IN THE SUPERIOR COURT OF RICHMOND COUNTY
STATE OF GEORGIA

RONALD DENT, individually and as husband of RUBY MAE MCCLADDIE DENT, deceased, and GARY HAMMOND as Administrator of the Estate of RUBY MAE MCCLADDIE DENT,	)	
Plaintiffs,	)	CIVIL ACTION NO. _____
v.	)	Jury Trial Demanded
UNIVERSITY HEALTH SERVICES, INC. d/b/a UNIVERSITY HOSPITAL; PRUITTHEALTH-AUGUSTA HILLS, LLC; PRUITTHEALTH, INC. a/k/a UHS PRUITT CORPORATION; PRUITTHEALTH CONSULTING SERVICES, INC.; NEIL L. PRUITT, JR.; JOHN DOES 1-5; and RICHARD ROE CORPORATIONS 1-5,	)	
Defendants.		

COMPLAINT FOR DAMAGES

COMES NOW Plaintiffs Ronald Dent, individually, as husband of Ruby Mae McCladdie Dent, deceased, and Gary Hammond as Administrator of the Estate of Ruby Mae McCladdie Dent, by and through counsel, and file this Complaint for Damages against Defendants University Health Services, Inc. d/b/a University Hospital; PruittHealth – Augusta Hills, LLC; PruittHealth, Inc. a/k/a UHS Pruitt Corporation; PruittHealth Consulting Services, Inc.; Neil L. Pruitt, Jr.; John Does 1-5; and Richard Roe Corporations 1-5 as follows:

PARTIES, JURISDICTION, AND VENUE

Plaintiffs

1. Plaintiff Ronald Dent is the surviving husband of Ruby Mae McCladdie Dent, deceased, ("Ms. Dent") and is authorized to bring this action in tort for the wrongful death of his wife. O.C.G.A. §§ 51-4-2 and 9-2-40.

2. Plaintiff Gary Hammond was appointed as Administrator of the Estate of Ruby Mae McCladdie Dent on May 10, 2018, in the Probate Court of Richmond County, Georgia and is authorized to bring claims belonging to Ms. Dent in life and belonging to her estate including, but not limited to, pre-death pain and suffering and medical, funeral and burial expenses. O.C.G.A. § 9-2-41.

UHS, Inc. Defendant

3. At all material times, Defendant University Health Services, Inc. ("UHS, Inc.") was a Georgia corporation authorized to transact business in the State of Georgia and doing business in Richmond County.

4. UHS, Inc. owned, operated, maintained, or controlled an acute care hospital facility, University Hospital ("the hospital" or "University Hospital"), located at 1350 Walton Way, Augusta, Georgia 30901. UHS, Inc. may be served through its registered agent for service of process, Edward L. Burr, 1350 Walton Way, Augusta, Georgia 30901.

5. Upon information and belief, at all material times, UHS, Inc. established, owned, operated, managed, and/or controlled University Hospital and was, therefore, responsible for ensuring that the activities and operations of the hospital complied with all applicable laws and regulations, including rules and regulations adopted by the federal government and the State of Georgia pertaining to acute care hospitals, including but not limited to the Rules and Regulations adopted by the State of Georgia's Department of Human Services for hospitals (GA. COMP. R. & REGS. r. 111-8-40 *et seq*.).

6. At material times hereto, UHS, Inc. charged and was paid for services rendered to Ms. Dent.

7. Additionally, at all material times, University Hospital was a participant in the Medicare and Medicaid programs and was, therefore, required to comply with the provisions of

42 CFR § 483.1 *et seq*.

8. At all material times, the hospital staff at University Hospital, which included, but was not limited to, medical, nursing, pharmacy, dietary, rehabilitative, and custodial care provider staff (collectively referred to as "hospital staff"), were agents (actual or apparent), servants, and/or employees of University Hospital, and the hospital held them out and represented them as such. Plaintiffs and Ms. Dent justifiably relied on those representations in allowing the hospital staff to provide her with care and treatment. At all material times, the hospital staff was acting within the course and scope of their agency or employment with the hospital so that any acts or omissions on the part of said staff while caring for Ms. Dent are attributable to and imputed to UHS, Inc. pursuant to the doctrine of *respondeat superior* or similar theories of liability. Alternatively, the hospital staff were borrowed servants of UHS, Inc.

9. In the alternative, to the extent that UHS, Inc. and/or any of the hospital staff are found to be separate corporate entities and/or independent contractors, each remain liable for the acts and omissions of one another because UHS, Inc. and the hospital staff were engaged in a joint venture and enterprise and acted in concert in the operation of, and delivery of services at, University Hospital. UHS, Inc. and/or the hospital staff had mutual control of their venture, as well as to control the operation of, and delivery of services at University Hospital.

10. UHS, Inc. is vicariously liable for the negligent acts and omissions of all persons or entities under its control, either direct or indirect, including employees, agents, and consultants.

Pruitt Defendants

11. Upon information and belief, Defendant PruittHealth – Augusta Hills, LLC was at all material times a Georgia for-profit limited liability company authorized to do business in Georgia and doing business in Richmond County.

12. Defendant PruittHealth – Augusta Hills, LLC may be served through its registered

agent, Tyler L. Arnold, 1626 Jeurgens Court, Norcross, Georgia, 30093.

13. Upon information and belief, Defendant PruittHealth, Inc. a/k/a UHS Pruitt Corporation ("PruittHealth") was at all material times a Georgia for-profit corporation authorized to do business in Georgia and doing business in Richmond County. PruittHealth may be served through its registered agent, Tyler L. Arnold, 1626 Jeurgens Court, Norcross, Georgia, 30093.

14. Upon information and belief, PruittHealth Consulting Services, Inc. ("PruittHealth Consulting") was at all material times a Georgia for-profit corporation authorized to do business in Georgia and doing business in Richmond County. PruittHealth Consulting may be served through its registered agent, Tyler L. Arnold, 1626 Jeurgens Court, Norcross, Georgia, 30093.

15. Upon information and belief, Defendant Neil L. Pruitt, Jr. ("Pruitt") was and is acting as Chief Executive Officer and Chief Financial Officer of Defendants PruittHealth, Inc. and PruittHealth Consulting and established, acquired, owned, maintained, controlled and/or operated Defendant PruittHealth-Augusta Hills.

16. Upon information and belief, Defendant Pruitt is a Georgia resident, is subject to the jurisdiction of this Court, and may be served at his residence 4275 Lakehaven Dr. NE, Atlanta, GA 30319, Fulton County.

17. Whenever the term "Pruitt Defendants" is used in this Complaint, this term collectively refers to and includes PruittHealth – Augusta Hills, LLC, PruittHealth, PruittHealth Consulting, and Pruitt.

18. At all material times, the Pruitt Defendants remained actively engaged in and transacted business in Richmond County, Georgia, by establishing, acquiring, owning, maintaining, and/or operating PruittHealth – Augusta Hills, a skilled nursing facility (hereinafter "PruittHealth-Augusta Hills" or the "Facility"), located at 2122 Cumming Road, Augusta, Georgia 30904.

19. At all material times, Pruitt Defendants established, owned, operated, managed, and controlled PruittHealth-Augusta Hills pursuant to a permit issued to PruittHealth-Augusta Hills, LLC by the State of Georgia Department of Community Health. Defendants, therefore, were responsible for ensuring that the activities and operations of PruittHealth-Augusta Hills complied with all applicable laws and regulations pertaining to the Facility, including but not limited to the Rules and Regulations adopted by the State of Georgia's Department of Community Health pertaining to nursing homes. (GA. COMP. R. & REGS. r 111-8-56 *et seq*.).

20. At material times hereto, Pruitt Defendants charged and were paid for services rendered to Ms. Dent.

21. Additionally, at all material times, PruittHealth-Augusta Hills was a participant in the Medicare and Medicaid programs and was, therefore, required to comply with the provisions of 42 CFR § 483.1 *et seq*.

22. Pruitt Defendants are directly liable by virtue of their own conduct for the wrongful acts detailed herein. Pruitt Defendants are also vicariously or indirectly liable for the negligent acts and omissions of all persons or entities under their control, either direct or indirect, including employees, agents, and consultants and responsible for the wrongful conduct detailed herein under one or more of the following alternative legal theories:

a. ***Alter Ego***: At all material times, Pruitt Defendants were *alter egos* of one another. Defendants conducted these entities, including PruittHealth-August Hills, as if they were one by commingling them on an interchangeable basis or confusing separate properties, records, or control. Furthermore, PruittHealth-Augusta Hills was a subsidiary, affiliate, and/or alter ego of Pruitt Defendants. PruittHealth-Augusta Hills was merely a conduit through which the Pruitt Defendants did business. The management and operations of PruittHealth-Augusta Hills were so assimilated

within the Pruitt Defendants that PruittHealth-Augusta Hills was simply a name through which the Pruitt Defendants conducted their business. The Pruitt Defendants so dominated and controlled the operations of PruittHealth-Augusta Hills, and any assertions by the Pruitt Defendants that each was a separate corporate fiction with an independent and separate existence is a sham and part of a scheme to perpetrate fraud, promote injustice, and evade existing legal and fiduciary obligations.

b. ***Agency***: At all material times, Pruitt Defendants acted as agents for one another and each ratified or authorized the acts or omissions of the other.

c. ***Joint Venture/Enterprise***: In the alternative, Pruitt Defendants are each liable for the acts and omissions of the other because they were engaged in a joint venture and enterprise and acted in concert in the establishment, operation, management, and control of the facility. Pruitt Defendants shared a common purpose in establishing, operating, managing, and/or controlling PruittHealth-Augusta Hills and combined their property and labor in PruittHealth-Augusta Hills for the purpose of making a profit. Pruitt Defendants each had a right of mutual control over the establishment, operation, management, control, supervision and maintenance of PruittHealth-Augusta Hills.

All Defendants

23. Whenever the term "Defendants" is utilized in this Complaint, such term collectively refers to and includes all named Defendants in this lawsuit, unless specifically restricted within a cause of action or as further defined below.

24. Plaintiff intends to name as defendants any other entity that, either directly or by joining or in concert with others was negligent and breached the applicable standard of care in

assessing, diagnosing, caring for, and treating Ms. Dent while she was a patient at University Hospital and a resident at PruittHealth-Augusta Hills, and was responsible for the actions or inactions that caused Ms. Dent's injuries. Defendants John Does 1-5 are unknown or unidentified persons or entities within the network of individuals and businesses which participated in these acts and omissions.

25. Plaintiff intends to name as defendants any other entity who are, or were, an alter ego of the Defendants named in this action, or who were agents of or joint-venturers with the named Defendants. Defendants Richard Roes Corporations 1-5 are unknown or unidentified entities that are, or were, alter egos of Defendants or agents of or joint-venturers with the named Defendants in the establishment, ownership, operation, management, or control of University Hospital or PruittHealth-Augusta Hills. Plaintiff cannot determine the exact number or identities of such individuals or entities at this time.

26. Defendants are directly liable by virtue of their own conduct for the wrongful acts detailed herein.

27. Whenever in this Complaint it is alleged that Defendants did any act or failed to do any act, it is meant that the officers, agents, or employees of the designated Defendants respectively performed, participated in, or failed to perform such acts while in the course and scope of their employment or agency relationship with the Defendants.

28. The acts and omissions forming the basis of this Complaint arose in Richmond County, Georgia, and Defendants are subject to the jurisdiction of this Honorable Court. Ga. Const. 1983, Art. VI, Sec. IV, ¶ 1; O.C.G.A. § 15-6-8. Venue is proper in Richmond County, Georgia. Ga. Const. 1983, Art. VI, Sec. II, ¶ 6; O.C.G.A. §§ 14-2-510, 14-3-510.

FACTUAL BACKGROUND

29. On April 4, 2013, Ms. Dent was admitted to PruittHealth-Augusta Hills, at the age

of sixty-seven (67), for skilled nursing care.

30. When Ms. Dent was admitted to PruittHealth-Augusta Hills, she was dependent on the staff at the Facility for nursing and rehabilitative care, as well as assistance with her daily needs including, but not limited to: transfers; mobility; turning and repositioning; pressure relief; adequate nutrition and hydration; toileting; hygiene and grooming; and other activities of daily living.

31. On December 30, 2016, Ms. Dent was transferred to University Hospital with diagnoses for systemic inflammatory response syndrome (SIRS), altered mental status, hypernatremia, and acute kidney injury due to dehydration as a result of intravascular volume depletion.

32. At the time of her admission to University Hospital, Ms. Dent was at risk for skin breakdown, and she needed carefully planned and managed care. Given her compromised condition, Ms. Dent was totally dependent on the hospital staff at University Hospital not only for treatment for her SIRS, hypernatremia, and acute kidney injury, but to meet her every need. During the course of her hospitalization, Ms. Dent needed appropriate precautionary measures to be taken by the hospital to prevent skin breakdown. Ms. Dent also needed assessment and care planning to prevent skin breakdown and to maintain good health.

33. While at University Hospital, Ms. Dent developed skin breakdown to her right and left sacral areas, right and left groin, and left upper thigh. The right and left sacral wound measured 2.0 x 2.0 x .1 cm.

34. The wounds were still present when Ms. Dent was transferred back to PruittHealth-Augusta Hills on January 6, 2017 for skilled nursing care.

35. When Ms. Dent was readmitted to PruittHealth-Augusta Hills, she remained dependent on the staff at the nursing facility for nursing and rehabilitative care, and assistance with

all of her daily needs, including wound care, turning and repositioning, pressure relief, adequate nutrition and hydration, and grooming and hygiene to promote healing of her skin breakdown and prevent infection.

36. At all times relevant to this action, Pruitt Defendants were fully aware that the delivery of care and custodial services to residents in PruittHealth-Augusta Hills, including Ms. Dent, required: (a) provision of adequate and appropriate staffing at the Facility; and (b) appropriate and manageable census levels and types within the Facility.

37. Despite this knowledge, Pruitt Defendants made operational, budgetary, and administrative decisions that were determined more by the financial needs and goals of the Pruitt Defendants than by the custodial, medical, and nursing needs of residents of the Facility, including Ms. Dent.

38. Pruitt Defendants entered into a continuing course of negligent conduct, creating, implementing, and enforcing dangerous operational budgets, practices, and policies at the Facility which deprived residents, including Ms. Dent, of safe, adequate, and essential care and resources to meet their needs including, but not limited to: appropriate plans of care, assessment and continued monitoring of her condition, appropriate documentation for the care of Ms. Dent, assistance with activities consistent with daily living, pressure relief to prevent skin breakdown, fluids to prevent dehydration, adequate sustenance to prevent malnutrition, and a clean and safe environment to prevent infection.

39. Notwithstanding the Pruitt Defendants' decisions, directives, and practices which resulted in inadequate and inappropriate staffing of the Facility, Pruitt Defendants sought to market, recruit, and admit higher acuity, heavier care, higher pay residents to the Facility, even though the needs of the resident population, including the needs of Ms. Dent, exceeded the capacity of the staff.

40. At all material times, Pruitt Defendants had a duty to allocate resources and exercise fiscal and operational policies with reasonable care so as to prevent the infliction of harm on residents of the Facility, including Ms. Dent.

41. Pruitt Defendants breached their duty by failing to allocate sufficient financial and operational resources to the Facility, thereby causing harm to residents, including Ms. Dent. This conduct was specifically directed, controlled, and authorized by Pruitt Defendants, who knew or should have known that such conduct would likely cause harm to residents at the Facility, including Ms. Dent.

42. At all material times, Pruitt Defendants knew or should have known that the delivery of essential and necessary care would suffer due to their budgetary and operational decisions, causing resident injury if they did not provide needed resources to adequately and appropriately staff and operate the Facility.

43. As a result of the Pruitt Defendants' conduct, dependent residents, including Ms. Dent, suffered repeated and ongoing neglect and were subjected to dangerous conditions, including the routine deprivation of basic custodial care.

44. Upon information and belief, Pruitt Defendants were repeatedly placed on notice that the same kind of dangerous conduct and conditions which caused injury to Ms. Dent were occurring and had occurred within their facilities, including PruittHealth-Augusta Hills.

45. The repeated notice and warning of ongoing violations of the minimum standards of care experienced by other similarly situated residents within their facilities, including PruittHealth-Augusta Hills, was inextricably intertwined and connected to that neglect experienced by Ms. Dent and relevant to the Pruitt Defendants' knowledge, indifference, negligence, and willful and wanton conduct.

46. On May 5, 2017, Ms. Dent was sent to Doctors Hospital of Augusta after her urine

was noticed to be discolored. She arrived with a stage IV pressure ulcer to her sacrum and her diagnoses included Sepsis secondary to a urinary tract infection, healthcare acquired pneumonia, dysphagia, wound infection secondary to pseudomonas, and delirium.

47. After treatment with intravenous antibiotics in the ICU, Ms. Dent was discharged to Select Specialty Hospital on May 24, 2017 for continuation of intravenous antibiotics and wound care.

48. Ms. Dent was discharged from Select Specialty Hospital on June 14, 2017 to The Place at Deans Bridge after completing a course of intravenous antibiotics to treat her septic wound infection and healthcare associated pneumonia.

49. Ms. Dent resided at The Place at Deans Bridge and received skilled nursing care, including wound care, until June 28, 2017 when she was admitted to Doctors Hospital of Augusta where, once again, her diagnoses included Sepsis and healthcare associated pneumonia.

50. Ms. Dent was admitted to hospice on July 2, 2017 and passed away within hours. Her preliminary cause of death was Sepsis.

51. The neglect and injuries of Ms. Dent were foreseeable to the Defendants.

52. During her admission to Defendants' facilities, Defendants represented that: (a) they were competent to provide Ms. Dent with the necessary care, treatment and services and would provide the same; and (b) that Ms. Dent's condition was capable of being successfully managed by them.

53. Despite these representations, during her admission to Defendants' facilities, Ms. Dent suffered multiple foreseeable injuries at the hands of the Defendants including, but not limited to: (a) deterioration of her skin including, but not limited to, development and decline of pressure ulcers on her sacral areas, groin, and right thigh; (b) sepsis; (c) malnutrition; (d) dehydration; (e) urinary tract infection; (f) healthcare acquired pneumonia; (g) insults to her human

dignity; (h) violation of her rights; (i) physical pain and suffering; and (j) mental anguish, all contributing to and hastening Ms. Dent's untimely death.

COUNT I
PROFESSIONAL NEGLIGENCE
(UHS, Inc.)

54. Plaintiffs re-allege and incorporate by reference Paragraphs 1 through 53 as if fully set forth *verbatim*.

55. UHS Inc., individually and collectively, and by virtue of their own independent actions, and while acting as agents, servants, and/or employees of one another, and while acting through healthcare providers and the hospital staff employed or utilized by them at the hospital, owed a duty to Ms. Dent to comply with the standard of care, skill, and diligence exercised by healthcare providers generally under similar conditions and like surrounding circumstances as those presented during Ms. Dent's December, 2016, to January, 2017, admission at University Hospital.

56. UHS Inc., individually and collectively, and by virtue of their own independent actions, and while acting as actual or apparent agents, servants and/or employees of one another, and while acting through the healthcare providers and the hospital staff employed or utilized by them at the hospital, were negligent and breached the applicable standard of care with respect to their assessment, diagnosis, planning, care, treatment, and evaluation of Ms. Dent.

57. The professional negligence and breaches of the applicable standard of care by UHS Inc. included, but were not limited to, the following acts and omissions:

a. Failure to prevent the development and progression of avoidable pressure ulcers while Ms. Dent was a patient at University Hospital;

b. Failure to properly, accurately, and timely monitor, observe and assess Ms. Dent's skin condition and developing pressure ulcers;

c. Failure to develop and implement an adequate care plan for pressure

ulcer prevention;

d. Failure to provide appropriate pressure relief and redistribution, including turning and repositioning Ms. Dent at least every two hours;

e. Failure to use adequate pressure reduction in order to prevent the formation and deterioration of pressure ulcers;

f. Failure to supervise and monitor the effects of Ms. Dent's wound treatments and to adjust treatments as necessary;

g. Failure to provide accurate and consistent wound care evaluation and treatment of pressure ulcers; and

h. Failure to accurately and timely document treatment to prevent the worsening or deterioration of her pressure ulcers;

58. In addition to being negligent and breaching the standard of care, the conduct of the staff of University Hospital violated provisions of applicable federal and state law, including but not limited to, provisions of the Code of Federal Regulations (42 CFR § 482.1 *et seq*.), Georgia Rules and Regulations for Hospitals (GA. COMP. R. & REGS r. 111-8-40 *et seq*.), and the Georgia Nurse Practice Act (O.C.G.A § 43-26-1 *et seq*.).

59. Pursuant to O.C.G.A. § 9-11-9.1, and to the extent this statute applies to this action, Plaintiff has attached hereto and incorporated herein as Exhibit "A" the Affidavit of Luanne Trahant, MSN, who is qualified as an expert on the issues raised in this Complaint. This affidavit specifies at least one negligent act or omission by UHS, Inc. The attached affidavit is not inclusive of each act, error or omission that has been committed, or may have been committed, by the UHS, Inc., and Plaintiffs reserve the right to contend and prove additional acts, errors and omissions that reflect a departure from the requisite standard of care.

60. As a direct and proximate result of UHS Inc.'s violations of the standard of care and negligent conduct as described above, Ms. Dent suffered multiple injuries, which included, but were not limited to: development and deterioration of a sacral pressure ulcer. The sacral

pressure ulcer became infected and progressed to a Stage IV wound. Prior to her death, Ms. Dent also suffered infections, excruciating and unnecessary physical pain and suffering, disfigurement, mental anguish, insults to her human dignity, violation of her rights, significant medical expenses, and other economic and non-economic damages. UHS Inc.'s violations of the standard of care and negligent conduct contributed to her untimely death.

61. UHS, Inc. is liable to Plaintiff Ronald Dent, in his capacity as surviving husband of Ms. Dent, for the full value of the life of Ms. Dent.

62. UHS, Inc. is liable to Plaintiff Gary Hammond, in his capacity as the Administrator of the Estate of Ruby Mae McCladdie Dent, for physical and mental pain and suffering experienced by Ms. Dent prior to her death, as well as her medical, funeral, and burial expenses.

63. If any of the acts or omissions complained of in this count are deemed to involve ordinary negligence rather than professional negligence, they are alternatively incorporated and averred as part of Count II below.

COUNT II
ORDINARY NEGLIGENCE
(UHS, Inc.)

64. Plaintiffs re-allege and incorporate by reference Paragraphs 1 through 63 as if fully set forth *verbatim*.

65. This count asserts claims of ordinary negligence. The acts or omissions complained of herein may be assessed by the trier of fact on the basis of common, everyday experiences and the common knowledge of a lay person. The acts or omissions complained of here do not implicate questions of professional judgment or medical competence nor do they involve matters of medical science or art requiring specialized knowledge, training, or skills not ordinarily possessed by lay persons.

66. During Ms. Dent's hospital admission, it was known to UHS, Inc. that she had

become totally dependent upon the hospital to meet her most basic needs.

67. UHS, Inc., while acting through their actual or apparent agents, servants, and/or employees, had a duty to exercise ordinary diligence and reasonable care in the provision of services to patients, including Ms. Dent.

68. UHS, Inc. breached that duty of ordinary diligence and reasonable care as to Ms. Dent.

69. UHS, Inc.'s ordinary negligence, included, but was not limited to:

a. Failure to hire, train, and supervise appropriate, qualified personnel to monitor, oversee, and/or treat patients, including Ms. Dent;

b. Failure to schedule, assign, and place appropriate, qualified personnel to monitor, oversee, and/or treat patients, including Ms. Dent;

c. Failure to accurately and timely document and report information about Ms. Dent and the care and services she received; and

d. Failure to establish, implement and/or enforce appropriate safety, training, staffing, and other policies and/or protocols to prevent known harm to patients, including Ms. Dent.

70. As a result of the ordinary negligence of UHS, Inc. described above, UHS, Inc. proximately caused injuries and death to Ms. Dent as more particularly described in Paragraphs 53 and 60.

71. UHS, Inc. is liable to Plaintiff Ronald Dent, in his capacity as surviving husband of Ms. Dent, for the full value of the life of Ms. Dent.

72. UHS, Inc. is liable to Plaintiff Gary Hammond, in his capacity as the Administrator of the Estate of Ruby Mae McCladdie Dent, for physical and mental pain and suffering experienced by Ms. Dent prior to her death, as well as her medical, funeral, and burial expenses.

73. If any of the acts or omissions complained of in this count are deemed to involve professional negligence rather than ordinary negligence, they are alternatively incorporated and

averred as part of Count I above.

COUNT III
PROFESSIONAL NEGLIGENCE
(Pruitt Defendants)

74. Plaintiffs re-allege and incorporate by reference Paragraphs 1 through 53 as if fully set forth *verbatim*.

75. Pruitt Defendants, individually and collectively, and by virtue of their own independent actions, and while acting as *alter egos* and agents of one another, and while acting as joint venturers in the establishment, operation, management, and/or control of the facility, and while acting through the nurses employed by them at the facility, owed a duty to Ms. Dent to comply with the standard of care and skill exercised by nurses generally under similar conditions and like surrounding circumstances as those presented by Ms. Dent during her residency at the facility.

76. Pruitt Defendants, individually and collectively, and by virtue of their own independent actions, and while acting as *alter egos* and agents of one another, and while acting as joint venturers in the establishment, operation, management, or control of the facility, and while acting through the nurses employed by them at the facility, violated the standard of care and skill exercised by nurses generally under similar conditions and like surrounding circumstances such as those presented by Ms. Dent in their care and treatment of her. Their professional negligence includes, but is not limited to, the following:

Assessment

a. Failure to adequately assess skin breakdown;

Care Planning

b. Failure to develop and implement adequate care plans for pressure ulcer prevention and intervention, infection, dietary needs, and daily fluid requirements;

c. Failure to update and revise care plans to ensure interventions were implemented to meet Ms. Dent's specific care needs;

Skin Integrity and Wound Care

d. Failure to prevent the prevention and worsening of avoidable pressure ulcers while Ms. Roper was a resident at the Facility;

e. Failure to properly, accurately, and timely monitor, observe and assess Ms. Dent's skin condition and developing pressure ulcers and to adjust treatments as necessary;

f. Failure to provide appropriate pressure relief and redistribution, including turning and repositioning at least every 2 hours, implementation of heel protectors, and providing specialty mattress;

g. Failure to provide adequate and appropriate sacral wound care;

Nutrition and Hydration

h. Failure to properly, accurately, and timely monitor, observe, and assess Ms. Dent's nutritional risk and status and obtain appropriate interventions to prevent the development of malnutrition;

i. Failure to provide and maintain Ms. Dent's nutritional and hydrational intake at acceptable parameters;

j. Failure to provide eating assistance for Ms. Dent;

k. Failure to provide Ms. Dent with appropriate nutrition and hydration to prevent and assist in the healing of her multiple pressure ulcers and other complications;

Infection

l. Failure to provide adequate and appropriate personal hygiene;

m. Failure to properly, accurately, and timely monitor, observe, and assess Ms. Dent for signs of infection;

n. Failure to implement and adjust as necessary an infection prevention and control plan; and

Documentation

o. Failure to consistently and appropriately document information

related to Ms. Dent's health status, care, treatment, and injuries;

p. Failure to accurately and timely document the development of pressure ulcers by Ms. Dent so as to provide timely intervention by appropriate medical caretakers to prevent infection and the worsening of her pressure ulcers; and

q. Failure to accurately document the use or non-use of pressure relieving devices and weekly skin checks to prevent the development and worsening of Ms. Dent's injuries.

77. In addition to being negligent and breaching the standard of care, the conduct of Pruitt Defendants violated provisions of applicable federal and state law, including but not limited to provisions of the Code of Federal Regulations (42 CFR § 483.1 *et seq.*), Georgia Department of Human Services Rules and Regulations for Nursing Homes (GA. COMP. R & REGS. r 111-8-56 *et seq.*), and the Georgia Nurse Practice Act (O.C.G.A. § 43-26-1 *et seq*.).

78. Pursuant to O.C.G.A. § 9-11-9.1 and to the extent this statute applies to this action, Plaintiffs have attached hereto and incorporated herein as Exhibit "A" the affidavit of Luanne Trahant, MSN, who is qualified as an expert on the issues raised in this Complaint. This affidavit specifies at least one negligent act or omission by Pruitt Defendants. The attached affidavit is not inclusive of each act, error or omission that has been committed, or may have been committed, by Pruitt Defendants, and Plaintiffs reserve the right to contend and prove additional acts, errors and omissions on the part of the Pruitt Defendants that reflect a departure from the requisite standard of care.

79. As a direct and proximate result of Pruitt Defendants' violations of the standard of care and negligent conduct as described above, Ms. Dent suffered multiple injuries, which included, but were not limited to: deterioration of her sacral pressure ulcer which became infected and progressed to a Stage IV wound. Ms. Dent also suffered UTI; malnutrition; dehydration; excruciating and unnecessary physical pain and suffering, disfigurement, mental anguish, insults

to her human dignity; violation of her rights; significant medical expenses, and other economic and non-economic damages. Pruitt Defendants' violations of the standard of care and negligent conduct also resulted in her untimely death.

80. Pruitt Defendants are liable to Plaintiff Ronald Dent, in his capacity as surviving husband of Ms. Dent, for the full value of the life of Ms. Dent.

81. Pruitt Defendants are liable to Plaintiff Gary Hammond, in his capacity as the Administrator of the Estate of Ruby Mae McCladdie Dent, for physical and mental pain and suffering experienced by Ms. Dent prior to her death, as well as her medical, funeral, and burial expenses.

82. If any of the acts or omissions complained of in this count are deemed to involve ordinary negligence rather than professional negligence, they are alternatively incorporated and averred as part of Count IV below.

COUNT IV
ORDINARY NEGLIGENCE
(Pruitt Defendants)

83. Plaintiffs re-allege and incorporate by reference Paragraphs 1 through 53 and 74 through 82 as if fully set forth *verbatim*.

84. This count asserts claims of ordinary negligence. The acts or omissions complained of herein may be assessed by the trier of fact on the basis of common, everyday experiences and the common knowledge of a lay person. The acts or omissions complained of here do not implicate questions of professional judgment or medical competence, nor do they involve maters of medical science or art requiring specialized knowledge, training, or skills not possessed by lay persons. Moreover, the acts or omissions complained of herein involve custodial neglect perpetrated by persons who were not medical professionals and/or the acts and omissions complained of herein resulted from the dangerous administrative policies, systems, directives, and/or practices engaged

in by Pruitt Defendants which affected not only Ms. Dent, but an entire group of residents in the facility.

85. Pruitt Defendants had a duty to exercise ordinary and reasonable care in providing services to Ms. Dent, including, but not limited to, the following: assisting with activities necessary for daily living; assistance with turning and repositioning; assistance with mobility, personal hygiene, bathing, and toileting; providing appropriate plans of care; providing appropriate nutrition and hydration; and observing, documenting, and reporting abnormal findings to nurses and physicians.

86. Pruitt Defendants, individually and collectively, and by virtue of their own independent actions and while acting as *alter egos* and agents of one another, and while acting as joint venturers in the establishment, operation, maintenance, supervision, management, or control of the facility, and while acting through staff employed by them, failed to exercise ordinary and reasonable care in provision of services for Ms. Dent. Pruitt Defendants' ordinary negligence included, but was not limited to:

a. Failure to protect Ms. Dent from, and to prevent, injury;

b. Failure to accurately and appropriately document care provided to Ms. Dent;

c. Failure to keep complete, concise, and accurate medical records for Ms. Dent;

d. Failure to hire, adequately screen, and train adequate and appropriate personnel to monitor, supervise, care for, and/or treat Ms. Dent;

e. Failure to schedule, assign, and place appropriate, qualified personnel to monitor, oversee, care for, and/or treat Ms. Dent;

f. Repeated failure to establish and implement appropriate corporate budgeting policies which were consistent with the needs of residents of the facility, including Ms. Dent;

g. Continuing creation and enforcement of dangerous operational budgets which deprived residents of adequate staffing, supplies, and caused neglect;

h. Ongoing failure to allocate sufficient financial resources thereby causing the harm to Ms. Dent described herein;

i. Failure to establish, implement, and/or enforce appropriate safety, training, staffing, and fundamental policies and procedures to prevent harm to Ms. Dent and avoid the known consequences of inadequate care;

j. Failure to have systems in place to ensure that the staff functioned within the scope of their professional practice, education, and training to meet the needs of residents, including Ms. Dent;

k. Failure to have systems in place to ensure communication between nurses and nursing assistants regarding changes in resident condition for all residents to prevent harm to Ms. Dent;

l. Failure to provide licensed health care professionals with the knowledge and ability to accurately and regularly assess the condition of each resident in order to prevent harm to Ms. Dent;

m. Failure to investigate and correct known systemic breakdowns in the delivery of care at the facility to avoid the consequences and harm to Ms. Dent; and

n. Failure to provide proper care and services in accordance with Ms. Dent's rights and needs.

87. As a result of the ordinary negligence of Pruitt Defendants, the Pruitt Defendants proximately caused injuries and death to Ms. Dent as more particularly described in Paragraphs 53 and 79.

88. Pruitt Defendants are liable to Plaintiff Ronald Dent, in his capacity as surviving husband of Ms. Dent, for the full value of the life of Ms. Dent.

89. Defendants are liable to Plaintiff Gary Hammond, in his capacity as the Administrator of the Estate of Ruby Mae McCladdie Dent, for physical and mental pain and suffering experienced by Ms. Dent prior to her death, as well as her medical, funeral, and burial

expenses.

90. If any of the acts or omissions complained of in this count are deemed to involve professional negligence rather than ordinary negligence, they are alternatively incorporated and averred as part of Count III above.

COUNT V
VIOLATIONS OF THE GEORGIA BILL OF RIGHTS FOR RESIDENTS OF LONG TERM CARE FACILITIES
(Pruitt Defendants)

91. Plaintiffs re-allege and incorporate by reference Paragraphs 1 through 53 and 74 through 90 as if fully set forth *verbatim*.

92. Plaintiff is entitled to bring an action as a result of the Pruitt Defendants' violations of Ms. Dent's rights protected under the Bill of Rights for Residents of Long Term Care Facilities, O.G.G.A. § 31-8-100 *et seq*. ("Bill of Rights").

93. By virtue of their conduct described in this Complaint, the Pruitt Defendants, individually and collectively, and by virtue of their own independent actions and while acting as *alter egos* and agents of one another, and while acting as joint venturers in the establishment, operation, management, or control of the facility, and while acting through the nurses and custodial staff employed by them at the facility, failed to comply with the requirements and provisions of the O.C.G.A. § 31-8-100, *et seq.*, and violated Ms. Dent's rights enumerated under the Bill of Rights.

94. These violations on the part of the Pruitt Defendants proximately caused injuries and death to Ms. Dent as more particularly described in Paragraphs 53 and 79, all of which resulted in medical expenses and other damages.

95. Pruitt Defendants are liable to Plaintiff Ronald Dent, in his capacity as surviving husband of Ms. Dent, for the full value of the life of Ms. Dent.

96. Defendants are liable to Plaintiff Gary Hammond, in his capacity as the Administrator of the Estate of Ruby Mae McCladdie Dent, for physical and mental pain and suffering experienced by Ms. Dent prior to her death, as well as her medical, funeral, and burial expenses.

COUNT VI
MISREPRESENTATION
(Pruitt Defendants)

97. Plaintiffs re-allege and incorporate by reference Paragraphs 1 through 53 and 74 through 96 as if fully set forth *verbatim*.

98. In addition to the negligent conduct already described herein, Pruitt Defendants by virtue of their own independent actions, and while acting through their agents (actual or apparent), servants and/or employees engaged in a continuing and routine practice of misrepresentation which was a proximate cause of Ms. Dent's injuries, damages, and death.

99. At all material times, Pruitt Defendants represented and held PruittHealth-Augusta Hills out to the public, including Ms. Dent and her representatives, as a highly qualified and competent long-term care facility capable of providing skilled nursing care and custodial services to residents, including Ms. Dent, as prescribed by law and applicable professional standards.

100. The foregoing willful representations made by Pruitt Defendants about the level of care, services, and treatment PruittHealth-Augusta Hills which the facility could provide were false at the time the representations were made. Pruitt Defendants knew or should have known said representations were false and made them with the intention of inducing members of the public, including Ms. Dent and her representatives, to rely upon them.

101. Additionally, Pruitt Defendants engaged in misrepresentation by negligently and/or intentionally concealing, suppressing and/or failing to disclose material facts to Ms. Dent and her representatives. These material facts include, but are not limited to:

a. The fact that the staff of PruittHealth-Augusta Hills was not sufficient in number, qualifications, competency, or training to meet the care and treatment of residents, including Ms. Dent;

b. The fact that the acuity and care needs of residents, including Ms. Dent, exceeded the care capabilities, qualifications, and competence of staff;

c. The fact that no policies and procedures were in place to ensure staffing and qualifications were sensitive and responsive to specific needs of residents, including Ms. Dent;

d. The fact that Ms. Dent's needs were not being met, and in fact, Ms. Dent's status was severely worsening; and

e. The fact of Pruitt Defendants' continuing neglect of its residents, including Ms. Dent.

102. During Ms. Dent's residency, Pruitt Defendants were aware, or should have been aware, and knowledgeable of these material facts. Pruitt Defendants knew or should have known that Ms. Dent and her representatives were ignorant of the same, and Pruitt Defendants knew or should have known that Ms. Dent and her representatives did not have an equal opportunity to discover the truth about such facts.

103. As a resident who elected skilled nursing care and custodial care at PruittHealth-Augusta Hills over competing facilities, Pruitt Defendants owed Ms. Dent and her representatives a duty to disclose material facts that it knew or should have known would have affected the decision to admit Ms. Dent to the facility and allow her to remain a resident of the facility.

104. Pruitt Defendants' false representations and failure to disclose material facts about PruittHealth-Augusta Hill's commitment and capacity to provide the necessary level of skilled nursing care and custodial services to residents, including Ms. Dent, induced Ms. Dent's representatives to admit Ms. Dent to the facility and to remain a resident there. Ms. Dent and her representatives justifiably relied on Pruitt Defendants' ongoing misrepresentations, and trusting in them, Ms. Dent became a resident of PruittHealth-Augusta Hills in lieu of alternative nursing

facilities. These misrepresentations and the material consequences which flowed therefrom were a direct and proximate cause of Ms. Dent's catastrophic injuries, subsequent complication, and death.

105. These misrepresentations grew out of financial motives and a willful attempt to hide Pruitt Defendants' dangerous and ongoing calculated business practices engaged in to protect Defendants' revenue stream and to improve its profitability.

106. Pruitt Defendants are liable to Plaintiff Ronald Dent, in his capacity as surviving husband of Ms. Dent, for the full value of the life of Ms. Dent.

107. Defendants are liable to Plaintiff Gary Hammond, in his capacity as the Administrator of the Estate of Ruby Mae McCladdie Dent, for physical and mental pain and suffering experienced by Ms. Dent prior to her death, as well as her medical, funeral, and burial expenses.

COUNT VII
PUNITIVE DAMAGES
(All Defendants)

108. Plaintiffs re-allege and incorporate by reference Paragraphs 1 through 107 as if fully set forth *verbatim*.

109. The acts and omissions of the Defendants demonstrate fraud, intentional misconduct, willful and wanton misconduct, oppression, malice and/or a conscious indifference to the consequences, including the safety, health, and welfare of Ms. Dent.

110. The acts and omissions of the Defendants were accompanied by aggravating circumstances.

111. The conduct previously described herein was undertaken by Defendants in conscious and intentional disregard of and with indifference to the rights and safety of Ms. Dent.

112. Defendants knew or should have known that said conduct was substantially certain

to result in injury, damage, or other harm to Ms. Dent, and they had multiple opportunities to intervene and act to prevent the harm suffered by Ms. Dent. Notwithstanding notice of Ms. Dent's status and the reasonable likelihood of harm to her, Defendants failed to act to prevent such harm, including injuries, damages and death.

113. Defendants are liable for punitive damages to Plaintiffs, and punitive damages should be awarded against Defendants to deter them from repeated misconduct.

WHEREFORE, Plaintiffs pray for the following relief:

(a) That a process be issued and copy of this Complaint and Summons be served upon Defendants as provided by law;

(b) That Plaintiffs recover a judgment against the Defendants, jointly and severally, in the form of compensatory damages in an amount in excess of $10,000.00 for Ms. Dent's pain and suffering and medical expenses and as shown by the evidence at the trial of this case;

(c) That Plaintiff Gary Hammond, as Administrator of the Estate of Ruby Mae McCladdie Dent, recover a judgment against the Defendants, jointly and severally, in the form of compensatory damages in an amount in excess of $10,000.00 for the pain and suffering and medical expenses of Ms. Dent and as shown by the evidence at the trial of this case;

(d) That Plaintiff Gary Hammond, as Administrator of the Estate of Ruby Mae McCladdie Dent, recovers punitive damages from the Defendants;

(e) That Plaintiff recovers the costs of this action;

(f) That Plaintiff be granted a jury to try this case; and

(g) That the Court and jury grant such other and further relief as may be just and proper.

Respectfully submitted, this the 24th day of September, 2018.

/s/ *Anne K. Moore*
Anne K. Moore, Ga. Bar No. 786296
C. Caleb Connor, Ga. Bar No. 021436
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Attorneys for Plaintiffs

State of Louisiana
Rapides Parish+

AFFIDAVIT OF FRANCES LUANNE TRAHANT, BSN, MSN, APRN, FNP-BC

Comes now before me, an officer authorized to administer oaths, Frances Luanne Trahant, BSN, MSN, APRN, FNP-BC, who having been duly sworn, deposes and says:

1.

My name is Frances Luanne Trahant, BSN, MSN, APRN, FNP-BC, and my address is 804 Main St., Pineville, Louisiana 71303.

2.

I make this affidavit in support of an action to be filed in connection with the care and treatment received by Ruby Dent, while a resident of Pruitt Health Augusta Hills from April 4th, 2013 through May 5th, 2017 and a patient at University Hospital from December 30th, 2016 through January 6th, 2017. The opinions contained in this affidavit are expressed as an expert in the provision of nursing care to patients and residents in skilled and acute care nursing facilites such as Pruitt Health Augusta Hills and University Hospital.

3.

I have been a registered nurse duly licensed by the appropriate regulatory agency in the State of Louisiana for over 20 years and have actively practiced professional nursing since my graduation from nursing school in 1992. I received my Bachelor of Science Degree in Nursing in 1992 from Northwestern State University in Shreveport, Louisiana and my Masters of Science in Nursing, Cum Laude, in 2005 from the University of Phoenix. I completed post-graduate education at Northwestern State University in Shreveport, Louisiana in 2010 and became certified as a family Nurse Practitioner in 2010. I have served as a Registered Nurse, Director of Nursing, Administrator and as a Family Nurse Practitioner in the long-term care setting as well as acute care hospitals. I attach my CV for reference hereto.

4.

As a result of having been regularly and continuously engaged in the active practice of nursing from 1992 to the present, I have actual professional knowledge and experience in the areas of practice of providing nursing care and oversight to patients/residents such as Ruby Dent while she was a patient at University Hospital Augusta and a resident at Pruitt Health Augusta Hills. For greater than three of the last five years prior to the negligence described below, I have been actively

PLAINTIFF'S EXHIBIT
A

and regularly involved in assessing, planning, and caring for patients in the acute care and long-term care settings who suffered from the same or similar medical conditions as Ruby Dent while a patient at University Hospital Augusta and a resident of Pruitt Health Augusta Hills and exhibited clinical signs and symptoms that place them at risk of complications.

5.

Pursuant to the provisions of O.C.G.A § 9-11-9.1, which requires at least one negligent act or omission be specified for each named defendant in order to file a Complaint with the Court, I make this affidavit in support of an action to be filed on behalf of Ruby Dent alleging, among other things, negligence with regard to her care and treatment while a patient of University Hospital Augusta and a resident of Pruitt Health Augusta Hills. To date, I have reviewed the following records and materials related to Ruby Dent as listed below:

• Pruitt Health Augusta Hills Records	04/04/13 – 12/30/16; 01/06/17 – 05/05/17
• University Hospital Records	12/30/16 – 01/06/17
• Doctors Hospital of Augusta Records	05/05/17 – 05/24/17; 06/28/17 – 07/02/17
• Select Specialty Hospital Augusta Records	05/24/17 – 06/14/17
• The Place at Deans Bridge Records	06/14/17 – 06/28/17
• Doctors Hospital of Augusta Hospice Records	07/02/17 (DOD)
• Death Certificate	

6.

Based on my review of the foregoing documents, it is my opinion that the acts and omissions of University Hospital Augusta and Pruitt Health Augusta Hills and any other entity or person responsible for managing, supervising or operating said facilities and their staff in their care of Ruby Dent demonstrated outrageous deviations from the prevailing standards of nursing care and caused Ruby Dent injuries and unnecessary pain and suffering. Furthermore, it is my opinion that during the course of her residency at Pruitt Health Augusta Hills from April 4th 2013 through May 5th, 2017 and her admission to University Hospital from December 30th, 2016 through January 6th, 2017, Ruby Dent suffered from numerous, repeated, and inexcusable violations of her rights as resident and patient. Furthermore, Finally, the care provided to Ruby Dent both these facilities failed to comply with applicable federal and state regulations.

7.

OVERVIEW

Mrs. Ruby Dent was 67 years old when she was admitted to Pruitt Health on April 4th, 2013. Ruby Dent's medical history included dementia, diabetes mellitus, pulmonary edema, chronic renal

failure, morbid obesity, protein calorie malnutrition, osteoarthritis, rheumatoid arthritis, cerebral infarction, acute lacunar stroke, hypercholesteremia, GERD, neuropathy and depression.

By 02/24/16 Ruby Dent was documented as being understood and usually able to understand others. Her BIMS (brief interview for mental status) score was 11, signifying she was cognitively moderately impaired. Given her physical impairments, she was totally dependent on the staff for transfers, dressing, and ab extensive assist for bed mobility, toileting, personal hygiene and supervision with eating. She was always incontinent of urine and bowels, and weighed 264 pounds. While she had lost weight, she was not on a physician ordered weight reduction diet. She had a history of skin breakdown and was at risk for skin breakdown, but had no pressure ulcers. She had MASD (moisture associated skin damage), and a pressure reliving device was checked for her chair and bed. She was also on a turning and repositioning and nutrition program.

On 12/30/16, Mrs. Dent was sent to University Hospital with complaints of a possible CVA.

At the time of her admission, Ruby Dent was severely dehydrated with a BUN of 37 H (7-18) and creatinine of 1.5 H (0.6-1.3). Her albumin was low at 3.3 L (3.5-5.0), sodium was high at 162 H (136-145) and chloride 129 H (98-107). She was admitted with a diagnosis of SIRS (systemic inflammatory response syndrome), altered mental status, hypernatremia and acute kidney injury due to IVVD (intravascular volume depletion).

Despite a care plan for skin integrity being completed, she developed skin breakdown to her right and left sacral areas and right and left groin and left upper thigh, which was first documented on 01/03/17. On 01/04/17, the right and left sacral wound measured 2.0 x 2.0 x 0.1 cm and was described as red/black and moist with no drainage. The wounds were still present when she was discharged on 01/06/17. The nursing staff documented her wounds to be pink with serosangineous drainage upon her discharge.

When Mrs. Dent returned to Pruitt Health on 01/06/17, after her week-long hospitalization, she was documented to have 3 open areas on her bilateral buttocks and coccyx. Her Braden score was listed at 14, or moderate risk for skin breakdown.

The minimum data set dated 01/13/17 listed Ruby Dent as a 6 for BIMS score, and noted that she required extensive assist with eating. She had difficulty swallowing and was on a therapeutic, mechanically altered diet, was suffering from 3 stage II pressure ulcers. It was documented that she still had MASD, a pressure reducing device on her bed and chair, was to receive pressure ulcer care and a therapeutic diet. Her weight was listed at 257 pounds.

Ruby Dent's left buttock wound eventually resolved but unfortunately, the right buttock and coccyx merged into one large pressure sore area on 03/31/17.

Care plans were initiated on 04/18/17 for 'resident is at risk for UTI's (urinary tract infection), requires the use of a Foley catheter to promote wound healing'. On 05/03/17, care plans were initiated for 'pressure ulcer to coccyx and impaired skin integrity to right heel and potential for skin breakdown related to noncompliance with positioning'. The care plans listed generic interventions, nonspecific to Ruby Dent's situation.

Ruby Dent was sent to Doctors Hospital of Augusta on 05/05/17. She arrived with a stage IV pressure ulcer to her sacrum with a WBC of 18.03 (4.0-11.0) and an albumin of 2.2 L (3.4-5.0). She was diagnosed with leukocytosis, pyelonephritis and hypotension. Ruby Dent was discharged on 05/24/17 with discharge diagnoses that included Sepsis secondary to UTI, healthcare versus hospital acquired pneumonia, dysphagia, with PEG tube insertion, wound infection secondary to pseudomonas, morbid obesity, and delirium. She had been briefly admitted to the ICU, and was managed conservatively with intravenous antibiotics. Mrs. Dent was discharged to Select Specialty Hospital on 05/24/17 for continuation of IV antibiotics and wound care.

When Mrs. Dent arrived to Select Specialty Hospital, she was kept on intravenous antibiotics, wound care and PEG tube feedings. She was ordered a fluid immersion surface, Z flex boot, ROHO cushion for pressure reduction. Orders were also received to float heels beneath calves, turning every 2 hours, and a maximum sit time of 30 minutes.

Mrs. Dent was discharged from Select Specialty Hospital on 06/14/17 after completing a course of IV antibiotics to treat her septic wound infection and HCAP (healthcare associated pneumonia). Her dementia and delirium was said to have stabilized back to her baseline. She was maintained on tube feeds for her dysphagia and dysfunction.

Mrs. Dent was sent to The Place at Deans Bridge on 06/14/17 where she resided until 06/28/17. During her residency at The Place at Deans Bridge, she received daily wound care for her Stage IV pressure ulcer, had a Foley catheter in place and remained incontinent of stool. She was totally dependent on the staff for all activities of daily living, and was fed solely through a PEG tube. Her pain medications were adjusted frequently due to loud yelling out when ADL care or wound care was attempted. On 06/28/17, Mrs. Dent was found diaphoretic and lethargic in her bed with a high blood sugar reading. She was immediately sent out to Doctors Hospital for evaluation.

Unfortunately, Mrs. Dent made little progression once readmitted to the hospital, and her family opted for Hospice with comfort care measures. She was admitted to Hospice on 07/02/17 and passed away hours later. Her preliminary cause of death was sepsis.

NEGLIGENCE/BREACHES IN THE STANDARD OF CARE

It is my professional opinion, which I express within a reasonable degree of nursing certainty, that the acts or omissions by University Hospital Augusta and Pruitt Health Augusta Hills and any other entity or person responsible for managing supervising, or operating the nursing home and hospital or their staff was negligent and below the applicable standard of care/standard of practice for long-term and care facilities treating residents and patients with the same or similar conditions as Ruby Dent. Said negligence and substandard care directly and proximately caused and contributed to the injuries that Ruby Dent suffered, including avoidable injuries, which included, but were not limited to, skin breakdown, infections, malnutrition and dehydration. A summary such negligence follows

Failure to Prevent Skin Breakdown

A pressure ulcer is a direct result of pressure, friction or shear and typically occurs over an area of the body that sustains prolonged pressure; if pressure-redistribution interventions are not instituted appropriately and timely, this omission of care will lead to damage to the underlying tissue. Some risk factors that increase a patient's susceptibility to developing pressure injury and that may impair the healing of pressure sores include, but are not limited to, exposure of skin to urinary or fecal incontinence, impaired or decreased mobility, increase in friction or shear, and nutrition and hydration deficits.

An "avoidable" pressure wound is one that develops and the facility staff did not perform one or more of the following:

- Accurately evaluate the patient's clinical condition and pressure wound risk factors,
- Define and implement interventions that were consistent with the patient's needs arising from his or her clinical condition and within the standard of care,
- Monitor and evaluate the impact of the interventions, or
- Revise the approaches as appropriate.

In this matter, **University Hospital Augusta** was negligent and breached the applicable standard of care with respect to Ruby Dent's care in the areas identified below in that they:

- Failed to accurately identify Ruby Dent as a person at high risk for pressure ulcer development;
- Failed to develop and implement an adequate care plan for pressure ulcer prevention;
- Failed to consistently provide documentation that appropriate pressure ulcer prevention was performed during admission;

- Failed to provide appropriate pressure relief and redistribution; and
- Failed to prevent the development and progression of an avoidable coccyx pressure ulcer and avoidable bilateral buttock pressure ulcers while Ruby Dent was a patient from 12/30/16 through 01/06/17.

Examples of the negligent actions and accompanying documentation of skin breakdown identified by the staff of University Hospital Augusta included but are not limited to:

- 12/30/16 University Hospital Emergency Department documentation listed Ruby Dent's skin condition as dry/flakey.
- 12/30/16 Nursing admission listed skin integrity intact, dry and flakey.
- 12/30/16 Braden scale score 15, or mild for skin breakdown.
- 12/30/16 Potential for Compromised Skin Integrity Care Plan did not list current breakdown.
- 01/02/17 Braden Scale Score 13, or moderate risk for skin breakdown.
- 01/02/17 Skin care consisted of foam skin cleanser and medicated powder after diaper changes.
- 01/02/17 Physician order to turn patient received.
- 01/02/17 Physician order for wound/ostomy consult due to skin breakdown to sacrum and groin.
- 01/03/16 Nursing assessment documented skin breakdown to sacrum/groin.
- 01/04/17 Nurses notes documented skin breakdown to right/left sacrum, right/left groin and left upper thigh.
- 01/04/17 Braden Scale score 14 or moderate risk for skin breakdown.
- 01/04/17 Physician order to turn patient, elevate heels with pillow support.
- 01/04/17 Wound care assessment documented orders for right/left inner thigh/groin but no sacral wound care orders.

The nursing staff at **Pruitt Health Augusta Hills** was also negligent and breached the applicable standard of care with respect to Ruby Dent's care in care and treatment of her skin. The standard of care for long-term care facilities requires that a facility must ensure that a resident that enters the facility without pressure sores does not develop pressure sores, must promote the prevention of pressure sore development, and must promote the healing of pressure ulcers that are present, including prevention of any wounds becoming infected.

Pruitt Health Augusta Hills also negligently failed to adequately and appropriately preserve and protect Ms. Dent's skin. That facility and its staff failed to properly assess Ruby Dent, they failed to care plan accurately and appropriately, and failed to provide appropriate interventions to prevent her from suffering numerous, painful areas of skin impairment. As a consequence of their neglect, Ruby Dent suffered several documented areas of skin impairment before her

hospital admission as well as further deterioration of existing skin breakdown upon readmission. As a consequence she required painful wound care treatments and dressing changes and her wounds became necrotic and infected. Documented areas of skin breakdown upon her return from University Hospital included:

- 01/07/17 Body audit form documented open areas to bilateral buttocks and coccyx upon return from hospital
- 01/09/17 Bilateral buttocks and sacral wounds listed as stage II
- 03/31/17 Pressure ulcers on buttocks consolidated into one large pressure ulcer with sacrum
- 05/03/17 Care plan for pressure ulcer to coccyx and right heel initiated with generic interventions
- 05/05/17 Sacral pressure ulcer labeled as Stage IV on arrival to hospital
- 05/05/17 Sacral wound infected with pseudomonas
- 05/24/17 Sacral wound measurement of 10.0 x 14.0 x 4.0 cm
- 06/14/17 Sacral wound described as undermining and tunneling present, necrotic areas throughout wound, palpated down to bone with bone exposed

Failure to Prevent and Treat Avoidable Infections

The standard of care for long-term care facilities mandates that facilities must establish and maintain an infection control program designed to help prevent the development and transmission of disease and infection. Interventions include, but are not limited to, establishing an infection control program under which the facility decides what procedures should be applied to each resident and physically isolating residents to prevent the spread of infection. **Pruitt Health Augusta Hills** negligently failed to recognize signs and symptoms of infection, failed to take appropriate infection control practice measures, practice adequate and appropriate personal hygiene and Foley catheter care and failed to respond with appropriate treatments and interventions. As a result of this negligent conduct, Ruby Dent contracted numerous nosocomial infectious diseases, urinary tract infections, pneumonia, significant dehydration, electrolyte imbalance, and protein-calorie malnutrition. Examples of such avoidable infections include, but are not limited to:

- 01/20/16 Diagnosed with urinary tract infection
- 05/18/16 Diagnosed with cystitis with hematuria
- 10/14/16 Diagnosed with chronic cystitis
- 04/18/17 Care plan for at risk for UTI's, has Foley catheter for wound care initiated
- 05/05/17 Diagnosed with sepsis secondary to enterococcus urinary tract infection, healthcare associated pneumonia versus hospital acquired pneumonia and sacral wound infection secondary to pseudomonas

Failure to Provide Adequate Nutrition and Hydration

Federal and State rules and regulations require that a facility must provide each resident with a nourishing, palatable, well balanced diet that meets the daily nutritional and special dietary needs of each resident; and each resident must receive and a 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. The failure of **Pruitt Health Augusta Hill's** to provide timely assessments, interventions and care planning of Ruby Dent's hydration and nutrition status lead to numerous complications including severe dehydration, malnutrition, weight loss and the eventual insertion of PEG tube to assist with nutrition and hydration. These failures precipitated several hospitalizations and contributed to her unnecessary deterioration and contributed to her overall demise. A sampling of those issues follows:

- 03/05/15 Documented weight 299 pounds
- 11/12/15 Physicians order to push fluids, liberalized diet
- 08/24/16 Documented weight 271 pounds
- 09/22/16 Diagnosed with urinary tract infection
- 12/29/16 Physician order for IV fluids x 2 liters due to lethargy
- 12/30/16 Admitted to hospital with acute kidney injury related to intravascular volume depletion
- 12/30/16 BUN 47 H (7-18), Albumin 3.1 L (3.5-5.0), sodium 162 H (136-145)
- 01/18/17 Documented weight 254 pounds
- 05/03/17 Care Plan developed for potential for alteration in nutrition
- 05/05/17 Albumin 2.2 L (3.4-5.0), BUN 27 H (7-22)
- 05/05/17 Documented weight 227 pounds
- 05/24/17 PEG tube inserted due to dysphagia

In addition to breaching the standard of care, University Hospital - Augusta violated Federal and State regulations applicable to acute care hospitals including, but not limited to, provisions of the Code of Federal Regulation (42 CFR §482.0 et seq.), Georgia Rules and Regulations for Hospitals (O.C.G.A. Title 31-7-1 et seq.) and the Georgia Registered Professional Nurse Practice Act (O.C.G.A. §43-26-1 et seq.). Pruitt Health Augusta Hills conduct summarized above also violated Federal and State regulations including, but not limited to, provisions of the Code of Federal Regulations (42 CFR § 483.0 et seq.), the Georgia Nursing Home Regulations (111-8-56 et seq.), the Georgia Nurse Practice Act (O.C.G.A. § 43-26-1 et seq.), and the Georgia Bill of Rights for Resident of Long Term Care Facilities (O.C.G.A. § 31-8-100 et seq., and 111-8-50 et seq). It is my opinion that the violations of state and federal law were the direct and proximate cause of Ruby Dent's injuries with resulting pain and suffering

This Affidavit is by no means to be construed as an exhaustive recitation of all my opinions with regard to the care and treatment Ruby Dent received while she was a patient of University Hospital and Resident of Pruitt Health Augusta Hills. I reserve the right to supplement, amend, or change these opinions as additional information is produced for my review and evaluation.

FURTHER AFFIANT SAYETH NOT.

Luanne Trahant FNP BC

LUANNE TRAHANT, MSN, APRN, FNP-BC, LNCC

Sworn to and subscribed before me this 7th day of September, 2018

ROGER M McCOY #18373

NOTARY PUBLIC, STATE OF LOUISIANA

My commission expires: AT DEATH

Personally Known ✓ OR Produced Identification

Type of Identification produced _____

Luanne Trahant, MSN, APRN, FNP-BC

804 Main St. ~ Pineville, LA 71360
Phone 318-449-1305 ~ Fax 318-449-1213 ~ Email : consultingcinc@aol.com

EDUCATION

- Bachelor's of Science in Nursing, Northwestern State University, Shreveport, 1992
- Legal Nurse Consulting, Kaplan College for distance education, Certification, 2003
- Master's of Science in Nursing, C*um Laude,* University of Phoenix, 2005
- Post Graduate-Family Nurse Practitioner, Northwestern State University, Shreveport, 2010

EMPLOYMENT

RN, Rapides Regional Medical Center ***1992- 1996***
Charge nurse for a 20 bed acute cardiac unit, provided daily nursing care and managed staffing for the unit. Case Manager for a 30-bed med-surg telemetry floor, provided review for length of stay, insurance use and approval, quality and standards of care review. Inservice Coordinator

RN, Agency Nursing, Nurse Finders ***1993-2000***
Provide direct nursing care in various clinical settings including pediatrics, med-surg, ICU/CCU, physical rehab, psych units, cardiac units, orthopedics, long-term care and surgical units

RN, Case Manager, Staff Nurse, Agency Nurse, ***1996***
Interim Home Health Staffing

Direct care of home health patients, chart and standard of care review on all Medicare and Medicaid recipients of home health, staff development that included physicians, rehabilitative services and nurses in the field. Agency nursing in Long-term care, psychiatric care, medical-surgical nursing and pediatrics

Director of Nursing/Administrator, Wilshire Manor Nursing Home 1996-2000

provided direct nursing care as needed in long-term care setting, directed overall operations of 110 bed facility including staffing, budgeting, purchasing, development of policies and procedures, monitor adherence to policies and Medicare and Medicaid regulations, quality assurance, infection control coordinator, operation of 10 bed Medicare Skilled Unit, inventory, supplies and review for compliance with federal and state regulations as set forth by the Department of Health and Hospitals, directly responsible for providing staff development and chart review on residents weekly for breach of care or substandard care

RN, Case Manager, Staff Nurse 1998 & 2000
Thompson Home Health
Direct care of the home health patient, coordinate visits for home health recipients, JCAHO education for the staff, manage Medicare and Medicaid utilization, Supervisory duties in the field

Director of Nursing, Pecan Grove Training Center, 2000-2001
Oversee nursing department for a 130 bed facility for the mentally retarded including medical and training services, quality assurance, case management, infection control and overall health needs of the well client. Directly responsible for staff and client education regarding health and medical issues

RN, Night Manager/Charge, Christus St. Francis Cabrini Hospital Staff
RN/Agency RN 1993-2005
*P*rovide direct nursing care of the elective post surgical knee and hip replacement patients, direct care to long-term rehabilitation patients. Provided direct care to telemetry patients, long-term care patients, rehab patients, medical surgical and ICU patients

RN, Staff Nurse/Faith Foundation Hospice 2006-2010
provide direct nursing care on an as needed basis to patients with a variety of illnesses in the nursing home setting, provide quality assurance assessments and performance evaluations, member of the IDG team for evaluation of patient care, collaborate and coordinate care with the nursing home staff including evaluating and devising the plan of care, updating and changing the plan of care, monitoring care provided to the resident between nursing home visits, collaborating with the treatment team including the attending physician, nurses, therapists, social worker, pastor and administration, in order to provide consistent, comprehensive care to the residents.

FNP Clinical Residency 2008-2010
Responsible for providing assessments, plans, diagnoses and treatment to patients with a variety of illnesses. These services were provided in the clinic setting, nursing home, assisted living and hospital. The population served ranged from young adult to

geriatrics. Collaborate and coordinate care with an interdisciplinary health care team.

FNP-Applicant **5/2010-10/2010**
Responsible for providing assessments, plans, diagnoses and treatment to predominately geriatric patients with a variety of illnesses. These services were provided in the clinic setting, nursing home, assisted living and hospital. The population served ranged from young adult to geriatrics. Collaborate and coordinate care with an interdisciplinary health care team.

Family Nurse Practitioner-Christus Medical Group **1/2011-1/2012**
Responsible for providing assessments, diagnoses and treatment to patients in a quick care setting with a variety of illnesses. The population includes children, adolescents, adults and geriatric patients.

Family Nurse Practitioner/RN-Faith Foundation Hospice **10/2010-1/2012**
Responsible for providing assessments, plans, diagnoses and treatment to predominately geriatric patients with terminal illnesses and end of life issues. These services are provided in the home and long-term care settings. Courtesy visits are provided in the hospital setting. Member of the IDG team for evaluation of patient care, collaborate and coordinate care with the long-term care/hospice staff including evaluating and devising the plan of care, updating and changing the plan of care, monitoring care provided to the patient/resident between visits, collaborating with the treatment team including the attending physician, nurses, therapists, social worker, pastor and administration, in order to provide consistent, comprehensive care to the residents.

Brian Clinic-Dr. Jonathon Hunter **1/2012-7/2013**

Responsible for providing assessments, planning, diagnosis and treatment to residents/patients in the long-term care setting (which includes nursing homes and assisted living facilities) for a variety of illnesses. The population served is predominantly geriatric. Coordinate and collaborate with the interdisciplinary team for the delivery of patient care.

APRN, LNCC, Owner, Consulting Concepts ***2001-present***
In depth medical case review and reporting for plaintiff and defense firms nationwide. Provide consulting services in the areas of medical and nursing malpractice, nursing home litigation and Medicare and Medicaid fraud. Expert witness services are provided nationwide.

Louisiana College **Jan 2014-August 2014**
RN/FNP
Provide medical diagnoses, assessment and treatment to individuals at campus clinic; includes middle adult and geriatric populations; Provide education and guidance to Senior nursing students in the Baccalaureate program regarding assessment, care planning, intervention and evaluation for acute and chronic illnesses in various settings.

Louisiana College RN/FNP-BC **July 2015-Present**
Adjunct Faculty
Provide Didactic and Clinical education and guidance to entry level and senior level nursing students which includes the introduction to the nursing process and leadership role, development of care plans, designing interventions for age-specific populations and introduction and evaluation of the provision of nursing care, clinical

reasoning, evaluation of nursing care and revision process.

MEMBERSHIPS/PUBLICATIONS/ACCOMPLISHMENTS

- Louisiana Association of Nurse Practitioners, Member, 2009-Present
- Reviewer: United States Department of Justice,2011-Present
- Louisiana Association of Nurse Practitioners-Public Policy Review Committee-2011-2014
- American Association of Nurse Practitioners 2012-Present
- American Nurses Association

CERTIFICATIONS

- **2010/Board Certification-Family Nurse Practitioner-American Nurses Credentialing Center-Expires October 2020**