

Chair

TO OIG  
5/14

As a private veterans' advocate, I have dealt with dozens of veterans experiencing the same problems in the Battle Creek/Grand Rapids Michigan facilities as reported in Phoenix. In fact, months ago, our Congressman Huizenga became involved. Even he told Battle Creek V.A. they are not responding to his congressional requests. We are experiencing deaths, many misdiagnoses, staff shortages and robo calls/cards to present for appointments where there is no doctor for the veteran to see. If the veteran does not appear in person for the appointment, even knowing he will not be seen, he is told he will be dropped from the system. Over a year ago, our area lost several primary care providers -- as of a month ago, there was still a shortage of PCPs. I found a computer glitch that keeps reassigning over and over and over the same vets to non-serving doctors, yet VA refuses to recognize the problem. I ask that you have someone in the V.A. upper levels contact me to discuss this. I believe you will then see this scheduling problem is much greater than it appears even now. Veterans at the Grand Rapids Home for Veterans have an added layer of trouble. While it is a State run Home, it receives federal funding. Veterans must get a referral from a Home doctor, who refuses to grant referrals, before they can be seen by an outside PCP or at the VOC across the street. We are questioning high death rates, major life threatening misdiagnoses, inadequate care and much more. Many veterans in this area and I truly encourage the new V.A. leader to investigate what is happening here. I will gladly present details if it will help our veterans. Like a veteran having a widow maker heart attack, told it was stomach related and sent home. A veteran with such a severe radiation burn received at a V.A. facility it goes from his ear to his shoulder -- it will never heal and cancer has spread through his body. A veteran told he had strep throat who actually had throat cancer. A veteran with a misdiagnosed bowel blockage that burst and sent him into a coma. Four Namvets this month who were told to let baseball size growths grow before they will be treated. A veteran misdiagnosed at the GRH4V, was denied a referral to the VOC or outsider, admitted days later to ICU. A 59 year old Namvet dead a week after being misdiagnosed recently. A Purple Heart waiting over a year for treatment of a war injury. A veteran with a protruding broken collarbone still not operated on or set FOUR years later. Too many more to list. Our veterans deserved so much better. We MUST fix this NOW.

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6/14

The main effect is lack of timely care, vets are made to feel like second class citizens or prisoners, they believe some of these practices contribute to the higher death rate, money is being spent but services are not being given to patients.

I recently filed a similar complaint re the V.A. Outpatient Clinics being understaffed, dying veterans having needed appointments cancelled without notice after waiting for weeks, much needed medications canceled without notice, veterans going months without being able to get appointments, computer problems assigned vets to doctors who left then telling vets they must present at VOC or be dropped even though no one can see them, long waits at the Clinic, deadly misdiagnoses and more.

We have been experiencing problems with the V.A. medical system in Grand Rapids and Battle Creek for almost two years. I have been documenting example for months. The stories are horrific. Even our Congressman Huizenga, who has tried to help us, told V.A. at a public meeting two weeks ago, V.A. is not responding to even his requests -- from a congressman. He stated if he can't get answers or help, how is a veteran to get it???? Two weeks ago, I was approached by a group of about three dozen veterans from the G.R. Home for Vets telling me how bad things are there and they need HELP NOW. My attempt to work with the State ended up in an attempt to intimidate me and a refusal to allow legislators, who wanted to help our vets, look into this. They did not want the veterans heard and wanted to keep things "in-house." Not happening. These vets need and deserve help. We need the G.R.V.O.C. investigated as well as the GRH4Vets since they both receive federal funding and veterans are not getting enough or timely care.

PLEASE INCLUDE GRAND RAPIDS, MI; BATTLE CREEK, MI; DETROIT and ANN ARBOR V.A. FACILITIES AND THE G.R. HOME FOR VETERANS IN THE ONGOING INVESTIGATION THAT BEGAN WITH PHOENIX -- PLEASE! WE ARE HAVING IDENTICAL PROBLEMS AND NEEDLESS DEATHS AND DELAYS IN CARE. PLEASE, PLEASE, PLEASE HELP US.

**RE: 53E/71/2014-16192**

Since the original complaint was filed with OIG, much more has been uncovered and I have personally experienced that I need to add to that complaint or start as a new one. I have also filed a complaint with the State of Michigan LARA about Dr. Bates (herewith). Over 100 veterans or family members have contacted me for help since that initial report. I am personally seeing needless delays, pain, suffering and complications up to death and/or permanent injury of veterans. Also, this is placing added expense to the medical system, taxpayers and veterans, too many needlessly forced into bankruptcy or poor credit ratings for bills the VA and Home should have covered. Battle Creek VA has been working with me since May on these issues. However, we need to do more. This work only reaches a handful of veterans – who is helping the hundreds of other vets out there? My complaints fall into into three categories:

**ALLEGATIONS**

**FAILURE OF V.A., GOVERNOR SNYDER, HIS APPOINTEES AND HIS ADMINISTRATION TO PROTECT AND SERVE OUR VETERANS WHILE RESPECTING VETERAN AND CIVILIAN RIGHTS IN A TIMELY, RESPECTFUL MANNER – ESPECIALLY THOSE AT THE GRAND RAPIDS HOME FOR VETERANS AND WEST MICHIGAN VETERANS**

- FAILURE OF V.A., GOVERNOR SNYDER, HIS APPOINTEES AND HIS ADMINISTRATION TO PROTECT AND SERVE OUR VETERANS
- VIOLATIONS OF VETERAN AND CIVILIAN RIGHTS AND LAW, INCLUDING CONSTITUTIONAL, ADA, HITECH ACT AND HIPAA, AMONGST OTHERS.
- A DOCUMENTED UNWILLINGNESS OF GOVERNOR SNYDER TO DISCUSS VETERAN ISSUES AND PERFORMANCE OF HIS OWN TEAM WITH WEST MICHIGAN ADVOCATES REPRESENTING HOME VETERANS OR MEET WITH THE VETERANS THEMSELVES
- AS A RESULT, MICHIGAN RANKS AT THE BOTTOM IN NATIONAL POLLS FOR VETERAN CARE

**ALLEGATIONS SPECIFIC TO GRAND RAPIDS MI HOME FOR VETERANS RESIDENTS**

- ENDANGERMENT OF RESIDENTS, PREMATURE DEATHS AND MISDIAGNOSES.
- FAILURE TO HOLD DOCTORS ACCOUNTABLE FOR FREQUENT MISDIAGNOSES & DELAYED CARE.
- FAILURE TO PROTECT.
- SUPPRESSION OF RIGHTS AND FREEDOMS .
- DENIAL OF RESIDENTS' CIVIL AND RIGHTS TO ASSEMBLY, FREE SPEECH AND REPRESENTATION.
- VIOLATIONS OF AMERICANS WITH DISABILITIES ACT.
- REPEATED HITECH ACT AND HIPAA VIOLATIONS.
- TAMPERING WITH U.S. MAIL.
- DESTRUCTION AND/OR FAILURE TO DELIVER VOTING MATERIALS TO RESIDENTS PER LAW.
- IMPRISONMENT WITHOUT FAIR REPRESENTATION.
- GROSS ABUSE OF OFFICE.
- FAILURE TO PERFORM JOB REQUIREMENTS.
- FAILURE TO CORRECT ISSUES.
- FAILURE TO MAINTAIN & DESTRUCTION OF TAXPAYER, FEDERAL & STATE PROPERTIES.
- MISAPPROPRIATION AND MISUSE OF FEDERAL AND STATE FUNDING.
- FAILURE TO CURB ONGOING THEFT OF RESIDENTS' PROPERTY/BELONGINGS.

- FAILURE TO MAINTAIN NECESSARY, SUFFICIENT STAFFING LEVELS.
- FAILURE TO ASCERTAIN CONTRACT WORKERS, SPECIFICALLY J2S, ARE PROPERLY VETTED, TRAINED & SUPERVISED.
- USING TAXPAYER FUNDS TO HOLD EVENTS FOR CONTRACT WORKERS WHO ARE PAID BY J2S AND THAT SHOULD BE THE CONTRACTORS' JOB.
- MULTIPLE ISSUES OVER SMOKING AREAS AND PUNISHMENTS.
- OVER-MEDICATION OF RESIDENTS.
- FAILURE AND UNWILLINGNESS TO WORK WITH VARIOUS VETERAN ADVOCATES AND RESIDENTS.
- FAILURE TO PROVIDE AN IMPARTIAL MEDIATOR/ADVOCATE WHO IS AVAILABLE TO AND RESPONSIVE TO GRH4V RESIDENTS DESPITE MANY REQUESTS BY RESIDENTS TO DO SO.
- CRIMINAL ACTIVITIES AND/OR CONSPIRACY INCLUDING THE ABOVE BUT ALSO:
  - ONGOING ISSUES OF THEFT OF PERSONAL PROPERTY AND MONEY.
  - MILLIONS OF DOLLARS ARE SPENT BY VA ON PSYCHOLOGICAL CARE, BUT VERY FEW RESIDENTS AT THE HOME EVEN KNOW THE NAME OF A DOCTOR AVAILABLE FOR TREATMENT AT HOME OR OPTIONS AVAILABLE TO THEM. THERE ARE REPORTEDLY NO ONGOING RAP GROUP OR GROUP COUNSELING SESSIONS HAPPENING AT THE HOME, NO TRANSITIONING PROGRAMS – VETS ASK WHERE IS THAT MONEY GOING, IT IS NOT BEING USED TO HELP THEM – IT IS OUR UNDERSTANDING THE FEDS ARE FILTERING MONEY INTO THE COMMUNITY FOR THAT PURPOSE – WHERE IS IT? NOT ENOUGH IS REACHING VETERANS AT THE HOME.
  - COURT APPOINTED GUARDIANSHIP ISSUES, OVERCHARGES WITH LACK OF OVERSIGHT.
  - LACK OF AUDIT OF COURT APPOINTED GUARDIAN PRACTICES AND RECORDS, THE BOSS OF ONE GUARDIAN WHO CHARGES THE MOST ADMITTED TO ME THEY ARE FRIENDS AND SHE HAS NOT BEEN AUDITED IN AT LEAST TWO OR THREE YEARS.
  - GUARDIANSHIP SYSTEM FAILURE TO HONOR FOIA REQUEST FOR COPY OF GUIDELINES PREPARED & USED BY JUDGE AND HIS PEERS OVERSEEING VETERANS' GUARDIANSHIPS AND CASES. THIS INVOLVES VA INCOME AND CARE. IT SEEMS IF SELF-MADE GUIDELINES ARE BEING USED TO MAKE DECISIONS IMPACTING VETERANS AND THEIR MONEY, EVERY VETERAN UNDER GUARDIANSHIP SHOULD HAVE COPIES, AS SHOULD ADVOCATES OR THOSE REQUESTING THEM. ARE THOSE GUIDELINES EVEN LEGAL?
  - ADMIN., JUDGES, GUARDIANS, CONTRACTORS, SUCH AS J2S, ARE CLOSELY CONNECTED, CREATING AT THE LEAST A QUESTIONABLE APPEARANCE OF CONSPIRACY
  - VETERANS AND FAMILY MEMBERS HAVE REPORTED FINDING THEIR LINES ARE TAPPED. (THEY CLAIM THEY USED A PROGRAM THAT DETECTED THIS ACTIVITY) – WHO IS DOING THAT?
  - MISUSE OF FUNDS - WHERE DID ALL THE LINE ITEM ACCOUNT MONIES GO?
  - INTIMIDATION OF “WHISTLEBLOWERS” SUCH AS MYSELF.
  - PHYSICAL AND MENTAL ABUSE OF RESIDENTS
  - CONSPIRACY BETWEEN HOME, STATE OFFICIALS AND VA TO DENY VETERANS NEEDED CARE, ESPECIALLY TO PROVIDERS OUTSIDE THE SYSTEM OR SECOND OPINIONS, THE CASE OF LARRY KRUL IS AN EXAMPLE.

**ALLEGATIONS MORE SPECIFIC TO WEST MICHIGAN VETERANS AGAINST V.A. GRAND RAPIDS, BATTLE CREEK, DETROIT FACILITIES (THESE COULD ALSO APPLY TO GRH4V WHO GET TREATMENTS AT VA FACILITIES)**

- CONSISTENTLY INSUFFICIENT STAFFING LEVELS.

- WITHOUT A PRIMARY CARE PROVIDER, IT IS EXTREMELY TIME CONSUMING AND DIFFICULT, IF EVEN POSSIBLE, FOR A VETERAN OR CAREGIVER TO GET A PRESCRIPTION, APPOINTMENT, SEE A SPECIALIST, ETC.
- EXTREMELY LONG DELAYS IN GETTING PROPER, TIMELY CARE. WE ARE NOT TALKING DAYS, WE ARE TALKING MANY MONTHS FOR EVEN A PURPLE HEART WITH SERVICE CONNECTED INJURIES REQUIRING ATTENTION.
- FORCING ILL AND DYING VETERANS TO TRAVEL LONG, ROUGH DISTANCES EVEN THOUGH THE SAME SERVICES ARE AVAILABLE LOCALLY.
- AVOIDABLE VA REQUIRED TRAVEL IS EXASPERATING MEDICAL AND MENTAL CONDITIONS – USING AS AN EXAMPLE A VETERAN WITH BROKEN BONES, LUNG AND PROSTATE ISSUES TOLD TO TRAVEL THREE DAYS BY BUS TO GET FROM KENT COUNTY TO BATTLE CREEK TO DETROIT – THAT IS LESS THAN A 2-1/2 HOUR DRIVE ONE WAY. THIS HAPPENS FAR TOO OFTEN, DAILY.
- VETERANS FORCED TO USE BUSES WITH SEATS THAT ARE TOO SMALL AND TOO ROUGH INCREASING PAIN AND DEPENDANCE ON PAIN MEDS – THIS IS A MAJOR ISSUE ISSUE FOR VETERANS WHO HAVE HAD SURGERY, CANCER, ETC.
- A COMPUTER PROGRAM “GLITCH” THAT I UNCOVERED LEFT, BASED ON V.A. PROVIDED NUMBERS, A MINIMUM OF 3300 TO 6600 LOCAL VETERANS WITHOUT A PRIMARY CARE DOCTOR, SOME FOR OVER A YEAR.
- THAT HAPPENED BECAUSE VETERANS WERE FORCED TO PRESENT AT THE CLINIC – EVEN WHEN TOLD THEY WOULD NOT BE SEEN BY A DOCTOR – SYSTEM READ THAT WRONG, THAT VETS WERE BEING SEEN WHEN THEY WERE NOT.
- INTIMIDATION – VETS WERE TOLD BY VA STAFF IF THEY DID NOT SHOW FOR AN APPOINTMENT, EVEN KNOWING THEY WOULD NOT BE SEEN, THEY WOULD BE DROPPED FROM THE SYSTEM.
- VETERANS ARE FORCED TO WAIT FOR HOURS, OFTEN DAYS TO GET HELP FROM THE GR CBOC FOR A CRISIS. EVEN THIS PAST WEEK, AFTER REPEATEDLY WORKING WITH BATTLE CREEK ON THIS ISSUE, ONE VETERAN WAITED SEVEN HOURS TO GET A REFILL.
- VETERANS MENTAL AND PHYSICAL HEALTH IS ASSAULTED BY THESE PROBLEMS. LAST WEEK, TWO DAYS AFTER TO BEING FORCED TO WAIT FOR SEVEN HOURS WITH A ONE YEAR OLD BABY TO GET THAT REFILL THAT HIS WIFE CLAIMS HE WAS TOLD WOULD BE MAILED EVEN THOUGH HE WAS OUT, THAT VET WITH A TBI FROM AN IED DISAPPEARED FOR TWO DAYS WITH A GUN INTO THE WOODS, NOT ONLY DEPRESSED BUT ALARMING ALL INVOLVED. YES, VA DID OFFER ASSISTANCE DURING THE TIME THE VET WAS MISSING, BUT HOW DID IT ESCALATE TO THE POINT A VET WITHOUT MEDS HAD TO WAIT SEVEN HOURS FOR HELP?
- MANY MISDIAGNOSES, TOO MANY ARE SERIOUS AND/OR LIFE THREATENING: SEVERAL WERE TOLD THEY HAD STREP THROAT, ONLY TO LEARN IT WAS CANCER THAT HAD ADVANCED BY THE TIME A CORRECT DIAGNOSIS WAS MADE. WIDOW MAKERS WERE PASSED OFF AS INDIGESTION. BLOCKAGES THAT WERE VIEWED AS MINOR. SEVERAL WERE TOLD THEY ARE BI-POLAR INSTEAD OF PTSD, CUTTING OFF HELP AND BENEFITS FOR VETS WHO TRULY NEEDED BOTH. ONE VET FELL AND HAD HORRID PAIN FOR MONTHS BEFORE AN OUTSIDE DR. FOUND A NAIL LOGGED IN HIS BODY WHERE HE FELL. JUST TOO MANY TO LIST HERE.
- MULTIPLE REPORTS OF VETERANS IN CRISES SEEKING HELP AT LOCAL EMERGENCY ROOMS AND HOSPITALS BEING ADVISED THEY ACTUALLY HAD CANCER, WIDOW MAKERS, BOWEL BLOCKAGES REQUIRING IMMEDIATE TREATMENT AND MORE THAT VA FAILED TO PROPERLY ID AND TREAT
- TOO MANY TOO LONG DELAYS IN CARE AND TREATMENT
- CANCERS AND CONDITIONS WORSENING, SOME TO THE UNTREATABLE STAGE, DUE TO VA PRACTICES. EXAMPLE, ONE VETERAN HAS A BROKEN COLLARBONE/SHOULDER AREA FOR FOUR YEARS – VA LET THAT GO FOR FOUR YEARS!!! HE NOW HAS CANCER, PROSTRATE ISSUES, LUNGS ISSUES, ETC. THAT HAVE WORSENERED TO THE POINT HE IS NO LONGER A CANDIDATE FOR SURGERY FOR THE BONES. HE LIVES IN CONSTANT PAIN, YET VA LETS HIS MEDS RUN OUT.
- IN THE MEANTIME, GRVOC DOCTORS ARE MAKING SURE THE MEN HAVE A GOOD SUPPLY OF VIAGRA. AS ONE TOLD ME, HE DOES NOT WANT THEM, BUT VA PUSHES THEM, SO HE SELLS THEM ON THE STREET FOR

\$100 A BOTTLE. SO ONE VET CANNOT GET MEDS FOR SERIOUS INJURIES BUT VA MAKES SURE THE OTHER GUYS HAVE MORE THAN ENOUGH VIAGRA. VETS ALSO QUESTION IF DOCTORS ARE GETTING KICKBACKS FOR PRESCRIBING CERTAIN MEDS LIKE THAT ONE.

- PRESCRIPTION ORDERS BEING CANCELED, DELAYED BY VA WITHOUT PATIENT KNOWLEDGE.
- APPOINTMENTS CANCELLED BY VA WITHOUT NOTICE TO VETERAN OR CAREGIVER.
- VETERAN WAITS WEEKS TO MONTHS FOR AN APPOINTMENT, IF LATE EVEN FIVE MINUTES DUE TO TRAFFIC OR CONSTRUCTION, S/HE IS MARKED AS A NO SHOW AND NOT ALLOWED TO SEE DOCTOR.
- VA REFUSING TO PREAPPROVE SURGERIES OR PROCEDURES OR DENYING THEM AFTER APPROVING THEM, FORCING VETERANS TO PAY. THIS IS EVEN HAPPENING WITH 100 PERCENT SERVICE CONNECTED VETS.
- MUCH CONFUSION AMONG VETS ABOUT HOW GETTING EMERGENCY CARE SHOULD HAPPEN AND HOW IT IS BILLED. SAME FOR SURGERIES AND MEDICAL PROCEDURES.

## BACKGROUND SUMMARY

I cannot cover all the details right now. Please let me know if more is needed. Veterans have stated repeatedly that they fear for their safety and that of their peers. That is one of the most common concerns I hear from them on a regular basis. As a result, many are facing needless, avoidable health crises. They told me they fear for their health since they are routinely denied second opinions or even treatment at the VA Clinic next door. They fear retaliation, like the one who complained about his doctor was then told he was not allowed to go on a recent outing.

In short, I have for decades advocated for a number of veterans and patients in the public sector. The situation in West Michigan is the worse I have seen in decades. We need OIG to come in and truthfully address issues here. Please believe me, I know what I am talking about. Since the 1960's, I have been a veterans' advocate on a totally volunteer basis, never being paid. In the late 70's and early 80's, I became an associate member after we formed Vietnam Veterans of America and local Chapter 35. A national VVA board member appointed me Co-Chair of the first VVA PTSD Awareness Committee in the country. In the days before computers, my team traveled across the country and talked by phone to psychologists, psychiatrists, V.A. and others to get info on PTSD. At that time, it was thought to impact only veterans and very little was available to the public. So, my team and I wrote literature and launched a PTSD Awareness Program which took the term from the medical world to mainstream. In fact, some of that literature is unwittingly still in use by the V.A. without any credit to or recognition of our work. I then partnered with American Red Cross to develop a PTSD awareness program for victims of natural disasters, rape, fire, accidents, etc. that went national. As that awareness went mainstream, I remained very active in veteran issues, legislation and care. I am often contacted for referrals and information.

Long story short, in 2012, I began hearing of serious, escalating problems at the Grand Rapids Home for Veterans, for veterans in general across West Michigan and with V.A. There was a disconnect, which remains to this moment, between how V.A. perceives itself and how too many veterans perceive their care. In fact, I was told one veteran around Thanksgiving committed suicide after many requests for help from the V.A. Yet around that time, VA prided itself on doing an excellent job. In early 2013, I started hearing it was so bad Purple Heart Veterans could not get appointments for service injuries for MONTHS. Ironically, it was Purple Heart POW decades ago who first asked for my help. Then, I started getting calls from Service Organizations that veterans needed help getting a primary care doctor, appoints, prescriptions, referrals, etc. It boggles my mind how bad the situation was and remains.

We worked closely with Congressman Huizenga. But even he and his staff complained they were not getting timely answers from the V.A. So, a Town Hall type meeting was held this past May at the Grand Rapids Outpatient Clinic. Everything escalated from that day forward. It simply cannot continue any more. At that meeting were the Regional Director, Mary Beth Skupien, her staff members, the Congressman, veterans of all eras, male and female, spouses, caregivers and advocates. Mary Beth angered the crowd with her constant statement "I have only been on the job for 18 months, work with me." I recall the politest of the vets present told her if she worked in the real world, she would have had three months to prove herself or been fired. Others asked her to step down. I was one of those people after personal experiences with a veteran who lives with my sister. He is dying of cancer that was not diagnosed in time. He suffered MASSIVE radiation burns due to VA negligence that will never heal, VA took his jaw and his story is horrific. Yet, when he ran into troubles, the head nurse refused to help and that was my last straw.

When the media showed up, VA people tried to shut the meeting down. Vets WANTED to meet as a group. They needed to hear for themselves that their brothers and sisters were experiencing the same problems – that it was not just them, that it was not in their head. But Damian McGee kept trying to shut the meeting down. He repeatedly told the group if even one of them wanted the media out, media was gone. I think he asked six times before he finally comprehended the vets were there as group and they were not leaving, nor was the media. In response to that, Mary Beth made the mistake of telling rather than hold future group meetings, she preferred they have individual meetings. Well, that was perceived by the vets as an attempt to keep them separated and from talking with each other. They did not like that idea and that only distanced her more. They each told their stories and concerns at the meeting and then the congressman stayed to be sure each veteran was heard. The stories were horrific and sickening. Near fatal misdiagnoses one after another. Delays of months to have lumps that proved to be cancers checked, some too late for treatment. No primary care doctor. Trouble getting appointments. Trouble getting referral to specialists – even after waiting months to be seen by a "floater" doctor. It was bad.

Mary Beth called me into a private meeting moments before that Town Hall. She asked me to work with her. So, we have been working together almost daily since that meeting in May. To her credit, I will say she and her team have been much more responsive and have helped many of the veterans I represent. She is trying to a large degree. However, that help is a starting point but veterans need much more. The problems are systemic, larger than one person. And what I am doing with her team only touches a small group of vets compared with those in need. Do not get me wrong, my vets and I truly appreciate the work her team is doing with us. Instead of waiting 3 to 6 months for an appointment, they now get a call from VA usually within 24 to 48 hours of my involvement and their case is discussed with VA then escalated. But how many vets don't know we can help them? Bottom line, I believe Mary Beth and her team, once the problems were identified, have made an attempt to fix them and work with us. That part is a good thing.

Meanwhile, the Grand Rapids Home for Veterans is a different story. It is run by the State of Michigan but it also partners with the VA for services for its veterans and considerable amounts of federal money are funneled into the Home. Even the veterans' VA checks are used directly by the Home, they see next to nothing of their money. I think they get about \$107 a month to live on. It seems to me that those running the Home are more concerned about politics and appointments than what is in the best interests of the residents.

Since May and the Larry Krul incident, many, many serious issues were reported to me by residents that I was asked to help with. I would say from the Home alone, way over 100 veterans residents have contacted me. Add to that their family members and other advocates. They are literally begging us to help them as we are watching too many dying or being mistreated. Every day while they wait for us to clean up matters at the Home and in the V.A., veterans are not getting enough help or care. These men and women came to the Home after serving our country. They do not expect a lot. Just a safe, comfortable, respectful place to live and be cared for. Some get no visitors so I was most welcomed. They shared stories and begged for my help. I promised to help them and that is why I am writing for your help.

Attempts to work with Governor Snyder, his appointees and administration have only resulted in canceled meetings, bizarre, unprofessional actions, false statements and downright lies. To many veterans, family members and friends as detailed below, there also appears to be a conspiracy to take away the rights of the very veterans they are supposed to protect and serve. Veterans are simply asking for a more peaceful, capable, respectful Administrative team. They are requesting a safer living environment and less intimidation. They are asking for timely, accurate, responsive care from Home staff. For all the money coming into the Home, programs have been cut these past two years and not enough is being done for our vets.

They want Ms. Dunne, Administrator; Gary Davis, Social Services; and Jim Dunn, Deputy Director MIVAA fired, removed from the premises as this Administration has done to those who challenge them. They actually have a petition started to do just that. Even though Dunn is a veteran, they state he has repeatedly betrayed them, does not represent their interests and is held in lowest esteem. They believe Sara Dunne was appointed to her current position before she had proper credentials and without proper background. She is not a veteran and appears totally out of touch with the residents' needs. They do not trust her at all after all her broken promises and double talk. What she says or promises, mostly differs from her actions. Veterans routinely refer to GRH4V as "a prison," "hell" or a "poorly run hospital." They never say it feels like a home. Dunne will tell you differently. There is a clear disconnect between her and the residents that I noticed early on. They state their home would not have mice running through the common areas (photos herewith); walls would not be dirty, chipped and needing fresh paint; weeds would not be over six feet high in flower beds while checks go to groundskeepers (photos herewith), repairs would not take months, guests would not be sedated, have maggots, lie in their own waste or have bedsores from lack of rotation . . . and on.

A number of issues herein fall under the scope of failure of Michigan and its Administration team, especially the Home Director Sara Dunne, to do the jobs citizens expect them to be doing -- thereby failing to provide proper care in a safe, respectful, nurturing environment. However, we are aware her up-line, James Dunn, who is Deputy Director of the MVAA also has a direct role in this situation. See details below.

Michigan's Assistant Attorney General Joe Froelich has also admitted advising them on how to address matters at the Home. In fact, he is representing the State of Michigan in a lawsuit relative to a fight between two veterans with dementia type illnesses. That situation left one dead due to what some believe was the Home's failure to provide adequate security and safety measures. We wonder why Froelich, who is involved in the regular Home Board of Managers meeting and is self-admittedly counseling staff at the Home, is the State's attorney of record in the Andrew Ball case. Since he is a witness or involved in the situation, does he not have a conflict of interest? Seems someone else on the State's legal team should be handling that.

After meetings and documenting issues, advocates requested a meeting with Governor Snyder. It is his administration, his team and his responsibility but a meeting was denied. The response his staff emailed stated "Unfortunately, we do not have any openings in the Governor's schedule...the governor has an extremely aggressive calendar in the coming months." That upset the veteran community. The Governor, who is ultimately responsible for how his administration treats our veterans, has time to go to China, time to meet with reporters about nonissues, time to campaign, time to wine and dine his pals, but NO time for months to address issues undermining veteran quality of life at that Home which filters in federal money? And people wonder why Michigan ranks last in veteran care related polls????

Following concerns and details are as voiced to me by dozens and dozens of veterans, their family members, volunteers and other advocates in recent weeks. I have witnessed many of these myself. This is most serious.

Again, this escalated with that May event. Again, upon leaving, Larry Krul, said he was dying. In fact, he was -- needlessly. He stated his primary care doctor at the Home denied his request to see the V.A. doctor or get a second opinion. As a result, his health deteriorated to the point that a group of concerned Home residents pushed him in a wheelchair to the Clinic. That is when I found them and the congressman talked with him. Once there at the VOC, he was denied treatment because his GRH4V doctor had not granted the needed referral. The congressman advised him to contact me or his office if he did not get help. I received a call stating his family took him to the hospital and he was admitted to ICU. I called to see how he was and staff advised he was unlikely to make it through the night. Suggested I come see him then. They later said that he miraculously, with proper care, medication adjustments, pulled through and returned to the Home. A nurse told me had his care been delayed even an hour or longer, it is unlikely he could have survived. No veteran should have to go through such a process to be seen, especially when s/he is that ill.

When I discussed this with Administration, Sara Dunne's response was to the tune she was upset Larry "did not follow protocol" -- that "he should not have asked his family to take him to the hospital." Alarming, she failed to accept, in his eyes, he had tried everything, her protocol did not work and he was repeatedly denied the critical help he needed. He should not have to beg for help in a crisis. He did what he or any reasonable person would do to stay alive. She should be ashamed of herself and her response. This man WOULD be dead if someone outside then home had not taken him to the emergency room.

Bottom line, he and dozens of others then invited me to visit and hear their stories. Many Home residents have no family in the area and encourage my visits. I do enjoy listening to them and want to make their lives safer and better. They are the most amazing people I have met.

However, my findings and personal observations this summer were horrifying. Certain themes began to emerge. It appears to many that the repeated failure of this Administration to listen and respond properly is resulting in serious crises at the Home which are avoidable with better management. I agree with the veterans that the residents would be better served if Sara Dunne, Jim Dunn, Lino Pretto and Gary Davis were replaced. We need to bring in administrators who will respect their rights, make sure they have timely and accurate care by trained professionals. Meanwhile, this contract with J2S for privatized care is causing major complications and needs a complete review. If nothing else, a second company may be needed to bring in more care givers.

There are several who believe it is beyond time for the VA to take over the care of our veterans, not the State which is failing miserably. They believe the VA should take over control of both Michigan veteran homes. VA should then transfer all the current residents to independent or nursing homes closer to their families and this facility should be shut down. It should then be totally renovated, restaffed with vetted, trained people and only then reopened. Yes, it IS that bad.

## GRAND RAPIDS MI HOME FOR VETERANS ALLEGATION SUPPORT

### ENDANGERMENT OF RESIDENTS

### PREMATURE DEATHS AND MISDIAGNOSES

### FAILURE TO HOLD DOCTORS ACCOUNTABLE FOR FREQUENT MISDIAGNOSES & DELAYED CARE

Residents, family members, some workers and volunteers perceive there are far too many serious misdiagnoses and "premature" or "avoidable" deaths at the Home. I was told by Administration that about 150 of the current 430 residents died last year. That is roughly a 35 percent death rate at what should be a long term "home." The Home dropped from about 450 to 430 beds but that did not change the funding level. Now, there are less than 430 occupied beds while veterans are on the streets, homeless. Why, with fewer to care for and the same funding, is service not improving?

Even the Board of Manager Meeting Minutes from May of this year (copy herewith) stated: "Members are dying as soon as they come in." Administration's response is appalling: "working to getting information out to the public, discharge planners, etc. that the Homes have vacancies. A lot of discharge planners were so used to the Home having a waiting list in the past that they were not contacting our facilities. This will be changing." That read, to several of us as "send us your dying and they will be dead shortly, then just send us more. Should not the focus have been "Why are so many dying so quickly?" or "Is this Home the best place or proper place to be admitting people with certain medical conditions?" or "Is our haste to fill beds bringing in people the Home is not sufficiently equipped to help?" "How many deaths could have been avoided?" "What is the mental toll this high death rate is having on remaining residents?" "Why did the previous Administration have a wait list but this one does not, while, ironically, most nursing home in the area still do!?" And so on. That response came across as out of touch with the seriousness of the situation. Residents and I want the causes of these high death rates investigated and addressed. Something appears very, very wrong. Many question if there is some financial incentive to Administration to do it this way.

And the statement "used to a waiting list in the past...this will be changing" sounds very questionable and extremely ominous.

That also means, the mental toll on residents is staggering and highly detrimental. It is traumatic watching your fellow neighbors die. More so for veterans who have seen the horrors of war. Yet counseling services are seriously lacking, despite millions of dollars spent by the Feds and VA on mental health. Also, after an inexcusably long period without mental help, a multi-million dollar contract is now in place to provide mental health services specifically for Home veterans. When asked if they discuss their feelings over all these losses at weekly group counseling sessions, veterans told me there are no such meetings. In fact, most say they have no clue who their current psychologist even is! If the veterans are not receiving enough counseling to know who their psychologist is and if group counseling sessions are not being conducted, where is all that money going????? Who is really helping these men and women deal with their PTSD? Their grief over that high death rate of their peers?

It also raises the question if this State and Admin are taking money from the federal budget for services not being provided. It is our understanding the Home Administration chose to reduce the number of beds from 450 to 430 and retain current funding. However, with the Home failing to fill all 430 beds, would this not impact also the amount of funding being received since they are below the reported minimum needed to get that funding? It also raises the question, why are beds empty when many veterans are homeless and need a place to stay? We truly want to know, "why IS the Home allowed to fall below the 430 threshold yet receive the same payout they would get for 450 or so while veterans are homeless?"

Additionally, there are countless documented reports of the Home doctors making serious misdiagnoses, some resulting in death or near death. Yet, Administration does not appear to hold those doctors accountable for that. When that is combined with the fact the vets have a very difficult, if not impossible, time getting referrals to an outside doctor for a second opinion valuable treatment time is lost and conditions needlessly deteriorate. With cancer, those delays can be a death sentence or lost limb. Translated that also means deaths which appear as due to natural causes or disease are questionably due to misdiagnosis or delayed care. To support these allegations, residents and family often cite as examples the deaths and/or misdiagnoses of:

- Richard Ware
- Billy Ray Doughtry (not sure how he spelled that name)
- Dale Weaver
- Rodney Tardy
- Frank Grey
- Larry Krul
- Charles Renaissance
- Ken Kneely
- Randy Fortune
- Dan Dinnes
- Charles Dean Johnson
- Norman Tope
- Bill Yates

But those are far from the only ones. They claim at least two of those men had maggots in wounds while at the Home. Maggots indicate lack of proper care. Bill Yates stated he received a bill for a podiatrist – but he has no legs and did not see a podiatrist.

Larry Krul's case exemplifies a story told over and over – that if a Home doctor, who sometimes appears to be covering his own misdiagnoses, does not consent to a referral, a veteran is denied a second opinion, care at the VA and proper care outside the Home or VA systems. The fact the VA refused to help Mr. Krul, as just one example, when he was critically ill, has people wondering if there is some contract or conspiracy between the VA and Home that takes precedence over the well-being and treatment of the veterans. Why, when that veteran asked for help at the Coit VOC, did the VA refuse to help him, regardless of where he lives?

Most alarming, we were making a list one evening and a veteran pointed out many having trouble seem to have the same doctor, Dr. Bates. Residents question if he is totally incompetent or killing them purposely and getting away with it (more so after that Board meeting comment about things changing). How has the Administrator not noticed this pattern or addressed it? Why has Administration not made it easier for residents to get referrals to the CBOC next door or second opinions? How much harder will it be for veterans when the current CBOC closes and they must be bussed to the new CBOC in Wyoming, across town?

Also, quite alarming, when checking the backgrounds of these doctors, we were stunned to learn from LARA staff that some have lapsed licenses to prescribe! Dr. Bates since 2009, according to LARA personnel. How is the Administrator not addressing these things? Either they should not be prescribing or someone should be notifying LARA if their records are wrong. I did file a complaint with the State LARA system about that.

### FAILURE TO PROTECT

Under this category, doctors at the Home routinely refuse to allow second opinions or referrals to the VOC next door. As a result, medical conditions needlessly deteriorate. Dunne is apparently failing to help these veterans get the care they need. The fact she chose to chastise Larry Krul for having a family member take him to the hospital when all else failed, exemplifies her incompetence and lack of compassion in this matter. By failing to give these residents access to second opinions, she is not protecting their interests. This is perceived by many as her protecting doctors who may be making medical errors. She is failing to protect these residents.

I have heard many horror stories over injuries caused by J2S and improperly trained caregivers. This is a huge issue. One veteran advocate, Mike Burri, told me of four people who suffered injuries in one short time period because under-trained staffers did not know how to properly move them from their beds or wheelchairs. Some he stated have sustained bruises, others actual broken bones, he said. J2S caregivers are not being adequately vetted, trained and supervised. That was proven when a new J2S worker was removed from the property by Marshalls due to outstanding warrant. That was also verified by comments from workers. More than one stated she was hired in the morning and told to start work that day – before background checks were done. More than one complained that although promised training, they were told to start work and were limited to on the job training, if their upline had time. As reported to Administration, I actually caught them clocking in and out for each other. That created the appearance they were working, when, in fact, the employee had left the building and veterans were shorted a caregiver, who was on the clock being paid for work she was not even present to do. I have heard repeatedly from residents that even if they complain about a problem bus driver or caregiver, those people are not fired. They are often just moved to a different floor. This lack of vetting, training and supervision is believed to undermine the care of our veterans.

Recently, I received calls from Terry Laurain asking for help. For some reason, Terry has experienced one horrid event after another. He said a caregiver moved his call button so high on a "trapeze" that he had trouble reaching it, it fell on top of him and damaged his head this past week. He has all kinds of trouble and abuses relative to his catheter. He claims Dr. Bates refused to prescribe medications he needed unless he took a caregiver with him on his vacations. He said doing that cost him thousands of dollars and has hurt him financially. He said one of the caregivers he took on vacation was the mother of a woman who works in the Administrative office! I heard of multiple HIPAA violations as he told me his story! He said another was a married man, a caregiver. He said on vacation that man wanted to hire prostitutes, bought \$70 liquor and a watch as well as other items, that were all charged on the resident's account. Despite all the cameras in the building, Ms. Dunne has failed to identify who has taken Mr. Laurain's items on multiple occasions. He has had a laptop, leather backpack, etc. taken. Police refused to file a report because they told him it is the Administration's job to take care of theft at that facility and she has not called them for assistance. It was reported this week that a caregiver went into Terry's room without his permission, removed private, personal documents. After filing multiple complaints, Terry received what appeared to be retaliation from his doctor. He claimed he was banned at the last minute from a hunting trip he was looking forward to.

Multiple veterans were found at different times in distress on the grounds. I informed Administration about two years ago that I found a veteran outside the main door in coldest November without a coat or attendant. Not one staff person was assigned to watch or assist in that area. He was literally freezing, his catheter had an issue and he was surrounded by freezing urine. Barely able to speak or move. I wheeled him inside to warm him up and get him help. I truly believe had he been out there a little longer, he would have died. The lady at the desk refused to help, said she was new and it was not her job. Another vet instructed me where to take him, I did and he received immediate assistance from nursing. He should not have been left alone and that area should have had at least one staffer available to assist. It is impossible to believe with all the cameras Ms. Dunne had mounted that her Security team failed to notice this man sitting near their office.

Residents told me of at least two similar incidents this past winter. And at least a couple this summer and very hot days. For instance, this summer, a photo briefly surfaced of three veterans in wheelchairs stuck in an unfinished area that was not roped off. One of the veterans' wheelchairs had actually tipped over, he was stuck in that upside-down position with his head next to the brick wall for an extended period of time. For some reason, any veteran in a wheelchair who went to help him, ended up stuck also. I looked at that area and there appears to be a dip or drop in the sidewalk and that is hard for frail bodies to navigate.

I reported this to Dunne and Dunn. Instead of addressing the issue, she wanted to find the photographer and punish that person! She did not have the area repaired, roped off or completed for months. And that was simply a flower bed between the building and sidewalk. This Administration's priorities appear misplaced.

As a result, another incident recently resulted in a resident named Marco falling into that same area, hitting his head on the concrete and being transported to the hospital for several stitches. Luckily he was not impaled on the re-bar poles sticking out of the ground. This was totally avoidable had Administration done its job, fixed the problem when notified weeks earlier or at least roped it off or the area closed to access.

As detailed later in this, Admin has failed to protect patients' HIPAA protected information. This is a huge problem. It is disgusting where their protected information is found and how little privacy means to those staffers.

Lack of sufficient security measures has endangered patients. In fact, the Andrew Ball case is an example wherein one man with dementia actually did attack another resident and that ended in a patient's death. Had better security been in place, this may have been avoidable.

One evening I was visiting and the emergency phone was ringing – but there was no one in the Security Office to answer it. One of the residents called the number listed and received a recording to call the Security Office – the same one that was empty and had no one there to take the calls. So, it appeared to us, none was responding to the emergency calls. This went on for a considerable amount of time that evening and I was told this happens often.

The guards sit in a room near the main door but with their backs to the door. Pretty much anyone can walk in and move freely throughout the buildings. They also are not guards in the sense most of us think. They have extremely limited powers. So what happens when an anti-veteran or hate group gains access? Or a terrorist? A few weeks ago, a group of veterans returned from an outing on the bus in the evening. The door was locked and no guard was in sight. We learned later the patients were sleeping, the guard on duty that night routinely leaves his post and under the guise of doing rounds, was upstairs spending way too much time chatting with nurses and staff, leaving the front desk unmanned. Residents would like to have at least one person manning the cameras, main door and emergency phone at all times.

## SMOKING

In summary of the smoking topic: Many complaints hang around the canopy and smoking areas. That canopy was built to shelter the vets, many who were sitting outside in the elements smoking. We need to remember that many veterans did not smoke until they entered the service. They continued smoking after experiencing the horrors of war. It is a coping mechanism for some. While many of us do not support smoking, the fact is they do smoke and need protection from the elements since this Administration no longer allows for any indoor smoking. Instead, the veterans state that Sara Dunne coldly and with total disrespect for their well-being forced them outside, into the elements. A public cry went out and donations and volunteers created a small enclosed area for the vets. It is basic with plastic sheeting behind the building. A new canopy was built with donations near the front of the building. Dunne had a blue line painted OUTSIDE the canopy and now forces veterans to smoke on the other side of that blue line – which is in the elements of nature. They claim she tells them “don't soil the canopy with smoke.” Also, the “distance from building for smoking” she requires is grossly in excess of city and state codes. It not only pushes veterans into the elements, it puts them dangerously close to incoming and exiting vehicles. Veterans view this as an abuse of position.

A number of residents and their family members attribute Ms. Dunne's direct implementation of her heartless new smoking policy in such a careless manner that many veterans developed avoidable lung issues and pneumonia. They state she forced them outside in the dead of winter. One family member brought in a heater to help the veterans in the smoking area stay warm. Veterans claim Dunne removed it and said they did not need it, despite their plea for some warmth. She still forces them to smoke outside, beyond the front canopy area, even on rainy days. They believe the cold air is too hard on their aging lungs and sitting in the rain is not beneficial to their health either. Someone who researched numbers said deaths due to pneumonia peaked when she implemented her new policies against their wishes. She is not only failing to protect their health and well-being, if it is true cases of pneumonia could have been prevented, well, that poses a host of issues from failure to do her job to raising the costs of healthcare to causing them needless suffering. So while those pneumonia related deaths appeared natural, their question is “were they avoidable had she not pushed the outdoor, unprotected smoking issue?”

What is weird is that Dunne allows a smoking section at the back side of the same building, literally touching the Kozy Korners wall. But, she had a blue line painted many yards from the front building entrance, way in excess of City codes. Would the same law governing distance from a building for smoking not apply to both areas? Front and back of the building? Should she not know this? Should the distance not be governed by state and local laws – not abusively excessive as she made them? A check of that “fact” did not gel. We could find no distance on the books as far away from a building as Sara is using for her Blue Line, especially when the smoking area by

Kozy Korner actually touches the building. Many see that "Blue Line" as a psychological threat referencing what police call their "Thin Blue Line." Intimidation. Pushing a veteran out beyond the blue line and reprimanding him is also seen as embarrassment and harassment in front of peers. It also puts the resident in a dangerously close proximity to arriving and departing vehicles.

That canopy was built to protect the veterans from the elements while smoking, they should be able to sit under it and have protection from the elements. In fact, there is great controversy as to where that money came from. Administration claims it came from a large donation. However, the budget format was changed around that time and many line items, I am told, specifically earmarked or targeted donations, were apparently moved to the very account that money came from. That has many residents questioning if donations went to the intended purposes or were combined and used in part for the canopy.

Veterans state they have actually seen Dunne push veterans in wheelchairs from under the canopy into the elements while warning them she can have them removed from the Home for that. She has told some vets she does not want the canopy damaged by smoke! This is perceived as total disrespect to the residents, abuse of her position and sending the message the canopy is more important to her than the veterans she was entrusted to protect and care for – even though, again, that canopy was built to protect the veterans from the elements.

For the record, that canopy area is at the front of the building and offers a magnificent view of the grounds and river, making it a popular gathering spot.

When they complained about all the cameras and eavesdropping devices she had mounted in the smoking area, she responded by having even more cameras installed – which give them no privacy to converse and can hear a whisper. They say that was done on a day she was angry with them and done in a manner many vets saw as pure spitefulness on her part. That is another abuse of her office and needless waste of taxpayer, State and Federal monies they tell me. How many cameras does she need to watch a group of veterans sitting, chatting and smoking? Residents believe far fewer than are in use and want some private areas for gathering. Where can they go to talk or smoke in private?

And, even though that area is their designated smoking area, she forces veterans out of there for non veteran events. Like recently, she allowed an event to be held in their designated smoking area for workers, including those under contract with J2S. That day it was raining and the event lasted for hours, meaning the vets had no adequate smoking area. (They could not use the covered area at the back of the building because the event was there and they could not smoke under that canopy.) That is seen as a double slap to the veterans she refused to allow to smoke in the building then failed to protect against the elements when forced outside. That area is designated for smoking, as such, should not be used for other purposes. Especially not used for non veteran events or Administration events.

#### **FAILURE TO PROTECT AGAINST PREVENTABLE, TREATABLE DISORDERS IMPACTED BY NUTRITION AND DIET**

It is my understanding that the current Administrator had a background in nutrition and moved from the kitchen to her Administrative position before she had proper credentials to hold that position. However, diet and food are big issues at the Home. Residents and family members believe the diet they receive is too high in canned, overly processed food, including imitation or soy based "meats" that are not good for the body on a continuous basis. Vets cite lack of fresh fruits, vegetables and real meat as a likely high contributor to their digestive problems, diabetes, heart, obesity, gastrointestinal, bowel disorders and complications. Also, they state many foods do not mix with their meds. I could not survive without digestive trouble on their diets and the overly processed food they live on.

One veteran was at an event at my home and started crying when I brought out for the group large trays with things like melon slices, berries and large tomato slices. He said he has not had a fresh, vine ripened tomato, fresh berries or melon at the Home this season. How can this be with all the money intended to help our vets? How much pain and cost due to bowel and gastrointestinal issues, sugar issues and cost are these veterans incurring by Administration's failure to provide them with the same quality of food she herself is eating?

For the record, many veterans have health issues and should be on special diets. They want and need more guidance on what diets are best for them. Many have memory issues and need more help than they are getting at the time they are selecting food. With that, we also question how many veterans with special dietary needs are having those needs met under this Administration? From what residents tell me, not enough. In fact, veterans who are confined to their rooms and have meals delivered have claimed they are routinely brought trays with inappropriate food for their medical needs. They report if they complain, they are told that is what they are getting or they don't have to eat it. That is not OK.

We believe an investigation comparing the medical diagnoses with the diets too many are receiving would prove that concern to be valid. We believe more appropriate diets – like one including more fresh, in-season fruits, vegetables and meats – would result in better health and less discomfort. That in turn could seriously cut medical costs to the Home, VA and taxpayers. Given her background in nutrition, many are surprised it is such a low priority with Dunne.

We know she knows this is an issue because she does something that is deemed extremely cruel and disrespectful to the residents. Veterans say Sara actually has food catered in for herself and her visitors or associates that is extremely different than what she feeds the veterans. They say it is much, much higher quality. They say the way she and her peers eat it in front of veterans and laugh at the veterans reminds them of Hitler and the woman in Flowers in the Attic. There is no justifiable reason, with a cafeteria in that building, she should be wasting taxpayer money to cater food for herself and visitors that is better than the food she forces veterans to live on daily – the very people she is supposed to be serving and respecting. This is how she treats our country's treasured veterans.

They state they are afraid to complain because the Home puts medications into their applesauce and foods like that. Many veterans believe they are being sedated through their foods. I thought that was far fetched until I learned this is, in fact, common practice.

So, they ask, with a significant budget for food and her knowledge of nutrition, is Sara saving money at the expense of the veterans' diets and health? Where is that money spent? Would health care costs, cancers, bowel diseases, diabetes and such be considerably lessened if they had more appropriate food? Would veterans be healthier and happier with dietary changes? Why is that not happening?

And, given her background in nutrition, fully aware of many veterans dealing with diabetes, obesity and digestive issues, why did Dunne allow an ice cream machine to be installed that dispenses UNLIMITED ice cream 24/7 in some areas of the Home? Yes, it is a nice treat, but when unlimited, it only grossly contributes to health issues and obesity that are totally out of control at the home and avoidable with a little common sense. That is not responsible management or management of health care costs.

### OVER MEDICATION

Larry Krul told me his blood tests taken at the hospital when he almost lost his life show and prove he was overdosed at the Home.

Also, and I have seen this myself, many veterans are apparently being overly medicated and put to bed early against their wishes. As an example, I was watching a sunset with one veteran in Aug. He is an amputee and is losing his eyesight. He wanted to enjoy the moment while he could. A caregiver came outside, demanded he go inside and take his meds. He politely stated he wanted to stay up and watch the sunset. She demanded he go take his meds. But he said they were just meds to put him and the rest of his wing to sleep. That he survived in Nam, he should have a right to stay where he was and watch a sunset. He asked me to talk with them and ask them to just let him enjoy the sunset. So I asked his caregiver if it could wait. She, startlingly stated, he was correct, they were "just meds to put them to sleep before the next shift comes on or they would be short staffed." I asked what she meant. She stated they routinely sedate them to use less staff. That is not OK. Depriving a disabled, amputee veteran his right to enjoy a sunset so J2S can save money through staffing? No, that is not OK. at all.

A family member told me he has repeatedly been refused access to his father's medical records. He also stated a worker told him there are actually two sets of records. One is a false record of what they are supposed to be giving the patients, what they would show for an audit. That person claimed there is a second set of books usually kept near a nurses station that documents what they were actually given. I have not seen these books, but if true, that is serious.

One veteran, was doing remarkably well when his son and I visited him on a Sun. afternoon. He was outside, talking, alert, funny, reciting sport stats from years ago. That evening, his son found him nearly comatose from sedatives, lying in bed with his pants pulled down to his ankles, lying in a soiled diaper. The son claimed he could not awaken his father. Anyone walking past the room could have seen him in that degrading, disrespectful position. And the son stated he only saw two staffers scrambling to cover the entire wing. That is not the way to treat a man who served his country or any patient.

The Administrator must know this practice is happening and should be held accountable for not stopping it. If, by some off the wall chance she does not know this, she is totally out of touch with what is happening and should be replaced. We would like to have the doctors abusively prescribing too many sedatives too early in the evening to be held accountable as well as the staffers administering them.

Residents, family and advocates wonder if there is a way to perform a sting operation – come in unannounced on a Sun. night and take random blood samples of those who are lying in near comatose states to see what levels of medication are in their bodies. Also, to look at autopsy blood reports to check for drugs and overdose.

### ONGOING THEFT OF PERSONAL PROPERTY/POSSESSIONS

In fact, theft at the Home is rampant. Hardly anyone I spoke with has not had something stolen in the last months. Terry Laurain, as stated, had a laptop, leather backpack and wallet stolen at three different times. Another claims he had over \$1100 taken recently. Wallets are often found without money. Cell phones disappear and so so on. Eye glasses and even teeth disappear. They report these things but not enough is done by Dunne to fix the problem. These people live on very little each month. To lose anything is a major hardship to many of them. There is too much of it to be accidental. With all the cameras in the building, residents and I wonder how has Administration not been able to id the thieves and hold them accountable? Most residents see this as an example of Dunne failing to perform her duties. Is she not required to provide a safe environment for them? In fact, no one is even aware of any serious attempt by Administration to find and hold accountable the thieves.

Then we have the issue of J2S workers conning these people out of money. Recently, one man told me he gave \$900 to his caregiver then learned his neighbor had given her \$600 or so. I am told this was reported but the caregiver is still there. Others have told me caregivers offer to be their "girlfriend" then ask for money.

I have told those residents they need to report those people. But, who is screening these workers? I was told of a new person starting and a couple days or so later, Marshalls came in and took the person away in handcuffs because he was a wanted felon. That should have come up in a background check.

However, one staffer told me they do not undergo timely background checks. Again, she said she had an interview with J2S in the morning and was told to report to the Home for work that night. There was no background check that she knew of. She also claimed she did not get training, other than on the job. I heard she quit shortly thereafter. Residents do not feel safe because they question the qualifications and backgrounds of some of the people coming in these days.

In short, I am told these incidents have been reported but not enough was done by Dunne according to the vets. Bottom line, the residents believe sufficient background checks are not being done. They also believe insufficiently trained personnel are causing needless injuries and providing less than desirable care.

I believe it was 2012, I volunteered to help serve a Thanksgiving Dinner to residents at the Home and had a bizarre encounter with a woman who id'd herself as the supervisor over the kitchen. That meal, intended for the veterans, was paid for and sponsored by a veterans group. There was food left over and I had been asked to deliver some of that to a group of homeless veterans in the woods nearby. As I left to do so, I was stopped in the hall by a woman who demanded to know when her food was coming. I had no clue what she was talking about. She identified herself as the supervisor over the kitchen staff. She said there is an "understanding" that any group that brings in food must bring in extra to also serve the staff. As we talked, she admitted she has her staff make extra food for herself and some employees to take home. She claimed that since they cook all day, they should not have to cook when they get home after work. That whole encounter still stuns me to this day. They are hired to do a job yet she DEMANDED the staff be fed? She is routinely using taxpayer money to make meals for staff to take home while she is being paid to work? I do not think too many taxpayers would be happy to hear that. Especially after they themselves work and then have to go home to make their own meals.

#### **SUPPRESSION OF CONSTITUTIONAL RIGHTS & FREEDOMS AND VIOLATION OF AMERICANS WITH DISABILITIES ACT, TAMPERING WITH U.S. MAIL AND DESTRUCTION OF VOTING MATERIALS**

In short, veterans' rights to representation, free speech, assembly and disabilities are grossly trampled on by Dunne's and Dunn's flagrant abuse of office. We have confirmed her staff has admitted to ballot tampering, meaning veterans are not getting ballots and federal mail is reportedly being destroyed under this Administration's direction. An investigation has been started by the Clerk's Office. I was advised they did find "irregularities" and violations.

I heard from many vets after the last election stating they did not get Absentee Ballot Applications or Absentee Ballots. This was after Dunne made a strange comment to me that she could not do a certain project because "we are working with the ballots right now." I could not understand why Dunne stated she was too involved in the voting process and touching ballots, as that comment indicated. So, I checked with the Election Board and learned the voting materials were sent via U.S. Mail directly to each veteran as appropriate. They should have been delivered to the veterans with their routine mail and there was no valid reason for staff or Dunne to be involved. Any going to a resident with a guardian would have that handled with the guardian following that resident's wishes. All the Home had to do was sort the mail and deliver it.

However, I learned the ballots and applications were sorted and handled by Administration and staff. Instead of returning ballots for those who were deceased or left the Home and were simply living elsewhere, a woman named Cassie who works under Dunne told the City Clerk's Office she had been instructed by Administration to throw those out in the trash! Yes, she admitted throwing out voting materials. This was disturbing on many counts and is viewed as tampering with federal mail and violating the rights of veterans. They should have been returned to the Clerk or marked "deceased" or "undeliverable as addressed" so they could also be removed from voting records or attempts made to locate them through other means.

It was only after myself and another veteran leader started looking into this and why veterans did not get their ballots, that several residents told us their ballots started showing up in strange places. Like one vet who made his bed on Sat. claimed he found his ballot between the headboard and mattress – during election week and too late to submit. He had just made his bed and it was not there days before – who put it there when they were delivered to the Home weeks before? Of 430 potential residents, about 178 received ballot applications, the Clerk's Office said far less than 30 were returned and only 3 voted at a booth. Meanwhile, vets are asking why they are not getting their voting materials in time to vote! We know Dunne had them weeks before by her own admission.

For instance, we were told the City Clerk's Office sent current voting materials out last week, that some from citizens have already come back. As of today, most veterans at the Home have stated they did not receive them.

It was revealed to me this week that Gary Davis told Catherine Buckley, a leader in the veteran community, that he holds the mailed voting material in an office until the resident asks for it. First, that is viewed as withholding U.S. Mail from its intended recipient, which is a federal offense. Second, how can they ask something they were not advised he is holding?

Given the current situation, a veteran leader offered to bring in a team of nonpartisan, nonpolitical volunteers to hold a registration for the vets at the Home, and help those who need one fill out an Absentee Ballot Application form. Dunne refused to allow this to happen, even when it was pointed out that would also free up her staff to better attend to veterans' needs. Veterans and advocates no longer trust Dunne

and her team to ascertain every veteran who wants to vote and EARNED THE RIGHTS MANY OF ENJOY is registered, properly gets an Absentee Ballot and that all ballots are returned to the proper place. Clerk Offices have started an investigation into this after receiving complaints and finding irregularities.

Residents weekly report ongoing problems with mail tampering that Administration has failed to fix. Even though many residents have signed forms stating they do not want their mail opened by the Home staff, the staff opens it anyway. We are told this is a federal offense. Mail is reaching them opened, statements, checks and money are missing. One lady stated she overpaid a medical practice, two checks were sent to the Home in her name but were cashed by the Home and put into what appeared to be the Home's General Fund. She claimed she is supposed to be opening her own mail. Despite a procedure Administration agreed to implement – have the person who opens mail initial it – that is not happening. Complaints are made. But the problem continues.

And this is an ongoing issue under other categories listed herein. Despite calling out problems and presenting resolutions to Sara, Sara repeatedly violates her promises or does nothing. How is it decades after the Home was built there is still an inadequate system for delivering mail to the residents who do not want anyone opening their mail?

### **VIOLATION TO RIGHTS OF ASSEMBLY, FREE SPEECH AND REPRESENTATION**

Next, and this is extremely serious, vets at the Home arranged for two meetings that Administration canceled without prior notice. The manner in which this was done went beyond unprofessional and bordered on insane behavior to many involved. We have also been advised the manner in which this happened violated several of their legal rights.

A meeting was set for 6/21 to talk with Administration and a 6/26/14 meeting was scheduled at the Home in the All Purpose Room with a group of selected legislators the veterans chose and wanted to talk with. During the VA crisis, they wanted to discuss what was happening, what current benefits are available to them and have some questions answered. They reserved the All Purpose Room in the manner they understood they were to do that, sent out notices and were excited about the upcoming meeting. They needed that APR to allow disabled to attend. It was perfect for those in wheelchairs, with walkers and the microphone/sound system was needed for those with hearing aids. Since I was participating, I also needed the sound system due to a disability I have which resulted after spinal surgery impacted the vocal chords.

I have worked with many legislators on various projects over the years; so, I was stunned to get calls from some of them a day or two before the meeting the vets had scheduled for 6/26. They asked why the meeting had been canceled and stated that they looked forward to meeting with the vets! Well, neither the vets nor I canceled that meeting – they were looking forward to it. One legislator finally told me the calls to cancel the meeting had come from Administration, that perhaps I should call Dunne out on it.

So, I called Ms. Dunne directly. Her immediate, angry response was “I will not allow these residents to meet with legislators so they can say bad things about Sara Dunne, Jim Dunne...” and a couple other staffers. She talked about herself as if she was another person. She would deny veterans their constitutional rights to assembly, representation and free speech to protect herself???? That is the grossest abuse of office: denying the very veterans who fought for our rights their own rights for her personal insecurities.

It gets much worse if that is possible. She said they violated Home policy for holding meetings. When asked to see those policies, frankly, she refused until she finally had to admit a policy was never written up, there was none!!! So, she lied when making that statement as her justification. There was no policy written so it could not be violated as she claimed. The fact is that the veterans asked her staff if they were reserving the room correctly and were assured they were. Dunne had no valid reason to cancel that meeting thereby denying veterans their rights to assembly, free speech and representation. For the record, Jim Dunn was also involved in that meeting cancellation, they did this together. Veterans stated that Mr. Dunn may be a veteran, which they respect, but his actions that week were a betrayal and he lost all their respect. They do not feel he represents their interests.

### **IT GETS EVEN MORE UNBELIEVABLE AND WORSE:**

It still gets more unbelievable. As a secondary reason for canceling the residents' meetings, Dunne stated late in the conversation (almost like she realized the excuse she gave was lame), the Home and grounds cannot be used for political purposes, no campaigning. Again, Dunne was told repeatedly these veterans wanted to meet the people representing them, they wanted updates on the VA situation which was all over the news, information on benefits, transitioning from the Home to private life, and that sort of thing. They did not want to listen to campaigning and it was not about that.

However, after canceling the meetings veterans had set up for themselves, Dunne then turned around and allowed Terry Land, a candidate in the upcoming election and friend of those who appointed Dunne to her position, to attend the yearly carnival/picnic for residents of the Home. Land was not stopped by Administration from campaigning during that special veteran event. She was seen passing out campaign stickers and materials, as well as posing for photos with residents. Those photos were actually used as publicity shots, without consent of any veterans involved, creating the false impression she is supported by the veterans, when they were uploaded to Land's social media sites, like Facebook!!! Dunne could not have slapped the veterans in the face harder or insulted them more. After denying them their rights to assembly, free speech and representation, she allowed Land to invade and campaign at their yearly event! Wow! And, for the record, that event is put on by many groups and advocates for the veterans to have a fun, enjoyable experience. This is viewed as grossest abuse of her position. And it either violates election rules or Dunne lied about no campaigning on State property.

VanValkenburg has reportedly spread to the outside community a fabricated story about the 6/21 meeting. Having had no role in that meeting or planning, she was supposed to be running the clothing store, her actions and comments are completely out of line. The fact she is discussing residents and other privileged Home information at her outside events appears to violate HIPAA as well. People tell me her husband is president or leader of a veterans group in Grand Rapids, I believe it is a Legion post. I filed with Administration a complaint. While Administration said VanValkenburg was talked to, I have yet to see a formal write up or receive an apology as requested and still expect to receive. I am still hearing feedback that she speaks about private Home matters with outsiders.

Nor has Administration apologized or taken responsibility for the false statements it made to the veterans present or over the intercom. But that is how this Administration treats anyone who questions or challenges them.

That day felt like pure insanity. All veterans wanted was a chance to meet calmly to get answers to questions and address valid concerns. Out of fairness and in the hopes of an amicable meeting, Admin had been given questions in advance.

To this day, no one comprehends how Administration could be so out of touch and unprofessional as they were that day. They are supposed to be there to serve and support the residents, not play games and refuse to meet with them. But it was a good example of the abuse these veterans are enduring daily.

In fact, a person who attended one of the Board meetings following this event heard a member of the Administration state they would not allow anyone to come in and tell them what to do – they “would teach her a lesson who is in charge” [that person said they were referring to was presumed to be me as I attempted to mediate between the Home and residents.] If they go to this length to try to intimidate an outsider truly trying to help veterans, one must believe the stories of intimidation being told by residents.

Veterans have a right to assemble and speak amongst themselves. This Administrator has consistently failed to give them a room in which to do so and clear, written guidelines on how to reserve that room. Even if they wanted to hold a birthday party, there was no firm guideline on how to reserve a room. They had to rely on the directions given to them by Admin staff – which they did. Guidelines which should respect their rights to assemble, speak and be represented. The fact is that room was reserved as a resident who was instructed how to do so by Admin staff.

Bottom line: we had a group of veterans and family members with valid concerns. They wanted to amicably give Administration a chance to tell its side. Administration had been given questions in advance with time to prepare fair, knowledgeable answers. Their rights and needs were violated while Administration abused its powers. There was no valid reason to cancel that meeting other than abuse of power and failure to do their jobs.

### **ADMINISTRATIVE DISHONESTY**

Even stranger, Administration falsely claimed the APR had not been reserved. That was just one more lie from Administration. The fact is that the veteran who reserved the room called me after talking with staff in the Administration office and being told the room had not only been reserved for his group, she offered to put an announcement on the CCTV system! The fact is that Administration removed it from the main calendar without notice and stopped all CCTV announcements. Dunne later admitted to me that it was removed by her staff. Another of her lies exposed. Why did she lie about that? The only reason we can see is because it was her best attempt to falsely discredit us and excuse her team's inexcusable actions.

As you read through this report, you will notice multiple times that we have caught Sara Dunne being less than honest. The paragraph above was just one example. The section below relative to the 21 questions has more.

I have received reports from residents of Admin staff coming in after hours to shred documents. I was told this often happens before an audit or some such impending event. Residents have reason to believe someone in government or law enforcement is alerting the Home Admin to impending investigative actions, giving them time to destroy documentation.

### **ANSWERS TO 21 QUESTIONS**

So under FOIA, I requested written answers to what has become known as “the list of 21 questions.” Mr. Dunn passed that on to Sara Dunne. At first glance, her answers seemed reasonable. However, the majority failed to pass the fact check. A big issue I have with Ms. Dunne is I have repeatedly caught her in lies and that is totally unacceptable. She also fails to act as promised or follow through. As Director, she has a responsibility to do a better job.

For instance, she said residents should file reports on incidents, that that information was in the members' handbook. Well, when compared, the forms she supplied to me with that email were very different from the contents of that book – which conveniently or erroneously left out the addresses for outsiders to whom they should be sent! Thereby complaints were unlikely to reach the higher authorities in a position to address them. And most complaints are dismissed as unsubstantiated.

Another erroneous answer: The air-conditioning unit failed last fall and took too long for repairs. Vets notified media. Public was assured a large amount of money (some say close to two million dollars) was approved to make the repairs. The a/c went out again this year – for several weeks. Dunne and Dunn claimed in their written reply that repairs were made quickly. The fact, I was told, was they

addressed in part last year's problem, not this year's problem. Fact, that a/c unit was still down for weeks into June and July this summer during hot temps. Administration bragged about bringing in "treats" – an ice cream machine that allowed vets to take all the ice cream they wanted – to cool them down. How does that help veterans who are over-weight or obese or have sugar restrictive diets as many of them do? How is that cost effective? How does unlimited ice cream cool them down? I cannot imagine a more insane abuse of office. Her job was to have that unit fixed in a more timely and effective manner and be honest when addressing how long it truly took to make repairs.

I was also told what really happened and that was disturbing. There are two major a/c units for the Home. In theory, one could supply all the needs of the building if the other failed for a period of time. To reduce wear and tear, both units were in use. One failed last fall. Money was awarded to replace the broken unit. Instead, I was told parts were taken from the other unit to repair or upgrade it. That created the appearance Administration intended to divert that money to something else. However, as told to me, that created several problems. First, that left only one working unit. Second, that put extra stress on the functioning unit. Third, those parts were as old as the unit which they were taken from so it surprised none of the residents that the one unit they fixed last fall with borrowed parts also failed this summer. Meanwhile, Administration claimed a truck came in with a portable unit until spring. Meanwhile, the one "repaired" with old parts failed this summer and was down for weeks, not at all the short time as Administration's reply would indicate. I know that to be fact because for several weeks as I visited, the a/c was down. How is that cost effective or in the best interests of the vets? It had to be fixed, why add all the extra costs and drama? And why mislead in her response to my FOIA request for answer?

And so on with most of Dunne's answers. They simply did not meet the smell test or fact check. We can no longer trust what she states at face value.

### HITECH ACT AND HIPAA VIOLATIONS

HIPAA violations and violations of the Americans with Disabilities Act are rampant.

It has been called to my attention that not all the employees/volunteers have been required to sign a form ensuring they will comply with HIPAA and respect patient protected information. As a result, much private, protected information is flowing from the GRH4V.

As an example, I was told Sonya VanValkenburg, the same woman who ran through halls telling people there was no meeting on 6.21, also belongs to other groups outside the Home. I was told she reveals much information about the Home to others at the outside events. That should not be happening.

That raised the question, has anyone compared a list of employees/volunteers with signed HIPAA compliance type forms? It does not appear so. A volunteer who has been raising a number of questions and asking for accountability, advised me this weekend, she was told she needs to sign such a form immediately. I agree that woman should be respecting privacy. What is interesting though is that she has been working at the Home for years and is only now, after she started asking questions, being told to complete the form. Was that retaliation? Why was she singled out when many others are doing the same? Many staffers do not understand or respect the importance of the HIPAA laws.

In order to save money, the State brought in J2S to provide staff and care. Because of the extremely high turnover – which should be unacceptable to an Administrator – caregivers lack enough training and patient knowledge. Someone had the idea to create charts labeled "Cheat Sheet" for each shift. The chart lists residents', rooms, special needs, disabilities, meds, and most private details that are protected under HIPAA. There are several names on each sheet. They tell who is incontinent, has bowel issues, diabetic, needs diapers, needs bathing...their most private information.

These sheets are very regularly found in common areas on floors not even close to the patients' rooms. I have personally found them in the Main Lobby – accessible to anyone entering the building; in Kozy Korners, the game room where they gather; in the Cafeteria; in the restroom; as well as other places, like the outside patio, smoking area. I reported this to Sara Dunne and told her it is not acceptable. She assured me the practice would not continue and she would have the name of the caregiver written on it each sheet in case one showed up – so, if lost, that person could be identified and held accountable. That is not happening. Imagine my disbelief to find another group of them la recently, without any caregiver names and current dates. This is a MAJOR HIPAA violation Administration has failed to address even after advised.

I have also been advised that multiple people have been refused access to their own medical records. One son asked repeatedly to see his father's records, fearing he was being overdosed. They refused that request.

### LACK OF MEDIATOR/OMBUDSMAN/ADVOCATE AND CONFLICT OF INTEREST

Also, Mr. Pretto, professes to be the residents' advocate but hardly any know him. He had a chance that day – since vets were gathered – to talk with many of the veterans he has never spoken with. But he refused to do so. A veteran advocate refused to work with the people he supposedly represents? And Administration encouraged that. He chose to side with Administration and shut the residents' meeting down? Refused veterans their rights, since they were beginning to assemble, to continue their own meeting? Veterans that day stated Mr. Pretto claims to be a Purple Heart and they respect that. However, the majority stated that as a veteran he betrayed his brothers and sisters, they hold no respect for him. Residents say he does not represent them or even know most of them.

For the record, Mr. Pretto hands out two cards. He claims to represent the Administration as a Board member and he claims to be a veterans or residents' advocate.

Therein lies the next complaint. Their advocate, Lino Pretto, sits on the Board of Managers overseeing policy. He cannot serve two masters (Administration and residents), as was very well evidenced that day. However, Administration has stated he will continue in this manner, without question. We ask this be addressed. He is simply not representing veterans when he ignores their concerns. Residents no longer want him claiming to be their advocate.

And calls to Steve Chambers, who is supposed to be their ombudsman per Administration, have gone unreturned and most veterans claim they have not met him. He stated at a meeting early this past summer that he is ombudsman for something close to 19 facilities across the state. It is impossible for one man to do an adequate job while representing that many people.

Administration has a responsibility to give veterans an advocate or ombudsman who is willing to represent the residents. Veterans feel they do not have adequate representation or a "mediator" between themselves and Administration. Most complaints they filed are deemed "unsubstantiated" or rejected and unresolved by Administration.

### FUNDS AND GUARDIANSHIP ISSUES

The next allegation is that there are many concerns about missing money and property as well as inappropriate or failed maintenance. Several said it has been difficult to get accounting of their funds managed by the Home. Some who did get them say there appears to be money missing.

Theft in the building is rampant, yet not enough is done by Administration to curb it. One man claims he recently had \$1100 taken from his room, all the thief left was his empty wallet. See above for more examples. It should not be so hard for Administration to find a way to deal with this. But even after complaints, this continues.

There have been reports for a long time about donations to the Home not reaching the veterans.

There have been ongoing issues with items being donated, but shipped out to other organizations. It is fact that many people make donations to be used to help the veterans directly. Yet, they often say they cannot obtain a shirt or certain items they need. Why not? Where are those dollars and clothes going? The veterans claim not to them.

There is also discussion that the Home needs stronger accounting and auditing of items and money coming into the Home and going out. They see a need for an outside presence overseeing this matter. They also feel lumping everything (into a general fund for example) as opposed for line item accounting as had been done, only opens the system for misdirection of donations for Administration purposes. Residents believe this is what happened in part with the canopy.

Veterans are being forced, they claim, by Administration into guardianship they say they do not want and feel they do not need. Then, many have stated significant amounts of money are missing and that the system used is corrupt. The court appointed guardian sees multiple residents and bills each separately. An audit of her time, would likely prove there are not as many hours in a day as she bills for. However a check with her up-line indicates she has not been audited in the past two or three years. Should Administration not be ascertaining that is happening?

Also, at least one Guardian is paid the high end of fees, yet does not break down billable hours into fractions, as is required under the law. She rounds them off to the hour. So, if she spent five minutes with a veteran, she would charge for 60 minutes, we often found. At \$75/hour, that means instead of charging say 1/5th and hour at \$12.50, she bills \$75.00 – a difference of \$62.50 – that adds up quickly and bilks residents out of significant money. More so when one considers she sees multiple vets in the same hour.

The widow of Richard Ware claims her husband was forced into a guardianship he did not want by the Home. She claims the Home and guardian then used that resident's own money to file for a divorce neither he nor his wife wanted. When the wife protested at one court session, she was jailed on contempt. She was not allowed to see her husband for months.

Many have reported thousands of dollars missing from their accounts and have been unable to get accurate accountings. During a call to the person who supervises the Guardian, she unwittingly claimed she has not audited her court appointed guardians' records in recent times. So, someone needs to do so and hold them all accountable. No one should be using their position to make money off disabled vets. How is Dunne, the Home's Administrator not seeing this or allowing it to happen?

Also, crazy amounts of money were used to build an elaborate canopy to protect veterans from the elements. In its infancy, it is already showing rust and damage. Veterans claim they believe line item monies were combined into the General Fund and some of that money intended for other projects ended up paying, in part, for that canopy. They would like to know where all the line items and donations to specific projects went. Were they used as intended by donors? Vets do not believe so and ask for a full accounting of what happened to the line items. They see this as an abuse by Administration. Also, given the rust and damage appearing to the canopy, they are stunned Dunne has not had the contractor fix it.

## **FAILURE TO MAINTAIN AND DESTRUCTION OF PROPERTY**

The kitchen and cafeteria are infested with rodents. During a recent visit, I was sitting in the cafeteria listening to a veteran and mice ran around. There was one trap that was either broken or not set. The mouse actually played on and in the trap. Rodents in a food preparation area are not acceptable and Administration has a responsibility to have them eliminated. (Photo herewith.)

Another complaint is that there has been much discussion over the Courtyard. The Courtyard was a gorgeous area filled with thousands of dollars in plantings and landscaping. Sara failed to have it weeded and properly maintained. Despite that, at one time, it had the most beautiful plants and a family of ducks entertaining the residents. Then, Sara had people come in and literally tear it all up and throw the plantings away with total disrespect for their value. We watched in shock as they threw away into rubbish containers thousands and thousands of dollars worth of plantings put in and maintained by taxpayer and donor dollars – simply tossed into trash containers. They should have and could have been used elsewhere on the property or donated to a place like a veterans' memorial site. No, she simply had thousands of dollars in landscaping materials destroyed. I still cannot comprehend what I saw. Then, that area was left torn up and “under construction” (meaning little to nothing has happened) for months. What went into the area was very cheap looking and sparse.

There is also remains concern for the “pet” ducks which had occupied that area. They were very important and comforting to the vets sitting in that area. They said one day Sara had them suddenly removed, in what residents said was a very cold-hearted way, and they were never seen again. Ducks inherently return to the same spot. So, those veterans are concerned about “what did she have done to those birds? Where are they? Why? To the vets, it was just one more abuse of her power.

During several trips to the Home this summer, the grounds were very poorly maintained, grass not cut and weeds took over flower beds and other areas. It was in a state of serious disrepair. Herewith are photos taken recently of areas literally adjacent to the building. You will note the area is filled with weeds, some over six feet tall. Yet, if you check records, we are sure someone is getting paid for ground maintenance work that is not being done!

Repairs that should have taken days lingered for weeks or months, not only being unsightly, some were downright dangerous. Dunne failed to protect residents from those reported dangers.

There was that photo of three veterans, in tipped over wheelchairs, in a torn up flower bed, with re-bar poles sticking out of the ground next to a brick wall in June. Not only was no one there to help, after reported, Dunne did not have repairs completed. Needless to say, about two weeks ago – in August – another veteran fell into that area, this time actually striking his head on the bricks. He had to be taken to the hospital by ambulance and received stitches. This would not have happened had Dunne done seen to it that these repairs and projects were done in a timely and responsible manner. Veterans view that as one of her many failures to perform her duties.

It also raises the question, how are these needlessly long projects being paid for? By the hour? For real. Some believe that to be the case. Like why did it take all summer to fill a simple, basic, rectangular flower bed between the building and sidewalk with mulch????

The public believes the upper floors are being renovated to give the veterans more space and cleaner surroundings. I was stunned to learn how little progress has been made on that project. I was actually asked to join a board to solicit the public and businesses for funds to complete that remodel. Meanwhile, veterans claim maintenance type people are doing little bits of work in that area while doing their other jobs – hence, all projects are dragging on. Point being, much needed renovations are not happening in a timely manner under this Administrator and that is not acceptable. This alone is directly impacting the lower quality of life veterans are living in.

## **INTIMIDATION AND RETALIATION**

The biggest thing is that veterans believe Sara and her staff are deliberately violating their constitutional, civil and simple rights by doing so in ways that are sometimes inhumane. Almost all state they are extremely fearful of retaliation. For instance, if they speak out or rebel, they can be considered unruly, sent to the Courtyard, controlled with needless medication, then moved from the independent section to the “medicated” section, from which they cannot leave. With that over their heads, they live in constant fear. GRH4V is advertising in pamphlets and online as a “Home” – that is not how the residents tell me they see it during this Administration.

One veteran reported he was wearing a shirt for a veterans organization some of the members at the Home formed for themselves. He said his caregiver, who was also a supervisor, asked him about it. He said she then told him not to wear the shirt and that they (staff) had been told by Administration not to support that group.

Another member of that same group claimed he was told to remove his shirt with their group's name on it. Why can the residents not have their own group and meet regularly in their Home?

The bottom line, the veterans say the Home feels like a prison or prison camp since Sara Dunne and the current Administration were put into place. The abuses are rampant. Instead of getting a homey, caring place to live after serving their country with pride, they say they live under constant threats, intimidation and fear of ramifications. This MUST stop. Sara needs to be replaced or held accountable. And, that is the reason for this complaint, filed on behalf of many veterans at the Home who are too afraid to speak out. The current Administration also needs to be held accountable for letting her treat our treasured veterans with so much disrespect and abuse.

## **STAFFING ISSUES**

## STAFFING ISSUES

Again, staffing and J2S come up in almost every conversation with a resident or family member. I could write another long report on this issue. The long time State workers were replaced during Dunne's Administration by privatized workers from a company called J2S. Horror stories abound about the lack of staff, inadequately trained staff, high turnover, injuries resulting from improperly trained staff moving veterans, over medication, time clock fraud and worse. A complete investigation should be done into the staffing issues and why this Administrator has not demanded higher accountability in the caliber and performance of staff coming in contact with our veterans.

Despite that, I received several calls from veterans stating Dunne recently moved veterans from their designated smoking area on a rainy day to hold an event honoring the staff and J2S workers. It seems to most that event should have been held by J2S for its own employees, not Administration which buys its services. Does Admin hold events for every contractor? As one stated, Admin is using tax payer dollars to cover an event their employer should be footing the bill for. It appeared they were being paid while on the clock to party in an area reserved for veterans' use.

## SUMMARY

We ask for a complete investigation into these and related matters. The allegations herein come from many veterans who have asked me to speak for them. I have witnessed many of these situations first hand. Many residents believe it is time to replace the current Administrative team and bring in people who truly respect our veterans, their needs and concerns. They strongly believe Dunn and Dunne are not the right people to be running the State's Home for Veterans. I believe so as well based on what I have seen and experienced there since May. In fact, we will go one step farther and say this Administration should also be held criminally accountable for issues that fall under that scope. We thank you for looking into these allegations and, hopefully, helping the men and women who served our country regain the respect and dignity they earned.

*Gov. Declination*

616-719-3122

**From:** "Morgan Bedan (GOV)" <BedanM@michigan.gov>  
**To:** "Kooyers, Catherine" <catherinekooyers@comcast.net>  
**Sent:** Tuesday, June 10, 2014 4:40:13 PM  
**Subject:** RE: Decision Concerning Event Request: Grand Rapids Home for Veterans Town Hall - 24,339 CRM:0050156

Hi, Catherine.

*2nd Denial*

Unfortunately, we do not have any openings in the governor's schedule. We will keep your request in mind should something change. We appreciate your flexibility as the governor has an extremely aggressive calendar in the coming months.

Best,  
 Morgan

**From:** catherinekooyers@comcast.net [mailto:catherinekooyers@comcast.net]  
**Sent:** Tuesday, June 10, 2014 4:29 PM  
**To:** Bedan, Morgan (GOV)  
**Subject:** Re: Decision Concerning Event Request: Grand Rapids Home for Veterans Town Hall - 24,339 CRM:0050156

Thank you for taking time to respond.

Is there a different date that we could work around? The veterans at the Grand Rapids Home for Veterans would really like to have the Governor visit the home to talk with them about state and veteran issues. They will gladly work around his schedule.

Thank you for your time and consideration.

**From:** "Morgan Bedan (GOV)" <BedanM@michigan.gov>  
**To:** "Kooyers, Catherine" <catherinekooyers@comcast.net>  
**Sent:** Tuesday, June 10, 2014 3:08:10 PM  
**Subject:** Decision Concerning Event Request: Grand Rapids Home for Veterans Town Hall - 24,339 CRM:0050156

Dear Catherine,

*1st Denial*

Thank you for the invitation for Governor Rick Snyder to participate in the Grand Rapids Home for Veterans Town Hall. We respectfully decline this invitation as the governor is unable to participate attend.

Sincerely,

Morgan Bedan  
 Scheduling Office  
[govscheduling@michigan.gov](mailto:govscheduling@michigan.gov)

*Gov. Declination*

XFINITY Connect

catherinekooyers@comcast.net

± Font Size :

**RE: Town Hall CRM:0050545**

**From :** Morgan Bedan (GOV) <BedanM@michigan.gov>

Wed, Sep 24, 2014 12:11 PM

**Subject :** RE: Town Hall CRM:0050545

**To :** catherinekooyers@comcast.net

**Cc :** Kaitlin Nye (GOV) <NyeK@michigan.gov>

*By  
Denial*

Hi, Catherine.

Thank you so much for the invitation. We will keep your offer in mind as we move closer to the end of the year. I have copied Kaitlin, Manager of our Constituent Relations office, she is an excellent resource for information regarding the State's policies and information related to both veterans and seniors. Please do not hesitate to contact our office, if we can ever be of assistance.

Thank you, again, for the invitation.

Sincerely,

Morgan

**From:** catherinekooyers@comcast.net [mailto:catherinekooyers@comcast.net]  
**Sent:** Tuesday, September 23, 2014 4:10 PM  
**To:** Bedan, Morgan (GOV)  
**Subject:** Town Hall

Local veterans and their advocates are interested in a Town Hall or meeting with the Governor. Your team refused to meet with them at the Home for Veterans. So, we have been holding our own meetings off-site.

We have heard through the media the Governor is scheduling Town Halls across the State of Michigan. Would the Governor be willing to meet with them and seniors at a site other than the Home? I have held a series of "Meet Your Rep" meetings in Wyoming, MI over the past three years. We have had a wide range of guests from both parties, all levels, and others. Congressman Huizenga held his first Town Hall meeting here when he took over this district and works well with veterans and advocates on veteran issues. Mark Schauer accepted an invitation and did speak here a few weeks ago. We would like to hear your side about veteran issues, the Home for veterans, senior issues and such. What are your plans to take veteran services from the bottom? What are your plans to improve service with J2S and so on. Typically we have a main speaker who talks about who he is, what he does, and where he is going. Usually, that speaker then takes questions from the audience, which is quite amicable. We are across the street from the newer Metro Hospital, off M-6, and across from the new Veterans Outpatient Clinic which will open Nov. 14, 2014. We hope you will reconsider.

For the record, I have been a veteran and patient advocate for decades. No one pays me. I am bi-partisan. My life has been dedicated to improving lives and giving voters a chance to meet and get to know the people they are electing to offices. Bayberry Farms Village, where we host these meetings, has a light, airy Community Room that holds a good hundred people, more if we open to the adjoining room. It is a village of independent seniors, many of whom are veterans or their widows.

Catherine Kooyers



**VA**  
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JUL 10 2014

In Reply Refer To: 515/012GR

Ms. Sara Dunne, Commandant  
Grand Rapids State Home for Veterans  
3000 Monroe Avenue NW  
Grand Rapids, MI 49505

Dear Ms. Dunne:

The Battle Creek VA Medical Center (VAMC) Michigan Survey Team conducted the Annual Survey of the Grand Rapids State Home for Veterans (GRSHV) on March 4-7, 2014. During the survey, deficiencies were cited and a letter was sent to you on April 1, 2014, listing those deficiencies.

On April 22, 2014, you responded with the Grand Rapids SHV final Corrective Action Plan and on May 15, 2014, you were granted full certification for 2014 for your Domiciliary. On June 13, 2014, you provided more information showing compliance to Standards 73, 91, 93, 94, and 95 to VA Nursing Home Standards. After the survey team reviewed the evidence of implementation of the Corrective Action Plan, it is determined that your facility, Grand Rapids SHV, is in compliance with all VA Nursing Home Standards and I have granted the Grand Rapids State Home for Veterans full certification for the year 2014.

If you should have any questions regarding the Grand Rapids SHV certifications or the information provided to you, please contact Mr. Greg Harris, Clinic Manager, at (616) 365-7573.

Thank you for your continued service to our nation's Veterans.

Sincerely,

Mary Beth Skupien, Ph.D.  
Medical Center Director

cc: Chief Consultant, Geriatrics and Extended Care (10P4G)

**Department of Veterans Affairs Medical Center**  
**5500 Armstrong Road**  
**Battle Creek, MI 49037-7314**



**DEPARTMENT OF VETERANS AFFAIRS  
Office of Inspector General  
P.O. Box 50410  
Washington DC 20091-0410**

In Reply Refer To: 53E/71/2014-16192

September 19, 2014

Catherine Kooyers  
catherinekooyers@comcast.net

Ms. Kooyers,

The U.S. Department of Veterans Affairs Office of Inspector General (OIG) Hotline received your complaint. The VA OIG's mission is to detect and prevent fraud, waste, and abuse within VA programs. The Hotline accepts tips or complaints that, on a select basis, result in reviews of:

- VA-related criminal activity.
- Systemic patient safety issues.
- Gross mismanagement.
- Misconduct by senior VA officials.

In order to examine the issues you have raised, it may be necessary for the OIG to take actions that will effectively release your identity as the complainant. Accordingly, we request that you review, complete, and return the enclosed release of identity form to us before we take further action on your complaint. You may return your completed form by fax (202-495-5861), by email ([vaoighotline@va.gov](mailto:vaoighotline@va.gov)), or by mailing it to:

VA OIG Hotline  
P.O. Box 50410  
Washington, DC 20091-0410

Information on the OIG Whistleblower Protection Program is available at:  
<http://www.va.gov/oig/hotline/whistleblower-protection.asp> Thank you for your interest in the VA OIG Hotline.

Enclosure

Faxed 9-22-14  
12:20pm

**PERMISSION TO DISCLOSE COMPLAINT INFORMATION**

TO: VA Office of Inspector General  
Department of Veterans Affairs

Re: OIG Hotline Complaint 2014-1619271

many more incidents  
have happened since my  
original complaint was  
filed. Am sending an  
update w/ photos + docs to  
you via U.S. mail this week.

Please make a selection for (1) Release of Identity and (2) Release of Written Complaint and Other Documentation. Place your initials next to your selections, and sign, print your full name, and enter the date where indicated below.

1 X  
here with  
9/24

1. Release of Identity

ok I give permission to the VA OIG to release my name to VA management in connection with the complaint I filed with the VA OIG Hotline.

\_\_\_\_\_ I do not give permission to the VA OIG to disclose my identity to VA management in connection with the complaint I filed with the Hotline. I understand that my failure to consent to the release of my name may inhibit the proper review of my issue.

2. Release of Written Complaint and Other Documentation

ok I give permission to the VA OIG to release to VA management my written complaint (including my name, duty station and any other personally identifying information that may be contained in the complaint) and/or other documentation submitted by me or on my behalf in connection with the complaint I filed with the VA OIG Hotline.

\_\_\_\_\_ I do not give permission to the VA OIG to release to VA management my written complaint (including my name, duty station and any other personally identifying information that may be contained in the complaint) and/or other documentation submitted by me or on my behalf in connection with the complaint I filed with the IG Hotline

SIGNATURE Catherine Koopers (616) 719-3122  
FULL NAME (PRINTED) Catherine Koopers  
DATE 9-20-14

September 24, 2014

Department of Veterans Affairs  
Office of the Inspector General  
P.O. Box 50410  
Washington DC 20091-0410

RE: 53E/71/2014-16192

Since my original complaint was filed with OIG, there have many new, alarming developments and incidents uncovered.

After almost daily visits to the Grand Rapids Home for Veterans for four months, I have compiled a detailed report for your investigation. Since I deal with veterans in the general public arena as well, this report details in a separate section their circumstances as well. I did not include the names of that group at this time to protect their identities until I am assured there will be no retaliation against them.

This report includes additional details on the original complaint and what has happened or been uncovered since then. I am available to discuss this with your team if that helps.

Thank you for considering this report and working to ensure our veterans are protected and get the care they need and earned.

Sincerely,



Catherine Kooyers  
2520 56<sup>th</sup> St., S.W.  
Unit 105  
Wyoming, MI 49418  
616-719-3122  
catherinekooyers@comcast.net



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF HEALTH CARE SERVICES  
HEALTH PROFESSIONS DIVISION

*Gerrit's Son*



MIKE ZIMMER  
DIRECTOR

February 19, 2015

Catherine Kooyers  
2520 56th St., SW 105  
Wyoming, MI 49418

RE: Mark William Bates, MD  
File # 134613

Dear Ms. Kooyers:

Some time ago you filed with this office an allegation against the above-named licensee. Please be advised that under the Public Health Code [MCL 333.16231(2)], we can only conduct an investigation if so authorized by the board chairperson or his/her designee.

Your allegation was reviewed by a member of the appropriate board who determined that there was insufficient basis to authorize investigation of your allegation. Since no investigation was authorized we have no choice but to close your file with no further action taken as we do not have the authority to override a decision of the board.

I am sorry we cannot be of further assistance in regard to your allegation.

Sincerely,

Sherri Johnson, Manager  
Allegation Section  
Enforcement Division  
(517) 373-9196 "5"

SJ: ljl

*Which member?  
Which board?  
Not even w/ a  
license lapsed since  
2009!??*



STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
BUREAU OF HEALTH CARE SERVICES

RICK SNYDER  
GOVERNOR

MIKE ZIMMER  
ACTING DIRECTOR

September 17, 2014

Catherine Kooyers  
2520 56th St., SW 105  
Wyoming, MI 49418

Re: Mark Bates,  
File #43-134613

Dear Ms. Kooyers:

We have received the information that you provided regarding the above referenced licensee. This information will be reviewed to determine whether there has been a violation of the Michigan Public Health Code. You may be contacted if more information or signed releases are needed. We appreciate your patience in this matter and you will be notified as soon as a determination is made.

PLEASE REFER TO THE ABOVE-REFERENCED FILE NUMBER IN ANY FUTURE COMMUNICATIONS WITH THIS OFFICE.

Sincerely,

A handwritten signature in cursive script that reads "Sherri Johnson".

Sherri Johnson, Manager  
Allegation Section  
Enforcement Division  
Bureau of Health Care Services  
Telephone: (517) 373-9196

SJ: ljl

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ENFORCEMENT DIVISION

611 W. OTTAWA • P.O. BOX 30670 • LANSING, MICHIGAN 48909-8170

[www.michigan.gov](http://www.michigan.gov) • (517) 373-9196

**Michigan Department of Licensing and Regulatory Affairs**  
**Bureau of Health Care Services**  
 Enforcement Division  
 P.O. Box 30670  
 Lansing, MI 48909-8170  
 (517) 373-9196  
**ALLEGATION FORM**

<b>Office Use Only</b>
File #:

Authority: Public Act 368 of 1978, as amended  
 Completion: Voluntary Penalty: None

I wish to complain against the individual named below. **I understand that this agency and the Licensing Board DO NOT assist citizens seeking reimbursement or resolution of billing and fee disputes.**

**INSTRUCTIONS:** Print legibly or type information. Complete all sections of this form. Sign at the bottom. Return the white copy to the address above. Please complete a separate form for each practitioner you are filing an allegation against. **Please be advised that this agency DOES NOT investigate anonymous allegations.**

Information About You		
Your Name <i>Catherine Kooyers</i>		
Street Address <i>2520-56th St, S.W., 105</i>		
City <i>Wyoming</i>		
State <i>MI</i>	Zip Code <i>49418</i>	Country <i>USA</i>
Patient's Name <i>Multiple - Attached</i>		
Patient's Date of Birth (MM/DD/YYYY) <i>"</i>		
Patient's Last 4 Digits of Their Social Security Number <i>na</i>		
Your Telephone Numbers With Area Code		
Cell:		
Home: <i>616-719-3122</i> Work:		

Allegation Being Filed Against	
Practitioner's First and Last Name <i>Mark Bates</i>	
Street Address <i>69. B. Home for Veterans</i>	
City <i>3000 Monroe Ave., N.E.</i>	
State <i>MI</i>	Zip Code <i>49505</i>
Practitioner's Telephone Number <i>616-364-5300</i>	
Treatment/Incident Date <i>Various - Attached</i>	

**Check the profession for which you are lodging an allegation about:**

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Dietitian or Nutritionist	<input type="checkbox"/> Optometrist	<input type="checkbox"/> Respiratory Therapist
<input checked="" type="checkbox"/> Allopathic Physician (MD)	<input type="checkbox"/> Marriage & Family Therapist	<input type="checkbox"/> Osteopathic Physician (DO)	<input type="checkbox"/> Sanitarian
<input type="checkbox"/> Athletic Trainer	<input type="checkbox"/> Massage Therapist	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Social Worker
<input type="checkbox"/> Audiologist	<input type="checkbox"/> Nurse (RN or LPN)	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Speech/Language Pathologist
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Nursing Home Administrator	<input type="checkbox"/> Physician's Assistant	<input type="checkbox"/> Veterinarian
<input type="checkbox"/> Counselor	<input type="checkbox"/> Nurse Aide (CNA)	<input type="checkbox"/> Podiatrist	
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Psychologist	

Is there civil actions pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a police report? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	May we release your name and this information to the practitioner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Will you testify at an Administrative Hearing if necessary? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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**Please provide details of your specific concerns related to the treatment rendered. Attach additional sheets if necessary.**

*Attached*

Your Signature <i>Catherine Kooyers</i>	Date <i>8.28.14</i>
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Complaints:

1) Request investigation into deaths of patients under the care of Dr. Mark Bates at the Grand Rapids Home for Veterans. Reports from fellow residents indicate they have died of misdiagnoses, lack of timely and appropriate care. They claim seeing maggots on two of the deceased prior to their deaths. While this is only a sampling of his cases, those below were specifically disturbing to residents (these are the names as spelled and given to me by veterans):

Richard Ware  
Billy Ray Daughtry  
Dale Weaver  
Rodney Tardy  
Frank Grey  
Ken Kneely  
Mr. Renesaince

2) Request a review of Dr. Bates' cases relative to serious, repeated misdiagnoses. The cases in this group are too numerous to list. I am told, the ones below were confirmed by outside providers (again, these names are spelled as given to me by veterans):

The above listed veterans.

Larry Krul  
Charles Dean Johnson  
Norman Tope

3) LARA shows Dr. Bates' license to prescribe has been lapsed since 2009 – is this correct? If so, why is he prescribing meds for veterans at the Grand Rapids Home for Veterans?

4) Bates reportedly told Terry Laurain he (Bates) would not prescribe medications for Terry unless he took someone, a Home staffer, on vacation with him. That staffer hit the veteran's credit card with multiple personal expenses, such as \$70 a bottle cognac, a watch and more, according to the veteran. Terry claims the staffer even wanted to hire a prostitute for both of them, even though the staffer is married. Terry claims he discussed this with Dr. Edgar, who admitted Bates was in the wrong. Which raised the question, did Dr. Edgar report this or how was it dealt with? This same veteran claims he has been directed to take other staffers on extremely expensive vacations with him, like the mother of an Administration worker. Veteran feels he was "blackmailed" or coerced to do so in order to get necessary meds and travel. He would not only like Dr. Bates held accountable for this and his money back (which we understand LARA does not handle), he questions if this is not criminal as well as unethical.

5) There has been established a pattern complaints from veterans under the care of Dr. Bates that he is refusing to refer veterans to doctors at the Coit Veterans Outpatient Clinic or outside doctors for a second opinion. That has been a strong common theme I heard over and over. Larry Krul claims this almost cost him his life this May. So did Charles Dean Johnson. And others. Given the number of misdiagnoses we are hearing about, we question if he is afraid to have his cases reviewed and is purposely hindering veteran care and rights to protect himself.

6) Over medicating patients.  
Larry Krul

Joe Sheeran  
Richard Ware  
Evenings – entire wings of patients.

7) HIPPA violations. Caregivers at the Home are given “Cheat Sheets” as they are labeled with the most private of patient information on them. These sheets are routinely found in common areas like the Cafeteria, Kozy Corners, Lobby, Auditorium, etc. These details include things like they are incontinent, have bowels issues, meds, etc. – information that the doctor and Home are obligated to protect.

#### Summary/Details:

I have been a veteran advocate for decades. These complaints and allegations are as reported to me by dozens of veterans in the Grand Rapids Home for Veterans, their family members and others.

In May of 2014, as I left a meeting at the Coit VOC between regional VA, Congressman Huizenga, media and veterans, I encountered a group of veterans from the Home. I asked how they were and Larry Krul said “I am dying.” It turns out he really was. Since that day, I have been invited to visit dozens of veterans at the Grand Rapids Home for Veterans. They are begging for help and relaying terrifying stories of abuse, misdiagnosis and complications. A common theme I noticed is that the name “Dr. Bates” is the one that keeps coming up.

Larry Krul stated he was not well, asked his doctor (Bates) for a referral to see another doctor or see a doctor at the VOC. He claims his doctor denied that referral. So, a group of Home veterans wheeled Larry to the VOC. The VOC refused to see him without the referral. He ended up in ICU a couple days later. When I called to check on him, the nurse said he was not expected to live through the night – he was that bad. After a few days in the hospital, with a change of diet and meds, his condition improved and he was returned to the Home. He claims tests show he was overdosed by staff who gave him meds as prescribed by Dr. Bates.

He also claims the Home food contributed to problems with his sugar. Most of the foods they receive are overly processed, canned, very few fresh fruits and vegetables. The main fresh fruits are apples, oranges and bananas all year round – some not in their diets due to sugar or potassium and such. They claim seasonal fruits and vegetables are rare – like fresh berries, melons, beans, squash, etc. which would help diets.

Over the past weeks, I was then invited to speak with dozens of veterans at the Home and received calls from many family members, even volunteers and staffers. with concerns. Literally dozens and dozens have shared personal stories with me. The ones I focus on herein are those related to Dr. Bates. That is because as they shared their personal stories, not aware of details I was hearing from other veterans, the same themes emerged: premature or avoidable deaths, misdiagnoses, overmedications, refusal of requests for second opinions and lack of compassion were the major ones.

They told of several residents that they claim were all under the care of Dr. Bates then died under questionable and/or disturbing circumstances. It is believed some were grossly misdiagnosed, improperly cared for and that resulted in premature deaths, some avoidable. They claim the doctor's overprescription of drugs like Depakote is contributing to their demise and complications. They claim some veterans actually had maggots on their wounds before their deaths they state.

They report many veterans under his care are not getting proper "movement" or rotation and not only have serious bed sores, many become infected. If they ask the caregivers to clean them more gently, they are termed "unruly" or dangerous and are given meds to sedate them.

Amputees claim Bates is not doing enough to help them attain artificial limbs.

Some names (as given to me by residents) to support these claims are those listed above.

Then, I also heard horror stories related to gross misdiagnoses they claim he made to his patients. Usually these were discovered after veterans suffered severe complications and were taken to local hospitals or were seen by outside doctors. There are far too many to recount here. However, Larry Krul, Norm Tope, and Charles Dean Johnson are serious examples. It has been reported that prior to his death Ken Kneely was told he had strep throat – after an extended period of time and no recovery, it was discovered he actually had throat cancer. Dean Johnson claims he was told he had minor stomach issues, the doctor ignored his requests to do more, until he was sent to a local hospital after his colon burst from a blockage and he almost died, spending weeks in a coma. Dean Johnson also claimed he had a feeding system inadvertently pulled out by a careless caregiver – that caregiver was instructed on how to reinsert that over the phone – this should have been done by a professional in a different, sterile setting.

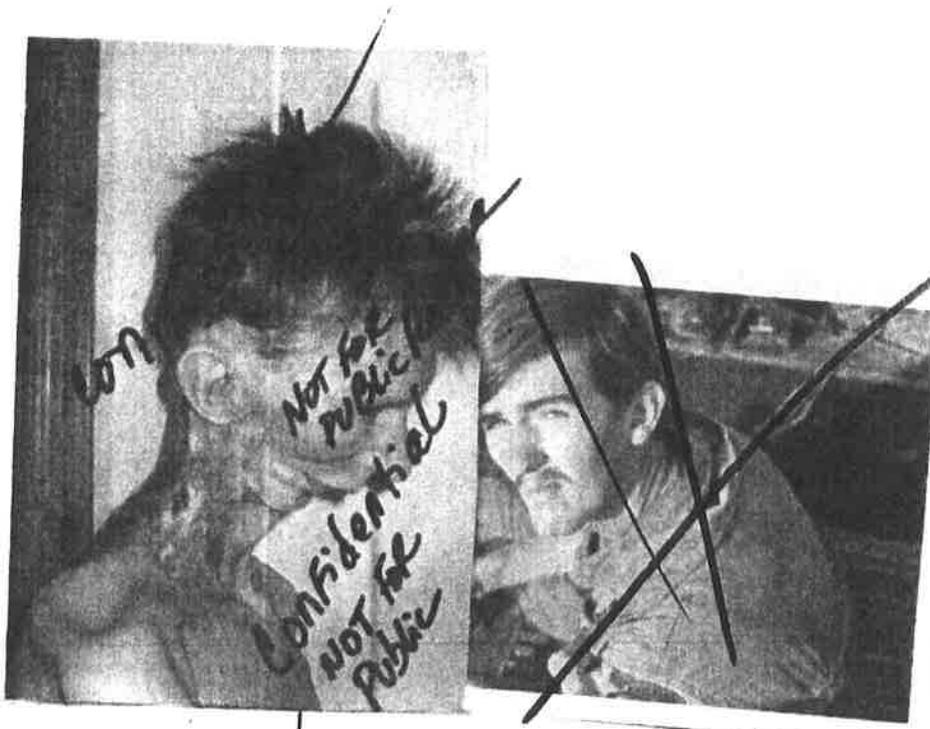
We are hearing of several veterans being overdosed and overly medicated who are under the care of Dr. Bates. Richard Ware was one of them who received questionable drugs like Depakote for an extended period of time. Larry Krul claims tests taken at the hospital proved his case. Also, Joe Sheeran was outside, alert, talkative. A short time later that day, his son claimed he entered his father's room to find him in a comatose like state, with his pants pulled down to his ankles and his dad lying on a soiled bed in a soiled diaper with no one around. One veteran was speaking with me at 7:30 p.m., a caregiver demanded he go upstairs for his nightly medication. He did want to go, he said he fought in Nam, let him decide when he sleeps. He simply wanted to enjoy the beautiful sunset over the river. He asked me for help. So, I asked her if it could wait, she said it was just medication to put him to sleep. She said, "off the record," they have the caregivers sedate the men so the Home needs less staffing at night! So, who is prescribing meds for Dr. Bates' patients if not him? This practice of overdosing to the point of comatose state or hospitalization must be investigated. In fact, I am requesting a qualified physician review each of Dr. Bates' cases to see if the medications being prescribed are appropriate and change what is not.

We have repeatedly found "Cheat Sheets" as they are labeled in common areas. Even after calling this problem to the attention of Admin., it continues as recently as this week. That is patient HIPPA protected information!!! Ultimately, it is the responsibility of Dr. Bates and the Home to make sure that information is protected. Just because the State of Michigan and the Home Director try to save money by hiring privatized workers who lack training and patient knowledge, does not override the rights to privacy to which these veterans and patients are entitled. This practice must cease or be better controlled so those documents do not leave their room. This is criminal.

They claim medical records are missing and some have been changed.

In short, there appear to be valid reasons to investigate Dr. Bates. He must be held accountable for his treatment of our country's cherished gift – our veterans.

Then and now 1.jpg



W77  
 Not for  
 Public  
 Confidential  
 Not for  
 Public

↓  
 Before V. A. Care

↓  
 After V. A. "Care"  
 & over-radiated by  
 V.A.



Spring Veteran rolling into unfinished  
unprotected area. Even after called  
to Director's attn., not repaired.  
months later vet hit head, taken  
to hospital for stitches