IN THE CIRCUIT COURT FOR BALTIMORE CITY, MARYLAND
Civil Division

BRIAN M. BRUH, Individually and As Personal Representative of the Estate of Mitchell L. Bruh, Deceased, 11510 Henegan Place Spotsylvania, Virginia 22551	
And	
JUDITH BRUH 11510 Henegan Place Spotsylvania, Virginia 22551	Case No. 24-C15005583
Plaintiffs,	
v.	
THE CHIMES, INC. Serve: Martin Lampner 4815 Seton Drive Baltimore, Maryland 21215	
Defendant.	

COMPLAINT AND JURY DEMAND
(Wrongful Death/Survival)

COME NOW Plaintiffs Brian M. Bruh, individually and as Personal Representative of the Estate of his deceased son, Mitchell L. Bruh, and Judith Bruh, individually, and for their Complaint against The Chimes, Inc., respectfully state as follows:

Nature of Action

This is an action to redress the tragic and wholly avoidable death of Plaintiffs' beloved severely developmentally disabled forty-four year old son, Mitchell Bruh, while he was in the custody and care of Defendant. Despite the fact that for many years Defendant was being funded by the State of Maryland to provide the necessary constant 1:1 close (i.e., within arm's length)

supervision that Mitchell required (due to, among other things, Mitchell's severe pica[1]), Defendant failed miserably in its duties. As a direct and proximate result of Defendant's failures, on June 2, 2014, Mitchell was left alone and unsupervised on a transport van. He ingested a latex glove left on the van and began to choke on it. Upon discovering Mitchell, the van driver failed to initiate and provide emergency care. Paramedics eventually arrived, and used to tongs to pull out a whole glove from Mitchell's throat, albeit too late for Mitchell to survive. Mitchell died at Sinai Hospital two days later, on June 4, 2014. On July 31, 2014, the State of Maryland issued a scathing report,[2] finding ***numerous*** acts of neglect by The Chimes, Inc., including *ten* acts of negligence and multiple violations of the Code of Maryland Regulations (COMAR). The State of Maryland found that "reportedly, [Chimes'] **unsafe and negligent transportation practices for individuals who required 1:1 supervision had been ongoing for at least 4-5 years**." Exhibit 1 (the Report), at 5.

Jurisdiction and Venue

1. This is a wrongful death action, brought pursuant to *Md. Code Ann., Cts. & Jud. Proc.* §§ 3-901 *et seq.* (2013 Repl.Vol.) and *Maryland Rule* 15-1001, and a survival action, brought pursuant to *Md. Code Ann., Est. & Trusts* § 7-401(y) (2011), for damages arising out of the death of Mitchell L. Bruh, as a result of Defendant's negligence.

2. Pursuant to *Md. Code Ann, Cts. & Jud. Proc.* § 6-202(8) (2013 Repl.Vol.), venue in this action properly lies in the Circuit Court for Baltimore City, Maryland, insofar as the cause of action arose in Baltimore City, Maryland.

Parties

3. Plaintiff Brian M. Bruh ("Mr. Bruh") is an adult, residing at 11510 Henegan

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[1] Pica is the craving or ingestion of non-food items.

[2] A copy of the State of Maryland's Report is attached hereto as Exhibit 1 and incorporated by reference herein.

Place, Spotsylvania, Virginia 22551. He sues individually and as the Personal Representative of the Estate of his deceased son, Mitchell L. Bruh ("Mitchell"). Mr. Bruh was appointed personal representative of Mitchell's estate in Howard County, Maryland (where Mitchell had resided) on July 27, 2015.

4. Prior to his death, Mitchell resided in a group home rented by The Arc of Howard County, located at 9341 Ourtime Lane, Columbia, Maryland 21045.

5. Plaintiff Judith Bruh, Mitchell's mother, is an adult, residing at 11510 Henegan Place, Spotsylvania, Virginia 22551.

6. Defendant The Chimes, Inc. ("Chimes") is a Maryland nonstock corporation, having its principal place of business at 4815 Seton Avenue, Baltimore, Maryland 21215.

7. At all relevant times herein, Chimes held itself out to the public as "Maryland's largest provider of community services for person with intellectual and developmental disabilities and co-occurring disabilities." http://www.chimes.org/maryland/pdf/chimes-md-overview.pdf.

8. At all relevant times herein, Chimes provided day habilitation services to, *inter alia*, adults with intellectual and developmental disorders, via a program called "Intervals, located in Baltimore City." http://www.chimes.org/maryland/pdf/chimes-md-day-habilitation-services-intervals.pdf.

Factual Background

9. Mitchell was born to Plaintiffs on February 11, 1970.

10. At the age of 5 ½ months, Mitchell began to have seizures, and was ultimately diagnosed with infantile spasms (a neurologic emergency that typically begins in the first 4 to 8 months of life and is characterized by a bending and jerking of the torso or neck and arms and

legs. An episode can range from a subtle head jerk to a flexion that lasts for a few seconds. Most often, the spasms occur in clusters.)

11. These frequent seizures completely disrupted Mitchell's early development and led to his permanent retardation. Mitchell has never had more than the mental capacity of a one year old.

12. By the time Mitchell reached 5 years old, it was clear that the lives of Plaintiffs and Mitchell's two siblings were completely consumed with him, as they could not make a sound in the house because Mitchell would have seizures if awakened.

13. Mitchell never understood danger and was very mobile, fast, and strong, requiring constant supervision during every moment of the day.

14. Plaintiffs ultimately decided to get help and enrolled Mitchell into The Woods Schools in Pennsylvania.

15. Eventually, Plaintiffs moved to Maryland and selected ARC of Howard County and Chimes, which Mitchell began attending in 1998.

16. Beginning in March 1998, and continuing until his tragic and untimely death in June 2014, Mitchell attended Chimes' Intervals program five days per week, where he received day habilitation services.

17. Intervals is located at 4814 Seton Drive, Baltimore, Maryland 21215.

18. Throughout his life, Mitchell would grab anything that was lying around and toss it into his mouth. One of Plaintiffs' biggest concerns was Mitchell's pica – his immediate environs needed to be clean and he needed to be watched at all times.

19. For instance, if Mr. or Mrs. Bruh was alone with Mitchell and had to go to the bathroom, they would take Mitchell into the bathroom with them to keep him safe.

20. Plaintiffs *repeatedly* informed Defendants' staff of Mitchell's pica disorder and Chimes repeatedly assured Plaintiffs that he would be properly supervised.

21. Plaintiffs were invited by Chimes to participate – and did participate -- in Mitchell's annual evaluation and plan for the upcoming year.

22. At almost every one of these sessions, Plaintiffs would reiterate to Chimes' staff their concerns for Mitchell's safety.

23. At times, Chimes' representatives would attend the meetings and state that the primary concern was Mitchell's safety and that his safety far outweighed training or any activities they might be doing with him.

24. Chimes' representatives stated that they knew if the staff should turn their head for a moment Mitchell might be in danger, and at all relevant times it has been undisputed that Mitchell required constant, one-on-one close (i.e., within arm's length) supervision.

25. At the time of the incident leading to Mitchell's death, he was under the daily care of Chimes with specific, individualized instructions regarding his supervision.

26. At all relevant times herein, Chimes was fully aware of, and agreed that Mitchell required literally constant 1:1 close (i.e., within arm's length) supervision.

27. Mitchell had a well-documented history at Chimes of attempting to and actually ingesting inedible objects, therefore, requiring constant supervision.

28. Chimes' own records include a prior pica incident, which was never reported to Plaintiffs despite Chimes' promise to do so, where Mitchell ingested a *latex glove*, the very item that ultimately caused his death:

> It is reported that Mitchell may suddenly reach for any small object that catches his eye. This is apparently anything different from the rest of the environment. This includes flowers and stones. If there is a single stone on the patio Mitchell will reach for it and attempt to place it in his mouth. **Recently**

there was a serious pica incident where he reportedly ingested a latex glove from a trashcan. All of Mitchell's behaviors occur without warning. His parents report this is how he has always acted. There appears to be no visible antecedent other than opportunity. **The only method proven to decrease the behaviors has been close supervision.** (*July 2006 Chimes Program Review/Summary Sheet (emphasis added)).*

29. Chimes' own records repeatedly document Mitchell's pica disorder and need for constant supervision:

- "Mitchell requires 1:1 staffing due to his behaviors and desire to be in constant motion. Mitchell's behaviors include...PICA." *October 2006 Service Funding Plan*
- "Requires 1:1 direct care staff daily due to PICA, SIB and Compulsive disorder." *August 2006 Individual Indicator Rating Scale*
- The staffing ratio needed for Mitchell is "1:1 during waking hours." *Annual Summary April 2013*
- With respect to the type of support needed, "Mitchell has no alone time." *April 2012 IP*
- "He has pica and is VERY quick to grab small objects and swallow them. He seems to be able to zero in on small objects that are dropped on the floor which most people wouldn't notice. Mitchell needs his program to be attentive to his surroundings and make sure that there's nothing around that Mitchell can grab and swallow." *April 2012 IP*
- "The house needs to be free of small items that can be swallowed because Mitchell has pica. He seems to have excellent eyesight as well because he can find any minute item /debri[s] or piece of lint on the floor and will put it in his mouth." *April 2012 IP*

- "[Mitchell] is diagnosed with profound mental retardation, seizure disorder and a history of pica behavior. [Mitchell] grabs food or, may attempt to ingest inedible objects, which continues to be a safety issue." *April 2013 Social Summary*
- "Mitchell has PICA" and "is very quick with picking up inedible items and ingesting them." *October 2006 Service Funding Plan*
- Plan of Service: "Anchoring recommended for safety secondary to history of Pica and oral motor stimulation needs." *February 2008 Occupational Therapy Assessment*
- Risk Diagnosis: PICA. *September 2013 Choking Risk Screening Tool*

30. Chimes' own records contain Mitchell's Nursing Diagnosis dated **April 2014 –** just two months prior to the incident – which stated the following:

> **Problem: Potential for [ingestion] of foreign objects.**
> **Goal: Mitchell will remain free of consuming non-edible objects X 180 days**
> **Action: 1) Mitchell's environment will be free of [foreign] objects. 2) Mitchell's environment will have dangerous products stored out of [ ] his range.** 3) All possible ingestion will be reported to the medical suite or the on call nurse immediately. Poison control will be called and appropriate treatment will be administered and/or 911 called. **4) Mitchell will be within arm's length of his behavior tech at all times.**
>
> *April 2014 Nursing Diagnosis (emphases added).*

31. At all relevant times herein, Chimes was paid by the State of Maryland in connection with Chimes' care of Mitchell.

32. At all relevant times, and for many years leading up to the time of Mitchell's death, Chimes was receiving from the State of Maryland well over $34,000.00 per year to provide Mitchell with 1:1 constant close (i.e., within arm's length) supervision.

The Incident

33. On June 2, 2014, at approximately 2:20 p.m., Mitchell was moved onto a Chimes transport vehicle (hereinafter the "Van") by a Chimes employee ("Behavior Technician, Staff #2").

34. At the time that Behavior Technician, Staff #2 moved Mitchell onto the Van, a Chimes employee, the Van driver (the "Van Driver"), was on the Van.

35. After moving Mitchell onto the Van, Behavior Technician, Staff #2 strapped Mitchell in a seat belt, and, in direct violation of his and Chimes' duties to Mitchell and mandate by Chimes, left him alone and unattended to work as a van aid on another van.

36. Behavior Technician, Staff #2's exiting the Van and leaving Mitchell without 1:1 close supervision was in direct violation of Mitchell's Individual Plan of Care ("IP") at Chimes.

37. Behavior Technician, Staff #2's exiting the Van and leaving Mitchell without 1:1 close supervision was in direct violation of Mitchell's Nursing Plan at Chimes.

38. Behavior Technician, Staff #2's exiting the Van and leaving Mitchell without 1:1 close supervision was in direct violation of Mitchell's Desired Outcomes and Goals at Chimes.

39. Behavior Technician, Staff #2's exiting the Van and leaving Mitchell without 1:1 close supervision was in direct violation of Chimes' Individual Plan for Mitchell Bruh.

40. Behavior Technician, Staff #2's exiting the Van and leaving Mitchell without 1:1 close supervision was in direct violation of Mitchell's Individual Indicator Rating Scale at Chimes.

41. Behavior Technician, Staff #2's exiting the Van and leaving Mitchell without 1:1 close supervision was in direct violation of the Service Funding Plan for Mitchell.

42. At all relevant times, Chimes knew that Mitchell had a Nursing Diagnosis that included "PICA, Potential for ingestion of foreign objects."

43. The Van Driver was neither trained to closely supervise, nor did he actually supervise, Mitchell at any time while Mitchell was on the Van.

44. Another Chimes employee and staff member ("Staff #3") then brought another individual onto the Van.

45. A Chimes Van Aid (the "Van Aid") then brought an individual to the driver side of the Van, where the Van Driver was, and walked from the Van back into the building to obtain other individuals for transport.

46. The Van Driver then loaded that individual into the Van, and observed Mitchell leaning over to one side into the aisle.

47. The Van Driver tapped Mitchell on the shoulder but Mitchell did not respond as he normally would do.

48. The Van Driver did not make any attempt to determine what was wrong with Mitchell or why he was unresponsive.

49. The Van Driver exited the Van, saw a Chimes instructor (the "Instructor") who was leaving a classroom, and asked the Instructor to watch the individuals on the Van.

50. By leaving Mitchell alone in the Van and not ensuring that Chimes maintained 1:1 close supervision of Mitchell, the Van Driver was also in violation, *inter alia*, of the Service Funding Plan for Mitchell and the requirement that he have constant close supervision.

51. The Instructor asked the Van Driver what was wrong and the Van Driver responded that he was going to find Behavior Technician, Staff #2 (*i.e.*, Mitchell's 1:1 staff).

52. The Instructor stepped onto the Van and observed that Mitchell was leaning over and had turned blue in the face.

53. The Instructor yelled Mitchell's name, but Mitchell did not respond.

54. The Instructor then yelled for someone to call 911 and to get one of Chimes' Registered Nurses, also a Chimes employee.

55. At no time did any Chimes employee check Mitchell's airway to determine whether he was choking on something.

56. Baltimore City Fire Department EMTs responded to the scene at about 2:45 p.m. and found Mitchell cyanotic.

57. Upon examination, Paramedic Christopher Cole found a latex glove sticking out of Mitchell's trachea, and removed it with forceps.

58. As Mr. Cole noted in his report, and was obviously told by Chimes staff at the scene, "PT HAS PICA BEHAVIOR AND HAS DONE THIS BEFORE, BUT NOT THIS BAD."

59. Mitchell was transported to Sinai Hospital of Baltimore, and by the time he arrived at the hospital, he had returned to normal spontaneous circulation.

60. A CT scan performed in the Emergency Department revealed diffuse cerebral edema that appeared to be the result of an anoxic brain injury.

61. All treaters at the hospital causally connected Mitchell's asphyxiation and anoxic brain injury with the ingestion of a glove.

62. Mitchell died at around 3:15 p.m. on June 4, 2014, as a result of the injuries suffered from his ingestion of the glove.

63. Mitchell's Death Certificate reflects his cause of death as "asphyxiation due to foreign body obstruction."

64. In the wake of Mitchell's tragic and avoidable death, the State of Maryland conducted an investigation into this incident, and completed such investigation in or about July 2014.

65. As the Maryland Department of Health and Mental Hygiene ("Health Department") "Statement of Deficiency Resulting from the 2014 Onsite Survey #MD000084238" (the "Report") concluded, Mitchell experienced "severe" neglect in his care, leading to his tragic and avoidable death. Mitchell is identified in the Report as "Individual #8249." See Ex. 1.

66. Following an onsite survey on July 31, 2014 – and without the benefit of knowledge of Mitchell's prior ingestion of a surgical glove at Chimes – State of Maryland investigators found at least *ten counts* of neglect, reflected in the Report as follows:

* The Van Driver failed to initiate and provide emergency care when he found Mitchell was unresponsive on the van.
* Chimes failed to provide 1:1 supervision while Mitchell was on the Van.
* Chimes' failure to provide 1:1 supervision while Mitchell was on the Van was reportedly a routine practice. Mitchell's Service Funding Plan provides "[Mitchell's] S/A matrix was "5" which = 20 hours of support. Mitchell will require an additional 20 hours of support to aid with transportation during the program hours."
* The Van Driver and Staff #3 had failed to ensure that Mitchell and another individual (who needs 1:1 supervision) were supervised on the

Van. Reportedly, Staff #3 left the Van while the only other staff – the Van Driver was helping load an individual [...]. There was an undetermined period of time when Mitchell and another individual (who also needs 1:1) were not supervised by any staff on the Van.

* There were no written standard procedures regarding 1:1 supervision during transition and transportation. The transportation supervisor reported, during face to face interview...that it was the Van Driver and/or the Van Aid's responsibility to supervise Mitchell on the Van. Both the transportation supervisor and Behavior Technician, Staff #2 and Staff #3 reported, during face to face interview...that as long as the Van Driver or the Van Aid was on the Van, the assigned 1:1 staff, Behavior Technician, Staff #2 and Staff #3 could leave the individuals, each requiring 1:1 staff assistance on the Van with either the Van Driver or the Van Aid. However, the Van Aid was not on the Van to provide supervision from Mitchell arriving on the Van until the incident occurred; reportedly, the Van Aid was in and out of the building to help transport individuals to the Van, while Mitchell and another individual (who also needed 1:1) were on the Van, the Van Driver got off the Van to help load other individual(s) ...and Staff #3 left the Van while no other staff were inside the Van to supervise individuals. Reportedly, Staff #3 supervised both Mitchell and another individual for 10-15 minutes before Staff #3 left the Van.

* There was no written documentation that the staffs were trained regarding the standard procedures for supervision during the process of transition and transportation.

* There [was] no documentation that the Van Driver and Staff #3 were trained to implement the IP and nursing care plan of Mitchell.

* Chimes failed to implement Mitchell's IP and nurse care plan. The IP indicated that the supervision was 1:1 in day program, community and transportation; the nurse care plan of...2014 indicated the following: 3) Mitchell will be within arm's length of his behavior tech technician at all times. The practice during the transition and transportation was contradictory to the guidelines in IP and nursing care plan.

* Chimes failed to monitor, detect, and correct the above practices: reportedly, the above unsafe and negligent transportation practices for individuals who require 1:1 supervision had been ongoing for at least 4-5 years.

* Chimes failed to implement Mitchell's nursing care plan. The nursing care plan of...2014 indicated the following: 1) [Mitchell's] environment will be free from foreign objects; 2) [Mitchell's] environment will have dangerous products stored out of [his] range. During the onsite investigation...it was noted that two open boxes of gloves were on the table in the classroom and one box of gloves was on top of the water cooler outside the classroom where Mitchell participated in activities.

These boxes of gloves were unattended and easily accessible to individuals in the program.

* IP does not have 1:1 protocol. There were no clear procedures how the 1:1 supervision should be provided.

67. As a result, the State of Maryland found that "the allegations of neglect were substantiated." Ex. 1, at 5.

68. The State of Maryland's findings, as reflected in the Report, supported a conclusion of severe, ongoing neglect in Mitchell's care by Chimes, causing his death on June 4, 2014.

69. The State of Maryland also determined that Chimes violated several sections of the *Code of Md. Regs ("COMAR")* governing the development of Mitchell's IP.

70. Those violations include (a) failing to provide for Mitchell's personal well-being, including living in places that are safe in violation of *COMAR 10.22.04.02.A2 (2014)* and (b) failing to provide for Mitchell's individual rights, including being free from abuse, neglect, and mistreatment in violation of *COMAR 10.22.04.02.B3 (2014)*.

71. Mitchell was a member of the class of persons these regulations are designed to protect.

72. By violating the aforementioned regulations, Chimes breached its duties owed to Mitchell, as a member of the class of persons intended to be protected by such laws.

73. After Mitchell's death, Chimes' own Quality Assurance Department conducted a neglect investigation and found that its own employee, the Van Driver, had committed neglect in connection with his failures as aforesaid.

74. Chimes' own Quality Assurance Department also found that Behavior Technician, Staff #2 had committed neglect in connection with his failures as aforesaid.

75. Chimes' own Quality Assurance Department also found that Staff #3 had committed neglect in connection with his failures as aforesaid.

76. Ultimately, Chimes terminated the Van Driver and Staff #3 for their failure to provide emergency care for Mitchell.

77. Behavior Technician, Staff #2 received from Chimes a written disciplinary reprimand.

78. The sole and proximate cause of the incident and Mitchell's eventual death, with absolutely no contributory negligence or assumption of the risk by Mitchell, was Chimes' failure to properly supervise Mitchell, who was solely in Chimes' custody at all relevant times.

79. Chimes expressly agreed to accept Mitchell in its custody and control, and to be responsible for him while in its care.

80. Chimes readily accepted literally hundreds of thousands of taxpayer dollars from the State of Maryland, over the course of a number of years, in exchange for its promise, agreement, and representation that it would provide 1:1 close supervision of Mitchell.

81. Despite its acceptance of hundreds of thousands of dollars from the State of Maryland, it failed to provide Mitchell precisely the services for which it was being paid, and upon information and belief, these failures persisted for years.

82. At all relevant times herein, the above-referenced Chimes staff, including but not limited to Behavior Technician, Staff #2, Van Driver, Staff #3, and Van Aid were acting within the course and scope of their employment and/or agency with Chimes, thereby rendering Chimes vicariously liable for their negligent acts and omissions as aforesaid.

COUNT I
Wrongful Death – Negligence

83. The allegations of the preceding paragraphs are re-alleged and incorporated by reference as if fully set forth herein.

84. This count is brought by Plaintiffs individually and as wrongful death statutory beneficiaries.

85. The aforesaid incident was caused by and was the direct, sole, and proximate result of the negligence of Defendant.

86. At all relevant times, Chimes owed Mitchell the duty to care for him in accordance with all applicable standards for day habilitation services, as well as his particular treatment plans as aforesaid, including but not limited to, the provision of close 1:1 supervision at all times while he was in the possession, custody and control of Defendant.

87. At all relevant times, Chimes owed Mitchell a duty to care for him in accordance with all applicable laws, including but not limited to, COMAR.

88. Chimes negligently breached its duties as aforesaid, thereby causing the tragic and wholly avoidable death of Mitchell, by, among other things: failing to closely supervise Mitchell as required by the standards of care applicable to day habilitation services; failing to provide Mitchell the care required by his treatment plans, including his Individual Plan and his nurse care plan; failing to comply with COMAR; failing to provide emergency care once he was discovered unresponsive in the Van; failing to properly train and supervise its staff; failing to have proper protocols and procedures for loading and unloading individuals such as Mitchell, for Intervals van runs (including a failure to have written standard procedures regarding 1:1 supervision during transition and transportation); failing to have proper protocols and training for dealing

with unconscious and conscious choking individuals; and failing to have Mitchell within arm's length of his behavior technician at all times.

89. Mitchell's death was a direct and proximate result of the aforesaid wrongful acts and neglect of Defendant Chimes.

90. Mitchell was, as a matter of law, incapable of being contributorily negligent or assuming any risk, given his profound developmental disabilities.

91. But for the negligence committed by Chimes as aforesaid, Mitchell would not have been injured as he was on June 2, 2014, and would not have died as a result thereof.

92. As a direct and proximate result of Chimes' negligence as aforesaid, Plaintiffs have suffered and will continue to suffer non-pecuniary losses that include mental anguish, emotional pain and suffering, loss of society, loss of companionship, and loss of comfort, on account of the death of their beloved son Mitchell.

93. As a direct and proximate result of Chimes' negligence as aforesaid, Plaintiffs have incurred a total of $24,088.00 in medical and funeral expenses.

WHEREFORE Plaintiffs Brian M. Bruh and Judith Bruh seek judgment on the wrongful death claim against Defendant Chimes, for compensatory damages in an amount exceeding $75,000.00, to be apportioned pursuant to § 3-904(c) of the Courts and Judicial Proceedings Article, plus interest and costs, and such other relief as the Court deems appropriate.

COUNT II
Survival Action – Negligence

94. The allegations of the preceding paragraphs are re-alleged and incorporated by reference as if fully set forth herein.

95. This count is brought on behalf of the Estate of Mitchell L. Bruh.

96. The aforesaid incident was caused by and was the direct, sole, and proximate result of the negligence of Defendant.

97. At all relevant times, Chimes owed Mitchell the duty to care for him in accordance with all applicable standards for day habilitation services, as well as his particular treatment plans as aforesaid, including but not limited to, the provision of close 1:1 supervision at all times while he was in the possession, custody and control of Defendant.

98. At all relevant times, Chimes owed Mitchell a duty to care for him in accordance with all applicable laws, including but not limited to, COMAR.

99. Chimes negligently breached its duties as aforesaid, thereby causing the tragic and wholly avoidable death of Mitchell, by, among other things: failing to closely supervise Mitchell as required by the standards of care applicable to day habilitation services; failing to provide Mitchell the care required by his treatment plans, including his Individual Plan and his nurse care plan; failing to comply with COMAR; failing to provide emergency care once he was discovered unresponsive in the Van; failing to properly train and supervise its staff; failing to have proper protocols and procedures for loading and unloading individuals such as Mitchell, for Intervals van runs (including a failure to have written standard procedures regarding 1:1 supervision during transition and transportation); failing to have proper protocols and training for dealing with unconscious and conscious choking individuals; and failing to have Mitchell within arm's length of his behavior technician at all times.

100. Mitchell's death was a direct and proximate result of the aforesaid wrongful acts and neglect of Defendant Chimes.

101. Mitchell was, as a matter of law, incapable of being contributorily negligent or assuming any risk, given his profound developmental disabilities.

102. But for the negligence committed by Chimes as aforesaid, Mitchell would not have been injured as he was on June 2, 2014, and would not have died as a result thereof.

103. Between the time of his injury and the time of his death, Mitchell sustained non-economic damages, including pre-death conscious pain, suffering, and mental anguish, as a direct and proximate result of the negligence of Defendant.

104. As a direct and proximate result of the negligence of Defendant, Mitchell's Estate has suffered economic damages including medical expenses, burial expenses and other economic losses.

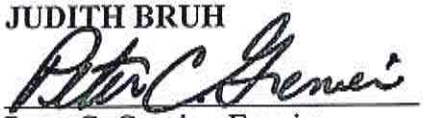
WHEREFORE Plaintiff Brian M. Bruh, as Personal Representative of the Estate of Mitchell L. Bruh, seeks judgment on the survival action against Defendant, for compensatory damages in an amount exceeding $75,000.00, plus interest and costs, and such other relief as the Court deems appropriate.

JURY DEMAND

Plaintiffs demand a trial by jury with respect to each of the claims alleged herein.

Respectfully submitted,

BRIAN M. BRUH, INDIVIDUALLY AND AS PERSONAL REPRESENTATIVE OF THE ESTATE OF MITCHELL L. BRUH, AND JUDITH BRUH

By: 

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Dated: November 3, 2015

COUNSEL'S CERTIFICATION PURSUANT TO MARYLAND RULE 1-313

Undersigned counsel, pursuant to Maryland Rule 1-313, hereby certifies that he is admitted to practice in Maryland and that he is a member of the bar in good standing.

Peter C. Grenier

COUNSEL'S CERTIFICATION PURSUANT TO MARYLAND RULE 1-313

Undersigned counsel, pursuant to Maryland Rule 1-313, hereby certifies that he is admitted to practice in Maryland and that he is a member of the bar in good standing.

Kenneth J. LaDuca

EXHIBIT 1

Statement of Deficiencies and Plan Correction	(X1) Provider/Supplier/CLIA Identification Number	(X2) Multiple Construction	(X3) Date Survey Completed
	DD0010	A. Building_____ B. Wing_____	07/31/2014

Name of Provider or Supplier	Street Address, City, State, Zip Code
Chimes, Inc.	4814 Seton Drive Baltimore, MD 21215

L000	Initial Comments [redacted], a complaint investigation. MD000084238 ASPEN CLOT1 was initiated in response to allegations of neglect. Activities included visiting individual #8249 [redacted] on [redacted] with family at bedside; visiting the day program site DL6268 [redacted] reviewing records of individuals #8249, reviewing records of nine staff members who worked with individual #8249 and/or witnessed the incident of [redacted] and interviewing administrative and direct support staff at the day program [redacted]. The allegations of neglect were substantiated. The licensee was not found to be in compliance with: COMAR Title 10, Subtitle 22 Developmental Disabilities Regulations. The investigation is specific to site #|DL6268 Service|Day Habilitation Individual #|8249	L000	Provider's Plan of Correction
L1110 SS=C	10.22.04.02.A2 Values-Values in IP;Wel being;Living safe .02 Values to be Considered in the Development of the IP. A. Personal well-being, which includes: (2) Living and working in places that are safe: This Requirement is not met as evidenced by: **See deficiency statements under tag L1140.**	L1110	**Corrective Action (L1110)** **See Chimes, Inc's plan of corrections for tag L1140.**

L1140 SS=C	10.22.04.02.B3 Values-Values in IP:Ind rights:free of neglic .02 Values to be Considered in the Development of the IP. B. Individual rights, which include: (3) Being free from abuse, neglect, and mistreatment: This Requirement is not met as evidenced by: Licensee failed to provide the supervision that individual #8249 needed and was funded; licensee failed to ensure individual #8249's safety, resulting in asphyxiation due to foreign body obstruction (cause of death noted by the Medical Examiner). The licensee's investigation report revealed: "On [redacted] 2014 at approximately 2:20pm, the van "Driver [staff #1] was on the van and observed that 1:1 Behavior Technician [staff#2] brought [Individual #8249] onto the van, seated [Individual#8249] onto the seat and strapped [individual #8249] in a seat	L1140	**Corrective Action (L1140)** Chimes, Inc's Quality Assurance Department conducted a thorough neglect investigation regarding incident #MD00084238. The Quality Assurance Department concluded that Neglect was founded against Staff #1 [Driver], Staff #2 [1:1 Behavior Technician for individual #8249] and Staff #3 [1:1 Behavior Technician]. All were suspended pending the closure of the investigation. Staffs #1 and #3 were terminated from Chimes, Inc. for failure to provide emergency care for Individual #8249, effective their last day worked. Staff #2 was reinstated on 6/11/14 and received a written disciplinary **(see attachment #1).** Staff #2 did not receive wages lost during the suspension and was required to re-take and successfully complete the Fundamental Rights training and "No Secrets" (Preventing Abuse and Neglect). Staff #2 successfully completed No Secrets Training on 6/30/14. **(see attachment #2).** Staff #2 is currently scheduled to attend the next Fundamental Rights training on 8/22/14 during new employee orientation. (Tag L1140 #1, #3) The Deputy Director of Intervals Day Program provided a "No Secrets" (Preventing Abuse and Neglect) Refresher Training to all Intervals Day Program Staff, including all direct care staff, management staff, and medical suite staff. These trainings were completed on the following dates:
L1140	belt. Reportedly, staff #2 left the van to work as a van aid on another van. "[Staff#3] then brought another individual on the van. Van Aid [staff #4] then brought a person [redacted] to the driver side of the van, where the driver [staff #1] was, and walked from the van back into the building to obtain other individuals for transport. Driver [staff #1] then got off the van to load the person onto the van [redacted]. Staff [staff #3] then got off the van and went back inside Intervals. Driver [staff #1] loaded the individual [redacted] onto the van [redacted] Driver [staff #1] then observed that [Individual #8249] was leaning over to one side into the aisle. The driver [staff#1] stated that he tapped	L1140	6/18/14, 6/23/14, 6/24/14, 6/27/14, and 6/30/14. These trainings were documented on a Chimes, Inc. C-708 training form. In addition, on 6/9/14, the Intervals Deputy Director purchased combination locks for all cabinets in each programming room. The locks were distributed to each programming room for usage and secure storage of disposable gloves on 6/9/14. All cabinets in the programming rooms will remain locked when staff persons are not obtaining supplies. A purchase order was also submitted to the Chimes Business Office, on 8/6/14, to purchase 24 trasheans with locking lids **(see attachments #3 & #4- invoice request and email confirmation from the vendor).** The trash cans were delivered on 8/12/14. All current Intervals trash cans will be discarded by 8/15/14 and replaced with the secure cans. Each programming room and bathroom will utilize the trasheans with locking lids to prevent individuals from obtaining any items that have been discarded by staff. (L1140 #9)
L1140	[individual #8249] on the shoulder and [Individual #8249] did not respond as he normally does. Driver [staff #1] then got off the bus, saw Instructor [staff #5] who was leaving the classroom, and asked Instructor [staff #5] to watch the individuals on the van. Instructor [staff #5] asked what was wrong and Driver [staff #1] stated that he was going to find Behavior Technician [staff #2]. [individual #8249] 1:1 staff]. Instructor [staff #5] stepped onto the bus and	L1140	The Intervals Transportation Supervisor developed written unloading and loading procedures for each of the Intervals van runs. On 7/18/14, the Transportation Supervisor reviewed the unloading/loading procedures for each van run with the driver, aide(s), and 1:1 staff persons on each run. After the review of the procedures, the drivers, aides, and 1:1 staff persons signed the procedure. The unloading and loading procedures will be kept in the office of the Deputy Director of Intervals Day program and updated by the Transportation Supervisor when the drivers, aides, or 1:1 staff person change on any of the van runs. When updated, the new unloading and loading procedures will be reviewed

	observed that [individual #8249] was leaning over and had turned blue in the face. Instructor [staff #5] then yelled		with the new driver, aides, or 1:1 staff person and the driver, aide, or 1:1 staff will sign that they reviewed the procedures. The unloading and loading procedure for each
L1140	[individual #8249]'s name. [Individual #8249] did not respond. Instructor [staff#5] then yelled for someone to call 911 and to get [staff #6], RN. At that time, Instructor [Staff #8] came out of the classroom and onto the bus. Instructors [staff #5] and [Staff #8] unbuckled [individual #8249], laid Individual [individual #8249] onto the van floor and started doing CPR on [individual #8249] until Nurses [staff #6] and [staff #7, RN] arrived at the van then began doing CPR. Staff was instructed to call 911 and the ambulance arrived. As witnessed by the Program Supervisor, the paramedics were continuing to perform CPR and observed that there was something in the back of [individual #8249]'s mouth. The paramedic then took a "tong-like" instrument and pulled out a whole glove from [individual #8249]'s throat." [Individual #8249] was taken to [redacted]	L1140	van run includes the statement "No driver, aide, or 1:1 staff person should ever leave the individuals unattended. If you are the only staff person on the vehicle with individuals, do not leave the vehicle." **(see attachment #5- protocols).** In addition, all Drivers/Van Aides will be briefed on the Chimes Policy I.E.n **(see attachment #6).** All drivers and aides will be assigned to certain individuals that they load and unload daily. There is now a logout sheet that the drivers will sign for the Individuals in the morning when arriving and the afternoon when departing from Intervals for more accountability. When the driver is operating the vehicle (in transit) it is understood that they are not part of the staffing ratio that will be supervising the individuals on the bus. In the event there is an emergency, i.e. medical, behavioral etc. the driver will pull over and assist the aides and/or 1:1 staff on the vehicle. The individual transportation ratios will be determined during IP's meetings in accordance to the individual's needs and funding. The Transportation Coordinator is responsible for quality assurance oversight and monitoring of this part of the portion of correction. (Tag L1140 #4, #5, #8)
L1140	Hospital and admitted into ICU. [Individual #8249] was put on life support. [redacted] licensee's COO, entered the conference room while the 2 OHCQ investigators were on site interviewing licensee's QA Director and Case Manager. The COO reported that the COO had received a call from the Medical Examiner's Office stating that individual #8249] was deceased. The discharge summary preliminary report that was obtained from the [redacted] hospital on [redacted] reported that the medical examiner "indicate that the manner of death was an accident. The medical examiner also indicated that the cause of death be noted as asphyxiation due to foreign body obstruction." As of the date of this statement of deficiency, the death certificate was pending.	L1140	Refresher trainings regarding "The Unconscious and Conscious Choking" and the "Check, Call, Care" procedures was provided to all Intervals staff by the Intervals Program CPR/First Aid Instructor. These Refreshers were conducted during the Intervals staff meeting held on 6/24/14, and the Transportation staff meetings held on 7/3/14 and 7/23/14. All drivers, aides, and 1:1 staff persons will be trained on the Individual Plans, Behavior Plans, and Nursing Care Plans for the persons served on their van runs. The Individual Program Coordinator will be responsible for completing the trainings on the IP's. The Psychology Associate will be responsible for completing the training on the BP's. The RN will complete the trainings on the NCP's. All trainings will be completed by 10/1/14 and will be documented on the Chimes, Inc. C-708 training forms. The Intervals Deputy Director will be responsible for quality assurance oversight and monitoring of the above plan of correction. (Tag L1140 #6, #7 & #9). During annual IP Meetings the supervision requirements will be determined and/or reviewed in accordance with the individual's needs and funding. Written individualized 1:1 protocols will be established for each staff person providing
L1140	Based on the licensee's incident report, staff interview and record review, it was determined: 1. The van driver [staff #1] failed to initiate and provide emergency care when staff #1 found individual #8249 was unresponsive on the van. 2. Licensee failed to provide 1:1 supervision while individual #8249 was on the van. Reportedly, it was a routine practice.	L1140	1:1 supervision. The procedures will be clearly defined and include: -a bulleted list of responsibilities for the 1:1 staff -the appropriate supervision level, i.e. line of sight, arm's length etc. -Specifications of the 1:1 supervision, i.e. during program hours, transportation, community etc. -allergies, diagnoses and other health and behavioral precautions specific to the individual -Who to contact in the event the staff needs to take a break or needs to be relieved, i.e. bathroom breaks etc.(so that

L1140	Individual #8249s Service Funding Plan provides "[individual #8249]'s S/A matrix was "5" which =20 hours of support. [Individual #8249] will require an additional 20 hours of support to aid with transportation and during the program hours. " 3. The van driver and staff #3 had failed to ensure that individual #8249 and another individual (who needs 1:1 supervision) were supervised on the van. Reportedly, staff #3 left the van while the only other staff - the driver was helping load an individual [redacted]. There was an undetermined period of time when individual #8249 and another individual (who also needs 1:1) were not supervised by any staff on the van; 4. There were no written standard procedures regarding 1:1 supervision during transition and transportation. The transportation supervisor reported, during face to face interview on [redacted] that it was the driver and/or the van aid's responsibility to supervise the individual #8249 on the van. Both the transportation supervisor and staff #2 and #3 reported, during face to face interview on [redacted], that as long as the driver or the van aid was on the van, the assigned 1:1 staff, Staff #2 and	L1140	proper supervision can be provided) The individualized 1:1 responsibility protocol form will be completed by the Individual Program Coordinator. The protocol does not take the place of the Behavior Plan nor release the staff person from being trained on the IP, BP and/or NCP. **(see example attachment #7).** By September 5, 2014, all Individual Program Coordinators will review the program files (of individuals who receive 1:1 funding) to ensure that all individualized 1:1 responsibility protocol forms are up-to-date, consistent with the supervision levels in the IP/SFP and that the current 1:1 staff providing the supervision has been specifically trained on the procedures. The 1:1 protocols will be updated, as needed and/or annually in accordance with the development of the IP. 1:1 staff will be trained annually or in the event changes occur to the 1:1 responsibilities. The Individual Program Coordinators are responsible for ensuring this plan of correction is adhered to. (L1140 #10 & #2) On 6/10/14, the Director of Clinical Services obtained a computer-generated list of all individuals being served at Chimes, Inc. that have a diagnosis [redacted]. This list was reviewed to determine those individuals that do not have a behavior plan currently in place. Behavioral data collection was initiated for all those individuals, by 6/20/14, regardless of previous history [redacted]. The behavioral data will be analyzed on a monthly basis by the Clinical Services Director to determine the need for development of a behavior plan. The need for a behavior plan will be addressed and documented annually during the individual's annual IP meeting. The Director of Clinical
L1140	#3 could leave the individuals, each requiring 1:1 staff assistance on the van with either the driver or the van aid. However, the van aid was not on the van to provide supervision from the individual #8249 arriving on the van until the incident occurred; reportedly, the van aid was in and out of the building to help transport individuals to the van; while individual #8249 and another individual (who also needed 1:1) were on the van, the van driver got off the van to help load other individual(s) [redacted], and staff #3 left the van while no other staff were inside the van to supervise individuals. Reportedly, staff #3 supervised both individual # 8249 and another individual for 10-15 minutes before staff #3 left the van. 5. There was no written documentation that the staffs were trained regarding the standard procedures for supervision during the process of transition and transportation.	L1140	Services will be responsible for quality assurance oversight and monitoring of this portion of the plan of correction. (Tag L1140 #9, #10 & Tag L1355)
L1140	6. There were no documentation that the van driver and staff #3 were trained to implement the IP and nursing care plan of individual #8249. 7. Licensee failed to implement the IP		

L1140	and the nurse care plan. The IP indicated that the supervision was 1:1 in day program, community and transportation; the nurse care plan of [redacted] 2014 indicated the following: 3) individual #8249 will be within arm's length of his behavior tech [technician] at all times. The practice during the transition and transportation was contradictory to the guidelines in IP and nursing care plan. 8. Licensee failed to monitor, detect, and correct the above practices; reportedly, the above unsafe and negligent transportation practices for individuals who required 1:1 supervision had been ongoing for at least 4-5 years. 9. Licensee failed to implement the nursing care plan. The nursing care plan of [redacted] 2014 indicated the following: 1) individual #8249's environment will be free of foreign objects; 2) individual #8249 ' s environment will have dangerous products stored out of [redacted] range; ..."		
L1140	During the onsite investigation [redacted] it was noted that two open boxes of gloves were on the table in the classroom and one box of gloves was on the top of the water cooler outside the classroom where individual #8249 participated in activities. These boxes of gloves were unattended and easily accessible to individuals in the program. 10. IP does not have 1:1 protocol. There were no clear procedures how the 1:1 supervision should be provided. (See . tag#1355). Based on the above, the allegations of neglect were substantiated. Scope: Isolated; Severity: Severe This deficiency also applies to tag L1110.		
L1355 SS=C	10.22.05.01.A4 Components IP:IP is:spec assessment serv training .02 Components of the IP. A. The IP is: (4) Intended to specify all needed assessments, services, and training. This Requirement is not met as evidenced by: The licensee failed to include in the Individual Plan (IP) or develop an individualized 1:1 protocol. Individual #8249's service funding plan (SFP) and Individual Plan (IP) of [redacted] 2014 indicate individual # 8249	L1355	**Corrective Action (L1355)** During annual IP Meetings the supervision requirements will be determined and/or reviewed in accordance with the individual's needs and funding. Written individualized 1:1 protocols will be established for each staff person providing 1:1 supervision. The procedures will be clearly defined and include: -a bulleted list of responsibilities for the 1:1 staff -the appropriate supervision level, i.e. line of sight, arm's length etc. -Environment/Scope of the 1:1 supervision, i.e. during program hours, transportation, community etc. -allergies, diagnoses and other health and behavioral precautions specific to the individual

L1355	receives 1:1 at "all program hours" in day program, community and transportation. The nurse care plan of [redacted] 2014 instructs that individual #8249 "will be within arm's length of his behavior tech [technician] at all times." [redacted]. However, there was no evidence that a 1:1 protocol was developed on how to provide the 1:1 supervision while engaging individual #8249 in structured as well as leisure activities. The Educational Alert on 1:1 Supervision issued by DDA to all licensed service providers on August 26, 2008 requires that an individual's 1:1 supervision be concretely defined based on the individual's needs and that each staff person who provides the 1:1 supervision be specifically trained." The Educational Alert requires that "the interdisciplinary team should discuss and include the following in the IP: Type of supervision, e.g., 1:1, awake overnight; Concrete definition of what the supervision entails. Staff might have differing interpretation of terms such as, "line of sight", e.g., does line of sight apply 100 yards away at a crowded flea market or when in the same room? Please include the environment in which the supervision should be provided and the specific time/shift the supervision should occur. The 1:1 staff person's need to access the individual should be specified, e.g., arm's length, within earshot, 15-minute checks, etc. Coverage during staff breaks. Rationale and purpose of the 1:1 supervision. If the supervision is for behavioral reasons, supervision guidelines should be incorporated into the behavior plan (refer to COMAR10.22.10) Staff training: how the training should be provided. Based on the above findings, this regulatory requirement was not met. Scope: Isolated; Severity: Severe	L1355	-Who to contact in the event the staff needs to take a break or needs to be relieved, i.e. bathroom breaks etc.(so that proper supervision can be provided) The individualized 1:1 responsibility protocol form will be completed by the Individual Program Coordinator. The protocol does not take the place of the Behavior Plan nor release the staff person from being trained on the IP, BP and/or NCP. **(see example attachment #7).** By September 5, 2014, all Individual Program Coordinators will review the program files (of individuals who receive 1:1 funding) to ensure that all individualized 1:1 responsibility protocol forms are up-to-date, consistent with the supervision levels in the IP/SFP and that the current 1:1 staff providing the supervision has been specifically trained on the procedures. The 1:1 protocols will be updated, as needed and/or annually in accordance with the development of the IP. 1:1 staff will be trained annually or in the event changes occur to the 1:1 responsibilities. A Transportation Agreement will also be completed at each IP meeting based on the individual services and funding **(see attachment #8).** When the driver is operating the vehicle (in transit) it is understood that they are not part of the staffing ratio that will be supervising the individuals on the bus. In the event there is an emergency, i.e. medical, behavioral etc. the driver will pull over and assist the aides and/or 1:1 staff on the vehicle. The individual transportation ratios will be determined during IP's meetings in accordance to the individual's needs and funding. The Individual Program Coordinators are responsible for ensuring this plan of correction is adhered to. The Deputy Director of Intervals will be responsible for quality assurance oversight and monitoring of this plan of correction. In addition, on 6/10/14, the Director of Clinical Services obtained a computer-generated list of all individuals being served at Chimes, Inc. that have a diagnosis [redacted] This list was reviewed to determine those individuals that do not have a behavior plan currently in place. Behavioral data collection was initiated for all those individuals, by 6/20/14, regardless of previous history [redacted] The behavioral data will be analyzed on a monthly basis by the Clinical Services Director to determine the need for development of a behavior plan. The need for a behavior plan will be addressed and documented annually during the individual's annual IP meeting. The Director of Clinical Services will be responsible for quality assurance oversight and monitoring of this portion of the plan of correction. On 8/7/14, the Quality Assurance Director emailed all Chimes, Inc. Program Directors a copy of the Educational Alert issued by DDA regarding 1:1 supervision as (1) a reminder of the licensed service provider requirements; (2) for distribution to staff/supervisors involved in the IP Process and (3) for training purposes.