Anthony Cocca, Esq. #000821994
COCCA & CUTINELLO, LLP
The Point at Morristown
36 Cattano Ave., Suite 600
Morristown, NJ 07960
(973) 828-9000; Fax (973) 828-9999
Attorneys for Defendants
Elmwood Evesham Associates, LLC d/b/a Care One at Evesham,
Care One Management, LLC and Joseph Mina

JOSEPH L. CAPANO, Executor of the Estate of ANDREW P. CAPANO, Plaintiff, v. CARE ONE AT EVESHAM, ELMWOOD EVESHAM ASSOCIATES, LLC, JOSEPH MINA, ADMINISTRATOR, CARE ONE MANAGEMENT, LLC, JOHN/JANE DOE ADMINISTRATOR 1-100; JOHN/JANE DOE DIRECTOR OF NURSING 1-100; JOHN/JANE DOE NURSE 1-100; JOHN/JANE DOE CNA 1-100; JOHN/JANE DOE MANAGEMENT COMPANY 1-100; JOHN/JANE DOE MEDICAL DIRECTOR 1-100; JOHN/JANE DOES 1-100; JOHN/JANE DOE CORPORATION 1-100, individually, jointly, severally and/or in the alternative, Defendants.	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: CAMDEN COUNTY DOCKET NO. CAM-L-0507-17 Civil Action **NOTICE OF MOTION**

TO:

Richard Talbot, Esq.
Law Offices of Andrew A. Ballerini
535 Route 38, Suite 328
Cherry Hill, NJ 08002

COUNSEL:

PLEASE TAKE NOTICE that on Friday, June 21, 2019, at 9:00 a.m. or as soon thereafter as counsel may be heard, that Cocca & Cutinello, LLP, counsel for defendants Elmwood Evesham Associates, LLC d/b/a Care One at Evesham, Care One Management and

Joseph Mina, shall move the above Court for an order dismissing with prejudice for failure to state a claim upon which relief may be granted and/or for summary judgment in defendants' favor on the following claims set forth in plaintiff's complaint:

> The second count, alleging violations of New Jersey's Nursing Home Responsibilities and Rights of Residents Act ("NHA"), N.J.S.A. 30:13-1 to -17 and noncompliance with the federal Requirements for Long Term Care Facilities or "OBRA regulations", 42 C.F.R. § 483;
>
> All claims alleging noncompliance with New Jersey and federal statutes and administrative regulations, including those set forth in the first count ¶3 and ¶13(G), and in the second count;
>
> The NHA "rights" claim set forth in the sixth count;
>
> All claims for punitive damages, including those set forth in the fifth count and in the wherefore clauses in each count of the complaint; and
>
> All claims against Care One Management, LLC and Joseph Mina, in his capacity as administrator of Care One at Evesham, including those set forth in the eighth count of the complaint.

Defendants shall rely upon the enclosed brief, certification of counsel and statement of material facts. A proposed form of order is also provided. Oral argument is requested.

Pretrial Conference: None
Trial Date: August 19, 2019
Calendar Call: August 19, 2019

COCCA & CUTINELLO, LLP
Attorneys for Defendants
Elmwood Evesham Associates, LLC d/b/a
Care One at Evesham, Care One Management, LLC
and Joseph Mina

Dated: May 16, 2019

By: _____
Anthony Cocca, Esq.

CERTIFICATION OF SERVICE

I hereby certify that on this date an original and one copy of the within notice of motion and supporting papers were submitted for filing and service on counsel listed below, through the New Jersey Judiciary's Electronic Filing System.

Richard Talbot, Esq.
Law Offices of Andrew A. Ballerini
535 Route 38, Suite 328
Cherry Hill, NJ 08002
dchico@comcast.net
Counsel for plaintiff Joseph L. Capano, Executor of the Estate of Andrew P. Capano

I hereby certify the foregoing statements made by me are true. I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

Jessica A. Piccola

Dated: May 16, 2019

Anthony Cocca, Esq. #000821994
COCCA & CUTINELLO, LLP
The Point at Morristown
36 Cattano Ave., Suite 600
Morristown, NJ 07960
(973) 828-9000; Fax (973) 828-9999
Attorneys for Defendants
Elmwood Evesham Associates, LLC d/b/a Care One at Evesham,
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JOSEPH L. CAPANO, Executor of the Estate of ANDREW P. CAPANO, Plaintiff, v. CARE ONE AT EVESHAM, ELMWOOD EVESHAM ASSOCIATES, LLC, JOSEPH MINA, ADMINISTRATOR, CARE ONE MANAGEMENT, LLC, JOHN/JANE DOE ADMINISTRATOR 1-100; JOHN/JANE DOE DIRECTOR OF NURSING 1-100; JOHN/JANE DOE NURSE 1-100; JOHN/JANE DOE CNA 1-100; JOHN/JANE DOE MANAGEMENT COMPANY 1-100; JOHN/JANE DOE MEDICAL DIRECTOR 1-100; JOHN/JANE DOES 1-100; JOHN/JANE DOE CORPORATION 1-100, individually, jointly, severally and/or in the alternative, Defendants.	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: CAMDEN COUNTY DOCKET NO. CAM-L-0507-17 Civil Action **ORDER**

THIS MATTER having been opened to the Court by Cocca & Cutinello, LLP, attorneys for defendants Elmwood Evesham Associates, LLC d/b/a Care One at Evesham, Care One Management and Joseph Mina, by way of motion to dismiss specified claims with prejudice for failure to state a claim upon which relief may be granted and/or for summary judgment in defendants' favor, and the Court having considered the papers submitted, opposing papers and oral argument, if any, and for good cause having been shown;

IT IS on this day of 2019;

ORDERED that defendants' motion to dismiss the specified counts of plaintiff's complaint for failure to state a claim upon which relief can be granted is **GRANTED**; and it is further

ORDERED that defendants' motion for summary judgment on the specified counts of plaintiff's complaint is **GRANTED**; and it is further

ORDERED the second count of plaintiff's complaint, alleging violations of New Jersey's Nursing Home Responsibilities and Rights of Residents Act ("NHA"), N.J.S.A. 30:13-1 to -17, noncompliance with the federal Requirements for Long Term Care Facilities or "OBRA regulations", 42 C.F.R. § 483, and other federal and New Jersey statutes and administrative regulations are **DISMISSED WITH PREJUDICE**; and it is further

ORDERED that all claims alleging noncompliance with New Jersey and federal statutes and administrative regulations, including those set forth in ¶3 and ¶13(G) of the first count and in the second count of plaintiff's complaint are **DISMISSED WITH PREJUDICE**; and it is further

ORDERED that all claims for punitive damages, including those set forth in the fifth count and the wherefore clause in each count of the complaint are **DISMISSED WITH PREJUDICE**; and it is further

ORDERED that all claims against defendant Care One Management, LLC are **DISMISSED WITH PREJUDICE**; and it is further

ORDERED that all claims against Joseph Mina, in his capacity as administrator of Care One at Evesham, including those set forth in the eighth count of the complaint are **DISMISSED WITH PREJUDICE**; and it is further

ORDERED that an executed copy of this order shall be served upon all parties by way of operation of the Court's electronic filing system.

_____

, J.S.C.

Opposed _____
Unopposed _____

Anthony Cocca, Esq. #000821994
COCCA & CUTINELLO, LLP
The Point at Morristown
36 Cattano Ave., Suite 600
Morristown, NJ 07960
(973) 828-9000; Fax (973) 828-9999
Attorneys for Defendants
Elmwood Evesham Associates, LLC d/b/a Care One at Evesham,
Care One Management, LLC and Joseph Mina

JOSEPH L. CAPANO, Executor of the Estate of ANDREW P. CAPANO, Plaintiff, v. CARE ONE AT EVESHAM, ELMWOOD EVESHAM ASSOCIATES, LLC, JOSEPH MINA, ADMINISTRATOR, CARE ONE MANAGEMENT, LLC, JOHN/JANE DOE ADMINISTRATOR 1-100; JOHN/JANE DOE DIRECTOR OF NURSING 1-100; JOHN/JANE DOE NURSE 1-100; JOHN/JANE DOE CNA 1-100; JOHN/JANE DOE MANAGEMENT COMPANY 1-100; JOHN/JANE DOE MEDICAL DIRECTOR 1-100; JOHN/JANE DOES 1-100; JOHN/JANE DOE CORPORATION 1-100, individually, jointly, severally and/or in the alternative, Defendants.	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: CAMDEN COUNTY DOCKET NO. CAM-L-0507-17 Civil Action **CERTIFICATION OF COUNSEL**

Anthony Cocca, Esq., of full age, hereby certifies and says:

1. I am an attorney at law of the State of New Jersey and a partner with the law firm of Cocca & Cutinello, LLP, attorneys for defendants Elmwood Evesham Associates, LLC d/b/a Care One at Evesham, Care One Management and Joseph Mina. As such, I am familiar with the facts set forth herein.

2. I make this certification in support of defendants' motion to dismiss for failure to state a claim upon which relief may be granted or for summary judgment in defendants' favor on the specified claims set forth in plaintiff's complaint.

3. Attached hereto as Exhibit A is a true and correct copy of plaintiffs' complaint, filed February 2, 2017. Andrew P. Capano passed away April 1, 2017, about two months after suit was filed. This firm was substituted as defense counsel on February 18, 2019. Based on a review of the file received from prior counsel and available through the Court's website, we are unable to determine how the caption was modified.

4. Attached hereto as Exhibit B is a true and accurate copy of the opinion in Watson v. Sunrise Senior Living Facility, Inc., 2015 U.S. Dist. LEXIS 93962 (D.N.J. July 17, 2015). Pursuant to R. 1:36-3, I am not aware of any contrary unpublished opinions.

5. Attached hereto as Exhibit C is a true and accurate copy of the opinion in Friedenberg v. Lincoln Park Care Center, LLC, Docket No. ESX-L-003475-14 (Law Div. Mar. 28, 2016). Pursuant to R. 1:36-3, I am not aware of any contrary unpublished opinions.

6. Attached hereto as Exhibit D is a true and accurate copy of the report of Lance R. Youles, served by correspondence dated October 12, 2018.

7. Attached hereto as Exhibit E is a true and accurate copy of the report of John Kirby, M.D., served by correspondence dated October 5, 2018.

8. Attached hereto as Exhibit F is a true and accurate copy of the report of Bonnie Tadrick, R.N., served by correspondence dated January 23, 2019.

I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

Dated: May 16, 2019 By: 

Anthony Cocca, Esq.

Exhibit A

Appendix XII-B1

CIVIL CASE INFORMATION STATEMENT (CIS)

Use for initial Law Division
Civil Part pleadings (not motions) under *Rule* 4:5-1
Pleading will be rejected for filing, under *Rule* 1:5-6(c), if information above the black bar is not completed or attorney's signature is not affixed

FOR USE BY CLERK'S OFFICE ONLY
PAYMENT TYPE: ☐ CK ☐ CG ☐ CA
CHG/CK NO.
AMOUNT:
OVERPAYMENT:
BATCH NUMBER:

ATTORNEY / PRO SE NAME Richard J. Talbot, Esquire	TELEPHONE NUMBER (856) 665-7140
FIRM NAME (if applicable) Law Office of Andrew A. Ballerini	COUNTY OF VENUE Camden
OFFICE ADDRESS Cherry Tree Corporate Center 535 Route 38, Suite 328 Cherry Hill, NJ 08002	DOCKET NUMBER (when available) L-507-17
	DOCUMENT TYPE Complaint
	JURY DEMAND ■ YES ☐ NO

FILED
FEB - 2 2017
Camden County Superior Court

NAME OF PARTY (e.g., John Doe, Plaintiff) Andrew P. Capano by and through his POA, Joseph L. .Capano, Plaintiff	CAPTION Andrew P. Capano by and through his POA, Joseph L. Capano vs. Care One at Evesham, et als
CASE TYPE NUMBER (See reverse side for listing) 607	HURRICANE SANDY RELATED? ☐ YES ■ NO
IS THIS A PROFESSIONAL MALPRACTICE CASE? ■ YES ☐ NO IF YOU HAVE CHECKED "YES," SEE *N.J.S.A.* 2A:53 A -27 AND APPLICABLE CASE LAW REGARDING YOUR OBLIGATION TO FILE AN AFFIDAVIT OF MERIT.	
RELATED CASES PENDING? ☐ YES ■ NO	IF YES, LIST DOCKET NUMBERS
DO YOU ANTICIPATE ADDING ANY PARTIES (arising out of same transaction or occurrence)? ☐ YES ■ NO	NAME OF DEFENDANT'S PRIMARY INSURANCE COMPANY (if known) ☐ NONE ■ UNKNOWN

THE INFORMATION PROVIDED ON THIS FORM CANNOT BE INTRODUCED INTO EVIDENCE.

CASE CHARACTERISTICS FOR PURPOSES OF DETERMINING IF CASE IS APPROPRIATE FOR MEDIATION

DO PARTIES HAVE A CURRENT, PAST OR RECURRENT RELATIONSHIP? ☐ YES ■ NO	IF YES, IS THAT RELATIONSHIP: ☐ EMPLOYER/EMPLOYEE ☐ FRIEND/NEIGHBOR ■ OTHER (explain) Patient/Resident ☐ FAMILIAL ☐ BUSINESS

DOES THE STATUTE GOVERNING THIS CASE PROVIDE FOR PAYMENT OF FEES BY THE LOSING PARTY? ■ YES ☐ NO

USE THIS SPACE TO ALERT THE COURT TO ANY SPECIAL CASE CHARACTERISTICS THAT MAY WARRANT INDIVIDUAL MANAGEMENT OR ACCELERATED DISPOSITION

DO YOU OR YOUR CLIENT NEED ANY DISABILITY ACCOMMODATIONS? ☐ YES ☐ NO	IF YES, PLEASE IDENTIFY THE REQUESTED ACCOMMODATION
WILL AN INTERPRETER BE NEEDED? ☐ YES ☐ NO	IF YES, FOR WHAT LANGUAGE?

I certify that confidential personal identifiers have been redacted from documents now submitted to the court, and will be redacted from all documents submitted in the future in accordance with *Rule* 1:38-7(b).

ATTORNEY SIGNATURE: 2-1-17

Side 2

CIVIL CASE INFORMATION STATEMENT
(CIS)

Use for initial pleadings (not motions) under *Rule* 4:5-1

CASE TYPES (Choose one and enter number of case type in appropriate space on the reverse side.)

Track I - 150 days' discovery

151 NAME CHANGE
175 FORFEITURE
302 TENANCY
399 REAL PROPERTY (other than Tenancy, Contract, Condemnation, Complex Commercial or Construction)
502 BOOK ACCOUNT (debt collection matters only)
505 OTHER INSURANCE CLAIM (including declaratory judgment actions)
506 PIP COVERAGE
510 UM or UIM CLAIM (coverage issues only)
511 ACTION ON NEGOTIABLE INSTRUMENT
512 LEMON LAW
801 SUMMARY ACTION
802 OPEN PUBLIC RECORDS ACT (summary action)
999 OTHER (briefly describe nature of action)

Track II - 300 days' discovery

305 CONSTRUCTION
509 EMPLOYMENT (other than CEPA or LAD)
599 CONTRACT/COMMERCIAL TRANSACTION
603N AUTO NEGLIGENCE – PERSONAL INJURY (non-verbal threshold)
603Y AUTO NEGLIGENCE – PERSONAL INJURY (verbal threshold)
605 PERSONAL INJURY
610 AUTO NEGLIGENCE – PROPERTY DAMAGE
621 UM or UIM CLAIM (includes bodily injury)
699 TORT – OTHER

Track III - 450 days' discovery

005 CIVIL RIGHTS
301 CONDEMNATION
602 ASSAULT AND BATTERY
604 MEDICAL MALPRACTICE
606 PRODUCT LIABILITY
607 PROFESSIONAL MALPRACTICE
608 TOXIC TORT
609 DEFAMATION
616 WHISTLEBLOWER / CONSCIENTIOUS EMPLOYEE PROTECTION ACT (CEPA) CASES
617 INVERSE CONDEMNATION
618 LAW AGAINST DISCRIMINATION (LAD) CASES

Track IV Active Case Management by Individual Judge / 450 days' discovery

156 ENVIRONMENTAL/ENVIRONMENTAL COVERAGE LITIGATION
303 MT. LAUREL
508 COMPLEX COMMERCIAL
513 COMPLEX CONSTRUCTION
514 INSURANCE FRAUD
620 FALSE CLAIMS ACT
701 ACTIONS IN LIEU OF PREROGATIVE WRITS

Multicounty Litigation (Track IV)

271 ACCUTANE/ISOTRETINOIN
274 RISPERDAL/SEROQUEL/ZYPREXA
281 BRISTOL-MYERS SQUIBB ENVIRONMENTAL
282 FOSAMAX
285 STRYKER TRIDENT HIP IMPLANTS
286 LEVAQUIN
287 YAZ/YASMIN/OCELLA
289 REGLAN
290 POMPTON LAKES ENVIRONMENTAL LITIGATION
291 PELVIC MESH/GYNECARE
292 PELVIC MESH/BARD
293 DEPUY ASR HIP IMPLANT LITIGATION
295 ALLODERM REGENERATIVE TISSUE MATRIX
296 STRYKER REJUVENATE/ABG II MODULAR HIP STEM COMPONENTS
297 MIRENA CONTRACEPTIVE DEVICE
299 OLMESARTAN MEDOXOMIL MEDICATIONS/BENICAR
300 TALC-BASED BODY POWDERS
601 ASBESTOS
623 PROPECIA

If you believe this case requires a track other than that provided above, please indicate the reason on Side 1, in the space under "Case Characteristics.

Please check off each applicable category ☐ **Putative Class Action** ☐ **Title 59**

RICHARD J. TALBOT, ESQUIRE ID#: 040771993
LAW OFFICE OF ANDREW A. BALLERINI
Attorney At Law
Cherry Tree Corporate Center
535 Route 38, Suite 328
Cherry Hill, New Jersey 08002
(856) 665-7140
Attorney for Plaintiffs

ANDREW P. CAPANO, by and through his Power of Attorney, JOSEPH L. CAPANO,	:	SUPERIOR COURT OF NEW JERSEY
	:	CAMDEN COUNTY
Plaintiff,	:	LAW DIVISION
vs.	:	DOCKET NO.: CAM-L-507-17
CARE ONE AT EVESHAM, ELMWOOD EVESHAM ASSOCIATES, LLC, JOSEPH MINA, ADMINISTRATOR, CARE ONE MANAGEMENT, LLC, JOHN/JANE DOE ADMINISTRATOR 1-100; JOHN/JANE DOE DIRECTOR OF NURSING 1-100; JOHN/JANE DOE NURSE 1-100; JOHN/JANE DOE CNA 1-100; JOHN/JANE DOE MANAGEMENT COMPANY 1-100; JOHN/JANE DOE MEDICAL DIRECTOR 1-100; JOHN/JANE DOES 1-100; JOHN/JANE DOE CORPORATION 1-100; individually, jointly, severally, and/or in the alternative,	:	COMPLAINT, DEMAND FOR JURY TRIAL, AND DESIGNATION OF TRIAL COUNSEL
Defendants.	:	

Plaintiff, Andrew P. Capano, by and through her Power of Attorney, Joseph L. Capano, residing at 128 Knollwood Drive, Cherry Hill, Camden County, New Jersey, by way of Complaint against all Defendants, states as follows:

1. All statutory and regulatory claims, claims of negligence, gross negligence and punitive damages are specifically alleged against each and every Defendant named in all Counts. The Plaintiffs, by way of Complaint against all of the above-named defendants, Care One at Evesham, Elmwood Evesham Associates, LLC, Joseph Mina, Administrator, Care One Management, LLC, John/Jane Doe Administrator 1-100, John/Jane Doe Director of Nursing 1-100, John/Jane Doe Nurse 1-100, John/Jane Doe CNA 1-100, John/Jane Doe Management Company 1-100, John/Jane Doe Medical Director 1-100, John/Jane Does 1-100, and/or John/Jane Doe Corporation 1-100, individually, jointly, severally, and/or in the alternative, say as follows:

FIRST COUNT

1. The resident, Andrew P. Capano, was a resident of the defendant nursing home, Care One at Evesham, otherwise named above, as well, located at 870 East Route 70, in Marlton, Burlington County, New Jersey, 08053, on or about the dates of November 24th, 2015, through on or about

February 16, 2016, during which time he developed significant pressure ulcer(s) and a significant catheter injury to his penis.

2. The resident, Andrew P. Capano, was born on December 28, 1957, and was 57 and 58 years of age at the time these cause(s) of action arose.

3. The provisions of OBRA (Omnibus Budget Reconciliation Act of 1987) were applicable with regard to the Plaintiff's condition as it existed at all relevant times.

4. The above named defendants held themselves out as specialists in the field of adult nursing care and rehabilitation with the expertise necessary to maintain the health and safety of persons unable to care adequately for themselves.

5. The above named defendants were under a contractual duty to provide reasonable and adequate health care and rehabilitation to resident, Andrew P. Capano, consistent with existing community standards.

6. At all times pertinent hereto, resident, Andrew P. Capano, was a resident of the above-named defendants at a nursing facility, known as defendant, Care One at Evesham, pursuant to the terms of the Admission Agreement and, as

such, was under the exclusive care and control of the defendants and their agents, officers, servants and/or employees.

7. The defendants, its agents, officers, servants and/or employees failed, refused and/or neglected to perform the duties to provide reasonable and adequate health care and rehabilitation to and for resident, Andrew P. Capano, who was unable to attend to his/her own health and safety.

8. The defendants, its agents, officers, servants and/or employees negligently, carelessly and/or recklessly provided care and treatment to resident, Andrew P. Capano, and all of the alleged acts, omissions and occurrences herein described or performed by the defendants, its agents, officers, servants and/or employees fell within the course and scope of their agency and employment with the defendants and in furtherance of the defendants' business.

9. While the resident, Andrew P. Capano, was a resident of the defendant nursing facility, she/he sustained serious injuries due to the negligence of the defendants and violations of residents' rights, in addition to suffering, severe bedsores, pressure ulcers, infection, catheter injury(ies) and medical complications caused by

inappropriate monitoring of medical conditions and medicinal monitoring, over the course of his/her residency at the defendant nursing home.

10. Throughout the time that resident, Andrew P. Capano, was a resident of the defendant nursing facility, defendants, Care One at Evesham, Elmwood Evesham Associates, LLC, John/Jane Does 1-100, and/or John/Jane Doe Corporation 1-100, owned the physical plant of the defendant nursing facility.

11. Throughout the time that resident, Andrew P. Capano, was a resident of the defendant Nursing facility, Defendants, Care One at Evesham, Elmwood Evesham Associates, LLC, Care One Management, LLC, John/Jane Doe Management Company 1-100, John/Jane Does 1-100, and/or John/Jane Doe Corporation 1-100, were, managers, director(s), officer(s), and/or stockholder(s) of the applicable defendants.

12. Throughout the time that resident, Andrew P. Capano, was a resident of the defendant nursing facility, all of the named defendants, had significant control over the day to day operations of the defendant nursing facility.

13. The negligence, as well as gross negligence, and violations of rights committed by all of the defendants included, but was not limited to the following, to wit: (A)permitting abuse of the Plaintiff; (B) condoning the failure of employees to immediately report to supervisory personnel acts of abuse of the Plaintiff; (C)) permitting inadequate and false charting of the Plaintiff's medical records; (D) failure to notify the physician and the Plaintiff and Plaintiff's family in a timely manner of action which affected the Plaintiff's safety and well-being; (E) failure to hire a sufficient number of trained and competent staff, as evidenced by continuous under staffing; (F) condoning questionable recording/charting in the Plaintiff's medical records; (G) violating New Jersey Statutes, New Jersey Administrative Regulations, as well as OBRA regulations; (H) failure to adhere to the plan of care; (I) failure to discharge employees when the facility knew or should have known of the employee's propensity for negligent care of the Plaintiff; (J) condoning, and thus allowing, untrained/unlicensed individuals to provide care to the Plaintiff; (K) failure to properly train employees to

deal with geriatric residents who are unable to care for themselves as well as residents in need of rehabilitation; (L) failure to properly investigate the background of perspective employees; (M) failure to notify supervisors of the on-call physician's failure to properly care for the resident, Andrew P. Capano, as required by regulations in effect at the time of this incident; (N) failure to train the employees to recognize medical conditions/symptoms which required the Plaintiff's transfer to the hospital; (O) failure to properly train employees to deal with geriatric/disabled residents who are incapacitated; (P) failure to provide an appropriate and/or timely care plan; (Q) failure to properly train employees to deal with geriatric/disabled residents who are incapacitated and likely to develop decubitus or pressure ulcers; (R) failure to prevent development and/or worsening of decubitus or pressure ulcers; (S) failure to properly treat, recognize and/or diagnose decubitus or pressure ulcers; (T) failure to prevent infection; (U) failure to provide adequate nutrition; (V) failure to provide adequate hydration; (W) failure to properly manage and administer the subject nursing home; (X) failure to properly monitor and assess;

(Y) failure to transfer the resident to the appropriate facility; (Z) failure to properly administer medication(s); (AA) failure to appropriately catheterize, treat and/or monitor the cathertization.

14. This action is commenced within two years of the date(s) of the accrual(s) of this/these cause(s) of action.

15. As a direct and proximate result of the aforesaid carelessness, recklessness and negligence, as well as gross negligence, of all of the defendants the resident, Andrew P. Capano, sustained severe personal injuries of both a permanent and temporary nature, and was forced to endure great pain and suffering, as well as damages of economic and non-economic nature, disability, impairment and the loss of enjoyment of life, in to addition to being forced to incur medical expenses in the care and treatment of said injuries.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative, which will reasonably compensate them/him/her for the significant injuries, pain and suffering, compensatory damages of economic and non-economic nature, and other damages sustained, together with attorneys' fees, punitive damages, interest and costs of suit.

SECOND COUNT

1. For the sake of brevity, the Plaintiff hereby repeat the allegations of the previous Counts and incorporate those allegations in this Count as if set forth more fully herein.

2. N.J.S.A. 30:13-1, et. seq. requires that the defendants comply with all Federal, State and local rules, regulations, and statutes, with regard to long-term care facilities.

3. All of the defendants violated OBRA regulations, which establish the minimum standard of care to be followed by defendants, including but not limited to the following: (A) **42 C.F.R. § 483.13 (C))(2)** the facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures, including to the State Survey and Certification Agency; (B) **42 C.F.R. § 483.30(a)(1)** the facility must provide services by sufficient number of each of the following types of personnel on a twenty four (24) hour basis to provide nursing care to all residents in accordance with resident care plans (I) except when waived

under paragraph (C)) of this section, licensed nurses; and (ii) other nursing personnel;(C)) **42 C.F.R. § 483.25** each resident must receive and the facility must provide, the necessary care and services to attain and maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment;(D) **42 C.F.R. § 483.20(b)(4)(iv)** the facility failed to conduct an assessment after a significant change in resident's condition;(E) **42 C.F.R. § 483.20(d)(1) Comprehensive Care Plans** the facility must develop a comprehensive care plan that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psycho-social needs that are identified in the comprehensive assessment. The plan of care must deal with the relationship of items or services ordered to be provided (or withheld) to the facility's responsibility for fulfilling other requirements in these regulations; (F)**42 C.F.R. 483.10 Residents' Rights;** (G) **42 C.F.R. § 483.20(b)(4)(iv)** the facility failed to conduct an assessment after a significant change in resident's condition;(H) **42 C.F.R. § 483.25** based on a resident's comprehensive assessment, the facility must ensure that a resident (1) maintain acceptable parameters of

nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrate that this is not possible; and (2) receive a therapeutic diet when there is a nutritional problem;(I) **42 C.F.R. § 483.25 (C)) of the OBRA Regulations** based on the comprehensive assessment of a resident, the facility must ensure that (1) a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing; (J) **42 C.F.R. 483.15 Quality of Life;** (K) **42 C.F.R. 483.75 Administration;** and (L) **42 C.F.R. § 483.25** (l), regarding unnecessary drugs by administering the wrong drug(s).

4. The resident, Andrew P. Capano, fell within the class of persons the statutory rules, regulations and laws were intended to protect by virtue of N.J.S.A. 30:13-1, et. seq. and the Federal Regulations at 42 C.F.R. 483, et. seq., thus entitling the plaintiff to adopt such laws as the standard of care for measuring defendants' conduct.

5. The Plaintiff pleads all of the state and federal statutes, rules and regulations in support of both the negligence claims in proving deviations from standards of care, and the violations of rights claims, under N.J.S.A. 30:13-1, et. seq. and the Federal OBRA Regulations at 42 C.F.R. 483, et. seq.

6. As a direct and proximate result of the aforesaid carelessness, recklessness and negligence, as well as gross negligence, of all of the defendants, Resident, Andrew P. Capano, sustained severe personal injuries of both a permanent and temporary nature, was forced to endure great pain and suffering, damages of economic and non-economic nature, disability, impairment and the loss of enjoyment of life, and was forced to incur medical expenses in the care and treatment of said injuries.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative, which will reasonably compensate them/him/her for the significant injuries, pain and suffering, compensatory damages of economic and non-economic nature, and other damages sustained, together with attorneys' fees, punitive damages, interest and costs of suit, consistent with OBRA Regulations, and N.J.S.A. 30:13-1, et. seq.

THIRD COUNT

1. For the sake of brevity, the plaintiffs hereby repeats the allegations of the previous Counts and incorporate those allegations in this Count as if set forth more fully herein.

2. At all relevant times hereto, all of the defendants knew or should have known that their residents were elderly and/or disabled and in need of particular care and supervision.

3. The defendant nursing facility, and all of the defendants failed to exercise adequate care in the supervision of their elderly and/or disabled residents, such as the resident, Andrew P. Capano, to whom they owed such a duty.

4. As a direct and proximate result of the aforesaid carelessness, recklessness and negligence, as well as gross negligence, of all of the defendants, the resident, Andrew P. Capano, sustained severe personal injuries of both a permanent and temporary nature, was forced to endure great pain and suffering, damages of economic and non-economic nature, disability, impairment and the loss of enjoyment of life, and was forced to incur medical expenses in the care and treatment of said injuries.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative, which will reasonably compensate them/him/her for the significant injuries, pain and suffering, compensatory damages of economic and non-economic nature, and other damages sustained, together with attorneys' fees, punitive damages, interest and costs of suit.

FOURTH COUNT

1. For the sake of brevity, the plaintiffs hereby repeat the allegations of the previous Counts and incorporate those allegations in this Count as if set forth more fully herein.

2. All of the Defendants are responsible for hiring competent supervisors, managers, nurses and any other personnel necessary to oversee and monitor the treatment at the defendant nursing home/facility, and its residents, such as resident, Andrew P. Capano.

3. The managers, supervisors, nurses and other personnel, at the defendant nursing home, failed to exercise due care in monitoring, treating, and/or assessing the residents therein.

4. All Defendants are liable for the negligence, as well as gross negligence, carelessness and recklessness of its employees, subcontractors and agents under the Doctrine of Respondeat Superior.

5. As a direct and proximate result of the aforesaid carelessness, recklessness and negligence, as well as gross negligence, of the defendants, the resident, Andrew P. Capano, sustained severe personal injuries of both a permanent and temporary nature, was forced to endure great pain and suffering, damages of economic and non-economic nature, disability, impairment and the loss of enjoyment of life, and was forced to incur medical expenses in the care and treatment of said injuries.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative which will reasonably compensate them/him/her for the significant injuries, pain and suffering, compensatory damages of economic and non-economic nature, and other damages sustained, together with attorneys' fees, punitive damages, interest and costs of suit.

FIFTH COUNT

1. For the sake of brevity, the plaintiff(s) hereby repeat the allegations of the previous Counts and incorporate(s) those allegations in this Count as if set forth more fully herein.

2. The aforementioned acts and/or omissions of all of the defendants were outrageous, willful and wanton, and with complete disregard to Plaintiff's rights, and in reckless indifference to the rights of others, specifically those of resident, Andrew P. Capano, and those acts shocked the conscience of the community.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative which will reasonably compensate them/him/her for the significant injuries, pain and suffering, compensatory damages of economic and non-economic nature, and other damages sustained together with attorneys' fees, punitive damages, interest and costs of suit.

SIXTH COUNT

1. For the sake of brevity, the plaintiffs hereby repeat the allegations of the previous Counts and incorporate those allegations in this Count as if set forth more fully herein.

2. During the entire period of the resident, Andrew P. Capano's, residency at the defendant nursing facility, the defendants were subject to N.J.S.A. 30:13-1, et seq., including N.J.S.A. 30:13-5, regarding the responsibilities and rights of residents in skilled nursing facilities. Based on the aforementioned allegations, all of the defendants breached N.J.S.A. 30:13-1, et seq in their actions toward the plaintiff. The Plaintiff asserts claims for negligence and gross negligence, as well as claims under the Nursing Home Responsibilities and Resident's Rights Act, N.J.S.A. 30:13-1, et. seq., for violations of the plaintiff's rights as a nursing home resident.

3. As a direct and proximate result of the aforesaid carelessness, recklessness and negligence, as well as gross negligence, and violations of residents' rights, committed by all of the defendants, the resident, Andrew P. Capano, sustained severe personal injuries of both a permanent and temporary nature, was forced to endure great pain and suffering, damages of economic and non-economic nature, disability, impairment and the loss of enjoyment of life, and was forced to incur medical expenses in the care and treatment of said injuries.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative, consistent with N.J.S.A. 30:13-1, et seq., in general, and particularly, but not limited to N.J.S.A. 30:13-5 and N.J.S.A. 30:13-8, for actual damages, punitive damages, interest, reasonable attorneys' fees and costs for bringing said action.

SEVENTH COUNT

1. Plaintiff(s) repeat the allegations of the previous Counts and incorporate(s) them into this Count as if set forth more fully herein.

2. The defendant, John/Jane Doe Medical Director 1-100, was the medical director of the defendant nursing facility, while resident, Andrew P. Capano, was a resident at the defendant nursing facility.

3. At all times mentioned hereinafter, the defendant, John/Jane Doe Medical Director 1-100, was, and is now, a medical doctor licensed to practice medicine under the laws of the State of New Jersey.

4. At all times mentioned hereinafter the defendant, John/Jane Doe Medical Director 1-100, was engaged in the practice of his profession at the subject nursing home, in the State of New Jersey.

5. At all times mentioned hereinafter the defendant, John/Jane Doe Medical Director 1-100, professed and held himself out to the public and to the resident, Andrew P. Capano, as being skilled, careful and diligent in the practice of general medicine, and geriatric medicine. Specifically, the defendant held himself out as one who is competent to assess, diagnose, supervise a plan of care, implement said plan of care and evaluate the effectiveness of said plan of care with regard to nursing facility residents, such as the resident, Andrew P. Capano. The defendant, John/Jane Doe Medical Director 1-100, also held himself out as one who was competent to treat and initiate medical and nursing interventions, to treat and prevent skin breakdown and adequately monitor residents' conditions.

6. The defendant, John/Jane Doe Medical Director 1-100, in his treatment, care and supervision for the resident, Andrew P. Capano, did personally, and by and through his agents, servants and/or employees, negligently fail to exercise ordinary care, and otherwise failed to exercise the degree of care exercised by other doctors in like cases, having regard to the existing state of knowledge in general medicine and geriatrics.

7. As a direct and proximate result of the defendants' negligent and/or grossly negligent treatment, evaluation and assessment, resident, Andrew P. Capano, was required to obtain additional extensive medical treatment, causing him/her to expend great sums of money for said treatment, causing Plaintiff temporary and permanent injury, and great pain and suffering, damages of economic and non-economic nature, disability, impairment and the loss of enjoyment of life.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative which will reasonably compensate them/him/her for the significant injuries, pain and suffering, compensatory damages of economic and non-economic nature, and other damages sustained, together with attorneys' fees, punitive damages, interest and costs of suit.

EIGHTH COUNT

1. For the sake of brevity, the plaintiffs hereby repeat the allegations of the previous Counts and incorporate those allegations in this Count as if set forth more fully herein.

2. The defendants, Joseph Mina, Administrator, John/Jane Doe Administrator 1-100, was the Administrator(s) of the defendant nursing facility, while resident, Andrew P. Capano, was a resident at the defendant nursing facility.

3. At all times mentioned hereinafter, the defendant, Joseph Mina, Administrator, and/or John/Jane Doe Administrator 1-100, was, and is now, an administrator licensed under the laws of the State of New Jersey.

4. At all times mentioned hereinafter, the defendant, Joseph Mina, Administrator, and/or John/Jane Doe Administrator 1-100, was engaged in the practice of his profession at the subject nursing home, in the State of New Jersey.

5. At all times mentioned hereinafter the defendant, Joseph Mina, Administrator, John/Jane Doe Administrator 1-100, professed and held herself/himself out to the public and to the resident, Andrew P. Capano, as being skilled, careful and diligent in the practice of the administration of nursing homes.

6. The defendant, Joseph Mina, Administrator, and/or John/Jane Doe Administrator 1-100, did personally, and by and through his/her agents, servants and/or employees, negligently fail to exercise ordinary care, and otherwise

failed to exercise the degree of care exercised by other administrators in like cases, having regard to the existing state of knowledge in general nursing home administration.

7. As a direct and proximate result of the defendants' negligent and/or grossly negligent acts and/or omissions, resident, Andrew P. Capano, was required to obtain additional extensive medical treatment, causing him/her to expend great sums of money for said treatment, causing Plaintiff temporary and permanent injury, and great pain and suffering, damages of economic and non-economic nature, disability, impairment and the loss of enjoyment of life.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative which will reasonably compensate them/him/her for the significant injuries, pain and suffering, compensatory damages of economic and non-economic nature, and other damages sustained, together with attorneys' fees, punitive damages, interest and costs of suit.

NINTH COUNT

1. For the sake of brevity, the plaintiffs hereby repeat the allegations of the previous Counts and incorporate those allegations in this Count as if set forth more fully herein.

2. The defendant, John/Jane Doe Director of Nursing 1-100, was the Director of Nursing of the defendant nursing facility, while resident, Andrew P. Capano, was a resident at the defendant nursing facility.

3. At all times mentioned hereinafter, the defendant, John/Jane Doe Director of Nursing 1-100, was, and is now, a registered nurse, licensed to practice nursing under the laws of the State of New Jersey.

4. At all times mentioned hereinafter the defendant, John/Jane Doe Director of Nursing 1-100, was engaged in the practice of his/her profession at the subject nursing home, in the State of New Jersey.

5. At all times mentioned hereinafter the defendant, John/Jane Doe Director of Nursing 1-100, professed and held herself/himself out to the public and to the resident, Andrew P. Capano, as being skilled, careful and diligent in the practice of nursing. Specifically, the defendant held himself/herself out as one who is competent to assess, supervise a plan of care, implement said plan of care and evaluate the effectiveness of said plan of care with regard to nursing facility residents, such as the resident, Andrew P. Capano. The defendant, John/Jane Doe Director of Nursing 1-100, also held himself/herself out as one who was

competent to treat and initiate nursing interventions, to prevent falls and injuries, to treat and prevent skin breakdown and adequately monitor residents' conditions.

6. The defendant, John/Jane Doe Director of Nursing 1-100, in his/her treatment, care and supervision for the resident, Andrew P. Capano, did personally, and by and through her/his agents, servants and/or employees, negligently fail to exercise ordinary care, and otherwise failed to exercise the degree of care exercised by other nurses in like cases, having regard to the existing state of knowledge in general nursing.

7. As a direct and proximate result of the defendants' negligent and/or grossly negligent treatment, evaluation and assessment, resident, Andrew P. Capano, was required to obtain additional extensive medical treatment, causing him to expend great sums of money for said treatment, causing Plaintiff temporary and permanent injury, and great pain and suffering, damages of economic and non-economic nature, disability, impairment and the loss of enjoyment of life.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative which will reasonably compensate them/him/her for the significant injuries, pain and suffering,

compensatory damages of economic and non-economic nature, and other damages sustained, together with attorneys' fees, punitive damages, interest and costs of suit.

TENTH COUNT

1. For the sake of brevity, the plaintiffs hereby repeat the allegations of the previous Counts and incorporate those allegations in this Count as if set forth more fully herein.

2. The defendant, John/Jane Doe Nurse 1-100, were nurses at the defendant nursing facility, while resident, Andrew P. Capano, was a resident at the defendant nursing facility.

3. At all times mentioned hereinafter, the defendants, John/Jane Doe Nurse 1-100, was, and is now, a registered nurse, licensed to practice nursing under the laws of the State of New Jersey.

4. At all times mentioned hereinafter the defendant, John/Jane Doe Nurse 1-100, was engaged in the practice of his/her profession at the subject nursing home, in the State of New Jersey.

5. At all times mentioned hereinafter the defendant, John/Jane Doe Nurse 1-100, professed and held herself/himself out to the public and to the resident, Andrew P. Capano, as being skilled, careful and diligent in

the practice of nursing. Specifically, the defendant held himself/herself out as one who is competent to assess, supervise a plan of care, implement said plan of care and evaluate the effectiveness of said plan of care with regard to nursing facility residents, such as the resident, Andrew P. Capano. The defendant, John/Jane Doe Nurse 1-100, also held himself/herself out as one who was competent to treat and initiate nursing interventions, to treat and prevent skin breakdown and adequately monitor residents' conditions.

6. The defendant, John/Jane Doe Nurse 1-100, in his/her treatment, care and supervision for the resident, Andrew P. Capano, did personally, and by and through her/his agents, servants and/or employees, negligently fail to exercise ordinary care, and otherwise failed to exercise the degree of care exercised by other nurses in like cases, having regard to the existing state of knowledge in general nursing.

7. As a direct and proximate result of the defendants' negligent and/or grossly negligent treatment, evaluation and assessment, resident, Andrew P. Capano, was required to obtain additional extensive medical treatment, causing him to expend great sums of money for said treatment, causing

Plaintiff temporary and permanent injury, and great pain and suffering, damages of economic and non-economic nature, disability, impairment and the loss of enjoyment of life.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative which will reasonably compensate them/him/her for the significant injuries, pain and suffering, compensatory damages of economic and non-economic nature, and other damages sustained, together with attorneys' fees, punitive damages, interest and costs of suit.

ELEVENTH COUNT

1. For the sake of brevity, the plaintiffs hereby repeat the allegations of the previous Counts and incorporate those allegations in this Count as if set forth more fully herein.

2. The defendant, John/Jane Doe CNA 1-100, were CNA's at the defendant nursing facility, while resident, Andrew P. Capano, was a resident at the defendant nursing facility.

3. At all times mentioned hereinafter, the defendants, John/Jane Doe CNA 1-100, was/were, and is/are now, a certified nurses aide(s), certified to practice healthcare as aides, under the laws of the State of New Jersey.

4. At all times mentioned hereinafter the defendant, John/Jane Doe CNA 1-100, was engaged in the practice of his/her profession at the subject nursing home, in the State of New Jersey.

5. At all times mentioned hereinafter the defendant, John/Jane Doe CNA 1-100, professed and held herself/himself out to the public and to the resident, Andrew P. Capano, as being skilled, careful and diligent in the practice of nursing. Specifically, the defendant held himself/herself out as one who is competent to assess, supervise a plan of care, implement said plan of care and evaluate the effectiveness of said plan of care with regard to nursing facility residents, such as the resident, Andrew P. Capano. The defendant, John/Jane Doe CNA 1-100, also held himself/herself out as one who was competent to treat and initiate nursing interventions, to treat and prevent skin breakdown and adequately monitor residents' conditions.

6. The defendant, John/Jane Doe CNA 1-100, in his/her treatment, care and supervision for the resident, Andrew P. Capano, did personally, and by and through her/his agents, servants and/or employees, negligently fail to exercise ordinary care, and otherwise failed to exercise the

degree of care exercised by other CNA's in like cases, having regard to the existing state of knowledge in general nursing.

7. As a direct and proximate result of the defendants' negligent and/or grossly negligent treatment, evaluation and assessment, resident, Andrew P. Capano, was required to obtain additional extensive medical treatment, causing him to expend great sums of money for said treatment, causing Plaintiff temporary and permanent injury, and great pain and suffering, damages of economic and non-economic nature, disability, impairment and the loss of enjoyment of life.

WHEREFORE, Plaintiffs, demand judgment against all of the defendants, individually, jointly, severally, and in the alternative which will reasonably compensate them/him/her for the significant injuries, pain and suffering, compensatory damages of economic and non-economic nature, and other damages sustained, together with attorneys' fees, punitive damages, interest and costs of suit.

TWELFTH COUNT

1. For the sake of brevity, the plaintiffs hereby repeat the allegations of the previous Counts and incorporate those allegations in this Count as if set forth more fully herein.

2. Plaintiffs hereby name John/Jane Doe Administrator 1-100, John/Jane Doe Director of Nursing 1-100, John/Jane Doe Nurse 1-100, John/Jane Doe Management Company 1-100, John/Jane Doe Medical Director 1-100, John/Jane Doe 1-100, and John/Jane Doe Corporation 1-100, and John/Jane Doe CNA 1-100, fictitious names, as individuals, partnerships, companies and/or corporations who have either been misidentified and/or omitted, and whose negligence, as well as gross negligence, violations of residents' rights, acts and/or omissions contributorily caused the injuries sustained herein by the resident, Andrew P. Capano.

WHEREFORE, Plaintiffs demand judgment against all of the defendants, individually, jointly, severally, and in the alternative which will reasonably compensate them/him/her for the significant injuries, pain and suffering, compensatory damages of economic and non-economic nature, and other damages sustained, together with attorneys' fees, punitive damages, interest and costs of suit.

DATED: 2-1-17

RICHARD J. TALBOT, ESQUIRE
Attorney for Plaintiff

NOTICE PURSUANT TO RULES 1:5-1(a) AND 4:17-4 (c)

Please take notice that the undersigned attorneys, counsel for the plaintiffs, do hereby demand, pursuant to Rules 1:5-1(a) and 4:17-4 (C)), that each party herein serving pleadings and interrogatories and receiving answers thereto, serve copies of all such pleadings and answered interrogatories received from any party, including any documents, papers and other material referred to therein, upon the undersigned attorneys. Please take notice that this is a continuing demand.

DATED: 2-1-17

RICHARD J. TALBOT, ESQUIRE
Attorney for Plaintiff

CERTIFICATION

I further certify, pursuant to Rule 4:5-1, that I know of no other proceedings that are pending or that are being contemplated, in any court or arbitration proceeding, concerning this subject matter, and know of no other parties that need to be joined with this action at this time.

DATED: 2-1-17

RICHARD J. TALBOT, ESQUIRE
Attorney for Plaintiff

DEMAND FOR JURY TRIAL

Demand is hereby made for jury trial as to all issues.

DATED: 2-1-17

RICHARD J. TALBOT, ESQUIRE
Attorney for Plaintiff

DESIGNATION OF TRIAL COUNSEL

Pursuant to R.4:5-1 (c), Richard J. Talbot is designated as Trial Counsel for the above mentioned Plaintiff.

DATED: 2-1-17

RICHARD J. TALBOT, ESQUIRE
Attorney for Plaintiff

Exhibit B

DAVID WATSON, individually and as Executor of the ESTATE OF NANCY CLARE GIMENEZ-WATSON, Plaintiffs, v. SUNRISE SENIOR LIVING FACILITY, INC. d/b/a BRIGHTON GARDENS OF EDISON, BRIGHTON GARDENS OF EDISON, SUNRISE SENIOR LIVING, INC., JANE DOE NURSES 1-50, JANE DOE NURSES TECHNICIANS, CNA'S AND PARAMEDICAL EMPLOYEES 1-50, ABC CORPORATION, ABC PARTNERSHIP, and XYZ CORPORATION (these names being fictitious as their true names are unknown), Defendants.

Civ. No. 10-cv-230 (KM)(MAH)

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY

2015 U.S. Dist. LEXIS 93962

July 17, 2015, Decided
July 17, 2015, Filed

PRIOR HISTORY: *Watson v. Sunrise Senior Living Servs., 2013 U.S. Dist. LEXIS 2627 (D.N.J., Jan. 8, 2013)*

COUNSEL: [*1] For DAVID WATSON, individually, and as Executor of the ESTATE OF NANCY CLARE GIMENEZ-WATSON, Plaintiff: THOMAS SMITH HOWARD, LEAD ATTORNEY, KIRSCH, GARTENBERG & HOWARD, ESQS., TWO UNIVERSITY PLAZA, HACKENSACK, NJ.

For SUNRISE SENIOR LIVING SERVICES, INC., doing business as BRIGHTON GARDENS OF EDISON, JAMES POPE, JOHN GAUL, LISA MAYR, SUNRISE SENIOR LIVING, INC., SUSAN TIMONER, Defendants: JOHN M. DEITCH, LEAD ATTORNEY, MENDES & MOUNT, LLP, NEWARK, NJ; ROBERT F. PRIESTLEY, LEAD ATTORNEY, CLYDE & CO. US LLP, Florham Park, NJ; TIMOTHY MICHAEL JABBOUR, CLYDE & CO LLP US, Florham Park, NJ.

For DANIEL SCHWARTZ, Defendant: JOHN M. DEITCH, LEAD ATTORNEY, MENDES & MOUNT, LLP, NEWARK, NJ; TIMOTHY MICHAEL JABBOUR, CLYDE & CO LLP US, Florham Park, NJ; ROBERT F. PRIESTLEY, LEAD ATTORNEY, CLYDE & CO. US LLP, Florham Park, NJ.

JUDGES: KEVIN MCNULTY, UNITED STATES DISTRICT JUDGE.

OPINION BY: KEVIN MCNULTY

OPINION

KEVIN MCNULTY, U.S.D.J.:

This is a personal injury action brought by David Watson ("Mr. Watson") individually and on behalf of the estate of his mother, Nancy Gimenez-Watson ("Mrs. Watson"). Mrs. Watson was a patient-resident at Brighton Gardens of Edison ("Brighton Gardens"), a New Jersey assisted living facility. On April [*2] 26, 2008, she died after choking on food that was served to her at Brighton Gardens. Mr. Watson alleges that his mother's death was caused by negligence and mistreatment by Brighton Gardens' operator, Sunrise Senior Living Services, Inc. ("Services"), and its parent company, Sunrise Senior Living, Inc. ("SSLI"). Now before the Court is the defendants' motion for summary judgment.[1] For the reasons set forth below, the motion is granted in part and denied in part.

1 "Defendants," as used in this Opinion, refers collectively to Services and SLLI, the movants.

I. BACKGROUND

Brighton Gardens is an assisted living facility and nursing home in Edison, New Jersey. Brighton Gardens is licensed and operated by Services, a Delaware corporation. Services is a wholly owned subsidiary of SSLI, a

Delaware corporation with its principal place of business in McLean, Virginia.

On March 25, 2006, Mrs. Watson, who suffered from Alzheimer's disease and dementia, entered Brighton Gardens as a "resident."[2] (Defs. *L. R. 56.1* Statement of Undisputed Material Facts ("Def. Facts"), Dkt. No. 158-1, ¶¶18-19) All residents of the assisted living facility receive certain "base services," such as "reminders and supervision" with regard [*3] to "eating, bathing, dressing, grooming, toileting, ambulating, and orientation." (Residency Agreement, Ex. E, Cert, of Tim M. Jabbour ("Jabbour Cert."), Dkt. No. 158-8, at 5) They are also given three meals per day in the facility's dining room. (*Id.* at 6) Mrs. Watson was placed in the facility's "Assisted Living Plus" program, which meant that she require[d] or prefer[red] more frequent and intensive assistance with activities of daily living" than were provided at the basic level of care. (*Id.* at 19) In May 2006, Mrs. Watson was moved to the "Reminiscence Plus" program (Def. Facts ¶21), which provides a greater level of care specifically designed for residents who have a diagnosis ...of Alzheimer's disease or related disorder such as dementia." (Residency Agreement, at 7)

> 2 A "resident" is "any individual receiving extended medical or nursing treatment or care at a nursing home." *N.J.S.A. 30:13-2(e)*; *see also N.J.A.C. 8:39-1.2* (defining "resident" as "a person who resides in [a long-term care] facility and is in need of 24-hour continuous nursing supervision).

Brighton Gardens' Medical Assessment Policies

The policy of Brighton Gardens is to assess any changes in a resident's medical condition to determine whether the level of care given to that resident is [*4] adequate. Changes are reported to the resident's attending physician, who can order Brighton Gardens to implement an appropriate medical response. In addition, Brighton Gardens' nurses are required to create an "Incident Report" whenever a resident experiences one or more predefined "incidents," including "[c]hoking which requires emergency actions" and "[f]alls with injury." (Incident Reporting, Ex. 22, Decl. of Thomas S. Howard ("Howard Decl."), Dkt. No. 167-22, at 3) The nurse who witnessed the incident must complete the Incident Report "as soon as possible...but no later than the end of their shift." (*Id.* at 2) The nurse must also make an entry regarding the incident in the resident's Progress Notes--a daily record compiled for each resident. (*Id.*) Finally, the resident's attending physician must be notified of the incident within 12 hours. (*Id.* at 4)

Brighton Gardens also has a specific protocol for treating a resident who suffers choking or a blocked airway. The protocol instructs the staff members to "Call 911"; "Clear the resident's airway immediately if the resident is not able to talk or cough by performing the emergency procedure for choking"; "document[] the incident in the resident's Progress Notes"; and [*5] "Complete an incident report." (Choking or Blocked Airway, Ex. 25, Howard Decl., Dkt. No. 167-27, at 2)

Mrs. Watson's Decline in Health

The issue in this case is whether Brighton Gardens adequately responded to the apparent deterioration in Mrs. Watson's health. The parties agree that when Mrs. Watson first came to Brighton Gardens, she was able to walk and dine independently. (Def. Facts ¶22). According to Mr. Watson, however, Mrs. Watson thereafter experienced significant changes in her medical condition which the defendants, in violation of their own policies and the prevailing standard of care, failed to recognize and address.

Mrs. Watson reportedly sustained falls on six occasions in early 2008. Two of those falls, both on April 1, 2008, resulted in injury. Although an Incident Report was filed, Brighton Gardens allegedly waited until April 12, 2008, to update her medical records. (Second Am. Compl., Dkt. No. 97-3, ¶36)

On April 11, 2008--the day before the belated entries were allegedly made--a nurse found Mrs. Watson choking on her food. (Def. Facts ¶72) The nurse initiated the Heimlich maneuver and dislodged the obstruction. (*Id.* ¶73) Mrs. Watson was sent to JFK Medical Center for [*6] further observation and returned the same day. (*Id.* ¶¶73, 77) Although it is standard protocol to perform a formal reassessment of a resident's condition anytime she requires hospitalization, no such assessment was performed on Mrs. Watson. (*See* Deposition of Eileen Hesse ("Hesse Dep."), Ex. 3, Howard Decl., Dkt. No. 167-5, at 4-5) The nurse who witnessed the April 11 choking incident stated that she completed an Incident Report, but the defendants have been unable to locate or produce it. (*See* Hesse Dep., Ex. 2, Howard Decl., Dkt. No. 167-4, at 4-5)

Mrs. Watson's attending physician, Dr. Arvind Doshi, was informed about the choking incident by telephone the following morning. (*Id.* at ¶79) Dr. Doshi testified at his deposition that he saw no need to examine Mrs. Watson because no one from Brighton Gardens recommended that he do so. (Deposition of Arvind K. Doshi ("Doshi Dep."), Ex. E., Jabbour Cert., Dkt. No. 158-9, at 81). If there were "any [] major issue" regarding Mrs. Watson's health, Dr. Doshi said, a "nurse would tell me...that you need to come and see her." (*Id.*)

A few days later, on April 14, 2008, Mrs. Watson was reportedly observed "leaning to one side and looking

tired." [*7] (Expert Report of Gail King, R.N., Ex. 27, Howard Decl., Dkt. No. 167-29, at 11) Mr. Watson asserts that there is no evidence that nursing staff subsequently reassessed Mrs. Watson's condition or notified Dr. Doshi.

Mrs. Watson fell twice more, once on April 16 and and once on April 17, 2008. An Incident Report was filed after the second fall, but Dr. Doshi was not notified.

On April 27, 2008, Mrs. Watson suffered a second choking episode. (Def. Facts ¶86) It occurred at dinnertime in the Brighton Gardens dining room. The parties dispute whether any of Brighton Gardens' staff members performed the Heimlich maneuver. (Pl. Response to Defs. Statement of Material Facts and PI. Supp. Statement of Disputed Material Facts Pursuant to *L. Civ. R. 56.1* ("Pl. Facts), Dkt. No. 167-32, ¶89) The defendants contend that the staff "noticed Mrs. Watson standing, realized she was choking, called 911, and administered the Heimlich maneuver." (Def. Facts ¶89) Mr. Watson, however, points to the report of the paramedics who responded to the 911 call, which states that there was "[n]o Heimlich maneuver nor CPR started prior to E-FD's arrival." (Pl. Facts, ¶89)

By the time paramedics arrived, Mrs. Watson had stopped breathing. [*8] The paramedics' report describes what they found: "On exam BLS suctioned the airway but unable to clear the airway. CPR was continued while ALS crew suctioned while using laryngoscope. Copious amounts of food found." (*Id.*) The paramedics "extracted a large piece of chicken from Mrs. Watson's throat," placed her on a ventilator, and transferred her to JFK Medical Center. (*Id.* at ¶95) The parties agree that Mrs. Watson was still alive when she left Brighton Gardens. Once she arrived at the hospital, she was attached to a "breathing apparatus." (Def. Facts ¶97)

Before this incident, Mrs. Watson had given a healthcare proxy to Mr. Watson. (Pl. Facts, ¶98) Pursuant to that authority, Mr. Watson decided to remove the ventilator. Mrs. Watson died on April 27, 2008.

The Current Action

Mr. Watson commenced this action on December 7, 2009, in the Superior Court of New Jersey, Middlesex County. The Complaint named as defendants Services, SSLI, and five of SSLI's corporate officers: Daniel Schwartz, James Pope, John Gaul, Lisa Mayr, and Susan Timoner. On January 14, 2010, the defendants[3] removed the case to federal court. (Dkt. No. 1)

3 All named defendants joined in the removal notice. (*See* Dkt. No. [*9] 1)

Mr. Watson twice amended the Complaint. (Dkts. Nos. 69, 106) The Second Amended Complaint alleges (1) violations of the New Jersey Nursing Home *Bill of Rights, N.J.S.A. 30:13-1 et seq.*, the Federal Nursing Home Reform Amendments of 1987, *42 U.S.C. §§ 1395i, 1396r*, and provisions of the N.J.A.C. governing the licensure of assisted living and long-term care facilities, *N.J.A.C. §§ 8:36-1.1, et seq.*, 8:39-1.1, *et seq.*; (2) gross negligence; (3) negligence; (4) medical malpractice and professional negligence; (5) wrongful death; and (6) that the corporate veil should be pierced so that liability extends to Services' parent, SSLI.[4] (Dkt. No. 97-3, at 21)

4 Mr. Watson sought to include a seventh count alleging liability under a participation theory and under *N.J.A.C. 8:36-5.2(c)*. In an Order dated January 8, 2013, however, Magistrate Judge Hammer denied Mr. Watson's motion amend to the Complaint to the extent it sought to add this claim. (Dkt. No. 106, at 33)

Defendants Services and SSLI moved for summary judgment on June 13, 2014. (Dkt. No. 158)

II. JURISDICTION

This Court has subject matter jurisdiction over this case pursuant to *28 U.S.C. § 1332(a)*, as there is complete diversity of citizenship between the parties and the amount in controversy exceeds $75,000.

III. SUMMARY JUDGMENT STANDARD

Federal Rule of Civil Procedure 56(a) provides that summary judgment should be granted "if the movant [*10] shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." *FED. R. CIV. P. 56(a)*; *see also Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986)*; *Kreschollek v. S. Stevedoring Co., 223 F.3d 202, 204 (3d Cir. 2000)*. In deciding a motion for summary judgment, a court must construe all facts and inferences in the light most favorable to the nonmoving party. *See Boyle v. County of Allegheny Pennsylvania, 139 F.3d 386, 393 (3d Cir. 1998)*. The moving party bears the burden of establishing that no genuine issue of material fact remains. *See Celotex Corp. v. Catrett, 477 U.S. 317, 322-23, 106 S. Ct. 2548, 91 L. Ed. 2d 265, (1986)*. "[W]ith respect to an issue on which the nonmoving party bears the burden of proof ... the burden on the moving party may be discharged by 'showing'--that is, pointing out to the district court--that there is an absence of evidence to support the nonmoving party's case." *Id. at 325*.

If the moving party meets its threshold burden, the opposing party must present actual evidence that creates

a genuine issue as to a material fact for trial. *Anderson, 477 U.S. at 248*; *see also FED. R. CIV. P. 56(c)* (setting forth types of evidence on which nonmoving party must rely to support its assertion that genuine issues of material fact exist). "[U]nsupported allegations ... and pleadings are insufficient to repel summary judgment." *Schoch v. First Fid. Bancorporation, 912 F.2d 654, 657 (3d Cir. 1990)*; see also *Gleason v. Norwest Mortg., Inc., 243 F.3d 130, 138 (3d Cir. 2001)* ("A nonmoving party has created a genuine issue of material fact if it has provided sufficient evidence to allow a [*11] jury to find in its favor at trial.").

IV. ANALYSIS

A. The Negligence Counts

Mr. Watson asserts three counts of negligence: gross negligence (Count 2), negligence (Count 3), and medical practice and professional negligence (Count 4). Each essentially alleges that Brighton Gardens' staff violated a duty of care owed to Mrs. Watson, and that this violation proximately caused her injury and death. Services, Mr. Watson claims, is liable for the negligent actions of Brighton Gardens' staff based on respondeat superior.[5]

> 5 The potential extension of liability to Services' parent company, SSLI, is discussed in section IV.D, *infra*.

To prove negligence, a plaintiff must establish: (1) that the defendant owed the plaintiff a duty of care; (2) that the defendant breached that duty of care; and (3) that the defendant's breach proximately caused the plaintiff's injury. *Boos v. Nichtberger, 2013 N.J. Super. Unpub. LEXIS 2455, 2013 WL 5566694, *4 (N.J. Super. Ct. App. Div. Oct. 10, 2013)* (citing *Endre v. Arnold, 300 N.J. Super. 136, 142, 692 A.2d 97 (App. Div. 1997)*). The difference between "gross" and "ordinary" negligence is "one of degree rather than of quality." *Fernicola v. Pheasant Run at Barnegat, 2010 N.J. Super. Unpub. LEXIS 1614, 2010 WL 2794074, *2 (N.J. Super. Ct. App. Div. July 2, 2010)*. "Gross negligence refers to behavior which constitutes indifference to consequences." *Griffin v. Bayshore Medical Center, 2011 N.J. Super. Unpub. LEXIS 1165, 2011 WL 2349423, *5 (N.J. Super. Ct. App. Div. May 6, 2011)* (citing *Banks v. Korman Assocs., 218 N.J. Super. 370, 373, 527 A.2d 933 (App. Div. 1987)*). Unlike simple negligence, gross negligence requires wanton or reckless disregard for the safety of others. *Griffin v. Bayshore Medical Center, 2011 N.J. Super. Unpub. LEXIS 1165, 2011 WL 2349423, *5 (N.J. Super. Ct. App. Div. May 6, 2011)* (citing *In re Kerlin, 151 N.J. Super. 179, 185, 376 A.2d 939 (App. Div. 1977)*).

Medical malpractice [*12] is a kind of negligence. A medical malpractice action is based on the "improper performance of a professional service that deviated from the acceptable standard of care." *Zuidema v. Pedicano, 373 N.J. Super. 135, 145, 860 A.2d 992 (App. Div. 2004)*; *see generally Sanzari v. Rosenfeld, 34 N.J. 128, 134-35, 167 A.2d 625 (1961)*; *F.G. v. MacDonell, 291 N.J. Super. 262, 271-72, 677 A.2d 258 (App. Div. 1996), aff'd in part, rev'd in part on different grounds, 150 N.J. 550, 696 A.2d 697 (1997)*; *61 Am. Jur. 2d, Physicians, Surgeons, Etc. § 287* (2002). In a typical medical malpractice action, a plaintiff must establish by expert testimony the applicable standard of care owed by a physician to a patient, a deviation from that standard of care, and that the deviation proximately caused the injuries. *Verdicchio v. Ricca, 179 N.J. 1, 23, 843 A.2d 1042 (2004)*.

The defendants contend that summary judgment must be granted on each of the three negligence claims because the record evidence conclusively establishes that Brighton Gardens and its nursing staff conformed to the duty care. (Def. Mot. for Summ. J. ("Def. Mot."), Dkt. No. 1582, at 12) The defendants state that as a matter of law, "[a]n assisted living provider is not held to the same professional standard of care as a medical doctor, and in fact, is required to obtain, defer to, and follow medical directives from each resident's treating physician before rendering medical treatment." (Def. Mot. at 12) The defendants add that Dr. Doshi's deposition testimony proves that he never ordered anyone [*13] at Brighton Gardens to modify Mrs. Watson's treatment. Absent such a doctor's order, they say, they cannot have violated any duty by failing to modify Mrs. Watson's care in a manner that would have prevented either the first or the second choking incident. As additional support, the defendants cite the deposition testimony of Mr. Watson and his medical expert, Dr. Perry Starer.

The defendants present no evidence regarding the other elements of Mr. Watson's negligence claims. Accordingly, the decision to award summary judgment on these claims turns solely on whether Mr. Watson is able to raise a question of material fact concerning the defendants' professed adherence to the applicable standard of care.

The defendants' assertion that an assisted living facility such as Brighton Gardens is not held to the same standard as a physician does not, in itself, rule out negligence. Both assisted living facilities and physicians qualify as "licensed persons" under New Jersey law. *See N.J.S.A. 2A:53A-26(f), (j)*; *see also N.J.S.A. 26:2H-2(a)*. Any action alleging malpractice or negligence against such licensed persons in their "profession or occupation" must establish that the services rendered "fell outside acceptable professional or occupational [*14] standards or treatment practices." *N.J.S.A. 2A:53A-27*; *see also Zuidema, 373 N.J. Super. at 145*. True, those standards

and practices may differ based on the particular profession at issue, but the legal standard for determining liability is the same: failure to conform to the duty of care accepted within the profession.

In that regard, the defendants maintain that the duty of care applicable to an assisted living facility requires no more than "following the protocol" for communicating with a resident's treating physician and faithfully implementing whatever that physician may order. According to the defendants, the nursing staff of Brighton Gardens did just that throughout Mrs. Watson's time as a resident. In short, the defendants argue that it was the doctor's responsibility, not theirs, to evaluate the need for further measures to prevent choking.

Dr. Doshi testified at his deposition that Brighton Gardens' practice was to call him or send him a memorandum if there was any issue with a patient. (Doshi Dep. 32:13-19) If he had been informed that Mrs. Watson had experienced swallowing problems or any other condition that might indicate she was at risk of choking, Dr. Doshi stated, he would have made a notation in his records and ordered [*15] some form of evaluation, such as a speech therapy or a swallowing consultation, to determine whether she required any additional treatment. (Doshi Dep. 41:22-25, 42:1) Here, according to the defendants, Dr. Doshi did not conclude that the reports he got from Brighton Gardens merited any further evaluation. (Doshi Dep. 44:22-25, 45:1-4, 47:1-6) Therefore, their argument goes, Dr. Doshi could not have been expected to order Brighton Gardens to implement any measures to prevent Mrs. Watson from choking. And because the Doctor never gave such an order, the defendants insist, they could not have violated any duty of care when they failed to prevent either of Mrs. Watson's choking episodes.

The defendants point to evidence that, after the first choking episode on April 11, 2008, they adhered to Brighton Gardens' medical assessment policies. The nurse on the scene administered the Heimlich maneuver, removed the blockage, and asked a colleague to call 911. (*See* Progress Notes, Ex. G, Jabbour Cert., Dkt. No. 158-10, at 7-8) Dr. Doshi was notified by phone the following day that Mrs. Watson had choked. (Doshi Dep. 63:3-6) Aven after learning that Mrs. Watson had been hospitalized, Dr. Doshi believed [*16] it was unnecessary to visit and examine her. (Doshi Dep. 81:13-19) He testified that choking was a relatively common occurrence--"food will go through the wrong pathway sometimes"--and that one instance of choking did not establish any "issue with swallowing trouble." (Doshi Dep. 41:2-3, 81:13-19) Dr. Doshi testified that it would have been premature to order speech therapy or a swallowing consultation--or any other potentially preventative diagnostic--after a single episode of choking. (Doshi Dep. 81:23-25, 82: 1-6) Passing the responsibility back to the defendants, Dr. Doshi testified that such a move would be necessary only if "the caregiver feels that [a resident] has problems swallowing and if there is a recurrent episode." (Doshi Dep. 81:23-25, 82:1-6) At least at this point, the defendants say, neither a swallowing problem nor a recurrent episode was present. Since it was Dr. Doshi's medical opinion that the type of care given to Mrs. Watson was sufficient, the defendants argue that they cannot be held liable for failing to prevent Mrs. Watson's second, fatal choking episode.

As additional support, the defendants point to Mr. Watson's own deposition testimony. Mr. Watson testified [*17] that, after the first choking episode, he visited Mrs. Watson and considered her to be "fine." (Deposition of David Watson ("Watson Dep."), Ex D., Jabbour Cert., Dkt. No. 158-7, 97:4, 98:13-16) Defendants also cite the testimony of Dr. Starer that a speech therapy evaluation was not medically necessary after Mrs. Watson's first choking incident. This medical testimony, they say, further vindicates the actions of Dr. Doshi and Brighton Gardens. (Deposition of Dr. Perry Starer, Ex. H, Jabbour Cert., Dkt. No. 158-11, at 98)

When the second choking episode occurred on April 27, 2008, the defendants say, Brighton Gardens' staff again adhered to the medical assessment policies. A nurse administered the Heimlich maneuver (though this is disputed) and called 911. (Deposition of Merleine Fredrick, Ex. I, Jabbour Cert., Dkt. No. 158-12, 21:20-25, 22:1-25) Mrs. Watson was transported to JFK Medical Center for further treatment, and Mr. Watson was immediately notified by telephone of what had happened. (Watson Dep., 132:9-11, 134:16-25)

In sum, the defendants argue that Brighton Gardens followed its internal protocols and the instructions of Dr. Doshi. That, they say, is sufficient to discharge [*18] the duty of care imposed on an assisted living facility when caring for a resident. After reviewing the record, however, I find that Mr. Watson has successfully raised a factual dispute regarding whether or not the defendants met this burden.

There is a certain circular quality to the defendants' argument. To take an extreme and hypothetical example, if a care facility completely failed to report an injury to the doctor, it could not disclaim liability because the doctor had failed to prescribe any treatment. Here, the defendants exculpate themselves by pointing to advice (or lack of advice) from Dr. Doshi. But Dr. Doshi's advice relied on the defendants' accurately reporting the medically relevant facts to him.

The defendants' argument that Brighton Gardens was powerless to alter Mrs. Watson's treatment between the first and second choking episodes begs that informa-

tional question. As Dr. Doshi testified, he was "relying on the nurses to provide [him] with the information [he] need[ed] in order to place physician's orders for [Mrs. Watson]." (Doshi Dep., 60:15-19) If, as Mr. Watson submits, the defendants negligently failed to provide that information after the April 11, 2008 episode, then [*19] Dr. Doshi would have been ill equipped to give appropriate orders regarding her care.

Has Mr. Watson submitted evidence sufficient to create an issue of fact as to the defendants' accurate and complete reporting of the April 11, 2008 episode to Dr. Doshi? I believe he has.

Brighton Gardens' policy was to evaluate a resident's medical condition any time she was admitted to the hospital and returned to the facility. Eileen Hesse, a registered nurse who worked at Brighton Gardens, testified that if a resident "went out to the emergency room for an evaluation and then they returned, there would be some sort of assessment." (Hesse Dep., 96:18-20) According to Hesse, this evaluation would consist of "a head-to-toe physical assessment" focused on the "reason that that the [] resident went out to the hospital." (*Id.* at 97:6-9, 97:22-23, 98:16-18) No such assessment appears to have been conducted after Mrs. Watson returned from the hospital after her first choking episode. (Deposition of Kimberly Walling, Ex. 5, Howard Decl., 167-7, at 35:4-18, 36:15-20) Indeed, Dr. Doshi testified that apart from the initial phone call he received after Mrs. Watson had been taken to the hospital, no one from [*20] Brighton Gardens ever followed up with him about her condition. (Doshi Dep., 64:12-25, 65:1-14)

Mr. Watson contends that this lapse in evaluation and reporting prevented Dr. Doshi from effectively supervising his mother's care. Dr. Doshi testified that if the nursing staff had "let [him] know...there is a problem with any [] swallowing," then would have ordered a speech therapy evaluation. (Doshi Dep., 48:11-20) But because the nursing staff never evaluated Mrs. Watson after she first choked, Mr. Watson says, there was no way for Dr. Doshi to know whether the choking episode was an isolated incident or evidence of a growing inability to swallow. As Mr. Watson's expert registered nurse, Gail King, writes her in report: "There were no further progress notes written that monitored [Mrs. Watson] after [the first choking] episode nor did the nursing staff speak with the physician about utilizing the services of the in-house speech-language pathologist to assess Mrs. Watson's swallowing skills which can often deteriorate with Alzheimer's disease." (Expert Report of Gail King ("King Report"), R.N., Dkt. No. 167-29, 11)

Mr. Watson documents other apparent failures in Brighton Gardens' communication [*21] with Dr. Doshi. On April 14, 2008, the Daily Log notes that Mrs. Watson was "leaning to the side a bit and looking very tired." (Daily Log April 2008, Ex. 21, Howard Decl., Dkt. No. 167-23, at 6) Although the entry states that the staff "notif[ied] team members and [the] nurse" (*id.*), there is no evidence that any further action was taken or that Dr. Doshi was notified. Dr. Doshi testified that this is exactly the kind of information that he would expect the nurses to report to him, because it could be indicative of a "minor stroke" or a "medication side effect." (Doshi Dep., 65:15-24, 66:2-4)

Additionally, Mr. Watson points to evidence that Brighton Gardens failed to follow its own Incident Report policy. Nurse Hesse testified that she prepared an Incident Report following the first choking episode and "left it in the nurse's station." (Hesse Dep., 28:3-5). Throughout the course of this litigation, however, the defendants have been unable to locate this document. (*See* ¶3, Howard Decl.) The Court must construe all facts and inferences in the light most favorable to Mr. Watson. *See Boyle, 139 F.3d at 393*. For purposes of this analysis, then, I will assume that no Incident Report was created following Mrs. Watson's [*22] first choking episode--a clear violation of Brighton Gardens' policy.

Rounding out the picture, both of Mr. Watson's experts--Nurse King and Dr. Starer--have submitted opinions that these oversights violated the duty of care and proximately caused Mrs. Watson's second, fatal choking episode.

Nurse King testified that after the first choking episode, the nursing staff should at least have finely cut Mrs. Watson's food for her and watched her eat to determine whether she continued to experience swallowing issues. That would have minimized the risk of choking at least until Dr. Doshi--assuming he had been properly informed--could order a speech therapy evaluation. (Deposition of Gail King, R.N., Ex. 28, Howard Decl. 67:22-69:23) Such simple commonsense precautions did not require medical authorization. Nurse King's report identifies a number of lapses by the Brighton Gardens staff: "Lack of communication by the staff at all levels to ensure her basic needs were met"; "Lack of reassessment by the staff once physical or behavioral changes were observed"; "Lack of timely follow-up intervention to ensure her health & safety"; "Lack of timely and/or consistent documentation to ensure staff were aware [*23] of her needs or changes demanded due to these needs"; and "Lack of timely notification to physicians with changes in her condition." (King Report, Dkt. No 167-29, at 13-14) The report states that these failures and oversights "caused direct harm and injury" to Mrs. Watson and "contributed to her death." (*Id.* at 14)

Dr. Starer, the expert physician, agreed with Nurse King's conclusions. He found that Mrs. Watson's second,

fatal choking could have been prevented had Brighton Gardens observed a reasonable degree of care:

> As a foreseeable result of the staff of Brighton Gardens of Edison not providing care to prevent aspiration, Ms. Watson aspirated on April 26, 2007. Ms. Watson's history of aspiration was known to the staff of Brighton Gardens of Edison. Ms. Watson required aspiration precautions. She should have been maintained in an upright position during and after meals. Food of appropriate size and consistency should have been provided...There is no evidence that Ms. Watson was properly assessed or monitored.
>
> ...
>
> As a result of the staff of Brighton Gardens of Edison not properly providing care to prevent aspiration, Ms. Watson aspirated. As a result of choking on food, her airway was obstructed. [*24] As a result of her airway being obstructed, she suffered cardiac arrest and died...Brighton Gardens of Edison failed to ensure that Ms. Watson received appropriate routine medical and nursing care[.]
>
> ...
>
> Brighton Gardens of Edison's failure to comply with the applicable standards of care caused, within a reasonable degree of medical certainty, Ms. Watson to aspirate, suffer cardiac arrest and die...These injuries to Ms. Watson could have, within a reasonable degree of medical certainty, been prevented if the standards of care had been followed.

(Starer Report, Ex. 8, Howard Decl., Dkt. No. 167-10, at 6)

Finally, Mr. Watson notes that Brighton Gardens failed to follow its Choking or Blocked Airway policy during Mrs. Watson's second choking incident. That policy instructs the nursing staff to "[c]lear the resident's airway immediately if the resident is not able to talk or cough by performing the emergency procedure for choking." (Choking or Blocked Airway, Ex. 25, Howard Decl., Dkt. No. 167-27, at 2) Brighton Gardens asserts that staff members "administered the Heimlich maneuver" immediately after realizing Mrs. Watson was choking. (Def. Facts ¶89) But the paramedics who responded to the 911 call [*25] recorded in their report that "No Heimlich maneuver or CPR started prior to E-FD's arrival." (Patient Care Report, Ex. 7, Howard Decl., Dkt. No. 167-9, at 2)

I do not suggest, of course, that the evidence marshaled by Mr. Watson compels judgment in plaintiffs favor. But it is more than sufficient to raise a question of material fact regarding whether the defendants followed the duty of care, and therefore, to preclude summary judgment in the defendants' favor. The defendants' motion for summary judgment is thus denied as to Mr. Watson's claims for gross negligence (Count Two), negligence (Count Three), and medical practice and professional negligence (Count Four).

B. Punitive Damages

Mr. Watson seeks punitive damages on all three negligence counts. The defendants argue that even if the Court does not grant summary judgment on those counts in their entirety, it should nonetheless grant partial summary judgment to the extent that they seek punitive damages. The defendants claim that, as a matter of law, the conduct alleged by Mr. Watson simply does not rise to the level of culpability required to impose punitive damages.

The Punitive Damages Act ("Act") governs claims involving punitive [*26] damages. *N.J.S.A. § 2A:15-5.9-5.17*. Under the Act, a New Jersey court may award punitive damages only if:

> [T]he plaintiff proves, by clear and convincing evidence, that the harm suffered was the result of the defendant's acts or omissions, and such acts or omissions were actuated by actual malice or accompanied by a wanton and willful disregard of persons who foreseeably might be harmed by those acts or omissions. This burden of proof may not be satisfied by proof of any degree of negligence including gross negligence.

N.J.S.A. § 2A:15-5.12(a). The Act defines "actual malice" as an "intentional wrongdoing in the sense of an evil-minded act" and "wanton and willful disregard" as a "deliberate act or omission with knowledge of a high degree of probability of harm to another and reckless indifference to the consequences of such act or omission." *N.J.S.A. § 2A:15-5.10*.

A court should therefore award punitive damages "only where the evidence shows that the defendant knows or has reason to know of facts that create a high risk of physical harm to another and deliberately pro-

ceeds to act in conscious disregard or, or indifference to, that risk." *Sipler v. Trans Am Trucking, Inc., 2010 U.S. Dist. LEXIS 126047, 2010 WL 492393, at *3 (D.N.J. Nov. 30, 2010)* (citing *Burke v. Maassen, 904 F.2d 178, 181 (3d Cir. 1990))*. It is "not enough to show that a reasonable person in the defendant's position would have realized or appreciated [*27] the high degree of risk from his actions." *Id.* Rather, "there must be some evidence that the defendant *actually realized* the risk and acted in conscious disregard or difference to it." *Id.* (emphasis added)

Mr. Watson alleges that the defendants intentionally decided to understaff Brighton Gardens, and that this decision "created an environment in which the staff were too busy to pay attention to the residents" or "to monitor their condition and their needs." (Plaintiff's Brief in Opposition to Def. Sum. J. Mot. and in Supp. of Pl. Cross-Motion for Leave to Am. the Compl. ("Pl. Br."), Dkt. No. 167, at 31) His principal evidence in support of this contention is that the defendants failed to replace Jonelle West, the Coordinator of the Reminiscence Unit--the part of the facility specially designed for residents suffering from Alzheimer's where Mrs. Watson had resided since May 2006--after she filed for disability in April 2008 and took a leave of absence. (See Pl. Facts, ¶ 1163) Mr. Watson states that instead of hiring someone to fill this supervisory position, the defendants "requir[ed] instead that others cover for her absence and effectively le[ft] no one in charge." (Pl. Br., at 31) He charges that [*28] had West been replaced, a supervisor would have been present during Mrs. Watson's second choking episode. The decision to not replace West, Mr. Watson says, is part of the defendants' deliberate decision to keep Brighton Gardens understaffed. Further, he maintains that all of the alleged derogations from the standard of care discussed in Section IV.B., *supra*, derived from understaffing.

I find that this issue is not suitable for resolution on summary judgment based on this record. Certainly punitive damages are not prohibited as a matter of law. Striking down an exculpatory contractual clause that precluded punitive damages, the Appellate Division has stated that "[t]he preclusion of punitive damages touches upon the societal interest of expressing the community's disapproval of outrageous conduct. In the context of nursing home abuse, punitive damages also serve an 'admonitory' function." *Estate of Ruszala v. Brookdale Living, 415 N.J. Super. 272, 298, 1 A.3d 806 (App. Div. 2010)*. The issue is a fact-sensitive one that may depend on the evaluation of witness testimony. While defendants have ample grounds for their opposition to punitive damages, I cannot rule them out under every plausible scenario that may occur at trial.

I therefore deny the motion for summary judgment as to punitive damages. I [*29] do so, however, without prejudice to the renewal of these arguments at the close of plaintiff's case or at the close of all the evidence. I further note that, in diversity cases, the Court generally adheres to the state-court procedure of bifurcating the trial, presenting the punitive damages issues to the jury only if, and after, the jury has awarded compensatory damages.

C. The Statutory Violations

Count One of the Second Amended Complaint alleges that the defendants violated four statutory or regulatory schemes:

> o The New Jersey Nursing Home Responsibilities & Rights of Residents Act, *N.J.S.A. § 30:13-1 et seq.* (the "NHRRRA"),
>
> o The Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, *N.J.A.C. § 8:36-1.1 et seq.* (the "SLALR")
>
> o The Standards for the Licensure of Long-Term Care Facilities, *N.J.A.C. § 8:39-1.1 et seq.* (the "SLLTCF"), and
>
> o The Federal Nursing Home Reform Amendments, *42 U.S.C. § 1396r et seq.* (the "FNHRA").

The defendants cite a recent decision of this district court which held that the NHRRRA does not apply to assisted living facilities such as Brighton Gardens. *Andreyko v. Sunrise Sr. Living, Inc., 993 F. Supp. 2d 475, 481-85 (D.N.J. 2014)*. Adopting Judge Debevoise's analysis, I will grant summary judgment on Count One to the extent it alleges violations of the NHRRRA.

Of course, disposing of the NHRRRA allegations [*30] does not dispose of Count One. I therefore consider the other statute and regulations under which Mr. Watson seeks relief. I hold that they either do not confer a private right of action or do not apply to Mrs. Watson, and therefore I will grant summary judgment on Count One in its entirety.

First, the state regulations. There is no private right of action to enforce the provisions of the SLALR and the SLLTCF. Both are promulgated under Title 8 of the New Jersey Administrative Code. The SLALR, codified at Chapter 36, "establish[es] minimum standards with which an assisted living residence, comprehensive per-

sonal care home or assisted living program must comply in order to be licensed to operate in New Jersey." *N.J.A.C. 8:36-1.2*. It provides that each resident is entitled to an enumerated list of rights, such as "the right to receive a level of and services that addresses the resident's changing physical and psychosocial status," and "the right to be free from physical harm and mental abuse and/or neglect." *N.J.A.C. 8:36-4.1*. Although this is styled as a list of "rights," the regulation does not promulgate a liability-creating scheme that affords a private right of action against infringers. To the contrary, the SLALR explicitly [*31] provides only that the New Jersey Department of Health and Senior Services ("DHSS") can enforce the provisions of this chapter. Typically, DHSS will do so by denying or revoking a facility's license, assessing monetary penalties, or by removing residents from the facility. *N.J.A.C. 8:36-2.8, 2.9, 3.5*.

The SLLTCF is substantially similar in design. Codified at Chapter 39, it establishes "rules and standards intended to assure the high quality of care delivered in long-term care facilities, commonly known as nursing homes, throughout New Jersey." *N.J.A.C. § 8:39-1.1*. The rules are "intended for use in State surveys of the facilities and any ensuing enforcement actions." *Id.* The SLLTCF also sets forth a list of rights to which the residents of such facilities are entitled. *N.J.A.C. § 8:39-4.1*. The only reference to enforcement in this chapter states that "violations of this subchapter may result in act by the Department [*i.e.*, DHSS] in accordance with *N.J.A.C. 8:43E*." *N.J.A.C. 8:39-2.7*. That provision, in turn, provides that only "the Commissioner [of DHSS] or his or her designee may impose [] enforcement remedies against a health care facility for violations of licensure regulations or other statutory requirements." *N.J.A.C. 8:43E-3.1*. Again, there is no provision for a private right of action, and [*32] the enforcement provision appears to rule out such a right of action.

Because neither the SLALR nor the SLLTCF may be enforced through private civil litigation, Mr. Watson's claims for violations of those statutes must therefore fail as matter of law.

Finally, Count One alleges a violation of a federal statute, the FNHRA. FNHRA was passed by Congress to provide for the oversight and inspection of nursing homes that participate in the Medicare and Medicaid Programs. *42 U.S.C. §§ 1395i-3(g), 1396r(g)*. This statute affords nursing home residents certain rights so as to establish minimum standards of care. Like the New Jersey statutes, the FHNRA does not expressly authorize a private cause of action. The Third Circuit, however, has held that a private litigant may seek redress through *42 U.S.C. § 1983* for violations of the rights conferred by FNHRA. *See Grammer v. John J. Kane Regional Centers-Glen Hazel, 570 F.3d 520, 525 (3d Cir. 2009)*.

Nevertheless, FNHRA does not apply here, for several reasons. First, the Third Circuit stated that "Medicaid recipients were the intended beneficiaries of *§ 1396r*." *Id. at 527*. Mr. Watson makes no allegation or showing that his mother was a Medicaid recipient. Second, even if Mrs. Watson did receive Medicaid, violations of the FNHRA can be enforced only through *§ 1983*. Mr. Watson asserts no such claim, [*33] nor could he, because Brighton Gardens is a private actor. *See, e.g., Boykin v. 1 Prospect Park ALF, LLC, 993 F. Supp. 2d 264, 283 (E.D.N.Y. 2014)* ("Plaintiffs' *section 1983* claims would still require proof that the deprivation of their federal rights occurred 'under color of [State] law.' The defendants here are private parties, not state actors, and it is undisputed that at all relevant times the [facility in question] 'was private pay--not Medicaid.'") (internal citations omitted). Finally, the allegations of the complaint and the proofs I have analyzed leave it unclear whether Brighton Gardens, an "assisted living facility" under New Jersey law, *see Andreyko, 993 F. Supp. 2d. at 481-85*, meets the FNHRA's statutory definition of a "nursing home." For these reasons, I conclude that Mr. Watson's FNHRA claim fails as a matter of law.

Summary judgment is granted on Count One in its entirety.

D. Piercing the Corporate Veil

Count 6 of the Second Amended Complaint alleges that SSLI should be held liable for the alleged tortious conduct of Services, its subsidiary. Services, recall, is the licensed operator of Brighton Gardens. Mr. Watson contends that SSLI dominated Services to such an extent that it is permissible for the Court to pierce the corporate veil. The defendants urge the Court to enter summary judgment [*34] on this count because, they say, the evidence shows that Services did not abuse the corporate form. I disagree. The evidence presented by Mr. Watson is sufficient to raise genuine, material factual issues regarding the relationship between Services and SSLI.

Piercing the corporate veil is a "tool of equity." *Carpenters Health & Welfare Fund v. Kenneth R. Ambrose, Inc., 727 F.2d 279, 284 (3d Cir. 1983)*. It provides a remedy "when [a subservient] corporation is acting as an *alter ego* of [a dominant corporation.]" *Bd. of Trustees of Teamsters Local 863 Pension Fund v. Foodtown, Inc., 296 F.3d 164, 171 (3d Cir. 2002)* (citations omitted). A plaintiff seeking to pierce the corporate veil bears the burden of establishing that the corporate form should be disregarded. *Richard A. Pulaski Constr. Co. v. Air Frame Hangars, Inc., 195 N.J. 457, 472, 950 A.2d 868 (2008)*. Under New Jersey law, the plaintiff must show

that (1) "the parent so dominated the subsidiary that it had no separate existence but was merely a conduit for the parent," and (2) "the parent has abused the privilege of incorporation by using the subsidiary to perpetrate a fraud or injustice, or otherwise to circumvent the law." *Pharmacia Corp. v. Motor Carrier Services Corp., 309 F. App'x 666, 672 (3d Cir. 2009)* (quoting *State Dep't of Env. Prot. v. Ventron Corp., 94 N.J. 473, 468 A.2d 150 (1983))*. Factors relevant to piercing the corporate veil include:

> [G]ross undercapitalization ... failure to observe corporate formalities, non-payment of dividends, the insolvency of the debtor corporation at the time, siphoning of funds of the corporation by the dominant stockholder, non-functioning [*35] of other officers or directors, absence of corporate records, and the fact that the corporation is merely a facade for the operations of the dominant stockholder or stockholders.

Foodtown, Inc., 296 F.3d at 172.

Whether the veil should be pierced is ordinarily a fact-intensive issue: "The issue of piercing the corporate veil is submitted to the factfinder, unless there is no evidence sufficient to justify disregard of the corporate form." *N. Am. Steel Connection, Inc. v. Watson Metal Products Corp., 2010 U.S. Dist. LEXIS 95594, 2010 WL 3724518, at *10 (D.N.J. Sept. 14, 2010)* (citations omitted) *aff'd, 515 F. App'x 176 (3d Cir. 2013)*.

Mr. Watson persuasively cites deposition and other testimony that suggests that Services functioned as the alter ego of SSLI. Bradley Rush, who from 2005 to 2007 simultaneously served as the Chief Financial Officer of SSLI and the sole member of Services' board of directors, testified that Services had no employees of its own and held no formal board meetings. (Deposition of Bradley Rush ("Rush Dep."), Ex. 9, Howard Decl., Dkt. No. 167-11, at 13:9-10, 16:10-12) Rush testified that Services did not keep its financial books and records separate from those of SSLI. (*Id.* at 35:11-13) He further stated that the money generated by the assisted living facilities operated by Services was routinely "swept into a centralized account at the bank of [SSLI's Virginia] [*36] location." (*Id.* at 24:21-25, 25:1-2) Although Services formally maintained its own bank accounts, it did not retain "any portion" of the revenue generated by the assisted living facilities. (*Id.* at 25:8-10) Instead, Rush said, when Services needed to pay its staff or make other expenditures, "funds would be swept back down from [SSLI's] centralized account to cover that." (*Id.* at 28:1-7). Typically, however, Services' bank accounts "were always maintained at zero." *Id.* at 28:4-18) Rush also testified that SSLI determined the staffing levels at the facilities operated by Services, like Brighton Gardens. (*Id.* at 30-31) For these reasons, Rush maintained that SSLI and Services "acted as the alter ego of each other," and that SSLI "completely dominated and controlled the activities and finances of...Services." (*Id.* at 33:12-19)

Richard Nadeau, who succeeded Rush as the Chief Financial Officer of SSLI, gave trial testimony in a separate action against SSLI that corroborates Rush's deposition testimony.[6] Nadeau testified that he was unable to estimate the worth of Services because he said, referring to SSLI, "we don't keep the books and records of the corporation that way. We keep the records at the [*37] consolidated level." (Testimony of Richard Nadeau, Ex. 11, Howard Decl., Dkt. No. 167-13, 6:19-26) Nadeau, like Rush, stated that all of the revenue generated by Services through its assisted living facilities is deposited into an account controlled by SSLI, and that SSLI then decides how those funds will be allocated. (*Id.* at 14-15) Nadeau could not recall if Services ever paid a dividend to SSLI. (*Id.* at 13) Furthermore, although he was an officer of SSLI, Nadeau also performed work on behalf of Services. (*Id.* at 10:12-14)

> 6 Nadeau was called to testify on behalf of SSLI on May 14, 2008 in the case of *Adams v. Villa Valencia Health Care Center and Sunrise Senior Living, Inc., et al.*, in the California Superior Court of Orange County (Case No. 05CC13199).
>
> This transcript may constitute admissible hearsay in its own right. It is a statement "made by a person whom the party authorized to make a statement on the subject," and also, because it is a statement "made by the party's agent or employee on a matter within the scope of that relationship and while it existed." *FED. R. EVID. 801(d)(2)(C)-(D)*. SSLI's Form 8-K, dated May 29, 2009, confirms that Nadeau was CFO of SSLI when he gave the testimony quoted in the text. ([*38] *See* Ex. 12, Howard Decl., Dkt. No. 167-14). At the very least, this transcript may be considered, like an affidavit, as a sworn statement of a person who could presumably be called as a witness.

The former executive director of Brighton Gardens, Nelson Duran, testified at his deposition that he had never heard of Services, even though it held the license for the facility he oversaw. (Deposition of Nelson Duran, Ex. 14, Howard Decl. Dkt. No. 167-16, 11:12-14) He also testified that he received "training regarding proce-

dures and protocols" to be used at Brighton Gardens at SSLI's office in Virginia. (*Id.* at 9:16-25, 10:1-15) According to Duran, Brighton Gardens' entire policy manual was prepared by SSLI. (*Id.* at 49:4-16). That point was reinforced by Thomas Kessler, SSLI's Area Manager of Operations in New Jersey. Kessler testified that SSLI set the policies to be used at the facilities operated by its subsidiaries and then took steps to ensure compliance with those policies. (Deposition of Thomas Kessler, Ex. 13, Howard Decl., Dkt. No. 167-15, 20:7-25, 22:18-23:2, 35:13-17, 45:16-47:13)

The defendants protest that SSLI and Services have not "abused" the corporate form. However, they offer [*39] scant evidence to contradict the testimony marshalled by Mr. Watson. There is the declaration of Susan Timoner, the Vice President of Services, which states that although SSLI "has overarching goals for its subsidiaries (as would any parent company)," it has "no involvement in the day-to-day operations or management" of Services. (Declaration of Susan Timoner, Ex. J., Jabbour Cert., Dkt. No. 158-13, ¶¶20, 30) Timoner's declaration also states that SSLI and Services each have their own officers and boards of directors, and that Services "maintains bank accounts in its name and issues W-2s to its thousands of employees." (*Id.* at ¶¶11, 13)

In support, the defendants submit copies of W-2s issued by Services as well as what are described as Services' financial records and bank statements. I find problems with each piece of evidence. The W-2s do list Services as the employer, but the address listed is that of SSLI. (Ex. N, Jabbour Cert., Dkt. No. 158-17) The alleged financial statements are two Independent Auditors Reports for the period between 2005 and 2008. (Ex. L, Jabbour Cert., Dkt. No. 158-15) Inexplicably, both reports consist of balance sheets that are completely devoid of financial [*40] figures. There are, for example, no dollar amounts listed for "Total assets" or "Total liabilities"; indeed, there are no dollar amounts listed in *any* rows or columns. (*Id.*) The alleged statement from Services' bank account is similarly perplexing. (Ex. M., Jabbour Cert., Dkt. No. 158-16) It is completely redacted, and contains no information of any kind.

I do not suggest that defendants' evidence could not be believed or credited. But in light of the evidence presented, I find that Mr. Watson has raised material factual questions of fact regarding both prongs of the veil-piercing test.

As to the first prong, a reasonable jury could find that Services was merely a conduit for SSLI: for example, Services allegedly failed to hold board meetings or pay dividends, Services allegedly does not keep independent financial records, SSLI allegedly diverted all of Services' revenue into its own bank account, and SSLI allegedly trained and supervised Services' staff. *See Foodtown, Inc., 296 F.3d at 172*.

As to the second prong, "abuse" of the corporate form, the evidence is likewise sufficient to raise a factual issue. The United States Court of Appeals for the Third Circuit has stated "the hallmarks of ... abuse are typically [*41] the engagement of the subsidiary in no independent business of its own but exclusively the performance of a service for the parent, and even more importantly, the undercapitalization of the subsidiary rendering it judgment proof." *Pharmacia Corp., 309 F. App'x at 673* (quoting *OTR Assocs. V. IBC Servs., Inc., 353 N.J. Super. 48, 801 A.2d 407 (App. Div. 2002))*. Testimony cited by Mr. Watson suggests that Services was merely a shell that licensed and operated assisted living facilities for the benefit of SSLI. There is also evidence that Services remits all of its revenue to SSLI, has no substantial assets, and therefore is judgment-proof. That evidence is sufficient to permit a reasonable jury to conclude that SSLI abused the privilege of incorporation by using Services "to perpetrate a fraud or injustice, or otherwise to circumvent the law." *Pharmacia Corp., 309 F. App'x at 672*.

Accordingly, the defendants' motion for summary judgment on Count 6 is denied. The issue of piercing the corporate veil is one for the finder of fact.

V. CONCLUSION

For the reasons set forth above, the defendants' motion for summary judgment is **GRANTED IN PART** and **DENIED IN PART**.

An appropriate order will issue.

/s/ Kevin McNulty

KEVIN MCNULTY, U.S.D.J.

Date: July 17, 2015

ORDER

KEVIN MCNULTY. U.S.D.J.:

This matter comes before the Court on the motion for summary judgment [*42] filed by defendants Sunrise Senior Services, Inc. and Sunrise Senior Living, Inc. (the "defendants") (Dkt. No. 158); and the plaintiff having opposed the motion (Dkt. No. 167); and defendants having filed a reply (Dkt. No. 171); and the Court having considered the submissions of the parties pursuant to *Fed. R. Civ. P. 78*; and for good cause shown;

IT IS this 17th day of July 2015,

ORDERED, in accordance with the accompanying Opinion and pursuant to *Fed. R. Civ. P. 56*, that the de-

fendants' motion for summary judgment is **GRANTED** as to Count One of the Complaint, and it is further

ORDERED the motion is **DENIED** as to Counts Two, Three, Four, Five and Six of the Complaint.

/s/ Kevin Mcnulty

KEVIN MCNULTY

United States District Judge

Exhibit C

SUPERIOR COURT OF NEW JEREY
ESSEX COUNTY: LAW DIVISION

PREPARED BY THE COURT

MICHAEL FRIEDENBERG, ET AL.	Docket No. : ESX-L-003475-14
Plaintiff(s),	CIVIL ACTION
v.	AMENDED ORDER
LINCOLN PARK CARE CENTER, LLC, ET AL.	
Defendant(s).	

THIS MATTER having been presented to the Court by application of Steven I. Greene, Esq., attorney for the plaintiffs, and good cause having been shown;

IT IS on this 28th day of March, 2016,

ORDERED that the plaintiffs' application for leave to file an amended complaint to add Dr. Arthur Sheppell, in his capacity as Medical Director of Lincoln Park Care Center, LLC, is hereby denied for reasons set forth in the attached statement.

IT IS FURTHER ORDERED that a copy of this Order be served on all parties within seven (7) days of the date hereof.

Hon. Frank Covello, J.S.C.

__X__ OPPOSED

____ UNOPPOSED

Friedenberg v. Lincoln Park Care Center
ESX-L-3475-14
Statement of Reasons

This matter comes before the Court on the Plaintiffs' motion seeking leave to file a sixth amended complaint to add Dr. Arthur Sheppell, in his capacity as Medical Director of Lincoln Park Care Center ("LPCC"), as a defendant. On January 8, 2016, this Court granted an Order allowing the plaintiff to file a 6th Amended Complaint to add Dr. Jason Prager and Jeanne Mahalik as defendants. However, the parties were directed to brief the issue of futility of the proposed amended complaint in addition to the other arguments of the parties.

This case arises from the death of Alyce Friedenberg which occurred on December 14, 2012, after she had been under the care of defendant Lincoln Park Care Center from November 16, 2012 through December 10, 2012. During the relevant period of time, Dr. Arthur Sheppell was the Medical Director of Lincoln Park Care Center. The original Complaint was filed on May 14, 2014, and amended complaints were filed on May 23, 2014, June 4, 2014, July 25, 2014, October 28, 2014, August 21, 2015 and February 1, 2016. The Fourth Amended Complaint, October 28, 2014, added "John Doe, Medical Director" as a defendant. At the time, the statute of limitations had not expired, and Dr. Arthur Sheppell had already been a named defendant in his capacity as a treating physician.

The Plaintiffs' original motion was to file a Sixth Amended Complaint to add Dr. Jason Prager, Jeanne Mahalik and Dr. Sheppell as defendants. The motion was granted as to Dr. Prager and Ms. Mahalik, and a Sixth Amended Complaint was filed. If granted, this motion will allow for the filing of a Seventh Amended Complaint.

It should be noted that Dr. Sheppell's answers to Form C interrogatories, served on or about September 9, 2014, did not identify himself as the Medical Director for Lincoln Park Care Center (LPCC). However, Defendant Sheppell asserts in his opposition papers that various documents produced during discovery contained his signatures which identified him as the

Medical Director of Lincoln Park Care Center. The signatures did not include a printed name with them, but would have required a signature comparison to determine if the signature was that of Dr. Sheppell. Also noteworthy is that on February 12, 2015, the Defendant sent the Plaintiff a letter acknowledging Dr. Sheppell as the Medical Director at LPCC. Furthermore, on February 24, 2015, the defendant provided to the plaintiff, a copy of a contract where Dr. Sheppell was identified as the medical director of LPCC. Thus, it was in February, 2015 that Dr. Sheppell was first officially identified to the Plaintiffs as the Medical Director of LPCC.

Interestingly, the Plaintiffs filed an Amended Complaint on August 21, 2015 which did not identify the medical director as Dr. Sheppell, and on December 8, 2015, the Plaintiff settled with all of the LPCC and Pine Brook defendants leaving only Dr. Sheppell, in his capacity as a treating physician, and Nurse Gallagher as defendants. Eight days later on December 16, 2015, the Plaintiff filed a motion to serve a 6th Amended Complaint to name Dr. Sheppell in his capacity as Medical Director.

LEGAL ANALYSIS

I. Plaintiff's Motion for Leave to Amend

Motions for leave to amend is required by the rule to be liberally granted without consideration of the ultimate merits of the amendment. Notte v. Merchants Mut. Ins. Co., 185 N.J. 490 (2006). However, "the decision to deny a motion to amend is not mistakenly exercised when it is clear that such an amendment is so meritless that a motion to dismiss under R.4:6-2 would have to be granted, the so-called futility prong of the analysis. Amendment should be liberally exercised at any stage of the proceedings, unless undue prejudice would result. Franklin Med. v. Newark Pub. Sch., 362 N.J. Super. 494 (App. Div. 2003).

N.J.S.A. 2A:14-2 provides that every action at law for an injury to the person caused by the wrongful act, neglect or default of any person within this state shall be commenced within two years next after the cause of any such action shall have accrued. Patterson v. Monmouth Regional High School Bd. of Education, 218 N.J. Super. 284 (App. Div. 1987). Medical malpractice also falls into the purview of N.J.S.A. 2A:14-2, and thus has a two year statute of limitations. The statute of limitations for the Plaintiff's claims in this case expired in December, 2014.

The Plaintiff is seeking to utilize the discovery rule, a rule of equity which permits the statute of limitations to be extended pursuant to Farrell v. Votator Div. of Chemetron Corp., 62 N.J. 111 (1973). "Justice impels strongly towards affording the plaintiffs their day in court on the merits of their claim; and the absence of prejudice, reliance or unjustifiable delay, strengthens the conclusion that this may fairly be done without any undue impairment of the two-year limitation or the considerations of repose which underlie it." Id. at 122-123. The Farrell Court held in this case that even though the statute of limitations had expired, an action "may be held timely on a proper balance of considerations of individual justice." Id. at 122. The Court went on to say, "[the action] may be held timely on a similar balance where, as here, the plaintiffs in good faith brought their action expeditiously against the manufacturer under a fictitious name, identified it by amendment as soon as they discovered its true name, and served the amended complaint diligently thereafter." Id. An important consideration for the Court was that "There is no suggestion that the lapse of time has resulted in loss of evidence or impairment of ability to defend; nor is there any suggestion that the plaintiffs have been advantaged by it." Id.

In this case, the Plaintiffs filed an Amended Complaint to include allegations against the medical director of LPCC before the statute of limitations expired. Thus, the motion to amend pursuant to the fictitious name practice is proper. The issue for the Court to determine is

whether, due to the Plaintiffs' conduct, the amendment would otherwise be barred by the statute of limitations. This Court finds that although the Plaintiffs could have learned of the identity of the medical director before the statute of limitations expired, the actual formal notice of same did not come until February, 2015, after the statute of limitations expired. The fact that the Plaintiffs failed to move more quickly to amend the complaint will not bar the amendment in this case, primarily because Dr. Sheppell was a defendant in the case and *knew* of the claims against the medical director, but did not alert the Plaintiffs to this fact. This clearly demonstrates a lack of prejudice to the Defendant if the amendment is permitted at this time. Therefore, the amendment is not barred by the statute of limitations.

II. Futility

The New Jersey Supreme Court has construed R. 4:9-1 to "require that motions for leave to amend be granted liberally," even if the ultimate merits of the amendment are uncertain. Kernan v. One Wash. Park Urban Renewal Assoc., 154 N.J. 437, 456 (quoting G & W, Inc. v. Borough of E. Rutherford, 280 N.J. Super. 507, 516 (App.Div.1995)). One exception to that rule arises when the amendment would be "futile," because "the amended claim will nonetheless fail and, hence, allowing the amendment would be a useless endeavor." Notte v. Merchants Mut. Ins. Co., 185 N.J. 490, 501 (2006). "'[C]ourts are free to refuse leave to amend when the newly asserted claim is not sustainable as a matter of law. . . . [T]here is no point to permitting the filing of an amended pleading when a subsequent motion to dismiss must be granted.'" Ibid. (quoting Interchange State Bank v. Rinaldi, 303 N.J. Super. 239, 256-57 (App.Div.1997)). To determine whether an amendment to a pleading will be futile, the court must undertake the same analysis as for a dismissal for failure to state a claim for relief. As such, if the complaint states no basis for relief and it is clear that discovery would not provide one, dismissal of the complaint under R.

4:6-2 is appropriate. Energy Rec. v. Dept. of Env. Prot., 320 N.J. Super. 59, 64 (App. Div. 1999), aff'd o.b., 167 N.J. 205 (2001). On a Motion to Dismiss pursuant to R. 4:6-2(e), the Court accepts all of a plaintiff's factual allegations as true. NCP Litig. Trust v. KPMG LLP, 187 N.J. 353, 365 (1995). With the maxim in mind, the Court is charged with examining a plaintiff's complaint challenged by a motion to dismiss to "determine if a cause of action can be found in its four corners". Van Natta Mechanical Corp. v. Di Staulo, 277 N.J. Super. 175, 180 (App. Div., 1994).

On a motion to dismiss, the Court does not concern itself with whether a plaintiff can prove any of the allegations in its complaint. Printing Mart-Morristown v. Sharp Electronics Corp., 116 N.J. 739, 746 (1989). Rather, the inquiry is "limited to examining the legal sufficiency of the facts alleged on the face of the complaint". Ibid. (citing Rieder v. Dep't of Transp., 221 N.J. Super. 547, 552 (App. Div. 1987)). The examination of the complaint is to be conducted liberally, "with a generous and hospitable approach". Ibid. The motion to dismiss is therefore to be denied if "the fundament of a cause of action may be gleaned even from an obscure statement of claim". NCP, 187 N.J. at 365. However, dismissal of plaintiff's pleading is mandated when even a generous reading of the allegations fails to reveal a legal basis for recovery. Edwards v. Prudential Prop. & Cas. Co., 357 N.J. Super 196, 202 (App. Div.), certif. denied, 176 N.J. 278 (2003).

It is therefore necessary to evaluate the Plaintiffs' proposed claims against the Dr. Sheppell in his capacity as medical director of LPCC to determine whether the claims would properly be dismissed for failure to state a claim, which would warrant the denial of the Plaintiffs' motion to amend.

A. Negligence Claims

The defendant alleges that a negligence claim against Dr. Sheppell in his capacity as the Medical Director of LPCC is futile because under New Jersey Law, there can be no "Captain of the Ship" liability attributed to the medical director. To establish a prima facie case of negligence in a medical-malpractice action, a plaintiff must present expert testimony establishing: (1) the applicable standard of care; (2) a deviation from that standard of care; and (3) that the deviation proximately caused the injury. Gardner v. Pawliw, 150 N.J. 359, 375 (1997). A physician must act with that degree of care, knowledge, and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in the field. Velazquez v. Portadin, 163 N.J. 677, 686 (2000).

However, the doctrine of "the captain of the ship," a concept that makes a physician vicariously liable for the negligence of others who were involved in caring for the same patient, but were not under the doctor's control or supervision, has been expressly rejected in New Jersey by C.W. v. Cooper Health Sys., 388 N.J. Super. 42, 65 (App. Div. 2006); Tobia v. Cooper Hosp. Univ. Med. Ctr., 136 N.J. 335, 346 (1994); Diakamopoulos v. Monmouth Med. Ctr., 312 N.J. Super. 20, 34-35 (App.Div. 1998); Johnson v. Mountainside Hosp., 239 N.J. Super. 312, 322 (App. Div.), certif. denied, 122 N.J. 188 (1990).

It is clear that any claim of negligence against Dr. Sheppell in his capacity as the medical director of LPCC is a vicarious "captain of the ship" theory of liability. This theory of liability cannot survive a motion to dismiss and likewise warrants the denial of a motion to amend the complaint to assert such a claim.

B. New Jersey Nursing Home Responsibilities and Rights of Residents Act (NHA)

The Nursing Home Responsibilities and Rights of Residents Act ("NHA") was enacted in 1976 to declare "a bill of rights" for nursing home residents and define the "responsibilities" of nursing homes. N.J.S.A. 30:13-1. The "rights" of nursing home residents are set forth in N.J.S.A. 30:13-5(a) to (n), and include a resident's right to: manage his or her own financial affairs, unless a guardian authorizes the nursing home to do so; privacy; retain the services of his or her own physician; unrestricted communication and personal visits at a reasonable hour; food that meets religious dietary requirements; and "a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident." Ibid.

The NHA was amended in 1991, adding two statutory sections, which are codified in N.J.S.A. 30:13-4.1 and N.J.S.A. 30:13-4.2. which provide that a person "shall have a cause of action against the nursing home for any violation of this act." Under N.J.S.A. 30:13-4.2, the Department Of Health is authorized to bring an action to enforce the provisions of "this act and any rules and regulations promulgated pursuant to this act." Ibid. In Ptaszynski v. Atlantic Health Sys., 440 N.J. Super. 24, 35-36 (App. Div. 2015), the Appellate Division held that a resident of a nursing home does not have a private cause of action to enforce the NHA's "responsibilities provision," N.J.S.A. 30:13-3, but a resident does have a private cause of action for the breach of a "right" under the statute, N.J.S.A. 30:13-5. Id. N.J.S.A. 30:13-5 provides the following rights:

Every resident of a nursing home shall:

> **a.** Have the right to manage his own financial affairs unless he or his guardian authorizes the administrator of the nursing home to manage such resident's financial affairs. Such authorization shall be in writing and shall be attested by a witness that is unconnected with the nursing home, its operations, its staff personnel and the administrator thereof, in any manner whatsoever.

b. Have the right to wear his own clothing. If clothing is provided to the resident by the nursing home, it shall be of a proper fit.

c. Have the right to retain and use his personal property in his immediate living quarters, unless the nursing home can demonstrate that it is unsafe or impractical to do so.

d. Have the right to receive and send unopened correspondence and, upon request, to obtain assistance in the reading and writing of such correspondence.

e. Have the right to unaccompanied access to a telephone at a reasonable hour, including the right to a private phone at the resident's expense.

f. Have the right to privacy.

g. Have the right to retain the services of his own personal physician at his own expense or under a health care plan. Every resident shall have the right to obtain from his own physician or the physician attached to the nursing home complete and current information concerning his medical diagnosis, treatment and prognosis in terms and language the resident can reasonably be expected to understand, except when the physician deems it medically inadvisable to give such information to the resident and records the reason for such decision in the resident's medical record. In such a case, the physician shall inform the resident's next-of-kin or guardian. The resident shall be afforded the opportunity to participate in the planning of his total care and medical treatment to the extent that his condition permits. A resident shall have the right to refuse treatment. A resident shall have the right to refuse to participate in experimental research, but if he chooses to participate, his informed written consent must be obtained. Every resident shall have the right to confidentiality and privacy concerning his medical condition and treatment, except that records concerning said medical condition and treatment may be disclosed to another nursing home or health care facility on transfer, or as required by law or third-party payment contracts.

h. Have the right to unrestricted communication, including personal visitation with any persons of his choice, at any reasonable hour.

i. Have the right to present grievances on behalf of himself or others to the nursing home administrator, State governmental agencies or other persons without threat of discharge or reprisal in any form or manner whatsoever. The administrator shall provide all residents or their guardians with the name, address, and telephone number of the appropriate State governmental office where complaints may be lodged. Such telephone number shall be posted in a conspicuous place near every public telephone in the nursing home.

j. Have the right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident, including the right to expect and receive appropriate assessment, management and

> treatment of pain as an integral component of that person's care consistent with sound nursing and medical practices.
>
> **k.** Have the right to refuse to perform services for the nursing home that are not included for therapeutic purposes in his plan of care as recorded in his medical record by his physician.
>
> **l.** Have the right to reasonable opportunity for interaction with members of the opposite sex. If married, the resident shall enjoy reasonable privacy in visits by his spouse and, if both are residents of the nursing home, they shall be afforded the opportunity, where feasible, to share a room, unless medically inadvisable.
>
> **m.** Not be deprived of any constitutional, civil or legal rights by reason of admission to a nursing home.
>
> **n.** Have the right to receive, upon request, food that meets the resident's religious dietary requirements, provided that the request is made prior to or upon admission to the nursing home, and if the resident is not a Medicaid recipient, that the resident agrees to assume any additional cost incurred by the nursing home in order to meet those dietary requirements. If the resident is a Medicaid recipient upon admission, or becomes eligible for Medicaid after admission, the nursing home shall include the cost of the religious dietary requirements in its Medicaid cost report for consideration under applicable reimbursement processes. As used in this section, "Medicaid" means the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

Under Ptaszynski, a resident of a nursing home does not have a private right of action under this statute against a nursing home (or its director) unless a violation of one of these "rights" has been violated. In Count Eight of the Plaintiffs' proposed 6th Amended Complaint, the plaintiffs allege "infringements of Alyce Friedenberg's rights as set forth in N.J.S.A. 30:13-5, including the right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of Alyce…" However, there is no specific allegation of how the defendants infringed upon Ms. Friedenberg's right to a safe and decent living environment. A search of the pleading would lead this Court to conclude that the factual allegations to support the claim would be the lack of proper nutrition and hydration which is the

underlying factual basis for the malpractice claims. Thus, the Plaintiffs' claim must fail, because it is a veiled attempt to bring a medical malpractice claim through the "rights" violation.

C. Breach of Contract Claim

The Plaintiffs also postulate a theory that they can bring a breach of contract claim against Dr. Sheppell in his capacity as the Medical Director of LPCC as the 3rd party beneficiaries of the employment contract between Dr. Sheppell and LPCC. (The employment contract is attached to Plaintiffs' opposition papers as Exhibit F).

N.J.S.A. 2A:15-2 allows an injured person to sue on any contract for whose benefit the contract was made. This statute merely restates established New Jersey law that third-party beneficiaries may sue upon a contract made for their benefit without privity of contract. Rieder Cmtys. v. N. Brunswick, 227 N.J. Super. 214, 220-221 (App. Div. 1988) (quoting Houdaille Constr. Materials, Inc. v. American Tel. & Tel. Co., 166 N.J. Super. 172, 184-185 (Law Div. 1979). The standard applied by courts in determining third-party beneficiary status is "whether the contracting parties intended that a third party should receive a benefit which might be enforced in the courts. . . ." Brooklawn v. Brooklawn Housing Corp., 124 N.J.L. 73, 77 (E. & A. 1940). Unless such a conclusion can be derived, a third party has no cause of action despite the fact that it may derive an incidental benefit from the contract's performance. Gold Mills, Inc. v. Orbit Processing Corp., 121 N.J. Super. 370, 373 (Law Div. 1972).

In this case, there is no named 3rd party beneficiary to this contract. In these situations, courts ascertain the parties' intention from a consideration of all the surrounding circumstances. Atlantic Northern Airlines, Inc. v. Schwimmer, 12 N.J. 293 (1953). A review of the contract at issue demonstrates that the medical director is obligated to: (a) insure there are primary and alternate physicians to care for each resident, (b) ensure all physician orders are properly

executed, (c) review patient care plans and schedules, (d) review all incident reports, and (e) respond to medical emergencies when not being handled by another attending physician. It appears that the patients are the 3rd party beneficiaries of the contact as the language explicitly requires the medical director to provide for their care. However, even a most liberal search of the pleading reveals that this is another attempt to vicariously assert a claim against the medical director, for the conduct of the employees of Lincoln Park. This theory of liability again is a veiled attempt to assert a medical malpractice claim (through a contract claim) which essentially is a "captain of the ship" theory of liability which is not recognized in the state of New Jersey. Thus, the contract theory of liability must fail.

Conclusion

For the reasons set forth above, while the Plaintiffs are not barred by the statute of limitations from amending their complaint against Dr. Sheppell in his capacity as medical director, the causes of action against him as medical director would not survive a motion to dismiss for failure to state a claim, and therefore the amended complaint would result in futility. There are no viable claims, under the theories expressed in the proposed Amended Complaint, against Dr. Sheppell in his capacity as medical director. For these reasons, the Plaintiffs' motion to file the 7th Amended Complaint to name Dr. Sheppell in his capacity as medical director, is denied.

Exhibit D

LAW OFFICE OF
ANDREW A. BALLERINI
Cherry Tree Corporate Center
535 Route 38, Suite 328
Cherry Hill, New Jersey 08002

ANDREW A. BALLERINI, ESQUIRE
CERTIFIED CIVIL TRIAL ATTORNEY
MILLION DOLLAR ADVOCATES FORUM MEMBER
MEMBER N.J. AND PA BAR

Tel. 856-665-7140
Fax 856-665-8885
www.ballerinilaw.com

RICHARD J. TALBOT, ESQUIRE
CERTIFIED CIVIL TRIAL ATTORNEY
MILLION DOLLAR ADVOCATES FORUM MEMBER
MEMBER N.J. AND PA BAR

(Forwarded by facsimile transmission
973-912-9212 and regular mail)

October 12, 2018

Robert E. Blanton, Jr., Esquire
HARDIN, KUNDLA, McKEON & POLETTO
673 Morris Avenue
Springfield, NJ 07081

RE: Capano v. CareOne at Evesham, et al
Docket No. CAM-L-0507-17
Your File No. 1481.44924

Dear Mr. Blanton:

Enclosed please find the October 12 2018, report and *Curriculum Vitae* of Lance R. Youles, BS, LNHA, Plaintiff's expert in the field of Nursing Home Administration, Bates Stamped "CAPANO 00903-003937". Same shall be considered an Amendment to the Plaintiff's Interrogatory Answers. No submissions by the Plaintiff shall be considered adoptive admissions.

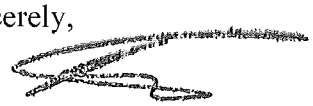
Mr. Youles is hereby named as the Plaintiff's expert in the field of nursing home administration. Mr. Youles is expected to testify as to various nursing home laws, nursing home standards of care, administrator standards of care and the application of those laws and standards to the Defendants, including the nursing homes' staff. Mr. Youles is also expected to testify as to the fact that the facility is a nursing home and falls under nursing home laws and standards. Mr. Youles is also expected to testify regarding staffing. Mr. Youles' opinions should not be considered to be constrained by the "four corners" of his report or this letter.

You are free to take the deposition of Mr. Youles during the discovery period upon appropriate scheduling and notice with my office.

The supplying of this report and this correspondence shall be considered an Amendment to Answers to Interrogatories but no submission by the Plaintiff shall be considered an adoptive admission.

Thank you for your courtesy and cooperation in this matter.

Sincerely,



RICHARD J. TALBOT, ESQUIRE

RJT/dmc

Report of L. R. Youles

Estate of Andrew P. Capano v. Care One at Evesham, et al.

Lance R. Youles, BS, LNHA certifies and describes as follows:

1. I am competent to testify to the statements contained within.

2. I was retained by the Law Office of Andrew A. Ballerini which represents the Plaintiff.

3. For purposes of this report, all references made to "COE" shall mean Care One at Evesham, Elmwood Evesham Associates, LLC, Care One Management, LLC, and Joseph Mina in his capacity as Administrator of COE.

4. For purposes of this report and my opinions, all references made to **Governing Body** shall mean Care One Management, LLC.

RECORDS RECEIVED, ACQUIRED, REVIEWED, AND RELIED UPON

5. I have reviewed records and information from the following facilities, agencies, individuals, and sources concerning Andrew Capano and COE:

   - Please see attachment "A" to this report.

BACKGROUND AND FINDINGS

6. COE is a 144 bed for-profit Skilled Nursing Facility (SNF) in Marlton, New Jersey with 64 long term care beds, and an 80 bed "Subacute Care" unit with Peritoneal Dialysis. The nursing facility operates on a campus that includes assisted living.

7. COE is licensed and regulated by the New Jersey Department of Health and Senior Services, Long Term Care Complaint and Surveillance, Long Term Care Assessment & Survey (DHSS).

8. Elmwood Evesham Associates, LLC is the legal business name of the facility.

9. COE is operated by Care One, a regional eldercare chain that provides nursing home and assisted living services in New Jersey, Connecticut, Maryland, Virginia, Pennsylvania, and Massachusetts.

10. The following parties have a 5% or greater direct ownership interest in COE:

    - Care One LLC (since 9/29/06)
    - Daniel Straus (since 7/1/2000)
    - Moshael Straus (since 3/29/03)

    Source: Medicare.gov

11. The following entities have a 5% or greater indirect ownership interest in COE:

- DES Holding Co, Inc., (since 9/29/06)
- DES-C 2-9 Grat (since 10/26/09)

Source: Medicare.gov

12. The following entities have operational/managerial control over COE:

- Care One Management, LLC (since 4/1/07)
- Healthbridge Management, LLC (since 7/25/08)

Source: Medicare.gov

13. Joseph Mina was the Administrator during Mr. Capano's stay at COE.

14. Chereece Steele, RN was the Interim DON during Mr. Capano's stay at COE.

15. The following excerpt was taken from www.care-one.com:

- "CareOne at Evesham's comprehensive sub-acute rehabilitation (offered seven days a week) and long term care services offer expert care in a nurturing homelike environment."

16. COE received the following federal (CMS) survey violations in 2015 and 2016:

Care One at Evesham (COE)

FEDERAL (CMS) SURVEY VIOLATIONS

SURVEYS

Period:	2015 – 2016
Survey Agency:	DHSS

2/25/15:	8/27/15:	2/11/16:	4/29/16:
F-246 @ E	F-281 @ D	F-157 @ D	F-226 @ J
F-253 @ D		F-281 @ D	F-279 @ J
F-281 @ D		F-309 @ D	F-281 @ J
F-282 @ G		F-315 @ D	F-323 @ J
F-309 @ D		F-329 @ E	F-514 @ D
F-314 @ D		F-425 @ D	
F-323 @ G		F-428 @ D	
F-441 @ D			
F-456 @ D		Red denotes Actual Harm or greater violations	

COMPARISONS

Period:	COE:	NJ Average:	US Average:
1/1/16 – 12/31/16	13 violations	4.8 violations	7.5 violations
1/1/15 – 12/31/15	8 violations	4.2 violations	7.1 violations

Sources: CMS and DHSS records
Note: Comparisons do not reflect all violations received in 2015 and 2016
Comparisons do not reflect Life Safety violations

17. The following conclusions resulted from my analysis of COE federal survey violations in paragraph 16:

- COE received several repeat violations
- COE received several complaint violations
- COE received twice as many violations as the average NJ facility
- COE received 2 Actual Harm violations during the 2/25/15 survey
- COE received 4 Immediate Jeopardy violations during the 4/29/16 survey
- COE Immediate Jeopardy problems occurred during Mr. Capano's stay
- COE immediate Jeopardy violations resulted in facility sanctions and fines
- COE violations during the 2/25/15 survey reflect severe understaffing levels
- COE violations during the 2/25/15 survey reflect resident rights violations
- COE violations during the 2/25/15 survey reflect resident dignity violations
- COE violations represent a pattern of regulatory noncompliance
- COE violations related to negligent conduct in this case include:
  - F-279 (Care Plans)
  - F-281 (Professional Standards)
  - F-282 (Assessments)
  - F-309 (Quality of Care)
  - F-314 (Pressure Ulcers)
  - F-441 (Infections)
- COE operates below the NJ and US mainstream industry
- COE violations are especially troubling for a subacute facility
- COE violations are especially troubling for a dialysis facility
- COE violations reflect a significant disregard of resident rights
- COE violations reflect "systemic" operational problems
- COE violations reflect ineffective facility administration
- COE violations reflect an irresponsible governing body

18. The following excerpts were taken from the 2/25/15 DHSS survey report at COE:

- "Based on observation, interview and record review, it was determined that the facility failed to respond in a timely fashion to multiple residents who used the call bell system for staff assistance." [1]
- "Resident #15 told the surveyor that staff will come in immediately to turn it off and will tell the resident "I will be back". It would then take up to 2 to 3 hours for staff to return. The resident at one time called the reception desk in the evening asking when someone is going to come help and was told, "I don't have anything to do with that, and the receptionist hung up." [3]
- "Resident #12 stated that at approximately 9:30 p.m. a CNA "slammed the door wide open" and came in and asked the resident "what are you doing" and "what do you want now?" [3]
- "According to the resident, while in the bathroom, he/she called for help but no one came. Resident #22 then called a family member to tell her he/she was stuck in the bathroom. When someone arrived to help, it was 30 minutes later. The family member complained to the facility staff and a corporate staff member. However, the family member never received a response." [4]

19. COE received the following CMS Five Star Quality Ratings in February 2016:

CMS Five Star Quality Ratings

Care One at Evesham (COE)

Month/Year:	Overall:	Health Inspections:	Quality:	Staffing:	RN Staffing:
February 2016	3 Stars	2 Stars	5 Stars	3 Stars	4 stars

Rating Key:

1 Star	= Much below average
2 Stars	= Below average
3 Stars	= Average
4 Stars	= Above average
5 stars	= Much above average

20. The following comparison measures COE resident "acuity" levels (i.e., Medicare) against New Jersey and US averages in 2016:

Resident Acuity Comparison

Care One at Evesham (COE)

Medicare Occupancy vs. New Jersey and US Averages

	COE:	New Jersey:	US:
Medicare Occupancy:	47% (Average)	17.6%	13.6%
Period:	January – February 2016	2016 (Annual)	2016 (Annual)
COE Variance:	N/A	2.67 times higher	3.45 times higher

Note: Medicare occupancy is the nursing home industry standard of measurement for resident acuity
Source: CMS Casper data via American Health Care Association

21. The following comparison measures COE CNA-to-resident ratios during the relevant time period against New Jersey averages:

Staffing Comparison

Care One at Evesham (COE)

Comparison Period:	2016 (1st quarter)
Comparison Group:	Certified Nurse's Aides (CNA)
Standard:	Direct care staff-to-resident ratios
Comparison:	COE CNA-to-resident ratios vs. New Jersey averages
Sources:	DHSS Nursing Home Staffing Reports

	Day Shift:	Afternoon Shift:	Night Shift:
COE:	12.8 to 1	11.9 to 1	20:1 to 1
New Jersey (8 hr. shifts):	8.4 to 1	10 to 1	16.5 to 1
(12 hr. shifts):	10.8 to 1	No data	13.2 to 1

Note: Lower ratios are better

22. The following comparison measures COE direct care HPPD during Mr. Capano's stay against New Jersey and US averages:

Staffing Comparison
Care One at Evesham (COE)

Comparison Period:	11/24/15 – 2/16/16 (Mr. Capano's stay)
Comparison Group:	Direct care staff (i.e., Floor RN's, LPN's, and CNA's)
Standard:	Hours-Per-Patient-Day (HPPD)
Comparison:	COE HPPD average versus New Jersey and US HPPD annual averages
Sources:	COE Labor Reports January 2016 CMS Casper data via American Health Care Association

	RN's:	LPN's:	Aides:	Total:
2016 NJ Average:	.73 HPPD	.77 HPPD	2.28 HPPD	3.78 HPPD
2016 US Average:	.54 HPPD	.85 HPPD	2.48 HPPD	3.86 HPPD

Category:	COE:	vs. New Jersey:	vs. US:
RN's	.55 HPPD	COE is 25% lower	COE is the same
LPN's	1.47 HPPD	COE is higher	COE is higher
Aides	1.74 HPPD	COE is 24% lower	COE is 30% lower
Unit Mgr.	.04 HPPD	N/A	N/A
Total:	3.80 HPPD		

23. The following chart compares COE reported staffing levels against CMS expected staffing hours based on CMS **RESIDENT ACUITY** time studies:

Staffing Comparison
Care One at Evesham (COE) Reported HPPD
vs. CMS Expected HPPD Based on CMS Resident Acuity Time Studies

Period:	November 2015 – February 2016
Standard:	Hours-Per-Patient-Day (HPPD)

	Aides:	LPN's:	RN's:	Total:
COE Reported:	1.74 HPPD	1.16 HPPD	1.28 HPPD	4.19 HPPD
CMS Expected:	2.59 HPPD	.73 HPPD	1.40 HPPD	4.73 HPPD
COE Variance vs. CMS:	33% Lower	Higher	9% Lower	11% Lower

Note: Expected Hours are calculated by summing the nursing times (from CMS Time Study) connected to each RUG category across all residents in the category and across all categories. The hours are then divided by the number of residents included in the calculations. The result is the expected number of hours for the nursing home. Expected hours are based on actual resident acuity. These "reported" COE hours were derived from a standard annual survey during 2015-16.

Comparison Group:	The source for the staffing measures is CMS form CMS-671. The specific fields that are used in the RN, LPN, and Nurse's Aide hours are:
Sources:	Medicare.gov (CMS Five Star Quality Ratings archives), and CMS Five Star Quality Rating System Technical User's Guide

24. The following excerpt was taken from a 1/31/16 "Employee Education Attendance Record at COE:

- "Don't say we are short staffed"

25. The following excerpts were taken from "Resident Comment Forms" at COE with redacted resident names:

5/31/15:

- "Daughter came up to me and said her mother was complaining whenever she is wet and needs to be changed it takes a very long time to get someone in there to change her. I went to talk to the resident and asked her if it was any particular shift. She said it doesn't matter. It happens all the time. Sometimes it takes up to 2 hours."

10/15/15:

- "Complaining that she was left soaking wet throughout the 11-7 shift on 10/14. She asked the aide to speak to Nursing Supervisor and aide claimed she could not find supervisor."

11/9/15:

- "Mr. Fisher spoke to me about 3-11 aides at night. He said aides are coming into his room at night and sleeping in the bed/chair next to him. This happened before and spoke to Denise, things were better before and it's happening again. Also was waiting 6 hours for pain meds for his head. The most recent was last night, but told me it's never his aide that sleeps there – it's a different one. He does not know the name and won't describe the person to me. Aide Willie watching football and eating dinner. He is not the only one. Wanted me to promise Willie won't be told he gave his name."

1/10/16:

- "Patient calls her "disappearing Daphne" because she is never around and does not answer for at least an hour. Resident says around 2:30 p.m. there is never help. She also stated that when she needs help she is told they can't right now because they have to go on break or that it is time for them to go. Resident no longer wants Daphne as a CNA."

1/21/16:

- "Resident not receiving assistance at night with bi-pap."
- "Resident not receiving assistance at night when elevating legs when getting in bed."

1/29/16:

- "They are not happy with services and call bell response, family member states she spoke with nursing in regards to her mother almost getting the wrong information, the bell response time, and that she thought it was a safety situation."

2/1/16:

- "Daughter upset all weekend had to help aides change Mom. Did not know who the nurse was or aide was for mom for weekend – just feels like no one cares."
- "Patient admitted Friday 1/29/16 @ 4:00 p.m. Requested air mattress prior to admission. No air mattress on bed when they arrived."
- "On 1/29/16 waited 45 minutes to be put on bed pan."
- "Patient had blood coming from legs. Nurse said to put a towel under her and left room."
- "Nurse rolled her eyes multiple times at patient and told her she needed to wait for assistance."
- Patient has wounds on back. Sheets stuck to wounds. Sheets were pulled away from wounds without notifying patient of what was going to happen."

10/3/16:

- "Weekend staff are "not worth" working here. Not enough help, takes longer to answer call bell."
- "At 3 a.m. this morning I turned my call bell no one answer until 5 a.m. The aide told me she will call the nurse but the nurse did not show up until 6 a.m."
- "I told her my skin is burning because it was leaking since 3 a.m., but she said she will come back. My colostomy bag was not changed until close to 7 a.m."

26. The following conclusions resulted from my analysis of COE staffing issues identified in paragraphs 18 – 25:

- COE was rated at 2 stars by CMS for "Health Inspections" (¶19)
- COE CMS staffing ratings do not reflect actual staffing conditions
- COE understaffing problems caused a pattern of noncompliance (¶16)
- COE understaffing problems caused severe regulatory violations (¶16)
- COE understaffing problems were identified in the DHSS 2/15/15 survey (¶18)
- COE understaffing problems were identified in nursing in-service records (¶24)
- COE understaffing problems were identified in Resident Comment Forms (¶25)
- COE resident acuity was 2.67 times higher than the average NJ facility (¶20)
- COE resident acuity was 3.45 times higher than the average US facility (¶20)
- COE nurse's aides (CNA) were 24% below the average NJ facility (¶22)
- COE floor RN's were 25% lower than the average NJ facility (¶22)
- COE CNA's were 33% below CMS expected staffing levels (¶23)
- COE staffing levels were dangerously low based on acuity (¶20)

- COE RN's were 9% below CMS expected staffing levels (¶23)
- COE RN staff levels were extremely low for a subacute facility
- COE RN staffing levels were extremely low for a dialysis facility
- COE CNA and RN staffing patterns reflect rigid operating budgets
- COE CNA and RN staffing patterns reflect corporate rationing practices
- COE staffing patterns represent a marginal and custodial level of care that is not sufficient to protect high risk residents like Mr. Capano from harm
- COE understaffing contributed to false charting practices in this case
- COE understaffing contributed to negligent assessment/care plans in this case
- Some COE corrective actions to complaints of short staffing include "placing residents on 2 hour √'s" which is very troubling because visually checking all residents every 2 hours or less is the minimum standard of care
- No internal facility policy has a greater impact on resident care than staffing. Unfortunately, the COE staffing policy provides no measurable formula and/or guidance for determining sufficient staff, including acuity-based factors and individualized nursing care/supervision for high risk residents like Mr. Capano. COE officials references F-353 (Sufficient Staff) in the policy but fail to specify how they intend to comply with this standard
- It is important to recognize that payroll accounts for 55-70% of operational expenses at most nursing facilities, and direct care staffing levels have the greatest impact on payroll expenses. Therefore, no operational factor has a greater impact on profitability than direct care nursing staff
- It would be inappropriate and misleading to measure COE based solely on compliance with New Jersey "minimum" staffing numbers, because federal regulations measure staffing based on sufficiency regardless of numbers, which is a "resident specific" and not an overarching facility standard
- COE officials failed to assign direct care nursing staff based on resident acuity (i.e., Medicare Part-A census). In particular, they operated at the following Medicare levels during Mr. Capano's stay:
  - November 2015 50%
  - December 2015 48%
  - January 2016 46%
  - February 2016 48%
- The term "short staffed" was a common response by staff to residents/families
- Staffing levels at COE are characteristic of "one-size-fits-all" assignments where nurses and CNA's are expected to squeeze high risk residents like Mr. Capano into unrealistic workloads
- This level of understaffing at COE represents a conscious disregard of CMS, NJ, and industry numbers/standards
- Please see the deposition testimony of Joseph Capano (¶39)
- Please see the deposition testimony of Chereece Steele, RN, DON (¶36)
- This level of understaffing violated Mr. Capano's resident rights
- This level of understaffing set the stage for Mr. Capano's negative outcomes
- This level of understaffing left Mr. Capano's safety and welfare to chance
- This level of understaffing represents egregious owner/corporate conduct
- This level of understaffing resulted from ineffective facility administration
- This level of understaffing resulted from an irresponsible Governing Body

27. Andrew P. Capano was 58 years old when he was admitted to COE on 11/24/15 for quality nursing home care, treatment, supervision, and protection.

28. Mr. Capano represented himself at COE with assistance from his brothers Joseph and Michael.

29. Lisa Ructor, DO was Mr. Capano's attending physician at COE.

30. Mr. Capano relied on the Medicaid Program to pay for his stay.

31. Mr. Capano was extremely dependent on COE for quality nursing home care due to limitations imposed by his diagnoses.

32. Mr. Capano was considered a **PRESSURE ULCER RISK** at COE.

33. Mr. Capano is described as follows according to a 2/16/16 "Minimum Data Set" (MDS) at COE:

- Entry Date: 11/24/15
- No behavioral symptoms
- No rejection of care
- Extensive assistance with bed mobility, transfers, locomotion off unit, dressing, toilet use and bathing
- Limited assistance with hygiene
- Independent with eating
- Stage IV sacral pressure ulcer
- Life expectance is greater than 6 months
- No problem conditions
- No falls since admission

34. Mr. Capano's stay at COE was characterized by the following negative outcomes:

Negative Outcomes

Andrew P. Capano at Care One at Evesham (COE)

Stay: 11/24/15 – 2/16/16
(Discharged home)

Negative Outcomes:

* Injury to penis from catheter insertions
* In-house acquired sacral ulcer
* Daily pain symptoms
* Loss of quality of life
* Loss of dignity

Sources: Mr. Capano's medical records

35. The following excerpts were taken from the 5/21/18 deposition transcript of Joseph Mina (Administrator):

- Q: "And the acuities would be the various conditions and needs of the residents, correct?"
- A: "Generally speaking yes."
- Q: "And the higher the acuity, the higher the need for staffing."
- A: "Yes." [51]

36. The following excerpts were taken from the 7/17/18 deposition transcript of Chereece Steele, RN (Interim Director of Nursing):

- Q: "Were you aware of there being a problem with the staff responding to the call bells in February of 2015?"
- A: "Yes." [69]

- Q: "All nine residents at the group interview said the staff will immediately come into the room and turn off the bell and tell them, I will be back. However, they don't come back at all or much later. The staff tells the resident, we are short-staffed. Were you aware of those allegations?"
- A: "Yes, I was."
- Q: "Did you in the time that you were at Care One in any capacity, Care One at Evesham, did you find that the facility was ever short-staffed?"
- A: "Yes." [71]

- Q: "I mean RN's, LPN's, CNA's, in the broadest sense any nursing staff, did you ever feel as though the facility was understaffed with regard to nursing staff?"
- A: "At times."
- Q: "And which aspect? Which of those?"
- A: "Both nurses and CNA's"
- Q: "LPN's, RN's, and CNA's?"
- A: "Yes."
- Q: "Did you ever ask for more nursing staff?"
- A: "Yes, I also interviewed, I also worked."
- Q: "Who would you ask for more nursing staff?"
- A: "Joe Mina." [72]

- Q: "And you actually observed it happening?"
- A: "Yes."
- Q: "So if it had happened before plus the time you saw it, it happened at least twice?"
- A: "Yes."
- Q: "But you definitely saw three CNA's sleeping - -"
- A: "I didn't see three CNA's, but I saw staff sleeping." [88]

- Q: "So instead of caring for the residents, that person was sleeping on the job?"
- A: "Yes." [88]

- Q: "But were you aware that a resident was alleging that an aide would come into his room to sleep?"
- A: "Yes." [90]

- Q: "And as far as the turning and repositioning program, how are we to determine what turning and repositioning program he was on?"
- A: "I don't know." [127]

- Q: "So you think the 12/1/15 MDS is incorrect?"
- A: "Yes, I do." [127]

- Q: "Do you know when, if at all, a turning and repositioning program was instituted for him?"
- A: "In January."
- Q: "After he developed the pressure ulcer?"
- A: "Yes." [128]

- Q: "But there's no question that even though it doesn't say on this form, on the third page of Steele-12, there's no question that the sacral pressure ulcer developed in Care One at Evesham?"
- A: "Yes." [140]

- A: "Right, but the nurse could have got mixed up with her area when she was doing her assessment."
- Q: "How can you say that if the sacral wound was already - - if a sacral wound was being redressed on 12/29/15, how could it have started on 12/29/15 if it was already dressed? In fact 12/28/15 - - "
- A: "I believe that Cathleen Brown made a mistake." [155]

- Q: "How about on 12/18/15 on page nine of the nurses notes, or progress notes, do you believe that Nurse Mary Young got it wrong when she says she gave treatment to the sacral area as ordered."
- A: "On the 18th?"
- Q: "Yes."
- A: "Yes."
- Q: "So you think she was wrong too?"
- A: "Yes, I do."
- Q: "And do you think Nurse Brown was wrong again on 12/17/15 when she indicates she redressed the sacral wound as ordered?"
- A: "Yes, I do."
- Q: "So do you think that those three times that nurses noted that they redressed the sacral wound prior to 12/29, that they were wrong?"
- A: "I think they made a mistake, yes, I do."

- Q: "How can you redress a wound if it's not already dressed?"
- A: "I don't know." [156]

37. The following excerpts were taken from the 5/22/18 deposition transcript of Cathleen Brown, RN (COE Floor Nurse):

- Q: "Do you recall Mr. Capano developing an injury to his penis?"
- A: "Yes." [47]

- Q: "Would there be any reason why there'd be two different nurses making entries on the same day in the pressure ulcer record?"
- A: "No." [61]

- Q: "So that would tell us that there were two different pressure ulcers that Mr. Capano had, correct?"
- A: "Yes."
- Q: "And the sacral pressure ulcer also developed in Care One at Evesham, correct?"
- A: "Yes." [62]

- A: "You're right, I didn't specifically put it here but it doesn't mean it wasn't done." [69]

38. The following excerpts were taken from the 7/17/18 deposition transcript of Kiyetta Shields, LPN (COE Floor Nurse):

- Q: "So the fact that there's no turning and repositioning program noted would indicate he was not on a turning and repositioning program, is that true?"
- A: "Yes." [43]

39. The following excerpts were taken from the 2/7/18 deposition transcript of Joseph Capano:

- A: "The first complaint was not taking care of the Foley that was inserted." [40]

- Q: "Did he say whether or not that was a one-time occurrence that it wasn't checked or if it was something that had happened more than once?"
- A: "Only it had been left in for too long and that was the results of not having the nurses monitor him and correct it to change it or replace it." [47]

- Q: "What's the next complaint?"
- A: "I received at least a dozen or so phone calls from my brother informing me that the staff at Care One had left him in soiled diapers for anywhere between an hour to two hours time after he had pushed the button for them to come and change him." [48]

- Q: "We were talking about complaints your brother had in regards to bowel care and being changed while he was at Care One before we took the break; correct sir?"
- A: "Yes." [50]

CONCLUSIONS

40. The following conclusions were reached during the course of my records review, research, and analysis:

A. Mr. Capano was extremely dependent on COE management and staff for quality nursing home care and treatment.

B. Mr. Capano was entitled to the resident rights identified in paragraph (54).

C. COE violated Mr. Capano's rights under NJSA 30:13-5(j) as evidenced by the following failures:

- Failure to provide continuity of care
- Failure to prevent his negative outcomes
- Failure to provide a subacute level of care
- Failure to provide accurate and timely assessment/care planning
- Failure to provide incontinence care in a timely/responsible manner
- Failure to provide repositioning in a timely/responsible manner
- Failure to provide accurate/timely medical records
- Failure to protect his quality of life and dignity
- Failure to address his complaints in a responsible manner
- Failure to devote sufficient bedside care from RN's
- Failure to devote sufficient bedside care from CNA's
- Failure to provide staff of good moral character
- Failure to provide qualified nursing staff

D. As a Nursing Home Administrator, I would not be able to convince a DHSS surveyor that Mr. Capano's negative outcomes at COE were unavoidable based on the continuity of care failures and staff credibility issues identified during my review. In particular, **his medical records failed to demonstrate that he received the necessary care and services to attain or maintain his highest practicable physical, mental, and psychosocial well-being in accordance with his comprehensive assessments and plans of care.**

E. Mr. Capano's medical records at COE include evidence of "false charting" as follows:

- Treating wounds before they were identified (¶36)
- Two nurses documenting the same treatments (¶37)
- Creating or revising care plans in April after his discharge in February. In particular, Chereece Steele, RN, DON allegedly authored the April entries even though she was discharged from COE in February (¶36)
- Inaccurate MDS information (¶36). It is important to recognize that the MDS is not only designed to capture data for care planning purposes, but it also serves as a monthly billing mechanism (invoice) for nursing home residents. Aside from causing and/or contributing to negative resident outcomes, inaccurate MDS information can be a serious infraction and may constitute billing fraud.

F. One of the overarching issues in this case is whether Mr. Capano received timely turning/repositioning at COE despite his pressure ulcer development. Only (6) progress notes verify this practice, so the only nursing records that support this defense are CNA flow sheets (Care One: 3727, 3732, and 3738). Based on the lack of progress notes, false charting practices, understaffing, and CNA integrity issues previously identified in paragraphs (18) and (25), these CNA flow sheets are not reliable. This includes several shifts when turning/repositioning was not recorded or the timing of documentation is not credible.

G. Please see survey analysis in paragraph (17).

H. Please see staffing analysis in paragraph (26).

I. Direct care staffing levels (i.e., Floor Nurses and CNA's) have a significant impact on pressure ulcer prevention and development as follows:

- Staffing determines the frequency of turning/repositioning
- Staffing determines the frequency of incontinence care
- Staffing determines the frequency/timeliness of personal hygiene
- Staffing determines the timeliness of wound treatments
- Staffing determines the effectiveness of treating wound pain
- Staffing determines the discovery of new wound development
- Staffing determines the frequency of wound documentation
- Staffing determines the accuracy of wound documentation
- Staffing determines communication of wound changes and issues
- Staffing determines whether wounds are properly assessed/staged
- Staffing determines whether treatment orders are followed
- Staffing determines whether wound care plans are followed
- Staffing determines whether staff nurses are certified in wound care
- Staffing determines whether clinical practice standards are followed
- Staffing determines whether policies and procedures are followed
- Staffing determines whether wound care regulations are followed
- Staffing determines whether floor nurses are properly supervised
- Staffing determines whether wound development is avoidable
- Staffing determines whether wounds resulted from neglect
- Staffing exposes the intent of owners and corporate staff

The underlying causes of Mr. Capano's skin breakdown and penis injury at COE can be traced to many of these staffing factors, because there was simply not enough direct care staff to address his high level of acuity. Consequently, he was denied:

- Turning/repositioning every 2 hours or less
- Timely and responsive nursing assessment
- Timely and appropriate catheter care
- The right to a safe living environment
- The right to a dignified living environment

J. Nursing home "direct care" staffing levels are measured by two standards; **numbers** and **sufficiency regardless of numbers.** Unlike numbers which are derived from hours-per-patient-per-day (HPPD) and staff-to-resident ratios, the sufficiency staffing standard is based on individual resident outcomes. In other words, the sufficiency standard determines if a resident received necessary face-to-face bedside supervision based on assessed risk factors. In this case, it is my opinion that COE did not provide **sufficient** nursing staff to prevent the negative outcomes Mr. Capano received.

K. COE staff failed to comply with internal policies and procedures based on the negative outcomes Mr. Capano experienced.

L. COE failed to provide nursing staff of good moral character based on the evidence identified in paragraphs (18) and (25). It is important to recognize that this **harmful culture of caregiver complacency/disrespect** frequently occurs when there is no daily presence of upper management on the floor, especially the Administrator and DON.

M. The COE 6/16/15 Employee Education Attendance Record (in-service) regarding **wounds** is a reliable index of the problems COE nursing officials were facing during that period. This was problem-solving meeting and not a general in-service based on the subject matter.

N. COE officials misrepresented the quality of their services to Mr. Capano and his family based on the failures identified in this report.

O. It would be inappropriate and deflective to blame Mr. Capano for his negative outcomes at COE.

P. Many of the failures identified in this report are common to nursing facilities with ineffective management companies.

Q. Many of the failures identified in this report are common to nursing facilities with ineffective Administrators.

R. Many of the failures identified in this report are attributed to the failure of the Governing Body to establish and implement policies and procedures, which impacted Mr. Capano's rights.

S. Care One Management, LLC did not earn its management fees at this facility based on the failures identified during my review.

T. **Protecting Mr. Capano's resident rights under NJSA 30:13-5(j), by providing a sufficient number of floor RN's and CNA's,** would have prevented and reduced the risk of failures identified in this report.

U. **Properly documenting Mr. Capano's wound care** would have prevented and reduced the risk of failures identified in this report.

V. **Providing accurate timely assessment and credible care plans** would have prevented and reduced the risk of failures identified in this report.

W. **Repositioning Mr. Capano every (2) hours on a consistent basis** would have prevented and reduced the risk of failures identified in this report.

X. **Providing timely ADL's including incontinence care** would have prevented and reduced the risk of failures identified in this report.

Y. **Providing a subacute level of nursing care** would have prevented and reduced the risk of failures identified in this report, including Mr. Capano's pressure ulcers and penis injury.

Z. **Complying with CMS and New Jersey standards** would have prevented and reduced the risk of failures identified in this report.

AA. **Providing an effective Administrator and responsible Governing Body** would have prevented and reduced the risk of failures identified in this report.

BB. As a nursing home administrator who is responsible for administering a facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident under NJ/CMS standards, I found evidence that COE staff violated Mr. Capano's resident rights.

OPINION

41. **Based on my education, training, management expertise, regulatory knowledge, and knowledge of skilled nursing facilities, it is my belief to a reasonable degree of professional certainty that COE and its Management Company officials and staff, Administrator, DON, and facility staff of COE failed to provide the necessary care and services for Andrew Capano to attain or maintain his highest practicable physical, mental, and psychosocial wellbeing, which violated his resident rights. The repeated failure of COE to protect his rights and to prevent the corporate and management failures identified in this report caused, significantly contributed to and increased the risk of his negative outcomes, which included the pressure ulcers and penis injury. Accordingly, COE fell below the standards for a skilled nursing facility operating in New Jersey during 2015 and 2016 based on standards identified in paragraphs (51) – (58) in general and the following failures in particular:**

A. FAILURE TO PROTECT RESIDENT RIGHTS;

Applicable Standards:	Breach of Standards:
* Federal Regulation:	42 C.F.R. § 483.10, F-150
* New Jersey Statute:	NJSA 30:13-5(j)
* Industry (NJ & US):	Apply, and there is a breach

B. FAILURE TO PROVIDE SUFFICIENT NURSING STAFF; AND;

Applicable Standards:	Breach of Standards:
* Federal Regulation:	42 C.F.R. § 483.30 (a), F-353
* New Jersey Regulation:	N.J.A.C. 8:39-25.2
* Industry (NJ & US):	Apply, and there is a breach

C. FAILURE TO PROVIDE EFFECTIVE FACILITY ADMINISTRATION AND A RESPONSIBLE GOVERNING BODY.

Applicable Standards:	Breach of Standards:
* Federal Regulations:	42 C.F.R. § 483.75, F-490 42 C.F.R. § 483.75 (d), F-493
* New Jersey Regulations:	N.J.A.C. 8:34-1.4 (a) N.J.A.C. 8:39-9.2 (a) N.J.A.C. 8:39-9.1 (a) & (a)(1)
* Industry (NJ & US):	Apply, and there is a breach

MY NURSING HOME EXPERTISE

42. Based upon my education, training, experience, and research, I am familiar with the standard of care for skilled nursing facilities (i.e., nursing homes) operating in New Jersey during 2015, 2016, and currently.

43. Based upon my education, training, experience, and research, I am familiar with the standards for administrators of skilled nursing facilities operating in New Jersey during 2015, 2016, and currently.

44. Based upon my experience as a consultant, corporate executive, and owner of nursing facilities, I am qualified to opine on the duties of nursing homes, nursing home owners, administrators, management companies, and the **Governing Body**. This includes hiring a competent administrator, establishing, monitoring, and enforcing internal operating standards, maintaining compliance with state and federal regulations, providing sufficient facility resources and operating capital, promoting ethical management practices, and to pursue facility profitability without compromising the quality and continuity of resident care.

45. During my professional career I have experience with nursing home residents who were at high risk of negative outcomes due to their diagnoses and complete dependency on facility governing boards, administration, management, and staff to ensure that they attain or maintain their highest practicable physical, mental, and psychosocial well-being in accordance with state and federal (CMS) standards.

46. I possess highly specialized knowledge and expertise in the field of nursing home administration, multi-facility management, ownership, eldercare laws, regulations, industry standards, and resident rights.

SCOPE OF MY REVIEW

47. As is customary for professionals in my field, I have relied on my review and analysis of Mr. Capano's medical records, COE records, DHSS records, research, depositions, and other information to formulate opinions concerning the standard of care at COE during his stay from 11/24/15 to 2/16/16.

48. The opinions expressed in this report are limited to the operation of skilled nursing facilities in New Jersey. The scope of my review includes regulatory compliance, internal standards, facility ownership/governance, corporate control and oversight, facility administration, day-to-day operations, caregiver staffing levels, operating policies and procedures, caregiver competency, unsafe acts, unsafe conditions, resident rights, and the hiring, training, direction, supervision, and management of individuals who practiced or worked at COE during Mr. Capano's stay.

49. My findings and opinions may reference practitioners, clinicians, and unlicensed staff as employees, agents, or contractors of COE, but only to the extent of their conformance with nursing home laws, regulations, internal operating standards, and industry practices.

ADMINISTRATOR AUTHORITY AND DUTIES

50. The authority and duties of Nursing Home Administrators in New Jersey are defined as follows:

42 C.F.R. § 483.75:

"A facility must be administrated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident."

N.J.A.C. 8:34-1.3 (b):

"The licensed nursing home administrator performs functions including, but not limited to, ensuring quality resident care management, personnel management, financial management, environmental management, regulatory management, organizational management, marketing, and community and public relations."

N.J.A.C. 8:34-1.4 (a):

"The licensed administrator shall be responsible for the administrative functions at the nursing home to assure that the nursing home is operated at all times in compliance with N.J.A.C. 8:39, Licensing Standards for Long Term Care Facilities, and other applicable State and Federal rules, regulations, and laws."

APPLICABLE NURSING HOME STANDARDS

51. My opinions are based on the following nursing home laws, regulations, standards, and practices:

- Volume 42, Code of Federal Regulations, Part 483, Subpart B;
- Volume 42, Code of Federal Regulations, Part 488;
- New Jersey Statutes, Title 26;
- New Jersey Statutes, Title 30;
- New Jersey Administrative Code, Title 8, Chapter 39;
- New Jersey Administrative Code, Title 8, Chapter 34;
- Nursing home industry standards; and,
- COE internal standards (i.e., policies, procedures, protocols, etc.).

52. The following federal (CMS) regulatory doctrine constitutes the essence of Volume 42, Code of Federal Regulations, Part 483, Subpart B:

Essence of 42 C.F.R. § 483, Subpart B

"Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."

53. The responsibility of New Jersey nursing facilities is defined as follows:

Nursing Home Responsibility

N.J.S.A. 30:13-3:

Every nursing home shall have the responsibility for:
"h. ensuring compliance with all applicable state and federal statutes, rules, and regulations."

Note: Failure to comply with these laws is a breach of the standard of care

54. New Jersey nursing home residents are entitled to the following rights:

Resident Rights

N.J.S.A. 30:13-5-j:

"Have the right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident, including the right to expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care consistent with sound nursing and medical practices."

55. Federal (CMS) nursing facility staffing standards are as follows:

Federal (CMS) Staffing Standards

42 C.F.R. § 483.30 (a), F-353:

"The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i). Licensed nurses.
(ii). Other nursing personnel (CNA's)."

56. New Jersey nursing facility "minimum" staffing standards are as follows:

New Jersey Staffing Standards

N.J.A.C. 8:39-25.2:

1. **" Combined caregiver hours (Nurse/CNA) may not be less than 2.5 hours per-patent-per-day (HPPD).**
2. **An acuity factor is added to 2.5 HPPD to compensate for wound care, NG tubes, O2 therapy, trach's, IV's, respirators, head trauma, and neuromuscular – orthopedic care.**
3. **Facilities over 150 beds must have an Assistant Director of Nursing (ADON).**
4. **RN's must be on duty at all times for facilities with more than 150 beds.**
5. **20% of all hours must be provided by licensed nurses.**
6. **An RN must be on duty during all day shifts."**

57. An **AVOIDABLE PRESSURE ULCER** is defined by CMS as follows:

Avoidable Pressure Ulcer

42 C.F.R. § 483.25 (c), F-314 – Guidance to Surveyors:

"Avoidable means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."

58. The **GOVERNING BODY** of a nursing facility is defined by CMS as follows:

Governing Body

42 C.F.R. § 483.75 (d), F-493

(1). "The facility must have a governing body, or designated persons functioning as a a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and
(2). The governing body appoints the administrator who is –
(i). Licensed by the State where licensing is required; and
(ii). Responsible for the management of the facility."

59. The following excerpts were taken from CMS publications regarding the impact of direct care staffing levels to nursing home quality and care:

Direct Care Staffing vs. Quality/Care

"There is considerable evidence of a relationship between nursing home staffing levels, staffing stability, and resident outcomes."

"The CMS Staffing Study found a clear association between nurse staffing ratios and nursing home quality care, identifying specific ratios of staff to residents below which residents are at substantially high risk of quality problems."

Source: CMS Five Star Quality Rating System Technical User's Guide

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"In addition, if a facility meets the State's staffing regulations that is not, by itself, sufficient to demonstrate that the facility has sufficient staff to care for its residents."

"Concerns such as falls, weight loss, dehydration, pressure ulcers, as well as the incidence of elopement and resident altercations can also offer insight into the sufficiency of the numbers of staff."

Source: CMS State Operations Manual, Phase 2; 42 C.F.R. § 483.35(a) (1) & (2), Guidance to Surveyors

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"Staffing within long-term care (LTC) facilities significantly effects the type of care delivered to residents"

Source: CMS 4/21/2017 Memorandum to State Survey Agency Directors

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"Adequate quantity and quality of staffing in a nursing home are key determinations of the level of care residents receive."

Source: CMS Survey and Certification Group 2016/2017 Nursing Home Action Plan

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"Staffing is a vital component of quality care for nursing home resident. Associations have been found between higher staffing levels in nursing homes and fewer hospitalizations, fewer infections, fewer pressure ulcers, less skin trauma, less weight loss, decreased resistance to care, and improved functional status."

Source: CMS "Improving the Nursing Home Compare Web Site; Material for Nursing Homes Open Door Forum – 6/24/08

60. The following excerpts were taken from a nursing home industry white paper regarding Medicare Part-A Skilled Care:

Medicare Part-A Skilled Care

"In analysis concentrating on five ADL's (bathing, bed mobility, transfer, toilet use and eating), **95.2% of Medicare admissions need some degree of assistance, on four or five ADL's.** [2]

A larger percentage of Medicare admissions, 72.7%, require extensive assistance or are totally dependent with bed mobility as compared to Non-Medicare and long-stay residents. This pattern also holds true for transfer, toilet use, and bathing. [8]

Source: Pruitt Jr., Neil. Chairman & CEO, UHS-Pruitt, Corporation, Commissioner, Commission on Long-Term Care; "Quality of Care in Skilled Nursing Care Centers"; American Health Care Association; August 2013

61. Patient/resident **ACUITY** is defined as follows:

> **Patient/Resident Acuity**
>
> **"Acuteness; the level of severity of an illness. This is one of the parameters considered in patient classification systems that are designed to serve as guidelines for allocation of nursing staff, to justify staffing decisions, and to aid in long-range projection of staffing and budget."**
>
> **Source: Medical Dictionary**
>
> ---
>
> **"The definition of acuity is the intensity level of services necessary to provide care to a resident on a daily basis including both physical and emotional needs."**
>
> **Source: Atlantic Quality Innovation Network**
>
> ---
>
> **"Acuity can be defined as the measurement of the intensity of nursing care required by a patient. An acuity-based staffing system regulates the number of nurses on a shift according to the patient's needs, and not according to raw patient numbers."**
>
> **Source: www.americansentinel..edu**
>
> ---
>
> **"Acuity index is a measure of the care needed by a nursing home's residents. It is calculated based on the number of residents needing various levels of activities of daily living (ADL) assistance, the number of residents receiving special treatment."**
>
> **Source: www.ltcfocus.org**

APPLICABLE PUBLICATIONS

62. Youles, Lance R., "Preventing Neglect"; Advance for Long-Term Care Management; posted on 2/16/11.

63. Youles, Lance R., "Why a Chain Facility Fails"; McKnight's Long Term Care News; posted on 2/1/16.

64. Youles, Lance R., "When Understaffing becomes Rationing" McKnight's Long Term Care News; posted on 4/22/16.

CLOSING COMMENTS

65. My current curriculum vitae is attached hereto.

66. I have testified in New Jersey courts as a nursing home expert.

67. All conclusions and opinions expressed in this report are offered to a reasonable degree of professional certainty.

68. My conclusions and opinions are based on a thorough analysis of this case which may not be contained or attached to this report. Therefore, I reserve the right to disclose these additional details during my deposition and/or trial testimony.

69. I offer my opinions with confidence. However, I reserve the right to amend my report if significant additional information becomes available through discovery.

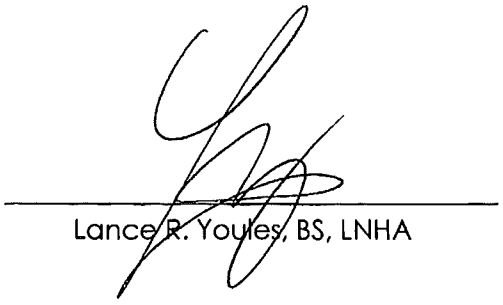
70. All opinions in this case are framed within the following three (3) domains:

1. Regulatory standards:
   (i.e., Applicable nursing home and vulnerable adult laws and regulations);
2. Administrative standards:
   (i.e., Facility governance, and the practice of nursing home administration); and,
3. Institutional/Facility standards:

   (i.e., Nursing home industry, and facility/company policies, procedures, and practices).

71. All conclusions and opinions contained within this report are based on the records provided to me, my research, education, professional training, and experience.

Respectfully submitted:



Lance R. Youles, BS, LNHA

October 12, 2018

Attachment A

I have reviewed records and information from the following facilities, agencies, individuals, and sources concerning Andrew Capano and COE:

- Death certificate;
- Power of Attorney;
- Wound photographs;
- COE: Admission and medical records;
- COE: In-service education records;
- COE: Policies, procedures, and index;
- COE: Staffing, census, and labor reports;
- COE: Employee monthly schedules;
- COE: 2012 – 2013 Medicaid Cost Reports;
- COE: Redacted management agreement;
- COE: Resident Council meeting minutes;
- COE: Resident Comment Forms;
- COE: 2013 Medicare Cost Reports;
- COE: Promotional website via www.care-one.com;
- COE: Facility floor plan;
- Delaware Valley Urology: Medical records;
- William C. Cody, MD: Medical records;
- Matthew J. Finnegan, MD: Medical records;
- Bayada Home Health Care: Medical records;
- Lourdes Medical Associates: Medical records;
- Wound Healing solutions, LLC: Medical records;
- Premier Physician Network, LLC: Medical records;
- Cooper University Health Care: Medical records;
- Associates in Internal Medicine: Medical records;
- St. Mary's Center for Rehabilitation & Healthcare: Medical records;
- Deposition Transcripts and Exhibits: Joseph Capano, Cathleen Brown, Chereece Steele, Joseph Mina, Tina Nelson, Kiyetta Shields, Monica Walker, and Denise Finch;
- New Jersey Department of Health and Senior Services, Long Term Care Complaint and Surveillance, Long Term Care Assessment & Survey (DHSS): COE licensing records, Casper Report, surveys, plans of correction, staffing records, and correspondence;
- Office of the Ombudsman for the Institutionalized Elderly: Correspondence;
- www.medicare.gov: Background research regarding COE;
- CMS Five Star Ratings Archives: Background research regarding COE;
- American Health Care Association (AHCA) CMS Casper data (2015 - 2016);
- Defendant's Answers to form C, C(3), and Supplemental Interrogatories;
- Executed Stipulation extending Time to Answer;
- Defendant's Answers to Form C interrogatories;
- Plaintiff's Answers to Supplemental Interrogatories;
- Plaintiff's Answers to Form A Interrogatories with multiple material included;
- Defendant's discovery responses;

- 10/4/18 expert report of John Kirby, MD;
- Affidavit of Merit of Bonnie Tadrick, RN; and,
- Legal correspondence between the parties.

Exhibit E

LAW OFFICE OF
ANDREW A. BALLERINI
Cherry Tree Corporate Center
535 Route 38, Suite 328
Cherry Hill, New Jersey 08002

ANDREW A. BALLERINI, ESQUIRE
CERTIFIED CIVIL TRIAL ATTORNEY
MILLION DOLLAR ADVOCATE FORUM MEMBER
MEMBER N.J. AND PA BAR

Tel. 856-665-7140
Fax 856-665-8885
www.ballerinilaw.com

RICHARD J. TALBOT, ESQUIRE
CERTIFIED CIVIL TRIAL ATTORNEY
MILLION DOLLAR ADVOCATE FORUM MEMBER
MEMBER N.J. AND PA BAR

October 5, 2018

Robert E. Blanton, Jr., Esquire
HARDIN, KUNDLA, McKEON & POLETTO
673 Morris Avenue
Springfield, NJ 07081

RE: Capano v. CareOne at Evesham, et al
Docket No. CAM-L-0507-17
Your File No. 1481.44924

Dear Mr. Blanton:

Enclosed please find the October 4, 2018, report and September 18, 2018 *Curriculum Vitae* of John Kirby, M.D., Plaintiff's expert in Medicine and Internal Medicine, Bates Stamped "CAPANO 003858-003902". Same shall be considered an Amendment to the Plaintiff's Interrogatory Answers. No submissions by the Plaintiff shall be considered adoptive admissions.

Dr. Kirby is expected to testify as to: standards of care and deviations from same; State and Federal Statutes, rules and regulations governing nursing homes and violations of same, diagnosis; prognosis; causation; permanency; the nature and extent of the injuries caused by the accident; the nature and extent of restrictions on activities of daily life; aggravation/acceleration/exacerbation (if applicable) of any pre-existing conditions; as well as costs of same; disability and/or limitations regarding employment; economic loss; radiological studies; and/or black and white and color exhibits of radiological studies and/or surgeries. The Plaintiff's experts will not be limited to the "four corners" of their reports and you are free to schedule the discovery deposition of the Plaintiff's experts to take place during the discovery period.

Thank you for your courtesy and cooperation.

Sincerely,

RICHARD J. TALBOT, ESQUIRE

RJT/dmc
Enclosure

1210 Brace Road, Suite 102
Cherry Hill, NJ 08034
October 4, 2018

Richard J. Talbot, Esquire
Law Office of Andrew A. Ballerini
Cherry Tree Corporate Center
535 Route 38, Suite 328
Cherry Hill, NJ 08002

Re: **Andrew Capano v. Care One *et al***

Dear Mr. Talbot:

In preparation of my report, I reviewed the following materials:

Avista Healthcare 11/21/15
Bayada Home Health records and bills
Care One at Evesham
Care One Documentation Survey Reports
William Cody, Virtua Surgical Group
Cooper University [C] healthcare records and bills 11/12/15 – 11/22/15, 11/23/15 – 11/24/15, 12/2/15, 1/6/16, 7/29/16, 8/19/16, 9/20/16, 1/10/17, 1/11/17, 3/16/17
St Mary's Center for Rehab and Healthcare 2/27/17 – 3/19/17
Cooper Neurosurgery
Delaware Valley Urology records and bills [DVU]
LMA Surgical Associates (Dr. Matthew Finnegan) records and bills 3/28/16
LMA Cherry Hill Family Care (Dr. Petruncio)
Premier physician network bill (Julia Bornmann, NP)
Virtua Marlton
Samaritan Hospice
Wound Healing Solutions records and bills
Death Certificate 4/1/17

Depositions
Deposition of Cathleen Brown [CB]
Deposition of Joseph Capano [JC]
Deposition of Joseph Mina [JM]
Deposition of Tina Nelson [TN]
Deposition of Kiyetta Shields [KS]
Deposition Wendy Smollock [WS]
Deposition of Chereece Steele [CS]

Care One Floor Plan

Care One 2012 and 2013 cost reports and 2013 cost report worksheet
Care One at Evesham and Care One Management, LLC's Answers to Form C, C3, and Supplemental Interrogatories
Care One's Certificate of Liability Insurance
Care One's Licensure and Associated Documents
Care One's Nursing Staff Requirements 11/6/13
Department of Health and Human Services Centers for Medicare & Medicaid Services State Surveys 2/2/12, 3/21/12, 5/29/12, 2/28/13, 11/6/13, 4/24/14, 11/3/14, 2/25/15, 4/14/15, 4/16/15, 6/10/15, 8/27/15 with Plan of Correction, 11/16/15, 2/11/16, 4/1/16, 4/29/16, 6/24/16
Care One Resident Comment Forms
Table of Contents for Care One's Policy and Procedures manual
Care One Table of Contents Nursing Policies and Procedures, Second Version of Care Plan, Point of Care Documents including Activities of Daily Living and Turning and Repositioning Sheets [Bates stamp Care One 3665– 3740]
Care One's Policies and Procedures Including but not limited to Grievance/Complaint Log, Medication Administration & Documentation Shift to Shift Review during Handoff, Abuse Definitions, Grievance/Complaint Log – Staff Responsibility, Investigating Grievances/Complaints, Staffing, Employee Education Attendance Records: Wounds; Don't Say "We Are Short Staffed;" Abuse in Service; Turning and Positioning; Reporting Changes in Residence by Using Alerts in Point of Care Kiosk/What Happens When Changes Are Reported Using Point of Care/No Exception. Expectation of Point of Care Documentation: Touch the Patient, Touch the Kiosk; Nursing Assistant General Duties; Care Plans – Comprehensive; Goals and Objectives, Care Plans; Change in the Resident's Condition or Status, Skin Integrity Program: Identification and Prevention; Skin Integrity Program: Evaluation and Documentation of Wounds; Clinical Practice Guidelines for the Prevention and Management of Pressure Ulcers and Other Wounds; and Definitions: Pressure Ulcer.
Additional Care One Policies [Bates Stamp Care One 3741-3827]

Affidavit of Merit
Medicaid Lien Information
New Jersey State Department of Health Records.

Photos taken by Joseph Capano –
Bates Stamp 2374-2380: 7 photographs taken by Joseph Capao on or about spring 2016 (two sacral pressure ulcer, four penis injury, one sacral pressure sore)
Bates Stamp 870-875: 12/5/16 (two sacral pressure ulcer, two catheter, two penis injury)

Plaintiff's discovery including the following documents:

- 03-07-18 - Capano - Amendment to Rogs - LMA Cherry Hill Family BS 3731-3853
- 03-22-17 - Capano - Amendment to Rogs to include Bayada Home Health & Ombudsman ltr BS2402-2962
- 03-22-17 - Capano - Amendment to Rogs to include State of NJ response re Care One BS2963-3390
- 03-28-17 - Capano - First Demand for Production and Deposition notices
- 3-8-17 - Capano - Letter Amending Rogs re #24
- 3-8-17 - Capano - Plaintiff's Answers to Rogs with CDs-List-CV of Tadrick
- 3-13-17 - Capano - Amendment to Rogs with Medicaid and Wound Healing Sol records and bill
- 3-13-17 - Capano - Letter to Poletto regarding Medicaid letter re January and Feb charges
- 3-31-17 - Capano - Letter to defense amending rogs with Sussman and Bayada records-BS3391-3420
- 4-13-17 - Capano - Letter to defense amending rogs re Andrew's death
- 05-01-17 - Capano - Amendment to Rogs with 2 new witnesses and Dr. Sussman billing
- 5-12-17 - Capano - Letter to Defendant Amending Rogs with Medicaid estate and tort liens
- 5-17-17 - Capano - Letter to Poletto amend rogs with Death Cert and Cooper Bill BS3466-3470
- 06-01-17 - Capano - Amendment to Rogs St. Mary's and Medicaid Lien
- 6-26-17 - Capano - Letter to defense amending rogs with Medicare correspondence
- 6-30-17 - Capano - Letter from defense with Supp Rogs to be answered by Plaintiff
- 07-19-17 - Capano - Plaintiff's Answers to Supplemental Interrogatories sent to defense
- 7-7-17 - Capano - Plaintiff's Answers to Supp Rogs (proposed)
- 7-14-17 - Capano- Plaintiff's Answers to Supplemental Interrogatories - signed by client
- 08-14-17 - Capano - Letter to defense that Plaintiff's Answers to Supp Rogs are good
- 8-3-17 - Capano - Letter from defense re deficient supp rogs
- 8-17-17 - Capano - Letter to defense amending rogs with Medicaid letter showing credit for real prop
- 09-20-17 - Capano - Letter Defense providing Short Certificate BS CAPANO 003730

Defendants's Discovery Submissions including:

- 6-11-18 - Capano - Defendants Submission of Management Agreement per Order of Court-OCR

- 01-26-18 - Capano - Additional Discovery - Care One's Staffing policy
- 01-29-18 - Capano - Letter to def. still need few items in Discovery
- 1-11-18 - Capano - Letter from defense with CD containing Discovery BS 886-3290
- 1-16-18 - Capano - Letter from defense with Discovery BS 3291-3294
- 1-16-18 - Capano - Letter from defense with Discovery BS 3291-3294-OCR
- 3-8-17 - Capano - Notice to Produce and Supp Rogs to be Answered by Def
- 3-12-18 - Capano - Letter to Blanton regarding outstanding Discovery and deps
- 3-22-18 - Capano - Defendants' response to Req-Retenton of Med Records
- 3-23-18 - Capano - Letter from defense identifying witnesses and coordinating deps
- 3-26-18 - Capano - Letter to defense re outstanding Discovery and deps and Notice of Dep of Mina
- 05-02-18 - Capano - Letter from defense regarding deps and request we withdraw motion
- 05-29-18 - Capano - Letter to defense following-up on depositions
- 05-30-17 - Capano - Letter to defense overdue discovery & providing Con. Order to Amend Caption
- 5-14-18 - Capano - Letter from defense with additional policies BS3296-3300-OCR
- 5-14-18 - Capano Letter from defense with additional policies BS3296-3300
- 06-14-18 - Capano - Ecourts filing of letter to Judge Pugliese for extensions
- 06-14-18 - Capano - Fax to defense for unredacted Mgmt. Agreement & Bonus Plans
- 06-14-18 - Capano - Letter to Judge Pugliese for extension of deadlines
- 6-1-17 - Capano - email of Supp Rogs to defense attorney
- 6-8-18 - Capano - Letter from defense amending rogs with various records
- 6-11-18 - Capano - Defendants Submission of Management Agreement per Order of Court (confidential)
- 6-21-18 - Capano - Letter to defense regarding dep of Wallace and design of Org Des P&P
- 6-26-17 - Capano - Letter to defense requesting Discovery or Motion
- 07-18-18 - Capano - Letter to defense re depositions and providing DVD's
- 7-3-18 - Capano - Letter to Judge Pugliese regarding difficulties with Court-Ordered Discovery & dep
- 7-5-18 - Capano - eilfed Letter to Judge Pugliese re court-ordered Discovery & deps
- 8-3-17 - Capano - Letter from defense with medical records CareOne 1-818
- 8-4-17 - Capano - Defendants' Response to Notice to Produce

- 8-4-17 - Capano - Defendants' Response to Notice to Produce
- 8-8-17 - Capano - Defendants' Answers to Form C, C(3) and Supp Roggs
- 9-28-17 - Capano - Letter from defense with Amendment to Rogs-BS 819--895
- 9-29-17 - Capano - Letter to Blanton requesting TOC for nursing manual
- 10-26-17 - Capano - Letter to Blanton regarding outstanding discovery 10 days or Mtn. Strike
- 11-06-17 - Capano - Letter from Defense with proposed Confidientiality Order
- 11-09-17 - Capano - Letter to defene to provide the discovery ordered or motion 7 days
- 2018.01.11 Capano. -Supplemental Production-OCR
- 2018.01.11 Capano.Resident Counsel Minutes (bs3209-3290)
- 2018.01.11 Capano.Resident Counsel Minutes (bs3209-3290)-OCR
- 2018.01.11 Capano.Supplemental Production
- 2018.02.12 Capano.Cooper Hospital (Neurosurgery) Records FROM DEFENSE (bs 1-92)
- 2018.04.10 Capano.Records Recieved from DEFENSEBayada Home Health (bs 1-646)
- 2018.04.10 Capano.Records Recieved from St. Mary_s Rehab (bs 1-290)
- 2018.05.22. Capano. Records recieved from Dr. Cody FROM DEFENSE (Bates CODY 1-8)
- Capano - CareOne000001-000818 (many more-but, a lot of blanks) Medical Records from Defense Me...
- Capano - CareOne000001-000818 (many more-but, a lot of blanks) Medical Records from Defense

Numbers in brackets refer to pdf file, **Bates stamp**, or **deposition page** numbers.

Record Review

In March 2015, a stress test did not reveal ischemia [C45].

Prior to admission to Cooper Hospital in 11/15, Mr. Capano was wheelchair bound [JC 21]. He was unable to use his legs [JC21]. He was performing self catheterization [JC23]. He had to be helped in in out of his wheelchair [JC 23].

Mr. Capano quit smoking in 2016 [JC 24].

Care One was cited by state surveyors on 2/25/15 for failure to respond in a timely fashion to multiple residents using the call bell system. Four of nine residents told to surveyors that they had experienced a delay in response to call bells, the response time varying from 30 to greater than 60 minutes. All nine residents told surveyors that staff immediately came into the room in response to the call bell, turned off the call bell, and told residents that they would be back. However, staff return to the room occurred much later or not at all and staff told residents that the Care One facility was short staffed [CS71]. Nurse Steele described nursing and certified nursing assistant understaffing [CS72]. Resident #15 told surveyors that staff responded immediately to turn off his call bell, indicated that they would be back, and then returned 2-3 hours later [CS73].

Care One was cited by state surveyors on 2/25/15 under F tag 314 for failure to prevent development of stage II pressure injury Care One [74].

Care One was cited by state surveyors on 8/27/15 for failure consistently to document that urinary catheter care was performed.

Cooper Hospital 11/12/15 – 11/21/15

Joseph Capano, date of birth 12/28/1957, had a past medical and surgical history of non-small cell lung cancer [151], elevated blood lipids, peripheral vascular disease status post seven stents [39], lumbar stenosis, cervical spine stenosis, high blood pressure, coronary artery disease status post heart attack and placement of six coronary artery stents, neurogenic bladder, and benign prostatic hyperplasia.

Mr. Capano had smoked one half pack of cigarettes daily for 40 years. He had one beer daily [39].

A cardiac ECHO performed 11/16/15 demonstrated an ejection fraction of 40% with inferoseptal, anteroseptal, basal inferolateral segment, basal inferior segment, and global hypokinesis. There was no significant valvular heart disease [337].

On 11/16/15, Mr. Capano required a left retromastoid craniectomy [JC29] for removal of a cerebellar tumor [JC31].

On 11/17/15, a brain MRI showed probable complete resection of a left cerebellar metastasis. There were no additional metastases. A ventriculostomy shunt catheter was in place. There were changes of chronic small vessel ischemia [152].

Chemotherapy for lung masses discovered in October 2015 [JC25] commenced in November 2015 [JC27].

On 11/20/15, blood glucose was 95. Blood urea nitrogen and creatinine were 24 and 0.6 [41]. Hemoglobin was normal at 14.6 on 11/22/15 [43].

11/22/15 blood urea nitrogen and creatinine were 21 and 0.56. Glucose was 211 [352].

Mr. Capano was discharged on a regimen of Decadron 4 mg twice daily for two days, then 4 mg daily for two days, than 2 mg daily for three days, then discontinue. Accordingly, Decadron discontinuation was planned on or about 11/28/15 [151]. Mr. Capano was to follow up with radiation oncology, oncology, and neurosurgery [153-154]. At discharge, Mr. Capano was incontinent of bowel. He straight catheterized himself every 4-6 hours [156].

Avista Healthcare 11/21/15

Mr. Capano was in the facility for one hour only.

Cooper Hospital 11/21/15 - 11/24/15

Mr. Capano was readmitted to Cooper Hospital with chest pain [JC32]. He ruled out for heart attack by EKG and troponin criteria and was transferred to Care One [45].

11/23/15 cholesterol was 108, triglycerides 66, HDL 47, and LBL 48 [70].

On 11/23/15 Decadron 4 mg was administered at 8:48 AM [77]. 2 mg were administered on 11/24/15 at 11:22 AM [80].

At the time of transfer to Care One, blood pressure was 119/58, heart rate 64, respirations 44, temperature 97.7°, height 5'5", and weight 153 pounds [11].

Care One at Evesham 11/24/15 – 2/16/16

Mr. Capano, date of birth 12/28/57, had a history of metastatic lung cancer, coronary artery disease, brain metastasis status post craniotomy in October 2015, hyperlipidemia, depression, anxiety, seizures, coronary artery disease status post heart attack, peripheral vascular disease, and gastroesophageal reflux disease [797].

Mr. Capano' code status was full code. He was awake, alert, and oriented to person, place, and time.

The admission nursing assessment 11/24/15 documented skin that was free of pressure injury. The *Resident Evaluation* form 11/24/15 documented the need for assistance of one person with bed mobility, bathing, dressing, transfers, and toileting.

A multivitamin with vitamin C was provided daily. Mighty shakes nutritional supplementation was administered during medication pass [761].

Decadron 4 mg twice daily was administered 11/24/15 and 11/25/15 then decreased to 4 mg daily for two days, then 2 mg daily for three days and discontinued after the dose on 12/1/15. Nursing staff failed to administer Decadron on 12/30/15 [782].

11/25/15 hemoglobin was 13.7. A white blood cell count of 18.95 was attributed to Decadron [801]. Albumin was 2.9 [802].

The 12/1/15 Minimum Data Set (MDS) section E 800 did not document refusal of care. Mr. Capano required extensive assistance of one person for bed mobility, transfers, toileting and of one person for personal hygiene and dressing. Section J 1400 documented a life expectancy exceeding six months. Mr. Capano was at risk for but did not have pressure injuries. Pressure reducing devices for bed and chair were in place. A turning and repositioning program was in place. The documentation of turning and repositioning program was disputed by director of nursing Steele who indicated that such a program was not in place until after development of pressure injury.

The *Interdisciplinary Care Conference* notes 12/3/15 indicated that Mr. Capano required assistance with hygiene, bathing, dressing, transfers, and toileting.

Decadron 2 mg twice daily was administered from 12/4/15 – 12/8/15 and then once daily through 12/13/15 and then stopped [781].

Albumin was 2.8 on 12/11/15. Hemoglobin was 11.7. White blood cell count had normalized to 8.7 [803].

Mr. Capano developed a "facility acquired" right gluteus pressure ulcer, initially noted on 12/16/15. At that time, the stage II pressure sore measured 2 x 1 cm.

A resident comment form indicated that on 12/14/15 Mr. Capano needed to be changed and was left for a long period of time without being changed. Mr. Capano's brother indicated that this was the second time this had happened. Nursing staff informed Mr. Capano's brother that Mr. Capano would be placed on every two-hour checks and an every two-hour toileting schedule [2923-4].

A *pressure ulcer record* was prepared 12/16/15 documenting a facility acquired right gluteus pressure sore. At the time of discovery this stage II pressure sore measured 2 x 1 cm and evidenced pink, pale tissue. There was scant serous exudate. There was no pain associated with this pressure injury.

On 12/17/15 at 5:09 PM, Cathleen Brown's note indicated that she had redressed the sacral wound [CS151].

On 12/17/15, unit manager Michelle McGlone (her note generated after the 5:09 PM note from nurse Cathleen Brown [CS151]) referenced a 2 x 1 cm left inner buttock small open area. Her note indicated that the plan was to add an air mattress and to add a turn and positioning tool and start Mr. Capano on an every two-hour toileting schedule. Director of nursing Steele testified that this note indicated that these interventions were to be implemented on 12/17/15 and had not been in place previously [151, 153, 159].

On 12/22/15, the right gluteus pressure sore measured 0.5 x 0.5 cm, stage II. The *Pressure Ulcer Record* indicated use of a specialty bed and a wheelchair cushion but did not indicate a turning and repositioning program. Wound care nurse Wendy Smolock (Wound Healing Solutions) note indicated that Mr. Capano had ambulation difficulty but he was able to self reposition. She defined self-repositioning as the ability to actually turn left to right to back without assistance or could mean that he was able to reposition a little bit but still required staff assistance to turn him left to right to back. She indicated "generally I'm not there long enough at the bedside to make that determination." She, therefore, deferred to nursing home records generated by the

nursing home staff to provide a clear picture of Mr. Capano's ability to turn and reposition himself [32-33]. Mr. Capano was on an alternating air support surface.

On 12/29/15, a stage II right gluteal pressure injury measured 0.4 x 0.4 cm. The *Pressure Ulcer Record* indicated use of a specialty bed and a wheelchair cushion but did not indicate a turning and repositioning program. Wound Healing Solutions documented a full thickness stage III bedsore of the sacrum measuring 7.8 x 3.8 x 1.7 cm. There was a pale granular base. There was a partial thickness ulceration of the right gluteal region measuring 0.4 x 0.4 cm.

A 12/29/15 *Unavoidable Form* indicated that consistent turning and repositioning was in place. However, Director of Nursing Steele testified that a turning and repositioning program had not yet been instituted [CS143]; a turning and repositioning program was not instituted according to nurse Steele until January 2016

On 12/30/15 a *Pressure Ulcer Record* first indicated development of a stage III sacral pressure injury measured 7.8 x 3.8 x 1.7 cm. There was scant serous drainage. There was no pain associated with this pressure injury. A Foley bladder catheter was inserted [759].

8 mg of Decadron were administered twice daily on 12/23/15, 12/24/15 [768], and 12/25/15.

The December 2015 Care One Documentation Survey Report turning and repositioning is reproduced below:

Turning & Repositioning	Qshift	11p-7a (2300-0700)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		Y 1234 05:07	Y dkg 03:49	Y vw 05:23	Y vw 02:54	Y vw 02:55	Y tf 01:14	Y vw 01:35
	Qshift	3p-11p (1500-2300)	X'	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Y 1234 21:32	Y dkg 22:40	Y 1234 21:03	Y mJ 20:23	Y 1234 21:19	Y 1234 22:07	Y 1234 22:59	Y dkg 22:34
	Qshift	7a-3p (0700-1500)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X			Y yg 13:27	Y dp 13:22			Y dp 14:39	Y dkg 14:18

(Effective Date: Created Date - Current) 1- Did you encourage/assist the patient to turn and reposition every 2 hours or as needed? Y - Yes

This form indicates that a turning and repositioning program was not instituted until 12/24/15, a full month after Mr. Capano had arrived in the facility and eight days after development of gluteal pressure injury. Furthermore, several of the night shift entries for turning and repositioning were documented at 1:14 AM and 1:35 AM, over five hours prior to end-of-shift. Documentation on these shifts, therefore, indicates a promise to turn and reposition, rather than actual documentation of every two-hour turning and repositioning After initiation, turning and repositioning was not accomplished on day shift 12/24/15, 12/25/15, 12/28/15, and 12/29/15 (4 of 23 shifts = 17%). Sacral pressure sore was discovered 12/30/15.

The 12/29/15 *Unavoidable Pressure Ulcer Physician Documentation* form signed by Dr. Dructor indicated that consistent turning and repositioning and every two-hour toileting were in place and that albumin was less than 3.4 and hemoglobin less than 12. Director

of Nursing Steele testified, however, that a turning and repositioning program was not yet in place at the time pressure ulceration developed [CS143, 153]. The unavoidable pressure ulcer form indicated that bowel incontinence, decreased lower body sensation, ongoing cancer diagnosis, steroid therapy, chemotherapy, and end-stage cancer were risk factors for development of pressure injuries. The form indicated that clean dry bed linens, pressure reducing surface, good skin care, and adequate nutrition and hydration were preventive measures that were in place. The handwriting of the person filling out the form appears to be different than that of Dr. Ructor.

Wound Healing Solutions 1/4/16 note documented fecal and urinary incontinence. Pressure injuries were painless. The stage III sacral pressure injury measured 4.8 x 1.6 x 1.1 cm. It was 95% slough covered. The partial thickness right gluteal pressure injury measured 0.3 x 0.3 cm. Albumin had increased to 3.0 (3.2-5.0) [806]. Hemoglobin was 9.5 [807].

On 1/5/16, blood urea nitrogen and creatinine were 9 and 0.5, glucose 93, and albumin 2.9 [439].

On 1/6/16, nurse Brown testified that Mr. Capano was on a special air mattress [CB63]. Right gluteal pressure injury was described as stage I measuring 0.4 x 0.3 cm. The *Pressure Ulcer Record* indicated use of a specialty bed but did not indicate a turning and repositioning program. The sacral pressure injury was stage III measuring 4.8 x 1.6 x 1.7 cm.

Wound Healing Solutions' 1/11/16 note described full epithelialization/closure of the right gluteal pressure injury. The full thickness stage III sacral pressure injury measured 4.8 x 1.8 x 1.1 cm. A low air loss air support surface and a gel cushion for the wheelchair were in place.

Advanced practice nurse internal medicine notes 1/12/16 documented stage III sacral pressure injury [155].

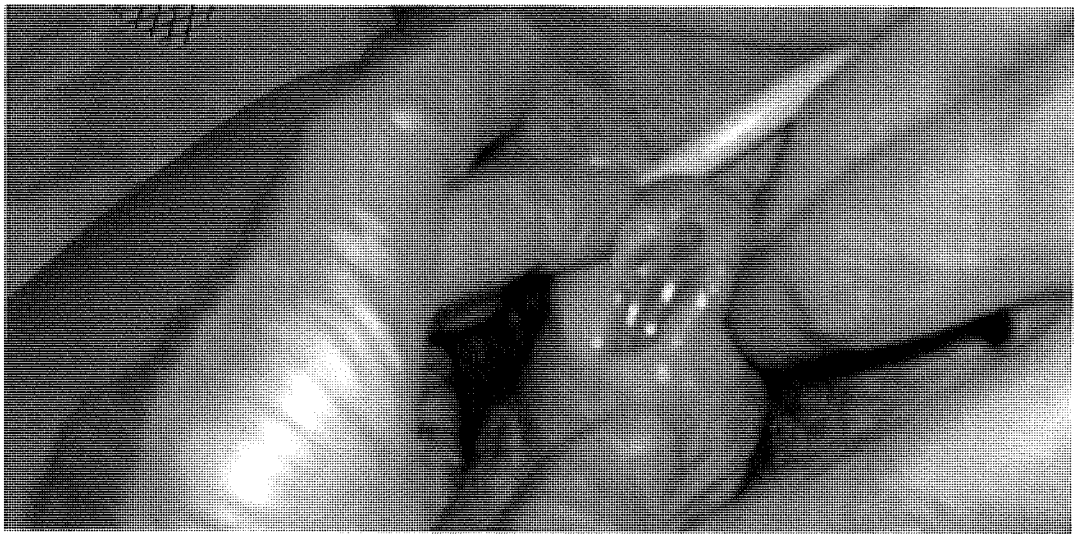
On 1/12/16, the sacral pressure injury was stage III measuring 4.8 x 1.6 x 1.6 cm. Hemoglobin was 9.1 [438].

8 mg of Decadron twice-daily were administered on January 13, 14, and 15 [767].

Advanced practice nurse internal medicine notes 1/15/16 documented stage III sacral pressure injury [155].

Advanced practice nurse internal medicine notes 1/18/16 documented stage III sacral pressure injury [159]. Hemoglobin was 9.5 [812]. Prealbumin was 13. Blood urea nitrogen and creatinine were 13 and 0.5 [436]. Hemoglobin was 9.5 and white blood cell count 8.7 [437].

The Foley catheter indwelling at Care One eroded the penile meatus for approximately 1 inch [JC 41] as pictured below:.



Wound Healing Solutions 1/19/16 note documented a 100% pale granular wound base. The sacral pressure injury was full thickness measuring 3.7 x 1.8 x 1.7 cm. There was 1.4 cm of undermining from the 2:00 – 5:00 position. There was mechanical erosion of the penile meatus.

1/25/16 hemoglobin was 8.8 [814].

On 1/26/16, Wound Healing Solutions notes described an unstageable sacral bedsore that measured 5.3 x 4.6 x 1.7 cm. It was fully covered by slough. 1.4 cm of undermining was found from the 1:00 – 3:00 position. Nurse Smollock indicated that Mr. Capano was "showing signs of terminal skin changes [Smollock-6]."

Advanced practice nurse internal medicine notes 1/26/16 documented penis pain which improved with pain medication. Advanced practice nurse Bornmann described a meatus tear [161].

Advanced practice nurse Bornmann described worsening of sacral pressure ulceration on 1/27/16. The wound had become unstageable [163].

Dr. Ructor's 1/28/16 note described an unstageable sacral pressure injury "due to skin failure." Dr. Ructor's note does not provide vital signs. Nor does it described failure of other organ systems. The penile meatus was split [165].

Mr. Capano was evaluated at the Virtua surgical group on 1/29/16, reporting a two-year history of inability to walk [427]. The sacral pressure sore measured 5 x 4 x 3 cm. The coccyx was palpable at the wound base [427]. There was significant necrotic tissue within the wound. Dr. Cody was concerned about osteomyelitis involving coccyx. He debrided necrotic tissue with the scalpel, removing a 5 x 4 cm area of necrotic tissue [428].

January 2016 Care One Documentation Survey Reports documented turning and repositioning as follows:

Turning & Repositioning	Qshift	11p-7a (2300-0700)	Y vm 01:31	Y vm 02:24	Y dkg 02:57	Y dkg 00:52	Y vm 02:13	Y vm 00:13	Y vm 02:36	Y vm 00:51	Y vm 01:31	Y vm 04:54	Y vm 02:44	Y vm 01:58	Y vm 00:45	Y vm 02:30	Y vm 02:12	Y vm 03:56
	Qshift	3p-11p (1500-2300)	Y ml 19:03	Y lf 21:27	Y dkg 21:51	Y eh 19:28	Y 1234 21:11	Y eh 22:39	Y 1234 20:06	Y dkg 21:50	Y 1234 20:33	Y vm 22:14	Y 1234 20:59	Y 1234 21:20	Y 1234 21:14	Y dkg 21:54	Y dkg 22:02	Y dkg 22:59
	Qshift	7a-3p (0700-1500)	Y som 14:50	Y dp 14:53		Y dp 13:19		Y dp 13:04	Y dg 14:44	Y dp 14:43	Y dp 13:44		Y dp 14:59	Y md 14:59		Y dp 12:48		Y sl 13:44

Turning & Repositioning	Qshift	11p-7a (2300-0700)	Y vm 02:18	Y vm 01:27	Y vm 01:27	Y vm 02:24	Y vm 02:02	Y vm 02:41	Y vm 02:38	Y vm 01:48	Y vm 03:44	Y vm 05:02	Y vm 01:43	Y vm 03:59	Y vm 01:48	Y vm 01:17	Y vm 01:43
	Qshift	3p-11p (1500-2300)	Y dkg 22:42	Y 1234 22:29	Y dkg 22:07	Y kb 21:54	Y 1234 20:14	Y dkg 19:23	Y 1234 21:41	Y 1234 22:59	Y 1234 22:32	Y 1234 21:55	Y 1234 20:50	Y 1234 21:54	Y dkg 22:54	Y dkg 17:02	Y ml 21:40
	Qshift	7a-3p (0700-1500)	Y yg 11:51	Y dp 13:22	Y dp 13:07	Y dp 13:29	Y md 14:36	Y dp 13:01		Y dp 13:53	Y sl 12:39	Y md 14:59	Y dp 13:10		Y md 14:59	Y md 14:53	Y md 14:19

(Effective Date: Created Date - Current) 1- Did you encourage/assist the patient to turn and reposition every 2 hours or as needed? Y - Yes

Turning and repositioning were not documented on 7 of 93 shifts (7.5%) in January 2016. On almost every night shift, documentation of turning and repositioning occurred well before end of shift, indicating the promise to turn and reposition every two hours rather than actual documentation of repositioning every two hours. Shifts in which documentation of turning and repositioning occurred significantly prior to shift end are highlighted in yellow.

Dr. Ductor's 2/1/16 note indicates a blood pressure 132/70, pulse 67, respirations 14, temperature 97.2, and pulse oximetry of 97%. Dr. Ductor described a stage III sacral pressure injury and describes skin failure due to cancer, malnutrition, and chemotherapy. However, cardiac pulmonary, abdominal, and extremity examinations were unremarkable [167].

On 2/2/16, odor emanated from the sacral pressure injury [WS104]. Wound Healing Solutions notes described in undermined unstageable sacral pressure injury measuring 4.8 x 3.7 x 2.4 cm and mechanical erosion of the penile shaft. Mr. Capano was evaluated by radiation oncology and neurosurgery. A 1/31/16 brain MRI did not show evidence of new metastatic disease [495].

On 2/3/16, hemoglobin was 8.8 and white blood cell 9.8 [419]. Blood urea nitrogen and creatinine were seven and 0.6. Albumin was 2.9 [420].

8 mg of Decadron twice daily was administered on February 3, 4, and 5 [316, Bates 762].

On 2/6/16, stool was positive for *Clostridium difficile* prompting the addition of Flagyl 500 mg three times daily [418].

On 2/9/16, Wound Healing Solutions notes described a stage IV sacral pressure ulceration measuring 3.8 x 3.2 x 2.4 cm. Bone was palpable at the base of the decubitus ulcer. Nurse Smollock debrided the pressure injury using surgical scissors. The pressure injury was painless. Local care with Dakins solution continued. An alternating pressure mattress was in place. Dr. Ructor's 2/9/16 note described sacral ulcer secondary to skin failure. Vital signs were not charted. Head, ears, eyes, nose, throat, cardiac, pulmonary, abdomen, and extremity examinations, however, were unremarkable [171].

On 2/12/16, Dr. Cody debrided the sacral ulcer to bone [417].

On 2/15/16, hemoglobin was 8.7. White blood cell count was 4.4 [820].

The 2/16/16 Minimum Data Set (MDS) section E 800 did not document refusal of care [99]. Mr. Capano required extensive assistance for bed mobility, transfers, toileting, and dressing and limited assistance with personal hygiene. Section J 1400 documented a life expectancy exceeding six months. There had been no recent weight gain or weight loss [105]. The Minimum Data Set (MDS) indicated that Mr. Capano was at risk for but incorrectly averred that he did not have pressure injuries. Pressure reducing devices for bed and chair were in place. A turning and repositioning program was in place. Glucose was 93. Blood urea nitrogen and creatinine were 9 and 0.5 [822].

On 2/16/16, Wound Healing Solutions notes documented stage IV sacral pressure ulceration measuring 3.8 x 2.8 x 2.4 cm. The wound base was 90% granular. Granulation tissue was no longer described as pale. Nurse Smollock described decreasing surface inflammation. The "site [was] responding very well [Smollock-9]."

The Care One Care Plan called for encouragement and assistance as needed to turn and reposition using assistive devices as needed, pressure reducing cushion for the wheelchair and a specialty mattress on the bed [590].

Turning and repositioning on an every two-hour or more frequent basis was not documented in the nursing notes [572-585].

February 2016 Care One Documentation Survey Reports documented turning and repositioning as follows:

Turning & Repositioning	Qshift	11p-7a (2300-0700)	Y vw 02:58	Y vw 01:26	Y vw 01:07	Y vw 00:22	Y vw 02:10	Y dkg 01:49	-99 vw 03:48	Y dkg 02:01		Y mm 02:48	Y dkg 04:01	Y dkg 03:44	Y mm 05:44	Y dkg 02:56			Y dkg 03:25	Y cb 06:52	X	
	Qshift	3p-11p (1500-2300)	Y 1234 21:01	Y 1234 21:11	Y 1234 21:18	Y 1234 21:24	Y dkg 22:59	Y 1234 22:01	Y dkg 22:37			Y eme 20:45	Y js 20:43	Y eh 21:22	Y dg 21:56	Y aom 22:05			.	X	X	
	Qshift	7a-3p (0700-1500)		Y dp 13:03		-97 sh 14:07	Y dp 14:52		Y sl 14:47	Y md 14:59				Y md 14:59		Y md 14:59					X	
(Effective Date: Created Date - Current) **1- Did you encourage/assist the patient to turn and reposition every 2 hours or as needed?** Y - Yes																						

Turning and repositioning were not documented on 12 of 46 (26%) shifts in February 2016. On almost every night shift, documentation of turning and repositioning occurred well before end of shift, indicating a promise to turn and reposition every two hours rather than actual documentation of repositioning every two hours. Shifts in which documentation of turning and repositioning occurred significantly prior to shift end are highlighted in yellow.

At the time of discharge, a hospital bed, air mattress, wheelchair, and a 3:1 commode were arranged for home use [369].

Care One Resident Comment Forms

Resident Comment Forms repetitively documented tardy responses to patients' call bells, failure to change soiled diapers [2927, 2949,], and an occasion in which a patient's family observed three night shift certified nursing assistants sleeping in the television area under blankets at 1 AM [2909].

Deposition of Joseph Capano

Joseph Capano is Andrew Capano's brother. Joseph Capano visited his brother daily, remaining at the Care One facility for between one and two hours [36].

Mr. Capano complained to Joseph Capano on at least 12 occasions that he was left and soiled diapers at Care One [48]. Mr. Capano told his brother that on occasion he had been left in a soiled diaper for between 60 and 90 minutes [51].

Mr. Capano was insensate from the waist down [57].

Mr Capano had never had any issues with skin breakdown in the area of his buttocks/anus prior to admission to Care One [57].

Mr. Capano had a wheelchair air cushion prior to admission to Care One [59].

Joseph Capano took pictures of his brother's wounds on or about 12/5/16, after discharge from Care One [66-67].

Home wound care was provided through Bayada visiting nurse service after discharge from Care One [73] up until February 2017 [79].

While at home, Joseph Capano turned his brother at least twice a day [93].

Deposition of Cathleen Brown, RN

Nurse Brown testified documentation helps one to determine what is working and what is not working [22]. She testified that pressure is always one of the causative factors in development of pressure ulcers [28]. She testified that turning and repositioning is

important in preventing pressure ulcers [28]. Nurse Brown testified that documentation of turning and repositioning once per shift would take a second or two [38].

Nurse Brown described sacral pressure ulceration [45].

Nurse Brown testified that prior to the development of pressure ulceration, the Care Plan called for repositioning every two hours [47].

Nurse Brown testified that a split penis can be caused by tension on the Foley catheter [50].

Nurse Brown testified that sacral and gluteal pressure sores would be two different wounds [57] and that both of these developed while a Mr. Capano was a resident at Care One at Evesham [62].

Nurse Brown testified that nurses at Care One were supposed to document turning and repositioning in the nursing notes.

Deposition of Joseph Mina

Mr. Mina is the regional director of marketing for Care One and a licensed nursing home administrator [10].

Mr. Mina expected for staff to follow Care One's policies and procedures [131].

Deposition of Kiyetta Shields, LPN

Nurse Shields' background included work as a certified nursing assistant [14].

Nurse Shields testified that nurses documented on the computer or in their notes when a patient was turned every two hours and whether a patient had an air mattress. Documentation of turning and repositioning can be found on the medication administration record, the treatment administration record, or in nursing (nursing progress) notes [24]. She testified that nurses documented when they turned patients and if they did not turn a patient they did not document turning and repositioning. She agrees with the axiom, "if it's not documented, it's considered not to have been done [25]."

Nurse Shields testified that residents who need turning and repositioning should be limited to 1-2 hours in a chair [31].

Nurse Shields described a basic turning interval of patients unable to turn themselves of every two hours [34].

Pressure is always a significant causative factor in development of pressure injury [35].

Nurse Shields testified that in the *Pressure Ulcer Record* if a turning and repositioning program is not indicated, a turning and repositioning program was not in place [43]. She testified that even if a patient were not on a special turning and repositioning program it was her habit and practice to turn and reposition her patients [53].

"I documented what I performed [53]."

Deposition Wendy Smollock, RN, NP, Certified Wound Specialist,
Nurse Smollock characterized the sacral wound as a pressure injury [12].

Nurse Smollock testified that pressure is a sine qua non for development of pressure injuries [17].

Nurse Smollock's wound care notes indicated that Mr. Capano was capable of self-repositioning. She defined self-repositioning as the ability to actually turn left to right to back without assistance or it could mean that he was able to reposition a little bit but still required staff assistance to turn him left to right to back. She indicated "generally I'm not there long enough at the bedside to make that determination." She, therefore, deferred to nursing home records generated by the nursing home staff to provide a clear picture of Mr. Capano's ability to turn and reposition himself [32-33].

Granulation tissue is considered healing tissue [51].

Nurse Smollock testified that when skin failure occurs, "circulation shift away from the skin to the central organs tends to deplete the sacral region most aggressively [54]."

Nurse Smollock testified that Mr. Capano did not have anorexia: "he was eating okay [58]."

Nurse Smollock characterized an albumin of 2.8 as "slightly depressed [59]."

Nurse Smollock described mechanical erosion of the penile meatus: generally it is secondary to a Foley catheter [70]. Nurse Smollock described use of a "tube stabilizer", an adhesive device typically placed along the thigh to secure the catheter to the thigh to reduce movement on the penis [71-72].

Nurse Smollock testified that no one made a determination that Mr. Capano was definitely showing signs of terminal skin changes or skin failure [76].

Nurse Smollock testified that if a patient articulates to her that he is not being regularly turned or repositioned or having his diaper changed or catheter care provided that she would record this information in her note. She did not have any recollection of Mr. Capano complaining to her about lack of attentiveness by the Care One staff [102].

Deposition of Chereece Steele, RN

Nurse Steele was the director of nursing at Care One prior to 11/24/15 [25] until late January 2016 [25].

Nurse Steele testified that a Foley catheter should be secured to a resident's body so that traction is not applied to the penis [32].

Nurse Steele testified that the initiation date on the Care Plan reflects the date when an intervention was put into place [35]. Nurse Steele could not explain why the Care Plans for actual skin breakdown of the sacrum and for nutritional status were initiated 4/8/16 when Mr. Capano had been discharged from the facility in February 2016 [59, 60, 62; Bates 123, 124, 126] nor could she explain why the Care Plan was attributed to her when she had left employment at Care One at Evesham in February 2016 [63]. A Care Plan for Foley catheter management was, in contrast, initiated 1/5/16 [62; Bates 129].

Nurse Steele described a standard interval for turning and repositioning the immobile patient in bed as at every two hours [39].

Nurse Steele was not aware of any rejection of care issues with Mr. Capano [42]. She also described him as sometimes noncompliant with straight catheterization and refusal to allow incontinence care [43].

Nurse Steele believes in and has practiced under the axiom, "if it's not documented, it's considered not to have been done [45]." She has provided in-service training regarding this type of documentation [45].

Nurse Steele testified that pressure is a sine qua non for development of pressure injuries [47, 111].

Nurse Steele agreed that neglect is a type of abuse [101].

Nurse Steele interpreted the Care One policy *Expectation of Point of Care Documentation: Touch the Patient, Touch the Kiosk* [1634] to mean that any time a patient was touched, documentation should be created [105].

Director of Nursing Steele testified that nursing staff should document refusal of care [108].

Director of Nursing Steele expected documentation in the nurses' notes when Mr. Capano was turned and repositioned [118]. Nurse Steele agreed that turning and repositioning was documented far, far less than every two hours during Mr. Capano residence at Care One [119]. There were only six references to turning and repositioning in the nurses' notes. (Turning and repositioning charting, as well as the lack thereof, was noted earlier in the report.)

Nurse Steele testified that there should be a form in the Care One chart chronicling two-hour toileting schedules when in place [121].

Director of nursing Steele testified that the 12/1/15 Minimum Data Set (MDS) which indicated that a turning and repositioning schedule was in place is incorrect [127]. Mr. Capano was not placed on a turning and repositioning schedule at the time of admission. A turning and repositioning program was not instituted until January 2016 at a time after which Mr. Capano had already developed gluteal and sacral pressure injuries [128]. "I did not see anything indicated on the treatment record that turning and positioning was in place, nor did I see anything else indicated that. The only place I saw it indicated was on the Care Plan [146]. Nurse Steele testified that she expected her nurses to turn and reposition patients even if there was no turning and repositioning program in place [147].

Nurse Steele confirmed that Mr. Capano entered Care One without pressure injury and left with stage IV sacral pressure injury [131].

Nurse Steele that Mr. Capano neither gained nor lost a significant amount of weight while at Care One [131].

Defendant's Answers to Form C3 Interrogatories

Answers to Form C3 Interrogatories indicated that Mr. Capano refused treatment to his sacral wound and straight catheter at times which may have contributed to or caused the alleged injuries.

Care One's Policies and Procedures

The duties of nursing assistants included, "change all bedbound patients/residents at least every two hours" and "turn all bedbound patients/residents at least every two hours [2212]."

The policy entitled *Skin Integrity Program: Identification and Prevention* defines pressure ulcer as "localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear." This policy and procedure indicates that it is in part derived from 2007 National Pressure Ulcer Advisory Panel documents.

Clinical Practice Guidelines for the Prevention and Management of Pressure Ulcers and Other Wounds. This guideline incorporates evidence-based research and standards of practice in wound management published by authorities in the field such as the Centers for Medicare and Medicaid Services (CMS), the National Pressure Ulcer Advisory Panel; Wound, Ostomy & Continence Nurses Society (WOCN); and the American Medical Directors Association [845].

Patient refusals are to be documented in the clinical record [823].

At Home 2/16/16 –

Bayada home health care visiting nurse notes 2/17/16 documented a stage III 4 x 3.5 x 3.5 cm sacral pressure sore [TN34]. At the start of care, nurse Nelson noted a pre-existing sacral pressure injury and injury to the penile meatus [TN70].

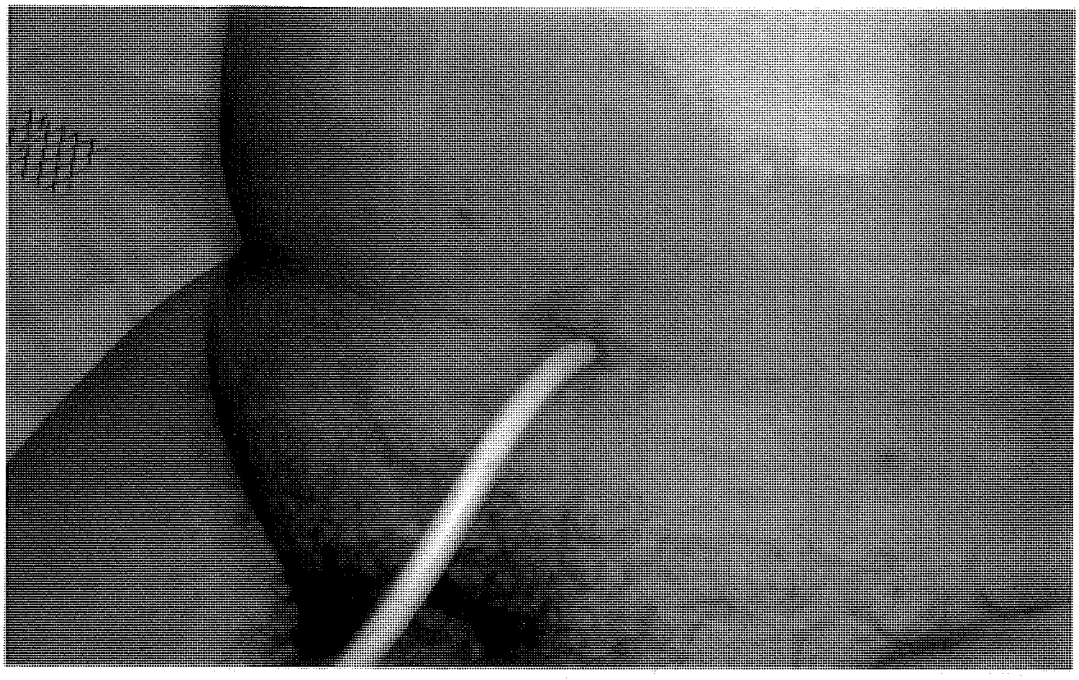
On 2/26/16, albumin was 3.1 (3.5-5.5) [2352].

On 2/29/16, Mr. Capano was evaluated by his neurologist for "severe meatal erosion due to chronic Foley [2236]." Suprapubic tube placement was contemplated.

On 3/14/16, the 4 x 3.5 x 3.5 cm stage III sacral pressure ulceration exhibited < 25% healthy granulation tissue [TN37, Nelson-4].

Mr. Capano's stage IV sacral pressure sore was evaluated by surgeon Dr. Matthew Finnegan on 3/28/16.

A suprapubic tube was placed on 4/5/16 for treatment of neurogenic bladder [2357]. The suprapubic catheters depicted below:



On 4/8/16, a suprapubic catheter was in place {Nelson-2]

On 5/4/16, the 3.2 x 3.1 x 2.9 cm stage IV sacral pressure ulceration [TN40] persisted. Granulation tissue covered 75-100% of the pressure injury [TN41]. There was a small amount of bloody exudate [Nelson-6]

On 7/6/16, the 3.8 x 4 x 2.8 cm stage IV sacral pressure injury continued to granulate [TN44]. There was purulent exudate [Nelson 7].

On 8/3/16, the 3.1 x 2.9 x 4.3 cm sacral pressure sore had a moderate amount of purulent exudate [Nelson 8].

On 8/24/16, the 2.4 x 3.6 x 4.9 cm stage IV sacral pressure injury had a moderate amount of purulent exudate [Nelson-10].

On 9/9/16, the 2.4 x 3.6 cm sacral pressure sore had a depth of 5.2 cm [TN49, Nelson 11].

On 10/3/16, the 2.4 x 2 cm sacral pressure injury was 4.8 cm deep [TN50, Nelson 12].

On 12/14/16, the 1.2 x 1.5 x 2.5 cm stage IV sacral pressure injury had a small amount of purulent exudate [Nelson 13].

On 12/21/16, the 1.2 x 1 x 2.9 cm stage IV sacral pressure sore had a small amount of purulent exudate [Nelson-14].

On 2/3/17 and 2/8/17, nurse Nelson documented purulent exudate emanating from the stage IV sacral pressure injury [TN54, 56]. On 2/3/16, stage IV sacral pressure injury measured 0.8 x 0.7 x 2.8 cm [Nelson-15].

On 2/8/17, the stage IV sacral pressure injury measured 0.6 x 0.8 x 2.6 cm [Nelson 16].

The last visiting nurse progress note was 2/22/17 [TN58]. The stage IV sacral pressure injury measured 0.6 x 0.8 x 2.8 cm. There was a small amount of purulent exudate. The wound was not granulating and was not epithelialized.

Deposition of Tina Nelson, RN

Nurse Nelson was taught the axiom, "if it's not documented, it's considered not have been done [11]."

Nurse Nelson was Mr. Capano's case manager from home care services.

Nurse Nelson testified that one factor requisite for development of pressure ulceration is pressure [18].

Cooper Hospital 2/17 – Neck surgery
On 2/23/17, Mr. Capano underwent a cervical laminectomy C3-C7 and instrumented fusion of C-3-T2 for cervical spine stenosis with myelopathy [3782].

St. Mary's Center for Rehab and Healthcare 2/27/17 – 3/19/17
On 2/28/17, nurses described a 0.9 x 0.8 x 3.2 cm intra-rectal lesion "possible previous pilonidal cyst [3617]." This location is distinct from a sacral lesion.

On 3/10/17, nurses described a 0.5 x 0.7 x 2.6 cm cyst at 12 o'clock position inside the rectum [3613].

The 3/15/17 [3539] and 3/19/17 Minimum Data Sets (MDS) documented skin that was free of pressure injuries [3506]. A 3/17/17 wound assessment sheet documented presence of a 0.8 x 0.5 x 2.5 cm sacral pilonidal sinus. This was not characterized as a pressure injury [3609].

Mr. Capano was recuperating from spine surgery when he developed chest pain. An EKG revealed ST segment elevation anteriorly.

Virtua Marlton 3/19/17
Mr. Capano was admitted with an anterior wall heart attack. In the emergency room, he had a ventricular fibrillation arrest requiring defibrillation and several rounds of epinephrine for resuscitation. He was taken on an emergency basis to the cardiac catheterization lab where he was found to have an occluded left anterior descending coronary artery. Two stents were placed into the left anterior descending artery. A large diagonal branch required balloon angioplasty. Cardiac ejection fraction had fallen to 20%. An intra-aortic balloon pump was removed because of iliac artery occlusive disease and fear of precipitating acute limb ischemia [3822].

At this juncture, lung cancer had been treated with chemotherapy, resection of a solitary brain metastasis, and Gamma knife therapy twice [3829].

Mr. Capano requested *Do Not Resuscitate* code status [3828].

Mr. Capano had discontinued cigarette use [3823].

3/19/17 chest x-ray showed a focal rounded density at the right lung base [3838].

Mr. Capano developed fevers cough, and diarrhea. He was placed on the intravenous antibiotic Rocephin [3836]. On 3/25/17, CT of the chest, abdomen, and pelvis showed right middle lobe lung cancer, right upper lobe pneumonia, left upper lobe pneumonia, trace right pleural effusion, and nodular opacities associated with interstitial thickening of both lungs felt most likely to be chronic reticular nodular interstitial lung disease. The radiologist was, however, unable to exclude tiny lung metastases [3840].

On 3/21/17, a repeat cardiac ECHO showed an ejection fraction of 10-15%. There were significant, diffuse wall motion abnormalities [3842].

Samaritan Hospice

Death Certificate 4/1/17
The death certificate lists metastatic lung cancer of unknown duration as the cause of death.

Professional Background
I received my medical training at the University of Pennsylvania Medical School from 1983-1987, graduating with a medical doctor degree. I participated in a three-year residency program in internal medicine from 1987-1990 at which time I was endorsed by the American Board of Internal Medicine as a board-certified internist. My internal medicine board certification has been maintained continuously from 1990 through the present time based on successful completion of a written examinations for the 1990-2000, 2000-2010, and 2010-2020 time periods. "Physicians certified by the American Board of internal medicine demonstrates that they have the knowledge, skills and attitudes essential for excellent patient care[1]."

"Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness[2]."

General internists are trained in the pathophysiology and pathology of adult medicine. The scope of a general internist is quite broad. General internists see patients with a broad array of problems related to the brain, spine, autonomic nervous system and peripheral motor and sensory nervous systems; hematological disorders; bones, joints, tendons, ligaments, and metabolic bone disease; genetic and inherited disorders; pharmacology; psychiatric illness; oral and dental problems; kidneys and genitourinary system; swallowing disorders; esophagus, stomach, small and large intestine, rectum, and anus; head, eyes, ears, nose, and throat; arteries and veins; endocrine diseases including but not limited to diabetes, thyroid disease, pituitary disease, and adrenal disease; high blood pressure; rheumatological and autoimmune diseases; infectious disease; cardiac valvular, conduction system, arterial, and heart muscle; the lungs, pulmonary vasculature, pleura, and chest wall; and diseases of the skin including rashes, eczema, contact dermatitis, blistering skin diseases, burns, and pressure injuries.

Internists provide pre-operative, perioperative, and postoperative care.

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[1] http://www.abim.org/ (American Board of Internal Medicine)
[2] https://www.acponline.org/about-acp/about-internal-medicine (American College of physician)

The internist receives training in interpretation of laboratory reports including microbiology, pathology reports, and interpretation of radiographic studies.

The internist, serving as a family physician for adults often provides first-line evaluation of problems associated with this wide variety of organ systems; the internist then decides whether to handle these problems primarily or to seek consultation with surgeons and/or non-surgical specialists to provide care in collaboration with these consultants.

Since completion of my internal medicine residency program in 1990, I have worked as a hospital-based physician from 1990-1995 providing care to thousands of hospitalized patients on the general medical and surgical floors, in the intensive care units, and as a consultant providing infectious disease expertise. From 1995 through the present time, I have provided hospital-based care, have seen patients in an outpatient general internal medicine office setting, and have provided care to thousands of patients in acute, subacute, and extended care nursing facilities. I have provided physician oversight to patients residing in assisted care facilities.

I have served as a medical director of two extended care facilities. In my capacity as medical director, I served as the liaison between physician staff and nursing/nursing assistant staff; between the physician staff and ancillary medical personnel (dietitian, respiratory therapist, restorative nursing aides, physical therapist, occupational therapist, activities coordinator, Minimum Data Set (MDS) coordinator); and between physician staff and nursing home administration. In my capacity as a nursing home attending physician, I participate in fall risk evaluation and implementation of fall risk prevention and injury mitigation strategies/interventions. In my capacity as a nursing home physician, I participate in the pressure sore risk evaluation, risk mitigation strategies/interventions, pressure injury evaluation and treatment.

In my roles as hospitalist, office-based physician, and a physician working in acute, subacute, and extended care facilities, I am routinely called upon by patients and families to render opinions regarding quantity and quality of life issues, to discuss the morbidities and mortality associated with operative and non-operative interventions, to advise on the advisability of operative and non-operative interventions based on a patient's life goals and medical conditions, to discuss end-of-life care, and to provide life expectancy prognoses.

As an office-based physician, I interact with/provide orders and oversight to visiting nurse personnel on a daily basis.

Given my extensive experience as a hospitalist; an office-based physician; a physician working in acute, subacute, and extended care facilities; and my experience as a medical director in long-term care facilities, I am intimately familiar with the standard of care required of physicians, ancillary medical personnel, and nurses in all three settings.

Minimum Data Set Attestation:
I understand the information is used as a basis for ensuring that residents receive appropriate quality care and is a basis for payment for federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of the information and that person(s) certifying as to the truthfulness and accuracy and completeness of the Minimum Data Set may be subject to or their organization may be subject to substantial criminal civil and/or administrative penalties for submitting false information.

The Importance of Documentation
Chart documentation is the cornerstone of communication amongst caregivers. Documentation allows subsequent caregivers to know what has happened on previous shifts. The accuracy of documentation is vitally important so that caregivers down the line are making decisions based on complete and accurate information.

Maintenance of an accurate and complete health record is requisite for patient safety and continuity of care.

The nursing process includes assessment, creation of a Care Plan (with planned interventions), application of interventions, documentation of interventions, reassessment, documentation of reassessment, and modification of the Care Plan if necessary. Documentation is an integral and critical part of the nursing process.

Discussion

The *Standard of Care* for the prevention and treatment of pressure sores derives from Federal OBRA regulations, New Jersey State statutes, New Jersey Regulations, AHCPR guidelines, the American Medical Directors Association, the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP), the Pan Pacific Pressure Injury Alliance, and Federal OBRA regulations expanded upon by guidance to surveyors under OBRA F-tag 314. These establish acceptable community norms for pressure sore prevention and treatment.

Federal and State Regulations

Federal Regulations

In 1987, President Ronald Reagan signed into law the first major revision of the federal standards for nursing home care since the 1965 creation of both Medicare and Medicaid. This landmark legislation changed society's legal expectations of nursing homes care. Long term care facilities desiring Medicare or Medicaid funding must provide services enabling residents to "attain and maintain their highest practicable physical, mental, and psychosocial well-being."

The Federal Nursing Home Reform Act or OBRA '87 created a minimum set of national standards of care and rights for people living in certified nursing facilities.

Federal OBRA regulations §483.20(k) Resident assessment specifies that "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment."

Federal OBRA regulations §483.25 (c) (1) requires that "a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable...." §483.25 (c) (2) specifies that " a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."

Federal OBRA regulations Section 483.20 (b) (1) (xii) requires a facility to make periodic comprehensive patient assessments [including skin condition].

Federal OBRA regulations §483.10 (b)(11)(B and C) requires that a facility immediately consult with the resident's physician when there is a significant change in the resident's physical status and/or a need to alter treatment significantly.

Federal OBRA regulations §483.75 (1) requires that nursing facilities maintain records on each resident in accordance with accepted professional standards and practice. F tag 514 provides guidance to surveyors in interpreting Federal OBRA regulations §483.75 (1), specifically requiring that clinical records are complete, accurately documented, easily accessible, and systematically organized. The CMS Interpretive Guidelines for F tag 514 direct state surveyors to ask the following question during the survey: "Is there enough record documentation for staff to conduct care programs and revise the program, as necessary, to respond to changing status of the resident as a result of interventions?"

Federal OBRA regulations §483.13 (c) specifies that "the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents."

New Jersey State Statutes

New Jersey State Statutes N.J.S.A. 30:13-3 (h) requires nursing homes to comply with "all applicable State and Federal statutes and rules and regulations."

New Jersey SA 30:13-5 Nursing Home Residents Bill Of Rights

N.J.S.A. 30:13-5 (j) specifies a patient's "right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident, including the right to expect and receive appropriate assessment,

management and treatment of pain as an integral component of that person's care consistent with sound nursing and medical practices."

Violation of the Federal Nursing Home Reform Act is, therefore, *de facto* violation of New Jersey statutes.

Violation of a nursing home law that causes harm is a violation of that resident's rights under N.J.S.A. 30:13-5 (j) which involves the rights to a dignified existence and a safe and decent living environment and individualized care that recognizes the individuality of the resident. Any inappropriate care that causes harm is a violation of the rights to a safe and decent living environment, a dignified existence, and care that recognizes the individuality of the resident as such harm logically infringes upon these rights.

Any violation of any applicable State or Federal Statute, Rule or Regulation is a violation of the New Jersey Nursing Home Act (New Jersey Nursing Home Responsibilities and Residents Rights Act) and a deviation from the standard(s) of care.

N.J.A.C. 8:39-27.1(a) provides that "the facility shall provide and ensure that each resident receives all care and services needed to enable the resident to attain and maintain the highest practicable level of physical (including pain management), emotional and social well-being, in accordance with individual assessments and care plans."

N.J.A.C. 8:39-27.1 (e) requires that "the facility shall take preventive measures against the development of pressure sores, including assessing the resident's skin daily and minimizing friction and pressure against clothing and bed linens. When present, pressure sore shall be identified, documented, and treated."

N.J.A.C. 8:39-27.2 (b) requires that non-ambulatory residents shall be repositioned at least once every two hours.

N.J.A.C. 8:39-4.1 (a) 5 specifies that each resident shall be entitled to the following rights.... To be free from physical and mental abuse and/or neglect.

Pressure Sores

The 12/19/89 Omnibus Budget Reconciliation Act (Public Law 101-239) established the Agency for Health Care Policy and Research (AHCPR). The AHCPR Publication number 92-0047, *Pressure Ulcers in Adults: Prediction and Prevention*, Clinical Practice Guideline Number 3, May 1992 provides what is still a pertinent review of pressure sores/decubitus ulcerations.

Stage I ulcers are defined as non-blanchable redness of intact skin.
Stage II ulcers are partial thickness skin loss involving the epidermis and/or the dermis which present as an abrasion, blister, or shallow crater.

Stage III ulcers are full thickness skin loss "involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia and present as a deep crater with or without undermining of adjacent tissues
Stage IV ulcers involve extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures [such as tendon or joint capsule]."

Deep Tissue Pressure Injury is a pressure-related injury to subcutaneous tissues under intact skin, initially presenting with the appearance of a deep bruise.

Unstageable/Unclassified: Full thickness skin or tissue loss-depth unknown
Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

On 4/13/16, the National Pressure Ulcer Advisory Panel (NPUAP) announced the change in terminology from pressure ulcer to pressure injury and updated the stages of pressure injury. The changes in terminology obviated confusion about stage I pressure ulcerations because stage I pressure ulceration actually describes intact but injured skin. The new pressure injury staging system in effect from 4/13/16 onward is as follows:

Pressure Injury:
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Additional pressure injury definitions.

Medical Device Related Pressure Injury:
This describes an etiology. Use the staging system to stage
This describes the etiology of the injury. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

Mucosal Membrane Pressure Injury: Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these injuries cannot be staged.

Agency for Health Care Policy and Research (AHCPR)[3]

The Agency for Health Care Policy and Research (AHCPR) was established in December 1989 under Public Law 101-239 (Omnibus Budget Reconciliation Act of 1989) to

[3] The AHCPR was later renamed the Agency for Healthcare Research and Quality (AHRQ).

enhance the quality, appropriateness, and effectiveness of health care services and access to these services.

AHCPR guidelines recommend assessing bed- and chair-bound individuals for risk factors including immobility, incontinence, impaired nutrition, and altered level of consciousness. They recommend use of a validated risk assessment tool such as the Braden scale. The guideline recommends reassessment at periodic intervals. Skin inspection is recommended once daily. The authors advocate minimizing exposure to moisture due to incontinence. Furthermore, they emphasize that "skin injury due to friction and shear forces should be minimized through proper positioning, transferring and turning techniques...friction injuries may be reduced by the use of lubricants (such as corn starch, and creams), protective films (such as transparent film dressings, and skin sealants), protective dressings (such as hydrocolloids, and protective padding." They stress that **interventions should be monitored and documented**.

The AHCPR recommends repositioning every 2 hours, that a written schedule for systematically turning and repositioning be used, and that positioning devices such a pillows or wedges be used "to keep bony prominences from direct contact with one another, again according to a written plan."

The AHCPR states, "uninterrupted sitting by at-risk individuals in chairs or wheelchairs should be avoided. If consistent with overall patient management goals, the individual should be repositioned, shifting the points under pressure, at least every hour or be put back to bed. Individuals who are able to move should be taught to shift weight every 15 minutes."

The AHCPR document urges that "anyone assessed to be at risk for developing pressure ulcers should be placed on a pressure reducing device when lying in bed - such as foam, static air, alternating air, gel, or water mattresses."

The AHCPR recommends that "educational programs for the prevention of pressure ulcers should be structured, organized, and comprehensive and directed at all levels of health care providers, patients, and family or caregivers." More specifically, this educational program should include information on the etiology and risk factors for pressure ulcers, risk assessment tools, skin assessment, selection and/or use of support surfaces, development and implementation of an individualized program of skin care, demonstration of positioning to decrease risk of tissue breakdown, and instruction on accurate documentation of pertinent data."

The AHCPR Guideline#15 *Treatment of Pressure Ulcers*, December 1994 discusses assessment and management of a patient with pressure ulcers. The authors stress "identification and management of illnesses that might impede healing such as peripheral vascular disease, diabetes mellitus, immune deficiencies, collagen vascular

diseases, malignancies[4], psychosis, and depression." Because of the association between malnutrition and the development of new pressure ulcers a nutritional assessment is mandatory.

AHCPR recommends a "low-air-loss or air-fluidized bed if a patient has large stage III or IV ulcers on multiple turning surfaces." The authors recommend debridement of necrotic tissue, wound cleansing...and using a dressing that keeps the ulcer bed continuously moist but the surrounding intact skin dry." The authors stress that "adequate cleansing and debridement prevent [bacterial] colonization from progressing to clinical infection." AHCPR recommends that pressure ulcers be reassessed at least weekly and that if the wound condition deteriorates the treatment plan be reevaluated **as soon as any evidence of deterioration is noted**." They recommend increased dietary intake or supplementation to place the patient in positive nitrogen balance. Vitamin C and Zinc supplementation are recommended to aid in wound healing. Patients should not be positioned on a pressure ulcer.

American Medical Directors Association

The American Medical Directors Association. Pressure Ulcers in the Long-Term Care Setting Clinical Practice Guideline. Columbia, MD: AMDA 2008 states that "nursing staff should document when turning and positioning occurs [16]." The monograph further states, "For ulcers that are not healing as anticipated, consider the following: addition or modification of a support surface, progressing to a low air loss mattress or an air-fluidized bed as appropriate [25-26]."

AMDA recommends an interdisciplinary wound care team. The wound care nurse's duties should include training new staff, evaluating the effectiveness of the current ulcer treatment regimen and helping to select appropriate support surfaces for patients with ulcers.

AMDA recommends inspection of the patient's skin at least weekly.

AMDA's guideline suggests that wound location, size, depth, maceration, color of ulcer and surrounding tissues, and description of drainage, eschar, necrosis, odor, tunneling, and undermining should be performed.

"The cornerstone of pressure ulcer management is prevention."

Unavoidable ulcers occur in the setting of "cachexia.... multiple organ failure, sarcopenia, severe vascular compromise, and terminal illness [page 11]."

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[4] Since publication of AHCPR guidelines in 1994, significant advances in cancer therapeutics have allowed significantly longer survival times (and survival with good quality of life) in many types of advanced/metastatic cancers and accordingly, the impact of metastatic cancer on pressure sore development, progression, and healing must be assessed on a case-by-case basis.

AMDA guidelines state that "**repositioning schedules should be individualized** according to a patient's needs."

"Nursing staff should keep the attending physician aware of the progress of all ulcers. [22].

Routine charting of turning and repositioning is important in patients with decubitus ulceration because if a patient is being repositioned every two hours and has worsening of skin condition, other interventions --- such as decreasing the turning interval to every hour or obtaining a better pressure off-loading bed surface --- need to be put into place. Without documentation of turning one cannot fully appreciate the reasons for wound treatment failure and, in turn, appropriate and timely therapeutic clinical decisions cannot be made.

Although designed to be treatment guidelines for care and prevention of pressure sores in the long-term care setting, the principles of prevention and treatment for pressure sores discussed in the AMDA monograph apply equally well to the hospital setting.

In my experience a shift nurse's note entry such as "T/P @ 2, 4, 6, 8" would take less than two seconds to document!

Complete and accurate charting by nursing staff is imperative so that attending physician staff can provide the best possible care and recommendation for a resident.

National Pressure Ulcer Advisory Panel (NPUAP) And European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Prevention And Treatment Clinical Practice Guideline, Second Printing, February 2010

This guideline recommends: "record repositioning regimes, specifying frequency and position adopted, and include an evaluation of the outcome of the positioning regime. ... Documentation provides a written record of care delivery and, as such, serves as evidence that repositioning has occurred. It is therefore important to record each repositioning episode and include a record of the individual's skin condition as an indicator of tolerance of that particular positioning plan [36]."

Although not specifying a specific turning and repositioning frequency, the guideline suggests that "frequent assessment of the individual's skin condition will help to identify the early signs of pressure damage and, as such, her/his tolerance of the planned repositioning schedule. If changes in skin condition should occur, the repositioning care plan needs to be reevaluated [34]."

The guideline specifies that nursing staff should "continue to turn and reposition, where possible, all individuals at risk of developing pressure ulcers. Repositioning is still required for pressure relief and comfort when a support surface is in use. The use of a

support surface is, therefore, not a justification for discontinuing the use of repositioning [39]."

"If pressure ulcers are not healing: re-evaluate the individual and his/her pressure ulcers, intensify prevention strategies as indicated, [and] consider changing the support surface to improve pressure redistribution, shear reduction, and microclimate control matched to the individual's needs [65]."

The guideline emphasizes that nursing staff should "limit the time an individual spends seated in a chair without pressure relief [36]."

National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP) and Pan Pacific Pressure Injury Alliance *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide*, Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014

The monograph recommends that caregivers consider the impact of mobility limitations on pressure ulcer risk [15].

For individuals at risk of pressure ulceration, a head-to-toe assessment with particular focus on skin overlying bony prominences is required. "Each time the patient is repositioned is an opportunity to conduct a brief skin assessment [16]." Every individual should be assessed for pressure ulcer risk within eight hours of admission [70].

An individualized pressure ulcer prevention plan should be documented and implemented [70].

The skin under and around medical devices should be inspected at least twice daily [17].

"Repositioning of an individual is undertaken to reduce the duration and magnitude of pressure over vulnerable areas of the body and to contribute to comfort, hygiene, dignity, and functional ability." In circumstances in which "regular positioning is not possible.... Because of their medical condition, and alternative prevention strategy such as providing a high specification mattress or bed may need to be considered [23]."

Repositioning frequency must take into account the pressure redistribution support surface in use, tissue tolerance, general medical condition, overall treatment objectives, skin condition, comfort, and level of activity and mobility. "If changes in skin condition should occur, the repositioning care plan needs to be reevaluated [23]."

When repositioning individuals in bed, the 30° side lying position is appropriate. The 90° side lying position and the semi recumbent position should be avoided. Limit head-of-bed elevation to 30° [24].

"Limit the time an individual spends seated in a chair without pressure relief [25]."

"Do not position an individual directly on a pressure ulcer [25]." Avoid seating an individual within ischial ulcer in a fully erect posture in chair or bed ... The ischia bear intense pressure when an individual is seated [64]." Do not position the individual directly on a medical device unless it can not be avoided [32].

"Continue to turn and reposition the individual regardless of the support surface in use.... No support surface provides complete pressure relief [25]."
"If sitting in a chair is necessary for individuals with pressure ulcers on the sacrum/coccyx or ischia limit sitting to three times a day in periods of 60 minutes or less [26]." Those who are unable to reposition independently must be repositioned [57].

Microshifts ("small shifts") "do not replace selection of a more appropriate pressure redistribution support surface when needed or turning (major shifts in body position) [55]."

An individual's cognitive status must be considered when developing a pressure ulcer prevention and treatment plan [56].

"Record repositioning regimes, specifying frequency and position adopted, and include an evaluation of the outcome of the positioning regimen. Documentation provides a written record of care delivery and, as such, serves as evidence that repositioning has occurred [26]." A repositioning schedule should be initiated as soon as possible after admission [55].

In order to prevent heel pressure ulcers, "ensure that the heels are free of the surface of the bed... Heel suspension devices are preferable for long-term use, or for individuals who are not likely to keep their legs on the pillows... Remove the heel suspension device periodically to assess skin integrity [27]."

For those individuals with existing pressure sores, "consider replacing the mattress with a support surface that provides more effective pressure redistribution, shear reduction, and microclimate control if he or she cannot be positioned off the existing pressure ulcer, has pressure ulcers on two or more turning surfaces... that limit turning options, [or] fails to heal or demonstrates ulcer deterioration [29]."

A pressure redistributing seat cushion is recommended to prevent pressure ulceration.

Pressure sores descriptions are to include location, stage, size, tissue type, color, the condition of the skin around the pressure sore, the wound edges, sinus tracts, undermining, tunneling, exudate, and odor.

Pressure sore infection can be diagnosed if there is redness extending from the edge of the ulcer, induration, new or increase in pain or warmth, purulent drainage, an increase in size, fever, malaise, lymphadenopathy, confusion or delirium, anorexia, crepitus, fluctuance, and/or discoloration of the surrounding skin [42].

"Conduct regular evaluation of organizational performance in pressure ulcer prevention and treatment and provide this information as feedback to these stakeholders [66]." There should be a tailored program of staff education and cues to perform pressure ulcer prevention [67]. A facility should develop an education policy for pressure ulcer prevention and treatment at an organizational level [67].

42 CFR 483.25 (c)

Interpretive F-tag[5] language for the above regulation explicates 42 CFR 483.25 (c) and clarifies the definition of avoidable and unavoidable pressure ulcers. **Avoidable** means "that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate." Conversely, **unavoidable** means "that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate."

The explanatory language for the F-tag under this regulation indicates that AHCPR, NPUAP, and AMDA are "recognized clinical resources regarding the prevention and management of pressure ulcers."

The explanatory language for the F-tag under this regulation identifies the following risk factors that increase a patient's susceptibility to develop or have persistence of pressure ulceration: "impaired or decreased mobility and decreased functional ability; comorbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids that may affect wound healing; impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency; resident refusal of some aspects of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; undernutrition, malnutrition, and hydration deficits; and a healed ulcer. The history of the healed pressure ulcer and its stage [if known] is important, since areas of healed stage III or IV pressure ulcers are more likely to have recurrent breakdown."

[5] OBRA F-tag 314

The explanatory language for the F-tag under this regulation emphasizes that "an overall [pressure ulcer] risk score indicating the resident is not at high risk of developing pressure ulcers does not mean that existing risk factors or causes should be considered less important or addressed less vigorously than those factors or causes in the resident whose overall score indicates he or she is at high risk of developing a pressure ulcer."

The explanatory language for the F-tag under this regulation specifies that "nutritional goals for a resident with nutritional compromise who has a pressure ulcer or is at risk of developing pressure ulcers should include protein intake of approximately 1.2-1.5 gm per kilogram body weight daily (higher end of the range for those with larger, more extensive, or multiple wounds)."

The explanatory language for the F-tag under this regulation specifies that, "the care plan for resident who... is dependent on staff for repositioning should address position changes to maintain the resident's skin integrity. This may include **repositioning at least every two hours or more frequently** depending upon the resident's condition and tolerance of the tissue load (pressure). Depending on the individualized assessment, more frequent repositioning may be warranted for individuals who are at higher risk for pressure ulcer development or who show evidence (e.g., Stage I pressure ulcers) that repositioning at two hour intervals is inadequate."

Furthermore, the explanatory language for the F-tag under this regulation specifies that "many clinicians recommend a **position change "offloading" hourly for dependent residents who are sitting** or who are in bed or a reclining chair with the head of the bed or back of the chair raised 30 degrees or more. Based upon an assessment including evidence of tissue tolerance while sitting... the resident may not tolerate sitting in a chair in the same position for one hour at a time and may require a more frequent position change.... A teachable resident should be taught to shift his/her weight approximately every 15 minutes while sitting in a chair."

"There isn't evidence that momentary pressure relief followed by return to the same position (that is a "microshift" of five or 10 degrees or a 10-15 second lift from a seated position) is beneficial. This approach does not allow sufficient capillary refill and tissue perfusion for a resident at risk of developing pressure ulcers."

The facility will be in violation of OBRA 42 CFR 483.25 (c) if the facility fails periodically to review and revise as necessary a Care Plan to prevent the development of pressure ulcers and to promote the healing of existing pressure ulcers.

Although designed to clarify OBRA guidelines for care and prevention of pressure sores in the long-term care setting, the principles of prevention and treatment for pressure sores discussed under F-tag 314 apply equally well to the hospital setting.

Right to a Safe, Decent Living Environment that Preserves Resident Dignity Right to Care the Recognizes Individuality

New Jersey Nursing Home Act requires that nursing facilities recognize the dignity of residents. The development of pressure sores reflects an unsafe/indecent living environment which degrades resident dignity. Failure of Care One staff to offload Mr. Capano's sacral and gluteal areas to prevent pressure ulceration was a failure to provide a safe and decent living environment and a failure to provide care that recognized Mr. Capano's dignity.

The failure of Care One staff to meet Mr. Capano's individual needs violated his right to care that recognized his individuality.

Never Events

The concept of a "Never Event" was promulgated by Dr. Ken Kizer, the former chief executive officer of the National Quality Forum (NQF) in 2001. A "Never Event" refers to an adverse medical event that is unambiguous (e.g., amputating the wrong limb), serious (i.e., resulting in death or serious disability), and usually preventable. The NQF disseminated its "Never Event" list in 2002.

Development of stage III or IV pressure sores in a health care facility is one such "Never Event."

Using explanatory language for the F-tag under42 CFR 483.25 (c), Mr. Capano's pressure ulceration was avoidable. Errors and omissions by Care One staff were responsible for development and progression of pressure ulceration. In this context, development of Mr. Capano's sacral pressure ulceration was a Never Event --- unambiguous, serious, and preventable.

Mr. Capano's Care: Penile Meatus Injury: Pathophysiology and Negligence

Mr. Capano entered Care One with an intact penile meatus. He was initially self catheterizing to empty his bladder. With the advent of sacral pressure ulceration, self catheterization was abandoned in favor of an indwelling Foley catheter. It was the obligation of Care One to secure the tubing emanating from the bladder catheter to Mr. Capano's leg to avoid the application of downward tension on the urethral meatus by the Foley catheter. Mr. Capano's legs did not move so application of a device to keep the bladder catheter tubing from pulling on that penile meatus should have been a very simple task; one would not have expected movement of the paralyzed legs to alter tension on the tubing. Nursing staff failed to secure the Foley catheter tubing, allowing downward pressure on the urethral meatus and causing gradual, painful erosion of the Foley bladder catheter through approximately 1 inch of the distal penis. If nursing staff had adequately secured the Foley catheter tubing to Mr. Capano's leg, downward pressure on the penile meatus would not have occurred and penile erosion would not

have taken place. Failure to secure the Foley catheter tubing deviated from generally accepted standards of medical/nursing care.

Mr. Capano's Care: Penile Meatus Injury: Causation
Nursing staff failed to secure the Foley catheter tubing, allowing downward pressure on the urethral meatus and causing gradual, painful erosion of the Foley bladder catheter through approximately 1 inch of the distal penis.

Mr. Capano's Care: Penile Meatus Injury: Injuries
Erosion of the terminal 1 inch of the distal penis was painful, permanently disfiguring, and created a hypospadias.

Erosion of the distal penis was a factor in the need for surgical placement of a suprapubic catheter. Suprapubic catheters require monthly changes.

Mr. Capano's Care: Pressure Injury: Pathophysiology and Negligence
Mr. Capano was admitted to Care One with skin that was free of pressure ulceration. Gluteal and sacral pressure ulceration developed at Care One.
When Mr. Capano entered Care One on 11/24/15, he was at risk the development of pressure injury because of immobility, lack of sensation in the sacral and gluteal area, lung cancer, urinary incontinence, and bowel incontinence.

Metastatic malignancy has often been viewed as a factor causing unavoidable pressure ulcerations. However, the biological behavior of Mr. Capano's non-small cell lung cancer did not place him in danger of imminent death and, therefore, Mr. Capano's pressure injury should not be considered unavoidable simply because he had metastatic malignancy. He had a solitary brain metastasis that was fully resected. He received gamma knife radiation therapy and chemotherapy and was faring quite nicely despite these treatments. Section J 1400 of the Minimum Data Sets (MDS) consistently document a life expectancy exceeding six months. Surgical treatment for removal of brain metastasis is not performed in patients who are expected to die in the near future from metastatic lung cancer. Furthermore, cervical spine surgery would not have been contemplated if surgeons and the non-surgical internal medicine physicians and internal medicine subspecialists felt that his life expectancy would be severely curtailed by metastatic lung cancer. After resection of the solitary brain metastasis in November 2015, a follow-up MRI in January 2016 did not show evidence of new metastatic intracranial disease.

Despite the diagnosis of metastatic cancer, section J 1400 of the Minimum Data Sets (MDS) at Care One documented a life expectancy exceeding six months.

Blood urea nitrogen and creatinine at the time of development of pressure injuries consistently failed to show renal insufficiency. For example, 11/20/15 blood urea nitrogen and creatinine were 24 and 0.6 Accordingly, there is no evidence that renal

dysfunction played any causative role in development or progression of pressure injuries.

The right gluteus pressure sore was fully epithelialized/closed by 1/1/16, indicating that blood flow, oxygen delivery, and nutritional status was sufficient in the gluteal area to allow wound healing. This healing is antithetical to the notion of skin failure or skin changes at the end of life.

11/22/15 hemoglobin was normal at 14.6. 11/25/15 hemoglobin was 13.7. 12/11/15 hemoglobin was 11.7. 1/4/16 hemoglobin was 9.5. During the time when gluteal and sacral pressure injuries were forming in mid-to-late December, hemoglobin was not depressed to the point where oxygen-carrying capacity of the blood would have been low enough to be a salient causative factor in development and progression of pressure injuries. Large, late stage sacral pressure injury, however, contributed to the anemia of chronic disease, worsening anemia and weakening Mr. Capano. By 1/25/16, hemoglobin had fallen to 8.8.

Mr. Capano was not hypotensive at Care One during the time when pressure injuries were forming and progressing; blood pressure was adequate to perfuse his sacral and gluteal skin.

Mr. Capano did not have low blood oxygen concentrations while a resident at Care One; low blood oxygenation was not a causative factor in development of progression of pressure injuries.

On admission and throughout his stay at Care One, Mr. Capano required assistance of others for bed mobility, bathing, dressing, transfers, and toileting.

Mr. Capano received Decadron, a steroid, for short bursts around the time of chemotherapy infusions. On most days while a resident at Care One, Mr. Capano received no steroid. Accordingly, although Decadron increased risk for the development and progression of pressure injury, the effect of Decadron on development and progression of pressure injury was minor.

Upon entry to Care One, albumin was slightly low at 2.9. Mild malnutrition was a risk factor for the development and progression of pressure injury. Nutritional supplementation, multivitamins, and vitamin C were administered to Mr. Capano during his residence at Care One. During his tenure at Care One, Mr. Capano did not experience a weight-loss that would be expected in a patient with terminal lung cancer. With development of the large, late stage, draining sacral pressure sore, metabolic demands on Mr. Capano's body increased, contributing to a shift towards catabolism as reflected in part by depressed prealbumin level noted on 1/18/16.

Contemporaneously generated notes and section the E 800 of the Minimum Data Sets (MDS)'s do not indicate that Mr. Capano refused turning and repositioning.

Care One was cited in February 2015 for failure to respond to call bells in a timely fashion. Care One Resident Comment Forms described nursing staff inattentiveness in answering the call bells and in attending to patient needs. These comment forms indicated failures to change soiled diapers. A 12/14/15 Care One Resident Comment Form filed on behalf of of Mr. Capano indicated that he was left in a soiled diaper for prolonged period of time. This was a second instance in which this had occurred. This incident occurred two days prior to discovery of a facility acquired stage II right gluteus pressure sore. Andrew Capano's brother Joseph testified that Mr. Capano was left in soiled diapers on at least a dozen occasions for between 60 and 90 minutes. **Failure of Care One to change Mr. Capano's soiled diaper in a timely fashion** contributed to development of pressure ulceration and deviated from generally accepted standards of medical/nursing care; AHCPR, AMDA, NPUAP, EPUAP, and Pan Pacific Pressure Injury Alliance guidelines; and violated New Jersey state statutes; New Jersey Regulations; and federal OBRA regulations.

Pressure is the sine qua non for the development of pressure injury. It was therefore, incumbent upon Care One staff consistently to turn and reposition Mr. Capano at a minimum interval of every two hours on all shifts while in bed and every hour while in a chair as he was unable to reposition himself. The repositioning schedule prior to development of pressure injury should have been an iterative process: 30° right, supine, 30° left, 30° right, supine, 30° left etc. After development of posterior body surface pressure injuries of the right gluteal area and sacrum, the turning and repositioning schedule should have been changed to 30° right, 30° left, 30° right, 30° left etc. The Minimum Data Set (MDS) section G 12/1/15 described Mr. Capano's need for extensive assistance of one person for bed mobility; he was not able to self reposition. Director of nursing Steele testified that despite the Minimum Data Set (MDS) 12/1/15 denoting that a turning and repositioning program was in place, a turning and repositioning program was not in place until after pressure ulcerations had developed. **Failure of Care One to reposition Mr. Capano at a minimum interval of every two hours and to document repositioning efforts** deviated from generally accepted standards of medical/nursing care; Care One's own care plan,; AHCPR, AMDA, NPUAP, EPUAP, and Pan Pacific Pressure Injury Alliance guidelines; and violated New Jersey state statutes New Jersey Regulations, and federal OBRA regulations. The repetitive nature of negligent pressure off-loading over a period of months speaks to a corporate culture that failed to provide adequate education to nursing personnel about pressure off-loading and failed to provide adequate oversight and support to ensure that appropriate pressure off loading techniques were being applied at Care One.

At the time of discovery of the sacral pressure sore it was full thickness, stage III, measuring 7.8 x 3.8 x 1.7 cm.

Failure to observe pressure ulceration at an early stage

Mr. Capano was totally dependent on the staff for bathing, toileting and hygiene, which required the staff to visually observe his body. Had the staff been providing daily meticulous bathing and frequent incontinence care, a competent caregiver would have noticed the early signs of skin breakdown, notably discoloration of the sacral skin and/or mild irritation or discomfort. Discovery of Mr. Capano's sacral pressure sore when it was late stage, large, and deep indicates that Care One were not paying meticulous attention to Mr. Capano's skin, a deviation from generally accepted standards of medical/nursing care.

Dr. Ructor's 1/28/16 and 2/1/16 notes indicated that sacral pressure injury was due to skin failure. However, at that time, cardiac pulmonary, abdominal, and extremity examinations were unremarkable. Blood pressure was 132/70, pulse 67, respirations 14, temperature 97.2, and pulse oximetry 97%. At the time of Dr. Ructor's notes there is no evidence of multiorgan system failure that would have precipitated skin failure. Similarly, wound care nurse Smollock felt that pressure ulceration of the sacrum 1/26/16 represented terminal skin changes[6]. Nurse Smollock asserts this despite normal kidney function, normal blood pressure, no signs of active congestive heart failure, no signs of lung failure, no signs of liver failure, and no signs of decreased blood oxygenation. There were no signs that Mr. Capano was experiencing multiorgan system failure. Accordingly, her assertion that the sacral pressure sore was a function of terminal illness is untenable. Section J 1400 of the Minimum Data Sets (MDS) at Care One consistently documented a life expectancy exceeding six months. In fact, Mr. Capano lived well over a year beyond the data which Nurse Smollock asserted that he had terminal skin changes.

Nurse Smollock testified that when skin failure occurs, "circulation shift away from the skin to the central organs tends to deplete the sacral region most aggressively." This is incorrect. As blood pressure fails the extremities become cool and mottled preserving central circulation. It is not until fingers toes and distal extremities have impaired circulation that one would see impaired circulation in the more central sacral area.

On 2/16/16 --- after both Dr. Drucker's 1/28/16 and 2/1/16 notes describing skin failure and Nurse Smollock's 1/26/16 notes suggesting terminal skin changes --- Mr. Capano's sacral pressure sore had healthy red granulation tissue comprising 90% of the wound base. The presence of granulation tissue is antithetical to the notion of skin failure/terminal skin changes; simply put, in the process of skin death or skin changes at the end of life, granulation tissue does not develop.

Defendant's Answers to Form C3 Interrogatories

Answers to Form C3 Interrogatories indicated that Mr. Capano refused treatment to his sacral wound and straight catheterization at times which may have contributed to or

[6] Nurse Smollock **testified** that "terminal skin changes" were not definitively diagnosed.

caused the alleged injuries. This contention regarding failure to allow sacral wound care is not borne out by the contemporaneously generated medical record or by testimony of Care One employees. There is no chart evidence to support refusal of straight catheterization leading to or contributing to pressure injuries.

Mr. Capano's Care: Pressure Injury: Causation
Failure to turn and reposition Mr. Capano on an every two-hour or more frequent basis caused unremitting pressure to the skin overlying the sacral/gluteal area. This unrelenting pressure compounded by failure of Care One to maintain Mr. Capano in a non-soiled diaper caused development and progression of gluteal and sacral pressure injuries.

Mr. Capano's Care: Pressure Injury: Injuries
Failure to turn and reposition Mr. Capano on an every two-hour or more frequent basis caused unremitting pressure on the skin overlying the sacral/gluteal area. This unrelenting pressure compounded by failure of Care One to maintain Mr. Capano in a non-soiled diaper caused development and progression of gluteal and sacral pressure injuries.

The sacral/coccyx pressure sore required debridement on 1/29/16 by Dr. Cody.

Nurse Smollock debrided the pressure injury on 2/9/16 using surgical scissors.

On 2/12/16, Dr. Cody debrided the sacral pressure sore to bone.

The sacral pressure sore was malodorous. Mr. Capano was awake, alert, fully oriented, and sentient and would certainly have been able to appreciate and be offended by the odor emanating from his body.

Mr. Capano's Care: Costs Associated with Pressure Injury and Penis Injury
Costs for debridements 1/29/16, 2/9/16, and 2/16/16 were predicated solely upon development of pressure injuries at Care One.

The cost for all Wound Healing Solutions consultations except for the first visit in which only the scalp wound was addressed were predicated solely upon development and progression of pressure injuries at Care One.

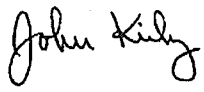
The cost for wound care supplies at Care One and while at home were predicated solely upon development and progression of pressure injuries at Care One.

The cost for Bayada visiting nurses was predicated solely upon development and progression of pressure ulceration at Care One.

My opinions are stated within a reasonable degree of medical certainty/probability.

I reserve the right to amend my opinions as further information becomes available.

Yours truly,



John Kirby, M.D.

Exhibit F

LAW OFFICE OF
ANDREW A. BALLERINI
Cherry Tree Corporate Center
535 Route 38, Suite 328
Cherry Hill, New Jersey 08002

ANDREW A. BALLERINI, ESQUIRE
CERTIFIED CIVIL TRIAL ATTORNEY
MILLION DOLLAR ADVOCATES FORUM MEMBER
MEMBER N.J. AND PA BAR

Tel. 856-665-7140
Fax 856-665-8885
www.ballerinilaw.com

RICHARD J. TALBOT, ESQUIRE
CERTIFIED CIVIL TRIAL ATTORNEY
MILLION DOLLAR ADVOCATES FORUM MEMBER
MEMBER N.J. AND PA BAR

January 23, 2019

SENT VIA FAX 973-912-9212 AND REGULAR MAIL

Robert E. Blanton, Jr., Esquire
HARDIN KUNDLA MCKEON & POLETTO
673 Morris Avenue
Springfield, NJ 07081

RE: Capano vs. CareOne at Evesham, et als
Your File #: 1481-44924
Docket #: CAM-L-00507-17

Dear Mr. Blanton:

Enclosed please find the January 12, 2019, report and Curriculum Vitae of Bonnie Tadrick, RN-BC, CWCA, Plaintiff's expert in nursing care, nursing, gerontological nursing and wound care, which has been Bates Stamped CAPANO - 004128-004149. Same shall be considered an amendment to the Plaintiff's interrogatory answers. No submissions by the Plaintiff shall be considered adoptive admissions.

Nurse Tadrick is expected to testify as to the deviations to the standards of care committed by the Defendants, nursing home standards, nursing standards, nursing in general, gerontological nursing, causation, diagnosis, wound care, wound prevention, pressure ulcers, pressure ulcer development and prevention, pressure ulcer treatment, staging of pressure ulcers, violations of Federal and State Nursing Home Law, violations of nursing home residents' rights, causation, diagnosis, damages suffered associated with the pressure ulcer and the like. The Plaintiff's experts will not be limited to the "four corners" of their reports and you are free to take the depositions of the Plaintiff's experts during the discovery period, upon appropriate notice to and scheduling with Plaintiff's counsel.

Thank you for your courtesy and cooperation.

Sincerely,

RICHARD J. TALBOT, ESQUIRE

RJT/lag
Enclosures

TCG Tadrick Consulting Group, LLC

24 Drew Mountain Road, Sussex, New Jersey 07461
Phone 973-222-5011 Fax 973-702-1169
E-Mail: btadrick@yahoo.com
Bonnie Tadrick, RN-BC, CWCA

January 12, 2019

Mr. Richard J. Talbot, Esq.
The Law Offices of Andrew Ballerini
Cherry Tree Corporate Center
535 Route 38, Suite 328
Cherry Hill, New Jersey 08002

Re: The Estate of Andrew Capano v. Care One at Evesham et al

Dear Mr. Talbot,
To date and prior to authoring this report I have reviewd:

1. CareOne clinical records admission 11/24/15 – 2/16/16
2. Cooper University Hospital medical records 11/12/15-11/22/15 and 11/23/15 – 11/24/15, 12/02/15, 12/05/15
3. Cooper University Hospital Neurosurgery Department records
4. Delaware Valley Urology records
5. Virtua Surgical Group (Dr. William Cody) records
6. Wound Healing Solutions clinical records
7. Bayada Home Health clinical records
8. LMA Cherry Hill Family Care and Internal Medicine records
9. LMA Surgical Associates
10. Cooper University Hospital Neurosurgery Department records
11. Dr. Cody office records
12. St. Mary's Rehabilitation Center clinical records
13. Death Certificate
14. Color copies of three photographs of Mr. Capano's sacral wound and four photographs of Mr. Capano's penile wound taken by Joseph Capano in approximately the Spring of 2016
15. CareOne at Evesham Cost Reports
16. Copies of photographs taken 12/05/16 by Joseph Capano: two photographs of Mr. Capano's sacral pressure ulcer; two photographs of Mr. Capano's suprapubic catheter; and two photographs of Mr. Capano's penile wound
17. Billing records from LMA Associates
18. Billing records from Delaware Valley Urology
19. Billing Records from CareOne at Evesham
20. Billing Records from Wound Healing Solutions
21. CareOne at Evesham Licensure Information
22. CareOne at Evesham Annual and Complaint Surveys
23. Plaintiff's Answers to Form A Interrogatories, Supplemental Interrogatories,
24. Defendant's Response to Plaintiff's Notice to Produce
25. Defendant's Answers to Form C, Form C(3), and Supplemental Interrogatories
26. Defendant's Amendment to Answers to Interrogatories and Responses to Plaintiff's Notice to Produce (bate stamped 003741-003827 – CareOne at Evesham Policies and Procedures
27. Defendant's Amendment to Interrogatories

28. Medicaid lien records
29. Various CareOne at Evesham Policies and Procedures
30. CareOne at Evesham Resident Comment Forms
31. CareOne at Evesham Employee Education Attendance Records
32. Deposition Transcript of Joseph Capano
33. Deposition Transcript of Joseph Mina, Administrator
34. Deposition Transcript of Denise Finch, RN
35. Deposition Transcript of Chereece Steele, RN DON
36. Deposition Transcript of Michelle McGlone, RN
37. Deposition Transcript of Wendy Smollock, NP
38. Deposition Transcript of Cathy Brown, RN
39. Deposition Transcript of Kiyetta Shields, LPN
40. Deposition Transcript of Daniel Greaves, CNA
41. Deposition Transcript of Da'Briah N. Pace, CNA
42. Deposition Transcript of Monica Wallace, RN
43. Deposition Transcript of Tina Nelson, RN
44. Deposition transcript of Toya Casper Cornelius

Pursuant to your request, I reviewed the records and documents provided relative to this matter. I am a registered nurse holding an active license. I possess a Diploma in Nursing from Clara Maass School of Nursing in Belleville, New Jersey. I also am Board Certified in Gerontological Nursing by the American Nurses Credentialing Center and Certified in Wound Care by the American Board of Wound Management. I am familiar with the laws, regulations, and standards of care for the reasonable and prudent care of adult persons in healthcare facilities including subacute rehabilitation, long term care, acute care, assisted living, and home health care. A copy of my CV is attached for reference.

Throughout my nursing career, I have cared for and been responsible for persons with diagnoses and conditions the same as, or similar to Andrew Capano ("Mr. Capano"). Based on the provided records and documents, my education, training, and experience, and rendering all to within a reasonable degree of nursing probability, I hereby tender my present held opinions regarding the care provided to Mr. Capano while he was a resident at Care One at Evesham ("Care One").

Care One at Evesham admission 11/24/15 – 2/16/16
Mr. Capano was admitted to Care One for subacute rehab, skilled nursing care, and further medical management status post hospitalization at Cooper University Medical Center, where he underwent a left retromastoid craniotomy for resection of lung cancer metastasis to the cerebellum. Mr. Capano's admitting diagnoses included lung adenocarcinoma with brain metastasis, ASHD, PVD, GERD, Anxiety Disorder, and muscle weakness. His past medical history included myocardial infarction and paresthesia of his lower extremities.

Medications prescribed to Mr. Capano upon admission and during his residency include Simvastatin, Zetia, vitamin supplements, Zolpidem, Alprazolam, Fioricet, Protonix, Xanax, Folic Acid, Lovenox, and Dexamethasone 8 mg daily from 12/23/15 to 12/25/15 and tapering Dexamethasone 2mg bid x 5 days and daily x 5 days and stop.

Mr. Capano had intact sutures and staples on the left side of his head and a nine cm surgical suture site on the back of his head. Relative to cognitive function, Mr. Capano was alert and oriented to person, place, and time and could make his needs known. Relative to physical functioning, Mr. Capano required moderate to extensive assistance for ADLs and was able to feed himself. The MDS indicated Mr. Capano required extensive assistance of two for bed mobility. He was incontinent of urine, requiring self catheterization secondary to BPH and was incontinent of stool. A Foley catheter was placed several days after admission.

Mr. Capano resided with, and was primarily cared for by his brother Joseph, as well as other family members in a private residence. The discharge plan was for Mr. Capano to complete his skilled services to regain his prior functional abilities and then go home in the care of his brother.

Nursing admission assessment indicated Mr. Capano had no skin breakdown. The Admission Braden Scale scored Mr. Capano as a low risk for pressure ulcer development. Weekly Braden Scale Assessments x 4 weeks were ordered by the attending physician. In my review of the records provided by Plaintiff and Bate Stamped records provided by Defense, only the admission Braden Scale was located and scored Mr. Capano at #18, low risk for skin breakdown. The nurse performing the admission Braden Scale Assessment indicated that Mr. Capano had no sensory impairment and that friction and shear were not a problem. The fact that Mr. Capano had parenthesis of his lower extremities and required extensive assistance with bed mobility and transfers was apparently not factored into this initial assessment by the nurse. The subsequent Braden Scale Assessments, if done, should reflect those factors in the scoring of his skin breakdown risk. Under the category, "Sensory Perception" Mr. Capano had sensory impairment which limited his ability to feel pain or discomfort in one or two extremities, which would score at #3, slightly limited. Mr. Capano required moderate to maximum assistance with bed mobility and transfers and would be at risk for friction and shearing, scoring at least a #2, Potential Problem, under the Friction and Shear category. That would bring his score to #16.

The Registered Dietician performed an evaluation and noted Mr. Capano's nutritional status was stable and he would consume 75% to 100% of his meals. Labs indicated mild depletion of protein stores with an albumin level of 2.8 (normal 3.2-5.0) on 12/11/15, trending up to 3.0 on 1/04/16.

Most of the care plans are dated as initiated on 4/08/16, several weeks after Mr. Capano was discharged from the facility. The care plan specifically for "***Actual skin breakdown to sacrum related to impaired mobility and disease process***" indicated it was initiated on 4/08/16 and created by Chereece Steele, RN, who was the Interim Director of Nursing. It is indicated that the care plan was revised on 4/08/16 by Elaine Summers, Clinical Services Coordinator. The care plan has a "Target Date" of 3/02/16, the date by which the proposed "Goals" will be met and the care plan will be reviewed. It appears that Elaine Summers revised the care plan on 4/08/16 and then cancelled out the care plans. The care plans are supposed to be cancelled out when the resident is discharged. The standard of care requires the nursing staff to develop, implement and evaluate the care plan while the resident is in the facility. After a resident is discharged and all necessary discharge documentation is completed, any prior nursing documentation including care plans are not to be changed or edited for any reason.

Chereece Steele, RN the Interim Director of Nursing testified that she was no longer at CareOne at Evesham on 4/08/16. She testified that the date an intervention is initiated on the care plan, it will automatically show up. Nurse Steele testified that the EMR records show electronic entries made on 4/08/16 with regard to Mr. Capano's sacral skin breakdown. She testified that she had no knowledge as to who made those entries on 4/08/16, after Mr. Capano was discharged on February 16, 2016. [Deposition pages 58-61]

In the records produced by Defense Counsel as part of Discovery, Care Plans identified as Bate Stamp CAREONE003708 – CAREONE003711, there are light printed sections of this set of care plans. Under the care plan "Focus" section, Nurse Steele documented that this care plan was initiated on 12/17/15 and revised by Nurse McGlone on 1/28/16. This documentation is in lighter print underneath the bold printed "Cancelled" care plan with the reference initiation dates of 4/08/15. Nurse Steele placed the following documentation:

- Actual skin breakdown to sacrum related to impaired mobility and disease process. *(Revised by Nurse Mcglone on 1/28/16)*
- Actual skin breakdown related to (right inner buttocks Stage 2 and sacrum) impaired mobility, pressure ulcer. *(Revised by Nurse Mcglone on 1/11/16)*

Because Mr. Capano was at risk for skin breakdown secondary to the Braden Scale Assessment, his deconditioned state, having lower extremity paresthesia, being non ambulatory and having incontinency, the standard of care required the nursing staff to develop an individualized preventative plan of care upon admission to mitigate his risk for pressure ulcer development.

The National Pressure Ulcer Advisory Panel (NPUAP) recommends that along with structured risk assessments:

- **Develop and implement a risk based prevention plan for individuals identified as being at risk of developing pressure ulcers. Caution – Do not rely on the total risk assessment tool score alone as a basis for risk based prevention. Risk assessment tool subscale scores and other risk factors should also be examined to guide risk-based planning.**

The CareOne nursing staff did not develop upon admission, a care plan that identified his risk for skin breakdown and the interventions necessary for Mr. Capano to attain or maintain his highest practicable level of physical, mental, and psychosocial well being. The CareOne nursing staff failed to recognize and assess factors that placed Mr. Capano at risk for skin breakdown; failed to define and implement interventions in accordance with his needs, goals and recognized standards of care; failed to monitor and evaluate his response to preventative efforts and treatment; and failed to revise the approaches as appropriate. These requirements could not be met because the CareOne nursing staff did not appropriately plan Mr. Capano's care needs in regards to maintaining his skin integrity, mitigating risk factors, and preventing avoidable skin breakdown.

The failure of the CareOne nursing staff to develop a plan of care upon admission addressing Mr. Capano's risk for skin breakdown and individualizing it to meet his needs for mitigating his risks factors left him at risk for skin breakdown. The failure to do so was a departure from the accepted standards of care and practice and in violation of the following:

- **42 CFR §483.20 Resident Assessment:** Services must meet professional standards of quality and be provided by qualified persons in accordance with each resident's plan of care.
- **42 CFR §483.20 Resident Assessment: Comprehensive Care Plans.** The facility must develop a comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.
- **N.J.A.C. 8:39-11.2 Mandatory Policies and Procedures for Resident Assessment and Care Plans.** An initial assessment and care plan shall be developed on the day of admission and shall address all immediate needs, including, but not limited to, personal hygiene, dietary needs, medications, and ambulation.
- **42 CFR §483.25 (c) Quality of Care: Pressure Sores.** Based upon the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.
- **N.J.A.C. 8:39-27.1 Mandatory Quality of Care: Mandatory Policies, Procedures and Practices for Quality of Care.** (a) The facility shall provide and ensure that each resident receives all care and services needed to enable the resident to attain and maintain the highest practicable level of physical, emotional and social well-being, in accordance with individual assessment and care plans. (e) The facility shall take preventative measures against the development of pressure sores, including assessing the resident's skin

daily and minimizing friction and pressure against clothing and bed linens. When present, pressure sores shall be identified, documented, and treated.

- **Facility Policy: Skin Integrity Program: Identification and Prevention.** Residents with risk factors for pressure ulcer development will be identified, and a risk based interdisciplinary plan of care will be implemented. **Purpose**- To prevent pressure ulcer formation by identifying residents at risk for developing pressure ulcers, implementing appropriate interventions, and evaluating their effectiveness. **General Information** – Risk identification and skin observations must be completed promptly after admission and interventions initiated since at risk residents can develop pressure ulcers within 2-6 hours of the onset of pressure. **Process** – The nurse must also identify any resident specific risk factors that may not be reflected on the risk evaluation tool but may impact the resident's skin condition. A comprehensive, interdisciplinary plan of care will be developed and implemented to the unique identified risk/need(s) to prevent or treat impaired skin integrity or existing ulcers. The effectiveness of the interventions will be evaluated and the plan of care will be reviewed and revised as needed.

Mr. Capano appeared to acclimate to his new environment and participated in physical and occupational therapies, making progress and attaining some of the goals set by him and the therapists.

Mr. Capano had chronic generalized pain and his pain management regimen included Oxycodone 5 mg, one or two tablets prn for pain that provided him with relief.

On 11/30/15 while being assisted out of bed to the wheelchair, Mr. Capano lost his balance and was lowered to the floor by the staff. He did not suffer injury from the fall. His transfer status was changed to Hoyer lift with two staff assist.

On 12/02/15 Mr. Capano went to Cooper University Medical Center for a follow-up evaluation with Neurosurgery and Oncology. His wounds were healing well and there was normal pulsation felt at the level of the left burr hole. The head CT scan showed improvement in cerebellar edema. Mr. Capano was cleared to move forward with Gamma Knife radiosurgery to the tumor bed on 12/03/15.

Mr. Capano underwent the Gamma Knife radiosurgery procedure as an outpatient on 12/03/15 and upon his return to the facility he had a bandaid on his forehead and on the back of his head.

On 12/14/15 Joseph Capano reported that his brother Andrew needed to be changed and was left for long period of time without being changed and that this was the second time this happened. Denise Reed completed this Complaint/Concern Form and forwarded it to the nursing department. (Exhibit Steele -4) The resolution conveyed to Mr. Capanos's brother Joseph that Mr. Capano would be placed on every two hour checks/toileting schedule with documented outcomes each time he was toileted.

Joseph Capano testified that his brother had multiple complaints regarding his care and treatment at CareOne. Joseph Capano testified receiving at least a dozen or so phone calls from his brother informing him that the staff at CareOne had left him in soiled diapers for anywhere between an hour to two hours time after he had pushed the button for them to come and change him. These phone calls were made mostly at night and on weekends. Joseph Capano testified that he in turn would call CareOne and speak with the head nurse, informing the nurse what had taken place and that he wanted someone to get in there and change Mr. Capano. Joseph Capano testified that there were occasions when he would receive a second call from his brother telling him that the staff had not attended to him. Joseph Capano testified that he would go to CareOne personally to address the problem and that this had occurred approximately half a dozen times. Joseph Capano testified that he was told by the male head nurse and a female nurse that they would address the problem; however, it was not adequately addressed as Joseph Capano testified that he had to keep going back to CareOne at times for this issue. [Pages 48, 49, 50, 51, 52, 53, and 54].

The failure of the CareOne nursing staff to provide prompt incontinent care to Mr. Capano was a departure from the accepted standards of care and practice and infringed upon his right to dignity. It is outrageous that Mr. Capano became so desperate to reach out for someone to meet his needs for incontinence care that he called his brother multiple times for help. Mr. Capano had the right to have his call bell answered in a timely manner and his needs addressed promptly and in a respectful manner. Mr. Capano should never have been made to feel that he was a burden on the staff and that his needs were not important. The staff failed to adequately accommodate his needs multiple times. The fact that these events tended to occur during the night and on weekends indicated inadequate staff to meet the resident's needs and/or a total disregard for Mr. Capano's well being and dignity. A resident should never have to wait more than 15 minutes to have their needs for incontinence care taken care of properly. Making Mr. Capano wait an hour or more to have incontinence care after a bowel movement was disrespectful, negligent, unkind, and fell outside accepted standards of care and practice. The failure of the CareOne nursing staff to provide prompt incontinence care left him at risk for skin breakdown, which did occur just two days later on 12/16/15. It is more likely than not that failing to provide prompt and scrupulous incontinence care contributed to the development of a right gluteus pressure ulcer.

The failure of the CareOne nursing staff to respond in a timely manner to Mr. Capano's requests for assistance and provide prompt incontinence care to Mr. Capano infringed upon his right to dignity, constituted neglect, and was a departure from the accepted standards of care and practice and in violation of:

- **42 CFR §483.13 (c) Resident Behavior and Facility Practices: Staff Treatment of Residents.** Each resident has the right to be free from mistreatment, neglect, and misappropriation of property.
- **N.J.A.C. 8:39-4.1 Mandatory Resident Rights.** (5) Each resident shall be entitled to the following rights; to be free from physical and mental abuse and/or neglect.
- **42CFR §483.15 Quality of Life: Dignity.** A facility must care for its residents in a manner or in an environment that promotes maintenance or enhancement of each resident's life. The facility must promote care for the residents in manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
- **N.J.A.C. 8:39-4.1 Resident Rights.** Each resident shall be entitled to the following rights: To be treated with courtesy, consideration, and respect for the resident's dignity and individuality.
- **42CFR§483.15(e) Quality of Life: Accommodation of Needs.** A facility must care for its residents in a manner or in an environment that promotes maintenance or enhancement of each resident's life. A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.
- **Facility Policy: Answering the Call Light.** The purpose of this procedure is to respond to the resident's requests and needs. (8) Answer the resident's call as soon as possible.
- **Facility Policy: Quality of Life-Dignity.** Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents shall be treated with dignity and respect at all times. Staff shall promote dignity and assist residents as needed by promptly responding to the resident's request for toileting assistance.

The National Pressure Ulcer Advisory Panel in its 2014 publication: Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline states that maintaining skin integrity is essential in the prevention of pressure ulcers. NPUAP recommends:

- **Keep the skin clean and dry.**
- **Develop and implement an individualized continence management plan: Cleanse the skin promptly following episodes of incontinence.**

Mr. Capano developed skin breakdown on 12/16/15 as evidenced by a 12/17/15 nursing entry by Nurse McGlone that indicated the IDCP team met to review the incident in which a CNA noted a small open area on Mr. Capano's left inner buttock measuring 2 x 1 cm. This facility acquired right gluteus pressure ulcer (apparently erroneously referred to as the left inner buttock in the 12/17/15 nursing progress note) was described on the 12/16/15 Pressure Ulcer Record as a Stage II wound measuring 2 x 1 cm with no depth. The wound bed was comprised of pink pale tissue with a reddened periwound. The wound was not painful to Mr. Capano. The attending physician was notified and gave orders for cleansing the wound with normal saline solution and applying Safegel to the wound twice daily. The Pressure Ulcer Record indicated that this wound decreased in size and was responding favorably to treatment. The last wound assessment was performed by Nurse Brown on 1/06/15 in which she indicated the wound was now a Stage I pressure ulcer measuring 0.4 x 0.3 cm. There was no further weekly wound assessments performed by the nursing staff. The wound was described as healed by Nancy L. Amorosi, NP, CWS, WCC, on 1/11/16.

Pressure ulcers are never to be back staged as Nurse Brown did. In the event of healing, which was apparent for this right gluteal wound, this pressure ulcer should be referred to as a healed Stage II wound. A healed Stage II pressure injury typically presents with pink/light red toned intact blanchable skin.

Pressure ulcers are classified and identified by a staging system developed by the National Pressure Ulcer Advisory Panel ("NPUAP") that addresses the extent of tissue damage in Stages I through IV and Deep Tissue Injury and Unstageable Pressure Ulcers. The NPUAP redefined the definition of pressure ulcers to pressure injuries and updated the staging system during the NPUAP Staging Consensus Conference held in April of 2016.

Pressure Ulcer Stages/Categories (National Pressure Ulcer Advisory Panel)

Suspected Deep Tissue Injury:
Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Further description:
Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Stage I:
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Further description:
The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk)

Stage II:
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Further description:
Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
***Bruising indicates suspected deep tissue injury**

Stage III:
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Further description:
The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Stage IV:
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Further description:
The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Unstageable:
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Further description:
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

There is a telephone voice order dated 12/16/15 from the attending physician for the wound team to evaluate Mr. Capano and to cleanse the wound with NSS and apply Safe Gel and a dressing BID. The TARS indicated cleansing the sacral wound with NSS and applying Bacitracin BID which was signed off as done on 12/18/15 and 12/19/15. The order date is noted as 12/17. Right below this treatment on the same page it is written *"Cleanse wound with NSS, apply Safe Gel, cover with Dressing."* The order date is not documented and should be as per the standard of care. This treatment was signed off as done on 12/20/15 to 12/29/15. On 12/29/15 the wound treatment to the right gluteus wound was changed to Bactroban and cover with dressing BID. The treatment was discontinued on 1/30/16.

In review of the Physician Orders I cannot locate a physician order for the wound treatment with Bacitracin rendered on 12/18/15 and 12/19/15. The standard of care requires the nursing staff to obtain physician orders for wound treatment, as it is outside the scope of nursing practice to prescribe the administration of topical treatments. The failure of the nursing staff to obtain the required physician order for Bacitracin to the right gluteal wound was a departure from the accepted standards of care and practice and in violation of:

- **N. J. S.A. Title 45. Chapter 11 New Jersey Board of Nursing Statutes: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health**

counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human responses means those signs, symptoms, and processes which denote the individual's health need or reaction to an actual or potential problem.

The Practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.

- **42 CFR §483.20 Resident Assessment:** Services must meet professional standards of quality and be provided by qualified persons in accordance with each resident's plan of care.

- **Facility Policy: Pressure Ulcers/Skin Breakdown – Clinical Protocol. Treatment/Management.**
  1. The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated for type of skin alteration. [CareOne 000865]

- **Care Plan: Actual skin breakdown to sacrum related to impaired mobility and disease process.**
  - Administer treatment per physician orders

In addition, this right gluteal pressure ulcer was found by a CNA on 12/16/15, yet wound treatment did not commence until 12/18/15 with using Bacitracin and a dressing, and the ordered Safe Gel treatment did not commence until 12/20/15. This caused a delay in required wound treatment, a departure from the accepted standards of care.

In the second set of care plans provided by Defense , the care plan initiated by Nurse Steele on 4/08/16"***Actual skin breakdown to the sacrum related to impaired mobility and disease process"*** does not accurately reflect the location of the wound indicated as the right gluteal area in the Pressure Ulcer Records. This entry, ***"Actual skin breakdown to the sacrum related to impaired mobility and disease process"*** is repeated in light print and noted as initiated on 12/17/15 by Nurse Steele. There is another entry under the Focus section of the care plan dated 12/17/15 (in light print) placed by Nurse Steele that reads, ***"Actual skin breakdown related to (right inner buttocks stage 2 and sacrum), impaired mobility, pressure ulcer."*** Then there is a third 12/17/15 Entry on the care plan by Nurse Steele that reads, ***"Actual skin breakdown related to (L inner buttocks stage 2) impaired mobility, pressure ulcer."*** There is one more entry (in light print) on the care plan by Nurse Steele dated 12/17/15 that reads ***"Actual skin breakdown to scrum (misspelling of sacrum) related to impaired mobility and disease process."*** It is not clear as to why Nurse Steele placed these four entries on the care plan and dated all of them 12/17/15. This care plan for "Actual Skin Breakdown" called for the following interventions:

- Suspend/float heels as able – 4/08/16 or 12/17/15
- Toileting program as indicated -4/08/16 or 12/17/15
- Turn and position q 2 hours as needed 4/08/16 or 12/17/15
  (Not described what as needed means) Should be a consistent schedule to fit the needs of the resident
- Wound Team Consult - 4/08/16 or 1/28/16
- Administer treatment per physician orders -4/08/16 or 12/17/15
- Encourage and assist as needed to turn and reposition; use assistive devices as needed - 4/08/16 or 12/17/15

- Follow-up care with physician as ordered - 4/08/16 or 12/17/15
- Obtain labs and report results to physician – 4/08/16 or 1/28/16
- Pressure reducing cushion to wheelchair - 4/08/16 or 1/28/16
- Provide diet and supplements per physician orders -4/08/16 or 1/28/16
- Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Notify physician prn - 4/08/16 or 1/28/16
- Specialty mattress on bed - 4/08/16 or 1/28/16
- Straight cath QID and PRN for distended bladder -4/08/16 or 1/28/16
- Suspend/float heels as able -4/08/16 or 1/28/16
- Toileting program as indicated - 4/08/16 or 1/28/16

The care plan was deficient in interventions to alleviate the deleterious effects of prolonged pressure to vulnerable areas including the sacral region while seated. Mr. Capano would spend time seated in wheelchair or Gerichair during the daytime hours as the milieu of the typical subacute rehab environment encourages a home like and therapeutic atmosphere in which the residents participate in prescribed therapies, attend activities and have meals in dining rooms. Based on Mr. Capano's condition and known diagnoses upon admission and the 11/24/15 Braden Scale, interventions necessary to meet those needs included ensuring proper positioning in the chair secondary to decreased mobility, at least hourly shifts in position while seated to alleviate pressure, and limiting seating times in accordance with tissue tolerance load.

Mr. Capano required extensive assistance with bed mobility and moderate to extensive assistance with transfers, was essentially chairfast, had very limited ability to change or adjust his body position, and was at risk for shear and friction. Mr. Capano would not be able to adequately shift his position while seated due to generalized muscle weakness and chronic pain. Mr. Capano had lower extremity paresthesia, likely secondary to spinal stenosis which meant he would not appreciate pressure related discomfort from sitting as would an otherwise neurologically intact person would. These intrinsic and extrinsic factors placed Mr. Capano at great risk for skin and soft tissue breakdown of which the nursing knew or should have known and therefore was required to adequately and properly care plan for to mitigate those factors upon admission and at the onset of skin breakdown.

The care plan indicated that a pressure reducing cushion for Mr. Capano's wheelchair was provided on or about 1/28/16 or 4/08/16. Michelle McGlone, RN, Unit Manager testified that all residents admitted to the facility are provided with a gel cushion for the wheelchair. [Page 66] The standard of care required the nursing staff to properly evaluate Mr. Capano's actual and potential needs upon admission and they failed to do so as evidenced by the lack of a care plan addressing all required and necessary interventions to mitigate his risk for skin breakdown.

The CareOne nursing staff apparently kept Mr. Capano seated in a wheelchair for extensive periods of time as evidenced by the 1/29/16 letter from William C. Cody, MD in which Mr. Capano told him that he has been sitting a lot on his bottom and was recently noted to be developing a pressure sacral decubitus ulcer.

The failure of the nursing staff to adequately address seated pressure relief/redistribution was a departure from the accepted standards of care and practice and in violation of the following:

- **42 CFR §483.20 Resident Assessment: Comprehensive Care Plans.** The facility must develop a comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

- **N.J.A.C. 8:39-11.2 Mandatory Policies and Procedures for Resident Assessment and Care Plans.** An initial assessment and care plan shall be developed on the day of admission and shall address all immediate needs, including, but not limited to, personal hygiene, dietary needs, medications, and ambulation.

- **Facility Policy: Repositioning.** Repositioning is critical for a resident who is immobile or dependent upon the staff for repositioning. Assist the resident to change position in the chair. Residents who are in a chair should be on an every hour repositioning schedule. Evaluate the need for scheduled position changes or if the resident needs position changes more than hourly.

The care plan called for "turning and positioning every two hours as needed". The standard of care requires the nursing staff to develop and implement a turning and repositioning schedule designed to meet Mr. Capano's individualized needs. There are no descriptive terms to indicate what "as needed means" and were left open to interpretation, which can adversely affect continuity of care. Mr. Capano would have benefited from a consistent and effective turning and repositioning schedule developed by the nursing staff with his input, as he was certainly capable of participating in his own care.

An important component of the plan of care for a resident at high risk for pressure ulcer development and being treated for existing pressure ulcers is adequate and timely individualized turning and repositioning. It is not enough to assume that the nursing staff is performing consistent and timely turning and repositioning and providing positional changes while up in the chair. The standard of care calls for the nurse to not only develop and plan appropriate interventions; but to also implement those interventions and clearly document them in the record. This requirement for documentation is reflected in the CareOne Facility Policy for Repositioning. As pressure relief was paramount to the well being of Mr. Capano, it is expected that the implementation and evaluation of a turning and repositioning schedule be evident. Review of the records clearly demonstrate that Mr. Capano was not turned and repositioned at least every two hours while in bed and provided with short intervals of time sitting in a wheelchair gerichair with appropriate off-loading of pressure.

The American Nurses Association Scope and Standards of Practice 3rd Edition delineates the professional scope and standards of practice and responsibilities of all professional registered nurses in every setting. The Standards of Professional Nursing Practice are authoritative Statements of the duties that all registered nurses, regardless of role, population, or specialty are expected to perform competently.

- **Standard 5. Implementation:** The registered nurse implements the identified plan. **Competencies:** The registered nurse documents the implementation and any modifications, including changes or omissions, of the identified care plan.

Nurse Steele testified that if a resident was being provided with turning and repositioning by the nursing staff that information would be documented on the TARs. Nurse Steele testified that Mr. Capano was not on a turning and repositioning schedule prior to his development of the sacral pressure ulcer. In referencing the "***Unavoidable Pressure Ulcer Physician Documentation***", the form indicated Mr. Capano was turned and repositioned consistently. In review of the TARs, there is no documentation indicating the CareOne nursing staff ensured Mr. Capano was turned and repositioned for pressure offloading in a regular manner.

It is the standard of care for the nurse to document nursing interventions, so as to validate and provide evidence that the care required was provided. In the long term care setting, the CNAs provide much of the hands on care and are responsible for turning and repositioning the residents they are providing care to. It is the licensed professional nurse's responsibility to delegate those nursing tasks to those staff members who are qualified to provide such care and to supervise those ancillary staff members to ensure those tasks are completely carried out. The licensed professional nurse should be proactive in providing turning and repositioning of their residents, as it affords them the opportunity to assess skin integrity, dressing placement, perform pain assessment and resident

response to the turning and repositioning schedule. It is obvious that the nursing staff failed to uphold the standard of care and did not provide Mr. Capano with frequent and consistent turning and repositioning as evidenced by the development of a Stage II right gluteal and a large Stage IV sacral pressure ulcer that extended down to bone as per the 2/12/16 consult of Dr. Cody.

Prolonged pressure causes tissue ischemia by cutting off the blood supply to the skin and underlying soft tissues, depriving those tissues of oxygen and nutrients. Over time with repeated episodes of prolonged damaging pressure causing deformation (tissue strain) further tissue damage will occur. This damaged tissue can be further insulted via tissue reperfusion injury following pressure relief, creating a cycle of re-injury to the skin and soft tissues, resulting in tissue necrosis (tissue death) and development of a pressure ulcer. The failure of the nursing staff to properly plan, develop, and implement an appropriate and individualized turning and repositioning schedule for Mr. Capano set the stage for tissue loading and pressure ulcer formation. This was a departure from the accepted standards of care and practice and in violation of:

- **42 CFR §483.25 (c) Quality of Care: Pressure Sores.** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based upon the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

- **N.J.A.C. 8:39-27.1 Mandatory Quality of Care: Mandatory Policies, Procedures and Practices for Quality of Care.** (a) The facility shall provide and ensure that each resident receives all care and services needed to enable the resident to attain and maintain the highest practicable level of physical, emotional and social well-being, in accordance with individual assessment and care plans. (c) The facility shall take preventative measures against the development of pressure sores, including assessing the resident's skin daily and minimizing friction and pressure against clothing and bed linens. When present, pressure sores shall be identified, documented, and treated.

- **N.J.A.C. 8:39-27.2 Mandatory Resident Services for Personal Care.** (a) Non-ambulatory residents shall be repositioned at least once every two hours.

- **42 CFR §483.20 Resident Assessment:** Services must meet professional standards of quality and be provided by qualified persons in accordance with each resident's plan of care.

- **Facility Policy: Skin Integrity Management: Clinical Practice Guidelines for the Prevention and Management of Pressure ulcers and other Wounds.** Staff should implement resident specific turning and repositioning programs based upon the resident's assessment. Nursing staff should collaborate with therapy staff for residents presenting with positional challenges.

- **Facility Policy: Repositioning.** Repositioning is critical for a resident who is immobile or dependent upon the staff for repositioning. Residents who are in bed should be on at least an every two hour repositioning schedule. For residents with a Stage I or above pressure ulcer, an every two hour repositioning schedule is inadequate.

The National Pressure Ulcer Advisory Panel in its 2014 publication: Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline recommends:

- **Reposition all individuals at risk of, or with existing pressure ulcers, unless contraindicated.**

- **Determine repositioning frequency with consideration to the individual's tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, skin condition and comfort.**
- **Consider the pressure redistribution support surface in use when determining the frequency of repositioning.**
- **Establish pressure relief schedules that prescribe the frequency and duration of weight shifts.**
- **Regularly assess the individual's skin condition and general comfort. Reconsider the frequency and method of repositioning if the individual is not responding as expected to the repositions regimen.**
- **Reposition the individual in such a way that pressure is relieved or redistributed.**
- **Limit the time an individual spends seated in a chair without pressure relief.**
- **Use a pressure redistributing seat cushion for individuals sitting in a chair whose mobility is reduced and who are thus at risk of pressure ulcer development.**
- **Record repositioning regimes, specifying frequency and position adopted, and include an evaluation of the outcome of the repositioning regime.**

The Agency for Health Care Policy and Research in its Clinical Practice Guideline #3, Pressure Ulcers in Adults: Prediction and Prevention recommends:

- **Any individual in bed who is assessed to be at risk for developing pressure ulcers should be repositioned at least every 2 hours if consistent with overall patient goals. A written schedule for systematically turning and repositioning should be used.**
- **Any person at risk for developing a pressure ulcer should avoid uninterrupted sitting in any chair or wheelchair. The individual should be repositioned, shifting the points under pressure at least every hour or be put back to bed if consistent with overall patient management goals. Individuals who are able should be taught to shift weight every 15 minutes.**
- **For chair bound individuals, the use of pressure–reducing devices such as those made of foam, gel air or a combination is indicated.**

A nursing entry authored by Nurse Cathleen Brown in the Progress Notes dated 12/29/15 timed 11:54 indicated that the wound nurse evaluated the sacral wound and redressed as ordered. Physician orders for wound treatment with packing the sacral wound with gauze moistened with ¼ Dakin's Solution and cover with a large Bandaid Gauze twice daily. A nursing entry dated 1/11/16 in the Progress Notes authored by Nurse Michelle McGlone indicated that on 12/29/15 an open area measuring 7 x 3 cm was found on Mr. Capano's sacrum. The Pressure Ulcer Records indicate that on 12/30/15 Mr. Capano had a Stage III sacral pressure injury measuring 7.8 x 3.8 x 1.7 cm with scant serous drainage and periwound edema. The characteristics of the wound bed were not described. Nursing performed two subsequent sacral wound assessments, on 1/06/16 and 1/12/06. This was a new pressure ulcer, distinct from the right gluteus Stage II pressure injury (referred to as left buttock pressure ulcer in the deposition of Nurse McGlone).

Nurse McGlone testified, that this sacral pressure injury was a separate wound from the left buttock wound (referred to as left buttock wound in deposition, documented as right gluteus on Pressure Ulcer Record) and that Nurse Brown referencing the sacral region in an entry dated 12/28/15 was attributed to Nurse Brown using the wrong terminology/anatomy when referring to the left buttocks. [Pages 72-74]

Nurse Steele testified that Mr. Capano's Stage III pressure ulcer was first noted in the Pressure Ulcer Record on 12/30/15 and that there was no question that the sacral pressure ulcer and the gluteal pressure ulcer both developed at CareOne. [Pages 140 and 141]

The fact that Mr. Capano was care planned for actual skin breakdown, was identified as at risk for skin breakdown, and did develop a sacral pressure ulcer that was not identified until it was a large full thickness Stage III wound, indicated failure in skin assessment, failure to implement appropriate interventions and failure to

prevent an avoidable pressure ulcer. Delayed identification of this Stage III wound which worsened to a Stage IV pressure ulcer indicated a delay in appropriate wound treatment, which placed Mr. Capano at great risk for significant wound deterioration and infection.

The failure of the CareOne nursing staff to provide Mr. Capano with the most basic of nursing care to prevent the development of a Stage II right gluteal and Stage III sacral pressure ulcers constituted neglect and was a departure from the accepted standards of care and practice and in violation of:

- **42 CFR §483.25 (c) Quality of Care: Pressure Sores.** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based upon the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

- **N.J.A.C. 8:39-27.1 Mandatory Quality of Care: Mandatory Policies, Procedures and Practices for Quality of Care.** (a) The facility shall provide and ensure that each resident receives all care and services needed to enable the resident to attain and maintain the highest practicable level of physical, emotional and social well-being, in accordance with individual assessment and care plans. (e) The facility shall take preventative measures against the development of pressure sores, including assessing the resident's skin daily and minimizing friction and pressure against clothing and bed linens. When present, pressure sores shall be identified, documented, and treated.

- **N.J.A.C. 8:39-27.2 Mandatory Resident Services for Personal Care.** (a) Non-ambulatory residents shall be repositioned at least once every two hours.

- **42 CFR §483.20 Resident Assessment:** Services must meet professional standards of quality and be provided by qualified persons in accordance with each resident's plan of care.

- **42 CFR §483.13 (c) Resident Behavior and Facility Practices: Staff Treatment of Residents.** Each resident has the right to be free from mistreatment, neglect, and misappropriation of property.

- **N.J.A.C. 8:39-4.1 Mandatory Resident Rights.** (5) Each resident shall be entitled to the following rights; to be free from physical and mental abuse and/or neglect.

The services of Wound Healing Solutions started on 12/22/15 with the initial assessment of Mr. Capano's Stage III sacral pressure ulcer on 12/29/15. Subsequently Wound Healing Solutions practitioners provided weekly wound assessments and treatment recommendations. On 1/04/16 Wendy Smollock, NP, CWS, performed a comprehensive wound assessment, noting the sacral pressure ulcer was a full thickness wound measuring 4.8 x 1.6 x 1.1 cm with a wound bed comprised of 95% slough with scattered surface inflammation. The periwound was intact and the wound was draining scant nonodorous serous exudate. She also assessed Mr. Capano's partial thickness right gluteus/gluteal region pressure ulcer and noted it to measure 0.3 x 0.3 cm with a clean wound bed comprised of pink epithelial tissue and scant nonodorous serous drainage. The sacral wound was noted as stabilizing.

On 1/11/16 Nancy L. Amorosi, NP, CWS, WCC, evaluated Mr. Capano and noted that the right gluteal pressure ulcer was fully epithelialized. The sacral pressure injury measured 4.8 x 1.8 x 1.1 cm with a wound bed comprised of 95% slough and 5% granulation tissue, with scant nonodorous serous drainage, adherent wound edges and intact periwound.

On or about 1/19/16 Mr. Capano developed a meatal tear attributed to the Foley catheter. The Foley catheter was placed on 11/30/15 and the nursing staff was to provide Foley catheter care every shift. The TARs indicated the nursing staff was to change the Foley catheter as needed in the event of blockage, leakage or dislodgement. There was no indication that the nursing staff secured Mr. Capano's Foley catheter with a securement device attached to his thigh, to prevent traction and pulling on the catheter. The meatal tear he suffered was caused by traction of the catheter. The photographs of Mr. Capano's meatal tear taken by Joseph Capano clearly demonstrate significant injury that could only be caused by the indwelling catheter not being properly secured. The injury was significant and required a course of oral antibiotics as there was drainage noted from the wound. Topical antibiotics were administered as well. Dr Sussman, the Urologist, noted during Mr. Capano's 1/25/16 office visit that he had a significant meatal tear with discharge. On 2/29/16 Dr. Sussman noted during a follow-up office visit that Mr. Capano had severe meatal erosion due to the Foley catheter.

The CareOne nursing staff failed to ensure proper securement of Mr. Capano's Foley catheter and failed to change the catheter in a timely manner, causing injury. This was a departure from the accepted standards of care and practice and in violation of:

- **42CFR 483.25(d) Quality of Care: Urinary Incontinence.** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based upon the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infection and to restore as much normal bladder function as possible.

- Facility Policy: Catheter Care, Urinary. Ensure that the catheter remains secure with a leg strap to reduce friction and movement at the insertion site. (note: Catheter tubing should be strapped to the resident's inner thigh)

On 1/26/16 Mr. Capano was seen by Wound Healing Solutions and his Unstageable sacral pressure ulcer was noted as deteriorating as it increased in size with increasing surface inflammation with mottling noted along the perisacral tissue.

On 1/29/16 Dr. William Cody performed a physical examination on Mr. Capano in his office at Virtual Surgical Group and noted he had a deep sacral pressure ulcer with significant necrotic tissue measuring 5 x 4 x 3 cm. Dr. Cody noted he could feel the coccyx in the wound and that it felt like he most likely had osteomyelitis involving the coccyx bone. Dr. Cody debrided necrotic tissue from the sacral wound bed down to bone and recommended wound treatment with Santyl, a chemical debriding agent.

On 2/02/16 Wound Healing Solutions evaluated Mr. Capano and noted his sacral pressure ulcer measured 4.8 x 3.7 x 2.4 cm with palpable bone and increased malodorous serous drainage. The wound now had undermining of 1.4 cm at 1-3 o'clock. Due to increased wound bioburden, wound treatment was changed back to ¼ Dakin's Solution moistened gauze packed into the wound.

On 2/12/16 Dr. Cody performed wound debridement on Mr. Capano's sacral pressure ulcer. Mr. Capano had developed a C-difficile infection and was being treated with Flagyl. Dr. Cody noted some healthy tissue within the wound bed and debrided the necrotic tissue to the bone.

On 2/16/16 Wendy Smollock, NP, CWS, evaluated Mr. Capano's Stage IV sacral pressure ulcer, noting the full thickness wound measured 3.8 x 2.8 x2.4 cm with the wound bed comprised of 90% granular tissue with 10% thinning slough and slightly palpable bone. The wound edges were adherent to the wound base, there was

moderate nonodorous serous drainage and an intact periwound. Wendy Smollock noted that the wound was responding very well and had decreasing surface inflammation.

On 2/16/16 Mr. Capano was discharged from Care One to home under the care of his brother. Mary Drennan, NP noted that the family was insistent on taking Mr. Capano home.

Bayada Home Health Care 2/17/16 – 4/11/17
Upon admission to Bayada home services, Mr. Capano's Stage IV sacral pressure ulcer measured 4 x 3.5 x 3.5 cm and was draining a large amount of purulent exudate. He had a hospital bed with an air flow mattress. Mr. Capano underwent another course of chemotherapy during the March/April 2016 timeframe. In April 2016 he underwent placement of a suprapubic catheter.

By October 2016, Mr. Capano's sacral wound was demonstrating signs of healing. The wound measured 1.5 x 1.4 x 3.2 cm with serosanguinous drainage. On 2/15/17 the wound measured 0.5 x 0.8 x 2.4 cm with a small amount of serosanguinous drainage. The wound was closing up and being treated with Hydrogel and gauze. Mr. Capano's sacral wound achieved significant healing while under the care of his brother and the support of Bayada home care services.

On 2/23/17 Mr. Capano was admitted to Cooper University Hospital to undergo scheduled cervical spine surgery.

Saint Mary's Rehabilitation Center 2/27/17 – 3/19/17
Mr. Capano was admitted to St. Mary's for sub acute rehab, skilled nursing care and further medical management status post cervical /thoracic spine fusion. His sacral pressure ulcer remained stable. Unfortunately, on 3/19/17 Mr. Capano developed substernal chest pain and 911 was activated. He was admitted to Virtua Marlton ICU in critical condition. Mr. Capano was made a DNR and transferred to Samaritan Hospice to receive end of life care and passed away on 4/01/17. The Death Certificate listed Metastatic Lung Cancer as the immediate cause of death.

Summary
It is my professional opinion that CareOne at Evesham deviated from the accepted standards of care and practice in failing to provide the care necessary to prevent Mr. Capano from developing a Stage II right gluteal pressure ulcer, a Stage IV sacral pressure ulcer, and skin/soft tissue injury to his penis from a Foley catheter.

The nursing staff could not demonstrate the development of Mr. Capano's Stage II right gluteal pressure ulcer, IV sacral pressure ulcer, and soft tissue injury to his penis was unavoidable as they failed to:

- recognize and assess factors that placed Mr. Capano at risk
- define and implement interventions for pressure ulcer prevention in accordance with Mr. Capano's needs, goals and recognized standards of practice
- Monitor and evaluate responses to interventions
- Revise the approaches as appropriate
- Develop and implement and evaluate an appropriate individualized plan of care focusing on the healing of Mr. Capano's sacral pressure ulcer once it developed in accordance with his needs, goals and recognized standards of practice
- Develop and implement and evaluate an appropriate individualized plan of care focusing on the prevention of traction of the indwelling Foley catheter and potential injury

CareOne at Evesham deviated from the aforementioned standards of care and violated various laws set forth in this report; thereby causing the significant and avoidable Stage IV sacral pressure ulcer, an avoidable Stage II right gluteal pressure ulcer as well as traction induced penile laceration.

CareOne at Evesham under the following section of the Nursing Home Act also infringed upon and violated

Mr. Capano's rights as a resident in a long-term care facility in the State of New Jersey:

New Jersey Statute 30:13-5(j): Rights of Residents

- **The right to a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident, including the right to expect and receive appropriate assessment, management, and treatment of pain as an integral component of that person's care consistent with sound nursing and medical practice.**

As stated throughout this report, Defendant CareOne at Evesham violated various Federal and State Statutes, Rules and Regulations. In addition, Defendant CareOne at Evesham violated Mr. Capano's rights under the New Jersey Nursing Home Responsibilities and Residents' Rights Act, specifically the rights enumerated at N.J.S.A. 30:13.5(j) as evidenced by the failures to provide appropriate care causing the above described harm.

There was a failure to provide a safe and decent living environment; a failure to provide individualized care that recognized Mr. Capano's individuality; and a failure to provide care that recognized his dignity by neglecting to provide care necessary to avoid the development of the Stage II right gluteal pressure ulcer and Stage IV sacral pressure ulcer, and penile injury.

There was a failure to maintain and enhance his dignity by neglecting to provide Mr. Capano with prompt incontinence care on multiple occasions.

Each of the aforementioned deviations and violations of Federal Regulations, State Statutes, State Regulations, Facility Policies and Procedures and standards of care in general, as previously discussed were a cause of the development and deterioration of Mr. Capano's Stage IV sacral pressure ulcer, the development of the Stage II right gluteal pressure ulcer, and of the development of the traction induced penile laceration.

I reserve the right to amend this report should additional materials be made available for my review.

Bonnie Tadrick, RN-BC, LNC, CWCA

Bonnie Tadrick, RN-BC, LNC, CWCA