From: Boyce, Bonnie <bonnie.boyce@vermont.gov>
Sent: Wednesday, October 23, 2019 3:10 PM
To: Emily Corwin <ecorwin@vpr.org>
Subject: Public Records Request

Dear Emily,

Attached are the responses to your latest public records request.

Best
Bonnie

Bonnie Boyce
Paralegal
Medicaid Fraud and Residential Abuse Unit
Office of the Attorney General
109 State Street
Montpelier, VT 05609-1001
(802) 828-5511
www.ago.vermont.gov

Criminal Division Case Opening/Closing Forms
(Any Category With * **Must** Be Filled In when opening and/or closing)
Revised 01/28/14

Case #: 2014-3251

*Date Received in Office: _3/3/14_
*Case Name: In re William Dubuque
*Date Opened: 3/3/14 *Date Closed: Vibrs #13ag: __
* AAG1: DT AAG2: __ AG Investigator Initials: __
*County: Grand Isle *Court: n/a Court Docket No.: __
*Town: South Hero

*Charge / Allegation: neglect of the elderly

*Case Type:
___ Investigation
___ Prosecution
__x_ Prosecution Review
___ Appeal
___ VOP
___ PCR
___ Habeas Corpus
___ Extradition
___ Other Other Description:

Grant Cases:
___ STOP
___ Arrest
___ Meth
___ Byrne

*Investigating Agency: VSP Referral Information: ___

***Litigation Hold Review**

Matter reviewed to assess whether there is reasonable and foreseeable grounds for civil litigation against a state agency or employee.

__x_ no action taken
___ referred to Criminal Division Chief _____ (date)

*Advocate Information

___ No Victim
Victim Name: Alden Dubuque (deceased)
Victim Contact Information: __
Advocate Assigned: __

*Describe Outcome of Case - Include the Specific Terms of Plea Agreement or Sentence:
Closed without action

Incident
Incident Number: 14GIC0020 Nature: Agency Assist
Case Number: Image:
Address: [redacted]
City: South Hero State: VT ZIP: 05486
Area: 0705 SOUTH HERO Contact: 108

Complainant
Numbr:
Last: Fst: Mid:
DOB: SSN: Adr:
Race: Sx: Tel: Cty: ST: ZIP:

Details
Offense Codes: ASST Reported: Observed: ASST
Circumstances: LT20
Rspndg Officers: Allen, R.
Rspnsbl Officer: Allen, R. Agency: 3007 CAD Call ID:
Received By: Campbell, B Last RadLog:
How Received: T Telephone Clearance: RTF Report to Follow
When Reported: 12:04:00 12/29/2013 Disposition: ACT Disp Date: 01/06/2014
Occurrd between: 12:04:00 12/29/2013 Judicial Sts:
and: 12:04:00 12/29/2013 Supervisor:
MO:

Narrative
Narrative: (See below)
Supplement:

= =

INVOLVEMENTS:

Type	Record #	Date	Description	Relationship
NM	1726959	12/29/2013	Dubuque, Alden N	POI

LAW Incident Offenses Detail:
Offense Codes

Seq	Code	Amount
1	ASST Agency Assist	0.00

LAW Incident Circumstances:

Seq	Contributing Circumstances Code	Comments
1	LT20 Residence/Home	

LAW Incident Responders Detail

Responding Officers

Seq	Name	Unit
1	Allen, R.	108

Narrative:

assist VSP

I received cell phone call from Ray W. Allen [redacted] (father & Chief South Hero Rescue) at 12:10 hours 12/29/13. He advised that he was contacted by William (Bill) Dubuque [redacted] of [redacted] South Hero. Bill said that his father Alden Dubuque [redacted] had passed away.

I was requested to respond but was unable since I was in St. Albans area. I said that they needed to contact the State Police.

I was returning from Franklin County and stopped at the residence at [redacted] to assist. I arrived at approximately 12:40 hours. I was met at the door by Bill Dubuque who invited me in the residence.

Inside the residence was also Alison Dubuque [redacted] (wife of Bill), Ray W. Allen and Andrew Allen [redacted] (my son who was with me and wanted to pay respects to family).

Personal history with family. I have known the Dubuque family my entire life. They are neighbors. Also my children have grown up with their kids.

I began documenting names of family members and Alden's primary care physician who was Dr. David Hobbs of Keeler Bay Family practice. Bill said that Alden had not been seen since around June by Hobbs.

At this time I asked Bill the last time they had seen Alden alive. Bill said he had checked on him about 3:30 Saturday afternoon and had given him some water. Bill said Alden didn't want anything to eat.

Bill said the entire family had caught the flu around Christmas and they were trying to stay away from Alden so they didn't pass it on to him. Bill said he had dropped the ball in the past few days in regards to his caregiving of Alden because he had been so sick.

Bill said that he was the only caregiver for Alden. Bill said that Alison cooked meals but refused to allow her to give care(cleaning, bathing etc) to Alden because it was his responsibility.

Bill said that Alden had been living with them for about 2 years since he was taken out of the nursing home because of care provided there.

Bill made the comment that after the holidays he was going to put Alden into a nursing home because the care was getting to be too much for him. Bill said Alden was becoming harder to handle. He said he would spread poop all over the walls and would throw things. Bill said it was the beginning of dementia. He said Alden was also calling out for his deceased wife and his parents who are deceased. Bill said that he was becoming more angry and aggressive. Bill said Dr. Hobbs had prescribed a medication for this. Bill said he had not been giving it to Alden lately.

I asked to view Alden and Bill said where he was. Our conversations were taking place in the kitchen dining area. located off the kitchen area was Alden's bedroom located in the northeast corner of the residence.

I opened the closed bedroom door and viewed Alden laying in a hospital bed which was slightly inclined. Alden was laying on his back with his eyes closed. He was covered up by blankets and wearing a sweatshirt. The blankets came up to his mid chest area.

The room was clean and organized, there was the odor of the body releasing its self.

I did not touch or inspect anything and left the room and closed the door.

About this time Trooper Hall arrived and I gave him all the information that I had written down.

Det. Sgt Ed Meslin arrived at 1:10 pm. Det. Sgt Meslin contacted and spoke with Dr. David Hobbs who advised that he would sign off on death

certificate.

A assistant medical examiner arrived and inspect the body with Det.Sgt Meslin, Ray W. Allen (rescue chief) and I present.

When the blankets were pulled down Alden was only wearing a diaper from the waist down. I observed [redacted] that appeared to be covered partially by old gauze dressings. [redacted]. The diaper appeared that it had not been changed in several days. My view was limited since I was standing back by the door.

On completion of the examine the medical examiner said that the body needed to go to the State Medical examiner's office to be cleaned and further examination needed to be completed.

This information was told to Bill who again said that he had dropped the ball this week while he was sick and that he was ashamed that he let things go.

Minors funeral home removed the body.

Incident
Incident Number: 13A205788 Nature: Dead Body
Case Number: [redacted] Image:
Address= [redacted]
City: South Hero State: VT ZIP: 05486
Area: 0705 SOUTH HERO Contact:

Complainant
Numbr: 160788
Last: Dubuque Fst: Alison Mid: F
DOB: [redacted] SSN: [redacted] Adr= [redacted]
Race: U Sx: F Tel: [redacted] Cty: South Hero ST: VT ZIP: 05486

Details
Offense Codes: 0107 Reported: DBOD Observed: 0107
Circumstances: LT20
Rspndg Officers: Hall, Lucas Meslin, E
Rspnsbl Officer: Meslin, E Agency: SPA2 CAD Call ID: 5449481
Received By: Kelley, Rich Last RadLog: 14:56:54 12/29/2013 CMPLT
How Received: T Telephone Clearance: RBL Reviewed by Lt/Capt/C
When Reported: 12:04:23 12/29/2013 Disposition: ACT Disp Date: 12/29/2013
Occurrd between: 12:04:10 12/29/2013 Judicial Sts: NCI Non-criminal Incident
and: 12:04:10 12/29/2013 Supervisor: thango
MO:

Narrative
Narrative:
Supplement: (See below)

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INVOLVEMENTS:

Type	Record #	Date	Description	Relationship
NM	317440	01/02/2014	Dubuque, William A	POI
NM	1726959	01/02/2014	Dubuque, Alden N	Victim
NM	160788	12/29/2013	Dubuque, Alison F	*Complainant
CA	5449481	12/29/2013	12:04 12/29/2013 Dead Body	*Initiating Call

LAW Incident Offenses Detail:

Seq	Code	Offense Codes	Amount
1	0107	Natural Death	0.00

LAW Incident Circumstances:

Seq	Code	Contributing Circumstances	Comments
1	LT20	Residence/Home	

LAW Incident Responders Detail

Seq	Responding Officers Name	Unit
1	Hall, Lucas	221
2	Meslin, E	289

Main Radio Log Table:

Time/Date	Typ	Unit	Code	Zone	Agnc	Description
14:56:54 12/29/2013	1	289	CMPLT	SPA2	SPA2	incid#=13A205788 Completed cal
13:22:26 12/29/2013	1	221	CMPLT	SPA2	SPA2	incid#=13A205788 Completed cal
13:10:14 12/29/2013	1	289	ARRVD	SPA2	SPA2	incid#=13A205788 Arrived on sc
12:10:13 12/29/2013	1	221	ENRT	SPA2	SPA2	incid#=13A205788 Enroute to a

Law Supplemental Narrative:

Seq	Name	Date	Supplemental Narratives Narrative
1	Meslin, E	12:37:08 01/02/2014	

CASE NUMBER: 13A205788

OFFICER: Det/Sgt Edward Meslin

INCIDENT/STATUTE VIOLATION: Untimely Death

DATE/TIME OF INCIDENT: December 28, 2013 around 1530hrs to December 29, 2013 1100hrs

LOCATION OF INCIDENT: [redacted] South Hero

VICTIM: Alden Dubuque [redacted]
[redacted]
South Hero, Vermont

COMPLAINANT: William Dubuque [redacted] son

ACCUSED: N/A

MODUS OPERANDI: Victim passed away in bed

NARRATIVE: On December 29, 2013 at approximately 1210hrs I was contacted by dispatch and advised of an untimely death in the town of South Hero. Dispatch advised the victim had not been transported and was currently at his home located at [redacted] in South Hero. I asked dispatch to notify the on call AME.

While travelling to the scene I was contacted by Grand Isle County Sheriff Ray Allen. Ray advised he was on scene and he had known this family for many years and the death appeared to be of natural causes. Ray advised that the PCP (Doctor Hobbs) had agreed to sign the death certificate. Ray advised that his father and First Responder Ray Allen had spoken with Doctor Hobbs and received this information. I advised Ray I would speak with him further when I arrived.

I arrived on scene at 1309hrs. I met with Sheriff Allen. Sheriff Allen turned over a page of notes he had taken from the family prior to my arrival. I learned the victim was Alden Dubuque [redacted]. I was also introduced to the victim's son, William Dubuque [redacted].

While waiting for the AME to arrive I spoke with William. Between what William advised and the notes that Sheriff Allen took the following information was obtained:

William advised that on February 25, 2011 his father (the victim-Alden)) fell down a flight of stairs. His father got himself back up the stairs and into bed. When the fall was discovered by family his father was brought to the hospital where it was learned he broke his neck, eye socket and arm. Alden spent 2 months in ICU. After getting out of the hospital Alden was placed in a nursing home. Bill advised that his father was "dropped" while at the nursing home so he decided to take his father out of the nursing home and care for him at his own house. William advised his father has been under his care for about the last 3 years.

William went on to say that his father had been bed ridden for about the last 2 years. William also advised (Sheriff Allen's notes) that his entire family had been suffering with the flu over the last week or so so they have had as little contact with his father as possible, so as not get him sick. William pointed out that his father has his own bedroom which is equipped with a lift.

William advised that the last contact he had with his father was around 3:30pm the previous day when he gave him some ice water. At around 11:00am today he went to check on his father as he had not heard any activity from within the bedroom and found Alden to be unresponsive.

I also contacted Doctor Hobbs by phone to verify that he would sign a death certificate for Alden. Doctor Hobbs advised he would. I asked Doctor Hobbs what he would be listing as a cause and Doctor Hobbs advised "old age." I asked Doctor Hobbs for something more specific (and also medical in term) and Doctor Hobbs advised he would have to look at Alden's medical history and could provide a specific cause the following day. Doctor Hobbs advised that Alden was slowly deteriorating.

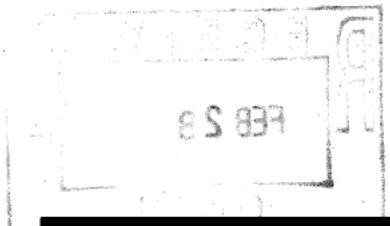
AME Ginny Eriksen arrived. After introductions we went into the bedroom where the victim was. I observed Alden was in his bed on his back. Sheriff Allen was also in the room with us. While conducting the body examination we observed that Alden was wearing Depends. [redacted]. AME Eriksen removed the dressing to uncover a large festering bed sore. AME Eriksen advised the dressing had not been changed in a long time and this sore appeared to almost be gangrenous. AME Eriksen was very concerned about what she was seeing based on the condition. I advised AME Eriksen I would speak further with William. I obtained photographs of the examination and exited the bedroom.

I located William and asked him if he would accompany me outside. I asked William to have a seat in my cruiser which he did. Upon getting situated in the car I advised William that the AME was seeing some very concerning things involving his father. During our conversation William again mentioned the family being sick all week and he did not put the effort he should have into his father's care. William advised he had been battling bed sores and had been turning his father every 2 hours. William advised he does all the care for his father and his wife does the meals. William advised he had been contemplating putting his father in a nursing home or having the VNA start to do home visits. I asked William when he last changed Alden's dressing(s). William advised he changed them on Friday (2 days ago). I asked William when Alden was last physically out of bed. William advised the date was December 18, 2013 (11 days prior) and his father did not want to get out. William advised he let his father's care (or lack of) get out of control and said he was ashamed for what happened over this past week. I asked William when it was that the VNA last did any care for his father. William advised they cared for his father about 2.5 years ago for 4-6 months.

After speaking with William I spoke with AME Eriksen. She advised she had spoken with Doctor Shapiro and he wished that the victim be sent to the OCME for further examination. I advised AME Eriksen of my conversation with William. AME Eriksen was not in agreement with William's advising he changed Alden's dressing only 2 days ago. AME Eriksen advised this case needed should be referred to Adult Protective Services (APS). We then spoke with William and advised him that the OCME requested his father be sent to their office. Minor's Funeral Home removed the victim.

On December 30, 2013 I spoke with Doctor Shapiro regarding this death. Doctor Shapiro expressed his concerns over what he observed and advised he would notify APS. Doctor Shapiro advised this case may not be criminal but there was at least a possible case of passive neglect (cited in Preliminary Report of Autopsy) that may have been occurring and someone (VNA, Home Health?) more capable of providing professional care likely should have been brought in a long time ago.

On December 31, 2013 I spoke with APS Investigator Steve Dixon. Investigator Dixon advised he opened a case on this death. I provided Steve the case number should he need a report.



SUMMARY: Manner of death is pending. [redacted]

This case is also being investigated by APS. On January 2, 2014 I spoke with SA Dave Miller. SA Miller advised he had spoken with Doctor Shapiro involving this death.

This case will remain open. Further action will be at the guidance of SA Miller.

_____

Detective

VERMONT STATE POLICE INVESTIGATION REPORT

[redacted]
pelier, VT 05601-0067

1 - The Art of Bookmaking Thurs 5-730 pm JEM 281

U.S. POSTAGE PITNEY BOWES
ZIP 05602 $ 000.48[5]
02 1W
0001369372 JUN 15 2015

Capstone

GED 562 * By arrangement only

[redacted]

Thesis Research (3)

Educator as Researcher (3)
5-730 pm STE 307
Claudine Bedell

057338102B C002

Sunday 454 pm 6/21/15
Mom - U need your help
please come.

Sunday 457 am 6/21/15
6:00 am - Mom
Our House, Too
- Nurse here telling
Mom.

Sunday 735 am 6/21
Our House 2 = Mom calling -

Sun. 6/21 - 13 28 pm
Mom.

Monday 6/22 10 01 AM

Monday 6/22 @
Wendy - Nurse at House
420 pm 6/22 [redacted]
Wendy

Rick D. [redacted] Wed 6/10 7:53 pm

Thur May 7 11:23 am
Dina @ Bradenton Oaks Sat May 9th
secured Memory care Assisted Living
[redacted]

Naomi London [redacted]
Our House in Rutland
Fri 6/5 @ 2:18 pm

Laura LaMountain
Mikhael's #
Rita Laura H [redacted]

Mom - I'm having trouble down here, getting yelled at & disrespected. Not feeling very good, so Please come & get me. Fri 6/5 @ 2:28 pm [redacted]

✓ Brittany @ Our House Fr. 6/5 @ 4:08 pm
* Mom agitated and jumped the fence
Please call

Sun 6/14 @ 3pm [redacted] Our House

Brittany - Mom would like to talk to you
Please call when you can.

Sun 6/14 @ 3:10pm Mom - please call re: eye glasses
confused with seasons
shampoo

Marilyn Kelly
Our House Residential Care Home

This is the statement of June Kelly, daughter of Marilyn Kelly.

Marilyn Frances Kelly, "Mom" was born on March 1, 1937.

Marilyn F. Kelly was widowed. She married Peter Joseph Kelly on January 28, 1961. Peter passed away on May 29, 2008. Marilyn and Peter Kelly have seven children, June Kelly, Peter Kelly, Mary Kelly, Ralph Kelly, Alice Kelly Ruffner, Grace Kelly Parenteau, and Michele Kelly Marion.

During 2014, family noticed Mom's mental health was changing and there were concerns for her safety. On December 12, 2014, my sister Alice called advising that Mom had gained about 8 pounds in weigh in about one week and Mom wasn't feeling well. I told her to get Mom to the doctor's and I would be on my way. We took Mom to the Danville Health Center and learned she was having a [redacted] to get her to the ER. We took Mom directly to Northeastern Vermont Regional Hospital (NVRH) ER and she was admitted. She was treated for [redacted]. Mom was discharged from the hospital on Tuesday, December 16, 2014.

On January 12, 2015, family member met with Attorney Kyle Sipples to file an emergency petition for Guardianship on Mom. The temporary order was granted by the Caledonia Probate Court Judge that day and I was awarded temporary guardianship for Mom's safety. Meanwhile, Mom was now staying with Michele at her house in St. Johnsbury, VT.

On January 22, 2015 at 1 pm, we had a Guardianship hearing at Caledonia Probate Court to determine continued Guardianship. Mom was appointed an attorney, Jay Abramson, to represent her. An evaluation was ordered by the court.

On March 2, 2015, at 1 pm, Caledonia Probate Court held another guardianship hearing in which the evaluation results were available to the court which confirmed Mom's need for 24/7 support.

On Friday, March 13, 2015, at about 11 am, I received a call from [redacted] who was in crisis with Mom. Subsequently, Mom was admitted to UVM Medical Center for [redacted].

On March 16, 2015, I met with the hospital social worker and brought legal documents. We still did not have the final guardianship order yet. Mom stayed at UVM Medical Center for the next two months while we looked for a care home placement with the social worker staff. They all agreed she needed daily care for medication prompting, hygiene, eating and she needed a private room.

On May 5, 2015, I received a call that Our House RCH in Rutland had an opening coming up. I toured Our House at 69 ½ Allen Street, Rutland, VT. I met with Paula Patorti, Owner, at her office at 196 Mussey Street, Rutland VT, [redacted]. She advised she would go and interview Mom to determine if she would be a good fit for the RCH. I was provided with a contract and paperwork needed to be filled out. Paula asked me if I had a doctor for Mom in

Rutland and I said, no. She said they have their own medical staff and would I like to have Mom seen by them. She told they use Patti Thornton of Convenient Medical and she comes right to the care home to see patients. I said, yes, that would be great because I had not found a doctor for Mom. I mentioned that actually Mom had seen Dr. Thornton in the past when Mom was visiting me and we went there because Mom had a bad cold and needed medication to help her. [I later learn that Patti Thornton, PA-C and she works with Dr. Timothy Cook, owner of Convenient Medical.]

On May 6, 2015, I fill out the Our House Residency Admission Agreement. Our House is licensed as a Level III residential care home with the State of Vermont.

On May 7, 2015, I called the Caledonia Probate Court and Attorney Sipples. I learned that the guardianship court order was still sitting on the Judge's desk. (We had been waiting to hear if the order was finalized since the March 2, 2015 hearing.)

On May 8, 2015 at 6 pm, Alice came and toured Our House RCH to offer her input. On May 9, 2015, Alice and I visited Mom to tell her of the care home we had found and that we wanted to know what she needed for furniture and clothing.

On May 11, 2015, Mom was transferred from UVM Medical Center to Our House Residential Care Home (RCH) in Rutland, Vermont. Mom had been at the medical center for two months waiting to find her a placement in one of many care homes that we had her name pending an opening.

Paula Patorti advised that it was best if family had no contact with Mom while she got settled into her new home. Patorti recommended to give Mom about two weeks or so to adjust. I asked if I could call to check on her and she advised to call Beth or staff anytime.

On May 11, 2015, within two hours of being at the care home Mom hopped the fence in the backyard of the care home trying to elope. The staff returned her without incident a short time later.

On May 14, 2015, Guardianship was granted by Judge Balivet, Caledonia Probate Court. Order subsequently received in the mail.

On May 18, 2015, I emailed family Mom's new contact information address and the care home phone number later if they wanted to visit, send cards or call.

On May 31, 2015, I picked up Mom and she goes with me to her grandson's high school graduation in Lyndonville. We went to lunch after the graduation. Mom became agitated after lunch and refused to go back to Our House RCH Rutland after already in my car. This resulted in a police call and family support to get her back in car with Mary bringing her back to Our House RCH. Staff at Our House were called and informed of Mom's behavior and asked for support if needed getting her back inside RCH when Mary arrived. The staff greeted Mom and Mary at the door and Mom went in without incident. I spoke with Paula Patorti about what to do

with Mom's behaviors and she made suggestions, obviously too soon to take Mom out on a long road trip and long day.

On June 5, 2015, I received a text from Paula Patorti that Mom had jumped their patio fence. I called Out House and spoke with Brittany who was working and she advised they got Mom back and calmed down. I also sent Paula email contacts for family as she informed me that Mom was on the phone with a family member earlier which upset her and precipitated the fence incident. Later, Our House Too installed a better perimeter fence for resident safety/security.

On June 24, 2015, I visited Mom with Mary. Mom was agitated punching her window and screen. I told RCH staff and asked them to check Mom's hand. Mom also tried to block my exit from the care home with staff's their help I left. I later talked with Paula Patorti about Mom's behavior. She made suggestions of just leaving and it was ok to leave when Mom was acting up. Our House ended up screwing Mom's window shut.

On July 1, 2015 at 5 pm, I, Mary and Alice had first Care Plan Meeting at Our House Main Office with Paula Patorti, Patti Thornton and Beth Peer. We discussed prescription cost because I was going to Walmart to get Mom's prescriptions. They suggested Health Direct Pharmacy because the can often keep prescription costs down and they delivered directly to the care home. We discussed Mom's medications and it was agreed to try Sertraline HCL 50 mg and cancel Haldol use. I explained how Mom was on Sertraline also known as Zoloft and it helped with her mood and depression. Patti Thornton advised she would prescribe the Zoloft and see how that helped Mom. They were continuing the Gabapentin to help with the Scleroderma/Raynaud's nerve pain. I explained that Mom had a reaction to Hydrocodone that previously made her hallucinate. Mary and I were working on getting Mom and eye exam and new eye glasses. Mom was diagnosed at the eye exam with the start of cataracts to keep and we were waiting for glasses from Lens Crafters. I asked if they would check Mom foot wound because she kept picking at a planter's wart. We discussed her previous bout of Shingles and a head/scalp wound that continued to bother her from the previous Shingles rash.

I asked about recreational activities for Mom and was told by Paula they encouraged the staff to play card games, do art activities and throw a ball around the room with residents. Paula said however it was often hard to get the residents engaged in the activities. I asked about Mom as she was entitled to activities and I was going to arrange swimming as an activity for Mom and would check into it and get a swim pass for her. Policy says they can take Mom out for appointments once a week and would they support that? I was told, yes. Beth advised she observed where Mom likes to help and often thinks she is working for Our House, so that works to keep her engaged in a positive way. I was provided the Health Direct telephone number of [redacted] ask for Courtney or Erin, if I had questions I could call them. Our House would set up prescription coverage for Mom.

On July 4-5, 2015, I visited Mom and she was complaining of something stuck in her tooth. Upon checking her mouth I discovered no one was helping her brush her teeth. She had a dead black tooth and food was stuck by it. [redacted] and I helped her brush and clean her teeth. We then picked her up mouth wash. I immediately complained to Our House Staff and the House Manager Beth Peer. Beth advised they often took resident to Dr. D'Auria for dentist

appointments because she understood the resident's needs and was close by in Rutland. An appointment was made and Mom was scheduled to go on January 10, 2015 at 1:10 pm.

On July 6, 2015, Mom had met with Ann Doucette, of the VT Long Term Care Ombudsmen. Ann was a volunteer advocate for the Ombudsmen Program. I spoke with Jane Monroe, Esq., the Long Term Care Ombudsmen representative for VT Legal Aid Office in Rutland. We talked about Mom's care and how the program was available to help with long term care resident's concerns. We spoke for about 90 minutes, I learned about the program and services that were available, and I shared what I observed at Our House. I asked about how to go about getting Our House to offer activities.

On July 10, 2015 at 1:10 pm, Beth Peer took Mom to dentist appointment with Dr. D'Auria. Mom's dead infected tooth was extracted with instruction to keep clean for next week and rinse, etc.

On July 21, 2015, I called Beth Peer about recreational activities for Mom, because Paula Patorti had promised that there were activities for the residents. This was yet to be seen as I had purchased a swim pass right after our care plan meeting and Beth kept telling me she was going to take Mom to open swim because I had given her all the times. Beth kept complaining how her schedule was so crazy and that she would take Mom next week. The only events that I had seen were [redacted], another resident of Our House had her husband who visited frequently and once a week he would play piano for everyone.

On July 27, 2015, from1130 am to 1230 pm, Beth Peer took Mom swimming at the Mitchell Pool in Rutland. Beth and I spoke about Mom's energy level and plan to take her again but encourage Mom to not overdo it. Beth said staffing was the problem to taking Mom.

On July 28, 2015 at 3 pm, Mom had a foot doctor appointment for her foot wound care (as planned from the 7-1-15 care plan meeting). Beth Peer took her to the foot doctor appointment with Dr. Mary Schech on Common Street in Rutland just down the road from the care home. Dr. Schech treated Mom's plantar wart and said to follow up if needed.

On August 4, 2015 at 5:27 pm, Wendy Daley, RN, the nurse from Our House called to tell me that Mom took a fall yesterday outside her room. Wendy Daley, RN, told me that there were no injuries that she had checked Mom and she was just calling to let me know.

On August 13, 2015 at 11 am, during a visit with Mom, I noticed Mom's ankles and feet were swollen. I asked the nurse to check Mom.

On 8/19/15, RRMC, lab work records.

On August 27, 2015 at 9:30 am, Mom was taken by Our House Staff to an appointment at Convenient Medical.

On August 28, 2015 at 7 pm, I received a call from .... Mom was distraught and I stayed until 9 pm with her.

On August 29, 2015, Beth Peer texted. Mom upset from construction workers coming into home causing distress. Kitchen floor was torn up…home without water, no food capacity, and couldn't use kitchen. Was DAIL notified?

On August 31, 2015 at 3:15 pm, Beth Peer advised Mom refused meds, angry, and paranoid.

On September 2, 2015 at 4:50 pm, Beth Peer – Mom refused to go to Doctors.

On September 4, 2015, I visited Mom from 1 to 5:30 pm, discovered lice in Mom's hair now second time just went through 2-3 weeks of treatment. Now, lice back and showed Beth Peer. We brought bedding, clothes and all laundry to laundromat for Our House in the back of my truck. [redacted] lab work brought to RRMC but sample was bad.

On September 4, 2015, Mom eloped from Our House RCH. At 9:24 pm, after a Health Direct pharmacy delivery man let Mom out the door to Our House. Staff did not notice her missing for over an hour and half after her departure. Police are reportedly notified at 10:45-11 pm that Mom is missing and search started. Paula advised they had to watch their video tape surveillance to figure out what happened. Hospital records show Haldol PRN…

On September 5, 2015 at 1:22 am, I receive a phone call that Mom was missing. We had searched all night with the help of police, fire, RCH staff and others. She was found safe around 10:30 am by Rutland Police Department at the Comfort Inn in Rutland. She was transported to the RRMC to make sure she was ok.

On September 8, 2015 at 1 pm, a Care Plan Meeting was held with Paula Patorti and Beth Peer. We discussed events from Friday night, September 4, 2015. The concerns were late notification of Mom missing (1:20 am), when she was already missing for 4 hours. Paula advised that the Health Direct Driver that let Mom out that night was [redacted] and his supervisor was [redacted] telephone [redacted] [redacted] was the former Our House employee who now works for the Comfort Inn front desk that vouched for Mom and let her check into the hotel. According to Paula, [redacted] bragged on Facebook that she didn't think Mom belonged at Our House.

On September 17, 2015 at 4 pm, reported fall with [redacted]. Mom is taken to the ER, full set of x-rays are done, no reported fractures, and Mom is released back to Our House at 6 pm.

On September 20, 2015, during the evening, Peter takes Mom to the ER. Mom's right leg is swollen, she is complaining of pain, and he is concerned she might have [redacted] caused by fall on 9/17.

On September 23, 2015, Mom eloped and Beth Peer had an ambulance take her to ER for evaluation. Mom was found walking at construction site off Allen Street. Mom was uncooperative and agitated.

Mom eloped another time going out the door on staff and Beth got her to return.

On September 30, 2015 at 8:30 pm, Mom is brought to the ER because she broke phone, agitated and they wanted her checked out.

On October 6, 2015 … ER visit … Fall with seizure concern; BP falling?

During October, 2015, I repeatedly asked Our House RCH to have Mom taken off Haldol because I found her in a stupor or deep sleep. When RCH staff was asked why, they explained my Mom was assaulting staff or residents but I never was called about any such incidents. I learned that Mom had assaulted [redacted] another resident causing her a laceration and bruise to her chin but I was never called. I learned this from Caregivers Mihayla Stone and Erica Grosso (who since has been fired). I asked Paula to let me know of such incidents that justified my Mom's need for such medication since her entire stay at UVM MC only required the use of Haldol on two occasions. They told me the Haldol was issued PRN but I found out that they were giving it to her 3 times a day and was not informed of this.

On/about November 3, 2015, Patti Thornton assured me Mom was coming off Haldol. [*We talked about Teepa Snow videos on Alzheimer's training.]

On November 12 at 9 am, Beth and I took Mom to her DHMC Scleroderma appointment with Dr. Nicole O. We talked about the food service concerns. Beth explained how Our House had a nutritionist/meal planner come in and recommendations were made for monthly meals. Beth advised that "Lisa Patorti will not follow recommendations". Lisa will not listen to others and she orders the same things each month such as chicken nuggets, hot dogs and what is easy. The PCA staff is expected to make the meals and they couldn't do preparation for other meal plan so thus what is served.

On November 13, 2015, Our House was out of decaf coffee and the staff intended to serve regular coffee to residents at supper (5-6 pm) meal. I went to main office and had them get decaf for residents. Lane Patorti went to the grocery store. I spoke with Lisa Patorti about menu and asked to limit chicken nuggets and hot dogs.

On November 18, 2015, note about Norvasc to check on prescription ordered by DHMC Dr. O.?

November 20, 2015, 3 pm – 6 pm, Dirty laundry from two days earlier (Wed.) was still in laundry basket in Mom's room. The Care House was out of eggs and juice for residents. I asked staff to call main office and ask to get food needs. Wendy Daley the nurse showed up with juice and eggs.

November 22, 2015 – Fall – report found in Our House Too paperwork – Never reported to family.

On November 23, 2015, I set up a hospital bed in Mom's room after talking with staff to make sure okay. (Beth and Paula) I am trying to get Mom to sleep and brought the bed in hopes that would help. Staff is reporting Mom's insomnia keeping her up. I had set the bed up just as her

other was set up but house staff (Nancy or Barb) tell me to move bed against the wall and they do so.

On November 24, 2015, I receive a call that Mom fell out of bed because bed too high and tell me I should not have set it up against wall. I explained I did not put the bed against that wall because staff put it there. There was no record of this fall.

I texted Paula that Mom had an appointment with Dr. Conway for her leg swelling and wound treatment.

{Note: During this time period, there was a reported article in the Free Press about how Our House hires ex-heroin users.}

On November 26, 2015, Thanksgiving dinner Mom complains her head is bothering her. I look at her head and find blood under her hair and area turning to a purple bruise. The injury looks like it happened today. I find blood under the side table of Mom's room. None of the staff know of injury or how it happened. It appears that Mom struck corner of table in her room. As a precaution since Mom is complaining of head pain, I take her to the hospital ER for an unwitnessed fall, scalp contusion. Mom also need treatment for her Unna Boot as it is too tight and cutting off circulation.

On November 27, 2015, I talked with Wendy Daley about Unna Boot care and how Unna Boot was too tight. Later hand written sign appears on kitchen refrigerator "Do not touch Marilyn's Unna Boot only Doctor"

On November 30, 2015 at 2 pm, Mom and I go to appointment with at Dr. Conway's Office (vascular doctor). Mom refuses treatment.

On December 4, 2015 at 12 pm, I meet Paula _____ to have a Care Plan Meeting

On December 8, 2015, Beth Peer took Mom to rescheduled Dr. Conway appointment. I talk to Dr. Conway on _____ about care concerns with Wendy Daley and lack of oversight on Unna Boot, PCA'a not knowing how to shower/bath Mom etc. He orders RAVNA to do follow up visits and care with managing Unna Boot.

On December 11, 2015, I learn Mom has been incontinent for two months. No one told me. Mom has her leg check up with VNAs for wound care. Mom is in good spirits.

On December 15, 2015, Cindy Dahlin, the on call nurse, calls reporting that Mom has taken another fall and that she is not there at the Care Home. She advised she triaged the incident by phone with the PCAs and recommends Mom goes to the hospital. I say absolutely and don't hesitate anytime to get Mom to the ER is she is hurt.

On December 16, 2015 at 9:15 am, Mom goes to Cardiologist appointment at Rutland Heart Center and refuses ultrasound (echocardiogram). At 3:30 pm, I have a meeting with Paula about concerns with medication, falls and what to do next.

On December 21, 2015, I brought clothes for Mom without zippers because I learn from staff that Mom is having accidents because she couldn't work zippers on her pants.

On December 22, 2015, Beth Peer takes Mom to Rutland Heart Center appointment. Mom is frightened and uncooperative. According to Beth, Mom's Norvasc medication is stopped. Medical staff at Heart Center notes that Mom is dehydrated and hydration is needed.

On December 25, 2015, Christmas Dinner at Our House.

On December 29, 2015, Dr. Conway wound care finished and Mom's legs look better. ?

On December 29, 2015, called Patti with concerns about Depakote, Haldol; sore throat and took nose dive

On December 31, 2015 at 11:23 am, I rec'd a telephone call from Wendy Daley, RN, who represents Our House as their on-call nursing staff. She also stops in during evenings at Our House caring for residents. Wendy told me that Mom had taken two falls today. One in the morning about 2 am when she fell out of bed on her hip, and again this morning, just before she called me when Mom fell off the couch and struck the side of her head. As a precaution, they wanted to take Mom to the ER to have her hip checked and x-rayed. I was told that Mom had range of motion when they checked her in the early morning, iced her hip and then put her back to bed...however, her hip was now more swollen and stiff so they were sending her to get it checked. I said, yes, please do and I will go to the RRMC emergency room as soon as possible.

I got to the hospital sometime between 1 - 1:30 pm. I met my mom and Beth Peer in room 12 of the ER. I greeted mom and hugged her when I got there. She told me "they hurt me". She was in and out of sleep. At the time I did not know all the details and only that she was being treated for the reported falls. Beth advised Mom had just come back from being x-rayed and they were waiting for the results to make sure her hip was not fractured. Later, the nurse and Dr. Hartmann came in to let us know there were no broken bones. The doctor advised that Mom had a large hematoma to her right hip and buttock. Around 2:15-2:30 pm, the doctor advised that they would get care instructions, discharge information, and the nurse would be in to arrange. Upon discharge, Mom was transported back to Our House by ambulance because she was in tremendous pain and there was no way I could comfortably transport her in my car.

At about 2:45 pm, I returned to Our House RCH and met the ambulance at the facility located at 69 1/2 Allen Street, Rutland, VT. Mom was brought in and carefully moved to her bedroom to rest. About five minutes later, I received a phone call from Paula Patorti, Owner/Manager of Our House RCHs asking if I could meet with her immediately at her office. I asked if it could wait because I was wanted to meet with Patty Thornton (PA-C, Our House staff medical person), who was coming in to meet with another resident's family. I mentioned I wanted to discuss fall prevention and care planning for Mom. Paula asked what time Patty was coming in and I advised I was told 3 pm or so. Paula said come on over and have the girls call the office if she comes in so they'll let us know and I could head right back. I said, ok, I would be right over.

I meet with Paula Patorti and Beth Peer at the Our House RCH business office on Mussey Street in Rutland, which is just a block away from their Allen Street care home. At this time, Paula told Beth and me that Mom had been assaulted by Marissa, one of their caregivers at about 2 am that morning and Mom's hip injuries were not from a fall. Paula explained that she reported the incident to Rutland City Police and APS for investigation and charges.

I was told by Paula the following:

The story about Mom falling did not make sense so she reviewed the video from the Our House cameras. She viewed where Mom was up not sleeping, you could see Colleen (the other care attendant), who was working with Marissa gathering the seat pads and blankets off the living room furniture to do the daily midnight shift washing of the items. Mom walks up to Colleen (saying that's mine) and grabs onto one of the pads in Colleen's hands. Colleen is aware enough not to release the pad because Mom is pulling on it and doesn't want Mom to fall back. Colleen then coaxes the pad away and goes about her business to the laundry room with Mom following her. As Mom walks in the hallway towards the laundry room Marissa walks past Mom in the hallway then Marissa turns around and shoves Mom from behind causing Mom to fall striking her hip in the hallway by the two couches. Mom is then seen on the floor trying to get up and cannot. It appears she is flailing on the floor. The staff comes up to her several times to help her get up and try to assess her injuries and Mom wants nothing to do with them. On the video Marissa then is seen on her cell phone not helping Mom and about 3 am (approx. one hour) after the assault walks out the door and off the job. Colleen also tries repeatedly over the course of the hour to help Mom but Mom won't let anyone near her. Mom later gets up for the staff member, Shania, who is called in to replace Marissa.

NB: **Shania Galiano** was the RCH caregiver that was called in when Marissa Flagg walked off the job. **Colleen Knowles** is the RCH caregiver that was doing laundry at the RCH when Mom was assaulted by Marissa Flagg.

Paula also explained the following in our conversation:
Colleen called Lisa (Patorti) immediately when Marissa walked off the job to get help for staffing. Colleen told Paula that she heard a thud and Mom hollering/screaming, so knew something wasn't right so they reviewed the video from the morning to determine what happened. Rutland City PD Officer Rosario met with her and left about 1:30 pm and she (Paula) also filed a report with Adult Protective Service (APS). Officer Rosario was apparently familiar with Marissa because the police were at her house on a disturbance call this morning, something to do with a domestic disturbance and that she was admitted to RRMC because of a suicide threat. Officer Rosario was given a copy of the video tape showing the assault.

I asked Paula to call Officer Rosario to see if he wanted to arrange photographs of Mom's injuries. Officer Rosario advised he would meet Beth and me shortly at the care house. (Officer Rosario ended up getting busy later so we never met that night. He met up with House Manager Beth Peer the next day.) I then received word that Patty Thornton was at Our House so I left to meet with her about 4 pm.

Once back at Our House RCH on Allen Street, I waited until Patty Thornton was done with another resident's care and told her of the assault incident. I asked her to check Mom which she did. Beth Peer came back to check on Mom after getting an in-house video monitor for Mom's room and Beth put a clip alarm on Mom for fall prevention safety. Mom was in a lot of pain. We iced her injury and got her some Tylenol. I stayed for a while to make sure she was going to be okay.

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I met with Paula Patorti on Monday, 1/4/16 at 2:30 pm at her request to meet with me and [redacted] another Our House resident's daughter. We discussed different concerns regarding care with Paula regarding my Mom[redacted]. We discussed communication concerns that had to be worked out in advocating for our mothers. I shared with her that I was upset about the fact that she knew Mom had been assaulted while we were up at the hospital ER and it would have been helpful for the doctor to have this information because Mom would have been more thoroughly examined and the doctor would know specifically what to look for.

Paula commented that she didn't think Mom was a good fit for Our House. She was thinking of giving notice for Mom to leave. Paula spoke with [redacted] and I about her concerns because we were sharing our concerns i.e. [redacted] Nurse Daley not responding to needs of residents (Unna boots[redacted], food concerns and overall staff care. Also present at this meeting were [redacted]. We discussed staffing, hiring of better staff and overall care of our mothers and that [redacted] and I were going to continue to watch out for each other's mother.

On January 6, 2016, lab work/blood drawn on 1/6 from order by Patti Thornton sent to RRMC.

On Wednesday, 1/13/16, I visited Mom and I noticed she was very tired and sleeping most of our visit in the recliner. I noticed with her being so tired there were changes to her breathing and I asked the staff, Mihayla, to keep an eye on Mom.

On Thursday, 1/14/16, the AG's Office advised they would be handling the assault of a vulnerable adult investigation.
Virginia Merriam, CFE / Detective
Office of the Attorney General / Medicaid Fraud & Residential Abuse Unit
109 State Street, Montpelier, VT 05609-1001
802-828-5342

On Friday, 1/15/16, Mom was transported to the ER as a result of my sister, Grace and brother, Ralph finding Mom unresponsive and out of it at the care home. PCA (male care attendant) will not transport Mom to ER even though she is obvious distress until the nurse calls him back.

Later, I went to the care home to get clothes for Mom, Our House staff, Mihayla, advised she called the nurse, Wendy Daley, on the evening of Wednesday, 1/13, because Mom's breathing

was bad and she was concerned enough that she thought the nurse should check it. Mihayla advise she did not do anything at that time.

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On Friday, January 15, 2016, Mom was transported to RRMC. My brother and sister we're visiting Mom at Our House Friday morning when they described she was found not breathing well and unresponsive on the couch in the hallway at the care home. Mom was taken by ambulance on Friday, 1/15 about 11 am to the ER. It turns out she has pneumonia and has had a heart attack sometime that day or over the course of the past days. She was admitted to the hospital from the ER later that day for care.

My brother and sister said the staff could not answer them about when they should call the ambulance when a resident was in distress. The staff told my sister/brother they needed to call the nurse first.

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While at the hospital we learned that Mom also was severely dehydrated upon admission. When they introduced fluid to treat the dehydration it made the pneumonia worse. This then caused congestive heart failure putting water around the heart. To fight the CHF, they gave Mom Lasix and that was not going to work because Mom's quality of life was not going to return.

On January 18, family met with hospital staff to figure out rehab and long term care options for Mom. We were not going to allow Mom to go back to Our House because she was not safe there and had been actively looking at trying to find an opening at another care facility. We didn't expect Mom to die.

On January 20, 2016, we removed all of Mom's belongings from Our House Too RCH.

On January 23, 2016, the family a week after Mom's admission to the hospital had to decide whether to transition Mom to comfort care as her life was so compromised by the pneumonia, dehydration (all the events) that her health status would never be the same.

On Saturday, January 24, 2016, we found out that Mom had a compression fracture of her T7 and it is unknown whether it is acute or not. The doctor explained that it was not there from x-rays taken on 9/17/15. The radiologist did not assess the age of the fracture only its existence. The hospital did the additional x-ray at our request when they did her chest x-ray because of Mom's back pain complaints.

Mom passed away on February 1, 2016.

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Concerns

1. Medication
Mom was over medicated by Haldol, Depakote and Sertraline. They are all antipsychotic drugs which reportedly have black box warnings. The research indicates the drug Haldol needs to have documented use of the lowest dose. The reasons for the drug use to control agitation must be documented and the drug cannot be used as chemical restraint because staff is not properly trained.

2. Food concerns
Foods fed to residents are high sodium foods. In my Mom's case, she was to a person with leg swelling and heart concerns. They repeatedly did not bring this to the doctor's attention. On 12/31/15, in my conversation with Patty Thornton, PA-C, I asked her to issue an order for Mom to be on a low sodium diet. The RCH meal plans consisted of processed foods such as hot dogs and chicken nuggets. I had met with Paula, Wendy Daley, RN, and talked to Lisa Patorti, RN, about food concerns but as time went by they did nothing. One day they were going to feed regular coffee to resident's at 5 pm dinner because the house was out of decaf coffee. I made them get decaf. Another day they were out of eggs and juice in the house. During the week of January 10th, the RCH had hot dogs twice in the meal plan for residents to eat. These are 490 mg sodium hot dogs. I asked Lisa Patorti to change the food service to better foods and this never happened for the residents.

I observed where residents also had difficulty eating certain foods such as pizza and they were not offered alternatives. Also, when they don't eat their food provided a nutritional supplemental drink. This happened on several occasions and I brought this to Paula's attention and was informed the staff is trained to offer a drink supplement. I shared how that was not being done.

3. Staffing
The lack of consistent staffing creates care problems for all residents. It is most everyday there is a new face/person hired to they point it is problematic for all in knowing residents' needs. Then on top of this the staff complained to me because they are not consistently assigned to the same house. One staff member told me she was working 20 hours in one day's period and another mentioned she had worked 3 double shifts in a row due to staffing shortages. I am told Lisa Patorti does the schedule and has no concern about ordering staff over even with the amount of time the staff had already worked or that they have had no sleep. Staff has commented in front of me and other families about these situations. I have talked to Paula Patorti as have others about the lack of consistency with staffing effecting quality of care. This needs to change. All of this impacts communication which is a problem, too. They also switch staff between houses working doubles, too.

4. Care Planning & General Care
The seven months my mother was at Our House Too communication was horrible at the house. When I have talked to staff, the nurse, medical they don't talk always talk to each other or pass on concerns. This impact care planning which had to be initiated by the resident's family is not the best. We suggested a log book or some way for staff to take ownership to relay messages to

the nurse or doctor. Beth Peer is the Care Home Manager and I know she has gone to Lisa and Paula to address change and it fell on deaf ears.

On two occasions, there were no bandages or band aids to use for care for Mom and the staff had to improvise. I brought this to Paula attention. I tried repeatedly to make them aware of such situations that over the course of seven months added up to repeated lack of leadership, supervision, poor training, and omissions on behalf of the RCH administration. Staff not knowing how to bathe someone with an Unna Boot, so a resident going without personal hygiene needs being met. It was not just my Mom's care there too, as there are 10 or so other residents; and more in three other care homes managed by the same administration.

The events reinforced the inconsistency of care and lack of oversight at Our House RCH. I couldn't fix there inept miscommunication, staffing issues and inconsistent care. I tried. Others need to know of this situation that was at the expense of my mother's health and life.

On January 27, 2016 at 12 pm, I was the RRMC, when two residents from Our House Too were brought into the ER. Both were admitted. Both residents' families came to visit Mom and share their stories of care concerns. [redacted] who was a resident of Our House Two. They shared their concern about the daily use of Haldol on their loved one, [redacted] even though she had compromised kidney function. They are willing to speak to their concerns with care such as Haldol on [redacted] and coming in to visit after my Mom had been injured in a fall.

They used Haldol indiscriminately on Mom. I was not told about the Haldol use a first then I was lead to believe it was being administered "PRN" as needed for agitation. This was not the case. I had to dispute with Paula why Haldol was being used when there was no agitation and Mom was in a stupor and/or lethargic. I explained that UVM MC only used Haldol a couple times in two months and they had Mom there not like Our House had Mom on it every day. I told them of Mom's hypersensitivity to meds and concern with her kidneys. I have notes about this and how long it took them to finally get Mom off the Haldol after requesting several times. They stated she was combative as the reason but told me of only a handful of incidents but never told me when Mom supposedly assaulted [redacted] I brought up all my concerns in care planning.

[redacted]. On 1/27/16, [redacted] after [redacted] admission to the hospital visited my Mom. [redacted] told me that my Mom was just left on the floor for a while after her collision with [redacted] on 9-17-2015. Staff did not help her so he went over and held her hand. She was complaining of back pain and he had to get them to get her medical help.

[redacted] also allegedly was dehydrated upon admission to the hospital. They could tell you about her stoma looking infected and what they shared with me.

The other Our House Two resident that was admitted to the hospital on 1/27/16 is [redacted]. Her contact family is [redacted] was admitted to RRMC the same day as [redacted] are residents of Our House Two who lived with Mom.

Lack of activities

[redacted]can share her insights and our meeting with Paula which addressed care, concerns with staffing, inconsistencies with communications and other concerns.

Upon viewing Mom's records, I found several ADL sheets that were not filled out fully and where food and fluid intake was not being tracked.

5. Safety and Security
The RCH never change their door access codes even after firing employees.

The perimeter gate does not close or lock properly. The owners tried to fix the gate but it is probably still not working. It was reported by Mihayla Stone while I was a the courthouse waiting for Marissa Flagg to be arraigned on the assault of my Mom that Marissa vandalized this front gate door at Our House Too. Mihayla stated that Marissa had a fit of rage and smashed the gate door damaging it two week before she assaulted my mom. This act of vandalism was reported to Lisa Patorti but she did nothing about it.

Staff taking keys home so no keys for bathroom doors. My Mom had a food care package stolen, lamp stolen, mittens stolen and other items not found. Paula told me how staff stole the Christmas dinner in the past. This was part of a discussion about screening staff better.

6. Staff Training / Calling an ambulance
Staff does not know when to call an ambulance. The very upsetting part of watching your Mom suffer was witnessed by my brother and sister on Friday, January 15, 2016, when staff delayed getting Mom help because they did not call an ambulance right away.

While at the hospital with Mom before she died, I learned from [redacted] that when Mom collided with [redacted] another resident at Our House Too on September 17, 2015, that staff let Mom suffer in pain on the living room floor until the [redacted] insisted they call an ambulance.

One day I met a new hire named Cynthia, she was an older women who shared she had received no training so far. She just started working and I saw her briefly at Our House Too. She told me she had no specific training dealing with Alzheimer and Dementia residents. I told her about Teepa Snow, a woman that does video training on the subject and you can view her on-line. She said she would.

I heard comments from Our House personal care attendants on how they were treated, low pay, the amount of turnover, being ordered over to cover shifts and lots of overtime.

Remedy

- ☐ Accountability for inappropriate care, medication, chemical restraint, lack of staff training, negligence, and supervision.
- ☐ Fines imposed as allowed for everyday Our House Too fails to comply with second Medication Management violations on second inspection with repeated violations.
- ☐ Update 16 year old Residential Care Home Regulations