CONTACT	STATE	SETTING OF DRUG ADMINISTRATION	CLAIMS MADE BY CONTACT
A.R. (spouse of victim)	Arizona	Nursing Facility	Victim suffers from ALS and dementia. Victim's spouse acts as victim's POA. Victim given **Lorazepam** and **Depakote**, without notice or consent of patient or his POA. Research shows that state regulators were present at facility the day an alleged instance of physical abuse occurred.
C.H. (niece of victim)	California	Nursing Facility	Contact alleges that victim died from overdose of **Haldol**, administered to her during stay in a nursing facility.
M.C. (relationship to victim not disclosed).	California	Nursing Facility	Victim admitted for rehabilitation care after suffering fall. Victim explicitly told facility that she did not want to be given anti-psychosis drugs. However, after victim allegedly assaults four staff members, facility forcibly injects victim with **Haldol**. Victim subsequently lapses into PVS coma.
D.T. (daughter of client)	Connecticut	Hospital	Victim suffers fall, and is brought to Bridgeport Hospital; there, she is put on **Seroquel** and **Lorazepam** for anxiety, and **Abilify**. Contact is not notified that victim is placed on these medications until victim is discharged from hospital. Prior to hospitalization, victim suffered from dementia, but was in stable health and not on any medication. Victim remains at Bridgeport Hospital for two weeks, during which time contact alleges that victim is over-medicated and neglected. Victim is discharged from hospital to nursing facility for rehabilitation, but contact and family are not notified in advance. Contact reports that throughout victim's hospitalization, she and victim's family received no communication on treatment and care-planning of victim.
D.B. (brother of victim)	Florida	Nursing Facility	Administration of anti-psychotic medication to victim contributed to his death. Additional information forthcoming.

D.H.E. (daughter of victim)	Georgia	Nursing Facility	Victim underwent hip surgery, and underwent rehabilitation in a nursing facility afterwards. During a five-month stay, victim was allegedly given 15 different anti-psychotic drugs. Contact states that these medications disoriented and confused victim, and led to her suffering insomnia and immobility. Contact had victim taken off anti-psychotic medication, and her health and dexterity improved. Contact notes that victim received care in a facility operated by Omnicare, and questions whether a class action lawsuit might be filed against the facility.
H.H. (daughter of victim)	Hawaii	Nursing Facility	Victim is currently on five anti-psychosis medications (**Risperdal** and four others (n/p)), which contact alleges makes him "combative." Nursing facility allegedly prevents victim from seeing an outside geriatric psychiatrist, and has physically abused victim on several occasions. Contact reports having video evidence of physical abuse; and, upon showing said evidence to the facility, staff banned her and other family members from entering victim's room. Victim has reported nursing facility to state APS and Ombudsman. After showing video to ombudsman, ombudsman declined to pursue matter. Victim's 85-year-old spouse has his POA, and contact is secondary POA.
B.M. (daughter of victims—victims are mother and father of contact)	Idaho	Nursing Facility	Victims given anti-psychosis medication—including **Haldol**—for treatment of anxiety and depression. Victims sleep most of day as a result, and father-victim loses ability to speak. Contact requests medication change to alleviate side-effects, but is told that the medication is not cause.
D.T. (daughter of victim)	Illinois	Nursing Facility	After being diagnosed with Alzheimer's dementia, victim was placed in nursing facility. Prior to entering the facility, victim did not take any medications. However, upon admission, facility began administering medications (including **Haldol**) to victim without contact's consent (whether contact had POA is not disclosed). Contact believes that victim was medicated because victim was active, and facility staff wanted to "calm him down." Contact states that medication reduced victim's mobility, and resulted in bedsores.

J.A. (son of victim)	Kentucky	Nursing Facility	While residing in nursing facility, victim is given anti-psychosis medications. Nursing facility did not disclose administration of this medication, and now refuses to disclose names of these drugs to family. Contact believes victim was over-medicated without consent. Victim suffered from dementia-related behavioral problems—wandering, confusion, difficulty with speech. While residing in nursing facility, victim's daughter visited her and discovered she had—unbeknownst to facility staff—suffered a stroke. At hospital, victim was also observed to have bedsores.
B.E. (daughter of victim)	Louisiana	Nursing Facility	Victim entered facility not on any prescription medications. However, shortly after entering facility, she was put on **Risperdal** and other anti-psychotic medications. Contact has POA over victim, but was not informed of administration of these drugs, and did not consent to administration of these drugs. Victim subsequently discharged from facility, and is no longer taking these medications. Contact states that victim's health has improved, but her mental/cognitive state is impaired as a result of past administration of these medications.
L.M. (daughter of victim)	Louisiana	Nursing Facility	Administration of anti-psychotic medication to victim contributed to his death. Additional information forthcoming.
D.D.A. (daughter of victim)	Massachusetts	Nursing Facility	Prior to admission to nursing facility, victim prescribed **Lorazepam** for short-term treatment of dementia. While taking lorazepam, however, victim continues to drink alcohol, and suffers falls and disorientation. Contact attributes these side effects to the alcohol-drug combination, and believes victim's physician wrongly prescribed the drug to victim. After verbally threatening his wife, victim is admitted to a psychiatric ward, and then discharged to nursing facility. There, victim is prescribed **Risperdal**. At facility, victim has suffered physical abuse by other residents and staff, negligent treatment (non-treatment of scabies for over one month; non-treatment of severe blood clots). Contact filed a complaint with the state against the facility;

			and, in retaliation, the facility barred her from visiting. Contact subsequently obtained a preliminary injunction to visit. Contact alleges that facility routinely overmedicates disruptive residents, and fails to hydrate and feed residents.
G.H.R. (spouse of victim)	Massachusetts	Nursing Facility	Victim allegedly receives unnecessary **electroconvulsive therapy (ECT)**. Victim's niece acts as victim's HCP, and did not participate in correspondence.
D.B. (daughter of victim)	Michigan	Hospital	Victim lived as resident in nursing home, maintaining an active life with stable physical and mental health. After exhibiting combative behavior, victim transferred hospital, for treatment and testing as to the cause of her behavior. There, victim allegedly misdiagnosed as suffering from dementia, and administered **Risperdal** 2mg twice daily for treatment. Victim's physical and mental health declines precipitously as a result of this medication, as she experiences hallucinations, and loses the ability to dress, eat, and walk independently. Although contact and her sister share PoA for victim, neither is contacted to authorize Risperdal, and victim was unable to consent. Several days into her stay at hospital, victim has further testing performed, which reveals a bladder infection. Contact believes the bladder infection caused victim's prior behavioral changes. Victim subsequently administered antibiotics for treatment, and—upon contact's request—given a much lower dosage of Risperdal (1mg once daily). Victim discharged back to nursing home. There, however, victim regularly administered Risperdal at the initial high dosage she had previously been prescribed (2mg twice daily). Contact alleges that this increase in victim's Risperdal dosage was the result of an administrative error by hospital, which contact believes sent a discharge plan to nursing home that incorrectly listed the original dosage amount. Victim's physical and mental health again profoundly decline while receiving the higher dosage. A month after Victim's discharge from hospital, contact discovers the administrative error by hospital, and had victim's Risperdal dosage reduced accordingly. But, by that time, it was too late, and victim died of congestive

			heart failure shortly after.
I.R. (daughter of victim)	New Jersey	Nursing Facility	Victim, suffering from Alzheimer's dementia, is admitted to nursing home for care. There, she is given anti-psychosis medication to prevent wandering. Contact alleges that the facility would "drug [victim] because they did not want to deal with anyone who was mobile," and that the facility would typically leave victim in-bed all day. In one incident, victim left the nursing home, and wandered outside on a winter night. Victim also suffered numerous falls, which contact attributes to lack of facility supervision. After one fall, nursing facility transferred victim to a mental institution; but, victim returned to facility weeks later, after finding that she was not mentally ill. Contact eventually obtained POA over victim, and had her transferred to a different nursing facility, where she is now happy. During this series of incidents, however, contact states she was under "so much stress that [she] had a mini stroke and had [a] speech impairment for 6 months."
S.A.B. (daughter of victim)	New York	Nursing Facility	Victim hospitalized after suffering fall, and is subsequently discharged to nursing facility for rehabilitation. At time of nursing facility admission, victim uses a walker, but is otherwise mobile and independent—cognizant and only taking cholesterol medication. However, while at facility, victim is diagnosed with dementia and remains there. Contact later receives call from victim's psychiatrist, notifying contact that victim is being administered **Haldol**, and asking why. Contact follows up with nursing facility, which explains victim was being prescribed Haldol, and that contact had consented to administration of this medication. Contact alleges she never did consent. Victim subsequently suffers multiple strokes, and loses ability to walk or eat independently, which contact attributes to reaction to Haldol. Contact alleges that nursing facility provides inadequate supervision, as it has 44 rooms and only 3 CNAs.

J.M.H. (daughter of victim)	Ohio	Nursing Facility	Victim suffers from dementia. Upon admission to nursing facility, victim administered **Risperdal** without his or his spouse's consent (unclear whether spouse has POA). Contact states that victim has suffered an adverse reaction to this medication, as it has made him "little more than a vegetable."
L.S. (mother of victim)	Oklahoma	Group Home	Victim is adult child of contact, suffering from Down Syndrome and living in a group home. Contact alleges that the group home director took victim to a psychiatrist who put her on anti-psychotic medication, which turned her into a "zombie." Contact subsequently transferred victim to another facility and has taken her off the anti-psychotic medication.
S.M. (daughter of victim)	Pennsylvania	Nursing Facility	Victim suffered from mild dementia and, after suffering a stroke, resided in a nursing facility. While in residence at the facility, victim suffered numerous incidents of neglect by staff. Contact alleges that had she not been present during incidences of neglect, victim would have died; and, attributes victim's death in facility to staff-neglect. Contact states that the problem of patient neglect in nursing facilities is widespread and deserves greater attention.
D.H. (daughter of victim)	Tennessee	ALF (dementia care wing)	Victim maintained active lifestyle, walking daily, and maintaining ADLs despite also suffering from Alzheimer's dementia. Contact does not fully describe care provided to victim in ALF, but laments that the CNAs caring for her were untrained.
D.M. (son of victim)	Information forthcoming.	Information forthcoming.	Administration of anti-psychotic medication to victim contributed to her death. Additional information forthcoming.
E.H. (spouse of victim)	Not provided.	Nursing Facility	Victim given medication while in nursing facility for rehabilitation. Victim did not have opportunity to approve/consent to medication list, and facility administrator refused to show victim the list of medications given to her.

K.M. (son of victim)	Not provided.	Nursing Facility	Victim admitted to nursing facility for rehabilitation after breaking his pelvis. There, contact signed sheet authorizing the facility to give victim different drugs. Contact laments having signed this sheet, and believes the medication did not help victim. Contact remarks, "what about … children trying to take care of the elderly like my sister and I have been doing, yet making decisions that were probably not in their parents best interest unknowingly[?]" Contact is uncertain whether victim was given anti-psychotic medication, but expresses dissatisfaction at how victim was generally treated in the facility.
P.D. (spouse of victim)	Not provided.	Nursing Facility	Victim suffered from dementia, and received care, on-and-off, in various nursing facilities. During several of these stays, victim was administered anti-psychotic medications that caused such side effects as tremors, speech problems, and insomnia. Contact alleges that other patients in these facilities were physically restrained by staff.
K.S. (relationship to victim not provided)	Not provided.	Hospital	Administration of anti-psychotic medication to victim contributed to his death. Additional information forthcoming.