ex. 361.37.) Gaulin noted that the biscuit served with that meal was uncooked. (Trial Tr. Vol. 12 (Gaulin) at 1914.)

376. John Thomas, a CNA at Moran Lake, testified that residents often received "child portions" and half-glasses of milk. (Trial Tr. Vol. 14 (Thomas) at 2195, 2213-

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15.)

377. Stephanie Lee, an LPN at Moran Lake, testified that residents received extremely small portions, such as a single tablespoon of eggs for breakfast. (Trial Tr. Vol. 14 (Lee) at 2297-98.)

378. Tatum Zackary, a CNA at Moran Lake, testified that the portions of food served to residents at mealtime "was maybe enough to feed a two-year-old. A slice of bread, one piece of bacon, you might get grits, you might get eggs, then like a half a cup of juice or milk, sometimes coffee." (Trial Tr. Vol. 15 (Zackary) at 2383.)

379. Ms. Browning testified about the food at Wildwood as follows:

> A lot of times they ran short on it. They may have on the menu spaghetti that day, and you might get noodles or you may just get the spaghetti sauce,

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> but seldom did you get both, and if they had a salad you didn't get salad dressing for it. The food was always short there.

(Browning Dep. at 10-11.)

389. Ms. Browning and other witnesses testified that milk was not always available to residents. (Browning Dep. at 20; Trial Tr. Vol. 5 (Greenway) at 802; Trial Tr. Vol. 10 (Dodson) at 1533; Trial Tr. Vol. 12 (Usher) at 1783; Trial Tr. Vol. 15 (Cox) at 2439; Gov't Ex. 355.)

f. Lack of Food Deliveries

381. The food vendor for the nursing homes was U.S. Foods when Defendant and Washington assumed control of the homes in 2003. (Trial Tr. Vol. 4 (Testimony of Michael Birke) at 580-81.) In mid-2005, Defendant changed the food vendor to Sysco Food Services ("Sysco"). (Id. at 562-63, 580-81.) Based on Defendant's payment history

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with U.S. Foods, Sysco agreed to supply food to Defendant's three nursing homes on a cash-on-delivery ("COD") basis only. (Id. at 563-64, 580-81.) Most of Sysco's customers are sufficiently credit-worthy so that Sysco allows the customers to pay on monthly terms. (Id. at 565-66.) Sysco remained the nursing homes' food vendor until the nursing homes closed in 2007. (Id. at 564.)

382. When Sysco began delivering food to the nursing homes, it made two deliveries to each nursing home per week, and the nursing homes were to pay Sysco's drivers when they arrived at the nursing homes. (Trial Tr. Vol. 4 (Birke) at 564-65.) After a few weeks, Sysco agreed to Defendant's request for payment on weekly terms. (Id.) Under that arrangement, payment for one week's deliveries was due on the following Friday. (Id.) When Defendant

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applying for terms with Sysco, he gave Sysco's sales representative, Michael Birke, a personal financial statement that claimed that Defendant had a personal net worth of slightly less than twenty-five million dollars. (Id. at 565.)

383. Mr. Birke testified that Sysco had difficulty obtaining payment from Defendant. (Trial Tr. Vol. 4 (Birke) at 566-67.) Although most of Sysco's customers transmit their payments to Sysco, Mr. Birke testified that had to drive to Rome every week and find Defendant to obtain payment, because only Defendant could sign FHG checks. (Id.)

384. On one occasion, Mr. Birke sat in the FHG office in Rome and waited to collect a payment from Defendant. (Trial Tr. Vol. 8 (Burrell) at 1245.) Defendant appeared and gave Mr. Birke a check. (Id.) After Mr. Birke left, Defendant

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stated that he hoped that Mr. Birke did not cash the check immediately because the account did not have money to cover the check. (Id.)

385. After Defendant began writing worthless checks to Sysco, Mr. Birke began taking Defendant's checks to the bank immediately after receiving the checks, where he converted the checks into cashier's checks. (Trial Tr. Vol. 4 (Birke) at 567-68.) According to Mr. Birke, this tactic helped him avoid taking a bad check, or, alternatively, allowed him to find out sooner, rather than later, that the check was worthless. (Id. at 567.) In 2007, Sysco changed to an electronic payment system that allowed Defendant to authorize direct withdrawals from his account. (Id. at 568-69.) According to Mr. Birke, after Defendant authorized a payment to Sysco, he would later cancel his authorization

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