COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT DEPT
OF THE TRIAL COURT
Civil Action No.
2484CV00824

ADAM OWENS, ALVIN WALKER,
Petitioners,

v.

EDGAR P. BENJAMIN HEALTHCARE CENTER,
Respondent.

AFFIDAVIT OF MARISE COLSOUL

I, Marise Colsoul, make the following affidavit based on my personal knowledge, under the penalty of perjury that the following is true and correct:

1. I am the Director of Nursing at the Edgar P. Benjamin Healthcare Center ("the Benjamin").
2. I received my nursing degree in 2017 from Laboure College in Milton, Massachusetts.
3. I began working with residents of the Benjamin in 2019 as a hospice nurse for Hospice of Massachusetts. In that same year, I began working at the Benjamin as a per diem nurse (on-call/as needed).

4. In 2019, I was hired by the Benjamin as a nurse working the evening shift from 3pm-11pm daily.
5. In 2020, the Administrator, Tony Francis, asked if I would provide continuing education to other nurses at the facility. After performing this role for about a month, Mr. Francis promoted me to Director of Nursing. I still hold this position at the facility.
6. As Director of Nursing, I oversee the nursing department at the facility by supervising nurses and certified nursing assistants ("CNA"), ensuring protocols and procedures are followed by nursing and CNA staff, and overseeing scheduling for nursing and CNA staff.

Background On The Facility

7. The Benjamin is divided into 3 units-1 West, 2 West and 2 East. 1 West is on the first floor of the building, 2 West and 2 East are on the second floor of the building.
8. Each unit has 2 sides with 12-14 patients on each side. There are currently about 70 residents in the facility.
9. Residents in 1 West are more independent, handling their own activities of daily living (also known as "ADLs") and are more ambulatory.
10. The majority of residents in 2 West suffer from dementia and the majority of residents in 2 East suffer from diseases such as schizophrenia and dementia.
11. The Benjamin primarily serves people of color, with around 98% of the residents being Black or Latinx.

Inability To Meet Payroll

12. Nurses, Administrators and other non-union staff are paid bi-weekly, while union staff including CNAs and licensed practical nurses ("LPNs") are are paid weekly.
13. For 3 weeks in November 2023, both union and non-union staff were not paid. Tony Francis informed employees at a staff meeting that the facility was having financial hardship and having trouble making payroll.
14. This occurred again in December 2023, with employees of the Benjamin not getting paid for 2 weeks of work. Again, at a staff meeting Tony Francis cited financial issues as the reason for non-payment of wages.
15. During both occurrences, nursing and CNA staff began calling into the Benajmin to inform the facility they would not be at work. On several days due to the lack of adequate staff, myself and another nurse were required to work double shifts-totaling about 16 hours of work at a time.
16. This left the 3 units with 1 nurse per unit per shift. I was working with residents in 2 West, the other nurse tasked with working double shifts was working with residents in 2 East and a third nurse was working with residents in 1 West.
17. Also, staff retirement payments have been impacted. In 2023, payments were missed to the third party responsible for maintaining the 401K plans for staff. As a result of this, the Department of Labor Relations was informed, and I cashed out my 401K in August 2023 due to mistrust and mismanagement of these funds.

Dangerous Under-Staffing At The Facility

18. When this type of under-staffing occurs, it poses a great threat to the safety and well-being of residents. Residents remain soiled and lying in feces and urine for longer time periods, it delays food delivery to the residents and medication doses are not delivered

within their required timeframe when staffing levels are low. Not only is inadequate changing intervals an affront to human dignity, it leads to medical harm like sores, skin irritation and urinary tract infections. Additionally, weight loss for residents is associated with adverse health outcomes like progressing pre-existing disabilities and increasing the risk of mortality.

19. Medication delivery is a vital part of resident care. The facility has an allotted timeframe- a 2 hour window- for delivery of medication to residents. With a lack of adequate staff, medication delivery is delayed which means life or death for residents and could lead to additional medical conditions and complications.
20. Additionally, working for 16 hours doing patient care impacts the level of service delivery a nurse can provide as the physical demands of the position leads to exhaustion.

Changes In Staffing

21. There are 3 shifts for nurses and CNAs at the facility. The shifts are 7am-3pm, 3pm-11pm and 11pm-7am.
22. When I began as Director of Nursing in 2020, there were 6 nurses working per shift for the 7am-3pm and 3pm-11pm shifts with 2 nurses assigned to each unit.
23. Currently, the nursing staff has been severely reduced. Instead of 6 nurses working per shift with 2 nurses assigned to each unit, there are only 3 nurses split between 2 units for the 7am-3pm and 3pm-11pm shifts.
24. These 3 nurses are assigned to the 2 units housing residents with conditions like schizophrenia and dementia-units 2 West and 2 East.
25. Within the last year, staffing at the facility has changed. When I began as Director of Nursing in 2020, there was one unit manager on each floor-3 unit managers per shift. The

unit manager would oversee medical appointments for residents, staff scheduling, follow-up requirements for resident specialties, check care plans, ensure consent forms were up-to-date and look for any changes in resident conditions.

26. Presently, there is no unit manager position, placing the abovementioned assignments on the reduced nursing staff.

27. Additionally, in 2020, there was a doctor on-site at the facility and the dietician made frequent visits to the facility to check on residents. Currently, the doctor comes into the facility only on Saturdays and does not even meet with residents. He neglects his duties as facility doctor and placing residents at risk of substantial harm without regular examinations of their health. The dietician does not visit on a regular basis and is allowed to work remotely. Changes in the medical condition of residents are not being monitored by the doctor or dietician which leads to serious injury and delayed response to immediate needs.

28. There are also required weekly risk assessment meetings for residents to be attended by nursing staff, the facility dietician and the facility doctor. The risk assessment meetings are to monitor residents and assess weight loss, wounds, and identify potential medical issues for residents. The last risk assessment meeting was held on January 11, 2024.

29. The substantial risk of harm is actualizing for more than a dozen residents at the Benjamin. As a result of these neglected meetings, there are several residents who have significant weight loss. For example, one resident in particular has lost 10 pounds and another has lost 15 pounds. There are at least 20 residents that have significant weight loss from December 2023 to March 2024, showing the lack of risk assessment meetings is directly impacting the residents. Properly monitoring residents' nutrition is necessary to

prevent a decline in resident health and prevent the likelihood of death or serious injury. The risk of harm is significantly increasing daily showing there is an emergency at the Benjamin.

Lack Of Supplies And Vendors

30. Approximately 10 call lights are currently non-functioning. Call lights are a mechanism next to resident beds that they can pull when they need assistance or in case of emergency. Call lights are absolutely critical in a nursing facility, and it puts residents at grave risk when they are not working. If a resident is facing a medical emergency, they have no way to reach the staff without a call light, particularly at night. Many of our residents are non-ambulatory and would have no way to get help. A delayed response to medical emergencies could lead to severe injury or even death for residents. Staff have been requesting replacement cords for call lights since December 2023 to no avail.
31. As recently as February 2024, the colostomy bag supply was depleted as they were not ordered leaving residents without this vital supply. As a result of the depletion, the facility had to borrow bags from another facility. The health, cleanliness and well-being of the residents are directly impacted when this supply is not available.
32. Additionally, scales used to weigh residents have not been functioning properly for months leading to inaccurate readings. The scale needs to be calibrated by an outside vendor to ensure proper functioning and accurate weight data of residents. The vendor has not performed calibration as the vendor is owed money. Accurate readings are important to assess and track the nutrition, monitor fluid balance and to calculate medication dosage for residents. Inaccurate readings could lead to harm to residents in

the form of improper meal planning and adverse drug events due to improper medication dosages.

The Situation Is Only Getting Worse

33. Recently, housekeeping staff was informed their hours would be reduced and they would not be afforded the opportunity for overtime hours. Additionally, janitorial staff have been laid off. The housekeeping staff performs tasks like cleaning up bodily fluids after an accident in a resident's room. With decreased staff, this causes delays in service delivery and could lead to slip and falls for residents who are vulnerable to injury. Just one slip for a resident could lead to extended recovery, restricted mobility, the need for additional support from staff for daily living activities, or non-recoverable, serious injury to parts like the head or back.
34. I have cared for the residents at the Benajamin on a regular basis since I began working with the facility in 2019. I have a connection with the residents at the Benajamin and I am extremely concerned that the health and safety of these residents is currently at high risk of declining further based on the financial mismanagement of Administrator Tony Francis-through consensus of the Board of Directors-which has caused a lack of adequate staffing, delayed payment of wages, lack of food service delivery, and lack of adequate supplies.
35. I believe that appointment of a receiver would assess the financial position of the facility making it possible to alleviate the current emergency at the Benjamin and take the residents out of harms way.

Signed under pains and penalty of perjury this 27th day of March 2024.

Marise Colsoul

Marise Colsoul