IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF GEORGIA

ROME DIVISION

UNITED STATES OF AMERICA	:	
	:	CRIMINAL INDICTMENT
v.	:	
	:	NO. 4:10-CR-012-HLM-WEJ
GEORGE D. HOUSER	:	

UNITED STATES' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW, VOL. II

Comes now the United States, by and through Sally Quillian Yates, United States Attorney for the Northern District of Georgia, and Glenn D. Baker and William G. Traynor, Assistant United States Attorneys, and hereby submits its proposed findings of fact and conclusions of law. Due to its length, the Government has split its submission and is filing it in three volumes.

V. RESIDENT CARE

Medicare and Medicaid require that skilled nursing facilities provide a level of nursing care that enables residents to attain and maintain the highest practicable level of physical, mental, and psychosocial well-being. Mauldin Tr. at 139, 153; 42 C.F.R. § 483.25 (quality of care) & 483.30 (nursing services). This includes helping residents eat, bathe, groom and clean themselves, turn in their beds, keeping them hydrated, and providing other, similar care, such as incontinence care. Mauldin Tr. at 153-56. Providers must also have a medical director and provide services that are essential to furnishing physician-ordered care, such as laboratory services, x-ray, and pharmaceutical services. Mauldin Tr. at 160-67. A nursing home provider must "follow the doctor's orders. That's not – that's not even a question." Mauldin Tr. at 161.

By signing the enrollment applications to seek Medicare and Medicaid payments for their residents, Rhonda and Houser certified that they were aware of all the applicable federal statutes and regulations governing the operating, staffing, and maintenance of nursing homes, and they certified that they would comply with those statutes and regulations and not knowingly present or cause to be presented false claims for payment. Sheppard Tr. at 1080-87, 1088-1094, 1098; Austin Tr. at 632-650; Exs. 100, 101, 102, 103, 104, 105, 106, 107, 108, 110, 111, 112, 116,

117, 118, 122, 123, 124, 125, 126, 127.

Houser and Rhonda were paid more than $32.9 million in the three-year conspiracy period based on claims for payment they filed with Medicare and Medicaid. Sheppard Tr. at 1078-1080; Canon Tr. at 1309, Exs.254, 254a, 255a, 255b, 255c, 255d. In filing those claims, Houser and Rhonda represented that they provided the nursing care services that Medicare and Medicaid require at the level they require. Goldsmith Tr. at 2881; Cox Tr. at 2460-61, Mauldin Tr. at 142-43.

NURSING SUPPLY SHORTAGES

In addition to running short of food, milk, and bread, the Moran Lake, Mt. Berry and Wildwood nursing homes frequently ran out of basic nursing supplies needed to care for the residents, such as diapers (or "briefs"), wound care supplies, blood sugar testing supplies, medications, and ice. The homes went days or weeks without access to laboratory, pharmaceutical, x-ray and other essential services. The Moran Lake and Mt. Berry homes went lengthy periods without medical supplies. All of these shortages can be traced directly to Houser's failure to pay vendors and his reliance on employees and residents' family members to furnish the supplies and services that Medicare and Medicaid require.

The Court heard repeatedly throughout the month-long trial that all three homes frequently ran out of diapers, wound care supplies, and basic nursing

supplies. Stanley Tr. at 17-19; Knowles Tr. at 313-14, 320, 342; Hinkley Tr. at 754-55; Greenway Tr. at 830-31; Herrington Tr. at 1043-44; Grant Tr. at 1323; Hannay Tr. at 1454-55; Dodson Tr. at 1529-30; Peyton Tr. at 1555-56; Dixon Tr. at 1564-65; Edwards Tr. at 1592-93; Landers Tr. at 1733-34, 1758; Brunner Tr. at 1816, 1846; Collins Tr. at 1870-71; Gaulin Tr. at 1899; Fuqua Tr. at 2141-43, 2165; Thomas Tr. at 2194; Zackary Tr. at 2382; Lee Tr. at 2284-85; Garrett Tr. at 2698-99; Exs. 361.32, 487 (faxes dated September 5, 2006, October 4, 2006, November 1, 2006, March 2, 2007), 517.

These shortages had a direct impact on resident care, because a nursing home staff cannot provide quality care to residents without a sufficient and steady supply of the supplies necessary for incontinence care and infection control. Williams Tr. at 2650-51. A nursing home cannot adequately take care of a person without the necessary supplies. Williams Tr. at 2651.

Frances Browning, who lived at Wildwood from 2005 until shortly before it closed in September 2007, testified that the home ran out of diapers "quite often," such that she bought her own every month because she could go to the drugstore in her wheelchair. Browning depo. ex. 634a at 13-14. Family members and friends also supplied her with diapers, and she shared her supply with other residents who needed them. Browning depo. ex. 634a at 13-14. Browning

developed pressure sores at Wildwood, and the home nursing staff rarely had the zinc ointment necessary to treat them so, like her diapers, Browning addressed the shortage by buying her own ointment several times. Browning depo. ex. 634a at Browning at 14-15. Browning testified that her fellow Wildwood residents had to depend on family members and friends to bring them food, nursing supplies, shampoo, and soap. Browning depo. ex. 634a at 17-18.

Hazel Evans, who was visiting her mother at Wildwood when Browning lived there, testified that six-to-eight months before Wildwood closed, it seemed to run out of diapers, medications, linens, wash cloths and towels. Evans depo. ex. 633a at 20-21, 24. Evans started bringing all these basics when she visited her mother rather than take the chance of finding the home without. Evans depo. ex. 633a at 24.

Also at Wildwood, Winifred Herrington bought diapers, latex gloves and other nursing supplies for her aunt because of frequent shortages at the nursing home. Herrington Tr. at 1043-1044. Numerous witnesses testified that family members supplied residents with diapers, wound care supplies, and other basic nursing supplies. Stanley Tr. at 17-18, 68; Hinkley Tr. at 754-55; Greenway Tr. at 830-31; Dodson Tr. at 1530; Peyton Tr. at 1555-56; Gaulin Tr. at 1899.

Testifying about his mother's experience in Mt. Berry, Pete Peyton testified:

"The only reason my mother got took care every day is that we were there every day. We made sure Mother had her own snacks. We also made sure that she had her own diapers that she had to wear because of a lot of times at that nursing home they didn't have any." Peyton Tr. at 1555. Ylaunda Dixon, a CNA at Mt. Berry, testified that "[w]e didn't have no diapers. . . . No ointments, no sheets." Dixon Tr. at 1565.

Kenneth Hinkley brought diapers for his mother in law at Mt. Berry, and he later discovered that her diapers were being given to other residents. Hinkley Tr. at 754-55. Greenway said that family members like Hinkley brought diapers to Mt. Berry because they knew they were in short supply in the home. Greenway Tr. at 831.

Linda Dodson testified that several times she visited her brother at Moran Lake and found him sitting in his wheelchair soaking wet with urine. Dodson Tr. at 1529-30. He would not have a diaper on, and the nursing staff advised her on those occasions that the home was out of diapers in her brother's size. Dodson Tr. at 1530. She would then drive to a store and buy him diapers. Dodson Tr. at 1530.

When Lisa Landers was the social worker at Moran Lake from November 2005 to May 2007, she actually telephoned family members and asked them to

supply residents with diapers. Landers Tr. at 1729, 1733. "I was, at one point, trying to get diapers from the families. You know, when they had run out of diapers, we was trying to get some of the families to purchase diapers." Landers Tr. at 1758. At Moran Lake, CNAs had to use socks to bathe residents because they did not have wash cloths. Thomas Tr. at 2194, Garrett Tr. at 2698.

Tammy Edwards, an LPN and charge nurse at Moran Lake for several years until the home closed in July 2007, testified that the nursing staff had to compromise in treating wounds and pressure sores because of the lack of supplies. Edwards Tr. at 1587, 1593. She testified: "We just tri[ed] to do everything we could. We did not have everything we needed." As an example of a compromise, Tatum Zackary, a CNA at Moran Lake, said that when the staff had no gauze and tape to cover pressure sores, they would clean the sores and leave them open – and vulnerable to infestation by flies, of which Moran Lake had many. Zackary Tr. 2382; Wells Tr. at 2081-82. Edwards summarized the situation at Moran Lake as follows:

> Q: Now, you mentioned you had a problem with – there was a shortage of blankets in the winter. Other than the blankets, did you have enough linens and supplies for the people in your hall?
>
> A: No. No, we did not. We didn't have enough diapers so people would – we would pool together, buy diapers,

> buy milk. We'd go get a loaf of bread, each one of us bring a loaf of bread in. You know, whatever we could help up out – make sure everybody's belly was full and they were dry and warm and that's what we tried to do.
>
> Q: Were you able to always do that?
>
> A: Well, I mean, when you don't get paid sometimes, not always, no.

Edward Tr. at 1592 (emphasis added).

Similarly, Sonya Brunner, an LPN at Wildwood, testified:

> We did [pay for things out of our own pockets] but that was not enough. We could not provide for their needs. Our paycheck could not cover us and those patients. We just do what we could. But it was not providing them quality services; it wasn't giving them what they needed.

Brunner Tr. at 1846.

LACK OF LABORATORY TESTING SERVICES

Medicare and Medicaid providers must have laboratory services so that the nursing home staff can follow physicians' orders for the monitoring of blood work and medication levels. Mauldin Tr. at 162, 180-81; Knowles Tr. at 318-19, 333-34; Greenway Tr. at 785-86; Hannay Tr. at 1443-46; Gaulin Tr. at 1896; Chandler Tr. at 2323-24; 42 C.F.R. § 483.75(j). Many medications that nursing home residents take require lab results – blood and urine analysis – so their physician can monitor them for possible complications or changing levels of blood

chemistry. Free Tr. at 405-06; Greenway Tr. at 785; Hannay Tr. at 1443-46; Gaulin Tr. at 1896; Chandler Tr. at 2323-24. Lab work must be done in a timely manner, as the physician directs. Mauldin Tr. at 162, 180-81; Hannay Tr. at 1443-46. The unavailability of lab work puts residents in immediate jeopardy of serious harm or death. Free at Tr. 405-06; Greenway Tr. at 785; Hannay Tr. at 1443-46; Gaulin Tr. at 1896; Chandler Tr. at 2323-24.

Moran Lake

The Moran Lake nursing home went without lab testing for weeks at a time because Houser did not pay for the services. Knowles Tr. at 292-94, 303-04, 318-19, 325, 333-34, 341-42; Hannay Tr. at 1443-46. In a letter faxed July 24, 2006, Knowles warned Houser that the lack of lab service "continue[d] to be an unresolved issue." She noted that the home was not able to draw labs as quickly as the physicians ordered, which put the home out of compliance with Medicare and Medicaid regulations requiring prompt and appropriate lab services. Ex. 487. She warned the lack of lab services could lead to the home being cited for putting residents in immediate jeopardy of harm or death. Ex. 487; Knowles Tr. at 318-19. Knowles repeated the same warning a month later in a letter faxed August 21, 2006. Ex. 487.

In a letter faxed July 11, 2006, Knowles told Houser:

> **CLINICAL LAB SERVICE**: THIS CONTINUES TO BE AN UNRESOLVED ISSUE. WHILE I HAVE A STAFF MEMBER DRAWING [LABS], AT TIMES WE ARE NOT ABLE TO COMPLETE LAB ORDERS AS QUICKLY AS PHYSICIANS WOULD LIKE WHICH PUTS US OUT OF COMPLIANCE. THIS CAN PLACE US IN AN IMMEDIATE JEOPARDY TAG.

Ex. 487 (emphasis in original).

In a letter faxed September 5, 2006, Knowles warned Houser that Redmond Regional hospital was no longer processing labs for Moran Lake residents.

In letters faxed October 4 and October 30, 2006, and again on November 1, 2006, Knowles warned Houser that "WE ARE IN A JEOPARDY SITUATION BEING UNABLE TO DRAW THE AMMONIA LEVELS" for the residents who were on dialysis. Knowles Tr. at 318-19; Ex. 487 (emphasis in original). Mt. Berry Administrator Lois Greenway had first-hand experience with the jeopardy posed by an inability to monitor a resident's ammonia levels, because one of her residents had to be hospitalized for problems that arose when his ammonia levels were unmonitored. Greenway Tr. at 871; Ex. 565.

In a letter faxed on December 13, 2006, Knowles told Houser:

> **LABS**: WE ARE IN A JEOPARDY SITUATION BEING UNABLE TO DRAW THE AMMONIA LEVELS FOR THE [RESIDENTS] EXPERIENCING KIDNEY PROBLEMS, SOME ON DIALYSIS. THERE HAS GOT TO BE SOME RESOLUTION ASAP ON

> THIS. **GEORGE WE ARE GOING TO BE IN BIG TROUBLE FOR THIS IF SOMEONE CALLS THE STATE. THIS HAS DRAGGED ON FOR A WHILE AND IT IS REALLY MAKING ME NERVOUS!!!!!**

Ex. 487 (emphasis in original).

In a letter faxed March 2, 2007, Knowles told Houser: "LABS HAVE NOT BEEN DONE FOR THE PAST 2 DAYS. WHEN IS THIS GOING TO BE DONE?" Ex. 487 (emphasis in original).

Knowles testified that "probably weeks" before she left Moran Lake in mid-May 2007, labs were not being done because Redmond Regional hospital had refused to process them. Knowles Tr. at 363.

Mt. Berry

Suzanne Stanley was the administrator at Mt. Berry when Houser and Rhonda assumed control of the home in 2003, and she remained in that position until January 2005. Stanley Tr. at 4. During her tenure, there were times that residents' labs could not be processed because Houser had failed to pay the service. Stanley Tr. at 19.

Lois Greenway was the administrator from January 2006 until late February 2007. Greenway Tr. at 778. The interruption of lab services because of Houser's failure to pay the lab services was a problem that plagued Greenway throughout

her tenure. Greenway Tr. at 785-86, 805-06; 821, 845-46, 851-55, 869-72, 891-92, 951; Exs. 800 (letter faxed July 13, 2005); 471 (letter faxed September 14, 2005); 497 (letter faxed May 16, 2006); 512 (letter faxed June 26, 2006); 809 (letter faxed July 5, 2006); 811 (letter faxed July 11, 2006); 791 (letter sent September 12, 2006); 563 (letter faxed November 28, 2006); 565 (email dated November 28, 2006).

In a letter faxed July 13, 2005, Greenway warned Houser that the lab service did not draw labs that day, and if the state surveyors were to discover that the home was not complying with federal law, they would cite the home for putting the health and lives of the residents in "immediate jeopardy." Greenway Tr. 785-86; Ex. 800. Greenway warned Houser, "AND I AM SURE SOMEONE WILL REPORT IT TO THE STATE." Ex. 800.

In a letter faxed September 14, 2005, Greenway again warned Houser that the lab service had not drawn labs, and "IT WILL BE AN IMMEDIATE JEOPARDY IF [the state surveyors] FIND IT!!!!!!!!!!!!" Greenway Tr. 805-06 (labs "frequently" cut service because of Houser's lack of payment); Ex. 497.

On May 16, 2006, Clinical Laboratory Services notified Greenway that it was terminating lab service because of nonpayment. Greenway Tr. at 821; Ex. 497. Houser had not paid the lab service in eight months and owed $8,531.14.

Greenway Tr. at 821; Ex. 497. Greenway forwarded the cutoff notice to Rhonda. Ex. 497.

In a letter faxed on Monday, June 26, 2006, Greenway warned Houser and Rhonda that the home had gone three days without being able to have labs drawn and analyzed as the residents' doctors had ordered. Greenway Tr. at 845-46; Ex. 512. Greenway further warned Houser that "WE CANNOT BE WITHOUT THE ABILITY TO HAVE LAB WORK DONE PER DR'S ORDERS!!!!!!!!!!!!" Ex. 512. She again warned that the lack of lab service would merit an "immediate jeopardy" tag if the state surveyors were to discover that the home was violating federal law. Ex. 512. Greenway was able to have Redmond Regional hospital process a few labs, but not many. Greenway Tr. at 846.

In a letter faxed a few days later, on July 5, 2006, Greenway warned that the home still had no lab service and Redmond Regional refused to run any more labs for the home. Greenway Tr. at 871, Ex. 809. Greenway advised that some nurses in the home had persuaded the lab at Floyd County Medical Center to process labs for the home, but she did not expect that service to last long, in part because those nurses were leaving the home because they were nervous and worried about the harm that could come to the residents because of lack of lab work. Greenway Tr. at 850; Ex. 809. Greenway also warned Houser that Dr. Keith Hannay, who had

been the home's medical director, was "very upset" at the lack of lab service, because it was his responsibility to see that his patients were cared for properly, and lab work was necessary for proper patient care. Greenway Tr. at 850-51; Ex. 809; *see also* Hannay Tr. at 1443-46.

In a letter faxed a week later, on July 11, 2006, Greenway warned Houser and Rhonda that the home still lacked lab services. Greenway Tr. 854-55; Ex. 811.

Floyd Medical Center agreed to provide lab testing services to Mt. Berry in an agreement dated August 1, 2006. Ex. 791. In a letter dated September 12, 2006, Floyd Medical Center notified Greenway that it was terminating that agreement, and it would no longer process lab testing for the home. Greenway Tr. at 891-92; Ex. 791.

In a letter faxed November 28, 2006, Greenway warned Houser and Rhonda that the lack of lab services had resulted in one resident having to be hospitalized "hopefully to prevent any more damage to him." Greenway Tr. at 869-71; Ex. 563. She warned Houser and Rhonda:

> WE HAVE NO WAY TO DO AMMONIA LEVELS AT ALL. WE HAVE HAD A RESIDENT WITH AN AMMONIA LEVEL WHICH DID NOT GET DONE.
>
> HE HAS ENDED UP IN THE HOSPITAL WITH

> THESE PROBLEMS!!!!!!!!!!
>
> THIS CAN BE AN IMMEDIATE JEOPARDY WHICH WILL STOP PAYMENTS AND ADMISSIONS!!!! !!!!!! IT IS A BAD OUTCOME FOR A SERVICE WE DID NOT PROVIDE!!!!!!!!!!
>
> WE WERE INFORMED AND I FAXED ONTO YOU THAT IF THE LAB IS NOT TAKEN CARE OF BEFORE DECEMBER 1, 2006 THEY WILL NOT BE BACK!!!!!!!!!!
>
> THESE LEVELS ARE CRUCIAL TO MANAGE RESIDENTS WITH RENAL DISEASE.

Ex. 563 (emphasis in original).

In an email dated the same day, November 28, 2006, Greenway advised Rhonda and FHG Office Manager Cheryl Dawson that Moran Lake Administrator Kim Knowles had six ammonia levels that had not been tested as doctors had ordered, and she repeated the warning that failure to provide lab testing for renal patients puts them in immediate jeopardy to their health and lives. Greenway Tr. 870-872; Ex. 565.

Lab testing services must be available every day, and as Greenway's testimony, letters and emails show, that was not the case at Mt. Berry. Greenway Tr. at 785-86. Greenway testified, "I tried everything that I could do to have it [the lab work] done, but I was unsuccessful to get them all done...[i]n the time they

were ordered by the physician for proper evaluation." Greenway Tr. at 900-01.

Lab testing remained intermittently unavailable under Anggie Chandler, who was the administrator at Mt. Berry after Greenway, from March through July 2007. Chandler Tr. at 2306-07. Like Stanley and Greenway, Chandler "had a hard time" retaining lab testing "becomes the companies wouldn't come because the facility owed them bills, and we would have to try to take them to the hospital or something like that, an alternate route." Chandler Tr. at 2323. Despite her efforts to find "alternate routes," some residents' lab work was never done because the home could not get it tested. Chandler Tr. at 2323. This lack of lab testing put residents in jeopardy of harm or death. Chandler Tr. at 2323-24.

Wildwood

Rosa Free was the administrator of Wildwood from August 2003 until July 2005. Free Tr. at 394. Rhondia Grant succeeded Free, and was the administrator until she resigned in April 2007. Grant Tr. at 1317-18. Lab testing was interrupted at Wildwood under both Free and Grant because of Houser's failure to pay the services. Free Tr. at 405-06, 436-37; Grant Tr. at 1353, 1392, 1414; Gaulin Tr. at 1894, 1896; Exs. 361.30; 831.37.

It is "critical" to have labs drawn and tested because many nursing home residents are "very brittle" and must have the effects of their medications

monitored. Free Tr. at 405. "We have to know – a lot of the medications require labs, and we need to know the results that the medication's having on that body," Free testified. Free Tr. at 405. If a resident's labs are not being drawn and tested, his doctor will not know whether to increase or decrease his medications. Free Tr. at 405; Hannay Tr. at 1443-46. The lack of information caused by a lack of lab testing could lead to a resident bleeding to death or suffering a stroke or other "long-range problems." Free Tr. at 405; Hannay Tr. at 1443-46. As at Moran Lake and Mt. Berry, there were periods where Wildwood residents' labs were not drawn and tested because Houser defaulted on his payment plans with lab services. Free Tr. at 405-06, 436-37; Grant Tr. at 1353; Ex. 831.37.

Rhondia Grant was sometimes able to obtain lab testing results because she was personal friends with a lab manager. Grant Tr. at 1292. The manager would give the results to Grant after "a lot of pleading and begging," not because of anything Houser did. Grant Tr. at 1392. It is not acceptable to go any length of time without being able to have residents' lab work tested. Grant Tr. at 1414. Yet there were times at Wildwood under Grant in which that situation occurred because Houser did not pay the lab service. Grant Tr. at 1353; Ex. 831.37.

MEDICATION SHORTAGES

Nursing homes must provide residents with pharmaceutical services,

including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. 42 U.S.C. § 1396r(a)(4)(iii); 42 C.F.R. § 483.60; Mauldin Tr. at 138, 171-72. Whenever a doctor orders a medicine for a resident, it must be available in the nursing home, and it must be given as ordered. Mauldin Tr. at 138. It is the nursing home owner's responsibility to contract for and pay for pharmacy services. Mauldin Tr. at 172.

The Court heard substantial testimony that at various times during the conspiracy period, the nursing homes were without the required pharmaceutical services after vendors would stop service because of Houser's failure to pay them. For example, in July 2003, PharMerica, Inc. agreed to provide pharmacy services and healthcare products to Moran Lake, Mt. Berry, and Wildwood. Tr. at 2311-13; *PharMerica, Inc. v. Forum Healthcare Group, Inc., Forum Healthcare Group d/b/a Moran Lake; Forum Healthcare Group d/b/a Mt. Berry; and Forum Healthcare Group d/b/a Wildwood Park*, 4:05-CV-275-HLM; Tr. 2311-13. PharMerica alleged that all three Forum Healthcare nursing homes became severely delinquent on their accounts, failed to comply with payment schedules when they were put on C.O.D. status, and owed a total of $322,305 when PharMerica terminated service. Tr. 2311-13. On November 27, 2006, summary

judgment was entered against the defendant Forum Healthcare nursing homes for more than $537,000, plus interest and court costs. Tr. 2311-13. The nursing homes did not appeal the judgment, permitting it to become a final judgment by the end of December 2006. Tr. 2311-13; Fed. R. App. P. 4(a)(1) (notice of appeal in a civil matter must be filed within 30 days of the entry of the judgment being appealed).

Administrators and nursing home employees testified about their experiences when the homes had no pharmaceutical services. *E.g.*, Stanley Tr. at 18, 65; Edward Tr. at 1593-94; Brunner Tr. at 1818-19, 1831-32; Lee Tr. at 2284; Ex.1239a (Dr. Hannay Letter to state surveyors: "I was informed that [Mt. Berry had] **No** pharmacy services!"(emphasis in original)). During these times of no service, some residents would have to go without their prescribed medicines until Houser paid the bill. Stanley Tr. at 65; Brunner Tr. at 1831-32 ("there were times when they didn't get their medicines."); Lee Tr. at 2284.

At times, nurses would negotiate the shortages by "borrowing" medications for residents. They would do this because it would endanger certain residents if their medications were interrupted. Edwards Tr. at 1593. If Resident "A" was out of medicine, and Resident "B" took the same medicine at the same dosage, the nurses would "borrow" Resident B's medicine and give it to Resident A. Edwards

Tr. at 1593-94; Brunner Tr. at 1818-19, 1831-32; Lee Tr. at 2284. Resident B would be "paid back" when pharmaceutical service was restored and Resident A was resupplied. The nurses would try to repay the resident from whom medication was borrowed when the next order came in, but if the medication did not come in, then that resident just came up short. Edwards at Tr. 1593-94; Brunner Tr. at 1818-19, 1830. Insulin was "borrowed" as well as pharmaceutical medications. Edwards Tr. at 1594. But "borrowing" was not always possible, because it could not be done without a "donor" resident who had the appropriate medication in the appropriate dosage. Brunner Tr. at 1818-19, 1832-32; Lee Tr. at 2284. When "borrowing" was not possible, residents did not receive their medications. Brunner Tr. at 1818-19, 1832-32; Lee Tr. at 2284.

Barbara Lynch's mother lived in Mt. Berry for three years, from approximately 2004 until the home closed. Lynch Tr. at 1518-19. Lynch was satisfied with the care her mother received when she first moved into the home. Lynch Tr. at 1519. Before the home closed, Lynch saw that it suffered from large staff turnover ("[t]hey lost lots of help because they were not getting paid"), the dumpster was full, and "they didn't have water and then the laundries didn't work and, you know, it was just a sad situation." Lynch Tr. at 1520-21. At this time, Lynch saw that her mother was not receiving her medication. Lynch Tr. at 1521-

22. Lynch visited her mother frequently, and she would find her mother's pills on her bed or on the floor. Lynch Tr. at 1521. It had become difficult to find a nurse or CNA in the home, but Lynch would find one and report that her mother was not receiving her medication properly. Lynch Tr. at 1521-22. Lynch's reports and complaints, however, had no effect. Lynch Tr. at 1521.

STAFF SHORTAGES

Nursing homes must have sufficient nursing staff to take care of the residents. Mauldin Tr. at 143-45; 42 U.S.C. § 1396r(a)(4)(A)(i); 42 C.F.R. § 483.30. The Court heard testimony that staffing levels at the Moran Lake, Mt. Berry and Wildwood homes were often stretched to the limit – or beyond. Staffing problems were exacerbated by the payroll chaos discussed in another section in these proposed findings of fact. There was also substantial testimony that patient care suffered as a result of staffing issues, especially when they were combined with the leaking roofs, lack of air conditioning and heat, and shortages of food, nursing supplies, and equipment discussed throughout the case.

Mt. Berry

Suzanne Stanley, Houser's first administrator at Mt. Berry, was "uncomfortable" with the cuts in staffing that he wanted her to make. Stanley Tr. at 42. Staff quit because of the payroll problems, and it was difficult to recruit

new staff because the community knew about the difficulties with payroll and did not want to work at the facilities. Stanley Tr. at 12. There were times when staffing was short because employees left to race to the bank and try to get their paychecks cashed. Stanley Tr. at 79. Staff members would be pulled from their regular jobs to take laundry to the laundromat or to shop for food and supplies for the residents. Stanley Tr. at 34; Knowles Tr. at 300, 306-07, 312-13; Grant Tr. at 1362.

Stanley's successor, Lois Greenway, received multiple complaints from family members about staffing levels in the home. Greenway Tr. at 872. Mt. Berry had a smaller nursing staff than it needed, but Houser nonetheless pressured Greenway to reduce her nursing staff. Greenway Tr. at 882-83; Ex. 594. Payroll problems – bouncing paychecks, delayed paychecks, lapses of insurance coverage – combined with nursing staff fears about the consequences of the shortages in the home, and the inability to advertise for new employees to replace those who were leaving, deprived Greenway of the ability to maintain the staffing level she thought necessary to provide quality care to her residents. Greenway Tr. at 843-44, 850, 856, 958; Exs. 471, 800, 809, 811, 812. There were periods during Greenway's tenure when she was not able to maintain the staff levels needed to provide adequate care to the residents. Greenway Tr. at 907.

Carolyn Williams was a restorative aid under Greenway, but because of staff shortages, she actually spent all of her time working as a CNA and never worked as a therapist. Williams Tr. at 2518-2522.

Family members noticed the staffing shortages at Mt. Berry. Barbara Lynch, whose mother lived in Mt. Berry for about three years before it closed, testified that in its final months, the home no longer had enough staff "to care properly for everybody that was there." Lynch Tr. at 1522. The homes lacked sufficient staff to feed her mother, and "[t]here were times you could not find a nurse or a CNA." Lynch Tr. at 1521. Lynch attributed the declining staff to payroll problems, testifying, "[t]hey 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." Lynch Tr. at 1520.

Kenneth Hinkley's mother in law did not receive the physical therapy at Mt. Berry that had been prescribed because the home had no physical therapist. Hinkley Tr. at 756-57.

FHG Payroll Manager Laverne Burrell moved her mother to Mt. Berry in 2005. Burrell Tr. at 1264-65. The next year, however, the Mt. Berry administrator and some CNAs warned her that they could not care for her mother like they did when she first arrived. Burrell Tr. at 1264-65. These members of the Mt. Berry

administration and nursing staff warned Burrell to move her mother to another home, which she did. Burrell Tr. at 1264-65.

Moran Lake

Staffing was also a problem at Moran Lake. Edwards Tr. at 1591-93; Terhune Tr. at 2618, 2640. Employees would not come to work because of payroll problems. Edwards Tr. at 1591. Consequently, as a charge nurse, Edwards would not have enough staff to take care of the residents on her wing. Edwards Tr. at 1591. For example, she should have had two CNAs on her floor, but at times there would only be one to care for 44-48 residents. Edwards Tr. at 1591-92; *see also* Cox Tr. at 2445 (resident complained of staff turnover); Terhune Tr. at 2618, 2640 (Moran Lake had good people, just not enough between September 2006 and April 2007); Ex. 354.

Wildwood

Rhondia Grant employed "creative staffing" in the fall of 2006 – scheduling employees to work long shifts and substantial overtime – to make it appear to state surveyors that Wildwood had sufficient staffing "on paper," but she knew she was "wearing out what little staff" she had. Grant Tr. at 1337; Ex. 831.9. This might have passed muster with the surveyors, but as LPN Sonya Brunner testified, it did not provide for sufficient staffing in the home, as "[j]ust because it's [staffing]

posted on this schedule does not mean those people were present." Brunner Tr. at 1865.

Indeed, Tonia Hamilton said there were not enough CNAs at Wildwood to do all of the work. Hamilton Tr. at 667. Hamilton said the staffing posted on the schedule always met the state requirement, but she never saw as many staff on duty as was posted. Hamilton at 668.

Grant also moved residents out of their rooms and consolidated them in wings, in part because of clinical staffing shortages. Grant Tr. at 1343-45; Ex. 831.23. Being moved around upset the residents, and it meant that residents who were at risk of wandering out of the home were moved to unlocked, unsecured wings. Gaulin Tr. at 1909.

To cut costs, Wildwood nursing staff would be sent home early, leaving the home short-staffed on night shifts, leaving too few CNAs to properly care for the residents. Brunner 1822-23; Collins Tr. at 1887; Browning depo. ex. 634A at 21-22.

Short staffing was family members' chief complaint, but employees were not to verbally acknowledge the insufficient number of staff members, though it was obvious. Brunner Tr. at 1814, 1854. LPN Brunner testified:

> 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.

Brunner Tr. at 1854; *see also* 1814 (there were not enough CNAs per patient); Gaulin Tr. at 1919 & Ex. 361.37 (complaints about staffing shortages increasing in March 2007); Browning dep. ex. 634a at 22 (short staffing at Wildwood at nights made residents wait longer for help and to be changed).

As in the Rome homes, Wildwood was plagued with frequent employee absenteeism because of, among other things, payroll problems. Grant Tr. at 1337, 1358; *see also* Free Tr. at 300 (call lights went unanswered because employees were racing to the bank to try to cash their paychecks). Grant's predecessor, Rosa Free, was constantly worried about having enough staff to take care of her residents. Free Tr. at 404.

When Barbara Chal came to Wildwood in July 2007, she found that she could not keep sufficient staff at the home because of its payroll problems and

many other problems. Chal Tr. at 2681-82. The staff was not going to work for free, she found. Chal Tr. at 2682. Chal resigned on August 3, 2007, because Wildwood was incapable of providing the care and services needed to meet the needs of the residents. Chal Tr. 2677-78; Exs. 361.47, 1104. Under Houser's management, the home did not provide residents with a safe environment or balanced, nutritional meals. Chal Tr. at 2678.

URINE-SOAKED RESIDENTS

Incontinent nursing home residents are supposed to be checked and changed at least every two hours. Brunner Tr. at 1814. Residents who cannot turn themselves must be turned every two hours. Collins Tr. at 1868-69. These two-hour changes and turns are important to the residents' health, hygiene, dignity, and overall well-being. Brunner Tr. at 1815-16; Collins Tr. at 1868-69; Davis Tr. at 2590. Regularly changing and turning the residents is "part of taking care of people." Brunner Tr. at 1815-16. But because of shortages of staff and supplies, many residents often endured lengthy periods soaked in urine or caked in their own feces, or both.

At Wildwood, Tonia Hamilton, Lurette McPherson and Hazel Evans visited Evans' mother daily. "Many, many times" they found her "soaking wet with urine from head to toe." Hamilton Tr. at 668; Evans depo. ex. 633a at 19-20.

McPherson found her grandmother caked in dried feces at least five times. McPherson Tr. at 692. On another occasion, Evans found that her mother had been lying in her own feces for so long that it had thoroughly dried and caked to her skin. Evans depo. ex. 633a at 18-19. Evans said that she found her mother soaked in urine once out of every three or four visits. Evans depo. ex. 633a at 20. Evans testified it was "an everyday occurrence" to see Wildwood residents soaking wet, with pools of urine beneath their chairs or wheelchairs. Evans depo. ex. 633a at 20, 23.

Reba Usher's mother's roommate at Wildwood wet her bed often, such that her soaked mattress continually emitted a "very horrible" odor. Usher Tr. at 1778-79. Usher's mother's room reeked of urine the entire time she lived in Wildwood. Usher Tr. at 1778-79.

LPN Sonya Brunner testified that with the short staff at Wildwood, it was impossible for the nursing staff to check, change, and turn residents every two hours. Brunner Tr. at 1815-16. She 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.

Brunner Tr. at 1815.

Residents also went longer than two hours between changes because the nursing staff had to conserve diapers and other supplies. Brunner Tr. at 1814. Brunner explained that "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 was just wet a little bit, that diaper was not coming off right then." Brunner Tr. at 1814; *see also* Browning dep. ex. 634a at 22 (short staffing at Wildwood at nights made residents wait longer for help and to be changed).

Rev. Kenneth Hinkley starting bringing diapers when he visited his mother-in-law at Mt. Berry "[b]ecause she wasn't being changed." Caren Kelley would find that her mother's bed was wet, and often she could not find clean linens to change her mother's bed. Kelley Tr. 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. Williams Tr. at 2523.

At Moran Lake, Linda Dodson often found her brother sitting in his wheelchair soaking wet with urine. Dodson Tr. at 1530. Several times she found that he was not wearing a diaper, and when she asked the nursing staff, she was told that the home had no diapers in his size. Dodson Tr. at 1530. Three times she turned her brother's bed down for him, only to discover that his bed was wet with

urine beneath the dry cover. Dodson Tr. at 1530. On other occasions, Dodson found that her brother had not been cleaned and he had feces on his hands, his legs, and under his fingernails. Dodson Tr. at 1530-31.

Similarly, Lynn Terhune's father, Morris Ellison, lived at Lake Moran from September 2006 until April 2007. Terhune Tr. at 2617; Collins Tr. at 2757-58. She visited him several days a week, and she found him lying in a urine-soaked bed on approximately forty percent of her visits. Terhune Tr. at 2623-24. She would find him in soiled, unchanged diapers. Terhune Tr. at 2624-25. Terhune's friend tipped a staff member $20 to encourage him to check on Ellison, but the staff was too small to keep him and his room clean. Terhune Tr. at 2618, 2624. Terhune said Ellison liked the staff members, "but there just wasn't enough people to go around to do what needed to be done." Terhune Tr. at 2624.

The problem with short staff was obviously even more pronounced on paydays, when employees raced to the bank or stood in line to cash their checks at the money van. Fuqua Tr. at 2145, 2185; Lee Tr. at 2281-82. Residents would have to wait "a couple more hours" to be changed or fed. Lee Tr. at 2281-82.

LACK OF MEDICAL DIRECTORS

Medicare and Medicaid require nursing homes to have a physician as a medical director. 42 C.F.R. § 483.75(i); Mauldin Tr. 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).

Dr. Keith Hannay was the medical director at Moran Lake and Mt. Berry from 1999 until May 2005. Hannay Tr. at 1425-27; Ex. 1233. Floyd Medical Center terminated its agreements with FHG that permitted Dr. Hannay to serve as medical director as of May 4, 2005. Hannay Tr. at 1427; Exs. 1232 & 1233. The hospital terminated the agreements because (1) Houser had not paid the medical director fee ($1,000 per month) in several months and (2) the nursing homes had no medical malpractice insurance for their medical director. Hannay Tr. at 1426-28; Exs. 1232 & 1233.

After they lost Dr. Hannay, the nursing homes were without a medical director until a Dr. Evans was hired. Greenway Tr. at 782-84. Dr. Evans later left that position because of nonpayment, and there is no evidence that he was ever replaced. Greenway Tr. at 782-84.

LACK OF EQUIPMENT AND SERVICES

The homes lacked other equipment and services needed to monitor and care for the residents' health.

Monitoring Blood Sugar

Frances Browning testified that while she lived at 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 depo. ex. 634a at 15-17. Browning testified that many nights she would go through the different wings in the home begging for blood sugar testing strips from residents because the nursing staff had none. Browning depo. ex. 634a at 15-17. "Quite often," she testified, she was unsuccessful in her attempts to scrounge up testing strips for the nurses. Browning depo. ex. 634a at 15-17. "I'd go down [the halls] almost every night and probably three out of four I was unsuccessful." Browning depo. ex. 634a at 16. This situation endured the entire time she lived in Wildwood. Browning depo. ex. 634a at 16.

Nebulizers

Nebulizers are devices that are used to administer medication in the form of a mist inhaled into the lungs of patients with respiratory illnesses. Edwards Tr. at 1593. Each patient should have their own nebulizer. Edwards Tr. at 1593. Having different people use the same nebulizer is unsanitary and creates a risk of infection. Edwards Tr. at 1593. Moran Lake had many residents with respiratory illnesses, some of whom needed to use a nebulizer four times a day. Edwards Tr. at 1593. But the nursing staff had only one nebulizer. Edwards Tr. at 1593. Consequently, the staff used the nebulizer on all of the patients, because the

nursing staff "had to do what [it] had to do." Edwards Tr. at 1593.

Beds

Beds were a problem in the homes. Prince Tr. at 606; Herrington Tr. at 1054-55; Peyton Tr. at 1550-51; Fuqua Tr. at 2149-50; Lee Tr. at 2290, 2301; Zackary Tr. at 2381. The hand-cranking mechanism failed to work on many beds, which meant that residents' beds were propped up and positioned with cinder blocks. Herrington Tr. at 1054-55; Fuqua Tr. at 2149-50; Lee Tr. at 2290. Moran Lake had no bariatric beds for heavy residents. Lee Tr. at 2301. When Pete Peyton's mother needed a low bed, Mt. Berry staff built her a cage-like frame with her mattress snaking over hard plastic pipes. Peyton Tr. at 1550-51; Ex. 628.

At Wildwood, many of the mattresses were so worn out and discolored that the staff covered them "with sheets and stuff" to hide the stains and bolster the mattresses. Brunner Tr. at 1858. The home had no bed-to-chair devices to help residents get in and out of their beds. Brunner Tr. at 1858. The home had few turning aides, such as foam blocks used to position a resident who needs help maintaining a position. Brunner Tr. at 1858. In sum, the staff lacked many necessities for caring for the residents. Brunner Tr. at 1858.

Emergency Supplies

Nursing homes must have a 72-hour supply of food for emergency supplies.

Goldsmith Tr. at 2800. They must have water available and/or a contract with a company that will make sure that they provide the home with water in an emergency. Goldsmith Tr. at 2800. Nursing homes must also have an emergency supply of medications. Goldsmith Tr. at 2800.

At Moran Lake, the kitchen staff sometimes had to use the emergency food supply just to make it through routine days because Houser failed to pay the food supplier. Williamson Tr. at 1581, 1584.

Mt. Berry had no emergency water supply because Houser did not pay the supplier. Greenway Tr. at 798.

At Wildwood, the home was no longer able to maintain the necessary emergency medical supply stock because the staff had to use the emergency supplies when they ran out of daily supplies. Grant Tr. at 1352, Brunner Tr. at 1829.

Alarms

At Moran Lake, residents were ambulatory or could wheel around. Someone had to stand at the door "for hours at a time" to block residents from leaving when the door alarm did not work. Knowles Tr. at 295; Fuqua Tr. at 2150-51; Young Tr. at 2574-75. Residents occasionally left through a door and had to be brought back. Fuqua Tr. at 2170.

Fall alarms to be worn by residents who were prone to fall did not work, many could not be repaired, and new ones could not be ordered because Houser would not pay for them. Fuqua Tr. at 2151-52.

The fire alarm monitoring service at Moran Lake and Mt. Berry was terminated because Houser would not pay for it. Stanley Tr. at 32, Knowles Tr. at 295, Greenway Tr. at 798.

When Southeast Georgia Health Systems took over the Wildwood buildings in September 2007, Dennis Johnson inspected the condition of the home and found, among other things, that the interior fire sprinkler system was not connected to anything. Johnson Tr. at 2044-45.

Transportation for Treatment

At Moran Lake, Kim Knowles continually notified Houser that the non-emergency transport service was not being paid. Knowles Tr. at 299; Ex. 487. To compensate for the lack of a non-emergency transportation service, staff members were pulled from their regular jobs on the floor and used their personal cars to take residents to doctor's appointments and other non-emergency visits. Knowles Tr. at 300, 306-7.

At Mt. Berry, Lois Greenway notified Houser in June 2006 that the transport service for Medicare Part A patients was not being paid. Greenway Tr.

at 832; Exs. 790, 811. The next month, Greenway told Houser that "I am having problems admitting [residents] because of the inability to get transport for Medicare Part A residents." Greenway Tr. at 860; Ex. 519. By late October 2006, Houser was $5,000 behind on his payments to the Redmond Regional non-emergency transport service, which had already agreed to cut its bill in half. Greenway Tr. at 868; Ex. 552. Because of the unpaid bills, Mt. Berry residents who could not be taken in an automobile had to be taken in an emergency ambulance. Greenway. Tr. at 961.

At Wildwood, Winifred Herrington's aunt was a dialysis patient, and Medicaid paid the nursing home to provide her transportation from the nursing home to the dialysis clinic. Herrington Tr. at 1050-52. On many occasions, however, Herrington's aunt missed her dialysis because the transportation company refused to service Wildwood because of unpaid bills. Herrington Tr. at 1050-52. This was a recurring problem after the home changed transportation companies. Herrington Tr. at 1052.

No Ice

Providing residents with ice chips is an important part of maintaining their hydration. Brunner Tr. at 1810. But the vendor that supplied the ice machine at Wildwood frequently disconnected it for lack of payment, which meant the staff

had leave the home to buy ice. Grant Tr. at 1339; Brunner Tr. at 1809; *see also* Herrington Tr. at 1044-45 (no ice at Wildwood unless she or nurses bought it). But even when the ice machine worked, employees were reluctant to use it because it was full of mold. Brunner at 1809.

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

No Evacuation Plan

The Georgia Emergency Management Agency required Wildwood to have a hurricane evacuation plan. Chal Tr. at 2661-62, 2667; Exs. 1091, 1098. GEMA required the home to have a contract in place with an ambulance company to transport the residents under the evacuation plan. Chal Tr. at 2661-62. The only ambulance provider in Brunswick, however, refused to do business with Houser because of unpaid bills. Chal Tr. at 2662; Ex. 1091. Wildwood never had an evacuation plan during Barbara Chal's tenure as administrator, which occurred during hurricane season. Chal Tr. at 2662, 2667.

WEIGHT LOSS

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. Mauldin

Tr. at 160; Hannay Tr. at 1451. Weight loss and malnutrition makes the residents "more susceptible to disease, infection, and aggravates the chronic illnesses that they already have." Cox Tr. at 2441. Nursing homes must keep track of their residents' weights and investigate when a resident loses five percent of his body weight in a month. Hannay Tr. at 1451. The Court heard substantial evidence that residents of Moran Lake, Mt. Berry and Wildwood suffered weight loss problems during the conspiracy period, though as developed below, faulty equipment, falsification of residents' records, and Houser's failure to preserve the residents' medical records make a full investigation of this matter impossible.

Moran Lake and Mt. Berry

Dr. Keith Hannay was the medical director at Moran Lake and Mt. Berry from 1999 until May 2005, and he continued to see many residents as his patients until the homes closed in July 2007. Hannay Tr. at 1422-23, 1425-28; Ex. 1233. Dr. Hannay usually spent a day a week at each home. Hannay Tr. at 1448. The Moran Lake and Mt. Berry residents' weight loss was constantly brought to his attention. Hannay Tr. at 1451. Dr. Hannay had two nurse practitioners who monitored the residents, and both grew concerned about the residents' weight loss. Hannay Tr. at 1451. Hannay also grew concerned about his patients' weight loss, and he reported his concern to the state. Hannay Tr. at 1447-50; Ex. 1237. In a

letter he wrote in May 2007, Dr. Hannay reported that at the two homes, "we are experiencing unnecessary weight losses that herald even bigger problems in the future." Ex. 1237. Hannay has specialized in long-term care since 1984, and he observed that the residents' weight loss in Moran Lake and Mt. Berry "was out of proportion to what we would, typically, expect." Hannay Tr. at 1468.[1]

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. Ex. 355. As described above, employees bought food for the residents during food shortages, but they were unable to buy the quantity and types of foods and supplements necessary to prevent weight loss among residents. Lee Tr. at 2286-87.

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." Zackary Tr. at 2383, 2390-91. The residents who gained weight filled

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[1]Dr. Hannay has treated patients in nursing homes and has been the medical director of several nursing homes since 1984, but he has never found it necessary to file complaints with the state about the operation of any nursing homes except the complaints he filed about Moran Lake and Mt. Berry between 2005 and 2007. Hannay Tr. at 1450.

up on snack food from the vending machines or received food from family members. Zackary Tr. at 2390-91.

Zackary's observations were consistent with Dr. Hannay's finding that some of the residents at Moran Lake ate snack food voraciously out of the vending machines. Hannay Tr. 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 amounts from the vending machines." Hannay Tr. at 1469-70. The residents who were eating voraciously from the vending machines tended to weigh more and lost less weight than the residents who did not eat "huge amounts" of snack food from the Moran Lake vending machines. Hannay Tr. at 1469-70.

Dr. Hannay never testified that he worried that any Moran Lake residents were gaining excessive amounts of weight. Rather, in May 2007 he reported to the state that the residents of both Moran Lake and Mt. Berry were "experiencing unnecessary weight losses that herald even bigger problems in the future." Ex. 1237.

When Mattie Cox inspected Moran Lake on May 16, 2007, her initial scan of the home's records led her to believe, mistakenly, that residents' weights were stable. Cox. Tr. at 2327, 2439. In her subsequent, in-depth review of the home's

records found that some residents had lost weight such that she notified ORS about her finding. COX Tr. at 2439; Ex. 355.

Instructions To Stop Recording Weight Loss

In response to resident weight loss, Houser instructed the nursing staff to falsify the residents' weight records. While Ylaunda Dixon was the record CNA at Mt. Berry, she recorded that "a lot of the residents was losing a whole bunch of weight." Dixon Tr. at 1564. She noted that the weight loss occurred when the residents were being served half-size portions of food at their meals, and nutritional supplements and therapeutic diets were not available. Dixon Tr. at 1562-64.

After the residents "started losing so much weight," the nursing staff met with their supervisor, Barbara Hamilton. Dixon Tr. at 1564. Hamilton instructed the staff to stop recording the residents' weight loss "per George Houser." Dixon Tr. at 1564.

The Unavailability of the Residents' Records

Full investigation of resident weight loss or gain is impossible because Houser failed to preserve his residents' medical records. Rotti Tr. at 2542-46; Exs. 2001 & 2002. After Houser, as custodian of FHG's records, received a subpoena for the residents' records on March 22, 2010, he (1) moved to quash the

subpoena and (2) stopped paying rent for the storage unit where he had stored those records. Rotti Tr. at 2542-2546; Exs. 2001 & 2002. Pursuant to the storage facility's policy, after Houser failed to pay the rent for three months, it sold the contents of his storage unit on August 4, 2010, and the purchaser discarded all the paperwork and records that Houser had stored. Rotti Tr. at 2542-45, 2547. In December 2010, Houser's newly appointed defense counsel investigated the whereabouts of records that would have been responsive to the subpoena, and he learned that the storage company had auctioned them away the preceding August. Rotti Tr. at 2547.

But on March 25, 2010, a few days after Houser was subpoenaed for the residents' medical records, a police investigator in Rome happened to recover some of the records of a former Mt. Berry resident. Rotti Tr. at 2545-47; Ex. 696a. The investigator found the records in a pile of trash that was strewn on the curb in front of the FHG offices. Rotti Tr. at 2545. On March 26, 2010, an FBI agent sifted through the trash pile and found, among other things, a Forum Healthcare Group check. Rotti Tr. at 2546-47; Ex. 696a.

Equipment Problems

Determination of resident weight loss was also complicated by equipment problems. At Mt. Berry, the home lacked a sling to use to weigh residents in

wheelchairs. Greenway Tr. at 833. When Anggie Chandler arrived at Mt. Berry in late March 2007, she discovered that the scales used to weigh residents did not work properly. Chandler Tr. at 2324. That malfunction made it impossible to conduct accurate assessments of the residents' health. Chandler Tr. at 2338.

In Brunswick, the Wildwood home had no scale to weigh the obese residents. Grant Tr. at 1350-51; Ex. 831.33.

THE RESIDENTS' HUNGER UPON TRANSFER

Many residents gained substantial amounts of weight after they were removed from Moran Lake and Mt. Berry in June and July 2007.

Cedar Springs Healthcare

In June 2007, approximately 21 Moran Lake and Mt. Berry residents were transferred to the Cedar Springs Healthcare nursing home in Cedartown, Georgia. Davis Tr. at 2577-78. They appeared to be unkempt. Davis Tr. at 2580. Pam Davis, the administrator at Cedar Springs Healthcare, did not know the residents' weight histories because their medical records were not transferred with the residents. Davis Tr. at 2591. Davis was never able to obtain the residents' records. Davis Tr. at 2592-93.

The residents all complained of being hungry when they arrived at Cedar Springs Healthcare. Davis Tr. at 2580. 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." Davis Tr. at 2581.

Many former Moran Lake residents hoarded food. Davis Tr. at 2581-82. They would put a biscuit or a piece of cake in their pocket "for later because they said they were afraid they wouldn't have any supper." Davis Tr. at 2581. Some would eat half their plate and attempt to take the other half back to their rooms to eat later. Davis Tr. at 2582. This type of food hoarding is unusual in a nursing home. Davis Tr. at 2582. It took two-three weeks for the residents to believe that they would regularly receive full meals and snacks, and that they did not have to hoard food in their rooms. Davis Tr. at 2582. One resident told Davis "I just can't believe that I can ask for a snack and I have it anytime I want." Davis. Tr. at 2582-83. Most of the residents steadily gained weight in their first three-four months in Cedar Springs Healthcare. Davis Tr. at 2583-85; Ex. 794.

Reliable Health and Rehab at Lakewood

Michelle Prince was the administrator at Moran Lake from 2002 – when it was a Sunbridge facility – until November 2003, a few months into Houser's management. Prince Tr. at 599-600. She resigned because she felt that Houser's mismanagement was putting her administrator's license at risk. Prince Tr. at 607.

After she left Moran Lake, she went to work in another Sunbridge facility, and she became the administrator of the Reliable Health and Rehab nursing home in Atlanta in March 2007. Prince Tr. at 598-600. In June 2007, approximately 15 Moran Lake residents were transferred to Reliable Health and Rehab. Prince Tr. at 607-08. The residents were unkempt. Prince Tr. at 608.

As at Cedar Springs Healthcare, the residents who were transferred to Prince's nursing home hoarded food. Prince Tr. at 608; Davis Tr. at 2581-82. The residents would hide food in their purses or wheelchairs, and when asked about their hoarding, they said they wanted food for later. Prince. Tr. at 608, 619.

Prince recognized several of the residents from the time when she was the administrator at Moran Lake, and she observed that they had suffered "significant" or "noticeable" weight loss. Prince Tr. at 608-09, 621-22. Unlike at Davis at Cedar Springs, Prince obtained the medical records for the residents who came to her nursing home. Prince Tr. at 621-22. The records showed that some residents had lost more than five percent of their body weight in the preceding 30 days, which is "significant" weight loss under the applicable regulations. Prince Tr. at 621-22. Prince could not recall how many of the residents met the regulatory standard for "significant" weight loss, but she recalled that they 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." Prince Tr. at 621-22.

Waycross Health & Rehabilitation Center

Utrena Grant was an RN who went to Wildwood in September 2007 to bring 11 residents back to Waycross Health & Rehabilitation Center, which was the nursing home where she worked. Grant Tr. at 2004-05. When she arrived she saw that very few Wildwood staff members were still working at the home – few enough to count on one hand. Grant Tr. at 2005. The residents were hoarding food. Grant Tr. at 2006-07. The residents were extremely unkempt and heavily soiled. Grant Tr. at 2007, 2011. Like Davis at Cedar Springs Healthcare, Grant was unable to obtain the residents' medical records, which significantly limited the staff's ability to assess and diagnose the new residents. Grant Tr. at 2007.

Joyia Williams was a CNA at Sears Manor Nursing Home in Brunswick, and she worked at Wildwood the last two nights it was open. Williams Tr. at 2643-44. When she arrived at Wildwood, the nurses and CNAs expressed a great need for nursing supplies. Williams Tr. at 2644-45. Both nights she worked at Wildwood she went there, made a list of needed supplies, went back to Sears Manor for the supplies, and then returned to Wildwood. Williams Tr. at 2644-45, 2651. Wildwood was sparsely staffed, and the home did not have enough staff or supplies to take care of the residents. Williams Tr. at 2645. All the residents were

dirty, in need of immediate attention, and in need of being changed, cleaned and bathed. Williams Tr. at 2646-47.

ACTUAL RESIDENT HARM

The nursing supply shortages, staff shortages, payroll problems, the lack of regular lab work, the inability to provide residents with their prescribed medications, the last-minute bill paying, the frequent changing of vendors, and Houser's practice of not addressing problems until state surveyors threatened to fine him, created an atmosphere of chaos in which some residents endured actual harm. Free Tr. at 411; Greenway Tr. at 856; Fuqua Tr. at 2184-88. Residents were not checked, changed and turned in a timely manner and 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. Fuqua Tr. at 2188. The homes were reluctant to fire poor-performing employees, or employees who left work to rush to the bank to try to cash their paychecks, because they could not hire anyone else. Fuqua Tr. at 2188. Employees, in turn, were embarrassed in the community to reveal where they worked. Landers Tr. at 1737. The staff at Moran Lake did not understand how the state could let the home operate, because it was obvious that the residents were cold and hungry. Edwards Tr. at 1611. Similarly, staff members at Mt. Berry reported their nursing home to the state hoping it could

remove Houser from its management. Williams Tr. at 2523-24.

Drawing direct connections between conduct and a nursing home residents' specific injury is not always possible because of the nature of the environment and the residents' compromised conditions. Dr. Hannay summarized the difficulty as follows:

> [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, 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.

Hannay Tr. at 1435-36

There was, however, evidence admitted of **supply shortages** that led to residents receiving a level of care that is far below anything that would be acceptable under the applicable federal law and regulations.

CNA Tatum Zackary testified that when the Moran Lake nursing staff had no gauze or tape to treat bedsores properly, they would leave the sores open and uncovered for more than one or two days at a time. Zackary Tr. at 2382, 2399. This meant that those residents had to lie on open sores for days at a time, during which time the sores could be contaminated with feces or urine. Zackary Tr. at 2399. Moreover, flies are drawn to open wounds and can lay eggs in them, which can lead to an infestation of maggots. Wells Tr. at 2081-82. An untreated bed sore "escalates" and grows larger and deeper. Brunner Tr. at 1817. Obviously, the residents who had to endure open bedsores until their nursing homes were resupplied with wound care supplies suffered actual harm as a direct result of the supply shortage. *E.g.,* McPherson Tr. at 692 (grandmother's skin would be split open with no ointment or dressing); Hinkley Tr. at 753-54 (mother-in-law's bedsore untreated at Mt. Berry and eventually ate down to her bone, causing her great pain); Dodson Tr. at 1527-29 (brother's severe pressure sore on his heel not properly treated at Moran Lake); Browning depo., ex. 634a at 15 (untreated pressure sores would break down and bleed because Wildwood rarely had the zinc ointment needed to treat them); *see also* Lee Tr. 2302 (residents did not receive adequate or "proper care that they should have" because of food and supply shortages); Zackary Tr. at 2384-85 (residents did not receive adequate care

because of food and supply shortages); Chandler Tr. at 2338 (residents must wait for care when staff members have to leave the home to buy supplies or food); Cox Tr. at 2437 (Moran Lake staff did not have enough supplies and equipment to provide quality care and, consequently, Medicaid was not getting what it paid for when it paid Houser's claims).

There was also evidence of **staff shortages** that undoubtedly led to residents receiving a level of care that is far below anything that would be acceptable under the applicable federal law and regulations. 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. Brunner Tr. at 1814; Lee Tr. at 2281-82; Williams Tr. at 2522-23; Browning dep. ex. 634a at 22 (short staffing at Wildwood at nights made residents wait longer for help and to be changed); *see also* Greenway Tr. at 907 (she was not able to maintain the staff at times necessary provide adequate care to the residents).

The evidence of actual harm to individual residents included the following:

Moran Lake

Morris Ellison lived at Moran Lake from September 2006 until early April 2007, and his autopsy shows that he suffered severe malnutrition, dehydration, and muscle wasting while he lived in that home. Terhune Tr. at 2617; Frist Tr. at

2234-35, 2239-2242, 2244-45, 2256; Exs. 944 & 949.1.

On April 7, 2007, Ellison fell and broke his hip, and he was admitted to Floyd Medical Center. Frist Tr. at 2230-33; Collins Tr. at 2764. He was transferred to a hospice facility on April 13, 2007, and he died after four days in hospice. Frist Tr. at 2230-33; Collins Tr. at 2764, 2771. Ellison was 82 when he died. Frist Tr. at 2267. Dr. Brian Frist, the Chief Medical Examiner of Cobb County, conducted an autopsy on Ellison the next day, April 18, 2007. Frist Tr. at 2230-33; Exs. 944 & 949.1.

Records from the Fifth Avenue nursing home show that Ellison weighed 127 pounds in September 2006. Collins Tr. at 2764. He was 5'8" and weighed approximately 100 pounds when he died. Frist Tr. at 2235.[2]

According to testimony about Moran Lake records, Ellison weighed 148 pounds in February 2007, two months before he died. Collins Tr. at 2764.

The nursing home employees were instructed "per George Houser" to falsify weight records. Dixon Tr. at 1564.

The autopsy photos show that Dr. Frist accurately described Ellison as

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[2]Dr. Frist estimated Ellison's weight. Frist Tr. at 2246. Estimating the weight of a decedent is the standard practice at the Cobb County Medical Examiner's office, and has been for 25 years, because the county office does not have scales to weigh entire bodies. Frist Tr. at 2246, 2260.

appearing to be a concentration camp victim, with extreme muscle wasting, bulbous knees, very little flesh or tissue between his feet, and starkly visible hip joints. Frist Tr. at 2234-35, 2239-2242, 2244-45, 2256; Ex. 949.1.

Dr. Frist acknowledged that muscle wasting occurs as humans age. Frist Tr. at 2235. He also acknowledged that he did not conduct the tests that could determine to what degree Ellison suffered from malnutrition and dehydration before he died. Frist Tr. at 2247. But Ellison's muscle wasting was so extreme that "the pictures speak for themselves." Frist Tr. at 2247; Ex. 949.1.

The autopsy photographs, and Dr. Frist's findings, make it clear that Ellison did not weigh 148 pounds two months before he died, and that he suffered from muscle wasting, malnutrition and dehydration while he lived at Moran Lake. Ex. 944, 949.1.[3]

Defense expert Dr. Kim Collins testified that there was no evidence that

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[3]Frist was told that Ellison had fallen and fractured his left hip months before his death, and he fell a second time shortly before he died. Frist Tr. at 2234. Ellison's hips were intact when he was hospitalized in September 2006 for leg surgery. Terhune Tr. at 2617, 2642. The first fall could have occurred any time between his leg surgery in September 2006 and early April 2007. Collins Tr. at 2766-67. Ellison's daughter, Lynn Terhune, testified that Ellison's first fall also occurred at Moran Lake, a few months before his second fall. Terhune Tr. at 2621. There is no evidence that gives any basis for defense counsel's claim that Dr. Frist's autopsy found that the first hip fracture could have occurred eight or ten months before his death. Terhune Tr. at 2642; Ex. 944.

former Moran Lake resident Morris Ellison was malnourished or suffered from muscle wasting. Collins Tr. at 2767. She testified that the Moran Lake records indicated that Ellison weighed 148 pounds two months before he died. Collins Tr. at 2767. When shown an autopsy photograph of Ellison and asked by the Court to comment about his weight, Dr. Collins refused, stating that she did not want to guess. Collins Tr. at 2768.

Also at Moran Lake, a resident was dropped to the floor because the lift failed mechanically and the CNA who was operating it was working without any help because of the short staff. Fuqua Tr. at 2163-64; 2176-77. The resident eventually died, and Christie Fuqua, the assistant director of nursing, could not rule out the connection between the resident being dropped and her death. Fuqua Tr. at 2176-77.

Mt. Berry

In November 2006, a Mt. Berry resident had to be hospitalized, "hopefully to prevent any more damage to him." Greenway Tr. at 869-71; Exs. 563, 565. He had to be hospitalized because he had a renal disease and needed to have the ammonia levels in his blood monitored closely and regularly. Greenway Tr. at 869-71, Ex. 563, 565. Monitoring ammonia levels is "CRUCIAL" to caring for residents with renal disease. Ex. 563 (emphasis in original). But it was

impossible to monitor the ammonia levels in the resident's blood, because Mt. Berry had no laboratory testing service in November 2006. Greenway Tr. at 869-71, Ex. 563, 565. The resident became ill as a direct result of Houser's failure to provide basic laboratory testing services for his residents and had to be hospitalized. Greenway Tr. at 953.

FHG Maintenance Supervisor Jerry Chisolm's grandmother lived in Mt. Berry. Chisolm Tr. at 557-59. While she lived there, she had her mandible removed, and she never received the speech therapy that she was supposed to receive. Chisolm Tr. at 557-58. She fell twice and broke her hip while she was in the home, and she died after the second fall. Chisolm Tr. at 557-58.

Anggie Chandler was the administrator at Mt. Berry from March-July 2007. Chandler Tr. at 2306-08. She testified that the food served at Mt. Berry during that time was worthless because the portions were too small. Chandler Tr. at 2334-36.

Wildwood

Joyia Williams, a CNA at Sears Manor Nursing Home in Brunswick, worked at Wildwood the last two nights it was open in September 2007. Williams Tr. at 2643-44. She found that the residents were dirty and needed to be changed, cleaned, and bathed. Williams Tr. at 2646-47. She found one resident, an elderly

woman, lying in her bed, covered from her neck to her feet in small black bugs. Williams Tr. at 2647. The woman's eyes were matted completely shut from lack of care. Williams Tr. at 2647. Williams was able to wash the woman's face until she could open her blue eyes, but she was not able to determine how long the woman's eyes had been matted shut. Williams Tr. at 2647.

In early July 2007, Connie Petty, a resident at Wildwood, slipped and fell two separate times on water that leaked in her room. Gaulin Tr. at 1926-27; Ex. 361.41. Water leaking from a water pipe penetrated a wall and pooled on the floor in Petty's room. Gaulin Tr. at 1926-27; Ex. 361.41. Petty fell for the first time on July 2, 2007. Ex. 361.41. She reported her fall, but nothing was done by staff. Gaulin Tr. at 1926-27; Ex. 361.41. She fell the second time the next day, July 3, 2007, and she fractured the fibula in her left leg. Gaulin Tr. at 1926-27; Ex. 361.41. The Wildwood staff moved her to another room after her second fall. Gaulin Tr. at 1926-27; Ex. 361.41.

In another event that involved a leaking water pipe, there was a fire in one resident's room in Wildwood because a water leak soaked the exposed wiring that connected the air conditioning unit in his room to the power. Patrick Tr. at 1275.

In late April 2007, Ervin Simmons complained to the state that his uncle's groin area had become badly infected because the Wildwood staff was not

providing proper care. Ex. 361.39. The uncle, Oliver Dixon, had been hospitalized on March 1, 2007 with a urinary tract infection. Ex. 361.39. Dixon was treated, a urinary catheter was inserted, and he was returned to Wildwood that day with orders that his catheter be changed every month and as needed. Ex. 361.39. The nursing notes showed that on April 19, 2007, a CNA told a nurse that she was concerned about the appearance of Dixon's penis. Ex. 361.39. His physician referred the situation to a urologist, who saw Dixon three times and had a different catheter inserted on May 3, 2007. Ex. 361.39. Investigation found that Dixon's catheter was never changed between March 1 and May 3, and there was no evidence that he had ever received any routine catheter care. Ex. 361.39.

Winifred Herrington's aunt, Mrs. Campbell, lived in Wildwood from May 2006 until July 2007. Herrington Tr. at 1031. In those fourteen months, Campbell developed pneumonia twice. Herrington Tr. at 1036-37. Campbell's doctor attributed her second case of pneumonia to the fact that the shower room was heated, but the hallway and Campbell's room had no heat, and the temperature changes aggravated a cold she had until it developed into pneumonia. Herrington Tr. at 1036-37. Campbell developed bed sores because she was not turned properly. Herrington Tr. at 1044. Campbell missed dialysis appointments because Houser failed to pay the service that transported Wildwood residents to the

dialysis clinic. Herrington Tr. at 1050-53. Campbell also had to be hospitalized in approximately July 2007 for dehydration and the effects of the poor diet she was fed at Wildwood. Herrington Tr. at 1048-49. During that stay, a doctor who was treating Campbell for ear discomfort removed a roach that was burrowing deeply into her ear. Herrington Tr. at 1048-49.

The Court heard lengthy testimony about the leaking roof in Wildwood, and how fiberglass ceiling tiles became saturated with water and fell to the floor. A saturated ceiling tile fell on the foot of Winifred Herrington's aunt's roommate's bed immediately after the roommate had moved to the head of her bed. Herrington Tr. at 1046.

Edna Walker lived in Wildwood from July to October 2005 and again from February 2006 until the home closed. Hamilton Tr. at 660; Evans depo., ex. 633a at 6-7. During her second stay in the home, Walker had to be hospitalized for two weeks because of dehydration. Hazel Evans depo., ex. 633a at 16-18. Walker's daughter, Hazel Evans, and granddaughters, Tonia Hamilton and Lurette McPherson, testified at length about the frequency with which they found Walker soaked in urine or caked in dried feces, and with her skin split open for lack of ointment and dressing.

When Barbara Chal came to Wildwood in July 2007, she found that she

could not keep sufficient staff at the home because of its payroll problems and many other problems. Chal Tr. at 2681-82. She resigned on August 3, 2007 because Wildwood was incapable of providing the care and services needed to meet the needs of the residents. Chal Tr. 2677-78; Exs. 361.47, 1104. Under Houser's management, the home did not provide residents with a safe environment or balanced, nutritional meals. Chal Tr. at 2678.

HOUSER REMAINED RESPONSIBLE FOR HIS RESIDENTS

The Moran Lake and Mt. Berry homes were placed in immediate jeopardy by the surveyors on May 23, 2007. Exs. 292, 306. Both facilities were terminated from the programs on June 15, 2007. Exs. 134, 361_10. Wildwood was placed in immediate jeopardy for most of August and September 2007, and was in immediate jeopardy at the time the facility was terminated on September 13, 2007. Chal Tr. at 2680-83, 2694-95; Exs. 136, 323-28. Each facility's termination letter contained a notice that Medicare and Medicaid payments for services rendered to residents would continue to be made for a 30-day period from the date of termination in order to facilitate the orderly transfer of the residents. Chandler at Tr. at 2320-21; Exs. 134, 136, 361_10.

Houser submitted claims and received payment that was 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. Cannon Tr. at 1310-11, Exs. 254 & 254a; Exs. 134, 136, & 361_10. When ORS began monitoring the homes, state surveyors came to the homes and observed their operation, but the state did not insert a management team or assume responsibility for operating the homes and caring for the residents. Chandler Tr. at 2316-18, 2321-22; Chal Tr. at 2680-81. Anggie Chandler, for example, remained the administrator at Mt. Berry throughout the monitoring, the FHG nursing staff still cared for the residents, and FHG still billed Medicare and Medicaid as long as each resident remained in the homes. Chandler Tr. at 2316-18, 2321-22. Similarly, Barbara Chal and the FHG staff remained responsible for the Wildwood residents until the last resident was removed from the home. Chal Tr. at 2680-81. Mattie Cox confirmed that the owner and staff of the facility are responsible for providing the care even if monitoring is being done by the surveyors. Cox Tr. at 2442-43. The provider is the one being paid and is therefore responsible for providing care. Goldsmith Tr. at 2865-66.

There is no evidence that anyone other than Houser and FHG received payment and was responsible for the residents' care, or the lack of care that occurred during this time, until they were transferred to new homes. Houser, however, kept all that money and did not pay the Moran Lake and Wildwood

employees for the last four weeks they worked. Edwards Tr. at 1598-99; Lee Tr. at 2280-2283; Chandler Tr. at 2338-39. Individuals like Joyia Williams, who volunteered to come to the facilities and help out, were paid by their own nursing homes, not Houser. J. Williams Tr. at 2651. Many Forum employees sued Houser for pay they never received, and Houser promised the court that he would pay the employees, but he never did. Lee Tr. at 2280-2283.

VI. LACK OF FOOD

Medicare and Medicaid providers are required to give their residents nourishing, palatable, well-balanced diets that meet the daily nutritional and special dietary needs of each resident. Mauldin Tr. at 159-161, 168-174; 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. Mauldin Tr. at 159-161, 42 C.F.R. § 425(i)(1). 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. Mauldin Tr. at 159-161; 42 C.F.R. § 483.35. Residents must be served three full meals per day, and nutritional snacks, including a snack a bedtime. 42 C.F.R. § 483.35(f)(1), (2) & (3). Snacks are especially important for

diabetics, but they help all residents sleep through the night. Mauldin Tr. at 170-74.

Nursing homes must post their menus in advance and, unless an emergency intervenes, they should serve the meals that are on the menus. Mauldin Tr. at 169-170. This serves the residents, many of whom look forward to their meals. Mauldin Tr. at 169. As a planning device, menus also help nursing homes order the food and supplies necessary to provide nutritious, well-balanced meals that meet all of their residents' special needs. Mauldin Tr. at 169-70.

A Medicare and Medicaid provider cannot rely on his employees, residents, or residents' family members to provide the residents with meals and snacks that the law requires. Goldsmith Tr. at 2881. Mattie Cox of Medicaid explained:

> We'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.

Cox Tr. at 2460.

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. Goldsmith Tr. at 2881; Mauldin Tr. at 159-161, 168-174; 42 C.F.R. §§ 483.25(i) & 483.35.

INADEQUATE MEALS

Often during the conspiracy period residents of the Moran Lake, Mt. Berry, and Wildwood nursing homes were served nutritionally inadequate meals with exceedingly small portions, no extra portions ("seconds"), and often, little or no milk. Stanley Tr. at 14-17, 42, 72-73 (Mt. Berry); Knowles Tr. at 358; Free Tr. at 408-412, 437 (Wildwood); Glymph Tr. at 456-57; Hamilton Tr. at 665, 670 (Wildwood); Herrington Tr. at 1038-42 (Wildwood); Patrick Tr. at 1277 (Wildwood); Grant Tr. at 1374 (Wildwood); Kelley Tr. at 1499-1509 (Mt. Berry); Williamson Tr. at 1581-82 (Moran Lake); Dodson Tr. at 1533 (Moran Lake); Edwards Tr. at 1594-95, 1600 (Moran Lake); Dixon Tr. at 1562-64 (Mt. Berry); Landers Tr. at 1735 (Moran Lake); Usher Tr. at 1783, 1793 (Wildwood); Gaulin Tr. at 1897-98, 1905-14 (Wildwood); Fuqua Tr. at 2181 (Moran Lake); Thomas Tr. at 2194-95, 2212-14, 2222-23 (Moran Lake); Lee Tr. at 2285-87, 2290-91 (Moran Lake); Zackary Tr. at 2383-84 (Moran Lake); Cox Tr. at 2439 (Moran Lake); Williams Tr. at 2534 (Mt. Berry); Chal Tr. at 2663, 2666-69, 2691-94 (Wildwood); Garrett Tr. at 2700-2701 (Moran Lake); Frances Browning depo., ex.

634a at 10-11, 20 (Wildwood); Exs. 355; 361.33, 361.37, 361.46, 1091, 1092, 1097, 1099.

NO DIETARY SUPPLEMENTS

Residents with special dietary needs often went without protein shakes or other dietary supplements, and were not served the required therapeutic meals. Stanley Tr. at 15; Knowles Tr. at 290, 324-25; Free Tr. at 411; Hamilton Tr. at 665; Primus Tr. at 740, 748; Greenway Tr. at 859, 926; Herrington Tr. at 1063-64; Hannay Tr. at 1433-36; Kelley Tr. at 1499; Dixon Tr. at 1564; Williamson Tr. at 1581; Edward Tr. at 1600-01; Gaulin Tr. at 1906, 1915-16; Fuqua Tr. at 2179-81; Lee Tr. at 2285-87; Zackary Tr. at 2383-84; 2397; Terhune Tr. at 2619-20. On May 15, 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. Ex. 355.

NO SNACKS

Residents often went without any snacks. Dixon Tr. at 1563-64; Edwards Tr. at 1600; Gaulin Tr. at 1897Fuqua Tr. at 2181; Lee Tr. at 2285-86; Zackary Tr. at 2383; Williams Tr. at 2534; Browning depo., ex. 634a at 11; Ex. 361.30.

THERAPEUTIC DIETS NOT SERVED

Food shortages and irregular food supplies made it impossible for the homes to follow their posted menus ("make menu") and provide therapeutic diets. Knowles Tr. at 290, 324-25, 358; Free Tr. at 410-11; Hamilton Tr. at 665; Primus at 740, 748; Greenway Tr. at 859; Grant Tr. at 1374; Dixon Tr. at 1564; Williamson Tr. at 1579-83; Gaulin Tr. at 1915; Fuqua Tr. at 2178; Zackary Tr. at 2397; Cox Tr. at 2438.

TESTIMONY ABOUT WORTHLESS DIETARY SERVICES

Anggie Chandler, who was the administrator at Mt. Berry from late March 2007 until it closed in June 2007, said the food service her nursing home provided the residents during the last month of her tenure was "worthless" because the portions were so small. Chandler Tr. at 2334-36. She did not know if residents ever received any snacks or if residents with special dietary needs received therapeutic diets. Chandler Tr. at 2334-36.

Suzanne Stanley, the administrator at Mt. Berry from January 2000 until January 2005, testified that under Houser's management, both the quality and the quantity of food served to the residents "was not of a standard appropriate for the residents." Stanley Tr. at 5, 72-73.

Rosa Free, who was the administrator at Wildwood from August 2003 to

July 2005, testified that "[l]ots of times we didn't have milk to offer them [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." Free Tr. at 394, 408-412, 437.

When Christie Glymph inspected Moran Lake in late January 2007, she saw that residents were served only three of the nine items listed on the menu. Glymph Tr. at 456-57.

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. Hamilton Tr. at 660; Evans depo., ex. 633a at 6-7. Hamilton visited Walker three times a week. Hamilton Tr. at 661. Between Hamilton, her mother (Hazel Evans), McPherson, and other family members, a family member visited Walker nearly every day. Hamilton Tr. at 661, McPherson Tr. at 691; Evans depo. ex. 633a at 8-9. During Walker's second stay in Wildwood, Hamilton said the quality of the food deteriorated, from where "you may see a piece of chicken and green beans or potatoes to where it looked like slop you would feed

your 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." Hamilton Tr. at 665.

Hamilton testified: "When it got so bad to where you couldn't recognize the food, we brought Grandma [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." Hamilton Tr. at 670. Walker was a diabetic with special dietary needs, but Hamilton testified "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 the person next to you had." Hamilton Tr. at 665. Hamilton complained to the state about Walker's treatment, but she saw nothing change after she filed her complaint. Hamilton Tr. at 659, 670-673; Ex. 628b.

One day for lunch in 2007, Walker was served a ham sandwich with green spoiled ham, one and one-half green beans, and approximately five French fries. McPherson Tr. at 694-96; Evans depo. ex. 633a at 26-27; Ex. 628a. McPherson photographed the sandwich, and showed the sandwich to a county commissioner, who said he would not have fed it to his dog. McPherson Tr. at 694-96; Ex. 628a.

Walker's roommate, Mary, was also served a green ham sandwich that day. McPherson at 696; Ex. 628a.

Winifred Herrington's aunt lived in Wildwood from May 2006 until August 2007, and she visited her daily. Herrington Tr. at 1031, 1042. Herrington never saw her aunt served a full balanced meal. Herrington Tr. at 1039-40. Once her aunt, who was on dialysis, was served only white rice and white bread for lunch, which was far too starchy a meal for a dialysis patient. Herrington Tr. at 1038-39.[4] Sometimes Herrington's aunt was served vegetables but no meat (such as a "meal" of green beans and saltine crackers) or, at other times, only a hot dog. Herrington Tr. at 1039-40. Many residents told Herrington, "we can't eat this garbage." Herrington Tr. at 1041. Herrington said that often the food was prepared poorly, or it was inedible. Herrington Tr. at 1040-41. The unbalanced and inedible meals were an on-going problem the entire time Herrington's aunt lived in Wildwood. Herrington Tr. at 1039-40. When Herrington asked the home's dietician about the meals, the dietician explained that she had to serve what she had, which was especially difficult when the food truck did not make deliveries. Herrington Tr. at 1039-40. Herrington testified that her aunt would save some of her food for fear

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[4]Such a meal consists only of two starches, which the body processes into sugar and, consequently, it would be an all-sugar meal with no nutritional value. Davis Tr. at 2588-90.

that she would not be served anything to eat later, and her aunt was not served the protein shakes she needed as part of her therapeutic diet. Herrington Tr. at 1038-40, 1063-64.

Danny Patrick, a maintenance man at Wildwood who sometimes helped feed residents, testified that he was concerned about the small portions the residents received. Patrick Tr. at 1277. He testified that if the kitchen staff made bologna sandwiches, each resident received half of a sandwich. Patrick Tr. at 1277. He testified that he was puzzled how one could share a single egg, but residents' breakfasts appeared to consist of half an egg. Patrick Tr. at 1277.

Dr. Keith Hannay, the attending physician for the majority of residents at Moran Lake and Mt. Berry during the entire conspiracy period, and the medical director at the homes for a portion of that period, testified that because of food shortages, he once saw Moran Lake residents served "a piece of salami and a piece of bread for breakfast." Hannay Tr. at 1434-35. He angrily went to the kitchen to complain and was told: "This is all we've got . . . the pantry is empty. There is nothing else to feed these people." Hannay Tr. at 1435.

Caren Kelley's mother lived in Moran Lake from 2003 until July 4, 2007. Kelley Tr. at 1497. Toward the end of 2006, her mother started calling her almost daily and said "I'm starving" and "they're not feeding us good." Kelley Tr. at

1499. Kelley testified about her mother: "She wanted more food. See, she was so easy to please. You know, she could have had – if they had bread, she could have had a scrambled egg sandwich or if they had eggs, she could have had a scrambled egg sandwich. Or if she had peanut butter, she'd take a peanut butter sandwich. She wasn't a picky eater." Kelley Tr. at 1499-1500. Kelley said in 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." Kelley Tr. at 1508-09.

When Ombudsman Kathy Gaulin visited Wildwood in late October 2006, residents complained to her about the quantity and quality of the food served in the home. Gaulin Tr. at 1905-06, Ex. 361.33. Several residents complained about the quality, and said they were served very small portions in the past few days. Gaulin Tr. at 1905-06, Ex. 361.33. When they complained about the small portions, they were told that "the food truck had not come." Gaulin Tr. at 1905-06, Ex. 361.33. Residents reported that they were not served any eggs for breakfast, and "a scoop of mashed potatoes and rice," but no meat, for lunch and

dinner. Gaulin Tr. at 1905-06, Ex. 361.33. Gaulin testified that she thought "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.'" Gaulin Tr. at 1906.

Gaulin visited Wildwood frequently between 2004 and 2007. Gaulin Tr. at 1890-91. In the last two years the home was open, she visited almost weekly. Gaulin Tr. at 1891. Residents complained to her about food every week. Gaulin Tr. at 1898. From what Gaulin saw and experienced, she found the food served to Wildwood residents to be "pretty disgusting." Gaulin Tr. at 1897. She explained: "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." Gaulin Tr. at 1897-98.

Gaulin was at Wildwood when dinner was served on March 22, 2007, and she described it as follows: "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." Gaulin Tr. at 1914; Ex. 361.37. Gaulin noted that the biscuit served with that meal was uncooked. Gaulin Tr. at 1914.

John Thomas, a CNA at Moran Lake, testified that residents were often served "child portions" and half-glasses of milk. Thomas Tr. at 2195, 2213-15.

Stephanie Lee, an LPN at Moran Lake, testified that residents were served extremely small portions, such as a single tablespoon of eggs for breakfast. Lee Tr. at 2297-98.

Tatum Zackary, a CNA at Moran Lake, testified that the portions of food served to residents at meal time "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." Zackary Tr. at 2383.

Frances Browning, who lived at Wildwood from 2005-2007, testified that regarding food served at the home, "[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, 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." Frances Browning 634a at 10-11. Browning was one of several witnesses to testify that milk was not always available to residents. Browning depo., ex. 634a at 20; *see also* Greenway Tr. at 802; Dodson Tr. at 1533; Usher Tr. at 1783; Cox Tr. at 2439; Ex. 355.

FAILURE TO HAVE FOOD DELIVERED TO THE HOMES

Houser failed to pay his food vendors to deliver food to the three nursing homes. When Houser and Rhonda assumed control of the homes in 2003, their food vendor was U.S. Foods. Birke Tr. at 580-81. In the middle of 2005, Houser changed vendors to Sysco Food Services. Birke Tr. at 562-63, 580-81. Based on Houser's payment history with U.S. Foods, Sysco agreed to supply food to his three homes on a cash-on-delivery basis only. Birke Tr. at 563-64, 580-81.[5] Sysco remained the homes' food vendor until they were closed in 2007. Birke Tr. at 564.

When Sysco began delivering food to Houser's and Rhonda's homes, it made two deliveries to each home per week, and the drivers were to be paid when

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[5]Most of Sysco's customers have sufficient creditworthiness that they pay on monthly terms. Birke Tr. at 565-66.

they arrived at the homes. Birke Tr. at 564-65. After a few weeks, Sysco agreed to Houser's request for payment on weekly terms, meaning that payment for one week's deliveries was due the following Friday. Birke Tr. at 564-65. In applying for terms, Houser gave Birke a personal financial statement that claimed that he had a personal net worth of slightly less than $25 million. Birke Tr. at 565.

Obtaining payment from Houser proved to be difficult for Sysco. Birke Tr. at 566-67. Most of Sysco's customers transmit their payments to the vendor, but Sysco Sales Representative Mike Birke had to drive to Rome every week and chase Houser around the county to obtain a check, because only Houser could sign Forum Healthcare Group checks. Birke Tr. at 566-67.

Once Birke sat in the FHG office in Rome and waited to collect a payment from Houser. Burrell Tr. at 1245. Houser appeared and gave Birke a check. Burrell Tr. at 1245. After Birke left, Houser said he hoped that Birke did not go cash the check immediately because there was not any money in the account to cover it. Burrell Tr. at 1245.

After Houser started writing worthless checks to Sysco, Birke began taking Houser's checks to the bank immediately upon receiving them and coverting them into cashier's checks. Birke Tr. at 567-68. Doing this, Birke could avoid taking a bad check, or he would find out sooner, rather than later, that the check was

worthless. Birke Tr. at 567. In 2007, Sysco changed to an electronic payment system in which Houser could authorize direct withdrawals from his account. After authorizing a payment to Sysco, Houser would later, without Sysco's knowledge, cancel his authorization and leave Sysco without payment. Birke Tr. at 568-69. By the time the homes closed, Houser owed Sysco approximately $53,000, which he never paid. Birke Tr. at 567-71.

When Houser fell behind in his payments to Sysco, Birke would telephone the administrators in the nursing homes and warn them that they would not be receiving their food delivery. Birke Tr. at 570-571. "Occasionally," he testified, the administrators "would find a way to have the check" and pay for a delivery. Birke Tr. at 571. On one occasion, an employee paid for a delivery – which typically cost between $1,200 and $1,600 – and on other occasions, Sysco never sent trucks to the homes. Birke Tr. at 569, 571; Knowles Tr. at 338.

The administrators communicated constantly with Houser about their residents' need for food and the interruption of Sysco deliveries. For example, in a letter faxed February 16, 2007, Knowles told Houser:

> **SYSCO**: WE DID NOT GET A FOOD DELIVERY YESTERDAY. THERE IS NOT ENOUGH FOOD TO GET PAST LUNCH TODAY. I NEED TO KNOW WHAT IS GOING TO BE DONE TO RECTIFY THIS ASAP."

Ex. 487 (emphasis in original).

Similarly, Wildwood administrators Rhondia Grant and Barbara Chal telephoned, faxed letters and sent emails to Houser urging him to pay Sysco so that it would send food to the homes. Grant Tr. at 1335; Chal Tr. at 2663, 2668-69; Exs. 831.7, 1092, 1097.

Food shortages were an ongoing problem at Mt. Berry. Stanley Tr. at 14-15; Greenway Tr. at 858, 928. At times, Mt. Berry residents did not get all the nutrition they needed because of the food shortages. Greetway Tr. at 971. Mt. Berry once went a week without a food delivery because Houser would not pay Sysco. Greenway Tr. at 928.

EMPLOYEES PURCHASE FOOD AND MILK

When the Sysco truck did not deliver food to the homes, the administrators and other employees went shopping and bought food for the residents to eat. Stanley Tr. at 33-35; Knowles at 287, 312-13, 340, 352, 358; Free Tr. at 408-12, 437; Primus Tr. at 740, 748; Greenway Tr. at 810, 859-60, 877-78, 881; Grant Tr. at 1321-23, 1401; Williamson Tr. at 1579-83; Collins Tr. at 1871; Williamson Tr. at 1579-81, 1583; Gaulin Tr. at 1899; Lee Tr. at 2285; Chandler Tr. at 2338; Zackary Tr. at 2389; Williams Tr. at 2524-25; Chal Tr. at 2660-61; Browning depo. ex. 634a at 11-13; Exs. 361.32; 487.

Many times when the administrators and employees bought food for the residents, Houser did not reimburse them. Stanley Tr. at 33-35; Knowles Tr. at 287, 301, 313; Free Tr. at 410; Primus Tr. at 740 (Knowles reimbursed her, not Houser); Greenway Tr. at 859-60, 877-78, 881; Grant Tr. at 1321-22, 1401; Williamson Tr. at 1580 (Knowles reimbursed him, not Houser); Collins Tr. at 1871; Gaulin Tr. at 1899; Lee Tr. at 2285; Chandler Tr. at 2338; Zackary Tr. at 2389; Williams Tr. at 2524-25; Chal Tr. at 2660; Browning depo. ex. 634a at 12-13; Ex. 361.22 ("Employees are not reimbursed.").

The Moran Lake and Mt. Berry nursing homes each generally had between 90 and 100 residents, and Wildwood's population was typically between 140 and 190. Stanley Tr. at 7; Free Tr. at 394, 398 (Wildwood had 187 residents in July 2005); Austin Tr. at 631; Justice Tr. at 1150; Landers Tr. at 1737; Mattie Cox. Tr. at 2428 (Moran Lake had 95 residents in late May 2007); Exs. 76a, 76c, 116, 117 & 118. When the employees bought food for the residents, they were able to buy enough food to keep the residents from starving, but they were unable to buy the types and quantities of food necessary to serve nutritious, balanced, therapeutic meals.

Administrator Knowles explained that in the last few months of her tenure at Moran Lake, the employees "made sure [the residents] received food. We were

not able, though, to follow the therapeutic diets and that sort of things. So if they were diabetic or had CHS that had therapeutic diets, once [the employees] were buying food, it was like we were buying what we could afford and what we could get in bulk to feed them." Knowles Tr. at 358.

Tamara Primus summarized the situation in her testimony: "Well, everybody got the same thing. So if it was bologna and biscuits, everybody got bologna and biscuits." Primus Tr. at 748.

When the employees had to buy the food at Moran Lake, patients received vanilla pudding or apple sauce instead of the protein shakes and nutritional supplements they required. Williamson Tr. at 1581. A cook at Moran Lake, Williamson testified "we couldn't make sure that, you know, all the vitamins and everything was met to the requirements because we didn't have everything. But we always made sure that [the residents] got something." Williamson Tr. at 1831.

Stephanie Lee, an LPN at Moran Lake, explained the situation:

> One thing is milk; a lot of times we wouldn't have any milk. So a lot of the staff would put money together to go buy, you know, a couple of gallons. Things like snacks, bread to make sandwiches for snacks. We didn't have any bread, so we would buy loaves of bread. And then, a lot of times, we would just buy Little Debbie cakes or something, anything to give them a snack. And at mealtimes, like I said, the break and milk were a big issue. The portions were smaller than what they should

> have been at meals. . . . [the portions were smaller even when the employees bought the food] because 100 residents you can't supply that much. Lee Tr. at 2286.

Similarly, Tatum Zackary, a CNA at Moran Lake, testified that diabetic residents were not served therapeutic diets because the staff "fed them what we had to feed them. We couldn't go by what their menu was supposed to be because we didn't have the supplies to give them." Zackary Tr. at 2397.

At Mt. Berry, irregular food deliveries and dependance on employees' purchases meant that residents were not served the menus that the home's nutritionist had approved. Greenway Tr. at 858-59; Ex. 517. Ylaunda Dixon, a CNA at Mt. Berry, testified that in the last months she worked at the home, food portions were half-sized and the many residents who wanted second helpings could not receive any more food because there was no more to serve. Dixon Tr. at 1562-64. Residents with special dietary needs and therapeutic diets did not receive the food and supplements they needed; instead, all residents were served the "same exact food." Dixon Tr. at 1564.

At Wildwood, Administrator Rosa Free testified that her nursing home could not serve full, balanced, nutritious and therapeutic meals – or even offer seconds to hungry residents – when she had to go grocery shopping for nearly 200 nursing home residents. Free Tr. at 408-412, 437. "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." Free Tr. at 409. Regarding portion size, she testified, "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." Free Tr. at 410. Portions were necessarily small, she testified, because she "didn't have that kind of money" to buy the full menu for 187 residents. Free Tr. at 410.

HOUSER'S COST-CUTTING

In addition to failing to pay Sysco to deliver food for the residents, Houser also contributed to the food deficiencies at the homes by instructing his administrators and kitchen staffs to cut costs. Houser told Mary Alice Cunningham, the kitchen supervisor at Mt. Berry, to keep food costs to a minimum, and she told her administrator that she would follow those orders. Stanley Tr. at 16-17. As an unappetizing example of Cunningham's cost-cutting, she served the residents spaghetti sauce over instant mashed potatoes instead of noodles, because the instant mashed potato flakes were less expensive than pasta. Stanley Tr. at 17. As a result of Houser's orders to cut food costs, residents were given small portions and inadequate amounts of food. Stanley Tr. at 17, 42.

In April 2007, Houser asked Sysco's Mike Birke to help him cut his food costs. Birke Tr. at 572. To calculate Houser's food costs, Birke obtained the census data for the three homes for January, February and March 2007. Birke Tr. at 573-74, Exs. 76a & 76c. Birke then divided the total amount that Houser spent on Sysco for those months by the homes' bed counts (numbers of occupied beds) to calculate the amount per resident that Forum spent with Sysco. Birke Tr. at 573-78. At the time, 75 percent of the nursing homes in the country were spending more than $5.60 per day on residents' daily food costs. Birke Tr. at 576.

At Moran Lake, Houser spend **$3.07** per resident per day at Sysco in January 2007. Birke Tr. at 575, Ex. 76d. The February 2007 daily food cost was $5.75, and March 2007 was $4.39. Birke Tr. at 575-76, Ex. 76d.

At Mt. Berry, Houser spent **$3.50** per day per resident at Sysco in January 2007, **$1.83** in February 2007, and $4.25 in March 2007. Birke Tr. at 576, Ex. 76d.

Birke told Houser that the food costs at Moran Lake and Mt. Berry for January, February, and March 2007 were "very low." Birke Tr. at 577. Birke said he knew of no way for Houser to lower his food costs. Birke Tr. at 577-78.

Heart-broken by Houser's cost-cutting, Barbara Chal resigned as Wildwood administrator on August 3, 2007, because under his management, the home was

incapable of providing the care and services needed to meet the needs of the residents. Chal Tr. 2677-78; Exs. 361.47, 1104. She conceded the home did not even provide residents with a safe environment or balanced, nutritional meals. Chal Tr. at 2678.

MORAN LAKE – NO FREEZER

At Moran Lake, it was also impossible for the nursing home kitchen to serve residents the nutritious, balanced, and therapeutic meals they required because the freezer stopped working in September 2006, eliminating the ability to store frozen food. Knowles Tr. at 312-313. In a letter faxed September 5, 2006, Knowles told Houser:

> **FREEZER**: RASEEN IS WORKING ON THIS TODAY. HE HAS WRITTEN THE EQUIPMENT HE NEEDS TO FIX AND WILL TALK TO YOU ABOUT THE MONEY HE NEEDS. NORTH GEORGIA EQUIPMENT LOOKED AT THIS ALSO AND SAID IT WOULD BE ROUGHLY $2500 FOR THEM TO FIX.

Ex. 487 (emphasis in original).

The freezer was repaired and worked intermittently for a few months after September 2006, but it eventually stopped working altogether, and Houser never replaced it. Knowles Tr. at 312-13, 324-25, 338; Ex. 486 (letters faxed to Houser about the freezer dated October 4, 2006, November 1, 2006, January 15, 2007

(WHEN ARE WE GETTING OUR FREEZER), January 16, 2007 (WHEN ARE WE GETTING OUR FREEZER), March 2, 2007 (WHEN ARE WE GETTING OUR FREEZER?)).

Nursing homes are required to keep a three-day supply of food on site. Knowles Tr. at 324-25. But when the freezer at Moran Lake did not work, the kitchen staff had to go to commercial grocery stores and shop meal-by-meal for the nearly 100 residents. Knowles Tr. at 312-13, 324-25. Shopping meal-by-meal made it impossible for the home to serve its menu, or to serve therapeutic meals to the residents who needed them. Knowles Tr. at 324-25. Knowles testified:

> Because we were not able to store the food, and when we'd go and buy food you're not able to – you're supposed to have a three-day supply of food and also to just – when we're buying the meals like that, we're not able to follow, like, a therapeutic diet. People that's on no concentrate sweet, no added salt. When we're buying the food, we're buying it in bulk to feed everybody. You know, we're not able to differentiate and make different menus for those folks for therapeutic diets. Knowles Tr. at 324-25.

Summarizing the interconnection between the lack of food and lack of storage space, Knowles testified, "We were not utilizing the freezer because we didn't have anything to put in the freezer." Knowles Tr. at 317.

VII. EMPLOYEES' ISSUES

The success of a nursing home depends on its ability to maintain an adequate staff of compassionate, dedicated employees. Goldsmith Tr. at 2872-73. A nursing home provider should seek to maximize staff stability, because continuity of care is important for the residents. Goldsmith Tr. at 2873. Employees, in turn, need to feel that the provider "is preparing for the future and will stay in the business of giving healthcare." Goldsmith Tr. at 2877.

The Moran Lake, Mt. Berry and Wildwood homes were beset throughout the conspiracy period with payroll problems, food and supply shortages, disappearing employment benefits, and other, similar problems that diminished resident care by inciting high turnover, worrying residents, and depriving them of continuity of care.

PAYROLL – BOUNCING PAYCHECKS

FHG employees were paid biweekly during the conspiracy period – every other Friday. Franke Tr. at 2467. There were approximately 100 employees at Moran Lake and Mt. Berry, and 150 at Wildwood. Burrell Tr. at 1251-52.

Employees' paychecks started bouncing in the latter half of 2004, and some checks bounced every pay period thereafter until the homes closed. Burrell Tr. at 1224-25; *see also* Knowles Tr. at 302-03, 309, 311; Greenway Tr. at 790 (payroll

problems and the employee turnover it caused were problems throughout her tenure); 841-42; Chal Tr. at 2663 (Wildwood employees unable to cash paychecks in July 2007); Exs. 487 (Knowles' letters faxed July 11, 2006, August 21, 2006, September 5, 2006, and January 1, 2007); 1092.

After the paychecks started bouncing, check-cashing businesses and convenience stores refused to cash FHG checks. Knowles Tr. at 302-03; Greenway Tr. at 790-93; Zackary Tr. at 2384. Local businesses posted signs advising that they would not cash FHG checks. Knowles Tr. at 302-03; Greenway Tr. at 790-93. FHG employees then had to go to the bank upon which the checks were drawn to cash their paychecks. Knowles Tr. at 302; Greenway Tr. at 790-93; Zackary Tr. at 2384, 2394-95.

By July 2006, banks in Rome would no longer do business with Houser, who then moved the FHG accounts to the Bank of America. Knowles Tr. at 302; Greenway Tr. at 790-93. The closest Bank of America branch to Rome was in Cartersville, a drive of approximately 25 miles from the nursing homes. Knowles Tr. at 302-03; Greenway Tr. at 790-93; Landers Tr. at 1735-36; Zackary Tr. at 2384, 2394-95.

Paychecks bounced because Houser did not deposit enough money in the bank to cover the entire payroll. Knowles Tr. at 303; Landers Tr. at 1735.

Employees knew that those toward the end of the line would not be able to cash their checks on payday. Knowles Tr. at 303; Edwards Tr. at 1595-98; Landers Tr. at 1735-36; Brunner Tr. at 1820-22; Easterling Tr. at 2018; Thomas Tr. at 2196; Lee Tr. at 2280-81; Zackary Tr. at 2384; 2394-95.

Most employees who could not cash their paychecks on payday would have to wait until the following Tuesday or Wednesday to cash their checks. Knowles Tr. at 303; Thomas Tr. at 2196; Zackary Tr. at 2384. Some employees, however, were never able to cash some paychecks. Brunner Tr. at 1838-38; Zackary Tr. at 2394; Chal Tr. at 2663; Exs. 487 (Knowles letter faxed Jan. 15, 2007); 831.45 (email from Rhondia Grant to Rhonda Houser April 17, 2007, reporting returned and uncashed paychecks); 1092. CNA Tatum Zackary explained that if she lost the race to the bank or the money van, "I just had a check that I couldn't do nothing with because stores wouldn't cash 'em." Zackary Tr. at 2394.

The prospect of not receiving pay prompted many employees to drive to the bank as quickly as possible on payday. Knowles Tr. at 303; Greenway Tr. at 792-95; Landers Tr. at 1735-36; Brunner Tr. at 1820-22; Thomas Tr. at 2196; Zackary Tr. at 2384, 2394-95;

Employees who were supposed to be caring for residents were away from the homes as they raced to the bank. Stanley Tr. at 79; Free Tr. at 400; Greenway

Tr. at 793-95; Landers Tr. at 1735-36; Brunner Tr. at 1820-22, 1839, 1852; Lee Tr. at 2281; Zackary Tr. at 2384. Administrators and other supervisors tried to stand in for missing employees, but they could not provide the timely care of a staff of CNAs and, consequently, resident care suffered. Greenway Tr. at 793-95; Landers Tr. at 1735-36; Brunner Tr. at 1820-22, 1839, 1852; Lee Tr. at 2281-82; Zackary Tr. at 2384. At these times of payday chaos, with employees leaving the homes and racing to the bank, the staffing levels did not comply with the Medicare and Medicaid regulations. Fuqua Tr. at 2145, 2186. Wildwood LPN Sonya Brunner explained:

> Q: And was your ability to give timely care affected by people running off to get their paychecks cashed?
>
> A: Yes, because not only – yes. I couldn't – the supervisors that come to the floor, we only had a handful of even that – the few people that was there was not enough to meet the needs of those people after 2:00 o'clock. Turning people in the bed, giving snacks, hydration, toileting. There was too much.

Brunner Tr. at 1852.

In addition to racing to the bank, on two occasions employees left the nursing homes during business hours and went to the FHG office to confront Houser about not being able to cash their paychecks. Burrell Tr. at 1227-28. The first time about twenty employees came to the office. Burrell Tr. at 1227-28. The

second visit occurred in the summer of 2006 and lasted several hours when approximately 100 employees converged upon the office to confront Houser. Burrell Tr. at 1227-1228.

As conditions in the homes deteriorated, supervisors could not fire or discipline employees who left the homes to cash their paychecks because they could not hire replacements. Fuqua Tr. at 2188.

In July 2006, Houser hired Marrie Franke's mobile check-cashing service to drive to the Rome homes and cash the employees' checks. Franke Tr. at 2463-2467. Instead of racing to the bank, employees tried to be first in line when the van arrived. Greenway Tr. at 794; Edwards Tr. at 1595-98; Lee Tr. at 2281; Zackary Tr. at 2384. Employees started lining up hours before the van arrived, and they sat in the cold or under the hot sun for hours. Edwards Tr. at 1595-98; Franke Tr. at 2468-69, 2471-72, 2483, 2485. Employees waiting in line to cash their checks were not in the homes caring for the residents and, consequently, resident care suffered. Greenway Tr. at 793-95, 843-45; Lee Tr. at 2281; Zackary Tr. at 2384.

In mid-December 2006, after an entire payroll bounced (approximately $120,000) and Houser did not repay the Frankes, they required him to supply the currency to use to cash the employees' checks. Franke Tr. at 2469-2473. Houser

was late every pay period. Franke Tr. at 2483. Because the Frankes had to wait on Houser, "those poor people [the employees] had to stand in line for hours waiting . . . ." Franke Tr. at 2483.[6]

Finally, as noted in the Resident Care section of the United States' Proposed Findings of Fact, Medicare and Medicaid paid Houser for every day the residents were in his nursing homes. Cannon Tr. at 1310-11; Chandler Tr. at 2322. But House kept all that money and did not pay the Moran Lake and Wildwood employees for the last month they worked. Edwards Tr. at 1598-99; Lee Tr. at 2280-83; Chandler Tr. at 2339.

PAYROLL – LAPSED INSURANCE AND UNPAID GARNISHMENTS

No Health Insurance

Employees at Houser's three nursing homes endured numerous other hardships, including lapsed health insurance and even being arrested, as a result of his payroll mismanagement.

Houser deducted insurance premiums from the employees paychecks, but he did not pay the premiums over to the insurance company and, as a result, many

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[6]Houser signed a promissory note for $117,500 to cover the worthless payroll, and though he later told Marrie Franke that he never planned on ever paying them back, they were able to recover approximately $86,500, leaving a debt of $31,000 that Houser never paid. Franke Tr. at 2469-74.

employees were rudely surprised with medical bills of thousands of dollars because they did not have the insurance they had paid for. Stanley Tr. at 37-38 (employees complained of discovering lack of insurance); Knowles Tr. at 349, 369-70 (employees learned they had no health insurance when they were billed for medical expenses); Free Tr. 403-04 (employees with serious medical conditions were angry about lack of insurance despite having paid for it); Hinkley Tr. at 756 (skilled nurse at Mt. Berry left for another job after going to a doctor for treatment and learning that she had no insurance); Greenway Tr. at 789 (several Mt. Berry employees learned at doctors' appointments that they had no insurance despite having paid the premiums); Burrell Tr. at 1242-43; Grant Tr. at 1323 (nurse had eye surgery, was later turned over to collections because of lack of insurance); Brunner Tr. at 1826-27 (learned her insurance did not cover her family and she ended up paying numerous medical bills after having had premiums deducted from her paycheck); Collins Tr. at 1878 (after Collins learned she had no insurance despite having paid for it, a humans relations officer at Wildwood wrote a letter confirming that she had no insurance so she could obtain treatment for high blood pressure at a free community clinic); Easterling Tr. at 2019 (had to pay doctor's bills and Houser never reimbursed her); Fuqua Tr. at 2146-49 (had an MRI, then learned she had no insurance, and had to pay the entire bill); Chandler Tr. at 2324-

26 (had emergency surgery in 2007, then learned she had no medical insurance, and is still paying a $20,000 surgery bill in 2012); Chal Tr. at 2665 (Wildwood employee was hospitalized and later found she had no insurance); Williams Tr. at 2525-27 (has a lung disease that requires weekly treatment; she was billed $17,000 because Houser didn't pay her premiums, though one doctor wrote off her bill of $10,000, leaving her to pay $7,000 to Floyd Medical Center).

Once Houser was able to have the insurance reinstated for a period of time, but only a few employees were able to file claims retroactively during that period. Knowles Tr. at 369-70; Burrell Tr. at 1263; Brunner Tr. at 1851-52. Other than that period of reinstatement, employees were not reimbursed for their premiums or medical costs. Knowles Tr. at 369-70; Burrell Tr. at 1263; Brunner Tr. at 1851-52; Collins Tr. at 1878.

Houser instructed Rosa Free that she should terminate Wildwood employees who were using too much health insurance. Free Tr. at 404.

No Disability Insurance

Employees who were injured at work learned that they had no disability insurance despite having had premiums for the coverage deducted from their paychecks. Burrell Tr. at 1243-44 (Houser did not pay Aflac premiums); Grant Tr. at 1341; Exs.831.17, 831.18, 831.19, 831.45

No Worker's Compensation Insurance

Employees who were injured at work learned that FHG had no worker's compensation insurance. Burrell Tr. at 1244; Grant Tr. at 1353-54, Ex. 831.38.

Mt. Berry CNA Ylaunda Dixon broke her ankle at work. Dixon Tr. at 1560-62. She was pregnant when she was injured, and she gave birth the day after she was treated at the hospital for her broken ankle. Dixon Tr. at 1560-62. She later learned that FHG had no worker's compensation insurance. Dixon Tr. at 1560-62. She gave her medical bills to Houser and Rhonda, who said they would pay them, but they never did. Dixon Tr. at 1560-62. Her medical bills totaled more than $5,000, and she now loses twenty percent of her paycheck to a garnishment to pay those bills. Dixon Tr. at 1560-62.

No Unemployment Taxes

Houser paid no unemployment taxes. Stanley Tr. at 45; Ex. 462.

Garnishments Not Paid – Arrests

Laverne Burrell prepared the garnishments every payroll, and included them with the paychecks and tax payment coupons in the file she gave to Houser. Burrell Tr. at 1240-41. But Houser did not pay over the garnishments to the intended recipients, and Burrell received telephone calls every pay period from employees, child support offices, and magistrate judges. Burrell Tr. at 1241.

John Thomas was a CNA at Moran Lake from 2004 until 2007. Thomas Tr. at 2190. While he worked there, $144 was deducted from his paycheck every payroll for child support. Thomas Tr. at 2197. Thomas learned, however, that Houser was not paying that $144 to the child support office. Thomas Tr. at 2197-2200. Thomas started receiving letters from the child support office threatening to have his drive's license suspended. Thomas Tr. at 2197-2200. Thomas' license was suspended for two years as Houser continued to withhold the child support payments from Thomas' check, but did not pay over that money to the child support office. Thomas Tr. at 2197-2200.

Houser's failure to pay Thomas' child support created a strain between Thomas and his children. Thomas Tr. at 2199-2200. Thomas had to show them his paychecks to prove to them that the money was being taken out of his pay. Thomas Tr. at 2199-2200.

Thomas was arrested for failure to pay child support. Thomas Tr. at 2197-98. The officer who arrested him said it was Thomas' responsibility to pay his child support, not Houser's. Thomas Tr. at 2198.

Thomas spoke with Houser about his child support payments four times, and each time, Houser said he would "take care" of the matter. Thomas Tr. at 2198. But Houser did not, and Thomas eventually had to pay an additional $900

to cover the amount that Houser had taken from his paycheck and kept for himself. Thomas Tr. at 2198-99. Houser purported to reimburse Thomas with a check, but the check bounced. Thomas Tr. at 2218.

Larrious Williamson was a cook at Moran Lake for eight years, working there until the home closed in July 2007. Williamson Tr. at 1575-76. His child support was $188 every paycheck. Williamson Tr. at 1579. His child support was properly paid over to the child support office when Sunbridge managed the nursing home. Williamson Tr. at 1577. In approximately 2005, Williamson started receiving calls from the child support office threatening to suspend his driver's license because he was $900 behind in his payments. Williamson Tr. at 1576-77. Williamson complained to Houser, who paid the child support office at the last minute to forestall the suspension of Williamson's driver's license. Williamson Tr. at 1278.

Houser then resumed keeping Williamson's child support payments, one time letting him fall behind by $1,200. Williamson Tr. at 1578. Houser would pay the money over at the last minute to avoid the suspension of Williamson's driver's license. Williamson Tr. at 1578. Houser did this several times. Williamson Tr. at 1578. When the home closed in June 2007, Williamson was behind by $800, and he had to sue Houser to obtain that amount from him.

Williamson Tr. at 1578. Houser never compensated Williamson for the penalties and interest he had to pay to the child support office. Williamson Tr. at 1578.

A Wildwood employee, like Thomas and Williamson, was threatened with arrest for nonpayment of child support. Burrell Tr. at 1241-42; Grant Tr. 1320. A few Wildwood employees had money withheld from their paychecks for various reasons, but Houser did not pay their garnishments, and one CNA, a single mother of two children, had her car repossessed as a result. Burrell Tr. at 1242; Grant Tr. at 1319. Houser was aware of all these arrests and other problems his employees were facing because of his failure to pay over their garnishments because Burrell reported them to him. Burrell Tr. at 1242-43.

EMPLOYEES USED THEIR MONEY TO SUPPLY THE HOMES

The residents did not literally starve or fall further into neglect only because the employees spent their own money – without reimbursement – to buy food, nursing supplies, cleaning supplies, and maintenance parts and equipment. *E.g.*, Stanley Tr. at 33-35; Knowles Tr. at 287, 340, 352; Free Tr. at 410; Chisolm Tr. at 520; Greenway Tr. at 810, 876-78, 881; Patrick Tr. at 1269-70, 1278; Grant Tr. at 1321-22, 1401; Williamson Tr. at 1580 (Knowles reimbursed him, not Houser); Edwards Tr. at 1589, 1595 ("we'd run down to the dollar store and made sure everybody ate"); Brunner Tr. at 1846; Gaulin Tr. at 1899; Lee Tr. at 2285, 2303;

Chandler Tr. at 2338; Zackary Tr. at 2389 ("it was all of us chipping in together. We took it as a loss."); Williams Tr. at 2524-25; Young Tr. at 2552, 2567; Chal Tr. at 2660-61; Browning depo. ex. 634a at 12-13; Exs.361.32, 587, 588, 822.

In a letter faxed June 27, 2006, Rhondia Grant told Houser:

> **Housekeeping supplies – please contact Suncoast paper regarding payment schedule. I have been charging supplies to my personal credit card today, more than $1,000.00 worth of supplies is needed.**

Ex. 831.7 (emphasis in original).

In an email sent December 28, 2006, FHG Office Manager Cheryl Dawson told Mt. Berry Administrator Lois Greenway to stop spending her personal money to operate the nursing home, and to stop her employees from spending their money to run the home. Ex. 587. Greenway summarized the situation in her reply to Dawson and Houser:

> OF COURSE WE SHOULD NOT HAVE TO SPEND OUR OWN MONEY TO OPERATE THE BUSINESS!!!!!! HOW WELL WE KNOW IT.....!!!!! BUT WHEN WE ARE IN NEED, THERE IS OFTEN NO OTHER SOLUTION.
>
> WE MAKE EVERY EFFORT NOT TO SPEND OUR OWN MONEY, BUT I HAD TO WRITE A PERSONAL CHECK FOR THE FIRST PART TO THE WATER HEATER IN ORDER TO GET IT. WE THEN HAD TO GET CASH FROM GEORGE FOR THE SECOND PART AND NOW WE HAVE A THIRD PART ON

ORDER WHICH GEORGE GAVE ME A BLANK, UNSIGNED CHECK TO PAY FOR IT WITH. THE PLUMBER PROBABLY WILL NOT ACCEPT IT.

BUT THE STATE SURVEY OFFICE, THE OMBUDSMAN PROGRAM AND THE FAMILIES ARE GIVING US MORTAL HELL OVER THE HOT WATER BEING OUT. THE STAFF IS TOTING WARM WATER FROM THE KITCHEN..... TO BATHE OUR RESIDENTS!!!!!!!!!!!!

* * *

THE ADMINISTRATORS HAVE ALL PUT LARGE SUMS OF MONEY OUT OF POCKET TO KEEP THESE BUILDINGS GOING FOR GEORGE.

WITHOUT THIS HELP, WHERE WOULD WE BE?

Ex. 588 (emphasis in original).

Jamie Young and Jerry Chisolm did maintenance work for free after Houser had fired them because their friends at the homes needed their help and could not otherwise have the maintenance work performed. Chisolm Tr. at 540-41; Young Tr. at 2561; Ex. 589a.

Members of the Moran Lake management team made baked goods or blankets and sold them to staff members at bake sales to raise money to buy food and supplies for the home. Primus Tr. at 740-41.

STAFF TURNOVER AND LOSS OF STAFF

The bouncing paychecks, delayed pay, lapsed insurance, unpaid

garnishments, the personal problems that these matters caused employees, and Houser's failure to reimburse employees for supplying the homes with food and supplies, destroyed employee morale and gave rise to high staff turnover, absenteeism, and difficulty in recruiting new employees. Stanley Tr. at 12; Knowles Tr. at 294; Free Tr. at 404; Hinkley Tr. at 757; Greenway Tr. at 788, 827, 845-50, 853, 887; Herrington Tr. at 1042-43; Grant Tr. at 1358; Hannay Tr. at 1429; Lynch Tr. at 1520; Brunner Tr. at 1820.

Some of the best employees left because of the payroll problems. Greenway Tr. at 847; Herrington Tr. at 1042-43; Hannay Tr. at 1429; Ex. 809.

In a letter faxed July 11, 2006, Moran Lake Administrator Kim Knowles told Houser that making the employees race to Cartersville to try to cash their paychecks was "A SLAP IN THE FACE FOR ALL OF THEIR HARD WORK." Ex. 487.

In a letter she faxed on January 15, 2007, Knowles told Houser:

> **PAYROLL CHECKS**: I HAVE SEVERAL THAT WERE NOT ABLE TO BE CASHED. I HAVE SEVERAL EMPLOYEES TO QUIT THIS WEEKEND OVER THIS.

Ex. 487 (emphasis in original). The payroll problems caused employees to "quit without notice, not come back." Knowles Tr. at 294.

The loss of experienced staff left the homes "unable to really manage." Stanley Tr. at 12. Recruiting replacement staff "was very difficult because a lot of people in the community knew about the difficulties with the payroll checks and didn't want to" work at a Forum home. Stanley Tr. at 12; Edwards Tr. at 1591; *see also* Landers Tr. at 1737 (resigned because Moran Lake's reputation was so bad in the community that she was embarrassed to say she worked there). Greenway lost many key employees at Mt. Berry and was never able to hire "adequate replacements." Greenway Tr. at 853.

Recruiting replacement staff was made more difficult because Houser would not pay for help-wanted advertisements in the local newspaper – or the paper stopped taking his checks. Knowles Tr. at 294, 359; Greenway Tr. at 799, 853, 856; Exs. 487 (letters faxed July 17, 2006, Aug. 7, 2006, and January 2, 15, 16, 22, 24 and 31, 2007); 810, 812. In a letter faxed July 6, 2006, Greenway told Houser and Rhonda:

> I HAVE LOST 5 MANAGEMENT PEOPLE AND I NEED TO RUN AN AD IN THE PAPER ASAP !!!!!!!!!! THEY WILL NOT SEND IT WITHOUT THE BILL BEING PAID.

Ex. 810.

Similarly, in a letter faxed August 7, 2006, Knowles told Houser and

Rhonda:

> **ROMAN NEWS TRIBUNE**: THEY HAVE SEVERAL BOUNCED CHECKS TOTALING >$600. ALL ADS WILL HAVE TO BE PAID IN CASH BEFORE BEING PLACED IN PAPER. CURRENTLY I NEED AN AD PLACED FOR NURSING AND HOUSEKEEPING. **NEED STAFF ASAP!!!**

Ex. 487 (emphasis in original).

Resident care suffered because it was not possible to have adequate staff with the payroll issues, absenteeism, and low morale. Greenway 843-48, 887, 907; Edwards Tr. at 1591; Lee Tr. at 2281, 2302.

The high staff turnover and absenteeism troubled the residents, who saw the employees lining up to cash their paychecks and heard them talking amongst themselves about their payroll problems. Free Tr. at 404-05; Greenway Tr. at 845, 852-55, 883, 887-88; Herrington Tr. at 1042-43; Kelly Tr. at 1501-02; Lynch Tr. at 1520-22; Peyton Tr. at 1546-48; Gaulin Tr. at 1908, 1911, 1919; Fuqua Tr. at 2184-85; Ex. 361.35.

Residents and family members missed their favorite employees when they sought work elsewhere. Hinkley Tr. at 756-57; Greenway Tr. at 872; Herrington Tr. at 1042-43; Kelly Tr. at 1501-02; Lynch Tr. at 1520-22; Cox Tr. at 2445. For this reason alone, high staff turnover is hard on residents. Greenway Tr. at 847-

48.

The high staff turnover deprived residents of the continuity of care they needed. Free Tr. at 404-05; Greenway Tr. at 883, 909, 967-78; Hannay Tr. at 1429-30, 1446-47; Kelly Tr. at 1502; Goldsmith Tr. at 2873.