SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

PEOPLE OF THE STATE OF NEW YORK,
by LETITIA JAMES, Attorney General
of the State of New York,

Petitioner,

- against -

COLD SPRING ACQUISITION, LLC D/B/A COLD SPRING HILLS CENTER FOR NURSING & REHABILITATION, COLD SPRING REALTY ACQUISITION, LLC, VENTURA SERVICES, LLC D/B/A PHILOSOPHY CARE CENTERS, GRAPH MGA, LLC, GRAPH MANAGEMENT, LLC, GRAPH INSURANCE COMPANY A RISK RETENTION GROUP, LLC, HIGHVIEW MANAGEMENT INC., COMPREHENSIVE CARE SOLUTIONS, LLC, PHILIPSON FAMILY, LLC, LIFESTAR FAMILY HOLDINGS, LLC, ROSS CSH HOLDINGS, LLC, ROSEWELL ASSOCIATES, LLC, B&L CONSULTING, LLC, ZBL MANAGEMENT, LLC, BENT PHILIPSON, AVI PHILIPSON, ESTATE OF DEBORAH PHILIPSON, JOEL LEIFER, LEAH FRIEDMAN, ROCHEL DAVID, ESTHER FARKOVITS, BENJAMIN LANDA, DAVID ZAHLER, CHAYA ZAHLER, CHAIM ZAHLER, JACOB ZAHLER, CHESKEL BERKOWITZ, and JOEL ZUPNICK,

Respondents.

Index No.: _____

AFFIDAVIT OF DETECTIVE RYAN RICKER

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

Detective RYAN RICKER, being duly sworn, deposes and says:

1. I am a Detective employed by the Office of the New York State Attorney General, Medicaid Fraud Control Unit ("MFCU") assigned to the Hauppauge Regional Office.

2. I have been a Detective with MFCU for over ten years. In my current position I am charged with investigating and prosecuting, civilly and criminally, Medicaid Program provider fraud and patient abuse and neglect in nursing homes and board and care facilities, and protecting the integrity of the Medicaid Program. While serving at MFCU, I have investigated numerous instances of resident abuse and neglect at nursing homes, as well as financial crimes committed against the Medicaid Program.

3. The Attorney General, through MFCU, is investigating resident neglect and Medicaid provider fraud by Cold Spring Acquisition, LLC d/b/a Cold Spring Hills Center for Nursing & Rehabilitation ("Cold Spring Hills"), located at 378 Syosset-Woodbury Road, Woodbury, NY 11797. Cold Spring Hills is registered with New York State Department of Health ("DOH") as having a capacity of 588 certified beds, i.e., a resident capacity of 588. There are five resident buildings located on the property: Sagamore, Woodcrest, Norwich, Brookville, and Seacliff.

4. MFCU has received numerous complaints from Cold Spring Hills' employees and residents and their families. MFCU also has reviewed reports in the news and on social media of inadequate staffing, insufficient services and supplies, and violations of infection control at Cold Spring Hills. These complaints and reports reveal that Cold Spring Hills fails to provide adequate care for residents, resulting in neglect and harm.

5. Since the Spring of 2020, I and other MFCU Detectives have interviewed Cold Spring Hills past and present employees, residents, their family members, and the Cold Spring Hills Ombudsmen. These interviews were extensive. Some of them are reflected in other affidavits submitted with the Petition; some of the others I summarize below.

6. This affidavit and the facts stated herein are based upon my personal knowledge and upon information and belief. The sources of this information and bases for this belief are specified herein. Because this affidavit is being submitted for the limited purpose of supporting the Petition, I have not included details of every aspect of the investigation. Where actions, conversations, statements of others, and the contents of documents are related herein, they are related in sum and substance, except where otherwise indicated.

7. **Witness Interviews; Reliability; Methodology** – Each of the witnesses described below are persons I deem reliable as to the facts reported by them. All of the interviews described below were conducted live, either in person or by telephone or videoconference. Either I or one of my colleagues confirmed that the witnesses are who they purport to be and were in a position to make the observations reported. For example, if a witness purported to be a staff member of Cold Spring Hills, we confirmed that the person appeared in staffing records, as produced by Cold Spring Hills, during the relevant time frame. If a person was a resident or family member of a resident, we confirmed that the person was an in-patient resident at the relevant time or that the family member was providing information about a person who was an in-patient resident at the relevant time, through documents produced by Cold Spring Hills or through Medicaid or Medicare reimbursement claims submitted by Cold Spring Hills, or through documentation such as emails exchanged between the family member and Cold Spring Hills or text messages retained by staffers. If a witness was an outside healthcare professional, such as a nurse practitioner assigned to work at Cold Spring Hills, we confirmed their employment and observed entries made by them in the medical records submitted by Cold Spring Hills.

8. **Confidentiality Concerns: Family Members and Staff Fear Retaliation from Cold Spring Hills** – Some of the witnesses in this investigation expressed strong fear of retaliation

from Cold Spring Hills for cooperating in this investigation. One witness refused to talk with my Detective colleague after expressing a strong concern that if they cooperated in this investigation, their family member, who continues to reside at Cold Spring Hills, would face retaliation from Cold Spring Hills. Cold Spring Hills has identifying information for residents' family members and this resident is entirely dependent on Cold Spring Hills for all of their needs. The family member expressed concern on behalf of their loved one and reported a lack of care for their family member and a fear that the care provided to their family member would further decline in retaliation for cooperation in this investigation. This family member also reported a lack of responsiveness from a former administrator at Cold Spring Hills when they had previously expressed concern regarding the lack of care of their loved one. Similarly, staff members of Cold Spring Hills would speak with me and my Detective colleagues only on our assurance of confidentiality and that their identities would be protected; they feared that ownership and management of Cold Spring Hills would discover their cooperation with the investigation.

9. Because of these and other confidentiality concerns, some individuals referenced in this affidavit are identified by initials or aliases; the names of these individuals are known to me.

CHRONIC INSUFFICIENT STAFFING AT COLD SPRING HILLS HAS RESULTED IN NEGLECT[1]

Staff Describe Chronic Staffing Shortages

10. EMPLOYEE 1 is an individual whose identity is known to me and who has worked at Cold Spring Hills for over eight years. I interviewed EMPLOYEE 1 on several occasions

[1] New York law defines "neglect" as the "failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care . . . including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living." Affidavit of Medical Analyst Mary Conway, R.N. ("Medical Analyst Aff.") ¶ 18 (citing 10 NYCRR § 81.1(c)).

between August 25, 2020 and May 27, 2022 about the conditions at Cold Spring Hills, including its staffing. EMPLOYEE 1 told me that as of May 27, 2022, Cold Spring Hills operates without sufficient staff to cover all shifts necessary to care for residents' needs. Rather, staff are mandated to work beyond their scheduled shifts. These longer hours add stress to the lives of the staff and has caused more "callouts," meaning staff are not coming to work.

11. EMPLOYEE 1 explained that the insufficient staffing has also caused more "floating," i.e., staff moved from their regular unit to a different one, which prevents the staff from getting to know the residents.

12. EMPLOYEE 1 told me how insufficient staffing at Cold Spring Hills has resulted in residents falling more frequently, waiting longer to receive their medication, waiting longer for assistance to go to the bathroom, and sitting in feces waiting to be changed; they also do not receive proper hydration, or their showers or meals on time – and when they do get their food, they are rushed to eat quickly.

13. EMPLOYEE 2 is an individual whose identity is known to me and who has worked at Cold Spring Hills for more than eight years. I interviewed EMPLOYEE 2 on several occasions between August 20, 2020 and May 27, 2022 about the conditions at Cold Spring Hills, including staffing. On May 27, 2022, EMPLOYEE 2 confirmed that Cold Spring Hills' staffing numbers were still low. They said, like EMPLOYEE 1, that because of the low staffing levels, staff are required to work longer hours and carry heavier workloads.

14. EMPLOYEE 2 told me that Cold Spring Hills administration mandates staff to work additional hours; if a staff member tries to refuse, they are threatened with being written up or terminated.

15. EMPLOYEE 2 explained that the heavier workloads create friction amongst the staff and stress on the units. Staff feel rushed to finish with one resident and move on to the next resident. Some staff are "double diapering" residents to save time: staff will put two diapers on a resident so that when the resident needs a clean diaper,[2] a staff member will pull down both, take off the dirty one, and then pull the clean one back up.

16. EMPLOYEE 2 emphasized that low staffing prevents staff from developing relationships with the residents.

17. Despite the staffing issues, EMPLOYEE 2 told me that Cold Spring Hills laid off approximately 24 staff members between September and November 2020.

18. EMPLOYEE 3 is an individual whose identity is known to me and who has worked at Cold Spring Hills for over six years. On November 4, 2021, I interviewed EMPLOYEE 3, who told me that staffing has always been an issue at Cold Spring Hills - before, during and after the peak of the COVID-19 pandemic. At the time of the interview, EMPLOYEE 3 was regularly assigned to care for eleven residents, rather than the eight residents they should have been assigned. They have additional residents to care for because there are usually not enough certified nurse aides ("CNAs") assigned to the unit during shifts. For example, on the 7:00 a.m. to 3:00 p.m. shift there should be five CNAs, but there are usually only four.

19. EMPLOYEE 3 also explained that, at the time of the interview, there were a lot of staff at Cold Spring Hills who are employed by a staffing agency.

20. EMPLOYEE 4 is an individual whose identity is known to me and who has worked at Cold Spring Hills for over ten years. On October 27, 2021, I interviewed EMPLOYEE 4, who said that low staffing has been a major issue at Cold Spring Hills since before the COVID-19

[2] "Diapers" also includes disposable incontinence briefs or adult briefs.

pandemic – that it had been a problem and getting worse since at least 2017. Because of this, EMPLOYEE 4 has had to take time away from their nursing duties to perform CNA duties.

21. Other Cold Spring Hills staff members also said staff members have been "floated":

a. EMPLOYEE 5 is an individual whose identity is known to me and has worked at Cold Spring Hills for over eight years. On September 30, 2021 and January 19, 2022, I interviewed EMPLOYEE 5, who said that when the Sagamore building was closed,[3] its staff were placed on a floater list and assigned wherever they were needed.

b. EMPLOYEE 6 is an individual whose identity is known to me and has worked at Cold Spring Hills over three years. On September 25, 2020, EMPLOYEE 6 explained in an interview that they were a "float" nurse who was primarily assigned to a particular unit.

Ombudsmen Corroborate Poor Staffing

22. Members of the New York State Office for the Aging Ombudsman Program ("Ombudsmen") are advocates for nursing home residents and assist them in understanding and exercising their rights to good care in an environment that promotes and protects their dignity and quality of life. Ombudsmen receive extensive training before being certified, including on the aging process and its common illnesses and conditions, the long term care setting, residents' rights, and the complaint process. *See* https://aging.ny.gov/ltcop/helpful-information-residents-and-families. The Ombudsmen identify issues raised by residents and family members and work with

[3] The Sagamore building was closed during the summer of 2020. *See* Affidavit of Senior Auditor-Investigator Patrick Beltrani ("Auditor Aff.") ¶ 229 (citing the Affirmation of Special Assistant Attorney General Christina Pinnola ("SAAG Aff."), Exhibit 11 (Transcript of examination pursuant to Executive Law § 63(12) of Denise Cagno dated December 1, 2020 at page 117).

the staff of the corresponding nursing home to resolve these issues. If an issue is not resolved, the complaint is referred to DOH or another appropriate agency for investigation and any appropriate regulatory action.

23. On December 28, 2021, I interviewed five Ombudsmen, who identified staffing issues at Cold Spring Hills. According to the Ombudsmen, during a Resident Council[4] meeting a few months earlier, Gina Iovino, the President of Nursing at Cold Spring Hills, acknowledged and apologized for the staffing shortage at Cold Spring Hills.

INSUFFICIENT COMMUNICATION, STAFFING, AND SUPPLIES DURING THE PEAK OF THE COVID-19 PANDEMIC AND THEIR NEGATIVE EFFECTS ON STAFF AND RESIDENTS

24. EMPLOYEE 5 told me that during the height of the COVID-19 pandemic, working at Cold Spring Hills was so very stressful that they would sit in the car and cry for thirty minutes before going home from work.

25. EMPLOYEE 4 said a prayer on the way to work every day because they were risking their life going to Cold Spring Hills. During the pandemic, it was as if they were playing Russian Roulette every day, living in fear of catching the virus and bringing it home to family members – so they kept their distance from family, while at home.

26. EMPLOYEE 4 described a vivid memory of hearing a resident on their assignment repeatedly call out, "Don't leave me, I can't breathe." The resident had complained for two days they could not breathe, but the Medical Director denied an x-ray. The resident died soon after; pneumonia was listed as the cause of death on the death certificate.

[4] The New York State Office for the Aging explains: "Federal law requires that nursing homes assist in the establishment of resident councils. These councils provide a vehicle for resident participation in decision-making, grievances, and resolving differences. . . ." https://aging.ny.gov/ltcop/helpful-information-residents-and-families

27. EMPLOYEE 5 said that when they were notified during their shift that they tested positive for COVID-19, Cold Spring Hills' Director of Nursing ("DON") told EMPLOYEE 5: "You're asymptomatic, keep quiet, you're going to stay, and don't tell anyone." The DON made EMPLOYEE 5 finish their shift.

28. EMPLOYEE 5 further described that when staff were sick and tried to stay home, Cold Springs Hills management threatened them with lost pay or termination. Staff were also mandated to work double shifts and were threatened by the DON with termination if they did not. EMPLOYEE 5 said the Administrator, Yossi Emanuel, condoned these threats.

29. EMPLOYEE 2 further explained that staffing levels per unit should have included a registered nurse ("RN"), one to two licensed practical nurses ("LPNs"), and five CNAs, but that during the pandemic peak there was typically an RN covering three units, and each unit having only one LPN (or sometimes none) and only two CNAs.

30. EMPLOYEE 7 is an individual whose identity is known to me and who has worked at Cold Spring Hills over four years. In a September 14, 2020, interview, EMPLOYEE 7 said that in March 2020, at times they cared for about 20 residents, rather than the 10 they were supposed to at Cold Spring Hills.

31. EMPLOYEE 7 said Cold Spring Hills had limited personal protective equipment ("PPE") and had not announced the presence of COVID-19, even when two residents EMPLOYEE 7 was caring for became very ill with COVID-19 symptoms. EMPLOYEE 7 lacked PPE and tested positive for COVID-19 soon after treating these residents. EMPLOYEE 7 had to quarantine outside of work; Cold Spring Hills refused to pay EMPLOYEE 7 while they were not at work, sick with COVID-19.

32. When EMPLOYEE 7 returned to work, they were given one N-95 mask, a gown and a face shield, which were to last a while. Nursing staff would wear plastic bags when they were short of gowns.

33. EMPLOYEE 8 is an individual whose identity is known to me and worked at Cold Spring Hills for more than ten years. In an October 5, 2020, interview, EMPLOYEE 8 said that they contracted COVID-19 in March 2020 while working at Cold Spring Hills. They confirmed that PPE was difficult to find during March 2020 and upon their return to Cold Spring Hills after having COVID-19. EMPLOYEE 8 believed the seven residents who died on their floor during that time died from COVID-19. EMPLOYEE 8 believed their unit did not have enough staffing. EMPLOYEE 8 often had to help the CNAs in addition to performing their own duties of treating, assessing, and giving medication to residents.

34. EMPLOYEE 4 also confirmed that PPE had been difficult to get at Cold Spring Hills, at least early on during the COVID-19 pandemic, with staff buying it for themselves online. Some staff wore garbage bags while at work but were disciplined for doing so.

35. EMPLOYEE 2 learned that in March 2020 several residents died. In late May 2020, Cold Spring Hills stopped posting signs on the doors of residents who were suspected or confirmed COVID-19 positive. During the same time, infected and non-infected residents were not segregated. After this, many staff members became ill with COVID-19. EMPLOYEE 2 explained that in November 2020, PPE again became hard to acquire and Cold Spring Hills employees continued to get COVID-19. Even by December 2021, PPE was still not always available.

36. EMPLOYEE 6 described the lack of PPE and signage, early in the pandemic, necessary to inform staff of residents suspected or confirmed to have COVID-19 who came from the hospital and were placed on contact precautions.

37. EMPLOYEE 4 also noted that during the height of the pandemic, there was no housekeeping in residents' rooms because Cold Spring Hills did not provide housekeeping staff with PPE; housekeeping staff did not enter residents' rooms.

38. EMPLOYEE 2 provided a photo to MFCU taken in May 2020, a true and correct copy of which is below, that shows a dayroom in the Sagamore building where the wheelchairs were being stored. He explained these were wheelchairs of residents who had died.

CHRONIC NEGLECT BY COLD SPRING HILLS BEFORE, DURING AND AFTER THE HEIGHT OF THE FIRST WAVE OF THE COVID-19 PANDEMIC TO PRESENT, RESULTING IN POOR CARE, LOSS OF DIGNITY

Family Members Report Failure to Properly Care for Residents' Illnesses, Injuries and Conditions

39. Family members also reported failures to properly care for residents' illnesses, injuries and conditions.

40. One family member, Caroline Powers, described her grandfather, M.W., a former attorney, as easy to get along with. Ms. Powers said M.W. was admitted to Cold Spring Hills for rehabilitation in July 2020, upon his discharge from the hospital after being treated for falling and being unable to walk. He was at Cold Spring Hills for a little over two weeks before he returned to the hospital. Medical Analyst Aff., ¶¶ 107-108. Ms. Powers noted that her grandfather died at age 89.

41. Ms. Powers said that Cold Spring Hills failed to rehabilitate her grandfather's legs properly, instead leaving him in bed. Ms. Powers stated that her grandfather told her that Cold Spring Hills also failed to turn and position him as they should have, despite this being very important, as he was also susceptible to pneumonia.

42. Ms. Powers said that in August 2020, a Cold Spring Hills nurse telephoned Ms. Powers to tell her that they could not stabilize her grandfather's oxygen level and they wanted to transfer him to the hospital. When M.W. arrived at Plainview Hospital, she was told that he had severe pneumonia. The staff at Plainview Hospital told Ms. Powers that M.W.'s condition was the worst case of neglect that they had seen. One nurse in particular was very upset and told Ms. Powers that her grandfather's existing pressure injury did not happen overnight; an injury like that takes a while to develop. Ms. Powers said that when that hospital nurse called Cold Spring Hills to discuss her grandfather's condition, the person at Cold Spring Hills hung up on the hospital nurse. Ms. Powers further stated that her grandfather also had sepsis. Her grandfather died on August 22, 2020.

43. Another family member, Maria Arrazola, spoke with me on June 1, 2022, about her father, C.A. C.A. was a resident at Cold Spring Hills from late 2020 through November 2021. Medical Analyst Aff., ¶ 103. Ms. Arrazola's father was in his early 60s at the time; he was a jeweler

and [redacted] who helped rehabilitate people who had problems with [redacted]. She stated that prior to Cold Spring Hills, he had been in Winthrop Hospital with COVID-19, after which he transferred to Cold Spring Hills for long term care because he had suffered a bad stroke. Ms. Arrazola described that her father "could not do anything for himself, he was bedridden."

44. Ms. Arrazola is a CNA who worked at a hospital at the time of our discussion. She had worked at Cold Spring Hills in around 2018. She convinced her family to place her father in Cold Spring Hills because, at the time, she considered it to be a "good place" with "good people."

45. Ms. Arrazola stated that she now feels "so bad" about that decision because her father did not receive proper care at Cold Spring Hills. Ms. Arrazola said that when her father was admitted to Cold Spring Hills, he had a serious pressure injury, but while her father was at Cold Spring Hills, staff almost never got him out of bed – she saw her father in a chair only five of six times. And so, the pressure injury did not improve.

46. Ms. Arrazola recalled that her father was transferred to the hospital during his stay at Cold Spring Hills because his pressure injury appeared to have had gotten worse; it was darker and there was concern about infection. Upon examination at the hospital, it was determined that her father's pressure injury was not infected.

47. Another family member, Kimberly Biederman, spoke with me on June 1, 2022. Ms. Biederman's mother, L.K., was a resident at Cold Spring Hills from June 2020 through September 2020. Ms. Biederman's mother was 78 years old at that time. She had been a manager in a jewelry department, the wife of a retired police detective, a grandmother, and an avid churchgoer. Ms. Biederman said her mother was admitted to Cold Spring Hills for wound care and rehabilitation following surgeries to have a tendon removed, and then to have a skin graft performed for a wound

on her leg due to a radiation burn from a cancer treatment. Ms. Biederman said that, as part of L.K.'s treatment, a wound vac[5] was placed on her leg.

48. Ms. Biederman stated that while L.K. was living at Cold Spring Hills, she had weekly appointments with the outside surgeon who was treating her leg. On several occasions when L.K. arrived to her appointment with the surgeon, however, the surgeon identified that her wound vac was not operating. According to Ms. Biederman, Cold Spring Hills staff did not know for how long the wound vac was not working, nor had they documented it or alerted the surgeon that it was not working. Because Cold Spring Hills was not monitoring the wound vac, the surgeon removed it, stating the dressing should remain on the wound and changed regularly. But when L.K. next returned to the surgeon from Cold Spring Hills, the dressing on her leg wound had not been changed when it should have been.

49. Ms. Biederman added that during one of Ms. Biederman's mother's hospital transfers from Cold Spring Hills, hospital staff told her that her mother had a small bed sore. (This is separate from L.K.'s leg wound and is referred to herein as the "pressure injury.") After her mother transferred back to Cold Spring Hills, a Cold Spring Hills nurse practitioner told Ms. Biederman that her mother had a stage 2 pressure injury. [6] When her mother was later preparing to see the outside surgeon for her leg, a wound nurse at Cold Spring Hills told her that the Cold Spring Hills wound doctor wanted the surgeon to debride[7] the pressure injury and if he did not debride it, her mother would have to be sent to the hospital. However, the surgeon told Ms.

[5] A wound vacuum, or "wound vac," is a piece of equipment or a device that is attached to a wound to promote its healing. Medical Analyst Aff., ¶ 89.
[6] Pressure injuries are categorized by four possible stages of increasing severity: 1 to 4, with stage 4 being the most severe. Medical Analyst Aff., ¶ 48.
[7] Debridement is a procedure for treating a wound that involves the removal of infected, unhealthy or dead tissue to improve healing and decrease infection. It is often performed surgically with a small scalpel, or by use of a topical ointment. Medical Analyst Aff., ¶ 53 & FN13.

Biederman that debriding the pressure injury did not require going to the hospital; rather, if Cold Spring Hills changes the dressings, it will debride naturally.

50. Cold Spring Hills staff eventually told Ms. Biederman that her mother's pressure injury was unstageable.[8] Then, a few days before her mother left Cold Spring Hills at the end of September 2020, a wound nurse at Cold Spring Hills told Ms. Biederman for the first time that her that her mother's pressure injury was a stage 4 and the nurse taught her how to change the dressing. Ms. Biederman recounted that before this, no one at Cold Spring Hills had told her that the pressure injury had progressed to a stage 4. Ms. Biederman saw her mother's pressure injury for the first time when she brought her mother home and said it is "the most horrific thing I [have] ever seen in my life, you could literally take your fist an [sic] put [it] into the bed sore." She said that a homecare nurse, shocked when she saw it, measured it as 10 cm x 10 cm and 5 cm deep. Ms. Biederman took a photograph of her mother's wound on September 30, 2022, two days after she brought her home. A true and correct copy of that photograph is attached hereto as **Exhibit 1**.

51. Ms. Biederman's mother is now at another facility; the doctors there said that her mother's pressure injury might get smaller, but it will never go away.

52. On February 14, 2022, I interviewed [redacted]. [redacted] said [redacted], [redacted], whose identity is known to me (her "parent" or "Resident 47"[9]), was born in [redacted] and was admitted to Cold Spring Hills in November 2020, at age [redacted] after a ministroke. Resident 47 was a Cold Spring Hills resident at the time of the interview but has since died. Resident 47 also had dementia. Resident 47's daughter said that Resident 47 was ambulatory when admitted to Cold

[8] While some pressure injuries can be categorized by four possible stages of increasing severity, stages 1 to 4, some wounds are unstageable, which means the extent of the injury cannot be determined. An unstageable pressure injury is nevertheless very serious. Medical Analyst Aff., ¶¶ 48-49.

[9] Resident 1 through Resident 46 are referenced in the Auditor Aff., Exhibits thereto, and Exhibits to the SAAG Aff.

Spring Hills, meaning, able to walk around. Resident 47 lived in the rehabilitation unit for the first six months and was then moved to the dementia unit. Resident 47's daughter stated that, following a fall by Resident 47 at Cold Spring Hills, she requested a wheelchair for Resident 47. Cold Spring Hills provided a wheelchair, but it did not have footrests and thus Resident 47's feet dragged on the floor. Resident 47's daughter then had to request that Cold Spring Hills provide a footrest attachment.

Family Members Detail Neglect in the Provision of Nutrition

53. Numerous family members also described neglect in the provision of nutrition.

54. Although he was on a feeding tube, Ms. Arrazola said that her father lost a lot of weight during his stay at Cold Springs Hills.

55. Ms. Arrazola said to me that her father did not receive his meals on time.

56. Ms. Arrazola also said that when Cold Spring Hills began visitations again, she and her sisters took turns visiting their father. She visited in the evenings from 7:00 p.m. to 8:00 p.m. three times per week, and her sisters each visited in the mornings and sometimes in the evenings several times per week. When they visited, they found their father's gown wet with food from his feeding tube.

57. Resident 47's daughter stated that Resident 47 did not eat well when Cold Spring Hills staff served Resident 47 meals in their room (rather than in the dining room) because Resident 47 needed assistance to eat. However, no one would assist them, which their daughter attributed to a lack of staff.

Family Members Describe Neglect in the Provision of Basic Care Including Showering, Grooming, Dental Hygiene and Dressing

58. Family members reported neglect in the provision of basic care including showering, grooming, dental hygiene, and dressing.

59. Ms. Arrazola further said that staff had told her that for more than seven months they could not give her father showers because of COVID-19. Instead, he was to receive a bed bath two times a week – but even these staff did not provide regularly. Ms. Arrazola would FaceTime with her father one to two times per week in the afternoons; she could see he was being neglected and he was not receiving daily care. He was not shaven, his nails were not cut, he had lots of dandruff, and the skin around his "face was flakey." She notified the facility, and although initially responsive, it soon took staff about a week to return her calls, and still they did nothing to fix the situation.

60. In addition, Ms. Powers stated that when her grandfather was at the hospital in August 2020 after being at Cold Spring Hills, he told her that he had not been bathed regularly there. Moreover, according to Ms. Powers, Cold Spring Hills did not provide dental care to her grandfather and staff did not cut his fingernails and toenails. Once transferred from Cold Spring Hills to Plainview Hospital, hospital staff tended to his nails.

Ombudsmen Receive Complaints of Neglect in the Provision of Basic Care

61. During my December 28, 2021 meeting with the Ombudsmen, they informed me that they have received complaints about Cold Spring Hills regarding a lack of care, including that residents were not receiving regular showers.

62. The Ombudsmen also told me that they received complaints regarding Cold Spring Hills losing residents' clothing.

Family Members Describe Staff Putting Residents in Incontinence Diapers for Convenience

63. Family members also reported that staff put residents in incontinence briefs for staff convenience.

64. Resident 47's daughter said that Resident 47's bathroom door at Cold Spring Hills was jammed during a period of about four-months in 2021, and without bathroom access, Resident

47 would defecate and urinate on the floor of their room, which Resident 47's daughter saw when she visited. Resident 47's daughter described that Resident 47 wore diapers during that four-month period in 2021.

Family Members Describe Medication Delays and Errors

65. Family members reported medication delays and errors.

66. For example, Ms. Arrazola said her father was supposed to receive his medication every four hours, but he did not receive it for approximately six hours.

Family Members Detail Lack of Staff Responsiveness to Residents

67. Family members also detailed a general lack of staff responsiveness to residents, including a failure to respond to assist with toileting and to change incontinence diapers.

68. Ms. Arrazola said that when she and her sisters visited their father, they found his bed was soaked with urine and his room smelled of urine at least twice each week. She stated that there was something wrong every time they visited. When Ms. Arrazola questioned staff about her father's bed being wet with urine and his room smelling of urine, they told her that her father wets alot and claimed they recently changed him and said they would change him again. Ms. Arrazola, however, being a CNA, would end up changing her father because Cold Spring Hills staff took too long.

Staff Member Describes Lack of Staff Responsiveness to Residents

69. EMPLOYEE 2 provided to MFCU a photograph, a true and correct copy of which is included below, which was taken at Cold Spring Hills in August 2020. It shows a torn, cracked, and filthy mattress -- illustrative of a resident care problem caused by lack of supplies and understaffing.

70. In addition, in August 2020, EMPLOYEE 2 informed MFCU that it was said in an August 2020 meeting that chucks pads (bed pads) will no longer be used and this is a way to hold the nursing staff accountable for providing the residents with toileting assistance in a timely manner.

Ombudsmen Receive Complaints of Lack of Socialization and Recreation

71. In December 2021, the Ombudsmen told me that they had received complaints about a lack of socialization and activities for Cold Spring Hills residents during the COVID-19 pandemic. Residents were socially isolated and had to remain in their rooms with no activities provided. The Ombudsmen further said the residents were suffering from depression.

72. The Ombudsmen said Cold Spring Hills does not emphasize resident mental health; there is no one there interacting with residents.

REPORTED ABUSE AND MISTREATMENT[10]

73. Family members also reported abuse and mistreatment.

74. For example, Resident 47's daughter said that she made morning visits to Cold Spring Hills between March 2021 through June 2022, which occurred two to three times per week. She noted that Resident 47 spent a lot of time in a wheelchair in the dining room at Cold Spring Hills. On at least one occasion, she observed Resident 47 in their wheelchair pushed up against a table in the dining room with the wheels locked and their body pinned to the table to prevent movement. Although a Cold Springs Hills' supervisor said this was done for safety reasons, Resident 47's daughter, who had been working [redacted], considered this to be a restraint.

COLD SPRING HILLS FAILED TO PROVIDE CLEAN ROOMS IN GOOD REPAIR AND SANITARY CONDITIONS FOR ITS RESIDENTS, RESULTING IN LOSS OF DIGNITY, DISCOMFORT AND PLACING RESIDENTS AT RISK FOR INFECTION

Staff Describe Unsanitary Conditions

75. EMPLOYEE 2 relayed numerous unsanitary conditions at Cold Spring Hills. For example, they stated that Cold Spring Hills did not use dish soap to wash the dishes – they were washed only with hot water.

76. EMPLOYEE 2 also said that the buildings were not being cleaned properly. They described feces and mold on the walls of the building and feces on bedsheets. They said there were water leaks in the ceilings of the Seacliff and Brookville buildings, and mold on the water filters in the Brookville, Woodcrest, and Seacliff buildings.

Family Members Describe Unsanitary and Uncomfortable Conditions

[10] "Mistreatment" means "inappropriate use of medications, inappropriate isolation or inappropriate use of physical or chemical restraints on or of a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility . . . ." Medical Analyst Aff., ¶ 18 (citing 10 § NYCRR 81.1(b)).

77. Family members also described unsanitary and uncomfortable conditions.

78. As noted, Resident 47's bathroom door at Cold Spring Hills was jammed. Without bathroom access, Resident 47 would defecate and urinate on the floor of Resident 47's room.

79. Resident 47's daughter complained to the nurses and the receptionist about Resident 47 having to defecate and urinate on the floor of their room because of the jammed bathroom door. Yet, it still took nearly four months for the door to be repaired.

80. Resident 47's daughter said Resident 47's room was dirty in other ways, including: pudding and other food on the floor, flies in the room, and broken blinds. Only after she complained about the conditions did Cold Spring Hills clean the room and replace the blinds. Resident 47's daughter provided MFCU a photograph of the dirty floor in her parent's room at Cold Spring Hills, a true and correct copy of which is attached hereto as **Exhibit 2**.

COLD SPRING HILLS HAS BEEN OPERATING WITH INSUFFICIENT SUPPLIES

Staff Describe Chronic Shortages of Supplies

81. EMPLOYEE 2 also said that there was a shortage of towels for the Cold Spring Hills residents as recently as September 2021 and bedsheets for them from at least September through December 2021.

82. EMPLOYEE 2 also said there was a shortage of bedsheets, diapers and chucks pads (bed pads) for the residents as recently as December 2021.

83. When I spoke with EMPLOYEE 2 on December 21, 2021, they further stated that there are locks on the refrigerators in the dayrooms in the Norwich buildings, preventing the residents from accessing their drinks.

Ombudsmen Describe Chronic Shortages of Supplies

84. In our December 28, 2021 meeting, the Ombudsmen also informed me that there has been a chronic shortage of supplies at Cold Spring Hills – starting before the peak of the COVID-19 pandemic. For example, there has been a chronic shortage of disposable diapers since approximately 2009. The Ombudsmen said that the current Cold Spring Hills Administrator, Josef Simpser, knew about the shortage of briefs.

INFREQUENT, UNRELIABLE, AND INSENSITIVE COMMUNICATIONS FROM COLD SPRING HILLS STAFF

Family Members Say Cold Spring Hills' Communications Were Infrequent, Unreliable, and Insensitive

85. Family members also described infrequent, unreliable, and insensitive communications from Cold Spring Hills staff.

86. For example, Ms. Powers' grandfather was fed pureed food at Cold Spring Hills because he could not swallow. Once, when she was Face Timing with her grandfather, Ms. Powers observed a member of staff feeding her grandfather in a manner that she described as "force feeding" him during their call. This was dangerous because her grandfather had difficulty swallowing and would choke on food. He was also susceptible to pneumonia. The nurse motioned to the social worker holding the phone, then the FaceTime session ended. Concerned, Ms. Powers then tried to call the social worker and the nurses' station about what she had seen, but no one answered. When she finally did reach someone at the nurse's station, they told her they were busy.

87. Ms. Powers noted that communication with Cold Spring Hills staff was always poor. They never initiated communication with her and they did not answer the phone when she would call. She had to call multiple times before she would reach someone. And when she did manage to speak with a social worker, they always "painted a picture of sunshine and rainbows" and deflected her questions about her grandfather's care.

88. Resident 47's daughter said that Cold Spring Hills upper management is absent. She said that she left messages for management to call her but never received a call back.

89. Ms. Arrazola also said that, despite requests made to the wound nurse, social worker and head nurse on her father's floor for updates on the progress of her father's pressure injury, her family only received one, maybe two, calls from the wound nurse during her father's residency.

90. Russell Barbara's mother, K.B., resided at Cold Spring Hills for approximately ten years until she died there in April 2020. Mr. Barbara first learned from his mother that COVID-19 was present in Cold Spring Hills when she told him about it – in a whisper – on April 6, 2020; she also said she was told to "keep it quiet." Two days later, on April 8, 2020, Mr. Barbara spoke with his mother's nurse care manager, who told him, "they let it in . . . it's [COVID-19] everywhere . . . we're overrun with sick residents." Two days after that, on April 10, 2020, Mr. Barbara received a call from Cold Spring Hills that his mother had taken a turn for the worse. A nurse tried to facilitate a phone conversation with his mother, but his mother could not speak clearly, and the nurse took the phone back and told Mr. Barbara, "We're not set up for this," that Cold Spring Hills was short-staffed, and that staff was not allowed to go home. His mother was taken to the hospital and died later that day. Before his mother's death, Cold Spring Hills made no official communication to Mr. Barbara regarding his mother's exposure to COVID-19.

91. Nancy Gertler's mother, F.G., resided at Cold Spring Hills for over seven years. Ms. Gertler spoke with her mother via FaceTime on April 3, 2020, and was alarmed to see her mother in a communal dining room – Cold Spring Hills previously sent a communication that it was suspending communal dining due to COVID-19 concerns. Six days later, on April 9, 2020, during another FaceTime call, Ms. Gertler noticed her mother was lying in her bed and could not

sit up. The next day, on April 10, 2020, Cold Spring Hills staff told Ms. Gertler that her mother had been placed on "limited contact," but they did not communicate anything regarding her mother's condition having changed. Two days later, on April 12, 2020, Ms. Gertler received a call from RN Candida Saagber who told her that her mother did not look good, she was not breathing well and many people at Cold Spring Hills were dying. About two hours later, Ms. Gertler received a call from Cold Spring Hills telling her that her mother had died. She asked if her mother had COVID-19 and was told that Cold Spring Hills did not know because it was not testing residents for COVID-19. Prior to her mother's death, Cold Spring Hills did not inform Ms. Gertler that her mother was exposed to COVID-19.

92. Thomas Granito, Jr.'s mother, M.G.2, resided at Cold Spring Hills for approximately five years. Mr. Granito's mother was doing fine there until April 7, 2020, when he was told that his mother was not eating or drinking. Two days later, on April 9, 2020, Cold Spring Hills informed Mr. Granito that his mother would probably not live through the night. He went to Cold Spring Hills but was refused entry; after that, he attempted to FaceTime his mother without success. Mr. Granito never said goodbye to his mother. Prior to her death Cold Spring Hills did not tell Mr. Granito that his mother was exposed to COVID-19. Four months later, on August 18, 2020, Mr. Granito ran into a nurse who had worked on his mother's floor at Cold Spring Hills. The nurse told him that the floor where his mother resided "got decimated" by the virus.

93. Connie Virone-Mahoney's mother, C.V., resided at Cold Spring Hills for more than two years until her death in April 2020. Ms. Virone-Mahoney received a call from Cold Spring Hills on April 6, 2020, that her mother had a fever and that the doctor believed she had a urinary tract infection and would be treated for it. Two days later, on April 8, 2020, Ms. Virone-Mahoney received a call from a nurse practitioner who told her that her mother's fever was worse. Ms.

Virone-Mahoney asked if COVID-19 was present at Cold Spring Hills and the nurse practitioner told her that it was present, but on another floor, and that "people are dying here." Ms. Virone-Mahoney had not otherwise received any notification from Cold Spring Hills that COVID-19 was present at the facility. On April 10, 2020, Cold Spring Hills told Ms. Virone-Mahoney that her mother's health improved. The next day, her mother died. Ms. Virone-Mahoney is devastated by Cold Spring Hills' failure to care for her mother, additionally noting its egregious failures to test for COVID-19 and to notify her of the presence of the virus.

94. Lori Tessoriero's husband, S.T., resided at Cold Spring Hills for approximately two years until he was transferred to hospice in or around April 2020. Ms. Tessoriero learned on April 12, 2020, that the person residing across the hall from her husband died of complications from COVID-19. She received no notifications from Cold Spring Hills regarding the presence of COVID-19. A short time later, her husband developed a fever; Ms. Tessoriero insisted that Cold Spring Hills test her husband for COVID-19. After staff told her that her husband would not be tested for COVID-19, she spoke with the Administrator, Yossi Emanuel, who agreed to arrange for Cold Spring Hills to test her husband for COVID-19. The test showed her husband was positive for COVID-19. After learning the test result, Ms. Tessoriero had her husband moved to hospice, where he died a week later. Like many other family members, Ms. Tessoriero was unable to contact Cold Spring Hills staff when she attempted to do so; she also observed Cold Spring Hills' noticeably low staffing when she visited.

95. Debra Garofolo's mother, J.T., resided at Cold Spring Hills for six years until she died in April 2020. In March 2020, a nurse practitioner at Cold Spring Hills told her that her mother was sleeping a lot but had no signs of COVID-19. Ms. Garofolo asked if her mother was tested for COVID, and the nurse practitioner said that the testing was limited. After trying without success

to reach Cold Spring Hills over the next two weeks, on April 10, 2020, staff then informed Ms. Garofolo that her mother was not well and was near death. Ms. Garofolo said goodbye to her mother via FaceTime on April 12, 2020, the day her mother died. Ms. Garofolo never received written notice from Cold Spring Hills regarding COVID-19 at the facility and she thought Cold Spring Hills failed to properly respond to her communications. Her mother's death certificate did not list COVID-19, despite the fact that Ms. Garofolo believes her mother died of the virus.

96. Melody Marrero's father, G.M., entered Cold Spring Hills in January 2020 on a temporary basis to receive physical therapy after hospitalization. In March 2020, Ms. Marrero's father said he was afraid because staffing appeared to be lower and people were getting sick. In late April 2020, her father became feverish. Ms. Marrero struggled to reach Cold Spring Hills staff by phone; when somebody did answer, they told her they were short of staff and hung up. On May 2, 2020, Cold Spring Hills staff informed Ms. Marrero that her father had been sent to the hospital. Her father was ultimately diagnosed with double pneumonia and spent 30 days in the hospital before recovering.

Ombudsman Report Lack of Communication with Families

97. The Ombudsmen told me in December 2021 that they have received complaints about Cold Spring Hills failing to communicate with families. They said that staff do not return calls.

RESIDENTS LEAVE COLD SPRING HILLS DUE TO FAILURES IN RESIDENT CARE

98. Residents have left Cold Spring Hills due to failures in resident care.

99. For example, Ms. Arrazola's family moved her father, C.A., out of Cold Spring Hills and into another nursing home facility because of the "bad care" he received at Cold Spring

Hills. Since her father has been living at the new facility, she has seen improvement in his pressure injury to the point it totally resolved.

COMPLAINTS ABOUT NEGLECT AT COLD SPRING HILLS ON SOCIAL MEDIA

100. MFCU used websites, including Google, Caring.com and YELP, to search for online reviews of Cold Spring Hills that appeared to be written by residents, employees, and family members of residents, although we could not verify the identity of the review authors. Compiled below are some of the many reviews of Cold Spring Hills, downloaded from Google, Caring.com and Yelp, from March 2019 through March 2022. True and correct copies of these reviews are attached hereto as **Exhibits 3 to 13**.

Google

101. **Exhibit 3** contains a Google review from 2019, posted by "DiAnn Bell," regarding the care her mother received at Cold Spring Hills:

> ***There were at least three days where I called a few times over the course of the day. I was unable to connect with anyone regarding my mother's care. The phone at the nurses station rings unanswered and then disconnects. On those days I called back a few times and asked the operator to try to get some one [sic] for me to speak with and she was not able to find anyone. I also left messages in the admin and social work office. No one ever called me back. Respite care is just that- I shouldn't have to worry about my moms [sic] care to this extreme. I truly feel sorry for people there full-time.***

102. **Exhibit 4** contains a Google review from 2020, posted by "Lisa Folan," regarding the care her mother received at Cold Spring Hills:

> ***[S]he urinated herself and they let her stay wet for 4 hours before they helped her, they "forgot" to feed her meals so I was constantly trying to call the nurses station (which no one answers) until finally I called security to help. She kept buzzing for the nurse as she couldn't breathe one day…they unplugged her oxygen machine and forgot to plug it back in***.

103. **Exhibit 5** contains a Google review from 2021, posted by "Cathy Wagner," regarding the care her husband received at Cold Spring Hills:

My husband's health and mental status declined enormously in less than 72 hours of being there. He was given medication that he never received before and we were told he needed it to settle down. My husband is now in the ICU at North Shore Manhasset, unresponsive.

Caring.com

104. **Exhibit 6** contains an anonymous Caring.com review from October 7, 2019, regarding Cold Spring Hills:

They put them in diapers instead of taking them to toilet. The food is unpalatable and looks like dog food. They leave the patients in wheelchairs in the courtyard and don't come back.

105. **Exhibit 7** contains a Caring.com review from April 5, 2020, posted by "Margie3712," regarding Cold Spring Hills:

On night there was absolutely not one staff member on the floor. I had to call an ambulance because I opened the bandage on my brother's foot and saw all of the blackness! I called 911. I told the EMT's no one was there. They said 'there has to be someone. They walked the entire floor, returned, and said 'this is crazy! You better get your brother out of here' UNGODLY PLACE!

106. **Exhibit 8** contains a Caring.com review from on July 25, 2020, posted by "Taby," regarding the care her husband received at Cold Spring Hills:

Rude and unhelpful Nurses and staff. My husband was there for three weeks - could never get nurse or any staff to assist him while on the toilet. I was 80 yrs. old and I had to clean him after his toilet. He became very ill, nobody cared - everybody too busy to come and look at him. His doctor said "if I hadn't moved him out of there that night, he would have died." He went into Septic shock and had 106 temperature, that same night. I thank God I moved him fast enough out of that awful place. I would not put an animal in Cold Spring Hills Rehab Center.

107. **Exhibit 9** contains a Caring.com review from May 1, 2021, posted by "Angrysom," regarding the care her father received at Cold Spring Hills:

He was incoherent and struggling to speak could not open his eyes. Immediately I asked, he was just sleeping you didn't give him anything? They then told me he was given halodol which should not be given to anyone with heart condition. This facility is disgusting, has an onvious [sic] feval [sic] odor and inadequate staff who obviously are not concerned with the health of your loved ones. This place should absolutely [sic] not be allowed to operate, they have no interest in care

and will drug your loved ones as they see fit to not have to be bothered with them. Absolute garbage there is no rating low enough based on my observations.

Yelp

108. **Exhibit 10** contains a Yelp review from January 29, 2019, posted by "Kadina T.," regarding the care of her mother at Cold Spring Hills:

Mother was trached and had to suction herself because staff was too busy to worry about patients airway. Mother sat in chair 10 hours a day and developed a DVT in her leg. This place is the worst!!! Think twice

109. **Exhibit 11** contains a Yelp review from April 12, 2020, posted by "Tracee H," regarding the care her father received at Cold Spring Hills:

This place is the absolute worse they're negligent never answer the phone and If they do they're unprofessional...my dad died in this horrible place because he was ignored..Stay away because they definitely will not take care of your loved one..the absolute worse

110. **Exhibit 12** contains a Yelp review from July 2, 2020, posted by "Rona G," as a former patient at Cold Spring Hills regarding the care received:

I was a patient at Cold Springs for seven months. They were the worst seven months of my life. I have to say that the Physical and Occupational Therapists were excellent. I had two amazing therapists who were not only good at their jobs but wonderful, caring people. I am beyond grateful for them. Everything else, except one nurse, was awful. They were terribly understaffed and you could press the call button and wait for hours until someone showed up to help. The nights and weekends were nightmares. I would not recommend Cold Spring to anyone.

111. **Exhibit 13** contains a Yelp review from on March 28, 2021, posted by "Lenora S.," regarding Cold Spring Hills:

I personally saw one woman try to get up from her wheelchair and she fell and there was a large amount of blood on the floor. They just let her lie there for 5 minutes before anyone helped her.

112. For ease of reference, the table below lists the exhibits to this Affidavit described herein.

Exhibit Number	Description	¶ Reference
1	Photograph of resident L.K.'s wound	50
2	Photograph of Resident 47's dirty floor	80
3	Google review from 2019 posted by "DiAnn Bell"	101
4	Google review from 2020 posted by "Lisa Folan"	102
5	Google review from 2021 posted by "Cathy Wagner"	103
6	Anonymous Caring.com review from October 7, 2019	104
7	Caring.com review from April 5, 2020 posted by "Margie3712"	105
8	Caring.com review from on July 25, 2020 posted by "Taby"	106
9	Caring.com review from May 1, 2021 posted by "Angrysom"	107
10	Yelp review from January 29, 2019 posted by "Kadina T."	108
11	Yelp review from April 12, 2020 posted by "Tracee H"	109
12	Yelp review from July 2, 2020 posted by "Rona G"	110
13	Yelp review from on March 28, 2021 posted by "Lenora S."	111

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

Ryan Ricker

Detective Ryan Ricker

Sworn to before me this

13 day of December, 2022

Anne Liptak

Notary Public

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

CERTIFICATION PURSUANT TO RULE 202.8-b

I, Christina Pinnola, an attorney duly admitted to practice law before the Courts of the State of New York, hereby certify that this Affidavit contains 9,057 words, excluding the parts of the Affidavit explicitly exempted by the Rule, and that Petitioner's request for permission to file an oversize submission as provided in Rule 202.8-b(f) is forthcoming. In preparing this certification, I have relied on the word count of the word processing system used to prepare this Affidavit.

Dated: Hauppauge, New York
December 13, 2022

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

By:
Christina Pinnola

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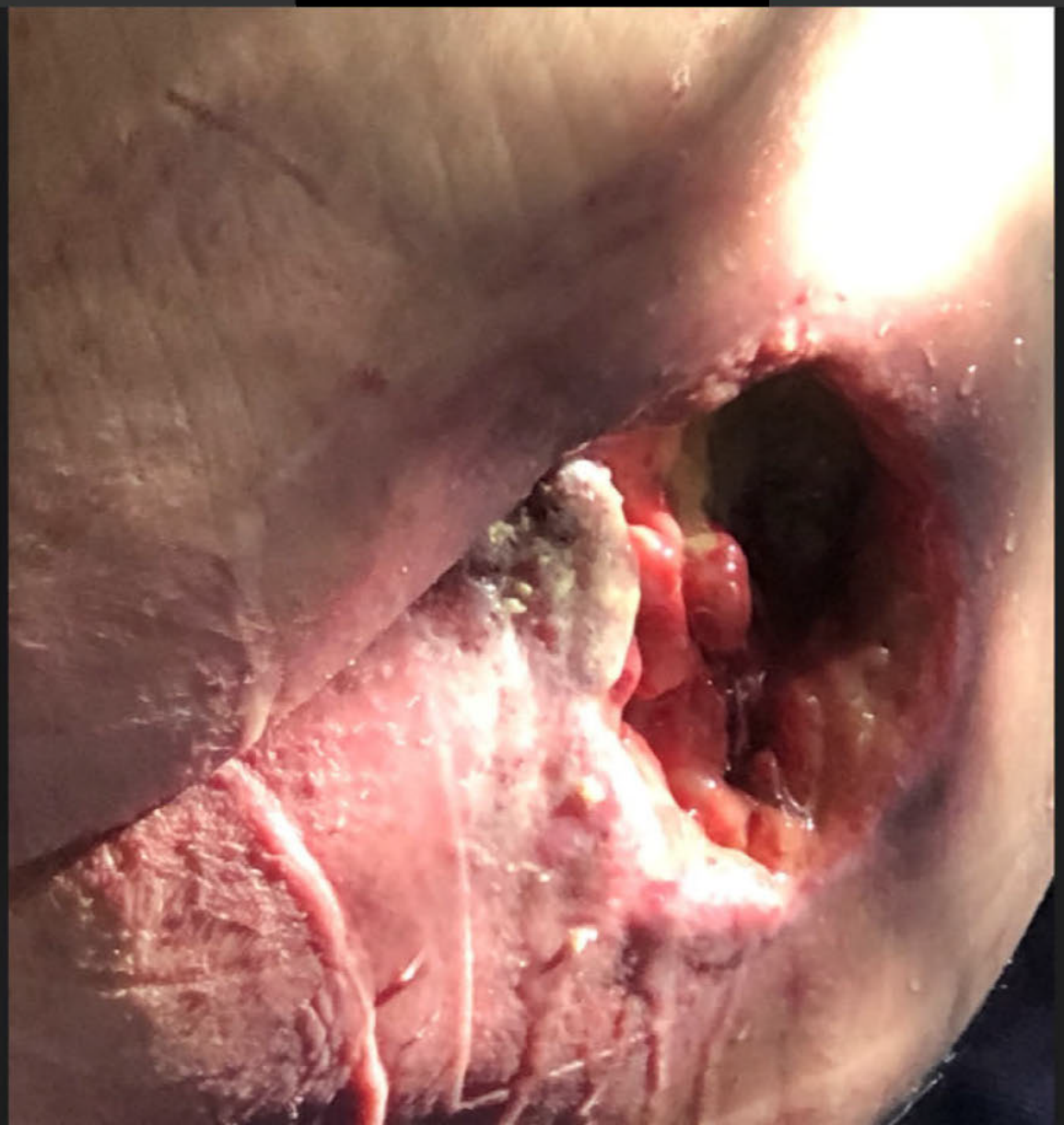

DiAnn Bell

3 years ago

My Mother was in this facility for respite care for 2 weeks. Before she went to the nursing home, I typed up a detailed page of simple instructions and gave to Ben the head of social work, as well as head nurse Donna. I also posted a copy on the bulletin board in my Mom's room. The note explained the obvious; please reposition mom every two hours and check her diaper at that time as well, please put collagen dressing on an existing bedsore, how and what to feed her etc. I have many complaints but the most serious are: 1. I received a call a few days after my Mom was there from Donna, the head nurse on Norwich 3. She told me my Mom had a red spot on one of buttocks. I called back a few times to inquire in the following days and was told it was still red. I arrived on the January 15 to pack up my Moms belongings, at that point I was told that the skin had broken and she had a pressure sore. I have a picture of it. The visiting nurse that came to my house after she came home for a home visit said the sore was unstageable since she couldn't tell how deep it was. 2. My Mom arrived at the nursing home with a customized wheelchair that was in excellent, new condition. Upon her arrival home by ambulette, her wheelchair was missing. She came home in a used, stamped travel style wheelchair. The chair had no leg rests, no back anti tip stoppers, no seat belt and the brakes don't work so when you transfer mom the chair slides out . Her chair had all those things and each one of them is a necessity to ensure her safety. I have called every department everyday since, I leave messages and speak with various people including the Norwich 3 nurses station, Ben and Amy Fink in social work dept, and Lorraine in Admin. No one has ever gotten back to me. 3. I left very high protein shakes on her dresser in her room. None were given to her despite the instructions to give 1 a day on the note given to all and posted in her room. I also left Collagen prisma pads to be put on an existing ulcer - again none were used despite being on the counter and included in the note. The existing sore got worse (white dead skin on top instead of the healthy pink skin that was growing in prior to her admission). 4. On quite a few occasions over the two weeks she was there, visitors came into the room to find her food ice cold at least an hour after meal delivery and untouched . She is unable to feed herself. She lost at least 5-8 lbs in the two weeks she was there. She was also in a soiled or wet diapers during the occasions visitors came and they had to request changes will there - one of which could not be completed in the time of the visit despite a few requests by the visitor. 5. There were at least three days where I called a few times over the course of the day. I was unable to connect with anyone regarding my mothers care. The phone at the nurses station rings unanswered and then disconnects.

On those days I called back a few times and asked the operator to try to get some one for me to speak with and she was not able to find anyone. I also left messages in the admin and social work office. No one ever called me back. Respite care is just that - I shouldn't have to worry about my moms care to this extreme. I truly feel sorry for people there full-time .

Lisa Folan

2 years ago

Do NOT bring your loved one to this horrific place! My mom (an elderly woman) was only there for 4 days and we couldn't get her out fast enough! Here's her experience: She urinated herself and they let her stay wet for 4 hours before they helped her, they "forgot" to feed her meals so I was constantly trying to call the nurses station (which no one answers) until finally I called security to help. She kept buzzing for the nurse as she couldn't breathe one day... they unplugged her oxygen machine and forgot to plug it back in. Again, I had to call security for assistance because no one is available at the nurses station. This is just some of the things she went through. Please spare yourselves and your loved one....do not go here!

15

Share

Cathy Wagner

10 months ago

0 STARS would be generous! My husband was transferred from North Shore Manhasset on a Thursday nite and I personally got an ambulance to transport him out of there by Saturday afternoon. My husband's health and mental status declined enormously in less than 72 hours of being there. He was given a medication that he had never received before and we were told he needed it to settle down. My husband is now in the ICU at North Shore Manhasset, unresponsive. When mentioning that I wanted to bring him back to the hospital, I was told that he is fine and that he was just sleeping. When I pointed out bloody bandages, I was told that it was not "active bleeding" When the EMT's came, they immediately gave him fluids and brought him to Plainview Hospital because he said he may need a blood transfusion asap. DO NOT BRING YOUR LOVE ONES HERE!!!

6 Share

Response from the owner 10 months ago

Hi Cathy, Sorry to hear that you did not feel your husband had a good experience in our facility. Can you please email us at coldspringhillsconcierge@gmail.com and tell us more about your experience?

October 07, 2019

 By Do not put your loved one here

I am a friend or relative of a current/past resident

The rooms are dirty There are a precious few nice nurses and aides. The majority are not nice, ignore the patients and infantilize the patients. They put them in diapers instead of taking them to toilet. The food is unpalatable and looks like dog food. The leave the patients in wheelchairs in the courtyard and don't come back. I had to take my mother by ambulance out of the facility back to the hospital due to multiple pulmonary embolisms. NO doctor or PA on staff. Stay away!!!!!!

April 05, 2020

By Margie3712

I visited this facility

This facility should be closed and condemned! My family member was treated so badly. He could tell for an hour or 2 and none came. One night, we came in and his lower body was hanging off the bed! His foot developed Gangrine where there was none. As opposed to calling in a Podiatrist, they called a 'wound care specialist. Look that up and see the credentials they require, then decide if you would like them caring for your loved one with Gangrine. On night there was absolutely not one staff member on the floor. I had to call an ambulance because I opened the bandage on my brother's foot and saw all of the blackness! I called 911. I told the EMT's no one was there. They said 'there has to be someone. They walked the entire floor, returned, and said 'this is crazy! You better get your brother out of here' UNGODLY PLACE!

July 25, 2020

By Taby

I am a friend or relative of a current/past resident

Rude and unhelpful Nurses and staff. My husband was there for three weeks - could never get nurse or any staff to assist him while on he toilet. I was 80 yrs. old and I had to clean him after his toilet. He became very ill, nobody cared -everybody too busy to come and look at him. His doctor said "if I hadn't moved him out of there that night, he would have died. He went into Septic shock and had 106 temperature, that same night. I thank God I moved him fast enough out of that awful place. I would not put an animal in Cold Spring Hills Rehab Center.

May 01, 2021

By angrysom

I am a friend or relative of a current/past resident

I spoke with my father yesterday as he areived at this awful facility for rehab after being discharged from the hospital. He was aware, energetic and coherent. Not even 24 hours later after multiple phone calls where the inept staff hung up in many case in mid sentence I was told my father spoke to a family member stating I'm in trouble and i need help. Overnight from aware to incoherent, i arrived at the facility demanding to see my father. After about 30 mins of run around I was told he was in one on one, then was told sleeping. Again demanding to see him I had them bring him to me in a wheelchair. He was incoherent and struggling to speak could not open his eyes. Immediately I asked, he was just sleeping you didnt give him anything? They then told me he was given halodol which should not be given to anyone with heart condition. This facility is disgusting, has an onvious feval odor and inadequate staff who obviously are not concerned with the health of your loved ones. This place should absolutley not be allowed to operate, they have no interest in care and will drug your loved ones as they see fit to not have to be bothered with them. Absolute garbage there is no rating low enough based on my observations.

Kadina T.
North Babylon, NY
48 8 1

1/29/2019

Overdosed my mother with Lasix. Stated she had severe heart failure and she didn't. Gave her 180 mg of lasix daily and caused kidney failure. Mother was trached and had to suction herself because staff was too busy to worry about patients airway. Mother sat in chair 10 hours a day and developed a DVT in her leg. This place is the worst!!! Think twice

Useful 10 Funny Cool

Tracee H.
Springfield Gardens, NY
0 2

4/12/2020

This place is the absolute worse they're negligent never answer the phone and If they do they're unprofessional..my dad died in this horrible place because he was ignored..Stay away because they definitely will not take care of your loved one..the absolute worse

Useful **5** Funny **1** Cool

Rona G.
Plainview, NY
0 1

7/2/2020

I was a patient at Cold Springs for seven months. They were the worst seven months of my life. I have to say that the Physical and Occupational Therapists were excellent. I had two amazing therapists
who were not only good at their jobs but wonderful, caring people. I am
beyond grateful for them. Everything else, except one nurse, was awful.
They were terribly understaffed and you could press the call button and
wait for hours until someone showed up to help. The nights and weekends were nightmares. I would not recommend Cold Spring to
anyone.

Useful **9** Funny Cool

Lenora S.
Linwood, NJ
0 48

3/28/2021

This place is highly understaffed. I went in there only to find my mother without any pants on in her wheelchair. We had a closet full of clothes for her but they kept saying we were "washing her clothes at home". I had brought her clothes to the front desk many times asking them to put labels and I changed their error from washing at home to wash at the facility.

My Mom was in good physical health when she got there. She must have choked, they arent telling me what really happened. She died only 6 months after being there.

No LPNs are at their station. Two alarms were going off and the ones around did not answer any alarms. I personally saw one woman try to get up from her ewheelchair and she fell and there was a large amount of blood on the floor. They just let her lie there for 5 minutes before anyone helped her. I stood there and took pictures which they rudely were about to confiscate my phone. They cleaned up the blood finally without any gloves on. Nor did they clean the area with the blood AFTER.

One woman who had her mother in there told me to come there about 9 or 10 pm and see what goes on. I saw many of the patients sleeping in their wheelchairs. I was told by another visitor they dont even put these people in their beds. I marked my mothers bed and took pictures of it so I would know if she had slept in it. It was exactly the same each morning. I placed little pieces of paper only I knew were there and they were not disturbed.

Spend the money if you have it on a private nursing home like a Sunrise. The care at Sunrise is superb.

This place needs to be investigated and shut down.