IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

UNITED STATES OF AMERICA, *ex rel.*,
ACADEMY HEALTH CENTER, INC. f/k/a
ADVENTIST HEALTH CENTER, INC., **Plaintiff/Relator**

v. **CIVIL ACTION NO. 3:10cv552 CWR-LRA**
(JURY TRIAL DEMANDED)

HYPERION FOUNDATION, INC.
d/b/a OXFORD HEALTH & REHABILITATION CENTER;
ALTACARE CORPORATION; HP/ANCILLARIES, INC.;
LONG TERM CARE SERVICES, INC.;
SENTRY HEALTHCARE ACQUIRORS, INC.;
HP/MANAGEMENT GROUP, INC.; HARRY McD. CLARK;
JULIE MITTLEIDER; DOUGLAS K. MITTLEIDER; and
JOHN DOES 1-200, **Defendants.**

UNITED STATES' COMPLAINT IN INTERVENTION

INTRODUCTION

1. The United States of America prosecutes this action pursuant to the False Claims Act ("FCA"), 31 U.S.C. §§ 3729 to 3733, and common law theories of payment by mistake and unjust enrichment, against defendants Hyperion Foundation, Inc. ("Hyperion"), AltaCare Corporation ("AltaCare"), Long Term Care Services, Inc. ("LTCS") and Douglas K. Mittleider ("Mittleider") (collectively, for purposes of this Complaint, "defendants").

2. This action arises from defendants' provision of non-existent, grossly deficient, materially substandard and/or worthless nursing home services from 2005 to 2012 at the Oxford Health & Rehabilitation Center in Lumberton, Mississippi ("Oxford"), which caused serious physical and emotional harm to highly vulnerable elderly, disabled and low income residents at Oxford.

3. Defendants made, or caused to be made, false or fraudulent claims to the federal-state Mississippi Medicaid program ("Medicaid") and the federal Medicare program for non-existent, grossly inadequate, materially substandard and/or worthless nursing home services. Moreover, defendants made false or fraudulent representations and certifications material to such claims, in violation of the FCA and the common law.

4. The United States suffered damages when Medicaid and Medicare paid defendants for such false or fraudulent claims.

5. Relator, Academy Health Center, Inc. ("Relator") filed its original *qui tam* Complaint in this action under the False Claims Act ("FCA"), 31 U.S.C. § 3729 *et seq.*, in the bankruptcy court on September 30, 2009, and filed a First Amended Complaint in that court on November 20, 2009. After the case was transferred to this Court on October 4, 2010, with leave of Court, Academy filed a Second Amended Complaint on February 11, 2011.

6. The United States, by its Notice of Election to Intervene in Part and Decline to Intervene in Part, dated November 30, 2012, and docketed on December 3, 2012, notified the Court of its decision, pursuant to § 3730(b)(2) and (4) of the FCA, to: (a) intervene in that part of the *qui tam* action which alleges that defendants Hyperion, AltaCare, LTCS and Mittleider, made, caused to be made, and/or conspired to make false claims and false statements material to false claims to Medicare and Medicaid, for nursing home services at the Oxford Health & Rehabilitation Center facility in Lumberton, Mississippi; and (b) decline to intervene as to the remainder of the allegations in the *qui tam* action, including in any claims against defendants HP/Ancillaries, Inc., HP/Management Group, Inc., Sentry Healthcare Acquirors, Inc., Harry McD. Clark and Julie Mittleider.

7. By reason of the United States' intervention in the *qui tam* action, Academy's FCA claims against Hyperion, AltaCare, LTCS and Mittleider are superseded to the extent of the United States' intervention. The United States shall control the prosecution of the claims upon which it has intervened, subject to such rights as are afforded to Academy as relator under § 3730(c) of the FCA.

JURISDICTION AND VENUE

8. The Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331, 1332, 1345, 1367(a) and the 31 U.S.C. §§ 3730, 3732.

9. Venue is proper in this district under 28 U.S.C. §§ 1391 and 1395(a), and 31 U.S.C. § 3732(a), because the acts alleged in this complaint occurred in the Southern District of Mississippi.

10. The Court has jurisdiction over defendants based upon their transaction of business within this judicial district and pursuant to 31 U.S.C. § 3730, permitting suit under the FCA in any judicial district in which a defendant or, in the case of multiple defendants, any one defendant, can be found, resides, transacts business, or in any judicial district in which any act proscribed by § 3729 occurred.

PARTIES

11. Plaintiff, the United States, prosecutes this action on behalf of the Department of Health and Human Services ("HHS") and its operating division, the Centers for Medicare & Medicaid Services ("CMS"), for losses that the United States incurred under the federal-state Mississippi Medicaid program and the Medicare program. At all times relevant to this action, the United States provided approximately 80 percent of the funds paid to providers by the Mississippi Medicaid program.

12. Defendant Hyperion is, or at all times relevant to this action was, a Georgia non-profit corporation, doing business in Mississippi from at least October 5, 2005 through at least May 1, 2012. Hyperion participated in the Mississippi Medicaid program under provider number 23002 and in the Medicare program under provider number 25-5157.

13. Defendant AltaCare is, or at all times relevant to this action was, a Georgia corporation, doing business in Mississippi from at least October 5, 2005 through at least May 1, 2012.

14. Defendant LTCS is, or at all times relevant to this action was, a Georgia corporation, doing business in Mississippi from at least October 5, 2005 through at least May 1, 2012.

15. Defendant Mittleider is an individual residing in Georgia, who serves, or at all times relevant to this action served, as chief executive officer, chief financial officer, and secretary of AltaCare and LTCS, and who controls, or at all times relevant to this action controlled, directly or indirectly, the operations of Hyperion, AltaCare and LTCS.

16. Mittleider, at all times relevant to this action, has controlled and operated Hyperion, AltaCare and LTCS in a manner that is inconsistent with their being treated as separate and distinct entities, such that in equity and fairness they should not be so treated for purposes of their liability in this action.

DEFENDANTS' OPERATION OF OXFORD AS A MEDICAID AND MEDICARE PROVIDER

17. From at least October 5, 2005 through at least May 1, 2012, defendant Hyperion was the nominal operator of Oxford, a 120-bed skilled nursing facility in Lumberton, Mississippi. For many years before that, other entities operated Oxford, apparently without the significant quality of care concerns at issue in this action.

18. Hyperion operated under the direction and control of defendant Mittleider. Mittleider exercised control over Hyperion through the appointment of his spouse, defendant Julie Mittleider, and later his acquaintance, defendant Harry McD. Clarke, to be the non-functioning Presidents of Hyperion, serving at the direction and for the benefit of Mittleider.

19. Mittleider caused Hyperion to lease the Oxford facility from Academy, and to contract with defendant AltaCare, which Mittleider owns and controls, and by which he is employed, to manage Oxford for a management fee paid to AltaCare, in an amount determined by Mittleider.

20. Mittleider and AltaCare controlled Hyperion's finances and thus controlled the funds available to operate Oxford and to provide the required bundle of essential nursing home goods and services, or not, for the care of Oxford's residents.

21. In connection with their control of Hyperion's finances, Mittleider and AltaCare caused LTCS, which operated under Mittleider's and AltaCare's direction and control, to provide funds to and take funds from Hyperion, at such times and in such amounts as were solely within Mittleider's and AltaCare's discretion.

22. Upon information and belief, Hyperion's funds were, from time to time, passed by Mittleider, through AltaCare and LTCS, to fund the operations and pay the debts of other entities, including other nursing homes, also owned, operated and controlled, directly or indirectly, by Mittleider and AltaCare.

23. Mittleider caused Hyperion to enter into Medicaid and Medicare Provider Agreements, to execute other documents necessary for Hyperion to participate in those programs, and to take such other steps and execute such other documents as were necessary for Hyperion to conduct business and receive payments as a Medicaid and Medicare provider.

24. Mittleider caused his spouse, Julie Mittleider, to sign Medicaid and Medicare Provider Agreements on behalf of Hyperion. The Medicaid Provider Agreement contained the following certification: "I understand that any omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to Medicaid to complete or clarify this application may be punishable by criminal, civil or other administrative actions."

25. Hyperion's Medicaid Provider Agreement also contained the following certification: "I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

26. Upon information and belief, in addition to the Provider Agreements, Hyperion also executed an Electronic Data Interchange ("EDI") Enrollment Form in order to bill Medicare electronically.

27. By executing the EDI Enrollment Form, a provider agrees to "be responsible for all Medicare claims submitted to CMS by itself, its employees, or its agents," and to "submit claims that are accurate, complete and truthful."

28. By executing the EDI Enrollment Form, a provider also acknowledges "that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim as required by this Agreement may, upon conviction be subject to a fine and/or imprisonment under applicable Federal law."

29. Hyperion submitted claims for payment to Medicare electronically, upon information and belief, on forms known as a UB-92, HCFA-1450 or UB-04, CMS-1450, which contain the following certification: "This claim, to the best of my knowledge, is correct and complete . . . ."

30. Hyperion was required to submit an annual cost report to CMS, in which a responsible official certified: "I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations." The certification must also acknowledge that "misrepresentation or falsification of any information contained in the cost report may be punishable by criminal, civil or administrative action, fine and/or imprisonment under federal law."

31. Mittleider signed Hyperion's cost reports as President of AltaCare, the Managing Agent of Hyperion, or otherwise caused such cost reports to be signed, for fiscal years 2006 to 2010 and 2012.

32. In order to participate in and receive payments under the Medicaid and the Medicare programs, a nursing home must execute a Health Insurance Benefit Agreement, Form CMS-1561 ("CMS-1561). *See* 42 U.S.C. § 1395cc. By doing so, a provider expressly agrees to conform with the applicable Code of Federal Regulations within Title 42, including the standard of care regulations that implement the Nursing Home Reform Act, 42 U.S.C. §§ 1395i-3, 1396r *et seq*. *See* 42 C.F.R. § 483.

33. Mittleider caused Julie Mittleider to execute the Health Insurance Benefit Agreement on behalf of Hyperion. The Health Insurance Benefit Agreement expressly commits the provider to comply with federal regulations in order to receive payment:

> In order to receive payment under title XVIII of the Social Security Act [42 U.S.C. § 1395cc], [Name of the nursing home inserted here] as the provider of services, agrees to conform to the provisions of section of [sic] 1866 of the Social Security Act and applicable provisions in 42 CFR [which includes the regulations on care provided in nursing homes].

34. To receive reimbursement from Medicaid and Medicare, Hyperion was required to complete and submit a Minimum Data Set ("MDS") form to CMS for all residents. 42 C.F.R. §483.315. The MDS form is the basis upon which CMS determines the *per diem* reimbursement rate for each Medicare Part A beneficiary in a nursing facility. In the MDS form, Hyperion must provide the government with an accurate and comprehensive assessment of each resident's functional capabilities, identify health problems and formulate a resident's individual plan of care. Based on the medical condition, nursing care needs, and other information provided in the MDS form, each resident is assigned to a specific Resource Utilization Group, which, in turn, determines the Medicare Part A reimbursement rate for that resident. Hence, CMS relies on the accuracy of the information the nursing facility provides on the MDS form.

35. Hyperion was required to complete MDS assessments for all residents upon admission and then quarterly thereafter.

36. Individuals at Hyperion who completed the MDS assessments were required to sign the forms, which contained the following certification:

> I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility or on its behalf.

37. As a result, *inter alia*, of the foregoing representations and certifications of present and future compliance made or caused to be made by defendants, Hyperion was permitted to participate in the Medicaid and Medicare programs and receive payments from both programs from in or about October 2005 through in or about May 2012.

38. From in or about October 2005 through in or about May 2012, Hyperion received aggregate payments from the Medicaid and Medicare programs of more than $30 million, for claims for nursing home services provided, or purportedly provided, to Medicaid and Medicare eligible residents at Oxford.

NURSING HOME SERVICES UNDER MEDICAID AND MEDICARE

39. The Medicaid and Medicare programs pay for a bundle of nursing home services, as described further below, provided to eligible residents on a *per diem* basis under the so-called prospective payment system (PPS). Based upon the MDS assessments that a nursing home submits to the government for each eligible resident, nursing homes are paid a *per diem* reimbursement for each day they provided the required nursing home care to such residents.

40. Statutes and regulations governing the Medicaid and Medicare programs require nursing homes to maintain substantial compliance with the pertinent rules and regulations governing those programs.

41. Among other things, nursing homes must assure that all services for which they submit claims are "of a quality which meets professionally recognized standards of health care." 42 U.S.C. § 1320c-5(A)(2).

42. As part of the Omnibus Reconciliation Act of 1987, Congress enacted the Nursing Home Reform Act, 42 U.S.C. §§ 1395i-3, 1396r et seq. ("the Act"), which took effect on October 1, 1990. The Act defines a nursing facility as an institution that:

> (1) is primarily engaged in providing to residents –
>
> (A) skilled nursing care and related services to residents who require medical or nursing care;
>
> (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
>
> (C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases . . . .

42 U.S.C. § 1396r(a). Oxford, at all times relevant to this action, was a nursing facility as defined by the Act.

43. The Act mandates that nursing facilities comply with federal and state requirements relating to the provision of services, and with professional standards and principles applicable to nursing facilities. 42 U.S.C. § 1396r(b); 42 U.S.C. § 1396r(d)(4)(A) ("A nursing facility must operate and provide services in compliance with all applicable federal, state and local laws and regulations . . . and with accepted professional standards and principles which apply to professionals providing services in such a facility.").

44. Specifically, with respect to quality of life for residents of nursing facilities, the Act provides: "A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." 42 U.S.C. § 1396r(b)(1)(A).

45. Additionally, nursing facilities "must provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a plan of care which . . . describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met." 42 U.S.C. § 1396r(b)(2)(A).

46. Under the Act, the manager of a nursing facility must fulfill the residents' plans of care by providing, or arranging for the provision of, nursing and related services and medically-related services that attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, pharmaceutical services, and dietary services that assure that the meals meet with daily nutritional and special dietary needs of each resident. 42 U.S.C. § 1396r(b)(4)(A)(i)-(iv).

47. The specific regulations with which a nursing facility must comply to qualify for participation in and receive payment from the Medicaid and Medicare programs are set forth at 42 C.F.R. § 483 *et seq*. These requirements "serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid." 42 C.F.R. § 483.1(b).

48. Federal regulations mandate that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment [of the resident] and plan of care." 42 C.F.R. § 483.25.

49. Specifically, the regulations provide (bold in original), *inter alia*:

> a. **Pressure sores**. Based on the comprehensive assessment of a resident, the facility must ensure that –
>
> (1) A resident who enters a facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
>
> (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
>
> 42 C.F.R. § 483.25(c).

b. **Nutrition**. Based on a resident's comprehensive assessment, the facility must ensure that a resident –

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when there is a nutritional problem.

42 C.F.R. § 483.25(i).

c. **Hydration**. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

42 C.F.R. § 483.25(j).

d. **Activities of Daily Life**. Based on the comprehensive assessment of the resident, the facility must ensure that – A resident's abilities in activities of daily life do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to -

(1) Bathe, dress, and groom;
(2) Transfer and ambulate;
(3) Toilet;
(4) Eat; and
(5) Use speech, language or other functional communication systems.

42 C.F.R. § 483.25(a).

e. **Medication Errors**. The facility must ensure that –

(1) It is free of medication error rates of five percent or greater; and
(2) Residents are free of any significant medication errors.

42 C.F.R. § 483.25(m).

f. **Unnecessary Drugs**.

(1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) In excessive dose (including duplicate therapy); or
(ii) For excessive duration; or
(iii) Without adequate monitoring; or
(iv) Without adequate indications for its use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above.

(2) **Antipsychotic Drugs**. Based on a comprehensive assessment of a resident, the facility must ensure that –

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical records; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

42 C.F.R. § 483.25(l).

g. **Accidents**. The facility must ensure that –

*** * ***

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

42 C.F.R. § 483.25(h).

h. **Urinary Incontinence**. Based on the resident's comprehensive assessment, the facility must ensure that –

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

42 C.F.R. § 483.25(d).

50. The regulations implementing the Act also require that nursing facilities maintain sufficient nursing staff "to provide nursing and related services to attain or maintain the highest

practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care." 42 C.F.R. § 483.30.

DEFENDANTS' NON-EXISTENT, GROSSLY INADEQUATE, MATERIALLY SUBSTANDARD, AND/OR WORTHLESS SERVICES TO OXFORD'S RESIDENTS

51. Defendant Hyperion, as the nominal operator of Oxford, defendant AltaCare, as the manager of the nursing home, LTCS, which controlled a substantial portion of the funding for the facility, and defendant Mittleider, who exercised pervasive control over these other defendants, were responsible for ensuring that Oxford provided its residents with a bundle of nursing home services that met the regulatory requirements and that, overall, would ensure "the highest practicable level of physical, mental, and psychosocial well-being [of] every resident." 42 U.S.C. § 1396r(b)(2)(A).

52. Instead, from in or about 2005 through in or about May 2012, defendants provided and billed the government for non-existent, grossly inadequate, materially substandard and/or worthless care to Oxford's residents. For example, and as described further below:

a. Defendants failed to meet the basic nutrition, hydration, and hygiene requirements of residents in accordance with their plans of care.

b. Defendants failed to provide skilled nursing services in accordance with physicians' orders.

c. Defendants failed to provide wound care as ordered by physicians, or take necessary prophylactic measures to prevent pressure ulcers, such as turning and repositioning.

d. Defendants failed to administer medications to residents as prescribed by their physicians. Instead, they gave residents either too much medication, too little

medication, or the wrong medications, resulting in serious adverse health consequences.

e. Defendants did not revise or update residents' plans of care to account for pressure ulcers, increased pain, or other deterioration in residents' conditions.

f. Defendants provided unnecessary and excessive psychotropic medications to residents.

g. Many of these failures of care were related to defendants' failure to provide sufficient staffing to meet residents' needs.

53. The Act and its regulations required defendants to ensure that Oxford had "sufficient nursing staff to provide nursing and related services" to ensure "the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care." 42 C.F.R. § 483.30. However, Oxford did not maintain nursing staff sufficient to provide the level of services necessary for its residents to receive the most basic nursing home goods and services such as food, drink, and assistance with bathing and toileting, among other goods and services needed to attain or maintain their highest practicable physical, mental and psychosocial well-being.

54. Registered nurses, licensed practical nurses and certified nursing assistants employed at Oxford, as well as family members of Oxford residents, observed inadequate staffing levels and alerted the defendants. But defendants failed to increase staffing to a level sufficient to provide the requisite care to Oxford's residents.

55. Defendants took various actions that contributed to the staffing shortages. Among other things, they: failed to provide adequate resources to attract and retain qualified staff; frequently failed to deposit sufficient funds into Oxford's payroll account, which caused payroll

checks to bounce, resulting in staff demoralization, absenteeism and defections; and frequently scheduled staff at or below the minimum levels required, then sent staff home early to save money, regardless of the needs of the residents.

56. Defendants' failure to provide qualified and adequate staffing at Oxford contributed greatly to Oxford's provision of non-existent, grossly deficient, materially substandard, worthless care.

57. Defendants failed to pay, or were consistently delinquent in paying, vendors of essential goods and services, including: food and drink; nursing supplies; therapy services; clinical laboratory services; pharmacy services; electric, gas and water services; a security system to protect wandering residents; and repair of washing machines, dryers, air conditioning and heating units, and a leaking roof.

58. As the result of defendants' failure to pay vendors, or to pay them in timely fashion, residents frequently lacked sufficient food and basic nursing supplies necessary for providing proper and adequate care to residents, such as incontinence briefs, wound care supplies, colostomy bags, urinary catheter drainage tubing, tube feeding supplies, wipes, and linens.

59. Defendants were responsible for providing Oxford's residents with a clean, safe and sanitary living environment. Defendants failed to do so. As a result, the Oxford facility was in constant need of essential repairs, including to its roof, ceilings, heating and cooling units, and door alarms.

60. The Oxford facility was frequently plagued by filth, mold, insects, snakes and rodents. Roaches were found on food trays and in the ice machine. A live rat was found in the

bed of one resident. When another resident complained of pain, a live snake was found in her bed, wrapped around her leg.

61. Defendants' failure to devote necessary resources to the care of residents at Oxford was the result, in whole or in part, of their diversion of funds received by Hyperion from the Medicaid and Medicare programs: (i) to Mittleider and AltaCare, in the form of excessive administrative expenses; (ii) to LTCS, in the form of transfers from Hyperion, which left Oxford with inadequate resources to meet resident needs ; and (iii) upon information and belief, to other entities owned, operated or controlled by Mittleider, including nursing homes, to pay for their operations or debts.

62. Defendants were aware of the problems with insufficient resources at Oxford and the resulting adverse health effects on Oxford's residents, but recklessly disregarded them, were deliberately ignorant of them, and ultimately, failed to resolve them, or to do so in a timely fashion.

EXAMPLES OF FALSE OR FRAUDULENT CLAIMS

63. The following paragraphs set forth examples of non-existent, grossly inadequate and materially substandard, worthless, harmful care provided by defendants, for which defendants made, or caused to be made, false or fraudulent claims to the Medicaid and Medicare programs, and for which they wrongfully received and retained payments.

64. The residents in these examples have not been identified herein, to protect their privacy and to preserve the confidentiality of their medical information. The United States will provide the identities of the residents to defendants upon defendants' agreement to the entry of an appropriate protective order in this action.

Resident #1

65. Resident #1, a 77 year-old woman, was admitted to Oxford on or about December 7, 2007. Her initial assessment upon admission indicates that she was alert and lucid, and had good communication skills and clear speech. She had a diagnosis of dementia, paranoia, possible psychosis, mild renal disease, mild anemia, and chronic back pain. She weighed 134 pounds and had no pressure ulcers when she was admitted to Oxford.

66. On September 3, 2008, Resident #1 was found unresponsive at Oxford and was admitted to the hospital with a decreased level of consciousness that was thought to be "probably secondary to medication." Resident #1 had to be intubated, breathing with the use of a ventilator for a period of time. Resident #1 was re-admitted to Oxford on or about September 11, 2008.

67. On or about September 13, 2008, Resident #1 was again found to be "unresponsive" at Oxford and was admitted to the hospital for altered mental status, most likely secondary to opiate intoxication with propoxyphene and benzodiazepine overdose, and dehydration. Resident #1 was re-admitted to Oxford on September 14, 2008 with instructions not to give her too much pain medication or Ativan.

68. On September 23, 2008, her chart noted that Resident #1 had an un-staged pressure ulcer on her right buttock, measuring approximately 2 cm, and a Stage II ulcer on her left buttock. However, on September 30, 2008, her chart noted a skin assessment indicating that she only had a reddened area over her coccyx, with no actual open skin areas. No pressure ulcers were noted.

69. Throughout Resident #1's stay at Oxford, the nursing staff failed to administer her medication in accordance with her physician's orders. For example, Resident #1 had a medical order to receive 50 mg of Prolixin, an antipsychotic, once every three weeks. From September

24, 2008 through 30, 2008, Resident #1 received 50 mg of Prolixin *every day*, seven times the normal therapeutic dose and contrary to her physician's order. The side effects of Prolixin include drowsiness, lethargy and, in large doses, can produce a catatonic-like state. It is also not recommended for inpatients with renal insufficiency.

70. On October 1, 2008, Resident #1 was admitted to the hospital for acute renal failure secondary to chronic renal failure and dehydration. Resident #1 returned to Oxford on or about October 6, 2008.

71. On October 8, 2008, her chart noted that Resident #1's groin area was red and irritated and that both heels were "purple and spongy" with blisters. Resident #1's physician was not notified but her chart contains no indication that any treatment was provided on this date.

72. Over the next several weeks, Resident #1's pressure ulcers had worsened significantly. By October 27, 2008, Resident #1 was treated the hospital for Stage III pressure ulcers located on both buttocks and on her right leg, and with pressure ulcers to both heels. A physician ordered the ulcers to be surgically debrided and to start treatment with topical medications.

73. Oxford failed to provide Resident #1 with routine nutrition, resulting in weight loss. By November 2, 2008, Resident #1 weighed 120 pounds, fourteen pounds less than her weight upon admission to Oxford.

74. On November 5, 2008, Resident #1 had a temperature of 103 degrees and was admitted to the hospital the following day with a fever and multiple septic Stage IV necrotic decubitus ulcers on her buttocks, heels, and legs. The hospital records describe the ulcers as "massive extremely foul smelling large decubitus ulcers with leukocytosis." She was subsequently discharged and returned to Oxford.

75. On December 15, 2008, Resident #1 was readmitted to the hospital. The hospital records show that ulcers on both of Resident #1's buttocks had progressed to a Stage IV, measuring up to 2.0 cm in depth with full thickness and with the bone exposed. She also had an additional Stage II ulcer on her left buttock and a Stage III ulcer on her left calf. The hospital records noted that "instructions [were] given on wound care in great specific detail to nursing home staff" and described Oxford's adherence to the plan of care as "poor."

76. On December 28, 2008, Resident #1 developed osteomyelitis, an infection of the bone, resulting from a Stage IV pressure ulcer on her buttock.

77. On January 26, 2009, her chart noted that Resident #1 had two Stage III ulcers and one Stage IV ulcer located on her buttocks. From January 6, 2009 through March 18, 2009, Oxford failed to clean or treat Resident #'s 1 pressure ulcers in accordance with her physician's orders.

78. On April 1, 2009, Resident #1 was readmitted to the hospital with two new pressure ulcers, both on her left hip. The hospital records noted that the ulcers were contaminated by feces and again described Oxford's adherence to the plan of care as "poor." The hospital ordered the patient to return to the hospital on April 7, 2009 for a diversion colostomy and bilateral above the knee amputations due to her infected ulcers.

79. On April 7, 2009, Resident #1 returned to the hospital for a colostomy procedure to prevent fecal contamination of her pressure ulcers. She refused to have the amputations.

80. On April 20, 2009, her chart noted that Resident #1 had two Stage IV pressure ulcers on her right sacrum and a Stage II wound on her right heel. Resident #1 was admitted the hospital on May 1, 2009 for toxicity and bleeding from her ulcer.

81. By May 8, 2009, her chart noted that Resident #1's weight had dropped to 110 pounds.

82. On June 11, 2009, Resident #1 was again sent to the hospital. The hospital records noted that the placement of a wound vacuum assisted closure (VAC) system to the sacral ulcer needed to be ordered to facilitate wound healing. The hospital records once again describe Oxford's adherence to its plan of care as "poor" and indicate that Oxford "has not had wound VAC since hospital visit 2 wks ago." The hospital records further state that "foul-smelling dirty dressings [were] present over ulcerations on the patient's lower extremities."

83 On July 9, 2009, Resident #1 returned to the medical center for five Stage IV ulcers that exposed the underlying tendon and muscle. The hospital records describe the ulcers as "giant decubitus ulcerations and open wounds."

84. On July 31, 2009, Resident #1 was again admitted to the hospital with decubitus ulcers and dehydration. A plastic surgeon described her ulcers as "large Stage IV sacral decubitus with necrosis that involves almost the entirety of the buttock area." He also noted that she had an ulcer on her left calf, measuring 10.0 cm by 5.0 cm with full thickness down to the gastrocnemius muscle.

85. On August 6, 2009, Resident #1's ulcers had progressed, the worst of which measured 23.4 cm in length with tendon and muscle exposed. She was again admitted to the hospital, which noted that the wounds "look terrible" and that Resident #1 again refused to undergo bilateral below-the-knee amputations. She received a medical order for a wound VAC to her sacral decubitus ulcer and was subsequently discharged back to Oxford.

86. On November 17, 2009, Resident #1 was admitted to the hospital for "multiple decubitus ulcers with MRSA infection." Methicillin-resistant staph aureus (MRSA) is a bacterial infection.

87. On March 27, 2010, Resident #1 was admitted to the hospital for severe renal failure. The hospital records indicate that severe dehydration was the cause of her renal failure.

88. By April 21, 2010, Resident #1 had developed a sacral wound infection, as a result of Oxford's failure to provide her with wound care as ordered by her physician.

89. On April 29, 2010, Resident #1's physician noted that she was malnourished and ordered that Oxford "aggressively follow weights and food choices."

90. During May and June 2010, Oxford again failed to provide Resident #1 with wound care as ordered by her physician.

91. On November 12, 2010, Resident #1 was admitted to the hospital with sacral decubitus ulcers, malnutrition, and acute worsening of kidney disease.

92. On June 20, 2011, Resident #1's physician ordered treatment for ulcers on her sacral area, left leg and right heel, which Oxford failed to provide.

93. By July 26, 2011, Resident #1 had a Stage IV ulcer to her sacral area. She also had a Stage II ulcer to her left lateral leg, measuring 2.5 cm by 19 cm, and a third ulcer for which the location was not identified.

94. On October 11, 2011, Resident #1 was admitted to the hospital for ulcers on her sacral area, bilateral lower extremities, and right hip.

95. In addition to its failure to provide wound care, Oxford failed to provide Resident #1 with basic hygiene care, such as showers, and oral care. Although Resident #1's care plan states that she was to receive a shower three times a week, there were numerous instances where

Resident #1 did not receive a shower or bath more than once or twice a month. There were also numerous instances of Resident #1 not receiving oral care for several days at a time. For example, in August 2011, Oxford failed to provide Resident #1 with oral care for eight consecutive days.

96. Oxford failed to provide Resident #1 with routine hydration and failed to document her daily fluid intake and output, resulting in repeated admissions to the hospital with dehydration. Oxford's records evidence that Resident #1 was admitted to the hospital for dehydration, among other things, on September 17, 2008, October 1, 2008, November 6, 2008, May 15, 2009, May 28, 2009, July 31, 2009, September 2, 2009, March 27, 2010, September 19, 2010, October 10, 2011, January 27, 2012, and March 23, 2012.

97. Defendants knowingly provided, or caused to be provided, non-existent, grossly inadequate, materially substandard and/or worthless services to Resident #1, and falsely or fraudulently represented or certified, or caused to be represented or certified, that such claims were properly payable by Medicaid and Medicare.

98. For the non-existent, grossly inadequate, materially substandard and/or worthless services provided to Resident #1 from December 7, 2007 to May 1, 2012, defendants knowingly submitted or caused to be submitted claims for payment to Medicaid, and Medicaid paid claims totaling $249,889.38.

99. For the worthless services provided to Resident #1 from December 7, 2007 to May 1, 2012, defendants knowingly submitted or caused to be submitted claims for payment to Medicare, and Medicare paid claims totaling $10,449.59.

Resident #2

100. Resident #2, a 65 year-old man, was admitted to Oxford on or about January 20, 2009. His initial diagnosis upon admission included respiratory failure, end stage renal disease, congestive heart failure, and hypertension. He was admitted with a feeding tube, otherwise known as a "PEG" tube, to provide nutrition, hydration, and medication directly into his stomach.

101. On March 3, 2009, Resident #2's physician ordered Oxford to monitor his intake and output every shift. The intake and output records were not consistently completed or evaluated for fluid imbalance.

102. On numerous occasions throughout Resident #2's stay, Oxford failed to provide him with adequate hydration, resulting in frequent admissions to the hospital for dehydration. For example, on April 22, 2009, Resident #2 was admitted to the hospital for dehydration. He returned to Oxford on April 29, 2009.

103. In August 2009, Resident #2's physician ordered Oxford to check and record the amount of residual liquid feeding in his stomach before starting new tube feeding. According to the medication administration records, Oxford failed to consistently implement this order.

104. On October 31, 2009, his chart noted that Resident #2 was complaining of abdominal pain. A licensed practical nurse (LPN) at Oxford noted that he had no distention and that his stomach was tender to the touch to the right side of the umbilicus. The LPN flushed the PEG tube with 60 cc of water and gave Resident #2 a Lortab. Resident #2 was admitted to a medical center the same day with a non-functioning PEG tube, severe dehydration, a urinary tract infection and pneumonia.

105. On April 8, 2010, Resident #2 was admitted to the hospital for pain in his leg and a hip fracture. The hospital records state that Resident #2, upon admission, was malnourished. Resident #2 was re-admitted to Oxford on April 22, 2010.

106. On June 30, 2010, Oxford's medical director noted that Resident #2 had urinary retention. He ordered an IV to administer 60 cc of fluid per hour. The nursing notes on the same date state that Resident #2 was not in distress and there is no mention of any signs or symptoms of urinary retention or dehydration.

107. On June 29, 2011, Oxford's medical director observed Resident #2 to be in excruciating pain in his lower extremities. A nurse described to him that Resident #2 had worsening, intermittent pain for the preceding six weeks, a decrease in oral intake, and increasing weakness. Resident #2 was admitted to the hospital that same day for bilateral deep venous thrombosis, dehydration, chronic renal insufficiency, a urinary tract infection, and anemia. Resident #2 returned to Oxford on or about July 6, 2011.

108. On August 1, 2011, Resident #2 was readmitted to the hospital after a blood urea nitrogen (BUN) lab report evaluating his kidney status showed that he had a level of 138 mg/dL. A normal BUN level range is between 10 and 20 mg/dL. Upon admission to the hospital, Resident #2 was diagnosed with dehydration, acute-on-chronic renal failure, hypoglycemia, and anemia. Resident #2 was returned to Oxford on or about August 8, 2011.

109. On September 9, 2011, Resident #2 was again admitted to the hospital with dehydration, a urinary tract infection, and acute-on-chronic renal insufficiency. The hospital gave him IV fluids to treat the dehydration and IV antibiotics to treat the urinary tract infection. Resident #2 was returned to Oxford on or about September 16, 2011.

110. On November 1, 2011, Resident #2 was admitted to the hospital with weakness and dehydration. The hospital records state that his PEG tube was clogged and needed to be replaced.

111. On November 14, 2011, Resident #2 returned to the hospital with dehydration and a recurrent urinary tract infection. He was returned to Oxford on November 18, 2011.

112. On December 16, 2011, Resident #2 was admitted to the hospital for nausea, vomiting, and decreased activity worsening over 36 hours. The hospital diagnosed him with dehydration with secondary renal failure, gastroenteritis, hypernatremia, and anemia. The hospital normalized his hydration and recommended that Resident #2 have "persistent, aggressive hydration." A medical order was given to administer Nepro at 35 cc per hour for nutrition and 300 cc of water every four hours.

113. In addition to its failure to provide sufficient hydration care, Oxford failed to provide Resident #2 with basic hygiene and catheter care. On January 28, 2012, a nurse noted that Resident #2 had a "markedly swollen penis" and that she was unable to retract the foreskin." Resident #2 was subsequently admitted to the hospital for severe dehydration and paraphimosis. Paraphimosis is an uncommon condition found in males above the age of seventeen that typically results when the foreskin of the penis is retracted for an examination, cleaning, or catheterization, and is not reduced. The hospital records state that Resident #2 had an indwelling Foley catheter that is "old and is poorly draining urine."

114. The hospital initially planned to perform a circumcision to resolve the paraphimosis, but was unable to reduce the swelling. Resident #2 was returned to Oxford on or about February 6, 2012.

115. Prior to his admission to the hospital, Resident #2's physician indicated on January 28, 2012 that Resident #2's tube feeding had been decreased because the resident had been eating fairly well; however, the physician was going to maintain him on tube feeds and water "as [Resident #2] intermittently simply stops eating and there appears to be a problem with my being informed when this occurs."

116. On February 17, 2012, Resident #2 was re-admitted to the hospital for tremors in his legs and head. The hospital recommended an increase in fluid intake and discharged him back to Oxford that day.

117. On February 18, 2012, Resident #2 was re-admitted to the hospital after suffering a seizure. The hospital chart noted that his PEG tube was clogged and that he had a tunneled infection around his Foley catheter. Resident #2 returned to Oxford on or about February 22, 2012.

118. On April 3, 2012, Resident #2 was again admitted to the hospital for dehydration. After observing Resident #2's increased BUN levels, his physician ordered increased water and the administration of Desmopressin, a medication used for patients with diabetes insipidus to control the amount of urine the kidneys make and help to prevent dehydration. He was discharged back to Oxford. The lab results came back worse, indicative that Resident #2's recurrent dehydration was not due to diabetes insipidus, and Resident #2 was readmitted to the hospital. Resident #2 returned to Oxford on or about April 14, 2012.

119. Defendants knowingly provided, or caused to be provided, non-existent, grossly inadequate, materially substandard and/or worthless services to Resident #2, and falsely or fraudulently represented or certified, or caused to be represented or certified, that such claims were properly payable by Medicaid and Medicare.

120. For the non-existent, grossly inadequate, materially substandard and/or worthless services provided to Resident #2 from January 20, 2009 to May 1, 2012, defendants knowingly submitted or caused to be submitted claims for payment to Mississippi Medicaid, and Mississippi Medicaid paid claims totaling $499,141.27.

121. For the non-existent, grossly inadequate, materially substandard and/or worthless services provided to Resident #2 from January 20, 2009 to May 1, 2012, defendants knowingly submitted or caused to be submitted claims for payment to Medicare, and Medicare paid claims totaling $62,806.53.

Resident #3

122. Resident #3, a 56 year-old woman, was admitted to Oxford on January 31, 2007. She was admitted with a Stage IV pressure ulcer on her coccyx and several rib fractures. #.

Resident #3 developed serious pressure ulcers during her stay at Oxford. On September 7, 2007, her chart noted that Resident #3 had a lesion on the side of her right knee. On September 10, 2007, her physician wrote an order for triple antibiotic cream to be applied once daily until healed. During October 2007, records indicate Resident #3 did not receive wound treatment for her right knee on thirteen separate occasions.

123. On November 23, 2007, the nursing notes state that Resident #3's skin was intact, warm and dry to touch. However, one day later, on November 24, 2007, the notes state that the wound to Resident #3's right knee continued to have drainage. By November 28, 2007, the wound infection on Resident #3's right knee continued to have a "greenish colored drainage."

124. On April 28, 2008, her chart noted that Resident #3 was complaining of pain to her left leg from a fall that happened two days prior. On June 18, 2008, Resident #3 was

transferred to the hospital for evaluation of left hip and back pain after her fall. According to the notes, her family was not notified of her fall until July 1, 2008.

125. On June 26, 2008, records indicate that Resident #3 suffered a fall on her way back from the bathroom. Her chart noted that she had severe pain to her left upper leg and hip. She was sent to the hospital that same day for evaluation of the fall. There is nothing in Oxford's records to indicate the results of the evaluation or any measures that Oxford undertook to prevent future falls.

126. On November 18, 2008, her chart noted that Resident #3 had redness on her sacral area.

127. On November 23, 2008, Resident #3 was admitted to the hospital after suffering a fall. An x-ray showed that she had suffered a probable acute or subacute fracture of the proximal right humerus in the humeral head and neck area and prominent deformity of both hips. A medical order was given for Resident #3 to follow up with an orthopedic surgeon for treatment of her humerus fracture in one week. Oxford failed to take Resident #3 for the follow-up appointment with an orthopedic surgeon until *four* weeks later, December 31, 2008, by which time her humerus had healed in a misaligned state, resulting in permanent disfigurement and loss of function in her right arm.

128. On March 12, 2009, Resident #3 was admitted to the hospital for a chronic Stage III sacral decubitus pressure ulcer, measuring 1.6 cm in length, 0.6 cm in width, and 0.4 cm in depth. The hospital records also noted that Resident #3 had an ulcer on her left second toe with intermittent healing. A medical order was given to clean the wound, apply ointment, and change the dressings daily. Oxford failed to implement that order on a consistent basis.

129. On April 20, 2009, Resident #3 returned to the hospital for a follow up visit. Her sacral decubitus ulcer measured 2.1 cm in length, 0.8 cm in width, and 0.8 cm in depth.

130. On May 4, 2009, Resident #3 had surgery at the hospital for debridement of her sacral ulcer.

131. On June 19, 2009, Resident #3 returned to the hospital, which noted that there had been no improvement in the healing of her sacral ulcer for some time. On June 23, 2009, Resident #3 had surgery at the hospital for excision and closure of her sacral decubitus ulcer. A medical order was given to keep dressings to the sacral area clean, dry, and intact, and to change the dressing as needed.

132. During July 2009, records indicate Oxford failed to provide Resident #3 with wound care prescribed by her physician, on seven days. Records further indicate that Oxford failed to turn her consistently every two hours in accordance with medical orders on sixteen days.

133. On July 23, 2009, Resident #3 was treated at the hospital for her sacral ulcer, measuring 3.0 cm in length, 1.0 cm in width, and 1.4 cm in depth with undermining.

134. On July 24, 2009, her chart noted that Resident #3's sacral ulcer had re-opened.

135. On July 30, 2009, Resident #3 returned to the hospital. The hospital records state that no dressings were on the wound upon her arrival. The records further note that the ulcer had 75 percent dehiscence, indicating that it had separated from the sutures holding it together. A medical order was given for a wound VAC to apply negative pressure wound therapy and change dressings every 48 hours or if the wound VAC could not keep a seal.

136. On August 6, 2009, Resident #3 returned to the hospital. Her sacral decubitus had deteriorated, increasing in depth to 1.7 cm. The hospital records noted that the certified nursing

assistant at Oxford confirmed that a wound VAC was not being applied to the wound as ordered. The hospital notes further state that instructions were given to Oxford with respect to the importance of compliance with wound VAC therapy.

137. On August 24, 2009, records indicate Resident #3 fell out of her bed and complained that she had hit her head. An LPN assessed Resident #3 as having no apparent injuries.

138. On September 1, 2009, Oxford's records indicate Resident #3's roommate found her on the floor beside her bed. Resident #3 stated that she had fallen out of bed. Her chart noted that she was able to move all extremities and had no complaint of pain. She was placed back in bed.

139. On September 2, 2009, Resident #3 was found to be unresponsive with decreased oxygen saturation. She was transferred to the hospital where she died on September 5, 2009.

140. Defendants knowingly provided, or caused to be provided, non-existent, grossly inadequate, materially substandard and/or worthless services to Resident #3, and falsely or fraudulently represented or certified, or caused to be represented or certified, that such claims were properly payable by Medicaid and Medicare.

141. For the non-existent, grossly inadequate, materially substandard and/or worthless services provided to Resident #3 from January 31, 2007 to September 2, 2009, defendants knowingly submitted or caused to be submitted claims for payment to Medicaid, and Medicaid paid claims totaling $106,326.00.

Resident #4

142. Resident #4, a 57 year-old man, was admitted to Oxford on or about April 16, 2008 for rehabilitation following a fall that required hip replacement surgery. Resident #4 had a

medical history of congestive heart failure, obesity, hypothyroidism, diabetes, and mental retardation. The hospital records state that Resident #4 should be on a sodium-restricted, high potassium diet. Resident #4 had a catheter and was continent of bowel upon admission. He had no pressure ulcers when he was admitted to Oxford.

143. Upon his admission to Oxford, the nursing staff and dietician failed to follow hospital orders for Resident #4 to be on a sodium-restricted diet. Instead of restricting his sodium intake as ordered, Oxford gave Resident #4 a low *potassium* diet until at least April 29, 2008.

144. While at Oxford, Resident #4 developed three severe pressure ulcers. On April 29, 2008, Resident #4 had a follow-up hospital visit to remove staples from the hip replacement surgery. His care plan noted "skin integrity impaired; abrasion to buttocks right and left." The hospital discharge orders stated that Oxford should keep the abrasion clean and dry, encourage assistance to turn and reposition, and change the dressings every three days and as needed.

145. Throughout Resident #4's stay, Oxford failed to provide him with basic hygiene care, including a shower or bed bath on numerous occasions. For example, every day from April 25, 2008 through May 5, 2008, Oxford records indicate they failed to provide Resident #4 with a shower or bath, and failed to turn or reposition him. On May 5, 2008, as a result of Oxford's failure to provide Resident #4 with proper hygiene, a urine culture indicated that he had a urinary tract infection with bacterial contamination of feces.

146. As a result of Oxford's failure to provide Resident #4 with toileting assistance, his chart noted that Resident #4 developed facility-acquired bowel incontinence while at Oxford.

147. On May 8, 2008, his chart noted that Resident #4 had Stage II pressure ulcers on his right and left buttocks, and his left heel. Resident #4 had a medical order to cleanse the right

and left buttocks and apply skin prep around the area with a pad, and to change every other day and as needed, and to change the dressing on the blister on his left heel every seven days and as needed.

148. On May 17, 2008, his chart noted that Resident #4's pressure ulcers were infected with two types of bacteria.

149. On May 20, 2008, Resident #4 was treated by a consulting physician at the hospital for extensive Stage IV pressure ulcers on both buttocks that were described to as "black overlying skin and [with] foul odor, draining some thin malodorous fluid." The chart noted that the pressure ulcer on Resident #4's right buttock was 8.0 cm in length, 6.6 cm in width, and 2.9 cm in depth. The pressure ulcer on Resident #4's left buttocks was 7.6 cm in length, 4.4 cm in width, and 1 cm in depth. Resident #4 also had a Stage IV decubitus pressure ulcer on his left heel, measuring 4.0 cm in length and 4.1 cm in width. The ulcers were debrided and medical orders were given for Resident #4 to be turned every two hours to avoid further breakdown of ulcers, and for his heels to be floated at all times.

150. On the May 20, 2008 visit to the hospital, Resident #4 was also treated for malnutrition. The hospital's consulting physician gave a medical order for Resident #4 to receive dressing changes twice per day, high protein shakes three times per day, vitamin C and Zinc, and to monitor his protein intake by measuring his pre-albumin and albumin levels. The physician also wrote an order for Resident #4 to receive a Stage IV bed and a wheelchair cushion.

151. On May 21, 2008, medical records indicate Resident #4 had a pre-albumin level of 8.2 mg/dL, significantly lower than the normal range of 18.0 to 45.0 mg/dL, suggesting that he was malnourished and that he needed aggressive nutritional support.

152. On May 27, 2008, Resident #4 was admitted to the hospital for "extensive sacral decubitus" ulcers on both his buttocks, measuring about twenty cm in length and about four to five cm deep. The treating physician determined that he required immediate surgery. Resident #4 underwent surgery the following day to treat his pressure ulcers. Resident #4 also needed an intravenous infusion of potassium because of his low potassium level.

153. Resident #4's family refused to re-admit him to Oxford following the surgery.

154. Defendants knowingly provided, or caused to be provided, non-existent, grossly inadequate, materially substandard and/or worthless services to Resident #4, and falsely or fraudulently represented or certified, or caused to be represented or certified, that such claims were properly payable by Medicaid and Medicare.

155. For such non-existent, grossly inadequate, materially substandard and/or worthless services provided to Resident #4 from April 16, 2008 to May 27, 2008, defendants knowingly made or caused to be made claims for payment to Medicaid, and Medicaid paid claims totaling $13,888.90.

Resident #5

156. Resident #5, a 71 year-old man, was admitted to Oxford on November 2, 2007 following treatment and surgical repair of a fractured hip. Admission notes reflect that he was incontinent. Medical orders and admission assessments do not identify pressure ulcer care or the existence of pressure ulcers. The skin assessment upon admission identifies "mild redness" on his buttocks.

157. On November 6, 2007, four days after his admission to Oxford, Resident #5 was admitted to the hospital with pneumonia, hyponatremia, and confusion. On November 14, 2007, Resident #5 had x-rays that identified "significant right knee effusion." On November 15, 2007,

a hospital physician noted that there were no abrasions or ulceration on Resident #5's feet. Resident #5 was re-admitted to Oxford on November 20, 2007. The hospital ordered that his lower extremities by elevated and his heels be floated at all times.

158. Upon his return to Oxford on November 20, 2007, Oxford's records state that Resident #5 had a necrotic area to his right heel. His physician ordered that Oxford should cleanse his right heel, apply topical ointment, and change his dressings three times weekly or as needed, and to float his heels.

159. From November 20 through 30, 2007, medical records indicate Resident #5 did not receive treatment for his ulcer as ordered by his physician.

160. On November 23, 2007, the records describe that a "dried-up blood blister" in an unspecified location on Resident #5's body and state that topical ointment was applied and that the heels were floated.

161. On the MDS form signed on November 29, 2007, there was no indication that Resident #5 had any skin breakdown during the reference period from November 24 through November 29, 2007.

162. On December 2, 2007, his chart noted that Resident #5 had a "blood blister" on his right heel.

163. On December 12, 2007, Resident #5's care plan noted the "potential for skin breakdown" and stated that a body and skin audit would be performed three times a week. Despite this care plan directive, during the entire month of December 2007, records reflect that Resident #5 received a total of only four body and skin audits.

164. On December 19, 2007, Resident #5's care plan noted that he had an unstageable area to his right heel. The plan directed an LPN to float his right heel at all times, give him two

scoops of protein powder with meals, perform weekly wound assessment and measurements, and offer health-shakes between meals. Resident #5 also had a physician's order for treatment to the right heel and dressing changes three times weekly and as needed.

165. During December 2007, the medical records indicate there were numerous instances when Oxford failed to provide Resident #5 with wound treatment for his right heel in accordance with his physician's orders. From December 1 through 18, 2007, medical records indicate wound care was provided a total of four times rather than the three times weekly as prescribed by the physician.

166. On January 7, 2008, Resident #5 was admitted to the hospital with an unstageable necrotic decubitus ulcer on his right heel, measuring 8 cm by 6.5 cm. He underwent serial debridement.

167. On January 8, 2008, the weekly skin assessment noted that Resident #5 had an open area to his coccyx that measured approximately 1 cm by 1 cm. The assessment note contained no mention of the ulcer on his right heel.

168. On January 24, 2008, Resident #5 returned to the hospital with a Stage IV pressure ulcer to his right heel, measuring 7 cm by 6.8 cm, with the tendon and bone exposed. He also had a Stage III sacral pressure ulcer, measuring 0.7 cm in length, 0.5 cm in width, and 0.3 cm in depth.

169. During January 2008, there were numerous instances when Oxford failed to float Resident #5's heels in accordance with his physician's orders. From January 14 through 21, 2008, Resident #5 did not receive wound treatment for his right heel.

170. Again, during February 2008, there were numerous instances when Oxford failed to float Resident #5's heels as ordered by his physician. Nor did Oxford turn and re-position him

every two hours in accordance with his care plan. There were also numerous instances when Oxford failed to implement physician orders for Resident #5 to receive Accuzyme for his heel twice daily. From February 12 through 14, 2008, Resident #5 did not receive any wound treatment for the ulcer on his right heel as ordered by his physician.

171. On February 13, 2008, Resident #5 was referred to restorative nursing for strengthening and endurance. There is no documentation to suggest that he was ever provided with restorative nursing care.

172. On February 21, 2008, Resident #5 was treated at the hospital for his Stage IV ulcer to his right heel, with tendon and bone exposed.

173. On March 7, 2008, the ulcer on Resident #5's right heel measured 9 cm in length, 9 cm in width, and 0.2 cm in depth with bone exposed.

174. On March 15, 2008, Resident #5's recent skin graft was not healing.

175. On March 28 and 29, 2008, the treatment administration record reflects that Resident #5 received no wound treatment for the ulcer on his right heel as ordered by his physician.

176. On April 7, 2008, Resident #5 was treated at the hospital for a decubitus ulcer plus an open wound to his right heel and his right Achilles tendon area. He underwent debridement of the skin, subcutaneous tissue and muscle. The hospital records state that an attempt to perform a gamma graft to the area had failed and "the necrotic ulceration extends upward along the Achilles tendon." Hospital records further noted that Resident #5 had no palpable pulse and he underwent an aortogram with bilateral run-off to determine if he had any significant circulation to the area.

177. During April 2008, Oxford failed to implement physician orders that Resident #5 receive wound treatments for his right heel and buttocks on nine separate days.

178. Also during April 2008, Oxford failed to implement physician orders that Resident #5 receive Accuchecks to determine his blood sugar levels.

179. Resident #5's care plan provides that he should receive three showers weekly. During April 2008, Resident #5 did not receive any showers. Instead, Oxford gave him seven bed-baths and twelve "partial bed-baths."

180. On May 8, 2008, Resident #5 was re-admitted to the hospital for treatment of his Stage IV pressure ulcer to the right heel, which measured 8 cm in length by 3.5 cm in width.

181. On twenty-two of the thirty-one days in May 2008, Oxford failed to implement physician orders that Resident #5 receive wound treatment for his right heel. During that same month, on thirteen morning shifts and 9 evening shifts, Oxford failed to implement physician orders that Resident #5 receive wound treatment for his buttocks. At no time during that entire month did he receive any treatment to his right groin incision, contrary to his physician's orders

182. During May 2008, Resident #5 received only five baths and one partial bath, contrary to his physician orders. Nor did he receive antibiotics, insulin and other medications ordered by his physician.

183. During June 2008, there were several instances when Oxford failed to perform Accuchecks to determine Resident #5's blood sugar levels. There were also numerous occasions during that month when Oxford failed to provide insulin, treatments to his buttock pressure ulcer, and treatments to his heel ulcer, as ordered by his physician.

184. On or about June 20, 2008, Resident #5 was admitted to the medical center after suffering a left-sided stroke.

185. Resident #5 did not return to Oxford following his stroke.

186. Defendants knowingly provided, or caused to be provided, non-existent, grossly inadequate, materially substandard and/or worthless services to Resident #5, and falsely or fraudulently represented or certified, or caused to be represented or certified, that such claims were properly payable by Medicaid and Medicare.

187. For the non-existent, grossly inadequate, materially substandard and/or worthless services provided to Resident #5 from November 2, 2007 to June 26, 2008, defendants knowingly made or caused to be made claims for payment to Medicaid, and Medicaid paid claims totaling $25,848.07.

188. For the non-existent, grossly inadequate, materially substandard and/or worthless services provided to Resident #5 from November 2, 2007 to June 26, 2008, Defendants submitted claims for payment to Medicare, and Medicare paid claims totaling $10,051.58.

Resident #6

189. Resident # 6, a 73 year-old woman, was admitted to Oxford on October 17, 2006. Her diagnoses upon admission included hypertension, edema, coronary atherosclerosis, hyperlipidemia, diabetes mellitus, and dysphagia. She was continent and independent with activities of daily living, except for needing assistance getting in and out of the bathtub.

190. Upon admission to Oxford, Resident #6 had physician orders to have her blood glucose levels checked before each meal and at bedtime, and to receive measured doses of insulin per a sliding scale system up to 4 times a day.

191. During February 2007, medical records indicate that on twenty-seven separate occasions, Resident #6 either did not receive insulin, received the wrong dose of insulin, or there was no documentation of the type of insulin administered.

192. During March 2007, records indicate Oxford did not check Resident #6's blood glucose levels on eleven separate occasions prior to administering insulin in accordance with medical orders.

193. On April 21, 2007, records indicate Resident #6 did not receive insulin in accordance with her physician's orders.

194. On June 24, 2008, records indicate Resident #6 was admitted to a medical center after suffering a fall that caused her to have sutures in her left knee.

195. On October 2, 2008, records indicate Resident #6 was admitted to the hospital after suffering a fall at Oxford that caused her to hit her forehead on the concrete. She had an abrasion above her right eye.

196. On December 16, 2008, Resident #6 was admitted to the hospital for sepsis secondary to a urinary tract infection.

197. On May 22, 2009, a wound assessment noted that Resident #6 had a "Stage II" ulcer on her coccyx, measuring 4.4 cm by 3.2 cm with eschar and a small amount of serous drainage. The surrounding skin was described as bright red and the wound edges were indicated to be hard/indurated. The assessment performed on June 4, 2009 described Resident #6's ulcer as a "Stage II" with slough and a small amount of non-odorous drainage. The surrounding skin was described as bright red, but with "normal" wound edges. Pressure ulcers that contain slough or eschar, which refer to dead tissue, are to be classed as "unstageable" because the underlying tissue cannot be visualized.

198. On June 11, 2009, Resident #6 was treated at the hospital for an unstageable decubitus ulcer on her coccyx. Resident #6 told the hospital staff that the ulcer had been there a few months.

199. On June 26, 2009, Resident #6 returned to the hospital for treatment of a Stage III sacral decubitus ulcer, measuring 1.9 cm in length, 1.6 cm in width, and 0.5 cm in depth. It was noted that she had no dressing on her sacral decubitus ulcer and that her wound had become contaminated by feces due to incontinence. The hospital records state that Oxford's adherence to the plan of care was "poor."

200. On July 9, 2009, records indicate Resident #6's sacral ulcer measured 2 cm in length, 1.6 cm in width, and 0.4 cm in depth. The hospital records describe her ulcer as "much deeper, tunneling, and [with] overhang" and contaminated with stool. An attempted debridement was "unsatisfactory" and it was indicated that she needed debridement and a colostomy.

201. By July 16, 2009, records indicate Resident #6's sacral ulcer had progressed to a Stage IV, measuring 2.3 cm in length, 3 cm in width, and 3 cm in depth with a foul odor and drainage.

202. On August 3, 2009, records indicate Resident #6 returned to the hospital for debridement of her Stage IV sacral ulcer, including skin and subcutaneous tissue, and a diversion loop colostomy. She was re-admitted to Oxford on August 10, 2009.

203. On August 17, 2009, records indicate Resident #6 was treated at the hospital for a Stage III sacral pressure ulcer, measuring 2.1 cm in length, 1.8 cm in width, and 2.2 cm in depth with tunneling noted. She also was treated for a Stage II ulcer on her buttock, measuring 3 cm in length, 3.3 cm in width, and 0.4 cm in depth.

204. On August 24, 2009, records indicate Resident #6 was treated at the hospital to determine whether surgical staples remained in her abdomen after removing her colostomy. The records state that her colostomy had become septic.

205. By August 31, 2009, records indicate Resident #6 had a Stage III sacral ulcer, measuring 2.3 cm in length, 1.7 cm in width, and 3.3 cm in depth, and a Stage II ulcer on her buttock measuring 0.5 cm in length, 0.7 cm in width and 0.3 cm in depth.

206. On September 14, 2009, Resident #6 was treated at the hospital for a Stage III sacral ulcer and a Stage II ulcer to her buttock. She received a medical order for a wound VAC to be ordered upon her return to Oxford.

207. On September 25, 2009, Resident #6 returned to the medical center for a follow-up appointment. The hospital notes show that a physician concluded that Resident #6 would not do well with any type of flap reconstruction and that she should continue with a wound VAC.

208. On October 13, 2009, a physician with the medical center recommended opening up the two wounds in the midline to better access the undermined areas for better treatment. A wound VAC was not to be used for two weeks until the next evaluation.

209. On October 27, 2009, Resident #6 was treated at the hospital for a Stage IV sacral ulcer that measured 1.9 cm in length, 2 cm in width, and 2.98 cm in depth with bone and muscle exposed. It was noted that there was undermining, a large amount of drainage and mild odor. The ulcer on her buttock was a Stage IV and measured 2.6 cm in length, 2.8 cm in width, and 5.72 cm in depth with muscle exposed and undermining. The hospital noted that there was no adherence by Oxford to the plan of care.

210. On November 10, 2009, Resident #6 was treated at the hospital for a Stage IV sacral ulcer that measured 5.9 cm in length, 2.4 cm in width, and 2.5 cm in depth with bone and muscle exposed.

211. On December 8, 2009, Resident #6 was treated at the hospital for a Stage IV sacral ulcer that measured 6 cm in length, 2.6 cm in width, and 2.1 cm in depth with

undermining. It was noted that a "KCI wound VAC System to sacral decubitus – do not substitute" was ordered by the physician but "apparently unavailable at pts nursing home". Nevertheless, a medical order was given for a wound VAC to be ordered. The hospital noted that there was no adherence by Oxford to the plan of care.

212. On January 26, 2010, Resident #6 returned to the hospital for a Stage IV sacral ulcer that they described to be tunneling and undermining with muscle and bone exposed. It was noted that a wound VAC was "not available."

213. On April 6, 2010, Resident #6 was treated at the hospital for a Stage IV sacral ulcer with undermining and muscle and bone exposed. A physician ordered a negative pressure wound therapy "as all other measures [are] not improving wound" and for her dressings to be changed every 48 hours or as needed.

214. On May 4, 2010, Resident #6 was treated at the hospital for a new pressure ulcer to her left ear that was a Stage II. The hospital records note that she continued to have a Stage IV sacral ulcer, now measuring 5.8 cm in length, 3.6 cm in width, and 3.3 cm in depth with undermining and muscle and bone exposed.

215. On May 25, 2010, Resident #6 was treated at the hospital for a Stage IV sacral ulcer. The hospital records note that she also had a Stage II pressure ulcer to her right anterior lower leg, measuring 11 cm in length, 1 cm in width, and 0 .1 cm in depth. It was noted that the Stage II pressure ulcer on her left ear had not healed.

216. During May 2010, Oxford records indicate there were numerous instances when Resident #6 did not receive wound treatment as ordered by her physician.

217. On July 28, 2010, Resident #6 was treated at the hospital. Her chart noted that she had several new pressure ulcers on her right foot, right ankle and left lower leg. She was

also treated for a Stage II ulcer to her left ear, a Stage II ulcer on her right leg, and a Stage IV ulcer on her sacrum.

218. Resident #6's family removed her from Oxford on August 11, 2010.

219. Defendants knowingly provided, or caused to be provided, non-existent, grossly inadequate, materially substandard and/or worthless services to Resident #6, and falsely or fraudulently represented or certified, or caused to be represented or certified, that such claims were properly payable by Medicaid and Medicare.

220. For such non-existent, grossly inadequate, materially substandard and/or worthless services to Resident #6 from November 2, 2007 to August 11, 2010, defendants knowingly made or caused to be made claims for payment to Medicaid, and Medicaid paid claims totaling $83,761.92.

221. For such non-existent, grossly inadequate, materially substandard and/or worthless services to Resident #6 from November 2, 2007 to August 11, 2010, defendants knowingly made or caused to be made claims for payment to Medicare, and Medicare paid claims totaling $1,937.65.

Resident #7

222. Resident #7, a 62 year-old woman, was admitted to Oxford on December 12, 2011. Her diagnoses upon admission included Guillain-Barre syndrome (a disease that causes paralysis beginning with the feet and hands and migrating towards the trunk and, in Resident #7's case, caused life-threatening respiratory complications), respiratory failure, hypertension, mental retardation, morbid obesity, malnutrition, and a bacterial infection.

223. At the time she was admitted, Resident #7 had a cuffed tracheostomy tube that had been recently inserted due to respiratory failure.

224. Resident #7 had medical orders for Oxford to suction the tracheostomy tube every four hours and as needed, to administer oxygen to the tracheostomy tube at 8 liters per minute, to maintain her oxygen saturation level at 92 percent or higher, to provide necessary respiratory treatments and tracheostomy care, and to provide intravenous antibiotics. Resident #7 also had medical orders for Oxford to provide tube feedings for nutrition and hydration, to monitor her intake and output, to manage her urinary catheter, and to provide medications, treatments and laboratory studies.

225. Upon her admission to Oxford, records indicate Resident #7 did not receive an assessment of her respiratory or airway status. Resident #7 was not provided with medically urgent breathing treatments for at least a week because Oxford reportedly did not have the proper equipment. Additionally, records indicate Oxford did not properly insert intravenous infusion devices and then failed to infuse ordered drugs at a rate sufficient to protect the patient from adverse events.

226. Throughout her stay at Oxford, records indicate Oxford failed to provide Resident #7 with necessary tube feedings and hydration as ordered by the physician, placing her at imminent risk for life-threatening kidney failure. Resident #7 had a medical order for Oxford's nursing staff to provide her with hydration by flushing her PEG tube with 250 cc of water every shift. There were numerous instances throughout Resident #7's stay when Oxford failed to flush her PEG tube with water, including on seven separate occasions from December 26 through December 31, 2011.

227. Throughout her stay at Oxford, records indicate Oxford failed to consistently monitor and document Resident #7's intake and output, placing her at risk for dehydration and

worsening kidney failure. On December 29, 2011, her chart noted that Resident #7 had only 56 cc of intake, which indicates that she had no tube feeding or water during an eight-hour period.

228. Throughout her stay at the nursing facility, records indicate Oxford failed to provide Resident #7 with the medications ordered by her physician or failed to properly administer medications in accordance with medical orders.

229. For example, in addition to not providing breathing treatments for a week because of the reported absence of the proper equipment, Oxford failed to record Resident #7's blood pressure prior to administering Amlodipine, a drug used to lower blood pressure. Without a record of her blood pressure, there was nothing to indicate whether administration of the drug was necessary or whether administering the drug would endanger her health.

230. Although Resident #7 had a medical order for tracheostomy suctioning to be performed every four hours and as needed, Oxford's records indicate that suctioning was performed on Resident #7 on only six occasions during her entire stay, between December 12 and 31, 2011.

231. Throughout her stay, Oxford records indicate that the facility never fully assessed her respiratory status despite her history of respiratory failure.

232. On at least ten days during December 2011, records indicate Oxford failed to monitor and record Resident #7's oxygen saturation levels. Failure to monitor and record Resident #7's oxygen saturation levels left her at risk for hypoxemia and respiratory failure, the conditions which ultimately caused her death.

233. Throughout her stay, records indicate that Oxford never changed Resident #7's tracheostomy collar and tubing, nor did they ever wash out her oxygen concentrator filter, as ordered by her physician, placing her at risk for worsening respiratory infection.

234. The record indicates there were numerous occasions during her stay when Resident #7's heplock intravenous device, which was used to administer antibiotics, was not flushed with a solution to keep it open and functioning, in accordance with medical orders and standards of practice. On December 20, 2011, Resident #7 was admitted to the hospital for a peripherally inserted central catheter line placement after the heplock device had "failed." Resident #7 also had a new cuffed tracheostomy tube inserted after a mucus plug was located and removed.

235. Resident #7 was re-admitted to Oxford on or about December 24, 2011. Upon her return, it was noted that she had an "angry red rash" covering her body. Upon admission, Resident #7 had a medical order to administer 1.25 gm. of Vancomycin, an antibiotic used to treat bacterial infections, intravenously every twelve hours. Resident #7's intravenous infusion rate was never recorded in Oxford's records. "Red Man Syndrome," an angry red rash, is an adverse reaction that can be caused by the rate of infusion of the drug Vancomycin, which must be infused slowly over at least an hour. Treatment of Red Man Syndrome requires the immediate discontinuation of Vancomycin.

236. On December 25, 2011, a licensed practical nurse at Oxford noted that Resident #7 was given 8 liters per minute of oxygen through her nasal cannula. Resident #7 had a cuffed tracheostomy tube in place, which did not allow for air to flow from her mouth and nose to her lungs. Delivering oxygen to Resident #7 through her nasal cannula would not have provided any oxygen to her lungs.

237. On December 26, 2011, Resident #7 continued to have a red rash to her entire body. Her oxygen saturation was recorded as 86 percent. A nurse at Oxford suctioned Resident

#7's tracheostomy tube and her oxygen saturation increased to 94 percent. Upon suctioning, it was noted that Resident #7 had relief with breathing.

238. On December 29, 2011, Resident #7's oxygen saturation was recorded as 89 percent. No suctioning of the tracheostomy was performed to clear her airway and increase her oxygen saturation to 92 percent, in accordance with medical orders.

239. At 10:15 a.m. on December 31, 2011, her chart noted that Resident #7 was alert and verbally responsive. At 2:05 p.m., a licensed practical nurse found Resident #7 having decreased respirations and to be slightly blue around the mouth. She called a registered nurse to the room. A registered nurse arrived three minutes later and found Resident #7 to be non-responsive with no pulse or respirations. No tracheostomy suctioning was performed to attempt to clear her airway. The nurse waited for the crash cart to arrive before beginning respirations with an Ambu bag. The EMT personnel arrived approximately twenty minutes later and Resident #7 was transferred to the hospital.

240. On December 31, 2011, Resident #7 was pronounced dead at the hospital as a result of cardiac arrest.

241. Defendants knowingly provided, or caused to be provided, non-existent, grossly inadequate, materially substandard and/or worthless services to Resident #7, and falsely or fraudulently represented or certified, or caused to be represented or certified, that such claims were properly payable by Medicaid and Medicare.

242. For such worthless services to Resident #7 from December 12, 2011 to December 31, 2012, defendants knowingly made or caused to be made claims for payment to Medicare, and Medicare paid claims totaling $7,782.39.

Other Residents

243. The foregoing are only examples of the non-existent, grossly inadequate, materially substandard, worthless care rendered to Oxford residents, with the knowledge of defendants, and the resulting false or fraudulent claims that defendants knowingly submitted or caused to be submitted to the Medicaid and Medicare programs, and false or fraudulent representations or certifications material to such claims, from in or about October 2005 to in or about May 2012. The United States has, and will develop through discovery and further analysis, including expert analysis, additional evidence of defendants' false or fraudulent claims, representations and certifications, and the United States' resulting damages.

EXAMPLES OF REPORTS AFFIRMING DEFENDANTS' KNOWLEDGE AND EVIDENCE OF DEFENDANTS' CONCEALMENT

244. Defendants possessed knowledge concerning the non-existent, grossly inadequate, materially substandard, worthless resident care at Oxford, not only by means of their direct operation and management of the facility, but also from various reports and events that affirmed such knowledge.

245. AltaCare's regional clinical director ("RDC") frequently visited Oxford, conducted reviews, and issued Facility Visit Reports recognizing numerous failure of care issues at Oxford, including: poor resident hygiene; poor wound care; poor hydration; poor pain management; inadequate food and food shortages; lack of heating in the facility; leaks in the roof; problems with vendors due to non-payment; filthy conditions; and pests. These reports were circulated to defendants' top management, including Mittleider.

246. By way of example only:

a. From September 2 through 4, 2008, the RDC visited Oxford and reported that: (i) residents complained of not having the opportunity to engage in activities outside

the facility, and that the facility lacked sufficient funds for gasoline to transport residents to such activities; (ii) residents were concerned about inadequate meals, short supplies, and lack of pain medications on weekends; and (iii) Oxford had persistent water leaks that created potential fall hazards.

b. From August 9 through 12, 2010, the RDC visited Oxford and reported that: (i) weekly skin assessments were not performed in timely fashion: (ii) residents were not adequately turned to avoid skin problems; (iii) weekly wound rounds were not done; (iv) water was often placed beyond the reach of bedbound residents; (v) residents' call lights also were often placed beyond residents' reach; (vi) incident/accident forms were not being completed; and (vii) interventions were not in place for residents at risk for falls.

c. During her visit from November 8 through 11, 2010, the RDC reported that: (i) Oxford's windows, furniture and equipment were dirty; (ii) weekly skin assessments were not being performed in timely fashion; (iii) wound rounds were not done weekly; and (iv) residents were not receiving routine hygiene care; for example, some were observed with food on their clothing and long dirty nails.

d. The RDC visited Oxford from December 13 through 16, 2010, and reported that: (i) the heating was not working properly, the temperature in the dining room was 59 degrees, and residents were eating dinner wearing their coats; (ii) heating repairs took two days to complete; (iii) staffing was not reviewed daily as recommended on her previous visit; (iv) pain medication was not offered before, during or after wound dressing changes; (v) residents were not properly turned to

avoid skin conditions; and (vi) there was no documentation to indicate that wounds were routinely being treated.

247. Defendants also had knowledge of the non-existent, grossly inadequate, materially substandard and/or worthless services at Oxford as the result of personal injury claims brought by former residents and their family members, including at least three claims resulting in litigation, and as the result of surveys by the Mississippi Department of Health ("DOH"), which resulted in civil monetary penalties for noncompliance with nursing home patient care requirements, pursuant to 42 U.S.C. §§ 1395i-3(h), 1396r(h) and 42 C.F.R. Part 488.

248. Defendants not only had direct knowledge of the non-existent, grossly inadequate, materially substandard and/or worthless services provided at Oxford, through their exercise of control over the budget, billing, and all other aspects of Oxford's operations, but they also they took affirmative actions that caused and contributed to the making of false or fraudulent claims, representations and certifications.

249. As set forth above, defendants failed to provide sufficient resources for staffing at Oxford, failed to pay vendors of essential goods and services on a timely basis, and diverted Medicaid and Medicare funds that should have been used for resident care to AltaCare, LTCS and Mittleider, in the form of management fees and other administrative expenses and transfers, and, upon information and belief, to other entities, including other nursing homes, owned, operated or controlled by Mittleider.

250. Defendants attempted to conceal evidence of their non-existent, grossly inadequate, materially substandard and/or worthless services to Oxford's vulnerable elderly, disabled and low income residents.

251. Nursing homes such as Oxford use medication administration records ("MARs"), treatment administration records ("TARs"), and activity of daily living ("ADL") sheets, to document resident care. The MARs, TARs and ADL sheets created and maintained at Oxford contained numerous blanks for extended periods of time, and at other times, contained demonstrably false entries, for example, purportedly documenting care provided to residents who were not even present in the facility on the dates of the purported care.

252. Moreover, at times, Oxford staff members were required to stay late into the evening on days before Mississippi DOH inspectors were scheduled to survey the facility, in order to falsify records that the inspectors would be examining.

253. The administrator of the Oxford facility stated that he maintained two sets of records, one for the regulators and one for the management of Oxford.

254. Defendants had actual knowledge, recklessly disregarded and/or remained in deliberate ignorance, of the truth or falsity or their claims, representations and certifications made to Medicaid and Medicare. Defendants knowingly made or cause to be made to Medicaid and Medicare false or fraudulent claims, representations and certifications, within the meaning of the FCA, 31 U.S.C. § 3729(b).

SUMMARY OF UNITED STATES' CLAIMS

255. Hyperion, AltaCare, LTCS and Mittleider, through their interrelated conduct in the operation of Oxford, submitted or caused to be submitted false or fraudulent claims, and false or fraudulent representations and certifications material to such claims, to the Medicaid and Medicare programs, for services that were non-existent, grossly deficient, materially substandard and/or worthless, and resulted in significant physical and mental harm to vulnerable elderly, disabled and low income residents of Oxford.

256. Despite their knowledge, reckless disregard, or deliberate ignorance of the fact that resident care at Oxford was non-existent, grossly deficient, materially substandard and/or worthless, and were, as the result, suffering significant physical and mental harm, defendants knowingly made, or caused to be made, and received and retained payments for, false and fraudulent claims for the bundle of nursing home services that Oxford was required to provide as a Medicaid and Medicare provider.

257. Defendants made, or caused to be made, false and fraudulent statements material to their false or fraudulent claims to the Medicaid and Medicare programs, and knowingly received and retained Medicaid and Medicare funds to which they were not entitled.

258. The Medicaid and Medicare programs mistakenly paid for defendants' non-existent, grossly deficient, materially substandard and/or worthless services.

259. The United States was damaged and defendants were unjustly enriched by the payments they sought and received from the Medicaid and Medicare programs for the non-existent, grossly deficient, materially substandard and/or worthless services defendants provided, or caused to be provided.

260. The United States is entitled to recover its damages, and in equity, fairness and good conscience, defendants should be required to account for and disgorge such unjustly obtained amounts.

COUNTS

Count I: False Claims Act, 31 U.S.C. § 3729(a)(1) (claims up to and through May 19, 2009) and 31 U.S.C. 3729(a)(1)(A) (claims from and after May 20, 2009)

261. The United States restates and incorporates by reference paragraphs 1 through 260 as if fully set forth herein.

262. Defendants knowingly presented or caused to be presented false or fraudulent claims for payment or approval by the Medicaid and Medicare programs, in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1), for claims up to and through May 19, 2009, and in violation of § 3729(a)(1)(A), for claims from and after May 20, 2009.

263. Pursuant to the FCA, defendants are jointly and severally liable to the United States for its damages resulting from such false claims, in an amount to be determined at trial, trebled, plus civil penalties of between $5,500 and $11,000 for each violation.

Count II: False Claims Act, 31 U.S.C. § 3729(a)(1)(B)

264. The United States restates and incorporates by reference paragraphs 1 through 260 as if fully set forth herein.

265. Defendants knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims, or false records and statements to get false claims paid, by the Medicaid and Medicare programs, in violation of the False Claims Act, § 3729(a)(1)(B).

266. Pursuant to the FCA, defendants are jointly and severally liable to the United States for its damages resulting from such false records and statements, in an amount to be determined at trial, trebled, plus civil penalties of between $5,500 and $11,000 for each violation.

Count III: Payment by Mistake

267. The United States restates and incorporates by reference paragraphs 1 through 260 as if fully set forth herein.

268. This is a claim for the recovery of monies paid by the United States to defendant Hyperion for its benefit and the benefit of the other defendants, as the result of mistaken

understandings of fact. The false claims that defendants submitted or caused to be submitted to the Medicaid and Medicare programs were paid based upon mistaken or erroneous understandings of material fact.

269. The Medicaid and Medicare programs, without knowledge of the falsity of the claims, representations and certifications that defendants made, or caused to be made, mistakenly paid defendants certain sums of federal monies to which defendants were not entitled.

270. Defendants are liable to account for and to repay such amounts to the United States, in an amount to be determined at trial.

Count IV: Unjust Enrichment

271. The United States restates and incorporates by reference paragraphs 1 through 260 as if fully set forth herein.

272. Defendants wrongfully received and retained the benefit of federal monies paid from the Medicaid and Medicare programs for nursing home services provided to Oxford residents that were non-existent, grossly deficient, materially substandard, and/or worthless, and resulted in serious physical and emotional harm to such vulnerable, elderly, disabled and low income residents.

273. Defendants were unjustly enriched with federal monies from the Medicaid and Medicare programs, which defendants should not in equity and good conscience be permitted to retain, and which defendants should account for and disgorge to the United States, in an amount to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, the United States of America prays for judgment against defendants as follows:

A. With respect to Counts I and II brought pursuant to the FCA, that judgment be entered against defendants jointly and severally, in the amount to be determined at trial, trebled, plus civil penalties of $5,500 to $11,000 for each violation;

B. With respect to Count III and IV, that judgment be entered against the defendants jointly and severally, in the amounts to be determined at trial by which the defendants were mistakenly paid and unjustly and unlawfully enriched; and

C. With respect to each Count, that the United States be afforded interest, attorney's fees and costs as allowed by law, and any and all further relief as the Court deems just and proper.

The United States demands a trial by jury on all issues so triable.

Dated: February 28, 2013

Respectfully Submitted,

STUART F. DELERY
Principal Deputy Assistant Attorney General

GREGORY K. DAVIS
United States Attorney,
Southern District of Mississippi

MICHAEL D. GRANSTON
SARA McLEAN
Attorneys, Civil Division
Commercial Litigation Branch

/s/ Edward O. Pearson
EDWARD O. PEARSON (MSB #4080)
Assistant United States Attorney
188 East Capitol Street, Suite 500
Jackson, MS 39201
Telephone: (601) 965-4480
Fax: (601) 965-4409

RICHARD S. NICHOLSON
ANDREW S. PENN
Attorneys, Civil Division
Commercial Litigation Branch
601 D Street, N.W., Room 9928
Washington, DC 20004
Telephone: (202) 616-0345
Fax: (202) 514-7361