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FILED
SUPERIOR COURT, METROPOLITAN DIVISION
COUNTY OF KERN
FEB 17 2009
TERRY McNALLY, CLERK
DEPUTY

SUPERIOR COURT OF CALIFORNIA

COUNTY OF KERN

PEOPLE OF THE STATE OF CALIFORNIA, **Plaintiff,** A.) **vs.** B.) **GWEN D. HUGHES; DEBBI C. HAYES; HOSHANG M. PORMIR, M.D.,** C.) **Defendants.**	**Case No:** BF 1266665 A-C **DECLARATION IN SUPPORT OF ARREST WARRANT & FELONY COMPLAINT** **[AG Docket No. FR2007100234]**

INTRODUCTION

I, Donny Fong, am a Special Agent for the State of California, Department of Justice, Office of the Attorney General's Bureau of Medi-Cal Fraud and Elder Abuse. In this declaration, I will set forth facts showing Gwen D. Hughes, Debbi C. Hayes, and Hoshang M. Pormir violated California Penal Code 368 (Elder Abuse) by ordering, prescribing and authorizing the use of psychotropic medications as chemical restraints on eight residents at Kern Valley Healthcare District (KVHD). The use of the psychotropic medications as chemical restraints resulted in eight residents at KVHD being physically and emotionally harmed. In this declaration, I will also set

forth facts showing Gwen D. Hughes, Debbi C. Hayes, and Hoshang M. Pormir violated California Penal Code 245(Assault) by authorizing and ordering the administering of forceful injections of psychotropic medications to two KVHD residents without proper consent and authorization.

INITIAL COMPLAINT

On April 01, 2008, I was assigned matter identification no. FR2007100234 regarding residents being chemically restrained at the skilled nursing facility, KVHD, located in Lake Isabella, California. The KVHD Director of Nursing Gwen D. Hughes, KVHD Director of Pharmacy Debbi C. Hayes, and KVHD Medical Director Hoshang M. Pormir were alleged to have prescribed and authorized the administering of psychotropic medications to residents in order to chemically restrain them for staff convenience. This investigation was referred to the Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) from the California Department of Public Health (DPH) after they received a complaint alleging the use of chemical restraints and the use of unnecessary medications on 23 residents at KVHD. In January 2007, DPH conducted an investigation on KVHD regarding the use of chemical restraints on their residents.

From their investigation, DPH immediately placed KVHD in "Immediate Jeopardy" for causing patient harm and administratively cited them for using chemical restraints and unnecessary medications on 23 of their residents. The DPH investigation identified both the KVHD Director of Nurses (DON), Hughes, and the Director of Pharmacy, Hayes, as those responsible for ordering these psychotropic medications for the 23 residents. DPH found all 23 of these residents suffered from some form of adverse physical reactions due to being given these medications. DPH identified 2 of the 23 residents who had been given forceful injections of psychotropic medications without their consent.

DEPARTMENT OF PUBLIC HEALTH INFORMATION

On May 6, 2008, I interviewed Linda Wilkonson, the acting District Administrator for DPH office in Bakersfield, California. Wilkonson is assigned to monitor KVHD. She stated that in January 2007 her office received a complaint from an Ombudsman regarding a KVHD

resident, Louise Zimmerman, who reportedly was held down by staff and given an injection of psychotropic medication by force. Wilkonson initiated an investigation on KVHD in January 2007. DPH Health Facilities Evaluator Nurses Ruth Hoover and Linda Goldsmith along with DPH Pharmacist Dr. Samuel Obair II and DPH Physician Dr. Michael Bennett participated in this Investigation.

Wilkonson stated that DPH selected a sample of 29 residents out of a total of 74 total residents from KVHD to investigate. The DPH Health Facilities Evaluator Nurses and Pharmacist interviewed numerous KVHD staff members and reviewed resident files and medical charts located at the facility. Based on their investigation, they determined that the KVHD Director of Nurses (DON), Hughes, directed the Director of Pharmacy, Hayes, to write doctor's orders for unnecessary psychotropic medications for the residents. Some of these doctor's orders were signed by the Medical Director, Dr. Hoshang Pormir. Hughes then directed the facility nurses to administer these psychotropic medications to the residents which resulted in them having adverse physical reactions. DPH cited KVHD for chemically restraining 16 of their residents. DPH also cited KVHD for giving unnecessary psychotropic medications to 22 of their residents (the aforementioned 16 residents along with 6 other residents). Based on these findings, DPH immediately placed KVHD in "Immediate Jeopardy" causing harm to residents' health and/or safety due to the use of chemical restraints.

On May 6, 2008, I interviewed Linda Goldsmith, DPH Health Facility Evaluator Nurse. Goldsmith stated that she participated in the DPH Investigation on KVHD in January of 2007. During the Investigation, she reviewed medical records and conducted numerous interviews with the facility management, staff, and residents regarding the use of psychotropic medications.

After reviewing the medical/patient charts and interviewing numerous KVHD staff and residents, DPH staff found that Hughes initiated Interdisciplinary Team (IDT) meetings to discuss the behaviors of some residents. During these IDT meetings, Hughes directed pharmacist Hayes to write prescriptions for psychotropic medications for some of the KVHD residents. Those present in these IDT meetings did not object to her order for these prescriptions. They trusted Hughes' knowledge of psychotropic medications, because they were told that she had a

wealth of experience working in psychiatric hospitals. Hayes wrote the orders for the psychotropic medications and the nurses administered the medication to the residents. The KVHD Medical Director Pormir would sign the orders at a later time. There were instances when Pormir did not sign the orders until 3 weeks after the medication was ordered.

Goldsmith stated that a physician or psychiatrist must make a medical/psychological diagnosis on a resident and obtain consent from the resident or his conservator prior to administering psychotropic medication to the resident

Based on DPH interviews with staff, Hughes was not approachable and did not interact with the residents. Hughes did not want to be bothered by the residents and if they continued to annoy or disagree with her, she would have an IDT meeting to place them on psychotropic medications.

KVHD Social Worker, Jason O'Donnell, who was a member of the IDT meetings, told Goldsmith that at first all staff trusted Hughes. Hughes told the staff that it was normal for the residents to have initial adverse reactions to the psychotropic medications, but she stated that the residents would get used to the dosage. There were several incidents, however, where residents were being forced to receive these psychotropic medications through injections. The nurses became alarmed and reported their concerns to other staff members and eventually to DPH.

Based on Goldsmith's interviews with KVHD staff, the nurses were all very fearful of Hughes. Hughes threatened to take away their Nursing Licenses and have them terminated if they did not follow the doctor's orders.

Goldsmith stated that KVHD resident, Opal Towery, who received Resperidol by intramuscular injection suffered harm. This medication stayed in her body for a month, and there was very good documentation by nurses of her adverse reactions, such as drooling, being noncognizant, being completely dependent of care, having severe tremors, and falling.

Many of the residents who were placed on psychotropic medications suffered weight loss, were lethargic, and dehydrated.

During their investigation, Goldsmith observed approximately 10 to 15 residents sitting in geri chairs lined up in the hallway. Based on Goldsmith's interview with social worker, Jason

O'Donnell, Hughes wanted to purchase many more of these geri chairs for other residents. Hughes wanted to medicate more of the residents with psychotropics and place them in geri chairs. California Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) Nurse Evaluators Cathy Long and Sherry Huntsinger, informed me that a geri chair is defined as a recliner with wheels for residents to sit or lie in. Nurses Long and Huntsinger stated to me that a geri chair may be considered a form of physical restraint for the resident due to the resident's inability to move freely in or out of them. A Geri chair may have a lap belt and/or locking lap tray that prevents a resident from moving out of the chair.

Goldsmith stated that she observed the residents at KVHD to be very quiet and somnolent. Based on her investigation, KVHD blatantly used psychotropic medications to chemically restrain many of their residents for staff convenience.

On May 15, 2008, I interviewed DPH Medical Consultant, Dr. Michael Bennett. Bennett stated that he has been employed by DPH for 3 years as a Medical Consultant and has been a Physician for approximately 27 years, specializing in family practice. Bennett participated in the DPH Survey of KVHD in April 2007. Bennett stated that his primary role in the survey was to interview the KVHD Medical Director, Dr. Hoshang Pormir.

Pormir told Bennett that he had been employed at KVHD for approximately twelve years. Pormir held the position of Medical Director of both the Acute Care Hospital and the Skilled Nursing Facility (SNF) of KVHD. Pormir worked primarily in the Acute Care Hospital of KVHD. Pormir stated to Dr. Bennett that prior to April 2007 he had little involvement with the SNF, but had recently become more involved.

Pormir told Bennett that the Interdisciplinary Team (IDT) made recommendations for certain medications for residents. The IDT would telephone him a doctor's order for a medication and he would sign the order at a later time. Pormir explained to Bennett that the IDT would write the doctor's orders for medication and then give it to the Charge Nurse to carry out the order.

Based on his interview with Pormir, Bennett believed that the KVHD Medical Director should have been more involved with medical care of the residents. KVHD staff were having

Pormir sign his signature to authorize requests to purchase equipment and order medication, and he did so without questioning them.

Bennett stated that Pormir, as the Medical Director of KVHD, should have been informed and aware of the medical care given throughout the facility. Based on his interviews with Pormir, it was obvious that Pormir was not aware of the care that was provided to the KVHD residents. Pormir was not aware of where papers such as the doctor's orders that were given to him to sign originated from. Pormir also did not follow up on the doctor's orders he signed to ensure that the orders were carried out, nor did he follow up on the outcomes of the patients. Pormir was very remote from the patients and was not involved with the day to day care at KVHD. He was also not involved with his staff in how they were providing the medical care to the residents.

Bennett stated that a Medical Director has the overall responsibility of how medical care is delivered in a facility as well as the quality of care provided. Pormir was either willfully or naively ignorant of all of this.

Bennett stated that it would not be adequate for a Director of Nurses (DON) and a pharmacist during an IDT to document medical symptoms or conditions of a resident in order to justify the use of psychotropic medications. A physician needs to observe and document the symptoms of a patient prior to ordering psychotropic medications.

Bennett stated that a doctor's order for medication must be given by a physician either by his verbal approval or by his signature prior to the medication being administered to the resident.

On May 19, 2008, I interviewed DPH Pharmaceutical Consultant, Dr. Samuel Obair II. Obair stated that he has been employed by DPH for 10 years and has been a Pharmacist for approximately 14 years. Obair received his Pharmaceutical Degree from the University of California, San Francisco. Obair stated that in January 2007, he participated in the DPH Investigation of KVHD regarding the use of chemical restraints on residents.

Obair stated that their investigation revealed 16 KVHD residents were given unnecessary psychotropic medication. The primary psychotropic medications being given at KVHD were Depakote, Resperidol, Zyprexa.

Obair stated that as part of their investigation, DPH also reviewed the resident medical files, and interviewed KVHD Director of Pharmacy Hayes and numerous KVHD staff nurses.

Hayes told Obair that she was directed by KVHD Director of Nurses (DON), Gwen Hughes, to write doctor's orders for psychotropic medications during the IDT meetings as well as personal meetings between Hayes and Hughes. Hayes stated to Obair that she trusted Hughes, thought she was very knowledgeable, and never questioned Hughes' judgement. Hayes told Obair that Hughes directed her to write the resident behavior symptoms in the doctor's orders.

Obair stated that during these IDT meetings, there was no psychiatrist in attendance. Hayes, Hughes, and the KVHD Social Worker, Jason O'Donnell, were present in the IDT meetings. Hughes ran all of these IDT meetings. Hughes recommended which medications were to be ordered, and had Hayes write the orders with the resident symptoms on these orders. The doctors'orders were written in triplicate with the yellow copy of the order placed in the KVHD Medical Director, Dr. Hoshang Pormir's, In-box. Pormir would sign these orders at a later date. Obair stated that based on his interviews with Hayes and staff nurses, he found that these orders were not immediately signed by Pormir and could have been signed after the medication had already been administered to the residents.

Obair stated that based on his experience this is not normal or proper protocol for how doctor's orders are written and signed. The physician needs to be made aware at all times what types of medication his patients are being given and he must be given the authority to approve or disapprove the medications recommended by nurses or pharmacists. Pormir was not given the opportunity or authority to disapprove the medications recommended in the doctor's order. Pormir basically trusted the medication ordered by Hayes. Pormir stated to Obair that there were occasions when he would receive a call from Hayes informing him that Hayes started a resident on a medication and that the yellow copy of the order was placed in his In-box for him to sign. Pormir would then sign the copy of the doctor's order and place it in the resident chart.

Obair stated that based on the conversations he had with Pormir, he did not believe that Pormir physically examined the residents shortly after they were given these medications.

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Pormir trusted Hayes fully with her recommendations for medications that were written in the doctor's orders.

Obair stated that both Hayes and the KVHD were both fined by the Board of Pharmacy, California Department of Consumer Affairs, for writing orders for medications without proper protocols in place. Hayes and KVHD were issued monetary citations.

Obair stated that Depakote, Zyprexa, and Resperidol are strong and powerful psychotropic medications. These and any psychotropic medications should only be prescribed and given to an individual after he has been examined and given a diagnosis from a medical physician or a psychiatrist.

Obair stated that there are much greater risks involved with giving psychotropic medications to geriatrics. All of the residents at KVHD who received these medications were geriatrics. Geriatrics are more prone to side effects than the general population and some psychotropics should not even be given due to the potential of these side effects.

Obair stated that geriatrics who receive Depakote, Zyprexa, Resperidol, and Seroquel, can have negative side effects such as psychosis, tremors, constipation, and lethargy. KVHD resident, Opal Towery, became so lethargic after receiving the psychotropic medication that she could not eat. Obair stated that Towery never did regain the full level of consciousness that she had prior to when she was given these medications.

Obair stated during the investigation, he observed doctor's orders written for intramuscular (IM) injections for some of the residents. In order for one to receive such an injection, one needs consent from the resident. Pharmacist Hayes stated to Obair that she believed that if two doctors had authorized the use of such injections, and the resident did not have a responsible party, then it was not necessary to obtain the consent from the resident for receiving the injection. Obair stated that this is absolutely not true and as an experienced pharmacist, Hayes should have known that having two doctors sign and authorize an order would not override the need for obtaining consent from a resident.

Obair stated that either consent from a resident or a court order is needed before an individual can receive IM injection of a psychotropic medications. Based on Obair's meeting

with both KVHD residents Towery and Louise Zimmerman, he stated that these two were able to make their own health care decisions. Both residents were able to articulate and hold normal conversations with other individuals. Both were given IM injections of psychotropic medications that stayed in their system for a length of time. Obair stated that he found three residents who were given these IM injections, Opal Towery, her husband Arthur Towery, and Louise Zimmerman. Obair stated that these injections were given for the convenience of the staff and were used as chemical restraints on these individuals. KVHD resident Zimmerman never recovered to her full conscious state afer receiving the IM injections. Both Zimmerman and Towery were bedridden after receiving the injections and never were able to ambulate in their wheelchairs as they had done prior to receiving these medications.

Obair stated that the KVHD residents who were put on these psychotropic medications absolutely suffered harm. Based on the review of the Nurse's Notes and Communication Logs, some of the residents suffered weight loss, body tremors, slurred speech, sat in geri chairs all day with glazed eyes, and some may have become psychotic. Some suffered from these symptoms for close to a month. During the DPH Survey, Obair observed approximately thirty residents sitting in geri chairs at KVHD.

Obair stated that based on his investigation, he believed that Hughes was ordering Depakote for residents for such things as glaring, responding to her in a disrespectful manner, or refusing to eat dinner in the dining room. Obair was told by the nursing staff that Hughes believed that all residents should have been put on Depakote.

Obair stated that in his professional opinion, the KVHD Medical Director Hoshang Pormir, Director of Nurses Gwen Hughes, and the Pharmacist Debbie Hayes, all were responsible for chemically restraining these residents.

Obair stated that the situation at KVHD has been the most severe and appalling to him in his entire professional career as a pharmacist. " It is beyond appalling to me and it is the first time that I have ever run into this severity where it affected so many individuals and was being done so blatantly. I have never gone into a facility and seen psychotropic medications and mood stabilizers such as Depakote, being used on so many patients, and so blatantly, without any

regards of any type of legitimate type of diagnosis, without any type of documentation of behaviors. I have never seen anything like this, and I have been doing this for ten years. I have never seen patients as 'zonked' and I have never seen those as affected by drugs as these people were." Obair stated that the nurses were the only individuals who complained and witnessed first hand the residents' conditions deteriorate while being put on these medications.

SUMMARY OF INTERVIEWS

On April 29, 2008, I interviewed Holly Lightner, former Licensed Vocational Nurse (LVN) of KVHD. Lighter worked as an LVN at KVHD from 1999 through mid 2007. Lightner stated that she contacted the California Department of Public Health (DPH) to report the use of chemical restraints at the hospital.

Lightner stated that KVHD was using psychotropic medications as chemical restraints such as Zyprexa, Depakote, Resperidol, and Seroquel, on many of their residents during the approximate time period of August 2006 through January 2007. The use of the psychotropic medications were ordered by former KVHD Director of Nurses (DON), Gwen D. Hughes.

Lightner stated that Hughes ruled the nurses with an 'iron fist' at KVHD. Hughes did not tolerate any nonsense from the nursing staff or from any of the residences. Hughes created an extremely hostile working environment for the nurses by her stern management style. Hughes would order psychotropic medications for minor behavioral issues displayed by the residents. Many of the residents at KVHD suffered from Alzheimer's or Dementia. Many of these residents were nonviolent, but moved around the hospital and were vocal. Due to their medical conditions, the nursing staff tolerated the residents moving around the hospital and talking among themselves. Most of the residents were innocent and not harmful to one another or to themselves. Hughes did not tolerate the behavior of residents who were vocal, loud, or being free to roam the hospital. She wanted to calm them. Hughes accomplished this by directing the KVHD Director of Pharmacy, Debbi Hayes, to write prescriptions for psychotropic medications to administer to these residents. This was done without a psychiatric or medical diagnosis performed by a psychiatrist or physician on the residents. KVHD did not employ a psychiatrist.

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Shortly after Hughes became the DON in August 2006, she began ordering the residents to be put on these psychotropic medications. Lightner and the other nursing staff began to notice many dramatic changes in the behaviors of the KVHD residents. The residents were very lethargic, slept around the clock, some could not talk, some were not cognizant and were like complete "zombies." Some of these residents became completely dependent for care, could not eat or drink, some became nonambulatory, and sat in geri chairs all day or were bedridden. Before the psychotropic medications were administered, most of these same residents, while at KVHD, were mobile in wheelchairs and were able to talk, eat, and drink, and bathe without assistance. Lightner believes that approximately over twenty residents were affected by the use of the psychotropic medications.

Lightner began doing her own research on these psychotropic medications. Lightner began informing the other nurses of what these medications were intended for and the risks they posed to the elderly. All of the nurses felt that it was wrong to administer these psychotropic medications to the residents and they voiced their disapproval to Hughes, Hayes, and Dr. Pormir. However, Dr. Pormir did not want to discuss the issue with the nurses.

Hughes verbally threatened Lightner and all of the other LVNs and RNs that if they refused to administer the psychotropic medications ordered to the patients, Hughes would report them to the State of California to have their nursing licenses taken away, and then they would be terminated by KVHD. All of the nurses were fearful of Hughes.

Hughes ordered KVHD resident, Gayle Hamilton, be put on Depakote due to Hamilton refusing to eat in the dining room. Hamilton had always eaten her meals in her bedroom prior to Hughes being hired. Depakote sprinkles were to be put into Hamilton's food which was written on the doctor's order. Lightner stated that this written order was in Hughes' handwriting.

KVHD resident, Opal Towery, threw her milk in the dining room, so she was injected with Zyprexa by LVN Julie Aguirre. Aguirre told Lightner that Hughes had ordered her to inject the Zyprexa into resident Towery. Towery told Lightner that she did not know the injection was for Zyprexa, but was tricked to believe that the injection was for another drug, Ativan. Towery stated to Lightner that she had signed a consent form to be injected with Ativan, not Zyprexa.

KVHD resident, Louise Zimmerman, told Lightner that on two occasions she was given injections of Resperidol without her consent. LVN Peggy Bibby administered one of these injections to Zimmerman. Bibby reported this incident to Lightner and told her that she felt very bad for having done this. Bibby stated to Lightner that she did not want to ever give another injection of a psychotropic medication to Zimmerman again. Bibby told Lightner that she felt compelled to give this injection to Zimmerman due to her fear of being terminated by Hughes if she had refused.

On April 29, 2008, I interviewed Natalie Davis, former LVN for KVHD. Davis worked as an LVN for KVHD from May 2003 to May 2007. She resigned from her position due to her displeasure with management. Davis stated that KVHD management required the nurses to give psychotropic medications to some of the KVHD residents. The nurses did not feel that this was appropriate as the residents were not displaying symptoms that required these medications. Davis feared that she could lose her nursing license due to this practice.

The Director Of Nurses (DON), Gwen Hughes, threatened Davis and the entire nursing staff to terminate them and have their nursing licenses taken away if they did not administer the medication that was ordered to the residents.

According Davis, before Hughes started working at KVHD, everything was fine among the residents and hospital staff. After Hughes was hired as the DON, she began changing the medications given to the residents who didn't act or comply with her demands.

Hughes told the nurses that the doctors had ordered these psychotropic medications for the residents, but the nurses knew that this was not true. The nurses observed where the orders originated. The orders were written by Hayes, but ordered by Hughes. Hayes verbally told Davis and the other nurses that Hughes had directed her to write the orders for the psychotropic medications for the residents.

KVHD resident, Opal Towery, was a resident who received an injection of a psychotropic medication due to her having an argument with Hughes. Davis stated that after receiving the injection, Towery did not know who she was for one week and was like a "zombie." After the injection, Towery was essentially nonfunctional and was fully dependent upon others for her

care. Davis could not recall who administered the injection to Towery.

KVHD resident, Mae Brinkley, was given Depakote and had an adverse reaction. She was rushed to the hospital Emergency Room (ER). She never recovered and died shortly after being taken to the ER. Davis estimated over twenty residents were prescribed these psychotropic medications and had adverse reactions.

On April 29, 2008, I interviewed Patricia Orr, former Charge Nurse at KVHD. Orr stated that she has been a Registered Nurse for over 35 years. Orr worked at KVHD as a Charge Nurse from 1982 to 2007.

On January 2007, Orr resigned from her position at KVHD due to almost having a mental breakdown due to working under the former Director of Nurses (DON), Gwen Hughes. Orr stated that Hughes ruled with threats. She verbally threatened to take away her nursing license, report her to the Nursing Board, and also have her terminated if she did not follow the doctor's orders for administering psychotropic medications to KVHD residents. Orr stated that Hughes essentially wrote the doctor's orders by directing the Director of Pharmacy, Debbie Hayes, to write them.

During case conferences-Interdisciplinary Team (IDT) meetings, Orr witnessed Hughes direct Hayes to write doctors' orders for psychotropic medications to be administered to KVHD residents. These medications were administered to the residents who Hughes considered troublesome. Troublesome was defined as they were being moody, irritable, confused, or wandered the facility. These psychotropic medications had adverse effects on the residents they were being administered to. These medications made the residents so lethargic that some could not eat or drink. Hughes directed Hayes to prescribe Zyprexa, Depakote, Resperidol, and Seroquel.

Orr stated that in these IDT meetings, Hughes portrayed herself as knowledgeable and had experience in the most current research on how to deal with these types of residents.

On May 01, 2008, I interviewed Susanne Willey, former LVN for KVHD. Willey stated that she has been an LVN for 23 years and received her Nursing Certificate from Bakersfield Junior College. Willey worked as an LVN at KVHD during 2006 to 2007.

According to Willey, the KVHD former Director of Nurses (DON), Gwen Hughes, was directing the KVHD pharmacist, Debbie Hayes, to order psychotropic medications for the residents. Willey stated that she observed a significant increase in KVHD residents on psychotropic medications since Hughes was hired as the DON in August 2006.

Willey stated that on one occasion, she administered an injection of psychotropic medication to KVHD resident, Louise Zimmerman to help her be less combative. Willey stated that Hughes and Hayes instructed her to administer the injection into Zimmerman. Willey did not want to give the injection, because she knew Zimmerman did not want the injection and did not give consent to receiving the medication.

Willey stated that after she gave the injection, Zimmerman reacted to the medication by constantly sleeping. Willey did not recall the duration of time that Zimmerman suffered this adverse reaction.

On May 27, 2008, I interviewed Pamela Ott, former CEO/Administrator for KVHD. Ott stated that Gwen Hughes was the DON at KVHD when she was the CEO/Administrator. Ott stated that during the time DPH conducted their investigation in January 2007, she was informed of accusations from the staff that residents had been held down in order to give them forceful injections of medications.

Ott stated that the nurses came to her to voice their concerns with Hughes being rude and cruel to staff, but was never made aware of the psychotropic medications being used or Hughes threatening staff for refusal to administer these medications. Only after DPH conducted their investigation was Ott informed that KVHD resident, Louise Zimmerman, had been given a forceful injection of Respiridol without her consent.

Ott stated that she and her staff conducted a full internal investigation of the forceful use of psychotropic medication and found the accusation to be legitimate. The investigation found that Zimmerman was biting, kicking, and hitting others and that the IDT had recommended to Pormir the use of Respiridol to treat her. Their internal investigation found that staff were directed by Hughes to go into Zimmerman's room to participate in administering the forceful injection to her. The internal investigation found that staff distracted Zimmerman. Then an

injection was given to her without her consent. In this investigation, Pormir stated that he approved the use of psychotropics on Zimmerman.

Ott stated that there was a written report completed regarding this internal investigation. This investigation is located at KVHD in the Quality Improvement (QI) file.

Ott stated that she considered the incident in which Zimmerman received a forceful injection of psychotropics as elder abuse at the highest level.

On May 28, 2008, California Department of Justice, Special Agent Supervisor, Robert Walker interviewed Zoretta Matthews. Matthews is currently working as an LVN for KVHD. Matthews has been an LVN for 6 years, all working at KVHD.

Matthews went on disability in September 2006. She noticed a big difference with the residents when she returned to the facility in November 2006. Many of the KVHD residents who were not previously in geri chairs were now in them. The residents who were active, vocal, and propelled themselves down the hallway in their wheelchairs were no longer doing this. They would sit in their chairs, sleep and were not as active. Matthews thought it might have been a result of the medications they were receiving. They were unable to sit up in their chairs, but geri chairs would allow them to recline.

Matthews also noticed a change in resident Vergil Kregger. Kregger had been very vocal and was able to propel herself in her wheelchair up and down the halls. In November, Matthews observed Kregger to be lethargic. She would not eat, wasn't swallowing her food, and was losing weight.

Matthews stated that KVHD resident Joseph Shepter changed. In November he stopped getting out of bed and would not propel himself. Previously, he was loud and would yell for help a lot. Matthews believes he was given Depakote to quiet him.

Wanda Peterson was a very vocal resident. She would visit with Matthews and go outside and smoke. Upon Matthews' return, she stopped doing all this.

Resident Louise Zimmerman complained about the inter-muscular (IM) injections staff were giving her. She complained of blurry vision, problems with her throat, and was lethargic which was not like herself.

On May 28, 2008, SA Tina Khang and I, interviewed Debbi C. Hayes. Hayes was then working as the Director of Pharmacy for KVHD. Hayes stated tht both Gwen Hughes and her made the joint decision to order the psychotropic medications prior to obtaining the physician's signed order. Hayes was remorseful and admitted that she "created a situation where residents were forced to take powerful medications, sometimes against their will." Hayes stated that believed that this was wrong.

Hayes stated that Hughes told her that obtaining two physician's signed consent would override a resident's consent rights. Hayes told me she believed a resident, Louise Zimmerman, was forced to take medication against her will. Hayes believes Zimmerman and another resident, Opal Towery, were both cognizant and able to give consent, were both given injections. Hayes believes Zimmerman was given an "IM" injection against her will. Hayes now believes that "if a resident is cognizant, then they have the right to refuse (medication)." Hayes knows this now because DPH had told her this was in the regulations.

Hughes told Hayes to write orders for "IM" injections and was "insistent" when she told her to write the orders. Hayes "deferred to Hughes because she felt Hughes was knowledgeable." Hayes stated that Hughes suggested using "Depakote" on the residents at Kern Valley because she was familiar with the drug at previous facilities she (Hughes) worked at. Hughes told Hayes that she (Hughes) would rather use Depakote and then told Hayes to order it. Hayes stated Hughes verbally told her to write orders. Two of the drugs Hayes prescribed included Depakote and Resperidol. Hayes stated she had only known about Resperidol in the "oral" form and was first informed of the "injectable" form from Hughes. Hayes stated that Hughes told her she preferred the injectable form Resperidol because "you only had to give the injection periodically as opposed to daily (for the oral) form."

On June 25, 2008, I interviewed Michael Fellen, Administrator at Sunnyside Convalescent Hospital (SCH) located at 2939 S. Peach, Fresno, California. Fellen stated that Gwen Hughes was employed as the Director of Nurses (DON) at SCH for approximately 6 months during 1998-1999. Fellen hired Hughes as the DON. Fellen stated that he terminated Hughes due to a large number of residents being over medicated with psychotropic medications.

Fellen stated that some time in either late 1998 or early 1999, the California Department of Public Health (DPH) issued SCH a Deficiency for over medicating residents with psychotropics. Fellen stated that the DPH found that Hughes and a psychiatrist were recommending and then administering psychotropics to residents at an exceptionally high frequency. Fellen presented the DPH findings to Hughes and she did not have an explanation. Fellen consequently terminated Hughes

Several nurses later told Fellen that Hughes had directed them to write doctor's orders for psychotropic medications for residents, or else they would be terminated. Fellen could not recall the names of these nurses. Fellen stated that the residents who were given these psychotropics were sleeping a great deal.

On June 25, 2008, I interviewed Olivia Segobia, LVN at Sunnyside Convalescent Hospital (SCH). Segobia stated that during 1998 and 1999, she worked under Hughes. Segobia recalls that Hughes had a very relaxed policy regarding ordering and administering psychotropic medications to residents. Segobia stated that at her prior employment at Fillmore Convalescent Home, they had a strict policy/protocol on when to use psychotropic medications for residents. At SCH, under Hughes, there was no such policy, and psychotropics were used much more freely.

At Fillmore Convalescent Home, the psychotic behaviors of the residents were well documented. Medical tests such as blood and urine tests were performed to rule out any medical condition. If needed, the residents were evaluated by a psychiatrist or physician and were started at a very low dosage of psychotropics. The residents who were given these medications were closely monitored. Segobia stated that there was no such protocol under Hughes at SCH. Hughes placed these residents immediately on psychotropics due to their behaviors. Segobia recalled that at that time she believed that this was not appropriate.

Segobia stated that many residents at SCH were Developmentally Disabled and suffered from mental disorders. Most of these residents didn't talk, but made verbal noises. Segobia stated that Hughes' way of dealing with these residents was to give them psychotropic medications to quiet them. Hughes told Segobia that these residents' behaviors were disruptive

to other residents and staff. Hughes directed the nurses to notify the psychiatrist to order these psychotropics medications for the residents.

Segobia stated that Hughes would give the nurses "papers" that stated the names of the residents along with their behaviors. These "papers" would also list the psychotropic medications that were used to treat these behavioral issues.

Haldol and Thoralzine were a favorite psychotropic medication of Hughes. Segobia stated that Hughes would have the nurses order these in high dosages.

Segobia stated that at that time, in the section of the facility she worked at, there were 30 residents. Segobia estimated that approximately 20 of those residents were being given psychotropics. The residents became very quiet due to being given these psychotropic medications. Many became lethargic and started losing weight.

Segobia stated that she and some of the nurses complained to Hughes regarding these adverse reactions the residents suffered and she replied that they needed to wait for the residents to become acclimated to the medication. They were told to wait approximately 3-4 months.

Segobia stated that Hughes made an implied threat to her and the nurses by stating that if they didn't perform their jobs of ordering and administering these medications they would be replaced by others who would perform their jobs.

FINDINGS AND OPINIONS OF DR. LOCATELL

Dr. Kathryn Locatell is a physician licensed by the state of California and board certified in internal medicine and in geriatric medication. She currently serves as an attending physician for nursing home residents, as a nursing home medical director and teaches nursing home medicine to physician trainees in internal medicine. She has previously served as Chief of Elder Care Services for the Kaiser Permanente, Sacramento region, and as Assistant Clinical Professor of Medicine at the University of California, Davis School of Medicine in the section of geriatric medicine. She has qualified as an expert in nursing home care in state courts in California, Washington, Florida, Arizona, Arkansas, Oklahoma, Kentucky and Alabama. Dr. Locatell has participated in inspections of skilled nursing facilities with BMFEA personnel and reviewed documents and drafted expert opinions for BMFEA criminal cases.

On, June 25, 2008, I received Dr. Locatell's review notes regarding her review of DPH's working papers for their Investigation of KVHD on the use of chemical restraints on their residents. The working papers consisted of the copies made by DPH of the KVHD residents' medical records/medical charts, doctor's orders, Interdisciplinary Team Meeting notes, DPH interview notes of staff and residents, notes made by the DPH Health Facilities Evaluator Nurses and Pharmacist, KVHD Nurses' Notes regarding residents, and Nurses' Communication Logs. The DPH working papers consisted of records pertaining only to those residents DPH identified as receiving psychotropic medications.

Based on Dr. Locatell's review of the DPH working papers, she stated that KVHD had some significant resident behavior management problems and clearly the first resort to dealing with these problems was to medicate the residents. The residents affected were aged 85 years and older and were being treated with a lot of medications in general. It is clear that the DON Gwen Hughes was the instigator of many negative changes during her 5 month tenure at KVHD.

Dr. Locatell noted that the pharmacist, Debbie Hayes, was highly involved in resident care, writing numerous orders for residents for psychotropic medications. When writing the orders for psychoactive medications, the pharmacist would list the behaviors to be monitored, which in many cases were not evident in any patient charting prior to the order being given.

On July 15, 2008 and September 24, 2008, the complete and original medical records for KVHD residents Vergil Kregger, Opal Towery, Louise Zimmerman, Alice Bednarz, Mae Brinkley, Joseph Shepter, Jack Wallace, Eddie Dolenc, and Alexander Zaiko were seized from KVHD via search warrants #13616 and # 13789 respectively. Both search warrants were issued by the California Superior Court of Kern County. These medical files were then copied/scanned and given to Dr. Locatell for her medical review.

On October 16, 2008 and January 16, 2009, I received two reports from Dr. Locatell regarding her findings based on her review of the medical records obtained via the aforementioned search warrants.

Dr. Locatell noted resident Mae Brinkley died on December 23, 2006 and had been receiving Depakote ordered by Pharmacist Hayes. Brinkley was severely dehydrated and sent to

the emergency room on December 15, 2006, and the nurses had charted that she had not been able to take her medications, nor was she able to eat or drink for 6 days. Dr. Locatell noted that the use of Depakote in this resident triggered a series of events, compounded by nursing neglect, that led to a severe fecal impaction, dehydration, a urinary tract infection, and ultimately death. Dr. Locatell also stated that based on the descriptions of her condition before Depakote was given, she would likely have lived an additional 1-2 years with proper nursing care.

Dr. Locatell noted resident Eddie Dolenc was given unnecessary psychotropic medication of Seroquel and Duragesic. Dr. Locatell strongly believes that these two medications made Dolenc extremely sedated, which caused him not being able to eat and drink, and that he likely died from some complication such as dehydration or pneumonia that was not noted by KVHD medical staff. Dolenc died at KVHD only after one month after being admitted to the facility.

Dr. Locatell noted that KVHD resident Joseph Shepter was sent to the emergency room on January 04, 2007 with dehydration and died about 5 hours later. He also had a foul-smelling bedsore on his right heel. According to Dr. Locatell, Shepter was given the following psychotropic medications of Seroquel, Depakote, and Zyprexa. Shepter was severely dehydrated and lost 24 lbs. in one month (December 2006).

Dr. Locatell stated in her report that it is her opinion that Shepter " was severely mal-treated by facility staff and Dr. Pormir, and the poor care and treatment caused Shepter to develop an infected heel ulcer, lose almost 20 % of his body weight in 3 months, become severely dehydrated, and spiral downhill with pneumonia and sepsis while no one noticed how sick he was until he was hours from death. Likely the addition of Seroquel, Depakote, and Zyprexa played a major role in this downhill course and in my opinion was totally unwarranted. This resident died because of over medication and nursing neglect."

Dr. Locatell stated that resident Jack Wallace was given high doses of psychotropic medications of Seroquel, Depakote, and Ativan at KVHD per orders of pharmacist Hayes. These three medications in combination surely caused resident to have severe side effects that led to his severe dehydration and near comatose state on October 3, 2006. Dr. Locatell believed that these medications at such high dosages were totally unwarranted. In Wallace's care plan review note,

Gwen Hughes wrote that Wallace was hallucinating and attempting elopement multiple times a day. Dr. Locatell did not find any notes/observations regarding these behaviors in the narrative nurses notes.

Dr. Locatell stated that resident Alexander Zaiko was admitted to KVHD on September 12, 2006 and was dead by September 20, 2006. He died at KVHD for pneumonia and severe dehydration. One day after being admitted to KVHD, pharmacist Hayes increased Zaiko's dosage of Zyprexa by 50%. Hayes then ordered Depakote for Zaiko for his dementia. On September 15, 2006, a nurse charted Zaiko as having drunk only about 1 oz of water and later that day he was moaning with pain, and did not respond verbally.

Dr. Locatell stated that resident Vergil Kregger was given high dosages of Depakote, Zyprexa, and Seroquel. These orders were given by Pharmacist Hayes. Dr. Pormir was seeing Kregger on a monthly basis but his notes contain no discussion of the resident's behaviors and the decisions to medicate her.

Kregger was noted as extremely lethargic after receiving the medications. She was noted as falling asleep with food in her mouth, which posed as a choking hazard.

In Dr. Locatell's opinion, there was no behavior demonstrated by Kregger that justified the use of the aforementioned psychotropic medications. The dosages used were far too high, were increased without rationale, and clearly had a negative effect on the resident.

Dr. Locatell stated that the medical treatments given to KVHD residents Louise Zimmerman and Opal Towery were outrageous due to the fact they were given medications via injections against their will.

Dr. Locatell stated that Louise Zimmerman received two forceful injections without obtaining any consent from either her or a responsible party of a long-acting antipsychotic drug (Risperdal Consta). This resulted in Zimmerman having difficulty in swallowing. Hayes wrote both orders for administration of injection. According to the Department of Public Health's investigation reported on January 31, 2007, it took 4 or 5 staff to hold Ms. Zimmerman down to administer the injection against her will. The nursing progress note for November 29, 2006, the first day the injection was given states only that she was combative with getting the shot.

Dr. Locatell also stated in her report "This case reflects severe deviations from generally accepted professional standards in the prescription (by Hayes) of increasing amounts of the antipsychotic drug Risperdal, against the resident's will. There was no justification whatsoever for forcing the resident to receive the drug. I consider the injections to have constituted an assault on her person, and believe they did cause substantial emotional and physical harm to the resident."

Dr. Locatell stated the following regarding the care given to resident Opal Towery at KVHD: " On December 14, 2006, Hayes ordered Zyprexa, an antipsychotic drug, to be given by intramuscular injection every 8 hours as needed for 'acute agitation' as manifested by 'refusal of care, throwing objects, striking out'. There is no description of any such behavior in the narrative nursing notes in the two weeks prior to Hayes writing this order. According to the DPH report, Ms. Towery accepted the injection because she believed it was a different drug, Ativan, that she was previously taking with good results (and which Hayes had abruptly discontinued). That evening, she was 'slow to respond, drooling, hard to awaken then extremely confused, tremors [complained of] leg pains . . . It took 3 people to assist her to even stand up, legs shaky & weak.'

The next entry in the narrative notes, 4 days later by DON Gwen Hughes, states that her behavior had been 'argumentative' and she 'slapped DON''s arm (no real injury).' The next day, Hayes wrote an order for Risperdal, another antipsychotic drug, to be given for 'combativeness, hitting, refusal of care, throwing objects, striking out, angry outbursts.' Three days later, she had a change in her level of consciousness with slurred speech and hands trembling, 'Res. not at all herself.' For the next several days the same observations were documented. The resident was not eating adequately and lost more than 8 lbs.

This case reflects an outrageous mis-use of two antipsychotic drugs by pharmacist Hayes as well as abusive, punitive behavior by Hughes. The resident clearly suffered significant side effects from both drugs; in the case of Risperdal, I also find it appalling that nurses continued to administer Risperdal for at least a week after she began showing severe side effects."

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CONCLUSION

Based upon the findings of Dr. Kathryn Locatell, witness statements, the DPH Investigation of the use of chemical restraints at KVHD, there is probable cause to believe that the aforementioned KVHD residents were neglected and assaulted at KVHD in violation of Penal Code sections 368 (b)(1) and 245. Furthermore, there is probable cause to believe that former KVHD Director of Nurses, Gwen D. Hughes and the Director of Pharmacy, Debbi C. Hayes, ordered these medications without psychotic indications that resulted in the neglect and assault of these residents. Futhermore, the KVHD Medical Director, Dr. Hoshang M. Pormir, allowed and authorized these residents to be given these psychotropic medications without properly assessing or monitoring their conditions.

Thus, it is my opinion that Gwen D. Hughes, Debbi C. Hayes, and Dr. Hoshang M. Pormir, committed the crime of elder abuse and assault in violation of Penal Code sections 368 (b)(1) and 245 against KVHD residents: Mae Brinkley, Eddie Dolenc, Joseph Shepter, Jack Wallace, Alexander Zaiko, Vergil Kregger, Louise Zimmerman, and Opal Towery.

Based on the facts presented in this declaration, I believe there is sufficient cause for the issuance of arrest warrants for Gwen D. Hughes, Debbi C. Hayes, and Dr. Hoshang M. Pormir for being in violation of elder abuse and assault.

DECLARATION

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Signed on the 10 day of Feb., 2009, at BAKERSFIELD, California.

Donny Fong
Special Agent
Bureau of Medi-Cal Fraud & Elder Abuse
California Department of Justice