SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

PEOPLE OF THE STATE OF NEW YORK, by LETITIA JAMES, Attorney General of the State of New York, Petitioner, - against - COLD SPRING ACQUISITION, LLC D/B/A COLD SPRING HILLS CENTER FOR NURSING & REHABILITATION, COLD SPRING REALTY ACQUISITION, LLC, VENTURA SERVICES, LLC D/B/A PHILOSOPHY CARE CENTERS, GRAPH MGA, LLC, GRAPH MANAGEMENT, LLC, GRAPH INSURANCE COMPANY A RISK RETENTION GROUP, LLC, HIGHVIEW MANAGEMENT INC., COMPREHENSIVE CARE SOLUTIONS, LLC, PHILIPSON FAMILY, LLC, LIFESTAR FAMILY HOLDINGS, LLC, ROSS CSH HOLDINGS, LLC, ROSEWELL ASSOCIATES, LLC, B&L CONSULTING, LLC, ZBL MANAGEMENT, LLC, BENT PHILIPSON, AVI PHILIPSON, ESTATE OF DEBORAH PHILIPSON, JOEL LEIFER, LEAH FRIEDMAN, ROCHEL DAVID, ESTHER FARKOVITS, BENJAMIN LANDA, DAVID ZAHLER, CHAYA ZAHLER, CHAIM ZAHLER, JACOB ZAHLER, CHESKEL BERKOWITZ, and JOEL ZUPNICK, Respondents.	Index No.: _____ **AFFIDAVIT OF MEDICAL ANALYST MARY CONWAY, RN**

State of New York)
) ss.:
County of Suffolk)

MARY CONWAY, being duly sworn, deposes and says:

1. I have been licensed as a registered nurse ("RN") since October 1997. I was appointed as a Medical Analyst by the Office of the New York State Attorney General, Medicaid Fraud Control Unit ("MFCU"), assigned to the Hauppauge Regional Office, in June 2016.

2. Prior to my appointment with MFCU, I practiced as an RN in a Long-Term Care Setting and a subacute facility, both commonly referred to as a nursing home. My experiences include performing comprehensive nursing assessments of new admissions on long term and cardiac subacute units, including risk assessments, medication order verifications, and entry into the electronic medical record ("EMR") system. My experiences also include medication and treatment administration, including complex treatments such as replacing gastrostomy tubes, providing wound vac care, conducting safety rounds and daily resident assessments, conducting incident/accident assessments, providing patient centered care, and establishing communication and building rapport with residents and their families. I reviewed discharge information with residents and their families and provided instruction for taking care of the residents' medical needs at home. I was also involved with the Suffolk County Community College Preceptor Program for Leadership and Management. This included rounding with student-nurses, daily report of patients, assessments, and effective communication with staff members to build cohesive quality work environments. Lastly, as a Nursing Supervisor, I implemented new policies and procedures and oversaw the delivery of care to residents. Prior to becoming an RN, I worked as a Certified Nurse Aide ("CNA") and then as a Licensed Practical Nurse ("LPN") in nursing homes.

3. In the course of my duties as a Medical Analyst, I, among other things, review medical records maintained by healthcare providers, including nursing home resident charts and/or the EMR and other facility records. In addition, I compare such records that I receive to those maintained by other healthcare providers treating nursing home residents, such as community-

based physician records and hospital records. I analyze data collection and review trends in the nursing home industry to assist in the improvement of quality care issues that are discovered. I also provide interpretation and support of medical concepts for other MFCU staffers.

4. In the body of this affidavit, I, in consultation with other MFCU Medical Analysts, have set forth some key concepts relating to the care of nursing home residents, including applicable laws and negative healthcare outcomes frequently experienced by nursing home residents who do not receive appropriate care. These concepts are explained below and include: Legal Duties of New York Nursing Home Operators to Provide Required Care to Residents (p. 4); Definition of Abuse, Neglect, and Mistreatment and the Duty to Report (p. 7); Duties and Responsibilities of Nursing Home Direct Care Staff, Administration and Governance (p. 8); The Dangers of Insufficient Staffing to Nursing Home Residents (p. 10); Insufficient Supervisory RN Staffing Results in Neglect of Residents (p. 11); Nursing Homes Operating with Insufficient Staffing Externalize Costs to Family Members Who Tip, Pay for Private Care or Provide Necessary Care Directly (p. 11); To Prevent Resident Neglect, it is Important to Assess Resident Acuity to Ensure Sufficient Staffing (p. 13); and Nursing Home Insufficient Staffing Creates and Exacerbates Many Hazards Residents Face (p. 14). Additionally, I have provided definitions of certain additional relevant terms (p. 40) and addressed my review of records provided by Cold Spring Hills and hospitals with regard to particular Cold Spring Hills residents (p. 42).

Residents' Increased Frailty and Medicaid Provider Duties

5. As a preliminary matter, it is important to note that for well over a decade, a greater proportion of the resident population in nursing homes has become increasingly frail, has greater acute care needs, and suffers more comorbidities. Although nursing homes are perhaps seen in popular culture and facility advertising as places where elderly people go to live and participate in

recreational activities, they are in fact "Skilled Nursing Facilities" that primarily provide subacute care to people who are very much dependent on the staff employed at the nursing home for their complex medical and basic human needs.

6. To participate in Medicare and Medicaid, nursing homes, like all providers enrolled in government-funded healthcare programs, must comply with federal and state regulations. *See* 42 CFR § 424.5; 10 NYCRR § 504.3; *See also* 42 USC §1396r and 10 NYCRR § 415.1.

Legal Duties of New York Nursing Home Operators to Provide Required Care to Residents

7. As detailed below, relevant state and federal statutes and regulations impose special obligations and comprehensive duties on nursing homes and their operators to provide all required care to nursing home residents and they prohibit the neglect, abuse, and mistreatment of residents. State and federal statutes require nursing homes to report suspected neglect, abuse, and mistreatment of residents. *See* 42 USC § 1320b-25 and Public Health Law ("PHL") § 2803-d.

8. The law views a nursing home as a resident's home, as much as a medical institution. 10 NYCRR § 415.1(a). The rights of nursing home residents flow from the concept that a nursing home is their *home*.[1] Thus, New York law imposes on operators of nursing homes a "special obligation" to care for their residents, and to meet every basic human need. 10 NYCRR § 415.1(a). To meet this obligation, nursing homes are required to ensure that each nursing home resident receives the care, treatment, diet, and health services that they need to attain or maintain their highest practicable level of well-being. *See* 10 NYCRR § 415.12.

[1] "The facility shall provide: (1) a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible; (2) housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior; (3) clean bed and bath linens that are in good condition; (4) comfortable and safe temperature levels; and (5) … the maintenance of comfortable sound levels. 10 NYCRR § 415.5(h).

The Resident Care Plan

9. As mandated by state regulation, nursing homes, in conjunction with a physician, are required to evaluate and describe each resident's needs in a "comprehensive care plan" ("care plan"). 10 NYCRR § 415.11(c). The resident care plan identifies health concerns and directs courses of care and treatment, specifying, among other things, medications, assisted movement, skin care, bowel and bladder care, and nutrition needs.

10. The staff at each New York nursing home is expected to create an individualized patient centered care plan and implement the care plan for each resident. Thus, "Doctor's Orders" direct what medication and treatments RNs and LPNs are required to administer, the care plan directs the responsibilities of the Interdisciplinary Team that must be followed,[2] which includes the duties that CNAs must perform.

Nursing Homes Must Have Sufficient Caregiver Staff to Care for Each Resident

11. New York law directs that nursing homes shall provide services by sufficient personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. 10 NYCRR § 415.13. These requirements include the obligation for nursing homes to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 10 NYCRR § 415.13(a), (b), and (c); *see also* 42 CFR § 483.35; 10 NYCRR §415.26.

12. To ensure nursing homes operate with sufficient resources to provide required resident care, New York nursing homes must limit admissions, and "accept and retain only those

[2] It is an "unacceptable practice," vitiating a claim for Medicaid reimbursement, for a nursing home to fail to meet recognized standards in furnishing medical care, services or supplies under 18 NYCRR §515.2(b)(12).

nursing home residents for whom it can provide adequate care . . . .” 10 NYCRR § 415.26(i)(1)(ii); *see also* 42 CFR § 483.25.

The Law Requires Nursing Homes to Treat Residents with Dignity/Resident Bill of Rights

13. Under New York law, each resident has the right to “adequate and appropriate medical care.” PHL § 2803-c(3)(e); *see also* 10 NYCRR § 415.3 and 42 CFR § 483.10(d)(2).

14. New York and federal law require nursing homes to treat each resident with courtesy, respect, and dignity, and to care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. *See* PHL § 2803-c(3)(g);10 NYCRR § 415.12 and 42 CFR § 483.10(a)(1).

15. New York law requires nursing homes to provide each resident with the enumerated rights under the Residents’ Bill of Rights codified at PHL § 2803-c. *See also* 10 NYCRR § 415.3.

16. Under the Residents’ Bill of Rights, nursing home residents have the right to be “fully informed … of his or her total health status, including but not limited to, his or her medical condition including diagnosis, prognosis and treatment plan.” 10 NYCRR § 415.3(f)(i). Moreover, residents have the right to “be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident’s well-being . . . .” 10 NYCRR § 415.3(f)(iv).

Nursing Homes Are Required to Document Resident Care They Provide

17. In any nursing home, staff are required to accurately document what care is – and is not – delivered. “The clinical record shall contain . . . the plan of care and services provided . . . .” 10 NYCRR § 415.22(f)(3). For instance, RNs and LPNs must record the medications they administer on a “Medication Administration Record” (“MAR”) and track treatments they provide on a “Treatment Administration Record” (“TAR”). CNAs must also document in an appropriate

medical record often referred to as a "CNA Accountability Log" or "Resident Kardex" that they delivered care such as bathing, oral care, turning and positioning, range of motion, toileting, changing briefs, and other services as required by the resident's care plan. New York law requires that these records must be "complete" and "accurately documented." 10 NYCRR § 415.22(a).

Definition of Abuse, Neglect, and Mistreatment and the Duty to Report

18. Residents of New York's nursing homes are protected by law from acts of abuse, mistreatment, and neglect. PHL § 2803-d(7). "Neglect" is defined as the "failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care . . . including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living." 10 NYCRR § 81.1(c). "Abuse" is defined as "inappropriate physical contact with a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility, which harms or is likely to harm the patient or resident." 10 NYCRR § 81.1(a). "Mistreatment" is defined as "inappropriate use of medications, inappropriate isolation or inappropriate use of physical or chemical restraints on or of a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility." 10 § NYCRR 81.1(b).

19. Nursing home operators, employees, and administrators as well as RNs and LPNs are required to report to the New York State Department of Health ("DOH") suspected abuse, mistreatment or neglect of a resident or misappropriation of a resident's property if they have reasonable cause to believe that a resident has been abused, mistreated, neglected or subjected to the misappropriation of his/her property in the facility. PHL § 2803-d.[3] The failure to report

[3] The requirement that misappropriation of property be reported under PHL § 2803-d became effective April 14, 2020.

suspected abuse, neglect, mistreatment or misappropriation of resident property is a crime. *See* PHL § 12-b.

Duties of Direct Care Staff at Nursing Homes

20. The direct caregivers in a nursing home are, in increased order of training and formal education, CNAs, LPNs, and RNs. The bulk of the hands-on care that nursing home residents require as specified in each resident's care plan is carried out by the CNAs. CNAs assist residents with activities of daily living ("ADLs"), such as ambulation, transfers to/from bed/chair/wheelchair/toilet, feeding, hygiene, toileting, bathing, dressing, bed cleaning and adjustments, turning and positioning of immobile patients in their beds/chairs/wheelchairs, and other care and comfort. LPNs primarily focus on medication administration,[4] monitoring vital signs, and providing certain treatments. RNs primarily supervise LPNs and CNAs and focus on resident acute care needs, complex treatments, compliance with medical orders, communication with physicians and specialists, record keeping, and complex health assessments. RNs spend much of their time assessing any changes in residents' condition, conveying that information to physicians, and then implementing any orders from the physicians (most commonly changes in medications or treatments), all of which are required to be documented in the resident's medical chart.

21. Although all nursing homes are required to have a medical director on call, physicians are not routinely on-site around the clock at nursing homes.

Nursing Home Administration and Governance

[4] When nursing homes operate with insufficient LPN staffing, they also assign RNs to administer medications (or perform "med pass") to residents on a given unit, which leaves such RNs less time to perform the important duties only RNs can perform.

22. The Administrator – Nursing homes operate under the supervision of a licensed administrator, who is required to manage the facility and recognize "that the institution exists to serve the interests of and the needs of the residents." 10 NYCRR § 415.26(a)(1); *see also* 42 CFR § 483.70(d)(2)(ii).

23. The "Governing Body" – Nursing homes are required to have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. The governing body, among other things, is required to establish and implement policies regarding the management and operation of the facility, appoint the administrator, and be responsible for the operation of the facility. *See* 10 NYCRR § 415.26(b).

24. The Medical Director – A nursing home is required to designate a full-time or part-time physician to serve as medical director. The medical director is responsible for implementing resident medical care policies and coordinating physician services and medical care in the facility. 10 NYCRR § 415.15(a). The medical care of each resident is required to be "supervised by a physician who assumes the principal obligation and responsibility to manage the resident's medical condition and who agrees to visit the resident as often as necessary to address resident medical care needs . . . ." 10 NYCRR § 415.15(b)(1)(i).

25. The Director of Nursing ("DON") or Director of Nursing Services ("DNS") – DONs or DNSs are responsible for leading and supervising RNs, LPNs, and CNAs in a nursing home. There are no regulations that define the duties and responsibilities of a DON/DNS in a nursing home. Typically, the DON/DNS is responsible for supervising the nursing care received by residents and reports to the administrator.

The Dangers of Insufficient Staffing to Nursing Home Residents - Generally

26. The adequacy of a nursing home's staffing is the measure most closely linked to the quality of care residents receive in nursing homes.[5] Insufficient staffing occurs when a nursing home lacks sufficient direct care staff to provide its residents with the care that the law requires and that is specified in the residents' care plans. Insufficient staffing at nursing homes is one of the most significant factors leading to resident neglect and abuse. Insufficient staffing can often lead to resident neglect and poor health outcomes. When there is insufficient staffing, residents are more likely to get injured by falling, or can suffer from malnutrition, dehydration, or pressure injuries as more specifically described below.

27. When a nursing home fails to sufficiently staff its residential units, the nursing home puts its caregivers into the impossible position of being assigned by the nursing home to provide too many services to too many residents within the caregiver's shift. Operating a nursing home with insufficient staffing – which includes insufficient supervision of staff – results in staff failing to provide care to residents. Insufficient staffing also results in staff neglecting or providing poor care or an environment where residents are endangered, as staff rush to complete their tasks before moving on to the next resident. As described below, when a nursing home has insufficient staff, staff fail to properly feed residents and fail to timely change residents' disposable briefs when they are wet or soiled.[6] Staff also fail to "turn and position" residents, leaving their skin at risk for pressure injuries. Staff will fail to bathe or provide personal care to ensure residents' good hygiene

[5] *See* C. Harrington, ME Dellefield, E. Halifax, M.L. Fleming, D. Bakerjian, *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*. Health Serv Insights 2020; 13: 1178632920934785 (published online June 29, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/.

[6] In addition, many residents who wear disposable incontinence briefs, sometimes referred to as diapers, require the assistance of multiple caregivers when they are changed. When there is insufficient staff on the unit, this can cause even more delay as the assigned caregiver must wait for an additional caregiver to become available.

and dignity. Moreover, residents who rely on their caregivers to feed them do not receive adequate nutrition or hydration as caregivers disregard care plans and rush through meals to move on to their next task.

Insufficient Supervisory RN Staffing Results in Neglect of Residents

28. When a nursing home fails to operate with sufficient supervising staff, including RN staffing, resident neglect often results. Typically, nursing homes assign dedicated RNs to train LPNs and CNAs through orientation and ongoing in-service lessons. RNs on the unit are responsible for supervising LPNs and CNAs to ensure they are performing their duties competently and diligently. Nursing homes must ensure that they operate with adequate RN supervision on the individual units to ensure that their staff are trained effectively and being attentive to and timely performing their assigned duties and providing care that complies with the residents' care plans. Staff who work under insufficient supervision too often neglect residents and provide care negligently, in violation of residents' care plans. RN supervision is essential on all units on all shifts, as LPNs cannot perform health assessments or other duties outside of their scope of practice. When a nursing home operates with insufficient RN staffing, its RNs do not have sufficient time during their shifts to perform assessments, supervision, and training functions effectively, and residents often suffer from neglect as a result.

Nursing Homes Operating with Insufficient Staffing Externalize Costs to Family Members Who Tip, Pay for Private Care or Provide Necessary Care Directly

29. When nursing homes operate with insufficient staffing, essential aspects of resident care are inappropriately pushed onto residents' loved ones.[7] Even though nursing homes are being

[7] This inappropriate externalization of costs by nursing homes of a portion of the actual cost of providing care to its residents effectively stopped during the pandemic when government regulations barred visitors including family members from visiting residents to protect them from COVID-19 infection. However, rather than hiring more staff to provide the care that the nursing

paid to provide care and treatment to residents, when they are operated with insufficient staffing, they put residents' families in the position to fill the void of care, forcing them to provide fundamental care directly to residents themselves. For example, resident families often feel compelled to feed their loved ones, wash their clothes, and provide basic grooming. Unfortunately, when a resident does not have family or other loved ones to help or are in situations where visitation is prohibited, like during the first wave of the COVID-19 pandemic, such residents lack the safety net of a loved one's help, and they are often left to suffer the indignities of neglect that stem from nursing homes operating with insufficient staff.

30. In addition, when nursing homes operate with insufficient staff — including insufficient supervisory staff — to provide the required care to its nursing home residents' families of nursing home residents often feel compelled to tip nursing home staff to try to prevent their loved ones from being neglected, and/or to pay out of pocket to hire private caregivers to provide needed care the nursing home is failing to provide. Families of nursing home residents who resort to paying tips to nursing home staff often do so in the hope that overworked staff will prioritize the care of their loved one over another resident. Nursing homes are required to operate with sufficient staffing and should do so. By enrolling in the Medicaid program, each nursing home agrees to accept payment under the Medicaid program as payment in full for the services rendered. *See* 10 NYCRR § 504.3. It is inappropriate for nursing home ownership to underpay direct care staff, thereby creating a situation in which staff may be tempted to accept or perhaps solicit tips from residents or a resident's loved ones — a prohibited act. 10 NYCRR §415.26(h)(3)(ii). In addition, each nursing home should prohibit tipping in a written policy and enforce that policy,

homes cynically counted on families to provide, many nursing homes simply failed to provide required care.

because it creates a two-tier system of inequality that discriminates against those residents who don't have family support or the economic means to tip. Even more importantly, operators should meet their legal obligations set forth above to operate each nursing home with sufficient staffing to provide its residents with all required care in their care plans. Doing so would prevent the nursing home operator from externalizing the cost of staffing its facility to others while it and its owners retain the revenue that accompanies each residents' admission.

To Prevent Resident Neglect, it is Important to Assess Resident Acuity to Ensure Sufficient Staffing

31. It is therefore crucial that nursing homes maintain safe staff-to-resident ratios based on each resident's acuity. "Acuity" refers to the level of nursing care required in practice for each resident's particular health conditions. Nursing homes that fail to employ sufficient staff place their residents at risk for serious injuries, and, when their staff are rushed and overworked, residents' concerning health conditions go unnoticed for prolonged periods of time, which can escalate those conditions' progressing into more significant health issues and even lead to death. Nursing homes that operate with safe staff-to-resident ratios enable caregivers to provide required care and attention to each individual's needs. If one resident's care plan requires two caregivers to assist the resident with various activities, such as turning and positioning, transferring a resident to and from his or her bed/wheelchair, toileting, and feeding, the facility must assign sufficient staff to a unit to ensure its direct care staff are available and able to assist the residents with their needs. Nursing homes must also consider how long various activities take for the individual residents when determining appropriate staffing levels. For example, a resident who is wholly dependent on staff for movement and requires the assistance of two caregivers or more with a mechanical lift, requires more time to get out of bed than a resident who can bear his or her own weight and needs the assistance of only one aide.

Nursing Home Insufficient Staffing Creates and Exacerbates Many Hazards Residents Face

32. As set forth below, there are a multitude of ways in which a nursing home that operates with insufficient staffing adversely impacts its residents' care and health.

33. **Injuries Caused by Incidents, Accidents, and Insufficient Staffing** – Accidents and incidents, which are more frequent in nursing homes with insufficient staffing, are a leading cause of injury in the elderly. A nursing home must ensure that "the resident environment remains as free of accident hazards as is possible," and that "each resident receives adequate supervision and assistance devices to prevent accidents." 42 CFR § 483.25(d). An avoidable accident is one that occurs because the facility failed to either 1) identify environmental hazards and individual resident risk of an accident (including the need for supervision); 2) analyze the hazards and risks; 3) implement interventions, including adequate supervision, consistent with the resident's individual needs and current standards of practice to reduce the risk of an accident; or 4) monitor the effectiveness of the interventions and modify them as necessary. Accidents can result in injury, including — fractures, contusions/bruises, burns, intracranial (head) injuries, — loss of consciousness and even death. A common avoidable accident in nursing homes is a fall, which is defined as an unplanned descent to the ground.

34. Every resident that is admitted to a nursing home is required to be screened for falls as part of their care plan. Conducting a comprehensive fall assessment and providing physical therapy ("PT") and occupational therapy ("OT") with goals and desired outcomes are essential aspects of nursing home care. Falls contribute to injury, loss of independence, decreased mobility, hospitalization, and premature death. Lack of ambulation, nursing rehabilitation, PT and OT lead to increased risk of falls. On the other hand, performing these services allows residents to increase their mobility and agility, and improves the residents' overall physical and mental health.

35. Medications such as diuretics, narcotics, and psychotropic medications can lead to a high risk of falls. Restraints such as the inappropriate use of bed siderails lead to a high risk of falls with increased injury, as residents may attempt to climb over them rather than call for assistance. Parkinson's disease and other movement disorders effect a resident's gross motor skills and can increase the risk of falling. Diagnoses such as arthritis, vertigo, syncope[8] and dementia[9] can also increase the risk of falls. Accordingly, nursing homes are required to consider these conditions as part of a resident's care plan and ensure that there is sufficient staff to implement the care plan to ensure the resident's safety.

36. **Lack of Monitoring Causes Preventable Falls** – Insufficient staffing to adequately monitor residents increases a resident's risk of falls. Evaluating the prevalence of falls and adding an intervention of additional staff members to the nursing schedule and additional interventions to a safety prevention program can contribute to a decrease in falls.[10] When residents are being cared for by a nursing home, nursing homes must operate with sufficient staffing in all areas of the building (CNAs, LPNs, RNs, maintenance, housekeeping, Safety Committee, administration/department heads, supervision, Dietary, PT, OT and Activities) in order to prevent

[8] Syncope involves fainting, passing out, or feeling dizzy or light-headed and is caused by a lack of blood flow to the brain, secondary to multiple conditions or illnesses. For example, syncope could be caused by low blood pressure (also known as hypotension), medications, carotid stenosis, or cardiac issues.

[9] Dementia is a group of symptoms characterized by impairment of at least two brain functions, such as memory loss and language skills that interferes with daily functioning. Dementia does not connote violence or dangerousness in any way. Per the U.S. Centers for Disease Control and Prevention, dementia is not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities, commonly seen in patients with Alzheimer's Disease and other diseases with significant cognitive impairments.

[10] *See* Mary T. Hoffman, *et al.*, *Decreasing the Incidence of falls in the Nursing Home in a Cost-conscious Environment: A Pilot Study*, J. Am. Med. Dir. Assoc., 2003 Mar-Apr 4(2):95-7, https://pubmed.ncbi.nlm.nih.gov/12807581.

resident accidents and incidents that result from inadequate staffing, and to prevent the resulting adverse events and negative outcomes.

37. **Falls from Unanswered Call Bells by Residents Seeking Help with Toileting** – Insufficient staffing to timely answer call bells to bring residents to the bathroom when they need to use the toilet leads to an increased risk of falls. This is because residents who need assistance and call for it, yet staff do not respond timely or at all, are more likely to try to stand up or get out of bed by themselves, and then try to walk or otherwise move to the bathroom. Such residents often fall in this situation. Insufficient staff to help residents carry out ADLs also increases the risk of falls and injury. This is because insufficient staffing causes staff to provide improper care to residents or to neglect them, such as an aide transferring a resident from their bed to a wheelchair alone despite the resident's care plan requiring the assistance of two caregivers. Insufficient supervising staff to oversee staff performing their job duties often results in resident neglect and mistreatment by direct care staff who fail to provide required care to residents, either due to inadequate or poor training, inattentiveness, or as discussed above, staff simply being left to do too much due to lack of support from other staff.

38. **Facility and Equipment Disrepair Can Cause Injury** – Nursing homes that are in disrepair, have equipment in disrepair or lack sufficient maintenance staff to monitor the physical aspects of a facility or to repair equipment, including medical devices such as a wheelchairs and lifts, can endanger residents. For example, lack of staff to perform temperature checks on the water systems for bathing can lead to resident burns from hot water. Residents who are forced to use broken wheelchairs can injure themselves or fall getting into or out of a broken wheelchair or a wheelchair that is missing parts like footrests.

39. **Insufficient Staffing Causes Neglect** – Insufficient dietary staff to perform temperature checks on meals or follow procedures of meal preparation can also increase risks to and harm residents (e.g., for a resident who is at risk of choking). Insufficient staff to perform safety rounds in which staff proactively monitor residents increases the risk of a resident sliding off their bed and onto the floor.

40. **Dangers from Lack of Infection Control Protocols Due to Insufficient Staffing** – Infection prevention and control is a critical aspect of basic nursing home care. Nursing homes are expected to take all reasonable steps to avoid the transmission of disease, and never was that obligation more important than during the COVID-19 pandemic. Nursing home infection control regulations require every nursing home to maintain an infection control program with policies designed to provide a safe, sanitary, and comfortable environment in which residents vulnerable to infection reside (and their health care providers work). 42 CFR § 483.80 and 10 NYCRR § 415.19. A facility is required to have an infection control program in which the facility: (1) investigates, controls, and takes action to prevent infections in the facility; (2) determines what procedures, such as isolation, should be utilized for an individual resident to prevent continued transmission of a disease; and (3) maintains a record of incidence and corrective actions related to infections. *See* 10 NYCRR § 415.19(a); *see also* 42 CFR § 483.80(a). Nursing homes are required to isolate residents when the infection control program determines that isolation is necessary, and properly sanitize and store all equipment to prevent the spread of infection. *See* 10 NYCRR 415.19(b). Facilities are also required to mandate basic infection control practices including

ensuring that staff wash their hands after each direct resident contact and properly handle and store linens.[11] *See* 10 NYCRR §§ 415.19(b)–(c); *see also* 42 CFR § 483.80(e).

41. Infection Preventionist – Every nursing home in the United States must designate a qualified professional to serve as an infection preventionist ("IP"). Each nursing home must employ one or more individuals who has "primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field" and who has "completed specialized training in infection prevention and control" as the IP who is responsible for the facility's infection control program. 42 CFR § 483.80(b). The IP "must be a member of the facility's quality assessment and assurance committee and report to the committee . . . on a regular basis." 42 CFR § 483.80(c).

42. As outlined in the Attorney General's January 2021 Report "Nursing Home Response to COVID-19 Pandemic" ("NH Report"), NYS DOH, the Centers for Medicare and Medicaid Services ("CMS"), and the U.S. Centers for Disease Control and Prevention ("CDC") issued guidance to nursing homes to ensure proper infection control measures to protect residents from COVID-19. Despite pre-existing protocols, best practices, and regulations, and further guidance, too many nursing homes violated infection control protocols when they: (1) failed to properly isolate COVID-19 residents when appropriate; (2) conducted lax employee COVID-19 screening that allowed positive cases into the facility; (3) demanded that sick employees continue working when symptomatic; and (4) failed to obtain, fit and train caregivers with personal protective equipment ("PPE"), thus neglecting residents under NY law by failing "to provide timely, consistent, safe, adequate and appropriate services, treatment, and/or care to a patient or

[11] The importance of clean linens to prevent the spread of infection is specifically delineated at 42 CFR 483.80(e) and 10 NYCRR § 415.19(c).

resident of a residential health care facility. . . .” 10 NYCRR § 81.1(c). The NH Report found that lack of infection control put residents at increased risk of harm and that nursing homes that entered the pandemic with low CMS staffing ratings had higher COVID-19 fatality rates than facilities with higher CMS ratings.

43. There is undoubtedly a connection between insufficient staffing and infection control because good infection control practices take staff time to complete. When a nursing home fails to invest in sufficient staff, there are simply not enough staff on duty to conduct the due diligence to maintain proper infection control. For example, overburdened staff are forced to move quickly from resident to resident and do not have time to comply with the methodical aspects of good infection control. Handwashing recommendations are to wash your hands for a minimum of 20 seconds before and after care. Donning and doffing PPE, including changing gloves properly, after providing care to each resident, takes time to complete. When facilities operate with insufficient staffing, all these steps become overwhelming for staff whom the facility assigns to care for too many residents. Under these conditions, staff are forced to choose between skipping steps required for sound infection control, shortening the recommended frequency and time frames of required steps, and/or failing to provide certain care completely to try to respond expediently to the care needs of as many residents as possible. Additionally, when a nursing home operates with insufficient staffing, the facility often reassigns designated infection control staff, like an IP, who would ordinarily oversee infection control practices and outbreaks in the facility, to instead help provide residents with basic required care.

44. This diversion of focus by the IP prevents a facility from timely identifying resident infections, and results in untimely tracking and documentation of infection outbreaks. Timely identifying resident infections, and tracking and documenting infection outbreaks, are critical to

combatting a communicable disease like COVID-19 in a medical facility. One of the mechanisms used for tracking residents with infectious conditions is the creation and completion of a tracking document, such as a line listing form, the purpose of which is to record all necessary information in a single document — thus obviating the need for staff to review numerous, individual residents' medical records to track infections.

45. Insufficient staffing can affect housekeeping personnel, and therefore, resident health, as well. High touch surfaces of a nursing home cannot be appropriately cleaned by already burdened staff, nor can all resident rooms and common rooms. All failures to appropriately clean rooms and surfaces increase the risk for infection transmission among residents and staff. When a nursing home operates with insufficient staffing, it too often either compels staff that may be sick themselves to come to work and potentially spread infection to residents and other staff members, or otherwise violates infection control protocols, disregarding the risk that its staff are sick and spreading infection. Continued testing and screening of staff, residents and visitors is time consuming and nursing homes with insufficient staffing too often disregard such infection control protocols when their staff are faced with high resident caseloads. This exposes residents to increased risk of infection from within and outside of the facility.

46. **Pressure Injuries Caused by Neglect from Insufficient Staffing –** Pressure injuries, also known as pressure sores, pressure ulcers or decubitus ulcers, are serious medical conditions and, according to the CDC, one of the important measures of the quality of clinical care in nursing homes. Based on the comprehensive assessment of each resident, nursing homes are responsible for preventing pressure injuries and they are required to take precautions and provide care to prevent pressure injuries from developing in the resident population. *See* 42 CFR § 483.25 (b)(1) and 10 NYCRR § 415.12(c). NYCRR § 415.12(c) also requires nursing homes to ensure that

a resident with a pressure injury receives the necessary treatment and services to promote healing, prevent infection and prevent new pressure injuries from developing. Pressure injuries, which may present as an open ulcer, are wounds that develop on skin covering bony areas of the body when pressure on that area of the skin cuts off blood supply for more than two to three hours. Pressure injuries can result from multiple sources, including misplaced or long-term use of devices, such as a wheelchair, braces, or bed side rails. However, the most common cause of pressure injuries in nursing home residents is the nursing home's failure to move a resident from a static position for an extended period of time. For example, leaving a resident lying down in bed in one position for hours at a time with parts of the resident's body, e.g., heels, buttocks, back, hips, etc., pressing down on the surface of the bed for an extended period, can cause the skin to degrade. These injuries too often occur when a nursing home resident is bedridden or continuously in a wheelchair, and the nursing home fails to provide necessary, very well-understood and successful preventative care to alleviate timely pressure from skin of the resident's body that is in contact with the bed or wheelchair.

47. While some people use the phrase "bed sores" to describe such injuries, "bed sore" is not a medical term and fails to convey the serious and painful nature of a pressure injury. A "bed sore" or a "pressure sore" is not at all the sort of minor ache and pain that a healthy person with a blister or sore elbow would experience. Facility acquired pressure injuries, which are often preventable and a sign of inadequate nursing home care and neglect, can lead to agonizing pain, bone infections, osteomyelitis, sepsis, and death.

48. Pressure injuries are categorized by four possible stages of increasing severity, based on the depth of soft tissue damage: stages 1 to 4, with stage 4 being the most severe. Additionally, some wounds are unstageable and other wounds are called "deep tissue injuries." A

Stage 1 pressure injury is a closed wound, meaning that the resident's skin is covering all parts of the body that are normally protected by skin. Stage 2, 3, and 4 pressure injuries are usually open wounds, meaning that portions of the resident's body that are normally covered by skin are exposed to open air or bandages if such are placed over the wound. Under federal guidelines, a Stage 1 pressure injury is defined as intact skin with non-blanchable redness of a localized area usually over a bony prominence. A Stage 2 pressure injury is partial thickness loss of dermis (the inner layer of the two main layers of skin) presenting as a shallow open ulcer with a red or pink wound bed, without slough. Slough is the dropping off of dead skin tissue from living tissue, after tissue has died. A Stage 3 pressure injury is full thickness tissue loss, where the lost tissue extends past the two layers of skin, and where the subcutaneous fat may be visible, but bone, tendon or muscle is not visible. Slough may be present but does not obscure the depth of tissue loss. A Stage 4 pressure injury is full thickness tissue loss, where the lost tissue includes all layers of skin, and exposed bone, tendon, or muscle is visible to the eye. Slough is a non-viable fibrous yellow tissue that forms as damaged tissue in a wound. Eschar, which is also necrotic, or dead, tissue that is dryer than slough, adheres to the wound bed, and may also be present on some parts of the wound bed.

49. In addition, an unstageable pressure injury is one where the extent of the injury cannot be determined due to non-removable dressings/devices, coverage of the wound bed by slough and/or eschar, or because it is a deep-tissue injury. A deep tissue injury, or "DTI," is a localized area of intact skin with unknown damage to the underlying soft tissue. Contrary to the implication of the word "unstageable" to a layperson, unstageable and deep tissue injuries are very severe and serious conditions.

50. To prevent pressure injuries from developing and worsening in residents who lack sufficient ability to move their own bodies independently, nursing home staff must frequently change the position of such residents' bodies (such as by rolling them from their back to one side, from one side to the other, or from one side to their back), which is often referred to as "turning and positioning."[12] Nursing homes must also appropriately use assistive devices such as gel cushions and air mattresses that induce some physical movement and reduce some of the pressure on the skin when they admit and provide new homes to residents who spend the bulk of their day either in a wheelchair or in bed. To prevent the development and worsening of pressure injuries, nursing homes must also provide regular skin integrity checks. By doing so, if a Stage 1 pressure injury does develop, treatment can be administered at the earliest moment to mitigate the likelihood that the injury progresses to a Stage 2 or worse.

51. Notably, although the phrase "turn and position" may sound like a relatively minor event, it plays an important role in preventing pressure injuries. Certain residents that require such turning and positioning may lack the physical and/or cognitive ability to perform the large and small adjustments necessary to meaningfully move their own bodies — to turn from their backs to their sides or from one side to the other in bed, to lift their heels, to sit up, or to lift their arms above their heads. Residents who need turning and positioning are not able to perform the position changes themselves, therefore they cannot relieve pressure from the skin that was in contact with the bed or chair. Turning and positioning helps to increase the blood flow to pressure prone areas and supports the wound healing process.

[12] Turning and positioning is also important for residents who are susceptible to pneumonia because it improves oxygenation, breaks up congestion and reduces pulmonary or breathing complications.

52. Residents that are immobile or suffer from incontinence, poor nutrition, dehydration, cognitive deficits, or medical conditions that affect blood flow, such as diabetes and heart disease, are more susceptible to developing pressure injuries. The risk of developing pressure injuries increases when nursing home staff fail to provide required care to ensure residents receive and consume adequate food and water, and as noted above, when staff fail to properly turn and position residents who require that care. Once a pressure injury has formed on a resident's body, poor nutrition or hydration impedes the body's ability to heal.

53. Facility acquired pressure injuries should never occur and are preventable when interventions are implemented timely by nursing staff. Some interventions include, as mentioned above, turning and positioning, proper hygiene, nutrition, hydration, range of motion exercises, as discussed below, and skin monitoring checks. A wound care nurse, or a nurse who performs wound care duties, is critical to the treatment of pressure injuries. As part of the identification, assessment and treatment of pressure injuries, a wound care nurse assists in assessing a wound, takes measurements of the wound and assists with bedside debridement of a wound.[13] The wound care nurse also completes wound tracking sheets to document any changes in wounds and in treatments that may be recommended by the wound doctor and verified by the Primary Medical Doctor ("PMD"). The wound nurse may also be responsible for ordering specialty treatment equipment that is not readily available at the nursing home. The wound care nurse reviews and may assist in processing orders that are verified by the medical doctor.

[13] Debridement of a wound is a procedure for treating a wound that involves the removal of infected, unhealthy or dead tissue to improve healing and decrease infection. Depending on any necrotic tissue formation, debridement can be repeated several times on a wound. Debridement is often performed surgically with a small scalpel, or by use of a topical ointment.

54. **Malnutrition/Dehydration/Weight Loss/Aspiration Caused by Insufficient Staffing** – Providing food and fluids to a nursing home resident is essential to sustain the resident's life, health, and well-being, and to promote healing. Malnutrition or dehydration, the lack of appropriate and adequate food and fluids, can lead to a host of physical issues, including weakness, infections, delirium, cardiac arrhythmia, and overall deterioration of the body; this can be particularly serious for nursing home residents, many of whom are already in a compromised state. These conditions are often the result of neglect or mistreatment, and they can also take an emotional and psychological toll on a resident, potentially causing a lack of motivation to participate in activities and lack of cooperation with his or her care plan.

55. A nursing home must ensure that a resident "maintains acceptable parameters of nutritional status, . . . is offered sufficient fluid intake to maintain proper hydration and health, . . . and "is offered a therapeutic diet." 42 CFR § 483.25(g)(1-3). Sufficient nursing home staffing plays a pivotal role in ensuring that a resident's proper nutritional needs are met. Many residents require physical assistance and/or supervision while eating. Such assistance may include providing encouragement to continue eating, supervising to ensure the resident does not aspirate, or full-on feeding a resident who is disabled and unable to feed him or herself. Essential supervision during mealtime includes monitoring food trays, supervising distribution of meals, ensuring compliance with residents' individual diets, and ensuring that residents are in a place where they can safely eat food properly. For example, a resident whose care plan requires precautions to minimize the risk of choking or aspiration –- which is the condition in which food, liquids, saliva, or vomit is breathed into a person's airways –- must be supervised during mealtimes to ensure his or her safety. A resident who has suffered a stroke resulting in paralysis or paresis (weakness to their limbs), or who suffers from Parkinson's disease or another neurological disorder may need to be safely fed

by a caregiver. Nursing homes must train staff members on how to provide the necessary supervision/assistance effectively to provide required care to such residents during mealtime. A nursing home that operates with insufficient staffing (whether by sheer number of direct care staff, insufficient supervisory staff, and/or staff that is incompetent or ineffectively trained), creates a risk that its residents will not be fed or provided hydration timely or at all, thereby resulting in malnutrition, dehydration, and weight loss that can, in turn, cause additional physical ailments and overall decline in health, and hinder a resident's ability to heal from injury.

56. **Medication Errors** – Nursing homes that operate with insufficient staffing create a higher risk of medication errors in administration of medication to their residents, as insufficient staff adversely impacts a nurse's ability to give adequate care and attention to the task at hand when the nurse is responsible for administering medication to too many residents during a shift. Examples of medication errors include administering the wrong medication to a resident, administering medication in an amount other than what is prescribed, or administering medicine when it is medically inappropriate to do so based on the resident's vital signs and the nurse did not appropriately, or at all, measure the resident's vital signs. Significant medication errors can be dangerous to a resident's health and safety and even cause death. Federal and state law require that nursing homes keep residents free from significant medication errors, and further require that medication errors be reported internally to the facility and to DOH. *See* 42 CFR § 483.45(f) and 10 NYCRR § 405.17. When a nursing home operates with insufficient staffing to provide required and appropriate care to its residents, it creates poor and stressful working conditions that place its nurses at greater risk of making transcription errors when receiving an order, and of making an error during the actual administration of medication.

57. Individuals who live independently may have the ability to identify and self-administer their medications and report any side effects to their physician. However, in nursing homes, many residents rely on the nurses to accurately administer, evaluate, and report all aspects of the resident's medication needs.

58. In a practical sense, medication errors often occur in nursing homes as omissions (medications were ordered but not administered), lack of authorization (no physician's order), or an administration outside of the "Five Rights," which are the "right" 1) patient; 2) time; 3) medication; 4) dosage (either amount or form, such as tablet rather than liquid); and 5) route (method of administration). Nurses are also required to complete the "Three-Check Process," which entails: 1) matching the label on the medication's container to what's listed on the MAR; 2) preparing the medication and identifying the medication by looking at it; and 3) conducting a final check to ensure that the label on the medication's container matches the MAR. Medication should not be prepared ahead of the scheduled time of administration to avoid an increased risk of medication errors. The nursing home is responsible for ensuring that nursing staff have time to administer medications and that "the Five Rights" and the "Three-Check Process" are incorporated and detailed in their own policies and procedures. If nurses are not adequately trained on the facility's policies and procedures when receiving an order, or are overwhelmed with the responsibility to care for the basic needs of too many residents, there could be a delay or error in the transcription and ultimate administration of that medication. Receiving medication that should not have been administered, or failing to receive a timely, proper dose of a medication that should have been administered, could have serious implications on a resident's overall health.

59. **Chemical and Physical Restraints –** Nursing homes that operate with insufficient or inadequate staffing increase the risk of care givers inappropriately or unlawfully physically or chemically restraining their residents. This unacceptable practice constitutes mistreatment.

60. A resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or the convenience of staff. 42 CFR § 483.10(e)(1); 10 NYCRR § 415.4(a). "Physical restraints" include leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions, lap trays or any other physical device that (1) a resident cannot easily remove, and (2) restricts the resident's movement. A "chemical restraint" is the inappropriate use of medication to restrict movement or suppress thought and/or free will. Psychotropic drugs frequently act as a chemical restraint and cause unsafe side effects such as lethargy, increased falls, abnormal involuntary movements, lack of socialization, and a decline in physical function. Minimizing these side effects while maintaining therapeutic effectiveness of the medication is imperative.

61. Each nursing home must develop and maintain a written policy prohibiting the use of inappropriate restraints and detailing the limited circumstances in which restraints may be used. The facility's policy and procedures must include considerations for the risk of physical and cognitive decline as a result of restraints and ensure that measures are in place to minimize any such decline. If any type of restraint is deemed appropriate, the facility must ensure that the least restrictive device is implemented for the least amount of time and that ongoing evaluations occur to reduce the need for the device (including tapering a resident from a chemical restraint-medication). The individual resident's medical record must include an order from an appropriate medical provider, a rationale for use of the device or medication, potential underlying causes of the behavior, documented attempts at less restrictive and nonpharmacological interventions, potential risks and benefits of the device or medication as discussed with the resident and/or the

family, specific target behaviors and expected outcomes, and a plan of care. Ongoing evaluations for the continued use of the restraint must occur at least quarterly and as needed. If psychotropic medications are prescribed to treat behavioral symptoms, the symptoms must be clearly documented, and a scheduled gradual dose reduction must be attempted to ensure that the resident is receiving the lowest possible dose of the medication for the shortest period of time.

62. Improper use of physical or chemical restraints can lead to life-threatening injuries and/or death. For example, improper use of side rails for a resident with impaired cognition and poor safety awareness can cause entrapment of the resident in the siderail, which can cause serious harm. Similarly, many psychotropic medications are accompanied by a United Stated Food and Drug Administration ("FDA") "Black Box" warning and are contraindicated for residents diagnosed with dementia as they can increase their risk of death.[14] Other potential injuries can include a decline in physical function, muscle contractures, increased incidence of infections, development of pressure injuries, falls, and incontinence. There can also be cognitive effects, such as increased agitation, depression, and anxiety. Moreover, restraints can lead to a resident becoming emotionally withdrawn and cause them to experience a decrease in self-esteem and, in turn, his or her quality of life. Chemical restraints have the potential to include all the above adverse effects, as well as toxic effects of the medication and other health conditions, and can result in a resident becoming catatonic.

[14] The FDA has required manufacturers to place the strongest caution, known as a "black box warning," on the packaging of many psychotropic drugs to advise against the medicines' use in patients suffering from dementia. According to the FDA, such drugs almost double the risk of death and have never been approved as safe or effective for treating symptoms of dementia. Despite the warning and in violation of federal regulations, nursing homes still often administer antipsychotic drugs, sometimes without seeking informed consent first.

63. To adequately monitor residents whose care plans appropriately include the use of restraints, a nursing home must operate with sufficient staffing to perform these duties. Often, a nursing home must increase direct care staffing to be able to perform the additional tasks that proper use of restraints requires. Specifically, physical restraints have release periods, during which the various restraints are required to be removed for a certain period of time at regular intervals. Similarly, chemical restraints often coincide with a resident being deemed a fall risk, which would, in turn, require increased monitoring. These additional caregiver duties cannot adequately be performed without sufficient direct-care staff in the facility. In addition, proper training and supervision of direct care staff are essential components to minimizing unnecessary restraints. Caretakers must be trained on various interventions to utilize when a resident exhibits aggressive behavior (such as re-direction, de-escalation, and calming techniques like offering a snack, taking the resident for a walk, or offering recreation therapy) before seeking an order for physical or chemical restraints. Unfortunately, high use of psychotropic medications on residents suffering from dementia correlates with insufficient staffing.

64. **Isolation and Depression – the Importance of Recreation for Residents** – Residents of nursing homes with insufficient staffing are more likely to experience isolation and depression. This is because such nursing homes assign their direct care staff to provide care to too many residents, forcing them to work under conditions where the staff are often forced to triage, and decide to allocate their limited time to provide care to the residents with the greatest needs, the most time-sensitive needs or to the residents who are most able to advocate for their own care needs. Moreover, the use of isolation by nursing home staff to punish or mistreat residents is improper and illegal. Isolation can be a contributing factor to a diagnosis of depression in a nursing home resident, which can cause a loss of interest in normal daily activities, a feeling of

hopelessness, a lack of productivity, lower self-esteem and an overall feeling of inadequacy that interferes with the ability to work, sleep, study, eat and enjoy life. To combat the severe risks associated with isolation, recreational therapy and other activity-based interventions are critical to improve a resident's overall physical health, cognition and emotional well-being.

65. Nursing homes must provide, based on each resident's care plan, "an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community." 42 CFR § 483.24(c). Research has consistently shown that loneliness and social isolation have a negative effect on physical and mental health, and they contribute to a higher mortality rate in older adults.[15] Prolonged loneliness and social isolation are associated with a wide range of physical, cognitive and psychological health conditions, which can lead to cardiovascular disease, hypertension, obesity, depression, substance abuse, suicidal ideation and suicide attempts, cognitive decline, progression of dementia, stroke and premature death. The rate of depressive symptoms among nursing home residents with dementia is higher than it is among the general population, and such residents may exhibit additional symptoms, such as delusions and hallucinations.

66. Additionally, inconsistent and unfamiliar staffing, such as when there is high employee turnover due to poor working conditions, or when staff are floated to different units, or when owners hire agency staff to avoid paying the cost of employee benefits, can also lead to feelings of distrust and loneliness for residents. It is important for residents to recognize and build trust and rapport with staff members. Also, if staff members understand the individual needs of a

[15] *See* Social Isolation, Loneliness in older people pose health risks, National Institute on Aging https://www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks.

resident, they are able to provide better continuity of care. Nursing homes with insufficient staffing frequently have high employee turnover. Agency staff, whether LPNs, RNs, or CNAs, are employed by an agency instead of the facility. Reliance on agency staff creates inconsistencies in staffing that can adversely impact the continuity of care of residents. In addition, the accountability of agency staff is reduced when they are assigned to multiple facilities or units, causing them to be in a different place from day to day; for example, they may not complete all tasks before they move on to a different assignment or leave the particular nursing home entirely.

67. Despite loneliness and social isolation being among the most fixable risk factors for mortality and morbidity, nursing homes too rarely prioritize providing care that addresses loneliness and social isolation. In fact, to cut the nursing home's expenses, too many nursing homes often first cut recreation therapy programs from their budgets. In nursing homes with insufficient staffing, overworked staff are required to focus on resident physical needs and do not have the opportunity to spend time with each resident, much less provide recreational therapy to a resident. Residents deserve to be offered therapeutic activities to maintain and improve their physical and cognitive function. Recreational therapists work with the healthcare team to set attainable goals and develop an individualized plan of care. Recreation therapists offer outcome-based therapeutic programs in small groups or one-to-one sessions for older adults with a variety of mental and physical conditions. Therapeutic recreation interventions or activities can include such things as physical games, cognitive games such as cards, trivia, social events, reminiscing activities, arts and crafts, sensory programs such as hand massage, and outings, including restaurants, ball games, and fishing trips. Research has shown that increased verbal activity improves self-esteem and

results in decreased levels of depression.[16] Residents with a dementia diagnosis should have specialized small group programs or individual programs to provide the right amount of challenge and stimulation to help maintain current function, which would, in turn, result in decreasing difficult behaviors. Recreational therapy interventions make a tremendous difference in the outcomes of older adults in nursing homes.

68. **Activities of Daily Living, Lack of Personal Care, and Loss of Dignity** – Nursing home residents need assistance with ADLs and personal hygiene due to difficulty with mobility, cognitive processing, or other reasons. Quality of life and dignity are essential components of the standard of care in a nursing home. Proper hygiene and grooming are important aspects of maintaining good health and allowing a nursing home resident to maintain their dignity as a human being. A nursing home must provide care and services relating to a resident's ADLs, which include: (1) "Hygiene – bathing, dressing, grooming and oral care;" (2) "Mobility – transfer and ambulation, including walking;" (3) "Elimination – toileting;" (4) "Dining – eating, including meals and snacks;" and (5) "Communication, including speech, language and other functional communication systems." 42 CFR § 483.24(b). Federal and state law recognize that "quality of life is a fundamental principle that applies to all care and services provided to facility residents." 42 CFR § 483.24; *see also* 10 NYCRR § 415.5. Under federal law, nursing homes are required to provide "the necessary services" to ensure that residents "maintain good nutrition, grooming, and personal and oral hygiene." 42 CFR § 483.24(a)(2); *see also* 10 NYCRR § 415.12. Every ADL is critical to a resident's ability to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

[16] *See, e.g.*, Sunghee H. Tak, Satish Kedia, Tera Marie Tongumpun, Song Hee Hong, Activity Engagement: Perspectives from Nursing Home Residents with Dementia, Educ Gerontol, 2015 Mar 41(3):182-192, https://pubmed.ncbi.nlm.nih.gov/25489122/

69. As part of their "special obligation to the residents who depend upon the facility to meet [their] every basic human need," 10 NYCRR § 415.1, a nursing home must "be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 CFR § 483.70 and 10 NYCRR § 415.26. Nursing home residents suffer when a nursing home operator fails to operate a nursing home with sufficient staff to provide the required care and services to assist residents with all of their ADLs consistent with state and federal law. Nursing homes that operate with insufficient staffing regularly direct their caregivers to work under poor and stressful conditions. These direct care employees are insufficiently supervised and are forced to try to "beat the clock" to provide required care to too many residents. In so doing, such nursing homes deprive residents of the care and services that the nursing homes are legally and morally required to provide, cheating Medicaid and Medicare, and accepting reimbursements for care that residents did not wholly receive.

70. **Mobility/Ambulation** – Mobility is critical to the overall health of nursing home residents, including to ensure that they maintain proper range of motion with their joints and limbs. Failure to keep a resident moving is known to cause functional decline and complications affecting the respiratory, cardiovascular, gastrointestinal, integumentary, musculoskeletal, and renal systems. Lack of mobility and ambulation can be especially devastating to an older adult when the aging process causes a more rapid decline in function and potentially leads to "contracture," which is the abnormal shortening of muscle tissue, rendering the muscle highly resistant to stretching. Contracture causes the joints to shorten and become very stiff, which can lead to permanent disability. The way to prevent this deterioration is through ambulation and passive or active range of motion on a regular daily schedule. Ambulation provides not only improved physical function,

but also improved emotional and social well-being. A lack of the ability to ambulate puts limitations on one's social life — including limitations on visiting with friends or close relatives and religious and artistic expressions — and increases the incidental encroachment of non-therapeutic solitude. The necessary range of motion activities vary from resident to resident based on their individual functional abilities. Some residents may need assistance in moving their limbs while lying in bed, while others may require assistance in walking certain distances a certain number of times each day. When facilities fail to adequately staff their units based on the needs and acuity of the residents, staff members are more likely to rush through their tasks and fail to provide the necessary range of motion activities to the residents or even to get them out of bed to ambulate.

71. **Toileting** – Urinary and fecal incontinence are comorbid conditions affecting many nursing home residents. Toileting refers to assisting dependent residents with their waste elimination needs and can vary from assisting a resident to walk to the toilet in a bathroom or a bedside commode to assisting a resident with the use of a bedpan or urinal, or, for a more dependent or incontinent resident, to meet their elimination needs with the use of adult disposable briefs, incontinence pads or urinary catheters. Proper toileting is critical to the overall health of a nursing home resident as failure to toilet is linked to serious health outcomes. Proper toileting or bowel and bladder training is also necessary to assist a resident to help them regain continence or contain incontinence when possible. Proper toileting is, of course, also central to an individual's sense of dignity and control. Failure to assist a resident with toileting can lead to a resident falling if the resident attempts to toilet themselves without proper assistance. A resident who has basic cognition, but impaired mobility, will naturally wish to avoid the embarrassment and physical

discomfort of incontinence, and may fall while attempting to get to a toilet by themselves if they call for assistance and the nursing home fails to provide it on a timely basis or at all.

72. A nursing home's failure to promptly change a resident's soiled adult disposable brief can cause severe health problems for the resident who is left sitting or lying in a soiled brief. When nursing homes operate with insufficient staffing to provide required care to the residents, based on the needs and acuity of the residents, the nursing homes' direct care staff cannot timely respond to resident call bells, forcing residents to suffer excessive delays in receiving assistance with toileting. This, in turn, too often results in continent residents holding their urine for excessive periods of time, in hopes that help will eventually come, which increases the risk of urinary tract infections and pressure injuries.

73. **Dining** – Dining, hydration, and a healthy diet are critical to ensure that a resident receives the nourishment required to maintain health. The level of assistance required by residents to eat varies greatly. Some residents may need to be spoon-fed, while others may only require encouragement to continue their meal or monitoring to prevent the risk of choking and aspiration. As described above, when nursing homes operate with staffing that are insufficient to meet the needs and acuity of their residents, their overburdened and/or under-supervised direct caregivers do not have sufficient time to properly assist and/or are rushed when assisting all of their residents with dining. The level of assistance required by residents to eat varies greatly. Some residents may have difficulty with or be entirely unable to lift and move a utensil to the mouth, or to do so accurately; to open packaging containing plastic silverware or food items; or to cut the food to an appropriate size for the person's chewing ability and swallowing ability, to avoid choking. Other residents (e.g., those who are reluctant or depressed) may need encouragement to consume

sufficient quantities of food or liquids, whereas others may require monitoring to prevent choking, aspiration or vomiting.

74. **Communication** – Communication is critical to avoid devastating isolation, as described above. When a nursing home fails to provide to a resident any of these critical aspects of life that are so easy for able-bodied people to take for granted, it deprives the person living in the nursing home of their dignity, and, eventually, potentially their will to live.

75. **Hygiene** – Nursing homes must maintain a resident's personal hygiene to maintain their dignity and ensure that a resident attain or maintain the highest practicable physical, mental, and psychosocial well-being, such as regular bathing, grooming, dental hygiene, and dressing.

Bathing – Regular bathing is fundamental to maintaining an individual's physical and psychosocial well-being. Nursing homes should take individual preferences into account when determining how residents should be bathed, whether receiving showers,[17] full baths, sponge baths, etc. Not only does bathing remove dirt and bacteria[18] and promote blood circulation, but it also plays a vital role in maintaining a resident's overall self-esteem and self-image. Like all ADLs, the level of assistance needed in bathing varies from one resident to the next. Some may only require assistance in getting to and from the bathroom, while others may be wholly dependent on their caregivers for bathing.

[17] A bariatric chair may be needed to provide certain nursing home residents with showers. It can enable individuals with an illness or physical condition that makes taking a shower difficult to shower safely. Bariatric shower chairs can be purchased at a variety of prices, including $600 or less. *See, e.g.*, https://www.rehab-store.com/

[18] Cellulitis is a type of bacterial skin infection. A break in the skin can cause bacteria to enter and effect the layers of the skin. Good hygiene, including meticulous skin, fingernail and toenail care is imperative in preventing bacterial infections of the skin such as cellulitis.

Grooming – Grooming, which includes hair care and nail care, is also essential to maintaining a resident's health, dignity and self-esteem. Regularly brushing a resident's hair not only impacts their self-image but prevents hair from tangling and becoming matted. Regular nail care helps residents present a neat appearance, and also prevents residents from accidentally injuring themselves by scratching themselves, or from getting dirt and/or bacteria stuck under their nails. Assistance with these basic ADLs gives residents dignity and improves their self-esteem. When nursing homes operate with insufficient staffing to provide required care to its residents, based on the needs and acuity of the residents, their direct caregivers are more likely to fail to properly groom residents, thereby negatively impacting the residents' physical and psychosocial health.

Dental Hygiene – Dental hygiene is incredibly important to the overall health of a nursing home resident. Failure to maintain good dental hygiene has been linked to heart disease and other conditions, as well as overall mouth health. Nursing homes must assist residents with routine dental care and provide emergency dental services to meet the needs of each resident. 42 CFR § 483.55. Nursing homes must operate with sufficient staffing to provide required care to brush their residents' teeth and to assist them with other good oral care. Nursing homes that operate with insufficient staffing increase the likelihood that their staff will fail to regularly brush their residents' teeth and/or otherwise provide good dental hygiene, thereby increasing the risk that their residents' teeth will decay, rot, develop infection, need to be extracted, and cause the residents to experience preventable pain, suffering and bad breath.

Dressing – Nursing home residents often need assistance with dressing, an ADL which requires significant dexterity and hand-eye coordination. Though seemingly mundane, getting dressed is a daily activity that significantly impacts a resident's psychosocial welfare. Dressing can also constitute an important segment of a resident's prescribed Occupational Therapy (OT). Nursing homes that operate with insufficient staffing also increase the risk that a resident needing assistance with dressing will grow frustrated when forced to wait and can fall while attempting to get dressed independently. Or, they will be deprived of that segment of their prescribed OT, or even remain in a gown or in soiled, unsanitary clothing.

76. **Property** – Nursing homes must ensure that residents have the "right to retain and use personal possessions, including furnishings, and clothing . . . ." 42 CFR § 483.10(e)(2). When nursing homes operate with insufficient staffing to provide required care to their residents, residents' personal belongings, including important medical devices such as dentures and hearing aids, are frequently discarded or lost within the facility. It is well known in geriatric care that nursing home residents suffering from cognitive deficits are prone to misplace their possessions, including by leaving them in unmade bedding or on a meal tray. Staff who are assigned to provide care to too many residents are predictably rushed into performing overwhelming care duties and frequently discard residents' personal property or otherwise fail to take adequate care to safeguard residents' personal property when cleaning residents' rooms or removing meal trays after meals. Too often when nursing homes operate with insufficient staffing, they fail to safeguard residents' clothing, which deprives residents of a key aspect of their self-esteem and dignity. Insufficiently staffed nursing homes also often "cut expenses" by failing to invest in sufficient staff to properly handle the important obligation of labeling, washing, folding, and returning clothing to its

residents. Sadly, for the same reasons, when residents lose their dentures or hearing aids in such nursing homes, residents or their families are often forced out of necessity to bear the cost of replacing those important items — even though it is the facility's responsibility to replace the items lost or damaged. This is because during the time that it takes the resident, family members, or the nursing home to replace the item, the resident is forced to live in the nursing home without the benefit of the lost item. For example, during the time that the resident is waiting for a replacement for the lost item, the resident is forced to wear ill-fitting clothing, someone else's clothing, or no clothing at all except for a gown. If a resident's dentures are misplaced, he or she is left unable to chew properly. If a resident's hearing aid is lost, he or she is left hearing impaired and cannot participate fully in conversations or hear prompts offered by his or her caregivers while rendering care.

Additional Definitions

77. **AMBU BAG:** a handheld device to provide ventilation to residents who are not breathing adequately. Also known as a BVM or Bag valve mask.

78. **Amyotrophic lateral sclerosis, or ALS:** a progressive neuro degenerative disease that affects the nerve cells in the brain and spinal cord, affecting muscles of movement, speaking, eating, and breathing. Also known as Lou Gehrig's disease.

79. **Chucks pads:** disposable bed pads that absorb bodily fluids.

80. **Edema:** a condition characterized by an excess of watery fluid collecting in the tissues of the body.

81. **Feeding tube:** a tube that is inserted through the stomach wall that provides nutrition directly to the stomach. A gastrostomy tube, or "g-tube," is a type of feeding tube.

82. **Patient Review Instrument ("PRI")**: a New York State Department of Health assessment tool used to assess selected physical, medical, and cognitive characteristics of nursing

home residents to determine the level of care a person requires. It includes, among other topics, information about a person's diagnoses, Activities of Daily Living, treatments, medications and behaviors. PRIs are completed by Registered Nurses and must accompany the resident entering a Skilled Nursing Facility ("SNF") / Nursing Home.

83. **Pulse oximeter:** a noninvasive diagnostic tool to measure the oxygen level in a resident's blood. It is usually placed on the finger and alerts the caregiver if quick medical attention is needed.

84. **Sepsis:** a systemic inflammatory response to infection in which there is fever, increased heart rate, decreased blood pressure, increased respiration and inadequate blood flow to internal organs. Complications of sepsis may include shock, multiple organ system failure and death.

85. **Suctioning:** a method of removing mucous or congestion from the lungs to help keep the airway clear. Suctioning is performed with a catheter and can be done nasally, orally, or via tracheostomy.

86. **Tracheostomy, or "trach":** surgical incision performed in the front of the neck area/throat so a tube can be inserted into the windpipe (trachea) allowing for a direct airway to deliver oxygen to help an individual breathe.

87. **Urinary catheter:** a tube that is inserted and forwarded into the bladder and attached to a collection bag to collect urine.

88. **Wheelchair footrests:** plates that attach to a wheelchair so that the user's feet can be supported and rest elevated, off the ground. Footrests can be purchased for under $200 at major online retailers. *See, e.g.*, http://wheelchairparts.net.

89. **Wound vacuum, or "wound vac":** a piece of equipment or device that promotes healing of a wound by applying continuous negative pressure. The device attaches to a wound by tubing and a vacuum seal. The pumping action of the wound vac helps to pull fluids out from a wound, remove bacteria, stimulates the growth of new tissue and helps to pull the wound edges closer together.

Reviews of Records Regarding Certain Cold Spring Hills Residents

90. I have reviewed records of various Cold Spring Hills residents; summaries of certain aspects of those records follow below.

91. **Resident S.H.** – Cold Spring Hills records reveal that resident S.H. lost at least 60 pounds during her five-month residency.

92. **Resident P.L. –** Cold Spring Hills records for resident P.L. contain a court order dated 2017 appointing P.L.'s cousin, Elsie Limage, as one of the two co-Guardians for the Personal Needs of P.L. and setting forth the co-Guardians' responsibilities regarding P.L.'s health care and eventual death, among other things.

93. Cold Spring Hills records reflect that P.L. had diagnoses including diabetes,[19] dementia and Alzheimer's Disease, among other things.

94. Cold Spring Hills records contain a nurse's note dated April 3, 2020 at 11:39 p.m. stating P.L. died at 11:15 p.m. on April 3, 2020. The records indicate that, during the period from March 27, 2020 through the night of April 3, 2020, P.L. had pneumonia, sepsis and hypernatremia, among other things. Progress notes dated April 3, 2020 indicate P.L. was unable to tolerate medication and his overall prognosis was poor. The Physician Monthly Progress Notes prepared

[19] Diabetes is a disease that occurs when a person's blood glucose, also known as blood sugar, is too high or too low. It causes poor circulation in feet, making a person with diabetes less able to fight infection and to heal when injured.

between April 3, 2020 and April 6, 2020 document that P.L. had been "confused, obtunded, non-verbal[.]"

95. The nurse's note dated April 3, 2020 at 11:39 p.m. additionally states that P.L.'s son was made aware of his death, and he will discuss funeral arrangements with his family and call Cold Spring Hills with a contact number. Another note, barely an hour later at 12:49 a.m. on April 4, 2020, documents another call to P.L.'s son to speak about the "status for funeral home information to pick up body." According to the note, P.L.'s son became upset at the nurse's instruction during that call that a funeral home needs to be contacted as "the body will need to be picked up."

96. **Resident C.P**. – Cold Spring Hills' records regarding resident C.P. reveal that C.P. fell in the Cold Spring Hills dining room on June 5, 2021 at 9:40 p.m. While certain Cold Spring Hills records indicate the fall was unwitnessed by staff, as further described below, other Cold Spring Hills records indicate that the fall was witnessed. For example, a progress note states that, as per a CNA, she "was ambulating[,] lost her balance and landed on her left side." C.P. was reportedly observed "lying on the dining room floor" and was "taken to her room to get clean." The Cold Spring Hills incident/accident report documents the following statement from a CNA on June 5, 2021: "Staff witness resident fall in the dining room while walking, resident loss [sic] her balance . . . get pm care and diaper change." However, the incident/accident report also contains a statement dated June 5, 2021 from an LPN, as follows: "CNA who was monitoring the [dining room] called for help . . . ." The CNA monitoring the dining room stated on June 5, 2021, "I was giving PM care to a resident in the dining room bathroom and I heard a noise and saw the resident laying down on the floor." There are notes documenting that C.P. sustained a cut to her left upper lip and her upper bridge had four loose teeth. A nurse documented that the next day at 7:00 a.m.,

C.P. was sitting in the dining room and was observed to be missing her upper bridge. The note states the nurse asked staff to search for her upper bridge, which they reportedly found on the top of her dresser in a plastic cup. Moreover, Cold Spring Hills' progress note dated June 7, 2021 states: "S/P unwitnessed fall: pt noted with abrasion on lip, broken tooth appliance . . . ." ("S/P" refers to "status post," meaning an event that someone previously experienced, and "pt" refers to patient.)

97. The records also reflect that C.P.'s daughters were in contact with Cold Spring Hills numerous times regarding the fall and C.P.'s teeth. The records further reflect that, two days after the fall, at the request of her family, C.P. was transported to the hospital for further evaluation, including a CT scan of her head. This was after Cold Spring Hills reviewed with her family the "[b]enefit of keeping pt at facility vs transferring" her to the emergency room.

98. Additionally, Cold Spring Hills' records contain a physician's note of January 2020 stating that C.P. was diagnosed with cellulitis on her ankle resulting from her "scratching the area where a wander guard was attached;" scratch marks were present. As addressed in ¶75 and footnote 18 herein, good hygiene is important in preventing bacterial skin infections.

99. **Resident** [redacted] – Cold Spring Hills' records regarding resident [redacted] ("Resident 47") document that the resident had dementia. According to the Cold Spring Hills records, Resident 47's ambulatory functioning varied over the course of their residency, including times when the resident was able to ambulate independently. Records reflect the resident was provided a wheelchair and walker.

100. The records further document that Resident 47 wandered into other residents' rooms. They additionally state that, on October [redacted] 2021, staff put Resident 47 in a wheelchair

from the resident's room and transported the resident to the dining room "for safety." The records reflect that Resident 47 spent a considerable amount of time in the dining room.

101. The records further reveal that Resident 47 fell several times while attempting to stand up and get out of the wheelchair while living at Cold Spring Hills. On different occasions, the resident was observed leaning forward in the wheelchair and fell when attempting to stand up. Recent notes in Cold Spring Hills records include one dated January [redacted] 2022, that states Resident 47 was found on the floor beside their bed. On February [redacted] 2022, the resident was witnessed falling on their left side in the dining room upon getting up from their wheelchair. On March [redacted] 2022, the resident slipped when getting up from their wheelchair. And, on March [redacted], 2022, the resident slid out of the wheelchair.

102. As a general matter, placing a resident in a locked wheelchair pushed up against a barrier that is in front of him or her is not an acceptable method of monitoring a resident or preventing falls and it constitutes mistreatment.

103. **Resident C.A.** – Cold Spring Hills records for resident C.A. state that he was admitted to Cold Spring Hills in December 2020 and discharged to another nursing home in November 2021.

104. The records reflect he had a sacral pressure injury when he was admitted to Cold Spring Hills from a hospital. The Cold Spring Hills wound doctor classified it as a stage 3 pressure injury near the time of his admission. During C.A.'s residency of nearly a year, the wound doctor documented that it had advanced to a stage 4, requiring debridement of dead tissue.

105. While he lived at Cold Spring Hills, C.A. was dependent on a feeding tube for nutrition. However, he lost over 20 pounds during his year there, according to the weights that Cold Spring Hills staff documented. On December 22, 2020, Cold Spring Hills documented his

weight as 160 pounds. On January 5, 2021, mere weeks later, the records state his weight was 136 pounds. Despite the serious loss of approximately 24 pounds within a short time, there is no documentation that staff re-weighed C.A. to verify the loss, which would have been standard practice. There is also no documentation indicating they addressed the loss until January 12, 2021. On January 12, 2021, the records state he weighed 146.4 pounds, and they increased the volume of his feeding. C.A.'s care plan addressed a significant weight loss and dietary notes document the increase in his tube feeding, but he continued to lose weight, and Cold Spring Hills documented that he weighed 136 pounds when he was discharged in November 2021.

106. **Resident M.W. –** M.W. was discharged from Plainview Hospital and admitted to Cold Spring Hills in late July 2020. Cold Spring Hills records reflect that M.W. was admitted while sitting in a wheelchair, instead of laying on a stretcher. He was then discharged from Cold Spring Hills around mid-August 2020. A Plainview Hospital PRI dated July 22, 2020, documented that M.W. had a pressure injury to his sacrum. Cold Spring Hills nursing admission and Admitting Physical History and Physical assessments dated the day of and day after his admission, respectively, stated that he had a "small opening." Cold Spring Hills records refer interchangeably to the pressure injury as located at his sacrum and his coccyx. Based on the Cold Spring Hills record, no measurements of the pressure injury were obtained at this time, nor were treatments obtained for the location of this pressure injury at this time. Cold Spring Hills' care plan for M.W. addressed that he was at risk for impaired skin integrity, turning and positioning was to be performed every two hours, wound rounds were to be performed weekly, and treatments were to be applied as ordered. However, Cold Spring Hills' records further reflect that it was not until ten days after M.W.'s admission that a wound doctor for Cold Spring Hills first performed a wound care assessment, at which time, in early August, he classified the pressure injury as "unstageable,"

documented its measurements for the first time at Cold Spring Hills and recommended a particular course of treatment for the pressure injury.

107. The Cold Spring Hills care plan for M.W. additionally stated that he was to be provided with a shower twice a week and when necessary. However, the records reveal that staff never showered resident M.W. during his entire 17-day residency at Cold Spring Hills.

108. M.W. was then transferred from Cold Spring Hills to the hospital in August 2020. Plainview Hospital records reflect that the pressure injury in his sacral area had quickly worsened in size and severity. Specifically, the Cold Spring Hills wound doctor recorded the pressure injury as measuring length 1.5 cm x width 0.9 cm x depth 0.2 cm at the time of his assessment in early August. Plainview Hospital records reflect the sacral pressure injury as measuring length 9 cm x width 7 cm x depth 2 cm within three days of M.W.'s departure from Cold Spring Hills. And, within days of that, the hospital record reflects the wound had advanced to a stage 4 with exposed muscle and bone. The hospital records further state that he was admitted with deep tissue injuries (DTIs), or breakdown, to both heels. Plainview Hospital records also show that he was admitted with diagnoses of sepsis and pneumonia, among other things.

109. The Plainview Hospital records reflect that a RN with the same first name as that provided to MFCU by Caroline Powers, M.W.'s granddaughter, made entries in M.W.'s medical record at the hospital, including entries in connection with his sacral pressure injury. *See* Affidavit of Detective Ryan Ricker, ¶ 42.

110. The Plainview Hospital records reflect that M.W. was placed on palliative care and in patient hospice in approximately mid-August 2020, a week after his admission to the hospital. The New York State death registration system identified that sepsis was a cause of death.

111. **Resident L.G.** – Cold Spring Hills records regarding resident L.G. contain a document entitled "Surrogate List" that identified Margaret Galeno as the daughter of L.G. in a list entitled "Identification of a decision maker in order of priority." The Surrogate List is dated the same day in June 2020 as the date of L.G.'s admission to Cold Spring Hills. No other decision-makers are identified on the list.

112. Cold Spring Hills' records contain a PRI for L.G. from St. Francis Hospital dated June 16, 2020 that identified under the section of the form addressing treatments, including wound care, that L.G. had "r[ight] buttock/sacrum unstageable" pressure injury(s). He was admitted to Cold Spring Hills only days later in June 2020. On June 24, 2020, a wound doctor for Cold Spring Hills documented L.G.'s right buttock injury as unstageable and the sacral injury as stage 3. Cold Spring Hills' records dated mid-July 2020 indicate that a wound care doctor for Cold Spring Hills determined that the pressure injuries to the right buttock and sacrum merged into a single wound. On July 15, 2020, the wound doctor documented that L.G.'s sacral pressure injury measured length 7.0 cm x width 6.0 cm x depth 2.0 cm and he classified it as a stage 4. L.G. was transferred from Cold Spring Hills to St. Joseph Hospital on August 5, 2020. A hospital record dated August 6, 2020, confirmed it was a stage 4 sacral pressure injury.

113. Cold Spring Hills records additionally reflect that in August 2020, L.G. developed an infection at the site of his feeding tube.

114. St. Joseph Hospital records document that the hospital provided treatment to L.G. for severe sepsis, an infection at the site of his feeding tube, and ventilator-associated pneumonia, among other things.

115. **Resident G.S.** – G.S. was a patient at North Shore University Hospital ("NSUH"), which is also known as North Shore Manhasset Hospital, immediately before Cold Spring Hills in

June 2020. NSUH records state G.S. had muscle weakness from the neck down in all four limbs, causing impaired mobility known as quadriparesis, which left him totally dependent on Cold Spring Hills for all of his needs.

116. Cold Spring Hills records reflect that G.S. was on a ventilator, a tracheostomy tube, a feeding tube, and a urinary catheter.

117. Cold Spring Hills records state that G.S. was wholly dependent on Cold Spring Hills staff for nourishment via a feeding tube. Moreover, weight monitoring and nutritional intake were required as part of his nutritional care plan and were additionally a part of his treatment and plan of care for wound healing. *See infra* ¶ 118. Cold Spring Hills records contain a PRI from NSUH which documented his weight at 123 pounds.[20] Cold Spring Hills recorded G.S.' weight at admission in June 2020, as 115.4 pounds. The records do not indicate that Cold Spring Hills confirmed his weight at admission, given the discrepancy, e.g., by re-weighing him -- again, a standard practice. When he returned to NSUH from Cold Spring Hills in October 2020, however, NSUH documented his weight as approximately 105.4 pounds, nearly 10 pounds less than the last weight recorded by Cold Spring Hills, 115.2 pounds.

118. NSUH records dated June 2020 state G.S. had a pressure injury to his sacrum, described as having a dark ruddy red / purple hue, among other conditions. Cold Spring Hills records documented he had a sacral pressure injury, among other conditions, when he was admitted to Cold Spring Hills. In early July 2020, about a week after his admission, the Cold Spring Hills wound doctor documented that the sacral pressure injury was unstageable and measured length 5.0 cm x width 6.0 cm x depth 0.2 cm. Weeks later, the wound doctor for Cold Spring Hills documented the sacral pressure injury as a stage 4.

[20] Based on hospital records, this weight appears to be from May 2020.

119. Cold Spring Hills records also reflect that in late July 2020, Cold Spring Hills nursing staff obtained an order for a urinary catheter for G.S. They inserted the catheter that same day in late July 2020. Records state that blood was present in his urine occasionally thereafter. In late October 2020, nursing staff attempted to change his catheter. At that time, they inserted a new urinary catheter, but the catheter returned blood, not urine, and staff removed it. Nursing staff then reinserted the catheter that same day, which returned urine with blood. Later that day, Cold Spring Hills transferred G.S. to NSUH, where he was admitted. Hospital records reflect that the urinary catheter had been placed into G.S.'s prostate (rather than the catheter having been advanced from his urethra to his bladder). Hospital records additionally reflect that G.S.'s diagnoses included septic shock.

120. An NSUH record dated the day of his admission in October 2020 states that his sacral pressure injury had exposed bone. An NSUH record two days after his admission confirmed that his sacral pressure injury was stage 4 with possible osteomyelitis, which is infected bone. In addition, a wound consult note from a doctor at the hospital, dated two days after his hospital admission, documents a measurement of a sacral wound length 7.0 cm x width 6.0 cm x depth 1.5 cm. That hospital record also documented a left leg pressure injury upon admission.

121. **Resident T.S.** – A Nassau University Medical Center ("NUMC") PRI dated April 2021 documented that, prior to his admission to Cold Spring Hills, T.S. had a sacral pressure injury, a right knee pressure injury, left and right heel deep tissue injuries, and edema to his scrotum. He also had diagnoses including acute renal disease and sepsis.

122. Cold Spring Hills records reflect that in April 2021, the Cold Spring Hills wound doctor classified the sacral pressure injury as stage 3 and documented its measurements. The records further state that in June 2021, the wound doctor for Cold Spring Hills classified the sacral

injury as stage 4. In August, he documented it as having increased in size from the April measurements. In addition, Cold Spring Hills records reflect that he had a deep tissue injury to each heel when he was admitted. In May 2021, a wound doctor for Cold Spring Hills classified the right heel DTI as a stage 3, and then, in June 2021, he classified the injuries to both heels as unstageable.

123. Cold Spring Hills records indicate that T.S. lost at least 30 pounds during his less than four-month residency.

124. Cold Spring Hills records contain a note from its dietary staff in May 2021 documenting that, as per nursing staff, T.S. was observed disconnecting his feeding tube and sucking and swallowing the formula from it. During a visit from a nurse practitioner at Cold Spring Hills to follow up on the report that T.S. had been sucking on his tube feeding and the connected tubing, the nurse practitioner documented the resident was gesturing that he wanted a drink of water. This could indicate that he was hungry or thirsty, although Cold Spring Hills was to be providing his nourishment and hydration through a feeding tube. Records reflect that, at that time, Cold Spring Hills switched T.S. from a 20-hour tube feed to six BOLUS[21] feeds per day. Weeks later, Cold Spring Hills changed his formula. But the records further document that he continued to lose weight until the date of his discharge.

125. Cold Spring Hills records also reflect that T.S. fell in May 2021 and again in August 2021; both times, staff found him on the floor of his room.

126. In August 2021, T.S. was transferred from Cold Spring Hills to Plainview Hospital. Plainview Hospital records reflect that he was admitted with diagnoses including dehydration,

[21] BOLUS is a method of feeding a set amount of formula without the use of a feeding pump. The feeding is performed with a bulb syringe and occurs by gravity.

severe protein malnutrition with a significant underweight status, a stage 4 sacral pressure injury, and right foot osteomyelitis (infection in his bone).

127. Plainview Hospital records further reflect that T.S. gained over 10 pounds within his first two weeks at the hospital, after leaving Cold Spring Hills.

128. **Resident J.D.** – According to Cold Spring Hills records, staff did not provide resident J.D. with approximately eight of approximately 18 baths they should have provided to him as required by his care plan.

129. **Resident P.S.** – According to Cold Spring Hills records, P.S. fell in August 2020 and again in June 2021. After his fall in August 2020, P.S. was found on the floor in his room by a Cold Spring Hills housekeeper, who alerted the nursing staff. After the fall in June 2021, a CNA found P.S. laying in front of his wheelchair on the floor in his room. He sustained a skin tear to his left arm from both falls. P.S.'s care plan, which is to be utilized by nursing staff responsible for providing care to him, documented that he was on a toileting schedule, and that staff were to anticipate his needs and provide assistance to him with his ADLs.

130. Records provided by Cold Spring Hills records further state that in addition to cellulitis, P.S. had venous stasis and weeping edema in his legs. Weeping edema occurs when fluid is trapped in the legs and leaks through the skin.

131. According to Cold Spring Hills records, the hospital PRI dated April 2020 stated that P.S. weighed 166 pounds in April 2020, and Cold Spring Hills recorded his weight as 153.6 pounds near the date of his discharge from the nursing home in August 2021. However, four of the five intermediary weights documented at Cold Spring Hills reflected his weight was in the 140s, including a weight of 144 pounds just three weeks before the recorded weight of 153.6 pounds.

132. **Resident L.K.** – Cold Spring Hills records demonstrate that staff did not shower L.K. as often as required. Although she was to receive showers twice a week, in July 2020, staff did not provide her with six of those showers. In August 2020, staff did not provide her with three of the required showers. In September 2020, staff did not provide her with four of the required showers.

WHEREFORE, based upon the foregoing, I respectfully request that the Court grant the relief described in the Petition.

Mary Conway, R.N.

Sworn to before me this
13 day of December, 2022

Notary Public

ANNE E. LIPTAK
NOTARY PUBLIC, STATE OF NEW YORK
NO. 01LI6136142
QUALIFIED IN SUFFOLK COUNTY
MY COMMISSION EXPIRES OCT 31, 2025

CERTIFICATION PURSUANT TO RULE 202.8-b

I, Christina Pinnola, an attorney duly admitted to practice law before the Courts of the State of New York, hereby certify that this Affidavit contains 16,397 words, excluding the parts of the Affidavit explicitly exempted by the Rule, and that Petitioner's request for permission to file an oversize submission as provided in Rule 202.8-b(f) is forthcoming. In preparing this certification, I have relied on the word count of the word processing system used to prepare this Affidavit.

Dated: Hauppauge, New York
December 13, 2022

Respectfully submitted,
Letitia James
Attorney General of the State of New York

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