IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA and COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF PUBLIC WELFARE,	:	
Plaintiffs,	:	**CIVIL ACTION NO.:**
v.	:	
HOLLAND-GLEN,	:	
Defendant.	:	

VERIFIED COMPLAINT FOR INJUNCTIVE RELIEF

Defendant Holland-Glen has failed and continues to fail properly to care for its medically fragile juvenile residents and, in the process, continues to defraud the United States and the Commonwealth of Pennsylvania. Plaintiffs United States of America, through the United States Attorney for the Eastern District of Pennsylvania, and the Commonwealth of Pennsylvania, Department of Public Welfare, seek to enjoin defendant's ongoing fraud based on probable cause to find violations of 18 U.S.C. § 1347 (health care fraud); 18 U.S.C. § 1341 (mail fraud); 18 U.S.C. § 1343 (wire fraud); 18 U.S.C. § 1035 (false statements relating to health care matters); 42 U.S.C. § 1320a-7a(a) (civil monetary penalties); and Pennsylvania licensing standards. Plaintiffs bring this civil action under the Anti-Fraud Injunction Statute, 18 U.S.C. § 1345; 42 U.S.C. § 1320a-7a(k); and 62 P.S. §§ 1052, 1053.

In support of their Complaint and their request for a temporary restraining order and preliminary injunction to prevent continuing and substantial injury to the victims of defendant's fraud, and for such other relief as justice requires, the United States and the Commonwealth of Pennsylvania, Department of Public Welfare allege as follows:

I. PARTIES, JURISDICTION, AND VENUE

1. Plaintiff United States of America brings this action on behalf of itself, the United States Department of Health and Human Services ("HHS"), the Pennsylvania Medical Assistance Program, and the beneficiaries thereof.

2. Plaintiff Commonwealth of Pennsylvania, Department of Public Welfare ("DPW"), is statutorily charged with the licensing of facilities that serve persons with mental retardation. DPW brings this action on behalf of itself and persons with mental retardation who reside at defendant Holland-Glen's Hatboro facility.

3. Defendant Holland-Glen is a non-profit corporation incorporated under the laws of the Commonwealth of Pennsylvania, with its principal place of business at 412 South York Road, Hatboro, Pennsylvania, which is the site of its large group skilled nursing facility ("the Hatboro nursing facility").

4. William Schlachter is the President and Chief Executive Officer of Holland-Glen. He is also one of three members of its Board of Directors. Upon information and belief, Schlachter is an accountant and is not licensed as a physician, nurse, respiratory therapist, or in any health-care-related field. Notwithstanding Schlachter's full-time employment elsewhere, Holland-Glen has paid him compensation and benefits in excess of $120,000 per year.

5. Constance Bundra is Holland-Glen's Director of Nursing and is responsible for the day-to-day nursing care provided to the residents of the Hatboro nursing facility.

6. Schlachter and Bundra are responsible, in whole or in part, for the operation of Holland-Glen and for the health and safety of the persons residing at the Hatboro nursing facility.

7. This Court has jurisdiction over this action under 28 U.S.C. § 1331 (federal question), 28 U.S.C. § 1345 (civil action commenced by the United States), and 28 U.S.C. § 1367 (supplemental jurisdiction).

8. Venue is proper in this district because defendant operates the Hatboro nursing facility in this district and committed fraudulent acts in this district.

9. The United States issued to Holland-Glen subpoenas under the Health Insurance Portability and Accountability Act of 1996 (18 U.S.C. § 3486) for the production of documents, including medical records of numerous children who died while (or soon after being) residents at the Hatboro nursing facility. The United States is continuing its review of documents that Holland-Glen has produced in response, as well as additional information.

II. HOLLAND-GLEN IS A NURSING FACILITY

10. The United States Congress, in the Omnibus Budget Reconciliation Act of 1987 ("OBRA '87"), enacted the Nursing Home Reform Act, 42 U.S.C. §1396r et seq., (hereinafter "the Federal Nursing Home Reform Act"), which took effect on October 1, 1990. HHS subsequently issued implementing regulations that are found at 42 C.F.R. § 483, et seq.

11. Defendant Holland-Glen's Hatboro nursing facility is a "nursing facility" as defined by the Federal Nursing Home Reform Act. That Act defines a "nursing facility" as "an institution (or a distinct part of an institution)" that:

(1) is primarily engaged in providing to residents –

(A) skilled nursing care and related services for 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).

12. Individuals admitted to Holland-Glen's Hatboro nursing facility require -- and are promised -- skilled nursing care and related services (such as ventilator care and/or other skilled respiratory care) that the Federal Nursing Home Reform Act defines as "nursing facility"-provided services. To be sure, on its web site Holland-Glen describes itself as:

> [F]ocus[ed] . . . on ventilator[-]dependent, respiratory[-] impaired and multi-system failure pediatric/adolescent patients. [The company] receive[s] residents directly from the intensive care unit[s] of hospitals across the country. . . . [M]ost [residents] require maximum assistance with activities of daily living. . . . Nurses, respiratory therapists and nursing assistants provide comprehensive twenty-four hour professional and custodial care . . . . Holland-Glen is designed as a specialized organization dedicated to treating the pulmonary[-]impaired population who normally had to experience extended inpatient stays at acute care hospitals. . . . [The company's] medically complex program focuses on patients who traditionally would need long term hospitalizations in order to fully recover or rehabilitate. . . . The need for skilled nursing, IV Antibiotic therapy, wound and pain management are provided by [the company's] multi-disciplinary

> team. . . . Subacute/Skilled Nursing Care is provided by Holland-Glen at [its Hatboro nursing facility]. (http://www.hollandglen.org) (Interpolations added.)

13. Holland-Glen's Hatboro nursing facility is a residential skilled nursing facility for approximately twenty-to-thirty medically fragile residents, who range in age from infants to individuals in their early twenties. Many of the residents breathe with the assistance of a ventilator and are fed through the use of feeding tubes. Most of the child-residents require around-the-clock medical attention.

14. Although it promises to provide skilled nursing services to the residents of the Hatboro nursing facility, Holland-Glen has not applied for and does not possess any license from the Commonwealth of Pennsylvania to operate a nursing facility. Holland-Glen has a license to operate its Hatboro nursing facility only as a community group home for mentally retarded persons.

15. Holland-Glen receives millions of dollars in public health care funds each year. Most of its funding comes from public sources such as Medicaid. Those Medicaid funds come from American taxpayers through the governments of the United States and the Commonwealth of Pennsylvania. Holland-Glen also receives funding grants through county and municipal agencies overseeing public welfare and mental retardation; those grants are, in part, funded by the United States and the Commonwealth of Pennsylvania.

16. Notwithstanding Holland-Glen's lack of a license to operate the Hatboro nursing facility as a nursing facility, it bills Medicaid and other federally funded programs for skilled nursing services.

III. HOLLAND-GLEN'S FAILURES TO CARE PROPERLY FOR VULNERABLE, MEDICALLY FRAGILE CHILDREN

17. Holland-Glen's services substantially depart from generally accepted professional standards of care, thereby exposing individuals residing at the Hatboro nursing facility to significant risk and, in some cases, to actual harm.

A. Failure Properly To Respond To Respiratory Alarms and To Follow Physician Orders for Use of Pulse Oximeters

18. Holland-Glen fails to comply with professionally accepted standards of care relating to: (a) timely responding to residents' ventilator alarms; (b) using continuous pulse oximetry as ordered by residents' doctors; and (c) responding to residents' pulse oximetry alarms.

19. Many Holland-Glen residents are dependent on ventilators, which are machines that help the residents breathe. When a resident's ventilator alarm sounds, it means that the resident is likely having difficulty breathing and probably requires assistance such as suctioning the resident's airway.

20. Failure timely to respond to a ventilator alarm is a departure from the professionally accepted standard of care for ventilator-dependent residents and can result in serious harm to the resident, including death. During a recent DPW inspection at the Hatboro nursing facility in April 2007, Holland-Glen failed to respond in a timely manner to a resident whose ventilator alarm was sounding.

21. Many residents at Holland-Glen have orders for continuous pulse oximetry. A machine called a pulse oximeter measures the amount of oxygen saturation in the blood. A physician orders heart rate and oxygen saturation parameters, which are set on the machine. When turned on and properly attached to the resident and properly set, the machine's audible alarm will sound when the resident's heart rate or oxygen saturation fall outside of those parameters. The sounding of the alarm usually indicates difficulty breathing or a heart problem. The pulse oximeters that the medically fragile residents of Holland-Glen's nursing facilities require and that are used for them are equipped with audible alarms.

22. For these medically fragile residents, failure either to use a pulse oximeter with a properly engaged audible alarm or timely to respond to a pulse oximeter alarm is a departure from professionally accepted standards of care and can result in serious harm to the resident, even death.

23. By way of example, on numerous occasions, notwithstanding physician orders for the use of pulse oximetry for certain residents, Holland-Glen, by not using such equipment at all or by failing properly to engage the equipment alarm and/or to respond to it, has failed to follow those physician orders.

24. By way of further example, in one instance staff found a resident unresponsive. At the time, the pulse oximeter for the resident (which would have sounded had it been properly attached) was not sounding. The resident died the next day.

B. <u>Failure To Provide Proper Wound Care</u>

25. Holland-Glen fails to comply with professionally accepted standards relating to care of its residents' wounds.

26. Residents who are immobile (the condition of many Holland-Glen residents) can develop pressure ulcers if they are not properly cared for and do not receive appropriate nutrition. A pressure ulcer is an area of skin that breaks down when a resident remains in one position for too long without having his/her weight shifted. The constant pressure against the skin reduces the blood supply to the affected area, and the affected tissue dies. The ulcer can become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints.

27. On its web site (http://www.hollandglen.org), Holland-Glen describes its "Wound Care Program" as follows:

> One of the great challenges in treating a medically complex patient is wound care. At Holland-Glen we take great pride in prevention of skin breakdown and infection of wounds. . . . Many other medical facilities have requested copies of our protocol for infection control and wound care.

28. By way of example of Holland-Glen's failures to comply with applicable regulations and generally accepted standards relating to wound care, one Holland-Glen resident developed a pressure ulcer as large as a fist that eventually required hospitalization to remove the dead tissue in the wound.

C. Failure To Mitigate Pain

29. Holland-Glen fails to comply with generally accepted standards of care relating to pain management and assessment.

30. By way of example, Holland-Glen failed timely to assess and treat the splintered/crushed leg bone of a resident. When the fracture was finally diagnosed, the resident's pain resulting from the broken leg was not appropriately assessed or treated in a timely manner.

D. Failure To Provide Proper General Resident Care

31. Holland-Glen fails to comply with professionally accepted standards of care relating to general resident care.

32. By way of example, Holland-Glen caused a resident to suffer burns on her leg when she was placed in a wagon in such a way that she was allowed to come into contact with an oxygen tank.

E. Failure Properly To Administer Medications

33. Holland-Glen fails to comply with generally accepted standards relating to medication administration.

34. By way of example, one fragile baby with a serious cardiac condition resided at the Hatboro nursing facility for approximately seven weeks before he died. During that time, he likely repeatedly received only one tenth of the dose of one prescribed medication for his condition and 10 times the prescribed dose of another drug.

IV. RECENT SMOKE EVACUATION OF THE HATBORO NURSING FACILITY

35. On June 16, 2007, the Hatboro nursing facility was evacuated because of smoke in the facility. During DPW's inspection on June 18, 2007, Holland-Glen attempted to minimize the situation by telling DPW that: (a) an air conditioner, by releasing a mist into one of the facility rooms, caused the smoke alarm to sound; and (b) Holland-Glen had evacuated the residents in three minutes.

36. According to the Hatboro police department, which on June 16, 2007 responded to a 911 call stating that there was smoke at the Hatboro nursing facility, there was in fact light-to-heavy, gray-colored, acrid-smelling smoke throughout the building that the fire

department had to remediate. A copy of the police report and 911 dispatch report are attached hereto as Exhibit "1."

37. Although Holland-Glen is required to evacuate Hatboro nursing facility residents in eight minutes, there were insufficient staff to do so on June 16, 2007. With the assistance of the Fire Department, it took approximately twenty minutes (more than twice the required time) to evacuate the residents. A copy of the Hatboro Fire Marshal's recommended evacuation time is attached hereto as Exhibit "2."

V. HOLLAND-GLEN'S FALSIFICATION OF RECORDS

38. Holland-Glen has falsified both resident medical records and records of billings to governmental and other payors.

39. By way of example, Holland-Glen reported in a patient's medical record that she received care at the Hatboro nursing facility following her removal from the facility by ambulance and later death.

40. By way of further example, Holland-Glen falsified its billing records for nursing services, as evidenced by two contradictory documents that relate to services for the same resident for the same week.

41. By way of still further example, Holland-Glen separately provided records for one of its residents to the United States and to the Commonwealth of Pennsylvania. Though the records to state and federal government similarly purport to show the resident's care for a particular date, they record different care for that date; i.e., one record represents the providing of services that the other record demonstrates were not provided.

42. Holland-Glen directed its employees to "fill in the holes" in residents' medical records prior to state inspections so that it would appear that services, such as timely administration of medications, had been provided.

VI. HOLLAND-GLEN'S DISREGARD OF THE BACKGROUNDS OF THE EMPLOYEES IT HIRES TO WORK WITH VULNERABLE AND MEDICALLY FRAGILE CHILDREN AND YOUNG ADULTS

43. HHS excludes individuals and entities from participating in Federal Health Care Programs if they have committed health care fraud or certain crimes. HHS maintains a database of excluded individuals and entities that is accessible on the Internet through a publicly available website.

44. Beginning in January 2003, Holland-Glen employed at its Hatboro nursing facility a respiratory therapist who had been excluded from participation in Medicare, Medicaid, and all other federally funded health care programs.

45. Holland-Glen employed the respiratory therapist, Gerald Kin, to provide respiratory services to Holland-Glen residents whose care was paid for, in part, by federal funds. During the entire time of such employment, Mr. Kin was excluded from participation in federally funded health care programs.

46. Holland-Glen employed Mr. Kin with either knowledge of or reckless disregard of his exclusion from federally funded programs.

47. Holland-Glen eventually learned of Mr. Kin's exclusion by checking the exclusion database. Notwithstanding such knowledge, Holland-Glen promoted Mr. Kin to a job as a full-time employee respiratory therapist. Mr. Kin's employment was terminated only upon the United States notifying Holland-Glen of his exclusion.

48. In addition to failing to check the exclusion database, Holland-Glen, as averred at greater length in Paragraph 70 of this Complaint, falsified documents relating to criminal history checks and the training of its employees.

49. As a result of these actions, DPW refused to renew Holland-Glen's license. See Paragraph 70, infra.

50. Following Holland-Glen's appeal of its license non-renewal and as a part of a subsequent settlement, DPW required Holland-Glen to have an independent audit of its criminal history checks (such checks are required under Pennsylvania law) and verification of training procedures.

51. Notwithstanding Holland-Glen's history of failing properly to check the status of its employees before allowing them to have access to vulnerable, medically fragile children, Holland-Glen -- according to an audit that it recently submitted to DPW -- continues to fail properly to check the criminal history of its new hires and to verify training procedures. A copy of the audit is attached hereto as Exhibit "3."

VII. PRIOR REGULATORY AND COMPLIANCE EFFORTS HAVE FAILED

52. Holland-Glen, acting under both its current and previous name, WAC, has a long history of non-compliance with regulations, standards, requirements, directives, and agreements of, by, and/or with the United States and DPW.

53. In September 2000, Holland-Glen, under its previous name, WAC, entered into a Settlement Agreement and Corporate Integrity Agreement with the United States and DPW. Those agreements were based upon allegations of WAC's pattern and practice of: (a) billing Medicaid for services not provided; (b) seeking double payment for services; and

(c) seeking payment for unallowable expenses. A copy of the Settlement Agreement is attached hereto as Exhibit "4."

54. Holland-Glen previously operated a portion of its Hatboro nursing facility for residents who were mentally retarded. Holland-Glen chose to apply to the Commonwealth of Pennsylvania for, and obtained, a license to operate the entire facility as a community home for individuals with mental retardation, which placed the facility under DPW's licensing jurisdiction. In 2003, Holland-Glen eliminated its mental retardation program and thereafter focused on its pulmonary program for ventilator-dependent and other medically fragile residents. Notwithstanding that change, Holland-Glen did not apply to the Commonwealth for a different license for the Hatboro nursing facility, which consequently and incongruously has since remained licensed under DPW's jurisdiction as a community home for individuals with mental retardation.

55. The applicable licensing standards for a community home for individuals with mental retardation are found at 55 Pa. Code § 6400, et seq.

56. DPW inspections of Holland-Glen's Hatboro nursing facility in recent years reveal a long-standing pattern of violations of the regulations applicable to a community home for individuals with mental retardation. Those violations continue to the present.

57. Under Pennsylvania law, DPW is required to notify facilities that it licenses, such as Holland-Glen, when an inspection reveals a violation of Pennsylvania's Public Welfare Code and implementing regulations. Such notices must require the offending facility to take action to bring the facility into compliance with law. 62 P.S. § 1026(a). If DPW finds that the facility has engaged in "[g]ross incompetence, negligence, or misconduct in operating the

facility" or has "[m]istreat[ed] or abus[ed] individuals cared for in the facility," DPW must revoke the facility's license. 62 P.S. § 1026(b).

58. In 2002, because of significant violations relating to medication administration, DPW revoked Holland-Glen's license for the Hatboro nursing facility and issued a provisional license.

59. DPW's inspections in late 2002 and early 2003 revealed continuing, multiple issues relating to medication administration at the Hatboro nursing facility.

60. In July 2003, in the wake of a series of deaths of children who were or had recently been residents at the Hatboro nursing facility, DPW inspected that facility. Based on that inspection, DPW cited Holland-Glen for serious regulatory violations at the facility including: (a) failures to document criminal history records checks when hiring staff; (b) failure to maintain a current child abuse check for a staff member; (c) failure to notify authorities regarding an allegation of abuse; (d) inadequate documentation of medical treatment and administration of medications; (e) incorrectly labeling dosage on residents' medications (cited as "repeated non-compliance"); (f) multiple gaps in medication logs (cited as "repeated non-compliance"); and (g) failure to administer physician-ordered medication (cited as "repeated non-compliance") . A copy of DPW's inspection report is attached hereto as Exhibit "5."

61. In August 2003, DPW cited Holland-Glen for numerous regulatory violations, including failure to evacuate the Hatboro nursing facility within the required time. On the cited occasion, even twelve minutes after the fire alarm sounded, Holland-Glen still had failed completely to evacuate the building. A copy of DPW's inspection report is attached hereto as Exhibit "6."

62. In September 2003, DPW refused to renew Holland-Glen's license for the Hatboro nursing facility because Holland-Glen had repeatedly failed to comply with licensing requirements. A copy of the letter from DPW to William Schlacter is attached hereto as Exhibit "7."

63. In November 2003, a DPW inspection revealed that Holland-Glen, at the Hatboro nursing facility, had continued to violate medication administration requirements.

64. In February 2004, while Holland-Glen's appeal of the non-renewal of its license for the Hatboro nursing facility was pending, DPW inspected the facility. Based on that inspection, DPW cited Holland-Glen for the serious regulatory violation of deficient medication logs. A copy of DPW's inspection report is attached hereto as Exhibit "8."

65. In March 2004, DPW inspected the Hatboro nursing facility. Based on that inspection, DPW cited Holland-Glen for incorrectly labeling dosage on a resident's medication (cited as "repeated non-compliance"). A copy of DPW's inspection report is attached hereto as Exhibit "9."

66. In July 2004, Holland-Glen and DPW entered into a Settlement Agreement to resolve Holland-Glen's appeal of the non-renewal of its license for the Hatboro nursing facility. Under that agreement, Holland-Glen was required to "**respond to all ventilator and pulse oximetry alarms in a timely and appropriate fashion in accordance with acceptable medical standards and practices.**" A copy of the Settlement Agreement is attached hereto as Exhibit "10."

67. Among other terms agreed to in the July 2004 settlement were DPW's requirements that Holland-Glen:

a. provide to DPW monthly reports documenting resident care episodes at the Hatboro nursing facility, including those relating to ventilator and/or pulse oximetry alarms, and make corresponding notes in resident charts pursuant to standard medical practices; and

b. maintain a sufficient number of staff and have a supervisory nurse (without direct resident care responsibility) present at all times at the Hatboro nursing facility. See Exhibit "10."

68. In November 2004, DPW inspected the Hatboro nursing facility. Based on that inspection, DPW cited Holland-Glen for serious regulatory violations including: (a) failure to administer physician-ordered medication (cited as "repeated non-compliance"); and (b) incorrectly labeling dosage on a resident's medication (cited as "repeated non-compliance"). A copy of the inspection report is attached hereto as Exhibit "11."

69. In March 2005, DPW inspected the Hatboro nursing facility. Based on that inspection, DPW cited Holland-Glen for several regulatory violations.

70. In October 2005, DPW made a "preliminary determination to nonrenew" Holland-Glen's group home license for the Hatboro nursing facility. See Exhibit "12" hereto. DPW grounded this determination upon the following allegations:

a. Holland-Glen, in attempting to have its license renewed, had fraudulently misrepresented facts concerning employee criminal background checks and employee training; and

b. DPW inspectors had found 14 regulatory violations, two of which were repeat violations.

71. On December 20, 2005, DPW inspected the Hatboro nursing facility. Based on that inspection, DPW cited Holland-Glen for serious regulatory violations, including: (a) failure to document criminal history records checks and child abuse checks when hiring staff; and (b) omissions in medication logs. A copy of the inspection report is attached hereto as Exhibit "13."

72. In April 2006, following Holland-Glen's appeal of DPW's "preliminary determination to nonrenew" Holland-Glen's license for the Hatboro nursing facility, the company entered into a second Settlement Agreement with DPW, which remained effective until April 2007. A copy of the Settlement Agreement is attached hereto as Exhibit "14."

73. The Commonwealth of Pennsylvania has continued to find violations at Holland-Glen's Hatboro nursing facility. On April 9, 2007 and May 10, 2007, DPW conducted unannounced inspections of the facility. Based on those inspections, DPW cited Holland-Glen for serious regulatory violations including: (a) the failure of staff to attend to four children who had been left in a day room; (b) unsanitary conditions; and (c) gaps and omissions in medical records. See Exhibit "15."

VIII. HOLLAND-GLEN IS SUBJECT TO QUALITY OF CARE STANDARDS

74. Holland-Glen is a Medicaid provider, receiving payment from Medicaid funds for its services to residents of the Hatboro nursing facility. By accepting Medicaid funds and voluntarily becoming a Medicaid provider, Holland-Glen agrees to comply with all Medicaid requirements.

75. Providers such as Holland-Glen may not submit Medicaid claims for services that are "of a quality which fails to meet professionally recognized standards of health care." 42 U.S.C. § 1320a-7(b)(6)(B); 42 U.S.C. § 1320c-5.

76. Holland-Glen, as a nursing facility, is required to comply with the Federal Nursing Home Reform Act and applicable regulations.

77. The Federal Nursing Home Reform Act provides that " [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." 42 U.S.C. § 1396r(d)(4)(A).

78. The Federal Nursing Home Reform Act further states that "[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).

79. That Act also provides that 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[.]" 42 U.S.C. § 1396r(b)(2).

80. Holland-Glen, because its Hatboro nursing facility is a "long-term care facility," is required to provide nursing services there that meet the needs of the facility's residents. Among such required services are "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; see also 28 Pa. Code § 211.12(a).

COUNT I:
INJUNCTION AGAINST FRAUD (18 U.S.C. § 1345)

81. Plaintiffs incorporate by references as if fully set forth herein at length the averments in Paragraphs 1 through 80 of this Complaint.

82. Defendant fails to provide adequate care to the residents of the Hatboro nursing facility, and it continues to submit claims to the United States and the Commonwealth of Pennsylvania for care that in fact is so inadequate or deficient as to constitute worthless services.

83. Defendant uses the United States mails and/or wires to bill for services to residents of the Hatboro nursing facility and to receive payment for those services.

84. Defendant devised and continues to perpetrate a scheme to defraud the United States of America and the Commonwealth of Pennsylvania by billing for worthless services as if the services had been provided and are being provided in full at the Hatboro nursing facility and in accordance with accepted standards of care.

85. Defendant engaged and is engaging in a scheme and artifice to defraud by: (a) falsely representing that the required care, services, and environment would be provided to residents of the Hatboro nursing facility; (b) failing to provide the required care, services and environment; and (c) falsely representing that the required care, services and environment are being provided.

86. Defendant defrauded and is defrauding a health care benefit program and obtained and is obtaining by means of false or fraudulent pretenses, representations, or promises money owned by or under the custody or control of a health care benefit program.

87. Defendant, in a matter involving a health care benefit program, knowingly and willfully falsified and is falsifying, concealed and is concealing, and/or covered up and is covering up by trick, scheme or device a material fact or made and is making materially false, fictitious or fraudulent statements or representations, or made and is making or used and is using materially false writings or documents, knowing the same to contain materially false, fictitious or fraudulent statement(s) or entry(ies) in connection with the delivery of or payment for health care benefits, items or services.

88. Defendant is perpetrating an ongoing violation of the mail fraud statute (18 U.S.C. § 1341), the wire fraud statute (18 U.S.C. § 1343), the health care fraud statute (18 U.S.C. § 1347), and the health care false statements statute (18 U.S.C. § 1035).

89. Defendant, knowing that it engaged in and is engaging in or enabled and is enabling the fraudulent schemes described above, committed and is committing the acts alleged in this Complaint.

90. Unless the Court restrains it, defendant will continue to engage in the conduct and practices set forth above, to the detriment of the residents at the Hatboro nursing facility, the United States, and the Commonwealth of Pennsylvania.

COUNT II:
INJUNCTION TO ENJOIN CONDUCT SUBJECT TO A CIVIL MONETARY PENALTY (42 U.S.C. § 1320A-7A(k))

91. Plaintiffs incorporate by references as if fully set forth herein at length the averments in Paragraphs 1 through 90 of this Complaint.

92. The defendant, knowing that it engaged in or enabled the fraudulent schemes described above, committed the acts alleged in this Complaint.

93. Defendant is perpetrating ongoing violations that subjects it to civil monetary penalties under 42 U.S.C. § 1320a-7a(a).

94. Unless the Court restrains it, defendant will continue to engage in the conduct and practices set forth above, to the detriment of residents at the Hatboro nursing facility, the United States, and the Commonwealth of Pennsylvania.

COUNT III:
INJUNCTION FOR VIOLATION OF DPW REGULATIONS

95. Plaintiffs incorporate by reference as if fully set forth herein at length the averments in Paragraphs 1 through 94 of this Complaint.

96. Holland-Glen continues seriously to violate applicable DPW standards.

97. A single such violation is sufficient to warrant denial or revocation of a license.

98. Because the denial of a license may work a hardship, DPW can obtain injunctive relief pursuant to 62 P.S. §§ 1052 and 1053 requiring that violations be remedied.

99. Unless this Court restrains it, defendant will continue to engage in the conduct and practices set forth above, to the detriment of the residents at the Hatboro nursing home, the United States, and the Commonwealth of Pennsylvania.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs United States of America and Commonwealth of Pennsylvania, Department of Public Welfare, pray that this Court enter an Order or Orders:

A. Enjoining defendant, its agents, subordinates, successors in office, and all those acting in concert or participation with them from continuing the acts, practices and omissions set forth above and billing for the acts, practices and omissions set forth above;

B. Enjoining defendant, its agents, subordinates, successors in office, and all those acting in concert or participation with them from acting and/or from failing to act in a manner that violates generally accepted professional standards and from billing for any acts or omissions in violation of generally accepted professional standards;

C. Enjoining defendant, its agents, subordinates, successors in office, and all those acting in concert or participation with them from acting and/or from failing to act in a manner that violates the Federal Nursing Home Reform Act and its regulations and from billing for any acts or omissions in violation of the Federal Nursing Home Reform Act and its regulations;

D. Enjoining defendant, its agents, subordinates, successors in office, and all those acting in concert or participation with them from acting and/or from failing to act in a manner that violates the licensing standards of DPW and from billing for any acts or omissions in violation of the licensing standards of DPW;

E. Enjoining defendant, its agents, subordinates, successors in office, and all those acting in concert or participation with them from altering, destroying, hiding and/or disposing of any record(s) relating to the subject matter of this Complaint, including but not limited to any patient record(s), billing record(s), incident report(s), investigation report(s), staffing schedule(s), equipment and facility inspection record(s), plan(s) for correction, quality report(s), evacuation plan(s), calendar(s), letter(s), and/or complaint(s), whether in document, electronic, or other form;

F. Requiring that defendant substitute current management with a Court-approved temporary manager to run the Hatboro nursing facility to ensure the safety and well being of residents there;

G. Requiring that defendant hire a monitor to ensure that the Hatboro nursing facility is in compliance with generally accepted medical practices and the Federal Nursing Home Reform Act and its regulations; and

H. Granting such other and further equitable relief as Court may deem just and proper.

Respectfully submitted,

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