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PAHRUMP VALLEY GAZETTE

50¢

Thursday, December 4, 1997 Most read newspaper in Nye, Esmeralda & Death Valley Vol. XV. No. 20

Cover-up of abuse charged

by Andy Holtmann
PVG Staff

One current and two former employees of the Nye Regional Medical Center (NRMC) in Tonopah have been charged with the deliberate neglect of an elderly patient. The charges were issued by the state Attorney General's Office after a lengthy investigation which alleges improper medical procedures and attempts to cover-up those procedures.

The *PVGazette* broke the story last week when it was learned that the Attorney General's Office had arrested Patricia Perry Paul, a nurse at the medical center at the time of the incident. Paul and fellow caretakers Bernice Fay Anderson and Jane Rudolph have been charged with one felony count of Criminal Neglect of a Patient in violation of NRS 200.495 and one felony count of Abuse, Neglect, and Exploitation of Older Persons in violation of NRS 200.5099. According to Nye Regional's Interim Administrator Bill Welch, Anderson and Rudolph left the hospital prior to the investigation being completed.

According to Medicaid Fraud Unit Director Timothy Terry, Anderson and Rudolph have since fled the state, one of them apparently having fled the country. Arrest warrants have been issued and Terry said the Attorney General's Office is currently attempting to locate them.

"Representatives from our office were sent to Tonopah to apprehend Paul," Terry said. "After the investigation was complete, we had enough to go on to issue the warrants."

In documents obtained by the *PVGazette*, it was learned that Barbara Backman, an investigator with the Office of the Attorney General, Medicaid Fraud Control Unit, headed up the investigation. According to a criminal complaint filed by her, the incidents in question took place between November 23 and November 27 of last year.

Sarah McMurray, a 92-year-old patient at the NRMC, was allegedly under Anderson's and Paul's care at the time, suffering from rheumatoid arthritis, senile dementia and an unhealed fracture of her left leg. The state alleges that on November 23, between 11:00 a.m. and 2:00 p.m. when attempting to move McMurray to the shower room by hand, she was dropped on the floor.

In McMurray's charts, it stated that she was to be transported through the aid of a machine known as a Hoyer Lift. Anderson and Paul allegedly opted to move McMurray manually instead using what is called a Towel Lift. After bathing the patient, Anderson, according to state documents, lost her grip and McMurray fell to the floor.

The state further charges that Anderson told Paul not to tell anyone in an attempt to cover up the fact that the two nurses had used an improper method when transporting McMurray.

When McMurray began complaining of pain in her shoulder, Anderson left Paul with the patient and according to Backman, enlisted the help of Rudolph, a supervising nurse.

The complaint filed by Backman alleges that Rudolph

Continued on page 8

CHRISTMAS WISHES— Three year old twins Brandon and Brittany Cox share a moment with Santa. They were two of nearly 200 children who turned out to see Santa Claus when he visited the Bob Ruud Community Center on Saturday, November 29. Santa's visit was the main event at a Christmas party to kick off the holiday season.
Please see page 15 for more information
Photo by Andy Holtmann

Nye County looking to change insurance policy

by Andy Holtmann
PVG Staff

Nye County is flirting with the idea of switching their county wide insurance policy from a self-insured program to a commercial company. The talk of change comes at a time when the county commissioners are unhappy with what they see as financial flaws with the current system.

The county's interest in change has prompted proposals from two insurance firms, Pahrump Valley Insurance and Sierra Premiums. Both are vying for the account, and presented their proposals to the Commissioners at their meeting in Tonopah on December 2.

Roughly nine months prior at a public meeting the Commissioners heard a presentation by Bob Waldren, a consultant from Sedgwick, Noble and Lowndes, a brokerage group based in Reno. Waldren told the board that the county had two options at that time.

Plan A involved the county seeking outside firms and buying straight insurance packages. Waldren said this was probably not the best option because of the county's track record and the high number of insurance claims against the county. He noted that very few would want to deal with the county without charging extremely high premiums.

Plan B was for the county to find someone to properly handle brokerage of their self-insurance policy. Waldren recommended to the commissioners that his company could handle the job. He also recommended that Home Health Partners of Nevada be designated as the administrative end of the operations. The commissioners felt comfortable with the proposal at the time and opted to stay self insured.

The firm of Sedgwick, Noble and Lowndes was hired by

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Three charged, one arrested in alleged abuse cover up at Nye Regional Medical Center

Continued from front page

arrived at the medical center after being called in about the incident and quickly looked McMurray over claiming that no injury had occurred. The complaint further alleges Rudolph did not conduct a thorough examination or inspect the patient's extremities despite McMurray's complaint of her shoulder hurting.

Backman stated in her complaint that Anderson's and Paul's procedure in moving McMurray and Rudolph's acts in failing to properly examine or report the patient's injuries were direct departures from the medical center's policy and codes when dealing with Medicaid patients.

According to Backman, McMurray was transported back to her room and the incident ignored. It wasn't until an additional 24 to 36 hours later that her condition was properly diagnosed and it was discovered that she had suffered a dislocated shoulder.

McMurray's attending physician, Dr. John Schwartz was not notified until November 26 of her condition and the following day he examined her and found her shoulder to be "very bruised, swollen and dislocated." After a failed attempt to reduce the dislocation, Schwartz had McMurray transferred to the emergency room because she was medically unstable. She was later transferred to the acute care center, where her condition continued to get worse.

McMurray died on December 2, 1996 from internal bleeding, just nine days after the incident in the shower room occurred. According to Terry, the suspects are not being charged with her death at this time and the Attorney General's Office is not planning to bring charges in the future.

Backman interviewed a number of past and present employees of NRMC, the Division of Aging Services and the Bureau of Licensure and Certification. A full investigation of all documents pertaining to McMurray were examined as well as medical charts and procedure manuals. Anderson, Paul and Rudolph were also interviewed.

During two interviews with Paul on June 18 and August 13, 1997, Backman said that she was told by Paul that when Anderson dropped McMurray, Paul made the attempt to catch her. Backman said she shifted the blame to Anderson by stating that Anderson left to seek help after the initial incident. Certified Nurse Assistant Jennifer Zane was contacted and Anderson allegedly had told her that one of the geri chairs used in the manual transport was not locked.

Paul told Backman she had questioned Anderson's towel lift procedure from the very beginning as McMurray had a bad back. After the incident occurred, Paul said that Anderson instructed both her and Zane not to report the dropping of McMurray because they "could lose their jobs if the incident was reported."

It was alleged that when Paul had asked that McMurray be given some pain medication, Anderson refused saying that she had already given the patient medication earlier in the day.

When Backman interviewed Anderson, she received a different story. While she admitted to Backman that McMurray was dropped, she denied telling anyone not to report the incident. Anderson then told Backman McMurray was not injured and did not complain of any pain. She said McMurray was on a daily dosage of the pain reliever, Vicoden and that after the incident she contacted emergency room physician Dr. McGrorey.

But medical records obtained by Backman did not support Anderson's claim of the Vicoden treatment and Dr. McGrorey had no recollection of Anderson contacting him involving McMurray. McGrorey told Backman that if he had been notified of the incident, he would have wanted to assess the situation as soon as possible.

Both Paul and Zane stated to Backman that they told Anderson they would report the incident to Rudolph if she failed to do so. In a phone interview with Rudolph, Backman elicted from her that no "falling incident" occurred at all and that McMurray was in no pain. She said that McMurray did not hit the floor so it was not necessary to call a doctor. According to her it was not an incident at all but rather a "near incident."

In Paul's statement to Backman however, she described how Rudolph approached McMurray, put her hands on her hips as if to get her attention and asked if she was alright. McMurray responded yes, at which point Rudolph moved the hem of McMurray's skirt, briefly looked at her knees and said, "ok."

> ***"It wasn't until an additional 24 to 36 hours later that her condition was properly diagnosed and it was discovered that she had suffered a dislocated shoulder."***

Several days after the incident, Rudolph allegedly approached Paul and requested she sign a statement to the effect that the Hoyer lift should be used at all times *except* in the shower room. Rudolph told her that former supervising nurse Louise Rush had authorized manual transport in the shower room. Paul said she felt like she was being coerced into signing a falsified document.

When Backman contacted Rush, she denied ever authorizing such a procedure and reiterated that McMurray was to be transported by Hoyer lift only.

Interim Medical Center Administrator Welch told the *PVGazette* he was not with the medical center at the time of the incidents, but that the institution was not found to be at fault.

"This was an isolated incident," Welch said. "The center followed all of the procedures correctly and did not deviate from its purpose."

Welch said that he knew, as of mid-summer, that an investigation was underway involving the medical center's employees. It wasn't until early last week though, that he and the rest of the staff at NRMC learned of the violations that had occurred.

As far as Anderson, Paul and Rudolph, Welch said he hated to see the situation end up the way it did.

"It always creates a concern when a fellow employee has something like this happen to them," he said. "We try to provide the best care we can for our patients and something like this is very detrimental to what we are trying to accomplish."

Welch said that so far, the medical center had not heard of complaints from the community and there is still a waiting list to get in. Plans at the medical center to open up a new nine bed nursing home wing remain unchanged at this time.

In the meantime, Welch said there has been extra emphasis placed on the proper procedures and codes to be used when dealing with patients. At their weekly meeting Welch said he reminded employees of the consequences of ignoring policy.

NRMC's records and manuals include policy for reporting such accidents. The procedure is to report the incident to a department supervisor and a quality review form must be completed on the shift that the incident occurred. All three employees charged have had training on how to properly handle an accident situation.

"This situation has given us a chance to re-evaluate what happened and refresh ourselves on the proper practices when dealing with those we are trusted to care for," he said.

After being arrested and arraigned, Paul was later released on her own recognizance. According to the Justice Court in Tonopah, Rudolph is also being charged with a misdemeanor for failing to report the incident. Paul's preliminary hearing is set for December 10.

Editor's Note:
See sidebar on next page for complete word for word documentation of the criminal charges brought by the Attorney General's Office.

Text of complaint filed by State of Nevada:

CASE NO. 7976
FILED
J. Marey/Clerk
Justice of the Peace
November 21, 1997
IN THE JUSTICE COURT OF THE TONOPAH TOWNSHIP
AND FOR THE COUNTY OF NYE,
STATE OF NEVADA
****
STATE OF NEVADA,
Plaintiff,
vs.
BERNICE FAY ANDERSON,
PATRICIA PERRY PAUL and JANE RUDOLPH,
Defendants.

CRIMINAL
COMPLAINT

Personally appeared before the undersigned notary public this 20 day of November, 1997, BARBARA BACKMAN, an Investigator for the Office of the Attorney General, Medicaid Fraud Control Unit, who being first duly sworn and within her knowledge, information and belief, complains and charges BERNICE FAY ANDERSON, PATRICIA PERRY PAUL and JANE RUDOLPH, the above named Defendants, with each having committed the offense(s) of:

(1) Criminal Neglect of Patient, one (1) count, a felony, in violation of NRS 200.495, within Tonopah Township, Nye County; and

(2) Abuse, Neglect and Exploitation of Older Persons, one (1) count, a felony in violation of 200.5099 (3) and (7) and NRS 200.5092 (3) within Tonopah Township, Nye County, as follows:

COUNT 1 - (Felony)
CRIMINAL NEGLECT OF PATIENT
(NRS 200.495)
(Defendants ANDERSON, PAUL and RUDOLPH)

That within her knowledge, information and belief, BERNICE FAY ANDERSON, PATRICIA PERRY PAUL and JANE RUDOLPH, as professional caretakers, did between November 23, 1996 and November 27, 1996, fail to provide such service, care or supervision as was reasonable and necessary to maintain the health or safety of a patient, Sarah McMurry, age 92 with medical diagnoses including senile dementia, rheumatoid arthritis and an unhealed fracture of her left distal femur, in the following manner:

Specifically, as to BERNICE FAY ANDERSON (ANDERSON):

Defendant BERNICE FAY ANDERSON, between the hours of 11:00 a.m. to 2:00 p.m., November 23, 1996, while employed as a professional registered nurse/caretaker at Nye Regional Medical Center, a medical facility pursuant to NRS 449.0151, located within Tonopah Township, Nye County, did fail to provide such service, care or supervision as was reasonable and necessary to maintain the health or safety of patient, Ms. Sarah McMurry, in the following manner:

Defendant ANDERSON while acting as Charge Nurse did commit an aggravated, reckless or gross act by failing to follow facility protocol, the instructions of supervisory staff, notes in the facilities communications book, Ms. McMurry's patient care plan and her patient chart when transporting Ms. McMurry. Specifically, Defendant ANDERSON knowingly chose not to use a mechanical transport method, commonly referred to as a Hoyer Lift, when transporting Ms. McMurry within the shower room. Defendant ANDERSON knowingly chose to utilize a contraindicated two person manual transport method, commonly referred to as a Towel Lift. The act of using the Towel Lift was such a departure from the conduct of said ordinarily prudent and careful person under like circumstances that it constituted failure to perform her duties as prescribed in the Regulations of the Board of Nursing Chapter 623 of the Nevada Administrative Code and Chapter V of the Medicaid Services Manual. The act also constituted a disregard for danger to Ms. McMurry. Furthermore, it was reasonably foreseeable that substantial bodily harm could occur from ANDERSON'S use of the contraindicated Towel Lift transport method. In fact, by ANDERSON'S use of the contraindicated Towel Lift method, Ms. McMurry was dropped in the shower room, subjecting her to prolonged physical pain and impairment/separation of her left arm from her shoulder. Such resulting injuries were a natural and probable result of Defendant ANDERSON'S use of the contraindicated manual Towel Lift.

After dropping Sarah McMurry, ANDERSON then knowingly failed to take the proper actions to assess Ms. McMurry for injury, and knowingly failed to render appropriate aid and care to Ms. McMurry. Defendant ANDERSON, upon obtaining assistance from co-workers lifted Ms. McMurry up from the shower room floor, placed her in a geri chair, and instructed co-workers not to report the incident or mention it to others. Defendant ANDERSON repeated this instruction to co-workers after one co-worker advised ANDERSON that Ms. McMurry was in pain and her left arm hurt. ANDERSON'S actions and failure to assess were in direct contradiction to the instructions, policies and protocol of her employer, constituting aggravated, reckless or gross negligence. Her actions and omissions were such a departure from the conduct of an ordinarily prudent and careful person under like circumstances that it constituted a failure to perform her duties as prescribed in the Regulations of the Board of Nursing Chapter 632 of the Nevada Administrative Code and Chapter V of the Medicaid Services Manual. The acts and omissions also constituted disregard for danger to Ms. McMurry. Defendant ANDERSON'S omissions and affirmative attempts to thwart the proper reporting of the incident prevented Sarah McMurry from receiving reasonable and necessary care. Ms. McMurry remained in prolonged severe physical pain and did not receive treatment for her injuries for an additional 24 to 36 hours. On November 27, 1996, x-rays were conducted and her dislocated left shoulder was fully diagnosed.

The consequences of Defendant ANDERSON'S acts and omissions were reasonably foreseeable and the physical danger and prolonged severe pain were natural and probable results of Defendant ANDERSON'S actions and omissions.

All of this constitutes a felony offense of CRIMINAL NEGLECT OF A PATIENT in violation of NRS 200.495.

Specifically as to PATRICIA PERRY PAUL (PAUL):

Defendant PATRICIA PERRY PAUL, between the hours of 11:00 a.m. to 2:00 p.m. on November 23, 1996, while employed as a professional Certified Nurse Assistant/Caretaker at Nye Regional Medical Center, a medical facility pursuant to NRS 449.0151, located within Tonopah Township, Nye County, did fail to provide such service, care or supervision as was reasonable and necessary to maintain the health or safety of patient, Ms. Sarah McMurry, in the following manner:

Defendant PAUL did commit an aggravated, reckless or gross act by failing to follow facility protocol, the instructions noted in the facility communications book, Ms. McMurry's patient care plan and patient chart when transporting Ms. McMurry. Specifically, Defendant PAUL knowingly chose not to use a mechanical transport method, commonly referred to as a Hoyer Lift, when transporting Ms. McMurry within the shower room. Defendant PAUL knowingly chose to utilize a contraindicated two person manual transport method, commonly referred to as a Towel Lift. The act of using a Towel Lift was such a departure from the conduct of an ordinarily prudent and careful person under like circumstances that it constituted failure to perform her duties as prescribed in the Regulations of the Board of Nursing Chapter 632 of the Nevada Administrative Code and Chapter V of the Medicaid Services Manual. The act also constituted a disregard for danger to Ms. McMurry. Furthermore it was reasonably foreseeable that substantial bodily harm could occur from PAUL'S use of the contraindicated Towel Lift transport method. In fact, by PAUL'S use of the contraindicated Towel Lift method, Ms. McMurry was dropped in the shower room, subjecting her to prolonged physical pain and impairment/separation of her left arm from her shoulder. Such resulting injuries are a natural and probable result of PAUL'S use of the contraindicated manual Towel Lift.

All of which constitutes a felony offense of CRIMINAL NEGLECT OF A PATIENT in violation of NRS 200.495.

Specifically as to Defendant JANE RUDOLPH (RUDOLPH):

Defendant JANE RUDOLPH, between the hours of 11:00 a.m. to 4:00 p.m., November 23, 1996, while employed as a professional registered nurse/caretaker in a supervisory capacity at Nye Regional Medical Center, a medial facility pursuant to NRS 449.0151, located within Township, Nye County, did fail to provide such service, care or supervision as was reasonable and necessary to maintain the health or safety of patient, Ms. Sarah McMurry, in the following manner:

Defendant RUDOLPH did commit aggravated, reckless or gross acts by failing to follow facility protocol and reporting requirements; and by failing to adhere to required duties as prescribed in the Regulations of the Board of Nursing Chapter 632 of the Nevada Administrative Code and Chapter V of the Medicaid Services Manual in her provision of service, care or supervision of Ms. McMurry. Defendant RUDOLPH arrived at the facility in her supervisory nurse/caretaker capacity to respond to an incident involving Ms. McMurry being dropped in the shower room by two co-workers who at the time were utilizing a non-approved transportation method. RUDOLPH did not properly assess or examine Ms. McMurry for injuries or physical pain. RUDOLPH did not conduct a thorough physical examination or inspect or palpate Sarah McMurry's extremities. RUDOLPH did not contact Nye Regional's emergency room or contact a physician. RUDOLPH'S omissions and failure to act occurred with knowledge of Sarah McMurry's existing medical conditions.

Defendant RUDOLPH'S acts and omissions in failing to properly assess, examine or report Ms. McMurry's injuries constituted such a departure from the conduct of an ordinarily prudent, careful person under the same circumstances as to be a disregard for danger to Ms. McMurry, or constitutes indifference to the resulting consequences. With all of Defendant RUDOLPH'S training and experience, it was reasonable foreseeable that her failure to properly assess, examine or report Ms. McMurry's physical condition would lead to prolonged physical pain and/or medical complications. By being dropped in the shower room, Ms. McMurry was in fact subjected to prolonged physical pain, and an impairment/separation of her left arm from her shoulder, and this injury was not properly diagnosed for an additional 24 to 36 hours. Such resulting prolonged severe physical pain was a natural and probable result of RUDOLPH'S aggravated, reckless or grossly negligent acts and omissions of knowingly failing to properly assess, examine or report Ms. McMurry's injuries, and of RUDOLPH'S failure to properly carry out her duties.

All of which constitutes a felony offense of CRIMINAL NEGLECT OF A PATIENT in violation of NRS 200.495.

COUNT 2 - (FELONY)
ABUSE, NEGLECT AND EXPLOITATION OF OLDER PERSONS
(NRS 200.5099 (3) and (7); NRS 200.5092 (3))
(Defendants ANDERSON, PAUL and RUDOLPH)

That within her knowledge, information and belief, BERNICE FAY ANDERSON, PATRICIA PERRY PAUL and JANE RUDOLPH, as professional caretakers who assumed a legal responsibility or a contractual obligation for caring for an older person Sarah McMurry, age 92 with medical diagnoses including senile dementia, rheumatoid arthritis and an unhealed fracture of the left distal femur, to provide services which are necessary to maintain the physical or mental health of the older person failed to do so in the following manner:

Specifically as to BERNICE FAY ANDERSON (ANDERSON)

Defendant ANDERSON, as a registered nurse employed at Nye Regional Medical Center, did on November 23, 1996 through November 27, 1996, in Tonopah Township, County of Nye, Nevada, cause and permit Sarah McMurry to suffer unjustifiable physical pain and/or mental suffering as a result of neglect, or did permit Ms. McMurry to be placed in a situation in which she may, and in fact, did suffer unjustifiable physical pain and/or mental suffering as a result of neglect in that ANDERSON failed to provide services necessary for the physical and mental health of Ms. McMurry, a person over the age of 60 years, and for whom Defendant ANDERSON had assumed a legal responsibility and/or a contractual obligation to care for, in the following manner:

While working at Nye Regional Medical Center, ANDERSON chose not to follow facility protocol, instructions of supervisors, notes in the facility communications book, Ms. McMurry's patient care plan and patient chart when transporting Ms. McMurry. ANDERSON failed to perform her duties as prescribed in the Regulations of the Board of Nursing Chapter 632 of the Nevada Administrative Code and Chapter V of the Medicaid Services Manual.

ANDERSON failed to provide ambulation services and other services as required in the patient's care plan. On November 23, 1996, ANDERSON failed to use a mechanical transport method, commonly referred to as a Hoyer Lift, when transporting Ms. McMurry within the shower room. ANDERSON knowingly utilized a contraindicated two person manual transport method, commonly referred to as a Towel Lift. Through ANDERSON'S use of the contraindicated Towel Lift method, Ms. McMurry was dropped in the shower room, causing her unjustified prolonged physical pain and impairment/separation of her left arm from her shoulder. ANDERSON then obtained assistance from co-workers, lifted Ms. McMurry from the shower room floor and placed her in a geri chair. Upon doing so, ANDERSONdid not properly examine or assess Ms. McMurry. Instead, ANDERSON instructed co-workers not to report the incident or mention it to others. Defendant ANDERSON repeated this instruction to co-workers after one co-worker advised ANDERSON that Ms. McMurry was in pain and her left arm hurt. Defendant ANDERSON'S actions and efforts to thwart the proper reporting of the incident prevented Ms. McMurry from receiving the proper care or services necessary to maintain the physical or mental health of Ms. McMurry. These same actions caused Sarah McMurry to suffer physical pain or mental suffering and allowed Ms. McMurry to continue to suffer unjustifiably physical pain or mental suffering until her separated shoulder was properly diagnosed 24 to 36 hours after being dropped.

All of which constitutes a felony offense of ABUSE, NEGLECT AND EXPLOITATION OF OLDER PERSON in violation of NRS 200.5099 (3) and (7).

Specifically as to PATRICIA PERRY PAUL (PAUL):

PAUL, as a certified nurse assistant employed at Nye Regional Medical Center in Tonopah Township, County of Nye, Nevada, did on November 23, 1996 through November 27, 1996 cause and permit Ms. Sarah McMurry to suffer unjustifiable physical pain and/or mental suffering as a result of neglect, or did permit Ms. McMurry to be placed in a situation in which she may, and in fact, did suffer unjustifiable physical pain and/or mental suffering as a result of neglect in that PAUL failed to provide services necessary for the physical and mental health of Sarah McMurry, a person over the age of 60 years, and for whom Defendant PAUL had assumed a legal responsibility and/or a contractual obligation to care for, in the following manner:

While working at Nye Regional Medical Center, PAUL with co-worker BERNICE FAY ANDERSON, a registered nurse, chose not to follow facility protocol, instructions of supervisors, notes in the facility communications book, Ms. McMurry's patient care plan and patient chart when transporting Ms. McMurry. Defendant PAUL failed to perform her duties as prescribed in the Regulations of the Board of Nursing Chapter 632 of the Nevada Administrative Code and Chapter V of the Medicaid Services Manual.

Defendant PAUL failed to provide ambulation services and other services as required in the patient's care plan. On November 23, 1996, PAUL with co-worker ANDERSON, chose not to use a mechanical transport method, commonly referred to as a Hoyer Lift, when transporting Ms. McMurry within the shower room. Defendant PAUL knowingly utilized a contraindicated two person manual transport method, commonly referred to as a Towel Lift. Through Defendant PAUL'S use of the contraindicated Towel Lift method, Ms. McMurry was dropped in the shower room, causing her unjustified prolonged physical pain and impairment/separation of her left arm from her shoulder. ANDERSON then obtained assistance from other co-worker (s), including PAUL, and lifted Ms. McMurry from the shower room floor and placed her in a geri chair. Shortly after being dropped, Ms. McMurry complained to PAUL that she was in pain.

All of which constitutes a felony offense of ABUSE, NEGLECT AND EXPLOITATION OF OLDER PERSON in violation of NRS 200.5099 (3) and (7).

Specifically as to Defendant JANE RUDOLPH (RUDOLPH):

Defendant RUDOLPH, as a registered nurse supervisor employed at Nye Regional Medical Center, in Tonopah Township, County of Nye, Nevada, did on November 23, 1996 through November 27,1996 cause and permit Sarah McMurry to suffer unjustifiable physical pain and/or mental suffering as a result of neglect, or did permit Ms. McMurry to be placed in a situation in which she may, and in fact, did suffer unjustifiable physical pain and/or mental suffering as a result of negligence in that Defendant RUDOLPH failed to provide services necessary for the physical and mental health of Ms. McMurry, a person over the age of 60 years, and for whom Defendant RUDOLPH had assumed a legal responsibility and/or a contractual obligation to care for, in the following manner:

Defendant RUDOLPH did commit neglect by failing to follow facility protocol, or reporting requirements; and by failing to adhere to required duties as prescribed in the Regulations of the Board of Nursing Chapter 632 of the Nevada Administrative Code and Chapter V of the Medicaid Services Manual in her provision of care or services necessary to maintain the physical or mental health of Ms. McMurry. On November 23, 1996, RUDOLPH was summoned to the facility in her supervisory nurse/caretaker capacity to respond to an incident involving Ms. McMurry being dropped in the shower room by two co-workers, who at the time were utilizing a non-approved transportation method. Upon her arrival, RUDOLPH evaluated the situation, but did not properly assess or examine Ms. McMurry for injuries or physical pain, nor did she direct others to do so. Defendant RUDOLPH also failed to report the incident to Ms. McMurry's physician.

Defendant RUDOLPH'S neglect in failing to properly provide care or necessary services in assessing, examining or reporting Ms. McMurry's injuries caused, allowed and/or permitted Sarah McMurry to suffer severe prolonged physical pain and substantial bodily or mental harm for an additional 24 to 36 hours when an impairment/separation of her left arm from her shoulder was properly diagnosed. RUDOLPH'S failure to properly assess and/or diagnose injuries allowed Ms. McMurry to be neglected until she was properly diagnosed. These same neglectful failures of duty or responsibility by RUDOLPH caused or permitted Ms. McMurry to receive services in a manner that a reasonable person would not have allowed if information from a proper assessment, examination or reporting had been provided.

All of which constitutes a felony offense of ABUSE, NEGLECT AND EXPLOITATION OF OLDER PERSON in violation of NRS 200.5099 (3) and (7).

All of the above is contrary to the form, force and effect of the statutes as such cases made and provided, and the peace and dignity of the State of Nevada.

Said complainant prays that Arrest Warrants be issued for Defendants BERNICE FAY ANDERSON, PATRICIA PERRY PAUL, and JANE RUDOLPH; and that Defendants be dealt with according to law.

DATED this 20 day of November, 1997.
FRANKIE SUE DEL PAPA
Attorney General
By: Barbara Backman
Investigator
SUBSCRIBED AND SWORN to before me
this 20th day of November, 1997
by: BARBARA BACKMAN.
Doris T. Williams
Notary Public in and for the County
of Clark, State of Nevada
SUBMITTED
BY: FRANKIE SUE DEL PAPA
Attorney General
By: Mark N. Kemberling
Deputy Attorney General
Nevada Bar No. 5388
Medicaid Fraud Control Unit
555 E. Washington # 3900
Las Vegas, NV 89101
(702) 486-3777
Attorneys for Plaintiff
STATE OF NEVADA

EDITOR'S NOTE: Next week's *PV Gazette* will feature a copy of the affidavit of probable cause in support of criminal complaint and issuance of arrest warrant(s) in the matter of State of Nevada vs. Bernice Fay Anderson, Patricia Perry Paul and Jane Rudolph.