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Exempt from filing fees pursuant to Government Code section 6103

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SAN DIEGO

THE PEOPLE OF THE STATE OF CALIFORNIA, Plaintiff, **v.** **SWEETWATER CARE OPCO, LLC; SWEETWATER CARE RESOURCE, LLC; SWEETWATER YV CHOLLA OPCO, LLC; SWEETWATER YV JOSHUA OPCO, LLC; SWC CA OPCO, LLC; SWC CA OPCO 2, LLC; AJC HEALTHCARE, LLC; JBG PARTNERS, LLC; ALMOND VIEW CARE CENTER, LLC; BROOKSIDE CARE CENTER, LLC; EVERGREEN CARE CENTER, LLC; FEATHER RIVER CARE CENTER, LLC; FOWLER CARE CENTER, LLC; GRAND OAKS CARE, LLC; VINDRA, INC.; NOBLE CARE CENTER, LLC; ORCHARDS AT TULARE, LLC; PALMS CARE CENTER, LLC; RANCHO SECO CARE CENTER, LLC; RIVERWALK CARE**	Case No.: 25CU033612N ~~[PROPOSED]~~ ORDER GRANTING ENTRY OF STIPULATED FINAL JUDGMENT Dept: 28 Judge: Hon. Daniel Segura [STIPULATION FOR ENTRY OF FINAL JUDGMENT Filed Concurrently Herewith]

CENTER, LLC; ROLLING HILLS CARE CENTER, LLC; GATEWAY CARE, LLC; SHASTA VIEW CARE CENTER, LLC; VALLEY VIEW CARE CENTER, LLC; VINEYARDS AT FOWLER, LLC; AARON CHESLEY; JAMES GAMETT; AND DOES 1 THROUGH 300, INCLUSIVE,

Defendants.

Having fully considered Plaintiff's and Defendants' Stipulation for Entry of Final Judgment and the proposed Stipulated Final Judgment, this Court hereby finds:

WHEREAS, on June 23, 2025, Plaintiffs, the People of the State of California, filed a Complaint for Permanent Injunction, Civil Penalties, Restitution, and Other Equitable Relief pursuant to California Business and Professions Code, §§ 17200, 17500 *et seq.* against defendants Sweetwater Care Opco, LLC, Sweetwater Care Resource, LLC; Sweetwater YV Cholla OPCO, LLC; Sweetwater YV Joshua OPCO, LLC; SWC CA OPCO, LLC; SWC CA OPCO 2, LLC; AJC Healthcare, LLC; JBG Partners, LLC; Almond View Care Center, LLC; Brookside Care Center, LLC; Evergreen Care Center, LLC; Feather River Care Center, LLC; Fowler Care Center, LLC; Grand Care Oaks Care, LLC; Vindra, Inc.; Noble Care Center, LLC; Orchards at Tulare, LLC; Palms Care Center, LLC; Rancho Seco Care Center, LLC; Riverwalk Care Center, LLC; Rolling Hills Care Center, LLC; Gateway Care, LLC; Shasta View Care Center, LLC; Valley View Care Center, LLC; Vineyards at Fowler, LLC, Aaron Chesley, James Gamett, and Does 1 through 300;

WHEREAS, Defendants filed demurrers on August 29, 2025, which the Court overruled on October 24, 2025;

WHEREAS, the People moved for a preliminary injunction against Defendants on September 8, 2025, which the Defendants opposed. The Court heard oral arguments on the People's preliminary injunction motion on December 19, 2025, and requested the Parties submit additional briefing by January 23, 2026;

WHEREAS, the Parties agreed to toll the court's ruling on the People's preliminary injunction motion pending formal mediation;

WHEREAS, the Parties attended multiple mediation sessions with the Honorable Herbert Hoffman (retired), resolved their disputes, and reduced their agreement to a Stipulated Final Judgment, which was signed by counsel for the Parties;

WHEREAS, the Parties agreed that the Stipulated Final Judgment shall be entered as an order of this Court;

WHEREAS, the Stipulated Final Judgment contains time sensitive settlement conditions that affect healthcare for thousands of vulnerable skilled nursing facility residents, and is the product of arms-length negotiations between the People and Defendants.

Good cause appearing therefore, the Court hereby **GRANTS** the Parties' request for Entry of Stipulated Final Judgment.

THEREFORE, IT IS ORDERED that the Stipulated Final Judgment attached to this Order as **Exhibit 1** is hereby entered as an Order of the Court and as final judgment in this matter.

IT IS FURTHER ORDERED that:

1. The Honorable Herbert Hoffman (retired) is hereby appointed Special Master with the authority specifically enumerated in paragraph 34 of the Stipulated Final Judgment.
2. The Court retains jurisdiction over this matter pursuant to Code of Civil Procedure section 664.6 to enforce the Stipulated Final Judgment until full performance of all terms, including completion of the monitoring period and any required remedial measures.
3. This matter is hereby dismissed without prejudice as to Defendants Sweetwater Care OPCO, LLC; AJC Healthcare LLC; JBG Partners, LLC; Aaron Chesley; and James Gamett pursuant to stipulation of the parties at paragraph 6 of the Stipulated Final Judgment.

IT IS SO ORDERED.

DATED: 7/20/2026

Honorable Daniel Segura
Judge of the Superior Court

EXHIBIT 1

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Attorney General of California
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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN DIEGO

THE PEOPLE OF THE STATE OF CALIFORNIA, Plaintiff, **v.** **SWEETWATER CARE OPCO, LLC; SWEETWATER CARE RESOURCE, LLC; SWEETWATER YV CHOLLA OPCO, LLC; SWEETWATER YV JOSHUA OPCO, LLC; SWC CA OPCO, LLC; SWC CA OPCO 2, LLC; AJC HEALTHCARE, LLC; JBG PARTNERS, LLC; ALMOND VIEW CARE CENTER, LLC; BROOKSIDE CARE CENTER, LLC; EVERGREEN CARE CENTER, LLC; FEATHER RIVER CARE CENTER, LLC; FOWLER CARE CENTER, LLC; GRAND OAKS CARE, LLC; VINDRA, INC.; NOBLE CARE CENTER, LLC; ORCHARDS AT TULARE, LLC; PALMS CARE CENTER, LLC; RANCHO SECO CARE CENTER, LLC; RIVERWALK CARE**	Case No.: 25CU033612N **STIPULATED FINAL JUDGMENT**

CENTER, LLC; ROLLING HILLS CARE CENTER, LLC; GATEWAY CARE, LLC; SHASTA VIEW CARE CENTER, LLC; VALLEY VIEW CARE CENTER, LLC; VINEYARDS AT FOWLER, LLC; AARON CHESLEY; JAMES GAMETT; AND DOES 1 THROUGH 300, INCLUSIVE,

Defendants.

Based upon the stipulation of the Parties, the COURT HEREBY ENTERS JUDGMENT AS FOLLOWS:

1. Plaintiff, the PEOPLE OF THE STATE OF CALIFORNIA, appear herein through their attorneys, Rob Bonta, Attorney General of California, Jennifer Euler, Chief Assistant Attorney General, Meghan Anderson, Acting Senior Assistant Attorney General, Jennifer Turner, Supervising Deputy Attorney General, Deputy Attorneys General Tim Vanden Heuvel, Anna Molander, Jeffrey Darnell, Lili Graham and Jacob Smith.

2. Defendants, identified below, appear herein through their counsel of record, Hooper, Lundy, & Bookman, P.C.

3. Plaintiff and Defendants (hereinafter, "PARTIES") have stipulated that this *Stipulated Final Judgment* (hereinafter, "FINAL JUDGMENT") may be entered without trial or further adjudication in settlement of disputed claims between them as alleged in the Complaint.

Accordingly, IT IS HEREBY ORDERED, ADJUDGED, and DECREED AS FOLLOWS:

PARTIES

4. The People of the State of California (hereinafter, the "PEOPLE" or "PLAINTIFF") are the Plaintiff in this case. The People of the State of California have filed a complaint alleging conduct in violation of Business and Professions Code sections 17200 and 17500, which is incorporated by reference here as though fully set forth.

5. The Defendants are SWEETWATER CARE RESOURCE, LLC; SWEETWATER YV CHOLLA OPCO, LLC; SWEETWATER YV JOSHUA OPCO, LLC; SWC CA OPCO, LLC; SWC CA OPCO 2, LLC;ALMOND VIEW CARE CENTER, LLC; BROOKSIDE CARE

CENTER, LLC; EVERGREEN CARE CENTER, LLC; FEATHER RIVER CARE CENTER, LLC; FOWLER CARE CENTER, LLC; GRAND OAKS CARE, LLC; VINDRA, INC.; NOBLE CARE CENTER, LLC; ORCHARDS AT TULARE, LLC; PALMS CARE CENTER, LLC; RANCHO SECO CARE CENTER, LLC; RIVERWALK CARE CENTER, LLC; ROLLING HILLS CARE CENTER, LLC; GATEWAY CARE, LLC; SHASTA VIEW CARE CENTER, LLC; VALLEY VIEW CARE CENTER, LLC; VINEYARDS AT FOWLER, LLC; AND DOES 1 THROUGH 300 (hereinafter collectively, "DEFENDANTS").

6. Defendants SWEETWATER CARE OPCO, LLC; AJC HEALTHCARE, LLC; JBG PARTNERS, LLC; AARON CHESLEY; and JAMES GAMETT will be dismissed without prejudice upon entry of the FINAL JUDGMENT.

7. The SWEETWATER FACILITIES are (1) ALMOND VIEW CARE CENTER, LLC, dba Almond View Care Center (1224 E. Street, Williams, California); (2) BROOKSIDE CARE CENTER, LLC dba Brookside Care Center (1221 Rosemarie Lane, Stockton, California); (3) EVERGREEN CARE CENTER, LLC, dba Evergreen Care Center (5265 E. Huntington Avenue, Fresno, California); (4) FEATHER RIVER CARE CENTER, LLC, dba Feather River Care Center (1 Gilmore Lane, Oroville, California); (5) FOWLER CARE CENTER, LLC, dba Fowler Care Center (8448 E. Adams Avenue, Fowler, California); (6) GRAND OAKS CARE, LLC, dba Grand Oaks Care Center (897 North M Street, Tulare, California); (7) VINDRA, INC. dba Meadowood Nursing Center (3805 Dexter Lane, Clear Lake, California); (8) NOBLE CARE CENTER, LLC, dba Noble Care Center (2740 N. California Street, Stockton, California); (9) ORCHARDS AT TULARE, LLC, dba Orchards at Tulare (604 East Merritt Avenue, Tulare, California); (10) PALMS CARE CENTER, LLC dba Palms Care Center (1010 Ventura Avenue, Chowchilla, California); (11) RANCHO SECO CARE CENTER, LLC dba RANCHO SECO CARE CENTER (144 F Street, Galt, California); (12) RIVERWALK CARE CENTER, LLC, dba Riverwalk Care Center (1100 West Morton Avenue, Porterville, California); (13) ROLLING HILLS CARE CENTER, LLC, dba Rolling Hills Care Center (2108 Stillman Street, Selma, California); (14) GATEWAY CARE, LLC dba Sequoia Vista Care Center (3710 West Tulare Avenue, Visalia, California); (15) SHASTA VIEW CARE CENTER, LLC dba Shasta View Care

Center (1795 Walnut Street, Red Bluff, California); (16) VALLEY VIEW CARE CENTER, LLC dba Valley Care Center (729 Browning Road, Delano, California); (17) VINEYARDS AT FOWLER, LLC dba Vineyards at Fowler (1306 East Sumner Avenue, Fowler, California); and any other skilled nursing facility ("SNF") licensed to, or operated by, any DEFENDANT in the State of California, including, but not limited to, any SNF which is hereinafter licensed to, or acquired by, an entity owned in whole or part by any DEFENDANT, during the course of the MONITORING PERIOD, as defined below.

8. The injunctive terms herein further apply to DEFENDANTS set forth in paragraph 5 and to all aiders and abettors, subsidiaries, agents, servants, employees, representatives, officers, directors, managers, and specifically administrative service companies and Limited Partnership or Limited Liability Company managers, successors, and any corporation, limited liability company, partnership, or any other entity or organization which controls, owns, manages, is licensed, or operates the SWEETWATER FACILITIES (collectively, "ENJOINED PARTIES").

JURISDICTION AND VENUE

9. This civil law enforcement action is brought by PLAINTIFF in the public interest under the laws of the State of California. The San Diego County Superior Court has jurisdiction of the subject matter hereof and of the PARTIES hereto and is a proper venue for this action.

FINAL INJUNCTION

10. Pursuant to Business and Professions Code sections 17203 and 17535, all ENJOINED PARTIES are hereby enjoined and precluded from failing to comply with Federal or California laws and regulations, applicable to SNFs in California, as expressly and specifically set forth herein. ENJOINED PARTIES are hereby enjoined and precluded from failing to provide adequate staffing in accordance with applicable state and federal regulatory and statutory requirements regarding the levels at which a skilled nursing facility must provide staffing including, but not limited to, Health & Safety Code sections 1276.65 and 1599.1; California Code of Regulations, title 22, sections 72329, 72329.2, 72501, and 72527, subdivision (a)(24); 42 Code of Federal Regulations parts 483.35 and 483.70; and Title 42 United States Code section 1396r(b)(2).

11. Specifically included in the above term of injunction, but not limited to, are the legal requirements that:

A. At no time may SWEETWATER FACILITIES' staffing levels be less than 3.5 direct care service hours per patient day with a minimum of 2.4 hours per patient day for certified nurse assistants (as that and related terms are defined in Health & Safety Code section 1276.65) unless a SWEETWATER FACILITY is subject to a staffing or patient need waiver as granted by the California Department of Public Health;

B. SWEETWATER FACILITIES shall employ and schedule additional staff to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant state and federal staffing requirements as required by Health & Safety Code section 1276.65, 42 Code of Federal Regulations parts 483.35 and 483.70(e);

C. SWEETWATER FACILITIES shall provide at least 8 hours per day of registered nurse hours as required by 42 U.S.C. §1395i-3 and 42 Code of Federal Regulations part 483.35 and Health & Safety Code section 1276.65(d);

D. DEFENDANTS shall truthfully and accurately represent the number of direct care service hours worked by staff of any SWEETWATER FACILITY to the office of the Attorney General, the COMPLIANCE MONITOR, or to state or federal agencies including, but not limited to, the Centers for Medicare & Medicaid Services, California Department of Public Health, California Department of Health Care Services, or California Department of Health Care Access and Information;

E. DEFENDANTS shall comply with the Payroll Based Journal (PBJ) requirements in 42 Code of Federal Regulations part 483.70(p);

F. SWEETWATER FACILITIES shall provide sufficient staffing in number, competence, and supervision to ensure the provision of quality nursing services as required by California Code of Regulations, title 22, section 72311;

G. SWEETWATER FACILITIES shall not operate in such a manner that licensed vocational nursing staff of SWEETWATER FACILITIES practice outside the scope

of vocational nursing practice as required by California Code of Regulations, title 16, section 2518.5;

H. SWEETWATER FACILITIES shall not operate in such a manner that certified nurse assistants, licensed vocational nurses, or other personnel who are not licensed registered nurses provide care or services to patients which can only be provided by a registered nurse in accordance with California Code of Regulations, title 16, section 1443.5;

I. SWEETWATER FACILITIES shall report incidents that reasonably appear to be physical abuse, sexual abuse, abandonment, isolation, financial abuse, neglect, or reports by elder or dependent adults of such incidents as required by Welfare and Institutions Code section 15630.

12. The injunctive terms of this FINAL JUDGMENT ("FINAL INJUNCTION") will expire 90 days from the issuance of the final report of the COMPLIANCE MONITOR ("MONITORING PERIOD"). The PARTIES will jointly notify the Court of the expiration of the FINAL INJUNCTION.

13. The terms of this FINAL INJUNCTION shall commence no later than ninety (90) days following this Court's entry of this FINAL JUDGMENT.

14. At any time, the PEOPLE may, for good cause shown, move to modify the terms of the FINAL INJUNCTION to add or modify terms.

COMPLIANCE MONITOR

15. The PARTIES selected Christopher Cherney, of Skilled Review Consulting, LLC ("COMPLIANCE MONITOR") to monitor the provisions of this FINAL JUDGMENT and the DEFENDANTS' compliance requirements herein. The COMPLIANCE MONITOR will carry out its duties as described in this stipulated FINAL JUDGMENT. The COMPLIANCE MONITOR will carry out the scope of monitoring as defined herein and will proceed to monitor DEFENDANTS as set forth in this FINAL JUDGMENT.

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16. DEFENDANTS shall retain the COMPLIANCE MONITOR selected by the PEOPLE, to monitor compliance with this FINAL INJUNCTION during the MONITORING PERIOD.

17. If during the term of the MONITORING PERIOD, the COMPLIANCE MONITOR becomes unable to perform the obligations set out herein or if the PEOPLE, in their sole discretion, determine that the COMPLIANCE MONITOR cannot fulfill such obligations to the PEOPLE's satisfaction, which determination and the reasons set forth shall be set forth in writing to the DEFENDANTS, the PEOPLE shall notify the DEFENDANTS of a replacement COMPLIANCE MONITOR, who shall be retained by DEFENDANTS.

18. The COMPLIANCE MONITOR's contract will be provided to the PEOPLE prior to its execution and effective date and is subject to approval by the PEOPLE, who may, in their sole discretion, approve or reject such contract.

19. The COMPLIANCE MONITOR shall be on-site at the SWEETWATER FACILITIES at least one calendar day per quarter during the MONITORING PERIOD to conduct monitoring activities related to the subject of the FINAL INJUNCTION. In addition, the COMPLIANCE MONITOR shall retain the ability to be on-site at the SWEETWATER FACILITIES, office of SWEETWATER CARE RESOURCE, LLC, or any other RELATED PARTY[1] relevant to the scope of financial monitoring during the course of the MONITORING PERIOD to conduct monitoring and audit services within the scope of monitoring as set forth in this FINAL JUDGMENT and may otherwise conduct desk audits at any time during the

[1] "RELATED PARTY" is defined as stated in 42 C.F.R. Section 413.17(b), and means that the "provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies." "Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or the organization serving the provider." "Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution." Pursuant to 42 C.F.R Section 424.502, affiliate "means any of the following: (1) A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization. (2) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization. (3) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of this paragraph (3), sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization. (4) An interest in which an individual is acting as an officer or director of a corporation. (5) Any reassignment relationship . . ."

MONITORING PERIOD as necessary to carry out the COMPLIANCE MONITORING as required by this FINAL JUDGMENT.

20. DEFENDANTS represent and warrant to the Court and the PEOPLE that they will take no action to impede, mislead, interfere with, or otherwise circumvent the performance of duties or responsibilities of any individual or entity pursuant to this FINAL JUDGMENT.

MONITORING FRAMEWORK

21. The COMPLIANCE MONITOR shall monitor the SWEETWATER FACILITIES for compliance with the terms of this FINAL JUDGMENT. In addition, the COMPLIANCE MONITOR shall monitor the SWEETWATER FACILITIES and shall determine which expenditures will reduce the DEFENDANTS' COMPLIANCE SPENDING OBLIGATION in accordance with the criteria set forth below. The DEFENDANTS shall pay the fees and costs of the COMPLIANCE MONITOR during the MONITORING PERIOD.

22. Compliance Monitoring Methodology

a. The COMPLIANCE MONITOR and the Attorney General shall have access to all SWEETWATER FACILITIES and DEFENDANTS' records and employees during the MONITORING PERIOD for the purpose of monitoring compliance with this FINAL JUDGMENT entered into by the PARTIES and approved by the Court. This includes real-time access to electronic staffing and health dashboards as well as all relevant records including but not limited to PointClickCare. DEFENDANTS shall not block the COMPLIANCE MONITOR or Attorney General's access to patients at SWEETWATER FACILITIES. The COMPLIANCE MONITOR shall monitor DEFENDANTS' compliance with laws and regulations as set forth in this FINAL JUDGMENT.

b. Patient Care Focus Areas: The DEFENDANTS shall ensure that all patients receive the following care measures, all of which shall be recorded in the patient's medical records, reported quarterly, and auditable through patient interviews, medical record review, and COMPLIANCE MONITOR oversight:

i. Resident Repositioning: All residents with actual skin breakdown or "at risk" for skin breakdown based on MDS and/or skin care assessments, shall be turned and repositioned at least Q2 hours, unless contraindicated, and documented on the Activities of Daily Living "ADL" Flowsheet. In the first 90 days of compliance monitoring, the Attorney General shall take no action on noncompliance, unless the noncompliance is pervasive and life threatening.

ii. Full Body Checks: Residents with actual skin breakdown or who are at risk for skin breakdown shall receive full body checks at least once per day as documented on the Treatment Admission Record "TAR". In the first 90 days of compliance monitoring, the Attorney General shall take no action on noncompliance, unless the noncompliance is pervasive and life threatening.

iii. Resident Bathing: Residents who are able to receive showers shall be showered or bathed at least two times per week and documented on ADL Flowsheets.

iv. Appropriate Fluid Intake: Residents with dehydration, or identified to be at risk for dehydration, shall have a request to their physician for an order to be offered fluids three times daily, and, if ordered, shall be documented on the Medication Administration Record "MAR". In the first 90 days of compliance monitoring, the Attorney General shall take no action on noncompliance, unless the noncompliance is pervasive and life threatening.

v. Dental Evaluations: DEFENDANTS shall make reasonable efforts to secure residents' dental evaluations at least annually, and identified needs shall be addressed in a timely manner. Documentation of completed dental evaluations shall be noted in the patient electronic health record.

vi. Prompt Reporting of Suspected Incidents of Abuse: All suspected incidents of resident abuse shall be reported within the same periods as verified incidents of resident abuse, and in compliance with Welfare and Institutions Code section 15630.

c. Selected Quality Measures: In addition to the above-described Patient Care Focus Areas, the following Quality Measures (QMs) from the long-stay domain shall be subject to quarterly reporting by DEFENDANTS during the MONITORING PERIOD. These measures are selected because they most directly reflect resident care quality and staffing sufficiency:

i. Falls with Major Injury: Percentage of long-stay residents experiencing one or more falls with major injury.

ii. Pressure Ulcers (risk-adjusted): Percentage of long-stay residents with pressure ulcers.

iii. Urinary Tract Infections: Percentage of long-stay residents with a urinary tract infection.

iv. Catheter Use (risk-adjusted): Percentage of long-stay residents with a catheter inserted and left in their bladder.

v. Decline in ADL Function: Percentage of long-stay residents whose need for help with daily activities has increased.

vi. Antipsychotic Medication Use: Percentage of long-stay residents who received an antipsychotic medication.

vii. Decline in Mobility (risk-adjusted): Percentage of long-stay residents whose ability to walk independently worsened.

viii. Hospitalizations per 1,000 Days: Number of hospitalizations per 1,000 long-stay resident days (risk-adjusted).

ix. ED Visits per 1,000 Days: Number of emergency department visits per 1,000 long-stay resident days (risk-adjusted).

d. Reporting Protocol

i. CMS Five-Star Report Submission: DEFENDANTS will submit each SWEETWATER FACILITY'S CMS Provider Rating Report (the "Five-Star Report") to the COMPLIANCE MONITOR and Attorney General upon receipt from CMS.

ii. Breach of Reporting Protocol: Failure to follow the Reporting Protocol constitutes good cause to extend the monitoring period subject to approval by the Court.

iii. COMPLIANCE MONITOR Quarterly Reports: The COMPLIANCE MONITOR shall draft a quarterly report on DEFENDANTS' compliance with the terms of this monitoring protocol and the stipulated FINAL JUDGMENT, by written report to the Attorney General and copy to DEFENDANTS' counsel of record. Reports may be drafted on a per facility, or aggregated basis, at the discretion of the COMPLIANCE MONITOR.

iv. Resident Grievances and Complaints. The DEFENDANTS shall allow the COMPLIANCE MONITOR to review, track, and evaluate all resident grievances and complaints submitted to, or that come to the attention of, the COMPLIANCE MONITOR. The SWEETWATER FACILITIES shall further provide the COMPLIANCE MONITOR with timely, unredacted access to their grievance and/or complaint logs who shall further be permitted to conduct interviews of residents, resident representatives, and staff as appropriate. The DEFENDANTS shall not interfere with or retaliate against any person participating in the PEOPLE'S monitoring. The COMPLIANCE MONITOR shall not interfere with clinical decision-making but may seek all relevant information related to grievance or complaint.

e. Staff Training: DEFENDANTS shall develop and implement appropriate protocols that relate to the terms of this FINAL JUDGMENT, Patient Care Focus Areas, and QMs. Staff who have direct patient care responsibilities shall receive appropriate training on all protocols that relate to the terms of this FINAL JUDGMENT, Patient Care Focus Areas, and QMs. This training is in addition to and shall not replace any other training or professional education required by law or regulation. Inservice documentation establishing completion of annual training as required in this action shall be provided to the COMPLIANCE MONITOR.

f. Monitoring Termination

i. Monitoring Period. The length of the MONITORING PERIOD, as set forth *infra*, may be modified as provided in this Paragraph 22(f). The Court shall have the authority to extend the MONITORING PERIOD for good cause shown.

ii. Facility Graduation Criteria: At the sole discretion of the Attorney General, facilities exhibiting conditions such as no days below the California-required NHPPD minimum staffing levels, no significant acuity violations, and no class A or AA citations for a consecutive period of eight quarters may graduate from monitoring, subject to re-entry as described below.

iii. Facility Re-entry Criteria: At the discretion of the Attorney General, a graduated facility may re-enter the monitoring protocol. The COMPLIANCE MONITOR shall retain full access to the facility records of a graduated facility, and may also conduct inspections as appropriate, as directed by the Attorney General.

iv. Final Termination: The MONITORING PERIOD will terminate as provided in Paragraph 23 below, unless extended by the Court for cause, or when all facilities have graduated from the monitoring

protocol consistent with the Facility Graduation Criteria and subject to the Facility Re-entry Criteria, subject to the provisions of this FINAL JUDGMENT.

23. Compliance Spending Obligation

a. The DEFENDANTS shall spend two million five hundred thousand dollars ($2,500,000) on qualified expenditures as determined below (the "COMPLIANCE SPENDING OBLIGATION"). If the DEFENDANTS have not spent $2,500,000 on qualified expenditures at the end of the MONITORING PERIOD, the shortfall is considered to be a delayed penalty and shall be paid to the State of California. The qualified expenses are set forth in further detail below and include (1) qualified expenses related to recruiting, training, and retention; (2) qualified expenses related to staffing and care infrastructure; and (3) qualified incremental wages above the 3.5/2.4 NHPPD minimum staffing wages on days when staffing levels meet CMI Acuity Staffing levels.

b. Recruiting, Training, and Retention: Signing bonuses, continuing education in excess of state requirements, retention bonuses, new hire[2] wage rates above market baseline[3], tuition reimbursement for nursing staff are eligible COMPLIANCE SPENDING OBLIGATION expenditures.

c. Staffing and Care Infrastructure: Attorney General-approved expenses for scheduling technology, staffing management systems, float pool development, agency cost reduction initiatives that support sustained staffing improvements, and certain care-oriented technology (e.g. wander guard technology, technology to prevent falls and prevent wounds) are eligible COMPLIANCE SPENDING OBLIGATION expenditures. Expenditures for registry staff

[2] The term "new hire" shall refer to W-2 regular part-time or full-time nursing staff within their first 12 months of employment.

[3] As indicated by the United States Bureau of Labor Statistics at www.bls.gov.

provided by related-party staffing agencies shall qualify only on approval of the Attorney General.

d. Case-Mix Index Acuity Staffing Methodology: Eligible facilities may claim as qualified COMPLIANCE SPENDING OBLIGATION expenditures wage expenses above those spent to meet their 3.5/2.4 NHPPD obligations that are necessary to meet their Case Mix Index (CMI) acuity staffing level as set forth below.

    i. Case Mix Index: Each facility shall track its Case Mix Index (CMI) and determine its daily acuity staffing needs according to the staffing methodology outlined in the 2025 Harrington and McLaughlin study attached hereto and incorporated herein as Exhibit A. The guide in Section 4 and Table 2 of the Harrington study sets the minimum for CMI Acuity Staffing levels.

    ii. Eligible Wages: Wages paid to direct caregivers to attain 3.5 total nursing and 2.4 nurse aide NHPPD required staffing levels shall not be eligible expenditures. However, hourly wages (exclusive of taxes, benefits, and similar expenses) paid to direct care givers in excess of those required to reach the 3.5/2.4 NHPPD requirements, calculated on a daily basis, shall be eligible expenditures provided that the facility meets its daily acuity staffing requirements according to the staffing methodology outlined in the 2025 Harrington and McLaughlin study attached hereto as Exhibit A.

    iii. Eligibility Requirements: Eligible expenditures include the hourly wages necessary to meet a facility's Case-Mix Index staffing goals for each day that the facility meets this staffing level provided that the facility has also met the 3.5/2.4 NHPPD staffing level for each day in the relevant reporting quarter. Eligibility determination requests shall be submitted on a quarterly basis.

e. Determination of Qualified Expenditures:

i. Application: DEFENDANTS will submit to the COMPLIANCE MONITOR written requests to determine eligible expenditures on a quarterly basis.

ii. Verification: DEFENDANTS shall provide to the COMPLIANCE MONITOR all information the monitor deems necessary to determine whether an expenditure is a qualified expense of the COMPLIANCE SPENDING OBLIGATION. All expenses shall be submitted within 90 days of the close of a given quarter unless the monitor extends this deadline in writing. The DEFENDANTS' refusal or unreasonable delay in providing requested information to the COMPLIANCE MONITOR shall constitute sufficient cause to deny a request for determination of expenditure eligibility.

iii. Determination: Expenditures shall qualify as an expense of the COMPLIANCE SPENDING OBLIGATION only after they are verified and the COMPLIANCE MONITOR determines good cause exists for approval, subject to review and approval by the Attorney General. Within 45 days of submission, the COMPLIANCE MONITOR shall submit a report of its findings of approved expenditures with underlying substantiating documentation to the Attorney General, who shall have until the end of the following quarter to approve or reject any COMPLIANCE MONITOR-approved expenditures.

iv. Review or Rejection of Expenditures: The Court shall retain jurisdiction to review any rejection of expenditures upon a noticed motion.

v. COMPLIANCE MONITOR Fees and Costs: Fees and costs of the COMPLIANCE MONITOR and its staff are qualified expenditures of

the COMPLIANCE SPENDING OBLIGATION. Should the COMPLIANCE SPENDING OBLIGATION be exhausted prior to conclusion of the monitoring period, DEFENDANTS shall pay the COMPLIANCE MONITOR'S fees and costs at the COMPLIANCE MONITOR'S market rate through the duration of the monitoring period.

MONITORING COMPLIANCE

24. The COMPLIANCE MONITOR shall monitor for a period of three years following the Court's acceptance of this FINAL JUDGMENT, pursuant to and subject to modification as set forth in Paragraph 22(f) herein. This Court may, for good cause shown, continue the COMPLIANCE MONITORING beyond the three years or limit the monitoring and/or impose other remedies as authorized by law to ensure compliance with the FINAL INJUNCTION herein. In no event shall the duration of the FINAL INJUNCTION be less than three years. The COMPLIANCE MONITOR shall monitor all SWEETWATER FACILITIES beginning no later than ninety (90) days after the Court's entry of this FINAL JUDGMENT. At the sole discretion of the PEOPLE, subject to approval by the Court, the PEOPLE may elect to shorten the MONITORING PERIOD for any or all DEFENDANTS based on the PEOPLE's unilateral determination of a history of good faith compliance with the terms and requirements of the FINAL INJUNCTION.

25. The COMPLIANCE MONITOR shall, at ENJOINED PARTIES' expense, perform a baseline assessment to evaluate the quality and sufficiency of SWEETWATER FACILITIES' operational practices, staffing levels, and policies and procedures to ensure compliance with the FINAL INJUNCTION, including the MONITORING FRAMEWORK contained herein, according to the following parameters:

a. A quarterly announced or unannounced inspection and additional inspections as needed as determined by the COMPLIANCE MONITOR comprised of site visits to SWEETWATER FACILITIES and/or desk audits of all data and materials required by the

COMPLIANCE MONITOR to ensure compliance with the laws and regulations subject to the FINAL INJUNCTION;

b. Twice-yearly inspections or audits of financial books, records, receipts, and documentation by the COMPLIANCE MONITOR of services provided by a RELATED PARTY[4] to a California SWEETWATER FACILITY are within the permissible scope of such transactions as set forth in the Office of Statewide Health, Planning, and Development "Accounting and Reporting Manual for California Long-Term Care Facilities" and CMS Provider Reimbursement Manual.

26. The COMPLIANCE MONITOR shall prepare quarterly reports on the findings and recommendations arising from monitoring activities conducted at each SWEETWATER FACILITY and/or ENJOINED PARTIES, a copy of which shall then be provided to counsel for the PARTIES. The COMPLIANCE MONITOR shall ensure that reports will not reveal protected health information of any individual patient. The COMPLIANCE MONITOR's reports shall continue on an ongoing, quarterly basis, commencing within 180 days of the Court's acceptance of this FINAL JUDGMENT and shall continue on an ongoing basis unless modified by the Court or until the completion of the MONITORING PERIOD. Should the report contain any observed deficiencies or violations, the DEFENDANTS, through appropriate management personnel, shall meet and confer with the COMPLIANCE MONITOR regarding the observations and suggestions for improvement. The COMPLIANCE MONITOR's reports shall report violations of the FINAL INJUNCTION and suggest compliance methods.

[4] "RELATED PARTY" is defined as stated in 42 C.F.R. Section 413.17(b) and means that the "provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies." "Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or the organization serving the provider." "Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution." Pursuant to 42 C.F.R Section 424.502, affiliate "means any of the following: (1) A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization. (2) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization. (3) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of this paragraph (3), sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization. (4) An interest in which an individual is acting as an officer or director of a corporation. (5) Any reassignment relationship . . ."

27. The COMPLIANCE MONITOR shall have access to all records of the SWEETWATER FACILITIES and any ENJOINED PARTY entity which is involved with the operation, management, service, or control of the SWEETWATER FACILITIES including, but not limited to, *PointClickCare* or other electronic health records or cloud-based or electronic records and ENJOINED PARTIES shall provide passwords and other required credentials to enable full super-user remote access to staffing and patient records, including, but not limited to patient/resident charts, medical records, trust account records, and facility financial records. The COMPLIANCE MONITOR shall also have access to records related to staffing, including, but not limited to X-CHIVE reports, Payroll Based Journal Data, payroll records, Paylocity time detail data, timecard change requests, payroll audit/change reports, Key Factor Reports, Labor Management Reports, and access to any dashboard or electronic data management system which houses real-time or historical staffing data. ENJOINED PARTIES shall provide the COMPLIANCE MONITOR reasonable access to the facilities, residents, and residents' representatives. The COMPLIANCE MONITOR shall be copied on all reports and notices as required herein and as required to be submitted to any public agency or non-profit by law or regulation regarding the conduct of skilled nursing activities in California that in the COMPLIANCE MONITOR's discretion are reasonably necessary to determine compliance with the terms of this FINAL JUDGMENT. The COMPLIANCE MONITOR shall be provided access to facilities on an unannounced basis to engage in impromptu checks to ensure ongoing compliance with the FINAL INJUNCTION terms herein and reduce the need and expense of ongoing supervision. The COMPLIANCE MONITOR shall be provided access to and/or transfer of requested data, constituting financial books, and records, of ENJOINED PARTIES and all RELATED PARTIES upon request during the MONITORING PERIOD, which shall also be provided to the PEOPLE.

28. If the COMPLIANCE MONITOR raises concerns regarding financial operations of any ENJOINED PARTY, the PEOPLE shall be entitled to (a) the general ledger, bank statements, and related documents of the DEFENDANT entities, the SWEETWATER FACILITIES, and all RELATED PARTIES to the SWEETWATER FACILITIES including, but not limited to,

SWEETWATER CARE RESOURCE, LLC, and (b) conduct an onsite inspection at the office of SWEETWATER CARE RESCOURCE, LLC consistent with the scope and terms herein. ENJOINED PARTIES shall comply with the PEOPLE's request.

29. The ENJOINED PARTIES, by and through their employees, officers, directors, representatives, agents, and others, shall cooperate with the COMPLIANCE MONITOR.

30. If any of the ENJOINED PARTIES fail to implement or enforce any aspect of the FINAL JUDGMENT or fail to provide access to ENJOINED PARTIES' records, ENJOINED PARTIES shall be in breach of this FINAL JUDGMENT. The PEOPLE shall notify the ENJOINED PARTY in writing of the breach and that if the breach is not cured within fifteen (15) days of such notice, the PEOPLE may take action to seek enforcement of the FINAL JUDGMENT. In the event of exigent circumstances, the PEOPLE reserve the right to seek judicial intervention prior to expiration of the fifteen day cure period. In such event that ENJOINED PARTIES are in breach of this FINAL JUDGMENT, ENJOINED PARTIES will reimburse the PEOPLE for all reasonable costs of collection and enforcement of this FINAL JUDGMENT, including attorneys' fees and expenses.

31. The COMPLIANCE MONITOR shall maintain confidentiality of records covered by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), California medical privacy laws, and third-party privacy rights, such as employee records and non-public financial records, disclosing them only to COMPLIANCE MONITOR's staff, facility staff, counsel for both PARTIES and their employees, agents and experts, who shall also maintain such confidentiality, except that if the COMPLIANCE MONITOR observes any incident or conduct which constitutes suspected abuse or neglect pursuant to Welfare & Institutions Code section 15630, COMPLIANCE MONITOR may report the incident as though the COMPLIANCE MONITOR is a mandated reporter.

32. Upon request by the COMPLIANCE MONITOR for documents that include access to records privileged under the attorney/client or attorney work product privileges, ENJOINED PARTIES shall promptly identify such records or files so withheld by a privilege log which shall be provided to the COMPLIANCE MONITOR and counsel for the PEOPLE.

33. The COMPLIANCE MONITOR and its staff shall document their activities on an hourly basis and prepare invoices that segregate costs according to each respective facility of ENJOINED PARTIES commensurate with the time allocated to perform duties for the respective skilled nursing facilities ("MONITOR FEES AND COSTS"). Any dispute regarding MONITOR FEES AND COSTS shall first be presented to the COMPLIANCE MONITOR and counsel for the PEOPLE for the purpose of meeting and conferring and, if not resolved, may be presented to this Court upon noticed motion. Pending resolution of the dispute by this court, DEFENDANTS shall continue to make payments for the services of the COMPLIANCE MONITOR. The COMPLIANCE MONITOR's rate shall not exceed its customary rate and shall be consistent with the rate charged by other professionals with similar experience performing such oversight services. The COMPLIANCE MONITOR shall create an annual budget for each calendar year of the MONITORING PERIOD for the projected cost of monitoring all facilities. The COMPLIANCE MONITOR shall not exceed the total budgeted amount without first meeting and conferring with ENJOINED PARTIES and PLAINTIFF. The reasonable cost of the COMPLIANCE MONITOR shall be borne by ENJOINED PARTIES, and the COMPLIANCE MONITOR shall be paid by ENJOINED PARTIES upon presentation of invoices no more frequently than on a monthly basis. Invoices shall be paid within thirty (30) days.

34. Any dispute regarding the COMPLIANCE MONITOR including, but not limited to, the cost, scope, or activities of the COMPLIANCE MONITOR will be presented to Special Master, the Honorable Herbert Hoffman, for a report and recommendation to be submitted to the Court at the ENJOINED PARTIES' sole expense. Should any PARTY object to the Special Master's report and recommendation, either PARTY may move this Court for resolution. Should the PARTIES stipulate to the Special Master's report and recommendation, no motion shall be required. Should the Honorable Herbert Hoffman be unavailable to serve as Special Master, a new Special Master shall be appointed by the PEOPLE.

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35. On or near the annual anniversary of the entry of the FINAL JUDGMENT, the PARTIES shall meet and confer regarding the scope of the monitoring, the financial burden thereof, facility staffing, and the financial resources devoted to meeting required staffing, and other operational and financial issues related to compliance with this FINAL JUDGMENT in this action.

36. Should the COMPLIANCE MONITOR recommend decreased use of registry staff and corresponding increase in regular employee nursing staff to meet patient needs, DEFENDANTS shall make a good faith effort to implement the COMPLIANCE MONITOR's recommendations by exercising good faith efforts to hire full-time employees instead of independent contractors, agency staff, per diem workers, or temporary workers, unless operationally impossible as reported and approved by the PEOPLE. If temporary, per diem, or agency staffing is utilized to comply with staffing requirements, DEFENDANTS will thoroughly document the efforts they undertook to hire full-time and/or part-time employees before resorting to utilizing temporary, agency, or per diem staffing.

37. The PEOPLE retain the right to extend the MONITORING PERIOD as to any SWEETWATER FACILITY or DEFENDANT for any period up to an additional two years from the original three-year term based on the occurrences set forth in subsections (a)-(b) below by stipulation of the PARTIES or approval by the Court. If judicial review is sought and affirmed by the Court in the PEOPLE's favor, including extension of the MONITORING PERIOD, ENJOINED PARTIES will promptly make payment to the PEOPLE, as determined by the Court, for all attorney's fees and costs incurred by the PEOPLE in reviewing, analyzing, negotiating, defending, or otherwise litigating DEFENDANTS' request seeking judicial review at the PEOPLE's customary billing rate. The criteria on which the PEOPLE may extend the MONITORING PERIOD pursuant to this paragraph are:

a. A determination by the PEOPLE that one or more ENJOINED PARTIES has materially failed to comply with any obligation hereunder provided that the PEOPLE notified ENJOINED PARTY(IES) in writing of the material failure to comply and that material failure was not cured within fifteen (15) days of such notice;

b. A finding by the California Department of Public Health of Immediate Jeopardy, Level K and/or L relating to any matter subject to this FINAL JUDGMENT, as to conditions at any SWEETWATER FACILITY, or designation of any SWEETWATER FACILITY as a Special Focus Facility or Special Focus Facility candidate.

MONETARY RELIEF

38. Payment for civil monetary penalties and costs incurred arising from conduct of the DEFENDANTS are hereby awarded to PLAINTIFF against all DEFENDANTS set forth in Paragraph 5 jointly and severally in the amount of twelve million five hundred dollars ($12,500,000). The above payment includes costs and civil money penalties for violations of minimum staffing laws and acuity needs ("PENALTY PAYMENT"). The first payment of two million five hundred thousand dollars ($2,500,000) is due within sixty (60) days of the Court's entry of this FINAL JUDGMENT. The second payment of two million five hundred thousand dollars ($2,500,000) is due within ninety (90) days of the Court's entry of this FINAL JUDGMENT. The third payment of two million five hundred thousand dollars ($2,500,000) is due within one hundred twenty (120) days of the Court's entry of this FINAL JUDGMENT. Thereafter, DEFENDANTS will make equal quarterly payments beginning on October 1, 2026, for the outstanding five million dollars ($5,000,000) of the PENALTY PAYMENT. The remaining payments shall be made according to the following schedule: January 1, 2027, April 1, 2027, July 1, 2027, October 1, 2027, January 1, 2028, April 1, 2028, July 1, 2028, and October 1, 2028, January 1, 2029, April 1, 2029, and July 1, 2029. Late payments will be charged interest at the daily statutory rate.

39. In addition to the payments set forth in Paragraph 38, DEFENDANTS shall spend two million five hundred thousand dollars ($2,500,000), separate from the PENALTY PAYMENT, on qualified expenditures consistent with their COMPLIANCE SPENDING OBLIGATION before the end of the MONITORING PERIOD.

40. Payment pursuant to this FINAL JUDGMENT shall be paid to the Office of the California Attorney General, Department of Justice, care of Supervising Deputy Attorney General Jennifer Turner. Payment shall be made by cashier's check, wire transfer, or other certified funds

payable to the Attorney General, Division of Medi-Cal Fraud and Elder Abuse, care of Supervising Deputy Attorney General Jennifer Turner. Payment of penalties subject to this FINAL JUDGMENT allocated to the State of California shall be paid into the Unfair Competition Law Fund for the exclusive use of the Division of Medi-Cal Fraud and Elder Abuse for the enforcement of consumer protection laws.

41. DEFENDANTS have stipulated that DEFENDANTS, and each of them, have no current intention to file for bankruptcy within 90 days of the due date and/or payment of the PENALTY PAYMENT.

RETENTION OF JURISDICTION AND OTHER TERMS

42. Nothing in the FINAL JUDGMENT is intended to impose a standard lower than that imposed by law, or excuse ENJOINED PARTIES from complying with all applicable laws, regulations, and directives from regulatory agencies and shall not be deemed to relieve ENJOINED PARTIES of the obligation to follow an applicable law, statute, or regulation not referenced herein.

43. Any failure by any party to this FINAL JUDGMENT to insist upon the strict performance by any other party of any of the provisions of this FINAL JUDGMENT shall not be deemed a waiver of any of the provisions of this FINAL JUDGMENT, and such party, notwithstanding such failure, shall have the right to specific performance of any and all of the provisions of this FINAL JUDGMENT.

44. Time is of the essence in the performance of all obligations in this agreement.

45. This FINAL JUDGMENT does not apply to resolve, estop, adjudicate, preclude, or bar any claim for civil, criminal, or administrative liability that any person or entity, including DEFENDANTS, has or may have to the State's Medicaid Program, Medi-Cal (Welf. & Inst. Code, §§ 14000, et seq., 14200 et seq.; 42 U.S.C. Chapter 7, Subchapter XIX), including any such liability to the State's Medicaid Program arising from "managed care entities" as defined by Title 42 U.S.C. section 1396u-2(a)(1)(B), or any other State-funded, public assistance program.

46. This Court retains jurisdiction over this FINAL JUDGMENT and the PARTIES hereto for the purpose of enabling any party to this FINAL JUDGMENT to apply to the Court at

any time for such order or directions as may be necessary or appropriate for the construction of or carrying out of this FINAL JUDGMENT, or for the modification, addition, or termination of any of the provisions of the FINAL INJUNCTION, for good cause shown for appointment of a receiver, or for any other relief the Court deems proper.

47. The PEOPLE may move this Court for additional relief for any violation including, but not limited to contempt, additional injunctive provisions, and the appointment of a receiver. The PEOPLE may file a new action for additional penalties pursuant to Business and Professions Code section 17207 or any other applicable law or remedy. Unless otherwise set forth herein, nothing in the FINAL JUDGMENT shall limit any rights of the PEOPLE to seek any other relief or remedies provided by law including, but not limited to, liability for submission of false claims.

48. During the term of the injunctive terms herein, DEFENDANTS may sell one or more of their licensed facilities and, in addition to compliance with all applicable state and federal statutes and regulations regarding any such sale, DEFENDANTS will notify the PEOPLE through Supervising Deputy Attorney General Jennifer Turner, or designee, at least sixty (60) days prior to completing such sale. Such notice will include all information available regarding the proposed sale and DEFENDANTS will promptly provide all information requested by the PEOPLE to ascertain the affiliations of any prospective buyer or their assets or any portion thereof to ensure that such prospective buyer is not directly or indirectly affiliated with any of the DEFENDANTS or ENJOINED PARTIES, or any of their direct or indirect affiliates. Within a commercially reasonable period and upon the PEOPLE being satisfied that the buyer is not affiliated in any way with the persons or entities identified as ENJOINED PARTIES, the PEOPLE shall so notify DEFENDANTS.

49. No DEFENDANT, nor any entity associated with any DEFENDANT such as a "home office" or the like, shall claim any litigation cost incurred in connection with this action, including, but not limited to, costs related to monitoring and any monetary obligation identified herein, as a cost for reimbursement from Medi-Cal, Medicare, or any other taxpayer-funded, public assistance program. DEFENDANTS shall claim any such litigation costs on any applicable cost report solely as a non-reimbursable cost and, if audited, shall provide a copy of this

agreement to the auditor. In addition, this FINAL JUDGMENT is deemed a decision rendered in favor of a government agency.

50. This FINAL JUDGMENT shall be binding on all successors, heirs, and assigns of the PARTIES.

51. No costs are awarded to either party in this action, except as provided above.

52. In the event DEFENDANTS file for bankruptcy, insolvency, or reorganization under 11 U.S.C. § 101 et seq.:

a. The PEOPLE may file a proof of claim in the Bankruptcy Court for all uncollected amounts and interest thereon and DEFENDANTS agree not to object, join, support, or consent to any objection to California's unsecured proof of claim for the amounts set forth in paragraphs 34-35, provided that California files an unsecured proof of claim that conforms to this FINAL JUDGMENT. Nothing in this FINAL JUDGMENT prohibits or prevents California from also filing a claim under 11 U.S.C. § 502(h), provided that (1) DEFENDANTS' objections to a 502(h) claim are preserved and (ii) any 502(h) claim that is ultimately allowed is allowed as a general unsecured claim. DEFENDANTS agree to cooperate with California in seeking allowance of its proof of claim by providing any documentation, joinder, and/or seeking approval (if necessary) in the Bankruptcy Court (e.g., by filing of a stipulated proof of claim, by Rule 9019 motion, and/or by incorporating the FINAL JUDGMENT and allowed proof of claim into a Chapter 11 plan).

b. DEFENDANTS agree that any bankruptcy plan will not include any provision contrary to the Stipulated Final Judgment.

c. This FINAL JUDGMENT shall be binding on all of DEFENDANTS' affiliate successors, heirs, and assigns. References to DEFENDANTS shall include and encompass any reorganized entity or entities created by any approved plan approved by a bankruptcy court.

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53. All PARTIES waive their right to appeal, and this FINAL JUDGMENT shall take effect immediately upon entry hereof, and the PARTIES waive notice of entry of judgment.

IT IS SO ORDERED.

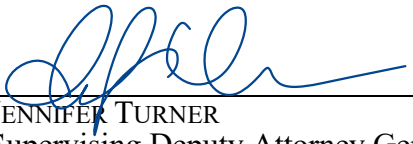
Dated: _____, 2026

_____
The Honorable Daniel Segura
JUDGE OF THE SUPERIOR COURT

AGREED AND ACCEPTED:

Dated: June 12, 2026

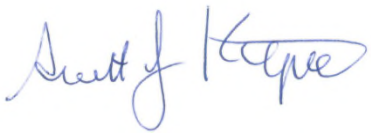
ROB BONTA
Attorney General of California



JENNIFER TURNER
Supervising Deputy Attorney General
Division of Medi-Cal Fraud and Elder Abuse
Attorneys for the People of the State of California

Dated: June 12, 2026

HOOPER, LUNDY & BOOKMAN, P.C.



SCOTT J. KIEPEN
Attorneys for Defendants SWEETWATER CARE OPCO, LLC; SWEETWATER CARE RESOURCE, LLC; SWEETWATER YV CHOLLA OPCO, LLC; SWEETWATER YV JOSHUA OPCO, LLC; SWC CA OPCO, LLC; SWC CA OPCO 2, LLC; AJC HEALTHCARE, LLC; JBG PARTNERS, LLC; ALMOND VIEW CARE CENTER, LLC; BROOKSIDE CARE CENTER, LLC; EVERGREEN CARE CENTER, LLC; FEATHER RIVER CARE CENTER, LLC; FOWLER CARE CENTER, LLC; GRAND OAKS CARE, LLC; VINDRA, INC.; NOBLE CARE CENTER, LLC; ORCHARDS AT TULARE, LLC; PALMS CARE CENTER, LLC; RANCHO SECO CARE CENTER, LLC; RIVERWALK CARE CENTER, LLC; ROLLING HILLS CARE CENTER, LLC; GATEWAY CARE, LLC; SHASTA VIEW CARE CENTER, LLC; VALLEY VIEW CARE CENTER, LLC; VINEYARDS AT FOWLER, LLC; AARON CHESLEY; and JAMES GAMETT

EXHIBIT A

Journal of the American Geriatrics Society

Journal of the
American Geriatrics Society

CLINICAL INVESTIGATION OPEN ACCESS

Nursing Home Guide to Adjusting Nurse Staffing for Resident Case-Mix

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Keywords: nurse staffing | nursing home | resident case-mix

ABSTRACT

Background: Nursing homes (NHs) are required to provide sufficient nursing staff to meet the needs of their residents. This study provides a guide for NHs to align nurse staffing levels with resident needs and calculates the gap between reported and expected NH staffing.

Methods: Using the best available research data and recent federal minimum staffing requirements, expected nurse staffing levels were estimated for the 25 resident case-mix index (CMI) groups established by the Centers for Medicare & Medicaid Services (CMS) using nonlinear least-squares regression analyses. We compared the reported to expected staffing for all US NHs (14,420) in 2024.

Results: Expected registered RN hours per resident day (HRPD) ranged from 0.55 to 2.39 for the lowest and highest CMIs. Certified nursing assistants HPRD ranged from 2.45 to 3.6 HPRD, and total nursing ranged from 3.48 to 7.68 HPRD. In 2024, US NHs reported that the average facility CMI was 1.35. Reported RN HPRD was 32% below expected staffing, CNA HPRD was 30% below, and total nursing HPRD was 22% below expected staffing. NHs in the three highest CMI groups were more likely to meet expected RN or total HPRD than NHs in lower CMI groups.

Conclusions: Most NHs need to increase staffing to meet resident acuity needs.

1 | Introduction

To participate in Medicare and Medicaid, nursing homes (NHs) (also called skilled nursing facilities and nursing facilities) must agree to meet all the federal requirements of participation [1]. Among the requirements, NHs:

> ...must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of

Summary

- Key points:
  - Under the federal requirements for nursing homes, every nursing home must provide sufficient nursing staff with appropriate competencies to assure resident safety and maintain the highest practicable well-being of each resident.
  - This study uses the best available research data and recent federal minimum staffing requirements to link RN, CNA, and total nurse staffing levels to each nursing home's resident case-mix groups as a guide for expected staffing.
  - Our analysis of recently reported nursing home staffing levels shows that most US nursing homes have RN, CNA, and total nurse staffing levels well below the expected staffing based on resident case-mix and federal minimum staffing requirements.
- Why does this paper matter?
  - To comply with the federal staffing requirements, nursing homes need to provide sufficient staff to meet the needs of their residents.
  - By linking the expected RN, CNA, and total staffing to resident case mix, nursing homes can better ensure resident safety and well-being.
  - This paper provides a guide for matching staffing to resident care needs and shows the gap between expected and reported staffing for US nursing homes.

> each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71 [2].

Resident care needs, characterized as case-mix or acuity, affect the number and skill level of nursing staff needed to meet Centers for Medicare & Medicaid Services (CMS) requirements [3]. The 2024 Office of the Inspector General guidelines make clear that when low staffing leads to substandard care, facilities may be providing worthless services, violating the False Claims Act, and be subject to enforcement actions [1].

Research has shown a strong relationship between NH nurse staffing levels and quality outcomes, especially registered nurse (RN) and certified nursing assistant (CNA) staffing levels [4]. Inadequate staffing has been associated with an increased risk of adverse resident outcomes, including hospitalizations and emergency room use [5], the incidence and prevalence of pressure injury [5–7], restraint use [6], urinary catheterizations [6] and urinary tract infections [8], contractures [7], inappropriate antipsychotic drug use [9, 10], pain [6], deficiency citations [4, 11], mortality [12], and the prevalence of infections (especially during the COVID-19 pandemic) [13]. Missed nursing care, or omissions, have been found to be related to insufficient or inadequate staffing and an array of adverse outcomes [14].

Following reports of low staffing and high rates of NH COVID-19 infections and deaths, CMS commissioned a study on NH staffing levels and minimum staffing standards [4]. In 2024, CMS established minimum nurse staffing levels to reduce the risk of residents receiving unsafe, low-quality care: 0.55 RN hours per resident day (HPRD); 2.45 CNA HPRD, and 3.48 total nursing HPRD (including all RN, licensed vocational or practical nurses (LVN/LPNs), and CNAs), phased in over 3–5 years [3]. Since 2016, NHs have been required to perform an annual facility-wide assessment of the staffing resources necessary for providing care for residents, taking into account the case-mix of residents [2, 15].

This article serves as a guide for NHs seeking to align nurse staffing levels with resident needs, as defined by the CMS case-mix index (CMI). The CMI uses resident assessment data to quantify the resource intensity of a resident's clinical condition [16]. Medicare pays higher rates to facilities with higher average CMI scores because they are expected to require more nursing hours to meet resident needs. Case-mix guidelines, however, have not been provided for staffing.

To fill this gap, this article first describes a process for translating the 25 CMI scores into expected RN, CNA, and total staffing levels, offering facilities a practical guide for aligning staffing with resident care requirements. Second, the article examines recent CMI scores and uses national data to compare expected nursing staffing with reported staffing.

2 | Background

2.1 | Assessing Care Needs and Classifying Residents Into Case-Mix Groups

CMS requires each NH to complete an assessment of each resident's care needs upon admission and periodically following admission. This assessment uses the Minimum Data Set (MDS) to develop a comprehensive care plan to meet each resident's needs [17]. Using MDS data in the early 1990s, CMS created a care group classification system for residents that reflects clinical needs and resource requirements, originally called resource utilization groups (RUGs) [18, 19].

In October 2019, CMS transitioned from RUGs to patient-driven payment model (PDPM) groups [20–22]. The PDPM system categorizes residents into 25 nursing case-mix groups, with each assigned a Health Insurance Prospective Payment System (HIPPS) code and a corresponding CMI score [22–24]. Since July 2024, CMS has published each NH's weighted average quarterly CMI score in its NH provider data files. Facilities can calculate their own CMI scores by averaging the data for residents, either by nursing unit or for the facility as a whole.

2.2 | CMS 5-Star Nursing Home Compare Website

CMS developed its 5-Star Nursing Home Compare website in 2008 and currently uses the CMI as part of its staffing rating. Its current methodology divides each facility's weighted average CMI by the national average CMI to create a CMI ratio [25]. The NH CMI ratio is multiplied by the national average HPRD to create "adjusted nursing hours" for each NH [25]. CMS divides

its staffing measures into deciles to calculate cut points and maintains a consistent distribution of ratings (ranging from 1 to 5 stars) over time [25]. Using the national average as a standard, this method reflects current practices. As such, it normalizes current staffing levels for each case-mix group, regardless of whether or not the actual staffing hours are sufficient to meet the resident needs at that level. The CMS website does not directly link staffing to resident case-mix and does not identify or use the 2024 CMS minimum staffing levels requirements in its calculations [3].

3 | Methods

3.1 | Rationale for Estimating CMI Scores to Staffing Time Plans

CMS first linked resident RUGs to staffing by conducting a staff time measurement (STM) time-and-motion study in the 1990s, which established the specific RN, LVN/LPN, and CNA staffing expectations and related costs for each RUG category [18–20, 24, 26]. CMS later used the STM time-and-motion data for its Five-Star Nursing Home Compare website to calculate expected staffing based on acuity from 2008 to 2018 [24].

We consider that the STM time-and-motion study provides the best available information for RN and LVN/LPN staffing times because the study oversampled NHs with high proportions of Medicare residents with a reputation for high quality [18–20, 24, 26]. CMS used the STM time-and-motion staffing for Medicare payment purposes from the late 1990s until after it conducted the Staff Time and Resources Intensive Verification (STRIVE) time and motion study in 2011 [27, 28]. The STRIVE study was initiated to collect and analyze the time that an average NH spent caring for residents, based on current practices for reimbursement purposes and did not screen facilities for quality [27]. CMS applied the STRIVE staffing data to Medicare payments for resident acuity [28].

Simulation models are considered a better approach than time and motion data because they allow for consideration of the time required to provide care at or above a specific level for different resident case-mix categories [29]. Although CMS had a partial simulation study conducted for licensed nurses in 2023, those data were limited to five activities conducted by licensed nurses [4], and are not sufficient to account for the many activities that require licensed nurses.

For care provided by CNAs, we used a 2016 CNA study, which determined the amount of CNA time needed to provide help with five basic activities of daily living [29]. Using simulations, the study determined that CNA staffing times to prevent care omissions below 10% ranged from 2.8 to 3.6 HPRD [29]. Given this evidence-based data, we used the 3.6 CNA HPRD for the highest PDPM group.

3.2 | Specific Methodology for Assigning Staffing Levels to Each Case-Mix Group

We calculated staffing expectations for NH average CMI scores that represent the acuity levels across the resident population [16]. For the lowest case-mix group (PDPM PA1 group with a CMI of 0.62), the staffing expectations were aligned with the CMS 2024 federal minimum requirements: 0.55 RN HPRD, 2.45 CNA HPRD, and 3.48 total nursing HPRD [3]. This threshold represents the minimum levels necessary to safeguard resident safety and care quality.

For the highest case-mix acuity group (PDPM ES3 group with a CMI of 3.84), staffing expectations were based on benchmarks set by the STM time-and-motion study [24] for licensed nurses and the 2016 CNA study for CNA time [28, 29]. These residents require extensive skilled nursing to provide tracheostomy and/or ventilator care or residents in isolation with active infectious disease [21]. These residents are expected to have 2.39 RN HPRD, along with 1.69 LVN/LPN HPRD and 3.6 CNA HPRD, for a total of 7.68 nursing HPRD every 24 h [24, 29].

To calculate the expected HPRD for residents in CMI PDPM groups with CMIs falling between the 0.62 minimum CMI and the 3.48 maximum CMI, we developed a formula relating each CMI PDPM group to an expected staffing level. This level was calculated as the minimum HPRD associated with the minimum CMI plus an HPRD associated with that group's CMI. Each group's HPRD was determined based on converting its normalized CMI value (ranging from 0 to 1, relative to given minimum and maximum values) into a normalized HPRD value, using empirical scaling factors as exponents for the conversion.

Separate scaling factors, ranging from 0.1 to 1.5, were calculated for RN, CNA, and total nursing HPRD. To determine the best scaling factor for each staffing type, we estimated nonlinear least-squares regression models using data from the STM time-and-motion study and the 2016 CNA study, described above. For the nonlinear regressions, we used Python 3.11 and the Levenberg–Marquardt algorithm for optimization to identify the best-fitting models.

Table 1 shows the nonlinear regression model for estimating total nursing expected times for each CMI category with standard errors and confidence intervals. For the total nursing HPRD, the best-fitting scaling factor was 0.715. The model had an R^2 of 0.881, confirming a strong fit. The best-fitting scaling factor for RN HPRD was 0.974, which had an R^2 of 0.683, and the best-fitting scaling factor for CNAs was 0.236, with an R^2 of 0.537. The scaling factor adjusts the rate at which staffing increases in response to changes in the CMI and smooths the transitions in staffing thresholds. For the details, see the Supporting Information.

3.3 | Methodology for Calculating the Differences Between Expected and Reported Staffing

For the analysis of expected and reported staffing, we examined the CMS NH provider file data on December 20, 2024 [30]. A total of 14,420 NHs were included in the analysis, and 387 facilities were excluded due to the absence of reported data.

Using Excel, we calculated the total number of NHs in each of the 25 nursing CMI groups, using each facility's weighted average CMI reported to CMS. CMI variations within facilities among units are not reported to CMS. Because each facility's

TABLE 1 | Nonlinear regression model for total nursing expected time for each CMI category compared to staffing study time.

PDPM group nursing HIPPS character	Case-mix index (CMI)	Total nurse HPRD from time-and-motion and CNA staffing studies	Total nurse expected HPRD using scaling methodology with $\gamma = 0.715$	Nonlinear regression total nurse expected HPRD standard errors	Lower 95% confidence interval	Upper 95% confidence interval
A	3.84	7.68	7.68	0.00	7.68	7.68
B	2.90	6.84	6.76	0.04	6.69	6.83
C	2.77	5.91	6.63	0.04	6.55	6.71
D	2.27	5.79	6.08	0.06	5.97	6.19
E	1.88	5.79	5.63	0.06	5.50	5.75
F	2.12	5.42	5.91	0.06	5.80	6.03
G	1.76	5.42	5.48	0.07	5.35	5.61
H	1.97	5.79	5.74	0.06	5.61	5.86
I	1.64	5.79	5.33	0.07	5.19	5.46
J	1.63	5.42	5.31	0.07	5.18	5.45
K	1.35	5.42	4.93	0.07	4.80	5.07
L	1.77	5.53	5.49	0.07	5.36	5.62
M	1.53	5.34	5.18	0.07	5.05	5.32
N	1.47	4.86	5.10	0.07	4.97	5.23
O	1.03	4.42	4.44	0.06	4.32	4.57
P	1.27	4.82	4.82	0.07	4.68	4.95
Q	0.89	4.42	4.19	0.06	4.08	4.30
R	0.98	4.30	4.36	0.06	4.24	4.48
S	0.94	4.30	4.29	0.06	4.17	4.40
T	1.48	4.90	5.11	0.07	4.98	5.25
U	1.39	4.90	4.99	0.07	4.85	5.12
V	1.15	4.53	4.64	0.07	4.51	4.77
W	0.67	4.10	3.69	0.03	3.64	3.75
X	1.07	4.50	4.51	0.06	4.38	4.63
Y	0.62	4.10	3.48	—	—	—

Note: Best-fitting scaling factor was 0.715; $R^2 = 0.881$.
Abbreviations: CNA = certified nursing assistant; HIPPS = Nursing Health Insurance Prospective Payment System; RN = registered nurse.
Source: FY 2025 PDPM case-mix adjusted federal rates and associated indexes. Highest expected staffing from CMS staff time measurement (STM) study time-and-motion study and the 2016 CNA staffing study. Lowest expected staffing from CMS 2024 minimum staffing requirements. Time in hours per resident day (HPRD). Total nursing = RNs, CNAs, and licensed vocational/practical nurses.

weighted average CMI may fall between the 25 nursing CMI categories, facilities were assigned to the closest PDPM group based on their average CMI.

We then calculated the average expected and reported staffing separately for RN, CNA, and total staffing for NHs in each PDPM/CMI group. We created a figure to show the gap between expected and reported staffing for NHs in each PDPM/CMI group. Finally, we created a figure to show the number of facilities that did not meet the 2024 CMS minimum staffing requirements for RNs, CNAs, and total nursing and the percent difference between the expected and reported staffing for NHs that did not meet the requirements.

4 | Results

Table 2 presents the calculated expected RN, CNA, and total nursing HPRD for each of the 25 nursing PDPM groups (and their nursing HIPPS character). To use the guide shown in

Table 2, NHs would identify the HIPPS character and its corresponding CMI for each resident in a facility or on a unit. First, NHs would add the number of residents in each CMI group and multiply this number by the CMI for each group. Then NHs would sum this number (all the CMI groups times the number of residents) in the facility and then divide that number by the total number of residents in the facility to obtain an average CMI. The NH average CMI will be compared to the closest CMI in Table 2 to identify the expected nurse staffing levels. For example, if a facility's average CMI is 1.34, the closest CMI would be 1.35 (PDPM HIPPS K). This approach could also apply to estimating staffing for facility units. The table shows that the expected RN staffing is 0.98 HPRD, CNA staffing is 3.26 HPRD, and total nursing is 4.93 HPRD for a CMI of 1.35.

Table 3 shows the distribution of average facility-level CMIs, the expected nurse staffing, and the average reported staffing for all US NHs for December 2024. The overall average NH CMI was 1.35 for the 14,420 facilities. Only 20 facilities were classified in the highest ES3 group, and 71 NHs were in the three highest ES1 to ES3 groups. It should be noted that while NHs may have a care unit for high-acuity residents, few NHs maintain an

TABLE 2 | Expected RN, CNA, and total nurse staffing hours per resident day (HPRD) for each nursing group and case-mix index (CMI).

	Patient-driven payment method (PDPM) group	PDPM nursing HIPPS character	CMI	Expected RN nursing HPRD	Expected CNA HPRD	Expected total nursing HPRD
Extensive services	ES3	A	3.84	2.39	3.60	7.68
	ES2	B	2.90	1.86	3.51	6.76
	ES1	C	2.77	1.79	3.50	6.63
Special care high	HDE2	D	2.27	1.51	3.43	6.08
	HDE1	E	1.88	1.29	3.37	5.63
	HBC2	F	2.12	1.42	3.41	5.91
	HBC1	G	1.76	1.22	3.35	5.48
Special care low	LDE2	H	1.97	1.34	3.39	5.74
	LDE1	I	1.64	1.15	3.33	5.33
	LBC2	J	1.63	1.14	3.32	5.31
	LBC1	K	1.35	0.98	3.26	4.93
Clinically complex	CDE2	L	1.77	1.23	3.35	5.49
	CDE1	M	1.53	1.09	3.30	5.18
	CBC2	N	1.47	1.05	3.29	5.10
	CA2	O	1.03	0.80	3.16	4.44
	CBC1	P	1.27	0.94	3.24	4.82
	CA1	Q	0.89	0.71	3.09	4.19
Behavioral symptoms	BAB2	R	0.98	0.77	3.14	4.36
	BAB1	S	0.94	0.74	3.12	4.29
Reduced physical function	PDE2	T	1.48	1.06	3.29	5.11
	PDE1	U	1.39	1.01	3.27	4.99
	PBC2	V	1.15	0.87	3.20	4.64
	PA2	W	0.67	0.58	2.88	3.69
	PBC1	X	1.07	0.82	3.17	4.51
	PA1	Y	0.62	0.55	2.45	3.48

Abbreviations: CNA = certified nursing assistant; HIPPS = Nursing Health Insurance Prospective Payment System; RN = registered nurse.
Source: FY 2025 PDPM case-mix adjusted federal rates and associated indexes. Highest expected staffing from CMS staff time measurement (STM) study time-and-motion study and the 2016 CNA staffing study. Lowest expected staffing from CMS 2024 minimum staffing requirements. Time in HPRD. Total nursing = RNs, CNAs, and licensed vocational/practical nurses.

TABLE 3 | US nursing home PDPM groups, case-mix indexes (CMIs), and expected and reported RN, CNA, and total staffing times, December 2024.

PDPM group HIPPS (CMI)	Number of NHs in each CMI group	Expected RN HPRD by CMI	Average reported RN HPRD by CMI	Expected CNA HPRD by CMI	Average reported CNA HPRD by CMI	Expected total nursing HPRD by CMI	Average reported total nursing HPRD by CMI
A (3.84)	20	2.21	2.11	3.57	3.50	7.38	8.03
B (2.9)	32	1.99	2.12	3.53	3.13	6.99	7.50
C (2.77)	19	1.75	2.02	3.49	2.91	6.55	6.42
D (2.27)	26	1.54	1.17	3.44	3.02	6.15	5.79
E (1.88)	126	1.28	0.80	3.37	2.17	5.62	3.94
F (2.12)	53	1.42	0.84	3.41	2.67	5.90	4.88
G (1.76)	224	1.20	0.73	3.34	2.18	5.44	3.76
H (1.97)	86	1.34	0.89	3.39	2.32	5.74	4.27
I (1.64)	323	1.17	0.69	3.33	2.17	5.36	3.79
J (1.63)	379	1.13	0.76	3.32	2.22	5.28	3.89
K (1.35)	2249	0.98	0.68	3.26	2.30	4.92	3.88
L (1.77)	123	1.24	0.76	3.36	2.20	5.52	3.92
M (1.53)	766	1.09	0.69	3.31	2.20	5.20	3.81
N (1.47)	841	1.04	0.69	3.29	2.25	5.07	3.86
O (1.03)	158	0.80	0.58	3.16	2.28	4.44	3.57
P (1.27)	3991	0.93	0.64	3.24	2.33	4.81	3.82
Q (0.89)	42	0.70	0.41	3.07	1.62	4.14	2.65
R (0.98)	56	0.77	0.53	3.14	2.15	4.37	3.39
S (0.94)	45	0.74	0.51	3.12	2.07	4.28	3.17
T (1.48)	439	1.06	0.69	3.29	2.22	5.13	3.85
U (1.39)	1597	1.01	0.69	3.27	2.28	5.00	3.90
V (1.15)	2369	0.88	0.59	3.21	2.31	4.66	3.69
W (0.67)	4	0.61	0.15	2.95	1.52	3.83	2.19
X (1.07)	452	0.83	0.60	3.18	2.35	4.53	3.70
Y (0.62)	0	0.00	0.00	0.00	0.00	0.00	0.00
Average		0.98	0.67	3.25	2.29	4.92	3.84

Abbreviations: CNA = certified nursing assistant; HIPPS = Nursing Health Insurance Prospective Payment System; RN = registered nurse.
Source: FY 2025 PDPM case-mix adjusted federal rates and associated indexes. Highest expected staffing from CMS staff time measurement (STM) study time-and-motion study and the 2016 CNA staffing study. Lowest expected staffing from CMS 2024 minimum staffing requirements. Time in hours per resident day (HPRD). Total nursing = RNs, CNAs, and licensed vocational/practical nurses.

average of the highest-acuity residents, and no facilities had an average CMI score of 0.62.

Table 3 also shows the difference between expected and reported staffing for each PDPM group. US NHs reported average RN staffing of 0.67 HPRD compared to an average expected RN staffing of 0.98 HPRD in 2024. The average CNA reported staffing was 2.29 HPRD compared to the expected staffing of 3.25. The total average reported staffing was 3.84 HPRD compared to 4.92 HPRD expected staffing. On average, RN reported staffing for all facilities was 32% below expected staffing, CNA staffing was 30% below expected staffing, and total staffing was 22% below expected staffing based on facility CMIs.

Figure 1 shows the percent differences between expected and reported staffing for NHs in the 25 HIPPS codes/CMI groups.

Positive deviations indicate that reported staffing exceeded expected staffing. Surprisingly, facilities with weighted average CMI values consistent with the three highest PDPM groups had reported RN or total staffing that exceeded the expected staffing. For facilities in other PDPM groups, the shortfall in expected RN staffing ranged from 25% to 75%. In general, NHs had the highest deviations for RNs and the lowest deviations for total staffing.

Figure 2 shows that 48% of NHs did not meet the CMS minimum staffing requirement of 0.55 HPRD for RNs, and these NHs had 68% lower RN HPRD than expected. For CNAs, 68% of NHs did not meet the minimum staffing level, and these facilities had 18% lower CNA reported levels than expected. Overall, 37.5% of NHs did not meet the CMS minimum of 3.48 HPRD for total nursing, and these NHs had 36.8% lower reported staffing than expected.

5 | Discussion

This article provides a practical framework for aligning NH staffing levels with average resident CMI scores, based on the best available staffing evidence [26, 29]. By anchoring staffing expectations to CMIs across acuity levels, NHs can better align their staffing to protect resident safety and comply with federal regulatory requirements. The guide should also be useful for facilities in conducting their required facility staffing assessments. The guide can also be used by the CMS Five-Star Rating System to better align the ratings with expected staffing based on case-mix.

NHs are required to conduct periodic facility assessments to determine staffing needs. Although these guidelines identify staffing expectations to meet clinical needs and regulatory requirements, facilities are not capped at any specific staffing level

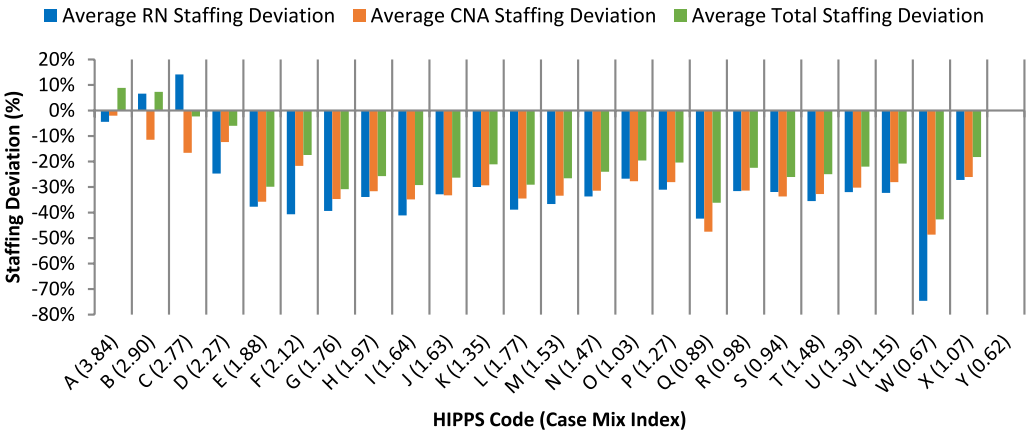

FIGURE 1 | Average staffing deviations (reported minus expected) by PDPM/CMI group.

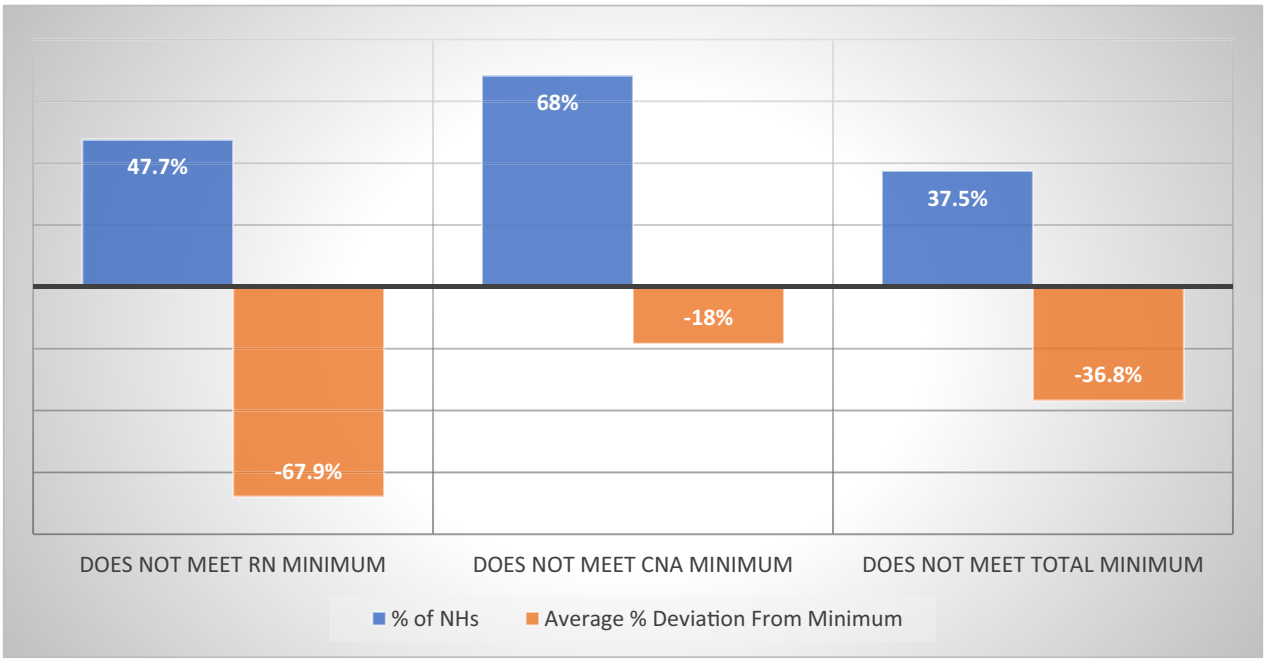

FIGURE 2 | Nursing homes failing to meet minimum staffing requirements and average % deviation, December 2024, $N = 14{,}420$.

and are encouraged to staff above these thresholds when necessary to meet the needs of their specific resident population. Abt Associates recently found that as staffing levels increase, quality levels increase without any apparent ceiling on improvement [4].

When comparing expected vs. reported staffing levels for RNs, CNAs, and total nursing staff, most discrepancies do not occur within the highest PDPM groups with high CMI scores. Instead, the majority of NHs with CMIs below 2.7 are understaffed relative to expectations, with the gap being more pronounced for RN staffing than for CNAs and total nursing. Many NHs may use LVN/LPN staff with lower wages as substitutes for RNs. While RN and CNA staffing levels have been found to be associated with higher quality and safety, LVN/LPN staffing levels show inconsistent relationships [4]. NHs with low staffing levels are likely to fall short of meeting their expected resident case-mix needs. These findings underscore the importance of maintaining higher staffing levels in most NHs.

One limitation of this study is that staffing time studies and simulation models have not been updated recently. Professional and regulatory expectations for resident quality and safety have increased over time. Because of these factors, our study may underestimate expected staffing levels. New studies are needed to ensure that expected licensed nurse staffing levels are sufficient to ensure safe and appropriate quality of care that meets current professional and regulatory standards. In addition, studies are needed to link case-mix adjusted staffing to resident outcomes.

6 | Conclusion

By prioritizing resident-centered standards and leveraging evidence that higher staffing levels improve care quality, this guide enables NHs to optimize resources, enhance resident outcomes, and meet federal care requirements for staffing based on resident case-mix developed by CMS. It supports a system that fosters accountability and transparency, encouraging NHs to deliver high-quality, safe, individualized care.

Author Contributions

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Conflicts of Interest

The authors declare no conflicts of interest.

References

1. U.S. Department of Health and Human Services Office of Inspector General, "Nursing Facility Industry Segment-Specific Compliance Program Guidelines," November 2024.

2. Centers for Medicare & Medicaid Services, "State Operations Manual Appendix PP—Guidance to Surveyors for Long Term Care Facilities," (Rev. 225), 8-8-2024. 42 C.F.R. §§ 483.35(a) (Nursing Services), https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf.

3. Medicare and Medicaid Programs, "Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, 89 Fed. Reg. 40876," May 10, 2024, https://www.federalregister.gov/documents/2024/05/10/2024-08273/medicare-and-medicaid-programs-minimum-staffing-standards-for-long-term-care-facilities-and-medicaid.

4. Abt Associates, "Nursing Home Staffing Study Comprehensive Report," Report Prepared for the Centers for Medicare & Medicaid Services, June 2023, https://edit.cms.gov/files/document/nursinghomestaffing-study-final-report-appendix-june-2023.pdf.

5. D. B. Mukamel, D. Saliba, H. Ladd, and R. T. Konetzka, "The Relationship Between Nursing Home Staffing and Health Outcomes Revisited," *Journal of the American Medical Directors Association* 25, no. 8 (2024): 105081.

6. N. G. Castle and R. A. Anderson, "Caregiver Staffing in Nursing Homes and Their Influence on Quality of Care: Using Dynamic Panel Estimation Methods," *Medical Care* 49 (2011): 545–552.

7. H. Lin, "Revisiting the Relationship Between Nurse Staffing and Quality of Care in Nursing Homes: An Instrumental Variables Approach," *Journal of Health Economics* 37 (2014): 13–24.

8. R. T. Konetzka, S. C. Stearns, and J. Park, "The Staffing-Outcomes Relationship in Nursing Homes," *Health Services Research* 43, no. 3 (2008): 1025–1042.

9. V. Chappell, J. Kirkham, and D. P. Seitz, "Association Between Long-Term Care Facility Staffing Levels and Antipsychotic Use in US Long-Term Care Facilities," *Journal of the American Medical Directors Association* 23, no. 11 (2022): 1787–1792.e1, https://doi.org/10.1016/j.jamda.2022.06.029.

10. J. L. Travers, E. M. Hade, S. Friedman, A. Raval, K. Hadson, and J. R. Falvey, "Staffing and Antipsychotic Medication Use in Nursing Homes and Neighborhood Deprivation," *JAMA Open Network* 7, no. 4 (2024): e248322.

11. J. R. Bowblis and A. R. Roberts, "Cost-Effective Adjustments to Nursing Home Staffing to Improve Quality," *Medical Care Research and Review* 77, no. 3 (2020): 274–284.

12. T. K. Trivedi, T. DeSalvo, L. Lee, et al., "Hospitalizations and Mortality Associated With Norovirus Outbreaks in Nursing Homes, 2009-2010," *Journal of the American Medical Association* 308, no. 16 (2012): 1668–1675.

13. Y. Li, H. Temkin-Greener, G. Shan, and X. Cai, "COVID-19 Infections and Deaths Among Connecticut Nursing Home Residents: Facility Correlates," *Journal of the American Geriatrics Society* 68, no. 9 (2020): 1899–1906, https://doi.org/10.1111/jgs.16689.

14. A. M. Ogletree, R. Mangrum, Y. Harris, et al., "Omissions of Care in Nursing Home Settings: A Narrative Review," *Journal of the American Medical Directors Association* 21 (2020): 604–614.

15. 42 C.F.R. §§ 483.71(a), 483.71(c); See Also 89 Fed. Reg. at 40,912.

16. Centers for Medicare & Medicaid Services (CMS), "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025; Final," August 6, 2024, https://www.federalregister.gov/documents/2024/04/

03/2024-06812/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.

17. Centers for Medicare & Medicaid Services (CMS), "Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual," https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual.

18. B. E. Fries, D. P. Schneider, W. J. Foley, M. Gavazzi, R. Burke, and E. Cornelius, "Refining a Case-Mix Measure Nursing Homes: Resource Utilization Groups (RUG-III)," *Medical Care* 32 (1994): 668–685.

19. C. White, S. D. Pizer, and A. J. White, "Assessing the RUG-III Resident Classification System for Skilled Nursing Facilities," *Health Care Financing Review* 24, no. 2 (2002): 1–15.

20. Centers for Medicare & Medicaid Services (CMS), "CMS Rugs Refinement," RUGS III/RUGS IV 2008 Distribution. RUG-IV Grouper Overview: Logic Version 1.03 and Code Version 1.03.0, July 18, 2013, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/RUGRefinement.

21. Acumen, "Skilled Nursing Facilities Patient-Driven Payment Model Technical Report," April 2018, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.

22. Centers for Medicare & Medicaid Services (CMS), "Patient Driven Payment Method for the Prospective Payment System," https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/pps-model-research, https://www.cms.gov/medicare/payment/prospective-payment-systems/hipps-codes.

23. Centers for Medicare & Medicaid Services (CMS), "Medicare Program Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities," Federal Register, Proposed Rule April 25, 2019, https://www.federalregister.gov/documents/2019/04/25/2019-08108/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities.

24. Centers for Medicare & Medicaid Services (CMS), "Design for *Care Compare* Nursing Home Five-Star Quality Rating System: Technical Users' Guide and Appendix, 2016 and 2019," https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/five-star-quality-rating-system/five-star-quality-rating-system-archives.

25. Centers for Medicare & Medicaid Services (CMS), "Design for *Care Compare* Nursing Home Five-Star Quality Rating System: Technical Users' Guident," July 2024, https://www.cms.gov/medicare/health-safety-standards/certification-compliance/five-star-quality-rating-system.

26. Centers for Medicare & Medicaid Services (CMS), "Medicare Program Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update," Health Care Financing Administration on 07/31/2000 *Federal Register. 42 CFR 41142 CFR 41342 CFR 489*. 65 FR 46770: 46770–46796. See Nursing and Therapy Minutes Used in Calculating Preliminary Rates, April 10, 2000 Fr 19188, https://www.federalregister.gov/documents/2000/07/31/00-19004/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing.

27. Centers for Medicare & Medicaid Services (CMS), "Time Study (STRIVE) Project," https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/timestudy.

28. C. Harrington, M. Dellefield, E. Halifax, M. Fleming, and D. Bakerjian, "Appropriate Nurse Staffing Levels for US Nursing Homes," *Health Services Insights* 13 (2020): 1–14, https://doi.org/10.1177/1178632920934785.

29. J. F. Schnelle, L. D. Schroyer, A. A. Saraf, and S. F. Simmons, "Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model," *Journal of the American Medical Directors Association* 17 (2016): 970–977.

30. Centers for Medicare & Medicaid Services (CMS), "Nursing Home Provider File," December 2024, https://data.cms.gov/provider-data/dataset/4pq5-n9py.

Supporting Information

Additional supporting information can be found online in the Supporting Information section.