UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK
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LORI LAROCK, as Administratrix of the Estate of ROGER A. SANFORD,

Plaintiff,

-against-

ALBANY COUNTY NURSING HOME; THE COUNTY OF ALBANY; LARRY SLATKY; DEBBIE GOSSMAN; RHONDA LYGA; JOHN AND JANE DOES #1-5;

Defendants.
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AMENDED COMPLAINT
JURY TRIAL DEMANDED

1:19-CV-0604

Plaintiff Lori LaRock, as Administratrix of the Estate of her father, Roger A. Sanford, by and through her attorneys, Emery Celli Brinckerhoff & Abady LLP, for her Complaint alleges as follows:

**THE CALLOUS AND CRUEL ALBANY COUNTY NURSING HOME**

1. Imagine this nightmare: a daughter shows up at a nursing home. Her father is in a room. He is drenched in sweat. He is gasping for breath. His oxygen tube is dangling from his nose. No one is with him. No one is helping him. He is fighting for his life, alone.

2. The daughter runs into the hallway, screaming for help. No one helps. She finds nursing home staff, begging for help for her father. They offer none.

3. She runs back to his room. He is still alone, gasping for breath. She frantically calls 911. But it is too late. By the time the ambulance arrives, the emergency medical team cannot save his life.

4. This is no dream, but what actually happened on March 1, 2018, when Lori LaRock found her father Roger Sanford dying alone in the Albany County Nursing Home (the "Nursing Home").

5. Even worse, for months before Mr. Sanford's death, this taxpayer-funded facility left Mr. Sanford unchanged, unfed, unmedicated, unwashed, unshaven, and even covered in his own urine and feces.

6. Ms. LaRock had complained repeatedly about her father's mistreatment to the Executive Director of the Nursing Home, Larry Slatky. In response, Slatky told her any complaint to the New York State Department of Health ("DOH") would be "lost," because his employee had a relative at DOH. When Ms. LaRock said she took a photo of her father covered in vomit, Slatky screamed at her. When Ms. LaRock asked Slatky for his email address so she could email him the photo or a complaint of mistreatment, he refused. When Ms. LaRock managed to email Slatky anyway, he ignored the email.

7. Slatky did nothing to help Mr. Sanford. Slatky had only one concern: to cover-up the Nursing Home's misconduct.

8. After Mr. Sanford's death, the Department of Health conducted an investigation. It found that the Nursing Home and its staff violated not one, not two, but three separate federal laws. They failed to give Mr. Sanford "basic life support, including CPR." They failed to give him "treatment and care in accordance with professional standards of practice." They failed to provide "respiratory care."

9. They also failed to call 911, failed to invoke emergency protocols, and even failed merely to be in the same room with a man struggling for his own life.

10. Roger Sanford was the loving husband of Lois Sanford; father of Lori LaRock, Susan LaRock and John Sanford; and grandfather to seven grandchildren and three great-grandchildren. Mr. Sanford led a successful career working for the American Red Cross, Parsons Child and Family Center, and for multiple group homes for persons with disabilities. He did not deserve to die like this.

11. Now it is time this Nursing Home, its director Mr. Slatky, and its staff be held accountable for their callous and cruel treatment of this helpless man.

**JURISDICTION AND VENUE**

12. This Court has jurisdiction pursuant to 28 U.S.C. § 1331. This action arises under 42 U.S.C. § 1396, *et seq.* and under the Fourteenth Amendment to the Constitution of the United States pursuant to 42 U.S.C. § 1983.

13. Venue is proper in this district under 28 U.S.C. § 1391(b).

14. On May 25, 2018, Ms. LaRock filed a notice of claim pursuant to General Municipal Law § 50-i.

15. On July 19, 2018, Ms. LaRock testified at a hearing pursuant to General Municipal Law § 50-h.

**THE PARTIES**

16. Plaintiff LORI LAROCK resides in Saratoga County in Clifton Park, New York. She is the administratrix of her father Roger Sanford's estate. Before his death, Mr. Sanford resided at Albany County Nursing Home in Albany, New York.

17. Defendant ALBANY COUNTY NURSING HOME was at all relevant times the Nursing Home where Mr. Sanford resided. As such, the Nursing Home was responsible for Mr. Sanford's safety, security, well-being, and medical care.

18. Defendant the COUNTY OF ALBANY was at all relevant times a municipal corporation responsible for the administration of the Nursing Home. The County was the employer of all Nursing Home employees. As such, it was responsible for Mr. Sanford's safety, security, well-being, and medical care.

19. Defendant LARRY SLATKY was at all relevant times the Executive Director of the Nursing Home. As such, he was responsible for Mr. Sanford's safety, security, well-being, and medical care.

20. Defendant DEBBIE GOSSMAN was at all relevant times the nursing supervisor at the Nursing Home. As such, she was responsible for Mr. Sanford's safety, security, well-being, and medical care.

21. Defendant RHONDA LYGA was at all relevant times a licensed practical nurse at the Nursing Home. As such, she was responsible for Mr. Sanford's safety, security, well-being, and medical care.

22. Defendants JOHN AND JANE DOES #1-5 were at all relevant times Nursing Home employees responsible for Mr. Sanford's safety, security, well-being, and medical care.

23. Gossman, Lyga, and John and Jane Does #1-5 are referred to collectively as the "Staff Defendants." Slatky and the Staff Defendants are referred to collectively as the "Individual Defendants."

24. At all relevant times, all Defendants acted within the scope of their employment by Albany County Nursing Home and the County of Albany and acted under color of the laws, statutes, and ordinances, regulations, policies, customs, and usages of the State of New York.

## FACTUAL ALLEGATIONS

25. In August 2017, Mr. Sanford's family placed him into Albany County Nursing Home.

26. Mr. Sanford was seventy-three years old. He suffered from Alzheimer's disease and multiple forms of heart disease.

27. Mr. Sanford was in poor health, and his Alzheimer's and overall worsening mental state had begun to prevent him from performing basic tasks, such as dressing himself, feeding himself, or taking his daily medications, without assistance. This need for constant assistance and supervision, beyond that which his elderly wife and daughter could provide, led Mr. Sanford's family to place him in a nursing home.

### I. The Nursing Home Neglects and Endangers Mr. Sanford

28. From the beginning of Mr. Sanford's stay at the Nursing Home, the home was chronically understaffed, and Mr. Sanford's most basic needs were neglected.

29. Ms. LaRock regularly arrived at the nursing home to find her father unwashed, unshaven, unchanged, and even covered in his own urine and feces.

30. On at least one occasion, Ms. LaRock found her father covered in his own urine only to be told that the Nursing Home was "short staffed" and that she would have to change him; otherwise, he would not be changed in the near future.

31. Another time, Ms. LaRock arrived to find her father only partially dressed—laying in bed with his shirt half on and hanging over the back of his neck with his chest and stomach exposed.

32. The Nursing Home often refused to feed Mr. Sanford. Ms. LaRock and her husband would frequently arrive to find Mr. Sanford sitting in bed with his dinner tray in front of him, unable to eat because no staff would assist him.

33. Mr. Sanford lost almost 20 pounds during his first four months at the Nursing Home.

34. Making matters worse, Nursing Home staff refused to treat Mr. Sanford's severe medical conditions.

35. Nursing Home staff would provide Mr. Sanford with a nebulizer to treat his chronic obstructive pulmonary disease, but often left before the treatment was complete.

36. Mr. Sanford was not capable of addressing or understanding his medical conditions.

37. Without staff supervision, Mr. Sanford would remove the nebulizer and would not complete his necessary medical treatment.

## II. Defendant Slatky Threatens Ms. LaRock for Complaining about her Father's Treatment

38. On or around December 6, 2017, Ms. LaRock called a staff social worker, Amy Bennet, to complain about her father's inadequate care and neglect.

39. Ms. LaRock asked that the conversation be kept confidential for fear staff would retaliate against her father if they found out she had complained.

40. Ms. Bennet stated she would discuss Ms. LaRock's concerns with Nursing Director Maureen Tomisman.

41. Ms. LaRock's request for confidentiality was not honored. Instead, when Ms. LaRock came to the Nursing Home that very day, a staff member angrily confronted her and sniped: "you don't have to tell on us."

42. Having lost trust in Ms. Bennet and Ms. Tomisman, Ms. LaRock called Defendant Larry Slatky, the Executive Director of the home.

43. Ms. LaRock and Mr. Slatky spoke on the phone.

44. Ms. LaRock explained to Mr. Slatky her concerns with her father's care as described above, and her new fear of retaliation against her father.

45. Ms. LaRock told Mr. Slatky that she had already moved her father out of two prior nursing homes and she had called DOH due to his poor care at those homes.

46. Mr. Slatky suggested Ms. LaRock stop by the staff Christmas Party at the Nursing Home that night to discuss her father's care.

47. When she arrived at the Nursing Home that evening, Mr. Slatky took Ms. LaRock into the hallway to speak with her.

48. Mr. Slatky did not address Ms. LaRock's concerns about her father's care.

49. Instead, Mr. Slatky threatened that any paperwork would be "lost" if Ms. LaRock complained about the Nursing Home to DOH.

50. Mr. Slatky boasted that a relative of a Nursing Home employee worked in the DOH department that receives complaints, and no complaint against the Nursing Home would see the light of day.

51. As Executive Director of the Nursing Home, Slatky had a responsibility to ensure that the Nursing Home was in compliance with all state and federal regulations.

52. As Executive Director of the Nursing Home, Slatky had a responsibility to ensure that all Nursing Home residents receive adequate care.

53. As Executive Director of the Nursing Home, Slatky had a responsibility to address specific complaints regarding patient care, including Ms. LaRock's complaints.

54. Instead of doing anything to help Ms. LaRock's father or keep him safe, Mr. Slatky threatened Ms. LaRock.

55. Unsurprisingly given his response, this meeting with Mr. Slatky did nothing to improve Mr. Sanford's care.

56. Ms. LaRock continued to find her father unchanged, unfed, unmedicated, and drenched in his own bodily fluids.

## III. Mr. Sanford's Health Deteriorates; Slatky Tries to Bury Ms. LaRock's Complaints

57. On February 24, 2018, one week before Mr. Sanford's death, Ms. LaRock noticed that her father did not seem like himself. He appeared to have vomited in his bed earlier that day (which, of course, had not been cleaned up); he seemed lethargic and was not getting out of bed; he coughed more than usual; and his breathing seemed raspy.

58. Ms. LaRock asked to speak to the head of nursing, Defendant Debbie Gossman.

59. Ms. LaRock asked Ms. Gossman to send her father to the hospital for further evaluation of his condition.

60. Ms. Gossman refused to send Mr. Sanford to the hospital.

61. Instead, Ms. Gossman stated that the Nursing Home had a chest x-ray machine and that all necessary testing and observation could be done at the Nursing Home.

62. The Nursing Home did not perform a chest x-ray on Mr. Sanford between February 24, 2018 and his death one week later.

63. On February 26, Ms. LaRock called Defendant Slatky on the phone.

64. Ms. LaRock told Slatky that she had found her father covered in vomit two days earlier and that he seemed ill.

65. Slatky seemed unconcerned about her Mr. Sanford's health.

66. Ms. LaRock then mentioned that she had taken a picture of her father covered in his own vomit, which she wanted to show him.

67. Slatky immediately became defensive.

68. Slatky shouted to Ms. LaRock that the picture "can't prove anything."

69. Ms. LaRock asked for Slatky's email address, so she could send him the picture and he could see her father's neglectful treatment.

70. Slatky refused to provide his email address.

71. Ms. LaRock figured out Slatky's email address on her own.

72. On February 26, 2018, at 2:01p.m., Ms. LaRock emailed Slatky the picture of her father covered in vomit.

73. Four minutes later, Slatky read Ms. LaRock's email, as confirmed by a read receipt sent to Ms. LaRock.

74. Slatky never responded to the email, orally or in writing.

75. Slatky never even acknowledged the email.

76. Slatky did nothing to protect or care for Mr. Sanford.

77. Slatky did not send Mr. Sanford to the hospital.

78. Slatky instead approved Mr. Sanford's continued maltreatment.

79. Had Slatky taken action to improve Mr. Sanford's care instead of endorsing his ongoing neglect and endangerment, Mr. Sanford would likely have lived.

80. On information and belief, Slatky spoke with no Nursing Home staff about improving Mr. Sanford's care, or providing him further medical attention.

81. Slatky's only apparent concern was burying Ms. LaRock's complaints.

## IV. The Nursing Home Leaves Mr. Sanford to Die

82. March 1, 2018 was one week after Ms. LaRock had first reported to the Nursing Home that her father seemed ill.

83. On March 1 at 6:10 p.m., Ms. LaRock received a voicemail from Defendant Gossman.

84. The voicemail stated that Mr. Sanford was ill and that Ms. LaRock should call her back so that Ms. Gossman could "let [Lori] know what's going on."

85. Panicked, Ms. LaRock called the Nursing Home immediately.

86. The Nursing Home security guard paged Ms. Gossman twice but received no response.

87. Ms. LaRock immediately left for the Nursing Home to see her father, an approximately twenty-minute trip.

88. Ms. LaRock arrived to a nightmare.

89. Her father was laying unattended in his room in agony as he struggled to stay alive.

90. No Nursing Home staff was with Mr. Sanford.

91. Mr. Sanford was drenched in sweat.

92. He was violently gasping for air.

93. An oxygen tube hung from Mr. Sanford's nose.

94. Mr. Sanford wasn't actually breathing through the oxygen tube, because no Nursing Home staff was there to administer the oxygen.

95. Ms. LaRock screamed for help.

96. No one responded.

97. Ms. LaRock left her father's room, desperate to find someone to help her father.

98. Ms. LaRock found a nurse, Defendant Lyga, in the dining room nonchalantly passing out medication.

99. Ms. LaRock told Lyga that her father needed urgent help and expressed amazement that he had been left in his present condition.

100. Lyga did not deny that Mr. Sanford was in urgent need of medical care.

101. Lyga stated "I didn't leave him there, Debbie Gossman did."

102. In short, Lyga knew that Mr. Sanford was alone in his room, unattended, while in desperate need of medical care.

103. Lyga made no effort to help Mr. Sanford or to get him emergency medical attention.

104. On her way back to her father's room, Ms. LaRock encountered at least two other John/Jane Doe Nursing Home staff in the hallway.

105. Neither helped her father.

106. On information and belief, additional John/Jane Doe staff in the Nursing Home knew about Mr. Sanford's grave medical condition, yet abandoned Mr. Sanford as he lay dying in his room.

107. Ms. LaRock returned to her father's room.

108. Mr. Sanford was still alone.

109. He was still gasping for breath.

110. Ms. LaRock immediately called 911.

111. At some point before the paramedics arrived, Ms. Gossman finally strolled in to Mr. Sanford's room.

112. Gossman reacted with no urgency to Mr. Sanford's declining health.

113. Gossman offered Mr. Sanford no medical assistance.

114. Gossman again left Mr. Sanford unattended by any medical personnel.

115. Contemporaneous records from emergency paramedics state that when they arrived, Mr. Sanford was "found laying in hospital bed unresponsive in obvious respiratory failure near respiratory arrest," was pale and sweating excessively, and "was in need of immediate airway support."

116. However, there was "no facility staff in the room" and "no report from facility staff available."

117. Mr. Sanford was transferred to Albany Medical Center, where he was treated in the Emergency Room and then the Intensive Care Unit.

118. Doctors at the hospital informed Ms. LaRock that her father likely aspirated on his own vomit and they would do their best to treat him.

119. This medical care was too late.

120. Mr. Sanford lived for another day and a half on a ventilator.

121. Mr. Sanford tragically passed away on March 3, 2018.

122. Autopsy results confirm that he died of aspiration pneumonia.

## V. The DOH Investigation Uncovers a Nursing Home Meltdown

123. Following her father's death, Ms. LaRock filed a complaint with DOH. DOH conducted an investigation, reviewed medical records, and interviewed various Nursing Home staff.

124. DOH interviewed two Nursing Home nurses.

125. DOH interviewed at least one Nursing Home doctor.

126. DOH interviewed the Nursing Home's Medical Director.

127. DOH interviewed the Nursing Home's Respiratory Therapist/Director.

128. The DOH Report is attached as Exhibit A

129. DOH concluded that the Nursing Home violated federal law.

130. DOH concluded that the Nursing Home committed three violations of federal regulations.

131. First, DOH found that the Nursing Home violated 42 C.F.R. § 483.24 by failing to provide Mr. Sanford with "basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives." Ex. A at 1-5.

132. This DOH finding is true.

133. On March 1, 2018, the Nursing Home and its employees, including the Staff Defendants, did not provide Mr. Sanford CPR prior to the arrival of emergency medical personnel.

134. Second, DOH found that the Nursing Home violated 42 C.F.R. § 483.25 by failing to "ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices," *id.* at 5-14.

135. This DOH finding is true.

136. The Nursing Home and its employees, including the Staff Defendants, failed to ensure that Mr. Sanford received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and Mr. Sanford's choices.

137. Third, DOH found that the Nursing Home violated 42 C.F.R. § 483.25(i) by failing to provide "respiratory care" and failing to ensure "that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences," *id.* at 15-19.

138. This DOH finding is true.

139. The Nursing Home and its employees, including the Staff Defendants, endangered Mr. Sanford by refusing to provide him with respiratory care consistent with professional standards of practice, the comprehensive person-centered care plan, or Mr. Sanford's goals and preferences.

140. In the course of their investigation leading to these conclusions, DOH uncovered a host of additional troubling facts.

141. For example, between 5:30-6:00 p.m. on March 1st, Defendant Gossman noted that Mr. Sanford's temperature had risen to 101.9 degrees and, by 6:04 p.m. had risen to 103.4 degrees. *Id.*at 3, 8.

142. Gossman also noted that Mr. Sanford's lungs were "congested with expiratory wheeze." *Id.* at 8.

143. At approximately 6:15 p.m.—roughly fifteen minutes before Ms. LaRock arrived—Defendant Lyga noticed that Mr. Sanford's breathing was "heavier than normal and faster." *Id.* at 18.

144. Despite these warning signs, Defendants Gossman and Lyga merely increased his oxygen and gave him an antibiotic before twice leaving him unattended.

145. Gossman, Lyga, and the other Staff Defendants did not follow numerous nursing home policies.

146. They failed to confer with a doctor to ensure that Mr. Sanford received the appropriate oxygen level. *Id.* at 15.

147. They failed to document how much oxygen they provided. *Id.* at 16-17.

148. They failed to provide an ongoing assessment of Mr. Sanford's respiratory status, including his response to oxygen therapy. *Id.* at 18.

149. The Nursing Home procedures provided a system for actions to be taken in the case of a medical emergency: a Code E.

150. When an emergency is ongoing, Nursing Home staff are supposed to (i) announce that a Code E is in place so other Nursing Home personnel can respond, and (ii) stay with the patient. *Id.* at 2.

151. Staff Defendants, including Defendants Gossman and Lyga, did not follow these procedures.

152. As Mr. Sanford lay dying in his bed, the Nursing Home and Staff Defendants failed to announce a Code E.

153. At no point on March 1, 2018 did any Nursing Staff announce a Code E for Mr. Sanford.

154. No Nursing Home staff stayed with the patient.

155. They left him to die alone.

156. The Nursing Home's Director of Nursing since admitted that had proper protocol been followed, they "certainly would have gotten staff to [Mr. Sanford] sooner" and "[t]hat's why we have a system in place." *Id.* at 14.

157. Gossman admitted to the DOH that she didn't even know whether Mr. Sanford was a "full code" (meaning all emergency services and CPR should be provided to preserve his life) or a "do not resuscitate" (for whom staff is not supposed to perform CPR) until she was making copies of his paperwork for EMS. *Id.* at 4.

158. Making matters worse, a medical doctor at the Nursing Home admitted to DOH that:

i. after learning that Mr. Sanford's temperature had risen to 101.3, he gave nursing staff instructions to "call the resident's family regarding their preferred hospital to send the resident out to";
ii. Defendants Gossman and Lyga did not inform him that Mr. Sanford's temperature had risen to 103.4 until after Ms. LaRock called EMS;
iii. Gossman and Lyga did not tell him that Mr. Sanford's condition had visibly worsened since the nurse's initial report to him; and
iv. Gossman and Lyga should have called a "Code E," and staff, including Gossman and Lyga, should have prepared to start CPR.

*Id.* at 14-15.

159. All of those statements by the Nursing Home medical doctor are, on information and belief, true.

160. Had either Gossman or Lyga sent Mr. Sanford to the hospital or, at a minimum, informed the Nursing Home medical doctor of his worsening condition, Mr. Sanford would likely have lived.

161. The Staff Defendants, including Gossman and Lyga, should have performed CPR on Mr. Sanford.

162. No defendant performed CPR on Mr. Sanford.

163. Had they performed CPR, Mr. Sanford would likely have lived.

164. The Nursing Home Medical Director also acknowledged that "as a physician, I would have expected the code to be called. Then they'd get a rapid response team." *Id.* at 15.

165. The Staff Defendants, including Gossman and Lyga, should have called a Code E.

166. None of the defendants called a Code E.

167. Had they called a Code E, Mr. Sanford would likely have lived.

168. DOH also correctly concluded that the Nursing Home did not ensure that Mr. Sanford's emergency status was known during a significant change in Mr. Sanford's respiratory condition; did not promptly identify and intervene for an emergent change in Mr. Sanford's condition; did not transcribe a physician order for Mr. Sanford to receive two liters of oxygen; did not monitor his respiratory condition; and did not document the oxygen therapy that he ultimately received. *Id.* at 5, 16.

169. The Staff Defendants, including Gossman and Lyga, were obligated to comply with these obligations.

170. None of them did.

171. As a result of Defendants' failures and misconduct set forth above, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, and lost life and enjoyment of life.

## VI. Prior Allegations of Slatky's Corruption

172. Before assuming his role as Executive Director of Albany County Nursing Home, Slatky was the Chief Operating Officer of Nassau Health Care Corp, overseeing the operations at publicly operated care facilities.

173. Prosecutors criminally charged Slatky with directing subordinates to award bids to provide services at health care facilities to company's operated by his friends. Even then, Slatky put his own interests above patient care. Slatky was ultimately acquitted after a bench trial.

174. The Nursing Home hired Slatky while under indictment with these criminal charges pending.

## VII. Slatky Takes a Victory Lap

175. Seven months after Mr. Sanford's death, the Nursing Home accepted a Bronze National Quality Award from the American Health Care Association and National Center for Assisted Living.

176. In response, Slatky said in a news release: "The transformation that is taking place at the Nursing Home is nothing short of miraculous."

177. On information and belief, neither the Nursing Home nor Slatky told the AHCA/NCAL about the mistreatment and death of Roger Sanford.

## VIII. *Monell* Allegations

178. During the timeframe in which the Nursing Home took responsibility for Mr. Sanford's care, the Nursing Home and Albany County had a pattern and practice of:

- leaving residents in their own urine, feces, and vomit without changing their clothes or their bedsheets;

- refusing to send residents to the hospital for emergency care or to provide residents end-of-life-care;
- refusing to administer residents' medication;
- refusing to feed residents who were unable to eat without assistance;
- refusing to wash or change residents' clothing;
- leaving its most ill and vulnerable residents unattended without adequate provisions to protect them from falling;
- ignoring residents' or their families' requests for assistance; and
- ignoring complaints regarding residents' care and threatening the family members of residents who complained.

179. The Nursing Home also had a pattern, practice, and policy of providing inadequate staffing to serve its vulnerable residents' needs. This pattern, practice, and policy contributed to the harms set forth above.

180. The following are just a few examples of the Nursing Home's pattern and practice of mistreatment:

**C.G.**

181. C.G. was admitted to the Nursing Home in March 2016. She was 60 years old and dying of lung cancer when she was admitted to the Nursing Home. Nursing Home staff knew her health condition upon admission to the Nursing Home.

182. Shortly after her admission into the Nursing Home, C.G. developed oral thrush. She had multiple sores on the outside of her mouth and refused to eat and drink. C.G.'s daughter informed Nursing Home staff of C.G.'s condition (no Nursing Home staff had informed her) and insisted that she received medication. Nursing Home Staff ignored her pleas for

medication for 4 days, stating only that they would "notate" her concerns and would "have [her mother] evaluated."

183. Finally, C.G.'s daughter told Nursing Home staff that if they continued to refuse to treat her mother, she would bring Nystatin, a medication to treat thrush, herself. The Nursing Home then promised to give C.G. medication for her condition.

184. It was a false promise. On March 24, 2016, Nursing Home staff told C.G.'s daughter they had given her mother Nystatin that morning. But when C.G.'s daughter arrived that afternoon, a cup of Nystatin was sitting in a cup next to C.G.'s bed, untouched. C.G.'s mouth had become so swollen that it took half an hour for her two daughters to remove her dentures so that she could take her medication.

185. C.G. was supposed to take a number of medications for other medical conditions. But on multiple occasions, C.G.'s daughter arrived at the Nursing Home and found that C.G. had spit out her pills and left them on her bed or on the floor. Despite C.G.'s inability to care for herself and to take her medications without supervision, no Nursing Home staff stayed with C.G. while she took her pills to ensure that she actually took the medicine.

186. The Nursing Home also refused to feed C.G. C.G.'s daughters would frequently arrive to find their mother's breakfast tray, lunch tray, or both, sitting in front of her with the plastic cover still on the meal. It was especially shocking when *both* C.G.'s breakfast and lunch were in front of her; staff knew she didn't eat breakfast, yet put lunch in front of her with the uneaten breakfast, and left without ensuring that C.G. ate anything.

187. The Nursing Home also failed to wash C.G. On multiple occasions, C.G.'s daughters arrived to find her entire body soaked in her own urine. Even when C.G. wore a disposable diaper, her daughter would find her entire body and bed covered with urine.

188. Nursing Home Staff would not wash C.G's dentures, either. As a result, her dentures were constantly covered in *fungus*, and would not be washed unless C.G.'s daughters washed them.

189. The Nursing Home also allowed C.G. to fall out of bed repeatedly. C.G. fell out of bed multiple times per week; staff did nothing to prevent these dangerous falls.

190. On March 27, 2016, C.G. fell out of bed and cut her head. Nursing Home staff informed C.G.'s daughter that they found C.G. bleeding from the back of her head by the entrance way to her room. They didn't know how she got there or how long she had been there. When C.G.'s daughter arrived at the Nursing Home, her mother was laying, unattended, bleeding on her pillow. Staff had not cleaned or dressed the cut on her head.

191. C.G.'s daughters complained to Nursing Home staff about all of this mistreatment multiple times. Staff rebuffed and dismissed them. Staff took no action in response to C.G.'s daughters' complaints, and C.G. continued to suffer in the last months of her life.

192. On March 31, 2016, C.G.'s daughters prepared a letter detailing their mother's mistreatment to the County of Albany Department of Residential Health Care Facilities and to Slatky. The letter described their concerns regarding the Nursing Home's refusal to treat C.G.'s thrush, to feed her, to change her, or to prevent her constant falls. C.G.'s daughters knew she was dying, and pleaded with the Nursing Home so that their mother "would not have to suffer any further in her last days."

193. Nursing Home staff responded only that they were "understaffed" and could not meet C.G.'s needs. The only change the Nursing Home offered was to move C.G. to a room closer to the nurses' station.

194. C.G. was bathed more frequently once closer to the nurses' station, but otherwise her care did not improve. She continued to suffer from the Nursing Home's neglect until she passed away on April 5, 2016.

**G.T.**

195. G.T. was admitted to the Nursing Home in June 2018.

196. G.T. was 87-years-old, had significant dementia, and had recently been treated for a urinary tract infection requiring two weeks of hospitalization when she was admitted to the Nursing Home. She was in poor health and in great need of supervision and assistance in performing day-to-day tasks such as eating, walking, and using the bathroom. Nursing Home staff knew of her conditions and limitations when she was admitted into their care.

197. At the Nursing Home, G.T.'s son frequently found his mother in bed covered in her own urine and feces. Towards the end of her life, as her ability to control her own bodily functions worsened, this was an almost daily occurrence.

198. When G.T.'s son complained to Nursing Home staff about this, they claimed they had "just checked her." When he disputed that his mother could not have urinated and defecated on herself every day in the time frame between when staff "just checked on her" and when he arrived, staff became hostile and defensive. For hours, staff left G.T. in her own bodily fluids before changing her.

199. G.T. had a history of urinary tract infections; an important element of her treatment was to keep her genital areas dry. Staff failed to do so. G.T.'s urinary tract infections returned multiple times during her nine-month stay at the Nursing Home.

200. G.T. also developed a rash in the area around her buttocks and lower back that would become covered in feces when she would defecate on herself.

201. On August 8, 2018, G.T.'s son found G.T. shaking uncontrollably in her wheelchair and covered in her own urine. When he asked a nurse how she could be left this way, the nurse stated that she saw G.T. shaking but that she "thought she was cold." G.T. was hospitalized that day with a urinary tract infection.

202. Another time, G.T.'s son found his mother's roommate covered in vomit. G.T.'s son found a nurse and informed her of the roommate's condition. The nurse responded, "she's not on my list" and did nothing to help.

203. G.T.'s son frequently witnessed his mother wave at Nursing Home staff in the hallway from her bed, signaling that she needed help. Nursing Home staff would just wave back and neither check G.T. nor provide her with care.

204. Because the Nursing Home would not provide G.T. with care, her son would call 911 when he noticed his mother developing symptoms of a urinary tract infection. Rather than assist in getting her treatment at a hospital, the staff would become angry and combative, claiming they could "handle it here."

205. In, June 2018, G.T. broke her nose and significantly bruised her body when she fell out of bed after staff left her unattended with no guard rails on the side of her bed.

206. This was a frequent occurrence for residents at the Nursing Home. During nine months visiting his mother at the Nursing Home, G.T.'s son frequently witnessed other unattended residents falling out of their wheelchairs and laying on the ground unable to get up, with no staff to be found.

207. G.T.'s son also witnessed staff planning to falsify reports.

208. For example, G.T.'s son witnessed an unattended resident fall and then, when staff finally picked the resident back up, one nurse said to another "you were with him right," implying they would document that staff was present when they were not.

209. Defendant Slatky was hostile to G.T.'s son when he complained about her care.

210. In June or July 2018, G.T.'s son met with Mr. Slatky and expressed his concerns about his mother's broken nose, his mother's being left in her own urine and feces, and general lack of staffing at the Nursing Home. Because G.T.'s son had never seen Mr. Slatky at the Nursing Home despite visiting his mother almost every day, he suggested Mr. Slatky come by the Nursing Home more often to witness for himself the care residents received. Mr. Slatky was enraged. He immediately became defensive and dismissive of G.T.'s son's complaints. He screamed that G.T.'s son "shouldn't be telling [him] how to run [his] nursing home."

211. A few months later, Mr. Slatky attended a care plan meeting with G.T.'s son and other Nursing Home staff. At that meeting, Mr. Slatky told G.T.'s son to stop calling 911 when his mother became ill. G.T.'s son protested that no Nursing Home staff was caring for her and he needed to call 911 to ensure she received medical attention when she exhibited symptoms of infection. Mr. Slatky was enraged and yelled at G.T.'s son that his complaints were "absurd" and that "if it was up to me, I wouldn't even let you in the building."

**C.W.**

212. C.W. was admitted to the Nursing Home in July 2018. He had multiple forms cancer and had just suffered a broken neck.

213. The day after C.W. was admitted, his son came to visit him and found C.W. in bed unattended with pillows surrounding his bed. He asked a nurse what the pillows

were for and she said that they were "in case he fell out of bed." C.W.'s son asked what that meant or why the pillows surrounding the bed would be helpful in case he fell. Nursing Home staff offered no explanation for how pillows would protect C.W. from falling.

214. Though C.W. had a broken neck, staff placed him in a bed with no bed rails and left him unattended with pillows as his only protection from falling.

215. On July 27, 2018, C.W.'s son arrived to visit his father. C.W. was visibly shaking and unresponsive to him when he arrived.

216. C.W. was experiencing congestive heart failure.

217. A nurse was in the hallway with C.W. but did nothing to treat C.W. or provide help. The nurse was attempting to feed C.W. pudding as he was dying before her eyes.

218. Eventually, Nursing Home staff told C.W.'s son that C.W. was dying and only had hours to live. C.W.'s son asked that C.W. receive hospice care. Nursing Home staff told C.W.'s son that the Nursing Home would administer a pill that would allow C.W.'s body to relax in the final hours so that he would not suffer.

219. Despite this assurance, no Nursing Home staff administered the pill for 4-5 hours. During those hours, C.W.'s son asked different Nursing Home staff to spare his father needless suffering. No one helped C.W.

220. C.W. passed away later that night.

221. These stories are illustrative examples of the Nursing Home's pattern and practice of mistreatment and policy of understaffing. Families of additional residents have reported finding their loved ones unwashed, unfed and covered in their own bodily fluids, having fallen out of bed or a wheelchair with no staff in sight, or with infections or even on the verge of

death with staff either nowhere to be found or non-responsive to residents' medical needs. Staff typically rebuffed and ignored their complaints.

222. Roger Sanford fell victim to these troubling Nursing Home practices, leading to his needless suffering and premature death.

**COUNT ONE**
(42 U.S.C. § 1983—Violation of Mr. Sanford's Right to Substantive Due Process)
(All Defendants)

223. Plaintiff repeats and realleges as if fully set forth herein the allegations contained in the foregoing paragraphs.

224. Defendants were at all times responsible for Mr. Sanford's well-being and medical care, and at all times acted under color of New York State law.

225. By their conduct as set forth above, Defendants had actual knowledge of, yet disregarded and endorsed, conduct creating an obvious or excessive risk of Mr. Sanford's death, as well as obvious risks to his health and well-being over many months.

226. By failing to provide Mr. Sanford with necessary day-to-day care such as washing him, changing his clothes, and feeding him; failing to supervise Mr. Sanford's breathing treatments; refusing to remedy these deficiencies despite multiple complaints from Ms. LaRock; refusing to send Mr. Sanford to the hospital or even to conduct a chest x-ray in-house despite his persistent vomiting in the week leading up to his death; failing to take necessary steps to protect Mr. Sanford's life; violating multiple federal regulations designed to ensure patient health, life, and safety, including Mr. Sanford's health, life, and safety; failing to help Mr. Sanford or call for emergency medical help as he lay dying under the Nursing Home's own roof; burying and threatening to bury complaints of mistreatment and poor care of Mr. Sanford; and by their other misconduct set forth above, Defendants shocked the conscience, violated any norm of

professional judgment, and were deliberately indifferent to Mr. Sanford's health and safety and to a known risk of serious and immediate risk of harm to him. Defendants' actions all but assured Mr. Sanford would suffer a painful and gruesome death.

227. Before, during, and after the violation of Plaintiff's constitutional rights, Albany County and Albany County Nursing Home had a pattern, practice, custom, and policy of unconstitutional treatment of Nursing Home residents, including

- leaving residents in their own urine and feces without changing their clothes;
- refusing to send residents to the hospital for emergency care or to provide residents end-of-care;
- refusing to administer residents' medication;
- refusing to feed residents who were unable to eat without assistance;
- refusing to wash or change residents' clothing;
- leaving residents at high risk of falling and sustaining injuries if left unsupervised without supervision;
- ignoring residents or their families requests for assistance;
- ignoring complaints regarding residents' care and threatening the family members of residents who complained; and
- providing inadequate staffing to serve its vulnerable residents' needs.

228. The County and the Nursing Home perpetrated, permitted, condoned, and were deliberately indifferent to these practices.

229. The Individual Defendants acted consistently with and pursuant to the County and Nursing Home's pattern, practice, custom, and policy when they engaged in their conduct set forth above.

230. Because of Defendants' violations of Mr. Sanford's constitutional rights, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, and lost life and enjoyment of life.

231. As a consequence, Ms. LaRock, as the administratrix of Mr. Sanford's estate, is entitled to compensatory and punitive damages against Defendants.

**COUNT TWO**

(42 U.S.C. § 1983—Violation of Mr. Sanford's Rights under the Federal Nursing Home Reform Amendments, 42 U.S.C. §§ 1396 et seq., and OBRA regulations, 42 C.F.R. §§ 483.1 et seq.)
(All Defendants)

232. Plaintiff repeats and realleges as if fully set forth herein the allegations contained in the foregoing paragraphs.

233. Mr. Sanford was a recipient of Medicare and Medicaid and was, at all relevant times, a resident of Albany County Nursing Home and, therefore, within the class of persons protected and granted an enforceable right under 42 U.S.C. §§ 1396 *et seq*., and OBRA regulations, 42 C.F.R. §§ 483.1 *et seq*.

234. Defendants at all times acted under color of New York State law.

235. As already set forth by DOH, Defendants' failure to provide Mr. Sanford with treatment and care in accordance with professional standards of practice, to provide him with basic life support, or to provide with adequate respiratory care on March 1, 2018 alone violated his federally protected rights under the Federal Nursing Home Reform Amendments 42 U.S.C. §§ 1396 *et seq*., and implementing OBRA regulations, 42 C.F.R. §§ 483.24-483.25.

236. By the above misconduct, including but not limited to the misconduct that led to the DOH findings, Defendants deprived Mr. Sanford of his federally protected rights under the Federal Nursing Home Reform Amendments 42 U.S.C. §§ 1396r and implementing OBRA regulations 42 C.F.R. § 483.10 and 42 C.F.R. § 483.12, including his right to live in an environment that promotes maintenance or enhancement of his quality of life; his right to services in his nursing facility that provide reasonable accommodation of his needs; the right to have a resident physician consulted upon a significant change in Mr. Sanford's physical health; the right to a sanitary and comfortable environment, including a clean bed; the right to have actions taken to prevent future violations of these rights while past complaints are being investigated; and the right to be free from abuse and neglect in a nursing home.

237. Before, during, and after the violation of Plaintiff's constitutional rights, Albany County and Albany County Nursing Home had a pattern, practice, custom, and policy of unconstitutional treatment of Nursing Home Residents, as set forth above.

238. The individual Defendants acted consistently with and pursuant to the County and Nursing Home's pattern, practice, custom, and policy when they engaged in their conduct set forth above.

239. Because of Defendants' violations of Mr. Sanford's federally protected rights, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, and lost life and enjoyment of life.

240. As a consequence, Ms. LaRock, as the administratrix of Mr. Sanford's estate, is entitled to compensatory and punitive damages against Defendants.

**COUNT THREE**
(Nursing Home Bill of Rights, New York Public Health Law § 2801-d)
(All Defendants)

241. Plaintiff repeats and realleges as if fully set forth herein the allegations contained in the foregoing paragraphs.

242. Mr. Sanford was, at all relevant times, a resident of Albany County Nursing Home and, therefore, within the class of persons protected and granted an enforceable right under New York Public Health Law § 2801-d.

243. By the above misconduct, Defendants deprived Mr. Sanford of his rights under New York Public Health Law §§ 2803-c(3)(e) & (3)(g), including the right "to receive adequate and appropriate medical care" and the right "to receive courteous, fair, and respectful care and treatment."

244. The Nursing Home's treatment of Mr. Sanford also violates his rights under the New York Compilation of Codes Rules and Regulations, enforceable through New York Public Health Law § 2801–d, including his right to a nursing home that provides the "necessary services to maintain good nutrition, grooming, and personal and oral hygiene" to residents who are unable to carry out activities of daily living, 10 NYCRR § 415.12(a)(3), and his right to a nursing home that ensures proper "respiratory care" to its residents, 10 NYCRR § 415.12(k)(6).

245. Defendant Slatky, as the Executive Director of the Nursing Home, was responsible for the Nursing Home's compliance with state regulation. His failure to make sure that Federal and State laws and regulations were implemented and adhered to, failure to ensure the adequacy of the Nursing Home's facilities and staffing, and failure to ensure that adequate

plans of care were developed for its residents likewise violated Mr. Sanford's rights under New York Public Health Law § 2801–d.

246. Because of Defendants' violations of Mr. Sanford's rights, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, and lost life and enjoyment of life.

247. In addition to being liable in their own right, Defendants Albany County Nursing Home and Albany County, as employers of each of the Individual Defendants—are responsible for their wrongdoing under the doctrine of *respondeat superior*.

248. As a consequence, Ms. LaRock, as the administratrix of Mr. Sanford's estate, is entitled to compensatory and punitive damages against Defendants.

**COUNT FOUR**
(Negligence)
(All Defendants)

249. Plaintiff repeats and realleges as if fully set forth herein the allegations contained in the foregoing paragraphs

250. Because Mr. Sanford was under Defendants' care, supervision, and control, Defendants had a special relationship with him, and owed him a duty of care.

251. Defendants had a duty to use the highest degree of care in monitoring Mr. Sanford's health and safety, and ensuring he received emergency medical treatment when needed. Defendants also had a duty to ensure that Mr. Sanford was adequately fed, dressed, and medicated on a daily basis.

252. Defendants breached this duty by their misconduct set forth above.

253. Defendants Albany County Nursing Home and Albany County, as employers of each of the Individual Defendants—are responsible for their wrongdoing under the doctrine of *respondeat superior*.

254. Because of Defendants' negligence, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, anxiety, and lost life and enjoyment of life.

255. As a consequence, Ms. LaRock, as the administratrix of Mr. Sanford's estate, is entitled to compensatory and punitive damages against Defendants.

**COUNT FIVE**
(Medical Malpractice)
(Defendants Albany County Nursing Home, Albany County, Staff Defendants)

256. Plaintiff repeats and realleges as if fully set forth herein the allegations contained in the foregoing paragraphs

257. At all times relevant to this Complaint, Defendants undertook to provide medical care to residents of Albany County Nursing Home including Mr. Sanford, and were legally obligated and had a special duty to do so effectively.

258. The Defendants held themselves out as possessing the proper degree of learning and skill necessary to render medical care, treatment, and services in accordance with good and accepted medical practice, and that they undertook to use reasonable care and diligence in the care and treatment of the residents of Albany County Nursing Home, including Mr. Sanford.

259. By their misconduct above, Defendants acted contrary to sound medical practice and committed acts of medical malpractice against Mr. Sanford.

260. Defendants Albany County Nursing Home and Albany County, as employer of each of the Staff Defendants—are responsible for their wrongdoing under the doctrine of *respondeat superior*.

261. Because of Defendants' negligence, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, and lost life and enjoyment of life.

262. As a consequence, Ms. LaRock, as the administratrix of Mr. Sanford's estate, is entitled to compensatory and punitive damages against Defendants.

263. A certificate of merit pursuant to Section 3012-a of the New York Civil Practice Law and Rules is annexed to Plaintiff's Complaint.

**JURY TRIAL DEMANDED**

264. Plaintiff demands a trial by jury.

WHEREFORE, Plaintiff respectfully request judgment against Defendants as follows:

a. compensatory damages in an amount to be determined at trial;

b. punitive damages in an amount to be determined at trial;

c. reasonable attorneys' fees, costs and disbursements pursuant to the Civil Rights Attorney's Fee Awards Act of 1976, 42 U.S.C. § 1988 and New York Public Health Law § 2801-d(6); and

d. such other and further relief as this Court deems just and equitable.

Dated: New York, New York
July 2, 2019

EMERY CELLI BRINCKERHOFF & ABADY LLP

By: /s/Ilann M. Maazel
Ilann M. Maazel
David B. Berman
600 Fifth Avenue, 10th Floor
New York, New York 10020
(212) 763-5000

*Attorneys for Plaintiff Lori LaRock, as Administratrix of the Estate of Roger A. Sanford*

# Exhibit A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/08/2018
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335425 | A. BUILDING _____ B. WING _____ | C 04/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY COUNTY NURSING HOME | 780 ALBANY SHAKER ROAD ALBANY, NY 12211 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 678 SS=E | Cardio-Pulmonary Resuscitation (CPR)<br>CFR(s): 483.24(a)(3)<br><br>§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview during an abbreviated survey (Case #NY00216244), the facility did not ensure personnels ability to provide emergency basic life support, including cardiopulmonary resuscitation (CPR), to residents requiring such care prior to the arrival of emergency medical personnel in accordance with the resident's advance directives and subject to related physician orders for one (Resident #1) of four residents reviewed. Specifically, the facility did not ensure Resident #1's advance directive status was known during a significant change in the resident's respiratory condition on 3/1/18.<br>This is evidenced by:<br><br>Refer to F684<br><br>Resident #1:<br><br>The resident was readmitted to the facility on 11/10/17, with a diagnoses of chronic obstructive pulmonary disease, dementia without behavioral disturbance, and hypertensive heart disease without heart failure. The Minimum Data Set (MDS) dated 2/15/18, assessed the resident with severe cognitive impairment.<br><br>The facility's Advanced Directive Policy and Procedure (P&P) dated 6/2017, documented that | F 678 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/07/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 678 | Continued From page 1<br>the MOLST (Medical Orders for Life Sustaining Treatment) form is a short summary of the resident's treatment preferences with a physician's order for care that is easy to read in an emergency situation. The medical orders must be followed by all health care professionals. CPR (cardio pulmonary resuscitation) restores cardiac function or supports ventilation in the event of a cardiac or respiratory arrest. If the resident/representative chooses CPR, the nurse will ensure that the resident's identification bracelet, doorway name plate, and medical record spine will be blue, and "full code" order will be obtained.<br><br>The facility P&P for "Code E Rapid Response" revised 6/2017, documented that "Code E" is utilized to designate a Medical Emergency. A "Rapid Response" is utilized when a Medical Emergency may be imminent based upon nursing assessments. The purpose of the P&P documented to provide for immediate Medical and Nursing response for residents when a medical emergency arises. The Procedure documented: 1) Announce a Code E, validate code status. 2) Stay with victim.<br><br>The resident's Medical Orders for Life-Sustaining Treatment (MOLST) dated 5/9/17, documented to attempt Cardio-Pulmonary Resuscitation (CPR) when the resident has no pulse and/or is not breathing,<br><br>The physician's order dated 11/10/17, renewed on 2/12/18, documented the resident's Advanced Directive status was a full code.<br><br>The Comprehensive Care Plan (CCP) for Advanced Directives updated 2/13/18, | F 678 | | |

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| F 678 | Continued From page 2<br>documented the resident's current code status is full code, with HCP (health care proxy) and MOLST on file.<br><br>The Nursing Progress Note written by the Registered Nurse Supervisor (RN #1) on 3/1/18 at 6:04 pm, documented the resident was noted to have a fever of "103.4" tympanic (taken via the ear). Tylenol 650 mg given per prn (as needed) order. Lungs congested with expiratory wheeze (high-pitched whistling sound made while breathing out). O2 SAT "81%" on room air; Oxygen started at 2 liters via nasal cannula. Nebulizer treatments (breathing treatments) given per order. Pulse between "180 and 220." MD (Medical Doctor) #1 made aware of above. The note did not include the resident's rate of respirations.<br><br>The Weights and Vitals Summary dated 3/1/18 at 6:10 pm, documented: Pulse 180 bpm (beats per minute); (normal is 60-100); Respirations 40 breaths/minute (normal is 12-22); Temperature 103.4 (tympanic) (normal is 97-99). The summary did not include a blood pressure.<br><br>The EMS Patient Care Record (PCR) dated 3/1/18, documented that EMS arrived in the resident's room at "6:45 pm." Patient was unresponsive and a family member was hysterical in the room screaming and crying. Facility staff were not in the resident's room. There was no report from facility staff. Patient found lying in hospital bed "unresponsive in obvious respiratory failure, near respiratory arrest." Hot, diaphoretic (sweating excessively), pale, accessory muscles (muscles of the neck, back, and abdomen that assist with respiration) used with breathing, decreased breath sounds on | F 678 | | |

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| F 678 | Continued From page 3<br>left and right, increased respiratory effort, and unresponsive. At 6:46 pm, non-patent (obstructed) airway in need of immediate airway support/control and the patient was bagged (artificial ventilation performed with a respirator bag). The patient remained unresponsive and at 7:07 pm was intubated.<br><br>Physician's order dated 3/1/18 at 7:17 pm, documented emergency room transfer for respiratory distress.<br><br>The Hospital Chart Report Visit documented the resident arrived on 3/1/18 at 7:40 pm with patient complaint of "respiratory arrest."<br><br>During an interview on 4/10/18 at 3:40 pm, LPN #1 stated she did not know the resident was a full code. She wasn't familiar with the resident and stated RN #1 might have checked. LPN #1 is CPR certified. She stated she was not able to recognize respiratory distress, respiratory failure, or respiratory arrest. "LPNs do not assess."<br><br>During an interview on 4/12/18 at 3:40 pm, RN #1 was able to identify a resident who is a full code; Blue wrist band, blue band on door, blue band on chart. RN #1 stated, "We check DNRs twice a day. You don't want to start CPR on someone who is a DNR." When asked if she realized the resident was a full code, she stated, "Not until making copies of the paperwork for EMS."<br><br>During an interview on 4/12/18 at 5:15 pm, the Director of Nursing (DON) stated that "Staff should know the resident's code status. That's why we have a system in place." | F 678 | | |
| F 684 | Quality of Care | F 684 | | |

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| F 684 SS=E | Continued From page 4<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews during an abbreviated survey (Case #NY00216244), the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for one (Resident #1) of three residents reviewed. Specifically, for Resident #1, the facility did not promptly identify and intervene for an emergent change in the resident's condition resulting in the family calling 911 to transport the resident to the hospital. The Hospital Chart Report Visit documented respiratory arrest. This is evidenced by:<br><br>Resident #1:<br><br>The resident was readmitted to the facility on 11/10/17, with a diagnosis of chronic obstructive pulmonary disease (COPD), dementia without behavioral disturbance, and hypertensive heart disease without heart failure. The Minimum Data Set (MDS) dated 2/15/18, assessed the resident with severe cognitive impairment.<br><br>The facility guide (undated) titled "Change in | F 684 | | |

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| F 684 | Continued From page 5<br>Condition - Identify, Communicate and Manage" documented:<br>Always assess vital signs before calling the physician service with a change in condition.<br>Normal values documented; Pulse 60-100, blood pressure (90/60 - 120/80), oxygen saturation level (O2 SAT) 95 - 100%, respiratory rate 12-22, temperature 97-99 degrees F.<br>Contact physician services for any changes in condition of the resident. Example - new onset of symptoms/exacerbations.<br>Timely communication is key to this treatment modality and needed to determine the next step in treating conditions effectively and safely.<br>Change in condition is any alteration from an individual's usual healthy or baseline status. The change may illustrate signs of acute distress or evidence of an increase in symptoms of an existing chronic disease.<br>Goal is to recognize a change in condition to initiate clinical action, determine clinical interventions based on the advance care plan and avoid potential complications of illness.<br>Additional signs to look for included difficulty breathing and abnormal vital signs.<br>Avoid delays to report a change in condition.<br>SBAR (Situation -What is going on with the resident? Background - What is the clinical background or context? Assessment - What is the problem? and Recommendations and Request - What would I do to correct it?)<br><br>The facility policy and procedure (P&P) for the "Notification of Significant Changes" revised 8/2017, documented that residents identified with a significant change receive appropriate intervention. The procedure in case of an extreme emergency documented the nurse may use clinical judgement and send a resident to the | F 684 | | |

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| F 684 | Continued From page 6<br>emergency room prior to receiving a physician order.<br><br>The facility Advanced Directive P&P dated 6/2017, documented the MOLST (Medical Orders for Life Sustaining Treatment) form is a short summary of the resident's treatment preferences and a physician's order for care in an emergency situation. These valid medical orders must be followed by all health care professionals. CPR (cardio-pulmonary resuscitation) means to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest.<br><br>The Oxygen Therapy P&P revised 6/2017, documented that an RN (registered nurse) may apply oxygen or increase current (oxygen) flow per their nursing judgment.<br><br>The facility P&P for "Code E Rapid Response" revised 6/2017, documented that "Code E" is utilized to designate a Medical Emergency. A "Rapid Response" is utilized when a Medical Emergency may be imminent based upon nursing assessments. The P&P documented to provide for immediate Medical and Nursing response for residents when a medical emergency arises. It documented: 1) Announce a Code E, validate code status. 2) Stay with victim.<br><br>The resident's Medical Orders for Life-Sustaining Treatment (MOLST) dated 5/9/17, documented when the resident has no pulse and/or is not breathing, attempt Cardio-Pulmonary Resuscitation (CPR).<br><br>The physician's order dated 11/10/17, renewed on 2/12/18, documented the resident's Advanced Directive status was a full code. | F 684 | | |

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| F 684 | Continued From page 7<br><br>The Comprehensive Care Plan (CCP) for Advanced Directives updated 2/13/18, documented the resident's current code status is full code.<br><br>The Comprehensive Care Plan (CCP) for Risk for Altered Nutrition Status updated 2/14/18, documented a goal for the resident to have clear lungs with no signs and symptoms of aspiration with an intervention to monitor for shortness of breath, choking, labored respirations, and lung congestion.<br><br>An Employee Statement written by LPN #1, on 3/1/18, documented that between approximately 5:30 - 6:00 pm, a CNA (certified nursing assistant) noticed the resident felt warm to touch and had a temperature of 101.9 F. Tylenol 650 mg and a Duoneb (breathing treatment) was given for wheezing. The Registered Nurse Supervisor (RN #1) arrived on the unit.<br><br>A physician's order dated 3/1/18 at 5:54 pm, documented for the resident to be given Levaquin 250 mg (antibiotic) 2 tabs, by mouth now, for 1 day, for elevated temperature and respiratory congestion.<br><br>The Nursing Progress Note written by the Registered Nurse Supervisor (RN #1) on 3/1/18 at 6:04 pm, documented the resident had a fever of "103.4" tympanic (ear). Tylenol 650 mg given. Lungs congested with expiratory wheeze (high-pitched whistling sound made while breathing out). O2 SAT "81%" on room air. Oxygen started at 2 liters via nasal cannula. Nebulizer treatments given. Pulse between 180 and 220. MD (Medical Doctor) #1 made aware. | F 684 | | |

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| F 684 | Continued From page 8<br>Order received for Levaquin (antibiotic) 500 mg now. The possibility of the resident's family wanting the resident to go to the hospital was discussed with the MD. The MD stated it was okay and to send the resident out if we are unable to get the resident to take the antibiotic.<br><br>The Weights and Vitals Summary dated 3/1/18 at 6:10 pm, documented: Pulse 180 bpm (beats per minute); (normal is 60-100) ; Respirations 40 breaths/minute (normal is 12-22); Temperature 103.4 (tympanic) (normal is 97-99). The summary did not document a blood pressure.<br><br>The resident's medical record did not include an SBAR (per facility policy) for the resident's change (decline) in condition.<br><br>The Employee Statement written by RN #1, on 3/1/18, documented RN #1 called the resident's daughter and left a message that the resident was sick. RN #1 left the unit to attend to another situation at approximately 6:15 pm.<br><br>The Employee Statement written by LPN #1, on 3/6/18, documented the supervisor left the unit. LPN #1 went back into the resident's room to check on him less than 10 minutes later, and noted the resident's breathing had become more rapid. O2 was increased to 5 liters and the supervisor was paged. RN #1 did not answer right away. The resident's daughter arrived on the unit and went directly into the resident's room.<br><br>The EMS (Emergency Medical Services) Pre-hospital Care Report (PCR) dated 3/1/18, documented EMS received a call regarding the resident's breathing problems from a family member at 6:34 pm. | F 684 | | |

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| F 684 | Continued From page 9<br><br>The Employee Statement written by RN #1, on 3/1/18, documented RN #1 left the unit to go to another unit to check on another situation. RN #1 was on the telephone on another unit when she heard a page for her to call Unit 5HR. As she finished the telephone call, maybe "5" minutes later, there was another page for her to call 5HR "STAT (right away). This occurred about "6:35 pm - 6:40 pm." RN #1 called the unit and was told the resident's daughter was there and was screaming. The resident's daughter had called 911. EMS arrived at about "6:45 pm."<br><br>The EMS Patient Care Record (PCR) dated 3/1/18, documented that the EMS arrived in the resident's room at "6:45 pm." Patient was unresponsive and a family member was hysterical in the room screaming and crying. Facility staff were not in the resident's room. There was no report from facility staff. Patient found lying in hospital bed "unresponsive in obvious respiratory failure, near respiratory arrest." Hot, diaphoretic (sweating excessively), pale, accessory muscles (muscles of the neck, back, and abdomen that assist with respiration) used with breathing, decreased breath sounds on left and right, increased respiratory effort, and unresponsive. At 6:46 pm, non-patent (obstructed) airway in need of immediate airway support/control and the patient was bagged (artificial ventilation performed with a respirator bag). The patient remained unresponsive and at 7:07 pm was intubated.<br><br>The Hospital Chart Report Visit documented the resident arrived on 3/1/18 at 7:40 pm, with patient complaint of "respiratory arrest." | F 684 | | |

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| F 684 | Continued From page 10<br>During an interview on 4/5/18 at 3:11 pm, RN #1 stated she was called to unit 5HR between 4:15 pm and 4:30 pm by LPN #1 stating the resident's temperature was "101." She went to the unit, got vitals, but had trouble getting the blood pressure. The temperature was "103 something." The O2 SAT was "82%" on room air. Pulse was "220" (via finger device). The resident's hands were shaking, hands were all over the place, which was his norm. She could not get a blood pressure. She left the room and told LPN #1 to start oxygen. LPN #1 had given Tylenol. RN #1 called the MD who gave an order for antibiotics. RN #1 asked the MD (#1) if he wanted the resident sent out to the hospital and was instructed to send the resident to the hospital per family request or if they couldn't get the antibiotic into him. LPN #1 gave the antibiotic. RN #1 completed documentation, and left the unit. While on the other unit, RN #1 heard an overhead page to call 5HR, and realized her radio was not working. She then got a page to call unit 5HR STAT. RN #1 called the unit and was told the resident's daughter was there. The resident's daughter was screaming, crying and had called 911. RN #1 was not given information about the resident's condition during the call. RN #1 went to the unit, walked into the resident's room, the resident's daughter stopped her, called her a few choice words" and refused to let her in (resident's room). The curtain was partially closed and only the resident's feet and the daughter could be seen. The resident was "gasping" and there was a significant change in his respiratory status." She texted MD #1 to tell him the resident was going to the hospital.<br><br>During an interview on 4/10/18 at 3:40 pm, LPN #1 stated the resident's temperature was "101.9" | F 684 | | |

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| F 684 | Continued From page 11 | F 684 | | |

when she gave Tylenol. LPN #1 gave the scheduled nebulizer treatment a little early because the resident was wheezing. LPN #1 stated the resident was breathing heavy, but did not seem to be in distress. She did not call the Supervisor because as she was signing for the medications, the Supervisor (RN #1) came onto the unit for rounds, around suppertime. RN #1 rechecked the resident's temperature and it was "103." RN #1 gave instructions to put the resident on oxygen after the breathing treatment for an O2 SAT in the 80's. RN #1 called MD #1 who ordered Levaquin (antibiotic). LPN #1 was not sure if the MD wanted the resident to go to the hospital. LPN #1 got cool wash cloths and wiped the resident down. RN #1 left the unit and came back with the antibiotic. LPN #1 gave the antibiotic (time unknown) and left the resident's room. RN #1 left the unit. About 10 minutes later, when the LPN went back into the resident's room, the resident was breathing heavier than normal and faster. LPN #1 increased the resident's oxygen because she thought it would help him, but did not recall the number of liters the oxygen was increased to. The O2 SAT or other vitals were not checked. The resident was wiped down with cool cloths. The LPN left the room to page RN #1. RN #1 did not call back (answer the page). The RN was not paged stat (immediately). In regard to calling a Code E, the LPN stated, "I can't do anything without going through the Supervisor. We have to let them know." Shortly after the Supervisor was paged, the daughter arrived on the unit. The daughter went into the resident's room and started screaming and that is when I paged the Supervisor stat. LPN #1 was behind the desk when the daughter arrived. Regarding whose responsible for monitoring the resident for respiratory distress, the LPN stated

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| F 684 | Continued From page 12<br>she can't stay in the resident's room. The LPN stated that she has to do everybody's meds and their pain pills. After the Supervisor was paged stat, she came to the unit. The resident's daughter was in the resident's room and would not let RN #1 in the room. LPN #1 was at the desk when RN #1 arrived on the unit.<br><br>During an interview on 4/12/18 at 3:40 pm, RN #1 stated when the resident was having "slight respiratory distress" per her assessment note, she meant that he had a cough and congestion. RN #1 stated she thought the resident's respirations were 24-28 breaths/min. RN #1 tried to get an apical pulse (placing a stethoscope on the heart) but was unable to get an accurate one because the resident was fighting/pushing her away. RN #1 believed the resident's change in condition was urgent, but did not know if the urgency was expressed to the MD. RN #1 stated when asked if she gave any specific instructions for monitoring the resident to LPN #1 that "I might have said to keep an eye on him. LPN #1 knew something was going on in there. She gave him the antibiotic." RN #1 did not believe there was a written protocol for full code or change in condition. The LPN should have "gotten a hold of an RN." After the stat page the RN went to the unit and the resident's "breathing was much worse." RN #1 was not aware that LPN #1 had increased the O2 to 5 liters. When asked if she realized the resident was a full code, she stated, "Not until making copies of the paperwork for EMS."<br><br>During an interview on 4/12/18 at 4:15 pm, CNA #1 stated the resident was restless ("fidgety in the recliner"). She decided to put him to bed and when she took his shirt off, she noticed that he | F 684 | | |

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| F 684 | Continued From page 13<br>felt hot. The resident's temperature was "101.9." The resident's temperature was reported to LPN #1. RN #1 showed up on the unit. CNA #1 said she did not stay in the resident's room. LPN #1 did not ask her to check on the resident. She stated that when she found that he was hot, she told the LPN, and the LPN told the Supervisor. LPN #1 was at the desk when the resident's daughter came in. CNA #1 was in the lounge and heard yelling coming from the resident's room. CNA #1 went into the resident's room, the curtain was partially closed and looked around the curtain. The daughter was sitting on the bed on her cellphone. The resident was sitting in an upward position. The daughter was screaming "at the top of her lungs" to someone on the phone.<br><br>During an interview on 4/12/18 at 5:15 pm, the Director of Nursing (DON) stated LPNs cannot assess residents. LPN's can initiate oxygen if a resident is having a respiratory issue. She stated, "If they come upon a resident and the O2 SAT is low, they then call the RN for the change in condition, so that an assessment can be done." For a change in condition, staff are supposed to take vitals and report to the nurse. The LPNs and RNs receive SBAR training. Code E is for assistance with any type of medical emergency. The DON stated that to her knowledge, a Code E was not called on 3/1/18. If the LPN called a Code E, it "certainly" would have gotten staff to her sooner. Staff should know the code status. That's why we have a system in place."<br><br>During an interview on 4/17/18 at 10:25 am, Medical Doctor (MD) #1 stated the resident's temperature was "101.3" and heart rate was around "100 - 120." Tylenol, oxygen, one dose of Levaquin (antibiotic) were ordered with | F 684 | | |

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| F 684 | Continued From page 14<br>instructions to call the resident's family regarding their preferred hospital to send the resident out to. MD #1 was not aware the resident's temperature was "103.4 F" until afterwards. One dose of the Levaquin was ordered to start until the family was called. The MD was not aware that the resident's condition worsened until informed that the family called 911. The MD stated that when the RN was attending to another situation, a Code E should have been called. Staff should have prepared to start CPR if the resident was a full code.<br><br>During an interview on 4/18/18 at 2:06 pm, with the Respiratory Therapist/Director (RT #1) stated for oxygen administration during respiratory distress, the respiratory rate, heart rate, and O2 SATs need to be checked and the resident needs to be evaluated. Each situation has its own set of variables. From the Respiratory Therapist's perspective, if the resident was in respiratory distress, he would check an O2 SAT. When a resident is found in respiratory distress the Supervisor should be called.<br><br>During an interview on 4/18/18 at 2:55 pm, with the Medical Director (MD #2) regarding the staff's response when the resident was found in respiratory distress, MD #2 stated "As a physician, I would have expected the code to be called. Then they'd get a rapid response team." The SBAR form is a good guide for RNs and LPNs to use and helps the MD a lot. MD #2 stated that when the resident's temperature is "103.4", there is no accurate heart rate, and no blood pressure, that's where the Code E comes in. The situation would have gone more smoothly had staff called a Code E. | F 684 | | |

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| F 684 | Continued From page 15<br>10 NYCRR 415.12 | F 684 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview during an abbreviated survey (Case # NY00216244), the facility did not ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for one (Resident #1) of four residents reviewed. Specifically, on 3/1/18, the physician order for Resident #1 to receive 2 liters of oxygen was not transcribed onto the electronic Physician Order Entry system, the resident's respiratory status was not monitored, and there was no documentation of the oxygen therapy. This is evidenced by:<br><br>Refer to F684<br><br>Resident #1:<br><br>The resident was readmitted to the facility on 11/10/17, with a diagnosis of chronic obstructive pulmonary disease (COPD), dementia without behavioral disturbance, and hypertensive heart disease without heart failure. The Minimum Data | F 695 | | |

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| F 695 | Continued From page 16<br>Set (MDS) dated 2/15/18, assessed the resident with severe cognitive impairment.<br><br>The facility's policy and procedure (P&P) for Oxygen Therapy revised 6/2017, documented oxygen will be administered by physician order or in emergency situations per nursing judgment. The oxygen order must include: type of administration (nasal cannula or face mask), number of liters per minute, continuous or PRN (as needed) administration, indications for use, specific parameters if the flow rate is determined by the resident's blood oxygen, as determined by the pulse oximeter. The Registered Nurse (RN) may apply oxygen or increase current flow per their nursing judgment. Oxygen therapy will be documented on the resident's TAR (treatment administration record) each shift by the licensed nurse. When a pulse oximeter is used, the oxygen saturation (O2 SAT) will be documented on the TAR and or nursing notes.<br><br>The Nursing Progress Note written by the Registered Nurse Supervisor (RN #1) on 3/1/18 at 6:04 pm, documented the resident was noted to have a fever of "103.4" tympanic. Tylenol 650 mg given per prn (as needed) order. Lungs congested with expiratory wheeze (high-pitched whistling sound made while breathing out). O2 SAT "81%" on room air; oxygen started at 2 liters via nasal cannula. Nebulizer treatments (breathing treatments) given per order. Pulse between "180 and 220." MD (#1) made aware of above. The respirations were not documented in the note.<br><br>The Weights and Vitals Summary dated 3/1/18 at 6:10 pm documented the following: pulse "180 bpm (beats per minute); respirations "40" | F 695 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 335425 | A. BUILDING _____ B. WING _____ | C 04/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALBANY COUNTY NURSING HOME | 780 ALBANY SHAKER ROAD ALBANY, NY 12211 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 695 | Continued From page 17<br>breaths/minute; temperature "103.4" (tympanic).<br><br>The was no documented physician order for the oxygen that included the oxygen delivery system (nasal cannula or face mask), parameters for administration (continuous or intermittent), equipment settings for the prescribed flow rates, and monitoring of O2 SATs.<br><br>There was no documentation of the oxygen therapy on the TAR.<br><br>The medical record did not reflect ongoing assessment of the resident's respiratory status and response to the oxygen therapy.<br><br>During an interview on 4/10/18 at 3:40 pm, Licensed Practical Nurse (LPN) #1 stated RN #1 left the unit after she assessed the resident for a change in condition. LPN #1 went back into the resident's room about 10 minutes later. The resident was "breathing heavier than normal and faster." She increased the oxygen, but could not recall the number of liters. She stated, "I did it because I thought it would help him." She did not check the O2 SAT and did not check any other vitals.<br><br>During an interview on 4/12/18 at 3:40 pm, RN #1 stated there are no standing orders for oxygen. The MD will order oxygen and tell the nurse what he wants the rate to be. She stated, "With all of the excitement, I didn't enter an order for it." After she was paged stat and went to the unit, the resident's "breathing was much worse." LPNs can check the O2 SAT. She was not aware that LPN #1 had increased the O2 to 5 liters. LPN #1 should have gotten permission to increase the oxygen. There is an oxygen policy that states | F 695 | | |

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|---|---|---|---|---|
| F 695 | Continued From page 18<br>nurses need to follow the MD's order.<br><br>During an interview on 4/12/18 at 5:15 pm, the Director of Nursing (DON) stated LPNs cannot assess residents. LPNs can initiate oxygen if a resident is having a respiratory issue. If they come upon a resident and the O2 SAT is low, they then call the RN for the change in condition, so that an assessment can be done. LPNs can check the O2 SAT; every unit has 2 devices. CNAs can also use them. Regarding the LPN not checking the resident's O2 SAT, she picked up the Oxygen policy and stated, "This is our policy and staff are trained when changes are made to it." For a change in condition, staff are supposed to take vitals. They should be reporting to the nurse. The nurse enters the vitals into the computer system. There are no standing orders for oxygen; there should have been an order. Sometimes the MD gives parameters to maintain the O2 SAT. She stated, "We have to monitor O2 SATs." The nurse can obtain an O2 SAT.<br><br>During an interview on 4/18/18 at 2:06 pm, with the Respiratory Therapist/Director (RT #1) stated for oxygen adminstration during respiratory distress, the respiratory rate, heart rate, and O2 SATs need to be checked and the resident needs to be evaluated. Each situation has its own set of variables. From the Respiratory Therapist's perspective, if the resident was in respiratory distress, he would check an O2 SAT. When a resident is found in respiratory distress the Supervisor should be called.<br><br>10 NYCRR 415.12(k)(6) | F 695 | | |

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK
----------X

LORI LAROCK, as Administratrix of the Estate of ROGER A. SANFORD,

Plaintiff,

**CERTIFICATE OF MERIT**

-against-

ALBANY COUNTY NURSING HOME; THE COUNTY OF ALBANY; LARRY SLATKY; DEBBIE GOSSMAN; RHONDA LYGA; JOHN AND JANE DOES #1-5;

Defendants.
----------X

DAVID BERMAN, an attorney duly admitted to practice law before the Courts of the State of New York, hereby affirms, pursuant to CPLR 3012-a

1. I am an associate at the law firm of EMERY CELLI BRINCKERHOFF & ABADY LLP.
2. I have secured Albany County Nursing Home and Albany County Medical Center records for Roger Sanford. I have reviewed the facts of this case and have consulted with at least one physician who is licensed to practice in this State, or any other State, and I reasonably believe that said physician is knowledgeable as to the relevant issues involved in this particular action, and I have concluded on the basis of such review and consultation that there is a reasonable basis for the commencement of this action.

Dated: May 21, 2019
New York, New York

David Berman

*Attorney for Plaintiff Lori LaRock*