COMMONWEALTH OF PENNSYLVANIA
COUNTY OF DELAWARE

Magisterial District Number: 32-2-37
MDJ: Hon. Honorable Tami Forbes
Address: 150 S. MacDade Boulevard, Suite E
Darby, PA 19023-1814

Telephone: (610)534-3504

POLICE CRIMINAL COMPLAINT
COMMONWEALTH OF PENNSYLVANIA
VS.

DEFENDANT: (NAME and ADDRESS):

CHAIM (First Name) | (Middle Name) | STEG (Last Name) | Gen.

1191 COUGHLIN STREET, LAKEWOOD, NJ 08701

NCIC Extradition Code Type

- ☐ 1-Felony Full
- ☐ 2-Felony Limited
- ☒ 3-Felony Surrounding States
- ☐ 4-Felony No Extradition
- ☐ 5-Felony Pending Extradition
- ☐ 6-Felony Pending Extradition Determ.
- ☐ A-Misdemeanor Full
- ☐ B-Misdemeanor Limited
- ☐ C-Misdemeanor Surrounding States
- ☐ D-Misdemeanor No Extradition
- ☐ E-Misdemeanor Pending Extradition
- ☐ F-Misdemeanor Pending Extradition Determ.
- ☐ Distance: _____

DEFENDANT IDENTIFICATION INFORMATION

Docket Number	Date Filed	OTN/LiveScan Number	Complaint/Incident Number	SID:	Request Lab Services?
CR-121-21	3/15/2021	R122609-4	MF205044		☐ YES ☒ NO

GENDER	DOB	Place of Birth	Addt'l DOB	Co-Defendant(s)
☒ Male ☐ Female	01/22/1981		/ /	☐

First Name	Middle Name	Last Name	Gen.
AKA YERICHAM/CHARLIE		STEG	

RACE: ☒ White ☐ Asian ☐ Black ☐ Native American ☐ Unknown
ETHNICITY: ☐ Hispanic ☒ Non-Hispanic ☐ Unknown

Hair Color: ☒ BLK (Black) ☐ BLN (Blonde/Strawberry) ☐ BLU (Blue) ☐ BRO (Brown) ☐ GRY (Gray) ☐ GRN (Green) ☐ XXX (Unk./Bald)
☐ PNK (Pink) ☐ PLE (Purple) ☐ ONG (Orange) ☐ RED (Red/Auburn) ☐ SDY (Sandy) ☐ WHI (White)

Eye Color: ☐ BLK (Black) ☐ BLU (Blue) ☒ BRO (Brown) ☐ GRN (Green) ☐ GRY (Gray)
☐ HAZ (Hazel) ☐ MAR (Maroon) ☐ PNK (Pink) ☐ MUL (Multicolored) ☐ XXX (Unknown)

Driver License	State: NJ	License Number S81857896301812	Expires: / /	Weight lbs.
Defendant Fingerprinted: ☐ YES ☒ NO	FBI Number			Height Ft. In.
Fingerprint Classification		MNU Number		
DNA: ☐ YES ☒ NO	DNA Location		Defendant a Veteran?	☐ YES ☐ NO

DEFENDANT VEHICLE INFORMATION

Plate Number	State	Hazmat	Registration Sticker (MM/YY)	Commercial Veh.	School Veh.	Oth. NCIC Veh. Code	Reg. same as Def.
		☐	/	☐	☐		☐

VIN	Year	Make	Model	Style	Color

Office of the attorney for the Commonwealth: ☒ Approved ☐ Disapproved because: _____

The attorney for the Commonwealth may require that the complaint, arrest warrant affidavit, or both be approved by the attorney for the Commonwealth prior to filing. See Pa.R.Crim.P. 507).

BENJAMIN MCKENNA (Name of the attorney for the Commonwealth) — (Signature of the attorney for the Commonwealth) — 3/15/2021 (Date)

JENNIFER L. NUTTER (Name of the Affiant) — BADGE #488 (PSP/MPOETC-Assigned Affiant ID Number & Badge #)

I, Pennsylvania Office of Attorney General (Identify Department or Agency Represented and Political Subdivision) — PA0222400 (Police Agency ORI Number)

do hereby state: (check appropriate box)

1. ☒ I accuse the above named defendant who lives at the address set forth above
   ☐ I accuse the defendant whose name is unknown to me but who is described as _____
   ☐ I accuse the defendant whose name and popular designation or nickname are unknown to me and whom I have therefore designated as John Doe or Jane Doe

with violating the penal laws of the Commonwealth of Pennsylvania at [301] (Subdivision Code) 1412 Lansdowne Avenue, Darby, a 19023 (Place-Political Subdivision)

in DELAWARE County [23] (County Code) on or about JANUARY 1, 2017 THROUGH SEPTEMBER 7, 2017

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Defendant Name:	First: CHAIM	Middle:	Last: STEG

The acts committed by the accused are described below with each Act of Assembly or statute allegedly violated, if appropriate. When there is more than one offense, each offense should be numbered chronologically.
(Set forth a brief summary of the facts sufficient to advise the defendant of the nature of the offense(s) charged. A citation to the statute(s) allegedly violated, without more, is not sufficient. In a summary case, you must cite the specific section(s) and subsection(s) of the statute(s) or ordinance(s) allegedly violated. The age of the victim at the time of the offense may be included if known. In addition, social security numbers and financial information (e.g. PINs) should not be listed. If the identity of an account must be established, list only the last four digits. 204 PA Code §§ 213.1 – 213.7.)

Inchoate Offense	☐ Attempt 18 901 A	☐ Solicitation 18 902 A	☐ Conspiracy 18 903	Number of Victims Age 60 or Older 3

Lead?	Offense#	Section	Subsection		PA Statute (Title)	Counts	Grade	NCIC Offense Code	UCR/NIBRS Code
☒	1	2705	(A)(1)	of the	TITLE 18	3	M2	1399	

PennDOT Data (if applicable)	Accident Number		☐ Interstate	☐ Safety Zone	☐ Work Zone

Statute Description (include the name of statute or ordinance): RECKLESSLY ENDANGERING ANOTHER PERSON

Acts of the accused associated with this Offense: On or about January 1, 2017, through September 7, 2017, in a continuous course of conduct, as a principal, accomplice, or co-conspirator, Chaim Steg did recklessly engage in conduct which placed B.W., Q.D., and L.C. in danger of death or serious bodily injury.

Inchoate Offense	☐ Attempt 18 901 A	☐ Solicitation 18 902 A	☐ Conspiracy 18 903	Number of Victims Age 60 or Older

Lead?	Offense#	Section	Subsection		PA Statute (Title)	Counts	Grade	NCIC Offense Code	UCR/NIBRS Code
☐				of the					

PennDOT Data (if applicable)	Accident Number		☐ Interstate	☐ Safety Zone	☐ Work Zone

Statute Description (include the name of statute or ordinance):

Acts of the accused associated with this Offense:

Inchoate Offense	☐ Attempt 18 901 A	☐ Solicitation 18 902 A	☐ Conspiracy 18 903	Number of Victims Age 60 or Older

Lead?	Offense#	Section	Subsection		PA Statute (Title)	Counts	Grade	NCIC Offense Code	UCR/NIBRS Code
☐				of the					

PennDOT Data (if applicable)	Accident Number		☐ Interstate	☐ Safety Zone	☐ Work Zone

Statute Description (include the name of statute or ordinance):

Acts of the accused associated with this Offense:

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2. I ask that a warrant of arrest or a summons be issued and that the defendant be required to answer the charges I have made.

3. I verify that the facts set forth in this complaint are true and correct to the best of my knowledge or information and belief. This verification is made subject to the penalties of Section 4904 of the Crimes Code (18 Pa.C.S. § 4904) relating to unsworn falsification to authorities.

4. This complaint consists of the preceding page(s) numbered 1 through 3.

The acts committed by the accused, as listed and hereafter, were against the peace and dignity of the Commonwealth of Pennsylvania and were contrary to the Act(s) of the Assembly, or in violation of the statutes cited.
(Before a warrant of arrest can be issued, an affidavit of probable cause must be completed, sworn to before the issuing authority, and attached.)

JENNIFER L. NUTTER — 3/25/2021 (Date) — (Signature of Affiant)

AND NOW, on this date March 25, 2021 I certify that the complaint has been properly completed and verified.

An affidavit of probable cause must be completed before a warrant can be issued.

32-1-27 (Magisterial District Court Number) — (Issuing Authority) — SEAL

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AFFIDAVIT of PROBABLE CAUSE

1. Your Affiant is Jennifer L. Nutter, Special Agent with the Pennsylvania Office of Attorney General, Bureau of Criminal Investigations, Medicaid Fraud Control Section (MFCS), Care-Dependent Neglect Team located at, Strawberry Square, 7th Floor, Harrisburg, PA 17120. As a Special Agent with the Care-Dependent Neglect Team, your Affiant has completed multiple professional trainings related to the investigation of crimes against care-dependent persons. Additionally, your Affiant has conducted numerous investigations and has executed search warrants and arrests. This affidavit is based upon the analysis of statements, information and records obtained by your Affiant during interviews and the general course of the investigation.

2. The Pennsylvania Office of Attorney General conducted an investigation into allegations of widespread neglect and abuse at the Saint Francis Center for Rehabilitation and Healthcare ("St. Francis") following dual referrals from the Pennsylvania Department of Health ("DOH") and the Darby Borough Police Department. Located in Darby, Delaware County, St. Francis is a nursing home with 273 beds and provides care for long-term care residents. In mid-August 2017, staff at Mercy Fitzgerald Hospital notified the Delaware County Office of Services for the Aging ("COSA") of concerns they had for the poor condition of several residents of St. Francis who were transferred to the hospital for treatment. COSA, in turn, notified both the DOH and the Darby Borough Police Department of the situation. The resulting investigation, conducted jointly with the Darby Borough Police, spanned more than three years and was presented to the Forty-Fourth Statewide Investigating Grand Jury. After hearing testimony from 22 witnesses and viewing 78 evidentiary exhibits, the Grand Jury found that reckless and unjustified decision-making by Chaim "Charlie" Steg ("Steg") caused serious bodily injury which led to the death of three St. Francis residents. The evidence presented before the Grand Jury established that Steg, the Regional Director of Operations at St. Francis acted as the highest decision-making authority for St. Francis and was responsible for the reckless decisions resulting in the residents' serious injuries primarily because of a lack of appropriate staffing in the facility.

3. The damage from Steg's reckless decision-making regarding their staffing crisis was exposed on August 18, 2017, when the DOH began investigating the facility in response to complaints. During its "survey," the DOH found widespread and systemic deficiencies that endangered the health and safety of St. Francis residents. The DOH surveyors identified multiple cases of neglect and nearly shut down the facility because of the severity and pervasiveness of the problems. Ultimately, the DOH placed the facility on a provisional license and declared an "Immediate Jeopardy" situation ("IJ"), the most serious violation that the DOH can assign.

4. An expert medical witness, board certified in geriatrics, family medicine, hospice and palliative medicine reviewed the medical records of three residents of St. Francis and observed the following facts and inadequacies in their treatment while residents of St. Francis. B.W., 87 years old, died on August 15, 2017 due to an infection caused by a massive fecal obstruction in her colon that staff failed to properly detect or treat, as well as dehydration. She had been a resident at St. Francis for approximately a month. By the time she was taken to the hospital, B.W. was already suffering from a urinary tract infection and sepsis which ultimately caused her death.

5. On August 20, 2017, 86 year old O.D. died at a hospital from septic shock and severe dehydration while suffering from Stage IV pressure ulcers that exposed his tendon and bone. There was no evidence of any appropriate medical interventions, such as barrier creams, regular repositioning, or a low air loss mattress used to treat O.D.'s wounds among O.D.'s medical records. There was also no evidence that O.D. received proper nutrition and hydration. In four months at St. Francis, O.D. lost 20 pounds and upon his final hospital

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there were no notations in the medical records indicating these fluids were actually administered to O.D. Twice O.D.'s family raised concerns of dehydration, but the St. Francis staff failed to follow up in those instances. Despite the responsibility to monitor and assess O.D., it was actually the resident's family members that recognized O.D. needed to be sent to the hospital for treatment on August 13, 2017. He died seven days later. O.D.'s death was due to acute renal failure secondary to dehydration, attributable to the lack of care provided by staff at St. Francis.

6. Finally, L.C., 87 years old, developed a severe pressure wound on her sacrum, requiring surgery and hospitalization. By the time L.C.'s wound was discovered by staff at St. Francis, it had progressed into the deeper structures of the body and was in the later stages of the wound process. A wound at that stage of development should have been detected at least several weeks earlier if properly trained staff had been performing routine care. Additionally, St. Francis staff failed to properly monitor L.C.'s bowel activity and urine output, a necessary step when caring for a resident such as L.C. who suffered from stercoral colitis, a chronic inflammation of the colon. L.C. was sent to the hospital on August 15, 2017 for surgical debridement of her sacral wound. Upon returning to St. Francis, St. Francis staff again failed to properly monitor and investigate bowel activity and urine output, even though L.C.'s family notified the staff they observed blood in her urine. Ultimately, she was returned to the hospital where they discovered she developed a bacterial infection in her blood that resulted in her death on September 7, 2017.

7. The medical expert who reviewed these residents' records further opined that the deaths of residents B.W., O.D. and L.C. were not isolated incidents of failure to provide proper care. Instead, he concluded that their deaths were the result of systemic failures within St. Francis. The residents suffered from routine conditions that nursing homes should be adept at treating and properly trained to handle. St. Francis, however, failed to meet the most basic needs of these residents.

8. The Grand Jury found that these serious injuries and deaths were avoidable insofar as they were the result of Steg's failure to address well-known staffing deficiencies at St. Francis that detrimentally impacted both the quantity and quality of care delivered to its residents. Despite making multi-million dollar annual profits, Steg, as Regional Director of Operations at St. Francis, recklessly chose not to adequately invest in adequate staffing and did not adjust other operational factors within his control to mitigate the ongoing staffing crisis. St. Francis was understaffed on a daily basis for months at a time and much of the staff that they did have was inexperienced and not sufficiently trained. The facility suffered from incredibly high turnover amongst the nursing staff and relied heavily on outside agency caretakers who were unfamiliar with St. Francis residents and procedures.

9. Steg was well aware of these persistent problems, but never properly addressed them due to financial concerns. St. Francis was rated as a one-star facility (the lowest score) by the Center for Medicare and Medicaid Studies (CMS) for staffing. This rating system contemplates the ratio of staff to residents, the amount of Registered Nurses working (as opposed Licensed Practical Nurses and Nursing Aides), and the acuity of the residents. Further, in April of 2017, St. Francis was cited by the Department of Health for insufficient staffing. Further, St. Francis' staffing budget called for about 3 direct care hours per resident per day (PPD) under Steg's leadership. However, the temporary managers appointed by DOH after the August 2017 believed a substantially higher PPD of 4.1 was required given the conditions in St. Francis and the acuity of the residents.

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10. Evidence from numerous witnesses and documents established that staffing levels at St. Francis were inadequate to care for the residents' needs. Despite repeated complaints to Steg by lower level managers and numerous suggestions to improve staffing, Steg only approved minimal adjustments to recruit, retain, and train qualified staff. A nurse at St. Francis, GW, told the Grand Jury that the conditions were so poor that she filed a complaint in April 2017 with the Department of Health citing concerns over the ratio of nurses to patients. It was the only complaint like this she filed in her entire career. One former staffing coordinator, JS, who worked at St. Francis from May 2017 through the time period when the residents above sustained their injuries, testified that St. Francis was understaffed on a daily basis and she received constant complaints from staff and family members of the residents. Another former staffing coordinator, TM, who worked at St. Francis between December 2016 and April 2017, testified that she complained to Steg on more than 40 occasions about the poor staffing, but he did nothing about it. Multiple witnesses testified that new hires rarely stayed past their orientation period. The former Administrator, WW, testified, that St. Francis was like a, "revolving door. You couldn't even keep track of . . . who was there."

11. Additionally, outside agency staff was needed to supplement staffing levels when sufficient in-house staff was not available to cover all shifts. Steg, especially in the summer of 2017, discouraged or forbid agency staffing because it is more expensive than in-house staffing. This created further strain on the already tenuous staffing situation. One former DON testified that she disobeyed Steg and used an agency nurse to cover shifts because, "I need to be able to sleep at night when I go home. So I did what I had to do."

12. By failing to properly address known deficiencies and engaging in reckless decision making regarding the operation of St. Francis, Steg caused the serious bodily injury of B.W., O.D. and L.C.

I, JENNIFER L. NUTTER, BEING DULY SWORN ACCORDING TO THE LAW, DEPOSE AND SAY THAT THE FACTS SET FORTH IN THE FOREGOING AFFIDAVIT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

Jennifer L. Nutter
(Signature of Affiant)

Sworn to me and subscribed before me this 25th day of March 2021.

Date: _____, Magisterial District Judge

My commission expires first Monday of January, 2022

SEAL