STATE OF CONNECTICUT

COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_

**AFFIDAVIT OF EXPERT, RN**

Personally, appeared before me, the undersigned officer, duly authorized to administer oaths, Expert, RN, who, after being placed under oath, deposes and states as follows:

My name is Expert, RN. I am over the age of eighteen (18) and otherwise competent to give this Affidavit. This Affidavit is based upon my personal knowledge, facts to which I am competent to testify, and education, training, and experience.

I am a registered nurse licensed to practice nursing in the State of Connecticut. I graduated with a Diploma in Nursing in 1984 from School of Nursing, City, Connecticut. In 1986, I graduated with a Bachelor of Science in Nursing from State University, City, Connecticut.

3.

I have continuously worked as a registered nurse since 1986. I currently am the Regional Care Director at a 102-operated assisted living community, specializing in resident care in City, Massachusetts. In this position, I am responsible for assuring state regulatory compliance, improving quality of care, establishing policies and procedures, nursing and Certified Nursing Assistant training and education, and day to day resident care and treatment in an assisted living and/or personal care home environment. I also am responsible for supervising CNAs, nurses and other professional and non-professional staff working in an assisted living facility similar to Assisted Living Facility.

4.

From 1988 to the present, I have worked in a variety of healthcare settings including hospitals, assisted living, personal care, and nursing homes. I have provided direct care to geriatric residents/patients with Alzheimer/Dementia who need assistance with activities of daily living (ADLs) such as eating. I am also familiar with how to properly perform the Heimlich maneuver and when to recognize an emergent situation where a resident is choking. I know how to effectively clear a resident’s airway who is choking on a foreign body obstruction (FBO) and have taught nurses and CNAs how to do so.

5.

Throughout my education, training and experience, I have supervised or taught nurses and other professional and nonprofessional healthcare staff, including CNAs, and medical aides who were employed by and/or were agents of assisted living centers and personal care facilities regarding clinical areas of assisted living care such as evaluating known choking risk factors for elderly residents, instituting choking prevention safety procedures, and evaluating and providing a safe environment with appropriate meal options for a resident with advanced stages of dementia. I have also been employed by assisted living facilities and/or personal care homes similar to Assisted Living Facility, and have provided day-to-day care and other care and treatment to residents like Jack Doe with similar diagnoses.

6.

In sum, during more than three out of the five years prior to and since December 31, 2017, I regularly and frequently care for residents such as Mr. Doe and/or have supervised nurses and other professional and non-professional staff including CNAs and medical aides who were responsible for caring for residents like Mr. Doe in assisted living and/or personal care facilities like Assisted Living Facility.

7.

Based upon my education, training and experience, I am familiar with, have actual, personal, and professional knowledge of, and am qualified to testify with regards to the applicable standard of medical care exercised by nurses and various health care provider personnel (professional and non-professional staff and other care providers), including CNAs and medical aides, in the evaluation, care, and treatment of residents of assisted living and/or personal care facilities such as Jack Doe who are at risk for choking on food or are actually choking and need immediate assistance.

8.

At the time of the negligent acts and omissions discussed herein, I was continuously practicing nursing in the State of Connecticut and was licensed by the Connecticut Board of Nursing. Attached hereto as Exhibit “A” is a true and accurate copy of my curriculum vitae, which is incorporated herein by reference.

9.

This Affidavit is also based upon the facts and information shown within the medical records from the following medical care providers and agencies, which I have reviewed:

(a) Assisted Living Facility;

(b) Pharmacy;

(c) EMS;

(d) VAMC;

(e) Nursing Home;

(f) Medical Center;

(g) Department of Community Health investigation;

(h) County Sheriff’s investigation;

(i) Georgia Bureau of Investigation autopsy report/pictures; and

(j) County Coroner’s report.

10.

Based upon my review of the above-referenced records, I have found the following facts to have occurred, and they are the basis upon which my opinions are founded.

11.

Jack Doe a 78-year-old man with multiple co-morbidities including progressive dementia with altered mental status, generalized weakness and limited communication because of progressive aphasia. He was right hand dominant with right upper extremity weakness thought to be related to a chronic rotator cuff issue. On October 23, 2017 Mr. Doe was admitted to Fellowship Home at Brookside and specifically to the Memory Care Unit. Mr. Doe was placed on a regular diet. Dietary preferences were addressed, and the initial plan of care indicated that Mr. Doe could feed himself and had no prior history of aspiration or dietary precautions.

12.

Mr. Doe was a high fall risk upon admission and sustained an initial fall approximately 3 weeks afterwards.

13.

On November 17, 2017 Mr. Doe fell and was treated for a right eyebrow laceration and back pain.

14.

On November 23, 2017 he suffered an additional fall which may have been from a wheelchair. No significant injuries were identified, and he was treated and released from the emergency room.

15.

On December 9, 2017 Mr. Doe suffered a third fall and was again sent to the emergency room for treatment of a forehead laceration. A head CT was negative, and no acute injuries were identified.

16.

On December 31, 2017 during lunch in the dining room at approximately 11:34 a.m., Mr. Doe began choking while apparently eating roast beef.

17.

Assisted Living Facility CNA performed a finger sweep of his mouth followed by an incorrect attempt of the Heimlich maneuver. Ms. CNA reported that she was able to clear his airway and asked an available aid to go and get a nurse on duty from another unit.

18.

LPN arrived as Ms. CNA was sweeping Mr. Doe’ mouth and described liquid and food on Mr. Doe’s shirt following the procedure.

19.

LPN indicated upon arrival that Mr. Doe did have a pulse and was barely breathing. She also described that the staff turned him on his side, and no further objects were coming out of his mouth.

20.

LPN later stated in an incident report to the County Sheriff’s Office that she “observed CNA sweeping the mouth area and noted liquid and food on the resident’s mouth.” She also described that Mr. Doe had a pulse and was breathing “very shallow” while lying on the floor.

21.

LPN then indicated that she left to contact the EMS, and when she returned, Mr. Doe was not breathing and without a pulse.

22.

Assisted Living Facility staff describe that they moved Mr. Doe to his room to “clean him up.” LPN later indicated in her voluntary statement to the County Sheriff’s Office that she was uncertain of the choking protocol and had to obtain advice from other Assisted Living Facility staff members. A medical aid suggested that they move Mr. Doe from the dining room back to his resident room to “clean him up.”

23.

At 12:09 p.m., EMS arrived and described that the Assisted Living Facility staff was cleaning up Mr. Doe in his room.

24.

EMS personnel asked the Assisted Living Facility staff to stop cleaning Mr. Doe and exit the room until the coroner arrived upon the scene.

25.

The County Sheriff’s Office was contacted to investigate the incident, and Mr. Doe’s body was transported to the county morgue.

26.

An autopsy was performed by GBI Pathologist, and she found that the presence of a mass of food matter (16 x 5 cm) completely occluded Mr. Doe’s upper airway. She determined that Mr. Doe died as a result of asphyxia due to choking. The manner of death was classified as accidental.

27.

On January 8, 2018, the State of Georgia Department of Community Health made a visit to Assisted Living Facility. Investigators reviewed Mr. Doe’s records. The investigators found that Mr. Doe choked on food during his lunch at approximately 11:34 a.m. on December 31, 2017. Assisted Living Facility staff attempted to perform the Heimlich maneuver and partially cleared the obstruction. Mr. Doe had a pulse at that time. After staff requested assistance, Mr. Doe lost consciousness and had no pulse. CPR was allegedly initiated.

28.

The DCH investigator’s review of the County EMS trip record demonstrated that a 911 call was received at 11:51 a.m. and that a time lapse of 17 minutes occurred between the report of the resident choking and the call out to 911.

29.

The State of Georgia cited Assisted Living Facility. The summary of the statement of deficiencies included that in the case of an accident or sudden adverse change in a resident’s change or adjustment, an assisted living community must immediately take actions appropriate to the specific circumstances to address the needs of the resident, including notifying the representative or legal surrogate, if any. The assisted living community must also retain a record of all such adverse changes and the assisted living community’s response in the resident’s files.

30.

The State of Georgia investigator further found that Assisted Living Facility failed to immediately take actions appropriate to the specific circumstances to address Mr. Doe’s needs while he was choking.

31.

It is my opinion to a reasonable degree of nursing certainty that the nursing staff, professional and non-professional health care staff, and/or various caregivers including nurses, CNAs, and medical aides who were employed by and/or were agents of Assisted Living Facility, violated the standard of care and skill generally under the same conditions and like surrounding circumstances in their care and treatment of Mr. Doe. The nursing staff, other professional, non-professional staff, and/or other various care givers including CNAs and medical aides who were responsible for Jack Doe’s day to day care and treatment deviated from the applicable standard of care by:

(a) failing to effectively clear Mr. Doe’ airway after the choking incident on December 31, 2017 resulting in his untimely death;

(b) failing to have a properly trained staff and supervision on how to handle a choking/foreign body obstruction incident;

(c) failing to notify EMS in a timely manner for additional assistance when the airway is compromised during the report of choking incident at 11:34 a.m.;

(d) failing to evaluate and provide a safe environment with appropriate meal options for a resident with advanced age and dementia; and

(e) failing to follow facility protocol for addressing an unexpected death following a choking incident.

32.

The applicable standard of care required the nursing staff, professional staff and non-professional staff, including CNAs and/or medical aides, employed by, or agents of Assisted Living Facility, to properly evaluate, monitor and assess Mr. Doe before providing him a large piece of uncut roast beef, especially since he had right upper extremity weakness. However, once he started choking, the Assisted Living Facility staff should have known how properly to remove a foreign body obstruction and should have immediately called EMS.

33.

This Affidavit is based upon my training, experience, personal and professional knowledge, and my review of the aforementioned records and documents. It is not the purpose of this Affidavit to set forth each and every opinion or to include all criticisms that I may have now, or may have in the future, based upon further review of the records and available information concerning the pertinent issues; rather, the purpose of this Affidavit is to comply with O.C.G.A. § 9-11-9.1 and O.C.G.A. § 24-7-702 for use in filing a Complaint in this action, and for any and all other purposes allowed by Georgia law. It is not intended to encompass all the opinions held by me. As discovery progresses, I reserve the right to modify or alter these opinions or form additional opinions.

FURTHER AFFIANT SAYETH NOT.

(*signature and jurat on next page*)

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EXPERT, RN

SWORN TO AND SUBSCRIBED BEFORE ME,

THIS \_\_\_\_\_\_\_ DAY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2021.

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NOTARY PUBLIC

AFFIX SEAL HERE

MY COMMISSION EXPIRES: