

No. 348 228825 08

STATE OF TEXAS,
Plaintiff,

v.

PAMELA CARROLL, *individually*,
and d/b/a LOVING CARE

Defendants

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IN THE DISTRICT COURT OF

TARRANT COUNTY, TEXAS

_____ JUDICIAL DISTRICT

FILED
TARRANT COUNTY
2008 FEB 14 P11 2:56
THOMAS A. WILDER
DISTRICT CLERK

**PLAINTIFF'S ORIGINAL PETITION
FOR INJUNCTIVE RELIEF AND CIVIL PENALTIES
AND APPLICATION FOR EX PARTE TEMPORARY RESTRAINING ORDER**

TO THE HONORABLE JUDGE OF SAID COURT:

NOW COMES the STATE OF TEXAS ("STATE"), Plaintiff, acting by and through its Attorney General GREG ABBOTT and at the request of the TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES ("DADS"), files this Original Petition against PAMELA CARROLL, individually, and doing business as LOVING CARE, Defendant, and for cause of action, would respectfully shows the Court as follows:

I. PARTY PLAINTIFF

1.1 This suit is brought in the name of the STATE OF TEXAS by and through its Attorney General, Greg Abbott, and under the authority of the Constitution, statutes, and laws of the State of Texas.

1.2 This suit is also brought at the request of the Commissioner of the Texas Department of Aging and Disability Services ("DADS"), as authorized by chapter 247 of the Texas Health and

Safety Code.

II. PARTY DEFENDANT

2.1 Defendant Pamela Carroll, individually, and doing business as Loving Care, owns and operates the alleged unlicensed assisted living facility known as Loving Care, located at 909 Forrester Drive in Arlington, Texas. **Pamela Carroll may be served with process at 909 Forrester Drive in Arlington, Tarrant County Texas 76010 or 401 Wilmington Ct., Grand Prairie, Dallas, County, Texas 75052.**

III. DISCOVERY CONTROL PLAN

3.1 Discovery in this suit is intended to be conducted under Discovery Level 2 pursuant to TEX. R. CIV. P. 190.1 and 190.3. However, due to the nature of this lawsuit, the STATE reserves the right to request a tailored discovery plan pursuant to TEX. R. CIV. P. 190.4 at a later date.

IV. AUTHORITY

4.1 Plaintiff has authority to bring this action in this Court under Chapter 247 of the Texas Health and Safety Code and the authority granted to the Attorney General of Texas pursuant to TEX. HEALTH & SAFETY CODE ANN. §§ 247.044(c)-(d) and 247.045(d).

V. VENUE

5.1 Venue is proper in Tarrant County pursuant to TEX. CIV. PRAC. & REM. CODE § 15.002(a)(1) and TEX. HEALTH & SAFETY CODE ANN. § 247.044(e) because the facility is located in Tarrant County and since all or a substantial part of events or omissions giving rise to this claim occurred in Tarrant County.

VI. PURPOSE OF SUIT

6.1 The purpose of this suit is to obtain a temporary restraining order, an injunction, and

to collect civil penalties from Defendant because Defendant is operating an unlicensed assisted living facility and the conditions at the facility constitute a serious and immediate threat to the health and safety of the facility's residents. The State seeks: (1) a temporary restraining order, (2) a temporary and permanent injunction, and (3) civil penalties, pursuant to chapter 247 of the Texas Health and Safety Code.

6.2 To protect the residents of Defendant's facility, the State is seeking a temporary restraining order along with a temporary injunction and a permanent injunction to enjoin Defendant from operating her unlicensed assisted living facility, Loving Care, located at 909 Forrestal Drive, Arlington, Tarrant County, Texas, or any other location.

6.3 A Temporary Restraining Order is necessary in this case because, in response to a received complaint, a detailed investigation was conducted by DADS surveyors to determine whether Defendant was operating an unlicensed assisted living facility and whether at least one resident was subject to abuse or neglect. The investigation revealed that Defendant was operating an unlicensed assisted living facility, in violation of the Texas Health and Safety Code. The investigation yielded strong evidence corroborating the complaint that resident abuse and/or neglect has occurred, and is likely to continue to occur, at the Defendant's facility. DADS has strong reason to believe that one resident of the facility was recently sexually assaulted by two other residents of the facility. The conditions at the facility constitute a serious and immediate threat to resident health and safety in which violent sexual acts are likely to continue unless Defendant is immediately restrained and enjoined and the residents are removed from the facility.

VII. APPLICABLE LAW

7.1 An "assisted living facility" is an establishment that furnishes, in one or more

facilities, food and shelter to four or more persons who are unrelated to the proprietor of the establishment and that provides personal care services. TEX. HEALTH & SAFETY CODE ANN. § 247.002 (1).

7.2 “Personal care services” means: the assistance with meals, dressing, movement, bathing, or other personal needs or maintenance; the administration of medication by a person licensed to administer medication or the assistance with or supervision of medication; or general supervision or oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence in an assisted living facility or who needs assistance to manage the person’s personal life, regardless of whether a guardian has been appointed for the person. TEX. HEALTH & SAFETY CODE ANN. § 247.002(5).

7.3 If an investigation reveals that abuse, exploitation, or neglect has occurred, DADS shall implement enforcement measures, including relocating residents. TEX. HEALTH & SAFETY CODE ANN. § 247.043(b)(1).

7.4 A person is a “controlling person” if the person, acting alone or with others, has the ability to directly or indirectly influence, direct, or cause the direction of the management, expenditure of money, or policies of an assisted living facility or other person. TEX. HEALTH & SAFETY CODE ANN. § 247.005(a).

7.5 A person may not establish or operate an assisted living facility without a license issued under chapter 247. TEX. HEALTH & SAFETY CODE ANN. § 247.021(a).

7.6 Upon petition and on a finding by the Court that a person is violating the standards or licensing requirements provided under chapter 247, a District Court may, by injunction: (1) prohibit a person from continuing a violation of the standards of licensing requirements provided

under chapter 247; (2) restrain the establishment or operation of an assisted living facility without a license; or (3) grant any other injunctive relief warranted by the facts. TEX. HEALTH & SAFETY CODE ANN. § 247.044(b).

7.7 A person who violates chapter 247 of the Texas Health and Safety Code or who fails to comply with a rule adopted under chapter 247 of the Texas Health and Safety Code and whose violation has been determined by DADS to threaten the health and safety of a resident of an assisted living facility is subject to a civil penalty of not less than \$1,000 nor more than \$10,000 for each act of violation, plus investigation costs and attorney's fees. Additionally each day of a continuing violation constitutes a separate ground of recovery. TEX. HEALTH & SAFETY CODE ANN. § 247.045(c).

7.8 The attorney general may institute and conduct a suit authorized by section 247.044 at the request of DADS. TEX. HEALTH & SAFETY CODE ANN. § 247.044(d).

7.9 The State is exempt from filing a bond. TEX. CIV. PRAC. & REM. CODE § 6.001.

VIII. FACTUAL ALLEGATIONS AND VIOLATIONS

8.1 Specific pleading of the facts at issue requires description of conditions and occurrences of an intimate and private nature involving individuals who are not parties to this suit. Disclosures of their identities would subject them and their families to needless and painful public scrutiny into their privacy without serving the ends of justice. Therefore reference to residents herein will be made to residents by designated number to protect their privacy. *See* TEX. HEALTH & SAFETY CODE ANN. § 247.064 and 40 TEX. ADMIN. CODE §§ 92.106 and 125(a)(2)

8.2 On or about February 11, 2008, DADS surveyors conducted a complaint investigation at an alleged unlicensed facility known as Loving Care, located at 909 Forrestal Drive in Arlington,

Texas. The complaint alleged that one resident of the facility was a registered sex offender and another resident was being sexually abused. The surveyors then conducted a thorough investigation of the facility and found evidence of resident abuse and/or neglect through interviews with residents, staff and the facility owner.

8.3 The DADS surveyors first met with Anthony Gibbs, a caregiver employed at the facility. Mr. Gibbs confirmed that seven individuals resided at the facility. Mr. Gibbs said that Pamela Carroll was the owner of the facility. Mr. Gibbs did not know the names of the residents. He stated that at least some of the residents took medications and that the residents were not allowed access to the medications. Mr. Gibbs stated that facility staff poured medication dosages and placed medications into the hands of the residents. Mr. Gibbs confirmed that Resident #1 required and received assistance from facility staff with bathing and toileting.

8.4 The surveyors met with Janice McDowell, another caregiver employed at the facility. Ms. McDowell stated that she provided supervision and assistance with medications. She said that residents' medications were maintained in a kitchen cabinet and the caregivers dispensed the medications as prescribed. Ms. McDowell also stated Resident #1 received assistance with bathing and toileting.

8.5 The surveyors interviewed Resident #5. Resident #5 told the surveyors that he had attempted to engage in anal sex with Resident #1. He described how he held down Resident #1 in order to keep him from moving. Resident #5 also stated that he had recently been in jail for molesting his cousin.

8.6 Surveyors interviewed Resident #2 who stated that he attempted to have anal sex with Resident #1. He stated he performed oral sex on Resident #1. He said that Resident #3 walked

in and caught him.

8.7 Resident #3 told the surveyors that he entered Resident #2's bedroom and observed what appeared to be Resident #2 engaging in anal sex with Resident #1. Resident #3 stated that he reported his observation to one of the caregivers, Sandra Francis.

8.8 The surveyors attempted to interview Resident #1. However, his responses were unintelligible and it appeared that Resident #1 was mentally retarded. The investigation revealed that Resident #1 lacked the capacity to make informed decisions.

8.9 The surveyors interviewed caregiver Sandra Francis who confirmed that Resident #3 reported the above described incident to her on January 19, 2008. Ms. Francis stated that she informed the owner/manager, Pamela Carroll. She also stated that the Arlington Police Department was notified.

8.10 Ms. Francis told the surveyors that Resident #1 required assistance with bathing and toileting and that she dispenses medications to residents.

8.11 An interview with Pamela Carroll, the owner/manager of the facility, confirmed that Ms. Francis had reported that Resident #3 had walked in on Resident #2 having sex with Resident #1 and that Resident #5 also admitted to having sex with Resident #1.

8.12 In response to questions from the surveyors about how she was ensuring the safety of the residents with Resident #2 and Resident #5 still residing at the facility, Ms. Carroll stated that staff was available at all times, Resident #1 was not allowed to be at the dining table with Resident #2 and Resident #5, and they were not allowed to go on outings or be transported together.

8.13 Ms. Carroll told surveyors that Resident #1 wore pull-ups due to incontinent episodes and that he required cueing and supervision while in the bathroom.

8.14 As part of the investigation, surveyor Lori Parrish determined that Resident #3, Resident #5, and Resident #4 are registered sex offenders.

8.15 As a result of this investigation, DADS determined that seven residents, unrelated to the owner, reside in the facility located at 909 Forrestal Drive in Arlington, Texas. The surveyors determined that the facility provides personal care services to at least one of those residents. The surveyors determined that at least one of the residents, a vulnerable, mentally retarded individual, has been the victim of sexual abuse at the facility and the facility has not provided adequate measure to protect facility residents from such abuse. The surveyors determined that the conditions at the facility constitute a serious and immediate threat to the health and safety of the residents of the facility.

8.16 In support of this petition, the State relies upon and adopts by reference for all purposes the attached exhibits as follows:

A. Exhibit A is an affidavit from Lori Parrish, L.M.S.W., DADS social services surveyor, dated February 13, 2008, describing her February 11, 2008 investigation of Defendant's facility.

B. Exhibit B is an affidavit from Shannon Wright, R.N., DADS registered nurse surveyor, dated February 13, 2008, describing her February 11, 2008 investigation of Defendant's facility.

C. Exhibit C is an affidavit from Lydia Maese, Legal Coordinator for DADS, dated February 13, 2008, establishing that Defendant did not have a license to operate an assisted living facility.

IX. REQUEST FOR EX PARTE TEMPORARY RESTRAINING ORDER

9.1 State's application for a temporary restraining order is authorized by section 247.044 of the Texas Health and Safety Code.

9.2 Pursuant to chapter 247 of the Texas Health and Safety Code, the State requests that the Court grant a temporary restraining order enjoining Defendant, her officers, agents, servants, and employees from operating the unlicensed assisted living facility, Loving Care, located at 909 Forrestal Drive, Arlington, Tarrant County, Texas, 76010, as well as enjoining Defendant from future operation of this or any other unlicensed assisted living facility in the State of Texas¹.

9.3 The State also requests that the Court grant a temporary restraining order enjoining Defendant, her officers, agents, servants, and employees from preventing DADS employees from entering the facility and transferring residents from the facility who may be at risk for abuse or removing as many residents as necessary to reduce the facility's census to three.

9.4 Notice of this filing was not given to the Defendant. It is paramount for DADS inspections and visits to be unannounced in order to ensure that a person operating a facility in violation of the law does not temporarily remove residents from the facility's premises in anticipation of an upcoming inspection or other authorized action. Accordingly, imminent and irreparable harm will result to DADS's ability to conduct an effective investigation or take other authorized action if the Court were to require advance notice be given to Defendant.

X. PRAYER

For these reasons, the State respectfully requests the following relief:

1. The State has statutory authority to seek and the Court has statutory authority to issue temporary restraining orders as well as other injunctive relief warranted by the facts. TEX. HEALTH & SAFETY CODE § 247.044. The Texas Supreme Court has stated that the State does not need to prove immediate and irreparable injury when seeking injunctive relief pursuant to an authorized statute. *State v. Texas Pet Foods*, 591 S.W.2d 800,805 (Tex. 1979). Moreover, the Court does not have to balance the equities when the State litigates in the public's interest and seeks injunctive relief that is prescribed by statute. *Ibid* at 805. Injunctive relief may be granted to the State upon a showing of only a violation of a statute. *Gulf Holding Corp. V. Brazoria County*, 497 S.W.2d 614 at 619 (Tex. Civ. App.-Houston [14th] 1973, writ ref'd n.r.e.).

10.1 That a **temporary restraining order** be issued without notice against Defendant Pamela Carroll, individually, and doing business as Loving Care, restraining Defendant, her officers, agents, servants, and employees from:

A. Preventing or hindering DADS agents or any other agent of the State from entering the facility, Loving Care, located at 909 Forrester Dr., Arlington, Texas 76010, or effectuating an orderly transfer of the residents from the facility to other licensed facilities or their families;

B. Interfering with or denying DADS agents or other agents of the State access to the facility, Loving Care, located at 909 Forrester Dr., Arlington, Texas 76010, or any other facility within the State of Texas owned or operated by the Defendant for the purpose of conducting an investigation or taking other appropriate action pursuant to chapter 247 of the Texas Health and Safety Code;

C. Removing any residents from the facility, Loving Care, located at 909 Forrester Dr.; Arlington, Texas 76010, without the authorization and direct supervision of DADS or other agents of the State;

D. Operating the facility, Loving Care, located at 909 Forrester Dr.; Arlington, Texas 76010, as an unlicensed assisted living facility;

E. Admitting residents to the facility, Loving Care, located at 909 Forrester Dr.; Arlington, Texas 76010, as an assisted living facility;

F. Operating, owning, or controlling, in whole or in part, any unlicensed assisted living facility within the State of Texas;

G. Admitting residents requiring personal care services to any unlicensed assisted living facility within the State of Texas;

H. Preventing or hindering a licensed home and community support services agency from providing services to any resident of Defendant's facility;

I. Failing to protect any resident of the facility from abuse and/or neglect;

J. Failing to care for residents on a temporary and emergency basis while DADS agents supervise and effectuate the transfer of the residents to other facilities;

K. Failing to follow any instructions given by DADS agents to Defendant and her agents in order to temporarily care for residents while DADS agents supervise and effectuate the transfer of the resident to other facilities; and

L. Withholding from residents, or their representatives, any property or records to which the residents are entitled.

10.2 That a temporary restraining order be issued without notice to Defendant that permits DADS employees to:

A. Remove any resident of Defendant's facility that may be at risk for abuse; and

B. Remove any residents in order to reduce the census of Defendant's facility to three.

10.3 That, after notice and hearing, a temporary injunction and, after final hearing a permanent injunction be issued against Defendant Pamela Carroll, individually, and doing business as Loving Care, and her officers, agents, servants, employees, and attorneys, and all persons in active concert or participation with the Defendant who receive actual notice of the order, enjoining them from the following:

A. Operating any assisted living facility without a license;

B. Operating the facility located at 909 Forrestal Drive, Arlington, Texas as an unlicensed assisted living facility;

- C. Administering medications to residents of the above mentioned facilities without a license issued under state law that authorizes the administration of medication; or without obtaining a medication aide permit, which allows the administration of medicines under the authority of a person who does hold a current license issued under state law to administer medication;
- D. Denying any agent of DADS or any other agent of the State access to any facility owned or operated by Defendant to monitor compliance;
- E. Preventing or hindering DADS agents or any other agent of the State from effectuating an orderly transfer of the residents from any facility owned or operated by Defendant to other licensed facilities or their families if relocation is required;
- F. Allowing an unlicensed home and community support services agency to provide services to any resident of Defendant's facility;
- G. Failing to care for residents on a temporary and emergency basis while DADS agents supervise and effectuate the transfer of the residents to other facilities;
- H. Failing to follow any instructions given by DADS agents to Defendant and his agents in order to temporarily care for residents while DADS agents supervise and effectuate the transfer of the residents to other facilities; and
- I. Withholding from residents, or their representatives, any property or records to which the residents are entitled.

10.4 That civil penalties to be awarded of not less than \$1,000 nor more than \$10,000 per violation and per each day of violation, plus investigation costs and attorney's fees, costs of court and for such other and further relief to which it is justly entitled.

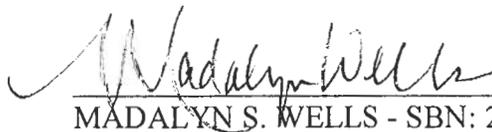
Respectfully submitted,

GREG ABBOTT
Attorney General of Texas

KENT C. SULLIVAN
First Assistant Attorney General

JEFF L. ROSE
Deputy First Assistant Attorney General

PAUL D. CARMONA
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ATTORNEYS FOR PLAINTIFF
THE STATE OF TEXAS

Exhibit A

STATE OF TEXAS }
 }
COUNTY OF TARRANT }

AFFIDAVIT OF LORI PARRISH, L.M.S.W.

Before me, the undersigned authority, personally appeared Lori Parrish, who by me having been duly sworn and identified by her Texas Drivers License, did upon her oath state as follows:

“My name is Lori Parrish. I am over 18 years of age, of sound mind, and capable of making this affidavit. I am personally acquainted with the facts stated herein, and verify that they are true and correct.

I am a Licensed Master Social Worker, licensed in Texas, with a Master of Social Work degree granted by the University of Maryland at Baltimore, Baltimore, Maryland. I hold a Bachelor of Social Work degree granted by the University of Texas at Arlington, Arlington, Texas. I have 11 years of experience as a Licensed Social Worker, of which 11 are in Long Term Care. I am currently employed as a Social Services Surveyor with the Texas Department of Aging and Disability Services (‘DADS’), Regulatory Services Division, located at 2561 Matlock Road, Arlington, Texas. DADS is a successor agency to the Texas Department of Human Services. I have been employed with DADS for seven (7) years and two (2) months. I successfully completed the state and federal government mandated Surveyor Minimum Qualifications Test in January, 2001. In my capacity as a Social Services Surveyor, my duties include the inspection of long-term care facilities, including assisted living facilities, to determine whether such facilities are in compliance with applicable state laws and regulations. During my employment with DADS, I have participated in approximately 800 surveys, complaints and incident investigations.

Chapter 247, Texas Health and Safety Code defines an assisted living facility as an establishment, that furnishes, in one or more facilities, food and shelter to four or more persons who are unrelated to the proprietor of the establishment and provides personal care services.

Chapter 247 defines personal care services as assistance with meals, dressing, movement, bathing, or other personal needs or maintenance; the administration of medication by a person licensed to administer medication or the assistance with or supervision of medication; or general supervision or oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence in an assisted living facility or who needs assistance to manage the person's personal life, regardless of whether a guardian has been appointed for the person.

In the course of my duties with DADS, I was assigned to conduct a complaint investigation at an alleged unlicensed facility known as Loving Care (the "Facility"), located at 909 Forrestal Drive, Arlington, Tarrant County, Texas. The complaint alleged that six individuals reside at the Facility, including one individual who is a registered sex offender. The complaint further alleged that one of the residents of the Facility was being sexually abused.

Prior to arriving at the Facility to conduct the assigned complaint investigation, I conducted a search via the Internet to determine who owned the property. I found, from the Tarrant County Appraisal District website, that the property is owned by an individual named Jack Loggins.

On February 11, 2008 at approximately 8:40 a.m., I arrived at the Facility to conduct the assigned complaint investigation. I was accompanied by Shannon Wright, a DADS Registered Nurse Surveyor. We were met at the Facility entrance by Anthony Gibbs, who identified himself as a caregiver employed by the Facility. Mr. Gibbs signed the Permission to Enter Form allowing us entry into the Facility to conduct the investigation. Mr. Gibbs confirmed to me that seven individuals, not related to the Facility owner, lived in the Facility, and that the Facility had a capacity for eight individuals.

Upon entering the Facility, I observed seven individuals whom Mr. Gibbs confirmed resided at the Facility. I noted that six of the residents shared bedrooms. Residents #1 and #7 shared a room, Residents #2 and #5 shared a room and Residents #3 and #6 shared a room. One individual, Resident #4, resided alone in another bedroom. Mr. Gibbs confirmed to me that he had been asleep on a fold out sofa in the living room.

Mr. Gibbs told me he had been employed at the Facility for approximately two weeks. He also told me the 'owner' of the Facility was Pamela Carroll, and the name of the Facility was 'Loving Care'. I asked Mr. Gibbs for the residents' names and he stated he did not know. Mr. Gibbs then proceeded to wake up the residents and ask them their names and the names of other residents. When I asked if any of the residents took medications, Mr. Gibbs responded in the affirmative and proceeded to show me where the medications were stored. Mr. Gibbs stated the residents were not allowed to access their medications, and that Facility staff were responsible for pouring medication dosages and placing the medication in the hands of the residents. Mr. Gibbs was unable to tell me the number of residents who required supervision/assistance with their medications. Mr. Gibbs further confirmed to me that Resident #1 required and received assistance from Facility staff with activities of daily living, including assistance with bathing and toileting.

At approximately 9:00 a.m. on February 11, 2008, another Facility caregiver arrived at the Facility. She introduced herself to Ms. Wright and I as Janice McDowell. Ms. McDowell stated she had been employed at the Facility for approximately one month. Ms. McDowell told me she provided supervision/assistance with medications. She stated the residents' medications were maintained in a kitchen cabinet and she along

with other caregivers dispensed the medications as they were prescribed. Ms. McDowell also stated Resident #1 required and received assistance from Facility staff with bathing and toileting.

During the course of our investigation, DADS Surveyor Shannon Wright and I used information provided by Facility staff and the residents to complete Services Rendered Forms. The forms are used to indicate the services provided, if any, to Facility residents. Ms. Wright and I also interviewed each of the seven residents as part of our investigation.

I interviewed Resident #5 on February 11, 2008 at approximately 9:30 a.m. Resident #5 told me he had attempted to engage in a sex act with Resident #1 in the past month. When I asked specifically about the sex act he was referring to, Resident #5 told me he attempted to penetrate Resident #1's anus with his penis. I then asked where this had occurred and Resident #5 told me it happened in Resident #5's bedroom which he shared with Resident #2. Resident #5 stated to me that he pulled Resident #1's pants down around his ankles and placed Resident #1 in a bent over position. Resident #5 told me he held Resident #1 down to keep him from moving while he was attempting to have sex with him. Resident #5 stated there were no witnesses, and that he did not actually have sex with Resident #1. Resident #5 further told me he had been molested as a child and had recently been in jail for molesting his cousin. Resident #5 stated, 'It's a cycle. I need help.'

At 9:35 a.m. on February 11, 2008, I interviewed Resident #2. He stated to me that he had attempted to have anal intercourse with Resident #1 (on an unknown date). Resident #2 stated he asked Resident #1 if he wanted to have sex, and Resident #1 indicated to him that he did. Resident #2 stated he assisted Resident #1 to pull his pants down around his feet. Resident #2 stated he attempted to 'penetrate' Resident #1's anus, but was not able 'to get it in'. Resident #2 stated he then performed oral sex on Resident #1. When asked what made him stop engaging in the sexual activity with Resident #1, Resident #2 said, 'I don't know.' Resident #2 then told me Resident #3 walked in and 'caught me'.

I interviewed Resident #3 on February 11, 2008 at 9:42 a.m. at the Facility. He told me he entered Resident #2's bedroom looking for Resident #1. He stated to me that he opened the door and observed Resident #1 standing with his pants down around his feet and Resident #2 was 'banging him in the ass'. Resident #3 stated he told Resident #1 to pull up his pants and come with him. Resident #3 told me he then left the room and reported his observation to Sandra Francis, another caregiver employed by the Facility.

On February 11, 2008 at approximately 9:48 a.m., I attempted to interview Resident #1. Resident #1 appeared to me to be mentally retarded. My attempts to interview Resident #1 were unsuccessful as the resident's responses to my questions were unintelligible.

I interviewed Ms. Francis on February 11, 2008 at 12:40 p.m. by telephone. She stated to me that on January 19, 2008 at approximately 7:30 p.m., she was approached by Resident #3 who told her he needed to 'talk with me' and 'it was urgent'. Ms. Francis stated to me that Resident #3 informed her he had witnessed Resident #2 behind Resident #1 'doing something he didn't have any business doing'. Ms. Francis stated she notified Pam Carroll, the Facility Owner/ Manager. Ms. Francis told me she spoke with Resident #2 after the allegation was made and he told her 'he did not penetrate [Resident #1].' Ms. Francis then stated the Arlington Police Department was notified. When I asked her if there were any registered sex offenders residing at the Facility, Ms. Francis told me she was not sure. I then asked Ms. Francis if Resident #1 had the capacity to make informed decisions. Ms. Francis stated he did not. Ms. Francis further told me Resident #1 would do anything anyone asked him to do. Caregiver Francis confirmed to me Resident #5 had also voluntarily provided a statement to the Arlington Police during their investigation of the allegation that he had attempted to have sex with Resident #1 on January 18, 2008.

Ms. Francis also told me Resident #1 required assistance with bathing and toileting. She stated Resident #1 would scald himself if left to run his own bath water, and that he requires a lot of cueing and was incontinent of bowel and bladder at times. Ms. Francis told me residents who were prescribed medications did not have access to their medications, and that the medications were maintained in a cabinet in the kitchen. Ms. Francis stated 'We pour them [medications] out of the bottle. We issue it out.'

I interviewed Pam Carroll, the Manager/ Owner of the Facility on February 11, 2008 at 1:05 p.m. by telephone. She told me Ms. Francis had reported to her that Resident #3 had walked in on Resident #2 having sex with Resident #1. She stated to me that after the Arlington Police arrived, Resident #2 informed her and the police that Resident #5 had also had sex with Resident #1. I asked Ms. Carroll how she was ensuring the safety of Resident #1 (and other residents) with Resident #2 and Resident #5 continuing to live in the same Facility. Ms. Carroll replied there was staff available at all times, and that Resident #1 was not allowed to be at the dining room table with Residents #2 and #5 at the same time. Additionally, she stated they were not allowed to go on outings or be transported in the same automobile together.

When I asked how much assistance Resident #1 required, Ms. Carroll told me the resident wore pull-ups due to incontinent episodes. She stated Resident #1 required cueing and supervision while in the bathroom, and that Resident #1 played in his feces so staff had to monitor him. Ms. Carroll also confirmed that she rented the house located at 909 Forrestal Drive from Mr. Jack Loggins.

As part of my investigation, I also conducted a search of the Texas Department of Public Safety website. My search revealed that Resident #3, Resident #5 and Resident #4 are registered sex offenders.

As a result of my personal observations and interviews, I determined that seven (7) individuals reside at the Facility operated by Pam Carroll located at 909 Forrestal Drive, Arlington, Tarrant County, Texas. I determined that none of the residents are related to Ms. Carroll. I further determined that Facility staff are providing personal care services, particularly assistance and/or supervision with medications, and assistance with toileting and bathing, to at least one of those residents. Therefore, I conclude that Facility staff are providing, to at least one of those individuals the personal care services for which a state license is required according to Chapter 247 of the Texas Health and Safety Code. I have also determined that at least one of the residents, a vulnerable, apparently mentally retarded individual, has been the victim of sexual abuse at the Facility and that no adequate measures have been implemented to protect Facility residents from such abuse. Therefore, I further conclude that conditions at this Facility constitute a serious and immediate threat to the health and safety of Facility residents."

Lori Parrish, LMSW
Lori Parrish, L.M.S.W.

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by
Lori Parrish on this the 13th day of February, 2008.

Sheri A. Briggs
Notary Public-State of Texas

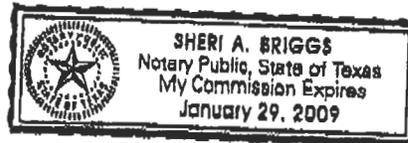


Exhibit B

STATE OF TEXAS }
 }
COUNTY OF TARRANT }

AFFIDAVIT OF SHANNON WRIGHT, R.N.

Before me, the undersigned authority, personally appeared Shannon Wright, who by me having been duly sworn and identified by her Texas Drivers License, did upon her oath state as follows:

“My name is Shannon Wright. I am over 18 years of age, of sound mind, and capable of making this affidavit. I am personally acquainted with the facts stated herein, and verify that they are true and correct.

I am a Registered Nurse, licensed in Texas, with an Associate of Applied Science degree in Nursing granted by Grayson County College, Denison, Texas. I have 14 years and nine (9) months of experience as a Registered Nurse, of which twelve and one half years (12½) were in Long Term Care, Home Health and/or Acute Care Hospital settings. I am currently employed as a Registered Nurse Surveyor with the Texas Department of Aging and Disability Services (‘DADS’), Regulatory Services Division, located at 2561 Matlock Road, Arlington, Texas. DADS is a successor agency to the Texas Department of Human Services. I have been employed with DADS for two (2) years and eight (8) months. In my capacity as a Registered Nurse Surveyor, my duties include the inspection of long-term care facilities, including assisted living facilities, to determine whether such facilities are in compliance with applicable state laws and regulations. I successfully completed the state and federal government mandated Surveyor Minimum Qualifications Test in November, 2005. During my employment with DADS as a Registered Nurse Surveyor, I have participated in approximately 200 surveys, complaints and incident investigations.

Chapter 247, Texas Health and Safety Code defines an assisted living facility as an establishment, that furnishes, in one or more facilities, food and shelter to four or more persons who are unrelated to the proprietor of the establishment and provides personal care services.

Chapter 247 defines personal care services as assistance with meals, dressing, movement, bathing, or other personal needs or maintenance; the administration of medication by a person licensed to administer medication or the assistance with or supervision of medication; or general supervision or oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence in an assisted living facility or who needs assistance to manage the person's personal life, regardless of whether a guardian has been appointed for the person.

In the course of my duties with DADS, I was assigned to conduct a complaint investigation at an alleged unlicensed facility known as Loving Care (the “Facility”), located at 909 Forrestal Drive, Arlington, Tarrant County, Texas. The complaint alleged

that six individuals reside at the Facility, including one individual who is a registered sex offender. The complaint further alleged that one of the residents of the Facility was being sexually abused.

On February 11, 2008 at approximately 8:40 a.m., I arrived at the Facility to conduct the assigned complaint investigation. I was accompanied by Lori Parrish, a DADS Social Services Surveyor. We were met at the Facility entrance by Anthony Gibbs, who identified himself as a caregiver employed by the Facility. Mr. Gibbs signed the Permission to Enter Form allowing us entry into the Facility to conduct the investigation. Mr. Gibbs confirmed to me that seven individuals, not related to the Facility owner, lived in the Facility, and that the Facility had a capacity for eight individuals.

Upon entering the Facility, I observed Resident #1 and Resident #7 sleeping in the same room, unattended. I observed Resident #2 and Resident #5 sleeping in another room, unattended. I observed Resident #4 was awake and sitting on his bed in a room to himself, and Resident #3 and Resident #6 were sleeping in another room unattended. Mr. Gibbs confirmed to me that he had been asleep on a fold out sofa in the living room.

Mr. Gibbs told Ms. Parrish and me he had been employed at the Facility for approximately two weeks. He also told us the 'owner' of the Facility was Pamela Carroll, and the name of the Facility was 'Loving Care'. Mr. Gibbs told us residents did receive medications and he proceeded to show us where the medications were stored. Mr. Gibbs stated the residents were not allowed to access their medications, and that Facility staff were responsible for pouring medication dosages and placing the medication in the hands of the residents. Mr. Gibbs was unable to tell us the number of residents who required supervision/assistance with their medications. Mr. Gibbs further confirmed that Resident #1 required and received assistance from Facility staff with activities of daily living, including assistance with bathing and toileting.

At approximately 9:00 a.m. on February 11, 2008, another Facility caregiver arrived at the Facility. She introduced herself to Ms. Parrish and me as Janice McDowell. Ms. McDowell stated she had been employed at the Facility for approximately one month. Ms. McDowell told us she provided supervision/assistance with medications. She stated the residents' medications were maintained in a kitchen cabinet and she along with other caregivers dispensed the medications as they were prescribed. Ms. McDowell also stated Resident #1 required and received assistance from Facility staff with bathing and toileting.

At approximately 9:30 a.m., I observed multiple bottles and bubble packs of prescription medication located in an unlocked kitchen cabinet. I reviewed the prescription labels on the medication in the kitchen cabinet and I noted they belonged to Residents #7, #4 and #1. Mr. Gibbs then told me the residents in the Facility 'knew not to mess' with the cabinet containing all the medications.

During the course of our investigation, Ms. Parrish and I used information provided by Facility staff and the residents to complete Services Rendered Forms. The forms are used to indicate the services provided, if any, to Facility residents. Ms. Parrish and I also interviewed residents as part of our investigation.

At 9:35 a.m. on February 11, 2008, I interviewed Resident #2. He stated to me that he had attempted to have anal intercourse with Resident #1 (on an unknown date). Resident #2 stated he asked Resident #1 if he wanted to have sex, and Resident #1 indicated to him that he did. Resident #2 stated he assisted Resident #1 to pull his pants down around his feet. Resident #2 stated he attempted to 'penetrate' Resident #1's anus, but was not able 'to get it in'. Resident #2 stated he then performed oral sex on Resident #1. When asked what made him stop engaging in the sexual activity with Resident #1, Resident #2 said, 'I don't know.' Resident #2 then told me Resident #3 walked in and 'caught me'.

I interviewed Resident #3 on February 11, 2008 at 9:42 a.m. at the Facility. He told me he entered Resident #2's bedroom looking for Resident #1. He stated to me that he opened the door and observed Resident #1 standing with his pants down around his feet and Resident #2 was 'banging him in the ass'. Resident #3 stated he told Resident #1 to pull up his pants and come with him. Resident #3 told me he then left the room and reported his observation to Sandra Francis, another caregiver employed by the Facility.

On February 11, 2008 at approximately 9:48 a.m., Ms. Parrish and I attempted to interview Resident #1. Resident #1 appeared to me to be mentally retarded. Our attempts to interview Resident #1 were unsuccessful as the resident's responses to our questions were unintelligible.

I interviewed Ms. Francis on February 11, 2008 at 12:40 p.m. by telephone. She stated to me that on January 19, 2008 at approximately 7:30 p.m., she was approached by Resident #3 who told her he needed to 'talk with me' and 'it was urgent'. Ms. Francis stated to me that Resident #3 informed her he had witnessed Resident #2 behind Resident #1 'doing something he didn't have any business doing'. Ms. Francis stated she notified Pam Carroll, the Facility Owner/ Manager. Ms. Francis told me she spoke with Resident #2 after the allegation was made and he told her 'he did not penetrate [Resident #1].' Ms. Francis then stated the Arlington Police Department was notified. When I asked her if there were any registered sex offenders residing at the Facility, Ms. Francis told me she was not sure. I then asked Ms. Francis if Resident #1 had the capacity to make informed decisions. Ms. Francis stated he did not. Ms. Francis further told me 'if anyone told [Resident #1] to go outside, he would go outside.' Caregiver Francis confirmed to me Resident #5 had also voluntarily provided a statement to the Arlington Police during their investigation of the allegation that he had attempted to have sex with Resident #1 on January 18, 2008.

Ms. Francis also told me Resident #1 required assistance with bathing and toileting. She stated Resident #1 would scald himself if left to run his own bath water, and that he requires a lot of cueing and was incontinent of bowel and bladder at times.

Ms. Francis told me residents who were prescribed medications did not have access to their medications, and that the medications were maintained in a cabinet in the kitchen. Ms. Francis stated 'We pour them [medications] out of the bottle. We issue it out.'

I interviewed Pam Carroll, the Manager/ Owner of the Facility on February 11, 2008 at 1:05 p.m. by telephone. She told me Ms. Francis had reported to her that Resident #3 had walked in on Resident #2 having sex with Resident #1. She stated to me that after the Arlington Police arrived, Resident #2 informed her and the police that Resident #5 had also had sex with Resident #1. I asked Ms. Carroll how she was ensuring the safety of Resident #1 (and other residents) with Resident #2 and Resident #5 continuing to live in the same Facility. Ms. Carroll replied there was staff available at all times, and that Resident #1 was not allowed to be at the dining room table with Residents #2 and #5 at the same time. Additionally, she stated they were not allowed to go on outings or be transported in the same automobile together.

As a result of my personal observations and interviews, I determined that seven (7) individuals reside at the Facility operated by Pam Carroll located at 909 Forrestal Drive, Arlington, Tarrant County, Texas. I determined that none of the residents are related to Ms. Carroll. I further determined that Facility staff are providing personal care services, particularly assistance and/or supervision with medications and assistance with toileting and bathing, to at least one of those residents. Therefore, I concluded that Facility staff are providing, to at least one of those individuals the personal care services for which a state license is required according to Chapter 247 of the Texas Health and Safety Code. I also determined that at least one of the residents, a vulnerable, apparently mentally retarded individual, has been the victim of sexual abuse at the Facility and that no adequate measures have been implemented to protect Facility residents from such abuse. Therefore, I further conclude that conditions at this Facility constitute a serious and immediate threat to the health and safety of Facility residents."

Shannon Wright RN
Shannon Wright, R.N.

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority by Shannon Wright on this the 13th day of February, 2008.

Sheri A. Briggs
Notary Public-State of Texas

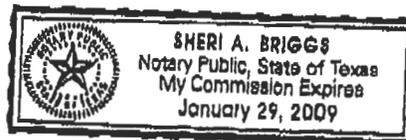


Exhibit C

STATE OF TEXAS

COUNTY OF TRAVIS

AFFIDAVIT OF LYDIA MAESE

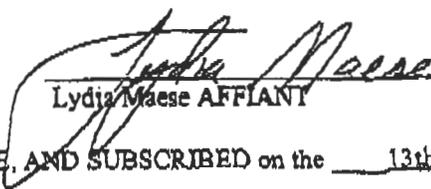
Before me, the undersigned authority, on this day personally appeared Lydia Maese, known to me to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that she executed the same for the purposes and consideration therein expressed.

"My name is Lydia Maese. I am of sound mind, legally competent to make this affidavit, and I am personally acquainted with the facts herein stated and verify that they are true and correct:

"I am employed with the Texas Department of Aging and Disability Services (DADS), as the Legal Coordinator in the Regulatory Services Division, Austin, Texas. One of my responsibilities as Legal Coordinator is to review and process inspection reports on unlicensed facilities.

"One of the activities of the Regulatory Services Division Provider Licensing Unit is to receive applications for licensure and to issue licenses for assisted living facilities. The licensure records indicating that a license has been issued are regularly made by the Licensing and Credentialing Section and preserved by the Department, which keeps these records in the regular course of business. In addition, the Department regularly makes and preserves a computer database consisting of those assisted living facilities that are licensed.

"A person must have a license from the Regulatory Services Division Provider Licensing Unit to operate a home as an assisted living facility. A diligent search of the licensure records and computer database was made. This search showed that an assisted living facility license has not been issued to 909 Forrestal Drive, Tarrant County, Arlington, Texas 76010, Facility ID #103366, nor are there any applications for state license pending. I certify that Pamela Carroll, owner, does not currently have a license to operate an assisted living facility at the above address."


Lydia Maese AFFIANT

SWORN TO OR AFFIRMED BEFORE ME, AND SUBSCRIBED on the 13th day of

February 2008.


NOTARY PUBLIC, STATE OF TEXAS

