

In the Matter of an Investigation Pursuant to
N.Y. Exec. Law § 63(12) *re*: Cold Spring Hills
Center for Nursing and Rehabilitation.

**AFFIDAVIT OF
ANDREA PARKER**

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

Andrea Parker, being duly sworn, attests as follows:

1. I am 42 years old and reside in Altamont, New York.
2. I am employed with a local municipality.
3. I submit this affidavit in connection with the New York Attorney General's investigation into Cold Spring Hills Center for Nursing & Rehabilitation ("Cold Spring Hills"), a nursing home located at 378 Syosset-Woodbury Road, Woodbury, New York 11797, and set forth below my experiences and observations while caring for and speaking with my mother, C.P., while she was a resident of Cold Spring Hills.
4. From April 9, 2018 to present, my sister and I have served as Health Care Proxies for my mother, and I also hold my mother's Power of Attorney.
5. My mother was born in 1950 and she has resided at Cold Spring Hills, in the Seacliff building, room 315B, since June 28, 2018. She has dementia with psychosis.
6. Before her admission to Cold Spring Hills, my mother was a credit manager for a company that makes home, car, and portable audio speakers. My mother enjoyed riding horses, spending time with her family and friends, and going to the salon. My mother was married until approximately 1997. She lived in Manorville, New York and has three daughters.



7. I do not believe my mother has received proper care while residing at Cold Spring Hills. For instance, there is insufficient staff to take care of the residents. They did not change her diapers often enough, and she developed a urinary tract infection ("UTI"). They did not take care of her feet, toenails, mouth, or teeth. They did not get her dental care after her front teeth were knocked out of her mouth, and she had to have several teeth extracted. There was a lack of communication about COVID-19 and visitation. Her bedroom and bathroom were filthy. I have been trying to get my mother out of Cold Spring Hills and bring her to a facility closer to my home, but I have not yet found a facility that can take her.

8. On September 18, 2019, one of my sisters and I met with Nancy, the Director of Nursing ("DON"), and Lea Klug, a social worker, at Cold Spring Hills. They told me that my mother was refusing to take showers. They said that because she was refusing to take showers, they were not going to bathe her – or even try to bathe her - anymore. So, I told them, "Okay. I'll go do it myself." I told them that I would come there and shower my mother each week, which I did from September 2019 through March 2020.

9. From March 2020 through April 21, 2020, I did not receive any communication from Cold Spring Hills regarding the COVID-19 virus, and thus I assumed it was not present in the facility.

10. On April 21, 2020, I called Cold Spring Hills to check on my mom. I spoke with DON Nancy. She told me that half of the residents that lived on my mom's floor died from the COVID-19 virus. I was shocked and upset. If I had known that the COVID-19 virus was present at Cold Spring Hills, I would have had a conversation with my family to see if anyone would be able to let my mom live with them.

11. At some point after April 21, 2020, I recall receiving an automated call on my cellphone detailing how many residents died that day and how many new resident and staff member infections there were at Cold Spring Hills. I started calling the Cold Spring Hills hotline daily, which was upsetting to me because I was hearing how many residents were dying from the virus at the facility where my mother lived.

12. Cold Spring Hills did not notify me when visitation was allowed again July 2020. During the summer of 2020, I FaceTimed with my mom once a week. When we FaceTimed, my mom always looked dirty, as if she was not receiving any showers.

13. On June 2, 2021, I visited my mom at Cold Spring Hills for the first time since the COVID-19 pandemic started. When I entered my mom's room, I felt very upset, angry, and infuriated. There was clothing, food, stuffed animals, a medication cup, a fork, shoes, a newspaper, and other garbage under her bed. In the bathroom, the floor was filthy, there was feces on the walls, no running water, the hot water handle was missing, and there was a wide ring of dark brown rust around the drain. I took photographs of the conditions of my mom's room and bathroom. Those photographs are attached hereto, as Exhibit 1.

14. Also, that day I noticed that my mom's toenails were very long, and her feet were very dry. I took photographs of my mom's feet as well. Those photographs are attached hereto, as Exhibit 2.

15. On June 3, 2021, I had an in-person meeting at Cold Spring Hills with Debbie Flack, the Administrator, ^{Laura} ~~Laurie~~ DiBlasi, part of administration, Vanessa Grasso, a nursing supervisor, and Vincent ^{Bellino} ~~Balino~~, a social worker, about the condition of mom's room and her feet. After that meeting, my mom's room and bathroom were cleaned, and the hot water handle was fixed.

16. I did not receive an answer from the people at the meeting about my mom's feet. I cut my mom's toenails and fingernails. I also brought cream with me and applied it to her feet.

17. On June 6, 2021, at about 6:00 a.m., I got a phone call from Wanda, a charge nurse at Cold Spring Hills. Wanda told me that my mom fell in the dining room the night before, at about 9:30 p.m. She also told me that my mom had a swollen lip, and that a head scan was not necessary because she was "fine."

18. On June 6, 2021, at 9:30 a.m., I got a phone call from Janice Keating, another charge nurse at Cold Spring Hills. Ms. Keating told me that my mother's bridge fell out, which were her front teeth. Ms. Keating said that she was holding my mother's three teeth in her hand. After that phone call, I emailed Administrator Flack, and told her that I wanted my mom seen by a dentist as soon as possible.

19. The next day, on June 7, 2021, one of my sisters and her husband went to Cold Spring Hills to see our mom. My sister told me that she was upset and shocked by what she saw. She said that our mom's upper front teeth were broken off and her root tips and metal posts were exposed. My sister took photographs of my mother's mouth and teeth. Those photographs are attached hereto, as Exhibit 3.

20. That same day, I spoke with Dr. Gross, a dentist for Cold Spring Hills. His recommendation, after seeing my mother's split lip and her root tips and metal posts exposed, was to leave my mom's mouth as it was. Dr. Gross said that she was not in pain and that it is difficult to make dentures for dementia patients because they are not capable of following the directions that are required to have dentures made.

21. On June 7, 2021, I received a phone call from Liz, a nurse practitioner at Cold Spring Hills, regarding my mom's fall on June 5th. Liz told me that my mom was "found" on the

floor of the dining room, but she was not sure if my mom actually fell because it was not witnessed. Liz told me that the incident was being categorized as an “unwitnessed injury.” On June 7, 2021, I told my sister to go to Cold Spring Hills to have them call an ambulance to take our mother to the hospital to have her head checked, to rule out a head injury.

22. Because my mom did not have any injuries other than to her mouth, I think it is possible that she was punched.

23. I, as Power of Attorney, and with my sister, as Health Care Proxies, made efforts to obtain a copy of the Cold Spring Hills accident/incident report, including making two FOIL requests. Cold Spring Hills denied each of our requests because they said it was an “internal” document and that only staff could view it.

24. Because Cold Spring Hills was not doing anything to help my mother with her missing teeth, on July 30, 2021, my sister brought our mom to the oral surgeon that our family uses, in Wantagh, New York. It took this long to get an appointment, because everything is scheduled through the medical office at Cold Spring Hills. It was out of my hands, and I had to wait for this dentist visit to be scheduled by Cold Spring Hills.

25. The oral surgeon could not believe the state of my mom’s teeth. There was extreme tarter buildup in her gumlines, her gums were bleeding, and she had to have nine teeth removed.

26. In August 2021, I visited my mom every day for a week and every day, when I arrived, her diaper was wet through to her pants. Sometimes the diaper was soaked with urine and sometimes it was soaked with urine and feces. I have no idea how long she was like that before I arrived. I would immediately go to the nurses’ station and tell them that my mom’s diaper is dirty and ask for someone to please change her. Each time, I waited approximately 10 minutes for an aide to come and change my mom’s diaper. The aide would also have to change my mom’s pants.



27. During one of my August 2021 visits, I saw an aide named [REDACTED] strike a resident whose first initial is [REDACTED] on his back with an open hand. I heard [REDACTED] screaming over and over, "Stop hitting me." This occurred on my mom's unit, Seacliff 3, in the dining room bathroom. I could see and hear it because the door was open.

28. On December 17, 2021, I visited my mom. Seacliff 3 was a ghost town. There was no staff around. It looked like my mom had not been showered in days and her toenails were long again. My mom was also wearing someone else's clothes. I did not mention this to anyone because my mom was almost always wearing someone else's clothes. That was the norm.

29. On December 27, 2021, a female nurse or aide from Cold Spring Hills told me that my mom tested positive for the COVID-19 virus. I was told that my mom would receive Doxycycline for two weeks, asthma therapy, and Vitamin C. I don't know if my mom was quarantined. The female also told me that I would receive a daily call to update me on how my mom was doing, but I didn't receive daily calls. And it was very difficult to get in touch with anyone at Cold Spring Hills when I reached out to them to get an update on my mom.

30. On March 14, 2022, at 8:45 p.m., I received a call from a nurse at Cold Spring Hills, Mimi, who advised me that my mom was found unresponsive, in a chair. Mimi did not tell me where my mom was found. Mimi told me that my mom had syncope, and I told Mimi that I did not know what that was. Mimi responded by saying, "Google it." Mimi assured me that my mom was "fine," that she was on oxygen, and that her vitals were good. I was under the impression that my mom had seen Dr. Allen because Mimi mentioned Dr. Allen's name. After the phone call with Mimi, I Googled the word "syncope," and the definition is a temporary loss of consciousness caused by a fall in blood pressure.

31. On March 15, 2022, at 9:00 a.m., I called to get an update on my mom. An aide told me that my mom was in bed and that the doctor ordered 24 hours of bed rest. Mom was still on oxygen. The aide said that my mom's muscles were fatigued due to a lack of oxygen. I asked the aide to have Owen, a nurse practitioner at Cold Spring Hills, call me. He never called.

32. On March 15, 2022, at 12:41 p.m., I called again to get an update on my mom. I spoke with an aide named Nedja. Nedja told me that all mom's vitals were normal, including her blood pressure. Nedja also told me that my mom was still in bed, lethargic, and she was not opening her eyes all the way. Nedja also said that if you touch my mom, she moves a little and makes a noise. Nedja also said that my mom was fed breakfast, and someone was going to feed her lunch. I told Nedja that I wanted to speak with Dr. Allen. Nedja said that she was looking for Dr. Allen and that he would call me within the hour.

33. On March 15, 2022, at 1:14 p.m., I FaceTimed with my mom, and she was unresponsive. When I said her name, she opened her eyes a little and then closed them immediately. She made no sounds. It was hard to see my mom like that, and I could tell something was wrong. During the FaceTime call, a female recreation aide was also in my mom's room. I asked her to have Dr. Allen call me immediately.

34. On March 15, 2022, at 1:41 p.m., Dr. Allen called me and told me that my mom did not have a stroke, because she could move her arms and legs, and she spoke some words. He didn't know why she fainted and said it could have been an infection. Dr. Allen mentioned that my mom's belly was distended, and it will take a long time to figure out what was wrong. As I was speaking with Dr. Allen, my mother was given a catheter because they had determined that she had a urine blockage. Dr. Allen said that her bladder was not functioning, and her kidneys were blocked.



35. I requested of Dr. Allen that he arrange for an ambulance to take my mom to the emergency room.


36. That day, March 15, 2022, after I spoke with Dr. Allen, my mom went to Syosset Hospital via ambulance. Upon arrival at Syosset Hospital, a nurse told me that my mom had a fever. My mom was diagnosed with a UTI. A doctor named Shalshin at Syosset Hospital told me that the UTI was likely due to mom's diaper not being changed in a timely manner. My mom spent approximately nine days in the hospital, first at Syosset Hospital and then at Plainview Hospital, where they transferred her because they had more beds available.

37. Since the UTI, my mom is more withdrawn and talks less. On April 6, 2022, Liz, from recreation at Cold Spring Hills, told me that that my mom's participation in recreational activities has decreased. My mom used to participate in dancing and now she does not.

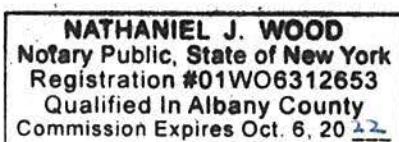
38. On May 18, 2022, during a care plan meeting, I expressed concern about how often my mom's diaper was being checked and changed. I don't want my mom to get another UTI. I was told by Nittu, a social worker at Cold Spring Hills, that he would get back to me. I still haven't received a call back from him.


Andrea Parker

Sworn to before me this
26 day of September 2022


Nathaniel J. Wood

Notary Public, State of New York
No. 01W06312653
Qualified in Albany County
Commission Expires: 10/6/2022





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 complies with the word count limit set forth in Rule 202.8-b as it contains 2,587 words, excluding the parts of the Affidavit explicitly exempted by Rule. 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 15, 2022

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

By:



Christina Pinnola
Special Assistant Attorney General
Office of the Attorney General
Medicaid Fraud Control Unit
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In the Matter of an Investigation Pursuant to
N.Y. Exec. Law § 63(12) re: Cold Spring Hills
Center for Nursing and Rehabilitation.

**AFFIDAVIT OF
MELISSA HECHÉ**

STATE OF NEW YORK)
)
COUNTY OF NEW YORK) ss.:

Melissa Heche, being duly sworn, attests as follows:

1. I am 47 years old and currently reside in New York, New York.
2. I am an audiologist and have had my own practice in Manhattan since 2003. I am also a speech pathologist and I work in acute and sub-acute care facilities with patients with acquired neurogenic disorders such as cerebral vascular accidents (strokes).
3. I submit this affidavit in support of the New York Attorney General's investigation into Cold Spring Hills Center for Nursing & Rehabilitation ("Cold Spring Hills"), a nursing home located at 378 Syosset-Woodbury Road, Woodbury, New York 11797, and set forth below my experiences and observations while caring for and speaking with my mother, S.H., while she was a resident of Cold Spring Hills.
4. My mother was born in 1946, and she resided at Cold Spring Hills from August 6, 2019 to January 6, 2020, on the second floor in the Norwich building. Prior to that, she had lived at her home with her husband, my father, and was able to walk with assistance for approximately 30 feet, using a rolling walker, and she also used a wheelchair. My mother was right-handed.
5. My mother suffered a massive stroke in the evening, on approximately July 7, 2019, and was hospitalized at Plainview Hospital. She was admitted to Cold Spring Hills for short-term



rehabilitation upon her discharge from Plainview Hospital, because the stroke affected her ability to walk, to use her right, dominant arm and hand, and her ability to speak. She could not feed herself or make her needs known and was totally dependent on her caregivers for all activities of daily living at Cold Spring Hills. She also ^{had} ~~she~~ suffered from obesity.

6. Prior to her stroke, my mother enjoyed doing word puzzles, reading, listening to music, learning about the lives of celebrities, and politics.

7. My sister and I became my mother's Health Care Proxies when my mother was admitted to Cold Spring Hills on August 6, 2019.

8. My father, my sister, and I took turns to ensure that at least one of us visited my mother at Cold Spring Hills every day.

9. My mother received a total of three showers while she was a resident at Cold Spring Hills, including one during the first week that she lived there. Her shower days were scheduled for Sunday and Thursday, and I visited my mother on Sundays, but did not see her being taken to the shower room. She always had bad body odor due to the lack of bathing. In mid-September, an aide at Cold Spring Hills told me that my mother was getting sponge baths instead of regular showers. The aide told me that the reason they couldn't give my mother a proper shower was because the bariatric chair that she needed for a shower was broken. The aide took me to the shower room and showed me the broken bariatric chair.

10. In October, at a care plan meeting, I confronted the nursing staff about my mother not being showered. They told me that my mother was being showered regularly and that the showers were documented in her chart. I told them that the chart was not an accurate record of what was happening because they simply did not have the correct chair. They told me that they would try to borrow a chair from another wing.

11. Because I wanted my mother to have a proper shower, I found a bariatric chair from a supplier. However, when I informed Cold Spring Hills that I found the chair, they said they would get a working chair from another building, on site. Cold Spring Hills brought another chair to my mother's room. But that one was broken, too.

12. In late November 2019, my mother had still not received a proper shower and someone in nursing told me that a chair had been ordered but had not yet arrived. In December 2019, there was still no shower chair and thus no showers. On January 3, 2020, I told Christine, the head of nursing, that I wanted my mother showered before we brought her home on the 6th. Christine said to my sister, "I really don't know how we are going to get it done," to which my sister stated, "The chair was ordered over a month ago." They did, somehow, manage to shower my mother before she came home with me.

13. During my frequent visits to see my mother at Cold Spring Hills, I saw that her nails on her right, paralyzed hand were too long. They were so long that they caused abrasions on the inside of her hand. I complained about my mother's nails and the abrasions they were causing to her hand to the administrator and the director of nursing. They told me that they would take care of it, but nothing was done. The nails on my mother's right hand were never cut during the five months that she lived at Cold Spring Hills. I took pictures of my mother's right hand and attached the pictures hereto, as Exhibit 1.

14. On August 18, 2019, my sister visited my mother right after lunch, at about 12:30 p.m., and noticed the odor in my mother's room. My sister asked the aide to change my mother, but the aide explained, "She is a 2 person assist, and I am the only one here – she will have to wait." My mother waited until well after dinner and sat in her own soil until she was changed at

about 6:30 p.m. At Cold Spring Hills, my mother sat in soiled diapers for extended periods of time waiting for someone to come and change her more times than I can tell you.

15. On another occasion I saw a feeding tray open and unconsumed, sitting in front of my mother, but she could not feed herself because of her stroke. No one from Cold Spring Hills was ever there to feed her. I took a picture of this and have attached that picture hereto, as Exhibit 2.

16. During one of my visits to see my mother at Cold Spring Hills, I found her medications crushed in a cup and unconsumed, inside her dresser drawer. I took a picture of this and have attached that picture hereto, as Exhibit 3.

17. At some point in September 2019, when I arrived at my mother's room at Cold Spring Hills, I observed a man standing in my mother's room looking at Facebook on his cell phone. After a few moments, I asked him who he was and what he was doing in my mother's room, and he looked up and stated that he was the weekend physical therapist and that he was just about to start with her. I told him, "No you weren't — you were literally standing here on Facebook, hovering over her as though she is not here. Please leave."

18. When my mother left Cold Spring Hills on January 6, 2020, she lived with her husband, my father, for a short time, with 24-hour home health aide care, and nurses who visited her and provided care. In February 2020, she was admitted to Plainview Hospital because she had a change in her mental status and because she was not feeling well. Staff at the hospital ran tests and determined that my mother had suffered another stroke. In mid-March 2020, she was ultimately discharged to a different nursing home for rehabilitation where she received good care and always looked clean in Zoom visits and a window visit. In April 2020, she was readmitted to

Plainview Hospital where she was diagnosed with the COVID-19 virus. She died on April 28, 2020, due to complications of the COVID-19 virus.

19. I have had numerous discussions with the Cold Spring Hills staff and ownership regarding the neglect and bad treatment my mother received at their facility. Since my complaints went ignored, I withheld payment after the Medicare one hundred days expired. I did that because I wanted Cold Spring Hills to address my complaints. Eventually, I heard back from "Mo" at Philosophy Care, who only wanted to speak about the outstanding balance he said I owed. I sent him a letter and the pictures I have attached hereto. The letter I sent him is attached hereto, as Exhibit 4. I also had an email dialogue with him, which I have attached hereto, as Exhibit 5, that references the photos I sent to him that are shown in Exhibits 1 through Exhibit 3, attached hereto. Mo told me that they would do better next time. Mo could not have cared less about the care my mother received or didn't receive at Cold Spring Hills.



Melissa Heche

Sworn to before me this
2nd day of OCT. 2022



Notary Public, State of New York

No. 01LU6020890

Qualified in SUFFOLK County

Commission Expires: MARCH 8, 2023



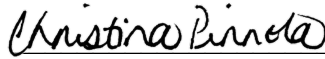
CERTIFICATION PURSUANT TO RULE 202.8-b

I, Christina Pinnola, an attorney duly admitted to practice law before the Courts of the State of New York, hereby certify that this Affidavit complies with the word count limit set forth in Rule 202.8-b as it contains 1,460 words, excluding the parts of the Affidavit explicitly exempted by Rule. 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 15, 2022

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

By:


Christina Pinnola
Special Assistant Attorney General
Office of the Attorney General
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Christina.pinnola@ag.ny.gov















[REDACTED]

January 20, 2020

Dear Sir or Madame:

We are writing on behalf of our mother/wife, S [REDACTED] H [REDACTED], who was an inpatient in your subacute rehabilitation program. She was admitted on August 7, 2019 after having suffered a left sided MCA stroke on July 7, 2019. The stroke was large and diffuse and impacted her right sided physical capacities in her upper and lower extremities. More devastatingly, the stroke also left her with an inability to verbally communicate and, consequently, periods of verbal outbursts due to frustration at her communication impairment. Concurrent symptoms included periods of emotional lability due to frontal lobe involvement in her stroke. Though the magnitude of my mother's stroke left her with significant challenges, she has been in complete understanding of everything around her and everything that happened to her.

We are writing to you to convey disappointment in the level of care that our mother/wife was given while in your facility. It was clear from the beginning that the complexity of her case was too much for your staff to handle and her lack of ability to express herself caused many staff members to treat her improperly during her stay for rehab. On one occasion, Melissa walked in to find a Per Diem physical therapist sitting in the corner of her room, scrolling through Facebook on his phone. She announced her presence and he assured her that he was "just about to start therapy with her." No, he wasn't instead he was taking advantage of a woman that could not express herself but knew full well what was going on around her.

Very distressing was the fact that she was not showered regularly during her stay. In fact, she had a total of 3 showers during her 5 month stay there. 3 showers! At one time, Melissa asked the aide when they were planning on giving her an actual shower and was quite nastily told that it could not be done. Apparently, you did not have the right chair and since so much time passed and you still did not get the proper chair it appears that you did not bother to order one. The nurse's assistants tried to pass off a sponge bath in bed as a complete shower which it is not. We were appalled that our loved one actually smelled of body odor on many occasions under your care! The nurse's aide on duty at the time was extremely rude and insensitive, stating that she could not be showered at all which is not true at all if you have the right equipment. You did not have the right equipment and Cold Spring Hills refused to purchase it to properly care for her, despite us being promised otherwise.

My mother sometimes screams out to communicate since she cannot put words together, out of attempts to communicate and also out of frustration. I was walking down the hall to go to her one day when one of your aides was walking in front of me and literally said out loud "there goes room [REDACTED] screaming again!" Two of us were standing right behind her. We were shattered to hear it besides the fact that it was not even she who was screaming! This is our wife and mother she was talking about!

Several other incidents occurred with nurse's aides who responded with extreme insensitivity that truly caused us to be hurt. She was trying to communicate which she did so by using the phrase "no no no" after her stroke. That was what she was left with functionally. We were all devastated that we could not communicate better together. There was an occasion where we were certain she was in pain based on her facial grimaces. In front of us, the nursing assistant asked her if she was in pain, to which she replied "no, no, no." The nursing assistant confirmed that she was not in pain but [REDACTED] stated that saying "no" did not actually mean "no." The nursing assistant very insensitively stated "then she should be saying yes, yes, yes." After her stroke, she simply could not say anything but "no." Hearing that statement from someone who

should be showing sensitivity was gut wrenching to us. Don't you think we wanted her to be able to say "yes?!" It was unnecessarily hurtful and incredibly insensitive. The fact that the Nursing Assistants were so insensitive and hurtful at such an incredibly vulnerable time was so disturbing that it was brought to the attention of the Nurses Manager, Christine Wolf. We were asked if an incident report was desired, but to save our mother/wife from any backlash we opted against it instead we asked that Christine retrain her employees regarding being sensitive to patients and their loved ones.

It broke us to know that our mother/wife was left without assistance on several occasions after she had an accident. She was a two person assist, we know, but that still did not justify her having to wait more than two hours to be changed! That is truly inhumane!

On November 13, 2019 her Medicare coverage expired. We opted to keep her at Cold Spring Hills for extended rehabilitation, hoping that the extra time would bring her more recovery and that we would be able to devise a long term plan during that extra time. We were told that we would be required to pay your daily rate out of pocket, which as quoted to be \$575/day. This is a high rate, and should be consistent with an elite level of care. We accepted this rate, in the hopes of it having a positive impact on my mother in the long term.

Sometime after that, the questionable care that she received reduced even further to a level that was marginal at best and at times inexplicable. Pictures are enclosed so that you can, in some way, experience what we saw. Please remember this is our wife and mother!

Around Thanksgiving I asked the nurse to cut my mother's nails as they were getting too long on her splinted hand. The nails were gradually growing so long that they were cutting into her skin. Every week, I would ask every week, I was told they would do it. The enclosed picture was taken in her room, a day before her discharge. The nails were never cut, and your facility allowed them to grow so long as to lacerate her other fingers by cutting into them! Pictures are enclosed to show you what it looked like. It is all still healing.

Many times that I would come in, I would see that my mother did not have her splint placed on her right (affected) hand. This was causing persistent contracture. I would fix it and place the splint on properly, and remind the aides who each told me they did not know she needed one and they did not know how to place it on her. There were signs all over her room reminding the nurses and assistants that she required splint placement and illustrating how it should get placed. There was no reason why the nurse's assistants should not have been doing this regularly. I spoke with occupational therapy about this issue, who confirmed that he not only placed signage around her room but also in serviced other nursing assistants. The nursing assistants, despite being "trained" had no knowledge of how to place the splint on her hand properly when they even did so. I have pictures enclosed of my mother on two occasions one of the many times where she was received with the splint off and one with the splint placed improperly. The nursing assistants are not skilled enough with respect to what to do with and how to care for a contracted hand and they should be. This is a facility that supposedly treats stroke patients just post hospitalization, there is no excuse for not having this ability to place a splint, to know that she needs one, and to recognize a contracted hand and still offer that hand care cleaning, etc. One aide told me she was afraid to touch the hand! If the hand is not cleaned properly and regularly it can get infected. Your aides have a fear of hand contracture?! Then they should not be aides! This was so disturbing. Please remember that we love S [REDACTED] she is our wife/mother this was a terrible way for her to be treated.

On several occasions, we would go up to her in order to help her eat. Sometimes, we would get to her room just after the aide brought her meal and meal was set up in front of her with nobody there with her! But she could not feed herself. Can you imagine how frustrated she must have felt to have had someone bring her food, set it up and walk out?! This happened on

multiple occasions where she was found sitting in front of a meal, crying. Someone set it up for her, but did not attempt to help her. A picture of this occurrence has been enclosed.

In late December, I was putting clean laundry back in her dresser drawers when I noticed that there was in old, half eaten medicine cup with old applesauce left in the cup that was stashed in the corner of her drawer. A picture of this is enclosed in this message. This meant that somebody bothered to put it there Almost to taunt her? Instead of throwing it in the garbage where it belonged. It also meant that somebody mixed this dirty, used medicine cup along with clean clothes. This was appalling!

The most distressing situation of all was when I walked into her room on Sunday, January 5 and found her sitting in her chair, watching television WITH THE NURSE HELP BUTTON WRAPPED AROUND HER NECK!!!! There is a picture enclosed to show you what I saw. My mother could not wrap this around her neck by herself! Someone there had to do it to her! I called a nurse in to see what I found and the nurse simply unwrapped the nurse button and shrugged her shoulders as though this was a normal finding. A picture of this has been enclosed so that you could see what we saw. Your facility and the employees within are supposed to have empathy for your customers your patients and their families. This is absolutely not what we found.

This is our wife and mother!!

We are extremely distressed about all of this and trying to figure out what to do with this information so that another patient and family do not have to suffer and be disrespected and have their safety challenged as we feel has happened here. We have not yet decided how we should handle this to ensure that another family's mother/father/sister/brother/daughter/son is treated as you would want your loved ones to be treated.

We waited to settle my mother at home before reaching out about these distressing occurrences. We opted to begin by writing to you for several reasons:

- 1 to make certain that administration was aware of this
- 2 to find out what your plan of action is for ensuring that this would not happen again and/or for making a facility determination that you are not adept at accommodating someone on the level of function of my mother
- 3 to see what reco you were willing to offer given the insensitive and safety challenged method by which S█████ H█████ our wife/mother was treated.

We have paid for my mother's stay at your facility through November 30, 2019. Your daily rate of \$575 suggests top tier, elite care. You provided far less than that. You were unable to take care of my mother properly you refused to shower her regularly and you declined to obtain an appropriate chair to do so. You challenged her safety and caused her skin breakdown which she is still healing from by not cutting her nails and by having a family member find her with the nurse's button wrapped around her neck. Further, you were disrespectful and insensitive in your constant behaviors of leaving a meal in front of her without helping her and with professionals "hiding out" in her room as though she did not realize that they were there, in addition to all the other issues mentioned that displayed a lack of knowledge, sensitivity, flexibility and ability to care for a patient at her functional level. This is our wife and mother we love her with all of our hearts and she/we deserved better care and more respect.

We wanted to address them to you first, before taking this issue to a higher level, to ascertain your response and potential willingness to figure a plan both within your facility and with our family. We were private pay patients from November 14, 2019 January 6, 2020. We would never put a monetary limit on caring for the woman who raised us and loved us who we love so

dearly with all of our hearts. But we cannot and will not pay the daily rate you are asking for care that challenged her safety and dignity and showed an entire lack of respect to her and her family. We need to come to some sort of agreement given this information. We do not feel that top tier remuneration is warranted as it suggests a level of professionalism that was not offered. In addition, we want to be assured that this type of treatment will not happen again to another patient or another patient's family. It is devastating enough to go through this, but to observe and endure this type of treatment from people who are supposed to care for you is one of the most cruel turns of experiences.

It is difficult enough to go through the emotional and practical aspect of dealing with our loved one's Devastating medical event that leads to a significant functional loss, thus changing your life together forever...we should be able to expect that the people and places that we choose to help us on our rehabilitation and caretaking journey will meet expectations with respect to competence, understanding, cleanliness, respect and sensitivity.

Thank you. We await your reply before we complete any further action.

Very truly yours,

che

A black rectangular redaction box covering the signature area.

From: Melissa Heche [REDACTED] >
Sent: Monday, July 13, 2020 6:18:51 AM
To: Mo Krigsman <MKrigsman@coldspringcare.com>
Cc: [REDACTED]
samanthamastro@philosophycare.com <samanthamastro@philosophycare.com>; Grace Lim <GLim@coldspringcare.com>; Yossi Emanuel <YEmanuel@coldspringcare.com>; Laura DiBlasi <LDiBlasi@coldspringcare.com>
Subject: Re: Mommy S [REDACTED] Cold Spring Hills Letter 1-2020

Dear Mr. Krigsman:

This took me quite a while to respond because I honestly did not even know how to respond to it and I was significantly upset at the actions that you had disclosed. Either myself or my sister or my father were literally at Cold Spring Hills every single day when my mother was there. I am unsure to what you are referring to when you state that "attempts to contact me were unsuccessful"? We were literally there - every day! Any phone message that was received was returned and - if you had any issues - we were physically at Cold Spring Hills every single day to address those issues. In addition, my sister brought a bank check to your office, so if there was anything that needed to be said - she was literally right there in your office for you to do so. I do not understand your claims at all.

We were very transparent with Cold Spring Hills from the first day of admission that we were looking for a full course of rehabilitation and would be planning on bringing my mother home. We were forthright in disclosing our pending application for community Medicaid to achieve that goal, which we ultimately achieved. I do not understand why you are bringing up Medicaid, why you are explaining that Medicaid did not pay for my mother's rehabilitation, and why this topic is even on the table. It seems as though you are gaslighting the main issue here: the abuse and safety-deficient care that my mother increasingly received while under your care. This is beyond disheartening.

However, we now have a further issue. None of us signed a release form enabling you to speak with Elaine Quigley regarding my mother. We did not give you permission to discuss anything directly with her office nor would we have given you permission. In fact, my mother would not have wanted you to speak to anyone but us about her healthcare and planning. You betrayed her wishes and did so without our permission.

All communication was going through us - myself, my sister, and my father only - and we were physically present in Cold Spring Hills daily and available via telephone in order for you to be able to contact us if necessary. Quite frankly, the only message we received from Cold Spring Hills from November onwards were bullying and coercion tactics that were trying to strong-arm us into transferring my mother into Long Term Care, despite our constant communication that was not what was desired. This browbeating came from your department, nursing, the social worker, and members of rehabilitation. It was infuriating that we were treated that way at the time and it is even more infuriating that you brought the exact same topic up again since we had been crystal clear to you that we wanted to take my mother home. The bullying and coercion was unacceptable then and it is even more out of line now. You were trying to solicit further "business" instead of adhering to our family's wishes - and in following through with your solicitation you contacted and communicated with an entity that we hired privately in an effort of coercion on your part. This information is actually quite chilling: that you spoke about my mother and our finances and applications to someone else without our consent. We were the

intermediary - not Elaine Quigley - and we never ever signed consent for you to discuss my mother's business with her. That you did was a violation to our privacy and a complete HIPPA violation. That you did this in an effort to bully us and engage in coercion for us to do what you wanted us to do - instead of what was right for my mother - is a breach of ethics and disrespectful to the patient and family.

After much consideration, I can no longer communicate with you about any of this as I am angry at how my mother and my family were treated in your facility - both in front and behind the curtains. I just cannot believe that a discussion was had about my mother, her care, and her finances to a third party - Discussion that we had no knowledge about, did not participate in, and would never have sanctioned. This violated our trust and privacy. The discussion in an effort to bully our family into doing what you wanted - instead of respecting our intentions - was unscrupulous and disreputable on your part.

My mother was abused in your facility by your employees and her privacy was not respected. There were clear safety, dignity, and HIPPA violations. That you cannot keep your HIPPA and medical ethical requirements straight - alongside everything else that you were complacent in - means Cold Spring Hills as a facility should be completely shut down. There are hundreds of patients there whose dignity, safety, and privacy are not being prioritized and it is beyond my personal scope to redirect a facility that should know better and should be beholden to standards in policies and procedures.

That job needs to be taken care of by professionals.

Dr. Melissa E. Heche, AuD
Doctor of Audiology

[REDACTED]

[REDACTED]

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From: Mo Krigsman <MKrigsman@coldspringcare.com>
Sent: Wednesday, June 3, 2020 3:21:16 PM
To: Melissa Heche [REDACTED]
Cc: [REDACTED]
samanthamastro@philosophycare.com <samanthamastro@philosophycare.com>; Grace Lim <GLim@coldspringcare.com>; Yossi Emanuel <YEmanuel@coldspringcare.com>; Laura DiBlasi <LDiBlasi@coldspringcare.com>
Subject: RE: Mommy S [REDACTED] Cold Spring Hills Letter 1-2020

Good Afternoon Melissa,

I hope this email finds you and your family well during these times. I spent several hours reviewing your emails and speaking with staff and administration related to your clinical and financial concerns.

If I understand your position correctly, the aspect of care that most disturbed you were the insensitivities the staff displayed to your mother – at a time when she had difficulty communicating because of her stroke. From personal experience, I understand this completely. Although not my mother, I witnessed my own aunt in an identical situation, and it is not one that any person should experience – neither patient or family.

You also mention several incidents in which you were perturbed by the care given to Mom, such as showers or a lack thereof, her nails, and an incident with a chord as you evidenced with photos. I want to assure you after discussing with our administrator, staff and consultants, we realized that we can certainly improve our education and training of staff to be more sensitive and to effectively communicate with those with limitations, and further expand our in-servicing for all aides to create a culture change in the care for the patients in that regard.

With respect to your financial concerns, our finance office tried reaching out to you, Laurie, and your father, on multiple occasions, in order to address the balance that would be due, in conjunction with invoices mailed out to the home. We knew that you had retained Elaine Quigley of Metro Eldercare to complete a community Medicaid application. From when I spoke with Elaine, she told me with certainty that had we applied on time for Medicaid, the invoices would have been paid nearly in full had the application process be converted over to a nursing home medicaid application, which from my understanding was told over to the facility that you had no interest in applying for nursing home medicaid (Community Medicaid does not pay for nursing home care). As a facility, we attempted to explain this to you as well. Unfortunately, our attempts to contact you were unsuccessful. We then contacted Elaine to check the status of the application process since we had not received payment.

With all that said, we would like to formally thank you for your concerns and recommendations. As committed healthcare workers, our staff acknowledges the emotional suffering that families endure while witnessing a loved one's acute health crisis and recovery or end-of-life events. We stand by our residents and their families, including yours, and are willing to assist in any way we can.

Please contact me at your convenience so we can discuss an amicable resolution.

Stay Safe,
Mo Krigsman
[REDACTED]

From: Melissa Heche [REDACTED]
Sent: Saturday, May 30, 2020 5:50 PM
To: Mo Krigsman <MKrigsman@coldspringcare.com>
Cc: [REDACTED]
samanthamastro@philosophycare.com; Grace Lim <GLim@coldspringcare.com>
Subject: Re: Mommy S [REDACTED] Cold Spring Hills Letter 1-2020

Dear Mr. Krigsman -

I apologize for my delay in response. I do think we have somehow miscommunicated. I think you were under the impression that we were merely negotiating a price on my mother? My mother is priceless, and we would do anything for her. Please for a moment picture that your mother was at Cold Spring Hills for 5 months and received a shower on only three occasions - challenging her personal hygiene - in addition to having medication hidden in her drawer (instead of actually administered to her), a help button wrapped around her neck, her fingernails left too long - causing abrasions on her hand - amongst everything else to which my mother was exposed. Imagine that was your mother who was abused in that manner, and then tell me what you think that type of treatment is worth.

I have made it clear since my very first communication that there we had three goals:

- 1 - To make certain that administration was aware of what happened
- 2 - To find out what your plan of action is for ensuring that this would not happen again and/or for making a facility determination that you are not adept at accommodating someone on the level of function of my mother
- 3 - To see what recourse you were willing to offer given the insensitive and safety challenged method by which S [REDACTED] H [REDACTED] - our wife/mother - was treated.

This stands as confirmation that we will not remunerate for an elite service you claimed to be providing for my mother when the employees in your facility who were supposed to care for her were actually chastising her and mistreating her in many

ways. Additionally, it is imperative to ensure that this sort of elder care abuse does not happen to anyone else. If it happened to my mother, it must be happening to other patients there. Cold Spring Hills treats hundreds of patients for short term rehabilitation or long term care, many of whom are unable to communicate for themselves for reasons similar to or even completely different than my mother's case. I will advocate for them all. When I had an issue with a particular Nursing Assistant, I spoke to Christine and agreed NOT to file a complaint if she engaged in retraining and in servicing. Your staff is insensitive. Your staff does not understand boundaries. Your staff cannot handle a low functioning patient, and your facility should therefore not be accepting them as patients at this time until you have a staff that is capable of properly managing a low level patient. Your staff is not managed well enough by administration to be able to accomplish this at this time. These assertions are based not only on our experience at Cold Spring, but also based on other research I have completed by speaking to other residents and staff.

When I spoke with Samantha back in February, she assured me that what happened to my mother would never happen again. As I told her on that call, that assertion is not good enough. You have been a nursing facility for 15-20 years! You have an extensive long term care component, which includes many people who are unable to communicate for themselves. You should, as a nursing facility, be able to handle bariatric patients. You failed at handling my mother's needs that, as a nursing facility with your tenure, you should have been able to meet. You have policies and procedures that are not in line with your supposed mission statement or they are not being complied with in a regular enough fashion. Those policies and procedures must be restructured. You need to have better communication between administration and staff, better education and in-servicing to your nursing assistants, and better communication to your patients - whether they can communicate or not. First, you never know how much someone understands regardless of how they express themselves, and second - you have a significant number of patients who can communicate who assert that Cold Spring Hills does not adequately inform them of ongoing situations. These are all reflective of breakdowns in your facility's policies.

Your response to our lengthy letter - and our pictures to support our claims - was a renegotiation. This is a tone deaf response that misses the point in its entirety. I am a political advocate and I will fight for the rights of people who are vulnerable and who are being mistreated. Nobody deserves to be paid for the privilege of abusing someone else.

At the very best, we will pay you the Medicare daily rate of \$175 to cover your expenses. We will not pay more than that. My mother was being treated at Cold Spring Hills for 52 days following her Medicare coverage. We have also already given a payment of \$9775.00. This exceeds the Medicare rate for the entire 52 day stay.

I suggest you take these claims back to administration. The problem at Cold Spring Hills is significantly greater than merely an open patient bill. The problem is your lack of care and your support of safety-challenged and abusive behaviors towards your residents. This is a problem that must be addressed and solved - whether it is done internally by you or externally through the direction of another entity.

Very truly yours,

Melissa Heche and [REDACTED]

Melissa E. Heche, Au.D
Doctor of Audiology

[REDACTED]

[REDACTED]

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On May 13, 2020, at 11:18 PM, Mo Krigsman <MKrigsman@coldspringcare.com> wrote:

Hello Dr. Heche,

I have reviewed your messages and photos.

I am prepared to offer a settlement at 85% of our billed charges as a final offer, given that we are paid by month's end.

Please advise if you accept our offer in writing so I can draft the settlement agreement.

Thank You,
Mo

From: Melissa Heche <[REDACTED]>
Sent: Tuesday, April 28, 2020 1:42 PM
To: Mo Krigsman <MKrigsman@coldspringcare.com>
Cc: [REDACTED]
samanthamastro@philosophycare.com
Subject: Fwd: Mommy S [REDACTED] Cold Spring Hills Letter 1-2020

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<image002.jpg>
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Dr. Melissa E. Heche, AuD
Doctor of Audiology
[REDACTED]
[REDACTED]
[REDACTED]

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From: Melissa Heche <[REDACTED]>
Sent: Friday, March 6, 2020 6:26 PM
To: samanthamastro@philosophycare.com
Cc: [REDACTED]
Subject: Mommy S [REDACTED] Cold Spring Hills Letter 1-2020

Dear Samantha -

Attached is the letter that we sent to Finance at Cold Spring Hills on or about January 20, 2020. The original letter sent had all of our signatures - this is only the "word" file. However, it conveys the message. The original letter also enclosed pictures - which I will be texting you immediately after this email Has been sent.

I have cc'd my sister on this correspondence so that she is a part of this conversation.

We appreciate being able to have this conversation. We await your response to this matter before we do anything else.

Thank you

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In the Matter of an Investigation Pursuant to
N.Y. Exec. Law § 63(12) re: Cold Spring Hills
Nursing and Rehabilitation.

**AFFIDAVIT OF
ELSIE LIMAGE**

STATE OF NEW YORK)
)
COUNTY OF SUFFOLK) ss.:

Elsie Limage, being duly sworn, attests as follows:

1. I am 54 years old years old and reside in Ronkonkoma, New York.
2. I have been employed as a Registered Nurse at a hospice for the past approximately four years.
3. I submit this affidavit in connection with the New York Attorney General's investigation into Cold Spring Hills Center for Nursing & Rehabilitation ("Cold Spring Hills"), a nursing home located at 378 Syosset-Woodbury Road, Woodbury, New York 11797, and set forth below my experiences and observations while caring for and speaking with my cousin, P.L., while he was a resident of Cold Spring Hills from June 2017 through his death on April 3, 2020.
4. My cousin was born in 1946. He was 73 years old when he died.
5. I served as co-guardian for my cousin from 2017 through his death in 2020.
6. Before his admission to Cold Spring Hills, my cousin was a Baptist pastor, and he enjoyed reading the bible, singing, and watching movies. He lived in Haiti and in Jamaica, New York and had two sons. One son lives in Chicago, Illinois. The other son passed away.

EL

7. My cousin lived at Cold Spring Hills from June 2017 through his death in April 2020. He lived mostly on the second floor of the Brookville building at Cold Spring Hills. He suffered from Alzheimer's disease and Type 2 diabetes. I visited him one to two times a week.

8. During the first year that my cousin lived at Cold Spring Hills, he could walk with no problem. During that first year, on Sundays, he would read the bible out loud in French and sing for other residents.

9. At the end of 2019, my cousin started using a wheelchair at Cold Spring Hills, because he was having difficulty walking. Cold Spring Hills provided him with a wheelchair that did not have footrests. When I visited him, I observed for about the first five to six weeks that, because the wheelchair did not have footrests, my cousin dragged both of his feet on the floor when he used the wheelchair and over that time, he developed sores on the toes of his right foot. Cold Spring Hills blamed diabetes for the sores on his toes and denied physical therapy for my cousin because nurse practitioner ("NP") Keisha Mahoney, said he could walk. NP Mahoney also told me that the nurses told her that my cousin was too confused and forgetful to do physical therapy. He was confused, because he had dementia.

10. During January 2020, I made multiple requests for consults with NP Mahoney because I was worried about my cousin's toes, because they were red and had sores on them. No one at Cold Spring Hills ever contacted me in response to my requests for a meeting and a meeting never happened. NP Mahoney did tell me over the telephone that they were treating my cousin's toes with an antibiotic.

12. Finally, in late January 2020, I insisted that my cousin be sent to the hospital, because I could see that the infection on his toes was red in color and was getting bad. My cousin was sent to Plainview Hospital in an ambulette. A doctor and the Care Coordinator at Plainview

Hospital told me that they were going to have to amputate three or four of my cousin's toes, because he had a major infection that antibiotics could not help. Fortunately, they only had to amputate a portion of his big toe. Unfortunately, my cousin had to go back to Cold Spring Hills because his insurance did not approve any other nursing homes that were located near me.

13. Almost every day in March and early April 2020, I remember that I would call and try to speak to my cousin, and I was told by Cold Spring Hills staff that he was sleeping and couldn't talk. Because I couldn't talk to my cousin, I would ask the staff at Cold Spring Hills how he was doing. They always told me that he was "fine."

14. On April 2, 2020, the day before my cousin died, I called Cold Spring Hills to see how he was doing, and they told me again that he was "fine." Then, on April 3, 2020, I received a phone call from my cousin's son, and he told me that my cousin had died. I thought to myself, how can this be? He was fine yesterday, and now he's in heaven? Cold Spring Hills never called me, and they should have because I was my cousin's co-guardian. I still don't know why he died.

15. I also noticed that when my cousin was moved to the second floor of the Brookville building at Cold Spring Hills, he always smelled of urine and that the second floor of the Brookville building also always smelled of urine.

16. I observed that my cousin was rarely, if ever, groomed. He was never clean shaven, and I had to cut his fingernails because no one at the facility did it for him. I cut his fingernails when I visited him, but I did not cut his toenails because he had diabetes. Sometimes, someone at Cold Spring Hills cut his toenails.

17. The floor of my cousin's room was always dirty, and so were the curtains and the toilet. However, when I complained to the Cold Spring Hills management about the conditions of the room, they put up new curtains, installed new floor tile, and painted the room.

18. My cousin would tell me that he did not like the food at Cold Spring Hills and that it tasted like it came from a can.

19. Cold Spring Hills didn't organize any activities for the residents. I observed the residents mostly in their rooms or walking around the unit.

20. My cousin was not properly cared for at Cold Spring Hills. If they offered to care for my dog, I would decline.

Elsie Limage
ELSIE LIMAGE

Sworn to before me this
27 day of Sept 2022

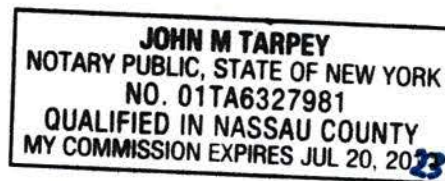
John M Tarpey

Notary Public, State of New York

No. _____

Qualified in _____ County

Commission Expires: _____



EL

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 complies with the word count limit set forth in Rule 202.8-b as it contains 997 words, excluding the parts of the Affidavit explicitly exempted by Rule. 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 15, 2022

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

By:



Christina Pinnola
Special Assistant Attorney General
Office of the Attorney General
Medicaid Fraud Control Unit
300 Motor Parkway, Suite 210
Hauppauge, New York 11788
Christina.pinnola@ag.ny.gov

In the Matter of an Investigation Pursuant to
N.Y. Exec. Law § 63(12) re: Cold Spring Hills
Center for Rehabilitation & Nursing

**AFFIDAVIT OF
CHELSEA HANSSON**

STATE OF NEW YORK)
)
COUNTY OF SUFFOLK) ss.:

Chelsea Hansson, being duly sworn, attests as follows:

1. I am 32 years old and currently reside in Huntington, NY.
2. I have been employed as a computer programmer for past four years.
3. I submit this affidavit in connection with the New York Attorney General's investigation into Cold Spring Hills Center for Nursing & Rehabilitation ("Cold Spring Hills"), a nursing home located at 378 Syosset-Woodbury Road, Woodbury, NY 11797, and set forth below my experiences and observations while caring for and speaking with my father, J.D., while he was a resident of Cold Spring Hills.
4. My father was born in 1948, and he suffers from ALS. My mother, Rebecca, is his Health Care Proxy.
5. My father resided at Cold Spring Hills from July 31, 2020 through October 4, 2020. He lived on the second floor, in the respiratory unit. He was there to receive rehabilitation due to a broken collarbone, to be weaned off his ventilator, and to receive a speech valve.
6. Before his admission to Cold Spring Hills, my father was a diesel mechanic for over 40 years. He has two sons, my brother and me, and I am a transgender male. My father loved to

CD

garden and hike, and he still enjoys bird watching, cars and watching military documentaries. He has resided in Syosset, New York for the past thirty-five years.

8. At the time my father was a resident at Cold Spring Hills, visitation was not allowed due to the COVID-19 virus. Cold Spring Hills had a tablet that we used to FaceTime in the mid-afternoon, once a day, or every other day. A week into his residency at Cold Spring Hills, my mom supplied my dad with a tablet. We then communicated multiple times a day on FaceTime.

9. My father's initial complaints to me about Cold Spring Hills were that staff was not coming into his room to check on him and that staff was not answering his call bell. He needed assistance with walking to the bathroom, moving from his bed to his chair and from his chair to his bed. He also used his call bell when he needed to receive his medication to relieve the gas buildup in his stomach from his gastroparesis, which was very painful. He only took this medication when he needed to and would ring the call bell in order to ask for it.

10. Regretfully, I did not pay much attention to these initial complaints because my father has anxiety, and I thought he was just panicking. I also did not pay much attention to these initial complaints because, at first, the communication I received from Cold Spring Hills regarding my father was good. I received daily updates from a female social worker over the telephone, and I was satisfied with the care my father was receiving, based on what the social worker told me.

11. However, I became concerned about the care my father was receiving approximately two to three weeks after he arrived at Cold Spring Hills. I FaceTimed with my father and, as time went on, when I saw him on the tablet camera, I became more and more concerned about how he looked. He appeared more and more unkempt. He was dirty, his hair looked greasy, and he was not clean shaven.

12. My father was able to use the bathroom by himself. He just needed assistance with the walking to the bathroom due to the lack of mobility in his legs. However, the staff at Cold Spring Hills had my father wearing a diaper, as a precautionary measure, because they consistently took too long to answer his call bell. My father told me that he waited thirty minutes to an hour for staff to answer his call bell and assist him with walking to the bathroom. He told me that this occurred mostly during the 3:00 p.m. to 11:00 p.m. shift every weekday, and that it occurred on all shifts during the weekends.

13. My father told me that he was embarrassed and humiliated wearing a diaper because he never had to wear one before. My father was continent. He still is.

14. My father would ring the call ball to go to the bathroom, but after waiting too long for someone to answer, he would go in the diaper because he could not hold it any longer. Then he would need to have the diaper changed, too. He told me that he would sit in his dirty diaper for thirty to sixty minutes until anyone answered his call bell. Sitting in a dirty diaper waiting for someone to change him made my father feel embarrassed and ashamed.

15. It appeared to me that my father was not being weaned off the ventilator and that he was not given his speech valve when he should have been. When I FaceTimed with him, he was always on the ventilator. Also, when we FaceTimed, there were times that he could not speak, because the speech valve was not in. This mostly occurred on the weekends, during the 7:00 a.m. to 3:00 p.m. shift. I never received a clear answer from the social workers about the weaning or whether they had given him the speech valve. The social workers, one male and I think another, female, would advise me to FaceTime with my father at a particular time during the 3:00 p.m. to 11:00 p.m. shift, stating that when we did, he wouldn't be on the ventilator and his speech valve



would be in. When I FaceTimed with my father at the time they told me, he would be on the vent and the speech valve would not be in place, so he wasn't able to speak with me.

16. My father also told me that he was not receiving physical therapy on the weekends, as he was supposed to.

17. I called the nurses' station three to four times every week to voice my concerns and received attitude from the staff that answered the phone. The staff seemed annoyed when I called, and they were short with me. My concerns were about my father having to wear diapers, and having to sit in dirty diapers, waiting too long for anyone to answer his call bell, the weaning and speech valve issues, and the weekend physical therapy. I called the nurses' station during the 3:00 p.m. to 11:00 p.m. shift during the week and during the 7:00 a.m. to 3:00 p.m. shift on the weekends. I never received any clear answers to any of my concerns and nothing improved.

18. As time went on, my father told me that staffing was okay during the week and that on the weekends, it was less. He told me that there were times, during the 7:00 a.m. to 3:00 p.m. shift, on the weekends, that no staff members came into his room.

19. I never received any COVID-19 related information from Cold Spring Hills.

20. During the last two weeks that my father was a resident at Cold Spring Hills, I started to look for another facility to place my father in. He did not look good on FaceTime, in fact, he looked scared, and he started to ask me to send him somewhere else. He didn't feel like he was getting the care that he was supposed to. I looked into sending him to Gurwin Jewish Nursing & Rehabilitation Center ("Gurwin"), due to its good reputation.

21. Before I could make arrangements to move my father from Cold Spring Hills to Gurwin, my mom received a phone call from a social worker at Cold Spring Hills. I was present with her when she received the call. The social worker told my mom that my father had bilateral

pneumonia and was sent to Plainview Hospital. Prior to this phone call, neither my mother nor I was aware that my father had any symptoms of being sick. No one had told either of us.

22. The days prior to being sent to Plainview Hospital, my father looked lethargic when we were on FaceTime.

23. I visited my father at Plainview Hospital the day after he was transferred there. He looked filthy. His toenails were yellow, his hair was overgrown, and he had bedsores on his buttocks and the back of his legs. I was not aware of the bed sores while my father was at Cold Spring Hills. I became aware of them after he was transferred to Plainview Hospital.

24. My father was in Plainview Hospital for six weeks due to his bilateral pneumonia. The bedsores he developed at Cold Spring Hills fully healed while he was in Plainview Hospital.

25. When he left Plainview Hospital, my father went to live at Gurwin. My mother would not let him go back to Cold Spring Hills because of the bad experience he had there, and my father did not want to go back there. I had already started looking to transfer him to Gurwin before he was transferred to Plainview Hospital.

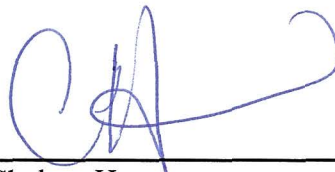
26. Thankfully, my father transferred to Gurwin and was a resident there for four to five months. During that time, my father got progressively stronger because he was well taken care of. At Cold Spring Hills he seemed to be in a daze, but at Gurwin he was so much more lucid. And Gurwin let me drop stuff off for him like treats, food, and clothes. There always seemed to be an aide in his room when we FaceTimed and they let my mom visit him, too.

27. My father is presently living back in his home with my mother. He continues to be lucid. My father and I watch TV together when I visit, we go for walks, and he has a motorized wheelchair. He has a 24-hour aide/nurse to assist him. He also receives assistance from Veterans



Affairs, the VA. They have provided him with medical care, the motorized wheelchair, and a van with a ramp for the wheelchair.

28. When my father first came home, he used to get visibly upset when speaking about Cold Spring Hills. He is a Vietnam Veteran and he developed Post Traumatic Stress Disorder ("PTSD") in Vietnam. His PTSD redeveloped as a result of his experience and due to his inadequate care at Cold Spring Hills. He experienced massive anxiety when he was left alone in a room, he was anxious if a family member was not home, and he became anxious if his needs were not met immediately because he feared that he was being ignored and no one would help him.



Chelsea Hansson

Sworn to before me this
29th day of SEPT. 2022



Notary Public, State of New York

No. 01LU6020890

Qualified in SUFFOLK County

Commission Expires: MARCH 8, 2023

PATRICK LUBIN
Notary Public, State of New York
No. 01LU6020890
Qualified in Suffolk County
Commission Expires March 8, 2023

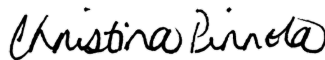
CERTIFICATION PURSUANT TO RULE 202.8-b

I, Christina Pinnola, an attorney duly admitted to practice law before the Courts of the State of New York, hereby certify that this Affidavit complies with the word count limit set forth in Rule 202.8-b as it contains 1,767 words, excluding the parts of the Affidavit explicitly exempted by Rule. 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 15, 2022

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

By:



Christina Pinnola
Special Assistant Attorney General
Office of the Attorney General
Medicaid Fraud Control Unit
300 Motor Parkway, Suite 210
Hauppauge, New York 11788
Christina.pinnola@ag.ny.gov

In the Matter of an Investigation Pursuant to
N.Y. Exec. Law § 63(12) re: Cold Spring Hills
Center for Rehabilitation & Nursing.

**AFFIDAVIT OF
MARY ANN GAGLIARDI**

STATE OF NEW YORK)
) ss.:
COUNTY OF SARATOGA)

Mary Ann Gagliardi, being duly sworn, attests as follows:

1. I am 65 years old and reside in Valley Stream, New York.
2. I was employed at a law firm located in Manhattan, New York as a legal secretary for 20 years. I am now retired.
3. I submit this affidavit in connection with the New York Attorney General's investigation into Cold Spring Hills Center for Nursing & Rehabilitation ("Cold Spring Hills"), a nursing home located at 378 Syosset-Woodbury Road, Woodbury, New York 11797, and set forth below my experiences and observations while caring for my mother, F.G., while she was a resident of Cold Spring Hills.
4. I have been my mother's Health Care Proxy since August 21, 2000.
5. My mother was born in 1923 and resided at Cold Spring Hills from May 2004 to December 30, 2019. She passed away on December 30, 2019.
6. Medicaid, Medicare, Social Security, and my father's pension, which passed to my mother after he died, paid a lot of money to Cold Spring Hills to take care of my mother, but the care she received was poor, especially after Sentosa took it over. Before Sentosa took over, there were always supplies, like diapers, Chux pads, towels, Lantiseptic incontinence cream and

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disposable wash pads. After Sentosa bought Cold Spring Hills, I noticed a decline in my mother's care. This was because there were never enough supplies or staff to take care of the residents. There were no diapers, no towels, no Chux pads, and never enough certified nurse aides ("CNAs"). Without enough staff and enough supplies, they were not able to take care of the residents. I visited my mother regularly but wonder what kind of care she received when I was not there.

7. Before her admission to Cold Spring Hills, my mother lived in Valley Stream, New York. She was a stay-at-home mom and took care of me and my brother. My mother was a good seamstress and made Halloween costumes for me and for my brother. She also liked to cook, garden, read the newspapers, do crossword puzzles, and entertain guests at our house in Valley Stream.

8. In her later years, my mother suffered from dementia. During the 15 years that my mother was a resident at Cold Spring Hills, she resided in the Sagamore Building for one month, then went to the Woodcrest building for four or five years, and then transferred to the Seacliff Building where she stayed until she passed away.

9. During that time, I worked fulltime in Manhattan and visited my mother on Saturdays. I usually visited from 3:00 p.m. to 9:00 p.m., and my mother and I ate dinner together. We had meatball heroes that I brought her from Subway because she enjoyed them. I also brought her a sweet potato and a banana because they were her favorites, and they were soft and easy for her to eat.

10. My mother was not able to make her own needs known because she stopped talking, which I believe was due to the dementia progressing. For example, she could not let anyone know when she had to go the bathroom or when she had a dirty diaper that needed to be changed.

11. Right after Sentosa took over, staff alerted me that Cold Spring Hills would only supply each shift with one diaper for my mother. My mother would sit in a dirty diaper until each shift changed. My mother was sitting in a dirty diaper almost every time I visited her at Cold Spring Hills. I had no idea how long she had been sitting in the dirty diapers each time before I arrived. I would have to go to housekeeping and force them bring more to diapers to mother's room because, once Sentosa took over, the supply closet on the unit was kept locked.

12. For instance, I visited my mother on May 13, 2018. It was Mother's Day, and I arrived at approximately 9:00 - 9:30 a.m. We had Mother's Day brunch together from approximately 10:00 a.m. to 12:00 p.m. After brunch, between 2:30 and 3:00 p.m., I told my mother's aide that my mother needed a diaper change. There were no towels or diapers in her room, as there should have been, and none on the entire unit to change and clean her. My mother had to wait approximately 45 minutes until her aide, and another aide, changed her. One of the aides told me that there were no diapers on the unit, but she had found one in another resident's room and had used that one to change my mother. No one brought a supply of diapers and towels to my mother's room until approximately 4:30 p.m. that day.

13. On June 2, 2018, while visiting my mother, once again I saw that there were no diapers or towels in her room or on the unit. I went to the supply room on the unit and there was nothing available. Sometimes aides used a strap to keep the supply room door open. That day the door was open. There were no supplies available.

14. Additionally, on June 2, 2018, during the 3:00 p.m. to 11:00 p.m. shift, one of the five CNAs assigned to my mother's unit was transferred to another unit because someone called in sick. This left only four CNAs for approximately fifty residents.

15. On July 20, 2019, a Saturday, at approximately 3:00 p.m., I recall walking onto my mother's unit, and immediately noticing that it was hotter inside than it was outside. It was 95 to 100 degrees outside. There was hot air coming out of the air conditioning vents. The air conditioning was not working in the dining room, hallways, and the two day rooms. The nurses, CNAs, and residents were not in good shape. Everyone was sweating. All the residents were in the dining room and not in their own rooms. I don't know why the residents were in the dining room.

16. A nurse said to me that "plant ops," the people in charge of taking care of the buildings, could not fix the air conditioning, and she asked if I would call them. I called "plant ops" and they told me that the air conditioning would not be fixed until Monday. I checked the air conditioning unit in my mother's room, and it worked, so I put it on and brought her in there. We stayed in her room the rest of the day.

17. That same Saturday, I contacted the Department of Health ("DOH") regarding the air conditioning issue. I called Cold Spring Hills the next day, on Sunday, and spoke with a nurse who told me that DOH was there, and that Yossi Emanuel ("Emanuel"), the CEO for Cold Spring Hills, and Ben, the grievance officer for Cold Spring Hills, were also there. The nurse told me that DOH had called Emanuel and Ben and told them to go there and see what was going on with the air conditioning and that Emanuel was annoyed that he had to come in on a Sunday. The same nurse told me that, in the interim, big fans and a hydration station were put on the unit.

18. The staff were very good. However, there were not enough of them, especially after Sentosa took over. If I got to Cold Spring Hills before the shift change from the 7:00 a.m. to 3:00 p.m. shift to the 3:00 p.m. to 11:00 p.m. shift, I would stand by the nurses' station and see how many CNAs came to work. If there weren't at least five CNAs, I would go to the scheduling

office and ask for another CNA to be assigned to the unit. Sometimes another CNA was sent to the unit and sometimes not. And the CNAs were not provided with enough diapers, towels, and Chux pads to complete their jobs and take care of the residents.

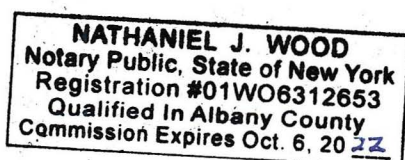
19. After Sentosa took over, I cut and filed my mother's fingernails because there wasn't enough staff, and they didn't do it. A hairdresser would come to my mother's unit every month and, if needed, the hairdresser would also cut her fingernails. A podiatrist was supposed to cut her toenails, but I don't believe that occurred because her toenails grew over her toes.

20. I was so upset about the lack of staff and lack of supplies for my mother and the other residents. ^{Called me} I ~~wrote~~ several complaints to DOH, left a voicemail for Mara Schwartz, the Ombudsman for my mother's unit, left voicemails for Emanuel, and left voicemails for Ben. Emanuel and Ben never called me back. Schwartz always called me back and thanked me for letting her know what was going on. DOH would call me back and tell me they received my complaint. I was complaining for the sake of my mother and for the other residents because no one else was going to call for them.


Mary Ann Gagliardi

Sworn to before me this
28 day of September 2022
Nathaniel J. Wood

Notary Public, State of New York
No. 01WO6312653
Qualified in Albany County
Commission Expires: 10/6/2022



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 complies with the word count limit set forth in Rule 202.8-b as it contains 1,495 words, excluding the parts of the Affidavit explicitly exempted by Rule. 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 15, 2022

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

By:



Christina Pinnola
Special Assistant Attorney General
Office of the Attorney General
Medicaid Fraud Control Unit
300 Motor Parkway, Suite 210
Hauppauge, New York 11788
Christina.pinnola@ag.ny.gov

In the Matter of an Investigation Pursuant to N.Y.
Exec. Law § 63(12) re: Cold Spring Hills Center
for Nursing and Rehabilitation.

**AFFIDAVIT OF
WENDY SHAPIRO**

STATE OF NEW YORK)
)
COUNTY OF NASSAU) ss.:

Wendy Shapiro, being duly sworn, attests as follows:

1. I am 65 years old and currently reside in Hicksville, New York. I have lived there for 62 years.
2. I have been employed at an accounting firm for the past 16 ½ years.
3. I submit this affidavit in connection with the New York Attorney General's investigation into Cold Spring Hills Center for Nursing & Rehabilitation ("Cold Spring Hills"), a nursing home located at 378 Syosset-Woodbury Road, Woodbury, New York 11797, and set forth below my experiences and observations while caring for and speaking with my husband, T.S., while he was a resident of Cold Spring Hills.
4. My husband was born in 1950, and we have two daughters. My husband owned a company that delivered food to restaurants in New York City. My husband liked to play golf and the guitar, sing, and go out to eat. Before his admission to Cold Spring Hills, he was at Nassau County Medical Center ("NCMC"), because he had been in a very bad car accident. My husband was 71 years old when he died.
5. My daughter, Ashely, was my husband's Health Care Proxy.

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6. My husband lived at Cold Spring Hills from April 22, 2021 through August 11, 2021. He lived in the Seacliff building, on the first floor. He was there because, when he came out of NCMC, he needed physical therapy for his legs for mobility.

7. I visited my husband at Cold Spring Hills Monday through Friday each week, from 5:30 p.m. to 7:00 p.m. On the weekends, I visited my husband on either Saturday or Sunday, for a couple of hours. When I visited my husband at Cold Spring Hills, he always looked like no one had taken care of him. He was never clean shaven, his fingernails and toenails were always long, and he always looked dirty. Though he was fed through a feeding tube while at Cold Spring Hills, I think he lost about 75 pounds while he was a resident there. He had sores on his heels with black skin coming off, his heels and toes were black, he had a hole in his scrotum, and he had sores on his buttocks. He also had shingles on his face and eyes.

8. My husband's room was gross, too. There were stains on the ceiling, his curtains were dirty, his toilet bowl was black, his sink faucet was always dripping water, and there was trash under his bed.

9. When I visited my husband at Cold Spring Hills, he was always lying on his back in his bed and his call bell was always on the floor, where he could not reach or use it. The floor that he lived on was always a ghost town and it was hard to find a staff member to talk to. One night when I was visiting my husband at Cold Spring Hills, he asked me why I put him here. This hurt me very much. Every night when I left Cold Spring Hills my husband gave me a look of, "Don't leave me here.", and I felt guilty.

10. On August 11, 2021, my husband went for a scheduled appointment at Plainview Hospital to have his dialysis port and trach taken out. A nurse at Plainview Hospital told me that he was dehydrated, and the dietitian said that there was no way Cold Spring Hills was feeding him

four to six times a day. When it was time for my husband to leave Plainview Hospital, I told the hospital staff, "over my dead body" was I sending my husband back to Cold Spring Hills.

11. At Plainview Hospital, my husband said to me, "They tried to kill me at Cold Spring Hills, and you put me there." Again, this hurt me deeply and I felt so guilty.

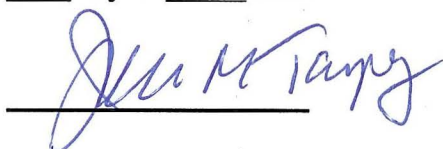
12. After leaving Plainview Hospital, on September 2, 2021, my husband went to Five Towns Nursing Home ("Five Towns"), and he finally got the care he was supposed to get at Cold Spring Hills. He received physical therapy, they changed his bedding and gown when needed, nurses were always around, and the social worker always took care of him.

13. Unfortunately, on December 21, 2021, Five Towns sent my husband to South Nassau Hospital because he was unresponsive. My husband died on December 25, 2021, from sepsis, pneumonia, and heart disease.

14. The guilt of putting my husband in Cold Spring Hills still weighs on me. I watched my husband die because of Cold Spring Hills. My husband deteriorated in front of my eyes because of Cold Spring Hills. My husband and I were married for 38 years and that went down the drain because of Cold Spring Hills.


WENDY SHAPIRO

Sworn to before me this
23 day of SEPT 2022



Notary Public, State of New York

No. _____

Qualified in _____ County

Commission Expires: _____

JOHN M TARPEY
NOTARY PUBLIC, STATE OF NEW YORK
NO. 01TA6327981
QUALIFIED IN NASSAU COUNTY
MY COMMISSION EXPIRES JUL 20, 2023

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 complies with the word count limit set forth in Rule 202.8-b as it contains 789 words, excluding the parts of the Affidavit explicitly exempted by Rule. 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 15, 2022

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

By:



Christina Pinnola
Special Assistant Attorney General
Office of the Attorney General
Medicaid Fraud Control Unit
300 Motor Parkway, Suite 210
Hauppauge, New York 11788
Christina.pinnola@ag.ny.gov

In the Matter of an Investigation Pursuant to
N.Y. Exec. Law § 63(12) re: Cold Spring Hills
Center for Nursing and Rehabilitation.

**AFFIDAVIT OF
SATWATTIE DAVI SINGH**

STATE OF FLORIDA)
)
COUNTY OF MARION) ss.:

Satwattie Davi Singh, being duly sworn, attests as follows:

1. I am 36 years old and currently reside in Ocala, Florida.
2. I was employed as a Licensed Practical Nurse ("LPN") in New York at the Bristol Assisted Living ("The Bristol") in Westbury. I currently reside with and take care of my two young children, and I am not presently otherwise employed.
3. I submit this affidavit in connection with the New York Attorney General's investigation into Cold Spring Hills Center for Nursing & Rehabilitation ("Cold Spring Hills"), a nursing home located at 378 Syosset-Woodbury Road, Woodbury, New York 11797, and set forth below my experiences and observations while caring for and speaking with my father, G.S., while he was a resident of Cold Spring Hills.
4. I have always made healthcare decisions for my father and have been his Health Care Proxy since October 30, 2020.
5. My father was born in 1959 and he resided at Cold Spring Hills from June 25, 2020 through approximately October 25, 2020.

6. My father lived in Queens, New York for 31 years prior to going to Cold Spring Hills. He worked as an auto collision mechanic and has two children. He loves dogs and cats. He especially likes cats and would feed all the stray cats in the neighborhood.

7. Prior to being admitted to Cold Spring Hills, my father was at North Shore Manhasset Hospital ("NSMH") for three weeks while the doctors figured out what was wrong with him. My father was finally diagnosed with a terrible case of West Nile virus. This caused him to get Guillain-Barre syndrome, and he had paresis from the neck down. At the hospital, my father was put on a ventilator and two days later he had a feeding tube inserted in his stomach.

8. My father was admitted to Cold Spring Hills on June 25, 2020. He lived on the first floor, in room 112 of the ventilator unit in the Seacliff building. I chose Cold Spring Hills for my father, because I had experience with its rehabilitation unit.

9. I was an LPN and case manager in the Director of Resident Relations Department when I worked at the Bristal in Westbury. One of my responsibilities there was to visit nursing homes, including Cold Spring Hills, to evaluate whether the Bristal residents who got sick and went to rehabilitation units at nursing homes were able to return to the Bristal. However, I did not realize that the ventilator unit at Cold Spring Hills was in a different building than the rehabilitation unit. After my father left Cold Spring Hills, I found out through a close friend that someone who worked on the ventilator unit at Cold Spring Hills resigned because the facility was neglecting residents on ventilators, and someone had died. My father was very close to dying at Cold Spring Hills.

10. I don't believe my father was properly cared for at Cold Spring Hills. He was on a feeding tube, but still lost weight, he developed urinary tract infections ("UTIs") due to lack of proper catheter care, his pressure wound became larger, he became septic due to the incorrect

placement of a catheter in his prostate, they were not suctioning him enough and did not even recognize when he needed to be suctioned, and they were not bathing him.

11. I was not able to visit my father when he was in Cold Spring Hills because of the COVID-19 virus. I was only able to video chat with him once or twice a week for about 20 to 30 minutes each time. My mother and I visited my father one time through the window. Unfortunately, after Cold Spring Hills resumed visitation, I still was unable to visit my father because each time I scheduled a visit someone in the facility was diagnosed with COVID-19 and my visit was canceled.

12. My father could not speak when he was at Cold Spring Hills because he was intubated, had a trach, and was on a ventilator due to the West Nile Virus. Even though he could not speak, in my opinion as an LPN, when my father was admitted to Cold Spring Hills he was alert and oriented. Because I am an LPN, I knew how to communicate with my father. My father would answer questions by nodding and turning his head from side to side, or would blink his eyes "yes" and "no." For example, I would ask him if he was in pain and if he gestured "yes," I would start at the top of his head and work my way down my father's body until I got a "yes" gesture. Then I would call the nurse and request that they give him his pain medication. He was also able to answer questions such as, "Do you know where you are?", "What is the day of the week?", and "What is your name?"

13. I had a care plan meeting for my father on July 17, 2020, more than three weeks after he was admitted, which was the first and only meeting I had at Cold Spring Hills. Being an LPN, I know that the nursing home is supposed to have a care plan meeting upon admission and then quarterly thereafter.

14. Prior to being admitted to Cold Spring Hills, while he was at NSMH, my father had a rectal tube inserted due to loose bowel movements and he developed a pressure sore on his sacrum. Cold Spring Hills told me that they were treating the pressure sore, but it got so bad that when my father was readmitted to NSMH in October 2020, the hospital had to put a wound vac on them to remove and suck out all the dead tissue. It was obvious that the pressure sore got larger while he was Cold Spring Hills.

15. My father had UTIs during the four months he was at Cold Spring Hills. As an LPN, I believe the reason my father had them was because the nurses were not performing proper catheter care. They were not properly flushing his catheter. Nurse Practitioner ("NP") Keisha Mahoney confirmed to me that my father was not receiving proper catheter care while he was at Cold Spring Hills.

16. My father was also treated for pneumonia while at Cold Spring Hills and it may have been due to him being on a ventilator.

17. When my father went to NSMH in October 2020, I also learned that he had developed sores on his ankles while he was at Cold Spring Hills. A nurse at NSMH showed me the sores and explained to me that, even though they were closed up, they were pressure sores, and I could see that they were now scabbed over. No one at CSH had ever told me that my father had these pressure sores on his ankles.

18. On July 17, 2020, my sister and mother were doing a FaceTime call with my father around 3:00 p.m. and my sister noticed that he was not his normal self. His nonverbal cues were off, and he was not responding to them the way he usually did, and he was falling asleep while they were talking to him. My sister called me to tell me what was happening with our father. I called the nurses' station to have them check on my father. Roseanne, the speech therapist who

knew my father well, checked on my father and went to the nurses' station to tell them something was wrong. Roseanne told me that Jen, the recreation therapist who was doing the FaceTime with my father, also notified the nurses' station about my father's condition and that it took a nurse over one-half hour to check on my father. One of the nasty nurses said he was on a video chat with his family, and he was okay. When a nurse finally checked on him, the nurse told me that he was having trouble breathing. I asked the nurse how he can have trouble breathing, he is on a ventilator. The nurse could not tell me what was wrong with my father. It took three nurses getting on the phone with me to tell me he was unresponsive. The staff called 911 and the nurses ambu bagged him, then suctioned him and a lot of mucus came out. Once that happened, he was back to his normal self. When 911 got there, they said "why did you call us, he is fine."

19. When I asked what the policy was on suctioning a vent resident, they could not tell me what the policy was. Instead, they told me that they suction a resident on a vent as needed, about once or twice a shift. My father had a lot of secretions and after the incident of July 17th, I requested that they suction him more frequency. However, Cold Spring Hills still never confirmed its policy on suctioning a vent resident.

20. I also questioned why my father did not have a pulse oximeter and the person from respiratory told me that it was not the policy of Cold Spring Hills to use pulse oximeters on vent residents. After I questioned them about how they would know if my father had proper O2 levels, they gave him a pulse oximeter.

21. My father was also supposed to have aggressive physical therapy because of the West Nile virus, so that he could get back to moving. When he went into Cold Spring Hills, he was able to move his toes and wiggle his fingers. When he left Cold Spring Hills his fingers were contracted. I asked the facility to put his hands into a brace, but I don't believe they ever did. If

they had put his hands in a brace, his fingers would not have been bent when he left Cold Spring Hills. A Cold Spring Hills staff member, maybe someone from Occupational Therapy, told me that my father refused to have the brace placed on his hand. I told the staff that if my father was refusing something, that they should call me so I could explain the importance of the treatment to my father.

22. On August 20, 2020, my sister received a letter from my father's health care insurance, Health First, that his rehab stay will be discontinued. I then called the physical therapist to ask him why my father's PT services were being discontinued. The physical therapist told me that my father had plateaued. However, the Social Worker also told me that my father's health care coverage was over, and I would have to apply for Medicaid for him.

23. I made a complaint to the facility about the way the Director of Physical Therapy was handling my father. The Director of Physical Therapy, Scott, was a nasty person who told me, "If you do not like the way I am handling your father, you can take your father somewhere else."

24. On August 25, 2020, during a meeting I had with Nancy, the Director of Nursing ("DON"), she told me that my father had a [REDACTED] which is why he was on a ventilator. She further told me that my father had chronic end stage respiratory failure because of [REDACTED]. I told Nancy that my father [REDACTED]. [REDACTED] I felt that Nancy was not prepared for this meeting, and it seemed like she just looked at the face sheet prior to the meeting. After this meeting, in the next phone conversation I had with NP Mahoney, I discussed my prior conversation with Nancy's and her diagnosis of chronic end stage respiratory failure. NP Mahoney reviewed my father's file and told me that he did not have

end stage respiratory failure. NP Mahoney also told me that Nancy assumed my father had chronic end stage respiratory failure simply because he was on a ventilator.

25. During the week of August 24, 2020, I spoke with NP Mahoney, and she gave me an update on my father. During this call, NP Mahoney told me that she was resigning from the facility, because they were not providing the proper care for residents. I thought that she was great. She was the most helpful person at the facility.

26. My father was on a feeding tube but lost weight while at Cold Spring Hills. He looked emaciated. I asked Nancy, the DON, several times if she could speak to the dietary unit to increase his formula to a higher calorie count formula. Nancy told me that it was not necessary. She told me, "Your father has gained weight since he has been at the facility." My father weighed about 117 pounds when he left the hospital and went to Cold Spring Hills. By the time my father left Cold Spring Hills, his weight was down to about 105 pounds.

27. A nurse practitioner at Cold Spring Hills told me that my father was on "weekly weighing." Because my father was in a ventilator unit, I thought, at first, that the facility may have had one of those special beds, like the ones in hospitals, that can weigh a patient. However, my father had a regular nursing home bed. I asked my father if he was being weighed, and he gestured to me "no." As an LPN, I know that the facility must maintain a weight log, and if Cold Spring Hills staff were not weighing him, his weight log must have been falsified.

28. Communication with the facility was terrible. When I would call the facility, and no one answered, I would give up after making five calls. If I happened to reach a voice mail box, the voice mail box would be full, so I was not able to leave a message. When I did get through to the DON, I told her that I had been trying to reach her. The DON asked me why I did not leave her a message on her voice mail. I explained to her that her voice mail box was full. The DON

told me that I was lying because she always listens to her voice mail messages. One night, June 26, 2020, I called the facility at 11:00 p.m. and the certified nurse aide who answered the phone told me that she had no time to speak with me.

29. I was never notified by the facility of any COVID-19 infections at Cold Spring Hills during the height of the pandemic. It was only after the facility allowed visitation that the facility would give me a notification that there was a COVID-19 infection in the facility.

30. My father was not being bathed and he was not receiving any daily care while he lived at Cold Spring Hills. When he was transferred to the hospital from Cold Spring Hills, his hands and in-between his toes were filthy, and he had long crusted nails. At the hospital, my father told me, using gestures in response to my questions, that he was never showered at Cold Spring Hills. I could see during FaceTime calls while he was at Cold Spring Hills that his teeth were not being cleaned and that he had a white film on his lips. I then asked my father if staff was brushing his teeth and he told me no. The speech therapist at Cold Spring Hills told me that they were not providing oral care for him, and they were not brushing his teeth. She told me that she would provide oral care if she had the time to.

31. My father told me that his room was never cleaned and that the nurses would leave old dressings on the floor of his room.

32. My father also told me that Cold Spring Hills was significantly understaffed and that is why nurses and aides did not come into his room unless to provide care or give him his medications. They should have been checking on him more frequently because he was on a ventilator.

33. I purchased new clothes for my father and brought them to Cold Spring Hills the day after he was admitted. I never saw my father in those clothes, and they were never returned when he left Cold Spring Hills.

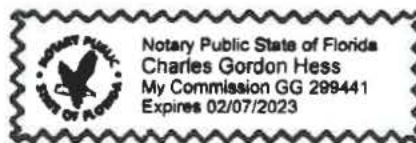
34. In October of 2020, my father was readmitted to NSMH. He had a fever and low blood pressure. The emergency room urologist told me that the catheter was not placed in his bladder but was instead in his prostate. Because of the incorrect placement of the catheter, my father became septic and he was in the hospital for a month. At the end of the month, my father refused to leave the hospital and go back to Cold Spring Hills. He cried like a baby and said that he was not leaving this hospital. My father was traumatized by the way he was treated at Cold Spring Hills. He felt he was left there to die. A staff person at the hospital finally told me that if my father did not leave the hospital, they would have to start charging us. My father did not go back to Cold Spring Hills and instead went to Meadowbrook Care Center ("Meadowbrook") in December of 2020 after being discharged from the hospital.

35. I had to fight to get my father out of Cold Spring Hills. I asked Laura, the social worker, to prepare the necessary paperwork, a Patient Review Instrument called a PRI. It took her a month to do so. This social worker finally prepared the PRI, but she told me that she accidentally faxed it to the wrong facility. She said she would fax it to the right facility, which was Meadowbrook. I called Meadowbrook and asked if they received my father's PRI, and they told me they never received it. When I questioned the social worker about this, she told me that she did send it to Meadowbrook. After that conversation the social worker went on vacation. I made a stink to Ben, the Director of Social Work, and he was able to get it done right away. However, the PRI had to be prepared again because over thirty days had passed since it was first prepared.

36. My father had a heart attack at Meadowbrook and was hospitalized. After being discharged from the hospital, he went to South Shore Rehabilitation & Nursing Center ("South Shore") in Freeport, where he currently lives. South Shore was able to reduce the size of the bed sore and they were able to get him off the ventilator. He is eating again. However, his fingers are still contracted and weak and his ability to ambulate is not the best, all because of the lack of physical therapy at Cold Spring Hills. My father cannot straighten his fingers, his hand looks like he is holding the cardboard tube from inside a roll of paper towel. If my father really tries, he can write with a pen, but not like a person without hand problems. My father also needs a special brace to use a spoon and fork and the handles must be thicker than normal utensils. I wish he had gotten the services he was supposed to get at Cold Spring Hills. He would be doing better now if he had.


Satwattie Davi Singh

Sworn to before me this
12 day of Oct 2022




Notary Public, ~~State of New York~~

No. 299441

Qualified in Marion County

Commission Expires: 02/07/2023

State of Florida
Marion Co

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 complies with the word count limit set forth in Rule 202.8-b as it contains 3,234 words, excluding the parts of the Affidavit explicitly exempted by Rule. 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 15, 2022

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

By:



Christina Pinnola
Special Assistant Attorney General
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In the Matter of an Investigation Pursuant to
N.Y. Exec. Law § 63(12) *re*: Cold Spring Hills
Center for Nursing and Rehabilitation.

**AFFIDAVIT OF
MARGARET GALENO**

STATE OF NEW YORK)
) ss.:
COUNTY OF NASSAU)

Margaret Galeno, being duly sworn, attests as follows:

1. I am 48 years old and reside in Queens, New York.
2. I have been employed as a special education pre-school teacher since February 1996.
3. I submit this affidavit in connection with the New York Attorney General's investigation into Cold Spring Hills Center for Nursing and Rehabilitation ("Cold Spring Hills"), a nursing home located at 378 Syosset-Woodbury Road, Woodbury, New York 11797, and I set forth below my experiences and observations while caring for and speaking with my father, L.G., while he was a resident of Cold Spring Hills.
4. My father was born in 1941, and he resided at Cold Spring Hills from June 18, 2020 to August 5, 2020. He was 78 years old at that time.
5. At the beginning of the COVID-19 pandemic, in approximately March of 2020, I began making healthcare decisions for my father. Making such decisions became too difficult for my mother, and so I took over that role in my family. My mother told me that I was to be the point person for Cold Spring Hills, which I told Cold Spring Hills.

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6. Before his admission to Cold Spring Hills, my father worked for the Brooklyn Union Gas Company, he had two children, my ^{brother} sister and me, ^{mg} and he lived in Howard Beach, New York.

7. My father was a patient at St. Frances Hospital from about the end of March 2020 until June 18, 2020. He had COVID-19 and was on a ventilator. On June 18, 2020, he was transferred to Cold Spring Hills.

8. I do not believe that my father received proper care while he resided at Cold Spring Hills. For instance, he was always wearing a gown, though part of his rehabilitation involved getting him dressed and I had provided clothing for him; no one answered the phone many times when I called and there was no real communication regarding his condition, the condition of his wound, or COVID-19; he did not received the therapies he needed; his fingernails were long and he did not appear to be bathed or clean shaven, though I provided a razor; the staff refused to allow me to FaceTime with him to keep him calm while attempting to wean him from his ventilator; staff were not prepared for a care plan meeting; and there was not enough staff to care for him. I kept a log of the events surrounding my father's residency at Cold Spring Hills.

9. My father was on a ventilator from having COVID-19 and lived on the first floor of the Seacliff Building, in room 106, bed #2, while at Cold Spring Hills.

10. Before he was transferred to Cold Spring Hills, one of the doctors at St. Frances Hospital told me that my father would be able to be weaned off the ventilator.

11. While at St. Frances Hospital, my father developed a bed sore on his butt. It was about two inches (5 cm) by one inch (2.5 cm) and less than 1/8 of an inch (0.3 cm) deep.

12. When my father was first admitted to Cold Spring Hills, he looked good. He was sitting up in a chair and talking with his hands, by making gestures that I could understand. About two weeks later, it all changed. He no longer looked well.

13. Laura Frawley, the social worker ("SW") at Cold Spring Hills, told me that there were three to four staff members for 40 residents. This concerned me so I asked her if I could hire a one-to-one aide for my father. I wanted a one-to-one aide to make sure that my father was being properly taken care of and that he was being turned in his bed so that his bed sore would heal and so that he wouldn't develop any other sores. I was told that the facility did not allow outside people to come into the facility. I was also told that the facility did not believe in one-on-one's because the resident would have a better relationship with the one-on-one and would not listen to the facility staff.

14. When my father was first admitted to Cold Spring Hills, I gave them an electric razor and a bunch of clothes. During the FaceTime sessions with my father, he was always in a gown. When I asked why they were not dressing him, SW Frawley told me that my father did not want to get dressed and they were not going to force him. However, SW Frawley and Director of Nursing ("DON") Nancy Fitzgerald had also told me that getting my father dressed was part of his care and therapy.

15. I also found communication with Cold Spring Hills to be terrible. Most of the time when I called the facility, no one answered. Sometimes I would make many calls in one day, but no one answered any of them. The phone would just ring and ring. Any time someone did answer, I got the run around when I asked questions about my father's care, such as they did not have my father's vital signs, "I am not your father's nurse today," "I am busy," "you have to call back," and "you have to talk to head nurse." I made complaints to the social worker and the head nurse. I

tried to call the administrator, but he never picked up the phone. I left several messages for him, but he never called me back. The social worker called me back instead.

16. The social worker was always upbeat about my father's care and always said that my father was "fine," "do not worry," and "he is in great hands."

17. I never received any COVID-related information from the facility about the number of COVID-positive cases, where the cases were in the building, and if someone who had COVID-19 was in contact with my father. I also did not receive any automated calls from Cold Spring Hills about its COVID-19 response.

18. I had only one care plan meeting at Cold Spring Hills and that was after my father was there for three weeks. During that meeting, the people from Cold Spring Hills who attended the meeting were totally unprepared to answer my questions about my father's care. The therapists from physical, occupational and speech therapy did not show up for the meeting. Instead, the facility had one representative for all three therapies who could not answer any of my questions.

19. My father was supposed to received physical therapy, occupational therapy, and speech therapy in accordance with his care plan, but he only received these services during his first two weeks at Cold Spring Hills. When I asked for my father's therapy schedule, they said that they could not provide me with one. The nurse told me several times that my father was refusing therapy on certain days, however my father told me, by gesturing during FaceTime, that he was not receiving therapy. I did ask him, "Were you sending them away?" and he replied to me, "No." The physical therapist where I worked showed me exercises for my father. While my father was at Cold Spring Hills, I showed these exercises to him when we would FaceTime, and he demonstrated them for me. My father was also able to perform all these exercises when he was in the hospital.

20. During my father's stay at Cold Spring Hills, his fingernails and toenails grew very long. On July 30, 2020, my father told me that he wanted his fingernails and toenails cut. That day, I asked Lorna, a certified nurse aide ("CNA"), about having a podiatrist come into the facility to cut his nails. CNA Lorna told me that the podiatrist comes in once a month, and they were not sure when he was scheduled to come in again. My father's fingernails were never cut while he lived at Cold Spring Hills, and no one ever told me that he was seen by a podiatrist and had his toenails cut or debrided.

21. When I would call Cold Spring Hills to check on my father's bed sore, the person who answered the phone would laugh and then hang up the telephone. On one of those calls, on July 17, 2020, nurse practitioner ("NP") Keisha Mahoney told me that my father was complaining that his "ass" was hurting him. I then asked NP Mahoney how my father's bed sore was, and she said, "it is fine, it's fine." NP Mahoney told me that they were turning him often. However, he was always on his back when I saw him weekly during FaceTime. When I questioned this, the nurses told me that he was "just on his side" and that they had "just finished turning him".

22. Cold Spring Hills had my father on a mattress which had an "A" and a "B" section, which I felt was not good enough to prevent the bed sore from getting bigger. I spoke to SW Frawley and DON Fitzgerald, and they said it would help.

23. The wound care nurse at Cold Spring Hills never contacted me about my father's bed sore. I had to call her, and I only spoke to her once. She told me that the "A" and "B" mattress would be a help in my father's bed sore healing. I told her he also needed to be turned and that he needed a wedge between his knees.

24. During that call, the wound care nurse also told me that the staff was cleaning and changing the dressing on my father's bed sore and that the bed sore was getting better.

25. However, as I describe below, my father was transferred to St. Joseph Hospital on August 6, 2020. When he was sent to the hospital, I learned that his bed sore had increased in size and was down deep, to the bone. The doctor at St. Joseph Hospital told me that the bed sore was a stage 4. He said that he could fit his entire hand into the bed sore. While at St. Joseph's on August 6, 2020, my father told me that he was never turned at Cold Spring Hills.

26. The staff at Cold Spring Hills controlled when I was allowed to FaceTime with my father. When my father was first admitted to Cold Spring Hills, staff told me that FaceTime calls would be scheduled to occur regularly each week, on a specific day and time, but that did not happen. Instead, I had to call Mary Beth from the Recreation Department each week to set-up individual FaceTime meetings. I did ask SW Frawley if I could give my father an iPad, and she said no.

27. When they did allow me to FaceTime with my father, he would shake his head as if to say, "It is not good here." While he was at St. Joseph Hospital, my father told me that he was never alone when he was FaceTiming with me at Cold Spring Hills, so he could not tell me how bad it was there. He also told me that the place was disgusting and filthy. He said that there was not much staff, that no one would talk to him, and that the nurses were not nice to him.

28. The nurses also would not let me FaceTime with my father when they were trying to wean him off the ventilator. I told the nurses that it was important for me to FaceTime with him when they were trying to wean him because my father would panic when they took him off the ventilator, and I thought it would help my father stay calm if he could see me. The nurses wouldn't do it and then they told me that he could not be weaned off the ventilator because he would always panic. I wish they had let me FaceTime with him.

29. During one FaceTime with my father, I noticed that he did not have a call bell. I had to call the facility to tell them to put a call bell in his room.

30. I also had two window visits with my father, one on June 26, 2020, and the other one on August 4, 2020. He was not in his room during these visits. He was in a room that looked like a break room for the nurses. Also, my father was never wearing a mask during these window visits, but the nurses were wearing masks.

31. On August 3, 2020, I spoke to NP Mahoney and learned that my father had a fever of 99.9, was put on antibiotics, and would undergo a chest x-ray.

32. During the August 4th window visit with my father, my family and I could tell that he was in distress. His face was red, he was sweating, he was not breathing right, and the nurses had a towel on his head. I thought he may have had a fever. My father also did not look clean, like he had not been showered. He was also not shaven, and he had a beard, which in my opinion could not be good for someone with a trach.

33. During this visit, I was shocked to learn from staff at Cold Spring Hills that my father was “getting over” pneumonia. At this time, I was unaware he had been diagnosed with pneumonia. When I got home that day, I made several calls to the facility, and at about 6:30 p.m., I was finally able to talk to Ashley from the Respiratory Department who told me that my father was fine. She said it was a hiccup, meaning an episode of anxiety. At approximately 10:30 p.m., I called the facility, and I was told that all of his stats were back to normal.

34. I spoke to CNA Charlene on August 5, 2020, and she told me that my father was okay. On August 5th, at 12:52 p.m., I FaceTimed with my father, and he seemed better, but he was coughing a lot. At 1:27 p.m., I left a message for DON Fitzgerald about my father’s condition. At 3:40 p.m. on August 5th, I received a call from NP Mahoney who told me that my father was being

sent to St. Joseph Hospital because his white blood cell count was high. NP Mahoney also told me that my father did not have a fever and she explained that the chest x-ray that they took on August 3rd, which they took because they thought he had pneumonia, did not show pneumonia. may just be residual since the last x-ray was done. At 3:47 p.m., Cold Spring Hills staff told me that my father was supposed to be leaving for the hospital by ambulance, but he did not arrive at the hospital until 7:07 p.m.

35. On August 6th, Dr. Krichmar, a Cold Spring Hills physician, told me that he told the hospital that my father was being sent to the hospital because of pneumonia. I did not understand how this could be possible because Ashley, from the respiratory department, told me that he was okay two days before, and NP Mahoney had just told me the day before, that his August 3rd x-ray showed no pneumonia.

36. When my father arrived at St. Joseph Hospital on August 6th, he had pneumonia from not being turned while at Cold Spring Hills. When I asked my father on FaceTime whether Cold Spring Hills staff was turning him, he said they were not. St. Joseph Hospital staff raised my father's vent back up to 100%, because his breathing was so labored, and they wanted to give him a break.

37. On August 6th, a nurse at St. Joseph Hospital told me that the source of my father's infection was his G-tube. She told me that it was so infected that it basically "fell out" in the emergency room, and that he had not been getting any nutrition or medication through it.

38. I also learned that the bed sore that my father had when he entered Cold Spring Hills two months earlier was now a stage 4 pressure sore. Another nurse from St. Joseph's told me that my father had sepsis from this bed sore and the infected feeding tube.

39. When I saw my father at St. Joseph Hospital on August 6, 2020, he looked dirty. The nurses at the hospital told me that they were disgusted at the condition he came in from Cold Spring Hills. They told me that they had never seen such neglect from a nursing home. The nurses also told me that my father was severely lethargic and dehydrated. The gastroenterologist told me that my father's feeding tube was not in his stomach and that his body had slowly pushed it out because it was a foreign object in his body, and it was infected. Because of this, the food was not going into my father's stomach. My father was in St. Joseph Hospital for three weeks.

40. On August 12, 2020, another doctor at St. Joseph Hospital told me that my father's bed sore, which was now a stage 4, was down to the bone and the bone was visible. Hospital staff told me that the bed sore was "going to do it in the end for him," meaning that it was going to kill him even if he was able to survive the sepsis.

41. The nurses at St. Joseph Hospital told me that there was no way my father should have come into the hospital in the condition he did, especially being dehydrated. On the advice of those hospital nurses, I filed a complaint with the Department of Health ("DOH"). In October 2020, DOH notified me that their findings were that Cold Spring Hills did nothing wrong, they were not negligent in anything.

42. I also called the Ombudsman, and spoke to someone named Kim, about the lack of care my father received at Cold Spring Hills. Kim told me that I should have been asking the facility for things such as a Geri chair. Kim also told me that I would have to make this call, because she was not allowed to make this type of call for me. Kim told me that she did call Cold Spring Hills and asked if Mr. L.G. (my father) had any complaints. Kim told me that the facility said that Mr. L.G. did not have any complaints. Kim told me that she was unable to visit the

facility because of COVID-19. I thought the Ombudsman would have been able to give me more assistance.

43. On August 30, 2020, my father was transferred from St. Joseph Hospital to Townhouse Center for Rehabilitation and Nursing and then to A. Holly Patterson Nursing Home on September 3, 2020. I have to say that A. Holly Patterson took the best care of my father. The facility allowed my father to have an iPad, and the wound care team at the facility kept me updated on the status of his bed sore.

44. My father passed away on April 28, 2021, at the Nassau University Medical Center, and his death certificate listed his cause of death as complications from a pressure sore, sepsis, and COVID-19.

Margaret Galeno
Margaret Galeno

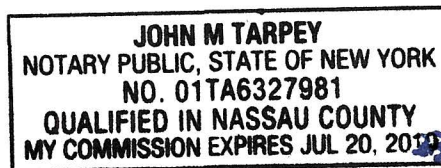
Sworn to before me this
09 day of SEPT 2022

John M Tarpey

Notary Public, State of New York
No. _____

Qualified in _____ County

Commission Expires: _____



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 complies with the word count limit set forth in Rule 202.8-b as it contains 3,218 words, excluding the parts of the Affidavit explicitly exempted by Rule. 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 15, 2022

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

By:



Christina Pinnola
Special Assistant Attorney General
Office of the Attorney General
Medicaid Fraud Control Unit
300 Motor Parkway, Suite 210
Hauppauge, New York 11788
Christina.pinnola@ag.ny.gov

In the Matter of an Investigation Pursuant to
N.Y. Exec. Law § 63(12) re: Cold Spring Hills
Nursing and Rehabilitation.

**AFFIDAVIT OF
CAROL BORRELLI**

STATE OF NEW YORK)
)
COUNTY OF SUFFOLK) ss.:

Carol Borrelli, being duly sworn, attests as follows:

1. I am 60 years old, and I reside in Amity Harbor, NY.
2. I have been a greeter at a local public school for 27 years.
3. I submit this affidavit in connection with the New York Attorney General's investigation into Cold Spring Hills Center for Nursing & Rehabilitation (Cold Spring Hills), a nursing home located at 378 Syosset-Woodbury Road, Woodbury, NY 11797, and set forth below my experiences and observations while caring for and speaking with my father, P.S., while he was a resident of Cold Spring Hills from April 2020 through August 2021.
4. My father was born in 1927. He worked as steward for a construction company for 25 years. He had two children, including me, and he liked to play cards, go to Atlantic City, dance, and sing. He died on August 18, 2021, in a hospice facility in Huntington, New York. He was 94 years old when he died. According to his death certificate, his causes of death were vascular disease and congestive heart failure. I believe he died from a blood infection.
5. I do not believe that my father received proper care while he resided on the short-term rehabilitation ("rehab") unit or later, as a long-term resident. For instance, he was not provided necessary physical therapy, there was a lack of staff and a lack of supplies needed to take

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care of him, in June 2021 he developed a urinary tract infection (“UTI”) and was given Rocephin to treat it, he developed cellulitis on his legs and an infection on his feet that were not being treated properly, there were medication errors, his room, his bathroom and the shower room were not clean, staff did not respond to his call bell and he fell twice, and they put him in diapers that he did not need or want.

6. My dad was admitted to Cold Spring Hills in April 2020 following his discharge from St. Joseph Hospital, in Bethpage, New York, where he was treated for COVID-19. Before going to the hospital, my father lived in his own home, and he had aides come in to help with his daily activities. When he was discharged from the hospital, he was very weak and needed rehabilitation for his muscle weakness. He was lucid, alert, oriented and he could walk with the assistance of a walker after leaving the hospital. He was admitted to Cold Spring Hills as a short-term rehab patient, but after his first 90 days on the rehab unit, he was moved to another unit, in a private room, as a long-term resident.

7. During my father’s 90-day stay on the rehab unit, he begged for rehabilitation care, but only received some services. On separate occasions, a female nurse and Dr. Mombeleur, a facility doctor, told me that there was an issue and they blamed it on Medicaid. There was no recreation, and my father was not allowed to leave his room due to COVID-19. He received physical therapy towards the end of his residence in 2021, which helped him. I really wish he had been receiving this physical therapy the whole time.

8. I visited my father every day, starting in March 2021, when he lived on the long-term unit. When visitation was allowed, I was there Monday through Sunday, from 11:15 a.m. to 6:30 p.m. and spent nights with him whenever he was sick. I walked the corridors at night and often noted lights flashing at the nurses’ station, but no one was around to answer them, so they

just kept flashing. One night, I saw an aide in the corner of the lunchroom watching television, while lights were flashing at the nurses' station. My dad hated nights because no one was around to help him if he needed something, anything. It was a ghost town during the 11:00 p.m. to 7:00 a.m. shift.

9. During my visits to see my father, there were two nurses and three aides on the day shift, from 7:00 a.m. through 3:00 p.m., and one nurse and two aides on the evening shift, from 3:00 p.m. through 11:00 p.m., caring for approximately fifty residents. When I stayed nights, I saw only one nurse and one aide for the fifty residents on his floor during the night shift, from 11:00 p.m. through 7:00 a.m. The one aide was always sleeping.

10. The nurses and aides on my dad's unit often complained to me that they were short staffed and short of supplies. When I spoke to the nursing supervisors and administrators, they told me that the nurses and aides were lying. The nursing staff on the unit also told me that there were days when there were no aides on duty and only one licensed practical nurse ("LPN") on duty for forty-six residents. I saw nothing done to address the shortage of staff and supplies.

11. While my father lived at Cold Spring Hills, I also noted that there was a high turnover rate of nursing staff, including the head nurse on my dad's unit, the supervisors, and even administration.

12. From January 2021 through early March 2021, several nurses, including an LPN named Marina on the day shift, a male nurse, and a few others, made medication errors, which included forgetting to give my dad his medication, giving him the wrong medication, and, on one occasion, I was present when LPN Marina gave my father unnecessary medication. For instance, on another occasion when I was present, my father's feet were swollen, and he was in pain, because they did not give him his Lasix until 2:30 in the afternoon, although he was supposed to receive it

in the morning. I believe that LPN Marina did not look at my dad's medication records before she gave him the medication and that the medication records were not updated. I complained to Dr. Mombeleur, and she spoke with LPN Marina and the male nurse. Dr. Mombeleur told me that she spoke with both of them.

13. In June 2021, my father had a UTI and was treated with antibiotics via IV. The antibiotics were started on June 11, 2021. My father was very ill and close to sepsis at the time. On June 19, 2021, I had to alert LPN Marina that he was due his antibiotics. LPN Marina was not aware of his UTI and that the antibiotic was due. If I had not visited my father that day and told LPN Marina about the antibiotic, he probably would not have received the medication. After my father completed his IV antibiotic treatment, the IV bag and pole was left in the corridor, and LPN Marina brought it back into his room to continue administering the antibiotics. I had to tell her that he was already finished with it because it was his last dose. This medication was for eight days only. The nursing supervisor told Marina that the medication was done.

14. In July 2021, my father was on two IV antibiotics for cellulitis that he had on both of his lower legs, below the knee, and an infection that he had on both his feet and his toes. Our family had to inform the nursing staff that the IV bag was hanging but that the IV antibiotic had not been added.

15. My father was supposed to have treatments done to his feet because of the infection. They were not changing the bandages/gauze pads enough and they were always wet. When I complained to the nurses at the nurse's station, they told me that there was no time and that they had other patients.

16. My father also had neuropathy that started years ago. His nerve endings were gone, and he had no feeling and no blood flow from his knees down. This began when he had quadruple

bypass surgery and it got worse as time went on. He told me that a male nurse, whose name he did not tell me, did not apply his leg wrappings according to the doctor's orders and he did not apply them the right way. His feet were wrapped in a heavy cast with no air circulation. He had black spots on his toes and his toes were oozing clear liquid. The bottoms of both of his feet and his legs were not cleaned. Gel was applied to his toes intermittently and his toes were covered with gauze pads and medical tape around the gauze. I took pictures of my father's legs and feet and have attached them hereto, as Exhibit 1.

17. My father also complained to the male nurse and other nursing staff of pain in his butt, and he was bleeding from above the crack of the buttocks. They were putting a medication that had sulfur ointment above the crack of his buttocks, and he was allergic to it. I told Dr. Mombeleur about this and she changed the medication. He had difficulty sitting because of this and because his skin was like paper. He had to sit on his side which he said was very uncomfortable. The male nurse did not refer him to a doctor. I complained to a nursing supervisor and requested that the male nurse stop being assigned to take care of my father. That nurse supervisor also complained to Dr. Mombeleur, and Dr. Mombeleur spoke with the male nurse about not reporting my father's complaint and his condition to her. The nursing staff told me that it was not a bed sore. Dr. Mombeleur told me that it was from his skin being very thin and she ordered a cream application. I took a photo of my father's buttock area, and have attached it hereto, as Exhibit 2.

18. On one occasion, in July 2021, I asked the nursing staff for my father's blood test results and was denied access and told I could not see them. I reported this to Dr. Mombeleur and asked her for my father's results and the doctor said that the results were in the computer. The

doctor did not attempt to look them up for me or tell the nurse to look them up. I did not pursue the matter after that.

19. On many occasions throughout his stay at Cold Spring Hills, my father had to transfer himself from his chair to his wheelchair and from his wheelchair to his chair, because no one responded to his call bells, and no one was around to help him.

20. My father also fell twice from his wheelchair while at Cold Spring Hills. One time during COVID-19 and one time in June 2021. He was found on the floor by the 7:00 a.m. to 3:00 p.m. cleaning lady both times. Each time, he slid onto his butt and bruised one of his arms. I really don't remember which arm. A nurse told me that he was fine. He was not sent to the hospital.

21. Throughout his stay at Cold Spring Hills, when my father had to go to the bathroom, he had to wait for over one hour for nursing staff to respond to his call bell. This was an ongoing issue. Ninety-five percent of the time, when the staff moved him to the bathroom, they left him there alone. When the nursing staff did not respond to his call bell, he called me on the telephone, and I telephoned the nurses' station. My dad told me that the average call bell wait time was thirty to forty-five minutes.

22. There were also times during COVID-19, when the call bells in in my dad's room and bathroom were not even working and the light above the door to his room was not flashing because it was not working either.

23. When my dad first became a resident, the nursing staff told my dad that he had to wear diapers because "it's easier for him and for them." My father did not want to wear diapers, but eventually he just gave in to what the staff wanted. When he started wearing the Depends, he had to beg for them, and he was allotted only five per day because they didn't have enough of

them. A head nurse advised me and my father that we should purchase our own if he needed more than five. Also, my dad was a size medium, but they kept giving him larger sizes. The larger sizes were too big for him, and they leaked all over and got his bed wet. Cold Spring Hills was also short of chucks-pads, so not only did his bed sheets and blanket get wet, but so did the mattress. The mattress had no mattress cover and there were holes in his sheets and blankets.

24. My father slept all day and did not eat well while at Cold Spring Hills. The food was terrible, and it was served cold. The roast beef was like rubber, and he could not chew it. He frequently did not get the food he requested on the meal form he filled out. I usually brought food from home for him so that he would have something that he would actually eat. The staff would not let me heat the food I brought for him and told they told me it was not allowed. One time, when I asked him how the macaroni and meatballs that my niece brought him were, he told me that he never received any macaroni and meatballs. When my father was admitted to Cold Spring Hills, his weight was approximately 160 pounds. At the end of his residence there, he was approximately 140 pounds.

25. My father's hearing aid was sent out several times to be fixed but it didn't need to be fixed because it was actually working fine. The biggest problem was that the nursing staff did not know how to adjust the volume and place it in his ear properly so that he could hear. Another problem was that the nursing staff did not have batteries available for the hearing aid.

26. In April 2021, my father told me that residents in his unit died of COVID-19. Cold Spring Hills did not notify the families of positive COVID-19 cases at Cold Spring Hills. My family and I did not get any mail correspondence or e-mails from Cold Spring Hills.

27. My father told me that the nursing staff entered his room without proper face masks, gloves, and gowns and that some staff wore street clothes, especially on weekends. My father and I were both vaccinated.

28. At the beginning of my father's time at Cold Spring Hills, they were not following DOH visiting rules. I telephoned the facility many times to schedule appointments to visit my father, but no one answered the phone. On many occasions, I left telephone messages, but did not receive any calls back. On occasions, I waited hours on hold to speak with the nursing staff.

29. In April 2021, Cold Spring Hills was not following DOH visiting rules, again. Cold Spring Hills only allowed visits once a week for thirty minutes and there was no visiting on Sundays. I reported this to DOH and a man from DOH contacted me and confirmed that Cold Spring Hills was not following COVID-19 regulations. After that, Cold Spring Hills corrected their visiting rules within three days.

30. In April and May 2021, my uncle made several attempts to make an appointment to visit my father. My uncle is my father's brother-in-law. My uncle left telephone messages with the social worker and administration and did not get any call backs. On one occasion, in April or May 2021, when my uncle was able to get an appointment, he was told upon his arrival to the facility that the visit was cancelled. An employee named Tom helped my uncle get FaceTime with my father instead. Tom had a big heart. Tom was moved to administration.

31. My father's room and bathroom were not clean. The floors were dirty. I took a picture of the mold in the shower room at Cold Spring Hills, and have attached it hereto, as Exhibit 3.

32. On a Sunday visit in June or July 2021, at 6:30 p.m., my nephew told me that during his visit with my father, a man entered my father's bathroom and cleaned the toilet bowl, the sink

and the floor with the same brush and then that the man entered the rooms of other residents with the same brush.

33. There were only two care plan meetings, and they were held on April 14, 2021, and in July 2021. On April 14, 2021, my father called me and told me that the heat in his room was not working and that he had chills. I went to Cold Spring Hills and asked to see Debbie Flack, the administrator. However, I was told that she was not available, so I asked to speak with Laura, who was also from administration. She, too, was not available. I waited for an hour and a half, and then someone brought me into a conference room, and I saw all the administrators in the room. During this meeting, the Director of Maintenance told me that my father “had neuropathy and that is why maybe he is cold.” I responded to him by telling him that I did not know that he was a doctor. At that meeting, I demanded to see my father, but they said I could not see him because he had a fever. I insisted and they did bring my father down so that I could see him. My father told me, “I have a temperature but this morning they told me I was fine.”

34. During the July 2021 care plan meeting, Administrator, Debbie Flack suggested to me that perhaps Cold Spring Hills was not a good fit for my father, and she suggested that I take him out of Cold Spring Hills and place him in another facility. Flack did not want to hear my complaints about the overall care my dad was receiving. Flack got up and left the meeting before it was over.

35. In July 2021, my father had a fever and chills, and he was on oxygen. Dr. Mombeleur told me that an infectious disease specialist would see my father to check the infection that was running through his body. The infectious disease specialist never came to see my father.

36. When it was time for my father to leave Cold Spring Hills to go into hospice, his transport to the hospice facility was delayed for one day, because Cold Spring Hills called the wrong transport company. They called an ambulette company, rather than an ambulance company.

37. I was in the ambulance when my dad was transported from Cold Spring Hills to the hospice facility. During the transport, a female EMT said to me, "Thank God, you got him out of there."

Carol Borrelli
Carol Borrelli

Sworn to before me this
28 day of September 2022

Allison Gionta

Notary Public, State of New York

No. _____

Qualified in _____ County

Commission Expires: _____

ALLISON GIONTA
Notary Public, State of New York
Qualified in Monroe County
No. 01GI6362539
Commission Expires July 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 complies with the word count limit set forth in Rule 202.8-b as it contains 3,165 words, excluding the parts of the Affidavit explicitly exempted by Rule. 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 15, 2022

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

By:



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