STATE OF NEW JERSEY

COUNTY OF COUNTY

**AFFIDAVIT OF EXPERT RN, BSN, MS, ANP, LNHA**

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

My name is Expert, RN, BSN, MS, ANP, LNHA. 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, Expert RN, BSN, MS, ANP, LNHA, am a registered nurse licensed to practice nursing in the State of New Jersey and North Carolina. I graduated with a Diploma in Nursing in 1965 from School of Nursing, City, State. In 1985, I graduated with a Bachelor of Science in Nursing from University, City, State. In 2000, I graduated from University with a Master’s degree in Science.

During the period of 1965-1970, I worked as a staff nurse and charge nurse at Medical Center, City, State.

During the period of 1975 – 1977, I worked as a staff nurse in the intensive care unit and critical care unit at Medical Center, City, State.

During the time period of 1977– 1978, I worked as the Director of Nursing of a 120-bed facility at Nursing Home, City, State.

During the time period 1990 - 1992, I worked as an Administrator of a 180-bed facility at Nursing Center, City, State.

. During that time period 1993-1995, I was the Vice President of Professional Services for the Company, City, State, and had responsibility for the quality of care in approximately 100 facilities located throughout New Jersey, Connecticut, Ohio, Illinois, Pennsylvania and Wisconsin. I was responsible for planning and implementing all nursing policies and procedures in the Company organization. I then worked as the Vice President of Operations at Company. I was responsible for the operation of 26 facilities in New Jersey, Connecticut, and Pennsylvania. I also held monthly meetings with administrators to review financial performance and set operational goals

During the time period 1996 to 2016, I worked as an Administrator at Adult Daycare Center in City, State. During that time period, I was also the administrator of Care Center, City, State.

Since the time period of 2016 through and including the present, I work as a Regional Nurse and Administrator for a chain of skilled nursing facilities, including the following facilities: {LIST OF FACILITIES}. My responsibilities include reviewing incident reports, developing and implementing care plans and infection control plans, and performing medical record audits. Additionally, I provided general nursing care, wound care, and fall prevention care to patients daily while making rounds with nurses and supervised other professionals as well as non-professional health care staff including CNAs employed by the skilled nursing facility.

Throughout my education, training, and experience, and within 3 out of the 5 years since October 12, 2019, I have supervised nurses, other professionals as well as non-professional health care staff including CNAs employed by and/or agents of skilled nursing and/or long-term care facilities regarding clinical areas of nursing such as taking care of residents with severe dementia, daily nursing assessment, standard wound care, and monitoring, fall prevention, abuse prevention, and communications with physicians and family.

At the time of the negligent acts and omissions discussed herein, I was continuously practicing nursing in the State of New Jersey. I have continually engaged in the act and practice and nursing as an RN since 1965. Attached hereto as Exhibit “A” is a true and accurate copy of my curriculum vitae, which is incorporated herein by reference.

1.

Throughout my education, training, and experience, I have worked at and supervised nurses and CNAs at skilled nursing facilities such as Health and Rehabilitation Center. It is my understanding that Health and Rehabilitation Center provides skilled nursing care, assisted living care, personal living care, Alzheimer's, and memory care for residents such as Jane Doe. Throughout my education, training, and experience, I have also supervised or taught nurses, and other professional as well as non-professional healthcare employed by and/or agents of skilled nursing facilities, assisted living centers, personal care facilities and/or Alzheimer’s memory care regarding clinical areas of assisted living care such as evaluating and treating wounds, pressure sores, and skin tears, evaluating known fall risk factors and the elderly; creating a safe environment; implementing fall prevention care plans and instituting fall prevention safety procedures; communicating with family members and physicians about a resident’s change of condition; and Alzheimer’s memory care. I have also been employed as a consultant by skilled nursing facilities, assisted living facilities, and/or personal care homes, similar to Health and Rehabilitation Center and have provided day-to-day care and other care and treatment to residents like Jane Doe I have also supervised the various care providers employed by skilled nursing facilities.

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), in the evaluation, care, and treatment of residents, presenting to skilled nursing facilities, such as Jane Doe.

I also have throughout my education, training, and experience, including those times when Jane Doe presented to and was a resident of Green Acres Health and Rehabilitation Center supervised and taught nurses and other various healthcare provider personnel employed by skilled nursing and/or long-term care facilities, including CNAs. Therefore, I am familiar with and have knowledge of the applicable standard of nursing care exercised by nurses and other various healthcare providers and personnel (professional and non-professional staff) working in a skilled nursing and/or long-term care facilities such as Green Acres Health and Rehabilitation Center.

Based upon my education, training, and experience, I am familiar with, have personal knowledge of, and am qualified to testify in regards to the applicable standard of nursing care exercised by nurses, and other various healthcare provider personnel (professional and non-professional staff), including but not limited to RNs, LPNs, and CNAs generally in the evaluation of residents with severe dementia and other medical conditions similar to Jane Doe. I also have personal knowledge of, am qualified to testify to evaluating and treating wounds and preparing care plans and fall prevention, for elderly residents like Jane Doe living in skilled nursing facilities and/or long-term care facilities such as Green Acres Health and Rehabilitation Center.

This Affidavit is also based upon the facts and information shown within the resident records from the following long-term care and/or medical care providers, which I have reviewed:

1. Hospice & Palliative Care;
2. Health and Rehab Center;
3. Medical Center; and
4. Medical Center.

Based on 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.

 Jane Doe was 93 years old at the time of her admission to Health and Rehabilitation Center on or about June 16, 2016.

 Jane Doe has a medical history that included Bradycardia, Hypertension, Hypothyroidism, Hyperlipidemia, Osteoporosis, Muscle weakness (generalized), Diverticulosis, Unspecified lack of coordination, difficulty in walking, Long term use of anticoagulants, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Chronic Constipation, Coronary Artery Disease, Sick Sinus Syndrome with a Pacemaker, Neuropathy, Dementia, Atrial Fibrillation, and Gastro-Esophageal Reflux Disease (GERD).

1.

 Ms. Doe’s initial plan of care noted that she was “at risk for falls and injuries from falls related to impaired mobility and medication regimen.” It also detailed a history of falls with a previous left femur fracture.

1.

 Ms. Doe’s initial plan of care dated June 16, 2016, described she was at risk for pressure sore development due to impaired mobility and the presence of pressure ulcers on her right knee and left posterior thigh. She was given an initial Braden score of 13.

1.

 The initial care plan included the following interventions with the goal of not developing a secondary infection: Provide treatment as ordered, Turn and reposition every 2 hours and as needed avoiding pressure to site, observe for signs and symptoms of wound infection, Cleanse after incontinent episodes and apply moisture barrier, pressure reducing mattress, provide heel protection, reposition or lift using turn/lift sheet, head of bed 30 degrees or less if consistent with medical condition, pressure reduction cushion when out of bed, use positioning devices such as pillows/wedges, refer to algorithm for nutritional support and refer to registered dietitian for dietary needs. Educate the resident and family, assess for pain, and treat as ordered.

1.

 On June 23, 2016, Health and Rehabilitation Center increased Ms. Doe’s Braden Score to 15.

1.

 On December 5, 2016, the Health and Rehabilitation Center nurse charted that Ms. Doe’s pressure ulcers on her right knee and left posterior thigh was resolved.

1.

 Ms. Doe’s care plans on June 2, 2017, and June 27, 2017, state that she is "[a]t risk for skin tears and bruising related to frail elderly skin and/or medications.” The June 27, 2017 care plan added the intervention of padding wheelchair arms even though it was to be implemented on June 2, 2017,

1.

 On August 12, 2017, Ms. Doe suffered an unwitnessed fall. A handwritten note by LPN states, "[h]eard resident yelling for help. Upon entering resident sitting on floor at bedside stated, ‘I slipped off the bed going to the bathroom.”

1.

 On August 21, 2017, Ms. Doe was admitted to Medical Center for altered mental status. Ms. Doe was sick for two weeks prior to admission. She was treated for UTI on August 12, 2017. She was weaker than normal and sleeping more. She had a urinalysis (UA) on August 20, 2017 that demonstrated the UTI had resolved.

 On August 31, 2017, Ms. Doe’s Care Plan Conference Sheet from Health and Rehabilitation Center described the following: “[f]amily expresses displeasure with the nursing care of the mother. Found mother on the floor with a staff member right outside of the door. Son stated mother has been weak and not herself for a few weeks. Nurse and CNA unable to obtain vitals because the son suspected the mother had UTI. Family states linens are soiled and dirty. He also found black banana peel and strawberry juice stains on her linen. Nursing services aware of concerns.”

1.

 On August 31, 2017, Ms. Doe was transferred back to Health and Rehabilitation Center via a stretcher. Admission documents from Health and Rehabilitation Center described that Ms. Doe “requires total care assist with ADLs and repositioning every 2 hours.”

1.

 On the September 7, 2017, an SBAR Communication form notifying NP of a change in condition, stated, “[r]esident complaint of tiredness and sleeping most of the day. The resident decreased in therapy and needing several repeated cues to move the upper and lower extremities. Meal intake is poor and complaints of trouble breathing.” and “[Ms. Doe] requires more assistant with ADL care due to poor activity tolerance and weakness. Moderate assistance with ADLs and bed mobility, Max assistance with transfers, and with ADLs.”

1.

 On October 19, 2017, Ms. Doe complained of right hand and back pain. Her right hand was swollen and hot to the touch. There was no fracture in her right hand. No explanation was provided for the pain or injury-causing incident.

1.

 On November 3, 2017, Ms. Doe sustained a skin tear on her left lower extremity when she was transferred.

1.

 On February 6, 2018, Ms. Doe sustained another skin tear to her left lower leg while being transferred to a wheelchair by nursing home staff. The staff member was instructed to use a Sabina lift with all transfers as an intervention for the injury.

1.

 Ms. Doe started hospice care on June 5, 2018; hospice's comprehensive assessment stated the following: "[p]atient bed bound and unable to sit up in a wheelchair. No side rails on the bed due to family removing them—high risk for falls. Braden Score of 7 (Very high risk of impaired skin integrity) has had three falls in the past 18-24 months. Each fall resulted in an injury. Totally dependent on all ADLs, including the need to be fed. Very paranoid. Incontinent of bowel and bladder.”

 On October 13, 2018, Ms. Doe developed a new wound of unknown origin on left foot 2nd toe with redness and scab on top of the toe. Ms. Doe stated to the nurse that it hurt badly. She was referred to wound care.

 On January 17, 2019, hospice nurse, RN notified Health and Rehabilitation Center that Ms. Doe might be discharged because of no decline in her health.

 On June 20, 2019, Ms. Doe developed a new wound on her left leg. She also had a wound on her right foot second toe that was covered with a dressing.

1.

 On June 24, 2019, Ms. Doe sustained a traumatic avulsion to her right lateral leg while being transferred from wheelchair to bed at the nursing home. Ms. Doe’s right leg came into contact with the bed rail or bed assist bar resulting in a deep cut. The wound measured 10cm length x 5cm depth width x 6cm wound depth. Her muscle and adipose tissue were exposed. The wound resulted in a large amount of blood loss. Ms. Doe was sent to Medical Center Emergency Room.

1.

 An investigation by the Department of Community Health found that the “assist bar” was removed from the resident's bed. There was no evidence that a thorough investigation was conducted. Additionally, there was no documentation that other beds and assist bars were audited to ensure that potential rough areas did not exist that could cause injury to other residents.

1.

 At Medical Center Emergency Room, Ms. Doe’s bleeding was controlled. She received 19 sutures to repair the laceration.

1.

 On June 25, 2019, Ms. Doe returned to the facility from the hospital with a new order for Keflex 500mg every 6 hours for seven days and an order for sutures to be removed in 10-14 days.

1.

 On July 1, 2019, Health and Rehabilitation Center nurse, RN, placed the following note in Ms. Doe’s resident record: “[t]he black plastic piece that was on the right side of resident's bed on which her right leg was accidentally bumped causing a traumatic injury was removed. This was part of the intervention to prevent further injury. Family aware.”

1.

 On July 9, 2019, Ms. Doe’s sutures were removed from the location of the traumatic avulsion on her right leg. The wound bed was noted to have a purplish area with a small amount of bleeding. There were no signs or symptoms of infection.

1.

 On July 12, 2019, MD, ordered care from Hospice and Palliative Care.

1.

 On June 12, 2019, Health and Rehabilitation Center LPN, completed an MDS Assessment on Ms. Doe. The MDS assessment demonstrated that Ms. Doe required two-person assists for bed mobility, toilet use, including incontinence care, and when being transferred.

 On July 13, 2019, Ms. Doe developed a Deep Tissue Injury (DTI) with an intact blister to left heel. She had a history of wounds on the toes of both feet.

1.

 On July 17, 2019, a low air pressure mattress ordered by Hospice & Palliative Care was delivered and successfully installed for Ms. Doe. Two days later, on July 19, 2019, Ms. Doe’s son complained that “staff didn’t know what they were doing with the air mattress and need someone to fix it.”

1.

 On July 29, 2019, a discolored area directly above Ms. Doe’s right heel, measuring 2x2cm, was discovered. Ms. Doe was receiving treatment to bilateral heels for bogginess. Her heels were floated with heel boots.

 On August 1, 2019, Ms. Doe suffered a new skin tear on her right shin, measuring 3x2x0.1 cm, due to leg positioning by staff while receiving wound care.

1.

 On August 2, 2019, Ms. Doe’s son complained that the staff does not encourage her to eat. They also wait until breakfast is cold before offering it to her.

1.

 On August 13, 2019, a Health and Rehabilitation Center CNA provided incontinence care while Ms. Doe was laying on her bed. This CNA turned Ms. Doe onto her side. The CNA then turned to get wipes and Ms. Doe fell out of the bed on the floor, injuring her head. On June 12, 2019, Health and Rehabilitation Center LPN completed an MDS Assessment on Ms. Doe. The MDS assessment detailed that Ms. Doe required two-person assists for bed mobility, toilet use, including incontinence care, and when being transferred.

 Ms. Doe sustained a laceration above her right eye from the fall. Ms. Doe was admitted to Medical Center.

1.

 At Medical Center, Ms. Doe received nine sutures to repair the 4cm laceration above her right eye. Medical Center discovered that Ms. Doe was bleeding within the brain parenchyma (intraparenchymal hemorrhage) due to trauma. Medical Center transferred Ms. Doe to the trauma center at Medical Center.

1.

 Ms. Doe was admitted to the neurointensive care unit at Medical Center for treatment of an acute traumatic intraparenchymal hemorrhage, subarachnoid hemorrhage, and a nondisplaced spiral fracture of the distal shaft of the left tibia. Her brain bleed was monitored with coumadin discontinued, and a boot was placed on the tibia fracture.

1.

 On August 17, 2019, Ms. Doe was transferred back to Health and Rehabilitation Facility. On August 18, 2019, MD ordered hospice care for Ms. Doe because of her score on the Palliative Performance Scale (PPS) of 40%. A week later, August 25, 2019, Ms. Doe had a PPS of 20%.

 On August 30, 2019, Ms. Doe exhibited more signs of decline. Ms. Doe was gurgling on secretions and she was unable to cough the secretions up. Health and Rehabilitation Center CNAs had to reposition her side to side every two hours to prevent her from aspirating.

1.

 On September 10, 2019, Ms. Doe developed an open wound on her sacrum measuring 1 x 1 x 0.1cm.

1.

 On September 26, 2019, LPN observed that Ms. Doe’s wound to her left heel had partial eschar detaching.

1.

 On October 7, 2019, Ms. Doe’s son visited her and discovered that her bed was not lowered for fall precautions. He reported this to the Assistant Director of Nursing.

1.

On October 12, 2019, at approximately 7:00 am, Ms. Doe died.

1.

 It is my opinion, within a reasonable degree of nursing certainty, that the nursing staff, professional and non-professional health care staff and/or various caregivers, including the CNAs employed by or agents of Health and Rehabilitation facility violated the standard of care and skill generally under the same conditions and like surrounding circumstances in their care and treatment of Jane Doe. In particular, the nursing staff and other professional and non-professional staff and other various caregivers who were responsible for Jane Doe’s day to daycare and treatment deviated from the applicable standard of care by:

1. failing to prevent Ms. Doe from falling multiple times during her residency at the Health and Rehabilitation Facility (42 CFR 483.25(d));
2. failing to appropriately implement and change her individual service plan after multiple falls (42 CFR 483.21(b)(2));
3. failing to appropriately transfer Ms. Doe on June 24, 2019, resulting in a traumatic skin avulsion requiring 19 sutures;
4. the staff of Health and Rehabilitation Center failed on multiple occasions to provide treatment and care in accordance with basic professional standards of nursing practice (42 CFR 483.25);
5. failing to ensure Ms. Doe’s environment was free of accident hazards by allowing the bed rail to contain a sharp and dangerous edge that cut her leg on June 24, 2019, resulting in a traumatic skin avulsion requiring 19 sutures (42 CFR 483.25(d));
6. failing to prevent the development of multiple Deep Tissue Injuries (DTIs) and pressure wounds multiple times during her residency at the Health and Rehabilitation facility (42 CFR 483.25(b)(1));
7. failing to maintain sufficient staffing to assist Ms. Doe on August 13, 2019, resulting in a fall causing an acute traumatic intraparenchymal brain hemorrhage, subarachnoid brain hemorrhage, and a nondisplaced spiral fracture of the distal shaft of the left tibia (42 CFR 483.35); and
8. failing to properly assist Ms. Doe on August 13, 2019, resulting in a fall causing an acute traumatic intraparenchymal brain hemorrhage, subarachnoid brain hemorrhage, and a nondisplaced spiral fracture of the distal shaft of the left tibia.
9.

 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 OCGA § 9-11-9.1 and OCGA § 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.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 EXPERT

SWORN TO AND SUBSCRIBED BEFORE ME,

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTARY PUBLIC

AFFIX SEAL HERE

MY COMMISSION EXPIRES: