FILED

IN THE JUSTICE COURT, LAS VEGAS TOWNSHIP
CLARK COUNTY, STATE OF NEVADA

Nov 18 8 33 AM '10
JUSTICE COURT
LAS VEGAS, NEVADA
BY _____ DEPUTY

STATE OF NEVADA,

Plaintiff,

v.

JANICE VIOLA BURCH,
ID No. 1785647,

Defendant.

Case No.: 10F21191X

Dept. No.: 11

AFFIDAVIT OF PROBABLE CAUSE IN SUPPORT OF COMPLAINT AND ISSUANCE OF SUMMONS IN LIEU OF WARRANT

State of Nevada)
) ss
County of Clark)

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

1. That since November, 2007, I have been employed by the Office of the Attorney General of the State of Nevada. I am a peace officer who, at the time of the investigation of this matter, was assigned as an Investigator with the Medicaid Fraud Control Unit ("MFCU"). The MFCU investigates criminal financial fraud occurring within the Medicaid plan as well as allegations of abuse, neglect and/or exploitation of older or vulnerable persons.
2. The MFCU recently investigated offenses of Neglect of Older Persons which took place at Skyview Group Home II, located at 3820 Golf Lane, Las Vegas, Nevada ("Skyview II").
3. Skyview II is associated with another group home, called Skyview Group Home I and located at 6195 Dundee Port Avenue, Las Vegas, Nevada ("Skyview I").
4. Based upon the investigation, there is probable cause to believe Janice Viola Burch ("defendant"), the owner and licensed administrator of Skyview II, assumed and had

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the responsibility or obligation to provide food, shelter, clothing or services for older persons C.D. (male, 60 years or older), M.V. (female, 60 years or older), R.G. (female, 60 years or older), C.M. (deceased) (female, 60 years or older), C.S. (female, 60 years or older) and I.P. (female, 60 years or older). Such food, shelter, clothing or services were necessary to maintain the physical or mental health of C.D., M.V., R.G., C.M., C.S. and I.P. Defendant knowingly failed to provide such food, shelter, clothing or services, thereby permitting or allowing C.D., M.V., R.G., C.M., C.S. and I.P. to be placed in a situation where they could suffer physical pain or mental suffering as a result of defendant's failure and/or neglect, 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/or neglected a duty imposed by law in willful or wanton disregard of the safety of persons or property, in violation of NRS 202.595(1), thereby constituting a gross misdemeanor(s).

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

5. In connection with the investigation, care providers, regulatory employees and other professionals were interviewed. I have also reviewed regulations and documents, including documents that indicated that residents C.D., M.V., R.G., C.M., C.S. and I.P. were each over the age of 60.

6. I have reviewed NAC 449.157 which includes in the definition of "Administrator":

> "a person: ... 3. Who is legally responsible for the care of the residents and the daily operations of the facility . . ."

7. I have reviewed NAC 449.194 which states in pertinent part:

> "The administrator of a residential facility shall:
> 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents received needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS.
> 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. . . . The administrator or an

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employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge. . . .
4. Ensure that the records of the facility are complete and accurate."

8. I have reviewed NAC 449.196 which states in pertinent part:

"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."

9. I have reviewed NAC 449.199 which states in pertinent part:

"1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility."

10. I have reviewed NAC 449.209 which states in pertinent part:

"1. A residential facility must: (a) Have a safe and sufficient supply of water, adequate drainage and an adequate system for the disposal of sewage...
8. The temperature of the facility must be maintained at a level that is not less than 68 degrees Fahrenheit and not more than 82 Fahrenheit..."

11. I have reviewed NAC 449.222 which states in pertinent part:

"2. Each residential facility that is issued an initial license on or after January 14, 1997, must have: (a) A flush toilet and lavatory for each four residents . . ."

12. I have reviewed NAC 449.2742 which states in pertinent part:

"1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months, the regimen of drugs taken by each resident of

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the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility; (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report . . .
6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. . . .
7. If a resident refuses, or otherwise misses, an administration of medication, a physician must be notified within 12 hours after the dose is refused or missed. . . ."

13. I have reviewed NAC 449.2744 which states in pertinent part:

"1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: ... (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician.
2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication."

14. I have reviewed NAC 449.2748 which states in pertinent part:

"1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.
2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room.
3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name

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of the prescribing physician; and (b) Kept in its original container until it is administered. . . ."

15. I have reviewed NAC 449.2749 which states in pertinent part:

"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, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident's physician and the next of kin or guardian of the resident or any other person responsible for him. (c) A statement of the resident's allergies, if any, and any special diet or medication he requires. (d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. (f) The types and amounts of protective supervision and personal services needed by the resident. (g) An evaluation of the resident's ability to perform the activities of daily living and a brief description of any assistance he needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his ability to perform the activities of daily living; and (3) In any event, not less than once each year. (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident. (i) The name and telephone number of the vendors and medical professionals that provide services for the resident. (j) A document signed by the administrator of the facility when the resident permanently leaves the facility. . . ."

16. I have reviewed NAC 449.2754 which states in pertinent part:

"1. A residential facility which offers or provides care for a resident with Alzheimer's disease or related dementia must obtain an endorsement on its license authorizing it to operate as a residential facility which provides care to persons with Alzheimer's disease. . . ."

17. On 12/16/08, officers T. McMeans and J. Rodriguez ("initially responding officers") from the Las Vegas Metropolitan Police Department ("LVMPD") responded to Skyview II in reference to a claim of neglect of group home residents. The initially responding officers:

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a. Observed C.D., M.V., R.G., C.M., C.S. and I.P. all residing at Skyview II and noted the birthdates of each resident reflecting that each resident was 60 years of age or older.

b. Were informed by caregiver Leissa Woodruff ("Woodruff") that defendant instructed Woodruff to forge documentation regarding administration of medication to residents of Skyview II.

c. Were informed by defendant that "her workers are not being honest and that [the allegations are] a fabrication due to not being paid their wages."

d. Contacted Abuse/Neglect Specialists from LVMPD.

18. On 12/16/08, Elder Rights Social Workers Stephanie Pappas ("Pappas") and Larry Woolen ("Woolen") from the Aging and Disability Service Division ("ADSD") conducted a field visit to Skyview II. Pappas and Woolen divided medications by respective resident, hand-counted medications and compared their findings to each medication's prescribed administration and to each resident's Medication Administration Records ("MAR"). For each resident, Pappas and Woolen found discrepancies between the prescriptions, the existing or remaining medication amounts and the MARS. In accordance with Pappas and Woolen's investigation:

a. Pappas observed that resident medications were "all over the kitchen counter" inside the residence, with some medications in an unlocked cabinet and other medications found contained in a plastic garbage bag in the garage of the residence. There were also several empty medication bottles.

b. Pappas reported, regarding resident M.V., that M.V. was prescribed multiple medications but was not being administered her medications as prescribed. Pappas also noted that some of the medication bottles had pills other than the listed medication mixed in to the bottles.

c. Pappas reported, regarding resident C.D., that C.D. was prescribed multiple medications but was not being administered his medications as prescribed.

d. Pappas reported, regarding resident C.S., that C.S. was prescribed multiple

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medications but was not being administered her medications as prescribed. Pappas also noted that two of the medications were altogether missing.

e. Woolen observed that residents' medications were found in an unlocked cabinet above the kitchen counter. Woolen also reported that medications were found contained in a plastic garbage bag in the garage of the residence. The medications in the bag were included in the inventory of the medications.

f. Woolen reported, regarding resident I.P., that I.P. was prescribed multiple medications but was not being administered her medications as prescribed. Woolen also noted that I.P.'s medication log noted six prescriptions, three of which were altogether missing, and a recent prescription order of another medication was missing. In addition, the MAR for I.P. indicated only five prescribed medications, of which only two were found. Woolen also noted that several medications were found in one prescription bottle.

g. Woolen reported, regarding resident C.M., that C.M. was prescribed multiple medications but was not being administered her medications as prescribed. C.M.'s medications were also among those found in the plastic bag in the garage.

h. Woolen reported, regarding resident R.G, that R.G. was prescribed multiple medications but was not being administered her medications as prescribed.

i. Woolen reported that defendant sought to justify some of the medication inconsistencies by stating that medications from older prescriptions are sometimes added to containers of medications from newer prescriptions.

19. On 12/16/08, LVMPD Abuse/Neglect Specialists Candice Barker ("Barker") and Cyndi Sauchak ("Sauchak") and LVMPD Detective R. Tennant ("Tennant") responded to Skyview II.

a. Sauchak and Tennant interviewed caregiver Woodruff, who informed:

a) Woodruff was employed as a caregiver in a Skyview Group Home

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business beginning on or about 11/28/08, when she began at Skyview I.

b) Woodruff was instructed by the house manager of Skyview I, John Robinson ("Robinson"), to administer medications. Woodruff was instructed by Robinson to enter defendant's initials (J.B.) on the MAR as if defendant had herself administered the medications. Woodruff questioned Robinson regarding the direction to document defendant's initials on the MAR, and Robinson forcefully reiterated his direction to Woodruff. Woodruff proceeded to record defendant's initials on the MAR.

c) Woodruff questioned defendant regarding the direction to document defendant's initials on the MAR, and defendant reiterated the direction to Woodruff. Defendant stated to Woodruff that Woodruff was not certified to administer medication and therefore had to enter defendant's initials as if defendant had herself administered the medications.

d) Although Woodruff had some past experience in administration of medications, she believed she was not properly certified to do so.

e) Woodruff began work at Skyview II on or about 12/13/08.

f) Some time after beginning work at Skyview II, Woodruff's review of the MAR and search for medications revealed to her that R.G., I.P. and C.D. were without particular prescribed medications. Woodruff also found that M.V. was not being administered medication as was prescribed to M.V.

g) Woodruff received conflicting direction from defendant and C.M.'s nurse regarding particular medication and noted further that medication documentation was in disarray. Woodruff decided at this point to notify authorities.

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h) One of the two toilets at Skyview II was inoperable.

i) On a Sunday (believed to be 12/14/08), defendant turned off the heat to Skyview II for approximately 24 hours, claiming to be unable to afford to pay for heat. Residents complained of the cold and had to be clothed in multiple blankets and layers of clothing.

j) Woodruff questioned defendant regarding a lack of necessities for the residents, and defendant claimed she did not have money.

k) Defendant was failing to pay caregivers for their employment, claiming she lacked money.

b. Barker and Tennant interviewed caregiver Toni Noble ("Noble"), who informed:

a) Noble began work at Skyview II on 10/04/08.

b) Noble had begun work at Skyview I on 10/03/08, but she was angrily directed out of the facility by a person she believed to be a caregiver named John Singleton. Thereafter, Noble spoke with defendant, and defendant offered Noble employment at Skyview II.

c) Woodruff brought up the issue of R.G.'s lack of appropriate medication. Noble affirmed that she also knew and was concerned about the same issue.

d) In the early part of December, 2008, one of R.G.'s medications, Risperdal (Risperidone) ("Risperdal"), had run out. The Risperdal was not immediately obtained for R.G. Noble was directed by defendant to administer a portion of C.D.'s Risperdal medication to R.G. Noble administered C.D.'s Risperdal medication to R.G. approximately three times.

e) Although Noble believed the other residents were getting their medications, Noble noted that M.V. sometimes refused a medication, and Noble did not then ensure the administration of the

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medication. Further, C.S. would refuse medication, and Noble would attempt to "mash [the medication] up and put it in something," although Noble did not know whether such method was proper.

f) Noble was instructed by James Hernandez, another worker at Skyview II, to enter defendant's initials (J.B.) on the MARS as if defendant had herself administered the medications. This instruction was reiterated to Noble by defendant. Noble thereafter entered defendant's initials on the MARS.

g) One of the toilets at Skyview II was inoperable, with a broken toilet tank.

20. On or about 12/16/08, BHCQC personnel performed a facility records review, as part of the survey of Skyview II. A review of Skyview II's records revealed that:

a. The employee file for caregiver Woodruff, who administered medications to the residents of Skyview II, lacked documented evidence of medication management training. Medication Administration Records (the medication records developed and maintained by the facility) ("MAR") for each resident revealed that Skyview II maintained control and administration of medication for each resident. At the time of the survey, there was no other employee on the premises who was trained in medication administration.

b. Files for residents C.D., R.G., C.S. and I.P. lacked documented evidence of six-month medication reviews. Such reviews are required to ensure the accuracy and appropriateness of the prescribed drug regimens.

c. Records for each resident demonstrated that Skyview II failed to comply with physician-ordered medication administration. Each of the six residents at Skyview II were prescribed a daily medication regimen, however there were multiple times on the MARs when there was no indication that medications had been given to the residents. Further, the MAR for C.M. indicated that a particular medication, Skelaxin, would be given once per day despite the

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prescription on the Skelaxin bottle indicating that it should be given every eight hours.

d. Residents C.D., R.G. and C.S. had documented histories of Alzheimer's disease or related dementia. However, there was no Alzheimer's endorsement on the facility license for Skyview II.

e. Resident C.M. was admitted to Skyview II on 12/08/08, however there was no resident file for C.M. Defendant explained that C.M. "won't sign any papers, she takes her own medications, so I have no records for her."

21. I reviewed the master licensure files for Skyview II and Skyview I. The master licensure files are maintained by, and were requested from, the Bureau of Health Care Quality and Compliance. A review of documents contained in those files show:

a. BHCQC issued a license to Skyview I for a Residential Facility for Groups for eight Category II residents with Alzheimer's disease, effective 11/12/04 with defendant listed as the owner and Edwin Valentin as the Administrator. On 03/11/05, defendant changed the Administrator to herself.

b. BHCQC issued a license to Skyview II for a Residential Facility for Groups for seven Category II residents, effective 01/01/08 with defendant listed as the owner and administrator. At all times pertinent to the events in this report, Skyview II did not have an Alzheimer's license endorsement that would have been required to house and care for residents suffering from Alzheimer's disease.

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

Defendant was the licensed administrator at Skyview II and was the responsible party to provide services in a manner necessary to maintain the physical or mental health of older persons C.D., M.V., R.G., C.M., C.S. and I.P. (See NRS 200.5092). By failing to appropriately administer each resident's medications, failing to properly document administration of each resident's medications, failing to properly supervise caregivers (including directing caregivers to falsify medication

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administration logs and failing to ensure that caregivers have medication administration training), failing to properly secure or store resident medications, failing to provide adequate toilet facilities and/or failing to maintain an appropriate temperature level in the facility, defendant permitted or allowed the residents to be placed in a situation where they could suffer physical pain or mental suffering as a result of the neglectful living conditions. (See NRS 200.5099(2)). Further, by failing to maintain documentation of medication reviews for residents C.D., R.G., C.S. and I.P., failing to maintain any file for resident C.M., and failing to obtain an Alzheimer's endorsement as required to house residents C.D., R.G. and C.S., defendant permitted or allowed these respective resident to further be placed in a situation where they could suffer physical pain or mental suffering as a result of the neglectful living conditions. (See NRS 200.5099(2)).

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23. Based upon the foregoing, there is probable cause to believe that Janice Viola Burch did commit the crimes of Neglect of an Older Person, a gross misdemeanor violation of NRS 200.5099(2) and 200.5092, six (6) 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.

WHEREFORE, your Affiant requests that a summons be issued for defendant Janice Viola Burch, and that defendant be dealt with according to the law.

DATED this 5th day of November, 2010.

CATHERINE CORTEZ MASTO
Attorney General

By: Holly Navarro
Holly Navarro
Investigator

Subscribed and sworn to before me this 5 day of November 2010.

Joye Barker
Notary Public

NOTARY PUBLIC STATE OF NEVADA County of Clark JOYE BARKER Appt. No. 00-63848-1 My Appt. Expires Aug. 12, 2013

Submitted by:

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