IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

BARBARA MEIER; MADISON HOUGH; JASON HOUGH; GOVINDA HOUGH; TIFFANY YOUNG; SANDRA STOKES; YOLANDA MCPHERSON; TROY HARVEY; AND BILL CROWELL *Plaintiffs*,	§	
v.	§	Civil Action No. 4:18-cv-00615-ALM
UHS OF DELAWARE, INC.; UNIVERSAL HEALTH SERVICES, INC. MAYHILL BEHAVIORAL HEALTH, LLC SABAHAT FAHEEM; KENNETH CHAD ELLIS; MILLWOOD HOSPITAL LP; SEJAL MEHTA; GARY MALONE ALAN B. MILLER; BEHAVIORAL HEALTH MANAGEMENT, LLC D/B/A BEHAVIORAL HOSPITAL OF BELLAIRE; JAMAL RAFIQUE; HICKORY TRAIL HOSPITAL, LP UNIVERSAL PHYSICIANS, P.A.; DR. SAYS LLC; YU-PO JESSE CHANG; QUINGGUO TAO; HARMANPREET BUTTAR; MD RELIANCE, INC.; YUNG HUSAN YAO. BEHAVIORAL HEALTH CONNECTIONS, INC.; WENDELL QUINN; JAN ARNETT, *Defendants*.	§	

PLAINTIFFS' FIRST AMENDED ORIGINAL COMPLAINT

COME NOW, Plaintiffs BARBARA MEIER; MADISON HOUGH; JASON HOUGH; GOVINDA HOUGH; TIFFANY YOUNG; SANDRA STOKES; YOLANDA MCPHERSON; TROY HARVEY; AND BILL CROWELL (collectively, "Plaintiffs") and file this First

Amended Original Complaint against Defendants UHS OF DELAWARE, INC.; UNIVERSAL HEALTH SERVICES, INC.; MAYHILL BEHAVIORAL HEALTH, LLC; SABAHAT FAHEEM; KENNETH CHAD ELLIS; MILLWOOD HOSPITAL LP; SEJAL MEHTA; GARY MALONE; ALAN B. MILLER; BEHAVIORAL HEALTH MANAGEMENT, LLC D/B/A BEHAVIORAL HOSPITAL OF BELLAIRE; JAMAL RAFIQUE; HICKORY TRAIL HOSPITAL, LP; UNIVERSAL PHYSICIANS, P.A.; DR. SAYS LLC; YU-PO JESSE CHANG; QUINGGUO TAO; HARMANPREET BUTTAR; MD RELIANCE, INC.; YUNG HUSAN YAO; BEHAVIORAL HEALTH CONNECTIONS, INC.; WENDELL QUINN; and JAN ARNETT ("Defendants"). In support thereof, Plaintiffs state the following:

I.
PARTIES

1. Plaintiffs are individuals and citizens of the state of Texas, who reside in various Texas counties.

a. Plaintiff Barbara Meier resides in Wylie, Collin County, Texas.

b. Plaintiff Madison Hough is an individual residing in Galveston, Galveston County, Texas.

c. Plaintiff Jason Hough is an individual residing in Red Rock, Bastrop County, Texas.

d. Plaintiff Govinda Hough is an individual residing in Red Rock, Bastrop County, Texas.

e. Plaintiff Bill Crowell is an individual residing in Pearland, Brazoria County, Texas.

f. Plaintiff Troy Harvey is an individual residing in Arlington, Tarrant County, Texas.

g. Plaintiff Yolanda McPherson is an individual residing in Mansfield, Tarrant County, Texas.

h. Plaintiff Sandra Stokes is an individual residing in Carrollton, Denton County, Texas.

i. Plaintiff Tiffany Young is an individual residing in Mansfield, Tarrant County, Texas.

2. Defendant UHS of Delaware, Inc. has appeared, answered, and removed this case to federal court.

3. Defendant Universal Health Services, Inc. ("UHS") is a Delaware corporation with its principal place of business at 367 South Gulph Rd., King Of Prussia, PA 19406. UHS does business as UHS and Subsidiaries, Inc. UHS is qualified to do business in the State of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. UHS committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, UHS has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. UHS can be served with citation through its registered agent: Corporation Service Company d/b/a CSC-Lawyers Incorporating Service Company, 211 E. 7th Street, Suite 620 Austin, TX 78701-3136.

4. Defendant Mayhill Behavioral Health, LLC ("Mayhill") was previously misnomered as Mayhill Hospital. It appears that Mayhill has appeared and consented to removal and is represented by the same counsel as Defendant UHS of Delaware, Inc. Mayhill is a limited liability company with its principal place of business at 367 South Gulph Road, King of Prussia, PA 19406-0958. Defendant Mayhill Behavioral Health, LLC is qualified to do business in the State of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. Mayhill Behavioral Health, LLC committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Mayhill Behavioral Health, LLC has had continuous and systematic contacts with the State of Texas and has

contracted with Texas residents over multiple years. Mayhill Behavioral Health, LLC can be served with citation through its registered agent: Corporation Service Company, 701 Brazos Street, Suite 1050, Austin, Texas 78701.

a. Defendant Sabahat Faheem is a natural person residing in the state of Texas. She is licensed to practice medicine in the state of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. She committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Sabahat Faheem has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Sabahat Faheem can be served with citation at her last known address: 2852 Gibraltar St., Irving, TX 75062-5298.

b. Defendant Kenneth Chad Ellis is a natural person residing in Dallas, Texas. Defendant Kenneth Chad Ellis has been a registered nurse in the State of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. Defendant Kenneth Chad Ellis committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Defendant Kenneth Chad Ellis has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Defendant Kenneth Chad Ellis can be served with citation at his last known address: 9746 Burleson Dr., Dallas, TX.

5. Defendant Millwood Hospital LP ("Millwood") is a Texas limited partnership with its principal place of business at 367 South Gulph Rd., King Of Prussia, PA 19406. Millwood is qualified to do business in the State of Texas and is engaging in business in the State

of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. Millwood committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Millwood has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Millwood can be served with citation through its registered agent: Corporation Service Company d/b/a CSC-Lawyers Incorporating Service Company, 211 E. 7th Street, Suite 620 Austin, TX 78701-3136.

a. Defendant Sejal Mehta is a psychiatrist in Plano, Texas who works at Millwood. Defendant Sejal Mehta is a natural person residing in the state of Texas, Collin County. She is licensed to practice medicine in the state of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. She committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Sejal Mehta has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Sejal Mehta can be served with citation at her last known address: 1707 Edinburg CT, Allen, TX 75013-5336.

b. Defendant Gary Malone is a psychiatrist in Grapevine, Texas who works at Millwood. He is licensed to practice medicine in the state of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. He committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Gary Malone has had continuous and systematic contacts with the State of Texas and

has contracted with Texas residents over multiple years. He may be served with citation at his last known address, 1450 Hughes Rd #108, Grapevine, TX.

c. Defendant Alan B. Miller is the CEO of UHS and, surprisingly, is a general partner of Millwood, who owns 81% of the general partnership interest of that Hospital. He is a resident of the state of Pennsylvania and may be served with process at 57 CROSBY BROWN RD, GLADWYNE PA 19035-151. He committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Alan B. Miller has had continuous and systematic contacts with the State of Texas, including the investment in and participation in Millwood and has contracted with Texas residents over multiple years, and this cause of action arises out of those contacts.

6. Defendants Universal Physicians, P.A.; Dr. Says LLC; MD Reliance, Inc.; Officewinsome, LLC are all companies that are the alter ego of Defendant Yupo Jesse Chang.

a. Defendant Yupo Jesse Chang operates a number of businesses out of a residential address in the neighborhood of Tanglewood, City of Houston, Harris County, Texas. He is listed on the staff at Millwood as someone who does patient intakes, but what occurs is that he generates reports for Millwood and other UHS hospitals that allow the other defendants to illegally detain and bill citizens of the state of Texas and/or their payors (private health insurance, Medicare, Tricare, etc.) to make money. All of the defendants in the immediately preceding paraghraph can be served with process through Yupo Jesse Chang at his last known address: 5566 CEDAR CREEK DR STE 100, Houston, TX 77056.

b. Defendant Yung Husan Yao is a notary who works for Yupo Jesse Chang and assists in the enterprise to generate false preadmission assessment reports and other documents used to unlawfully detain Texas citizens in facilities owned and operated by UHS and its affiliates. Defendant Yung Husan Yao can be served with citation at her last known address: 5566 CEDAR CREEK DR STE 100, Houston, TX 77056.

c. Defendant Quingguo Tao is a natural person residing in the state of Texas, licensed to practice medicine in the state of Texas, and engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. Defendant Quingguo Tao committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Defendant Quingguo Tao has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Defendant Quingguo Tao can be served with citation at his last known address: 9600 Bellaire Blvd., Ste. 200, Houston, TX 77036.

d. Defendant Harmanpreet Buttar is a natural person residing in the state of Texas, licensed to practice medicine in the state of Texas, and engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. Defendant Harmanpreet Buttar committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Defendant Harmanpreet Buttar has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Defendant Harmanpreet Buttar can be served with citation at her last known address: 11011 Lark Brook Ln., Houston, TX 77065.

7. Defendant BEHAVIORAL HEALTH MANAGEMENT, LLC D/B/A BEHAVIORAL HOSPITAL OF BELLAIRE (BHB) is a Texas limited liability company with its principal place of business at 367 South Gulph Rd., King Of Prussia, PA 19406. BHB is qualified to do business in the State of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. BHB committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, BHB has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. BHB can be served with citation through its registered agent: Corporation Service Company d/b/a CSC-Lawyers Incorporating Service Company, 211 E. 7th Street, Suite 620 Austin, TX 78701-3136.

a. Defendant Jamal Rafique is a natural person residing in the state of Texas. He is licensed to practice medicine in the state of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. He committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Jamal Rafique has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Jamal Rafique can be served with citation at his last known address: 1602 Pristine Way, Sugar Land, TX 77479.

8. Defendant Hickory Trail Hospital, LP is a Delaware limited partnership with its principal place of business at 367 SOUTH GULPH ROAD, PO BOX 61558, KING OF PRUSSIA, PA 19406-0958. Defendant Hickory Trail Hospital, LP is qualified to do business in the State of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. Hickory Trail Hospital, LP

committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Hickory Trail Hospital, LP has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Hickory Trail Hospital, LP can be served with citation through its registered agent: Corporation Service Company d/b/a CSC-Lawyers Incorporating Service Company, 211 E. 7th Street, Suite 620 Austin, TX 78701-3136.

9. Defendant Behavioral Health Connections, Inc. is a Texas corporation with its principal place of business at 367 SOUTH GULPH ROAD, PO BOX 61558, KING OF PRUSSIA, PA 19406-0958. Defendant Behavioral Health Connections, Inc. is qualified to do business in the State of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. Behavioral Health Connections, Inc. committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Behavioral Health Connections, Inc. has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Behavioral Health Connections, Inc. can be served with citation through its registered agent: Corporation Service Company d/b/a CSC-Lawyers Incorporating Service Company, 211 E. 7th Street, Suite 620 Austin, TX 78701-3136.

a. Defendant Jan Arnett is an individual involved in the business activities of Defendant Behavioral Health Connections, Inc. She resides in the state of Texas. She is a licensed professional counselor. Upon information and belief, on her LinkedIn page, she has been listed as an intake coordinator for Millwood Hospital. She is qualified to do business in the State of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas

Civil Practice and Remedies Code. Defendant Jan Arnett committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Defendant Jan Arnett has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Jan Arnett can be served with citation at her last known address: 1550 W Rosedale St # 518, Fort Worth, TX 76104.

b. Defendant Wendell Quinn is an individual involved in the business activities of Defendant Behavioral Health Connections, Inc. Defendant Wendell Quinn is a licensed master social worker and is qualified to do business in the State of Texas and is engaging in business in the State of Texas within the meaning of Section 17.042 of the Texas Civil Practice and Remedies Code. Defendant Wendell Quinn committed a tort in whole or in part in the State of Texas and caused injury to a Texas resident. Upon information and belief, Defendant Wendell Quinn has had continuous and systematic contacts with the State of Texas and has contracted with Texas residents over multiple years. Wendell Quinn can be served with citation at his last known address: 1350 N. Buckner, Dallas, TX 75218.

II.
JURISDICTION AND VENUE

10. This Court has subject-matter jurisdiction under 28 U.S.C. § 1331 because this action arises under the laws of the United States, and 18 U.S.C. § 1964(c), because this action alleges violations of the Racketeer Influenced Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1962. This court has subject matter jurisdiction under Tex. Health and Safety Code § 576.001, which extends the protections of the laws and Constitution of the United States to people in

mental health care facilities. This Court has supplemental subject matter jurisdiction over the claims that do not raise a federal question.

11. Venue is proper in this District under 28 U.S.C. § 1391 (a)–(d) because, *inter alia*, substantial parts of the events or omissions giving rise to the claim occurred in the District and/or a substantial part of property that is the subject of the action is situated in the District.

12. At all times relevant to these claims, Defendants had continuing and systematic contacts with the State of Texas and this judicial district by delivering services and products into the stream of commerce with the expectation that they would reach the State of Texas and this judicial district. Further, Defendants had minimum contacts with Texas and this judicial district and were doing business in Texas and this judicial district by, among other things, distributing, marketing, and selling their services and products to residents of the State of Texas and this judicial district. Plaintiffs' claims arise from such contacts and business.

III.
CONDITIONS PRECEDENT

13. All conditions precedent to Plaintiffs' right to recover the relief sought herein have occurred or have been performed.

IV.
FACTUAL SUMMARY

14. UHS is an American Fortune 500 company based in King of Prussia, Pennsylvania. UHS is one of the largest hospital management companies in the world.

15. Defendants Mayhill, Millwood, Hickory Trail, and BHB are mental health facilities owned and operated by UHS. Not unlike an all-inclusive hotel, these facilities charge by the day. The longer someone stays at one of these facilities, the more money is charged.

16. Defendant Behavioral Health Connections, Inc. ("the Connection") is a wholly owned subsidiary of UHS. UHS utilizes the Connection as a dispatch company, whereby a representative of the Connection personally visits a prospective patient and coordinates the intake of that patient to a UHS-owned facility. Part of that process involves securing a Preadmission Assessment, which is better explained in the following paragraph.

17. Defendants Universal Physicians, P.A.; Dr. Says LLC; MD Reliance, Inc.; and Officewinsome, LLC are all companies that are the alter ego of Defendant Yupo Jesse Chang. These defendants generate or facilitate the generation of preadmission assessments to meet a legal requirement so that a person can be admitted to one or more UHS facilities. These defendants also generate sworn documents via a notary, Defendant Yung Husan Yao, that are filed with Court to obtain detention orders. The documents are not actually witnessed. This system enables an ability to place and keep people in UHS facilities, whether they need to be there or not. Interviews that are purported to occur really don't occur and are a sham to secure the admission of a patient into a UHS facility or to keep a patient in a UHS facility.

18. Through the use of coordinated document generation efforts using the mail and wires, UHS and its affiliates have developed a pattern and practice to have people admitted to its facilities in Texas without satisfying threshold legal requirements. This coordinated effort operates as a criminal enterprise, in that it involves the ongoing and repeated violation of a number of state and federal laws.

19. The enterprise works to admit people to facilities, whether they need to be admitted or not. Then, once admitted, the enterprise goes to extraordinary lengths to ensure that a patient is kept as long as a payor will pay or, upon suspicion and belief, until such time as a replacement patient or set of patients can be obtained. In furtherance of this scheme, admission

documents are forged; documents to secure that a patient will remain in a facility are falsely notarized and then filed into the state court system; and, in some cases, a person's medical record is written to reflect that services were provided or that certain events occurred, when, in fact, they did not occur.

20. The enterprise uses intimidation, manipulation, and fear via personnel employed or working at the facilities or under the ostensible agency of the facilities to keep voluntary and involuntary patients from leaving the facilities. Here we are talking about doctors, nurses, counselors, social workers, and technicians.

21. Further, upon information and belief Defendants seek to improperly boost profits in some of the following ways:

a. Insurers are improperly billed for services that require a specific amount of face to face time, but those services are not provided;

b. Insurance coverage is often based upon a system where a patient is given a certain code and payment by the insurer is related to the code. The more intense and severe the need, the higher the reimbursement and accordingly, codes are manipulated to increase profits;

c. To effectuate a scheme to increase profits, UHS has persons that "crunch the numbers" so that every single service provided becomes a profit center;

d. Further, Administrators and other key personnel at each facility are taught how to best increase profits for each single service provided;

e. Patients are billed for individual therapy when they are in groups;

f. Patients are billed for group therapies that are provide by persons not licensed or credentialed to provide such services, and in this way, a UHS facility can pay a technician a lower rate than it would pay a licensed professional;

g. Services are provided but are billed to reflect that the services occurred more times than it actually did occur or a service may require a face-to-face contact whether by law, or by insurance carrier requirements, and it is not provided;

h. Patients are billed for diagnostic services, lab services, physician and other medical professional services, even if they have not received such services or items;

i. Physicians and other health care workers are given inducements to increase referrals, increase admissions and increase lengths of stay;

j. UHS and its affiliates will enter in clandestine joint ventures with physicians, predicated upon increasing referrals, increasing admissions and increasing lengths of stay;

k. UHS will offer a physician or other professional reduced rates in an office building that UHS owns or leases, for the physician to have an outpatient practice;

l. UHS will provide, at a reduced rate or even for free, services that the physician would otherwise be required to pay like training, billing services, travel expenses for conferences, and insurance;

m. UHS and its affiliates increase profits by limiting the number of staff available to serve patient needs in such a way to understaff its facilities;

n. To amplify profitability, UHS engages in a pattern and practice of teaching individuals at its various facilities about these and other illicit ways to induce referrals, increase admissions, increase length of stays and manipulate insurance

coverage availability in the manners and particulars noted above and more fully described in this lawsuit and as will be more fully developed at trial;

22. In the last decade, UHS and its affiliates have been sued by both the federal government and by dozens of state governments for insurance and health care fraud, some of which is mirrored in the preceding paragraph. UHS prefers to pay a fine rather than stop the abusive practices, because it is better for business.

23. Sone detailed allegations of UHS's wrongdoing are compiled at http://uhsbehindcloseddoors.org/, and the websites of various US Attorneys' offices, including the Western District of Texas, and the contents of those websites are incorporated herein as if set forth in full.

BARBARA MEIER

24. Barbara Meier ("Ms. Meier") was born on July 12, 1948. She does have a history of depression. She also suffers from Multiple Sclerosis (MS).

25. During the first half of December 2015, Ms. Meier was experiencing some depression because she stopped taking her medication for about three weeks.

26. In and around Friday, December 18, 2015, Ms. Meier's husband, Vern, took her to see her primary care physician who recommended that Ms. Meier check herself into a hospital until her medication could get "back on track."

27. That same day, around 7:00 p.m., Ms. Meier *walked* on her own through the doors of Mayhill with her husband to assess whether or not this facility would be able to serve her unique and individualized needs. At that time, she had all her self-help skills and was able to independently take care of all her own needs.

28. Mayhill quickly admitted Ms. Meier and failed to perform any assessment on Meier prior to her admission, apart from some paperwork.

29. Mayhill staff then took possession of Ms. Meier's walking cane.

30. There is nothing in the medical record that evidences anyone from Mayhill spoke to her about care or daily routine or schedule.

31. There is nothing in the medical record that evidences that anyone from Mayhill discussed the availability of her insurance coverage.

32. There is nothing in the medical record that evidences anyone from Mayhill informed her of the expected daily costs of staying at the hospital or what part of the hospital costs she would be responsible for.

33. There is nothing in the medical record that evidences anyone from Mayhill told her who would be the attending physician providing her care.

34. There is nothing in the medical record that evidences anyone from Mayhill informed Meier that she could be billed separately by the doctors or other medical professionals for services at the hospital.

35. There is nothing in the medical record that evidences anyone from Mayhill verbally advised her of the Patient's Bill of Rights.

36. There is nothing in the medical record that evidences anyone from Mayhill actually provided a written copy of the Patient's Bill of Rights nor did anyone have her sign a form stating that she was advised of those rights.

37. Likewise, there is nothing in the medical record that evidences that anyone from Mayhill gave Meier information, either verbally or in written form, on what specific rights she had during an inpatient stay at the hospital under the Mental Health Code.

38. Meier was purportedly given a "Pre-Admission Physical Exam" by Defendant Qingguo Tao, M.D., though he was not present at the time the examination was performed. Moreover, she was actually admitted to the hospital and brought back to a locked area, before the examination. Meier reasonably believes the examination was a sham.

39. There is nothing in the medical record evidencing that she ever agreed to the admission.

40. There is nothing in the medical record evidencing she ever received informed consent as to any of the medications she was prescribed.

41. On Saturday, December 19th, just one day after being admitted, husband Vern Meier and daughters Cindy and Holly Meier were "stunned" to see a different person brought out by staff for visitation.

42. Ms. Meier was pushed to them in a wheelchair. She was dirty, with drool hanging from the side of her mouth and was unable to communicate well. She was also hungry.

43. A nurse spoke with the family and made notes in Ms. Meier's file that, due to her MS, she needed help carrying her food tray, she needed her food cut in bite sizes, and needed help with showering.

44. The nurse suggested that the family bring in more clothes because Ms. Meier's belongings may have "found feet and walked away."

45. However, many of the family's important questions could not be answered.

46. When asked what medication Ms. Meier was on and if that was the reason she couldn't communicate, they were told there was no medication change listed in her file.

47. The nurse also told the family about the first of what would be many falls over a four (4) day period.

48. The family was also told that Ms. Meier would not be evaluated until the following Monday, more than 48 hours after she had been admitted.

49. Despite having nervous reservations, the family left feeling a little more comfortable after the nurse promised her needs would be met.

50. There was no visitation on Sunday, December 20th. The family did receive a call from a staff person that Ms. Meier had another fall but "seemed" okay.

51. On Monday, December 21st, the family arrived at the hospital at 6:00 p.m. for visitation. Ms. Meier finally arrived in the visitation room at approximately 6:45 p.m.

52. Ms. Meier was pushed into the room in a wheel chair. She wore a vomit-stained shirt. The family remembers that Ms. Meier was now having problems communicating and that she seemed to be "high" on something. Ms. Meier told her family that the pills the staff provided were making her sick, and she kept repeating that she needed to remember "apple, apple, apple," because if she could, it would mean that "she no longer has dementia."

53. Because of Ms. Meier's significantly deteriorated state, her husband Vern and daughter Cindy Meier insisted on talking to someone. They eventually were able to speak with a patient advocate named "Brett."

54. The family asked Brett why Ms. Meier was in her current "high" like condition, to which he stated that it was because the program was working and her outlook was changing.

55. When they mentioned that Ms. Meier told them she had not seen a doctor nor had an evaluation, they were told by Brett that "just because it wasn't in her folder didn't mean it didn't happen."

56. When they questioned Brett on why Ms. Meier still did not have clean clothes, he mentioned it was because she was not following protocol by putting her clothes outside her

bedroom door. Apparently, she was supposed to follow this protocol despite repeated falls, being in a wheel chair, having limited motor skills, and being highly medicated.

57. The family asked Brett why she had not taken a shower in over three days to which he said it was because she never had walked down to the desk to get her "hygiene bucket." Brett promised to call the family and follow up the next day, but he never did.

58. On Tuesday, Mr. Meier received a call from the hospital stating Ms. Meier had another fall. Staff stated that this fall was a bad one, and they would have someone staying with her for the next 24 hours and would be doing x-rays to make sure nothing was broken.

59. At this point, Mr. Meier told the nurse he wanted to see his wife first thing next morning, but staff told him it was not a visitation day. He refused to take 'no' for an answer and was finally told he could show up in the morning to try and get a doctor's approval for a visitation, which he did.

60. She had worsened again. Her eyes, eyelids, and forehead were swollen with burst blood vessels. Mr. Meier requested to talk to her doctor, but that request was denied.

61. After seeing Ms. Meier's condition, Mr. Meier, who had her Power of Attorney (POA), decided he was going to move her to a new facility.

62. However, Mayhill staff said that the POA was not valid.

63. After the family made arrangements to move her to Haven in Frisco, Texas, Cindy Meier called Mayhill and requested to speak to a nurse, social worker, or doctor. She was told all staff were busy and could not take her call. She then stated the family was having her mother transferred and that they were coming to get her.

64. Cindy was then quickly transferred to Brett who immediately apologized for not calling her back right away in the morning like he promised. He said things at the hospital got busy, and they were not able to update her mother's file.

65. He then said Ms. Meier was doing "great."

66. Cindy told him not to worry about updating her file and that they just wanted to transfer her to Haven, a facility that deals with 55 or over patients.

67. Brett's attitude then changed drastically. He told Cindy that the family had "no say" on whether Ms. Meier stayed, as it was Ms. Meier's choice. Mayhill's position was that unless and until Ms. Meier literally spoke the words to staff, nothing could legally be done about transferring her to a new facility. Brett then said he would have to get back to the family later in the day.

68. Approximately fifteen (15) minutes later, Brett called Mr. Meier and had Ms. Meier on speaker phone. The phone conversation consisted of Brett telling Ms. Meier what a good job she was doing in different therapy sessions and asking her if everyone was nice to her. He made several comments about how Ms. Meier didn't want to leave and then proceeded to tell Ms. Meier, "We are treating you good and you like it here. You don't want to leave do you Barb? Your family is trying to take you away!"

69. Fortunately, despite being heavily medicated, Ms. Meier was able to clearly state, "I will go wherever my family wants me to go."

70. A short time later, Cindy called Brett again. This time, Brett said one of Mayhill's attorneys had looked at the POA and confirmed it was for medical and could be used to initiate the transfer.

71. Nevertheless, Brett went on to say that these transfers "took weeks." In response, Cindy told Brett that she had already talked to Haven, and the facility informed her that transfers take hours, not days or weeks. She also informed Brett that Medicare had already approved the transfer.

72. Ms. Meier arrived at Haven later that night on December 22nd.

73. Medical records from Haven show that Ms. Meier was inpatient from December 22 – February 6, 2016. The Haven records also note that upon arrival, she was having severe vegetative symptoms and was hearing voices.

74. For over a month after leaving Mayhill, her face remained bruised, and her eyes were red from broken blood vessels from the repeated falls at Mayhill. During her entire inpatient stay at Haven, she was wheelchair bound.

75. Additionally, Ms. Meier stayed at Hollymead Rehabilitation Center in Flower Mound, Texas, from February 6 – March 3, 2016, in an effort to regain functions after her falls at Mayhill.

76. Over two years later, Ms. Meier continues to struggle feeding herself, and she never regained the ability to walk with a cane since her stay at Mayhill.

THE HOUGH FAMILY CASE

77. Madison Hough was a college freshman at TWU. Madison's roommate was going through a gender transformation and falsely reported that Madison attempted to overdose on ibuprofen. Madison was taken from TWU to Medical City Denton.

78. From Medical City Denton, Madison rode in an ambulance across the street to Mayhill.

79. Madison got off the gurney from the ambulance at Mayhill. Madison immediately went into intake, with Mayhill staff telling her that she was being admitted, despite her saying, “no” and that she “wanted to go home.”

80. Evidently, Mayhill was so desperate to fill an empty bed that Madison was admitted into the geriatric unit, despite being a college freshman.

81. At Mayhill she was informed that the psychiatrist would not be there until the morning, and there was no medical doctor there that night to help her. Mayhill staff said, "Stay here while we get stuff ready."

82. In the meantime, her parents drove up to Mayhill from Bastrop County. Her parents were able to meet with Madison before she left, but her parents were placed under the false impression that Madison was on a 24-48 hour hold, so they both thought that it was mandatory that she stay there.

83. Once her parents left, Madison went through some doors and was stripped down naked and touched, without her consent, under the guise of looking for things she was hiding. She was on her period at that time, and she was told she had to squat and push down, even though she was on her period and had no sanitary napkins to replace what she currently had. In response, the Mayhill staffer basically shrugged her shoulders and said, “this is what we need to do.”

84. She was not given her bill of rights until after the strip search, and only one of 4 pages were provided to her.

85. Although the receptionist behind the desk told Madison’s mother that a toothbrush, toothpaste, towels, and pads would all be provided to her, none of this was provided by Mayhill.

86. Phone calls could only be made in the hallway. No cell phones were allowed. There was no door to the bathroom and no door to the bedroom. It was a coed floor, she was in a room by herself, but she was concerned about the male who kept coming in at night.

87. She could hardly sleep at night because there would be screaming in the middle of the night from people, and the nurses would just scream back at them. She could not understand all the voices and all the yelling.

88. She did complain, "You're not giving me meds, why am I here?" Yet, she was afraid to even say that, but she did, and the medical records don't reflect that she was taking any medications.

89. In Mayhill, she felt like she had no power and no say in anything.

90. She repeatedly asked to go home verbally, but was told that if she signed a request for release, she would be placed on a 24-hour hold and she could be there 3 weeks to 90 days.

91. However, Madison did end up requesting to leave AMA. When she filled out her AMA form, she was being watched by the Mayhill staff. She wrote some positive things because the Mayhill staff were right there watching her fill out the document.

92. Nevertheless, Defendant Chad Ellis stated that he was going to call Dr. Faheem to put her on a 24-hour hold for her filling the form out. There was no 24-hour hold placed on her, but she was still kept in the facility.

93. Defendant Chad Ellis has a lengthy criminal history, including convictions for evading arrest, police chase, theft, felony forgery and several DWIs. In fact, Defendant Chad Ellis had failed a drug test a matter of days prior to Madison’s experience at Mayhill. Chad Ellis was the head nurse at Mayhill.

94. A trained peace officer, Mr. Hough helped her daughter to escape from Mayhill. The incident was captured on video, and was the subject of some media attention.

95. As a result of Madison's escape, Mayhill did everything it could in its power to harm the Hough family, including a malicious prosecution. In fact, Madison's medical records were forged and a "late entry" was made to make an attempt to show that the hospital had the right to detain Madison.

96. The state investigation found that the Hough family's claims were substantiated. The prosecution of Mr. Hough was dropped. The hospital failed to ensure that the notice of rights requirements were met for Plaintiff Madison Hough. The hospital failed to discharge Madison within four hours after a physician signed the discharge order at 0900. Through observation of the hospital video footage, Madison Hough did elope the facility at 1400, due to the hospital failing to discharge the patient with the assistance of her family.

97. But irreparable harm has been done to this family. As a result of her experience with Mayhill, Madison felt that she was not safe at TWU. She really did not feel safe with anyone other than her brother or her parents. She left TWU and moved to Galveston where her brother was residing.

98. Both Mr. and Mrs. Hough sustained personal injuries during the escape. This whole ordeal nearly cost Mr. Hough his job. The family has been devastated by what happened to them at Mayhill.

SANDRA STOKES

99. Sandra Stokes was born on December 10, 1975.

100. She has two degrees from the University of North Texas where she graduated *summa cum laude* each time. She has been a successful statistician. In fact, she worked for

banking giant, Citi, for eight years prior to transitioning into a role as a private consultant in 2014.

101. On May 14, 2017, she walked into the ER at Baylor Carrollton with a complaint of altered mental status. She felt anxiety over work as well as a recent job change. She had personality changes. Her behavior had been erratic with compulsive internet shopping, misplacing items, leaving oven or stove on, doors open. She had a history of a car crash and a mirror hitting her head in the previous month. She presented with an unsteady gait, insomnia, and mismanaging her medications.

102. She was not suicidal.

103. In fact, a UHS-owned facility that is not a party to this lawsuit refused to accept her based on unsteady gait, altered mental status, and the potential to accidentally hurt herself that was not related to being suicidal.

104. After an assessment, Ms. Stokes eventually agreed to go voluntarily to Mayhill.

105. At Mayhill, Ms. Stokes denied any suicidal intent at intake but was deemed to be at a high risk for a fall.

106. Ms. Stokes reported that her confusion was clearing up.

107. Indeed, the following day, she requested to leave Mayhill. She signed an AMA form. She reported that the conditions at Mayhill as cold, a little dirty, and “no rails on bed.”

108. Rather than discharge her after four hours, she was kept against her will.

109. Rather than being at home and safe, she fell and hit her head in Mayhill.

110. After the fall at Mayhill, Stokes was discharged to a different medical facility in Denton with no explanation provided in the medical records.

111. Stokes spent the next fifteen days in the hospital. She developed a seizure disorder. She then underwent significant medical treatment and multiple hospitalizations. She is not the same.

YOLANDA MCPHEARSON

112. Yolanda McPhearson went to the ER.

113. A representative from the Connection was dispatched to the ER. That representative was Defendant Wendell Quinn who recommended Millwood.

114. Prior to sending Yolanda McPhearson to Millwood, an ER doctor allegedly spoke to Defendant Hermanpreet Buttar who was represented to be with Millwood.

115. Millwood is in North Texas.

116. Defendant Buttar resides near Houston.

117. Defendant Buttar signed a report where she performed a preadmission assessment at the ER, but Defendant Buttar was never at the ER.

118. Upon information and belief, Defendant Buttar worked with Defendants Universal Physicians, P.A.; Dr. Says LLC; MD Reliance, Inc.; Officewinsome, LLC and Defendant Yupo Jesse Chang to generate false documents to secure Ms. McPherson's admission into Millwood.

119. Yolanda McPherson was sent to Millwood.

120. At Millwood, the admission documents were not signed by McPhearson, who was on the phone with her husband. Instead, the admission documents were signed by an employee of Millwood. She was never given a bill or rights and never signed a voluntary admission form.

121. At Millwood, Yolanda McPherson was intimidated and forced into a voluntary commitment.

122. At Millwood, Yolanda McPherson made repeated verbal requests to leave for 9 consecutively days to leave the facility. But they failed to release her until the 9th day. Eventually, McPherson was able to get her husband to help her to get out.

123. Prior to her leaving, they required her to sign a promissory note stating that she would pay all charges not covered by insurance.

124. Mrs. McPherson did not see a psychiatrist until less than 24 hours prior to her discharge.

125. Although she was there voluntarily, she was treated like a prisoner. She was strip searched, bed checks were 15 minutes throughout the night, and she was unable to even sleep. She had to sleep with the door open. There was a lot of noise outside including arguments and fights among individuals. She went into the group sessions, and everyone's full name patient-wise is on a door. Conversely, the staff's names are just an initial, there are no full names for the staff yet that courtesy of confidentiality is not extended to the patient.

126. Yolanda McPherson continues to suffer from the experience at Millwood.

TROY HARVEY

127. Troy Harvey was born on June 3, 1965.

128. He served in the United States Air Force from 1986 to 2013, including service in Afghanistan.

129. He is a teacher and a coach at Mansfield ISD.

130. He had an operation on his knee in the past. He experienced knee pain in September of 2016, and he was prescribed a Medrol doespak. On 09/20/2016, Mr. Harvey filled a prescription for methylprednisolone 4 mg prescribed by Joseph Berman, MD. On that same date, he was also given Naproxen 500 mg.

131. After Mr. Harvey had taken the methylprednisolone, he began to have problems at work and abruptly quit his job. The concern was that the methylprednisolone led to his mental changes.

132. On October 3, 2016, Mr. Harvey visited the ER at USMD hospital.

133. A representative of the Connection was dispatched to the ER. That representative was Defendant Jan Arnett, who recommended Millwood.

134. Defendant Jan Arnett lists that she is the intake coordinator for Millwood on her LinkedIn, although this was never disclosed to Mr. Harvey.

135. Mr. Harvey believed that he would only be at Millwood for 24 hours and that he could leave at any time, but that was not true.

136. Mr. Harvey first requested to leave on 10/04/2016 at approximately 8:30 a.m. This request was written.

137. Mr. Harvey was not released until 10/05/2016 at 1:30 p.m. He states that he visited the hospital with the intention of voluntarily admitting himself. He wanted them to do a 24-hour observation.

138. Mr. Harvey was not verbally advised of the Patient's Bill of Rights but was provided with a written copy, which he did sign.

139. Mr. Harvey’s assessment process was deceptive or misleading. He was told that he would have his own room and that after he saw a doctor in the morning he could go home, and that simply was not the case. No one had mentioned a 24-hour hold or observation.

140. He feels he was threatened by Dr. Malone, the psychiatrist, by inferring that if he left the insurance company would not pay his bill or that he would be secluded. Also, if he left AMA, he would have to be held for 7 to 10 days.

141. Mr. Harvey took contemporaneous notes while in the custody of Millwood. His notes for October 3rd reflect that he thought he would just be there 24 hours to allow the additional time for the medicine that he had been taking to leave his system. Around midnight on October 3'd going into October 4th, he was woken up and told he was moving to another room where he would share a room because they needed the empty room, but he spent part of the night in the day room.

142. On October 4, he could not have any of his questions answered, even though he asked. He had no idea how his day was supposed to work and where he was supposed to be, but his questions were ignored. It was the other patients who helped show him around. Eventually, he was able to get his wife to help him from the outside.

143. He had requested prior to his meeting with Dr. Malone to fill out an AMA request. When he saw Dr. Malone around 11:00 a.m. on Tuesday, they were together no more than 10 minutes. Dr. Malone continued to cut him off and tell the patient that he thought it was the medication, but that there was a more serious issue as to why he was in the hospital.

144. Dr. Malone also said that Mr. Harvey had attempted suicide multiple times, which was completely incorrect and not part of his past medical history. He felt Dr. Malone was being a bully. He told him his options and said that if he requested to leave, that he could either stay for 7 to 10 days at Millwood or he could proceed with the AMA, which would lead to a 24-hour hold, a judge placing him involuntarily, and that he had one hour to rescind the "AMA request." Mr. Harvey did rescind it because he was not sure what the doctor was capable of doing to him.

145. His records reflect a discharge date of 10/05/2016 and the reason for discharge as AMA. It also states that he would be going home to his family and being driven by his wife.

146. Rather than get better at Millwood and be watched for 24 hours, he was subject to a hostile environment. After his experience at Millwood, Mr. Harvey missed 6 weeks of work and suffered severe panic attacks. His medical record is also permanently stained by a false diagnosis of Bipolar disorder.

TIFFANY YOUNG

147. In early November 2017, Tiffany Young spent three days at Hickory Trail Hospital in DeSoto, Texas. Staff physician leadership on the Hickory Trail website reflects Rajinder Shiwach, MD, Medical Director; Farida Ali, MD; Shahzad Allawala, MD; and Kusi Fordjour, MD.

148. Ms. Young is a real estate investor. She is married and has 3 children.

149. During the first week of November 2017, she was very busy at work getting ready to put houses on the market that she was flipping. Her oldest son ran away from home. They found him later that night, but it was extremely stressful for her. She said she hadn't slept in several days.

150. During the night, she was having chest pain and numbness in her chin and pain in her shoulder. She got out of bed and went to Arlington Memorial Hospital without telling her husband, because she just felt like something was wrong. She arrived at Arlington and they did an EKG which she said was normal, and they took her right back since she said she thought she had chest pain. She said someone came in to talk to her and asked if she had stress, and she said she had tremendous stress in her life. This person asked if she had thought about ending her life? She said her reply was, "If you're going to honest, I'm sure everyone has at one point or another. And I never have had a plan of what I would have done, but if I would have done it, I would have done it today. But instead I came here for help."

151. Another person came in to talk to her.

152. Someone came in to give her something for sleep in the emergency room and she said it knocked her out. When she woke up, there was a male bearded gentleman who asked her questions about her mental health. She answered, "No, I do not want to end my life. Yes, I am depressed. Yes, I want help." He asked if she wanted inpatient or outpatient, to which she was thinking staying the night in the hospital here at Arlington would be fine so she said she wanted to spend the night. She said she thought it would be heavenly to have uninterrupted sleep for an entire night.

153. She said she slept a long time and then EMS came to the hospital to take her to where she was going. She asked to go home. She was essentially told, “No, sorry, no, you're going to the hospital." By this time, she had been able to call her husband who came to the emergency room. He said he wanted to leave with his wife but was told she going to take the ambulance to DeSoto.

154. She arrived in Desoto at Hickory Trail and her husband followed EMS to this facility. She walked into the facility herself. Her husband was not there yet. Upon arrival at Hickory Trail she was put in a plain room that was a lockdown room. She said she told the people at the hospital, the people in EMS the ambulance, as well as the check-in person at the reception area, and the intake person lady—all of them—that she had changed her mind, she wanted to go home, she did not want to go to or stay at Hickory Trail.

155. But she was clearly in a locked room. Her husband at some point was told, "No, you can't get her out of here. This is a locked facility." Someone answered the husband's question, “No, it's not against the law, but you can't leave.”

156. The next thing she knows, she's going down a hall to a locked facility and saying goodbye to her husband. They took her purse. They cut zippers and strings out of all her clothes. She started to cry when she realized what type of facility she was in.

157. Two workers came into what was going to be her room. They had the door wide open and performed a strip search. The entire time she was crying as she was very modest and not used to being naked in front of strangers. The staff also had the door wide open. The staff said they had to keep the door open to watch other people as well.

158. The hospital has insufficient staff if they cannot simultaneously search someone and watch a hallway full of people.

159. They strip searched her and put their hands in places that she did consent to be touched. She was extremely concerned during this time, as this was a coed facility with men walking up and down the hall. Standing naked, she could see the men there, which she believes means the men could see her as well. She asked to see a physician.

160. They told her, "No, you're going to have to wait 24 hours. That is our policy and you are staying here." One patient befriended her and told her she had to get control of herself or they were going to count it against her, so she did. Someone told her that she was in this part because the census was low in the other part, and she was in the part with the addicts and homeless people. It was only she and one other person that had insurance and a home. She said there were 12-15 folks in this section. The other girl that was there had very deep cuts in her wrists.

161. She was extremely uncomfortable. They took her bra because it had an underwire in it, and they forced her to wear sheer gown with no bra.

162. She went with a group to the cafeteria because she said she didn't want anything to eat, but someone told her it would be held against her. So she ordered something to eat and a girl came up to her and looked at her and said that she "must be cold." Apparently, the other person was inferring that because Ms. Young didn't have enough clothing on, the other person could see goose bumps on her body in various places that would normally be covered with a bra. This same lady came up to her and started playing with herself while looking at Tiffany.

163. There was also a man there that continued to make passes and was aggressive towards her. This occurred throughout her entire stay.

164. She ate and then went outside because they made everyone go outside for a smoke break even though she did not smoke. She said it was very cold this time of the year. No one had coats, and they were freezing. They weren't allowed to separate the group in half because they had to watch the staff altogether, so everyone had to go out in the cold together. When she got back in, she asked to have her clothing back because she was so cold. She got some of it back but it was all cut up.

165. She went to bed that night and she was sharing a room with a sweet lady that was addicted to meth. She went up to close the door and her roommate said, "No, you cannot do that. They won't let you do that."

166. Tiffany went to the nurse to explain that she wanted to close the door, and the nurse said you have to keep it open. She gave Tiffany a pill to sleep, and she went to sleep. In the middle of the night, a man was in her room with a flashlight looking under her covers. It woke her up out of a sound sleep.

167. She still had not seen any doctors by the next day. She went to two or three group sessions a day and then they had group play like with games. They couldn't even play Pictionary

because that required a pencil. They wouldn't allow her to have pen or paper. They did not give her a toothbrush, just some type of makeshift item to clean her teeth with. That day there was an incident with the prostitute on the unit having sex with a schizophrenic and it put the hallway in a frenzy while the staff was trying to take care of that.

168. The man that was bothering her was still bothering her every day.

169. When she finally saw a doctor she told him, "I do not belong here. I do not know what happened." She said “I'm a Sunday School teacher. I work. I own my own business. I have my own family.” The doctor said she tested positive for amphetamines and she couldn't even imagine how that could be.

170. She wanted to be released because her 8 year old was leading chapel in the morning at his school. The doctor said he could not let her go. He said you will stay another night and it may be as long as 2 weeks. She tried to give the doctor the name of her son's counselor who she was going to counseling with that was running away from home, or names of character witnesses, and he declined to take any of that information or contact any of those individuals.

171. She said you can make one phone call at night on the hall phone. They tried to limit the calls to 5 minutes each because so many people want to make a phone call. There were 2 phones in the hallway. Her husband told her that that night her middle son and oldest son got in a fight. Her middle son blamed the older son because of the mom being in the hospital, and the older son was so upset he ran away again. She went to bed thinking her son was missing. It wasn't until the next morning that she was told that he was at a grandparent's house and he was actually alright.

172. The second full day in the facility, she went to a counselor named Lemeita, who told her and kept asking her, “Why are you here?" She also said she wanted to help her get out of there. Tiffany said that she made a call and they asked the husband to tell the staff that he would be responsible for Tiffany in order for her to be released. This was noted in the notes but the physician did not approve, and she was just going to have to spend another night at the facility.

173. That night, a media piece on psychiatric facilities came on TV and they all watched it, including the staff.

174. She asked to leave the next day and was told that "If you do that, you'll be in here even longer." She said that there was someone there named Lameeka, who said, “Nope, you're going to be here longer if you do that.” On this day, another RN called a case manager, who came up, and he told her she shouldn't be in there. She felt like she could speak frankly to him and he is the one that told Tiffany that they closed the other facility because they didn't have enough census and that's why she was in this facility. The case manager read paperwork to Tiffany that said that she stated to someone that she was going to slit her wrists in the shower or come here for help. That is not in the context of what she actually said.

175. She wanted the doctor to speak to her and she stood at the counter, but he would never speak to her and never acknowledged her. There was an unwritten rule you could not speak to the doctor. The doctor could only speak to you.

176. In the group sessions, they never talked about addiction or depression or anything. Basically, they just gave people more meds and more meds. There was just no help to cope that was provided. She feels like this is a broken system.

177. The Patient's Bill of Rights was posted in the room but only in Spanish.

178. She asked at least 12 times to be released—she asked every person she came in contact with, including the person that opened the door for the smoke breaks.

179. She asked for an AMA release form, and she never got the form.

180. She saw patients with tracks and didn't understand what tracks were, and just couldn't believe she was in this environment.

181. Only after seeing a special on mental health facilities produced by WFAA and with the persistence and support of her family leveraging a number of resources was she able to leave.

182. She was really affected by the horrible conditions of the facility. She brought clothes and cigarettes up to the facility after her stay because she felt so badly for these individuals with no family.

183. It is a wonder how people ever get out without the support of family.

BILL CROWELL

184. Crowell was held at BHB. Crowell reported what happened to him to the Texas Department of Health and Human Services. Crowell was informed that all of the allegations that he made in his report were substantiated.

185. In the fall of 2014, Crowell's health began to fail. Ultimately, it was discovered that his lower back was in the process of a slow disintegration. He has undergone three prior back surgeries. When he found out that his beloved daughters were not going to be coming to Thanksgiving dinner, in a moment of desperation, he sent some tweets, which referred to his despondent state. This led to his arrest into protective custody.

186. His wife came home from shopping, and he was having a tear-filled discussion in the living room. He was angry and hurt and needed her terribly. She was helping. He did not have any weapons at hand, he had not stated that his ideation was immediate.

187. However, he was told that, because he had health insurance, they were trying to place him in a hospital for further treatment. He was taken to BHB. He was held in isolation in Unit 4.

188. He was called into an examination room where he was interviewed by a young, female doctor, who asked cursory questions about his health but did not perform an examination. She asked for a list of medications and he recited to the best of his ability from memory. He informed her that his wife had secured his firearms, had contacted his psychiatrist, and that they were waiting for him to be released back to their custody and care. He was under the assumption that she would determine that any crisis was over and that he would be returned to his wife and to the care of his own psychiatrist. But that was not to be the case.

189. When going through the list of medications, he disclosed that he was prescribed Norco for severe back pain - that it was prescribed by a pain-management specialist who was working with his back surgeon and that he was in the midst of receiving a series of spinal injections and anticipating yet more surgery. Indeed, he had had a spinal injection on October 23.

190. She promptly informed him that Dr. Rafique, the medical director, has a policy of not allowing opioids for all patients admitted to BHB. She would enter the information, but he would remove them from his treatment during his time at BHB.

191. BHB is divided into a number of "units," and each unit appeared to have a specific population. Unit 4 had people who are suffering from serious mental impairments and

some of whom are physically violent. It is a loud and unnerving place to be if one is a quiet introvert, like Crowell.

192. He was 3 days into this ordeal, and in extreme back pain.

193. The next morning he was interrogated by Defendant Jamal Rafique, the medical director. Dr. Rafique saw that he had taken anti-anxiety medications as well as pain killers and immediately diagnosed him as a drug addict. Rafique refused listen to any medical history, dosing instructions or any other piece of information.

194. Seizing upon the moment of the opioid epidemic, Rafique diagnoses him as an addict and determines that he will detox him for his own good. Knowing that insurance is not likely to reject coverage for this, the intent was to keep Crowell for as long as possible under the pretext of addiction, despite the fact that he had not taken a single pain killer in the past three days, has never had an addiction, and initially was admitted for situational depression.

195. Rafique examined Crowell's insurance benefits and then informed him that he was keeping Crowell for 8 days to detox off the anxiety medication and the pain killers. Nothing was said about Crowell's depression on the day in question. Nothing was asked about his physical condition. Crowell attempted to convey the medical information to Rafique, but it fell on deaf ears.

196. It became clear to Crowell that he was being used as a raw-material in an insurance racket. The standard of care for suicidal discussion is treatment of about 3 days' time and release back to family when out of imminent danger. There was no medical or psychiatric reason for incarcerating him for more than 3 days, and he had already been incarcerated for over 3 days.

197. Crowell knew that the only way he could escape was through the front door and with Dr. Rafique's signature. The following week became a test of wills. Rafique called him into the office each morning. Rafique would yell at him and call him an addict, and Crowell would reply that he was not.

198. Subsequently, he was presented with paperwork indicating that he would owe BHB $910 in coinsurance payments. Crowell considered himself under duress.

199. BHB is very much a prison. The security features are impressive. There is little in the way of natural sunlight in the Units. The windows are frosted with only a few inches of clear glass at the very top so it is not possible to assess what is beyond them. The doors have both heavy-duty latches and extremely powerful magnetic locks tied to a card-key system. The "beds" are plywood boxes with a top of 4" of foam rubber encased in vinyl. They are secured firmly to the wall and floor. This place of rest caused massive amounts of pain on his back.

200. Each room has a bathroom with a toilet, sink, and shower. The sink is activated with a timer and dispenses only cold water. The shower has hot water when available and the spray hit him squarely in the chest.

201. The orderlies want everyone out in the day-room. This is a larger room that is brightly lit with florescent lights and with rigid chairs and "love seats" around a large, flat-screen TV. Said TV is kept running from 7AM to 10PM and is kept loud. There is a defined routine of being awakened, going to the cafeteria for breakfast, going for a smoke break (despite being a nonsmoker it is the only chance to be outside), watching more TV, participating in "group therapy" sessions where one's attendance is mandatory for release. There is lunch, more smoke breaks and then evening dinner. It is a sad monotony. In all the time Crowell was there, he spent a total of 20 minutes speaking with a counselor.

202. There was a "group" meeting in the day-room area of Unit 8 with one of the staff. She explained some of the mechanics of the system. She discussed the admission papers and our "rights." One of our enumerated rights is called the "4 hour letter." This is a letter composed to the doctor stating that you wish to be evaluated within a 4 hour window and released if you were OK. We were told that writing said letter is not a good thing.

203. During his stay, he was pursued by a female. She kept telling him that he had "pretty eyes" and otherwise made sexual advances at him. He was careful not to provoke her by responding strongly as she would explode into a tirade at the slightest perceived offense. She kept placing her body in "sexy" positions attempting to get his attention. He brought this up with each of the duty nurses for several shifts to no effect.

204. He finally obtained paper and a golf pencil and wrote a letter to Defendant Rafique stating that he was dealing with violent people and was being sexually harassed. He submitted this letter to nurse Tonya. He asked for a copy of it for his own records. He repeatedly asked for his copy and has yet to receive it. Finally, he was informed that he would be moved to Unit 8, and he was told to keep quiet and not tell anyone.

205. The means of communicating with the outside world is extremely limited. There is 1 shared telephone right near the TV set. The TV is on from 7AM until 10PM, and everyone has to share it. It is impossible to have a private conversation, and yet Crowell becomes entirely dependent on people on the outside for assistance. He resolved to simply observe and wait for his insurance benefits to run out and to make the best of the time there. He spoke with other people and helped them cope with a difficult situation.

206. Crowell witnessed what happened in this facility if one requested to sign a 4-hour letter. If one sends a 4-hour letter to Dr. Rafique, he immediately goes to a judge to have one kept involuntarily.

207. Crowell believes that BHB is committing insurance fraud on an industrial scale. This extends to Medicare, and he submitted a complaint to the Center for Medicare and Medicaid Service Inspector General's office.

208. Crowell believes that a proper investigation will find that the stays are a function of insurance benefits, that fees are most likely substantially overcharged, and that people's lives are being ruined by fraudulent diagnosis codes. Had he admitted to Dr. Rafique of being an "opioid addict," this would be on his permanent record and would damage him for years to come.

209. One has to wonder about the interaction of Dr. Rafique with the courts. He finds it surprising that the 4-hour letter appears to come with a bench warrant in all cases. Again, he believes that further investigation is warranted.

210. Upon information and belief, Millwood and Mayhill have similar practices and rates of detention upon the submission of a 4-hour letter.

211. Crowell spent the past 30 years as an analyst, programmer and developer of practice management and electronic health records systems. He has been the CTO of two technology firms and has sat on the ANSI Standards committee for electronic health claims. His last post in healthcare was as the Senior Professional Claims Analyst for Novant Medical Group where he was responsible for the processing of claims for 1400 doctors. Being able to analyze the BHB operation for an entire week was extremely revealing to him.

212. BHB and Rafique irreparably damaged him. He was nearly killed by gross negligence. He was given antidepressant medication without his informed consent. His legal

rights were denied. He was deprived of necessary and lawfully prescribed medications by board-certified specialists. He suffers nightmares from the experience, and his wife has suffered greatly at the injustices inflicted upon him.

213. Crowell was threatened by personnel at BHB, and was discouraged to requesting a letter to leave the facility. Crowell witnessed a 100% warrant rate for the people who sought to leave the facility under a 4 hour letter.

V.
CAUSES OF ACTION

VIOLATIONS OF THE RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT (RICO)

214. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

215. To state a claim for a RICO Act violation, Plaintiffs must allege each of the following elements: "(1) conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity." *Manax v. McNamara*, 842 F.2d 808, 811 (5th Cir. 1988) (citing 18 U.S.C § 1962(c)).

216. For years, Defendants and other co-conspirators, named and unnamed, used the enterprise to commit the offenses of illegal remuneration for patient referrals, used the mail or any facility in interstate commerce to promote unlawful activity, in violation of Title 18, United States Code, Section 1952.

217. Highly unusual here is the direct investment by the CEO of UHS into at least one of the hospitals involved, Millwood. Regardless of whether any conflicts of interest exist that were or were not disclosed to the Board of Directors of UHS or to UHS' shareholders, the investment gives the CEO of UHS a majority stake in the general partner of Millwood and thus control over the entity. In Millwood's file appear the names of several people, including Yupo

Jesse Chang, involved in the securing of Preadmission Assessment documents that are used to allow a facility to admit a patient and in the securing of hold orders from courts of law.

218. Also, part of the enterprise is the Connection, a wholly owned subsidiary of UHS that dispatches employees of UHS to various emergency rooms to refer patients to UHS hospitals and then secure the Preadmission Assessment documents.

219. The Preadmission Assessment documents are generated to get around Texas laws that require an actual physician examination and recommendation prior to admitting a voluntary patient. The Assessments are generated via the businesses associated with Defendant Yupo Jesse Chang—all of which operate out of a mansion in Tanglewood.

220. The enterprise is a tangled web engineered to churn patients and fill beds for as long as they can get paid.

221. Upon information and belief, in order to induce such referrals, Defendants and others entered into agreements to provide marketing services, including advertising, crisis counseling centers and "1-800 telephone hotlines" to refer patients to UHS-owned hospitals and treatment programs throughout the United States, including Texas, to pay that corporation for such services.

222. Defendants associated together to function as a continuing unit for the common purpose of committing acts of commercial bribery, and health care fraud to extort billing money.

223. The continuing unit formed by that association in fact constituted a RICO "enterprise" within the meaning of 18 U.S.C. §1961(4) engaged in and affecting interstate commerce.

224. It was an integral part of the agreement between Defendants and other co-conspirators, named and unnamed, that participating professionals, would receive remuneration,

either directly or indirectly, from Defendants in exchange for the admission of potential psychiatric patients to hospitals operated by UHS.

225. In addition, it was an integral part of the agreement between Defendants and other co-conspirators that participating professionals individually or through entites, would receive remuneration, either directly or indirectly, from Defendants in exchange for the retention of psychiatric patients to hospitals operated by Defendant UHS.

226. Mayhill, Millwood, BHB, and Hickory Trails, among other UHS facilities, extend the length of stay of its patients in violation of Texas and Federal Law, the regulations promulgated thereunder, and standards set by the Centers for Medicare and Medicaid. This is accomplished through the enterprise—a network of doctors who pencil whip reports or create reports out of whole cloth and an on-demand team of people in the Connection who are dispatched to drum up patient referrals from Texas emergency rooms.

227. It was also an integral part of the agreement between Defendants that parties to the agreement would place long distance telephone calls, transmit long distance facsimile transmissions, and send other electronic communications in interstate commerce, travel in interstate commerce, and cause others to travel in interstate commerce with the intent to promote, manage, establish and carry on these unlawful activities, knowing that such unlawful activity violated the laws of the State of Texas and the United States.

228. Medical reports, purportedly signed by doctors, were faxed from Houston to the various UHS hospitals, and false reports were made that those physicians had examined the patient when the physician was not located in the same zip code of the patient.

229. The notary, Defendant Yung Husan Yao, rubber stamped physician reports that were used to detain a number of people who were in UHS facilities, thus making the threats of

continued confinement very real. This notarization is documented in a notary book, where almost all of the entries involved an involuntary commitment. In the course of one day, multiple reports are generated, allegedly by different physicians, all from the Tanglewood address in Houston. This criminal conspiracy is ongoing. It allows Millwood, Mayhill, BHS, and Hickory Trail to detain patients. The professionals and other personnel profit from the stays. The bulk of the profits are eventually funneled to UHS and whoever else owns the entities.

230. The enterprise committed mail and wire fraud by submitting claims and thereby implicitly representing that they were operating in accordance with federal and state law. The fraud can be found on each claim form submitted to an insurer in this case. The fraud can be found of each fraudulent Preadmission Assessment. By submitting a claim to a payor, the enterprise impliedly certifies that it has complied with certain laws, regulations, or contractual provisions. By holding a patient in this State it impliedly certifies that it has followed Texas law, including Chapter 164 of the Texas Health and Safety Code, the Texas Mental Health Code, see Tex. Health & Safety Code, Title 7, Subtitle C, 25 Texas Administrative Code; Texas Health & Safety Code § 576.021(5); 25 TAC 404.154(3) and 404.154(24); *see also* Title 4, Subtitle G, Chapter 321, § 321.003 of the Tex. Health & Safety Code regarding violations of patient rights.

231. By taking each person's personal property through the use of violence, intimidation, and fear, the enterprise also violated the Hobbs Act.

232. Each defendant and the enterprise Defendants, by and through the enterprise, knowingly and willfully executed, or attempted to execute, a scheme or artifice— (1) to defraud health care benefit programs; (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, the money or property owned by, or under the custody or control

of, health care benefit programs, in connection with the delivery of or payment for health care benefits, items, or services, in violation of 18 U.S.C. § 1347.

233. In consideration of these various statutory and regulatory violations by the enterprise, Plaintiffs brings forth a private cause of action predicated upon the violation of Plaintiffs' *Patient Rights* by the enterprise.

234. "The mail fraud statute applies to anyone who knowingly causes to be delivered by mail anything for the purpose of executing any scheme or artifice to defraud." *United States v. Whitfield*, 590 F.3d 325, 355 (5th Cir.2009) (internal citations and quotation marks omitted).

235. Similarly, wire fraud involves the use of, or causing the use of, wire communications in furtherance of a scheme to defraud. *United States v. Stalnaker*, 571 F.3d 428, 436 (5th Cir.2009).

236. "Once membership in a scheme to defraud is established, a knowing participant is liable for any wire communication which subsequently takes place or which previously took place in connection with the scheme." *Id.*

237. During the existence of the agreement between Defendants, the above noted predicate acts, were knowingly committed in order to accomplish the unlawful acts described above and as follows.

238. This RICO "scheme to defraud," is "measured by a nontechnical standard. It is a reflection of moral uprightness, of fundamental honesty, fair play and right dealing in the general and business life of members of society."

239. The RICO enterprise and actions in this case coalesce. There is an association-in-fact enterprise that (1) exists separate and apart from the pattern of racketeering, (2) is an ongoing organization, and (3) its members function as a continuing unit as shown by a

hierarchical or consensual decision making structure. This occurs from Pennsylvania into various parts of Texas, including this district. These facts also form the basis of a violation of the Travel Act.

240. Under the Travel Act, it is against the law to travel in interstate or foreign commerce, or to use the mail or any facility in interstate or foreign commerce, with intent to— (1) distribute the proceeds of any unlawful activity; or (2) commit any crime of violence to further any unlawful activity; or (3) otherwise promote, manage, establish, carry on, or facilitate the promotion, management, establishment, or carrying on, of any unlawful activity, including extortion and bribery, as defined by state law. 18 U.S.C. § 1952

241. Sending representatives of the Connection out to each ER to get patients and drum up business for the enterprise, the generation of Preadmission Assessments to allow the admission of a person to a UHS facility, and the creation of documents that allow the facilities to hold patients against their will involve bribe and kickback payments which incentivize the participants to steer patients to UHS hospitals for services and to keep patients in UHS hospitals. These actions constitute a violation of the Travel Act because it involves the violation of state laws that are aimed at preventing fraud, including Tex. Occ. Code Secs. 102.001 and 102.002.

242. The use of patient recruiters by the enterprise allows it to supply beneficiary information to the facilities and doctors and other people who bill, so that the facilities could then submit fraudulent bills to private health insurers, Medicare, and Tricare for services that were medically unnecessary or never performed.

243. The federal and Texas anti-kickback statutes are violated by providing out excessive compensation to the physicians to act as medical directors who perform little work and to counselors and social workers as employees of entities that are wholly owned subsidiaries of

UHS but are allegedly nonprofit. Money also flows to Univeral Physicians PA and Yupo Jesse Chang and the entities that he controls to generate Preadmission Assessments and documents designed to hold patients involuntarily.

244. Additionally, in a number of respects, the services provided at the UHS facilities to Plaintiffs were so deficient as to be worthless. There were too few staff, they provided inadequate care, and they failed to take measures to prevent falls. They admitted patients who had no business being admitted and would pass-off the act of coloring in a coloring book as therapy.

245. Plaintiffs were injured by the illegal conspiracy between Defendants and have a private cause of action pursuant to RICO thereby for the billing of insurance proceeds, taking of property, and other RICO damages, including lost earning capacity. Plaintiffs are persons who were injured in business or property by reason of a violation of the RICO statute as stated above and also by billing for medically unnecessary care and increasing claims through the use of inappropriate financial relationships with referral sources.

COUNTS IN THE ALTERNATIVE: VIOLATIONS OF THE REHABILITATION ACT

246. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

247. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 and its implementing regulations require that any program or activity receiving Federal financial assistance may not discriminate against an otherwise qualified individual with a disability. Programs or activities covered by Section 504 include corporations or private organizations principally engaged in the business of providing healthcare, 29 U.S.C. §794(b)(3). Under the

ADA Amendment's Act, the definition of a disability for purposes of the Rehabilitation Act of 1973 conforms to the definitions of disability under the ADA, 29 U.S.C. §705(20)(B).

248. Each defendant is principally engaged in the business of serving individuals with mental health issues, and as such, may not discriminate against a person because of their disability, pursuant to Section 504.

249. The facts as previously described identify Plaintiffs as qualified individuals with a disability.

250. The facts as previously described demonstrate violations of the regulations promulgated pursuant to Section 504 of the Rehabilitation Act, 29 U.S.C. §794. Such acts, omissions and failures by Defendants, caused injuries to Plaintiffs.

COUNTS IN THE ALTERNATIVE: VIOLATIONS OF TEXAS DECEPTIVE TRADE PRACTICES ACT; TIE-IN STATUTE CHAPTER 164 OF THE TEXAS HEALTH AND SAFETY CODE

251. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

252. Chapter 164 of the Texas Health and Safety Code requires an inpatient mental health facility, like Defendant UHS, to make certain disclosures to a prospective patient before, the prospective patient may be admitted to the facility. Specifically, hospital staff was required to provide Plaintiffs the following: the availability of insurance coverage to pay for services, the expected daily costs of staying at the hospital or what part of the hospital costs she would be responsible for; who would be the attending physician providing her care; that the patient would be billed separately by the doctors or other medical professionals and services at the hospital; notice of Patient's Bill of Rights; a copy of such rights and the duty to obtain a signature from the prospective patient that she had received such rights. Moreover, once admitted the patient

cannot be threatened or mislead about their right to leave the facility. *See* Texas Health & Safety Code §164.009.

253. Chapter 164 of the Texas Health and Safety Code comprises the Treatment Facilities Marketing Practices Act. Tex. Health & Safety Code §§ 164.001 et seq. A person may bring suit under the DTPA for a violation of that Act. Tex. Health & Safety Code § 164.013. This type of claim is referred to as a "tie-in statute," meaning that the statute ties into the DTPA but with greater damages. Instead of being restricted to traditional DTPA damages, "the claimant… may recover any actual damages," and if the conduct was committed knowingly or intentionally, then "the trier of fact is authorized to award a total of not more than three times actual damages." Tex. Bus. & Comm. Code § 17.50(h). Under the DTPA, "each consumer who prevails shall be awarded court costs and reasonable and necessary attorneys' fees." Tex. Bus. & Comm. Code § 17.50(d). The DTPA/Chapter 164 claims include:

254. **Preadmission Violations:**

i. Advertising, expressly or impliedly, the services of a treatment facility through the use of any unsubstantiated claims. Tex. Health & Safety Code § 164.010(1)(B);

ii. Advertising, expressly or impliedly, the availability of intervention and assessment services unless and until the services are available and are provided by mental health professionals licensed or certified to provide the particular service. Id. § 164.010(2);

iii. Failure to disclose an affiliation between a treatment facility and its soliciting agents/ contractors, before soliciting a referral source or prospective patient, to induce a person to use the services of the treatment facility. Id. § 164.010(3);

iv. Obtaining information considered confidential by state or federal law regarding a person for the purpose of soliciting that person to use the services of a treatment facility without consent. *Id.* § 164.010(4);

v. Failure to provide, in writing, the estimated charge with an explanation that patient will be billed separately for services provided by mental health professionals. *Id.* § 164.009(a)(1);

vi. Failure to provide, in writing, the name of the attending physician. *Id.* § 164.009(a)(2);

vii. Failure to provide, in writing, the current "patient's bill of rights". *Id.* § 164.009(a)(3);

viii. Misrepresentation made to a patient, parent, guardian, or spouse, about the availability or amount of insurance coverage available to the prospective patient. *Id.* § 164.009(b); and

ix. Any recommendation or representation that a prospective patient be admitted for inpatient treatment unless the representation is made by a licensed physician or, subsequent to evaluation by a licensed physician, by a mental health professional. *Id.* § 164.009(d).

255. **Postadmission Violations:**

i. If request to leave made against medical advice, unless made by a physician or made on the written instruction of a physician who has evaluated the patient within 48 hours of the representation, facility represents to the patient that the patient will be subject to an involuntary commitment proceeding or subsequent emergency detention. *Id.* 164.009(c)(1); and

ii. If request to leave made against medical advice, facility represents that the patient's insurance company will refuse to pay all or any portion of the medical expenses previously incurred. *Id.* 164.009(c)(2).

256. The Defendant Hospitals failed to satisfy the requisites in total or in part, as to each Plaintiff. Such failures rise to the level of a knowing violation of the *Texas Deceptive Trade Practices Act,* Texas, *see* Texas Health & Safety Code §164.013; Texas Business & Commerce Code, §17.46(b); §17.50(h).

257. Plaintiffs seek treble damages for this cause of action accordingly, in addition to attorney's fees and costs.

COUNTS IN THE ALTERNATIVE: CLAIM FOR STATUTORY DAMAGES UNDER CHAPTER 321 OF THE TEXAS HEALTH & SAFETY CODE, VIOLATIONS OF THE TEXAS MENTAL HEALTH CODE

258. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

259. A patient has a private cause of action against a mental health facility that violates Texas Health & Safety Code Chapters 241, 321, 571, 572, 574, 576, and 577 or any of the rules created to further those chapters. A plaintiff who is receiving care or treatment in or from the facility and who is harmed as a result of the violation may sue for "actual damages, including damages for mental anguish," "exemplary damages," and "reasonable attorney fees". TEX. HEALTH & SAFETY CODE § 321.003(a), (b), (c), & (d).

a. Chapter 241 Claims

260. Plaintiffs have a private cause of action against the mental health facilities for violating Texas Health & Safety Code Chapter 241, the Texas Hospital Licensing Law, for failing to have policies on patient transfers (§ 241.055) and for failing to secure the informed

refusal of a patient or of a person acting on the patient's behalf to a transfer or to related examination and treatment (§ 241.027(e)).

b. Chapter 321 Claims

261. Plaintiffs have a cause of action against the facilities that violate Texas Health & Safety Code Chapter 321, Provision of Mental Health, Chemical Dependency, and Rehabilitation Services. These claims largely pertain to "bill of rights" violations. The claims in this case are for:

i. Failing to ensure that within 24 hours of admission that the rights specified in the written copy of the patient's bill of rights are explained to the person and, if appropriate, to the person's parent, orally, in simple, nontechnical terms in the person's primary language. § 321.002(f);

ii. Failing to ensure that each patient admitted "signs a copy of the document stating that the person had read the document and understands the rights specified in the document" § 321.002(g)(1);

iii. Failing to ensure that "the signed copy is made a part of the person's clinical record." § 321.002(g)(2); and

iv. Failing to "prominently and conspicuously post a copy of the 'bill of rights' for display in a public area of the facility that is readily available to patients, residents, employees, and visitors" that is "in English and in a second language." § 321.002(h).

c. Texas Mental Health Code Claims [Chapter 571 to 578 Claims]

262. A patient has a private cause of action against a mental health facility that violates Texas Health & Safety Code Title 7 Subtitle C [Sections 571.001 et seq. to 578.001 et seq.], known as the Texas Mental Health Code.

263. Here Plaintiffs have **Chapter 571 Claims** because of each facility's failure to provide prescription medication information under § 571.0066; abusive treatment methods under § 571.0065; and failure to utilize the least restrictive appropriate setting under § 571.004.

264. Plaintiffs contend that in addition to, and in the alternative to the foregoing, every one of the various allegations of acts and omissions, separate and apart from the above, and regardless of whether or not the Defendant Hospital is negligent or has acted intentionally as to other theories of recovery, constitutes violations of Plaintiffs' general patient rights under the Texas Mental Health Code, see Tex. Health & Safety Code, Title 7, Subtitle C, and the 25 Texas Administrative Code; Chapter 404.

265. In addition, and in the alternative, Plaintiffs contend that their rights pursuant to Title 2, Article 3, Subchapter L, of the Tex. Health & Safety Code, relative to "Abuse, Neglect and Exploitation," and specifically found at the Texas Health & Safety Code § 576.021(5); 25 TAC 404.154(3) and 404.154(24) were likewise violated by Defendants.

266. In consideration of these various statutory and regulatory violations by the Defendant Hospitals, pursuant to Title 4, Subtitle G, Chapter 321, § 321.003 of the Tex. Health & Safety Code, Plaintiffs bring forth a private cause of action predicated upon the violation of their *Patient Rights* by each Hospital Defendant.

267. The Defendant Hospitals, by and through its agents, contractors and employees, failed to provide Plaintiffs services commensurate with their Patient Rights, which proximately caused injury to Plaintiffs.

268. The use of falsified medical documents in order to admit patients by falsely claiming a medical examination took place violates § 572.002 of the Texas Health and Safety Code, which requires a preliminary examination to determine whether a patient has symptoms of a mental illness.

269. The failure to release patients who have requested so is in violation of § 572.004 of the Texas Health and Safety Code, which requires an employee to assist a patient with writing a request for dismissal if said patient expresses a desire to leave the facility as soon as possible. The facility must then either release the patient within four hours, or, under certain circumstances, obtain a written order for further detention by 4 p.m. the following day. Here, the facilities failed to follow these requirements. They are keeping people against their will, after the patients have requested to be released, without obtaining the required order of detention.

COUNTS IN THE ALTERNATIVE: FALSE IMPRISONMENT

270. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

271. Plaintiffs allege that each Defendant Hospital, acting through its directors, officers, employees and agents, and contract services, willfully admitted Plaintiffs without following the standards set forth in Texas Health & Safety Code, Chapter 164 and as such each admission to the hospital and subsequent detention was wrongful, without legal authority or justification.

272. As a direct and proximate result of Defendant's willful, unjustified, and irresponsible detention and confinement, each Plaintiff suffered a loss of their freedom, severe humiliation, embarrassment, fear, frustration and mental anguish.

273. As a direct and proximate result of Defendant's willful, unjustified and irresponsible detention and confinement of Plaintiffs, they have incurred unnecessary medical expenses and have been subjected to unnecessary and unwarranted medical services and other harms and losses.

COUNTS IN THE ALTERNATIVE: CIVIL CONSPIRACY; WILLING PARTICIPATION IN TORTIOUS CONDUCT

274. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

275. Defendants all met with each other for an unlawful purpose or in addition and in the alternative, a lawful purpose but used unlawful means, and had a meeting of the minds on these unlawful objectives, committed an overt act in furtherance of such objectives, and Plaintiffs suffered an injury as a proximate result of such wrongful act.

276. The reason for the conspiracy between the Defendants was to increase profits for all participants, especially the corporate entity: UHS. To effectuate the conspiracy, Defendant UHS provided financial, administrative, and technical support as well as supervision and staff training on how local staff at the hospitals and the connection could increase admissions and lengths of stay for potential patients, to the financial benefit of both Defendants and to the detriment of people like the Plaintiffs in this cause.

277. Plaintiffs allege that the Defendants, acting in concert with each other, and with intent to commit civil conspiracy, and by and through its directors, officers, employees, agents, and contract services, willfully conspired to admit Plaintiffs without following the standards set

forth in Texas Health & Safety Code, Chapter 164 and violating Section 504 of the Rehabilitation Act of 1973 thereby.

278. Additionally, Plaintiffs alleges that the Defendants, acting in concert with each other, and with intent to commit civil conspiracy, and by and through its directors, officers, employees and agents, and contract services, willfully conspired to treat Plaintiffs without following the standards set forth in Texas Health & Safety Code, Chapter 571-577 and Chapter 321.

279. Plaintiffs further allege that the Defendants, acting in concert with each other, and with intent to commit civil conspiracy, and by and through its directors, officers, employees and agents, and contract services, willfully conspired to treat Plaintiffs without following the standards set forth in Texas Health & Safety Code, Chapter 571-577 and Chapter 321.

280. Plaintiffs additionally alleges that the Defendants, acting in concert with each other, and with intent to commit civil conspiracy, and by and through its directors, officers, employees and agents, and contract services, willfully conspired to falsely imprison Plaintiffs.

281. As a direct and proximate result of Defendants conspiracy, Plaintiffs suffered injuries.

282. As a direct and proximate result of Defendants civil conspiracy Plaintiffs incurred unnecessary expenses.

COUNTS IN THE ALTERNATIVE: RESPONDEAT SUPERIOR

283. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

284. Each Defendant is liable for the torts committed by employees or agents under its agency or control, including ostensible agency where those people were acting in the course and scope of their employment or agency at the time of the each occurrence.

COUNTS IN THE ALTERNATIVE: NEGLIGENCE

285. Plaintiffs incorporate by reference all of the above related paragraphs, as well as those below, with the same force and effect as if fully set forth herein.

286. Plaintiffs allege that each Defendant violated the applicable standard of ordinary care by failing to act as a reasonably prudent person would under the same or similar circumstances.

287. Plaintiffs allege that the Defendants, acting through its directors, officers, employees and agents, and contract services, violated the duty of care it owed to Plaintiffs to exercise that degree of care, skill, supervision, and diligence ordinarily possessed and used by other mental health treatment centers and hospitals, under the same or similar circumstances.

288. Plaintiffs allege that the Defendants were negligent in their capacity as health care providers and when providing inpatient mental health when it was not necessary, or beneath the operative standards of care, such failure a violation of the relevant professional standards for a reasonable and prudent mental health and substance abuse treatment facility operating in Texas.

COUNTS IN THE ALTERNATIVE: GROSS NEGLIGENCE

289. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

290. Plaintiffs allege that each Defendant's conduct, as described above and as will be more developed at trial, constitutes gross negligence as defined by Texas law. The Defendants' conduct, when viewed objectively from the Defendants' standpoint, involved an extreme degree of risk, considering the probability and magnitude of the potential harm to others, and the

Defendants had actual, subjective awareness of the risk involved, but nevertheless proceeded with a conscious indifference to the rights, safety and welfare of others, including Plaintiff. The Defendants' gross negligence was a proximate cause of the occurrence made the basis of this action and all of Plaintiff's resulting injuries and damages.

COUNTS IN THE ALTERNATIVE: SEXUAL EXPLOITATION BY MENTAL HEALTH SERVICES PROVIDERS

291. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

292. Plaintiff Madison Hough, Yolanda McPherson, Tiffany Young assert claims under Texas Civil Practice and Remedies Code Chapter 81 because of the sexual exploitation, sexual contact, and therapeutic deception, that each experienced at the hands of the mental health services providers employed by Mayhill, Millwood, and Hickory Trails. More specifically, Plaintiffs seek to hold the hospitals accountable under Section 81.003(a)(2)(B) for the acts and omissions of its employees, agents, or ostensible agents for that proximately and actually caused their actual damages, including mental anguish, exemplary damages, and reasonable attorney's fees.

COUNTS IN THE ALTERNATIVE: EXEMPLARY DAMAGES CAP BUSTING

293. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

294. Plaintiffs allege that the exemplary damage caps do not apply because Defendants' conduct was felonious and was committed knowingly or intentionally in violation of

- Texas Penal Code Section 22.04 (injury to an elderly individual or disabled individual where the conduct was not health care),
- Texas Penal Code Section 32.21 (forgery),

- Texas Penal Code Section 32.43 (commercial bribery), and
- Texas Penal Code Section 32.46 (securing execution of document by deception).

VI.
DAMAGES, COSTS, AND INTEREST

295. Plaintiffs incorporate all prior and subsequent paragraphs as if fully restated and re-alleged herein.

296. As a direct proximate result of the acts and/or omissions described above, Plaintiffs have suffered injuries and damages for which Plaintiffs seek recovery from Defendants.

297. As applicable, Plaintiffs seek full and fair compensation for actual damages.

298. As applicable, Plaintiffs seek attorneys' fees.

299. As applicable, Plaintiffs seek treble damages.

300. As applicable, Plaintiffs seek exemplary or punitive damages considering (1) the nature of the wrong; (2) the character of the conduct involved; (3) the degree of cul pability of the wrongdoer; (4) the situation and sensibilities of the parties concerned; (5) the extent to which such conduct offends a public sense of justice and propriety; and (6) the net worth of the defendant.

301. In the alternative and additionally, Plaintiffs seek personal injury damages in amounts the jury deems to be fair and reasonable consisting of the following:

- Past and future physical pain and mental anguish;
- Past and future loss of earnings and earning capacity;
- Past and future disfigurement;
- Past and future physical impairment;
- Past and future medical and healthcare expenses and mental care expenses; and/or

- Any other actual or compensatory damages allowable by law.

302. Plaintiffs also seek recovery for all costs of court and prejudgment and post-judgment interest at the maximum rates allowed by law.

VII.
PRAYER

WHEREFORE, Plaintiffs request that this Court enter judgment against Defendants and award Plaintiffs the following relief:

(i) A sum of money—as determined by a jury to be fair and reasonable—within the jurisdictional limits of this Court for the damages indicated above, at the Plaintiffs' election of remedy, to the extent applicable;

(ii) Pre-judgment and post-judgment interest at the maximum amount allowed by law;

(iii) Costs of suit; and

(iv) Such other and further relief to which Plaintiffs may be justly entitled.

RESPECTFULLY SUBMITTED:

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the 1st day of October, 2018, the foregoing document was electronically filed with the Clerk of the Court for the U.S. District Court, Eastern District of Texas, using the electronic case filing system of the Court. As a result of that filing, the electronic filing system sent a "Notice of Electronic Filing", with the foregoing document attached, to all attorneys of record:

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