IN THE CIRCUIT COURT
FOR BALTIMORE CITY

STATE OF MARYLAND
EX REL ANNE BARR
200 St. Paul Place
Baltimore, Md. 21202

Plaintiff,

v.

ADVOSERV, INC.,
2520 Wrangle Hill Road
Bear, DE 19701

ADVOSERV OF DELAWARE, INC.
2520 Wrangle Hill Road
Bear, DE 19701

ADVOSERV TRADE, INC.[1]
2520 Wrangle Hill Road
Bear, DE 19701

ADVOSERV PROGRAMS, INC.[2]
2520 Wrangle Hill Road
Bear, DE 19701

ADVOSERV GROUP HOME, INC.[3]
2520 Wrangle Hill Road
Bear, DE 19701

ADVOSERV MIDDLETOWN, INC,[4]
2520 Wrangle Hill Road
Bear, DE 19701

MATBE SCHOOL, INC.
4087 Kirkwood Road
Bear, DE 19701

CASE NO. 24-C-16-003547

[1] Subsequent to the Subsequent to the filing of the initial complaint in this case, the entity changed its name to Bellwether Behavioral Trade, Inc.
[2] Subsequent to the filing of the initial complaint in this case, the entity changed its name to Bellwether Behavioral Programs, Inc.
[3] Subsequent to the filing of the initial complaint in this case, the entity changed its name to Bellwether Behavioral Group Home, Inc.
[4] Subsequent to the filing of the initial complaint in this case, the entity changed its name to Bellwether Behavioral Middletown, Inc.

MATBE MIDDLE SCHOOL, INC.
4087 Kirkwood Road
Bear, DE 19701

MATBE TRANSITIONAL SCHOOL, INC.
4087 Kirkwood St. George's Road
Bear, DE 19701

ST. GEORGE ACADEMY, INC.
4185 Kirkwood St. George's Road
Bear, DE 19701

Defendants.

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COMPLAINT IN INTERVENTION

The State of Maryland, through its undersigned counsel, brings this Complaint against Defendants and says:

1. Children with severe developmental disabilities and mental health conditions may qualify to receive State-funded services at private residential and educational providers. Children who receive these services have been identified through their local school systems as having behavioral needs that cannot be safely addressed by the schools or a court has certified through a process known as voluntary placement that their behavioral needs cannot be safely addressed in their homes.

2. Because of the unique needs of these students and the possibility that they will engage in unsafe behaviors such as attempting to injure themselves or others, the private facilities entrusted with their care are required to meet high standards for staffing, training, and quality. These standards ensure that special-needs students are safe and able to live the most independent lives possible given their conditions.

3. To meet these high standards, facilities were paid more than $230,000 per child per year.

4. Defendants collectively operated residential and educational facilities for students with severe developmental disabilities and mental health conditions. Defendants did not meet the high standards required of them, failing to provide even minimally adequate care to the children under their protection. Although presenting themselves as a modern, progressive facility able to provide behavioral, medical, and educational services to this special-needs population, the reality was more Dickensian.

5. Defendants were understaffed and the staff they had were undertrained. Instead of diffusing potentially violent or injurious behavior in therapeutically appropriate ways, staff reacted with (at best) indifference or (at worst) aggressive confrontation that triggered or exacerbated behavioral issues, often resulting in staff physically restraining children. Students were also restrained for perceived insubordination or disrespect to staff. Children who misbehaved were punished by having all of their personal possessions taken away – a punishment described by one staff member as taking away anything that gave them joy.

6. When reporting incidents in which a child was physically restrained, Defendants minimized or concealed their staff's role in certain incidents, and always claimed that staff had attempted to redirect or diffuse the behavior before resorting to restraints. In reality, staff rarely attempted other behavioral management techniques, consistently defaulting to physical restraints to deal with any potential problems.

7. Defendants routinely failed to provide basic services to the children in their care. A review of the medication administration records for just 10 of the children placed with Defendants revealed 717 instances in which a child did not receive prescribed medication.

Defendants were aware of dozens more instances in which a child did not receive prescribed medication. Yet not one of the instances was reported to the State, despite Defendants' duty to report all medication errors – instances in which there was an omission or overdose of medication – to the State for all children placed through the Department of Human Services.

8. Although Defendants were to provide educational services to the children placed in their care, classrooms often lacked teachers and additional, required services such as speech language therapy were not provided.

9. Although Defendants were aware of the problems in their program, they failed to take real action to solve the problem. Defendants minimized problems and failed to take disciplinary action against staff who failed to act appropriately. When problems were serious enough that they could not be ignored, Defendants "retrained" the staff, often by sending them memos reiterating the standard that had just been broken, or by putting write-ups in their personnel files. These minimal actions had no effect on the quality of care provided and did not result in any improvements. Despite knowing that these minimal measures were not effecting changes in staff behavior, Defendants continued with the same head-in-the-sand/slap-on-the-wrist management style, allowing the same problems to occur over and over again with no real improvements.

10. Indeed, after an incident in which a student from Maryland ran away to engage in a sexual relationship with a staff member, the Delaware Department of Services for Children, Youth, and their Families noted its "ongoing significant concerns about the lack of adequate supervision of direct care staff across the Delaware facilities licensed to serve minors." It noted that despite terminating employees involved in serious incidents, Defendants "failed to demonstrate that its supervisory structure and management practices are minimally appropriate

in proactively assessing and responding to risks common in the provision of residential services – especially to vulnerable populations." The Department concluded that "these ongoing patterns of inadequate supervisory and management oversight remain extremely concerning."

11. Defendants consistently failed to meet the statutory, regulatory, and contractual requirements designed to protect the children placed in their facilities, resulting in Defendants submitting false or fraudulent claims for payment to the State of Maryland within the meaning of the False Claims Act. Defendants consistently failed to make required reports to the State of Maryland or made misleading reports to the State of Maryland, resulting in the Defendants making false statements or records within the meaning of the False Claims Act.

Parties, Jurisdiction, and Venue

12. Plaintiff, the State of Maryland is a free, sovereign, and independent State.

13. Defendants are Delaware corporations engaged in the business of providing residential and educational services to persons with disabilities. Their principal places of business are in Bear, Delaware.

14. Defendants are referred to collectively as AdvoServ. As is discussed in more detail below, Defendants serve as alter egos of each other, operating in a unified manner with no distinctions between them.

15. This Court has jurisdiction over the subject matter of this action pursuant to Md. Code Ann., Cts. & Jud. Proc. §1-501.

16. Venue is proper in this Court pursuant to Md. Code Ann., Cts. & Jud. Proc. § 6-201(a) and 6-202(3) because none of the Defendants maintains a principal place of business in Maryland, but they routinely conducted business in Baltimore City, meeting with parents and

students to encourage them to seek placements at AdvoServ and accepting student placements from Baltimore City.

AdvoServ is a Private, Out-of-State Placement for Disabled Students in Need of a High Level of Services

17. AdvoServ operates group homes, a middle school, and a high school program for children with disabilities.

18. Children from Maryland were placed at AdvoServ through either the Department of Human Services or through their local schools.

19. The Maryland Department of Human Services ("DHS") provides assistance to vulnerable individuals.[5] Among other things, the Department of Human Services pays for children with disabilities (through age 21) to receive private, residential treatment when required. The State pays for private, residential treatment when needed for foster children, children for whom the State serves as guardian, and for other children who cannot receive the services they need in their homes and whose parents or guardians have entered into an approved Voluntary Placement Agreement with DHS. DHS places children in private facilities when the nature of their disabilities means that they cannot be safely cared for at home.

20. On March 1, 2012, DHS entered into Purchase of Care Contract SSA/OOS/12/001 with AdvoServ.

21. Pursuant to the contract, AdvoServ was to provide residential care and services to children referred by local departments of social service. Specifically, AdvoServ was to provide a "safe, stable and appropriate setting, treatment modality and rehabilitation services . . . ."

[5] Prior to July 1, 2017, the Department of Human Services was called the Department of Human Resources. All references to the agency in this complaint refer to it by its current name.

22. The children placed at AdvoServ had cognitive disabilities and mental illnesses that cause them to engage in unsafe behaviors, such as physical violence, destroying property (kicking holes in walls, throwing objects), or self-injurious behavior such as head-banging, scratching, or hitting themselves.

23. The contract required that each invoice submitted by AdvoServ "certify that the work and services have been performed, payment for the work has not been received, and that the amount specified is due and payable."

24. The contract allows for payment to be refused, reduced, or withheld by DHS if services were unsatisfactory.

25. For residential services for students placed at AdvoServ under the DHS contract, AdvoServ was paid a base rate of $467.58 per day – $171,134.28 annually – for the 2015-16 fiscal/school year. In State fiscal year 2017, that rate increased to $472.26 per day – $172,374.90 annually.

26. The DHS contract with AdvoServ only covers residential services. It does not cover educational services. Pursuant to the DHS contract, AdvoServ was required to coordinate with local departments of social services and local school systems to ensure that the youth in its care were enrolled in appropriate educational or vocational programs and provided transportation to those programs.

27. Because AdvoServ also operates private schools for children with disabilities, the youth who received residential services at AdvoServ through the DHS contract were also enrolled in AdvoServ schools.

28. The Maryland State Department of Education paid for the private school enrollment at a rate of $251.98 per day – $61,231.14 for the school year – in State fiscal year 2016 and $254.47 per day – $62,345.15 for the school year – in State fiscal year 2017.

29. Most of the Maryland children placed at AdvoServ were placed through DHS under the Purchase of Care Contract.

30. The DHS contract requires AdvoServ to "comply with all applicable federal, State and local governmental law, regulations and standards applicable to its activities and obligations under this Contract, . . ."

31. Some children, however, were placed by their local schools with funding from the Maryland State Department of Education (MSDE).

32. Students with disabilities are entitled to special education services under the Individuals with Disabilities Education Act. Special education services generally are provided by and in the student's local school.

33. If the nature of the student's disabilities does not allow for services to be provided in the local public school, the student may be placed in a private school at government expense. Private school placement may be for only the school day or it may include residential services through a group home or other residential facility operated by or associated with the private school. School systems place children in private facilities when the nature of their disabilities means that they cannot be safely educated in the school or the school is otherwise unable to meet their needs.

34. MSDE approved AdvoServ as a non-public provider of residential special education services.

35. Pursuant to this approval, local school systems referred children to AdvoServ. Children placed at AdvoServ had cognitive disabilities and mental illnesses that cause them to engage in unsafe behaviors, such as physical violence, destroying property (kicking holes in walls, throwing objects), or self-injurious behavior such as head-banging, scratching, or hitting themselves.

36. MSDE paid for both educational and residential services for children placed at AdvoServ.

37. MSDE paid for the private school enrollment at a rate of $251.98 per school day – $61,231.14 for the school year – in State fiscal year 2016 and $254.47 per school day – $62,345.15 for the school year – in State fiscal year 2017.

38. For residential services for students placed at AdvoServ, MSDE paid AdvoServ a base rate $467.58 per day – $171,134.28 annually – for the 2015-16 fiscal/school year. In State fiscal year 2017, that rate increased to $472.26 per day – $172,374.90 annually.

AdvoServ Did Not Employ Enough Staff to Supervise, Assist and Care for the Students

39. Because AdvoServ was located in Delaware, it was required to comply with Delaware rules and regulations regarding operation of the facility. Pursuant to Delaware rules, AdvoServ was required to have at least one staff member at all times if there are five or fewer residents in a group home. It must have an additional staff member if more than five residents are in the home.

40. AdvoServ was also required to comply with the requirements of its Maryland DHS contract and the MSDE requirements for out-of-state facilities.

41. AdvoServ was not required to have a specific number of staff on hand to meet its separate obligations to Maryland, but it was required to have enough staff to meet the needs of

the students and provide a "safe, stable and appropriate setting, treatment modality and rehabilitation services . . . ."

42. Because some of the children placed at AdvoServ engage in high levels of maladaptive behaviors such as injuring themselves, throwing objects, or engaging in physical confrontations with others, either DHS, MSDE, or both provided additional funding for a one-on-one aide for certain children.

43. If DHS provided a one-on-one aide for a student, it increased the base rate paid to AdvoServ from $467.58 per day to $790.65 per day ($171,134.28 per year to $289,377.90 per year). This increase in compensation was to provide a one-on-one aide for eight hours per day on school days (to cover before and after school) and sixteen hours per day on the weekend. If the child also needed a one-to-one aide during school hours, MSDE paid $29.60 per hour for six hours per day on school days. Those rates increased to $798.45 and $27.17 for the 2016-17 school/fiscal year

44. If a child was placed at AdvoServ by a local school system and was determined to need a one-on-one aide during both the school day and outside of the school day, MSDE paid $29.60 per hour for sixteen hours of service per day, increasing to $27.17 for the 2016-17 school year.

45. Because one-on-one aides are to be assigned specifically to one child to monitor that child's behavior and promptly intervene when necessary, they are required to have the child to whom they are assigned in the aide's line of sight at all times and are not available to supervise or assist other children.

46. Thus, when determining the minimum staffing necessary to meet the Delaware mandatory minimum requirements and how many staff are necessary to provide a "safe, stable,

and appropriate setting, treatment modality and rehabilitation services" under its contract with Maryland, AdvoServ must have enough staff on hand to meet the requirements and needs of all children and an additional staff member to provide one-on-one services to each student for whom such services were ordered.

47. AdvoServ was aware of the consequences of not having staff to supervise the children. On June 26, 2015, it reminded all staff that the individuals in the program "***will*** engage in unsafe and/or inappropriate behavior if not properly monitored and supervised." (Emphasis in original) All staff (not just one-on-one staff) were instructed provide "***line of sight*** supervision for the individuals assigned to them." (Emphasis in original).

48. Yet despite its acknowledgment of the need for close supervision of the individuals in its program. AdvoServ often failed to have enough staff on hand to provide both the one-on-one supervision for students for whom this additional service was funded and the basic supervision required for all students in the program.

49. The failure to provide adequate staff to provide the one-on-one aides for which the State paid begins with AdvoServ's shift-scheduling process.

50. One-on-one aides are provided for sixteen hours each day so that they are available to assist the children with waking up, getting dressed, and getting ready for the day; with daily activities; and with getting ready for bed. One-on-one aides are not provided for overnight hours, when children are sleeping and therefore less likely to need such intense supervision.

51. Neither DHS nor MSDE specifies which sixteen hours of each day the one-on-one aide must be available, as this will vary from facility to facility and from child to child depending on the facility and child's daily schedule.

52. At AdvoServ, staff woke the children for the morning and begain morning activities around 6:00 am. Children were put to bed between 8:00 and 9:00 pm on school nights and 10:00 pm on weekends.

53. Thus, the appropriate times for the one-on-one aides to be on duty would have been 6:00 a.m. to 10:00 p.m.

54. For staffing purposes, AdvoServ broke the day into three shifts: day from 7:00 a.m. to 3:30 p.m., evening from 3:00 p.m.to 11:30 p.m., and night from 11:30 p.m. to 7:00 a.m.

55. AdvoServ employed the one-on-one aides on the day and evening shifts.

56. By failing to conform the one-on-one aides' schedules to the children's schedules, AdvoServ failed to provide one-on-one supervision in the mornings from 6:00-7:00 while the children were getting up and starting their day, but then had one-on-one aides working after the children were in bed, when one-on-one services were not required.

57. AdvoServ was aware that the children's day began earlier in the morning than the day shift for its employees. Day shift employees complained to management when they felt that the overnight shift had not done enough toward getting the children out of bed and ready for school, leaving this work for the day shift.

58. For example, one Maryland child placed at AdvoServ and for whom AdvoServ received additional compensation to provide a one-on-one aide was Student 27.[6] AdvoServ received multiple complaints from the day shift staff, which included Student 27's one-to-one aide, that when the days shift arrived, Student 27 was still in bed and had not had breakfast or taken a shower. Student 27 required a special diet, and the day shift staff noted that while the

[6] HIPPA, FERPA, and State law regarding recipients of social services prohibit the public identification of the children placed at AdvoServ without an order from the Court. The State will provide AdvoServ with a key identifying each of the students for whom AdvoServ is alleged to have submitted claims.

other residents in the house had already eaten breakfast prepared by the night shift, Student 27 had not eaten and no food was left for him. The day shift, at least according to their complaints, should not be "forced to cook for, AND wake, feed, and shower [Student 27]." Put another way, the day shift, which included Student 27's one-on-one aide, should not be "forced" engage in the activities that required the presence of a one-on-one aide because due to AvoServ's schedule mis-match, these tasks were generally handled by the overnight shift, which did not have a one-on-one aide to assist Student 27.

59. Despite this knowledge, AdvoServ did not adjust the schedules of the one-on-one aides to match the children's schedules and provide services for the 16-hour period during which the children were awake and in need of one-on-one services.

60. In addition to the scheduling mis-match, AdvoServ also failed to provide sufficient staff to provide both the general supervision required for all children and additional one-on-one supervision for those students for whom the State paid extra for this service.

61. This failure began with AdvoServ's creation of authorized staffing plans that did not allocate enough staff to provide all of the required services.

62. For example, in November 2015, ten children, five from Maryland, lived in a building known as 1968. This required two staff to be present at all times to meet Delaware's required 1:5 staff to student ratio.

63. One of the Maryland children residing at building 1968, was also supposed to have a one-on-one aide.

64. On information and belief, one additional child living in the 1968 house who was not placed at AdvoServ by Maryland also required a one-on-one aide.

65. AdvoServ, therefore needed four staff on duty during waking hours: two to provide one-on-one services to the two children who required it and two to provide general supervision and assistance to the other eight students.

66. AdvoServ, however, had not authorized and sometimes did not have enough staff to provide both the required general supervisor and the one-on-one aides.

67. Although it would require 5.6 FTE's per shift to meet both the general and one-on-one supervision needs, AdvoServ only budgeted to have 5 FTE's at the 1968 house on the day and evening shifts from November 2015 through February 2016, when the number of students living in the residence changed.

68. AdvoServ's approved authorized staffing plans for the residences known as 4815 and McCoy were also below the level needed to meet the minimum staffing and one-on-one staffing required in the homes in May and June 2016 (4815) and November 2015 through February 2016 (McCoy). The authorized staffing plans for other residences may also have been insufficient to meet the needs of the students residing there depending on the number of students from other states requiring one-on-one or other special services.

69. Even when the AdvoServ authorized staffing plans would have provided enough staff for a residence, it often did not have enough staff on hand to meet the required staffing levels.

70. The company did not employ enough people to meet the minimum staffing levels it had identified for each residence. It operated at about a twenty percent vacancy rate between the staffing plans and the number of staff actually employed.

71. Although the staffing levels and number of vacancies were reviewed each month, AdvoServ failed to increase the number of staff it had employed to match the staffing levels it had self-identified as being necessary.

72. As one of AdvoServ's Program Directors described it – "that leaves us with 39 CLS vacancies. Crazy."

73. Instead of hiring more staff to reduce the "crazy" number of empty staff positions, AdvoServ attempted to cover these deficits by refusing to give staff leave time and requiring the staff to work double-shifts. This strategy, however, failed to result in sufficient staff being on hand at all times. It was, in fact, counterproductive, as staff who were not able to arrange for days off when desired would simply call in sick to get the days off that they wanted.

74. For example, in the first week of November, the 4185 residence was understaffed for almost four hours; the 2416 residence for two and half hours, the 2960 residence for seven and a half hours, the 4087 residence for more than eight hours (including ten minutes when no adult was in the residence); and the 1968 building for two and a half hours. In the first week of January 2016, at the residence known as 1514, there was insufficient staff were on site for more than thirty hours, including a twenty-one minute period on January 2 when the children were left alone, with no staff in the residence.

75. AdvoServ also failed to increase staff in response to instances in which it determined that a student needed additional supervision. Two students in the residence known as 4087 had a number of fights with each other, with one attacking the other with a knife. AdvoServ's program staff determined that one student should be assigned a one-on-one aide and the other a two-on-one aide during waking hours as well as a one-on-one aide overnight.

AdvoServ did not increase the staffing allotted to the 4087 residence in response to this need for increased supervision; instead, it decreased the number of staff slots allotted to the building.

76. Altogether, AdvoServ failed to have enough staff on hand to provide one-on-one services more than ten percent of the time, often failing to have enough staff on hand to meet the 1:5 minimum ration required by Delaware and sometimes leaving the children completely unsupervised.

Even when Physically Present, AdovServ's
Staff did not Actually Supervise or Assist the Students

77. Even when AdvoServ had enough staff on hand to provide one-on-one services, it failed to actually provide those services.

78. A one-on-one aide is not simply another staff person who is available to assist and supervise the children. One-one-aides are provided when a child's maladaptive behavior, such as banging their head against the wall or becoming physically violent with others, creates a danger to the child or others. Accordingly, one-on-one aides are required to maintain visual supervision of the child to whom they are assigned at all times so that they can react immediately to stop problem behavior before a child can injure himself or others.

79. AdvoServ was aware of this requirement, explaining in its "1:1 Staffing Protocol," on which all staff were supposedly trained, that the "staff member must always maintain line of sight supervision of the individual unless a closer range of supervision is deemed necessary based on clinical input."

80. In June of 2016, AdvoServ issued a "1:1 Supervision and Programming" memo to the staff who supervised certain students reminding that staff that one-on-one aides "must remain within 3-5 feet of their assigned individual" and that "1:1 individuals should not be left unmonitored or unsupervised at any time."

81. AdvoServ's one-on-one staff failed to maintain line of sight supervision over the students for whom Maryland paid for this additional level of care.

82. The State paid for a one-on-one aide for Student 36. On January 2, 2016, Student 36 had been highly agitated and was physically restrained by AdvoServ staff multiple times. Yet AdvoServ security video footage shows Student 36 is often not supervised by her one-on-one aide, spending time in her bedroom with no staff member observing her.

83. The video shows that shortly after 8:00 p.m., Student 36 emerged from her room and banged her head on the wall, at which point staff, who were sitting in the living room area, engaged in a scuffle with her. Staff then took a floor mat into Student 36's room to continue physically restraining her, in violation of AdvoServ's policy to only restrain students in the common areas of the homes so that the restraint is captured by the security cameras, which are only used in the common areas.

84. Staff then left Student 36 in her bedroom, again without anyone in line-of-sight of her. Student 36 then emerged for her bedroom and stood in the hallway, where she was in full view of AdvoServ's staff. Student 36 banged her head into the wall – *eight times* – and hit the wall, while AdvoServ staff watch her and take no action to intervene.

85. AdvoServ is required to report all instances in which a student placed at the facility by DHS is physically restrained.

86. When AdvoServ reported the use of physical restraints on Student 36 on January 2, 2016, it did not inform DHS that one-on-one staff were not maintaining line-of-sight supervision over Student 36 (as required) or that its staff simply sat and watched as Student 36 repeatedly hit her head against the wall.

87. AdvoServ took no action against the staff involved for failing to properly provide line-of-sight supervision for Student 36 or for physically restraining her in her bedroom rather than in a common area.

88. The State paid for Student 39 to have a one-on-one aide because of her high level of self-injurious behavior, such as head banging and scratching herself. Student 39's levels of self-injurious behavior were so high that AdvoServ assigned two one-one-one staff to her to stop her from hurting herself.

89. AdvoServ was aware of the importance of preventing Student 39 from banging her head against the wall, instructing its staff in on June 2, 2015 that because of Student 39's head banging "and the potential long term effects it may have on her health," they were to "maintain line of sight supervision with [Student 39] during waking hours." If she was in her bedroom, staff were to be "positioned in or right outside of her doorway. It is NOT ACCEPTABLE for staff to sit at the end of the hallway near the dining when [Student 39] is in her bedroom." Staff must be in close proximity to block or re-direct the self-injury."

90. Despite the clear direction that it was NOT ACCEPTABLE for Student 39's one-on-one staff to be anywhere other than within line of sight and in close proximity, AdvoServ's staff proceeded to do exactly that, with no response from AdvoServ's management.

91. From June 1, 2015 through August 31, 2015, AdvoServ noted fifty-two instances in which Student 39 injured herself or had an injury resulting from an unknown cause.

92. In light of the high number of injuries to Student 39, on January 15, 2016, an AdvoServ nurse went to check on Student 39 in her residence. The nurse reported to AdvoServ's Assistant State Director that Student 39 had significant bruising and bleeding from head-banging. Although staff in the residence reported that Student 39 had been banging her

head "last night and today," they also told the nurse that they were not required to be in line of sight of Student 39. The nurse noted that it would be difficult to explain Student 39's injuries to her family, should they ask, given that Student 39 was supposed to be constantly supervised and also pointed out that Student 39's head-banging could cause a serious head injury.

93. A second staff member confirmed that when nursing checked on Student 39, the closest staff member to Student 39 was "out of sight and eating her lunch" and noted that the number of incidents of Student 39 injuring herself were "partly generated because of insufficient supervision."

94. AdvoServ's Assistant State Director's response was to ask the Program Director to "explain" the required supervisor level to the nurse, noting that "it sounds like she does not need closer staff proximity if she is causing this level of damage". The Program Director noted that she was "overwhelmed" with no clinical support "whatsoever" to assist in finding ways to address Student 39's behavior. She was told to raise the problems with AdvoServ's Clinical Director.

95. No action was taken by AdvoServ to ensure that staff were actually within line of sight of Student 39 to reduce the chances she would injure herself or to develop a new behavior plan to implement therapeutic measurers to address her behavior – the nursing staff noted that no one had responded to discuss the supervision needed to keep Student 39 safe.

96. To the contrary, in just the month of January 2016, AdvoServ noted 119 incidents in which Student 39 injured herself or had an injury the cause of which was unknown.

97. Although AdvoServ continued to keep records of injuries suffered by other students throughout 2016, it stopped keeping track of Student 39's injuries in January 2016.

98. Much the way AdvoServ's one-on-one aides functioned simply as an adult in the building rather than actively supervising and assisting the children assigned to their care, AdvoServ's staff in general often served simply as an adult in residence rather than providing substantive assistance or supervision.

99. AdvoServ was well aware of the lack of active monitoring or supervision by its staff, yet took no steps to ensure that its staff were actively monitoring the children in their care.

100. In September 2015, a Maryland child placed at AdvoServ ran away with an AdvoServ staff member who engaged in a sexual relationship with the child.

101. Subsequent investigation by the Delaware Department of Services for Children, Youth, and their Families found that the staff member and the child had an inappropriate relationship at AdvoServ, with the staff member spending "extensive" time in the child's bedroom watching movies and giving special telephone privileges to the child.

102. According to the Delaware investigation, "several" other staff members were aware of these inappropriate and concerning behaviors, yet AdvoServ took no action to address the issue or reassign the staff member.

103. The Delaware Department noted that this incident "highlights ongoing significant concerns about the lack of adequate supervision of direct care staff across the Delaware facilities licensed to serve minors." It noted that while AdvoServ terminated the employees involved in this and other serious incidents, it "failed to demonstrate that its supervisory structure and management practices are minimally appropriate in proactively assessing and responding to risks common in the provision of residential services – especially to vulnerable populations." The Department concluded that "these ongoing patterns of inadequate supervisory and management oversight remain extremely concerning."

104. Throughout 2015 and 2016, AdvoServ continued to demonstrate a pattern of lackadaisical (at best) or non-existent (at worst) supervision of the children in its care.

105. For example, Student 10 reported that he was allowed to go to stores and buy three liter bottles of soda, iced tea, honey buns, and other high fat and sugar foods, which he was allowed to "consume in a short period of time." Student 10 was overweight and receiving weight loss services from a weight clinic. Yet AdvoServ staff allowed him to engage in unhealthy binge-eating of junk food.

106. Student 9's mother reported that staff purchased Student 9 a water ice and later allowed him to go the Dollar Store and purchase candy. Student 9 was not supposed to eat these foods due to a medical condition.

107. AdvoServ described these as "issues I'm sure [Delaware licensing authorities] would be flipping out about!! Gosh". It did not, however, take any action to address these issues to ensure that they would not happen again.

108. An AdvoServ staff person had, on two occasions, taken a student out of the program alone. Although the staff member was told that not to take students outside of the program without another staff member, no disciplinary action was taken. In September 2015, the staff member, once again, took a student (Student 9) outside without another staff member to assist. The third offense (along with refusing to assist a student who soiled himself and asked for a shower, forcing him to go to bed without washing) finally earned her a three-day suspension.[7]

109. AdvoServ staff gave Student 24's glasses to "Tony" on July 10, 2015. Yet on November 10, 2015, staff were attempting to locate the glasses – which Student 24 had been

[7] The staff member had previous write ups for coming in late, calling out without leave, and using her cell phone while on duty rather than supervising the children. It was only when the staff member later walked off the job despite her supervisor's direct orders to stay that she finally did something that AdvoServ deemed serious enough to warrant termination.

without for four months! – not because ensuing that students who need glasses have their glasses is important, but because Student 24 had reported the missing glasses during a court hearing, his social worker had been inquiring about the glasses, and AdvoServ wanted to make sure he had them before having to make a report to the court admitting that they were missing.

110. In June 2016, Student 5's mother reported that during her visits to the facility, staff were usually lying around, sitting in chairs, and not supervising the students. She reported that Student 5 was not engaged in any activities and would call his family "all day." She also reported the Student 5 had made inappropriate statements while on the phone.

111. AdvoServ's supervisors learned that none of the staff in the residence could verify what Student 5 had said on the telephone call, which "appears to further support that [Student 5] isn't being provided direct supervision at times." Rather than address this issue, however, AdvoServ's staff complained about students having access to cell phones.

112. Despite these and other examples in which AdvoServ knew that staff were not actively supervising, assisting, and caring for the students, it failed to take any action to ensure that it was providing a safe, stable and appropriate setting, treatment modality and rehabilitation services.

AdvoServ's Schools Often Lacked Teachers

113. AdvoServ operated a middle school and a high school for the students in its program.

114. The MSDE requires that non-public schools that provide residential special education services maintain an average ratio of four students to each certified teacher or seven students per certified teacher if an aide is present in the class room.

115. AdvoServ never intended to fully comply with this rule. Its class roster shows that it assigned eight students – all from Maryland – to classroom B1 for the 2015-16 school year.

116. It also did not arrange for substitute teachers when the teacher assigned to a room was absent.

117. The teacher assigned to classroom B1 was on a medical leave for July 13, 2015 through August 28, 2015.

118. The teacher returned to work briefly, but had twenty more absences.

119. The teacher then resigned. The position was vacant from November 19, 2015 through December 25, 2015.

120. AdvoServ did not arrange for a substitute teacher to cover these absences.

121. AdvoServ was well aware of the fact that classroom B1 did not have a teacher. On November 5 2015, its State Director of Education noted that Student 24, who was assigned to a different class room, "has been able to go to B1, where there is no teacher." The clinician assigned to Student 24 noted that his plan allowed him to take breaks when needed, but that he should not take his breaks "in B1, which is unstable as it is with the current (non) teacher situation."

122. Altogether, AdvoServ's teachers were absent for 2318 hours on 376 school days from June 1, 2015 through August 16, 2016.

123. AdvoServ did not provide substitute teachers to cover these absences.

124. When teachers were absent, other teachers were asked to double-up on students or attempted to monitor more than one room by hovering in a connecting doorway or in the hallway. Other times, students were left completely unsupervised when their teacher was absent.

125. Supervision during the school day was so lax that in April 2016, AdvoServ had to remind the teachers to let someone know when the children would leave the facility on an outing, due to "previous incidents" when students were not on site and unaccounted for.

AdvoServ Failed to Provide IEP Services

126. Each student receives an Individual Education Plan discussing the nature of their disabilities and the strategies and services that will used to assist the student in obtaining the highest degree of educational attainment possible.

127. As part of those plans, some students were supposed to receive speech language therapy, occupational therapy, and counsel.

128. AdvoServ was required to provide these services and maintain documentation verifying that fact.

129. AdvoServ did not have a speech language therapist from September 11, 2015 through Jan. 2, 2016.

130. When the speech language therapist it hired in 2016 inquired as to whether she should note in quarterly progress reports that the company planned to try to make up the lost time, AdvoServ's State Education Director instructed her to attempt to make up the sessions for two students, but that "overall it's not necessary."

131. According to AdvoServ's records, it failed to provide 537.34 hours of speech language therapy ordered for Maryland students from September 11, 2015 onward.

132. AdvoServ does not have records to verify that speech language therapy services were provided prior to September 11, 2015.

133. Likewise, as of November 12, 2015, AdvoServ did not have an occupational therapist to provide the required occupational therapy and has no records to verify that any services were provided.

134. Although AdvoServ had a psychologist on staff who provided some therapy, it did not maintain records to show that all students received the counseling required in their IEP's.

135. Student 36 was admitted to AdvoServ on April 22, 2015 and was to receive two thirty-minute counseling sessions each week. On June 19, her social worker noted that she had not received any mental health services or medical appointments.

AdvoServ Failed to Administer Medications as Prescribed

136. AdvoServ was required to administer medications to students as prescribed by their treating physicians.

137. Many of the students placed at AdvoServ received psychotropic medications to treat mental health conditions. It is critical that these medications be administered correctly. Failure to do so may result in the student decompensating – showing a higher number of behavioral symptoms.

138. Each student who was prescribed medication had a medication administration record – a chart listing each medication with space for staff to initial each time a medication was given. If a medication was not given, staff were to initial the record and note a reason on the back.

139. Both Delaware and Maryland law require that all staff who administer medications have specialized training to do so. Part of the required training includes how to fill out a medication administration record.

140. AdvoServ's staff routinely failed to administer medications entirely or administered an incorrect does.

141. AdvoServ was aware of this, but took no action to stop these repeated, serious problems.

142. Delaware authorities conducted an inspection of AdvoServ from June 1- June 8, 2015. It found that medications had not been properly administered at the residence known as Bo Mill. In response, AdvoServ committed to re-train the Bo Mill staff on proper medication administration and pledged that medical staff would conduct "routine compliance checks" at the residences it operated.

143. On June 1, 2015, AdvoServ's nursing staff stated that they completed an incident report because Student 25 had missed eight doses of Clonidine over one weekend. The nursing staff requested that supervisors make sure that the staff administered medications as ordered.

144. AdvoServ did not report this incident to the State, and took no other action to make sure that staff correctly administered medications.

145. Not even two months later, on July 20, 2015, AdvoServ's Assistant Program Director noted that there were "3 med errors (ugh!)" over the weekend. None of these errors involved Maryland students. But despite "counseling" the staff involved, the medication errors at AdvoServ continued.

146. Student 11 was prescribed Valproic Acid. Blood tests showed that the levels of the medication in his blood were "going up and down without reason" leading the clinical staff to question whether Student 11 was receiving his medications. AdvoServ did not follow up on these suspicions or otherwise seek to determine why Student 11's blood tests did not show a consistent amount of medication in his system.

147. On February 13, 2016, one of AdvoServ's nurses reported that a Maryland Student 11 had three white pills during school. AdvoServ's staff was unsure who had given Student 11 his medications that day. Student 11 had been engaging in increasing numbers of maladaptive behaviors, which AdvoServ's nurse speculated might be caused by staff failing to make sure he was actually swallowing his medication.

148. AdvoServ took no action to address these issues and did not report to the State that Student 11 had missed some doses of medication.

149. On March 23, 2016, AdvoServ again noted instances of students not getting their medications correctly: Student 25 showed up at school with pills and offered them to other students and on a different day, pills were found sitting on the counter in a residence that staff "thought," but were not sure, were medications prescribed for Student 25 that he had not taken.

150. AdovServ's nursing staff noted that it was "really vital" for staff to administer medications correctly, noting that it "can really cause a big problem if meds end up in the wrong hands" and that students needed to take their medication as prescribed and not miss any doses.

151. AdvoServ took no action to address these issues and did not report to the State that Student 25 had missed some doses of medication.

152. May 17, 2016, AdvoServ's Assistant Program Director noted that Delaware state authorities would be conducting an inspection and instructed staff to make sure that the medication administration records had all initials on it.

153. It is improper to go back and add initials to a medication administration record after the fact. If the records did not have all the initials on them, they should have been left alone – allowing Delaware authorities to note the problems with the records.[8]

[8] The Assistant Program Direct also appears to tell staff to falsify documents of fire drills, water temperature checks, and meals served.

154. The Assistant Program Director also inquired who administered medication at on May 7, 8 and 14 because they were not given. The individual involved was not from Maryland.

155. On June 28, 2016, one of AdvoServ's nurses decided to conduct a medication check at the residence known as Bo Mill. She discovered not only that staff were not giving medications to the students as required, but that the staff were falsely stating on the medication administration records that the medications had been given.

156. The nurse found that Student 1 had not been receiving his Valproic Acid. She discovered that one bottle of medication, ordered in March and containing only enough medication for two days, still had medication in the bottle. The bottles for April and May were unopened. The bottle for June was opened, but despite the fact that the nurse was checking at the end of the month, the June medication bottle was still "practically full." AdvoServ's staff signed the medication administration records indicating that the medication had been given.

157. During the time period that he was not receiving his medication, Student 1 was observed to have "decompensated."

158. The nurse also uncovered that Student 26, was supposed to receive a medication that had not been given for at least two weeks, possibly longer, but AdvoServ's staff indicated on the medication administration records that the medication had been given.

159. The nurse also discovered that the Bo Mill residence lacked any measured medication cups for administering liquid medications. The residence had been out of cups for "a while" and had been "eyeballing" the medication given to the children.

160. In response, AdvoServ retained the staff in question and placed a write up in their file. It took no other action, although, in the words of AdvoServ's Program Director, "it looks really bad."

161. The nurse later learned that most of AdvoServ residences lacked measured cups for administering liquid medication and were "eyeballing" the medications given to students.

162. AdvoServ's nursing staff described "eyeballing" the amount of liquid medications as "completely intolerable," "crazy," and "neglect!!"

163. In response, AdvoServ's Program Supervisor instructed the supervisors at each residence staff to "review" proper medication protocols with the direct care staff, but took no additional action. In fact, its Clinical Director merely observed "I'm not surprised."

164. As part of administering medications to the students in its care, AdvoServ was required to keep prescriptions current, obtain orders for refills when needed, and have the prescriptions filled by a pharmacy.

165. AdvoServ often failed to administer medications as required because it did not have them on hand.

166. A review of the medication administration records for ten of the Maryland students placed at AdvoServ showed that on 717 occasions, staff noted that a medication or blood sugar test was not given because it was not available. Medications and testing supplies were not available for weeks at a time.

167. AdvoServ took no action regarding the missed medications.

168. To date, AdvoServ has not provided the medication administration records for the other Maryland students placed there. Given the systemic and sustained lack of medication availability in the ten records reviewed, there are likely hundreds if not thousands of additional instances of AdvoServ failing to make prescribed medications or blood sugar checks available to students.

AdvoServ's Failed to Accurately Report Incidents to the State

169. AdvoServ was required to submit critical incident reports in accordance with COMAR 14.31.06.13 and to comply with the standards for Residential Child Care Programs and Licensing & Monitoring of Residential Child Care Programs under COMAR 14.31.05 and 14.31.06.

170. This required AdvoServ to report to DHS any instances in which a child was physically restrained, any injury requiring medical treatment, any incident in which police were involved, and any instance in which a child received an overdose or an under dose of medication.

171. Despite the hundreds of instances in which Maryland students received an under dose of medication, either because it was not available or because staff simply didn't give it, AdvoServ did not report even a single instance of a medication under dose to DHS.

172. Despite knowing that its staff routinely "eyeballed" the amount of liquid medications, rather than measuring the correct dose, AdvoServ, once again, failed to report even a single instance of an incorrect dose given to a student.

173. AdvoServ reported numerous instances of physical restraints or injuries to DHS, but often left out crucial details or minimized the nature and severity of the incident.

174. Although AdvoServ's internal policies require the staff to fill out a so-called Delaware and Maryland Reporting Form whenever a restraint is used, these forms were either not completed or destroyed, so that it is not possible to compare the staff's original statement of what happened with the version untimely provided to DHS.

175. Likewise, when a child was injured or alleged abuse, AdvoServ's internal policies called for an investigation, including obtaining written statements from the staff involved about what happened. With a few exceptions, these statements were either not completed or destroyed,

so that it is not possible to compare the staff's original statement of what happened with the version ultimately provided to DHS.

176. The statements that were provided show that what staff reported internally and what AdvoServ reported to the State often differ.

177. AdvoServ's repeated inaccurate reporting to the State is ironic, in view of its internal False Reporting and Falsification or Destruction of Documentation policy which instructs employees in the importance of "timely, accurate and truthful" reporting "without any form of falsification or concealment of information."

178. Student 46 was involved in a fight with another student "in the summer of 2015" in which Student 46 struck the other child "multiple times" and was interviewed by the police.

179. AdvoServ failed to report this incident to DHS.

180. On or about August 14, 2015, Student 15 was restrained by AdvoServ staff. Student 15's mother took him home for the weekend and noticed red marks on Student 15's neck. According Student 15's mother, when she spoke to staff, they had no explanation as to how the marks got there. Student 15's mother the contacted AdvoServ's Program Director about the red marks and sent pictures of the injuries.

181. When asked about the incident, AdvoServ's staff claimed that Student 15 cut his lip during a restraint, and that the abrasions on his neck were merely a result of his shirt collar rubbing against his neck. Staff claimed that Student 15's mother confirmed that Student 15 had previously attempted to injure himself in similar ways with his clothing.

182. When AdvoServ reported this incident to the State, it reported only that Student 15 bit a staff member, and then bit his upper lip. It made no mention of the marks around his neck or the pictures of these injuries.

183. On December 20, 2015, Student 17 reported was physically restrained by AdvoServ's staff. She reported to them that one staff member hit her during the restraint. AdvoServ did nothing about Student 17's allegation. Staff later admitted that they saw a red mark on Student 17's nose, but did not notify nursing or follow up on the injury.

184. The next day Student 17's grandfather picked her up to spend a weekend at home. Her grandfather noticed that Student 17's nose was injured and took her to an urgent care medical center. Student 17 had a broken nose and an injury to her elbow that required physical therapy.

185. Student 17's grandfather notified AdvoServ of the injury, which then reported it to the State. AdvoServ did not tell the State that it initially ignored Student 17's allegation and her visible injury.

186. Incredibly, AdvoServ's internal investigation concluded that no disciplinary action should be taken against any of the staff involved – deciding that "no one can account" for how the student broke her nose and ignoring entirely staff's failure to obtain medical care for the visible injury or report either the injury or the allegation that a staff member struck a student. Delaware authorities were not so blasé about the matter, and the staff member who struck the student ultimately pled guilty to criminal charges.

187. Student 26 was punched and kicked by a staff member on February 20. Another staff member witnessed the incident and had to physically separate the assaultive staff from Student 26.

188. AdvoServ was well aware of this fact, noting on an "Incident/Injury Report" dated February 20 at 9:00 p.m. that staff punched and kicked Student 26 and had to be physically

directed to leave by other staff. It obtained written statements from those involved and another student who witnessed the assault on February 22, 2016.

189. Yet when it reported this incident to the State on February 23, AdvoServ merely stated that Student 26 reported that he had been struck by a staff member during an altercation. It did not note that it had, in fact, already confirmed that Student 26 was assaulted by a staff member.

190. On May 13, 2016, AdvoServ reported to the State that Student 36 was restrained four times to do her own aggressive behavior. As described to the DHS, while being restrained, Student 36 became aggressive and began hitting. Staff "attempted to block the aggression, but were unsuccessful."

191. In reality, Student 36 was sitting on the floor following a physical restraint. An AdvoServ staff member, who was sitting on the sofa across the room, suddenly got up, crossed the room, threw Student 36 to the floor, and returned to the sofa. The staff member then got off the sofa again, crossed the room, pushed Student 36, and then hit her. Other staff intervened to separate the assaultive staff from Student 36.

192. AdvoServ was well aware of this chain of events, as it was captured on security video. When reporting the incident to Delaware authorities, AdvoServ stated that a staff member slapped Student 36.

193. AdvoServ failed to report that Student 21 had a seizure on August 14 and was taken to the emergency room.

194. AdvoServ took other steps to conceal from the State the contractual and regulatory violations that were routinely taking place.

195. When Maryland regulators were scheduled to be on site, AdvoServ double-checked the files of each student to be reviewed, "making them pretty" – creating missing documentation so that regulators would see a complete file. The company's Clinical Director went so far as to add his signature to Behavior Plans that had not been authored by a licensed individual (as required) in order to be "safe from small minded surveyors."

196. When State regulators reviewed personnel files for AdvoServ staff members to ensure all regulatory requirements were met, AdvoServ only showed regulators the files for staff members if the file was complete – all training completed, the staff had a current C.P.R. card, etc. AdvoServ did not show regulators the files for all of the staff members who cared for Maryland students so that regulators would not see that a significant portion of the staff were not properly qualified to work with Maryland students.

197. In fact, nearly half of AdvoServ's staff had not received required training or did not have current CPR credentials, as required.

198. When State regulators went to AdvoServ for inspections, AdvoServ removed all students whom it believed were likely to act up or exhibit inappropriate or dangerous behavior. Students were taken on a "field trip," which often consisted of driving them around in a van until State regulators left. AdvoServ did not want State regulators to have the chance to see how many students engaged in maladaptive behaviors or observe its staff responding with aggressive use of physical restraints rather than attempting to de-escalate the behaviors with appropriate therapeutic techniques.

199. Pursuant to its contract with DHS, AdvoServ was required to pay all employees the living wage rate, as determined by the State.

200. The living wage is higher than the minimum wage, as is intended to make sure that persons working on State contracts are paid a wage high enough to maintain an adequate standard of living.

201. Pursuant to this requirement, AdvoServ was required to pay staff working on the DHS contract at least $13.39 per hour.

202. Many staff were paid less than $11 per hour.

203. AdvoServ underpaid the required wages by $419,822.

204. AdvoServ operates through a number of different corporate entities. Each residence is a separate entity, as well as the middle school and high school.

The Defendant Entities Function as One, Unified Organization

205. Each of the AdvoServ entities. They operated under the umbrella name of AdvoServ.

206. The entities share employees and operate functionally as one entity.

207. Employees were hired to work for "AdvoServ," regardless of the residence or school at which they are physically working.

208. The company's organizational chart depicts a singular "AdvoServ," for which all of the senior administrative and clinical staff work, showing the same employees working at the various "programs" within the company.

209. Employees were assigned to work at different residences or schools as the needs of the overall program dictated. Thus, employees may work at multiple residences and schools that are technically different companies during the course of a pay period, but clock in to and out from a singular payroll system and receive one paycheck for their work, regardless of how many separately-incorporated locations the employee physically worked at during the week.

210. The entities act as alter egos of each other and do not observe the corporate formalities between and among themselves.

211. The Defendant entities interacted with the State, they did so as a unified, "AdvoServ."

212. When submitting payment rates to the MSDE, AdvoServ described itself as "School-AdvoServ" and "Program-AdvoServ."

213. The DHS contract is between DHS and AdvoServ Programs, Inc. The contract explains that services will provided at one of AdvoServ Programs, Inc's "Affiliated Facilities" AdvoServ Middletown, Inc., AdvoServ Middletown School I, AdvoServ Middletown School II, AdvoServ Middletown School III, AdvoServ Middletown School IV, AdvoServ Middletown School V, Matbe School, Inc, Matbe Transitional School, Inc., Red Lion Group Home, St. George Academy, Inc., Summit Residential Facility, and Carlton Palms Educational Center, Inc.

214. When reporting critical incidents to DHS, the reports were made in the name of "AdvoServ Delaware" regardless of which residence or school (and hence which individual corporation) the incident took place at.

215. Because the AdvoServ entities operated as a unified whole, served as alter egos of each other, and presented themselves to the MSDE and DHS as a singular organization, they are jointly and severally liable to the State.

COUNT I
False Claims Act - Submission of False Claims
Md. Code Ann., Gen. Prov. § 8-102(b)(a)

216. The State incorporates the foregoing allegations as if fully set out herein.

217. AdvoServ submitted claims to the State for services provided to students from Maryland placed at AdvoServ pursuant to the DHS contract and by school systems.

218. Attached as Exhibit A is a list of students, admission dates, and discharge dates. AdvoServ submitted claims for each of these students for the time period they were in the AdvoServ program. AdvoServ submitted claims to DHS through a computer system known as CHESSIE and to the MSDE by sending invoices to the county department of education that placed the student at AdvoServ.

219. The Maryland False Claims Act prohibits the submission of false or fraudulent claims for payment to the State.

220. AdvoServ submitted false or fraudulent claims by, among other things, failing to provide one-one-one services because it did not have sufficient staff available to provide these services; failing to provide one-on-one services because one-on-one staff failed to maintain line of sight supervision over their assigned students at all times; failing to properly supervise students because it did not have enough staff available to meet the minimum staffing required by Delaware state regulations; failing to provide substitute teachers or other appropriate supervision when assigned teachers were absent; failing to provide basic necessities to students such as medications and eye glasses; failing to provide speech language therapy, occupational therapy, and counseling services; failing to pay the required wage rate to its staff; and failing to ensure that all staff were properly qualified in accordance with Maryland requirements for training and CPR certification.

221. The State reasonably relied on AdvoServ's submission of claims as evidence that AdvoServ had complied with all contractual and regulatory requirements.

222. AdvoServ's compliance with its contractual and regulatory requirements was material to the State's decision to pay the claims made by AdvoServ.

223. After the instant action was filed, DHS and MSDE conducted an unannounced visit to AdvoServ. As a result of the inspection and other information learned about AdvoServ, the DHS and MSDE removed all Maryland placed at AdvoServ.

224. The State paid AdvoServ more than $13 million for students placed at AdvoServ from June 1, 2015 until all students were removed in October of 2016.

225. The State would not have paid the claims submitted by AdvoServ had it known that AdvoServ had failed to provide the bargained-for services at even the most basic level of having sufficient staff on hand and administering medications as prescribed.

226. The State paid AdvoServ an additional $1.7 million for one-on-one services.

227. The State would not have paid the claims for one-on-one services had it known that AdvoServ had not provided these services.

WHEREFORE the State seeks damages in excess of $75,000, penalties of $10,000 for each violation of the False Claims Act, treble damages, and such other and further relief as the Court deems just and appropriate.

COUNT II
False Claims Act – False Statements or Records
Md. Code Ann., Gen. Prov. § 8-102(b)(2)

228. The State incorporates the foregoing allegations as if fully set out herein.

229. AdvoServ was required to report critical incidents to the State.

230. As described above, on at least six instances, AdvoServ failed to report a critical incident or reported the incident in a misleading manner, hiding the fact that AdvoServ's staff had (or may have) assaulted or injured students.

231. Although AdvoServ was required to report any instance in which a child place by DHS received an overdose or an underdoes of medication, AdvoServ failed entirely in its duty to do so – resulting in hundreds of incidents that were not reported.

232. The failure to report these incidents is a misrepresentation by omission, as it communicated to DHS that there were no instances of medication overdoses or under doses.

233. Each failure to report these medication errors is, therefore, as false statement within the meaning of the Maryland False Claims Act.

WHEREFORE the State seeks damages in excess of $75,000, penalties of $10,000 for each violation of the False Claims Act, treble damages, and such other and further relief as the Court deems just and appropriate.

Respectfully submitted:

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REQUEST FOR TRIAL BY JURY

Plaintiff the State of Maryland hereby requests a trial by jury on all issues so triable.

Shelly Marie Martin

REQUEST FOR WRIT OF SUMMONS

Plaintiff State of Maryland hereby request that a Writ of Summons be issued for each Defendant.

Shelly Marie Martin

Exhibit A

Student	Entry Date	Exit Date	One-on-One Aide
Student 1	3/23/2016	9/29/2016	Y
Student 2	1/22/2013	9/29/2016	
Student 3	3/22/2013	6/8/2016	
Student 4	4/20/2015	10/9/2016	
Student 5	12/12/2014	10/13/2016	
Student 6	5/14/2013	7/1/2015	Y
Student 7	1/26/2016	9/23/2016	
Student 8	7/13/2011	2/1/2016	
Student 9	6/28/2016	10/5/2016	
Student 10	8/25/2010	9/29/2016	
Student 11	3/26/2012	10/21/2016	Y
Student 12	4/22/2010	10/13/2016	Y
Student 13	4/20/2008	7/28/2015	
Student 14	11/5/2013	10/18/2016	
Student 15	11/29/2012	9/26/2016	
Student 16	7/1/2015	9/26/2016	
Student 17	2/24/2014	6/9/2016	
Student 18	3/25/2013	9/14/2016	
Student 19	4/1/2013	9/27/2016	
Student 20	4/16/2016	10/10/2016	
Student 21	7/23/2014	9/29/2016	
Student 22	7/13/2016	10/9/2016	
Student 23	11/19/2014	10/11/2016	
Student 24	11/5/2014	11/20/2015	Y
Student 25	11/19/2014	9/16/2016	
Student 26	4/6/2011	9/29/2016	
Student 27	6/30/2014	10/12/2016	Y
Student 28	2/18/2010	2/1/2016	
Student 29	12/1/2015	10/7/2016	
Student 30	6/1/2015	7/23/2015	
Student 31	11/16/2011	10/30/2015	Y
Student 32	7/28/2016	10/3/2016	
Student 33	3/13/2015	9/30/2016	
Student 34	1/27/2014	10/21/2016	
Student 35	8/19/2014	10/8/2016	
Student 36	4/22/2015	10/11/2016	Y
Student 37	10/30/2011	7/28/2015	Y
Student 38	5/30/2012	9/26/2016	
Student 39	9/24/2012	7/1/2016	Y
Student 40	10/9/2014	1/5/2016	
Student 41	11/6/2013	4/19/2016	
Student 42	9/21/2011	6/30/2016	Y
Student 43	11/25/2015	5/26/2016	
Student 44	2/19/2014	8/22/2016	
Student 45	4/27/2016	9/21/2016	
Student 46	6/25/2014	9/16/2016	
Student 47	4/16/2013	10/7/2016	