FILED

IN THE JUSTICE COURT, LAS VEGAS TOWNSHIP

CLARK COUNTY, STATE OF NEVADA

STATE OF NEVADA,

Plaintiff,

v.

ELEANOR LAROCK,
ID No. 1554585

Defendant.

Case No.: 10F11956X

Dept. No.: 9

AFFIDAVIT OF PROBABLE CAUSE IN SUPPORT OF CRIMINAL COMPLAINT AND ISSUANCE OF ARREST WARRANT

State of Nevada)
) ss
County of Clark)

I, Carrie Linskens, do hereby swear under penalty of perjury that the assertions of this Affidavit are true:

1. That since December 4, 2006, I have been employed by the Office of the Attorney General. I am a peace officer assigned to the Medicaid Fraud Control Unit (MFCU). The MFCU investigates criminal financial fraud occurring within the Medicaid plan as well as allegations of abuse and/or neglect of older or vulnerable persons.
2. The MFCU recently completed an investigation concerning offenses of Neglect of Older Persons which took place at Grace Elderly Care Home (hereinafter GECH) in July and August 2008. GECH is located at 1901 S. 6th Street, Las Vegas, NV.
3. Based upon the investigation, there is probable cause to believe Eleanor Larock (defendant), the owner of GECH, had the responsibility or obligation to provide care, shelter or services for older persons J.C. (male, 60 years or older) and C.M. (female, 60 years or older). Defendant knowingly failed to provide such care, shelter or services, thereby permitting or allowing J.C. and C.M. to be left in a situation where they could suffer physical pain or mental suffering as a result of defendant's failures, in violation of NRS 200.5099(2) and 200.5092(4), thereby constituting a gross misdemeanor(s). Defendant also did then and there perform an act and neglected a

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duty imposed by law in willful or wanton disregard of the safety of person or property, in violation of NRS 202.595(1), thereby constituting a gross misdemeanor.

The facts which Affiant, upon personal knowledge and/or information and belief, believes true and which establish probable cause are as follows:

4. In connection with the investigation, GECH residents and regulatory employees were interviewed. I have also reviewed regulations and documents, including documents that indicated that residents J.C. and C.M. were over the age of 60.

5. I have reviewed NAC 449.196 which states:

> "1. A caregiver of a residential facility must: ...(c) Understand the provision of NAC 449.156 to 449.27706, inclusive, and sign a statement that he has read those provisions; ...(f) Receive annually not less than 8 hours of training related to providing for the needs of residents of a residential facility...3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years pass an examination relating to the management of medication approved by the Bureau." [Emphasis added.]

6. I have reviewed NAC 449.200, which states:

> "1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his employment at the residential facility; (c) Records related to the training received by the employee..." [Emphasis added.]

7. I have reviewed NAC 449.2749, which states:

> "1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident..." [Emphasis added.]

8. I have reviewed NRS 449.249, which states:

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"1. A person, state or local government or agency thereof shall not operate a home for individual residential care without first obtaining a license for the home from the Health Division..." [Emphasis added.]

9. I reviewed documents from the Bureau of Health Care Quality and Compliance (BHCQC) regarding GECH which indicated defendant was the owner of GECH since on or about September 2004. Other documents, including GECH's Master Licensure File, were reviewed and are exemplified by:

   a. GECH was a licensed group home from on or about September 2004 until 06/26/08. On 06/26/08, GECH's group home license was suspended by BHCQC.

   b. Signed document dated 09/07/04 in which defendant indicated that GECH would maintain compliance with the requirements contained in NRS 449.176 to 449.188.

   c. License Renewal Application for GECH dated 11/14/07 in which defendant signed the application which stated: "I have read, understand and agree to comply with the rules and regulations pertaining to the specific type of facility for which licensure application is herein made."

   d. Letter from BHCQC entitled "Order of Summary Suspension and Revocation of License" dated 06/26/08 which stated that the Health Division suspended GECH's license due to concerns for public health, safety, and welfare of residents. The suspension was due to an incident on 06/24/08 in which neglectful living conditions required the transfer of residents out of GECH. As part of the suspension, GECH was ordered to transfer all residents from the facility and provide BHCQC with the address and phone number for where the residents were placed as well as the date and time that each resident was transferred.

   e. Letter from BHCQC entitled "Official Notice to Cease Operation Without a License" dated 08/08/08 which stated that defendant met with BHCQC to attempt to lift the suspension of GECH's license. After review, BHCQC

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decided not to lift the suspension due to the fact that BHCQC surveyors went to GECH on 08/06/08 and observed the operation of an unlicensed residential facility for groups. Specifically, four (4) residents were found to be receiving food, shelter, assistance and limited supervision on 08/06/08. [These residents were moved into GECH even though GECH did not have an active group home license.] Defendant was ordered to transfer all residents from the facility and provide BHCQC with, among other things, the address and phone number for where the resident was placed as well as the date and time that each resident was transferred.

f. Report dated 07/18/08 from Linda Pietershanski (Pietershanski), Health Facilities Surveyor II for BHCQC, which indicated that GECH was visited by Pietershanski on 07/15/08. During the visit, defendant admitted to Pietershanski that defendant was the caretaker for C.M. It was also observed that J.C.'s medication was not kept in a locked box or secured area.

g. Report dated 08/06/08 from Linda Pietershanski (Pietershanski), Health Facilities Surveyor II for BHCQC, which indicated that GECH was visited by Pietershanski on 08/06/08. During the visit, Pietershanski noticed that no administrator's license was posted at GECH and defendant was unable to produce the license. J.C. was also identified as a client of GECH and Pietershanski was informed that J.C.'s daughter no longer resided at the facility. There were incomplete medication administration records (MAR) for May and June 2008. No physician's records of medications were available. There were also no employee files available for caretakers Bryan Ikler and Lily Taylor.

10. On 08/13/08, I visited GECH and made the following observations:

a. Bryan Ikler (Ikler) was identified as a caregiver at GECH.

b. Lilith Taylor (Taylor) was identified as a caregiver at GECH.

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c. Defendant was not present. Defendant had previously been instructed by surveyors from BHCQC that she was the only licensed caregiver at GECH and could not leave residents at the facility without a qualified caregiver present.

d. J.C. was observed at GECH in a hospital bed with both side rails up.

e. J.C. was bed bound and not ambulatory. J.C. was also observed lying on a bed incontinence bad.

f. J.C. had a Foley catheter bag that appeared to be half full with a dark yellow liquid.

g. J.C.'s GECH admission record indicated that he required 24/7 care and his date of birth was listed as 07/19/47.

h. C.M. was observed at GECH. C.M. was not ambulatory however she did have an electric wheelchair.

i. C.M. admitted to wearing diapers that the caregivers changed twice a day.

j. C.M.'s bed had an incontinence pad on it.

k. Defendant did come back to GECH while Affiant was present on 08/13/08 and was able to provide copies of blank GECH documents. Blank GECH documents provided by defendant included: resident agreements, resident rights, incident reports, medication review, physician visits, resident discharge/transfer form, facility policy, and MARs.

l. Defendant was reminded by Affiant that defendant was not to leave the residents unattended at the facility without a qualified caregiver.

11. On 08/13/08, I spoke with Dorothy Sims (Sims), Health Facilities Surveyor III for the Bureau of Health Care Quality and Compliance (BHCQC). Sims stated that:

a. On 06/24/08, all residents of GECH had been moved out of the facility due to neglectful living conditions.

b. On 06/26/08, a letter of suspension of the GECH group home license was served upon GECH.

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c. On 08/06/08, a BHCQC surveyor visited GECH and found that even without a group home license, GECH moved both new and old residents back into the facility and were providing care to residents.

d. Due in part to the facility visit on 08/06/08, a cease of operations letter was sent by certified mail on 08/11/08 which indicated that upon receipt of the letter, defendant had ten (10) days to safely move out the GECH residents.

e. Both Ikler and Taylor were not certified caregivers and did not have the necessary caregiver training.

12. On 08/13/08, I spoke with defendant and defendant made the following admissions:

a. Defendant admitted to being the owner of GECH.

b. Defendant stated that even though Adelaida Tolentino was the administrator of GECH, defendant was not sure of Tolentino's whereabouts.

c. Defendant was instructed by Affiant that since defendant was the only licensed caregiver at GECH, then defendant was not to leave the facility or leave the residents unattended without a qualified caregiver.

13. On 08/18/08, I visited GECH and made the following observations:

a. Bryan Ikler (Ikler) answered the door and indicated that he was the only caregiver present at GECH.

b. Ikler stated that defendant was at a friend's house and should be back in a couple of hours.

c. J.C. was still a resident of GECH on 08/18/08.

d. J.C. was observed sitting up in a chair in his room and watching television. J.C.'s feet were a purplish color and his Foley catheter bag was full to the top of the bag with a yellowish fluid.

e. While MFCU investigators were present, J.C. began yelling for help because his Foley catheter bag was full and not allowing him to urinate. J.C. indicated that it was causing a burning sensation.

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f. Defendant arrived shortly after J.C. began complaining of pain with his catheter bag. Defendant emptied his catheter bag. At that time, J.C. indicated that he felt better but still did not feel safe at GECH.

g. Defendant stated that she was sorry she left GECH but she had to go to 7/11. Affiant reminded defendant of the conversation on 08/13/08 in which Affiant told defendant she could not leave GECH due to the fact that defendant was the only qualified caregiver. Defendant apologized again.

14. On 08/18/08 while at GECH, I spoke with J.C. J.C. stated that:

a. J.C. no longer felt safe at GECH because he was yelling for help during the previous weekend and nobody came.

b. J.C. indicated that he had bad chest pains and trouble breathing the past weekend (08/16/08). J.C. stated that his chest pains were gone but he was constipated and had back pain.

c. J.C. did not have access to a phone to dial 911.

d. J.C. did not receive all of his required medications on Saturday (08/16/08). Defendant told J.C. that defendant thought J.C. was over medicated so instead of giving J.C. his prescribed medications every four (4) hours, defendant only gave J.C. his prescribed medications at 10:00am and 10:00pm.

e. J.C. stated that defendant only provided J.C. with medications twice on Saturday (08/16/08) when he was supposed to take the medication six (6) times that day.

15. On 08/18/08, I spoke with C.M. concerning her stay at GECH. C.M. stated that:

a. C.M. was a resident at GECH from 07/01/08 to 08/16/08.

b. While a resident of GECH, C.M received assistance with bathing, grooming, meal preparation, continence, and ambulation.

c. On 08/16/08, Bryan Ikler (Ikler) was the only caregiver present at GECH.

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d. On 08/16/08, Ikler became angry at C.M. and began yelling at her. C.M. went into her room and closed the door. Ikler then began pounding on C.M.'s door.

e. C.M. was scared for her own personal safety so when the opportunity arose she went to a neighbor's house to borrow a phone and call 911.

f. Las Vegas Metropolitan Police Department (LVMPD) responded to the scene. C.M.'s blood pressure was elevated at that time so an ambulance transported C.M. to Mountain View Hospital.

g. After being admitted to Mountain View Hospital, C.M. was diagnosed with pneumonia, bladder infection, diaper rash, and elevated blood pressure.

h. Regarding the diaper rash and bladder infection, C.M. stated that the caregivers at GECH were not changing her diapers often enough.

i. C.M. stated that either Lilith Taylor (Taylor) or defendant would change her diaper in the morning and at night. Two (2) times a day was the most anyone changed C.M.'s diaper while she resided at GECH.

j. When C.M.'s diapers were changed, both Taylor and defendant would usually put three (3) diapers on top of one another in order for C.M. to make it through the entire day.

k. C.M. stated that on 08/14/08 and 08/15/08, none of the caregivers at GECH, specifically Taylor and defendant, changed her diaper in the evening. C.M. only had her diaper changed in the morning.

l. On 08/16/08, C.M. was bathed by Taylor who put three (3) new diapers on C.M. Ikler then came into the room and stated that none of the staff of GECH were going to feed C.M. or change C.M.'s diaper anymore. C.M. stated that she was not provided breakfast, lunch, or dinner on 08/16/08.

16. On 10/14/08, I spoke with C.M. concerning her stay at GECH. C.M. stated that:

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a. On 08/16/08, C.M. felt threatened and intimidated by Bryan Ikler (Ikler), the only caregiver present at GECH, because C.M. feared that she would not eat or have her diaper changed anymore.

b. C.M. stated that Ikler became angry and began pounding on C.M.'s door. C.M. admitted that she felt scared and intimated by Ikler's actions.

c. C.M. was frightened by her experience at GECH on 08/16/08 and described the situation at GECH as harmful.

d. C.M. began experiencing chest pains and felt her blood pressure increasing from the incident with Ikler yelling at her constantly. Due in part to these conditions, C.M. was transported by ambulance to Mountain View Hospital.

17. I reviewed documents from Odyssey Hospice concerning J.C. The documents indicated that J.C. was over the age of sixty (60). The documents also indicated that defendant became the caregiver for J.C. at GECH even after defendant's group home license was suspended. Initially, it appeared that J.C.'s daughter moved into GECH to provide care for J.C., however after 07/30/08 the documents indicated that defendant was providing care for J.C. [There were also no documents maintained by GECH to show defendant ensured that J.C.'s daughter met the requirements of a qualified caregiver.]

18. Defendant did not provide employee files for any of the caregivers at GECH.

19. I reviewed documents from Mountain View Hospital concerning C.M. The documents indicated that C.M. was over the age of sixty (60). The documents also indicated that C.M. was admitted to Mountain View Hospital on 08/16/08 with pneumonia, bladder infection, diaper rash, and elevated blood pressure.

20. I reviewed resident files for J.C. and C.M. that were provided by defendant. It should be noted that copies of documents, including resident files, were provided upon request when Affiant went to GECH on 08/13/08. When the original documents were requested via a grand jury subpoena, the documents were not produced by defendant. The review of resident files showed the following:

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a. The only document contained in C.M.'s resident file obtained from the subpoena was a notice of eviction dated 08/13/08. Copies of a residential agreement for C.M. were provided by defendant on 08/13/08. The residential agreement showed that C.M. moved into GECH after defendant's group home license was suspended.

b. The resident files for J.C. and C.M. did not contain medication administration records (MAR).

21. **In summary of the above**:

Defendant was the owner of GECH and was the responsible party to provide services in a manner necessary to maintain the physical or mental health of older persons J.C. and C.M. (See NRS 200.5092(4)). By neglecting to ensure there were qualified caregivers present and creating a situation where residents felt they were scared and could possibly be harmed, defendant permitted or allowed the residents to be placed in a situation where they could suffer physical pain or mental suffering. (See NRS 200.5099(2)). Defendant was aware of her responsibilities as she was the owner of GECH and admitted to knowledge of responsibilities as shown in signed documents defendant submitted to BHCQC.

21. Based upon the foregoing, there is probable cause to believe that Eleanor Larock did commit the crimes of Neglect of an Older Person, a gross misdemeanor violation of NRS 200.5099(2) and 200.5092, two (2) counts; and Performance of Act or Neglect of Duty in Willful or Wanton Disregard of Safety of Person or Property, a gross misdemeanor violation of NRS 202.595(1), one (1) count.

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WHEREFORE, your Affiant requests that an Arrest Warrant be issued for Eleanor Larock, and that defendant be dealt with according to the law.

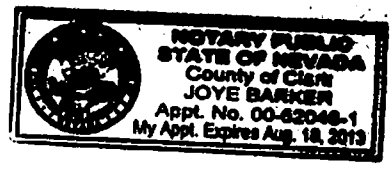
DATED this 22 day of June, 2010.

CATHERINE CORTEZ MASTO
Attorney General

By: Carrie Linskens
Carrie Linskens
Investigator

Subscribed and sworn to before me
this 22 day of June, 2010.

Notary Public Joye Barker



Submitted by:

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