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

Petitioner,

Index No. _____

AFFIDAVIT OF DETECTIVE JAIMIE KRZYSKOSKI

-against-

COMPREHENSIVE AT ORLEANS LLC d/b/a
THE VILLAGES OF ORLEANS HEALTH AND
REHABILITATION CENTER, TELEGRAPH REALTY
LLC, CHMS GROUP LLC, VILLAGES OF ORLEANS
LLC, ML KIDS HOLDINGS LLC, BERNARD FUCHS,
JOEL EDELSTEIN, ISRAEL FREUND,
GERALD FUCHS, TOVA FUCHS, DAVID GAST,
SAM HALPER, EPHRAM LAHASKY,
BENJAMIN LANDA, JOSHUA FARKOVITS,
TERESA LICHTSCHEIN, and DEBBIE KORNGUT,

Respondents.
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State of New York)
) ss.:
County of Erie)

Detective JAIMIE KRZYSKOSKI, being duly sworn, deposes and says:

1. I am a police officer employed as a Detective by the Office of the New York State Attorney General, Medicaid Fraud Control Unit ("MFCU") and I am assigned to the Buffalo Regional Office. I have been a Detective with the MFCU for over six years. Prior to being appointed as a Detective with the MFCU, I was an Inspector with the New York State Gaming Commission for four years.

2. I submit this Affidavit in support of the special proceeding commenced today through the Attorney General's Verified Petition seeking, among other things, restitution, injunctive relief and disgorgement from Respondents Comprehensive at Orleans LLC d/b/a The Villages of Orleans Health and Rehabilitation Center, Telegraph Realty LLC, CHMS Group LLC, Villages of Orleans LLC, ML Kids Holdings LLC, Bernard Fuchs, Joel Edelstein, Israel Freund, Gerald Fuchs, Tova Fuchs, David Gast, Sam Halper, Ephram Lahasky, Benjamin Landa, Joshua Farkovits, Teresa Lichtschein, and Debbie Korngut (collectively, "Respondents").

3. The Attorney General, through the MFCU, conducted an investigation (the "Investigation") of Comprehensive at Orleans LLC, d/b/a The Villages of Orleans Health and Rehabilitation Center, located at 14012 Route 31, Albion, New York ("The Villages"). The Villages is registered with the New York State Department of Health ("DOH") and has a capacity of 120 beds. A "bed" is simply a measure of resident capacity.

4. MFCU's Investigation commenced in the spring of 2020. MFCU interviewed past and present employees of The Villages, residents of The Villages, and family members of residents. I summarize the statements made by some of these witnesses below.

5. During the course of the Investigation, MFCU received numerous complaints from The Villages' employees, residents, family members of residents and media reports, regarding harm to residents as a result of inadequate staffing, insufficient services and supplies, failure to provide requisite quality of care and quality of life to residents, admitting residents it could not care for, neglect, failure to have an effective Infection Control program, and other failures of The Villages to meet the care needs of residents.

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 basis for this belief are

specified herein. Because this Affidavit is being submitted for the limited purpose of supporting the Attorney General's Verified Petition, I have not included details of every aspect of the investigation. Where actions, conversations, and 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 at The Villages, we confirmed that the person appeared in staffing records during the relevant time frame, as produced by The Villages. If a person was a resident or family member of a resident, we confirmed that the person was an in-patient resident during the relevant time frame or that the family member was providing information about a person who was an in-patient resident during the relevant time, using documents produced by The Villages, Medicaid or Medicare reimbursement claims submitted by The Villages, or documentation such as emails exchanged between the family member and The Villages or text messages retained by staffers.

8. **Confidentiality Concerns:** Many of the witnesses described below expressed strong concern that they faced retaliation from The Villages for cooperating in this investigation. Other witnesses refused to talk with me or other Detectives in this Investigation based on strongly held concerns that if they cooperated in this Investigation, they or their family members would face retaliation from The Villages. This includes residents who are entirely dependent on The Villages for all their needs and their family members.

9. I was told that in the past, when complaints were raised about the conditions and care provided to residents at The Villages, it was frequently met with a lack of responsiveness by the administration, senior nursing staff, or ownership, giving rise to a culture where many staffers refused to speak with MFCU Detectives except under promises of confidentiality.

Interviews of Staff Members Reveal Grossly Substandard Care

10. I conducted interviews of staff members of The Villages, including CNAs, Nurses, an Activities Aide, and a Physical Therapy Assistant, during which they detailed myriad ways in which The Villages failed to provide residents with the requisite quality of care and quality of life to which they were entitled.

11. Taken together, these staff members detail an environment at The Villages that was characterized by inadequate staffing, insufficient services and supplies, failure to provide requisite quality of care and quality of life to residents, admission of residents it could not care for, neglect, and failure to have an effective Infection Control program, and which resulted in The Villages' complete failure to meet the care needs of its residents. The staff members who engaged in witness interviews include:

Sheila Fernandez, Certified Nursing Assistant

12. On June 30, 2021, I spoke to CNA Sheila Fernandez ("CNA Fernandez") via telephone regarding The Villages. CNA Fernandez provided information about her employment at The Villages where she was employed as a Certified Nursing Assistant (CNA).

13. CNA Fernandez has been a CNA for eight years. After achieving her GED, CNA Fernandez held positions at Schoellkopf Nursing Center, and Our Lady of Peace, both located in Niagara County.

14. In 2018, CNA Fernandez began working at The Villages. She worked on and off at The Villages until April 13, 2020. She no longer works as a CNA.

15. During her time at The Villages, CNA Fernandez worked on the dementia unit from 6am-2pm and was paid $13.50 an hour.

16. According to CNA Fernandez, "the facility would knowingly admit residents they could not properly take care of."

17. According to CNA Fernandez, staffing at The Villages was "not consistent." She noted that for a unit to be fully staffed it must have four CNAs, however she recalls times where there was one CNA working both the dementia and rehab unit alone. On more than one occasion she worked the dementia unit by herself with no nurse and had to take care of 30 residents.

18. CNA Fernandez had many responsibilities, including getting residents dressed, fixing their hair, washing and toileting them, getting them up for breakfast, and any other activities related to daily living. While employed at The Villages, CNA Fernandez was also forced to perform many functions that were not a part of her job description: she performed wound treatments, replaced band aids, and passed medications to residents, all tasks that are supposed to be performed by a licensed nurse, and which are beyond the scope of professional practice of a CNA employed in a long-term care facility.

19. On one occasion in 2020, CNA Fernandez and CNA Lindsay Wilston ("CNA L. Wilston") were the only two aides working on the dementia unit. No nurse was assigned to the dementia unit, and, in fact, there was only one nurse for the entire building. That one nurse set up the residents' pills in individual cups and CNA Fernandez and CNA L. Wilston passed the medications to the residents at breakfast. The nurse then documented the completed medication pass, as if the nurse had distributed the medications.

20. Other CNAs were also forced to perform treatments such as wound care and passing medications, which were beyond the scope of professional practice for a CNA, and which should have been performed by licensed nurses. According to CNA Fernandez, there was often no Activity Aide on the unit so she and CNA L. Wilston divided their time between providing care for numerous residents and sitting in the dining room with other residents because they could not be left alone to eat. CNA Fernandez and other CNAs complained to the full-time nurses and the Director of Nursing ("DON"), Debra Donnelly ("DON Donnelly"), however their complaints were ignored.

21. At one point, CNA Fernandez and CNA L. Wilston wrote a letter to The Villages' Administrator, Brian Reader, ("Admin Reader") detailing their concerns, including: lack of staff, the shower room flooding, water underneath the shower tiles, mold on the bathroom walls, and the stand-lift in the shower room that never worked. Admin Reader told CNA Fernandez and CNA L. Wilston that he would take care of their concerns but he subsequently relayed that he was yelled at by DON Donnelly when he raised them. According to CNA Fernandez, Admin Reader was fully aware of the problems but could not do anything about them.

22. Due to lack of staff, CNA Fernandez observed directly how residents did not receive proper care. At times residents did not get a regular shower and the kitchen staff did not provide regular snacks. On some occasions, residents were left in bed for 24 hours straight. When they were short staffed, at times, one CNA had to feed seven-to-eight dementia residents. If a resident was losing or gaining weight it was never documented, one could only tell by looking at them or if their clothes fit differently.

23. According to CNA Fernandez, documentation was falsely filled out by nurses, especially when CNAs, including her, performed treatments and passed medication, which was

supposed to be done by nurses. The nurses would falsely document that they performed the treatment or passed the medication to the resident.

24. The Villages did not respond quickly to the COVID-19 outbreak. The facility did not provide the equipment that staff needed, and staff were floating from positive residents' to negative residents' rooms because they were so short staffed. The COVID-19 virus eventually spread to the dementia unit which has its own closed doors.

25. CNA Fernandez was also frequently bullied to stay past her shift and would get mandated to stay because the next shift was always late and understaffed. Tardiness for all shifts was a big issue at the facility, including many no-call no-shows. CNA Fernandez has children that go to school and need to get off the bus, so she needed prior notice to stay past 2:00 p.m. so that she could arrange for childcare. On April 13, 2020, CNA Fernandez's last day at The Villages, she walked out at 2:30 p.m., because her relief never showed up. As she was walking to her vehicle, DON Donnelly was outside on the phone with "Joe" from corporate and asked her where she was going. CNA Fernandez told DON Donnelly that the CNA for the next shift had not shown up yet but that she had to leave. DON Donnelly told CNA Fernandez that she had to stay and if she left it would be neglect and abuse. DON Donnelly told CNA Fernandez she had to talk to "Joe" and handed her the phone. "Joe" told CNA Fernandez over the phone that if she left it would be considered neglect and she would be fired. CNA Fernandez gave DON Donnelly her phone back and left The Villages for the last time.

Mary Fairbanks, Licensed Practical Nurse

26. On April 28, 2020, I interviewed Mary Fairbanks, LPN ("LPN Fairbanks"). LPN Fairbanks started at The Villages through an agency for four years and had since become a

permanent employee since 2017. She has been an LPN for 25 years. LPN Fairbanks was employed by The Villages at the time she conveyed the following information to me.

27. LPN Fairbanks has worked on every unit at The Villages and at the time of this interview worked as a Supervisor. She works a double shift from 2:00 p.m. - 10:00 p.m., and 10:00 p.m. - 6:00 a.m., on Sunday, Monday and Tuesday nights, and she is off Wednesdays through Saturdays. She often supervises the entire building.

28. LPN Fairbanks reported that she was highly concerned because CNAs at The Villages were performing Accu-Chek finger sticks to diabetic residents, which should not have been allowed, as this type of care is beyond the scope of professional practice for a CNA in a long-term care facility.

29. She also explained that March 30, 2020 was the facility's first case of the COVID-19 virus. The man who tested positive was sent to the hospital that day. According to LPN Fairbanks, his chart documented that he had a fever three days prior to being tested. This first case was treated as "a big secret," and for the next three weeks, the facility did not do anything to avoid the spread of the virus. She told DON Donnelly that they needed to lock down a unit for residents that tested positive to avoid the spread, but DON Donnelly ignored her concerns. Other employees also expressed their concerns to DON Donnelly but their concerns were similarly ignored.

30. In April 2020, an agency aide asked LPN Fairbanks for a mask and LPN Fairbanks had to call DON Donnelly to get one. DON Donnelly told her that the aide could only have a surgical mask because she did not have any N95 masks and that the aide "didn't need one". On April 19, 2020, DON Donnelly provided gowns for the staff, and stated "make these gowns last". On April 26, 2020, DON Donnelly had bins set up in front of the units with gowns and N95 masks. On April 27, 2020, the facility was already out of N95 masks.

31. On [redacted] 2020, and [redacted] 2020, due to lack of staff, LPN Fairbanks supervised three halls of the facility alone, and also had to handle the medication cart/medication pass for an additional unit (Orchard View). She also had to go over to an entirely different unit (rehabilitation) to check on a resident, and then had to go to yet another unit (dementia) because Resident 51 fell and cracked their head and was bleeding. Resident 51 died following this incident.

32. On May 4, 2020, I had a conversation with LPN Fairbanks via text message about the events of April 19, 2020, and April 20, 2020. A true and correct copy of the May 4, 2020, texts is attached hereto as **EXHIBIT A**.

33. On April 28, 2020, LPN Fairbanks worked the night shift and was instructed by DON Donnelly to put up isolation signs throughout the facility. This was a month after COVID-19 was known to be in the facility. The signs were printed off the computer and had a "stop hand" symbol on them and said, "Stop! Use Isolation Precautions." DON Donnelly directed LPN Fairbanks to put a sign on every door.

34. LPN Fairbanks put the signs up as directed. The following morning, DON Donnelly came in to work at 5:30 a.m. and brought out all new PPE supplies and collected all of the used gowns that had been hanging on the units. According to LPN Fairbanks, it was odd for DON Donnelly to come in to work so early and do all of that. Later that morning, personnel from the Department of Health ("DOH") arrived at the facility to conduct a survey.

35. I had a conversation with LPN Fairbanks via text message on April 29, 2020. The texts from LPN Fairbanks discuss the preparation for the DOH visit described above. LPN Fairbanks wrote, "The Director of Nursing Deb Donnelly came in early to be sure to put out new packages of PPE and brief the employees on infection control and isolation policies and what the DOH may ask… and that we need to use common sense when answering." LPN Fairbanks also

wrote, “I took this as a threat, that if we answer truthfully we may lose our job.” “The Director had night shift put up isolation signs… and other protection measures that should have been done over a month ago.” A true and correct copy of the April 29, 2020, texts is attached hereto as **Exhibit B**.

36. LPN Fairbanks recalled that she was “begged” to come in to work the evening of April 29, 2020, and the Administrator “Steve” offered to give her $100. DON Donnelly was regularly giving out $50 cash to employees that picked up additional shifts to help address staffing shortages.

37. Cross-contamination and lack of adequate PPE were also huge concerns in the facility. On one occasion, LPN Fairbanks was working on the Orchard View unit, that was full of COVID-19 positive residents. She was working that hall with two CNAs, and there were only two-to-three gowns for them to cover 30 residents. On another occasion, she had to wear the same gown from resident “A’s” room to go and test resident “B” for the COVID-19 virus. There were no biohazard bins for ripped or soiled gowns. LPN Fairbanks wore a ripped gown and had to throw it out in a regular garbage can in a resident’s room.

38. Another concern with respect to cross-contamination and lack of safety related to dietary care. The dietary staff was going from room to room and serving food on regular trays, not on Styrofoam trays.

39. According to LPN Fairbanks, the facility “screened” employees before they come into work but only up until 8:30 p.m. After 8:30 p.m., employees must take their own temperature and no one monitors this.

Hope Albone, Certified Nursing Assistant

40. On April 14, 2020, and April 20, 2020, I interviewed CNA Hope Albone ("CNA Albone") via telephone in regards to her employment at The Villages. CNA Albone worked as a part-time CNA at The Villages. She worked 2:00 p.m. - 10:00 p.m. every other weekend and part-time overnights, but she often worked other shifts as needed. CNA Albone was employed by The Villages at the time she conveyed the following information to me.

41. According to CNA Albone, staffing at the facility is "awful." On April 14, 2020, the date of her initial interview, at 4:30 p.m., there was only one CNA on each hall, no nurse on the dementia unit, and one Supervisor with two medication carts. Pregnant employees, or employees that were sick, were being fired if they could not come to work. Employees tried to bring up their concerns to DON Donnelly, but she "doesn't have the best attitude." To try to alleviate the staffing shortages, DON Donnelly was giving employees an extra $50 bonus for each extra shift they picked up. The staff, however, were "burnt out" and "tired" and residents were therefore not getting proper care.

42. On March 28, 2020, CNA Albone was the only CNA in the entire building for 120 residents. She called the Department of Health a few times but never heard back. She told "Jason" from corporate that if the State came in that weekend the facility would be "flagged," but "Jason" did not seem concerned, because according to CNA Albone, the facility "knows when the State comes in to do checks."

43. As of April 14, 2020, according to CNA Albone, the staff working on the Orchard View unit were not provided with covers to wear over their shoes, and only nurses were provided N95 masks. Aides were only provided with blue surgical masks, yellow gowns and gloves.

44. As of April 20, 2020, residents were still able to socialize outside of their rooms on the Canal View unit, despite positive cases of COVID-19 on the unit. All units at The Villages had residents that had tested positive for COVID-19 as of that date. The facility, nonetheless, began moving patients from other units to Orchard View, where 18 residents in the 24-bed unit had tested positive for COVID-19.

45. Another concern expressed by CNA Albone had to do with reusing gowns. Yellow gowns were frequently being reused on the Orchard View unit, where COVID-19 was rampant. She stated that DON Donnelly became upset when she learned that gowns were being thrown away and told CNA Albone that the gowns should be saved.

46. CNA Albone sent to me by text messaging a photograph of two gowns being reused and a staff schedule for the day of April 20, 2020. CNA Albone explained that the staff schedule shows that there was only one nurse, "M Fairbanks," for the dementia and rehabilitation units ("Autumn View (N)" and "Autumn View (S)"), and one nurse with two medication carts for Canal View and Garden View long-term care units. CNA Albone was the only CNA for both Canal View and Garden View. Further, there was only one CNA on the Orchard View long-term care unit. A true and correct copy of the text messages and attached photographs is attached hereto as **Exhibit C**.

Susan Nashburn, Activities Aide

47. On April 27, 2020, I spoke to Susan Nashburn ("Nashburn") via telephone about her employment at The Villages. Nashburn was previously employed by The Villages as an Activities Aide. Nashburn was employed approximately 5-6 times as an aide at The Villages, leaving her employment on numerous occasions due to confrontations with then DON Donnelly.

Most recently, Nashburn was employed by The Villages as an Activities Aide from March 12, 2020, to April 5, 2020, when she "walked out" of the facility.

48. As an Activities Aide, Nashburn worked one-on-one with residents. Her job duties included working with activity tools such as toys, coloring books, pool noodles, balls, and tennis rackets. She worked 9:00 a.m. - 3:30 p.m., with every Friday and every other weekend off. In the course of her duties, Nashburn covered three units.

49. According to Nashburn, staffing levels at The Villages were extremely low when she was there. CNAs would pass medication on the weekends when she was working, which they are not supposed to do, as it is beyond the scope of their certification. For example, she witnessed CNA Lisa James ("CNA James") pass medications. CNA James was also the Activities Director. At times, there was one CNA for an entire unit and one nurse for two units. Residents were being moved in and out of rooms without them being properly sanitized due to the lack of staff. A husband and wife on the dementia unit who both tested positive for COVID-19, and who eventually died, were able to wander the halls while positive due to low staffing; there was usually only one aide for that entire unit.

50. Nashburn "walked out" of The Villages after having a confrontation with DON Donnelly. Nashburn was supposed to be off on April 5, 2020, but volunteered to work a 16-hour shift taking employee temperatures. Nashburn was willing to work as long as she was taking temperatures and did not have to work on a COVID-19-positive hall. DON Donnelly agreed. During Nashburn's shift, however, DON Donnelly sent a nurse to tell her she needed to work as an aide on a COVID-19-positive hall by herself. Nashburn refused and got into a "screaming match" in the hallway with DON Donnelly, leading to her walking out of the facility.

51. Nashburn had to work one-on-one as an Activities Aide with COVID-19-positive patients, but DON Donnelly refused to give her and two other Activities Aides PPE gear. She was only provided a regular mask to wear and was told it only lasted 30 minutes. When everything "came to a peak," DON Donnelly provided her with an N95 mask, but she was directed to re-use it, and DON Donnelly told her to put it in the dryer every day to kill the germs.

52. At one point, every resident on the Orchard View unit was positive for the COVID-19 virus. Employees were directed to "gown up" and then hang the gown inside the resident's room on their closet door to be reused. Nashburn asked DON Donnelly for her own gown and DON Donnelly told her she could not pass them out "willy nilly," and that they were only for those "on the front line," despite Nashburn interacting closely with COVID-19-positive residents. Ultimately, the Activities Director obtained three gowns for the three Activities Aides, but they had to wear the same gown every day. The gowns became visibly soiled and had to be thrown out. After that, the Activities Aides began just wearing a regular sleeping gown over their clothes when tending to residents.

53. Nashburn also gave examples of the cross contamination taking place at the facility. On April 25, 2020, she observed, together in one room, resident "A" who had tested negative for COVID-19, and resident "B", who had tested positive. Meanwhile, the curtain dividing the room was wide open.

54. Nashburn's sister-in-law, Jill Rechtsiegel, is an LPN at The Villages. She tested positive for COVID-19 and was scheduled to complete her required 14-day quarantine and not return to work until April 29, 2020. DON Donnelly began pressuring her sister-in-law to return to work as of April 25, 2020, however, as long as she was asymptomatic, which was inconsistent with New York State policies at the time.

55. According to Nashburn, there were aides from Louisiana that had elevated temperatures but were allowed to continue working. An agency employee came back to work at The Villages from Louisiana after Mardi Gras. A few days after her return, the employee was complaining she did not feel well, but she was told to go back to work even though she was not feeling well. That employee ended up testing positive for COVID-19. The policy that was dictated to Nashburn, "per the owner Jason," was that if an employee had a temperature upon arriving to work, the employee was to go outside for one hour then come back inside and take their temperature again.

56. On May 8, 2020, I had a conversation with Nashburn via text message. Nashburn wrote, "they have 5 aides for the whole building how are they possibly getting the care they need." Nashburn continued, "Family members are taking there loved ones out, police were there today." A true and correct copy of the May 8, 2020, text messages is attached hereto as **Exhibit D**.

57. On May 11, 2020, I had an additional conversation with Nashburn via text message. The texts from Nashburn discuss the unannounced visit by DOH, and a resident death. Nashburn wrote, "when the state went in there yesterday not one aide or nurse had PPE on." Nashburn continued, "[A resident] died on the floor and they found him dead after hours of him laying there." A true and correct copy of the May 11, 2020, text message is attached hereto as **Exhibit E**.

Lucy Bucknan, Licensed Practical Nurse

58. On May 1, 2020, I spoke to LPN Lucy Bucknan ("LPN Bucknan") about her work at The Villages. LPN Bucknan is an agency LPN who was hired through Medical Staffing Network to work at The Villages. She worked as an LPN at The Villages from June 2019 until April 24, 2020, when she was fired for refusing to work in COVID-19-positive units. LPN Bucknan worked the dementia unit and all three long-term care units (Garden View, Canal View and Orchard View)

at The Villages. She worked both the morning (6:00 a.m. – 2:00 p.m.) and afternoon (2:00 p.m. – 10:00 p.m.) shifts during her time at The Villages.

59. According to LPN Bucknan, The Villages was always short-staffed and residents were not getting the proper care they deserved. She would often have two medication carts to pass medication to the dementia and rehabilitation units by herself.

60. On April 24, 2020, she was working the 2:00 p.m. – 10:00 p.m. shift. For two weeks prior, she had worked the dementia and rehabilitation units because she refused to work in the other units due to all of the positive cases of COVID-19 on those units. On April 24, 2020, however, DON Donnelly directed her to go work on another unit because they were "short staffed," and DON Donnelly wanted the "new nurse to work on the dementia and rehab units." DON Donnelly also wanted LPN Bucknan to take the keys for the entire building and medication carts for three units. LPN Bucknan told DON Donnelly, "no," and that she did not feel comfortable working on the COVID-19 positive hallways. In response, DON Donnelly told her to consider herself "DNR" (do not return to work), and she did not return to the facility.

61. According to LPN Bucknan, the facility had no PPE gear, and she did not know whether N95 masks were even available; she had to ask a supervisor in order to get one.

62. The facility never informed the staffing agency that there were positive cases of COVID-19 at the facility and there was a lack of N95 masks for agency employees. In the rehabilitation unit, there were some residents with high fevers. One gown was hung on each resident's door for the staff to share.

63. Ultimately, rehabilitation residents were moved to other units, where there were many COVID-19 positive residents, due to low staffing.

Stephen Dioguardi, Licensed Practical Nurse

64. On May 10, 2020 and August 10, 2020, I spoke to LPN Stephen Dioguardi ("LPN Dioguardi") via telephone about his employment at The Villages. LPN Dioguardi traditionally worked part-time on the day shift every other weekend. During the COVID-19 pandemic, he began working full-time, covering all shifts as needed. LPN Dioguardi was employed by The Villages at the time he conveyed the following information to me.

65. According to LPN Dioguardi, in the "beginning" of the pandemic, there was no PPE gear because DON Donnelly, had it "locked up." LPN Dioguardi believed that the outbreak of the virus happened so rapidly because of the lack of PPE and because there was not enough staff to contain the residents appropriately.

66. At the time of his interview, on May 10, 2020, LPN Dioguardi was floating between the dementia and rehabilitation units during the day because two of the day shift registered nurses ("RN") on those units were potentially COVID-19 positive. While the staff had greater access to PPE in May 2020, including goggles, face shields, and N95 masks, they still did not have enough gowns for all of the staff, causing gowns to be reused or for some staff to use cloth nightgowns.

67. With respect to COVID-19 testing, RNs, LPNs, and the assistant director of nursing ("ADON") performed the tests of residents. LPN Michelle Neal ("LPN Neal") performed six COVID-19 tests on May 2, 2020: five residents on the dementia unit and one resident on Canal View. On May 3, 2020, LPN Dioguardi found out that five of those tests "went missing" and only one was sent to the lab. LPN Dioguardi said whatever happened to the missing tests is "malicious" and is "killing people." He heard from the Assistant Director of Nursing Kathy Howard ("ADON Howard") that DON Donnelly had the missing swabs thrown out because she "didn't want to open

a can of worms." Reportedly, LPN Jill Rechtsiegel was the employee who was directed by ADON Howard to throw the test swabs away.

68. LPN Neal then became sick, so LPN Dioguardi went over to the dementia unit alone, where he found patients coughing, not eating, and gray in the face. On May 4, 2020, he expressed his concerns to ADON Howard about the residents showing symptoms on the dementia unit. Together, they went and spoke with DON Donnelly and the Administrator, who gave LPN Dioguardi the "ok" to "prioritize" and test six residents. Of those six residents, three tested positive.

69. The lab used by The Villages, "ACM," was "awful." They were not doing any blood draws at the facility; they were only picking up samples. The lab got into an argument with the DON Donnelly and would not come back for blood draws. Therefore, the nurses were forced to complete the blood draws. Given the low staffing and other issues at The Villages, it was hard for the nursing staff to complete as many blood draws as were needed throughout the facility.

70. The protocol for cultures or lab work was for the item to be put in the refrigerator. There was a logbook above the refrigerator that the cultures were to be signed into, which included the patient's name, the doctor, and the date. The information was also required to be noted in the patient's progress notes.

71. There were issues, however, with samples being picked up and processed by the lab, and samples appeared to have gone missing. According to LPN Dioguardi, he believes that many residents suffered because of this issue and that it was a "big problem." He gave the specific example of Resident 37 who went untreated for an infection after two urine samples that were supposed to have been taken were never processed.

72. According to LPN Dioguardi, he spoke to Resident 37's daughter about her concerns regarding Resident 37's urine samples. Resident 37's daughter told LPN Dioguardi that

a few urine samples were completed but she was unaware of any results. When LPN Dioguardi questioned a previous nurse, he was told the first urine sample test was done and was never picked up, and the second test was pending. LPN Dioguardi said he checked the computer and did not see any doctor's order or any progress notes for Resident 37's urine sample. LPN Dioguardi said there is no evidence that the two tests were ever done, so he obtained a doctor's order for the test to be completed. LPN Dioguardi said that, when he obtained a doctor's order for Resident 37's urine sample test, he was only able to get a "foamy" sample meaning "an infection was present." LPN Dioguardi was able to get an antibiotic prescribed for Resident 37 based on his findings.

Dawn Moore, Registered Nurse

73. On May 28, 2020, I spoke to Dawn Moore ("RN Moore") via telephone about her employment at The Villages. RN Moore is a registered nurse who worked at The Villages from January 2020 to March 2021. She has been a nurse for 20 years. RN Moore was re-interviewed on March 22, 2022. RN Moore was employed by The Villages at the time she conveyed the following information with respect to events and information up to May 28, 2020.

74. According to RN Moore, staffing was very short at The Villages. The staff worked long hours and had no days off. Steve Hefter, the Administrator ("Admin Hefter"), and DON Donnelly were "no help at all."

75. There should be two nurses on the day shift and three nurses on the evening shift. On the weekend of May 23, 2020, during the day shift, one nurse called off and another nurse was a "no call no show." This left one nurse for the entire building. For RN Moore's shift on May 28, 2020, she was the only nurse for the entire building, which she said was "overwhelming." Her duties alone included: stocking briefs, linens, PPE gear, stocking the medical room, getting reports ready for the doctor on day shift, and passing three medication carts.

76. If there is only one nurse at the facility, the ADON or DON are supposed to stay to be the second nurse. DON Donnelly never stayed, however, and did not pass medication. ADON Howard helped at times, but she was out in May 2020 after testing positive for COVID-19. On evenings at that time, there was one aide on each hall, but there should have been two. At the time of RN Moore's interview, there was only one aide working both the Canal View (red zone/COVID-19 positive) and Orchard View (recovery) long-term care units. For the week of her interview, RN Moore gave a rundown of her schedule and the lack of staff that week:

- Monday, May 25, 2020 - Moore worked 10:00 p.m. - 6:00 a.m.; she was the only nurse on The Villages (three units). There was one agency nurse that came in "whatever time she wanted," and there was one nurse on the dementia unit;
- Tuesday, May 26, 2020 - Moore stayed after her shift was supposed to end at 6:00 a.m. and worked until 12:30 p.m. because there was no other nurse. LPN Dioguardi worked The Villages and the dementia unit by himself. DON Donnelly was in the building, but did not come out of her office;
- Wednesday, May 27, 2020 – RN Moore worked 10:00 p.m. - 8:30 a.m. She was the only nurse, a "re-lo" nurse came in at 1:30 a.m. for the dementia unit, along with an agency nurse at 1:30 a.m.;
- Thursday, May 28, 2020 – the date of RN Moore's interview, Moore stated she was expected to work the night shift by herself.

77. According to RN Moore, "Re-lo" is a term that stands for "Relocation." The facility was using re-lo aides and nurses that came from Alabama, Louisiana, Georgia, and West Virginia to work at the facility in the early months of the pandemic. The re-lo staff was housed in apartments in Brockport, NY; they lived rent-free and were given a food allotment. RN Moore

stated that the re-lo staff was, “mouthy,” and “had attitudes,” but could get away with all of it because the facility was so short staffed.

78. In the time since her original interview in 2020, RN Moore worked as the overnight Nurse Supervisor. According to RN Moore, she often was made to feel like a janitor at the facility, in that her daily tasks included stocking briefs, doing residents’ laundry and stocking the supply room. DON Donnelly thought overnight Nurse Supervisors had, “free time” to complete these tasks. However, while stocking supplies and doing laundry, RN Moore was also responsible for passing medications with two to three medication carts. She stated it is not normal practice for one RN to be responsible for more than one medication cart. At her previous employment at Monroe County Hospital, RN Moore had not passed medications in 15 years. She explained that, after 15 years of not passing medications, having the responsibility of two to three medication carts at The Villages was overwhelming.

79. According to RN Moore, the lack of staff at The Villages caused staff to be overworked. The lack of staff during the COVID-19 pandemic was particularly awful. And while the facility hired agency staff from out of state, it did not change things. Many staff caught the virus and the staffing quickly continued to drop. RN Moore did not work double shifts until the COVID-19 outbreak.

80. During the COVID-19 outbreak, the physical therapy staff sometimes assisted the overnight nursing staff with postmortem care. This consisted of washing up residents that had recently died and helping to get them ready and dressed for the funeral home.

81. One of the most difficult responsibilities for RN Moore was keeping up with daily tasks. It was too hard to change the residents, make rounds every two hours and pass medications. If there was time, RN Moore would try to assist the CNAs with rounds after she passed

medications. On one occasion, staffing was so short that she placed a resident that required 15-minute checks in a wheelchair and pushed him around with her while she passed medications.

82. Due to lack of staff, there was no time to shower the residents in the morning at the end of her overnight shift. Overnight staff stopped providing morning showers for the residents unless there was enough staff.

83. Problems with equipment were "a big issue" at The Villages. The biggest problem with the equipment was the non-functioning Hoyer lifts. According to RN Moore, there should always be one Hoyer lift for each unit, but there were frequently issues with them. DON Donnelly told RN Moore that the people above her did not want to spend money to make repairs. The owners did not help DON Donnelly with repairing or replacing any of the large equipment that was needed for resident care. Due to lack of assistance from the owners, the issue was never resolved.

84. In March 2021, RN Moore submitted her resignation to the new director of nursing, DON Howard. RN Moore and DON Howard wanted to help and make changes for the facility, but they were not able to do that with the lack of help from The Villages' owners. The owners did not want to help and never made any changes. DON Howard provided the owners with suggestions, however, the suggestions seemed to stop at Jason Teitelbaum and go no further.

85. Staff did not have appropriate PPE gear until after DOH came in for an inspection. Prior to the DOH visit, RN Moore's husband, Adam Moore, donated eight boxes of N95 masks from his employer. RN Moore brought in the eight boxes of N95 masks and DON Donnelly locked them all up in her office. RN Moore's husband was able to get a few more boxes, so she kept them in her car and passed them out to staff members herself.

86. Prior to the DOH visit on April 29, 2020, some yellow gowns were available for staff as they were put out "sporadically." Aides were told that the yellow gowns were to be hung

on the back of the COVID-19 positive resident's door to be reused. The gowns were reused by staff on every shift. When DOH came, however, DON Donnelly claimed she never told the aides to reuse the yellow gowns. RN Moore would wear a regular hospital gown, which exposed her elbows down.

87. Prior to the DOH visit, if staff wanted to be tested for COVID-19 they had to have the testing done on their own. However, the facility began testing staff twice a week after the DOH visit.

88. Employees were not permitted to test residents without approval. If staff felt a resident was showing COVID-19 symptoms, they were required to pass the information to the day shift nurse. The day shift nurse then talked to DON Donnelly or medical director Dr. Thomas Madejski for testing approval. Positive and negative residents were in the same rooms together until they started "shuffling" them around.

Mike Estela, Physical Therapy Assistant

89. On June 4, 2020, I spoke to Mike Estela ("PTA Estela") via telephone about his employment at The Villages. PTA Estela is a Physical Therapist Assistant and worked 7:00 a.m. - 3:00 p.m. As a Physical Therapist Assistant, his job duties include ambulatory care, bed mobility, positioning and strengthening of residents. Since a variety of residents need physical therapy, including those on both long-term and short-term care units, PTA Estela has experience working on all of the units at The Villages during the course of his employment, since at least January 2020. PTA Estela was employed by The Villages at the time he conveyed the following information to me.

90. Staffing was so short that PTA Estela helped with room changes and postmortem care, a job that aides typically perform. Postmortem care included cleaning the bodies, including

hair, teeth, clean clothes, and clean briefs, covering the face with a towel, and wrapping the body in a sheet.

91. According to PTA Estela, the virus was so new back in March 2020 that "nobody knew what was going on." PPE gear was very limited at the facility, especially on Orchard View, which was the first "COVID-19 unit." There was one gown per resident hanging in the resident's room. "Per CDC guidelines," he was able to wear a gown throughout the entire COVID-19 unit because "everyone had the virus." He eventually purchased his own Tyvek plastic suit and sprayed it down and hang it to dry every night. He also purchased his own painter's mask.

92. The DOH showed up for a "surprise visit," on April 29, 2020, but the facility must have had a few days' notice because the facility provided staff with PPE gear when the DOH came.

93. The facility stopped using ACM labs and began using Quest to process its lab work. ACM labs no longer wanted to do business with the facility because DON Donnelly "got mouthy with them." However, when it came to COVID-19 testing, ACM labs would typically have results within 48-72 hours, while Quest results typically took 4-5 days.

94. After testing positive for COVID-19, PTA Estela was swabbed on June 1, 2020, by DON Donnelly, in order to determine if he could return to work. Days later, he went on the Quest app to check his results, but there were no results. It was later rumored that all the tests from June 1, 2020, were lost or went missing. Ultimately, PTA Estela had to be re-tested on June 4, 2020, by LPN Michelle Neal, who herself just returned to work after being quarantined due to testing positive for COVID-19.

95. PTA Estela stated that there was never any clear direction from management at The Villages. However, everything needed to be approved by them.

Glennis Poole, Certified Nursing Assistant

96. CNA Glennis Poole ("CNA Poole") has been a Certified Nursing Assistant since 2010. I spoke with CNA Poole on April 20, 2020. CNA Poole was employed by The Villages at the time she conveyed the following information to me.

97. When CNA Poole came in to work on May 3, 2020, the drawers for supplies were empty, she had to ask for a N95 mask and wear a cloth gown. The gowns at that point were still hanging everywhere. There were only two CNAs and one RN for all three units in The Villages from 10:00 p.m. - 6:00 a.m. There were three CNAs and one RN for the dementia and rehab units from 10:00 p.m. - 6:00 a.m.

98. CNA Poole was concerned that there was no 2:00 p.m. - 10:00 p.m. staff on May 3, 2020. When she came in at 10:00 p.m., a resident on Canal View still had on the same clothes from when she left at 6:00 a.m., and another had been in the same chair all day.

99. According to CNA Poole, at the time of her interview, there had been 16 deaths at the facility due to COVID-19, and an additional two residents had tested positive. Canal View and Garden View were housing positive and negative residents together. Meanwhile, every resident on Orchard View was positive except for one resident that was also a "wanderer." She did not know why the administration was keeping the only negative resident on a full positive unit.

Melissa Olles, Licensed Practical Nurse

100. On July 26, 2022, I spoke to LPN Melissa Olles ("LPN Olles") via telephone about her employment at The Villages. LPN Olles was an LPN at The Villages through the agency MSN

until February 2020. LPN Olles returned to The Villages in November 2021 and left prior to this interview.

101. Between July 2019 and September 2019, LPN Olles assisted the facility transition from paper documents to electronic files using Point Click Care (PCC). LPN Olles trained staff members on how to use the system in its entirety. Once the facility fully transitioned to PCC, LPN Olles discovered numerous PCC reports that were missing significant resident care information including nursing notes, doctor orders, and errors involving treatment and medication administration.

102. LPN Olles stated that after the training period, she noticed questionable changes that were being made in PCC. LPN Olles stated, "I know how I trained people in PCC, and I was on the floor working with these people too." LPN Olles further stated, "I would see something happen on a unit and then I'd go back to PCC, and it wouldn't be documented there." LPN Olles began running reports daily and noticed certain staff members were deleting and "striking" out notes in PCC.

103. LPN Olles stated that LPN Neal and DON Donnelly were "notorious" for making changes to resident records in PCC. LPN Neal was a unit manager on all three of The Villages long-term care units (Garden View, Orchard View and Canal View).

104. LPN Olles stated that LPN Neal would often not follow up on a doctor's order and then delete it in PCC to cover it up. LPN Olles described this type of incident; an RN must document in PCC any "note" with said date, and the name of the supervisor or DON that was notified.

105. Additionally, if an RN or Doctor did not follow up on the note and something went wrong, the responsibility would fall on the individual that entered the note. LPN Olles stated LPN

Neal would often be in this situation and would delete the note in PCC so she would not be held responsible if something went wrong with a resident.

106. LPN Olles recalled that numerous PCC errors and incidents involving LPN Neal. LPN Olles recalled that being present when a doctor ordered a medication for a resident to LPN Neal. However, there was no doctor order documented in PCC by LPN Neal.

107. LPN Olles recalled an incident involving a resident with multiple bruises. LPN Neal did not perform a full skin assessment on the resident but made a note in PCC that she completed the skin assessment.

108. LPN Olles stated that the note LPN Neal entered in PCC was for the opposite arm that was bruised. LPN Olles reviewed the resident's file and noted a flu shot on the opposite arm was the bruise that LPN Neal noted, along with a cortisone shot that included the doctor's note specifying the arm that was injected. LPN Olles found that the cortisone shot itself was never documented in PCC.

109. Overall, LPN Neal documented the resident's skin assessment that was never completed and bruising from a flu shot on the opposite arm in question.

110. After going to former DON Donnelly numerous times with her complaints, DON Donnelly took away LPN Olles' credentials for PCC. LPN Olles was unable to run reports and could no longer see what care was or was not being provided to residents.

111. During November 2019, LPN Olles came back to the facility after her day off to find that a resident's dressing was never changed. LPN Olles sent text messages to former DON Donnelly notifying her of the incident. A true and correct copy of the text message is attached hereto as **Exhibit F**.

112. LPN Olles stated that Resident 44's fentanyl patches "kept disappearing." LPN Olles informed former DON Donnelly via text message on November 8, 2019, that Resident 44's patch was missing, and that it was signed out incorrectly. LPN Olles stated that DON Donnelly did not address the incident and she did not know if DON Donnelly reported any of the incidents to the DOH. A true and correct copy of the November 8, 2019, text is attached hereto as **Exhibit G**.

113. Resident 45 was diagnosed with stomach cancer. While at the facility, Dr. Madejski found a mass on his stomach. According to LPN Olles, Dr. Madejski directed LPN Neal to schedule a biopsy for the mass. LPN Olles stated that LPN Neal left her job at The Villages and never scheduled a biopsy for Resident 45. LPN Olles stated that, approximately three months later, Resident 45 died. She stated Resident 45's condition regressed quickly.

114. LPN Olles stated that Resident 45's purported cause of death is "natural cause from cancer," however, LPN Olles stated, "He died because of delay in care." She stated that nobody will ever know what Resident 45's outcome would have been if the biopsy had taken place.

115. LPN Olles explained how the understanding of a resident's medication needs could lead to drug diversion at The Villages. LPN Olles stated that nursing staff "knows" which residents takes their "as needed" medication on a regular basis and which residents never request it. According to LPN Olles, when a resident does not often request their as needed medication but "all of a sudden" the medication administration record shows they requested it, it is a "red flag".

116. According to LPN Olles, RN "Crystal" (last name unknown) ("RN Crystal") was "always stealing morphine" from the facility. RN Crystal was part of the re-lo staff at The Villages.

117. LPN Olles stated that RN Crystal would put morphine in a plastic cup and take it to her medication cart. LPN Olles stated that, within a few minutes, RN Crystal was "nodding off at her cart." She stated that on one occasion, RN Crystal's face fell onto her desk.

118. LPN Olles stated that she and other staff members would voice their concerns about RN Crystal being under the influence while working to DON Donnelly and LPN Neal. She stated that DON Donnelly and LPN Neal never addressed the issue. LPN Olles stated that neither DON Donnelly nor LPN Neal would generate a narcotic error report after receiving drug diversion complaints.

119. LPN Olles stated that Resident 16, a lucid resident, often complained that she was not getting her narcotics. Resident 16's medication administration record was documented and signed by nursing staff as though she had received her narcotics. However, Resident 16 claimed she never received them.

120. LPN Olles stated that the situation with Resident 16 got so bad she had to obtain a new order. As a result, an RN was then required to watch the administering RN take the pill out of the blister pack, administer, and document the medication.

121. LPN Olles reported the incident to former DON Donnelly and Administrator Brian Reader; however, the issue was not addressed. LPN Olles states she continuously went to Admin Reader with her concerns, but he repeatedly told her that he was "in charge of the business" and DON Donnelly was "in charge of clinical." LPN Olles stated that Admin Reader could not go "above" DON Donnelly, furthermore, any issues voiced by staff never went above her.

122. LPN Olles stated that Dr. Madejski requested numerous formal investigations into incidents including Resident 44's fentanyl patch, but that DON Donnelly and LPN Neal never completed the investigations. LPN Olles stated that Dr. Madejski would question DON Donnelly

and LPN Neal about the investigations he requested, but stated that Dr. Madejski was too busy to follow up all the time.

123. During April 2021, Resident 35 had been moved from the Orchard View to the Garden View unit. Resident 35 frequently suffered seizures and required a liquid injection of Ativan. When Resident 35 arrived at Garden View unit, there was no order for her Ativan. LPN Olles received a verbal order to pull Ativan for Resident 35 from the emergency box if needed until her order arrived.

124. During this time, Resident 35 suffered a seizure and required an injection of Ativan. LPN Olles stated that LPN Neal took an Ativan injection that was reserved for another resident and administered it to Resident 35. This left the resident without an Ativan injection if needed. *See also* Affidavit of Donna Kelly.

Tonya Zambito, Registered Nurse

125. On August 25, 2022, I interviewed RN Tonya Zambito ("RN Zambito"). She started working at The Villages during August 2018 as a Nurse Supervisor. From November 2018 to 2020, RN Zambito was the assistant director of nursing ("ADON"). However, DON Donnelly and RN Zambito bumped heads all the time, which caused RN Zambito to step down as ADON and return to being a Nurse Supervisor. RN Zambito initially quit on June 12, 2020, citing "Covid-19 mismanagement."

126. On January 5, 2022, RN Zambito returned to The Villages because Administrator Eric Flugel ("Admin Flugel") "begged" her to come back. In mid-August 2022, RN Zambito notified DON Howard, who became DON in February 2021, of her resignation. However, RN Zambito accepted DON Howard's offer to take a 90-day leave of absence instead. As such, RN Zambito was employed by The Villages at the time she conveyed the following information to me.

127. RN Zambito described the staffing at The Villages during the COVID-19 pandemic as "horrible." During that time, all five units in the facility were utilized – the three residential units (Canal View, Orchard View and Garden View) and the dementia and rehabilitation units. She stated that at times there was only one nurse on day shift for all three of the residential units. There were times when only one CNA was present on each of the five units, or at times, only two CNAs for all three residential units.

128. RN Zambito stated that as a Nurse Supervisor, she would constantly go to Administration with her concerns over the lack of staff and Administration's constant flow of new admissions. She explained that a "critical staffing plan" was implemented by Administration to help with staffing issues.

129. RN Zambito stated that the "critical staffing plan" involved calling DON Donnelly, Admin Reader or his successor Admin Hefter, when staffing was extremely low. According to the plan, when DON Donnelly, Admin Reader or Admin Hefter received a critical staffing call, they were supposed to get a hold of additional staff to come in to work. RN Zambito described an example of critical staffing as having only two CNAs for the entire facility or under five CNAs for all three of The Villages' long-term care units.

130. RN Zambito stated the facility reached "critical staffing" levels several times a month. However, RN Zambito stated that when she would call DON Donnelly, Admin Reader, or Admin Hefter, her calls were ignored. She stated that Administration came up with this plan but never followed through to help with the critical staffing issues.

131. She added that, when the plan was first initiated, department heads would come in early to help but that was short lived. RN Zambito attempted to call additional staff for help on her own and tried to do the best she could with the staff she had available.

132. Due to short staffing, RN Zambito stated residents were neglected of their general needs, such as feeding and bathing. She stated there were days when a CNA would go into a resident's room once, possibly two times per day to provide basic care. She added the 2:00 p.m. - 10:00 p.m. shift was very bad when it came to staffing levels.

133. RN Zambito stated staff members would voice their concerns to her about the lack of care residents were receiving. She stated staff members would come to her and report that residents were in the same clothes, soiled with "piss and shit," and still in bed from the day before. She added that CNAs would show her certain residents with skin issues, and wounds with openings that had gotten worse.

134. RN Zambito stated CNAs performed many job duties that they were not qualified to do, including administering medications. RN Zambito stated that RNs would frequently get medications ready and give them to CNAs to pass out to residents.

135. Additionally, CNAs performed wound treatments and applied various lotions and creams, such as Nystatin, to residents' yeast infections. RN Zambito stated that residents' wounds did in fact get worse due to low staffing at The Villages.

136. Feeding the residents became "tricky," stated RN Zambito. She stressed her frustration when it came to critical staffing levels and the lack of help from Administration. RN Zambito stated the lack of help caused neglect to residents who needed assistance with eating. She stated that residents' food intake would have been better if there were more help available.

137. RN Zambito stressed that, if residents received more assistance from staff when eating, they would eat more. However, RN Zambito stated that the staff was unable to spend enough time with each resident due to staffing issues, thus leading to patterns of frequent weight loss.

138. RN Zambito stated Brittany Roberts of Human Resources created the staff schedules. Schedules with hardly any staff were provided to Administration, but RN Zambito noticed that, when she went to the copy room schedules were "beefed up" to appear as though more staff would be present, especially around the time DOH was coming.

139. RN Zambito stated that LPN Neal was a big issue at The Villages. Despite all the complaints to DON Donnelly, she never fired LPN Neal. LPN Neal came to work whenever she wanted to and showed up late for her shifts. RN Zambito stated LPN Neal was allowed to do things that other staff could not do.

140. RN Zambito went to DON Donnelly with her concerns numerous times, including complaints from family members, residents, and other employees. However, DON Donnelly never addressed the issue with LPN Neal.

141. During times of critical staffing, residents that required a two-person assist were not assisted in that manner. RN Zambito stated that there was "no such thing" as a two-person assist during the COVID-19 pandemic.

142. RN Zambito stated that, due to low staffing, resident care plans were continuing to break which led to an increase of falls. She stated that, overall, low staffing led to more injuries.

143. At the start of the COVID-19 outbreak, all PPE was locked in DON Donnelly's office. RN Zambito stated there was one gown per resident for staff to share. The gowns were hung on the residents' doors. She adds the facility mixed COVID-19 positive employees with COVID-19 negative residents, and mixed COVID-19 positive residents with COVID-19 negative residents.

144. RN Zambito voiced her concerns to DON Donnelly and the administrator, however, they continued to retain the PPE. She stated that the administrator attempted to get more PPE from corporate and Jason Teitelbaum but was unsuccessful.

145. RN Zambito recalled a married couple at The Villages, Residents 54 and 39. Both Residents 54 and 39 died a few days apart from contracting COVID-19 at the facility.

146. RN Zambito stated that Resident 54 and Resident 39 lived separately on different hallways. Their daughter requested her parents to be together in one room, but it took forever for The Villages to make the arrangement.

147. RN Zambito stated that, once Resident 54 and Resident 39 were moved to the same room, various staff members including those that were COVID-19 positive, went in and out of their room during the outbreak. Unfortunately, Resident 54 and Resident 39 both died a few days apart due to the virus. *See also,* Affidavit of Susan Fuller.

148. Shortly after RN Zambito returned to The Villages on January 5, 2022, she noticed residents were not getting physical therapy and occupational therapy services. RN Zambito stated that she was "flabbergasted" that the physical therapy department never came down any of The Villages' units to work with the residents.

149. When it came to therapy notes, RN Zambito voiced her frustration. The nursing staff at the facility do not have access to any of the residents' therapy notes, therefore, the staff do not know which residents receive physical therapy or occupational therapy. RN Zambito stated everything related to therapy is "a big secret".

150. RN Zambito and other nursing staff requested a list of residents that require therapy, but the therapy department never provided one. Additionally, the nursing staff did not receive any type of resident schedule for therapy services.

151. Most importantly, RN Zambito stated that nursing staff cannot access therapy notes and therefore are unaware whether residents were making progress in relation to their care plan.

152. RN Zambito expressed how the system is one-sided because the therapy department has access to all nursing notes in their PCC system. Additionally, the therapy department has the ability to input notes in PCC.

153. RN Zambito stated that she knows the therapy department is billing services for five days a week for many residents, despite the residents never going to the therapy room.

154. RN Zambito stated that The Villages "isn't even a nursing home anymore." The facility has recently increased admissions for individuals under the guardianship of Catholic Family Services (CFS). RN Zambito stated that The Villages "loves" getting people from CFS and does this because CFS act as guardians on behalf of those residents so that The Villages does not have to deal with family members.

155. RN Zambito stated that, since she came back to work in January 2022, the facility has been moving CFS residents every day to different rooms all over the facility. She added that, when a resident is moved to a different room, the facility is supposed to call the family and ask for permission. However, if the resident is under the guardianship of CFS, the facility only needs a letter from CFS prior to moving the resident to a different room.

156. RN Zambito stated that it is hurtful to residents when they finally get settled in a room and are then moved to different rooms numerous times. She noted Resident 49 has been moved five times to different rooms.

157. At the end of the interview, RN Zambito stated that The Villages "will never change until the ownership changes". She added that the owners do not care about the residents or employees. RN Zambito stated that The Villages needs to be shut down.

Photos & Other Tangible Evidence

158. Former MFCU Detective Milagro Ferrer obtained the cellular telephone (telephone # xxx-xxx-3622) from the former DON of The Villages, Karrie Mikits ("DON Mikits"). The contents of DON Mikits' phone were downloaded, and I reviewed text messages obtained from the phone.

159. On September 14, 2020, DON Mikits conveyed to Social Worker Sarah Woodin ("SW Woodin") in a text message: "What I left out is how great we are at making up policies on the fly! Lol and maybe a careplan or two." On September 15, 2020, DON Mikits wrote to SW Woodin: "I faked policies all week! Lol Google saves the day!" A true and correct copy of the September 14 and 15, 2020, text messages is attached hereto as **Exhibit H.**

160. On September 10, 2020, DON Mikits, in reference to preparing an incident or accident report regarding a resident, wrote to SW Woodin: "U rick [sic]. I'm gonna say I interviewed u k. Lol and u said that… he came in blah blah blah." A true and correct copy of the September 10, 2020, text message is attached hereto as **Exhibit I**.

161. On September 3, 2020, in an exchange of text messages, CNA Kathryn Wilston ("CNA K. Wilston") communicated with DON Mikits regarding a Hoyer lift that The Villages staff had previously reported to management:

Wilston: So, we don't have a working hoyer machine. Haven't all day.

Wilston: Eric helped us put [a Resident] in his recliner, and was supposed to help us put him to bed, and I'm pretty sure Eric left for the day.

Wilston: So now [a Resident] is stuck in his recliner and we have no way to put him in bed.

Mikits: Where is the charger?

Wilston: Someone broke it. Ripped it from the wall and the piece that goes into the hoyer broke off

A true and correct copy of the September 3, 2020, text messages is attached hereto as **Exhibit J**.

162. On December 10, 2020, Kim Brueckner of Office/Admissions (#xxx-xxx-5588) stated in a group text that included Admin Flugel (#xxx-xxx-9139), SW Woodin, Elijah Howard of Housekeeping (#xxx-xxx-8075), then-ADON Howard (#xxx-xxx-2653), and Occupational Therapist Assistant LeeAnna SanFilippo ("OTA SanFilippo") (#xxx-xxx-2150): "Room 202 is ready but has ant problem." Admin Flugel responded, "Eli, can it be vacuumed, wiped down? Maybe some food missed?" A true and correct copy of the December 10, 2020, texts are attached hereto as **Exhibit K**.

163. On December 16, 2020, DON Mikits received a group text in which ADON Howard wrote to Brueckner of Office/Admissions, Admin Flugel, SW Woodin, Howard of Housekeeping, and OTA SanFilippo: "We need more surgical masks for the residents. None in the main PPE room." The text shows that management was notified of the lack of PPE in the facility at that time. A true and correct copy of the December 16, 2020, text message is attached hereto as **Exhibit L**.

164. On November 7, 2020, CNA K. Wilston and DON Mikits exchanged a series of text messages about the severely low staffing that day and what they anticipated to be just as severe the following day. CNA K. Wilston texted: "Jill never showed. Katie left. Stephen is the only nurse in the building…We have one LPN and one CNA that will be here within the hour and that's all we can get." A true and correct copy of the November 7, 2020, text messages and attachments is attached as **Exhibit M**.

165. CNA K. Wilston then sent a text message to DON Mikits that attached a photograph of a Facebook message previously sent by CNA K. Wilston to CNA/Office Assistant Brittany Roberts. CNA K. Wilston stated in the Facebook message: "Karrie [Mikits] said its too short

staffed and we need as much help as possible to have you cone in and help." Roberts responded: "Ok it's not my fault if 2 cnas didn't call in and a ton of cnas up and left!!!!! I'm so sick of ppl not understanding. I'm not a slave for this building…" *See* **Exhibit M**.

166. CNA K. Wilston also texted to DON Mikits a screen capture of a text message she received from a resident, who stated: "We have no nurse and no meds here tonight. Please see if you can get us help." *See* **Exhibit M**.

167. CNA K. Wilston also sent to DON Mikits by text messaging a screen capture of a Facebook message sent by a resident, who wrote: "No nurse for anything. Stuart said he is only doing garden. No meds or sugar check for anything[.] Rob is doing all he can. He got meals out [resident] her food fed herself." *See* **Exhibit M**.

168. In response, DON Mikits, referring to the low staffing, wrote to CNA K. Wilston: "Okay. We're absolutely screwed for tomorrow. We're going to have 4 CNAs and no nurses." *See* **Exhibit M**.

169. On November 8, 2020, CNA K. Wilston texted to DON Mikits: "[Administrator] Eric [Flugel] knew we had no staff yesterday when he was here. I pointed out the schedule to him yesterday. And he did nothing, and now we have all these call ins because everyone is fed up." A true and correct copy of the November 8, 2020, text is attached hereto as **Exhibit N**.

170. On November 13, 2020, CNA K. Wilston texted to DON Mikits a photo of the staffing schedule for that day, where four out of the five residential halls only had one CNA scheduled to work during the 6:00 a.m. - 2:00 p.m. shift, while three of those four CNAs were scheduled to train new CNAs in addition to their regular duties. CNA K. Wilston further texted: "We have to work down the halls by ourselves ON TOP OF training the new girls!" A true and

correct copy of the November 13, 2020, texts and photograph attachments is attached as **Exhibit O**.

171. On December 20, 2020, CNA K. Wilston texted to DON Mikits: "Hey. We have critical staffing. 4-5 CNAs called in. Katie has called everyone and she can't get ahold of anyone." CNA K. Wilston then forwarded a photograph of the 6:00 a.m. - 2:00 p.m. staffing schedule, which showed five CNAs calling in as unable to work. A true and correct copy of the December 20, 2020, text and attachment is attached as **Exhibit P**.

172. On January 3, 2021, SW Woodin and DON Mikits discussed by text messages the January 2, 2021, death of a resident who overdosed on the illegal drug known as "K2":

> Woodin: Jesus I didn't realize why were up all night!! I heard wtf… was it K2 or some shitttt
>
> Mikits: I don't know.
> [Administrator] Eric [Flugel] was MIA though
>
> Woodin: Seriously he's on call 24/7 and he didn't answer his phone?
>
> Mikits: Nope
> And this is going to be a full blown investigation
>
> Woodin: Just what we need. Fuck! Did he show up at all?
>
> Mikits: No
> I didn't go to sleep until 6am. My last night with my girls and I lost that time.
> Oh no u r fine. Last night I wanted to just curl up and have 4 year old and 8 year old girl fun but I couldn't because we let people do drugs in our facility and our administrator doesn't care
>
> Woodin: We need to stop getting these prisoners. They need to stop admitting anyone and everyone. That's frustrating. I know it's not Kim [Brueckner of Office/Admissions] fault. I feel bad for her because they are hounding her to fill beds, not worrying about not having staff, nor trained staff to deal with addicts.

A true and correct copy of the January 3, 2021, texts is attached hereto as **Exhibit Q**.

173. On December 22, 2020, SW Woodin texted the following message to DON Mikits:

> Yes that's her, I know i was like what the hell is Karrie texting us for about a new admit!!!! They need to stop with all these admissions!! No one is caught up from last weeks. It's getting way to [sic] crazy!! All the room changes on top of 3 admissions in a day a few times a week. We need staff before more admissions

A true and correct copy of the text message is attached hereto as **Exhibit R**.

174. On September 21, 2021, I received from CNA Molly Brown ("CNA Brown") a photograph that she had taken on June 30, 2018, showing the thermometer inside the facility reading 80 degrees Fahrenheit. The accompanying text message from CNA Brown stated, "This was one of the hot days in the building when the ac didn't work. It was so hot and humid in the building we had to put wet towel around our necks while we were working and I had to do a breathing treatment because I couldn't breath [sic]." CNA Brown advised me that the thermometer was located in dining room where the residential halls are located. A true and correct copy of the photograph and the text message is attached hereto as **Exhibit S**.

Substandard Care Set Back Amputee's Recovery

175. On March 24, 2022, I interviewed former Resident 43 regarding his experience at The Villages from [redacted], 2020, to [redacted] 2021. He was [redacted] years old at the time.

176. Resident 43 stated that he has struggled with severe diabetes for approximately eight or nine years. In [redacted] 2019, he had his right leg amputated due to his diabetes. Following his surgery, he spent over one month at a hospital in Rochester, New York. When he was discharged from the hospital, his goals were to gain enough strength to get a prosthetic leg and to live independently. To achieve these goals, he first required daily physical and occupational therapy. He needed to transfer to a rehabilitation facility to receive these treatments.

177. Resident 43 sated that, on [redacted] 2020, he was transferred from the hospital to The Villages. The Villages' plan was to place him on the rehabilitation unit, where he was supposed to receive daily therapy sessions. However, he only received one or two therapy sessions, and after two to three weeks he was moved to the long-term care unit. After being moved, he never received another therapy session even though he was supposed to receive them daily.

178. Resident 43 stated that living in the long-term care unit was like being in *One Flew Over the Cuckoo's Nest*. The residents were loud and noisy and wandering around. The Villages moved dementia patients into the long-term care unit too, which made the floor even more noisy.

179. Resident 43 stated that, when he arrived at The Villages, he had a pressure sore on his right buttock. During his residency at The Villages, the staff never once measured his pressure sore, and the sore on his buttock progressively got worse.

180. Resident 43 stated that, during the approximately three months he was at The Villages, low staffing was an issue and staff response times were inconsistent. During this time, a nurse gave him sponge baths, and he only received one real shower. He only saw a staff member every three to four hours. Due to being diabetic, he needed to use the bathroom frequently. He would press his call light, and it took staff so long to respond that he was usually sitting in a puddle of urine when they arrived. He was also worried about his pressure sores as he was often sitting in his own urine and feces with only a barrier cream covering his sores.

181. Resident 43 stated that, one day, he could feel his blood sugar dipping, so he pressed his call light for help. One of The Villages' CNAs eventually arrived at his room and told him that he had to wait for help. He told the CNA that he could not wait any longer or his levels would get worse. The CNA said, "I don't care, let it get low."

182. Resident 43 stated that, as he had just had his leg amputated, he was in a lot of pain while at The Villages. He was prescribed 20 mg of Oxycodone as needed. He often called for more medication before he needed it, as it took so long for someone to administer the next dose. Often, The Villages staff told Resident 43 that he would have to wait fifteen to twenty minutes for medication, but he would actually end up waiting two to three hours for someone to administer his next dose.

183. Resident 43 stated that Dr. Madejski tried to ween Resident 43 from his 20 mg Oxycodone prescription to 3 mg Methadone immediately after he arrived at The Villages. Other residents at The Villages call Dr. Madejski "Dr. Methadone." Resident 43 was able to negotiate with Dr. Madejski to stay on his original prescription due to his pain level.

184. Resident 43 stated that he was only able to speak with the Director of Nursing if he demanded it. He also never saw the owners of The Villages.

185. Resident 43 stated that The Villages employed agency staff, who seemed to only be there for the paycheck and did not care about the residents. They were often rude, had attitudes, and frequently were only socializing with each other. Each morning, Resident 43 asked which CNAs were on duty, because he knew which CNAs and nurses would be helpful throughout the day, and which ones would not be.

186. Resident 43 stated that, if it were not for Registered Nurse "Melissa" (last name unknown) ("RN Melissa"), he thinks he would have lost his mind while at The Villages. RN Melissa took photos of his pressure sores and treated them as best she could with the lack of supplies, such as bandages and clean towels. She would clean his sores and put barrier cream on them.

187. Resident 43 stated that the few times he did receive physical and occupation therapy at The Villages, it was laughable. He would be brought to the physical therapy room and do nothing but sit there. There was no equipment that he could use. Resident 43's main goal of rehabilitation was to learn to walk again, and he was not able to do so at The Villages. Resident 43 questioned staff about why he was not receiving physical therapy, and they told him that he was "discharged" from the program. Resident 43 stated that The Villages staff claimed that he was difficult, vulgar, and refused to participate in sessions, which Resident 43 said was untrue. Resident 43 acknowledged that he was not a gentleman while he was at The Villages, but that he had just had his leg cut off, was on heavy painkillers and was not able to get enough sleep due to the rowdiness of the dementia patients on his floor. Resident 43 was also very frustrated that The Villages did not have the equipment that he needed to gain strength. The Villages also never arranged for Resident 43 to receive a prosthetic leg.

188. Resident 43 stated that the condition of his room at The Villages was awful. His room was old and dirty and only cleaned a few times over his three-month residency. His laptop was stolen while he was at The Villages, though The Villages denied that this happened. The food at The Villages was also unappetizing. It was so bad that Resident 43 often struggled to eat it, and he believed much of the food was handled improperly.

189. Resident 43 stated that The Villages' rooms were full of flies. Resident 43 said that when it was time to eat, "the flies were ready to join me with a fork and knife." The maintenance worker placed fly traps hanging from the ceiling. This was apparently not allowed, but the flies were so bad that the maintenance worker said he did not care if he got fired for putting them up.

190. Resident 43 stated that care at The Villages was so bad that he once called 911 because he needed assistance and felt like he was going to pass out. Resident 43 was told by the

aide to wait his turn. A fireman responded and asked what was wrong. Resident 43 told the fireman that he wanted to speak with a police officer. When the police came, they asked why Resident 43 wanted to speak with law enforcement, and Resident 43 said that he wanted the police to stop The Villages from treating its residents so badly. Resident 43 also informed the police that it took The Villages approximately two to three hours to administer medication to the residents. Resident 43 did not believe police did anything to help.

191. Resident 43 stated that, at the beginning of [redacted] 2021, he contracted COVID-19. As soon as he tested positive, The Villages staff came into his room and said, "Come on, you're going." They moved Resident 43 to a hospital. Resident 43 tried to take as many of his personal belongings with him as he was transferred to the hospital. There were some things that he was not able to take that are still at The Villages. After the hospital, he was thankfully transferred to a different facility after recovering from COVID-19, but Resident 43 was never able to get the rest of his belongings.

192. Resident 43 states that he had been making great progress at the new facility, where he was transferred in approximately [redacted] 2021. From the beginning, the staff at the new facility was right on top of treating his pressure sores, which have completely healed. The new facility's staff woke him up when it was time to take his medications, and the staff put cloth between his skin folds to prevent infection, which The Villages never did.

193. Resident 43 stated that, when he first arrived at the new facility, he received physical therapy and occupational therapy at the same time, and that it was amazing. He received occupational therapy in his own room, and he was able to incorporate some weight work. He attended physical therapy five times per week. He progressed from using a Hoyer lift to his own sit-to-stand machine, and he received a new prosthetic leg that the new facility arranged for.

194. Resident 43 stated that all of the accomplishments that he achieved at his new facility should have been achievable while he resided at The Villages. Resident 43 stated that, if he had never gone to The Villages, he would currently be at home living on his own. Resident 43 hoped that The Villages will be held accountable for the lack of care that it provided to its residents. Unfortunately, his health later declined, and he died in [redacted] 2022.

Resident Was Endangered by The Villages' Unsafe Decision to Discharge Her

195. On April 20, 2022, I interviewed Resident 22 at The Villages, where she had been a resident since December 2021. Resident 22 was 60 years old at the time. Resident 22 stated that she was diagnosed as a child with dermatomyositis, a rare disease that causes muscle inflammation and skin infections. Upon arriving at The Villages, Resident 22's overall goal was to gain more strength through rehabilitation therapy for a few months with the hope of being able to return home.

196. Resident 22 stated that she last participated in physical therapy in February 2022, when a physical therapist at The Villages told her that she was "done." When she initially started physical therapy she attended five times per week for the first month, and then three times a week for the second month.

197. Resident 22 complained that the staff was insufficient and unresponsive. She tried to use the bathroom on her own because she was tired of waiting for staff to assist her. There were occasions where she waited over an hour to receive help from The Villages' staff. On one occasion, when she was in the common living room area and needed to use the bathroom, there was no staff to assist her, so she sat on the floor, hoping that a staff member would notice and take her to the bathroom. After no one assisted her, she eventually urinated on the floor. No staff member noticed that she continued to sit on the floor in her own urine.

198. Resident 22 recalled that a day or two prior to the April 20, 2022, interview, she observed that her roommate was in the common living area sitting in a chair that was saturated with urine.

199. On August 4, 2022, I interviewed Resident 22 again at The Villages concerning a complaint that she had lodged about a male CNA, who worked during the night shift.

200. Resident 22 stated that her physical therapy had resumed in May 2022 until August 4, 2022. Her physical therapy sessions went from three-to-four times a week to every day in the past two weeks.

201. Resident 22 stated that she was scheduled to undergo surgery on her hip and to address the calcification buildup on August 31, 2022. She felt "ready to go home," but noted that she would have to get cleared by the physical therapy and occupational therapy teams, as well as receive medical clearance.

202. When I arrived at The Villages on August 4, 2022, at 7:04 p.m., in addition to the conditions set forth above concerning my April 20, 2022 visit, I observed that, in one of the long-term care rooms, a female resident was lying in a bed completely naked with no sheets or blankets. This was visible from the hallway because the door to the resident's room was wide open and the resident's bed was close to the door. I asked Resident 22 about this and she responded, "Because they don't care about people here." I subsequently asked RN Zambito on August 25, 2022, whether it was normal for a resident to be lying in bed naked with no sheets or blankets. RN Zambito replied that it was not and that the only reason a resident would be naked in bed is if the resident took off their clothes during the middle of the night.

203. On August 29, 2022, I interviewed Resident 22 at her residence in Brockport, New York, to check on her well-being upon learning that she had been discharged from The Villages on August 25, 2022.

204. Resident 22 stated that she was first notified that she was going to be discharged on August 24, 2022, the day before The Villages had its staff remove her from the facility. Physical therapy and occupational therapy had cleared her three days prior to being discharged. However, she was never assessed by a physician to be medically cleared for discharge. She also felt that The Villages' doctor would not have cleared her due to the open pressure sore on her tailbone that would not heal. I took a photograph of the pressure sore. A true and correct copy of the photograph is attached hereto as **Exhibit T**.

205. Resident 22 stated that, on August 24, 2022, she had an altercation with one of The Villages' nurses after the nurse accused Resident 22 of not taking her insulin properly to address her diabetes. The nurse told Resident 22, "You're out of here!"

206. Resident 22 stated that, on August 25, 2022, the day she was discharged from The Villages, CNAs entered her room and "threw" her belongings into bags and boxes. SW Woodin brought papers for Resident 22 to sign but did not explain what the papers were. As a result, Resident 22 was unsure whether she had signed herself out or was being discharged by The Villages. Resident 22 stressed that no one at The Villages explained anything to her at her discharge. Even though Resident 22 felt that she was "severely neglected" at The Villages, she stated, "I didn't feel good about leaving" in that manner.

207. Resident 22 stated that her boyfriend, a fellow resident at The Villages ("Resident 57") signed himself out the same day. The Villages "established" that the Resident 57 would live with her because he had nowhere else to live.

208. Resident 22 recounted that two CNAs transported Resident 22 and Resident 57 in a facility van to her residential apartment in Brockport, New York. SW Woodin followed in her personal vehicle. Upon arrival, the CNAs and SW Wooding left Resident 22's belongings on the doorstep. None of them entered the apartment to check on it. When Resident 22 began to unpack, she observed that all her medication was mixed up in different boxes and that some were mixed with her boyfriend's medication.

209. Resident 22 stated that The Villages did not notify any of her family members that she was being discharged. Additionally, she did not have a way to contact her son since she did not have a telephone. She had assumed the facility had contacted him. Her son learned about her discharge two days afterwards and was furious about the late notice.

210. I observed during this interview that Resident 22's apartment was at a low frigid temperature and that the floors were sticky. There was a large pile of clothes in boxes and laundry baskets, that Resident 22 identified as her dirty laundry from The Villages. I observed a box of crackers on her coffee table. Resident 22 stated that there was no other food in her apartment, but that her son brought her soup. Also on the coffee table were ten-to-fifteen syringes of various shapes and colors. On a nearby chair I observed a large stack of blister packs of narcotic medication, which I recognized based on my training and experience. I took photographs of her apartment. A true and correct copy of the photographs are attached as **Exhibit U**.

211. Resident 22 stated that Resident 57 has been physically abusive to her since The Villages moved him in with her. Resident 22 stressed that The Villages knew that Resident 57 was a "blackout drunk" but still allowed him to be discharged to her apartment. Since her discharge, Resident 57 threw a shoe and beer bottle at her head, grabbed her neck, kicked her in the stomach, dug his nails into her wrists and injured her knee.

212. During the interview I observed that Resident 22 had bruising on her face, scratches on her wrists and an injury to her right knee. I photographed the injuries. A true and correct copy of the photographs is attached hereto as **Exhibit V**.

213. On September 29, 2022, I attempted to locate Resident 22 at her residence to check on her safety. "Joanne" (last name unknown) who lives in the apartment unit across from Resident 22 stated that she had not seen Resident 22 in several days. Other neighbors advised me that Resident 22 had "not been the same" since she went to The Villages last year. The neighbors stated that Resident 22's family was never around and that they had seen her son there, but that he arrived empty handed.

214. The building manager permitted me to enter Resident 22's apartment, which was empty. As I departed, a neighbor named Amy Hacket said to me, "[Resident 22] should not be living alone! It isn't safe."

215. On September 30, 2022, I spoke briefly with Resident 22, who was in a hospital in Rochester, New York. She stated that she had been there since September 22 or 23, 2022, but at that time was unable to discuss why she was there. Later in the day I received a call from Orleans County Sheriff's Investigator Devon Pahuta, who advised that Resident 22's son had told Investigator Pahuta that Resident 22 went to the hospital for "bad sugar and a mental episode." *See also* Medical Analyst Aff., ¶¶ 89-101.

Funeral Home Director and Coroner Observed Poor Infection Control and Understaffing

216. On April 30, 2020, I spoke on the telephone with Chief Coroner of Orleans County Scott Schmidt ("Schmidt"), who is also a funeral director. Schmidt stated that on April 17, 2020, he entered The Villages as a funeral director to pick up the body of a deceased resident, whom the facility advised was COVID-19-positive. No staff took his temperature or inquired about his

health status upon his entry. Schimidt recalled there was a staff member who was COVID-19-positive but continued to work in the facility.

217. Schmidt advised that it is normal protocol for hospitals and nursing facilities to cover the face of a deceased individual. But when he entered the deceased resident's room, he observed that the deceased resident's face was left completely exposed. When the deceased resident's roommate asked why she was being wheeled out of the room and into the hall, the staff responded, "Because your roommate died."

218. On May 28, 2020, I spoke on the telephone with the Director of Cooper Funeral Home, Jacob Hebdon ("Hebdon"). Hebdon stated that he entered The Villages on seven occasions to remove the bodies of nine deceased residents on and between April 22, 2020 and May 23, 2020. Hebdon thought the facility was very understaffed and lacked procedure and competency. He thought about making a complaint but did not know whom to go to.

219. Hebdon stated that, in mid-April 2020, he removed the body of a deceased resident while the roommate was still present in their room with a hacking cough.

220. Hebdon observed nurses go in and out of residents' rooms that were both positive and negative with COVID-19, cross contaminating the residents. On one occasion staff members heckled him because he showed up in full PPE gear.

My Visits to The Villages Confirmed Poor Conditions

221. On April 20, 2022, I went to The Villages to complete resident interviews. While at the facility, I made the following observations, which corroborated accounts I had received from family members and staff regarding low staffing and difficulty communicating with residents.

222. Upon arrival at 11:00 a.m., I entered the first set of doors to the facility, there was a telephone on the wall to call reception to open the second set of doors. I called three times with

no answer. After approximately five minutes, two staff members happened to walk by and opened the door for me, without asking why I was there. I walked through the entrance, there was no reception staff, no sign-in book or thermometer. I had no idea where to go and walked down a few hallways until I found a staff member who was able to give me directions to the Garden View unit. This confirmed the many accounts I had received from family members and staff regarding low staffing.

223. Further evidence of low staffing was apparent when I visited Resident 35's room on April 20, 2022. *See* Affidavit of Donna Kelly.

224. Resident 35 requires a high level of assistance to eat. Resident 35's lunch was served at 12:23 p.m., I watched Resident 35 struggle to eat, which was only possible with assistance from her mother, Affiant Donna Kelly. I left Resident 35's room at 1:15 p.m.. During that time, no staff members came to assist or check on her. This confirmed that without her mother's help, Resident 35 would not have been able to eat and would eventually fall asleep on her tray.

225. Not only does Resident 35 need constant assistance and monitoring when eating, it is also documented on her menus that her food must be cut up and any lids on food or beverages must be taken off. Those food instructions were not followed for the lunch I observed. I took photographs of the menu instruction and food served. A true and correct copy of the photographs is attached hereto as **Exhibit W**.

226. At one point during the meal, I asked Resident 35's mother to back away from her daughter so that I could see what would happen when she was not there to help her daughter eat. Within a few minutes, Resident 35 had fallen asleep with her face resting in her lunch tray. I took photographs depicting this. Resident 35's mother relayed that, on numerous occasions, if she

arrived after lunch had been served, she observed her daughter asleep with her face in her food. A true and correct copy of the photographs is attached hereto as **Exhibit X**.

227. When I left Resident 35's room, there were residents sitting in the hall with meal trays. I walked up and down the hall and did not see any staff members. Nobody was at the nurse's station. One resident asked, "can you help me?" I looked over and she needed help opening her Boost drink. I asked if there had been anyone around to help her, she said "no." I took a photograph of the hallway. A true and correct copy of the photograph is attached hereto as **Exhibit Y**.

228. While walking through the facility at approximately 1:30 p.m., I observed numerous residents sitting in the halls but only one aide. I walked past the physical therapy room and it was empty. I observed one employee in the "TV Room" with the door closed. This room has been transformed to the "nurse's room" per Affiant Donna Kelly.

229. There are no telephones in the residents' rooms; there is one telephone in the hallway for the residents to share. During my visit to the facility, my cellular telephone never had service. I received similar complaints from some of the residents with cellular phones, including a resident who shared with me that she is unable to use her cellular phone because there is no service throughout the facility. The lack of telephone access coupled with the poor cellular phone reception confirmed the many accounts I had received from residents' family members regarding the challenges they had experienced attempting to reach and communicate with their loved ones, which left the residents and their family members feeling helpless and trapped.

230. On November 2, 2022, I entered The Villages with Affiant Vicki Juckett to interview her mother, Resident 40. *See* Affidavit of Vicki Juckett. Upon arriving at 5:45 p.m., no one requested that we sign in or take our temperatures. As I walked through the facility to the

long-term care units I did not observe any staff members in the hallways. Despite being dinner time, there were no residents in the dining room.

231. Affiant Juckett and I entered Resident 40's room at approximately 5:50 p.m. There was one staff member sitting in a chair next to Resident 40 with a meal tray, who immediately left. Due to the strong and obvious odor of urine in the room, Affiant Juckett inspected Resident 40's diaper, which was so saturated in urine that it had leaked through onto the bed pad.

232. Resident 40's food menu noted "puree" and "aspiration precautions." As Affiant Juckett assisted her mother with dinner, Resident 40 pulled out of her mouth what appeared to be a piece of celery that was not pureed properly. Affiant Juckett explained that concerns about aspiration risks were why she and her sister take turns everyday to assist their mother with every meal. Affiant Juckett took about an hour to assist her mother with dinner. I took photographs of the food menu and solid food particle. A true and correct copy of the photograph is attached hereto as **Exhibit Z.**

233. After Resident 40 finished dinner, a staff member who identified herself as a nurse came into the room to provide medication. The staff member advised Affiant Juckett that staffing was comprised of herself and one CNA until 10:00 p.m. None of the staff members wore any identification tags or badges.

234. I observed that the room's walls were in a state of repair. Affiant Juckett advised that the walls had not been fully repaired in months. I further observed that the floor was visibly dirty and sticky. I took photographs of the room's walls and floor. A true and correct copy of the photographs is attached hereto as **Exhibit AA**.

235. I asked Resident 40 if she uses her call light when she is alone and soils herself. Resident 40 replied that she does but "nobody comes so I press it again" and that "I sit here, nothing happens."

236. Resident 40 appeared to have difficulty breathing. Affiant Juckett noted that Resident 40's nasal cannula was placed upside down.

237. Affiant Juckett and I checked on Resident 40's diaper, which was heavily saturated and leaked even further onto the bed pad. The bandage over a pressure sore on the buttock was soaked with urine. I took photographs of the bed pad and urine-soaked pressure sore bandage. A true and correct copy of the photographs is attached hereto as **Exhibit BB**.

238. I asked Resident 40 if she were enjoying her stay at The Villages. She responded, "I want to get the hell out of here!"

Internet Evidence of Inadequate Staffing and Resident Neglect

239. I used online resources to search for social media references to The Villages. The paragraphs below refer to public posts made to the website Facebook.com (hereafter referred to as "Facebook"). I downloaded the following Facebook posts between March 2020 and May 2022. Except as noted below, I was unable to further verify the identity of the persons who made the posts.

240. In April 2020, Facebook user account "Sheila Fernandez" posted that she worked eight hours by herself on the dementia unit and "they" tried to make her stay another 8 hours to work by herself on the dementia unit. I interviewed CNA Fernandez, who was employed at The Villages at the time of the posting. *See* ¶¶ 14-27, *supra*. A true and correct copy of the "Sheila Fernandez Facebook posting" is attached hereto as **Exhibit CC**.

241. I spoke to Ondrea Pate on multiple occasions and confirmed that she authored the attached Facebook postings under the user account "Ondrea Brakenbury Pate." Ms. Pate is the daughter of Resident 7, a former resident of The Villages, who is now deceased. *See* Pate Aff., ⁋⁋ 1-2.

242. On June 9, 2020, Ms. Pate posted that a nurse did not move her mother to a different room after her mother's roommate tested positive for COVID-19 while her mother had tested negative:

> I still wake up in the middle of the night and wonder why she [a nurse] could not have just put my mom in a separate room after her test. She knew Mom was going home and they had they had [sic] empty rooms. I am so angry that she had such little respect for my mother's life. She was a wife, a mother, a grandmother, a sister, an aunt and a friend. She deserved better.

243. On September 6, 2020, Ms. Pate posted about her mother's death: "If I had known then what I know now that day in March when we put my mother in the back of an ambulance, I would have hugged her and told her I loved her." A true and correct copy of the "Ondrea Brakenbury Pate Facebook postings" are attached hereto as **Exhibit DD**.

244. I spoke to Timothy Myers, Sr., who confirmed that he authored the Facebook postings under the user account "Timothy Myers Sr." and that he is the son of a former resident of The Villages, who is now deceased.

245. In May 2020, Mr. Myers posted photographs taken during an "end of life" visit with his mother at The Villages, which included photos of rusted doorframes, peeling paint, missing ceiling tiles and broken floor tiles. A true and correct copy of the "Timothy Myers Sr. Facebook postings" are attached hereto as **Exhibit EE**.

246. On May 28, 2020, Facebook user account "Dawn Moore" posted, "One day off just isn't enough. Nap time, need to refuel for work tonight…. looking forward to the weekend off.

And I am not answering my phone!!!!" I interviewed RN Moore who was employed by The Villages when this was posted. *See* ¶¶ 76-91, *supra*. In April 2020, "Dawn Moore" publicly posted on Facebook that she was bullied at The Villages. A true and correct copy of the "Dawn Moore Facebook postings" are attached hereto as **Exhibit FF**.

247. On June 3, 2020, Facebook user account "Jessica Estela" posted statements regarding her husband "Mike" who worked as a Physical Therapist Assistant at a nursing home:

> We didn't know how much trauma working there through this would cause. Nor did we know how much panic and depression it would flood into our household…

and

> We didn't know that Mikes Physical Therapy skills would become spending his time going from room to room, syringe dropping water into their mouths, trying to keep people hydrated, changing them and turning them to keep them comfortable, while Covid over took them…

I spoke with PTA Estela, who confirmed that he was a Physical Therapist Assistant at The Villages. *See* ¶¶ 91-97, *supra*. A true and correct copy of the "Jessica Estela Facebook posting" is attached hereto as **Exhibit GG**.

248. On May 8, 2020, Facebook user account "Liza Brien" posted:

> I will fight for her dignity that she died with out I will prove she was sane and being abused and drugged up so many countless things I have handed over my case and evidence to the Orleans County Sheriff's Dept and I will not stop till justice is served for my mother and so many others hang on mom I will fight for you…

I spoke to Liza Brien, who confirmed that she authored the above-referenced posting and that she is the daughter of a former resident of The Villages, who is now deceased. A true and correct copy of the "Liza Brien Facebook posting" is attached hereto as **Exhibit HH**.

249. On April 1, 2020, Facebook user account "Jennifer Raschke Marcello" posted about her sister, a CNA at The Villages who is immune compromised:

> She called to let them know she would not be able to come into work as she is immune compromised, and as she was having this conversation on the phone with a coworker her Supervisor, in the background, yells out "If you don't come into work consider yourself unemployed…"

A true and correct copy of the "Jennifer Raschke Marcello Facebook posting" is attached hereto as **Exhibit II**.

250. On September 3, 2020, Facebook user account "Cindy Delaura" posted about the lack of communication from The Villages when her mother died:

> I don't know if anyone else is having this problem. But my mom passed away on May 23 after falling and breaking her hip. I was never even notified of this until I called them that day! They also said she was covid negative and when she went to Batavia Hospital she was covid positive... I never got to say goodbye to her…Now I get a bill from them demanding I pay them money! This is outrageous!

I spoke with Cynthia Delaura on September 10, 2020, and she confirmed that she authored the above Facebook posting. *See also* Affidavit of Cynthia Delaura. A true and correct copy of the "Cindy Delaura Facebook posting" is attached hereto as **Exhibit JJ**.

Respectfully submitted,

JAIMIE KRZYSKOSKI

Sworn to before me this
28th day of November, 2022

Notary Public

Mary L Henry
NOTARY PUBLIC, STATE OF NEW YORK
Comm. No. 01HE6299052
Qualified in Erie County
My commision expires March 17, 2026

CERTIFICATION PURSUANT TO RULE 202.8-b

I, Soo-young Chang, an attorney duly admitted to practice law before the Courts of the State of New York, hereby certify that this Affidavit contains 18,039 words, excluding the parts of the Affidavit explicitly exempted by Rule 202.8-b, and that Petitioner's request for permission to file an oversize submission as provided in Rule 202.8-b(f) is forthcoming.

Dated: New York, New York
November 28, 2022

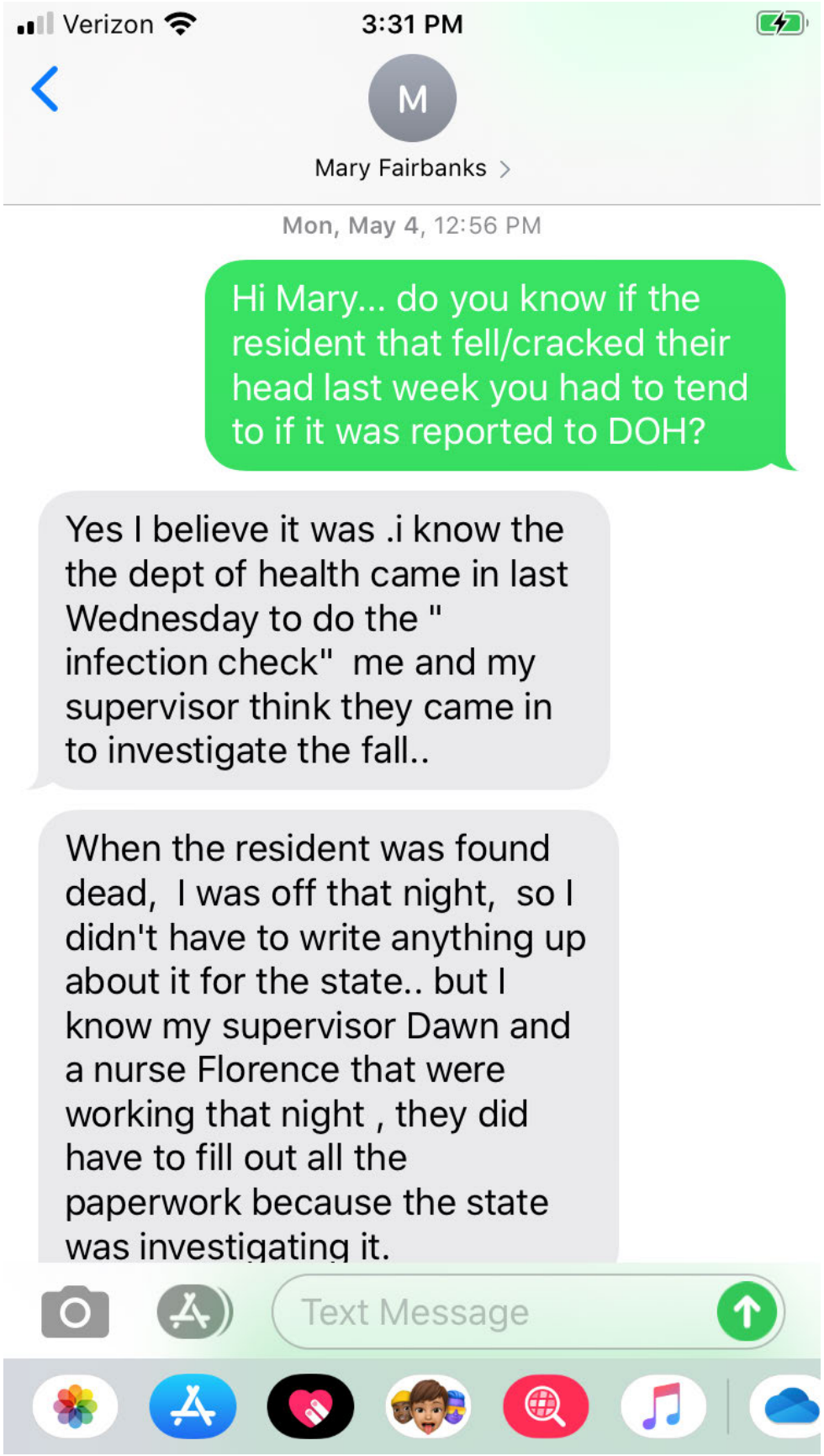
Respectfully submitted,

Letitia James
Attorney General of the State of New York

By: _____

Soo-young Chang
Special Assistant Attorney General
New York State Attorney General's Office
Medicaid Fraud Control Unit
(716) 249-5147
Soo-young.Chang@ag.ny.gov

EXHIBIT A


Verizon
3:31 PM
M
Mary Fairbanks
Mon, May 4, 12:56 PM
Hi Mary... do you know if the resident that fell/cracked their head last week you had to tend to if it was reported to DOH?
Yes I believe it was .i know the the dept of health came in last Wednesday to do the " infection check" me and my supervisor think they came in to investigate the fall..
When the resident was found dead, I was off that night, so I didn't have to write anything up about it for the state.. but I know my supervisor Dawn and a nurse Florence that were working that night , they did have to fill out all the paperwork because the state was investigating it.
Text Message

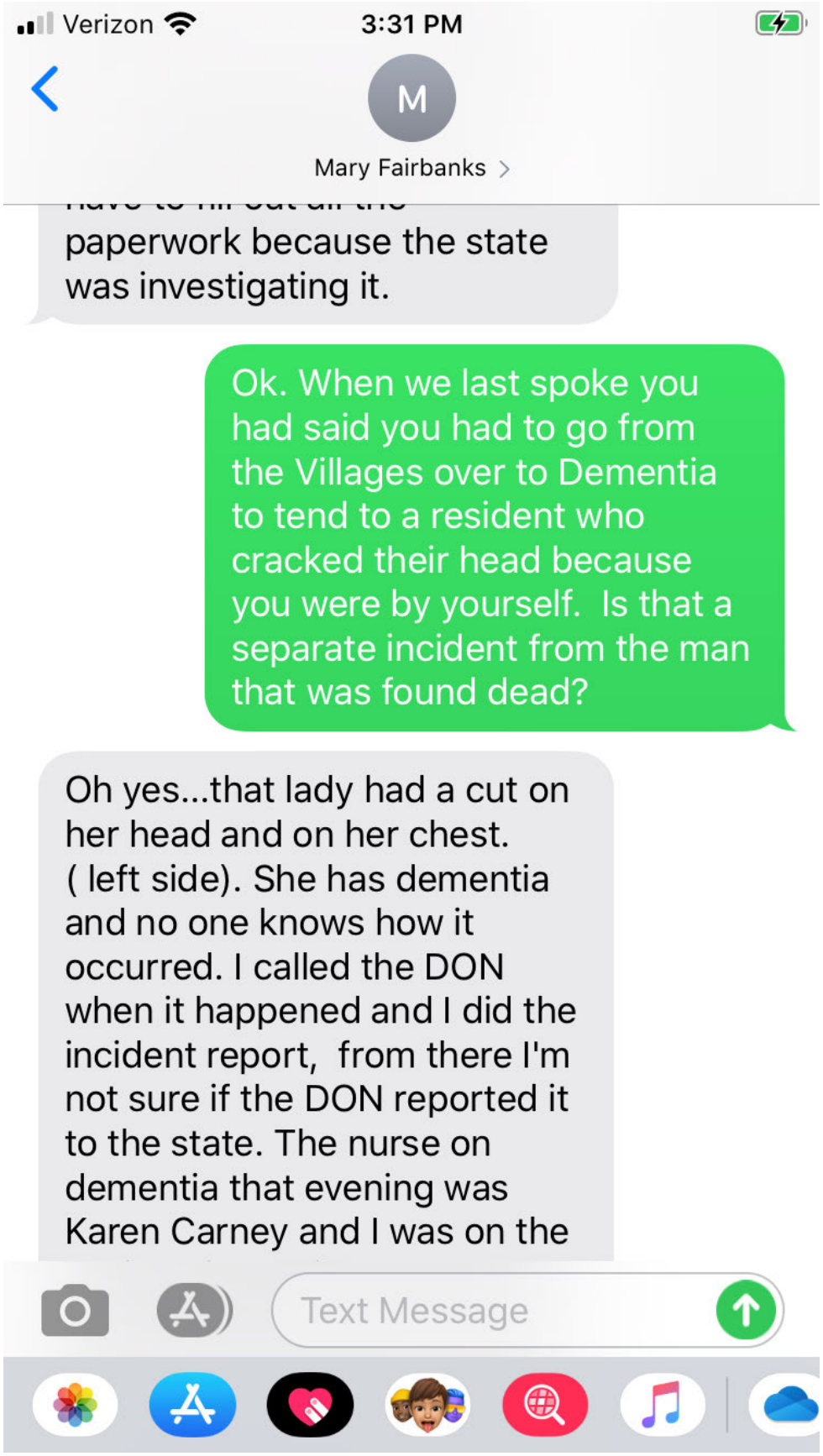
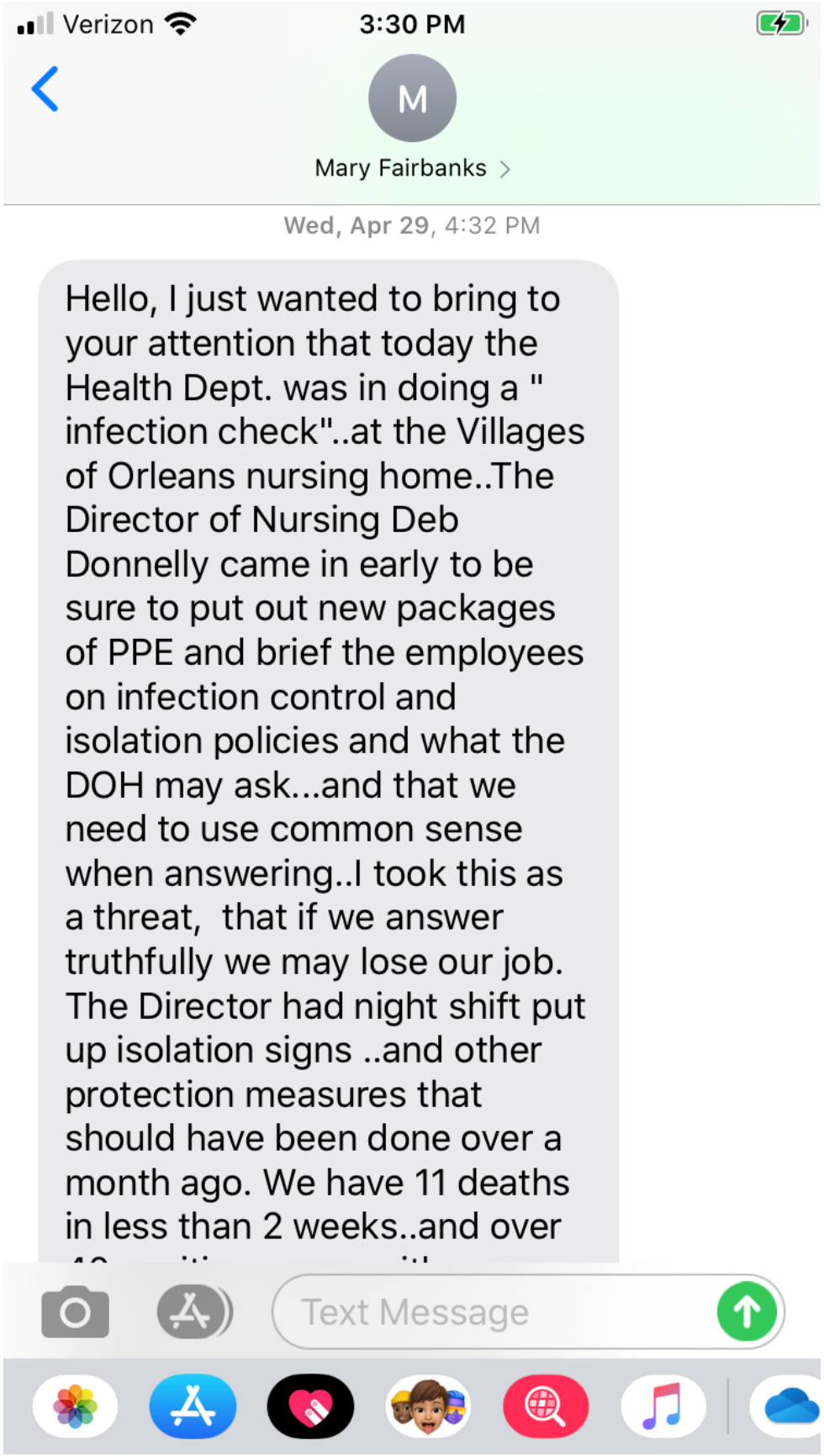

Verizon
3:31 PM
M
Mary Fairbanks
paperwork because the state was investigating it.
Ok. When we last spoke you had said you had to go from the Villages over to Dementia to tend to a resident who cracked their head because you were by yourself. Is that a separate incident from the man that was found dead?
Oh yes...that lady had a cut on her head and on her chest. (left side). She has dementia and no one knows how it occurred. I called the DON when it happened and I did the incident report, from there I'm not sure if the DON reported it to the state. The nurse on dementia that evening was Karen Carney and I was on the
Text Message

EXHIBIT B


Verizon
3:30 PM
M
Mary Fairbanks
Wed, Apr 29, 4:32 PM
Hello, I just wanted to bring to your attention that today the Health Dept. was in doing a " infection check"..at the Villages of Orleans nursing home..The Director of Nursing Deb Donnelly came in early to be sure to put out new packages of PPE and brief the employees on infection control and isolation policies and what the DOH may ask...and that we need to use common sense when answering..I took this as a threat, that if we answer truthfully we may lose our job. The Director had night shift put up isolation signs ..and other protection measures that should have been done over a month ago. We have 11 deaths in less than 2 weeks..and over
Text Message

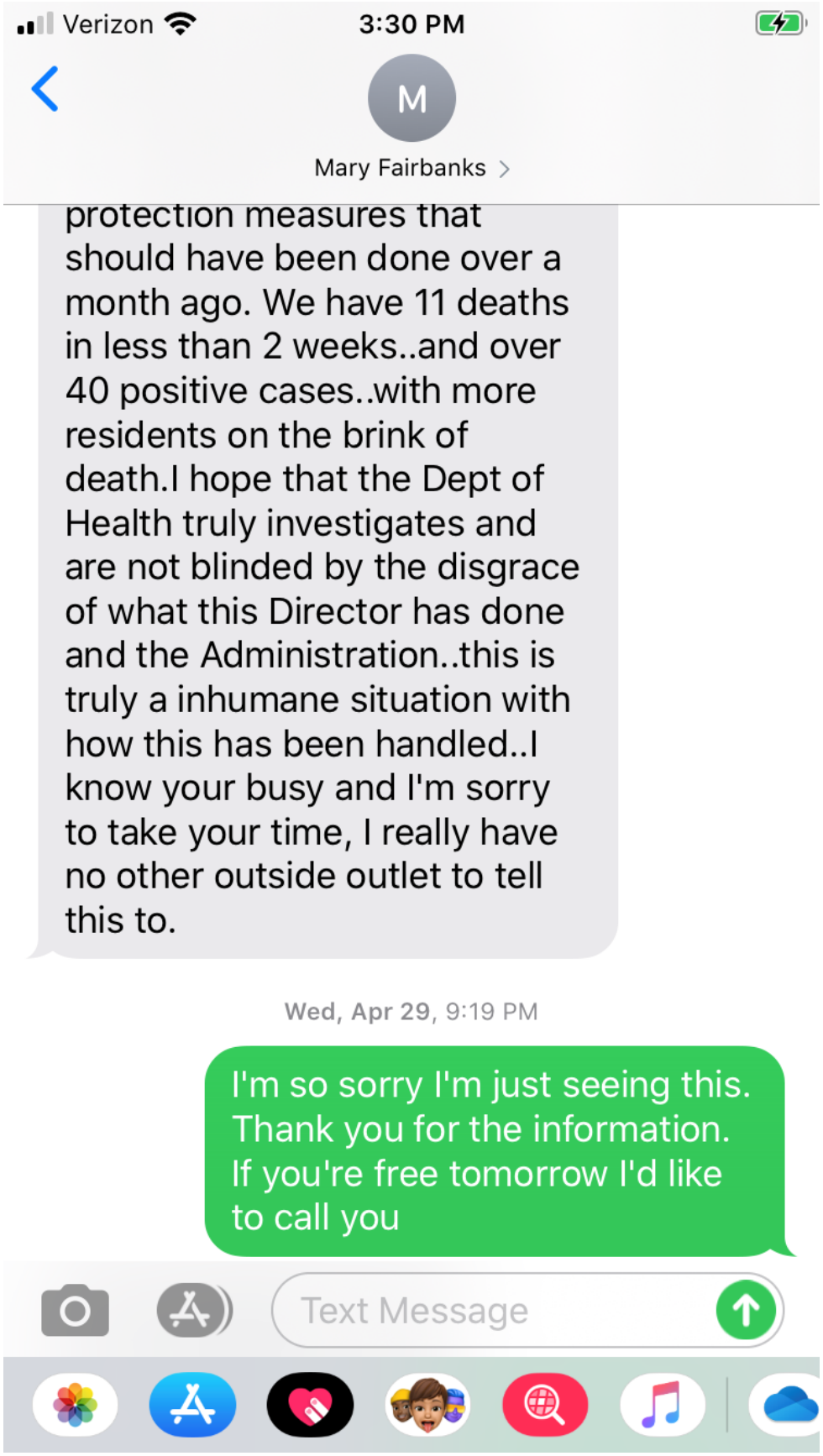
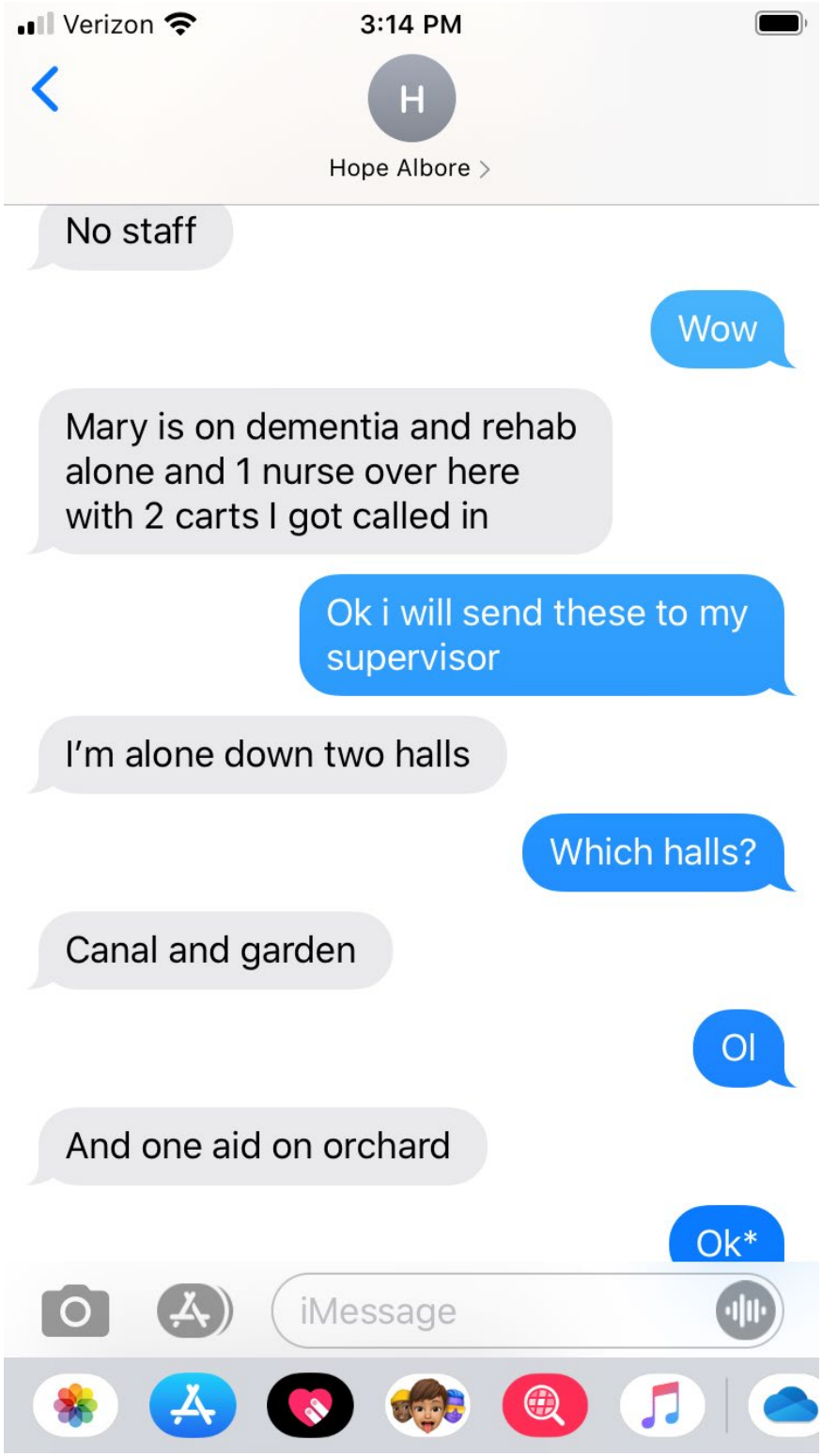

Verizon
3:30 PM
M
Mary Fairbanks
protection measures that should have been done over a month ago. We have 11 deaths in less than 2 weeks..and over 40 positive cases..with more residents on the brink of death.I hope that the Dept of Health truly investigates and are not blinded by the disgrace of what this Director has done and the Administration..this is truly a inhumane situation with how this has been handled..I know your busy and I'm sorry to take your time, I really have no other outside outlet to tell this to.
Wed, Apr 29, 9:19 PM
I'm so sorry I'm just seeing this. Thank you for the information. If you're free tomorrow I'd like to call you
Text Message

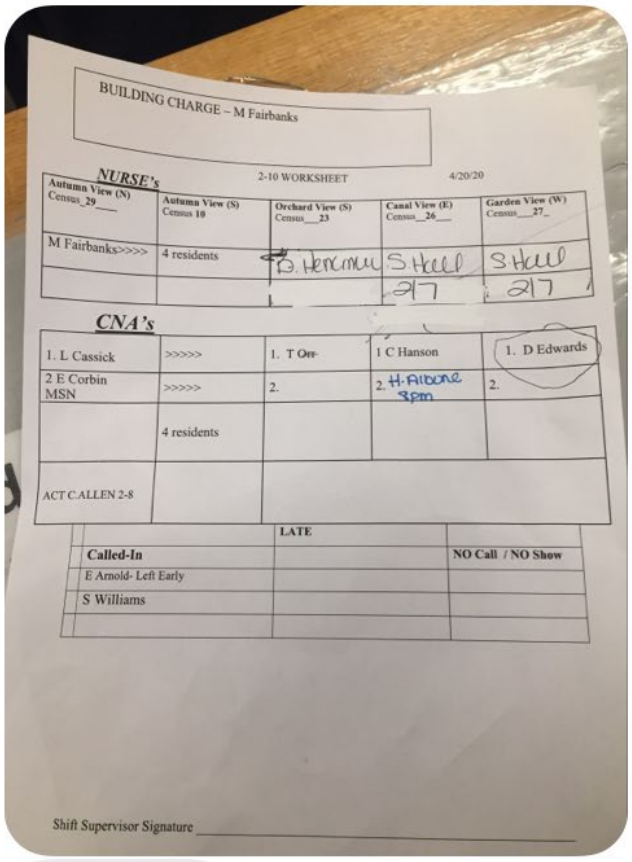
EXHIBIT C


Verizon
3:14 PM
H
Hope Albore
No staff
Wow
Mary is on dementia and rehab alone and 1 nurse over here with 2 carts I got called in
Ok i will send these to my supervisor
I'm alone down two halls
Which halls?
Canal and garden
Ol
And one aid on orchard
Ok*
iMessage

Verizon 3:13 PM

H

Hope Albore >



BUILDING CHARGE – M Fairbanks

2-10 WORKSHEET 4/20/20

NURSE's

Autumn View (N) Census 29	Autumn View (S) Census 10	Orchard View (S) Census 23	Canal View (E) Census 26	Garden View (W) Census 27
M Fairbanks>>>>	4 residents	D. Herrman	S Hall 2|7	S Hall 2|7

CNA's

1. L Cassick	>>>>>	1. T Orr	1 C Hanson	1. D Edwards
2 E Corbin MSN	>>>>>	2.	2. H. Albore 3pm	2.
	4 residents			
ACT CALLEN 2-8				

	LATE	
Called-In		NO Call / NO Show
E Arnold- Left Early		
S Williams		

Shift Supervisor Signature _____

No staff

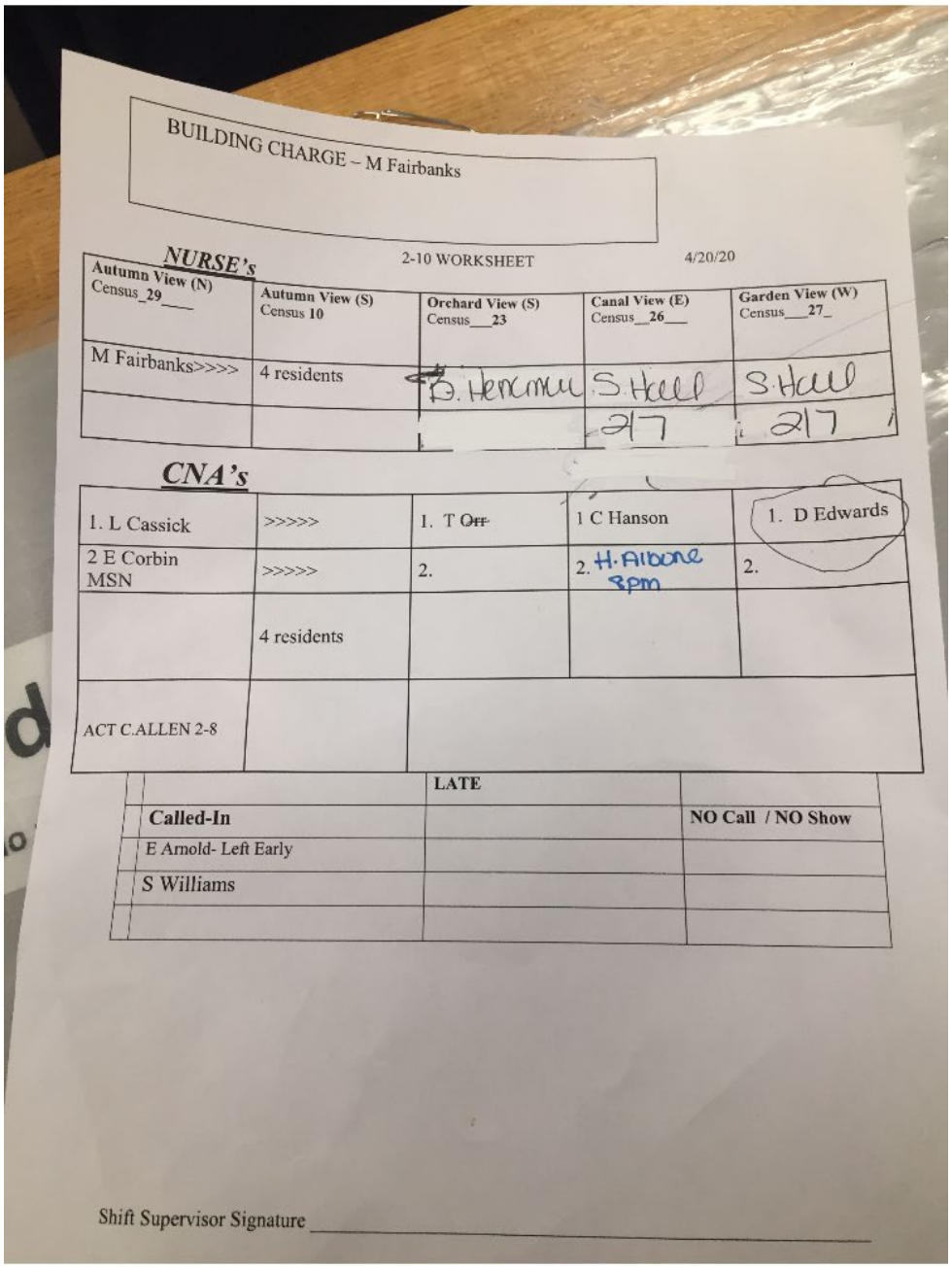
Wow

Mary is on dementia and rehab alone and 1 nurse over here

iMessage

Verizon 3:13 PM

Done 3 of 4



BUILDING CHARGE – M Fairbanks

NURSE's 2-10 WORKSHEET 4/20/20

Autumn View (N) Census_29___	Autumn View (S) Census 10	Orchard View (S) Census___23	Canal View (E) Census__26___	Garden View (W) Census___27_
M Fairbanks>>>>	4 residents	~~D~~. Herrmann	S Hall	S Hall
			2|7	2|7

CNA's

1. L Cassick	>>>>>	1. T ~~Off~~	1 C Hanson	1. D Edwards
2 E Corbin MSN	>>>>>	2.	2. H. Albone 8pm	2.
	4 residents			
ACT C.ALLEN 2-8				

	LATE	
Called-In		**NO Call / NO Show**
E Arnold- Left Early		
S Williams		

Shift Supervisor Signature _____

EXHIBIT D

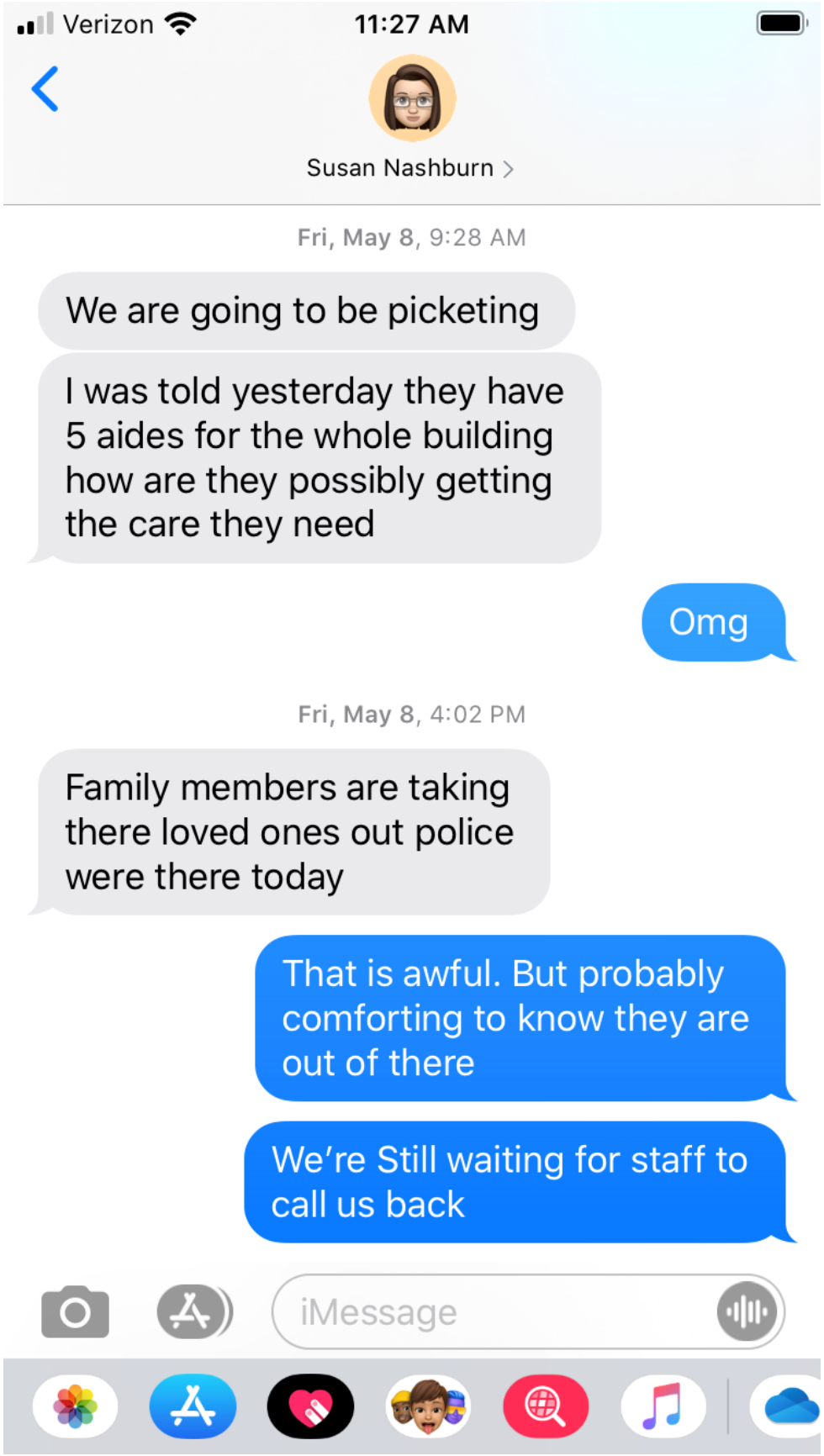

Verizon
11:27 AM
Susan Nashburn
Fri, May 8, 9:28 AM
We are going to be picketing
I was told yesterday they have 5 aides for the whole building how are they possibly getting the care they need
Omg
Fri, May 8, 4:02 PM
Family members are taking there loved ones out police were there today
That is awful. But probably comforting to know they are out of there
We're Still waiting for staff to call us back
iMessage

EXHIBIT E

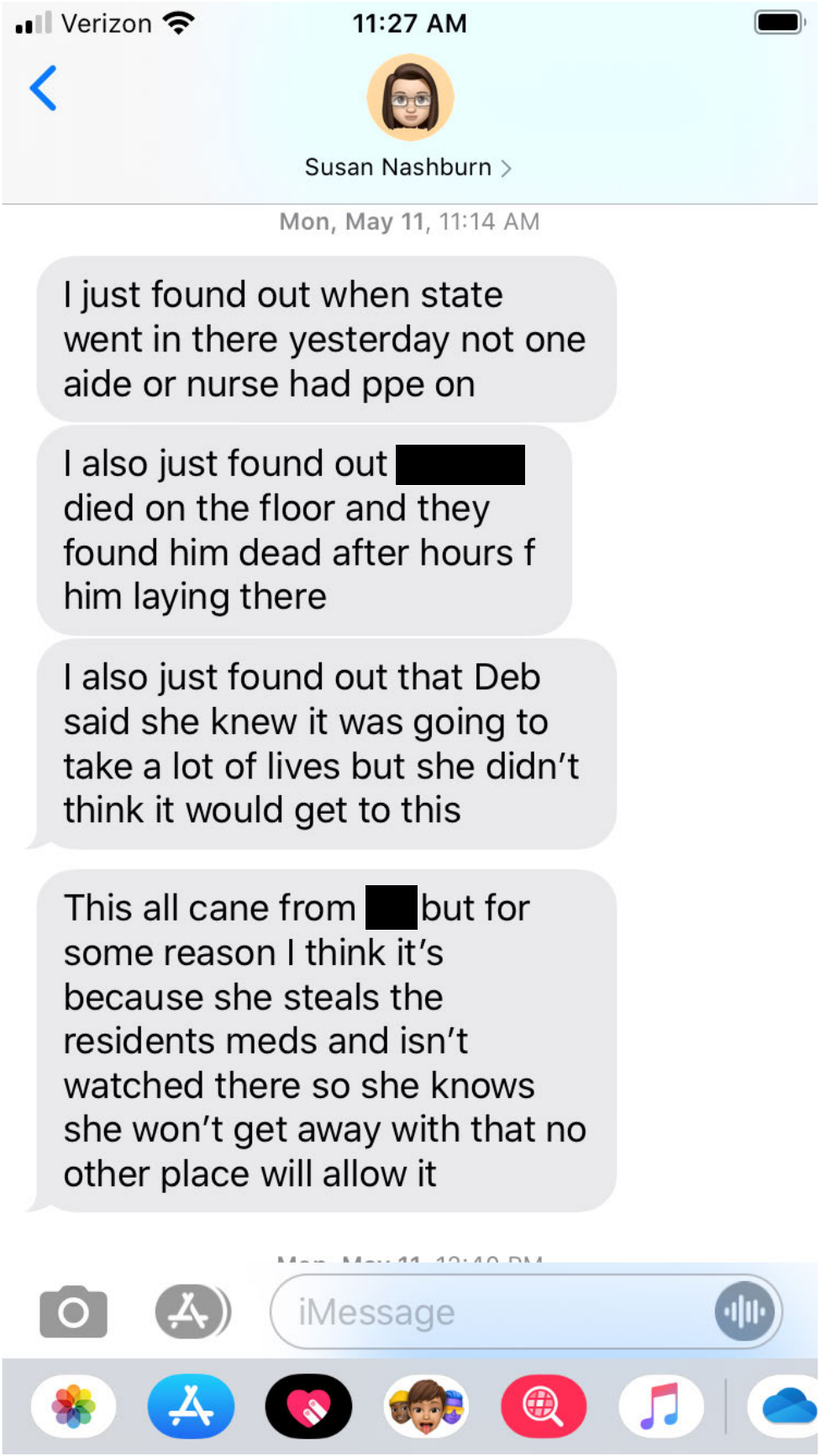

Verizon
11:27 AM
Susan Nashburn
Mon, May 11, 11:14 AM
I just found out when state went in there yesterday not one aide or nurse had ppe on
I also just found out [redacted] died on the floor and they found him dead after hours f him laying there
I also just found out that Deb said she knew it was going to take a lot of lives but she didn't think it would get to this
This all cane from [redacted] but for some reason I think it's because she steals the residents meds and isn't watched there so she knows she won't get away with that no other place will allow it
iMessage

EXHIBIT F

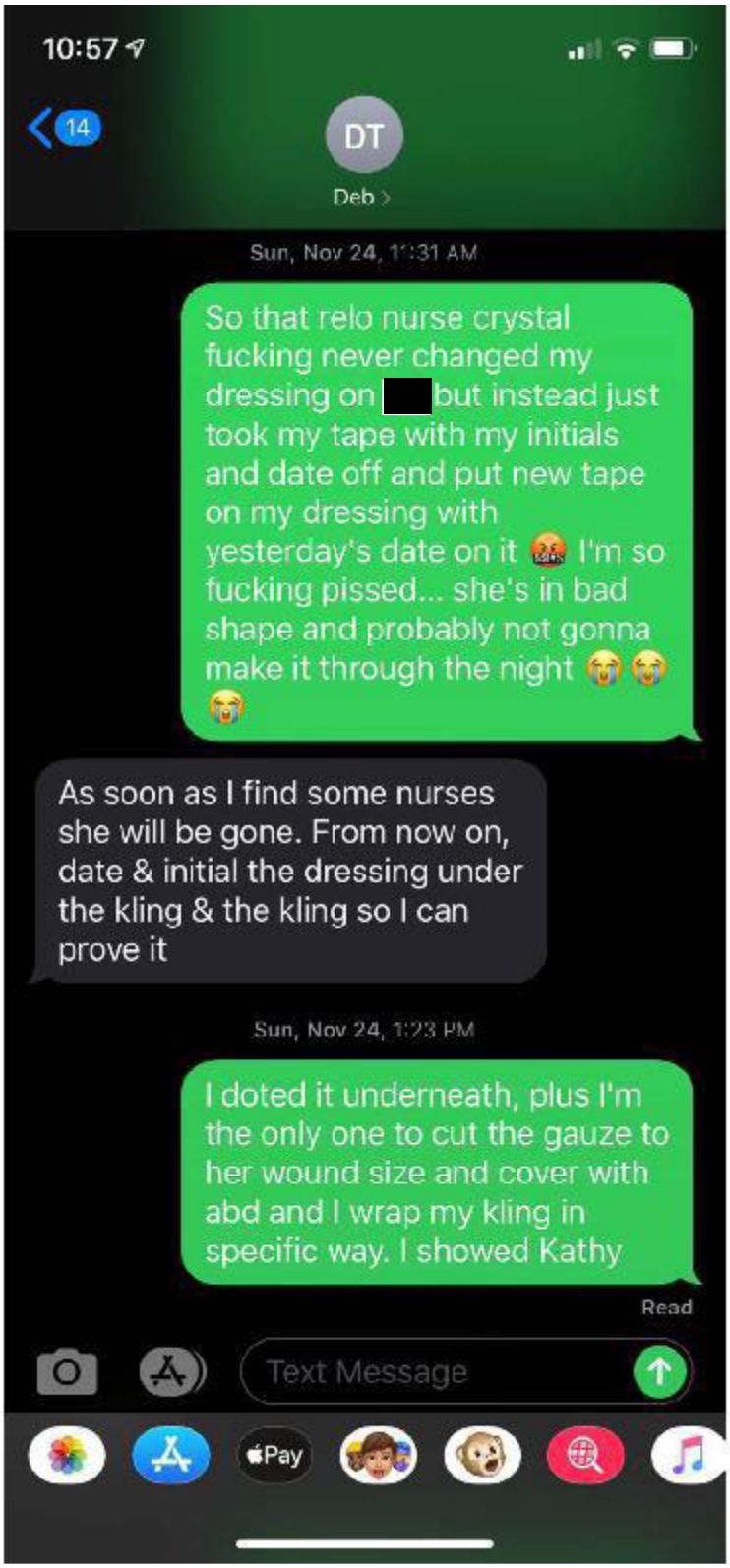

10:57
14
DT
Deb
Sun, Nov 24, 11:31 AM
So that relo nurse crystal fucking never changed my dressing on [redacted] but instead just took my tape with my initials and date off and put new tape on my dressing with yesterday's date on it 😡 I'm so fucking pissed... she's in bad shape and probably not gonna make it through the night 😭😭😭
As soon as I find some nurses she will be gone. From now on, date & initial the dressing under the kling & the kling so I can prove it
Sun, Nov 24, 1:23 PM
I doted it underneath, plus I'm the only one to cut the gauze to her wound size and cover with abd and I wrap my kling in specific way. I showed Kathy
Read
Text Message
Pay

EXHIBIT G


10:56
14
DT
Deb
Fri, Nov 8, 7:26 AM
[redacted]fent patch is MIA again and was signed out wrong
Sun, Nov 10, 10:07 AM
MD
My dressing from Friday that I changed on [redacted] this morning
Text Message
Pay

EXHIBIT H

620	Phone		[redacted] Villages Sarah *	**Timestamp:** 9/14/2020 11:58:58 PM(UTC+0)	**Direction:** Outgoing **Body:** What i left out was how great we are at making up policies on the fly! Lol and maybe a careplan or two **Participants:** Participant Delivered Read Played [redacted] Villages Sarah
618	Phone		[redacted] Villages Sarah *	**Timestamp:** 9/15/2020 12:01:59 AM(UTC+0)	**Direction:** Outgoing **Body:** I faked policies all week! Lol Google saves the day! **Participants:** Participant Delivered Read Played [redacted] Villages Sarah

EXHIBIT I

634	Phone		[redacted] Villages Sarah *	**Timestamp:** 9/10/2020 4:18:01 PM(UTC+0)	**Direction:** Outgoing **Body:** U rick. I'm gonna say I interviewed u k. Lol and u said that... he came in blah blah blah **Participants:** Participant / Delivered / Read / Played [redacted] Villages Sarah

EXHIBIT J

360	Phone	[redacted] Villages Kat *		Timestamp: 9/3/2020 8:14:27 PM(UTC+0)	Direction: Incoming Body: So, we don't have a working hoyer machine. Haven't all day.
359	Phone	[redacted] Villages Kat *		Timestamp: 9/3/2020 8:14:50 PM(UTC+0)	Direction: Incoming Body: Eric helped us put [redacted]n his recliner, and was supposed to help us put him to bed, and I'm pretty sure Eric left for the day.
357	Phone		[redacted] Villages Kat *	Timestamp: 9/3/2020 8:16:59 PM(UTC+0)	Direction: Outgoing Body: Where is the charger? Participants: Participant Delivered Read Played [redacted] Villages Kat
356	Phone	[redacted] Villages Kat *		Timestamp: 9/3/2020 8:17:23 PM(UTC+0)	Direction: Incoming Body: Someone broke it. Ripped it from the wall and the piece that goes into the hoyer broke off

EXHIBIT K

489		[redacted] Records Kim Medical*	[redacted] My Number * [redacted] Flugel Eric * [redacted] Villages Sarah * [redacted] EVS Eli * [redacted] Kathy * [redacted]	Timestamp: 12/10/2020 5:25:44 PM(UTC+0)	Direction: Incoming Body: Room 202 is ready but has an ant problem Participants: Participant / Delivered / Read / Played [redacted] My Number [redacted] Flugel Eric [redacted] Villages Sarah [redacted] EVS Eli [redacted] Kathy [redacted]
488		[redacted] Flugel Eric *	[redacted] Records Kim Medical* [redacted] EVS Eli * [redacted] Villages Sarah * [redacted] My Number * [redacted] Kathy * [redacted]	Timestamp: 12/10/2020 5:26:43 PM(UTC+0)	Direction: Incoming Body: Eli, can it be vacuumed, wiped down? Maybe some food missed? Participants: Participant / Delivered / Read / Played [redacted] Records Kim Medical [redacted] EVS Eli [redacted] Villages Sarah [redacted] My Number [redacted] Kathy [redacted]

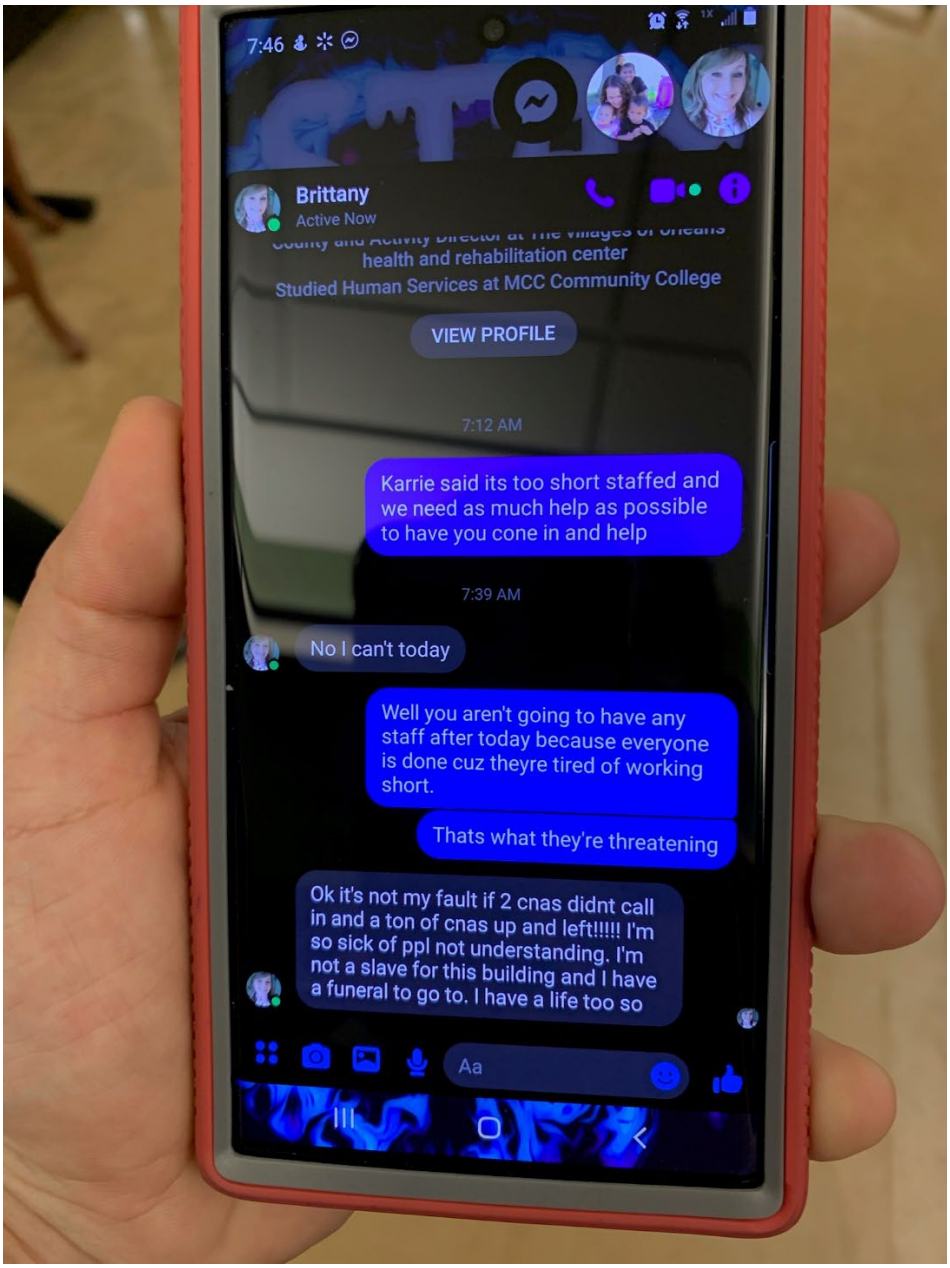
EXHIBIT L

344		[redacted] Kathy *	[redacted] My Number * [redacted] Records Kim Medical* [redacted] EVS Eli * [redacted] Flugel Eric * [redacted] Villages Sarah *	**Timestamp:** 12/16/2020 12:32:33 PM(UTC+0)	**Direction:** Incoming **Body:** We need more surgical masks for the residents. None in the main ppe room. **Participants:** Participant / Delivered / Read / Played [redacted] My Number [redacted] Records Kim Medical [redacted] EVS Eli [redacted] Flugel Eric [redacted] Villages Sarah

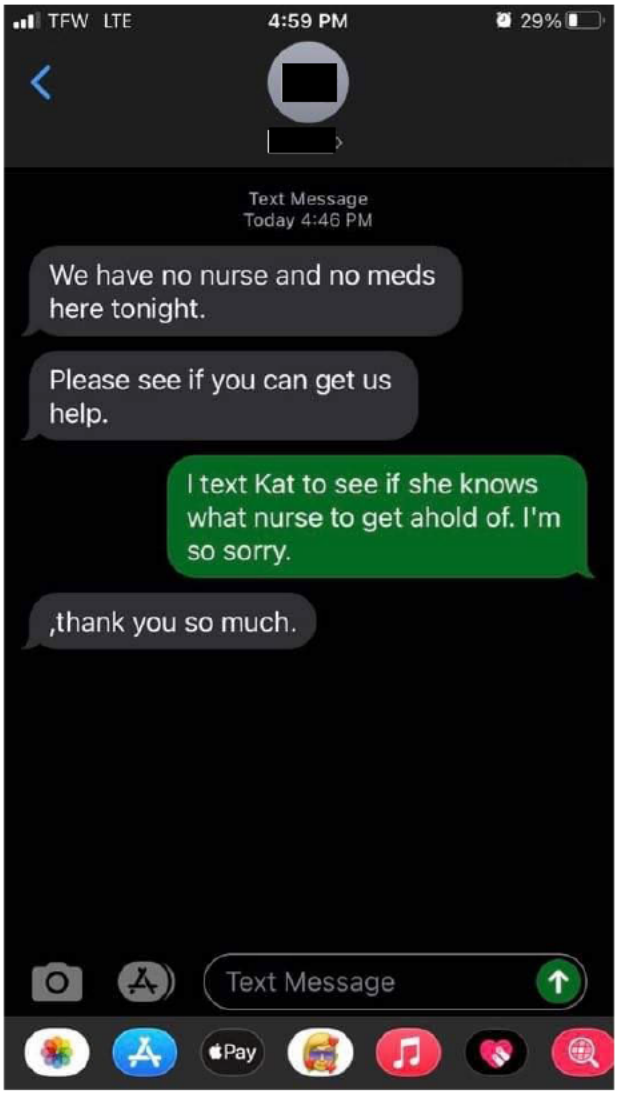
EXHIBIT M

262	Phone	[redacted] Villages Kat *		**Timestamp:** 11/7/2020 11:59:01 AM(UTC+0)	**Direction:** Incoming **Body:** Jill never showed. Katie left. Stephen is the only nurse in the building
254	Phone	[redacted] Villages Kat *		**Timestamp:** 11/7/2020 12:39:58 PM(UTC+0)	**Direction:** Incoming **Body:** We have one LPN and one CNA that will be here within the hour and that's all we can get

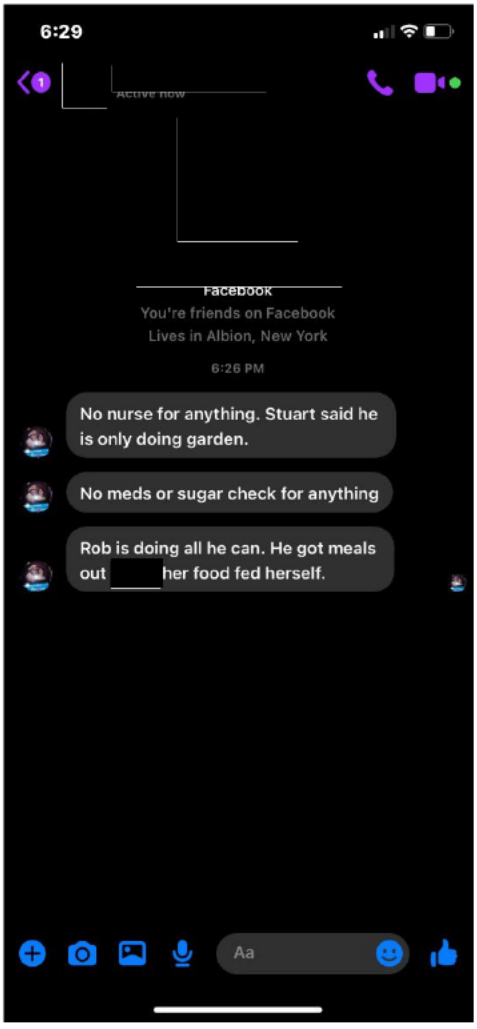
245		[redacted] Villages Kat *	[redacted] My Number *	Timestamp: 11/7/2020 12:46:59 PM(UTC+0)	Direction: Incoming Participants: Participant / Delivered / Read / Played [redacted] My Number Attachments: IMG_0083.jpg



166		[redacted] Villages Kat *	[redacted] My Number *	Timestamp: 11/7/2020 10:43:53 PM(UTC+0)	Direction: Incoming Participants: Participant / Delivered / Read / Played [redacted] My Number Attachments:  IMG_0093.jpg Source Extraction: Advanced Logical Source file: Attachments/1/IMG_0093.jpg : (Size: 55008 bytes) Status: Read Message Type: MMS Folder: Inbox Priority: Low



133		[redacted] Villages Kat *	[redacted] My Number *	Timestamp: 11/7/2020 11:29:39 PM(UTC+0)	Direction: Incoming Participants: Participant / Delivered / Read / Played [redacted] My Number Attachments:  IMG_0094.jpg Source Extraction: Advanced Logical Source file: Attachments/1/IMG_0094.jpg : (Size: 123841 bytes) Status: Read Message Type: MMS Folder: Inbox Priority: Low



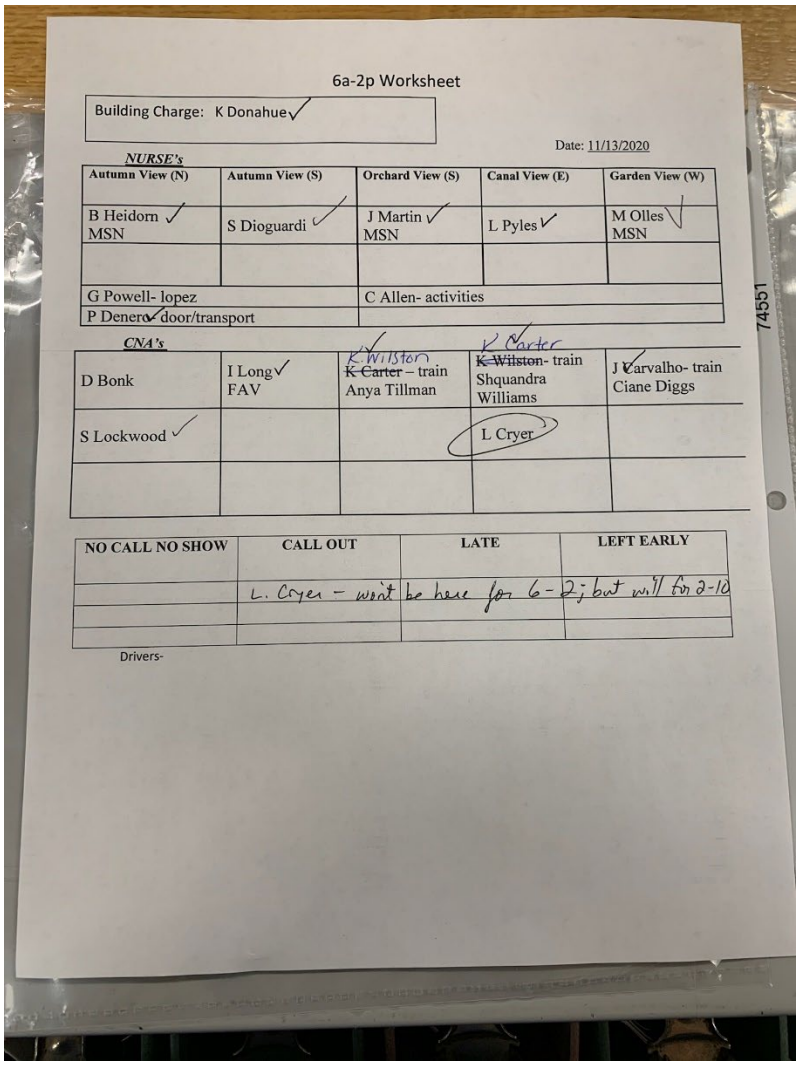
146	Phone	[redacted] Villages Kat *		**Timestamp:** 11/7/2020 11:03:25 PM(UTC+0)	**Direction:** Incoming **Body:** Okay. We're absolutely screwed for tomorrow. We're going to have 4 CNAs and no nurses --- **Source Extraction:** Advanced Logical Status: Read **Message Type:** SMS **Folder:** Inbox

EXHIBIT N

99	Phone	[redacted] Villages Kat *		**Timestamp:** 11/8/2020 2:42:22 PM(UTC+0)	**Direction:** Incoming **Body:** Eric knew we had no staff yesterday when he was here. I pointed out the schedule to him yesterday. And he did nothing, and now we have all these call ins because everyone is fed up. --- **Source Extraction:** Advanced Logical Status: Read **Message Type:** SMS **Folder:** Inbox

EXHIBIT O

84		[redacted] Villages Kat *	[redacted] My Number *	Timestamp: 11/13/2020 11:57:33 AM(UTC+0)	Direction: Incoming Participants: Participant / Delivered / Read / Played [redacted] My Number Attachments:  626961442.jpg Source Extraction: Advanced Logical Source file: Attachments/1/626961442.jpg : (Size: 502402 bytes) Status: Read Message Type: MMS Folder: Inbox Priority: Low



6a-2p Worksheet

Building Charge: K Donahue ✓

Date: 11/13/2020

NURSE's

Autumn View (N)	Autumn View (S)	Orchard View (S)	Canal View (E)	Garden View (W)
B Heidorn ✓ MSN	S Dioguardi ✓	J Martin ✓ MSN	L Pyles ✓	M Olles ✓ MSN
G Powell- lopez		C Allen- activities		
P Denero ✓ door/transport				

CNA's

D Bonk	I Long ✓ FAV	K Wilston ✓ ~~K Carter~~ – train Anya Tillman	K Carter ~~K Wilston~~- train Shquandra Williams	J Carvalho- train Ciane Diggs ✓
S Lockwood ✓			L Cryer	

NO CALL NO SHOW	CALL OUT	LATE	LEFT EARLY
	L. Cryer – won't be here for 6-2; but will for 2-10		

Drivers-

74551

83	Phone	[redacted] Villages Kat *		**Timestamp:** 11/13/2020 11:57:39 AM(UTC+0)	**Direction:** Incoming **Body:** We have to work down the halls by ourselves ON TOP OF training the new girls!

EXHIBIT P

51	Phone	[redacted] Villages Kat *		**Timestamp:** 12/20/2020 11:15:52 AM(UTC+0)	**Direction:** Incoming **Body:** Hey. We have critical staffing. 4-5 CNAs called in. Katie has called everyone and she can't get ahold of anyone

48		[redacted] Villages Kat *	[redacted] My Number *	**Timestamp:** 12/20/2020 1:58:36 PM(UTC+0)	**Direction:** Incoming **Participants:** Participant Delivered Read Played [redacted] My Number **Attachments:**  IMG_0382.jpg **Source Extraction:** Advanced Logical **Source file:** Attachments/1/IMG_0382.jpg : (Size: 298833 bytes) Status: Read **Message Type:** MMS **Folder:** Inbox **Priority:** Low

6a-2p Worksheet

Building Charge: K Donahue

Date: 12/20/2020

NURSE's

Autumn View (N)	Autumn View (S)	Orchard View (S)	Canal View (E)	Garden View (W)
J Martin	K Donahue ✓	J Rechtsiegel	S Dioguardi ✓	C Hulett Trusted Nursing
~~G Powell- door~~				

CNA's

K Daigler ✓	~~R Stevens~~	R Pankoke ✓	K Shawver	I Long FAV ✓
T Stevens	G. Powell ✓	K Wilston ✓	V Morris NF	

NO CALL NO SHOW	CALL OUT	LATE	LEFT EARLY
	J. Martin - Family Emergency		
	R. Stevens - Emesis		
	V. Morris - Car accident		
Drivers-	K. Shawver - Sick		
	T. Stevens - Car accident		

EXHIBIT Q

55	Phone	[redacted] Villages Sarah *		Timestamp: 1/3/2021 1:36:23 AM(UTC+0)	Direction: Incoming Body: Jesus I didn't realize why you were up all night!! I heard wtf.... was it K2 or some shitttt
54	Phone		[redacted] Villages Sarah *	Timestamp: 1/3/2021 1:46:07 AM(UTC+0)	Direction: Outgoing Body: I don't know. Eric was MIA though Participants: Participant Delivered Read Played [redacted] Villages Sarah
53	Phone	[redacted] Villages Sarah *		Timestamp: 1/3/2021 1:46:54 AM(UTC+0)	Direction: Incoming Body: Seriously he's on call 24/7 and he didn't answer his phone?
52	Phone		[redacted] Villages Sarah *	Timestamp: 1/3/2021 1:50:16 AM(UTC+0)	Direction: Outgoing Body: Nope Participants: Participant Delivered Read Played [redacted] Villages Sarah
51	Phone		[redacted] Villages Sarah *	Timestamp: 1/3/2021 1:50:30 AM(UTC+0)	Direction: Outgoing Body: And this is going to be a full blown investigation Participants: Participant Delivered Read Played [redacted] Villages Sarah
50	Phone	[redacted] Villages Sarah *		Timestamp: 1/3/2021 2:18:56 AM(UTC+0)	Direction: Incoming Body: Just what we need. Fuck! Did he show up at all?!
49	Phone		[redacted] Villages Sarah *	Timestamp: 1/3/2021 2:19:56 AM(UTC+0)	Direction: Outgoing Body: No I didn't go to sleep until 6am. My last night with my girls and I lost that time Participants: Participant Delivered Read Played [redacted] Villages Sarah

47	Phone		[redacted] Villages Sarah *	**Timestamp:** 1/3/2021 2:24:03 AM(UTC+0)	**Direction:** Outgoing **Body:** Oh no u r fine. Last night I wanted to just curl up and have 4 year old and 8 year old girl fun but I couldn't because we let people do drugs in our facility and our administrator doesn't care **Participants:** Participant Delivered Read Played [redacted] Villages Sarah
46	Phone	[redacted] Villages Sarah *		**Timestamp:** 1/3/2021 2:38:01 AM(UTC+0)	**Direction:** Incoming **Body:** We need to stop getting these prisoners. They need to stop admitting anyone and everyone. That's frustrating. I know it's not Kim fault. I feel bad for her because they are hounding her to fill beds, not worrying about not having staff, nor trained staff to deal with addicts

EXHIBIT R

212	Phone	[redacted] Villages Sarah *		**Timestamp:** 12/22/2020 10:24:32 PM(UTC+0)	**Direction:** Incoming **Body:** Yes that's her, I know i was like what the hell is Karrie texting us for about a new admit!!!! They need to stop with all these admissions!! No one is caught up from last weeks. It's getting way to crazy!! All the room changes on top of 3 admissions in a day a few times a week. We need staff before more admissions

EXHIBIT S

Verizon 2:39 PM 65%

M

M Brown

Today 4:16 AM

This was one of the hot davs in

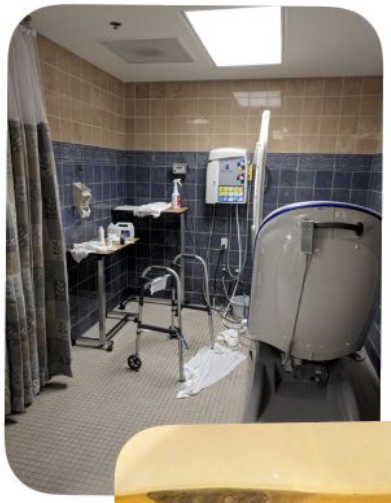
Text Message

Verizon 2:40 PM 65%

M

M Brown

This was one of the hot days in the building when the ac didn't work. It was so hot and humid in the building we had to put wet towel around our necks while we were working and I had to do a breathing treatment because I couldn't breath.



Text Message

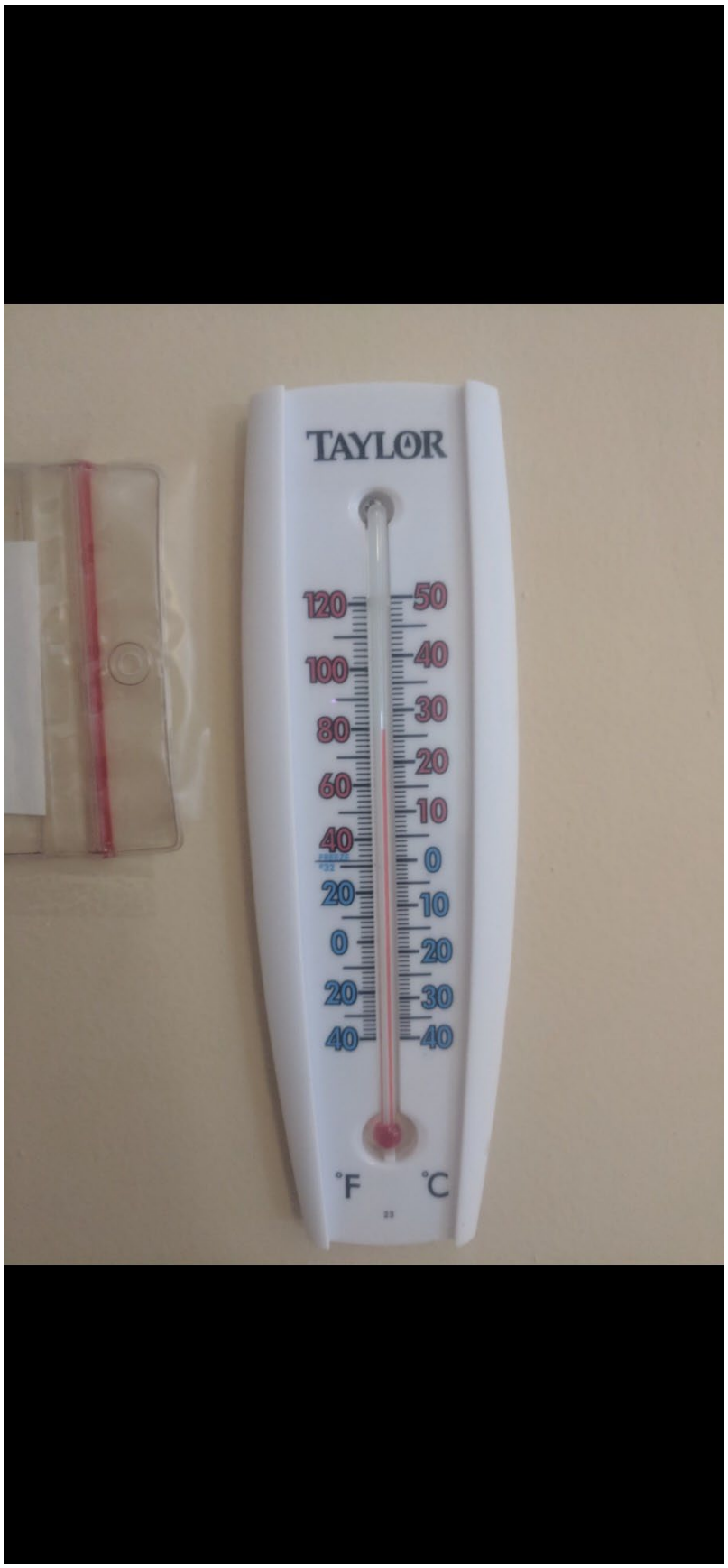

TAYLOR
120
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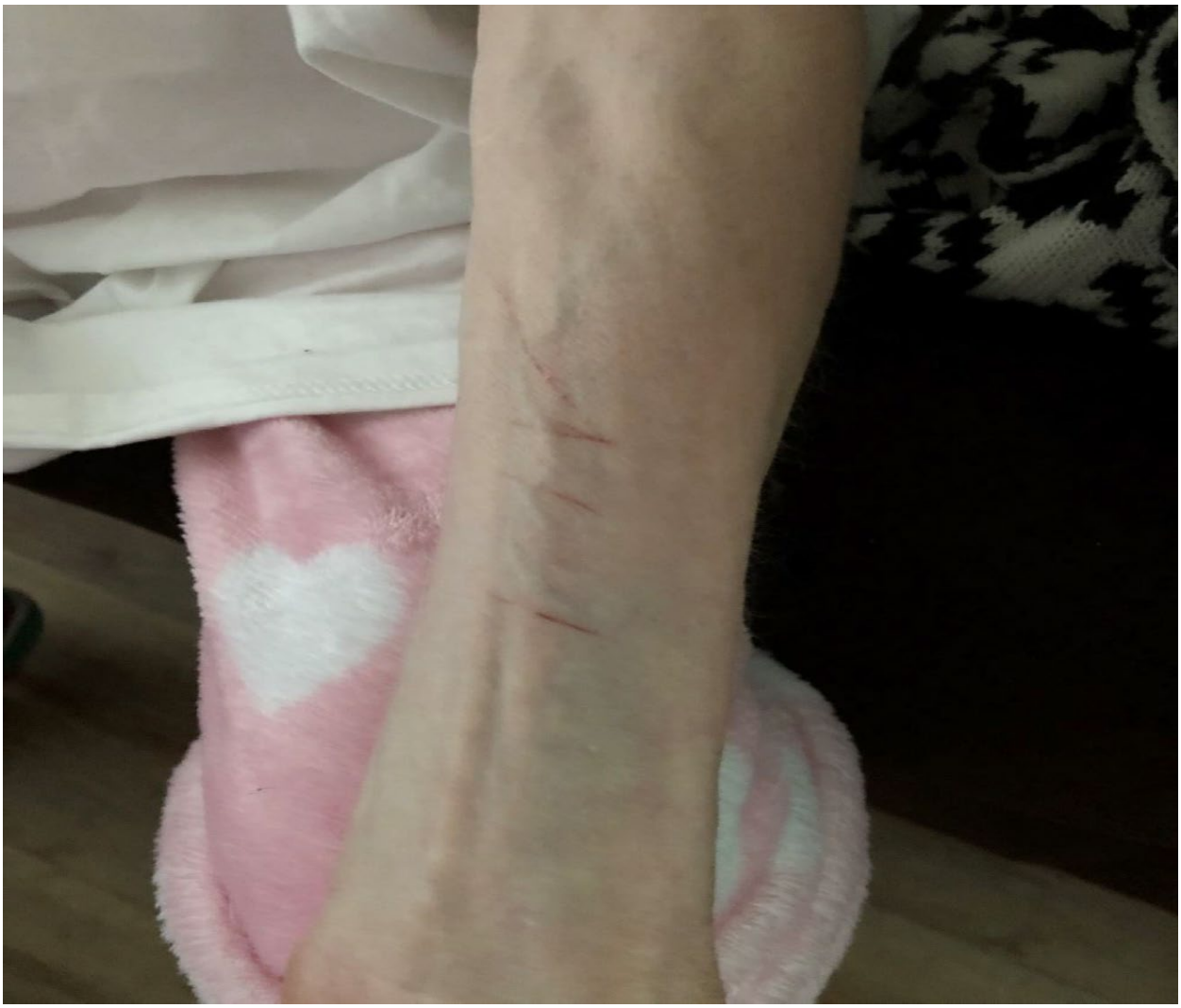
EXHIBIT T

Exhibit U

Exhibit V



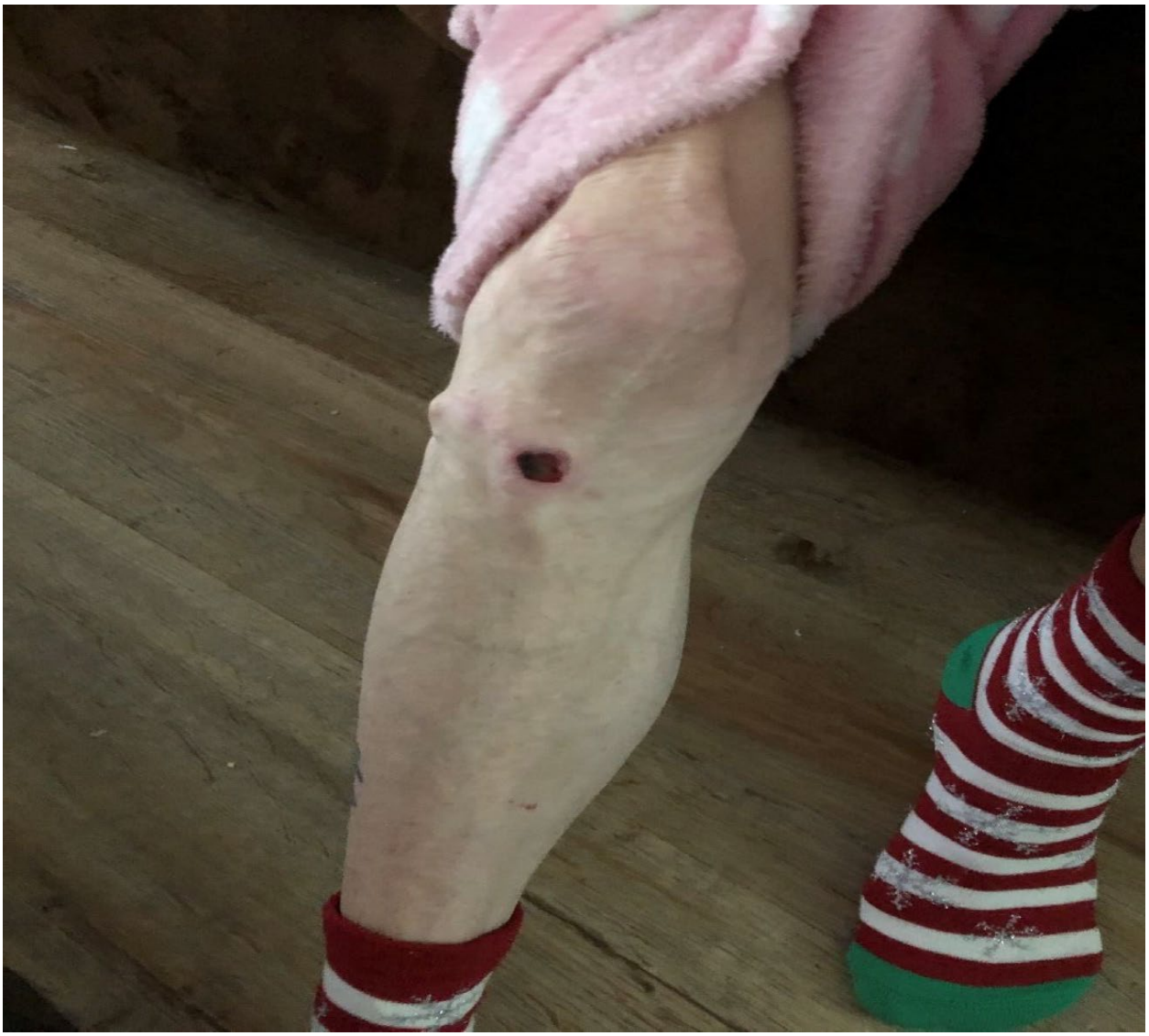
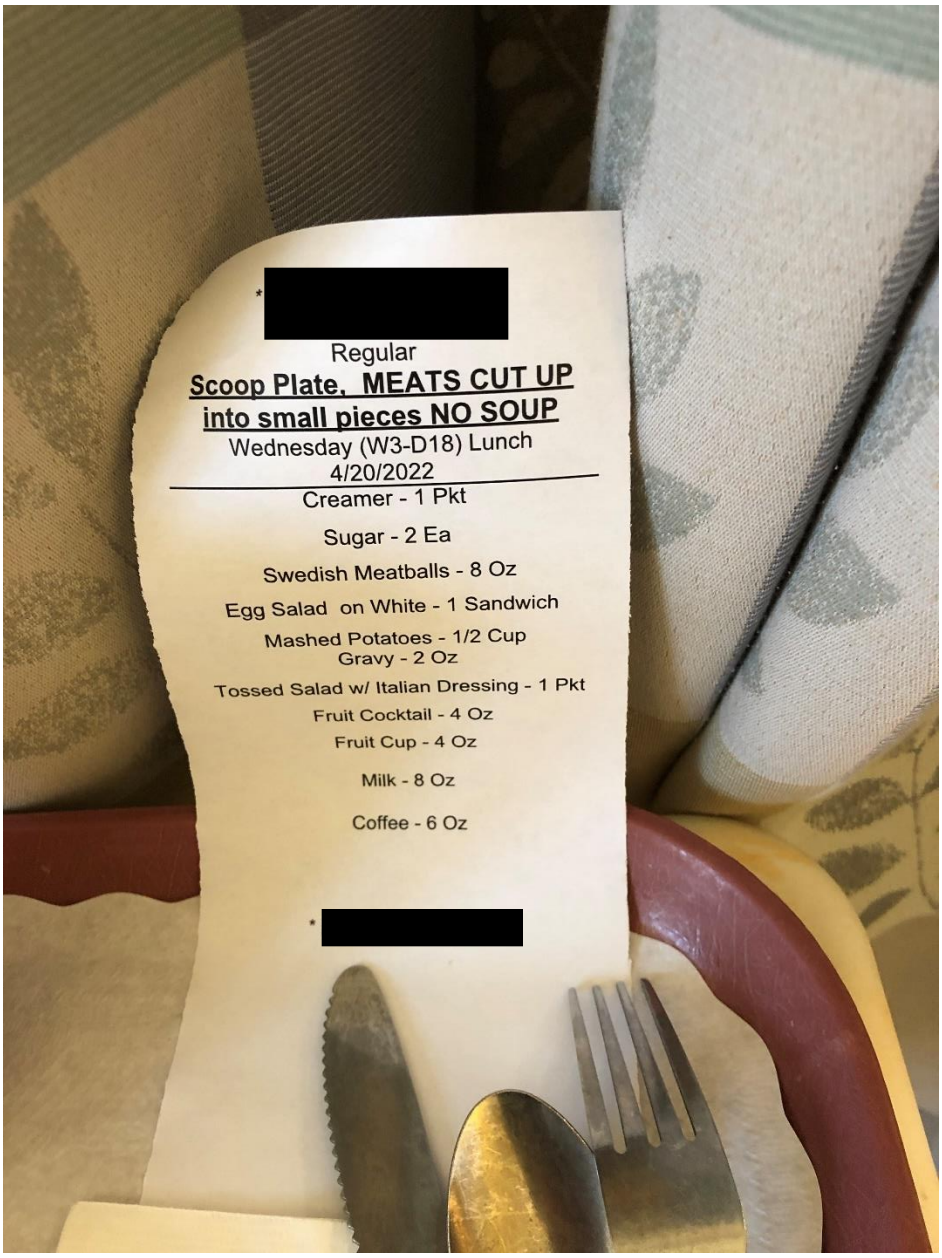


EXHIBIT W


*[redacted]
Regular
Scoop Plate, MEATS CUT UP into small pieces NO SOUP
Wednesday (W3-D18) Lunch
4/20/2022
Creamer - 1 Pkt
Sugar - 2 Ea
Swedish Meatballs - 8 Oz
Egg Salad on White - 1 Sandwich
Mashed Potatoes - 1/2 Cup
Gravy - 2 Oz
Tossed Salad w/ Italian Dressing - 1 Pkt
Fruit Cocktail - 4 Oz
Fruit Cup - 4 Oz
Milk - 8 Oz
Coffee - 6 Oz
*[redacted]


* Kelly, Karen - 14A GV
Garden View-14
Regular
Scoop Plate...MEATS CUT UP
into small pieces NO SOUP
Wednesday (W3-D18) Lunch
4/20/2022
Creamer - 1 Pkt
Sugar - 2 Ea
Swedish Meatballs - 8 Oz
Egg Salad on White - 1 Sandwich
Mashed Potatoes - 1/2 Cup
Gravy - 2 Oz
Tossed Salad w/ Italian Dressing - 1 Pkt
Fruit Cocktail - 4 Oz
Fruit Cup - 4 Oz
Milk - 8 Oz
[redacted]

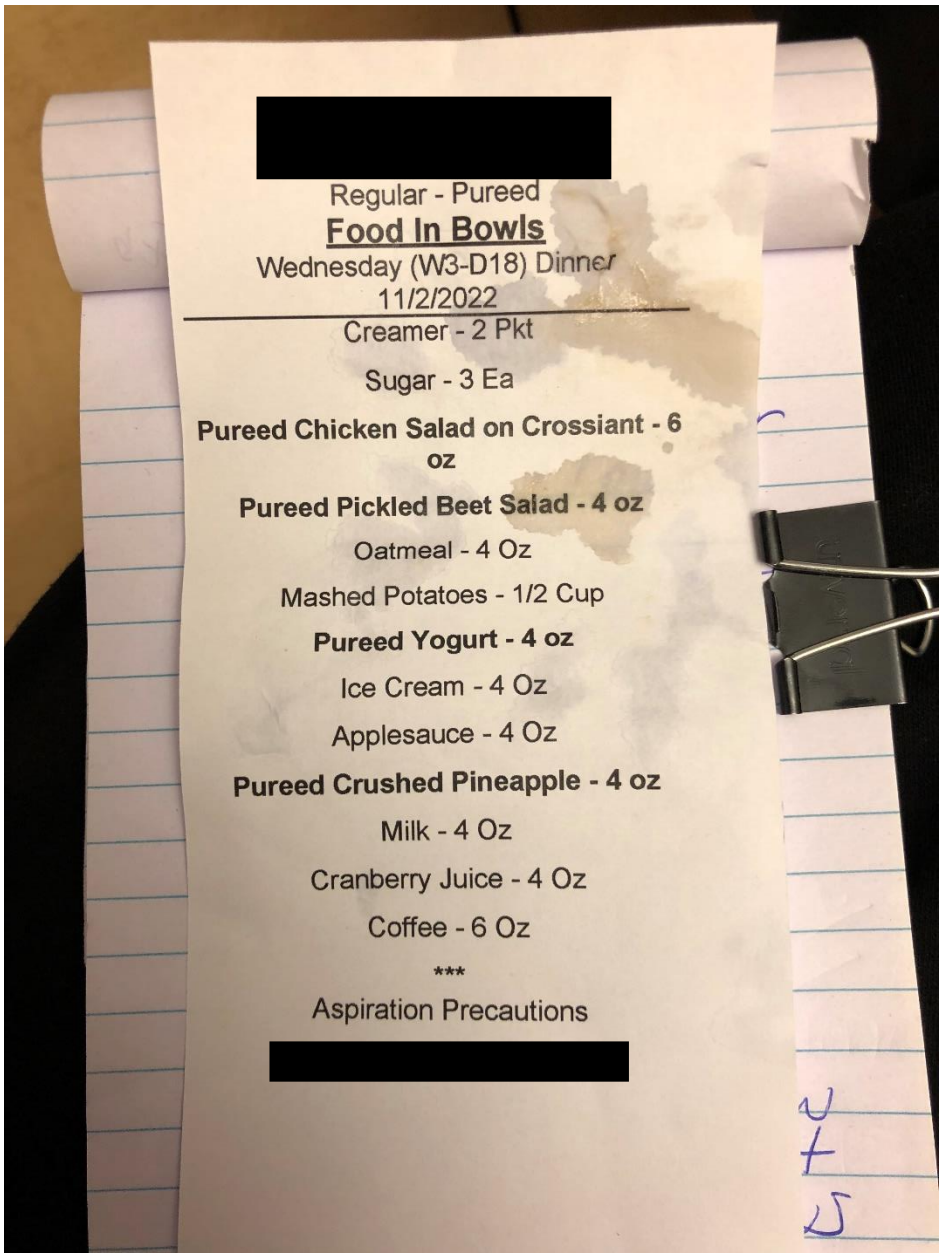
EXHIBIT X


HOSPITAL IN ROCHESTER
NEVER SEND HER TO
MEDINA OR BATAVIA.
Mom – Donna (585) 662-9839
drive


IF SENDING KAREN KELLY
OUT FOR MEDICAL CARE
ONLY SEND HER TO
*STRONG MEMORIAL
HOSPITAL IN ROCHESTER
NEVER SEND HER TO
MEDINA OR BATAVIA.
Mom – Donna (585) 662-9839

EXHIBIT Y

EXHIBIT Z



[redacted]

Regular - Pureed

Food In Bowls

Wednesday (W3-D18) Dinner

11/2/2022

Creamer - 2 Pkt

Sugar - 3 Ea

Pureed Chicken Salad on Crossiant - 6 oz

Pureed Pickled Beet Salad - 4 oz

Oatmeal - 4 Oz

Mashed Potatoes - 1/2 Cup

Pureed Yogurt - 4 oz

Ice Cream - 4 Oz

Applesauce - 4 Oz

Pureed Crushed Pineapple - 4 oz

Milk - 4 Oz

Cranberry Juice - 4 Oz

Coffee - 6 Oz

***

Aspiration Precautions

[redacted]

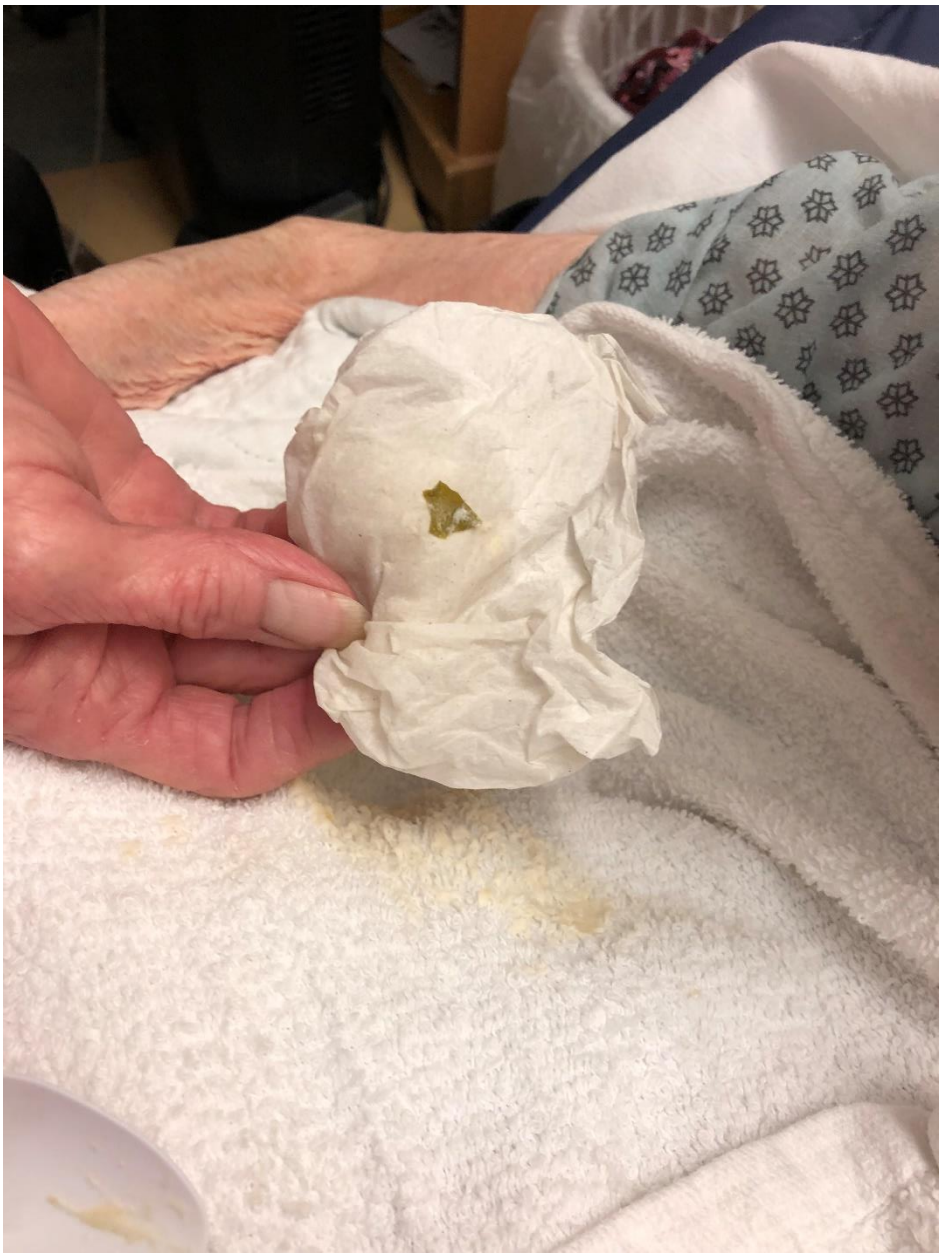


EXHIBIT AA


100
VINYL EXAM GLOVES
L
LARGE

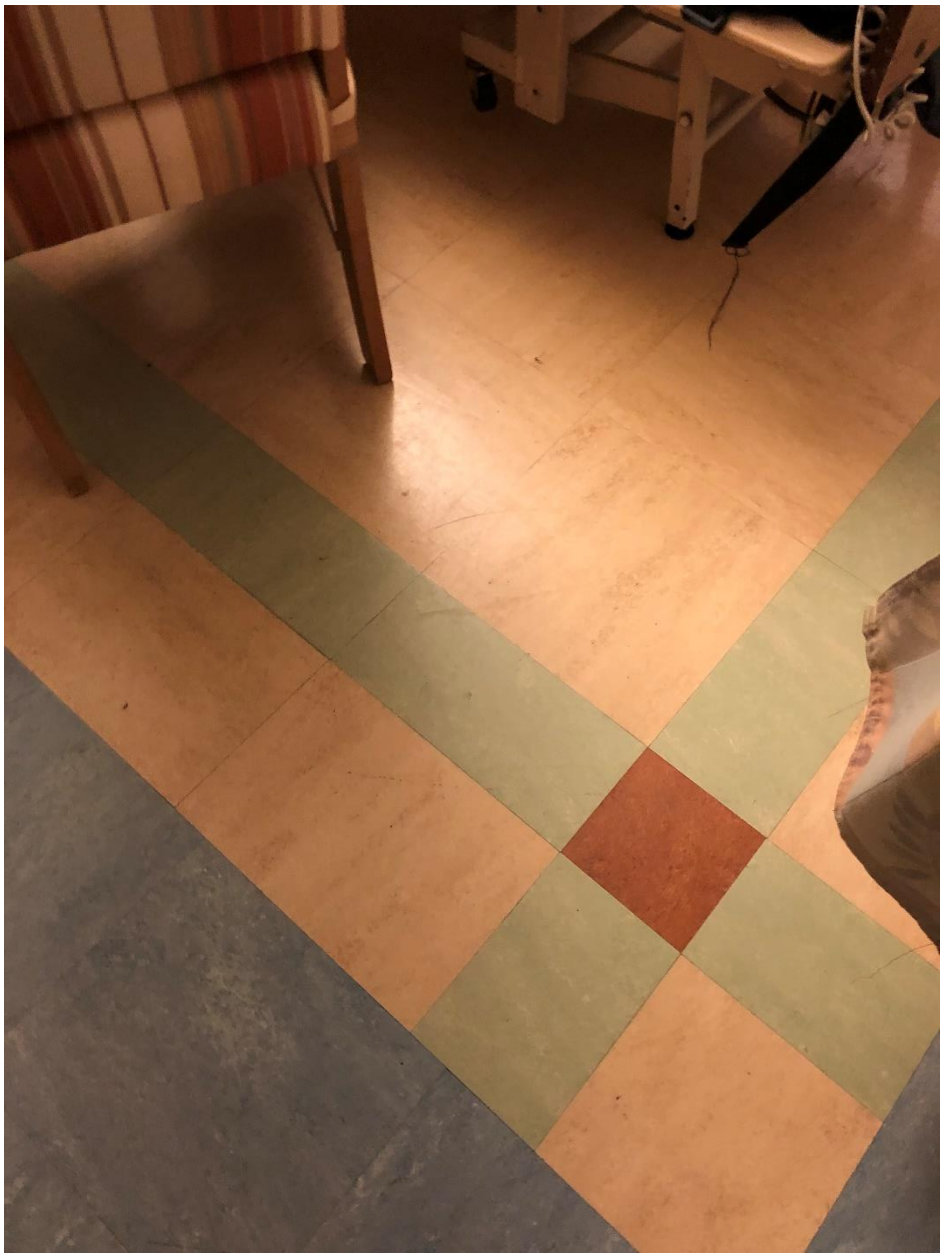


EXHIBIT BB

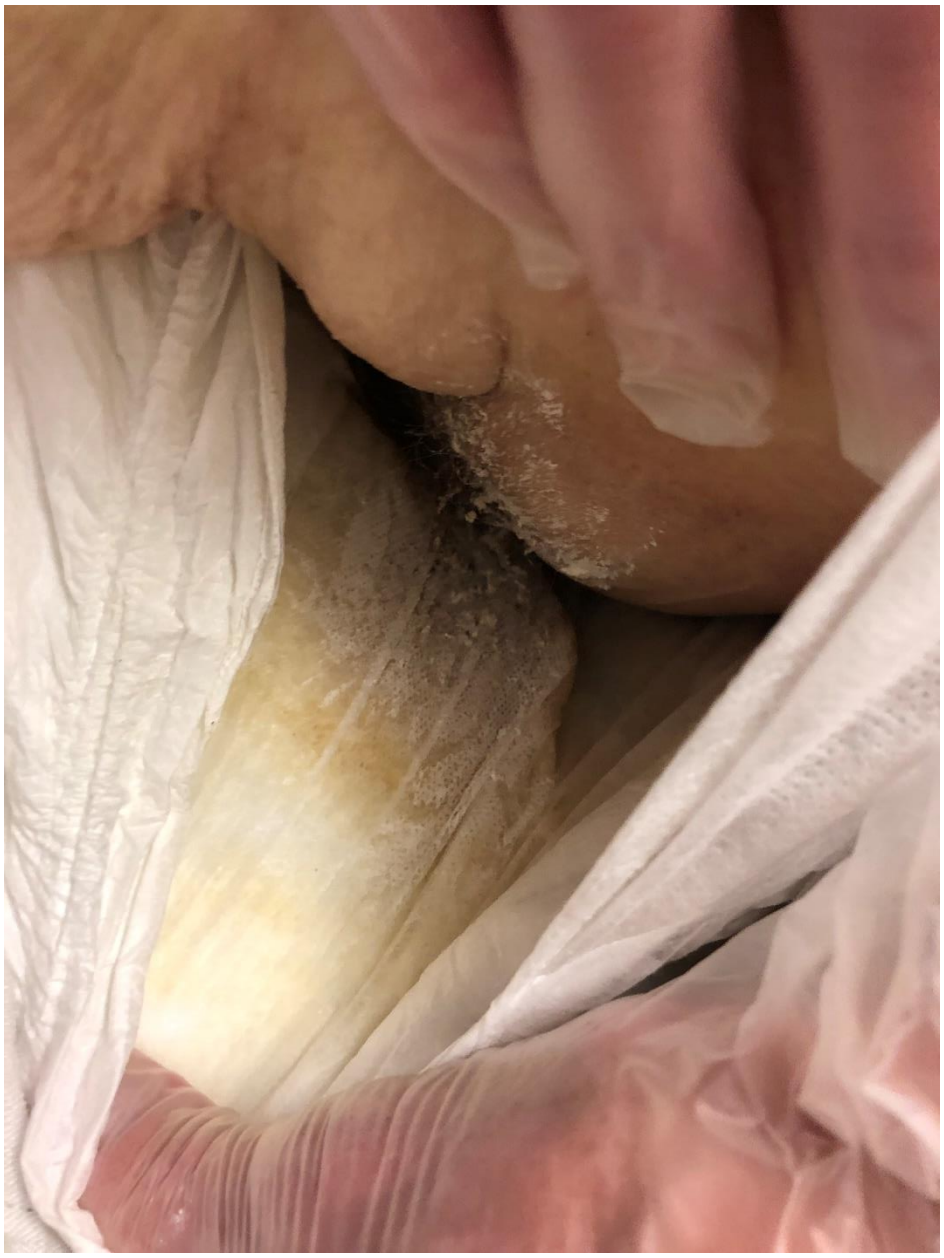


EXHIBIT CC

Sheila Fernandez
Thank you Jill for working as hard as you do. They tried to making me stay today . After I did the whole 8 hrs by myself on dementia. I was like nope I'm out ✌🏾

4d Like Reply

😮 1

Jill Rechtsiegel
Sheila Fernandez girl u deserve to go home .. I wanted to go at 2 and was told ABSOLUTELY NOT . After doing my unit with no aid and 2 med passes

4d Like Reply

EXHIBIT DD

Ondrea Brakenbury Pate
Admin · June 9, 2020 ·

On a personal note, for those that still feel alone, please know that you are not. I still wake up in the middle of the night and wonder why she could not have just put my mom in a separate room after her test. She knew Mom was going home and they had they had empty rooms. I am so angry that she had such little respect for my mother's life. She was a wife, a mother, a grandmother, a sister, an aunt and a friend. She deserved better.

53 9 Comments

Ondrea Brakenbury Pate
Admin · September 6, 2020 ·

I have learned many things as I have gone down this long road over the last six months but there is one thing that sticks out most. I wanted to share it with you, not for sympathy, but to assure those that feel the same way that you are not alone. If I had known then what I know now that day in March when we put my mother in the back of an ambulance, I would have hugged her and told her I loved her. I may have told her I loved her, I can't remember. I stayed away because of COVID. I would have hugged her.

29 3 Comments

EXHIBIT EE

Timothy Myers Sr. doesn't recommend The Villages Of Orleans County.

Yesterday at 8:47 AM ·

some ways to improve? close it down!!!! we just laid our mother to rest on Friday due to the sub par care and their mis management! This place is terrible to say the least! filthy, floor tiles broken, entry door ceiling tiles fallen out, entry door frame rusted, way too understaffed, families not notified of issues that are detrimental to their loved ones health, and above all... placing covid positive patients in the same room as those who are not positive. asking for a family member to be moved away from a covid positive patient only to be told nastily "we're at capacity"! If you value your family and love them, keep as far away from this place as possible. I'm looking into retaining someone who will get the answers we need!

1

1 Comment

EXHIBIT FF

9:35

Dawn Moore
3 hrs ·

One day off just isn't enough.
Nap time , need to refuel for work tonight...looking forward to the weekend off. And I am not answering my phone!!!!

Like Share

4

Shell Lynn Neal
Im turning mine off tomorrow after i leave work! I will NOT turn it back on until Sunday night!

9:36

Dawn Moore
Tuesday at 11:47 AM ·

This is how I feel about Bullying in the workplace!!!!

Like Share

18

1 share

Shell Lynn Neal

EXHIBIT GG

Jessica Estela
June 3, 2020 ·

We should've ran.
When I shared this post originally, we all knew it was only a matter of when Mike would contract Covid. What we didn't know-
•We didn't know how much trauma working there through this would cause. Nor did we know how much panic and depression it would flood into our household.
•We didn't know that Mike would be begged through the window by a residents loved one, to hold her hand and let her know that it's okay to just pass on.
•We didn't know that Mikes Phyisical Therapy skills would become spending his time going from room to room, syringe dropping water into their mouths, trying to keep people hydrated, changing them and turning them to keep them comfortable, while Covid over took them.
•We didn't know that we'd end up supplying our own PPE for him because everything would stay locked up and have to get reused until a huge investigation started.
•We didn't know that this would leave Mike not wanting to work in this career field anymore.
•We didn't know that it's common for people to remain covid positive for anywhere from 30days - 6 weeks.
•We didn't know that in week 3 we'd still have to beg and plead to get answers about getting paid the 80hrs of sick pay he is entitled to from his company, only to hear "I don't have any answers on that" or "have you contacted the DOL?" Or"have you reached out to your union rep? That's what they're there for isn't it?"
•We didn't know he'd have to obtain his own testing TWICE A WEEK, on our dime and with no reimbursement for time, mileage, etc - meanwhile they're testing all of the other staff members on site and on the clock. He's literally spent all morning on the phone trying to get someone in his building to answer the phone.
•We didn't realize how many people would harass us and joke that they hoped they get it too or they wish they could be on a "Covid vacation" too. (FYI- it's not glorious. I spend my days trying to decide if I want to sob or vomit).

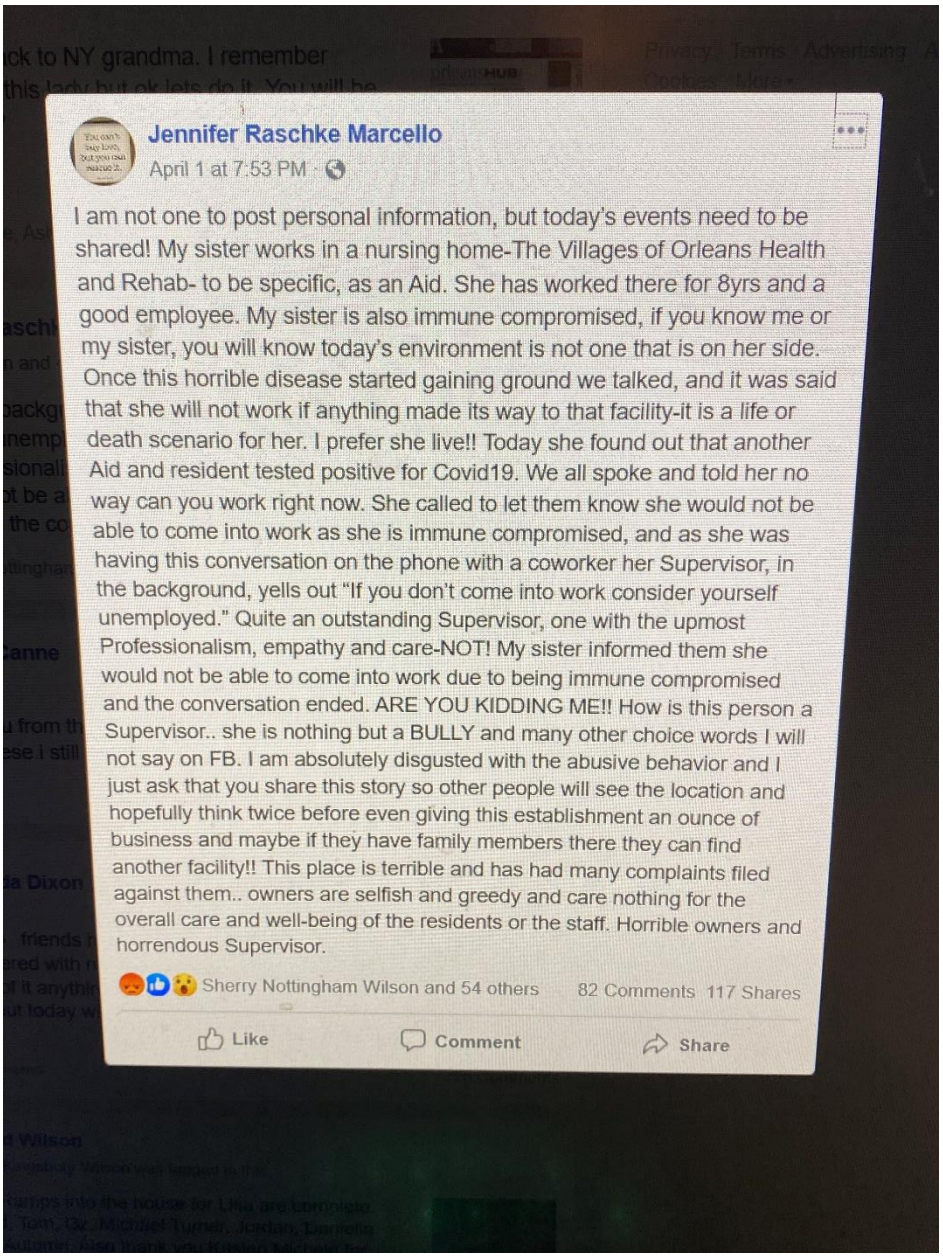
If we had known, we wouldn't have sold our home.
Because now we face having a lapse of income thanks to Mike's fantastic employer. That lapse of income will automatically disqualify us for our new mortgage. We will be left with no home. We will be left with a "serial positive" case of Covid, trauma, anxiety, depression and no support.

Some thanks, huh?
We should've ran.

EXHIBIT HH


Liza Brien
· May 8, 2020 ·
I will fight for her dignity that she died with out I will prove she was sane and being abused and drugged up so many countless things I have handed over my case and evidence to the Orleans County sheriff's Dept and I will not stop till justice is served for my mother and so many others hang on mom I will fight for you 💙 and I will see that justice is served and I will bring you the peace you deserved when you passed away all alone no warning no calls im sure you yelled for help and its killing me to think how it happened I am so sorry we where trying and she knew we where gonna get her out I just ran out of time so sorry 😔
19
7 Comments
Like
Comment
[redacted]
This place is just getting under my skin I want somebody,s ass ,my sister and i are going a tough time with these pricks.
Like Reply 1y
1
Liza Brien Author
[redacted]'m so so sorry for your situation 😢 this place has been the worst mo matter who ever owns it the place just sucks my mom worked their 16 years and told me and my dad way back in the 70s and 80s don't ever put her there which I DID NOT put her there she fell in there through being transferrd out of hospise and there was no beds anywhere else it was a temporary situation but we ran out of time im almost positive my mom was the first covid patient on 3/4 she passed strange the woman who went on a cruise 🛫 came back and 4 days later my mom no signs of illness copd getting worse no warnings no notta just gone in a blink of a eye 💔💔💔
Like Reply 1y
1

EXHIBIT II



Jennifer Raschke Marcello
April 1 at 7:53 PM

I am not one to post personal information, but today's events need to be shared! My sister works in a nursing home-The Villages of Orleans Health and Rehab- to be specific, as an Aid. She has worked there for 8yrs and a good employee. My sister is also immune compromised, if you know me or my sister, you will know today's environment is not one that is on her side. Once this horrible disease started gaining ground we talked, and it was said that she will not work if anything made its way to that facility-it is a life or death scenario for her. I prefer she live!! Today she found out that another Aid and resident tested positive for Covid19. We all spoke and told her no way can you work right now. She called to let them know she would not be able to come into work as she is immune compromised, and as she was having this conversation on the phone with a coworker her Supervisor, in the background, yells out "If you don't come into work consider yourself unemployed." Quite an outstanding Supervisor, one with the upmost Professionalism, empathy and care-NOT! My sister informed them she would not be able to come into work due to being immune compromised and the conversation ended. ARE YOU KIDDING ME!! How is this person a Supervisor.. she is nothing but a BULLY and many other choice words I will not say on FB. I am absolutely disgusted with the abusive behavior and I just ask that you share this story so other people will see the location and hopefully think twice before even giving this establishment an ounce of business and maybe if they have family members there they can find another facility!! This place is terrible and has had many complaints filed against them.. owners are selfish and greedy and care nothing for the overall care and well-being of the residents or the staff. Horrible owners and horrendous Supervisor.

Sherry Nottingham Wilson and 54 others 82 Comments 117 Shares

Like Comment Share

EXHIBIT JJ

Cindy Delaura
September 3, 2020 ·

I don't know if anyone else is having this problem. But my mom passed away on May 23 after falling and breaking her hip. I never was even notified of this until I called them that day! They also said she was covid negative and when she went to Batavia Hospital she was covid positive. I didn't get to be with my mom for 3 months before I only got face time a few times and a few phone calls. . I didn't get to be with her at The Hospital and I never got to say goodbye to her. That was enough for anyone to endure. Now I get a bill from them demanding I pay them money! This is outrageous!

😮😡😢 20 26 Comments

Like Comment