Official Receipt 2/2/2015
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CALDWELL COUNTY DISTRICT CLERK

201 EAST SAN ANTONIO
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LOCKHART, TEXAS 78644
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Issue to:

ORIGINAL

Receipt Number : 61657
Case No. : 15-0-039
Payment Method : Check
Account :
Check/MO/CC : 3324

Paid Date : 2/2/2015 4:02:23 PM
Paid By : MCIVER BROWN LAW FIRM
Received By : bgonzales
Remarks :

Cost Code	Amount Paid
IND LEG S	$10.00
RMP CV DC	$5.00
RMP CV	$5.00
JUD FEE A	$5.00
ELECTR FIL FEE-CV	$20.00
CRP - CV	$10.00
JUDIC FEE	$42.00
COURT REP	$15.00
JURY-CV	$30.00
CITATION	$8.00
LLB	$35.00
FILING	$50.00
CLERK CV	$50.00
CHS	$5.00
Total	$290.00

Amount Paid	$290.00
Amount Applied	$290.00
Amount UnApplied	$0.00

Case Balance $0.00

Caldwell County District Clerk 1/29/2015

Date	Type	Reference	Original Amt.	Balance Due	Discount	Payment
1/29/2015	Bill	Sealy, N.	290.00	290.00		290.00
					Check Amount	290.00

15-0-039

Chase - Checking Sealy, N. - Filing Fee 290.00

CAUSE NO: 15-0-039

MARTHA SHERWOOD, AS NEXT FRIEND FOR NATALIE SEALY,	§	IN THE DISTRICT COURT OF
Plaintiff,	§	
v.	§	CALDWELL COUNTY, TEXAS
PINNACLE HEALTH FACILITIES XIX, LP D/B/A PARKVIEW NURSING AND REHABILITATION CENTER,	§	
Defendant.	§	421st JUDICIAL DISTRICT

PLAINTIFF'S ORIGINAL PETITION

Plaintiff Martha Sherwood, as Next Friend for Natalie Sealy, files this, her Original Petition and respectfully shows the Court the following:

I.
DISCOVERY CONTROL PLAN

Plaintiff requests that this case be governed by Discovery Control Plan Level 3 pursuant to Texas Rule of Civil Procedure 190.4.

II.
PARTIES

a. Plaintiff, Martha Sherwood, is an individual residing in Caldwell County, Texas. She brings this suit as next friend for her mother, Natalie Sealy, who is unable to bring this suit on her own behalf.

b. Defendant, Pinnacle Health Facilities XIX, LP d/b/a Parkview Nursing and Rehabilitation Center, (hereinafter "Parkview Nursing"), is a Domestic Limited Partnership duly formed and existing under the laws of the state of Texas that may be served with citation by serving its registered agent for service, Robert J. Riek, at 5500 W. Plano Parkway, Suite 210, Plano, Texas 75093 USA.

FILED this 2 day of Feb 20 15
9:40A M
TINA MORGAN FREEMAN
CLERK DISTRICT COURT, CALDWELL CO., TX
By Robin West Deputy

c. To the extent that the above-named Defendant is conducting business pursuant to a trade name or assumed name, then suit is brought against it pursuant to the terms of Rule 28 of the TEXAS RULES OF CIVIL PROCEDURE, and Plaintiff hereby demands that upon answering this suit, that it answers in its correct legal name and assumed name.

III.
VENUE AND JURISDICTION

Plaintiff cites to and fully incorporates herein the facts set forth in sections II, IV, V, VI, VII, and VIII of this pleading.

Plaintiff affirmatively pleads that this Court has jurisdiction because the damages sought are in excess of the minimum jurisdictional limits of the Court. Furthermore, all of the causes of action asserted in this case arose in the State of Texas, and all of the parties to this action are either residents of the State of Texas or conduct business in this State and committed the torts that are the subject of this suit in whole or in part in Texas, as hereafter alleged in more detail. Therefore, this Court has both subject matter and personal jurisdiction over all of the parties and all of the claims.

Venue is proper in Denton County, Texas under the general venue statute of Texas Civil Practice and Remedies Code Section 15.002(a)(1) (West 2011) because all or a substantial part of the events or omissions giving rise to the claim occurred in Caldwell County, Texas and no mandatory venue provision applies.

IV.
BACKGROUND AND CAUSES OF ACTION

This claim is a healthcare liability claim under Chapter 74 of the Texas Civil Practice and Remedies Code. Defendant Parkview Nursing and its staff have provided long-term care to Natalie Sealy (hereinafter "Patient") since December 2012. Patient was admitted to Defendant

Parkview Nursing's facility for long-term care due to senile dementia. At the time of admission, Patient had a history of dementia, hypertension, hyperlipidemia, and peripheral vascular disease. While a resident at Defendant Parkview Nursing, Patient required total assistance with her Activities of Daily Living and remains incontinent of bowel and bladder.

On the morning of September 2, 2014, while in the care of Defendant Parkview Nursing, fire ants attacked Patient. Nursing notes indicate that while asleep in her bed at Defendant Parkview Nursing, Patient was found with fire ants crawling on her torso and arms. Upon discovery of the attack, Defendant Parkview Nursing's staff removed the fire ants from Patient's body. Not surprisingly, Patient's skin broke down from the fire ant bites. Additionally, fragile areas of Patient's face and upper extremities indicated irritation with formation of redness, swelling, and raised pustules. Eight hours after falling victim to attack by fire ants, Patient was transferred to Central Texas Medical Center (hereinafter "Central Texas") for evaluation and treatment.

Patient presented to Central Texas with skin complications necessitated by multiple fire ant bites. Upon admission, Patient was noted to have numerous oozing fire ant bites with weeping serous fluid. A skin assessment revealed fire ant bites on many different areas of Patient's body, including her shoulders, chest, head, arms, and areas of her upper legs. Additionally, Patient was noted to be withdrawn and her BUN was elevated, which indicated dehydration. Following the diagnosis of insect bites, skin eruption, and allergic reaction, Patient was provided bacterial antibiotics and discharged back to Defendant Parkview Nursing.

On the afternoon of September 2, 2014, Patient was re-admitted to Defendant Parkview Nursing. According to the records, Defendant Parkview Nursing was "continuing to closely monitor after room infestation with fire ants and multiple ant bites" to Patient. A skin

assessment indicated Patient manifested fire ant bites on her face, torso, arms, hands, and thighs. Other places of Patient's body subject to fire ant bite blisters and clusters included the delicate areas of Patient's forehead from her hairline to her eyebrows. Due to the severity of Patient's affected skin areas, an acute skin care plan was implemented. In an effort to prevent further skin irritation and breakdown, orders were given for application of antihistamine and hydrocortisone creams at each shift. Additionally, because Patient had developed an allergic reaction and dermatitis, Patient was prescribed Medrol.

In providing such medical treatment, Defendant Parkview Nursing, despite having a duty to act as a reasonable healthcare provider would have under the same or similar circumstances, committed negligence by failing to act as a reasonable health care provider would have under the same or similar circumstances.

Specifically, Defendant Parkview Nursing and its staff violated the standard of care by failing to provide Patient with a safe and comfortable resident environment. As 42 CFR, Part 483, Subpart B makes clear, a facility "must ensure that a resident's environment remains a safe, functional, sanitary, and comfortable environment for residents, staff, and the public." A safe and comfortable resident environment exists when a facility and its staff implement adequate interventions such as by exercising supervision of the resident environment or by identifying elements within the resident environment that would pose a threat or harm to those within the environment. Defendant Parkview Nursing failed to do these things. This is illustrated by the fact that Patient inhabited a resident environment wherein she remained sleeping in a room infested with fire ants, permitting Patient to fall victim to a swarming attack by fire ants. As a result of Defendant Parkview Nursing and its staff failure to provide the required resident environment, fire ants attacked Patient. Because Defendant Parkview Nursing and its staff failed

to provide a safe and comfortable resident environment, the standard of care was breached.

Defendant Parkview Nursing and its staff also violated the standard of care by failing to provide Patient with quality of care. As §242.001(a) of the Texas Health & Safety Code makes clear, "a nursing home shall, at a minimum, provide quality care." In addition to the requirement that physical care and treatment be provided, nursing homes are further required to provide quality care, which includes things such as safety of the environment. The services a nursing home provides to its patients during their confinement include meeting patients' fundamental needs. Part of the fundamental patient care required of a nursing home is to protect the health and safety of the residents. Defendant Parkview Nursing failed to do these things. This is illustrated by the fire ant infestation of Patient's environment while a resident at Defendant Parkview Nursing. Even more illustrative of its failure to provide quality care and ensure safety is Defendant Parkview Nursing's failure to protect patient from attack by fire ants. Because Defendant Parkview Nursing and its staff failed to provide quality care and protect the health and safety of Patient, the standard of care was breached.

Defendant Parkview Nursing and its staff further violated the standard of care by failing to implement the Texas Administrative Code, Chapter 19, Nursing Facility Requirements for Licensure and Medicaid Certification, Rule §19.1701. Patient received substandard levels of health care due to Defendant Parkview Nursing's failure to provide a safe, sanitary, and comfortable environment. Rule §19.1701 requires a nursing facility to "provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public." This includes maintaining an effective pest control program so that the facility is free of pests and rodents. Pest and rodent infestation can be prevented with interventions such as regular residence surveillance and pest management inspection. Defendant Parkview Nursing failed to

do these things. This is illustrated by the fact that Defendant Parkview Nursing permitted Patient to inhabit a resident environment infested with fire ants and by further permitting Patient to fall victim to attack by fire ants. Had Defendant Parkview Nursing maintained an effective pest control program, fire ants would not have infested Patient's environment. As a result of Defendant Parkview Nursing and its staff's failure to maintain an effective pest control program, fire ants attacked Patient. Because Defendant Parkview Nursing failed to maintain an effective pest control program, it failed to provide a safe, sanitary, and comfortable environment for Patient. Because Defendant Parkview Nursing and its staff failed to provide a safe, sanitary, and comfortable environment for Patient, the standard of care was breached.

Further, Defendant Parkview Nursing and its staff violated the standard of care by failing to implement the Texas Administrative Code, Chapter 19, Nursing Facility Requirements for Licensure and Medicaid Certification, Rule §19.1001. Patient received substandard levels of health care due to Defendant Parkview Nursing's failure to provide sufficient staff at its facility. Rule § 19.1001 requires a nursing facility to "provide sufficient staff in order to provide 24-hour nursing care and related services reflecting the complexity of the care required, the size of the facility, and the type of services delivered to attain or maintain the highest practicable physical, mental, and psychological well-being" of the facility's residents. These services are determined by each resident's assessment and individualized plan of care. Had staffing levels been appropriate, there would have been nurses and staff available to observe Patient's environment. If staffing levels had been appropriate, there would have been nurses and staff available to attend to Patient. Because Defendant Parkview Nursing and its staff failed to provide sufficient staffing levels and nursing care, the standard of care was breached.

Finally, Defendant Parkview Nursing and its staff violated the standard of care by failing

to follow the guidelines required by the Nursing Home Reform Act of 1987. The Act requires nursing home facilities to provide sufficient staffing levels who are properly trained and supervised. This is to ensure that nursing home residents receive the highest level of health care possible. Because Defendant Parkview Nursing failed to provide sufficiently trained staff at its facility, Patient never received the appropriate interventions required to protect and prevent her from exposure to attack by fire ants. As a result, Defendant Parkview Nursing failed to meet the regulatory requirements and the standard of care was breached.

Whether because of a lack of sufficiently qualified staff or because of a lack of training, policies, procedures, oversight, or enforcement, the facility failed to meet the standard of care, as did its staff. As a result of Defendant Parkview Nursing's negligence as stated above, Patient suffered a painful and intimate encounter of attack by fire ants, resulting in exposure to and infliction of multiple fire ant bites on vast portions of Patient's body.

When it is stated above that Defendant Parkview Nursing violated the standard of care, such violation of the standard of care includes acts by Defendant Parkview Nursing's agents, apparent agents, ostensible agents, agents by estoppel, and/or nurses.

V.
DAMAGES

The above breaches of the standard of care by Defendant Parkview Nursing were a proximate cause of harm to Patient. As a result of Defendant Parkview Nursing's conduct as set forth above, Patient suffered damages, including, but not limited to, the following:

(a) mental anguish;

(b) physical pain and suffering;

(c) reasonable and necessary medical, hospital, and nursing expenses;

(d) physical disfigurement;

(e) emotional distress;

(f) exemplary damages; and

(g) pre- and post-judgment interest to the extent allowed by law.

Plaintiff is seeking damages in an amount over $200,000 but not more than $1,000,000. The wrongful conduct specifically alleged above constitutes gross negligence as that term is defined by law. By reason of such grossly negligent conduct, Plaintiff is entitled to and therefore asserts a claim for punitive damages in an amount sufficient to punish and deter Defendant Parkview Nursing and other similar facilities from such conduct in the future. Despite knowledge of an extreme degree of risk to Patient's health and safety, Defendant Parkview Nursing's nurses and staff acted with conscious indifference to Patient's rights, safety, and welfare. The amount of damages prayed for far exceeds the minimum jurisdictional limits of this Court.

VI.
DISCOVERY REQUESTS

Pursuant to Texas Rule of Civil Procedure 194, Plaintiff requests Defendant Parkview Nursing to disclose, within the time required under Texas law, the information or material described in Rule 194.2 (a) through (l).

VII.
NOTICE

Plaintiff provided Defendant Parkview Nursing written notice of her claims as required by the Texas Civil Practice and Remedies Code section 74.051 of the Medical Liability and Insurance Improvement Act.

VIII.
EXPERT REPORT

Pursuant to Chapter 74 of the Texas Civil Practice and Remedies Code, Plaintiff hereby serves on the Defendant Parkview Nursing the expert report and curriculum vitae required. The expert report and curriculum vitae of Christopher Davey, M.D. are attached hereto as Exhibits A and B, respectively, and are served in compliance with the Texas Rules of Civil Procedure.

IX.
JURY TRIAL

Plaintiff respectfully requests a jury trial in accordance with the applicable provisions of the Texas Rules of Civil Procedure.

X.
PRAYER

For the above reasons, Plaintiff requests that Defendant Parkview Nursing be cited to appear and answer, and that on final trial Plaintiff has the following:

(a) All actual damages, general and special, to which she shows herself justly entitled;

(b) Exemplary or punitive damages to the extent allowed by law;

(c) Pre-judgment and post-judgment to the extent allowed by law;

(d) All costs incurred in this lawsuit; and

(e) Such other and further relief to which Plaintiff may be justly entitled.

Respectfully submitted,

MCIVER BROWN LAW FIRM

Robert M. Wharton
Texas Bar No: 24079562
Andrea A. Zarikian
Texas Bar No: 24093411
Mary E. Green
Texas Bar No: 24087623
JP Morgan Chase Bank Building
712 Main Street, Suite 800
Houston, Texas 77002
Telephone: 832-767-1673
Facsimile: 832-767-1783
Email: firm@mciverbrown.com
ATTORNEYS FOR PLAINTIFF

Exhibit A

Curriculum Vitae

Christopher M. Davey, M.D., P.A.
Medical Arts Bldg.
2191 9th Ave. North, Suite 115
Saint Petersburg, FL 33713
(727) 321-1234 office (727) 827-2966 fax
(727) 641-4501 cell
cdavey1@tampabay.rr.com

Dr. Davey trained as a pathologist at Mount Sinai Medical Center in Miami, Florida, but since 1987 has practiced in Family Practice and Geriatric Medicine in office, hospital, and nursing home settings. He has held hospital privileges in Family Practice at Edward White and St. Anthony's Hospitals in St. Petersburg, Florida since 1987. He is Advanced Cardiac Life Support certified. Dr. Davey has a special interest in wound diagnosis, prevention and treatment and is board certified by the American Academy of Wound Management as a Certified Wound Specialist (CWS), and is a trained Hyperbaric Specialist. Hyperbaric medicine is the treatment of severe wounds and other conditions using high pressure oxygen chambers. He is the Medical Director of Hyperbaric Medicine, as well as an active physician at the Edward White Center for Wound Care and Hyperbaric Medicine. He has been a consultant for American Medical Technologies in Irvine, CA on wound care dressings.

Personal

Place of Birth: London, England	
Fla. Medical License Number:	ME-034037
DEA Number:	AD8602371
Languages Spoken:	English, French and German

Areas of expertise

- Wound causation, care and treatment.
- Nursing Home and Hospital Standard of Care including preventable falls or bedsores and nursing home / hospital acquired infections.
- Cause of death related to above.

Forensic experience

I have testified extensively for both Plaintiff and Defense since 1998 involving Geriatric issues, falls, bedsores, pressure ulcers, complex medical cases and hospital and nursing home Standards of Care. I also have the expertise to render opinions on cause of death issues due to my pathology background.

Education

Medical School:

1968-1972	St. Mary's Hospital, University of London (Now: Imperial College, School of Medicine University of London, England, United Kingdom)

Internship:

1972-1973	Northwick Hospital and Research Center Harrow, Middlesex, England -Cardiology -General Surgery
1973-1977	Princess Margaret Hospital, Nassau, Bahamas (British Government Aid Program) -Internal Medicine with special interest in Marine Medicine

U.S. Residency:

1977-1980	Mt. Sinai Hospital Miami, Florida -Pathology: Anatomical and Clinical

Professional Experience:

1987-Present	Private Practice 2191 9th Ave. North Ste 115 Saint Petersburg, Florida 33713 -Adult and Geriatric Medicine -Special Interest in Skin and Wound Care, on staff at the Center for Wound Care and Hyperbaric Medicine at HCA Edward White Hospital. Medical Director of Hyperbaric Medicine at HCA Edward White Hospital.
1981-1987	Columbia Edward White Hospital 2323 9th Avenue Saint Petersburg, Florida 33713 -Emergency Medicine: including three years as Emergency Room Director.

Hospital Affiliations:
Active Medical Staff
Dept. of Family Practice:

Hospital Corporation of America
Edward White Hospital
2323 9th Ave North
St Petersburg, FL 33713

St. Anthony's Hospital
1200 7th Avenue
Saint Petersburg, FL 33705

Board Certification:

Board certified by the American Academy of Wound Management as a Certified Wound Specialist (CWS).

Most Current Education:

35th Annual John A. Boswick, MD
Burn and Wound Care Symposium
Wailea, Maui, Hawaii
February 18-22, 2013

Memberships and Positions Held:

Present:	Member of American Geriatrics Society and Florida Geriatrics Society
Present:	Medical Director for Hyperbaric Medicine, Center for Wound Care and Hyperbaric Medicine HCA Edward White Hospital
Present:	Utilization Review and Quality Assurance Committee member at HCA Edward White Hospital
Present:	Member of Association for Advancement of Wound Care (national organization)
Present:	Member of the Society of University Founders of the University of Miami, Coral Gables, Florida

Present:	Member of the Medical/Surgical Care Evaluation Committee at HCA Edward White Hospital
Present:	Member of the Infectious Control Committee representing the Center for Wound Care, HCA Edward White Hospital
Present:	Member of the Medical Quality and Education Committee at St. Anthony's Hospital
1989-1994:	Member of the Board of Trustees, Columbia Edward White Hospital
Previous:	Board Member of the Florida Medical Directors Association
Previous:	Medical Director of Sunrise Northshore, Assisted Living Facility and Nursing Home
Previous:	Utilization Review and Quality Assurance Committee member at St. Anthony's Hospital
Previous:	Member of Florida Medical Directors Association
Previous:	Certified Medical Director (AMDA)
Previous:	Member of the Florida Medical Association

Nursing Home Medical Directorships, Past

(Dates approximate)

Coquina Key Nursing & Rehabilitation Center: 2000-2007
Westminster ALF: 2001-2005
Northshore ALF: 1998-2002
Abbey Nursing Home: 1998-2000
Huber Nursing Home: 1992-2000
Greenbrook Nursing Home: 1994-1999
Heartland Nursing Home: 1988-1999
Shore Acres Nursing Home: 1996-1998
Alpine Nursing Home: 1995-1998
Carrington Place Nursing Home: 1995-1997
St. Pete Health Care Center: 1992-1995

Exhibit B

I am providing this expert report in the Natalie Sealy (also referred to herein as "the patient") matter. This report reflects my expert opinion regarding the standard of care and the proximate cause of injuries sustained by Ms. Sealy.

Summary of Findings

It is my opinion that Parkview Nursing and Rehabilitation Center (also referred to herein as "Parkview Nursing") breached the standard of care by exposing Ms. Sealy to pest infestation and allowing her to endure numerous painful fire ant bites during the time of her stay, which resulted in clusters of painful pustules to her upper extremities, facial area, torso, and hands (TR-000072). Ms. Sealy was admitted in 2012 to Parkview Nursing for long-term senile dementia (TR-000103). On 9/2/14, Ms. Sealy was discovered in her room being attacked by fire ants. The standard of care requires facilities like Parkview Nursing to provide a safe, functional, sanitary, and comfortable environment for its residents and maintain an effective pest control program so that the facility is free of pests and rodents. The staff at Parkview Nursing breached the standard of care by allowing fire ants to occupy Ms. Sealy's room and by allowing her to be attacked by fire ants, resulting in numerous fire ant bites and pus-filled sores to cover her body, including forehead clusters of bites from her hairline to her eyebrows (TR-000008, TR-000022, TR-000039, TR-000041, TR-000072 to TR-000073). Specifically, the staff at Parkview Nursing failed to implement an adequate and effective pest control program to ensure Ms. Sealy's protection from fire ant infestation and attack. Because the facility failed to provide a safe, sanitary, comfortable, and insect-free environment in order to protect to Ms. Sealy during her stay, she was attacked and bitten numerous times by fire ants. Ms. Sealy suffered harm as a result of the numerous painful, stinging fire ant bites, including itching, swelling, redness, skin oozing, eruption, and clusters of pustules to a vast portion of her body (TR-000008, TR-000039, TR-000041).

Qualifications

I am a licensed physician who has actively been practicing medicine since 1981. After graduating from medical school in 1972, I did internships in cardiology, general surgery and internal medicine and a residency in anatomical and clinical pathology. Initially I served as an emergency medicine physician at Columbia Edward White Hospital in Saint Petersburg, Florida, but since 1987, I have practiced Family Practice/Geriatric Medicine in office, hospital, and nursing home settings. In addition to my general adult and geriatric medicine practice, I have a special interest in skin care and wound care. I am board certified by the American Academy of Wound Management as a Wound Specialist and currently serve as the Medical Director and active physician at Hyperbaric Medicine at the Edward White Center for Wound Care and Hyperbaric Medicine. In addition to serving as the Medical director of 10 nursing homes over the last twenty years, I have also served as a board member of the Florida Medical Director's association. I also have served on the Utilization Review and Quality Assurance Committee at HCA Edward White Hospital and Columbia Edward White Hospital, on the Medical Quality and Education Committee at St. Anthony's Hospital, and hold admitting privileges at Edward White Hospital and St. Anthony's Hospital in St. Petersburg, Florida.

Over the course of my career I have treated many patients like Ms. Sealy in facilities like Parkview Nursing. The standards of care discussed in this report are national standards of care that apply in the nursing home/rehabilitation center setting. Based on my training, education, and experience, I am knowledgeable of the standards of care for the caregivers and facilities that provided care to Ms. Sealy. Having treated many patients like Ms. Sealy, I am also intimately familiar with the rationale behind the standard of care, what the standard of care requires, and what can occur if the standard of care is breached. I have seen patients like Ms. Sealy who received care that met the applicable standards of care set forth in this report who did not suffer harm resulting from pest, rodent, and insect infestation and attack. On the other hand, I have also seen patients like Ms. Sealy where the standards of care were not met and harm resulted from pest, rodent, and insect infestation and attack, leading to injuries similar to Ms. Sealy's. My experience treating patients like Ms. Sealy, and my education and training also provides me with knowledge of the injuries that can and often will occur when the standard of care is breached and a patient like Ms. Sealy suffers harm resulting from pests, rodents, and insects, such as fire ants. In summary, based on my education, training and experience which is outlined in this report and set forth in my attached curriculum vitae, I am qualified to render opinions as to the standards of care set forth in this report as well as what the breaches of the standard of care caused.

Materials Reviewed

In preparing this report, I have reviewed the medical records of: (1) Parkview Nursing and Rehabilitation Center and (2) Central Texas Medical Center. I base my opinions on the items I reviewed and my knowledge of the standard of care with which I am familiar because of my education, training, and experience. These records provide a sufficient basis for my opinion regarding the applicable standard of care, and that the breaches in the standards of care by Parkview Nursing were the proximate cause of injuries to Ms. Sealy.

Factual and Medical Background

Based on my review of the medial records referenced above, the following is a summary of events that led to Ms. Sealy's injuries:

Ms. Sealy, an 85-year-old female, was admitted to Parkview Nursing as a resident for long-term care (TR-000033, TR-000103). She had a history of long-term senile dementia, coronary artery disease, hypertension, hyperlipidemia, and peripheral vascular disease (TR-000008, TR-000103). Ms. Sealy also lacked coordination, exhibited general muscle weakness, had trouble walking and abnormality of gait, was incontinent of bowel and bladder, and required total care with her needs (TR-000049, TR-000073, TR-000074).

On 9/2/14 at approximately 2:45 a.m., nursing staff was called to Ms. Sealy's room (TR-000073). According to the records, fire ants had crawled onto Ms. Sealy while she had been sleeping in her bed (TR-000022, TR-000073). Observing the many fire ants located

on Ms. Sealy's torso and arms, the Parkview nursing staff began removing the fire ants from her body (TR-000073, TR-000095). While no swelling was yet visible, the medical records indicated open skin areas on Ms. Sealy's right hand (TR-000073, TR-000095). At 7:10 a.m., several hours following discovery of fire ants on her body, Benadryl was applied to the areas of Ms. Sealy's skin affected by the fire ant bites (TR-000053, TR-000072). According to the nursing notes, Ms. Sealy exhibited an increase in upper extremity and facial area redness with swelling and pustules to her torso area and hands (TR-000072). At 9:15 am, Ms. Sealy was transferred to the emergency room at Central Texas Medical Center (also referred to herein as "Central Texas") for evaluation, treatment, and screening of her injuries resulting from the fire ant bites (TR-000054, TR-000072, TR-000104). According to Ms. Sealy's transfer form, the reason for transfer to Central Texas was due to the multiple fire ant bites to upper and lower extremity and swelling with redness and pustules (TR-000104).

Ms. Sealy arrived to Central Texas on 9/2/14 at 10:08 am, almost eight hours after the staff at Parkview Nursing discovered Ms. Sealy's body covered with fire ants (TR-000005, TR-000073). She presented with an elevated BUN level of 38 mg/dL, which indicated dehydration (TR-000010). According to the medical records, Ms. Sealy presented to Central Texas with a chief complaint of insect bites and "skin problem; bite (insect)" (TR-000005, TR-000023). A skin assessment revealed that fire ants had entered Ms. Sealy's room and that because she had severe dementia, she was unable to get help (TR-000032, TR-000038). Specifically, the skin assessment notates that Ms. Sealy was found covered in fire ants, resulting in bites to her shoulders, chest, head, arms, and areas of her upper legs (TR-000038). The bites were described as oozing with weeping serous fluid from sites (TR-000009, TR-000038). At that time, she was noted to be withdrawn (TR-000038). She was administered diphtheria toxoid and tetanus toxoid (TR-000029, TR-000042). That same day, she was discharged with a diagnosis of allergic reaction, insect bite, rash, and skin eruption (TR-000029, TR-000041). To treat Ms. Sealy's bacterial infection and allergic reaction, she was prescribed doxycycline and diphenhydramine (TR-000010 to TR-000022).

Ms. Sealy returned to Parkview Nursing on the afternoon of 9/2/14 (TR-000054, TR-000072). She was noted to have ant bites throughout her torso, face, arms, hands, and a few patches on her thighs, as well as behind her left knee (TR-000072). Ant bite clusters were also noted to her forehead from her hairline to her eyebrows (TR-000072). Following re-admission to Parkview Nursing, nursing notes indicated that staff were "continuing to closely monitor after room infestation with fire ants and multiple ant bites" and that Ms. Sealy remained mildly lethargic (TR-000071). An acute skin care plan necessitated by fire ant bites to multiple areas of Ms. Sealy's body was implemented (TR-000093). According to the plan, treatment included application of Calamine lotion at each shift (TR-000093). Tylenol was administered for general discomfort and aching related to the fire ant bites. Orders for continued skin care with application of Calamine, Benadryl, and hydrocortisone creams were implemented to treat Ms. Sealy's affected skin areas and prevent further skin irritation (TR-000054 to TR000056, TR-000070 to TR-000073). To treat Ms. Sealy's allergic reaction and dermatitis, orders were issued on 9/4/14 to begin Medrol (TR-000071). Still, by 9/6/14, Ms. Sealy still exhibited redness,

swelling, and multiple raised pustules to her upper extremities (TR-000069 to TR-000070). On 9/11/14, nurse's notes indicated improvement to Ms. Sealy's affected skin areas (TR-000067). At that time, orders were implemented for Benadryl cream and Hydrocortisone 1% cream with soothing aloe and wrap with kerlix (TR-000067). Additionally, orders were issued to begin application of Vaseline to Ms. Sealy's face, chest, and bilateral upper and lower extremities (TR-000067). The next day on 9/12/14, she was noted to show improvement following insect bites to her upper torso, arms, hands, and thighs (TR-000067).

Following my review of the medical records in this matter, it is my opinion that the staff at Parkview Nursing violated the standard of care. For the purpose of this report, I will discuss the standard of care, breach of standard of care, and proximate causation.

Parkview Nursing and Rehabilitation Center

Relevant Standards of Care

Medicare and Medicaid provide rules that require long-term care facilities to provide a base level of care. Failure to meet the level of care provided by the rules found in 42 CFR 483, Subpart B is a violation of the regulations intended to protect residents. It is also an indication of a violation of the standard of care by the staff of the facility and the administration of the facility. Section 483.25 mandates that residents must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well being, in accordance with the comprehensive assessment and plan of care. This is the overarching standard of care that applies in a skilled nursing facility.

With respect to accidents and resident environment, Section 483.25(h) provides that a facility and its nurses must ensure that a resident's environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. The regulations state that the intent of Section 483.25(h) is to "ensure that the facility provides an environment that is free from accident hazards over which the facility has control." An "accident" refers to any unexpected or unintentional incident, which may result in injury or illness to a resident. A "hazard" refers to elements of the resident environment that have the potential to cause injury or illness. An "avoidable accident" refers to an accident that occurred because the facility failed to identify environmental hazards and individual resident risk of an accident, including the need for supervision. "Supervision" refers to an intervention and means of mitigating the risk of an accident. To prevent accidents, facilities are obligated to provide adequate supervision, which is based on the individual resident's assessed needs and identified hazards in the resident environment.

With respect to environmental conditions, Section 483.70(h) provides that a facility and its nurses must ensure that a resident's environment remains a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Section 483.70(h)(4) provides that a facility and its nurses must maintain an effective pest control program so

that the facility is free of pests and rodents. An "effective pest control program" refers to measures to eradicate and contain common household pests (e.g., rodents, ants, mosquitoes, flies, mice, and rats). Under the regulations, evidence of pest infestation in a particular space is an indicator of noncompliance.

Pursuant to these regulations and the standard of care generally, facilities and their staffs must meet the following standards of care.

First: Provide a resident environment that is safe, functional, sanitary, and comfortable for residents, staff, and the public.
Section 483.70 and the standard of care require facilities be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. Section 483.70(h) and the standard of care require facilities provide a resident environment that is safe, functional, sanitary, and comfortable for residents, staff, and the public. In order to ensure that a resident environment meets these criteria, a facility and its staff must implement adequate supervision and identify elements within the resident environment that would pose a threat to residents, staff, and the public. The purpose of these standards is to provide and maintain a resident environment and habitat that promotes resident safety, health, care, comfort, and well-being. A failure to provide a resident with an environment that is safe, functional, sanitary, healthy, and comfortable for residents, staff, and the public is a disregard for resident safety, care, and comfort. Failing to do any of the above is a breach of the standard of care.

Second: Maintain an effective pest control program so that the facility is free of pests and rodents.
Section 483.70(h)(4) and the standard of care require facilities maintain an effective pest control program so that the facility is free of pests and rodents. An "effective pest control program" refers to measures to eradicate and contain common household pests (e.g., rodents, ants, mosquitoes, flies, mice, and rats). Under the regulations, evidence of pest infestation in a particular space is an indicator of noncompliance. The standard of care requires regular pest management inspection reports be conducted by a facility. This entails surveillance of facility premises by the facility and staff in order to identify the presence of pests. Equally as critical, the standard of care further requires effective documentation of pest problems accompanied by coordination of pest control efforts. Additionally, the standard of care requires an effective eradication program in order to deny pests access to a facility. Even more, the standard of care further requires a facility to maintain policies and procedures regarding pests and to also sufficiently and adequately implement those policies and procedures to prevent pest infestation. The purpose of these standards is to provide and maintain a resident environment that is healthy, safe, and habitable. A failure to maintain an effective pest control program is a disregard for resident care and jeopardizes a resident environment that is safe, functional, sanitary, healthy, and comfortable for residents, staff, and the public. Failing to do any of the above is a breach of the standard of care.

Third: Implement 40 Texas Admin. Code, Rule 19.001. Another source of requirements that nursing homes must meet is Title 40, Chapter 19 of the Texas

Administrative Code. The Texas Administrative Code, Chapter 19, Nursing Facility Requirements For Licensure and Medicaid Certification, Rule § 19.1001 states (a) the facility must have sufficient staff to provide 24-hour nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individualized plans of care. When treating patients, a facility and its agents must properly and regularly monitor and assess the patient, identify her risks, evaluate those risks, and implement the necessary interventions to reduce her risk of harm from pests. There should also be continued assessment and survey of: i) resident environment conditions; ii) facility premises conditions; iii) climatic conditions; iv) whether staff is trained on pest control management; v) whether routine pest control prevention and management is implemented; vi) whether there is evidence necessitating pest control; and vii) whether receptacles are maintained to prevent the harborage and feeding of pests.

In addition, staffing levels should reflect the complexity of the care required, the size of the facility, and the type of services delivered. This means that the training, selection, and supervision of the staff must be sufficient to handle the nursing care that is needed by the residents who are accepted into the facility. Adequate staffing levels have a direct impact on a resident's risk of accident relating to environmental hazards. The facility and its nursing staff are responsible for monitoring each resident to determine the resident's environment. This would include monitoring and observing elements of resident and facility environment to mitigate the degree of risk and hazard to residents. Inadequate supervision of these environments by staff can increase the risk of harm and/or injury.

The history behind the nursing home regulations informs about its purpose. In the past, most nurses in nursing homes had little or no formal training in gerontology and long-term care (IOM, 1986). Many nursing home attendants or aides had no formal training. In 1986, only 17 states had mandated training requirements for nursing attendants, and there were no federal standards for training (IOM, 1986). In a 1986 study, conducted at the request of Congress, the Institute of Medicine found that residents of nursing homes were being abused, neglected, and given inadequate care. The Institute of Medicine proposed sweeping reforms, most of which became law in 1987 with the passage of the Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987. The basic objective of the Nursing Home Reform Act was to ensure that residents of nursing homes received quality care that resulted in their achieving or maintaining their "highest practicable" physical, mental, and psychosocial well-being.

Fourth: Implement The Nursing Home Reform Act of 1987. To secure quality care in nursing homes, the Nursing Home Reform Act requires the provision of certain services to each resident and establishes a Residents' Bill of Rights. Nursing homes receive Medicaid and Medicare payments for long-term care of residents only if they are certified by the state to be in substantial compliance with the requirements of the Nursing Home Reform Act. The purpose of these reforms was to ensure that facilities had sufficient staff that was sufficiently trained and supervised to provide quality care to the residents. Such training and supervision are especially important when it comes to care of dependent residents. Failing to have a staff that is sufficiently trained and supervised,

which includes the facilities policies as well as the implementation of those policies, to attain and maintain the highest practicable physical, mental and psychosocial well-being of the residents is a violation of the standard of care applicable to nursing homes.

Breaches of Standards of Care

Over the course of the care of Ms. Sealy, it is clear that Parkview Nursing violated the standard of care in the following respects:

First: Failing to provide Ms. Sealy with a resident environment that was safe, functional, sanitary, and comfortable;
Second: Failing to maintain an effective pest control program so that Parkview Nursing was free of pests and rodents;
Third: Failing to implement The Texas Administrative Code, Chapter 19, Nursing Facility Requirements For Licensure and Medicaid Certification, Rule § 19.1001; and
Fourth: Failing to implement The Nursing Home Reform Act of 1987.

First: Failing to provide Ms. Sealy with a resident environment that was safe, functional, sanitary, and comfortable.

Parkview Nursing and its nurses failed to implement measures to provide a safe, functional, sanitary, and comfortable environment as evidenced by the fact that Ms. Sealy was attacked by fire ants while a resident at Parkview Nursing (TR-000022, TR-000073). A safe environment for a resident is one in which a resident is kept free of unnecessary injuries, such as fire ant bites. On 9/2/14, at approximately 2:45 a.m., it was discovered that Ms. Sealy was being attacked by fire ants while resting in her bed (TR-000022, TR-000073). By the time staff was called to Ms. Sealy's room to remove the fire ants from her torso and arms, Ms. Sealy had already developed open areas on her right hand from the fire ant bites (TR-000073). The standard of care requires that a facility provide a safe, functional, sanitary, and comfortable environment. Based on the fact that fire ants attacked Ms. Sealy while she slept in her room, it is evident that Parkview Nursing failed to meet this standard of care. In order to safeguard the health and safety of residents, a facility and its staff are accountable for maintaining safe, functional, sanitary, and comfortable conditions. Ms. Sealy's exposure to fire ants indicates Parkview Nursing's non-compliance with providing a resident environment that is safe, functional, sanitary, and comfortable. In order to ensure that a resident environment meets these criteria, a facility and its staff must implement adequate supervision and identify elements within the resident environment that would pose a threat to residents, staff, and the public. Not only did the staff at Parkview Nursing fail to maintain adequate supervision of resident environment that would have identified the presence of fire ants in Ms. Sealy's room, they also failed ensure and promote Ms. Sealy's safety for so long that she developed open areas on her skin by the time staff discovered the fire ants on Ms. Sealy. Even more, a habitat ridden with fire ants compromised Ms. Sealy's ability to maintain the highest practicable level of safety, comfort, and well-being. As such, Ms. Sealy's resident environment was neither safe, sanitary, nor comfortable because Parkview Nursing permitted fire ants to enter Ms. Sealy's room and also because Parkview Nursing permitted fire ants to attack Ms. Sealy (TR-000032). This is evidenced by the fact that

Parkview Nursing staff discovered Ms. Sealy's body covered in fire ants, leaving clusters of bites and pustules to Ms. Sealy's skin that are described as form sites exhibiting oozing with weeping serous fluid (TR-000009, TR-000038). Because Parkview Nursing and its staff did not provide Ms. Sealy with a resident environment that was safe, functional, sanitary, and comfortable, the Parkview Nursing and its staff breached the standard of care.

Second: Failing to maintain an effective pest control program so that Parkview Nursing was free of pests and rodents.

In addition, Parkview Nursing and its staff failed to maintain an effective pest control program so that the facility was free of pests and rodents. When a facility implements a proper and effective pest control program, the likelihood of pests existing in a resident environment is significantly eradicated. When there is evidence of pest infestation in a particular space, it is an indicator of failing to maintain an effective pest control program. The medical records from Parkview Nursing demonstrate an ineffective pest control program by Parkview Nursing. This is evidenced by the fact that Ms. Sealy is found in her room covered in fire ants (TR-000038, TR-000073). With an effective pest control program, staff members continue observation of the resident environment, provide guidance to residents of keeping food in sealed containers, and are educated in pest control protocol necessary for pest management to prevent invasion. This would include continued surveillance for evidence of pests, rodents, droppings, and other sources of contamination in food storage areas. Additionally, to maintain resident health and safety, ongoing communication among staff concerning possible pest infestation and education of residents and staff in steps necessary to prevent pest infestation within the facility are critical elements of a proper and effective pest control program. Had Parkview Nursing and its staff implemented a proper and effective pest control program to determine, deny, and eradicate the existence of pests, specifically fire ants, fire ants would not have existed in Ms. Sealy's room. Additionally, had Parkview Nursing and its staff appropriately inspected and surveyed Ms. Sealy's room, as well as the facility premises, Parkview Nursing and its staff would have observed evidence indicating the presence of fire ant infestation within its facility. Because Parkview Nursing and its staff failed to eradicate and contain the existence of fire ants at its facility, Parkview Nursing failed to maintain an effective pest control program. Because Parkview Nursing and its staff failed to ensure that an effective pest control program prevented the existence of fire ants at its facility, Parkview Nursing and its staff breached the standard of care.

Third: Failing to implement The Texas Administrative Code, Chapter 19, Nursing Facility Requirements For Licensure and Medicaid Certification, Rule § 19.1001.

The staff at Parkview Nursing violated the standard of care by failing implement The Texas Administrative Code, Title 40, Chapter 19, Nursing Facility Requirements For Licensure and Medicaid Certification, Rule § 19.1001 by not providing sufficient staff to provide 24-hour nursing care and related services reflecting the complexity of the care required, the size of the facility, and the type of services necessary to attain or maintain the highest practicable physical, mental and psychosocial well-being of Ms. Sealy, as determined by the resident assessments and individualized plans of care. When a resident does not receive frequent and regular assessments and care, it is indicative of an

insufficient staff level. If staffing levels had been appropriate, there would have been staff available to attend to Ms. Sealy. The failure of the facility to provide sufficient staff and to provide 24-hour nursing care and related services is a breach in the standard of care.

Fourth: Failing to implement The Nursing Home Reform Act of 1987.
The staff at Parkview Nursing violated the standard of care applicable to nursing homes by failing to properly train and supervise its staff and by failing to have policies in place that are designed to maintain the highest practicable physical, mental, and psychosocial well-being of Ms. Sealy. Had the care to Ms. Sealy been provided by sufficiently trained staff and based on well-conceived policies and procedures, appropriate and timely care would have been implemented and interventions would have been put in place which would have prevented Ms. Sealy from being attacked by numerous fire ants (TR-000022, TR-000073). As a result, Parkview Nursing breached this standard of care.

Causation

The following is an explanation of how, to a reasonable degree of medical probability, the breaches of the standard of care identified above proximately caused Ms. Sealy's injuries:

The standards of care discussed above related to providing a safe, functional, sanitary, and comfortable resident environment focus on identifying and eradicating environmental hazards, such as pest infestation, by maintaining and implementing an effective pest control program. When a facility or its staff fails to provide a resident environment that is safe, functional, sanitary, and comfortable, the risk of a resident suffering exposure to a hazardous environment greatly increases. Likewise, when a facility or its staff fails to maintain an effective pest control program to prevent the existence of pests and rodents, specifically fire ants, within its facility, there is an increased likelihood that pests and rodents, specifically fire ants, will inhabit the facility. As a consequence, this increases the risk that residents will be exposed to serious harm due to the existence of pests and rodents, specifically fire ants, within the facility. When a facility or its staff fails to maintain adequate supervision, regular monitoring, and necessary interventions necessary to reduce a resident's risk of harm from pests and rodents, specifically fire ants, the risk of a resident being exposed to serious harm greatly increases. Finally, when a facility fails to maintain sufficient staff or fails to adequately train their staff, there is an increased likelihood that the patient will not receive the necessary care, and exposure to pests or rodents, specifically fire ants, and resulting injury will occur.

As I have stated several times in this report, in order to safeguard the health and safety of residents, a facility and its staff are accountable for maintaining safe, functional, sanitary, and comfortable conditions. That is, when the standard of care is followed, a resident's health, safety, comfort, and well-being is not jeopardized. Additionally, it has been my experience in treating patients like Ms. Sealy that when the standards of care identified in this report are met, patients like Ms. Sealy do not suffer serious injuries. However, it has been my training, education, and experience that when a facility and its staff breach the

standards of care identified in this report, it is likely a patient will suffer harm resulting from fire ant bites. In terms of reasonable medical probability, had Parkview Nursing: (1) provided a functional, sanitary, and comfortable resident environment; (2) promoted a habitable environment; (3) minimized environmental hazards; (4) maintained and implemented an effective pest control program; (5) adequately supervised and regularly monitored Ms. Sealy; and (6) educated and trained its staff on pest control management, the staff would have complied with the standard of care, fire ants would not have existed within Ms. Sealy's room, and Ms. Sealy would not have endured an attack by fire ants. Additionally, if staffing levels had been appropriate, there would have been nurses and/or staff available to attend to Ms. Sealy, and she would not have been exposed to fire ants and the resulting harm from their exposure. Had the care to Ms. Sealy been provided by sufficiently trained staff and based on well-conceived policies and procedures, an appropriate and effective pest control program would have been implemented and interventions would have been put in place which would have prevented Ms. Sealy from exposure to attack by fire ants. Since the standards of care were not met, ants were allowed in Ms. Sealy's room, where they attacked her by biting her all over her body. Specifically, the fire ants bit her face and forehead from her hairline to her eyebrows, along with her shoulders, chest, arms, hands, thighs, and upper leg areas which caused multiple oozing insect bites, skin eruption, swelling, and redness. As a result, she necessitated transfer to the emergency room where she was prescribed bacterial infection and allergic reaction medications (TR-000010 to TR-000022, TR-000029, TR-000038, TR-000041, TR-000072). Therefore, Parkview Nursing's breaches in the standards of care, in terms of reasonable medical probability, resulted in Ms. Sealy's exposure to fire ants and the resulting harm they imposed to her skin and body.

Conclusion

Accordingly, it is my expert opinion that the breaches of the standard of care by Parkview Nursing were proximate causes of injury and harm to Ms. Sealy. Absent the breaches in the standard of care, to a reasonable degree of medical probability, Ms. Sealy would not have suffered pain and discomfort from exposure to fire ant bites, which caused painful and irritating clusters of fire ant bite pustules to cover a vast portion of Ms. Sealy's skin and body, including her face (TR-000072 to TR-000073). I hold all of the opinions expressed in this report to a reasonable degree of medical certainty.

Christopher Davey, MD