BEFORE THE HEALTH CARE ALTERNATIVE DISPUTE RESOLUTION
OFFICE OF MARYLAND

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| Claimant | * | |
| vs. | * | HCA No. _ |
| Respondents | * | |



**CERTIFICATE OF QUALIFIED EXPERT**

I, , hereby certify and attest as follows:

1. Based upon my training, experience, and my review of pertinent medical records and other pertinent documents relating to this case, including photographs and videos, I am of the opinion within a reasonable degree of nursing/medical probability:

a.

, Respondents, who jointly own, and/or operate, and/or manage the assisted living facility known as , acting through their actual and/or apparent servants, agents, and/or employees, deviated from applicable standards of care in the custodial care and treatment of while he was an assisted living resident at their facility, as more fully described in my Report that is attached hereto and incorporated herein by reference;

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b. that ., Respondent, deviated from applicable standards of in her direct caregiver interactions with on February 16, 2015, as more fully described in my Report that is attached hereto and incorporated herein by reference.

c. that the aforesaid deviations from the applicable standards of care by , Respondents, acting through their actual and/or apparent servants, agents, and/or employees, and ., Respondent, were the proximate cause of alleged injuries, as more fully described in my Report that is attached hereto and incorporated herein by reference.

2. I am licensed in Pennsylvania as a Registered Nurse and as a Certified Registered Nurse Practitioner. I am certified by the American Nursing Credentialing Center as a Gerontological Nurse Practitioner.

3. I have had clinical experience, and/or provided consultation related to clinical practice, and/or taught medicine in the Respondent's field of health care in which the Respondents provided assisted living care or treatment to , within five years of the date of the alleged acts or omissions giving rise to this case.

4. My Report in support of this Certificate is attached hereto and its entire content is incorporated herein by reference.

5. My opinions expressed herein are based upon my current knowledge of the information relating to this case, and I reserve the ability to amend or modify my opinions as and/or if additional pertinent information becomes available to me.

6. I do not devote annually more than 20% of my professional activities to activities that directly involve testimony in personal injury claims.

**Report Regarding at**

This Report concerns residency at , located in , Maryland.

I am licensed in Pennsylvania as a Registered Nurse and as a Certified Registered Nurse Practitioner. I am certified by the American Nursing Credentialing Center as a Gerontological Nurse Practitioner. My professional activities include, but are not limited to: (1) Associate Program Director, Senior Lecturer, and Clinical Site Coordinator in the Adult Health and Gerontology Primary Care Nurse Practitioner Program at the University of Pennsylvania, Philadelphia, PA; (2) Nurse Practitioner in private practice in Kennett Square, PA; and (3) Federal Monitor with the United States Department of Justice in Philadelphia, PA.

I have reviewed pertinent documents/records relating to this case, including, but not necessarily limited to, the following:

(1) Videos and photographs taken at [1];

(2) Pertinent medical records regarding including, but not necessarily limited to records;

(3) Howard County Police Department Application for Statement of Charges against ;

(4) Statement made by in court on November 19, 2015; and

(5) Draft Statement of Claim.

My opinions expressed herein are based upon my education, training, and experience, and review of the above-referenced material that I have reviewed to date.

Background

I operates a 59 bed assisted living facility in Maryland. Within the facility is a separate unit known as " ."

[1] The entity " " refers herein jointly to both Respondent Health Care Providers, namely:

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provides specialized assisted living care to persons experiencing the effects of Alzheimer's disease, dementia and memory loss.

, 93 years old, was admitted as a resident of on August 12, 2014, and provided his own private room. , as a result of his advanced age and significant level of Alzheimer's disease/dementia, was a vulnerable adult who was dependent upon his caregivers at for assistance in the performance of various activities of his daily living.

Videos recorded by a video camera placed in room by his son evidenced conduct by staff members that constituted deviations from applicable standards of care, as follows:

1. Physical/Emotional Abuse on February 16, 2015

On the morning of February 16, 2015 at approximately 7:33 (per a date and time-stamped video), , a caregiver at , entered Mr. darkened room as he lay in bed under his covers and turned on the room's overhead lights. She went to the side of bed and appeared to have encouraged him to get up out of bed. left the room approximately two minutes later, with still in bed and the lights left on.

has claimed to have never provided direct caregiver services to one-on-one until the morning of February 16, although she had previously had opportunity to observe him in group settings. In describing what occurred that morning after she had been assigned as caregiver, stated:

> When I initially walked in . . . he didn't want to be, you know, dealt with at that time, so I went to my supervisor and said that, you know, he doesn't want me in there. So her response was to go back and try again. So, I, you know, I followed the protocol by going to a higher authority in that respect.

She was provided no additional staff to assist her with after being told by her supervisor to go back into his room.

During absence from his room, got up out of his bed and began dressing himself by putting on an undershirt over top the one that he was already wearing.

reentered room at 7:43 a.m. and shut the door behind her. was standing up dressed only in two undershirts, a wet appearing adult disposable brief, and socks. Beginning at approximately 7:45 a.m. and continuing until approximately 7:51 a.m., repeatedly physically abused during the course of her dressing him. Her abusive conduct included, but was not limited to: (a) she forcibly pushed to the floor of his room and later onto his bed; (b) she forcibly restrained the movement of

his hands and arms by tightly grabbing his hands and/or wrists, and further attempted to control the movement of his hands by covering them with his undershirt; (c) she appeared to strike him with her hand as well as with his trousers; (d) with kneeling on the floor at the foot of his bed and movement of his legs restrained by a new disposable brief and his trousers pulled partially up his thighs, she forcibly ripped out from between his legs the old wet disposable brief; and (e) she roughly picked up from a kneeling to a standing position.

had the obligation, among other duties of care, to: (a) protect right to be treated with consideration, respect and full recognition of his human dignity and individuality, and to be free from mental, verbal, and physical abuse and exploitation; (b) take reasonable steps to ensure safety, health and well-being; (c) provide with a caregiver who was adequately trained and experienced in the care of elderly residents suffering from Alzheimer's disease/dementia; (d) provide sufficient level of staffing to meet the individualized needs of ; and (e) provide appropriate supervision of caregiver involvement with .

, acting through its agents, servants, and/or employees including, but not limited to , deviated from its duties of care including, but not limited to: (a) failing to protect right to be treated with consideration, respect and full recognition of his human dignity and individuality, and to protect him from mental, verbal, and physical abuse and exploitation; (b) failing to take the necessary steps to ensure safety, health and well-being; (c) failing to provide a caregiver who was adequately trained and experienced in the care of elderly residents suffering from Alzheimer's disease/dementia; (d) failing to provide a sufficient level of staffing to meet the individualized needs of and (e) failing to provide appropriate supervision of caregiver involvement with .

physically abusive interactions with on the morning of February 16, 2015, as above-described, were outside the bounds of applicable standards of care and were clear deviations from them. It is never acceptable to abuse a vulnerable adult.

As a direct consequence of the above-described deviations from applicable standards of care by incurred both physical (skin tears, bruises, and abrasions) and emotional (fear and loss of human dignity) injuries.

2. Abusive morning routine - Unreasonable early awakening, etc. of

Recorded on video are instances where the apparently same unidentified female direct caregiver enters darkened room at unreasonably early times in the morning, awakens him, and makes him get dressed:

*January 2, 2015 beginning at 4:47 a.m.* - The direct caregiver entered darkened room, turned on the bright overhead lights, and began to gather clothing items. She

partially pulled down the bedcovers off of who thereupon appeared to pull them back up over himself. The caregiver then pulled the bedcovers completely off of and quickly exited the room as began getting up. Over the next minutes, the caregiver tossed clothing items to and, at one point, assisted him getting dressed as he sat on the toilet going to the bathroom.

*January 16, 2015 beginning at 5:18 a.m.* - The direct caregiver entered darkened room, turned on the bright overhead lights, and began to gather clothing items for to wear that day. The caregiver then began coaxing him to get up out of bed and dressed. appeared to be annoyed by her efforts, but eventually got dressed with some dressing assistance provided by the caregiver.

*January 23, 2015 beginning at 4:55 a.m.* - The direct caregiver entered darkened room, turned on the bright overhead lights, and obtained clothing items for to wear. Over the next minutes, the caregiver appeared to shake as he lay in bed under his covers, pulled the bedcovers off of him, and assisted him getting dressed.

There does not appear to have been any justifiable reason for awakening at such unreasonable early times in the mornings and compelling him to get out of bed and dressed for the day. The videos clearly evidence that was not ready to be awakened, and was resistant to the caregiver's actions. Obtaining an adequate amount of sleep is essential for persons, such as , suffering from the effects of Alzheimer's disease/dementia.

had the obligation, among other duties of care, to: (a) protect right to be treated with consideration, respect and full recognition of his human dignity and individuality, and to be free from mental, verbal, and physical abuse and exploitation; (b) take reasonable steps to ensure safety, health and well-being; (c) provide with caregivers who were adequately trained and experienced in the care of elderly residents suffering from Alzheimer's disease/dementia; (d) provide a sufficient level of staffing to meet the individualized needs of (e) provide appropriate supervision of the direct caregivers assigned to provide assisted living care and treatment to and (f) developing and implementing an adequate Service Plan that, among other things, addressed sleep habits and need for adequate amounts of sleep.

acting through its agents, servants, and/or employees (including the unidentified direct caregiver shown in the above-described videos), deviated from its duties of care including, but not limited to: (a) failing to protect right to be treated with consideration, respect and full recognition of his human dignity and individuality, and to protect him from mental, verbal, and physical abuse and exploitation; (b) failing to take the necessary steps to ensure safety, health and well-being; (c) failing to assign to caregivers who were adequately trained and experienced in the care of elderly residents suffering from Alzheimer's disease/dementia; (d) failing to provide sufficient level of staffing to meet the individualized needs of ; (e) failing to provide appropriate supervision of direct caregiver involvement with ; and (f) failing to

develop and implement an adequate Service Plan that addressed sleep habits and his need for adequate amounts of sleep.

By unnecessarily compelling to awaken at such early times in the morning, and forcing him to get out of bed and dressed, treated him in an abusive and dehumanizing manner, and otherwise violated rights as an assisted living resident. It is reasonable to believe that , acting through its unidentified direct caregiver(s), had established a pattern of such abusive conduct regarding . It deprived of his necessary sleep and, more likely than not, caused him increased disorientation, behavioral changes, and an otherwise worsening of his condition.