IN THE COUNTY COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR GADSDEN COUNTY, FLORIDA

STATE OF FLORIDA,

Plaintiff,

CASE NO.:

CHARGES:
(1) SECTION § 825.102(3)(c), F.S.
Neglect Elderly Disabled Adult,
(Felony, 3rd Degree)

Office of the Attorney General Case No: MFC-19-06806

v.

Pamela Lashell Grice
DOB [redacted], Black/Female
SSN: [redacted]
Address: 2137 Martin Luther King Jr Blvd., Midway, FL 32351

Defendant.
State of Florida /

ARREST WARRANT

IN THE NAME OF THE STATE OF FLORIDA, TO ALL AND SINGULAR THE SHERIFFS OF THIS STATE, AND THEIR DULY CONSTITUTED DEPUTIES:

The Court finds that there is probable cause to believe, based on the attached Affidavits, that the defendant, Pamela Lashell Grice, has committed in Gadsden County, Florida, one (1) count of Neglect of an Elderly Disabled Adult, against the peace and dignity of the State of Florida.

You are hereby commanded to arrest Pamela Lashell Grice and bring her before the Court to answer a complaint charging her with Neglect of an Elderly Disabled Adult, against the peace and dignity of the State of Florida.

The defendant is to be admitted to bail in the sum of $___ _____.

Special conditions of release: _____

WITNESS my hand and seal this day of , 2021 at Quincy, Gadsden

County, Florida.

_____
Circuit Court/Acting Circuit Court Judge
Second Judicial Circuit of Florida

WITNESS: ____ _____ , and the seal of the Clerk of the Court at Quincy, Gadsden County, Florida, this _____ day of _____, 2021.

WITNESS: ____ ____ (SEAL)

Received this Warrant the _____ day of _____, 2021, and executed it on the _____ day of_____ , 2021, by arresting the above-named defendant, Pamela Lashell Grice, and having her now before the Court.

_____
Arresting Investigator

IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT
IN AND FOR GADSDEN COUNTY, FLORIDA

STATE OF FLORIDA **MFCU AGENCY**
COUNTY OF GADSDEN **CASE # MFC-19-06806**

AFFIDAVIT IN SUPPORT FOR
AN ARREST WARRANT FOR PAMELA LASHELL GRICE

Before me, Howard Mack Osmond the undersigned Notary Public of the State of Florida, personally appeared Jerrod Rigdon, Law Enforcement Investigator with the Medicaid Fraud Control Unit, Office of the Attorney General, who first being duly sworn, deposes and states as follows:

Your Affiant, Jerrod Rigdon, has been employed, as a Law Enforcement Investigator, with the Medicaid Fraud Control Unit, a department within the Attorney General's Office, since April 2019. Prior to that, Your Affiant was employed by the Jefferson County Sheriff's Office, where Your Affiant served as a Patrol Sergeant for a period of two (2) years. Prior to that, Your Affiant was a Deputy with the Jefferson County Sheriff's Office for a period of five (5) years. During this time, your Affiant has conducted investigations involving crimes concerning persons, property and fraud.

The Medicaid Fraud Control Unit (MFCU) operates under the supervision of the Florida Attorney General's Office and exists to investigate fraud within the Medicaid Program. The MFCU is authorized to investigate the possible criminal violation of applicable state laws pertaining to fraud in the administration of the Medicaid program, in the provision of medical assistance, or in the activities of providers of health care under the Medicaid program, and to investigate alleged abuse, neglect or exploitation of patients' private funds in healthcare facilities receiving payments under the Medicaid program, pursuant to 42 U.S.C. § 1396b(q) and § 409.920(9), Florida Statutes. The MFCU is also authorized to investigate any other criminal violations uncovered during the course of those investigations pursuant to § 16.59, Florida Statute.

Your Affiant further states that the facts and reliable evidence supporting this Affidavit establish probable cause to believe that, on or between August 24, 2019 and August 26, 2019, **PAMELA LASHELL GRICE** a black female, [redacted], whose last known address is 2137 Martin Luther King Jr Blvd., Midway, FL 32351 did commit the following violation: One (1) Felony count of Neglect of an Elderly Person or Disabled Adult, committed within Gadsden County, Florida.

This investigation was predicated upon a complaint called into the Florida Abuse Hotline and an investigation conducted by the Florida Department of Children and Families, Adult

Protective Services. On August 26, 2019, it was reported to the abuse hotline that [redacted][1] [redacted]

This investigation determined that on Friday, August 23, 2019, Nurses from Big Bend Hospice (BBH) completed [redacted] daily care routine. BBH nurses returned on Monday, August 26, 2019, and while trying to complete [redacted] care, found [redacted] to be in excruciating pain on her left leg and bruising along her left side.

BBH nurses asked employees of [redacted] about the incident that caused [redacted] injuries over the weekend. Employees of the [redacted] had no incident reports or knowledge of any adverse incident involving [redacted] An X-Ray was performed and found that [redacted] had suffered a broken hip. Multiple medical opinions concluded that the hip could only have been broken by a fall. However, with [redacted] being unable to walk meant it could only have been caused by an employee having dropped [redacted]

Subsequent interview with [redacted] employee Carrie Jeanette Miller revealed that she had transferred [redacted] from the bed to the wheelchair by herself. Miller then attempted to push [redacted] into the lobby but found the wheelchair difficult to move. Miller gave an extra forceful push to the wheelchair causing it to bump and tip over, throwing [redacted] out and onto the floor. It was discovered that the reason the chair was difficult to push was because a cord attaching the remote control to the bed was lying on the floor and under the chair wheel.

Miller called for assistance from Pamela Lashell Grice, shift supervisor and the only other person working that shift. Grice assisted Miller in placing [redacted] back into the wheelchair and Miller wheeled [redacted] into the lobby. [redacted] was not properly evaluated for any injury by either caregiver.

Neither Grice nor Miller contacted [redacted] family, medical staff, facility supervisor, ambulance, or hospital to have [redacted] evaluated for the fall. Both Grice and Miller stated this was against policy and protocol. No report was completed advising [redacted] other caregivers of her injuries. This incident occurred on or around August 24, 2019, and the injury was not discovered until August 26, 2019. The caregivers failure to report delayed [redacted] from receiving proper care and treatment for her pain and injuries for up to two days.

The facts and evidence are as follows:

[redacted] was a 98-year-old female diagnosed with Dementia, Hypertension (HTN), Osteoporosis, History of Falls, and Hyponatremia. [redacted] became a resident of the [redacted] on January 13, 2015. On October 12, 2017, while a resident of the [redacted] [redacted] was accepted for care by Big Bend Hospice (BBH) based on a diagnosis of Dementia, with secondary debility. On October 16, 2017, Dr. Ronald Hartsfield completed a Resident Health Assessment form as required for Assisted Living Facilities. The assessment states [redacted] "needs assistance"

[1] The name of the Medicaid recipient has been reduced to initials to avoid the disclosure of confidential information pursuant to, inter alia, Federal HIPAA regulations and Section 409.920(9)(f), Florida Statutes.

[redacted] all her Activities of Daily Living (ADL) and noted under the comments section of Ambulation and Transferring, it states "Does Not Ambulate".

On September 9, 2019, at 9:35 PM at the Hospice House in Tallahassee, Florida (1723 Mahan Center Blvd. Tallahassee, Leon County, 32308), [redacted] was pronounced deceased.

Medical Examiner's Report states that on September 11, 2019, at 11:49 AM, Dr Anthony J. Clark conducted an inspection of [redacted] body. In the report is states, "I. Superficial lacerations, abrasions and contusions in various stages of healing of the upper and lower extremities. II. Embalming artifact. III. Clinical history of: A. Left hip fracture - history of multiple falls; B. Failure to thrive; C. Dementia; D. Chronic urinary tract infections; E. Hypertension; F. Hyperlipidemia; G. Osteoporosis; H. Traumatic subdural hemorrhage (2017). The cause of death is listed on the report as 'Failure to thrive.' Contributing conditions are 'Left hip fracture; urinary tract infections; dementia; hypertension; hyperlipidemia; osteoporosis.'"

The official death certificate shows the manner of death as "Accident" and the cause of death as "Failure to Thrive". It also shows "significant conditions contributing to death" as "left hip fracture; urinary tract infections; dementia; hypertension; hyperlipidemia; osteoporosis." The certificate further states, the injury occurred as the result of a fall and in a Nursing Home.

[redacted] medical records from Tallahassee Memorial Hospital (TMH) dated for Tuesday, August 27, 2019, at 10:11 PM shows that [redacted] was seen in the emergency room. The records show "*[patient]* brought via EMS from [redacted] Nursing staff does not know how *[patient]* was injured but noticed a bruise on her hip Sunday. An x-ray done, *[patient]* was sent to hospital for possible left hip fracture."

Another portion of the TMH records state, "Hip Injury-Pain The patient presents with hip injury, hip pain and Patient is a 98-year-old with history dementia who arrives from nursing facility after a bruise is noted on the left hip on Sunday. There was no reported fall or report of any injury but when asked the patient does admit that she has some pain in the left hip. Does not appear shortened." The final report states,

> *FINDINGS: There is a minimally displaced fracture with cortical step-off in the left femoral intertrochanteric region. Fracture predominantly involves the left greater trochanter with comminuted minimally displaced fractures along the cortical margins. Alignment of the femoral heads remains anatomic at the acetabulum. The bones are demineralized with degenerative change in the hips and pubic symphysis.*

BBH's records show [redacted] was admitted to hospice based on a diagnosis of Dementia, with secondary debility. [redacted] had secondary debilities of "History of subdermal *[subdural]* hematoma, August 30, 2017, frequent UTI's *[Urinary Tract Infections]*, Sepsis, and HTN *[Hypertension]*." On August 20, 2019, Dr. Nancy V. Chorba downgraded [redacted] FAST status from 7B to 7D. Stage 7 of FAST is defined as "Loss of speech, locomotion, and consciousness". 7B as "All intelligible vocabulary lost" and 7D as "Unable to sit up independently". FAST is the

Reisberg Functional Assessment Staging scale and is used to describe persons with AD (Alzheimer's Disease) and a prognosis of 6 months or less.

[redacted] only Incident Report documenting the incident, dated 8/27/2019, states "Samantha White ED was notified by Sherry *[Yates]* from Big Bend Hospice that resident's x-rays showed a fracture in greater trochanter left side, scratch and bruise on left breast, bruises on left shoulder, bruising and swelling on left knee. Hospice was notified by ED that resident was being transferred by EMS to TMH and her son [redacted] was also notified by ED, EMS arrived at _____ and transported resident to hospital."

The X-rays were completed on August 27, 2019, at 12:57 PM and were performed by Tech Care X-Ray, LLC. The radiology report states "Findings: Age-indeterminate fracture of the greater trochanter is present. Proximal and distal mild degenerative changes are present. No distal fractures appreciated. Overall, osseous mineralization is decreased. This could reflect osteopenia or osteoporosis, in the correct clinical context. IMPRESSION: Age indeterminate fracture of the greater trochanter. Correlate with mechanism of injury."

Natalie Melesia Johnson and Melissa Ann Mitchell are Certified Nursing Assistants (CNAs) for Big Bend Hospice and are assigned caregivers for [redacted] Both nurses provided separate sworn statements to your Affiant. Johnson had been responsible for the care of [redacted] for about two years. Mitchell was assigned to assist Johnson as [redacted] health continued to decline.

Debbie M. Cooper and Ida Loretta Colson are Certified Nursing Assistants (CNAs) for Big Bend Hospice. Both nurses provided separate sworn statements to your Affiant. Colson and Cooper were filling-in with the care of [redacted] They arrived on Monday August 26 to give [redacted] a bed-bath. They found [redacted] with a bruise on her left leg, left upper thigh, and upper left shoulder. [redacted] was clinching her left leg and crying out in a very long agonizing scream of pain. This was the first time either nurse had ever seen [redacted] react in such pain.

On Tuesday, August 27, Johnson and Mitchell went to give [redacted] her bed-bath. The nurses noticed immediately bruises on [redacted] left shoulder, left hip, and left leg near her knee. [redacted] would scream in pain about her leg and this was unusual for her. The nurses knew something was wrong. The nurses said whatever happened to [redacted] happened on Saturday August 24, or Sunday August 25, because they last saw [redacted] on Friday August 23 and there were no bruises or complaints of injuries. The nurses believed the injury could only have been sustained from a fall. However, [redacted] was bedridden and could not walk anymore.

Sherry Renee Yates is a Registered Nurse (RN) for Big Bend Hospice. Yates provided a sworn statement to your Affiant. Yates has seen [redacted] at least once per week for the entire length of her stay on Hospice. On Monday, August 26, 2019, Yates received a call from Debbie Cooper, to report multiple bruises found on the left side of [redacted] body and that every time they moved her left leg to reposition her, [redacted] would scream out in pain and grab her leg.

Yates noted 2 bruises to [redacted] left lateral leg, one on [redacted] left upper arm, and a smaller bruise on [redacted] left shoulder. Yates said she further found an abrasion on the lateral side of

[redacted] left breast. Yates found that every time [redacted] left leg was touched [redacted] had facial grimacing and would grab the leg.

Yates made contact with the Executive Director of the [redacted] Samantha White, to find out why [redacted] was not in pain on Friday afternoon (August 23, 2019) but Yates returned on Monday morning (August 26, 2019) to find the bruises and pain. White told Yates that she had looked for reports and/or documentation as to what happened to [redacted] but could not find anything. Yates said she told White she was concerned because something had happened to [redacted] and nobody at the [redacted] seemed to know how, why, or when.

Yates contacted Dr. Nancy Chorba, physician for BBH. Chorba ordered a mobile x-ray to scan [redacted] left leg and hip. The x-ray revealed that [redacted] had a fracture to her hip. After conferring with [redacted] family and Dr. Chorba it was decided that it would be for the benefit of [redacted] that she be sent to the Dozier House *[BBH's inpatient care facility]*.

According to Yates, the appearance of the bruises along with the broken hip could only have been caused by a fall. Yet, [redacted] could not walk. So, the fall could only have been the result of someone mishandling and dropping [redacted] Yates said due to [redacted] lack of proper reporting [redacted] was left in pain for several days until someone found her.

Laura Aleah Miller King, Licensed Practical Nurse (LPN) for [redacted] provided a sworn statement to your Affiant. King said she went into work on Sunday *[August 25, 2019]* around 2 PM. King saw [redacted] sitting in a recliner crying out in excruciating pain. King bypassed the time clock, went straight to the medicine cart, and began to give [redacted] morphine. [redacted] was then wheeled to [redacted] bedroom and put to bed.

King said from her understanding, the pain that [redacted] was in was caused by an incident from the previous night (Saturday) shift. King said Pam *[Pamela Lashell Grice]*, a long-time employee, was training a new person (King did not know her name but was later identified as Carrie Miller). Miller was told to transfer [redacted] from her chair to her bed. During the transfer Miller dropped [redacted] Miller was trying to move [redacted] by herself. Miller ran and got Pam. Both Pam and Miller picked [redacted] up and placed her into bed.

King documented finding [redacted] in a severe amount of pain. King believed that [redacted] was placed in unnecessary pain whenever she was sitting on her buttocks. King said [redacted] was regularly in pain but the level of pain that [redacted] was in that Sunday was extreme. King said when she saw [redacted] in that much pain, she did not initially suspect abuse. King believed it was due to the advancement of [redacted] disease process.

On December 18, 2019, Your Affiant conducted an interview with Carrie Jeanette Miller. Miller said the incident occurred during the second week of her training for the [redacted] was very elderly, and bedbound. Miller said she went to assist [redacted] out of bed and help get her ready for the day. Miller said she had transferred [redacted] from [redacted] bed to [redacted] wheelchair. Miller then proceeded to push the wheelchair but found the chair difficult to push. So, Miller said she gave the wheelchair a little extra force. Miller said this caused the wheelchair to bounce and [redacted] to fall to the floor.

Miller was unable to remember exactly which direction [redacted] fell. Miller re-enacted the incident and declared that [redacted] fell forward and to the right. Miller said while falling [redacted] stretched her arms out to brace herself for the fall. [redacted] landed on her arms and rolled over onto her side. Miller said the incident occurred so quickly it scared them both Miller and [redacted]

The wheelchair was difficult to push because a cord connecting the bed to the remote was stuck under the wheel. Miller said she attempted to just drive over the cord. Driving over the cord caused the wheelchair to bump, throwing [redacted] to the floor.

Miller said Pam *[Pamela Grice]* walked past [redacted] room, hearing [redacted] yell and cry out from the fall. Miller checked on [redacted] and [redacted] told Miller that she was not injured. Miller and Grice together placed [redacted] back into the wheelchair. Miller stated again that [redacted] had told her she was fine and had not been injured from the fall. So, Miller continued pushing [redacted] into the front lobby where [redacted] was left for the oncoming shift.

Miller said she examined [redacted] after the fall. Miller lifted [redacted] clothing, checking [redacted] completely. Miller did not locate any cuts or visible injuries. Miller said she apologized to [redacted] about the incident. Miller said [redacted] did not moan, cry, or complain of any pain.

Miller said she told Grice that [redacted] would need to "go out". Miller said "go out" means to be sent to the hospital for evaluation. Miller was asked if [redacted] was ever sent out and Miller said, "No, it did not happen." Samantha White asked Miller later if [redacted] had a fall. Miller told White, "Yes, [redacted] slid out of her chair while [Miller] was assisting [redacted] in going into the front lobby." White told Miller there was no report on the incident. Miller told White that Grice was supposed to have written it up.

Miller said when she returned to the [redacted] Miller wrote an incident report. Miller said after submitting the report, White had her go back and write another with more detail. Miller said she turned in both reports to the [redacted]

Miller said she and Grice were the only employees on duty for the [redacted] for that night's shift, 10 PM - 6 AM. Miller would get the residents up for the day around 5 AM - 5:30 AM. Miller believed the incident would have occurred sometime around 5 AM. Miller could not remember exactly what day the incident occurred on but believed it was a Thursday.

Miller said when she left that morning [redacted] was still in the wheelchair in the lobby. Miller said she assumed that [redacted] would be sent out on the next shift. Miller said she thought that Grice had informed the nurse *[unknown name]* that morning about the fall. Miller said it was protocol to inform the nurse. Miller said she assumed [redacted] would be sent out because whenever they inform the nurses of a fall, the nurses send the resident out for examination.

Miller said she assumed that Grice did not have [redacted] sent out, since [redacted] did not have torn skin or marks. Miller again said this was wrong, [redacted] should have been sent out as Miller was unable to tell if [redacted] had broken anything inside. Miller said if a fall occurs, even if no injuries are found, they are still to inform the family to see if they want the resident sent out. Miller said she did not know if Grice called [redacted] family. [redacted]

[redacted] Miller said she never spoke to anyone other than Grice about the incident that morning.

[redacted]

[redacted]

[redacted]

Time Sheet records from the [redacted] indicate that both Grice and Miller worked the overnight shifts together on Thursday August 22, Friday August 23, and Saturday August 24.

[redacted] (Veritas Incare LLC) post fall protocol issued 4/23/2019 and Revised 8/13/2019 states,

> *Upon the discovery of a fall, all direct care staff will adhere to the guidelines listed below.*
>
> - *If the resident is not experiencing pain/injury, provide transfer assistance if the resident is able to transfer.*
> - *If the resident is experiencing pain and/or showing signs or symptoms of pain,* ***DO NOT MOVE THE RESIDENT.***
>   - *Contact 911 upon discovery, then contact the RCD or designee, Shift Nurse, Executive Director (ED), and Responsible Party (in the order listed).*
> - *Take full set of the resident's vital signs (If within your scope of practice, otherwise another staff member will complete this procedure.)*
> - *Remain with the resident until Emergency Personnel arrive.*
>   - *Once Emergency Personnel arrives notify the resident's physician/healthcare provider via phone or fax.*
>   - *Complete Incident Report update the RCD or designee, Shift Nurse, resident's physician/healthcare provider, and responsible party.*
>   - *Document incident in resident's chart.*
>   - *Place resident on Post Fall Monitoring for three (3) full days.*

Your Affiant, who being duly sworn, deposes and says that he has reason to believe and does believe that probable cause exists, on or between August 24, 2019 and August 26, 2019, Pamela Lashell Grice, committed:

One (1) Felony count of Neglect of an Elderly or Disabled Adult: § 825.102(3)(c). Florida Statute, a third-degree felony, by failing to provide [redacted] an elderly person or disabled adult with the care, supervision, and services necessary to maintain her physical and mental health, by not providing her with adequate medical services that a prudent person would consider essential for [redacted] well-being.

Wherefore, Your Affiant requests that an Arrest Warrant be issued commanding the Sheriffs of the State of Florida, all or singular, their deputies, the Commissioner of the Florida Department of Law Enforcement, any of his constituted agents, the Attorney General's Medicaid Fraud Control Unit and its duly appointed Law Enforcement Investigators and all Florida Police Officers, with the proper and necessary assistance, to arrest, Pamela Lashell Grice.

Jerrod Rigdon, Affiant
Law Enforcement Investigator
Office of the Attorney General
Medicaid Fraud Control Unit

SWORN TO AND SUBSCRIBED BEFORE ME THIS 20th OF JANUARY 2021.

Notary Public
My Commission Expires:

HOWARD MARK ORMEROD
Commission # HH 004893
Expires June 28, 2024
Bonded Thru Troy Fain Insurance 800-385-701