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ESTATE OF ELIZABETH A. POULOS, by KRISTINE M. DELEG as administrator and administrator *ad prosequendum* of the ESTATE and ELIZABETH A. POULOS, individually, **Plaintiffs,** **v.** **THE WANAQUE CENTER FOR NURSING & REHABILITATION, WANAQUE NURSING AND REHABILITATION LLC, CONTINUUM HEALTHCARE LLC, CONTINUUM HEALTHCARE, INC., ROWENA BAUTISTA, RN, LNHA, KATHRYN REAP, RN, CDONA, JEAN BRUZZONE, DANIEL BRUCKSTEIN, EUGENE EHRENFELD, MAGED A. GHALY, M.D., ANDREI CONSTANTINESCU, M.D., MELISSA WALKER, N.P., CAROLINA ZAZULKEWYCZ, L.P.N., IBIDULLA UMORU, L.P.N., DARLENE GREEN, L.P.N., RUTH ALBA, R.N., KRISTY UBAS, L.P.N., KENT BLAIR, L.P.N., BEVERLY BUNCH, L.P.N., RENE SAN PASCUAL, R.N., KOVEN SARTOR, L.P.N., JESSICA RIOGELON, L.P.N., LAURA DYMOND, L.P.N., MALUZ VIRGES, R.N., IWONA BAGARES, L.P.N., AGNES BLASZCZYK, R.T., EDITH MAHECHA, R.T., TERESA PAULY, R.T., JOSE RIVERA, R.T., PURVI PATEL, R.T., ADRIANNA VELCKO, R.T., MARIELLA PLAZA OQUENDO, R.T., LUCIE TORRES-**	**SUPERIOR COURT OF NEW JERSEY** **PASSAIC COUNTY: LAW DIVISION** **DOCKET NO.:** **Civil Action** **COMPLAINT AND JURY DEMAND, DESIGNATION OF TRIAL COUNSEL, REJECTION OF NOTICE OF ALLOCATION, DEMAND FOR INSURANCE COVERAGE, DEMAND FOR DOCUMENTS, DEMAND FOR TRANSCRIPTION, DEMAND FOR INTERROGATORIES AND CERTIFICATION**

SHAKKOUR, R.T., John Does, 1-100 (representing presently unknown healthcare providers, including, but not limited to, doctors, fellows, residents, interns, nurses, technicians, etc.), Jane Does 1-100, (representing presently unknown health care providers, including, but not limited to, doctors, fellows, residents, interns, nurses, technicians, etc.) and ABC Corporations 1-100 (representing presently unknown facilities or entities who rendered, managed and/or controlled care given to the Plaintiff, ELIZABETH A. POULOS), **Defendants.**	

PARTIES

1. Decedent, Elizabeth A. Poulos, was a minor and daughter of Plaintiff, Kristine M. Deleg, and was one of thirty-six victims of an adenovirus outbreak occurring at Defendant's, The Wanaque Center for Nursing & Rehabilitation and Wanaque Nursing and Rehabilitation LLC, facility on or around September 26, 2018 to December 31, 2018.

2. At all times mentioned herein, Defendants, The Wanaque Center for Nursing & Rehabilitation, Wanaque Nursing and Rehabilitation LLC and Wanaque Nursing Home & Rehabilitation Center (hereinafter “The Wanaque Center”), were and are a long-term care facility and skilled nursing facility duly registered and licensed by the State of New Jersey, located at 1433 Ringwood Avenue, Haskell, New Jersey.

3. At all times mentioned herein, Defendants, The Wanaque Center, Continuum Healthcare LLC, Continuum Healthcare, Inc. and ABC Corporations are professional

associations, corporations, trade names, and/or other business entities that are duly incorporated and registered pursuant to the laws of the State of New Jersey, which owned, controlled, managed and/or operated The Wanaque Center located at 1433 Ringwood Avenue, Haskell, New Jersey.

4. Defendants, Rowena Bautista, RN, LNHA, Kathryn Reap, RN, CDONA, Jean Bruzzone, Daniel Bruckstein, Eugene Ehrenfeld, Maged A. Ghaly, M.D., Andrei Constantinescu, M.D., Melissa Walker, N.P., Carolina Zazulkewycz, L.P.N., Ibidulla Umoru, L.P.N., Darlene Green, L.P.N., Ruth Alba, R.N., Kristy Ubas, L.P.N., Kent Blair, L.P.N., Beverly Bunch, L.P.N., Rene San Pascual, R.N., Koven Sartor, L.P.N., Jessica Riogelon, L.P.N., Laura Dymond, L.P.N., Maluz Virges, R.N., Iwona Bagares, L.P.N., Agnes Blaszczyk, R.T., Edith Mahecha, R.T., Teresa Pauly, R.T., Jose Rivera, R.T., Purvi Patel, R.T., Adrianna Velcko, R.T., Mariella Plaza Oquendo, R.T., Lucie Torres-Shakkour, R.T., John Does 1-100 and Jane Does 1-100 were owners, principals, shareholders, executives, medical directors, administrators, directors, agents and/or employees of Defendants, The Wanaque Center, Continuum Healthcare, LLC, Continuum Healthcare, Inc., and ABC Corporations 1-100 at all times herein mentioned in this Complaint.

<u>FACTS COMMON TO ALL COUNTS</u>

5. On or around October 20, 2014, Plaintiff was admitted to Defendant, The Wanaque Center, for long-term care and treatment of her medical conditions.

6. On or around May 5, 2015, the New Jersey Department of Health (hereinafter “DOH”) conducted an inspection at Defendant’s, The Wanaque Center, facility.

7. During the May 5, 2015 inspection, DOH officials documented violations to section 483.80 of the Code of Federal Regulations (hereinafter, "CFR") and section 8:39-31.4(a) of the New Jersey Administrative Code (hereinafter "NJAC"), which relate to the duty of Defendants to maintain a safe, clean and orderly environment for its residents and to have an infection prevention and control program.
8. During the May 5, 2015 inspection, DOH officials documented excessive erosion on faucets throughout the premises, dark stains embedded in the floor, black substances and dirt embedded in a bathroom area, and accumulation of debris on heating/air condition units.
9. On or around March 17, 2016, the DOH conducted an inspection at Defendant's, The Wanaque Center, facility.
10. During the March 17, 2016 inspection, DOH officials documented violations of CFR 483.80 and NJAC 8:39-31.4(a), which relate to the duty of Defendants to maintain a safe, clean and orderly environment for its residents and to have an infection prevention and control program.
11. During the March 17, 2016 inspection, DOH officials observed nurses at Defendant's, The Wanaque Center, facility practicing poor hand hygiene while caring for patients and also documented that Defendants, The Wanaque Center, was deficient in providing sufficient certified nursing assistant hours as required by New Jersey regulations.
12. On or around May 5, 2017, the DOH conducted an inspection at Defendant's, The Wanaque Center, facility.

13. During the May 5, 2017 inspection, DOH officials documented violations of CFR 483.80 and NJAC 8:39-31.4(a), which relate to the duty of Defendants to maintain a safe, clean and orderly environment for its residents and to have an infection prevention and control program.

14. During the May 5, 2017 inspection, DOH officials noted that nurses on the pediatric floors of Defendant's, The Wanaque Center, facility used medication syringes in an unsanitary manner and failed to utilize germicide wipes to disinfect surfaces.

15. The findings of the May 5, 2017 DOH inspection were discussed with the Defendant's, The Wanaque Center, Director of Nursing, Kathryn Reap, RN, and the Administrator, Rowena Bautista, RN, who acknowledged that the procedure for utilizing, storing, and reusing syringes was not being followed by Defendants.

16. Defendant, Rowena Bautista, RN, also agreed that the medication trays had to be sanitized and dried between every resident and that scoopers should not be stored in powder canisters; rather, scoopers should be stored separately so as not to introduce bacteria.

17. On or around August 13, 2018, the DOH conducted an inspection at Defendant's, The Wanaque Center, facility.

18. During the August 13, 2018 inspection, DOH officials documented violations of CFR 483.10 and 483.24, which relate to the duty of Defendants to provide a safe, clean, comfortable homelike environment for its residents, including, but not limited to, providing adequate hygiene.

19. During the August 13, 2018 inspection, DOH officials documented a strong and unpleasant odor when entering the sleeping area of the residents on the fourth floor.

The area smelled of old carpet and mildew and was pervasive throughout the entire floor. The carpet had embedded stains and areas of discoloration. Upon information and belief, the carpet is more than fifteen years old and incapable of sustaining a routine cleaning.

20. On or around September 26, 2018, one of the Defendant's, The Wanaque Center, patients on the pediatric unit was caused to contract adenovirus.

21. Adenovirus is a virus that can be life-threating to children with compromised immune systems such as the Decedent, Elizabeth A. Poulos, and the adenovirus can spread when proper hygiene and proper infection control and prevention standards are not met.

22. At the time of the initial case of adenovirus, the Defendants did not have proper infection prevention and control programs, protocols, or procedures in place to remedy the infection and prevent it from spreading throughout its pediatric residents.

23. On or around September 30, 2018, Decedent developed a high fever and respiratory complications that persisted for the following days and week.

24. In addition to the Decedent, thirty-five other patients became infected with the adenovirus at the Defendant's, The Wanaque Center, pediatric unit requiring the State of New Jersey to intervene.

25. On or around October 2, 2018, Decedent was transferred to St. Joseph's Medical Center in critical and life-threatening condition where she was diagnosed with and treated for adenovirus infection.

26. On or around October 9, 2018, Defendants notified the DOH about the adenovirus outbreak. Defendants, however, failed to timely and appropriately inform the patients'

parents and/or legal guardians of the outbreak and failed to transfer the affected patients out to acute care facilities.

27. Communicable Disease Services (hereinafter "CDS") issued directives to Defendant, The Wanaque Center, on respiratory outbreaks and infection control protocols.

28. Defendant, The Wanaque Center, was asked to place a hold on any new admissions until the adenovirus outbreak was over.

29. DOH officials interviewed Administrator Bautista, Director of Nursing Reap, and the infection control (hereinafter "IC") staff confirmed the initially reported the incident to local Health Department/Communicable Disease Services on October 9, 2018.

30. On October 10, 2018, an e-mail was sent from Defendant, The Wanaque Center, to CDS to reports the incident.

31. On October 10, 2018, CDS discussed and reinforced infection control guidance with The Wanaque Center who agreed to begin implementation.

32. On or around October 12, 2018, Decedent was transferred back to Defendant, The Wanaque Center, in critical and life-threatening conditions to receive palliative and comfort care.

33. On or around October 21, 2018, DOH conducted an inspection at Defendants', The Wanaque Center, facility.

34. During the October 21, 2018 inspection, DOH officials documented violations of CFR 483.80 and NJAC 8:39-31.4(a), which relate to the duty of Defendants to maintain a safe, clean and orderly environment for its residents and to have a proper infection prevention and control program.

35. During the October 21, 2018 inspection, DOH officials documented that the nursing staff in the pediatric unit failed to utilize hand hygiene techniques according to acceptable standards of infection control practice according to the Centers for Disease Control and Prevention.
36. Decedent, Elizabeth A. Poulos, passed away on October 23, 2018 due to complications from the adenovirus infection.
37. On October 23, 2018, the DOH announced the adenovirus outbreak to the public, which then included eighteen confirmed pediatric adenovirus cases, including six deaths.
38. On October 30, 2018 and November 14, 2018, a survey team returned to Defendant, The Wanaque Center, in response to multiple complaints, and the survey team found serious infection control deficiencies.
39. On November 13 through November 17, 2018, inspectors from Centers for Medicare and Medicaid Services ("CMS") conducted inspections of The Wanaque Center. The CMS issued a report on November 17, 2018, which found numerous violations, including six immediate jeopardy citations, and concluded the patients at The Wanaque Center were in "immediate jeopardy of contracting adenovirus infections, with the likelihood to cause serious harms, impairment or death."
40. On November 14, 2018, DOH announced actions curtailing all new admissions, including to other units, until Defendant, The Wanaque Center, hired infection control experts.

41. Curtailment of admissions to the pediatric respiratory was ordered to remain in effect until Defendant, The Wanaque Center, demonstrated that it was able to fully cohort the patients.

42. Defendant, The Wanaque Center, separated the sick and well patients on November 17, 2018, and there was not a single additional patient that subsequently contracted adenovirus.

43. The CMS report dated November 17, 2018, concludes the patients at Defendant, The Wanaque Center, were "in immediate jeopardy of contracting adenovirus infections, with the likelihood to cause serious harm, impairment, or death."

44. The CMS report dated November 17, 2018, states that Defendant, The Wanaque Center, was notified of immediate jeopardy citations were due to failure to have an adequate infection prevention and control program (hereinafter "IPCP").

45. The CMS report dated November 17, 2018 states that the failure to provide timely interventions and care in accordance with professional standards of practice contributed to the delay in identification and containment of the adenovirus outbreak.

46. The CMS report dated November 17, 2018 states that the outbreak affected 33 residents, 1 staff and resulted in 11 pediatric deaths.

47. The CMS report dated November 17, 2018 states that additional immediate jeopardies were identified due to the failure of Administration, Medical Director, Quality Assessment and Assurance (hereinafter "QAA") Committee, and Quality Assurance and Performance Improvement (hereinafter "QAPI") Committee for failure to identify quality deficiencies and implement performance improvement project when adenovirus outbreak was identified.

48. The CMS report dated November 17, 2018 states that Defendant's, The Wanaque Center, failure to develop and implement action plans to monitor the outbreak and outcomes directly contributed to delay in containment of the adenovirus.
49. The CMS report dated November 17, 2018 indicates that the §483.15(c)(8) requirement is not met because Defendant, The Wanaque Center, failed to ensure that the Long-Term Care Ombudsman was notified of resident transfers to the hospital for eight of eight residents.
50. The CMS report dated November 17, 2018 indicates that the failure to notify the Long-Term Care Ombudsman prevented residents from having access to an advocate.
51. Administrator Bautista stated to CMS inspectors/representatives that they did not provide a list of pediatric residents transferred to the hospital to the Ombudsman.
52. The CMS report dated November 17, 2018 states that Patient R167 care plans were not updated to reflect the use of contact precautions, adenovirus infection, elevated temperatures, and wheezing.
53. The CMS report dated November 17, 2018 states delays in identification and treatment of communicable illness in the vulnerable population resulted in 33 of 53 sampled residents in the pediatric ventilator unit testing positive for Adenovirus, 24 transfers to the Emergency Room and/or hospitalization and 11 deaths.
54. The CMS report dated November 17, 2018 states that CFR §483.70 for administration requirement is not met as evidenced by Defendant, The Wanaque Center, administration's failure to use resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

55. The CMS report dated November 17, 2018 states that Defendant, The Wanaque Center, failed to identify quality deficiencies and implement performance improvement projects when problems were identified.
56. The CMS report dated November 17, 2018 states that Defendant, The Wanaque Center, failed to include the facility's quality assurance process and failed to designate specific responsibilities of oversight to professional staff providing medical services to the residents.
57. On November 17, 2018, Defendant, The Wanaque Center, was notified of an immediate jeopardy situation identified related to inadequate administrative oversight and failure to identify quality deficiencies and implement performance improvement projects.
58. The CMS report dated November 17, 2018 indicates that Defendant's, The Wanaque Center, failure to identify quality deficiencies and implement performance improvement projects contributed to the delay in identification and containment of the Adenovirus outbreak affecting 33 residents, 1 staff and resulted in 11 pediatric resident deaths.
59. Dr. Ghaly was designated the Pediatric Medical Director (hereinafter "PMD") of the 90-bed pediatric ventilator unit at Defendant, The Wanaque Center, since June 18, 2014.
60. Administrator Bautista admitted to CMS representatives that Dr. Ghaly had been disengaged.
61. On November 16, 2018, Dr. Ghaly stated to CMS representatives that: "I have been here 11 years. I have never attended the QAPI meetings. I have never been invited. I

have not participated in the surveillance of infection control and I can't give you any numbers."

62. During a November 16, 2018 interview with CMS representatives, Dr. Ghaly stated: "I have no formal method of measuring the infection rate. I have never been shown the Infection Control Report and I am not aware of the facility acquired infection rates. I haven't provided input in the policies of the unit and I have never been asked to review or sign a policy."
63. During a November 16, 2018 interview with CMS representatives, Dr. Ghaly stated: "No one at the facility has given me the regulations regarding the medical director and I have never read them. I didn't understand what medical director meant."
64. Administrator Bautista was responsible for assuring that Defendant's, The Wanaque Center, QAPI Program Complies with federal, state, and local regulatory agency requirements as of 2018.
65. Defendant's, The Wanaque Center, QAPI plan as of November 2018 did not include documentation that The Wanaque Center's medical directors or the director of nursing would be included in the QAPI committee.
66. On November 17, 2018, Administrator Bautista stated to CMS representatives that: "I wrote the QAPI plan in July as we were anticipating our state survey…The GMD, did not review or approve the plan. No one from corporate office approved the plan."
67. The CMS report dated November 17, 2018 states that 33 of 53 symptomatic residents tested positive for adenovirus which resulted in 34 transfers to an emergency room and/or hospitalizations and 11 deaths.

68. The CMS report dated November 17, 2018 states that a review of Defendant's, The Wanaque Center, assessment revealed that it lacked a facility and community based hazards risk assessment regarding active recognition, management, and mitigation of an active infectious disease outbreak.
69. The CMS report dated November 17, 2018 states that deficient practices contributed to the failure to contain and control the adenovirus outbreak in the pediatric ventilator unit.
70. The CMS report dated November 17, 2018 states that Defendant, The Wanaque Center, failed to address staff competencies that are necessary to provide the level and types of care needed for the resident population.
71. The CMS report dates November 17, 2018 states that review of the "Staff Resources" section failed to identify competencies and roles during an active infectious disease outbreak.
72. The CMS report dated November 17, 2018 states that the facility assessment failed to address recognition, mitigation and management of an active infectious outbreak.
73. The CMS report dated November 17, 2018 indicates that CFR §483.70(h)(1)(2) for Responsibilities of Medical Director requirement is not met as Defendant, The Wanaque Center, failed to ensure that the PMD provide medical input and support to the Administrator for services related to quality of care, QAPI, implementation of facility policies, and monitored infection control surveillance for prevention of facility acquired infections specifically related to the pediatric care of the facility.
74. Defendant, The Wanaque Center, had a 'Medical Director Agreement" with Dr. Ghaly that included a document entitled, "Medical Director Monthly Report," and the report

included areas for documentation of the current month, description of services, notes and hours column, policy development, physician and community education, staff training, quality assurance program activities, and other administrative services.

75. Administrator Bautista stated to CMS representatives regarding Dr. Ghaly that: "He does not attend QAPI meetings… I have been here four years and have never received a monthly report from him."

76. Administrator Bautista stated to CMS representatives that: "We have not had formal meetings to discuss issues with the children on the unit. I have never asked him to review or approve a resident care policy and he has not been involved in the facility's infections control surveillance."

77. Dr. Ghaly stated to CMS representatives that: "When [The Wanaque Center] asked me to be the medical director I agreed. No one gave me a job description and I signed the contract."

78. Dr. Ghaly stated to CMS representatives that: "I haven't provided input in the policies of the unit and I have never been asked to review or sign a policy."

79. Dr. Ghaly stated to CMS representatives: "[r]egarding the outbreak of the virus, I thought the state was overreacting, I said how is it going to spread? That was in October."

80. Dr. Ghaly stated to CMS representatives that: "I knew we had a problem after the [fourth] death. The root of the deaths is the deadly Adenovirus 7."

81. Dr. Ghaly stated to CMS representatives that: [w]e did not know about the virus until October 8th. I agree one hundred percent that we need to tighten up our process for infection control."

82. Dr. Ghaly stated to CMS representatives that: "[n]o one at the facility has given me the regulations regarding the medical director and I have never read them. I didn't understand what medical director meant."
83. Director of Nursing Reap stated to CMS representatives: "I didn't know Dr. Ghaly was the medical director over the pediatric unit. I just found out when we had our state survey this August. He has never attended the QAPI meetings and I have never asked him to attend. I thought he was the pediatrician for the vent unit."
84. The CMS report dated November 17, 2018 states that Defendant, The Wanaque Center, failed to ensure the administration of the facility performed in a manner efficiently and effectively to identify quality deficiencies and implement performance improvement projects when problems were identified.
85. The CMS report dated November 17, 2018 states that Defendant, The Wanaque Center, failed to include the facility medical director in the facility's quality assurance process and failed to designate specific responsibilities of oversight to professional staff providing medical services to the residents.
86. The CMS report dated November 17, 2018 states that Defendant, The Wanaque Center, failed to develop a QAPI action plan for the high-risk problem of respiratory infections in the pediatric ventilator unit.
87. The CMS report dated November 17, 2018 states that Defendant, The Wanaque Center, failed to implement an effective IPCP to help prevent the development and transmission of communicable diseases and infections in the facility.
88. The CMS report dated November 17, 2018 states that Defendant's, The Wanaque Center, failure to implement an effective IPCP lead to a delay in the prevention,

identification, reporting, investigation, and control of an outbreak of a communicable adenovirus infection within the facility's pediatric ventilator unit.

89. The CMS report dated November 17, 2018 states that Defendant's, The Wanaque Center, deficient practices resulted in the development of infections involving 53 residents, 11 of which died, and placed The Wanaque Center's other 150 residents in immediate jeopardy.

90. The CMS report dated November 17, 2018 states that Defendant, The Wanaque Center, failed to implement an antibiotic stewardship program.

91. The CMS report dated November 17, 2018 indicates that CFR §483.75(g)(2)(ii) for QAPI and QAA improvement activities requirement is not met as it was determined Defendant, The Wanaque Center, failed to ensure the QAPI committee developed improvement activities.

92. Administrator Bautista stated to CMS representatives that: "I have not received data collection from the infection control nurse regarding the facility acquired infection rate. This has not been provided to the QAPI committee. The QAPI committee has not taken minutes and I have none to provide."

93. Administrator Bautista stated to CMS representatives that: "[w]e have quality improvement program for pediatrics and respiratory. The respiratory therapist completes the report quarterly. I have the report for the first quarter, but I don't have anything past March of this year. We do an infection control audit quarterly. I don't have anything past March of this year. We do an infection control audit quarterly. I don't have a report of monthly rates for facility acquired infections or antibiotic stewardship."

94. Administrator Bautista stated to CMS representatives that: "[w]e have no documentation of minutes or any proof of analysis. I don't have a performance improvement plan based on those reports. We were meeting every day and discussing each sick child, but I don't have any documentation or an action plan for the increase in infections on the pediatric ventilator unit."
95. CMS report dated November 17, 2018 states that Defendant's, The Wanaque Center, failure to implement an effective IPCP lead to a delay in the prevention, identification, reporting, investigation, and control of an outbreak of a communicable adenovirus infection within the facility's pediatric ventilator unit had caused.
96. The CMS report dated November 17, 2018 states that Defendant's, The Wanaque Center, failure to implement an effective IPCP resulted in the development of infections involving 53 residents, 11 of which, died, and placed The Wanaque Center's other 150 residents in immediate jeopardy of contracting adenovirus infections, with the likelihood to cause serious harm, impairment, or death.
97. The CMS report dated November 17, 2018 states that this system failure of adequate surveillance lead to a delay in the prevention, identification, reporting, investigation, and control of an outbreak of a communicable adenovirus infection within the facility's pediatric ventilator unit.
98. An epidemiologist from the New Jersey Department of Health- Communicable Disease Services spoke with members of Defendant's, The Wanaque Center, administration on a conference call on October 11, 2018 and provided the facility with a list of DOH-recommended infection prevention and control actions to implement, and a list of disinfectants recommended by the CDC.

99. The CMS report dated November 17, 2018 states that the ICN did not use a professionally accepted source for the medical criteria or symptoms, which must be a present for an illness to be recognized as an infection.

100. Dr. Ghaly stated to CMS representatives that: "I have been here 11 years… I have not participated in the surveillance of infection control and I can't give you any numbers… I have no formal method of measuring the pneumonia rate or infection rate. I have never been shown the "Infection Control Report," and I am not aware of the facility's acquired infection rates."

101. Dr. Ghaly stated to CMS representatives that he had not attended any of the facility's QAA meetings and had not been invited to attend the QAA meetings.

102. The CMS report dated November 17, 2018 indicates that CFR 483.80(a)(3) for antibiotic stewardship program requirement is not met as it was revealed Defendant, The Wanaque Center, failed to implement an antibiotic stewardship program.

FIRST COUNT

103. Plaintiffs repeat each and every allegation of the prior count as if set forth herein at length.

104. All Defendants aforesaid, their agents, servants and employees were negligent, grossly negligent, careless and reckless and did deviate from accepted standards of medical and nursing practices and did deviate from accepted standards of long-term care facility practices, including, but not limited to, in failing to create and maintain appropriate infection control and prevention programs, policies, protocols and procedures. As a result of the deviations from accepted standards of practice of these Defendants, Decedent contracted the adenovirus in the pediatric unit of Defendant,

The Wanaque Center, which rendered her to be in critical and life-threatening condition and ultimately caused her death.

105. As a result of Defendants' negligence, gross negligence, recklessness and carelessness, lack of skill, and deviations from accepted standards of medical, nursing and long-term care facility practices, Decedent, Elizabeth A. Poulos, was obliged to undergo extensive medical treatment, incur great expense for medical and attendant care, and was caused to suffer great physical and mental pain and anguish, and ultimately passed away on October 23, 2018.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for compensatory and punitive damages together with interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

SECOND COUNT

106. Plaintiffs repeat each and every allegation of the prior count as if set forth herein at length.

107. All Defendants aforesaid, their agents, servants and employees were negligent, grossly negligent, careless and reckless and did deviate from accepted standards of medical, nursing and long-term care facility practices in failing to provide Decedent a safe, sanitary and hygenic environment to prevent the development and spread of communicable disease and infections, such as adenovirus. As a result of the deviations from accepted standards of practice of these Defendants, Decedent contracted the adenovirus while a patient of the Defendants and ultimately passed away from the contracted the adenovirus.

108. As a result of Defendants' negligence, gross negligence, recklessness and carelessness, lack of skill, and deviations from accepted medical, nursing and long-term care facility standards, Decedent was obliged to undergo extensive medical treatment, incur great expense for medical and attendant care, and was caused to suffer great physical and mental pain and anguish, and ultimately passed away on October 23, 2018.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for compensatory and punitive damages together with interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

THIRD COUNT

109. Plaintiffs repeat each and every allegation of the prior counts as if set forth herein at length.

110. All Defendants aforesaid, their agents, servants and employees were negligent, grossly negligent, careless and reckless and did deviate from accepted standards of medical, nursing and long-term care practices in failing to create and maintain necessary systems and procedures to prevent, identify, report, investigate, and control infections and communicable diseases for its patients in accordance with the applicable federal and state laws, rules, and regulations. As a result of the deviations from accepted standards of practice by the Defendants, Decedent contracted the adenovirus while a patient of the Defendants and ultimately passed away from the contracted the adenovirus.

111. As a result of Defendants' negligence, gross negligence, recklessness and carelessness, lack of skill, and deviations from accepted medical, nursing and long-term care facility standards, Decedent was obliged to undergo extensive medical treatment, incur great expense for medical and attendant care, and was caused to suffer great physical and mental pain and anguish, and ultimately passed away on October 23, 2018.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for compensatory and punitive damages together with interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

FOURTH COUNT

112. Plaintiffs repeat each and every allegation of the prior counts as if set forth herein at length.

113. All Defendants aforesaid, their agents, servants and employees were negligent, grossly negligent, careless and reckless and did deviate from accepted standards of medical, nursing and long-term care facility practices in billing and receiving Medicaid payments for medical care and treatment relating to the Decedent and all other residents in the pediatric unit insofar as such care and treatment amounted to fraud.

114. From the time that the Defendants offered and granted admission to Decedent into its facility, and continuing to the time of her transfer to St. Joseph's Medical Center, Defendants represented that the Decedent would receive medical care and treatment within accepted standards of care in exchange for the right to bill Decedent's health insurance companies, including Medicaid.

115. At the time that the Defendants offered and granted Decedent admission into its facility, Defendants knew that its facility and its medical providers could not provide Decedent with medical care and treatment within accepted standards of care that would meet acceptable standards of care.

116. From the time Defendants offered and granted Decedent admission into its facility, Plaintiffs believed the Defendants' representations regarding the level of care and treatment that would be provided to Decedent to be true and accurate, and Plaintiffs genuinely relied upon the Defendants' representations and agreed to have Defendants admit Decedent and bill Plaintiffs' health insurance companies for services to be rendered to Decedent.

117. As a result of Defendants' fraud, Decedent was obliged to undergo extensive medical treatment, incur great expense for medical and attendant care, and was caused to suffer great physical and mental pain and anguish, and ultimately passed away on October 23, 2018.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for compensatory and punitive damages together with interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

FIFTH COUNT

118. Plaintiffs repeat each and every allegation of the prior counts as if set forth herein at length.

119. The Defendants also failed to disclose to Plaintiff, Kristine M. Deleg, all necessary information that would have enabled Plaintiff to consider, weigh and choose

knowledgeably the options available regarding the admission into Defendants' facility, as well as the options relating to care and treatment available to Decedent, Elizabeth A. Poulos, thereby precluding Plaintiff from being able to make an informed decision regarding the treatment of her daughter.

120. As a result of that failure, Defendants were negligent, grossly negligent, careless and reckless in their care and treatment that was rendered to Decedent and did deviate from accepted standards of practice in rendering said medical care, and as a result of which Decedent was obliged to undergo extensive medical treatment, incur great expense for medical and attendant care, and was caused to suffer great physical and mental pain and anguish, and ultimately passed away on October 23, 2018.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for compensatory and punitive damages together with interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

SIXTH COUNT

121. Plaintiffs repeat each and every allegation of the prior counts as if set forth herein at length.

122. During Decedent's admission at Defendants' facility, Defendants deviated from accepted standards of nursing home, subacute, rehabilitation and/or long-term care and, as such, were the proximate cause of Plaintiffs' damages alleged herein.

123. Defendants violated certain provisions of the Nursing Home Reform Act (N.H.R.A.), 42 U.S.C. §1395(i), et seq., in that a nursing home, subacute, rehabilitation and/or long-term care facility must attain and maintain the highest practical, mental

and psychosocial well-being of each resident, including the right to be free from neglect.

124. Defendants violated the provisions of the Nursing Home Reform Act, in that the care rendered to Plaintiff was of substandard quality, in violation of 42 C.F.R. § 488.301 et. seq., and, further, said nursing home violated, inter alia, provisions of 42 C.F.R. § 488.410, 42 C.F.R. § 483.13, 42 C.F.R. § 483.10, 42 C.F.R. § 483.12, 42 C.F.R. § 483.25, 42 C.F.R. § 483.30, 42 C.F.R. § 483.25, placing Decedent in immediate jeopardy because of substandard medical treatment.

125. In addition, said Defendants violated certain provisions of the New Jersey Nursing Home Responsibility and Rights of Residents Act, N.J.S.A. §30:13-5(J) and N.J.S.A. §30:13-6, in that the care rendered to Decedent violated state and federal regulations, deviated from accepted standards, in that it was not consistent with sound nursing and medical practices and, further, there was inadequate staff supervision, understaffing, the intentional underutilization of critical services and inadequate notice of transfer of Decedent.

126. At all times hereinafter mentioned, said Defendants showed a reckless indifference and deliberate disregard of the consequences to care, health, and well-being of Decedent, so as to cause her to suffer irreparable injuries described herein.

127. This Count is brought pursuant to the New Jersey Nursing Home Responsibility and Rights of Residents Act, which allows a cause of action for violations of the Nursing Home Reform Act, 42 U.S.C. § 483.25, et. seq.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for compensatory and punitive damages together with

interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

SEVENTH COUNT

128. Plaintiffs repeat each and every allegation of the prior counts as if set forth herein at length.

129. All Defendants aforesaid, their agents, servants and employees were negligent, grossly negligent, careless, reckless, acted maliciously and egregiously, and acted in wanton and willful disregard of Plaintiffs' rights and did deviate from accepted standards of medical, nursing and long-term care practices in failing to create and maintain necessary systems and procedures to prevent, identify, report, investigate, and control infections and communicable diseases for its patients in accordance with the applicable federal and state laws, rules, and regulations. As a result of the deviations from accepted standards of practice by the Defendants, Decedent contracted the adenovirus while a patient of the Defendants and ultimately passed away from the contracted the adenovirus.

130. All Defendants aforesaid, their agents, servants and employees acted maliciously and with wanton and willful disregard of Plaintiffs' rights in withholding critical medical information from Plaintiff, Kristine M. Deleg, and intentionally attempting to preclude and/or delay the transfer of Decedent, Elizabeth A. Poulos, to an acute care medical facility for treatment of adenovirus.

131. All Defendants aforesaid, their agents, servants and employees acted maliciously and with wanton and willful disregard of Plaintiffs' rights in direct violation of N.J.S.A. 2A:15-15-5.9, et al.

132. As a result of Defendants' negligence, gross negligence, recklessness and carelessness, malicious and egregious conduct, wanton and willful disregard of Plaintiff's rights, lack of skill, and deviations from accepted medical, nursing and long-term care facility standards, Decedent was obliged to undergo extensive medical treatment, incur great expense for medical and attendant care, and were caused to suffer great physical and mental pain and anguish, and ultimately passed away on October 23, 2018.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for punitive damages together with interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

EIGHTH COUNT

133. Plaintiffs repeat each and every allegation of the prior counts as though set forth herein at length and made a part hereof.

134. Defendants, The Wanaque Center, Continuum Healthcare, LLC, Continuum Healthcare, Inc., Maged Ghaly M.D., LLC, John Does, 1-100 (representing presently unknown fellows, residents, interns, and/or medical students), Jane Does, 1-100 (representing presently unknown fellows, residents, interns, and/or medical students), and ABC Corporations 1-100 (representing presently unknown facilities or entities who rendered care to the plaintiff), had a duty to investigate the qualifications and credentials of Defendant, Maged A. Ghaly, M.D., and to only permit qualified physicians, nurses and medical staff to exercise the privilege to provide medical treatment at their facilities.

135. Defendants, The Wanaque Center, Continuum Healthcare, LLC, Continuum Healthcare, Inc., Maged Ghaly M.D., LLC, John Does, 1-100 (representing presently unknown fellows, residents, interns, and/or medical students), Jane Does, 1-100 (representing presently unknown fellows, residents, interns, and/or medical students), and ABC Corporations 1-100 (representing presently unknown facilities or entities who rendered care to the plaintiff), had a duty to comply with all applicable law, codes and hiring, training, appointment of, and oversight of medical directors.

136. Defendants, The Wanaque Center, Continuum Healthcare, LLC, Continuum Healthcare, Inc., Maged Ghaly M.D., LLC, John Does, 1-100 (representing presently unknown fellows, residents, interns, and/or medical students), Jane Does, 1-100 (representing presently unknown fellows, residents, interns, and/or medical students), and ABC Corporations 1-100 (representing presently unknown facilities or entities who rendered care to the plaintiff), had a duty to review the education, training and licensure of physicians, nurses and medical staff rendering medical treatment to patients in order to ensure that all were properly educated, trained and qualified to provide adequate medical treatment in their facilities.

137. Defendants, The Wanaque Center, Continuum Healthcare, LLC, Continuum Healthcare, Inc., Maged Ghaly M.D., LLC, John Does, 1-100 (representing presently unknown fellows, residents, interns, and/or medical students), Jane Does, 1-100 (representing presently unknown fellows, residents, interns, and/or medical students), and ABC Corporations 1-100 (representing presently unknown facilities or entities who rendered care to the plaintiff), failed to satisfy all of the aforementioned duties and did

therefore deviate from accepted standards of practice and were negligent so as to cause the same injuries, damages and losses to the Plaintiffs as set forth herein.

138. As a proximate result of such negligence by the aforementioned Defendants, the Decedent, Elizabeth A. Poulos, was caused severe injuries, causing her great pain and suffering, causing him to seek further medical treatment and incur additional medical bills, and ultimately passed away on October 23, 2018.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for punitive damages together with interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

NINTH COUNT-SURVIVORSHIP

139. Plaintiffs repeat each and every allegation of the prior counts as though set forth herein at length and made a part hereof.

140. As a direct and proximate result of the aforementioned negligence of the Defendants, the Decedent was caused to suffer extreme conscious pain and suffering before her death, as well as all other allowable survival action damages set forth in Civil Jury Charge 8.42.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for punitive damages together with interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

TENTH COUNT-WRONGFUL DEATH

141. Plaintiffs repeat each and every allegation of the prior counts as though set forth herein at length and made a part hereof.

142. As a direct and proximate result of the aforementioned negligence of the Defendants, the Plaintiff was caused to be deprived of the future earnings of the Decedent, the advice, guidance and counsel of the Decedent, and all other allowable wrongful death damages set forth in Civil Jury Charge 8.43.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for compensatory and punitive damages together with interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

ELEVENTH COUNT

143. Plaintiffs repeat each and every allegation of the prior counts as though set forth herein at length and made a part hereof.

144. Plaintiff, Kristine M. Deleg, was caused to suffer severe and permanent emotional harm and anguish as a direct result of all of the Defendants' negligent acts and conduct.

145. The negligence and gross negligence of all of the Defendants caused the minor Decedent, Elizabeth A. Poulos, to suffer severe and serious injuries, physical pain and suffering, emotional pain and suffering and disability.

146. Plaintiff, Kristine M. Deleg, observed and witnessed all of the severe and serious injuries, physical pain and suffering, emotional pain and suffering and disability

endured by the minor Decedent, Elizabeth A. Poulos, when she first came to know that there was an adenovirus outbreak at Defendant, The Wanaque Center.

WHEREFORE, Plaintiffs demand judgment against the Defendants, individually, concurrently, jointly and severally, for punitive damages together with interest, costs of suit, attorney's fees, and such other and further relief as the Court may deem equitable and just.

REJECTION OF ANY NOTICES OF ALLOCATION

Plaintiffs reject any Notices of Allocation asserted by any Defendant, whether made pursuant to Rule 4:7-5 or otherwise. Plaintiffs insist that the details upon which any claim of allocation is based be provided to Plaintiffs in a timely manner in discovery as is required by Young v. Latta, 123 N.J. 584 (1991).

DEMAND FOR TRIAL BY JURY

Plaintiffs hereby demand a trial by jury as to all issues involved herein.

DESIGNATION OF TRIAL COUNSEL

Pursuant to Rule 4:25-4, Paul M. da Costa has been designated as trial counsel in the above matter.

DEMAND FOR INSURANCE COVERAGE

In accordance with Rule 4:10-2, Defendants are demanded to provide a complete copy of their applicable liability insurance policies including any excess or umbrella policies, with declaration sheets, as well as the requisite Certifications regarding same pursuant to Rule 4:18-1(c) within fifty (50) days of service of this Complaint.

DEMAND FOR DOCUMENTS

Plaintiffs demand that the Defendants within thirty (30) days of service of this Complaint each produce certified copies of their complete records regarding the Decedent, Elizabeth A. Poulos, and those documents requested in the attached Notice to Produce.

DEMAND FOR TRANSCRIPTION

Plaintiffs demand that each Defendant produce a typed transcription of any and all of his/her handwritten medical records within thirty (30) days of service of the Complaint.

DEMAND FOR INTERROGATORIES

Plaintiffs demand that Defendants answer Form C and C(3) Interrogatories and the Supplemental Interrogatories attached hereto.

NOTICE TO PRODUCE

PLEASE TAKE NOTICE that in accordance with Rule 4:18 of the Rules governing the Courts of New Jersey, Plaintiffs hereby demand that you produce the following documents and permit them to be inspected and copied at the offices of Snyder Sarno D'Aniello Maceri & da Costa LLC, 425 Eagle Rock Avenue, Roseland, NJ 07068:

1. A complete copy of all medical records of the Plaintiff at The Wanaque Center, including, but not limited to, progress notes, consult reports, history and physicals, discharge reports, vital signs records, medication administration records, respiratory therapy notes, ventilator setting records, nutrition records, physical and/or occupational therapy records, educational records, or any other type of records of any kind relating to the Plaintiff.

2. A complete copy of Plaintiff's school records while at The Wanaque Center, including, but not limited to, any schooling assessments, plans, grades, tests, etc.
3. A complete copy of any incident reports relating to Plaintiff.
4. A complete copy of any reports of any reviews of any aspect of the care rendered to Plaintiff, including, but not limited to, any quality assurance, quality control or similar committees, or any morbidity and mortality or similar committees.
5. A complete copy of any records or reports forwarded to the Joint Commission on Accreditation related to the Plaintiff, including reports or records related to sentinel events, including, but not limited to, the adenovirus outbreak at The Wanaque Center.
6. All records which disclose the name and last known address of every person who made any notation in Plaintiff's medical records while at The Wanaque Center.
7. All records which disclose the name and last known address of every person who rendered any care or treatment to Plaintiff at The Wanaque Center.
8. The name and last known address of all persons employed by The Wanaque Center and who were assigned to, or caring for, the Plaintiff while at The Wanaque Center.
9. A complete copy of any and all protocols, policies, procedures or guidelines (as they existed from 2014 to the present) relating to the following departments or procedures of the Defendants:
    a. Pediatrics;
    b. Hygiene;
    c. Infection control and/or prevention;
    d. Quarantine of patients;
    e. Ventilators;

f. Nursing care and treatment;

g. Respiratory therapy care and treatment; and

h. Medical billing.

10. A copy of each and every protocol or other written policy and procedure maintained by any department of the Defendants which in any way relate to the treatment of Plaintiff.

11. Any and all documentation relating to the notification of the Plaintiffs, or any representative of the Plaintiffs, of any "serious preventable adverse event" and/or "adverse event" as defined by the Patient Safety Act, N.J.S.A. 26H: 2h-12.25 et seq. This request includes patient safety plans, reports, documentation and notification that Plaintiffs were made aware of any and all adverse events that are relevant to the subject matter of this litigation as defined by the above-referenced statute.

12. Any and all documents, records, notes, reports, log-books, etc. related to inspections carried out by any state and/or federal agency from the year 2010 to the present.

13. Any and all documentation in narrative form, including all factual medical information that cannot otherwise be discernible from reviewing Defendants' records relating to the Plaintiff. See Brugaletta.

14. Any and all documentation regarding internal investigations of Plaintiff's medical condition relevant to the subject matter of this Complaint.

15. Any and all personnel and/or credentialing/privileging files for Dr. Maged Ghaly, Nurse Kathryn Reap, and/or Administrator Rowena Bautista.

SUPPLEMENTAL INTERROGATORIES

1. Identify all times periods when the Plaintiff was a patient at The Wanaque Center.

2. Transcribe each and every statement of fact or history taken from the Plaintiff at the time of each admission of the Plaintiff to The Wanaque Center.

3. State the names, address, employer and occupation of each and every treating physician, nurse, respiratory therapist, nurse aid, or medical provider of any kind who attended, observed, examined or treated the Plaintiff during each admission of the to The Wanaque Center.

4. State the name, address, employer and occupation of each and every person who made any notation on the medical record, and attach a copy of all medical records, without limitation, hereto.

5. State the name, address and occupation of all employees of The Wanaque Center who attended, observed, examined or treated the Plaintiff, and state the date(s) and time(s) of attendance, observation or examination.

6. Attach copies of each and every written document which relates in any way to any review or investigation of any medical procedure, examination, treatment or operation performed upon the Plaintiff while at The Wanaque Center.

7. For each review or investigation of any examination, treatment, medical procedure or operation performed upon the Plaintiff, state the name, address and occupation of each person who participated in such review, the reason for such review, all information considered by the parties conducting such review, and the conclusion of the parties conducting such review.

8. Was any incident report, or other report of any kind, ever filed with regard to the Plaintiff or any procedure performed on the Plaintiff while at The Wanaque Center? If so, state the name and address of the person who filed the report, the content and substance of the report, the date the report was filed, the name and address of the person with whom said report was filed, and attach copies of each and every report.

9. State whether any medical record or other document of any kind relating to the Plaintiff, or the treatment of the Plaintiff, has ever been removed, replaced, altered, changed, erased or otherwise adjusted. If so, attach a copy of the record prior to such replacement, alteration, change, erasure or adjustment and a copy of all versions of the record subsequent to such replacement (s), alteration (s), change (s), erasure (s) or adjustments (s).

CERTIFICATION

I hereby certify that this matter is not the subject of any other action pending in any Court or a pending arbitration proceeding, nor is any other action or arbitration proceeding contemplated. All parties known to Plaintiff at this time who should have been joined in this action have been joined.

SNYDER SARNO D'ANIELLO,
MACERI & da COSTA LLC
Attorneys for Plaintiffs

s/ Paul M. da Costa
Paul M. da Costa, Esq.

Dated: April 15, 2020