STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

SHANICA LEAGUE, Personal Representative of the Estate of MORRIS LEE WILSON, Deceased,

Plaintiff, No. - NH

v Hon.

DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and VILLA OLYMPIA INVESTMENT LLC,

Defendants, Jointly and Severally.

DONNA M. MACKENZIE (P62979)
OLSMAN MACKENZIE PEACOCK, P.C.
Attorneys for Plaintiff
2684 West Eleven Mile Road
Berkley, MI 48072
248-591-2300 / 248-591-2304 [fax]

There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in this Complaint.

Donna M. MacKenzie, Esq.

COMPLAINT, JURY DEMAND AND AFFIDAVIT OF MERIT SIGNED BY CHARLOTTE SHEPPARD, R.N.

NOW COMES the Plaintiff SHANICA LEAGUE, Personal Representative of the Estate of MORRIS LEE WILSON, Deceased, by and through her attorneys, OLSMAN MACKENZIE PEACOCK, P.C., and does hereby complain against the Defendants DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and VILLA OLYMPIA INVESTMENT LLC in a civil action, stating unto this Court as follows:

1. Plaintiff SHANICA LEAGUE, Personal Representative of the Estate of MORRIS LEE WILSON, Deceased, is a resident and citizen of the City of Austin, County of Travis, State of Texas.

2. Defendant DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center owns and/or operates a nursing facility, which at all times relevant to this complaint was operating a facility in the City of Dearborn, County of Wayne, State of Michigan.

3. Defendant VILLA HEALTHCARE owns and/or operates a nursing facility, which at all times relevant to this complaint was operating a facility in the City of Dearborn, County of Wayne, State of Michigan.

4. Defendant VILLA OLYMPIA INVESTMENT LLC owns and/or operates a nursing facility, which at all times relevant to this complaint was operating a facility in the City of Dearborn, County of Wayne, State of Michigan.

5. The jurisdiction of this court is founded upon the parties hereto and the amount in controversy which exceeds Twenty-Five Thousand ($25,000.00) Dollars. Venue is premised upon the situs of the occurrence which is Wayne County.

6. DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and VILLA OLYMPIA INVESTMENT LLC failed to provide Mr. Wilson with the supervision and assistance he required to ensure his safety, resulting in him suffering multiple falls throughout his residence at Imperial, leading to a right hip fracture as a result of an unwitnessed fall on July 16, 2022.

7. Additionally, the neglect of Imperial Healthcare led to Mr. Wilson developing multiple wounds, ultimately leading to his death on February 21, 2023.

8. Mr. Wilson, age 69, was admitted to Imperial Healthcare Center on March 31, 2022, with diagnoses of Alzheimer's and schizophrenia.

9. Upon admission, Mr. Wilson was classified as a high fall risk due to his decreased safety awareness and cognitive impairment.

10. His initial Activities of Daily Living (ADL) care plan indicated a requirement for supervised transfers, reflecting his vulnerable state.

11. At the time, he weighed 122 pounds and had a history of two falls.

12. Despite his fall risk, Mr. Wilson's care plan lacked clear instructions for staff on the extent of assistance required for ambulation.

13. This oversight persisted even though the staff had recognized his propensity to fall and his previous fall incidents.

14. The plan failed to incorporate strategies to alert staff of his unsafe self-transfer attempts or measures to prevent further falls and injuries.

15. As time progressed, Mr. Wilson experienced additional weight loss, going from 140 lbs at the time of his admission to 122 lbs.

16. An MDS assessment conducted on July 8, 2022, revealed a Brief Interview for Mental Status (BIMS) score of 4/15, indicating significant cognitive decline.

17. It also specified that he required supervision with one-person physical assistance for transfers, walking in his room, and in the corridor, as well as extensive assistance with one-person physical assistance for toileting.

18. Despite these findings, his care plan remained unchanged, misaligned with the care needs identified in the MDS.

19. On July 16, 2022, Mr. Wilson was found on the floor following an unwitnessed fall.

20. Despite exhibiting both verbal and nonverbal signs of pain, it was not until four days later, on July 20, 2022, that Mr. Wilson was finally transported to Beaumont Hospital, Dearborn.

21. X-ray results confirmed an acute fracture of his right intertrochanteric femur.

22. Kelley Brossy, DO, recommended cephalomedullary nail fixation to manage pain, restore the anatomic alignment of the limb, and facilitate a hopeful return to immediate weight-bearing and ambulation.

23. Following the operation, Mr. Wilson was tolerating a regular diet, and his pain was being controlled with oral medication.

24. Mr. Wilson was discharged from Beaumont Hospital, Dearborn to Imperial Healthcare Center on July 26, 2022.

25. It was only after this incident that Imperial updated Mr. Wilson's ADL Care Plan to reflect the need for extensive assistance of one person for transfers.

26. On July 26, 2022, Mr. Wilson was immediately seen by wound care specialists.

27. His right hip displayed surgical incisions secured by 11 staples at the top and 6 at the bottom.

28. Treatments were promptly administered to these sites.

29. For complaints of pain, he was prescribed acetaminophen 500 mg capsules, two at a time, scheduled through October 2022.

30. However, it was noted that an excessive dosage of approximately 6000 mg of acetaminophen was administered daily from July 28, 2022, to October 6, 2022, surpassing the recommended maximum of 4000 mg within 24 hours.

31. Mr. Wilson also received one to two doses of hydrocodone-acetaminophen 5-325 mg, which contained acetaminophen, as needed in July, August, and September of 2022.

32. Mr. Wilson continued to experience frequent falls, and his functional status and mobility progressively declined, even with rigorous physical and occupational therapy.

33. By October 2022, his weight had dropped to 108 lbs, and he was on a pureed diet as recommended by a speech-language pathologist.

34. In November 2022, Mr. Wilson's wheelchair was replaced with a Geri chair.

35. His Braden Scale score was 18, placing him at risk for pressure sores.

36. Unfortunately, however, Imperial did not implement adequate interventions to prevent the development of pressure injuries.

37. On January 5, 2023, a pressure injury was identified on his right buttock.

38. The following day, a significant change in his Minimum Data Set (MDS) was recorded for the development of a stage III pressure ulcer, yet a turning/repositioning program was not implemented, despite being part of his care plan.

39. This ulcer was not identified until it had progressed to stage III.

40. The MDS also incorrectly stated that he required extensive assistance for walking, despite being nonambulatory.

41. On January 16, a Pressure Ulcer Unavoidable Evaluation was completed, presumably signed by a nurse practitioner.

42. After another fall on January 17, 2023, Mr. Wilson required an emergency department visit at Beaumont Hospital, Dearborn for sutures to a forehead laceration.

43. Mr. Wilson returned to Imperial Healthcare Center on the same day.

44. By January 24, 2023, oral antibiotics were prescribed for his unstageable and infected wound on the right buttock, and another pressure ulcer had developed on his sacral area.

45. A hospice referral was made on January 25, 2023, and Mr. Wilson's condition continued to deteriorate, and by January 30, 2023, he was transferred to the Beaumont Hospital, Taylor via LifeLine Concord for further evaluation due to worsening and infected wounds.

46. The emergency department nurse, Abigail Johnson RN, conducted an initial assessment of Mr. Wilson's wound located on his right buttock.

47. The nurse's report detailed the wound as undressed, revealing a large area with purulent drainage.

48. The wound was covered with a Mepilex pad and contained a latex glove with rolled-up gauze inside the wound cavity!

49. Mr. Wilson was promptly started on intravenous fluids and antibiotics to address the infection.

50. Subsequently, on February 1, 2023, a meticulous excisional debridement was performed on the right buttock wound.

51. The wound measured 8 x 6 cm and was classified as stage IV, extending down to and including the fascia and muscles.

52. The post-debridement dressing comprised fluffs and ABD pads to facilitate healing and manage exudate.

53. On February 3, 2023, a peripherally inserted central catheter (PICC) line was placed to ensure the continued administration of IV antibiotics.

54. The discharge plan from the ED included ongoing IV antibiotic therapy for the infected wound.

55. Following these interventions, on February 3, 2023, Mr. Wilson was transported back to Imperial for further recovery.

56. On February 4, 2023, a Skin & Wound Evaluation revealed a severe stage IV full-thickness skin and tissue wound on his right buttock.

57. To promote healing, he was treated daily with Santyl Ointment, a collagenase-based medication to help break down dead tissue in the wound.

58. A comprehensive care plan was developed.

59. This plan addressed his unstageable wound on the right malleolus, a stage III pressure ulcer on Mr. Wilson's sacrum, and the stage IV wound on his buttocks.

60. The dietician's assessment was concerning; the patient weighed 92.4 lbs, indicating a state of severe undernutrition.

61. His physical condition was described as extremely weak, and he was unable to utilize his hands and arms, further complicating his care.

62. The situation escalated on February 8, 2023, when Mr. Wilson's right buttock wound began to bleed uncontrollably.

63. Despite several attempts to manage the bleeding with dressing changes, the situation necessitated immediate medical attention.

64. Consequently, he was urgently transferred back to Beaumont Hospital, Taylor for advanced treatment.

65. This injury, along with other pressure ulcers Mr. Wilson had developed, was notably severe, with the significant ulcer being referred to as a large sacral wound.

66. Alarmingly, his hemoglobin (Hgb) level was critically low at 4.7, prompting an immediate need for blood transfusions.

67. To combat the infection at the wound site, intravenous antibiotics were resumed.

68. The operative report indicated that a washout procedure was essential to control the bleeding from the right buttock pressure injury.

69. Following his discharge from the inpatient hospital admission on February 11, 2023, Mr. Wilson was admitted to inpatient hospice under the care of Residential Hospice for General Inpatient Care.

70. This admission was to provide a short-term hospice level of care, focusing on pain management and the management of his acute symptoms.

71. These symptoms were associated with his open pressure injury, active bleeding, and the risk of further bleeding during transfer attempts.

72. The terminal diagnosis for his hospice care was sepsis, related to the pressure ulcer in his sacral region.

73. Mr. Wilson's care directives included nothing by mouth (NPO), administration of comfort medications only, and minimal movement due to his bedbound state.

74. This approach was taken to manage the massive amount of bleeding and blood clots that were observed with each dressing change.

75. Morphine IV was administered as a palliative measure before any wound care was provided to ensure the Mr. Wilson's comfort.

76. From February 11, 2023, to approximately February 17, 2023, Residential Hospice additionally provided daily follow-up care while Mr. Wilson remained at Beaumont Taylor Hospital Hospice.

77. On February 17, 2023, Mr. Wilson returned to Imperial Healthcare Center under the care of Residential Hospice.

78. Confined to bedrest, Mr. Wilson relied entirely on the staff for his care needs.

79. On February 18, 2023, his weight was recorded at 89.6 lbs using a Hoyer lift.

80. Notably, despite orders for comfort medications as needed upon his return to Imperial from Beaumont Hospital, the Medication Administration Record indicates that none were administered.

81. On February 20, 2023, Mr. Wilson was admitted to Assured Hospice, with a terminal diagnosis of COPD, with his stage IV pressure ulcer noted as the primary comorbidity.

82. His condition was described as lethargic, minimally responsive, withdrawn, disengaged, and nonverbal.

83. Hospice observed a decline in his appetite over the preceding months, requiring assistance with feeding and difficulty swallowing even a pureed diet with thickened liquids.

84. Additionally, five wounds were documented:

#1: A stage IV pressure injury on his right ischium.
#2: A stage III pressure injury in his sacral area.
#3: A stage II pressure injury on his right ankle.
#4: An unstageable wound on his left heel.
#5: An unstageable wound on his right heel.

85. On February 21, 2023, a notable deterioration in Mr. Wilson's condition was observed, with abnormal vital signs and increased lethargy.

86. Bleeding from his sacral area wound was evident, and his vital signs continued to decline.

87. Ultimately, Mr. Wilson became unresponsive and was pronounced deceased at 9:25 am, with his family present at his bedside.

88. The defendants DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and VILLA OLYMPIA INVESTMENT LLC, by and through their nursing staff employees, agents, and/or ostensible agents, including but not limited to, RNs, LPNs and nurse aides, owed a duty to Mr. Morris L. Wilson to provide care in conformance with the skill and care ordinarily possessed and exercised by practitioners of their profession in the same or similar localities.

89. The defendants DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and VILLA OLYMPIA INVESTMENT LLC, by and through their nursing staff employees, agents, and/or ostensible agents, including but not limited to, RNs, LPNs and nurse aides, further owed a duty to Mr. Morris L. Wilson to exercise due care and caution.

90. The nursing staff employees, agents, and/or ostensible agents of defendants DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and VILLA OLYMPIA INVESTMENT LLC, including but not limited to, RNs, LPNs and nurse aides, breached this duty when they performed the following acts of ordinary negligence and/or medical malpractice:

a. Negligently and recklessly failing to timely and appropriately ensure that Mr. Wilson is free from neglect, and is provided with the goods and services that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

b. Negligently and recklessly failing to timely and appropriately ensure that Mr. Wilson's environment remains as free of accident hazards as is possible, and that Mr. Wilson receives adequate supervision and assistance devices to prevent accidents.

c. Negligently and recklessly failing to timely and appropriately provide care, consistent with professional standards of practice, to prevent Mr. Wilson from developing pressure ulcers.

d. Negligently and recklessly failing to timely and appropriately provide necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent Mr. Wilson from developing new ulcers.

e. Negligently and recklessly failing to refrain from allowing Mr. Wilson to transfer and ambulate without the assistance that he required and immediately provide such assistance for Mr. Wilson when he attempted to get out of bed and/or attempted to transfer or ambulate unassisted.

f. Negligently and recklessly failing to perform timely and accurate comprehensive assessments and evaluations of Mr. Wilson, including but not limited to, his risk of falling, skin breakdown, and infection.

g. Negligently and recklessly failing to timely and appropriately recognize that Mr. Wilson was at high risk for falling, skin breakdown and infection.

h. Negligently and recklessly failing to timely and appropriately utilize the results of the comprehensive assessments and evaluations of Mr. Wilson to develop, review and revise appropriate care plans to attain or maintain Mr. Wilson's highest practicable physical, mental, and psychosocial well-being, including but not limited to, an appropriate care plan to prevent falls, and to promote healing, prevent infection and prevent new ulcers from developing.

i. Negligently and recklessly failing to timely formulate, implement and follow appropriate safety interventions, to prevent accidents and injuries for a resident such as Mr. Wilson, including but not limited to:

    i. Determine the appropriate level of assistance that Mr. Wilson required to keep him safe and ensure that it is communicated to all staff.

ii. Recognize that Mr. Wilson required physical assistance with ambulation and transfers to keep him safe.

iii. Provide support surfaces or overlays to reduce pressure and shear for Mr. Wilson, including but not limited to specialty bed mattresses or chair cushions, alternative pressure surfaces, or low air loss surfaces;

iv. Implement a turning and repositioning schedule for Mr. Wilson to reduce duration of pressure and shear;

v. Keep Mr. Wilson's skin clean and dry;

vi. Apply cleansers, moisturizers and creams as ordered for Mr. Wilson;

vii. Establish a toileting program for Mr. Wilson;

viii. Provide adequate protein, calories, and fluids for Mr. Wilson;

ix. Monitor Mr. Wilson's intake and output;

x. Perform weekly weights of Mr. Wilson to monitor for weight loss;

xi. Request consultations with nutritional services, a registered dietician, wound care specialists, physical therapy and/or occupational therapy for Mr. Wilson;

xii. Perform regular skin assessments of Mr. Wilson to identify any areas of skin breakdown; and

xiii. Perform proper daily assessments and documentation of each and every area in which Mr. Wilson experienced skin breakdown including descriptions of the size of the wound (length, width, depth and presence or absence of undermining and/or tunneling); tissue characteristics, including color, odor, nature of the tissue and the presence of any drainage; and stages of the wound in accordance with the standards set forth by the National Pressure Ulcer Advisory Panel.

j. Negligently and recklessly failing to timely ensure that all staff members are aware of, following and carrying out formulated interventions, and that such interventions are being implemented consistently across all shifts.

k. Negligently and recklessly failing to timely and appropriately assess and monitor Mr. Wilson for changes in his condition which may necessitate revision of his care plans and safety interventions, including but not limited

to, each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions are determined to be ineffective.

l. Negligently and recklessly failing to update, add to and/or revise care plans and interventions appropriately and in a timely manner, including but not limited to, updating the care plan with new interventions each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions are determined to be ineffective

m. Negligently and recklessly failing to ensure that the resident care guide is accurately completed upon admission, updated and/or revised with appropriate instructions in a timely manner, dated at the time the changes occur and that all staff members are aware of, follow and carry out instructions.

n. Negligently and recklessly failing to communicate all pertinent information to Mr. Wilson's physician in a timely manner, including but not limited to, each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions are determined to be ineffective

o. Negligently and recklessly failing to request any and all appropriate physician orders necessary to keep Mr. Wilson safe from accidents and injuries, including but not limited to, an order mandating the level of assistance to be provided to Mr. Wilson with ambulation and transfers, as well as orders necessary to prevent Mr. Wilson from developing pressure ulcers, and to promote healing, prevent infection and prevent Mr. Wilson from developing new ulcers, including but not limited to, an order for support surfaces or overlays to reduce pressure and shear, a turning and repositioning schedule, instructions to keep skin clean and dry, medications, treatments, cleansers, moisturizers and creams to protect the skin, a toileting program, laboratory studies, adequate protein, calories, and fluids, monitoring of intake and output, weekly weights, nutritional and/or dietary consultations, wound care consultations, physical and/or occupational therapy consultations, and regular skin assessments.

p. Negligently and recklessly failing to timely and appropriately follow and carry out all physician orders.

q. Negligently and recklessly failing to ensure that the services provided by the facility meet professional standards of quality, including but not limited to, maintaining a safe environment for a resident such as Mr. Wilson.

r. Negligently and recklessly failing to promote, advocate and protect the health, safety and rights of a resident such as Mr. Wilson, including but not limited to, informing supervisors and others in the chain of command of the need for Mr. Wilson, who was at high risk for sustaining falls, skin breakdown and infection, to receive timely and appropriate care to prevent accidents and injuries.

s. Negligently and recklessly failing to immediately notify Mr. Wilson's family and/or Patient Advocate when Mr. Wilson suffered a fall, had a change in his medical condition and if Imperial is unable to meet the needs of Mr. Wilson.

t. Negligently and recklessly failing to keep and maintain a record for Mr. Wilson, including an accurate, full and complete record of tests and examinations performed, observations made, treatments provided.

u. Negligently and recklessly failing to timely provide a basis for determining and managing Mr. Wilson's progress including response to treatment, change in condition and changes in treatment, through timely, complete, accurate and organized clinical information that is readily accessible for resident care.

v. Negligently and recklessly failing to ensure that all alleged violations involving the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness 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).

w. Negligently and recklessly failing to provide an adequate number of staff in order to ensure that appropriate assessments, care plans, monitoring, treatment, interventions, notifications and documentation are performed in a timely manner.

x. Negligently and recklessly failing to timely and appropriately ensure that all licensed staff supervise the nursing assistants, including but not limited to, ensuring that the nursing assistants are properly providing Mr. Wilson with the level of assistance that he required for safe ambulation and

transfers, as well as the necessary care and treatment to prevent skin breakdown and infection.

y. Negligently and recklessly failing to timely provide appropriate training for all staff including, but not limited to, RNs, LPNs and nursing assistants, in regard to how to provide appropriate safety precautions, implement interventions, and prevent injury to a resident such as Mr. Wilson who was at high risk for falls, skin breakdown and infection.

z. Negligently and recklessly failing to timely develop, orient all staff on, implement, ensure all staff follow, and enforce appropriate policies and procedures regarding interventions to prevent injury to a resident such as Mr. Wilson, who was at a high risk for falls, skin breakdown, and infection.

aa. Negligently and recklessly failing to perform other actions as may be learned during discovery on this case.

91. The defendants DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and VILLA OLYMPIA INVESTMENT LLC, are legally responsible for the ordinary negligence and/or medical malpractice of their nursing staff employees, agents, and/or ostensible agents, including, but not limited to, RNs, LPNs and nurse aides, under the doctrines of vicarious liability, *respondeat superior* and/or *Grewe v. Mt. Clemens General Hospital*, 404 Mich 240, 273 NW2d 429 (1978).

92. As a further direct and proximate result of the ordinary negligence and/or medical malpractice of the nursing staff employees, agents, and/or ostensible agents of defendants DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and VILLA OLYMPIA INVESTMENT LLC, including but not limited to, RNs, LPNs and nurse aides, Mr. Morris L. Wilson sustained serious and permanent injuries, including but not limited to:

a. Death;

b. Right hip fracture;

c. Multiple pressure injuries, including his right buttock / ischium, sacrum, right ankle, left heel and right heel;

d. Administration of excessive amounts of acetaminophen;

e. Significant weight loss and malnutrition;

f. Active bleeding from his right buttock pressure injury:

g. Sepsis;

h. Extensive monitoring and aggressive procedures and treatment including but not limited to, surgical repair, IV fluids, oral and IV antibiotics, placement of a PICC line, wound care treatment, narcotic pain medications, extensive physical and occupational therapy, wound care treatment, wound debridement, blood transfusions, and placement into hospice care.

i. Extreme physical pain and suffering;

j. Mental anguish;

k. Fright and shock;

l. Denial of social pleasure and enjoyments;

m. Embarrassment, humiliation and mortification;

n. Disability;

o. Disfigurement;

p. Decline in functional status and mobility;

q. Any and all damages available under the Wrongful Death Act, including but not limited to:

    i. Reasonable medical, hospital, funeral, and burial expenses for which the estate is liable;

    ii. Reasonable compensation for the pain and suffering, while conscious, undergone by the deceased during the period intervening between the time of the injury and death; and

    iii. Damages for the loss of society and companionship of the deceased;

r. Permanently incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of normal, daily living;

s. Other injuries and damages to be determined through the further course of discovery.

WHEREFORE, plaintiff prays for damages in whatever amount above Twenty-Five Thousand ($25,000) Dollars to which she is found to be entitled at the time of trial, together with interest, costs and attorney fees; wherefore, she brings this suit.

OLSMAN MACKENZIE PEACOCK, P.C.

Donna M. MacKenzie (P62979)
Attorneys for Plaintiff
2684 West Eleven Mile Road
Berkley, MI 48072
248-591-2300 / (248) 591-2304 [fax]

Dated: January 14, 2025

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

SHANICA LEAGUE, Personal Representative of the Estate of MORRIS LEE WILSON, Deceased,

Plaintiff, No. - NH

v Hon.

DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and VILLA OLYMPIA INVESTMENT LLC,

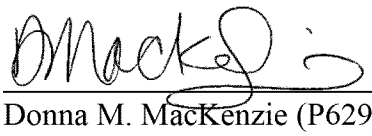
Defendants, Jointly and Severally.

DONNA M. MACKENZIE (P62979)
OLSMAN MACKENZIE PEACOCK, P.C.
Attorneys for Plaintiff
2684 West Eleven Mile Road
Berkley, MI 48072
248-591-2300 / 248-591-2304 [fax]

JURY DEMAND

NOW COMES the Plaintiff SHANICA LEAGUE, Personal Representative of the Estate of MORRIS LEE WILSON, Deceased, by and through her attorneys, OLSMAN MACKENZIE PEACOCK, P.C., and hereby demands a Trial by Jury in the above entitled matter.

OLSMAN MACKENZIE PEACOCK, P.C.



Donna M. MacKenzie (P62979)
Attorneys for Plaintiff
2684 West Eleven Mile Road
Berkley, MI 48072
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Dated: January 14, 2025

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

SHANICA LEAGUE, Personal Representative of the Estate of MORRIS LEE WILSON, Deceased,

Plaintiff,

v

DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and VILLA OLYMPIA INVESTMENT LLC,

Defendants, Jointly and Severally.

No. 25-000613-NH

Hon. Dana Margaret Hathaway

DONNA M. MACKENZIE (P62979)
OLSMAN MACKENZIE PEACOCK, P.C.
Attorneys for Plaintiff
2684 West Eleven Mile Road
Berkley, MI 48072
248-591-2300 / 248-591-2304 [fax]

AFFIDAVIT OF MERIT SIGNED BY CHARLOTTE SHEPPARD, R.N.

AFFIDAVIT OF MERIT
OF CHARLOTTE SHEPPARD, R.N.

STATE OF FLORIDA)
)ss.
COUNTY OF PASCO)

I certify that I have reviewed the Notice of Intent to File a Claim pursuant to MCLA 600.2912(b), MSA 27A.2912(2), and all medical records supplied to me by Plaintiff's attorneys with regard to Morris Lee Wilson concerning the allegations contained in the Notice. I further certify that during the year immediately preceding the date of the occurrence that is the basis for this claim, I devoted a majority of my professional time to the active clinical practice of Nursing and/or the instruction of students in an accredited health professional school or clinical research program in Nursing. I also state the following:

A. The Applicable Standard of Practice or Care

The standard of care applicable to the nursing staff who were agents, assigns, representatives or employees of DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and/or VILLA OLYMPIA INVESTMENT LLC, including but not limited to RNs, LPNs and nursing assistants, is the skill and care ordinarily possessed and exercised by practitioners of their profession in the same or similar localities.

At a minimum, the nursing staff who were agents, assigns, representatives or employees of DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and/or VILLA OLYMPIA INVESTMENT LLC, including but not limited to RNs, LPNs and nursing assistants, had a duty to:

1. Timely and appropriately ensure that Mr. Wilson is free from neglect, and is provided with the goods and services that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

2. Timely and appropriately ensure that Mr. Wilson's environment remains as free of accident hazards as is possible, and that Mr. Wilson receives adequate supervision and assistance devices to prevent accidents.

3. Timely and appropriately provide care, consistent with professional standards of practice, to prevent Mr. Wilson from developing pressure ulcers.

4. Timely and appropriately provide necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent Mr. Wilson from developing new ulcers.

5. Refrain from allowing Mr. Wilson to transfer and ambulate without the assistance that he required and immediately provide such assistance for Mr. Wilson when he attempted to get out of bed and/or attempted to transfer or ambulate unassisted.

6. Perform timely and accurate comprehensive assessments and evaluations of Mr. Wilson, including but not limited to, his risk of falling, skin breakdown, and infection.

7. Timely and appropriately recognize that Mr. Wilson was at high risk for falling, skin breakdown and infection.

8. Timely and appropriately utilize the results of the comprehensive assessments and evaluations of Mr. Wilson to develop, review and revise appropriate care plans to attain or maintain Mr. Wilson's highest practicable physical, mental, and psychosocial well-being, including but not limited to, an appropriate care plan to prevent falls, and to promote healing, prevent infection and prevent new ulcers from developing.

9. Timely formulate, implement and follow appropriate safety interventions, to prevent accidents and injuries for a resident such as Mr. Wilson, including but not limited to:

    a. Determine the appropriate level of assistance that Mr. Wilson required to keep him safe and ensure that it is communicated to all staff.

    b. Recognize that Mr. Wilson required physical assistance with ambulation and transfers to keep him safe.

    c. Provide support surfaces or overlays to reduce pressure and shear for Mr. Wilson, including but not limited to specialty bed mattresses or chair cushions, alternative pressure surfaces, or low air loss surfaces;

    d. Implement a turning and repositioning schedule for Mr. Wilson to reduce duration of pressure and shear;

    e. Keep Mr. Wilson's skin clean and dry;

    f. Apply cleansers, moisturizers and creams as ordered for Mr. Wilson;

    g. Establish a toileting program for Mr. Wilson;

    h. Provide adequate protein, calories, and fluids for Mr. Wilson;

    i. Monitor Mr. Wilson's intake and output;

j. Perform weekly weights of Mr. Wilson to monitor for weight loss;

k. Request consultations with nutritional services, a registered dietician, wound care specialists, physical therapy and/or occupational therapy for Mr. Wilson;

l. Perform regular skin assessments of Mr. Wilson to identify any areas of skin breakdown; and

m. Perform proper daily assessments and documentation of each and every area in which Mr. Wilson experienced skin breakdown including descriptions of the size of the wound (length, width, depth and presence or absence of undermining and/or tunneling); tissue characteristics, including color, odor, nature of the tissue and the presence of any drainage; and stages of the wound in accordance with the standards set forth by the National Pressure Ulcer Advisory Panel.

10. Timely ensure that all staff members are aware of, following and carrying out formulated interventions, and that such interventions are being implemented consistently across all shifts.

11. Timely and appropriately assess and monitor Mr. Wilson for changes in his condition which may necessitate revision of his care plans and safety interventions, including but not limited to, each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions are determined to be ineffective.

12. Update, add to and/or revise care plans and interventions appropriately and in a timely manner, including but not limited to, updating the care plan with new interventions each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions are determined to be ineffective

13. Ensure that the resident care guide is accurately completed upon admission, updated and/or revised with appropriate instructions in a timely manner, dated at the time the changes occur and that all staff members are aware of, follow and carry out instructions.

14. Communicate all pertinent information to Mr. Wilson's physician in a timely manner, including but not limited to, each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson

experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions are determined to be ineffective

15. Request any and all appropriate physician orders necessary to keep Mr. Wilson safe from accidents and injuries, including but not limited to, an order mandating the level of assistance to be provided to Mr. Wilson with ambulation and transfers, as well as orders necessary to prevent Mr. Wilson from developing pressure ulcers, and to promote healing, prevent infection and prevent Mr. Wilson from developing new ulcers, including but not limited to, an order for support surfaces or overlays to reduce pressure and shear, a turning and repositioning schedule, instructions to keep skin clean and dry, medications, treatments, cleansers, moisturizers and creams to protect the skin, a toileting program, laboratory studies, adequate protein, calories, and fluids, monitoring of intake and output, weekly weights, nutritional and/or dietary consultations, wound care consultations, physical and/or occupational therapy consultations, and regular skin assessments.

16. Timely and appropriately follow and carry out all physician orders.

17. Ensure that the services provided by the facility meet professional standards of quality, including but not limited to, maintaining a safe environment for a resident such as Mr. Wilson.

18. Promote, advocate and protect the health, safety and rights of a resident such as Mr. Wilson, including but not limited to, informing supervisors and others in the chain of command of the need for Mr. Wilson, who was at high risk for sustaining falls, skin breakdown and infection, to receive timely and appropriate care to prevent accidents and injuries.

19. Immediately notify Mr. Wilson's family and/or Patient Advocate when Mr. Wilson suffered a fall, had a change in his medical condition and if Imperial is unable to meet the needs of Mr. Wilson.

20. Keep and maintain a record for Mr. Wilson, including an accurate, full and complete record of tests and examinations performed, observations made, treatments provided.

21. Timely provide a basis for determining and managing Mr. Wilson's progress including response to treatment, change in condition and changes in treatment, through timely, complete, accurate and organized clinical information that is readily accessible for resident care.

22. Ensure that all alleged violations involving the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness 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).

23. Provide an adequate number of staff in order to ensure that appropriate assessments, care plans, monitoring, treatment, interventions, notifications and documentation are performed in a timely manner.

24. Timely and appropriately ensure that all licensed staff supervise the nursing assistants, including but not limited to, ensuring that the nursing assistants are properly providing Mr. Wilson with the level of assistance that he required for safe ambulation and transfers, as well as the necessary care and treatment to prevent skin breakdown and infection.

25. Timely provide appropriate training for all staff including, but not limited to, RNs, LPNs and nursing assistants, in regard to how to provide appropriate safety precautions, implement interventions, and prevent injury to a resident such as Mr. Wilson who was at high risk for falls, skin breakdown and infection.

26. Timely develop, orient all staff on, implement, ensure all staff follow, and enforce appropriate policies and procedures regarding interventions to prevent injury to a resident such as Mr. Wilson, who was at a high risk for falls, skin breakdown, and infection.

27. Perform other actions as may be learned during discovery on this case.

B. <u>The Applicable Standard of Practice or Care Was Breached</u>

The nursing staff who were agents, assigns, representatives or employees of DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and/or VILLA OLYMPIA INVESTMENT LLC, including but not limited to RNs, LPNs and nursing assistants, failed to:

1. Timely and appropriately ensure that Mr. Wilson is free from neglect, and is provided with the goods and services that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

2. Timely and appropriately ensure that Mr. Wilson's environment remains as free of accident hazards as is possible, and that Mr. Wilson receives adequate supervision and assistance devices to prevent accidents.

3. Timely and appropriately provide care, consistent with professional standards of practice, to prevent Mr. Wilson from developing pressure ulcers.

4. Timely and appropriately provide necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent Mr. Wilson from developing new ulcers.

5. Refrain from allowing Mr. Wilson to transfer and ambulate without the assistance that he required and immediately provide such assistance for Mr. Wilson when he attempted to get out of bed and/or attempted to transfer or ambulate unassisted.

6. Perform timely and accurate comprehensive assessments and evaluations of Mr. Wilson, including but not limited to, his risk of falling, skin breakdown, and infection.

7. Timely and appropriately recognize that Mr. Wilson was at high risk for falling, skin breakdown and infection.

8. Timely and appropriately utilize the results of the comprehensive assessments and evaluations of Mr. Wilson to develop, review and revise appropriate care plans to attain or maintain Mr. Wilson's highest practicable physical, mental, and psychosocial well-being, including but not limited to, an appropriate care plan to prevent falls, and to promote healing, prevent infection and prevent new ulcers from developing.

9. Timely formulate, implement and follow appropriate safety interventions, to prevent accidents and injuries for a resident such as Mr. Wilson, including but not limited to:

    a. Determine the appropriate level of assistance that Mr. Wilson required to keep him safe and ensure that it is communicated to all staff.

    b. Recognize that Mr. Wilson required physical assistance with ambulation and transfers to keep him safe.

    c. Provide support surfaces or overlays to reduce pressure and shear for Mr. Wilson, including but not limited to specialty bed mattresses or chair cushions, alternative pressure surfaces, or low air loss surfaces;

    d. Implement a turning and repositioning schedule for Mr. Wilson to reduce duration of pressure and shear;

    e. Keep Mr. Wilson's skin clean and dry;

    f. Apply cleansers, moisturizers and creams as ordered for Mr. Wilson;

    g. Establish a toileting program for Mr. Wilson;

    h. Provide adequate protein, calories, and fluids for Mr. Wilson;

    i. Monitor Mr. Wilson's intake and output;

    j. Perform weekly weights of Mr. Wilson to monitor for weight loss;

    k. Request consultations with nutritional services, a registered dietician, wound care specialists, physical therapy and/or occupational therapy for Mr. Wilson;

l. Perform regular skin assessments of Mr. Wilson to identify any areas of skin breakdown; and

m. Perform proper daily assessments and documentation of each and every area in which Mr. Wilson experienced skin breakdown including descriptions of the size of the wound (length, width, depth and presence or absence of undermining and/or tunneling); tissue characteristics, including color, odor, nature of the tissue and the presence of any drainage; and stages of the wound in accordance with the standards set forth by the National Pressure Ulcer Advisory Panel.

10. Timely ensure that all staff members are aware of, following and carrying out formulated interventions, and that such interventions are being implemented consistently across all shifts.

11. Timely and appropriately assess and monitor Mr. Wilson for changes in his condition which may necessitate revision of his care plans and safety interventions, including but not limited to, each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions are determined to be ineffective.

12. Update, add to and/or revise care plans and interventions appropriately and in a timely manner, including but not limited to, updating the care plan with new interventions each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions are determined to be ineffective

13. Ensure that the resident care guide is accurately completed upon admission, updated and/or revised with appropriate instructions in a timely manner, dated at the time the changes occur and that all staff members are aware of, follow and carry out instructions.

14. Communicate all pertinent information to Mr. Wilson's physician in a timely manner, including but not limited to, each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions are determined to be ineffective

15. Request any and all appropriate physician orders necessary to keep Mr. Wilson safe from accidents and injuries, including but not limited to, an order mandating the level of assistance to be provided to Mr. Wilson with ambulation and transfers, as well as orders necessary to prevent Mr. Wilson from developing pressure ulcers, and to promote healing, prevent infection and prevent Mr. Wilson from developing new ulcers, including but not limited to, an order for support surfaces or overlays to reduce pressure and shear, a turning and repositioning schedule, instructions to keep skin clean and dry, medications, treatments, cleansers, moisturizers and creams to protect the skin, a toileting program, laboratory studies, adequate protein, calories, and fluids, monitoring of intake and output, weekly weights, nutritional and/or dietary consultations, wound care consultations, physical and/or occupational therapy consultations, and regular skin assessments.

16. Timely and appropriately follow and carry out all physician orders.

17. Ensure that the services provided by the facility meet professional standards of quality, including but not limited to, maintaining a safe environment for a resident such as Mr. Wilson.

18. Promote, advocate and protect the health, safety and rights of a resident such as Mr. Wilson, including but not limited to, informing supervisors and others in the chain of command of the need for Mr. Wilson, who was at high risk for sustaining falls, skin breakdown and infection, to receive timely and appropriate care to prevent accidents and injuries.

19. Immediately notify Mr. Wilson's family and/or Patient Advocate when Mr. Wilson suffered a fall, had a change in his medical condition and if Imperial is unable to meet the needs of Mr. Wilson.

20. Keep and maintain a record for Mr. Wilson, including an accurate, full and complete record of tests and examinations performed, observations made, treatments provided.

21. Timely provide a basis for determining and managing Mr. Wilson's progress including response to treatment, change in condition and changes in treatment, through timely, complete, accurate and organized clinical information that is readily accessible for resident care.

22. Ensure that all alleged violations involving the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness 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).

23. Provide an adequate number of staff in order to ensure that appropriate assessments, care plans, monitoring, treatment, interventions, notifications and documentation are performed in a timely manner.

24. Timely and appropriately ensure that all licensed staff supervise the nursing assistants, including but not limited to, ensuring that the nursing assistants are properly providing Mr. Wilson with the level of assistance that he required for safe ambulation and transfers, as well as the necessary care and treatment to prevent skin breakdown and infection.

25. Timely provide appropriate training for all staff including, but not limited to, RNs, LPNs and nursing assistants, in regard to how to provide appropriate safety precautions, implement interventions, and prevent injury to a resident such as Mr. Wilson who was at high risk for falls, skin breakdown and infection.

26. Timely develop, orient all staff on, implement, ensure all staff follow, and enforce appropriate policies and procedures regarding interventions to prevent injury to a resident such as Mr. Wilson, who was at a high risk for falls, skin breakdown, and infection.

27. Perform other actions as may be learned during discovery on this case.

C. The Actions that Should Have Been Taken or Omitted in Order to have Complied With the Applicable Standard of Practice or Care

At a minimum, the nursing staff who were agents, assigns, representatives or employees of DETROIT NURSING CENTER, LLC d/b/a Imperial, A Villa Center; VILLA HEALTHCARE; and/or VILLA OLYMPIA INVESTMENT LLC, including but not limited to RNs, LPNs and nursing assistants, should have:

1. Timely and appropriately ensured that Mr. Wilson was free from neglect, and was provided with the goods and services that were necessary to avoid physical harm, pain, mental anguish or emotional distress.

2. Timely and appropriately ensured that Mr. Wilson's environment remained as free of accident hazards as was possible, and that Mr. Wilson received adequate supervision and assistance devices to have prevented accidents.

3. Timely and appropriately provided care, consistent with professional standards of practice, to have prevented Mr. Wilson from developing pressure ulcers.

4. Timely and appropriately provided necessary treatment and services, consistent with professional standards of practice, to have promoted healing, prevented infection and prevented Mr. Wilson from developing new ulcers.

5. Refrained from allowing Mr. Wilson to transfer and ambulate without the assistance that he required and immediately provided such assistance for Mr. Wilson when he attempted to get out of bed and/or attempted to transfer or ambulate unassisted.

6. Performed timely and accurate comprehensive assessments and evaluations of Mr. Wilson, including but not limited to, his risk of falling, skin breakdown, and infection.

7. Timely and appropriately recognized that Mr. Wilson was at high risk for falling, skin breakdown and infection.

8. Timely and appropriately utilized the results of the comprehensive assessments and evaluations of Mr. Wilson to have developed, reviewed and revised appropriate care plans to have attained or maintained Mr. Wilson's highest practicable physical, mental, and psychosocial well-being, including but not limited to, an appropriate care plan to have prevented falls, and to have promoted healing, prevented infection and prevented new ulcers from developing.

9. Timely formulated, implemented and followed appropriate safety interventions, to have prevented accidents and injuries for a resident such as Mr. Wilson, including but not limited to:

    a. Determine the appropriate level of assistance that Mr. Wilson required to keep him safe and ensure that it is communicated to all staff.

    b. Recognize that Mr. Wilson required physical assistance with ambulation and transfers to keep him safe.

    c. Provide support surfaces or overlays to reduce pressure and shear for Mr. Wilson, including but not limited to specialty bed mattresses or chair cushions, alternative pressure surfaces, or low air loss surfaces;

    d. Implement a turning and repositioning schedule for Mr. Wilson to reduce duration of pressure and shear;

    e. Keep Mr. Wilson's skin clean and dry;

    f. Apply cleansers, moisturizers and creams as ordered for Mr. Wilson;

    g. Establish a toileting program for Mr. Wilson;

    h. Provide adequate protein, calories, and fluids for Mr. Wilson;

    i. Monitor Mr. Wilson's intake and output;

    j. Perform weekly weights of Mr. Wilson to monitor for weight loss;

    k. Request consultations with nutritional services, a registered dietician, wound care specialists, physical therapy and/or occupational therapy for Mr. Wilson;

    l. Perform regular skin assessments of Mr. Wilson to identify any areas of skin breakdown; and

m. Perform proper daily assessments and documentation of each and every area in which Mr. Wilson experienced skin breakdown including descriptions of the size of the wound (length, width, depth and presence or absence of undermining and/or tunneling); tissue characteristics, including color, odor, nature of the tissue and the presence of any drainage; and stages of the wound in accordance with the standards set forth by the National Pressure Ulcer Advisory Panel.

10. Timely ensured that all staff members were aware of, following and carrying out formulated interventions, and that such interventions were being implemented consistently across all shifts.

11. Timely and appropriately assessed and monitored Mr. Wilson for changes in his condition which may have necessitated revision of his care plans and safety interventions, including but not limited to, each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions were determined to be ineffective.

12. Updated, added to and/or revised care plans and interventions appropriately and in a timely manner, including but not limited to, updating the care plan with new interventions each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions were determined to be ineffective

13. Ensured that the resident care guide was accurately completed upon admission, updated and/or revised with appropriate instructions in a timely manner, dated at the time the changes occurred and that all staff members were aware of, following and carrying out instructions.

14. Communicated all pertinent information to Mr. Wilson's physician in a timely manner, including but not limited to, each time Mr. Wilson experienced a fall, when Mr. Wilson displayed an increased risk of falling, when Mr. Wilson continued to attempt to self-transfer and ambulate, each time Mr. Wilson experienced a change in condition, an increase in risk of skin breakdown, evidence of skin breakdown and/or worsening of skin breakdown, signs and symptoms of infection, and/or when current interventions were determined to be ineffective

15. Requested any and all appropriate physician orders necessary to have kept Mr. Wilson safe from accidents and injuries, including but not limited to, an order mandating the level of assistance to be provided to Mr. Wilson with ambulation

and transfers, as well as orders necessary to have prevented Mr. Wilson from developing pressure ulcers, and to promote healing, prevent infection and prevent Mr. Wilson from developing new ulcers, including but not limited to, an order for support surfaces or overlays to reduce pressure and shear, a turning and repositioning schedule, instructions to keep skin clean and dry, medications, treatments, cleansers, moisturizers and creams to protect the skin, a toileting program, laboratory studies, adequate protein, calories, and fluids, monitoring of intake and output, weekly weights, nutritional and/or dietary consultations, wound care consultations, physical and/or occupational therapy consultations, and regular skin assessments.

16. Timely and appropriately followed and carried out all physician orders.

17. Ensured that the services provided by the facility met professional standards of quality, including but not limited to, maintaining a safe environment for a resident such as Mr. Wilson.

18. Promoted, advocated and protected the health, safety and rights of a resident such as Mr. Wilson, including but not limited to, informing supervisors and others in the chain of command of the need for Mr. Wilson, who was at high risk for sustaining falls, skin breakdown and infection, to receive timely and appropriate care to have prevented accidents and injuries.

19. Immediately notified Mr. Wilson's family and/or Patient Advocate when Mr. Wilson suffered a fall, had a change in his medical condition and if Imperial was unable to meet the needs of Mr. Wilson.

20. Kept and maintained a record for Mr. Wilson, including an accurate, full and complete record of tests and examinations performed, observations made, and treatments provided.

21. Timely provided a basis for determining and managing Mr. Wilson's progress including response to treatment, change in condition and changes in treatment, through timely, complete, accurate and organized clinical information that was readily accessible for resident care.

22. Ensured that all alleged violations involving the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness were 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).

23. Provided an adequate number of staff in order to have ensured that appropriate assessments, care plans, monitoring, treatment, interventions, notifications and documentation were performed in a timely manner.

24. Timely and appropriately ensured that all licensed staff supervised the nursing assistants, including but not limited to, ensuring that the nursing assistants were properly providing Mr. Wilson with the level of assistance that he required for

safe ambulation and transfers, as well as the necessary care and treatment to have prevented skin breakdown and infection.

25. Timely provided appropriate training for all staff including, but not limited to, RNs, LPNs and nursing assistants, in regard to how to have provided appropriate safety precautions, implemented interventions, and prevented injury to a resident such as Mr. Wilson who was at high risk for falls, skin breakdown and infection.

26. Timely developed, oriented all staff on, implemented, ensured all staff followed, and enforced appropriate policies and procedures regarding interventions to prevent injury to a resident such as Mr. Wilson, who was at a high risk for falls, skin breakdown, and infection.

27. Performed other actions as may be learned during discovery on this case.

D. The Manner in Which the Breach of the Standard of Practice or Care was a Proximate Cause of the Injury Alleged

The above breaches in the standard of care were the proximate cause of Mr. Wilson ambulating without the assistance that he required for his safety. The force of the fall caused him to suffer a right hip fracture that required surgical repair, wound care treatment, narcotic pain medications, and extensive physical and occupational therapy. The fracture resulted in a decline in his functional status and mobility.

The defendant's neglect also resulted in prolonged pressure over the bony prominences of his buttocks and sacrum, deterioration of his skin by urine and feces, and inadequate hydration and nutrition, resulting in Mr. Wilson suffering severe, life-threatening skin breakdown.

Prolonged pressure on Mr. Wilson's skin and underlying tissues reduced blood flow to his buttocks and sacrum. This pressure disrupted the normal delivery of oxygen and nutrients to the skin cells and impaired the removal of waste products. Without an adequate blood supply, his skin cells became deprived of oxygen and essential nutrients, leading to tissue ischemia (lack of oxygen) and subsequent cell death.

Excessive moisture on Mr. Wilson's skin softened his skin and made it more susceptible to damage. Moisture macerated his skin, making it more prone to breakdown. The moisture also made his skin more susceptible to friction and shear forces, which caused further damage to his skin.

Extensive exposure of Mr. Wilson's skin to urine and feces led to irritation and inflammation in his buttocks and sacrum. The enzymes in the urine and feces broke down Mr. Wilson's skin's protective barrier and increased its susceptibility to damage. The alkaline pH of his urine further exacerbated his skin irritation and breakdown.

Inadequate nutritional intake, such as proteins, vitamins, and minerals, compromised Mr. Wilson's body's ability to repair and regenerate his damaged skin tissue. His skin became more vulnerable to breakdown and less able to withstand the insults of pressure, moisture, and other factors.

Dehydration impaired Mr. Wilson's body's ability to maintain skin turgor and elasticity, making his skin more prone to damage. Inadequate hydration impaired the health and integrity of his skin, and damaged the structure and function of his skin cells. Inadequate hydration also impaired wound healing and prolonged his recovery process.

Collectively, prolonged pressure over the bony prominences of his buttocks and sacrum, deterioration of his skin by urine and feces, and inadequate hydration and nutrition, contributed to the breakdown of Mr. Wilson's skin integrity and the development of tissue damage, leading to stage IV pressure injuries on his buttocks and sacrum.

As Mr. Wilson's pressure injury progressed, his skin's natural barrier function was compromised. The integrity of his skin's epidermis and dermis were disrupted, creating a breach in the skin's protective barrier. This breach allowed microorganisms, including bacteria, fungi, and sometimes viruses, to enter the wound site. Once microorganisms gained entry into the wound, they found an ideal environment for proliferation and growth. Warmth, moisture, and nutrient-rich exudate from the wound provided an optimal setting for microbial colonization and multiplication. The presence of microorganisms triggered an inflammatory response in Mr. Wilson's body, characterized by the release of pro-inflammatory cytokines, recruitment of immune cells (such as neutrophils and macrophages), and activation of the complement system. This chronic inflammation in the setting of infection delayed wound healing and exacerbated tissue damage. Infection led to further tissue damage and necrosis (cell death) within the wound site. Bacterial toxins, proteases, and other virulence factors released by the microorganisms contributed to tissue destruction and breakdown. Necrotic tissue provided a nutrient-rich environment for bacterial growth and served as a reservoir for persistent infection. Microorganisms penetrated to deeper tissues, leading to systemic spread of infection, resulting in sepsis.

As a result of his pressure injuries, Mr. Wilson required extensive wound care and treatment, including but not limited to wound dressings, topical treatments, wound debridement, antibiotic therapy, and pain management.

As a result of Mr. Wilson's systemic infection, he became unresponsive and was rendered to be permanently incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of daily living.

Mr. Wilson's overwhelming infection impaired wound healing. In addition, the bacteria in Mr. Wilson's pressure injury entered his blood stream, triggering a systemic inflammatory response throughout the body, which damaged tissues, impaired the function of vital organs, including the lungs, kidneys, liver, and heart, and lead to hypotension. This caused inadequate tissue perfusion and oxygen delivery to vital organs, resulting in multiple organ failure and death.

Mr. Wilson died on February 21, 2023. His fall and pressure injuries caused and/or contributed to his death.

Mr. Wilson was further caused to expend and/or have expended on his behalf by sources of health care insurance large sums of money for medical and hospital care and treatment for which his estate is legally obligated as a result of claims of subrogation and liens.

Charlotte Sheppard RN
CHARLOTTE SHEPPARD, R.N.

Subscribed and sworn to before me
this 27th day of Dec., 2024

Kim M. Jarvis
Notary Public
County of Pasco
State of Florida
My commission expires Nov. 1, 2025