

2011 WL 9908300 (Pa.Com.Pl.) (Trial Motion, Memorandum and Affidavit)
Court of Common Pleas of Pennsylvania.
Delaware County

Linda A. CALLAN, Administratrix of the Estate of Marie R. Paolini, deceased, Plaintiff,
v.

MANOR CARE, INC.; Manor Care of America, Inc.; Manorcare Health Services, Inc.; Mercy/
Manor Partnership d/b/a Manorcare Health Services at Mercy Fitzgerald; Manorcare of Delaware
County, Inc.; Mercy Adult Services, d/b/a Manorcare Health Services At Mercy Fitzgerald; Mercy
Management of Southeastern PA, d/b/a Manorcare Health Services at Mercy Fitzgerald, Defendants.

No. 09002199.
March 2, 2011.

This is not an Arbitration Case; an Assessment of Damages is Required; Jury Trial Demanded

Plaintiff's Memorandum of Law in Opposition to Defendants' Motion for Partial Summary Judgment

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I. MATTER BEFORE THE COURT

Plaintiff, Linda Callan, as Administratrix of the Estate of Marie Paolini, deceased, by and through her counsel, Wilkes & McHugh, P.A, files this Memorandum of Law in Opposition to Defendants' Motion for Partial Summary Judgment.

II. STATEMENT OF THE QUESTIONS PRESENTED

1. Should Plaintiffs claim for punitive damages be dismissed?

Answer: No. There is no basis in law or fact for dismissing Plaintiffs claim for punitive damages.

2 Should Plaintiff's claim for negligence per se, for Defendants' violation of the Neglect of Care-Dependent Person Statute, [18 Pa.C.S.A. § 2713](#), be dismissed?

Answer: N. There is no basis in law or fact for dismissing Plaintiff's claim for negligence *per se*.

3. Should Plaintiff's claim for negligence *per se*, for Defendants' violation of the Pennsylvania Older Adults Protective Services Act, [35 P.S. § 10225.101 et seq.](#), be dismissed?

Answer: No. There is no basis in law or fact for dismissing Plaintiff's claim for negligence *per se*.

III. PROCEDURAL HISTORY

Plaintiff initiated this nursing home **abuse** and neglect case against all Defendants on February 13, 2009. See Plaintiff's Complaint (attached hereto as **Exhibit "A"**) Plaintiff's Complaint sets forth several theories of liability and damages that remain in this case, including corporate negligence, negligence, professional negligence, negligence per se, and punitive damages. On February 4, 2011, Defendants filed a Motion for Partial Summary Judgment to Dismiss Plaintiffs Claims for Punitive Damages and Statutory Claims. See Defendants' Motion (attached hereto as **Exhibit "B"**). The other remaining Defendants, Mercy Management of Southeastern PA, filed a Praecipe to Join Motion for Summary Judgment on February 10, 2011. See Defendants' Praecipe (attached hereto as **Exhibit "C"**).

IV. UNDERLYING FACTS

This nursing home neglect and **abuse** case concerns the responsibilities and duties of those who care for the **elderly** and disabled, and the legal consequences that should be imposed upon those who disregard their obligations. The facts surrounding this tragic case are set forth in the expert reports authored by Leonard Williams, MD, (attached hereto as **Exhibit "D"**) and Nurse Terri Antoinette, RNC, MHSA, CRRN, CLNC, CBIT, CDONA/LTC (attached hereto as **Exhibit "E"**), and are summarized below.

Defendants assert that Plaintiff has failed to produce sufficient evidence and expert testimony in support of her claims for punitive damages and negligence per se for violations of the Neglect of Care-Dependent Person Statute, [18 Pa.C.S.A § 2713](#), and the Pennsylvania Older Adults Protective Services Act [35 P.S. § 10225.101 et seq.](#), on the basis that there does not exist a cause of action under the law and that there is a lack of evidentiary support. The evidence and Plaintiffs Experts' Repots show that Defendants actions clearly support Plaintiffs claims for the same. For example, Plaintiffs physician expert opines: [T]he [Defendants] failed to provide proper care to Marie Paolini, and... these failures caused and increased her risk of harm for serious bodily injuries, pain, suffering and death...".¹

The [Defendants] failed to provide the appropriate pressure relieving measures and monitoring for Marie Paolini's sacral **pressure ulcer**, allowed her to become severely malnourished and dehydrated, *allowed her wound to deteriorate to the point that it became a serious stage IV infected **pressure ulcer** that caused her severe pain, sepsis, **acute renal failure**, myocardial damage and death.*²

Similarly, Plaintiff's nursing expert opines:

Mrs. Paolini did not receive appropriate nursing care from the [Defendants] which increased her risk of harm for injuries as evidenced by [numerous] breaches of the standard of care as per the Federal and State Regulations for Long Term Care.³

Thus, contrary to Defendants' assertions, Plaintiff's experts clearly state that Defendants' conduct violated the statutes in question, and was the proximate and legal cause of Ms. Paolini's injuries. As will be detailed below, Plaintiff has satisfied the evidentiary requirement for her claims of negligence per se against these Defendants.

Further, Defendants allege that there is no medical evidence to support intentional or reckless behavior on the part of the Defendants, or that their behavior had any causal significance in Ms. Paolini's deterioration, which could support a claim of punitive damages. Plaintiffs experts' reports, evidence, and deposition testimony demonstrate otherwise, as described in detail below.

A. Facts surrounding the underlying neglect and **abuse**

Defendants' recklessness and neglect, which caused this unfortunate chain of events, is corroborated by the evidence and testimony set forth below and by the available medical records. Defendants' practice of understaffing the facility, failing to implement and enforce proper procedures, and failing to provide Ms. Paolini adequate wound care resulted in needless harm to Ms. Paolini. Ms. Paolini resided at the facility from June 22, 2007, to July 7, 2007.⁴

Ms. Paolini was admitted to the facility for a short-term stay for rehabilitation to improve mobility, which was estimated to be a two-week stay.⁵ Though Defendants knew that Ms. Paolini possessed several [pressure ulcers](#) at the time of admission, they documented her as being at a low risk for [pressure ulcers](#).⁶ She had a reddened area over her coccyx, a [Stage II pressure ulcer](#) on her sacrum, and [Stage I pressure ulcers](#) on each heel.⁷ Incredibly, no care plan was "implemented to prevent the development of new [pressure sores](#) or the deterioration in the condition of her sacral and heel [pressure ulcers](#)."⁸ No care plan for [pressure ulcer](#) prevention and management was developed until June 25, 2007, three days later, by which time the [sacral] wound had already deteriorated significantly.⁹

On June 25, 2007, the sacral area wound had almost doubled in size.¹⁰ Additionally, there was a new wound noted on Ms. Paolini's left buttocks that was documented as unstageable.¹¹ There was also a new wound noted on the right buttocks, which was also documented as unstageable.¹² Ms. Paolini's heel [pressure ulcers](#) also increased in size.¹³ Outrageously, no family members were notified of the changes in the condition of Ms. Paolini's wounds.¹⁴

After noting this deterioration in Ms. Paolini's skin, it was only then that a plan was devised to treat the wounds.¹⁵ Additionally, Ms. Paolini's wound status was to be evaluated and recorded at least weekly, any new developments were to be reported, Ms. Paolini was to be checked for incontinence at least every two hours, and the **family was to be notified of the skin condition**.¹⁶ The care plan did not address turning and repositioning Ms. Paolini every two hours, which would have reduced pressure to the affected areas.¹⁷ A June 26, 2007, nursing note was the first time turning and repositioning was mentioned.¹⁸

Despite the knowledge of Ms. Paolini's deteriorating condition, Defendants failed to turn and reposition her on the 11-7 shift of June 25th, the 7-3 shifts for June 27th, 29th, and June 30th, the 7-3 and 3-11 shifts on July 1st, the 7-2 shift on July 4th, and the 7-3 and 3-11 shifts on July 7, 2007, as evidenced by blanks in the nursing notes.¹⁹ Further, no daily wound audits were performed June 22-June 30, 2007, with the exception of one on June 28, 2007.²⁰ The Defendants also neglected to apply the moisture barrier cream on the 7-3 shift on June 27 and June 28; her open wounds were exposed to urine and feces during these periods, in addition to the period of June 22 to June 25 when no barrier cream application had yet been ordered.²¹ In conjunction with this neglect, there were several occasions where it took Defendants 25-35 minutes to answer the call bell when Ms. Paolini had urinated or defecated, leaving the open wounds exposed to the excrement.²² Ms. Paolini's daughter testified that on July 6 she observed "*a hole bigger than a man's fist, and all the feces were going in this hole.*"²³ During the imposition of this sub-standard care, the sacral wound continued to increase in size by July 3, 2007.²⁴ This change "*clearly depicts[s] a serious deterioration*" had occurred, and the wound was now causing Ms. Paolini pain.²⁵

In addition to these failures to provide care and monitoring the condition of the wound, the Defendants failed to properly document such.²⁶ For example, a nursing note on June 25, 2007, documented Ms. Paolini's right buttock [pressure ulcer](#) as 1 x 1.5 x <0.1 cm and unstageable.²⁷ The next day, however, the wound was noted to be 1 x .5 x <0.1 cm and documented as a stage II wound.²⁸ These two nursing notes presented "serious discrepanc(ies)."²⁹ Additionally, a July 3, 2007, skin alteration report documents wound measurements, but fails to identify the location of the wound.³⁰ These are just a few of the instances that illustrate Defendants' failure to properly monitor and document Ms. Paolini's condition, which ultimately increased the risk of harm for her injury.³¹

To make matters worse, Defendants did not maintain an adequate hydration and nutrition level³² and further contributed to the weakening of Ms. Paolini's defenses and worsening condition.³³ Again, there were other documentation problems, which involved improper documentation of Ms. Paolini's weight upon admission. At the time of discharge from the hospital, her weight was noted as 110.2 pounds, but later on that same day, Defendants listed her weight as 100.8 upon admission to their facility.³⁴ An additional notation furthered the discrepancy; a different spot in that same admission documentation noted that Ms. Paolini had a weight of 108 pounds.³⁵ This improper weight monitoring was the start of inadequate nutritional interventions thereafter.³⁶

Defendants were aware that Ms. Paolini was at high risk for nutritional problems.³⁷ Defendants were further aware that Ms. Paolini required assistance with eating.³⁸ Despite the need for attention to her nutritional well-being, there were several occasions where Ms. Paolini was not even fed.³⁹ This was especially “**disturbing**” because Defendants were aware that Ms. Paolini had lost 5.4 pounds in only a week.⁴⁰ This weight loss in a 94-year-old woman with [pressure ulcers](#) is “**devastating and not compatible with wound healing**.”⁴¹ Further, a Late Loss ADL Worksheet noted that between June 22nd and June 30th, Ms. Paolini received assistance for only two meals.⁴² Defendants were completely disregarding physician's orders to assist Ms. Paolini with eating.⁴³

If Ms. Paolini did not eat a meal, Defendants were supposed to offer her a substitution.⁴⁴ This was not documented anywhere in the medical records as having ever been provided to Ms. Paolini.⁴⁵ Further lack of documentation pertaining to implemented nutritional interventions included: staff training for observing and reporting signs of dehydration and malnutrition, supervision by the nurses of the CNAs to assure they were following the prescribed diet plans, and physician notification of poor appetite.⁴⁶

It is clear that the Defendants did not provide adequate training to its staff to ensure the proper care would be provided for Ms. Paolini's needs.⁴⁷ The Defendants failed to even realize that Ms. Paolini's condition necessitated hospital admission, and it was not until Ms. Paolini's daughter, Linda Callan, demanded that her mother be sent to the hospital on July 7, 2007, that she was transferred there.⁴⁸ Under these conditions, it is not surprising that a wound on Ms. Paolini's sacrum grew to “a serious stage IV infected [pressure ulcer](#), that caused her severe pain, sepsis, [acute renal failure](#), myocardial damage and death.”⁴⁹ Tragically, Ms. Paolini's treating physician at the hospital “was convinced there was no chance for a meaningful recovery,” and she was placed on hospice and died four days later.⁵⁰

Defendants' neglect caused this unfortunate chain of events, as corroborated by Ms. Paolini's family members, Defendants' staff at the nursing home, and the available medical records.⁵¹ Chronic understaffing at the facility prevented the staff from adequately caring for the residents, such as Ms. Paolini.⁵² Defendants had actual and constructive knowledge that they did not have enough qualified staff to provide Ms. Paolini with needed care in a safe environment, but they made no attempt to correct this problem. Consequently, Ms. Paolini was not provided with the care and treatment that she needed, and as a result, she suffered immensely and died.

B. Supporting Evidence and Testimony

1. Former Employees

a. Testimony by Jenine McClosky, LPN⁵³

Jenine McClosky was a LPN at the facility during Ms. Paolini's residency who worked on Ms. Paolini's floor.⁵⁴ As a nurse, looking at Ms. Paolini's medical record, if there were blanks in Ms. Paolini's chart she would assume the care was not provided at those times.⁵⁵ Ms. McClosky testified that it was Defendants' policy and procedure that there should not be blanks in a resident's chart and **if it is not documented it is not done**. Moreover, she testified that Defendants needed to not only have sufficient staff to meet the needs of the residents but also to document appropriately.⁵⁶ Also, CNAs were documenting in residents' charts that they were providing care when they actually were not. This caused Ms. McClosky to **question the accuracy of residents' charts**.⁵⁷

CNAs, LPNs and RNs would complain that there was not sufficient staff to complete their job duties, which would include turning and repositioning.⁵⁸ Defendants were aware of these complaints.⁵⁹ She herself felt there was enough staff to complete her job duties and complained to her supervisor, the Assistant Director of Nursing.⁶⁰

Defendants' understaffing of the facility caused staff to be unable to answer call bells in a timely manner, and unable to feed residents. They made these complaints known to their supervisors.⁶¹ Defendants only staffed the building based on the census not the acuity of the residents. This is a problem because residents with higher acuity require more care, especially residents with **dementia**.⁶² In her experience failure to turn and reposition a resident every two hours could increase a resident like Ms. Paolini's risk of harm.⁶³ Ms. McClosky testified that **if Defendants are not turning and repositioning a resident like Ms. Paolini than that constitutes neglect**.⁶⁴

However, Defendants would **increase staffing while the DOH was in the building** conducting surveys. They paged a fictitious "Dr. Green" to alert everyone in the building to the presence of the surveyors. When the DOH left, staffing would return to its sub-standard pre-survey levels.⁶⁵ Ms. McClosky testified that this is wrong because **"it doesn't present a truthful picture as to what goes on when they are not there."**⁶⁶

It was Ms. McClosky understanding that the insufficient staffing and all of its accordant problems affected all of the residents on Ms. Paolini's floor. "I can say that safely it would have been a domino effect with all residents."⁶⁷ Defendants' policy of not providing enough staff to adequately care for the residents made Ms. McClosky's difficult job almost impossible.⁶⁸

b. Testimony by Jacqueline Ficklin, Activities Assistant⁶⁹

Jacqueline Ficklin was the Activities Assistant during Ms. Paolin's residency.⁷⁰ Ms. Ficklin testified that often call lights would go unanswered for long periods of time, up to forty five minutes.⁷¹ Instead of responding to the needs of the residents, the Defendants' staff would instead go turn off the lights, so the beeping would stop, and then leave without attending to the resident.⁷² When Ms. Ficklin saw unanswered call lights, she felt it was her responsibility to respond to the call lights since Defendants' nursing staff was not.⁷³ Ms. Ficklin testified that call lights went unanswered due to understaffing.⁷⁴ CNA's, LPNs, and RNs complained about being short staffed.⁷⁵ One CNA was actually fired by Defendants for letting a resident know about the understaffing at the facility.⁷⁶ Additionally, when Defendants did not have enough staff, maintenance workers were asked to provide care to the residents.⁷⁷ Defendants would increase staffing when the DOH was in the building for a survey so as to deceive the surveyors.⁷⁸

Ms. Ficklin often observed numerous instances of resident neglect. In addition to short staffing, the staff that was on duty would neglect the residents.⁷⁹ They would be sleeping on the job and putting the residents to bed by 6:30 pm just so they did not

have to deal with them, and they could instead go watch television.⁸⁰ She also noticed that residents with [pressure ulcers](#) had outdated bandages, **the wounds “oozing through the bandage.”**⁸¹

There were residents in the morning whose soiled diapers had not been changed from the night before, and dependent residents who were not being fed their breakfast, and it was just sitting there cold.⁸² Defendants' often neglected residents who could not speak; as evidenced by nonverbal residents more frequently being found in soiled clothing than those that were verbal and capable of complaining.⁸³ Family members of residents would complain often about their relative sitting in soiled diapers and call bells not being answered.⁸⁴ Ms. Ficklin told her supervisor of these complaints.⁸⁵ Her supervisor **would report the complaints to the administrator.**⁸⁶ Ms. Ficklin even brought the resident complaints to the attention of the DOH in 2009 during their annual survey, the same year she was terminated.⁸⁷ Ms. Ficklin further testified that Gretchen Mangone and Carmella Kennedy seemed disinterested in the needs of the residents.⁸⁸

c. Testimony by Annette S. Opoku, CNA⁸⁹

Annette S. Opoku was a CNA during Ms. Paolini's residency.⁹⁰ Ms. Opoku testified that the Defendants' facility was short staffed in 2007, during Ms. Paolini's residency.⁹¹ There were only three CNAs on her floor, and if one called out, the two CNAs would each have to take care of thirty residents.⁹² **The CNAs complained all the time about short staffing.**⁹³ The CNAs would complain to the administrator at monthly staff meetings.⁹⁴ When Ms. Opoku would complain, the response she received from the administrator was that they were over budget.⁹⁵ Ms. Opoku testified that when the DOH was in the building, however, the Defendants would put more staff on.⁹⁶ Ms. Opoku testified to the importance of having sufficient staff to care for residents' needs, like answering call bells in a timely fashion in order to prevent them from suffering harm or injury.⁹⁷

2. Testimony of Family Members

a. Linda Ann Callan, Plaintiff⁹⁸

Ms. Paolini's daughter visited her mother every day during her residency at the Defendants' facility.⁹⁹ Defendants' took an outrageously long time to respond to her mother's call bells.¹⁰⁰ The night before Ms. Paolini was transferred to the Emergency Room, Ms. Paolini defecated and the family rang the call bell, and fifty minutes went by before her grandson had to physically go fetch a nurse to come to the room and change his grandmother.¹⁰¹

When the nurse finally came in to change Ms. Paolini, this was when Ms. Callan saw the [pressure ulcers](#) on her mother.¹⁰² Her daughter was horrified by what she saw that night:

A: First thing they did was take my mother's socks off. She had blisters this big, bleeding and oozing on each one of her feet. And my daughter said oh my God; what did they do to my grandmother. That was the beginning. So they got to the diaper. On the left cheek, big black sore. I don't know what possessed my daughter, because I was like beside myself at that point. I was hysterical. My mother had lost weight, and, you know, they get flabby. And my daughter said move that flab a minute. **My mother had a hole bigger than a man' fist, and all the feces were going in this hole, and we were hysterical.** My son came running in the room. We were hysterical. My son put his hand on her head, and he said don't worry mommom, because she was hysterical crying at that point, and he said it's okay mommom; we are going to get you the hell out of here. She said, Joe, you promise me. He said, yea, we are going to get you out of here, mommo....¹⁰³

Ms. Callan told the facility to transfer her mother to the Emergency Room, and after much argument with the Defendants' nursing staff, the Defendants finally succumbed to Ms. Callan's demands.¹⁰⁴ Upon Ms. Paolini's admission to the ER the renal physician in the ER said **"this is the worst I have ever seen. Goddamn pure neglect."**¹⁰⁵

b. John Paolini¹⁰⁶

Ms. Paolini's son, John Paolini visited her every day from June 22, 2007, through July 4, 2007.¹⁰⁷ Half of those days, he visited her twice in one day, usually during meal time.¹⁰⁸ When asked why he went during meals, he answered:

A: Because I was concerned that she wasn't eating and they at ManorCare, they were making no attempt, to help her eat. **If they brought the tray and she didn't touch it, they took the tray.** Ninety-nine percent of the time they wouldn't offer her anything as a substitute for it. There was one occasion when one of the techs who had taken the tray asked her if she wanted a sandwich or something different, but that was the only occasion.¹⁰⁹

The staff also failed to respond to call lights in a reasonable time frame.¹¹⁰ On several occasions it would take the **staff up to 35 minutes** to respond to a call light when his mother needed to be changed after having gone to the bathroom in her adult diapers.¹¹¹

c. Barbara Anne Redheffer¹¹²

Ms. Paolin's granddaughter, Barbara Anne Redheffer, visited. her on July 8th, 2007, the day after she was admitted to the Emergency Room.¹¹³ She took several photographs of her grandmother's sacral wound that day.¹¹⁴ With her nursing background, she could tell it was a Stage IV wound, and that you could see the bone and **"pretty much put your hand in there."**¹¹⁵

3. Notice and Control of Corporate Defendants

a. Testimony by Cynthia Davis Jackson, DCD¹¹⁶

Cynthia Davis Jackson was the Director of Care Delivery ("DCD") during Ms. Paolini's residency. Ms. Jackson had provided care to Ms. Paolini and recalled her daughter, Linda Callan.¹¹⁷ She testified that it is a RN's duty to notify a resident's physician and family about a significant change in condition.¹¹⁸ Nurses and CNAs were expected to follow physician's orders.¹¹⁹ Documenting of care was expected to be done and was important to notify other nursing staff and doctors as to what care has been provided to the resident.¹²⁰

Residents' family members complained about excessive wait times for nurses to respond to call lights.¹²¹ Ms. Jackson testified that nurses should respond in less than 5 minutes to call lights, and that twenty minutes would be too long.¹²² She further testified that **leaving a resident with a pressure ulcer to lie in their feces for 40 minutes would be neglect**, and could even rise to the level of **abuse**.¹²³

Turning and repositioning should be implemented by the nursing staff upon patient's admission to the facility, not by the patient's physician.¹²⁴ A resident should be turned and repositioned every two hours to prevent pressure wounds.¹²⁵ **Turning and repositioning, adequate nutrition and hydration, and timely changing of adult diapers are all essential to pressure**

ulcer prevention.¹²⁶ If an ulcer develops on a resident at the facility, the resident's physician and family are to be notified.¹²⁷ They are also to be notified if the wound worsens or progresses into different stages.¹²⁸ Ms. Jackson testified that she would not be able to determine whether or not family or the physician was notified if it was not documented in the resident's chart.¹²⁹

b. Testimony by Scott Miller, RDO¹³⁰

Scott Miller was Defendants' Regional Director of Operations during Ms. Paolin's residency. Mr. Miller was aware that the facility was supposed to have sufficient staff to provide care to its residents, to ensure its staff was sufficiently trained to take care of the different types of resident needs, and have enough staff to turn and reposition all of those residents who required those services.¹³¹ He testified that **turning and repositioning was an important aspect of care for people at risk for the development of pressure ulcers.**¹³²

The lack of corporate concern was outrageous. When asked about tracking repeat deficiencies, Mr. Miller testified that his concern is about the present, and he is not concerned with whether the facility has been experiencing repeat deficiencies.¹³³ He was likewise not concerned with the neglect at the heart of past lawsuits, and failed to see how a lawsuit could bring to light certain areas of concern that might be ongoing in the facility.¹³⁴ Mr. Miller further denied that Defendants' staff leaving Ms. Paolini to "languish in feces for hours at a time and was not being turned and repositioned as often as required" had anything to do with chronic understaffing.¹³⁵

In an attempt by Defendants to insulate themselves from corporate liability, Defendants told its corporate employees to say that they were employed by Heartland Employment Services instead of by Defendants.¹³⁶ This came as a shock to Mr. Miller, who testified he has apparently been a member of Heartland Employment Services since 2005, but only learned of this a few weeks prior to his deposition when he was told by Defendants' legal department.¹³⁷

c. Testimony by Joanna Stuck, Director of Clinical Services Eastern Division¹³⁸

Joanna Stuck, Director of Clinical Services Eastern Division ("DCS"), was the Quality Regulatory Consultant ("QRC") at the facility during Ms. Paolin's residency and testified that her position required her to assist facilities with plans of correction, quality assurance, and ensuring regulatory compliance.¹³⁹ QRCs deal with facility issues, give recommendations regarding staffing, ensure facility compliance with federal and state regulations that govern long-term care, report staffing deficiencies and noncompliance with other guidelines, assist the building through the annual survey process, attend wound rounds and review treatment records, deal with issues in Quality Assessment and Assurance reports—such as an issue with **pressure ulcers** or short-term stay residents, conduct the Survey tools and review tools process, and oversee the implementation of plans of correction with regard to deficiencies.¹⁴⁰

DCS, CSC, and QRC are employees of Defendants.¹⁴¹ Ms. Stuck testified in her current position as DCS, she is the manager of the clinical services department, overseeing clinical services and quality regulatory consultants.¹⁴² The DCS's direct supervisor is the Assistant Vice President.¹⁴³ Ms. Stuck testified that her duties as a DCS are the same as the DCS in 2007.¹⁴⁴ She further testified the DCS's duties include reviewing the buildings deficiencies and plans of correction.¹⁴⁵ Part of this involved weekly conference calls with the CSC and QRC to **discuss resident care issues at the facility, including resident, family, and/or staff complaints.**¹⁴⁶

Ms. Stuck testified that the RDO has full responsibility over the nursing homes he oversees, including not only the business aspect of the facilities, but clinical as well.¹⁴⁷ In fact, the RDO would review proposed plans of correction before submitting them to the Department of Health (“DOH”).¹⁴⁸ Additionally, it is the Defendants, who **control budgeting, and therefore, staffing at the facility.**¹⁴⁹ The DCS would become aware of understaffing through communication by the CSC or QRC, or citations by the DOH for failure to provide sufficient staff.¹⁵⁰ The QRCs also reported to the RDO.¹⁵¹ The RDO would report deficiencies, of any type, to the Vice President of the Eastern Division.¹⁵²

Quality measures, performance measures, and incident accident reports were also monitored through building visits, meetings and computer-based systems.¹⁵³ Computer-based systems would track issues such as **pressure ulcers**, falls, and **urinary tract infections.**¹⁵⁴ Verbal exit reports after building visits by QRCs were reported to the RDO and administrator.¹⁵⁵ These reports included any negative findings, alerting these individuals to issues with resident care at the facility.¹⁵⁶

It is concerning that someone in a supervisory position, like a DCS, would exhibit such indifference to noncompliance with Defendants' own facility guidelines. Despite acknowledging that Defendants' had guidelines in place specifying that blanks should not be left in a resident's medical records, and that both nurses and physicians rely on the documentation in a resident's chart, Ms. Stuck testified that she would just assume that care had been given to a resident where a blank was left in the medical record.¹⁵⁷ This even though she acknowledged that she was not in the building during the Ms. Paolini's residency and would be unable to verify whether care was in fact provided.¹⁵⁸ Ms. Stuck testified:

Q: Now, would you agree with me that proper documentation in a resident' medical record is vital to preventing harm to that resident?

A: Not necessarily.

Q: Can I have your explanation of why not necessarily?

A: **Well, we're not sure if the task was completed or not...**¹⁵⁹

d. Testimony by Gretchen Mangone, Administrator¹⁶⁰

Gretchen Mangone was the Administrator at the facility during Ms. Paolini's residency. She testified that her duties included overseeing compliance with regulations, ensuring that quality care was provided to residents, and that she was the person ultimately responsible for operation of the facility.¹⁶¹

Ms. Mangone testified that hours of care per patient per day was considered into the proposed budget that was **ultimately approved by the Board of Directors for ManorCare.**¹⁶² She also testified that the nursing labor, particularly the Certified Nursing Aides, was the biggest part of the budget; approximately 65 to 75 percent of the budget.¹⁶³ Ms. Mangone was asked more specifically about staffing issues and testified that short staffing could affect staff morale, potentially increase the risk of harm to residents, and could contribute to staff turnover, which was an issue.¹⁶⁴ Ms. Mangone testified that **she received complaints about understaffing from residents and residents' families and staff themselves.**¹⁶⁵ Despite this knowledge, she clung to her opinion that the building was “extremely well staffed.”¹⁶⁶

e. Testimony by Carmella Kennedy, Director of Nursing¹⁶⁷

Carmella Kennedy was Director of Nursing during Ms. Paolini's residency. She testified that as Director of Nursing, her duties included ensuring the staff followed state and federal regulations, and provided resident with appropriate care.¹⁶⁸ Ms. Kennedy testified that the clinical services consultants would visit once every week, or every two weeks, and that both the CSC and Scott Miller were notified when the DOH came in to conduct a survey.¹⁶⁹ Further, she testified that **survey results were reviewed and discussed at monthly meetings**, which were attended by the CSC and ran by Scott Miller.¹⁷⁰

f. Testimony by Kathleen Douds, CSC¹⁷¹

Kathleen Douds was the CSC during Ms. Paolini's residency. Ms. Douds **visited the facility weekly and monitored and reported any trends in the facility**.¹⁷² She also assisted with instituting plans of correction after a DOH survey was completed, and she monitored the facility for continued compliance.¹⁷³ When the DOH was surveying the building, Ms. Douds would be at that building, and she testified as to the usual facility practice of "fixing" documentation before they turned it over to the DOH:

Q: What was your role in regard to the survey process other than the plans of correction, which we've discussed?

A: I would do rounds in the facility. When **the department of health**, usually if there's a third day they'll **start asking for a lot of documentation, I would** help get that documentation ready, **look at it prior to**, you usually have maybe five minutes to look at it before you hand it over. **And if there was anything that was found, we would fix it immediately that day and we would stay until it was done.**

Q: What do you mean by if there was something that was found that you would fix it immediately?

A: If there was an issue, for instance, let's say somebody had long fingernails, we would cut the person's nails and make sure there's not other patients who have long fingernails that need to be cut.¹⁷⁴

Ms. Douds testified that the facility should be following the stricter of the federal and state long-term care regulations, and that following the stricter of the regulations may lead to a better quality of care that's afforded to the residents.¹⁷⁵ She also testified that she has run into situations at Manor Care where the **state minimum staffing standard was not sufficient to meet the needs of residents**.¹⁷⁶ She further testified that she was now aware that **there was a point during Ms. Paolini's residency when the facility was understaffed**.¹⁷⁷

The facility tracked quality indicators such as the number of patients who were fractured, incontinent, had decreased ADL's, and had **pressure ulcers**.¹⁷⁸ Ms. Douds would review these quality indicator reports and these reports were also reviewed by the DOH.¹⁷⁹ Ms. Douds would investigate allegations that a resident was not being fed or was left in urine or feces for extended periods of time.¹⁸⁰ She testified that **if a resident is left to sit in urine or feces, especially a resident with pressure ulcers, the acid would begin to break down their skin**.¹⁸¹ Additionally, if a resident with **pressure ulcers** was not being fed, it would deplete the resident's protein stores, which are essential building blocks of the body and help the body heal.¹⁸²

Ms. Douds testified that care should not be age-dependent, and that someone who is ninety-four years old, like Ms. Paolini was, is entitled to receive the same level of care as someone who is seventy.¹⁸³ Ms. Douds testified that turning and repositioning can prevent **pressure ulcers**.¹⁸⁴ Ms. Douds testified that the **failure to turn and reposition a patient would constitute resident neglect**.¹⁸⁵

g. Testimony by Ruth Thomas, Vice-President of Operations for Mercy Fitzgerald Hospital¹⁸⁶

Ruth Thomas, was the Vice-President of Operations for Mercy Fitzgerald Hospital and sat on the partnership board of Mercy/Manor Partnership during Ms. Paolin's residency.¹⁸⁷ The partnership board met on an annual basis to review and approve the budget prepared by the facility.¹⁸⁸ ManorCare employees were members of this partnership board and attended these meetings.¹⁸⁹

V. LEGAL STANDARDS

A. Summary Judgment

"Pennsylvania law provides that summary judgment may be granted only in those cases in which the record clearly shows that no genuine issues of material fact exist and that the moving party is entitled to judgment as a matter of law." *Reliance Ins. Co. v. IRPC, Inc.*, 904 A.2d 912, 914 (Pa. Super. 2006). "The moving party has the burden of proving that no genuine issues of material fact exist." *Id.* "In determining whether to grant summary judgment, the trial court must view the record in the light most favorable to the non-moving party and must resolve all doubts as to the existence of a genuine issue of material fact against the moving party." *Id.* at 914-15. "Thus, summary judgment is proper only when the uncontroverted allegations in the pleadings, depositions, answers to interrogatories, admissions of record, and submitted affidavits demonstrate that no genuine issue of material fact exists, and that the moving party is entitled to judgment as a matter of law." *Id.* at 915. "In sum, only when the facts are so clear that reasonable minds cannot differ, may a trial court properly enter summary judgment." *Id.*

B. Punitive Damages

"Punitive damages are awarded for outrageous conduct; that is, for acts done with a bad motive or with a reckless indifference to the interest of others." 1 Summary Of Pennsylvania Jurisprudence 2d, Torts ("Summ. Pa. Juris. 2d, Tors"), § 9:93, at 399 (2005).¹⁹⁰ For example, punitive damages may be awarded if the actor's conduct was wanton, willful, or exhibited a reckless indifference to the rights of others. I at 399-400. Wanton misconduct, which is sometimes referred to as reckless indifference to the interests of others, means that the actor has "intentionally done an act of an unreasonable character, in disregard of a risk known to him or her or so obvious that he or she must be taken to have been aware of it and so great as to make it highly probable that harm will follow." *Id.* at 401. Wanton negligence, as distinguished from ordinary negligence, "is characterized by a realization on the part of the tortfeasor of the probability of injury to another, and a reckless disregard of the consequences." 1 P.L.E. NEGLIGENCE, §8 *see also* *Rossino v. Kovacs* 553 Pa. 168, 172, 718 A.2d 755, 756 (Pa. 1998); *Ogutu v. Lehigh Valley Apts.* 2006 U.S. Dist. LEXIS 7251, at *9 (E.D. Pa. Feb. 27, 2006).¹⁹¹ Our Superior Court has firmly established that punitive damages are appropriate in a nursing home **abuse** and neglect case, where "the facility was chronically understaffed and complaints from staff continually went unheeded." *Scampone v. Grane Healthcare Co.* 11 A.3d 967 (Pa. Super. 2010), *reargument denied* A.3d (Sept. 24, 2010).

Here, there is an abundance of evidence that the corporate decision-makers and facility management were aware of understaffing at the facility, yet no corrective action was taken.

C. Negligence per se

"The concept of negligence per se establishes both duty and the required breach of duty where an individual violates an applicable statute, ordinance or regulation designed to prevent a public harm." *Lux v. Gerald E. Ort Trucking, Inc.*, 887 A.2d 1281, 1288, 2005 PA Super 400 (quoting *Cabiroy v. Scipione*, 767 A.2d 1078, 1079 (Pa. Super. 2001)). To establish a claim based on negligence per se, the plaintiff must show: (1) that the purpose of the statute is at least in part, to protect the interest

of a group of individuals, as opposed to the public generally; (2) that the statute clearly applies to the conduct of the defendant; (3) that the defendant violated the statute; and (4) that the violation was the proximate cause of the plaintiffs injuries. *Wagner v. Anzon, Inc.*, 684 A.2d 570, 574 (Pa. Super. 1996).

The purpose of the statute must be: (1) to protect a class of persons which includes Plaintiff; (2) to protect the particular interest which is invaded; (3) to protect that interest against the kind of harm which has resulted; and, (4) to protect that interest against the particular hazard from which the harm results. *Congini by Congini v. Portersville Valve Co.*, 504 Pa. 157, 470 A.2d 515, 517-18 (1983); see also *Restatement (Second) of Torts* § 286 (1965).

D. Joint Venture Liability

A joint venture is an association of persons or corporations who by contract, express, or implied, agree to engage in a common business enterprise for their mutual profit. *Duquesne Light Co. v. Woodland Hills School Dist.*, 700 A.2d 1038 (Pa. Cmwlth. 1997); *McRoberts v. Phelps*, 391 Pa. 591, 600, 138 A.2d 439, 444 (1958). Individual parties to a joint venture are liable for injuries or harms committed in conducting the business of the joint venture. See *Newlin Corp. v. Department of Natural Resources*, 134 Pa. Commw. 396, 579 A.2d 996 (1990) (law of joint ventures imposed liability on both parties to a joint venture for violations of the Clean Streams Law). Each member of a joint venture is the agent or servant of the other members, and “the act of anyone within the scope of the enterprise is to be charged vicariously against the rest.” See *Continental Aircraft Sales v. McDermott Bros. Co.*, 316 F. Supp. 232 (M.D. Pa. 1970) (quoting *Restatement (Second) of Torts* § 491b (1965)) (emphasis added); See also *Roschmann v. Sanborn*, 363 Pa. 188, 192, 172 A.2d 657, 658 (1934) (“if two or more persons unite in the joint prosecution of a common purpose under such circumstances that each has authority, express or implied, to act for all in respect to the control of the means or agencies employed to execute such common purpose, the negligence of one in the management thereof will be imputed to all the others”).

The members of a joint venture are jointly and severally liable to a third party plaintiff for the tortious acts of an employee of the venture. *Sleasman v. Brooks*, 32 Pa. D. & C.3d 187 (C.P. Somerset 1984). See *Friedman v. Wilson Freight Forwarding Co.*, 181 F. Supp. 327 (W.D. Pa. 1960) (holding that freight company sued for personal injuries resulting from the negligence of one of its agents is entitled to indemnity from joint venturer provided freight company could prove driver negligently operated the truck in the prosecution of the business of the joint venture). In order to impute negligence from one joint venturer to the other, a joint venture must first be established. *Beavers v. West Penn Power Co.*, 436 F.2d 869, 872 (3d Cir. Pa. 1971).

VI. LEGAL ARGUMENT

A. There is a Valid Claim for Punitive Damages

This Commonwealth's Superior Court has found that punitive damages are appropriate in nursing home abuse and neglect cases where the facts so warrant. See Scampone, supra, (finding Defendants' practice of understaffing and “deliberately altering records” sufficient to submit question of punitive damages to jury).¹⁹² Punitive damages may be awarded in cases of negligence if the evidence is sufficient to establish that (1) a defendant had a subjective appreciation of the risk of harm to which the plaintiff was exposed, and that (2) he acted, or failed to act, in conscious disregard of that risk. *Hutchinson v. Luddy*, 582 Pa. 114, 124-25, 870 A.2d 766, 772 (2005).¹⁹³ Juries may assess punitive damages where a defendant deliberately acts (or fails to act) with conscious disregard for or indifference to facts that he knows, or has reason to know, create a high risk of physical harm to another. *Continental Grain Co. v. SHV Coal, Inc.*, 526 Pa. 489, 587 A.2d 702, 704-05 (1991) (discussing *Restatement (Second) of Torts* § 908(2), Comment A, as adopted by *Feld v. Merriam*, 506 Pa. 383, 485 A.2d 742 (1984)).

“Regardless of the phase of the case (demurrer, summary judgment, compulsory nonsuit, or JNOV), the trial court's standard [for evaluating such motions] is substantially the same;” namely, the court must accept “the plaintiff's evidence and reasonable inferences therefrom as true....” *Schindler v. Sofamor, Inc.*, 774 A.2d 765, 775 n.11 (Pa. Super.), appeal denied, 567 Pa. 727,

786 A.2d 989 (2001). Accordingly, to defeat such a motion, Plaintiff must only present evidence or testimony establishing the facts essential to the cause of action which the motion cites as not having been produced; *i.e.*, facts that evince Defendants' reckless indifference to Ms. Paolini's rights. As detailed above, the record is **replete** with such facts. *See* Section IV, *supra*.

Defendants argue that their agents and employees did not have the required knowledge and intent to justify the imposition of punitive damages. However, Plaintiff "need **not** produce any direct evidence of the [Defendants'] intent, but may rebut [Defendants'] motion... with **circumstantial evidence** from which a reasonable **jury could infer the [required] intent...**" *Susquehanna Bancshares, Inc. v. National Union Fire Ins. Co.*, 442 Pa. Super. 281, 297, 659 A.2d 991, 999 (1995) (emphasis and underlining added). *See e.g., McCann v. Unemployment Comp. Bd.*, 562 Pa. 393, 400, 756 A.2d 1, 5 (2000) ("Although Employer offered no direct evidence of McCann's intent, such direct proof of an actor's state of mind, often being impossible to obtain, is frequently inferred from the circumstances surrounding the actor's conduct."); *Commonwealth v. Sanders*, 426 Pa. Super. 362, 372, 627 A.2d 183, 188 (1993) (Although the defendant testified that he did not have the requisite intent, "it was solely for the jury to determine the credibility of the testimony."). Moreover, if the risk of harm from understaffing and underfunding a nursing home was "**easily perceptible**" to Defendants, then knowledge and intent may be inferred by the jury. *Zazzera v. Roche*, 54 Pa. D.&4th 225, 236 (C.P. Lacka. 2001) (emphasis added).

This point was illustrated in *Gregory v. Sewell & K.A.M. Trucking, Inc.*, 2006 WL 2707405, at *10 (M.D. Pa. Sept. 19, 2006), a trucking accident case. There, the plaintiffs claimed that the defendant truck driver (Sewell) was driving too fast (50 to 65 mph) for the condition of the interstate highway. *Id.*, 2006 WL 2707405, at *7-*8. The parties disputed whether the highway was icy at the time of the accident, and whether there were sufficient indicia of dangerous road conditions that should have alerted Sewell to the alleged danger. *Id.* at *13. The defendant truck driver claimed that he did not appreciate the risk of harm, and moved to dismiss the claim for punitive damages, but his motion was denied. In reasoning equally applicable here, the court explained:

It is **not** the court's task here to weigh the conflicting evidence... **It would not be unreasonable for a jury to find that defendant Sewell, with his experience and training, consciously appreciated the risk of harm from** driving fifty or sixty to sixty-five miles per hour on a freezing night that had seen snow fall and perhaps melt and freeze and consciously disregarded or was indifferent to that risk. The court recognizes that the plaintiffs' burden in proving punitive damages is high--higher than their burden in proving ordinary negligence. But if a jury were to credit the plaintiffs' arguments and evidence..., it could support a finding of fact that defendant Sewell's conduct was outrageous, satisfying the higher burden necessary to allow the plaintiffs to receive punitive damages.

Id. (emphasis added).

Applying this rationale to those who operate nursing homes, the Superior Court has found "reckless disregard" exists to justify punitive damages where a nursing facility and its corporate operators ignored and/or hid known staffing problems that resulted in harm to a resident. *Scampone*, at ¶75. The court noted that:

The record was replete with evidence that the facility was chronically **understaffed** and complaints from staff continually went unheeded. Grane and Highland employees not only were **aware of the understaffing** that was leading to improper patient care, they deliberately altered records to hide that substandard care by altering ADLs that actually established certain care was not rendered. Records concerning the administration of medications were **falsified**. Staffing levels were increased during state inspections and then reduced after the inspection was concluded.

Id. (emphasis added). Moreover, the court stated that "[d]eliberately altering patient records to show care was rendered that was actually not is outrageous and warrants submission of the question of punitive damages to the jury." *Id.* (emphasis added). Accordingly, the court reversed the trial judge's refusal to submit the issue of punitive damages to the jury and explicitly rejected

the defendants' argument that the above evidence did not satisfy Pennsylvania's standard for punitive damages under established case law and/or the MCARE Act. *Id.* at ¶76.

Finally, the Scampone court rejected the defendants' assertion that they were not subject to punitive damages because their conduct was unrelated to the decedent's injuries. *Id.* at ¶ 77. Rather, the court held that “[t]he evidence [of understaffing and insufficient care] in question related to all residents of Highland [the nursing facility]; [the decedent] was clearly a resident of Highland during the time covered by these witnesses. In addition, as analyzed above, the effects of understaffing was specifically connected to [the decedent's] care.” *Id.* Accordingly, the Superior Court reversed the trial court's refusal to submit the question of punitive damages to the jury. *Id.*

Similarly, it would not be unreasonable for a jury to find that Defendants, who own and operate a nursing home, consciously appreciated the risks that come with understaffing and failing to correct known problems with patient care (or the lack thereof) at the facility. Likewise, it would not be unreasonable for a jury to find that Defendants' staff members knew that Ms. Paolini depended on them to take seriously and respond appropriately to **many** incidents of neglect. Here, there are many incidents of conduct from which the required knowledge and intent may be inferred.

Time and time again, the corporate decision-makers and management were put on notice (by the Pennsylvania DOH, employees, and family members) that their facility was chronically ill equipped to provide basic care, and did little (if anything) to correct the problem. If a jury were to credit Plaintiffs arguments and evidence, such could **easily** support a finding of fact that Defendants' conduct was reckless, thus satisfying the higher burden necessary to allow Plaintiff to recover punitive damages.

The evidence and testimony in this case, when viewed in a light most favorable to Plaintiff (as it must be), establishes much more than simple and/or gross negligence. Defendants' employees/agents did not simply “forget” to provide Ms. Paolini with the care required to avoid the injuries she suffered. Defendants knew that their staff and practices were inadequate to meet Ms. Paolini' needs which, in turn, increased her risk of harm. Instead of correcting these problems, Defendants knowingly permitted these conditions to continue, causing Ms. Paolini additional, preventable, and ultimately, terminal injuries. ¹⁹⁴

As demonstrated above, there is ample authority in Pennsylvania to support the imposition of punitive damages in cases like the one at bar. Clearly, Plaintiff has made out *prima facie* case for punitive damages.

B. There is a Valid Claim for Negligence per se Under the Neglect of Care-Dependent Person Statute.

Defendants argue that Plaintiff cannot support a claim for negligence *per se* under 18 Pa. C.S. §2713 (hereinafter “§ 2713” because it is a criminal statute enforceable only by the Attorney General, and because Plaintiff has not demonstrated that Defendants violated the statute. Not only do Defendants mischaracterize Plaintiff's claims in this matter, as Plaintiff is **not** attempting to bring a private cause of action under a criminal statute, but the above-referenced testimony demonstrates that Plaintiff *does* in fact have a basis to bring a negligence *per se* claim. As outlined below, there are numerous reasons why Defendants' claims fail, and, therefore, Defendants' Motion for Partial Summary Judgment should subsequently be denied.

1. Under Pennsylvania law, Plaintiff is entitled to bring a negligence per se claim for violation of a criminal statute

A claim based upon negligence *per se* is not the same as a private cause of action. Contrary to Defendants' assertions, Plaintiff is not asserting a private statutory cause of action under the criminal statute 18 Pa. C.S.A. § 2713. Rather, Plaintiff alleges that Defendants breached the standard of care as proscribed in § 2713, which conveys an actionable tort duty, and therefore Defendants should be held liable for negligence *per se*. The doctrine of *per se* liability does not create an independent basis of tort liability but rather establishes, by reference to a statutory scheme, the standard of care appropriate to the underlying tort. *Cabiroy v. Scipione*, 767 A.2d 1078, 1082 (Pa. Super. 2001). Here, § 2713 establishes the requisite standard of care for the treatment of care-dependent individuals.

Contrary to Defendants' assertions, the absence of a statutory right to a private cause of action does not preclude a claim of negligence per se for violation of the statute. In a similar nursing home **abuse** and neglect case against some of these same Defendants, the Court held that a statute which does not provide a private right of action **can still be utilized to establish negligence per se**. *McCain v. Beverly Health and Rehabilitation Services*, 2002 WL 1565526 (E.D. Pa. 2002). Importantly, the Court noted that:

Courts in Pennsylvania have recognized that the "absence of a private cause of action in a statutory scheme is an indicator that the statute did not contemplate enforcement of an individual harm." However, it is just an indicator or a factor to consider and **"does not necessarily preclude [the statute's] use as the basis of a claim of negligence per se."** ¹⁹⁵

If a plaintiff can prove the defendant's negligence was the proximate cause of the injury in question, then the violation of the applicable statute is negligence per se and liability may be grounded on such negligence. *Cabiroy*, at 1079. A similar situation exists in the present matter. Although § 2713 does not provide a private cause of action, Defendants' conduct, as discussed in Part B.4 *infra*, breached the standard of care required by the statute, which makes Defendants liable for negligence *per se*.

Since Plaintiff is not bringing a private cause of action under § 2713, it is inconsequential that the **enforcement** of the **criminal aspect** of this statute lies with either the District Attorney of the county or the Attorney General of this Commonwealth. Plaintiff **does not seek to bring a criminal action** against Defendants under this statute. Plaintiff is therefore not required to plead facts which show that the Pennsylvania Attorney General's Office or the Delaware County District Attorney's Office filed charges against, or obtained a conviction of the Defendants, in order to hold Defendants liable for negligence per se. Defendants' argument regarding the same appears to be an attempt to mischaracterize Plaintiffs claims, and to confuse the Court as to the real issues in this case.

2. Pa.C.S.A. § 2713 is designed to protect the interests of care-dependent nursing home residents

As mentioned above, despite the absence of a private cause of action, violation of a criminal statute can constitute negligence per se if the plaintiff is within the class of persons the statute was intended to protect. *See Minnich v. Yost*, 817 A.2d 538 (Pa. Super. 2003); *Braxton v. Commonwealth Dep't of Transp.*, 634 A.2d 1150 (Pa. Cmwlth. 1993); *Commonwealth, Dep't of Welfare v. Hickey*, 582 A.2d 734 (Pa. Cmwlth. 1990).

Plaintiff must establish that the purpose of the statute is, **at least in part**, to protect the interest of a particular group of people, as opposed to the public generally. *Wagner v. Anzon*, 453 Pa. Super. 619, 627, 684 A.2d 570, 574 (1996). *See also Cabiroy v. Scipione*, 767 A.2d 1078 (Pa. Super. 2001) (holding that "although no private cause of action [was] set forth in the [Food, Drug and Cosmetic Act], it was certainly designed to protect a particular class of individuals") *Id.* at 1081. In the present matter, Pennsylvania's **elder** care criminal statute was established to protect a certain group of people - those who are care-dependent individuals residing in nursing homes, such as Ms. Paolini. The statute states that a caretaker is guilty of neglect of a care-dependent person if he:

Intentionally, knowingly or recklessly causes bodily injury or serious bodily injury by failing to provide treatment, care, goods or services necessary to preserve the health, safety or welfare of a care-dependent person for whom he is responsible to provide care.

¹⁹⁶ 18 Pa. C.S.A. §2713 (a)(1). This statute was not designed to merely protect the entire public at large - or even the entire **elderly** population, as many **elderly** people are completely self-sufficient. Rather, the statute specifically identifies that particularly vulnerable group of individuals who are unable to independently care for themselves, and therefore need the protection of the statute.

In a negligence action for injuries arising out of the implantation of a pedicle screw device in the plaintiff's spine, the Court concluded that "...despite the absence of a private right of action, the [Federal Food, Drug and Cosmetic Act] and [Medical Device Amendments] were enacted to protect the interest of a group of individuals. Indeed, they were enacted 'to provide for the safety and effectiveness of medical devices intended for human use. Thus, their purpose was, at least in part, to protect the interests of those individuals who require use or implantation of medical devices.'" *Sharp v. Artifex, Ltd.*, 110 F.Supp. 2d 388, 393 (W.D. Pa. 1999) (internal citations omitted). Likewise, the purpose of § 2713 is to protect the interests of those individuals who require the use of nursing home facilities and the assistance of the staff at those facilities for their day-to-day living. Ms. Paolini is one such individual, who was unable to independently care for herself, and therefore required the use of a facility such as Defendants' facility. Sadly, her family and she relied, to her own detriment, on Defendants' assurance that they could properly provide the services she required. Ms. Paolini clearly is a member of the group of people the statute was designed to protect, and therefore Plaintiff has satisfied the first requirement for a claim for negligence *per se*.

3. Plaintiff's claim for negligence *per se* furthers the policy of § 2713

Pennsylvania courts have held that "[a] statute may still be used as the basis for a negligence *per se* claim when it is clear that, **despite the absence of a private right of action, the policy of the statute will be furthered by such a claim** because its purpose is to protect a particular group of individuals." *McCain* at *1, citing *Fallowfield Development Corp. v. Strunk*, 1990 WL 52745, at *19 (E.D. Pa. 1990) (emphasis added). As the Third Circuit for the United States Court of Appeals noted, in the absence of a statutory private cause of action, it is up to the court to determine whether the policy of the statute will be furthered by allowing a claim for negligence *per se*:

Most formulations of the standards for implying a private cause of action center on the presence or absence of a legislative intent to impose civil liability. **In theory, at least, application of the negligence *per se* doctrine represents a judicial policy judgment independent of legislative intent with respect to the imposition of civil liability.** Both, however, address the question of whether the policy behind the legislative enactment will be appropriately served by using it to impose and measure civil damage liability.

Frederick L. v. Thomas, 578 F.2d 513, 517 n. 8 (C.A. Pa. 1978). In the present matter, the policy of § 2713 is to protect care-dependent individuals in a nursing home context. Sadly, Ms. Paolini was not afforded the full protection under § 2713 that she deserved. Defendants violated their duty under § 2713, as described in Part A.4 *infra*, by failing to provide adequate care to Ms. Paolini, which caused her to suffer severe pain, injury, and ultimately, death. Holding Defendants liable for their neglectful care of Ms. Paolini would properly further the policy of § 2713, so that future residents of Defendants' facility can be spared the same indignities and injuries suffered by Ms. Paolini.

4. Defendants' conduct was negligent under 18 Pa. C.S.A. § 2713

"In analyzing a claim based on negligence *per se*...the statute must clearly apply to the conduct of the defendant." *Frantz v. HCR Manor Care, Inc.*, 64 Pa. D.&C. 4th, 457, 462, citing *Braxton v. PennDot*, 160 Pa. Cmwlth. 32, 45, 634 A.2d 1150, 1157 (1993). As noted in Part A.2 *supra*, § 2713 holds that a caretaker is negligent for "intentionally, knowingly or recklessly" causing bodily injury to the care-dependent person for whom he is responsible to provide care. 18 Pa. C.S.A. § 2713 (a)(1). The above-referenced deposition testimony demonstrates Defendants' negligence in knowingly understaffing the facility, which created recklessly high nurse/resident ratios. Defendants knew that the personnel on duty would not be able to properly attend to the medical needs of the facility's residents.¹⁹⁷ Even worse, Defendants routinely increased the staffing levels during state surveys, and then reduced the staffing back to prior insufficient levels after the inspections were completed.¹⁹⁸ This conduct not only demonstrates Defendants' knowledge that the facility was understaffed, but their intent to deceive state inspection officials as to their staffing policies.

Neglect is defined by the Pennsylvania Health and Safety Code for Long-Term Care Nursing Facilities as the “deprivation **by a caretaker** of goods or services which are necessary to maintain physical or mental health.” 28 Pa. Code § 201.3(vi) (emphasis added). Due to complaints by the nurses, aides, residents and residents' family members, Defendants had knowledge of the many problems at the facility, including that call bells would go unanswered for **outrageous** periods of time, due to short-staffing maintenance staff were required to perform nursing duties, and there were instances where residents were forced to lie in their own urine and feces because there was not sufficient staff to attend to them.¹⁹⁹ Defendants' **intentional refusal** to act on their knowledge of the deplorable conditions at the facility constitutes an egregious violation of the standard of care.

5. Defendants' conduct was the proximate cause of Ms. Paolini's injuries and death

In the present matter, Defendants' neglect and breach of the standard of care under § 2713 clearly were the proximate cause of Ms. Paolini's injuries, as well as her eventual death. In deciding whether a plaintiff can bring a claim for negligence per se under a specific statute, the court must find “...a direct connection between the harm sought to be prevented by the statute and the injury.” *Wagner v. Anzon Inc.*, 453 Pa. Super. 619, 627, 684 A.2d 570, 574 (1996). The above-referenced testimony demonstrates Defendants' severe breaches in the standard of care during Ms. Paolini's residency at the facility. Defendants' intentional and reckless conduct in severely under-staffing the facility led to inadequate supervision of Ms. Paolini, thereby causing her to suffer from numerous **pressures ulcers**, exacerbation of existing **pressure ulcers**, malnutrition, and severe weight loss, which were contributing factors to her death. Defendants' neglect, as revealed through the deposition testimony above, had a severely negative impact on the care afforded to Ms. Paolini.

Accordingly, Plaintiff's expert reports, considered with the testimony and evidence set forth above, demonstrate sufficient evidence to make out a claim for negligence per se against Defendants. Plaintiff has established that Defendants breached the duty of care as proscribed by § 2713, regarding the duty to not neglect or **abuse** a care-dependent person. Further, Ms. Paolini suffered actual and serious bodily injuries, and Defendants' said breach was the proximate cause of those injuries.²⁰⁰ Plaintiff has therefore, made out a claim for negligence per se and it is respectfully submitted that Defendants' Motion for Partial Summary Judgment should be denied.

C. There is a Valid Claim for Negligence per se under the Pennsylvania Older Adults Protective Services Act

Defendants further argue that Plaintiff cannot support a claim for negligence *per se* under 35 P.S. § 10225.101, *et seq.*, “Pennsylvania Older Adults Protective Services Act (hereinafter “OAPSA” or “the Act”) because it is an administrative statute, it does not provide a private cause of action, and because Plaintiff has failed to demonstrate that Defendants have violated the statute, and in doing so, caused Ms. Paolini's injuries. As with § 2713, Plaintiff is not attempting to bring a private cause of action under OAPSA, and the above-referenced testimony and expert reports demonstrate that Plaintiff does in fact have a sufficient basis to bring a negligence per se claim. As outlined below, there are numerous reasons why Defendants' claims fail and Plaintiff should be allowed to bring a claim of negligence *per se* under OAPSA.

1. Under Pennsylvania law, Plaintiff is entitled to bring a negligence per se claim for violation of OAPSA

Contrary to Defendants' contention, Plaintiff is in fact entitled to bring a claim of negligence *per se* for violation of OAPSA. In *McCain v. Beverly Health and Rehabilitation Services*, discussed *supra*, the District Court for the Eastern District of Pennsylvania specifically addressed this issue, and denied the defendant nursing home's motion to dismiss plaintiff's negligence per se claims under OAPSA. As mentioned previously, the Court held that the plaintiff in that case had a valid claim for negligence per se under the statute, and noted that the absence of a private cause of action in the statute is merely a single indicator of whether the statute contemplates enforcement of an individual harm, and **does not preclude** the statute's use as the basis for a negligence per se claim. *McCain*, at *1. See also *Cabiroy v. Scipione*, 767 A.2d 1078, 1081 (holding that “[u]nder Pennsylvania law, the violation of a governmental safety regulation constitutes negligence per se if the regulation was, in part,

intended to protect the interest of another as an individual [and] the interest of the plaintiff which was invaded, was one which the act intended to protect”) (internal citations omitted). In the case sub judice, assuming Plaintiff establishes the required elements of negligence *per se*, which she has, then Plaintiff is entitled to use OAPSA as a basis for a claim of negligence *per se*.

2. OAPSA is designed to protect the interests of care-dependent nursing home residents

In order to bring a claim for negligence *per se* under OAPSA, Plaintiff must establish that the purpose of the statute is, at least in part, to protect the interest of a particular group of people, as opposed to the public generally. *Wagner v. Anzon*, 453 Pa. Super. 619, 627, 684 A.2d 570, 574 (1996). *See also Cabiroy*, at 1081 (holding that “although no private cause of action [was] set forth in the [Food, Drug and Cosmetic Act], it was certainly designed to protect a particular class of individuals.”) OAPSA sets forth civil and administrative penalties, as well as other consequences, for the **abuse** of a care-dependent person. The legislative intent of the Commonwealth of Pennsylvania regarding OAPSA is expressed as the following:

Older adults who lack the capacity to protect themselves and are at imminent risk of **abuse**, neglect, exploitation or abandonment shall have access to and be provided with services necessary to protect their health, safety and welfare. It is not the purpose of this act to place restrictions upon the personal liberty of incapacitated older adults, but this act should be liberally construed to assure the availability of protective services to all older adults in need of them. **Such services shall safeguard the rights of incapacitated older adults while protecting them from abuse, neglect, exploitation and abandonment.** It is the intent of the General Assembly to provide for the detection and reduction, correction or elimination of **abuse**, neglect, exploitation and abandonment, and to establish a program of protective services for older adults in need of them.

35 P.S. § 10225.102 (emphasis added).

Similar to § 2713 of the Crimes Code discussed supra, it is clear that OAPSA is also a statute that is intended to protect the interests of a select group of people - older adults who lack the capacity to protect themselves, and not simply the public at large. Ms. Paolini was an older adult who was a resident at Defendants' facility because she lacked the capacity to protect and care for herself. Therefore, Ms. Paolini falls within the class of persons OAPSA was intended to protect, thus entitling Plaintiff to allege that OAPSA created the duty required to be met by the Defendants in their care of Ms. Paolini. Additionally, OAPSA is directed, at least in part, to obviate the specific kind of harm which Ms. Paolini sustained.

3. Plaintiff's claim for negligence per se furthers the policy of OAPSA

The *McCain* Court, in holding that a nursing home resident falls within the older person protections intended by the OAPSA provisions including, inter alia, 35 P.S. §§ 10225.302, 10225.303, and 10225.309, noted that these types of “statutes and regulations are directed, at least in part, to obviate the specific kind of harm which was alleged to have been sustained,” including **pressure sores** (which are also at issue here). *McCain*, at *1. For these reasons, the Court concluded that “[t]he furtherance of those protective policies is a basis for delineating a nursing home's tortious duty in these circumstances.” *Id* Accordingly, the Court dismissed objections lodged by the nursing home, and allowed the plaintiffs decedent to pursue a negligence action where plaintiff alleged her mother had died from **pressure sores** she developed while a resident at the defendant nursing home facility. *Id* It is respectfully submitted that a similar outcome is warranted here.

There is little doubt that OAPSA was drafted to protect older Pennsylvanians such as Ms. Paolini. However, Defendants breached their duty under OAPSA to properly care for Ms. Paolini, and she suffered greatly as a result. Therefore, the legislature's policy to protect older adults such as Ms. Paolini from the **abuse** and neglect she suffered due to Defendants' conduct would be furthered by allowing Plaintiff's claim for negligence *per se* to proceed.

4. Defendants' negligent conduct breached the standard established by OAPSA

The statute defines the terms “**abuse**” and “neglect” in similar fashion:

“**Abuse.**” (2) The willful deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health.

“**Neglect.**” The failure to provide for oneself or the failure of a caretaker to provide goods or services essential to avoid a clear and serious threat to physical or mental health.

35 P.S. § 10225.701(a)(1). Further, as discussed supra, under the Pennsylvania Health and Safety Code for Long-Term Care Nursing Facilities, neglect is defined as a **form of abuse**. 28 Pa. Code § 201.3 (vi) (emphasis added).

Defendants failed to provide the goods and services necessary to avoid a physical threat to Ms. Paolini, evidenced by the deterioration of her **pressure ulcers** and other bodily injuries she suffered while a resident at Defendants' facility, and deprived her of the services she needed to maintain physical health. This conduct constitutes both neglect and **abuse** on behalf of Defendants.

Further, Defendants had reasonable cause to suspect that Ms. Paolini was the victim of such **abuse** and neglect. As indicated above, many of Defendants' staff made complaints to their superiors regarding the lack of staffing and the substandard conditions the residents were forced to endure at the facility as a result of understaffing. Without a doubt, Defendants were aware of the neglect suffered by Ms. Paolini. Under OAPSA, they had a duty to report that suspected **abuse** and neglect to the appropriate agency and law enforcement officials, yet Defendants failed to do so. Therefore, they breached their duty in direct violation of the statute, which was designed to prevent the **abuse** and neglect of the **elderly**.

5. Defendants' conduct was the proximate cause of Ms. Paolini's injuries and death

Defendants' neglect and breach of the standard of care established under OAPSA clearly were the proximate cause of Ms. Paolini's injuries, as well as her death. In deciding whether a plaintiff can bring a claim for negligence per se under a specific statute, the court must find “...a direct connection between the harm sought to be prevented by the statute and the injury.” *Wagner v. Anzon Inc.*, 453 Pa. Super. 619, 627, 684 A.2d 570, 574 (1996).

The above-referenced testimony demonstrates the severe breach in the standard of care suffered by Ms. Paolini during her residency at Defendants' facility. Defendants' intentional and reckless conduct in severely under-staffing the facility led to inadequate supervision of Ms. Paolini, thereby causing him to suffer from worsening of numerous **pressures ulcers**, malnutrition, and severe weight loss, which were contributing factors to her death. Defendants' neglect clearly had a severely negative impact on the care afforded to Ms. Paolini.

Further, Defendants' neglect in failing to report the suspected **abuse** and neglect suffered by Ms. Paolini also contributed to her injuries. Had some of Defendants' employees reported the **abuse** Ms. Paolini suffered due to inadequate care, lack of supervision, and all-around neglect, then her future injuries could have been prevented. The reporting provision, discussed supra, exists for just such a reason, and Defendants' failure to report the **abuse** prevented any outside agency from taking action to protect Ms. Paolini.

As demonstrated above, there is ample authority in Pennsylvania to support a claim of negligence per se based on the standard of care created by OAPSA. The statute created a duty for the treatment of older adults in nursing homes, Defendants breached that duty, and their breach of that duty was the proximate cause of Ms. Paolini's injuries. Plaintiff has therefore established a claim for negligence per se and it is respectfully submitted that Defendants' Motion for Partial Summary Judgment be denied.

D. Mercy Defendants are Liable for the Tortious Actions of ManorCare Defendants and their staff

Individual parties to a joint venture are liable for injuries or harms committed in conducting the business of the joint venture. *Newlin Corp, supra*. Each member of a joint venture is the agent or servant of the other members, and **“the act of anyone within the scope of the enterprise is to be charged vicariously to the rest.”** *Continental Aircraft Sales, supra* (emphasis added). The members of a joint venture are jointly and severally liable to a third party for the **tortious acts of an employee of the venture.** *Sleasman, supra*. The existence of a joint venture between the Mercy Defendants and ManorCare Defendants is undisputed. See Joint Venture Agreement attached hereto as **Exhibit “S.”** Mercy Management of Southeastern Pennsylvania²⁰¹ was formed to **“develop, own, manage and operate... long term nursing... facilities...including [anorCare-Mercy Fitzgerald].”** Exhibit S, p. 1. The Mercy Defendants desired to joint venture with the ManorCare Defendants to not only take advantage of ManorCare's “experience and expertise in such matters,” but also to share in the “costs and risks of the facility.” *Id.* Therefore, the Mercy Defendants are jointly and severally liable to Plaintiff for the injuries and harms committed against Ms. Paolini by the ManorCare Defendants. As was indicated above, the Mercy Defendants praeciped to join the ManorCare Defendants Motion for Partial Summary Judgment and must be bound this Court's denial of the same.

VII. CONCLUSION

For all of the foregoing reasons, it is respectfully submitted that Defendants' Motion for Partial Summary Judgment should be denied in its entirety.

Dated: 3/2/11

Respectfully submitted,

WILKES & McHUGH, P.A.

By:

Ian T. Norris, Esquire

Attorney for Plaintiff

Footnotes

- 1 Dr. Williams' Report, p.7.
- 2 *Id.* at p. 11 (emphasis added).
- 3 Nurse Antoinette's Report, p. 4.
- 4 Dr. Williams' Report, p. 8
- 5 Nurse Antoinette's Report, p. 2
- 6 *Id.*
- 7 Dr. Williams' Report, p. 2; Nurse Antoinette's Report, p. 2; Pressure sores progress in numeric fashion from Stage I to IV. Stage IV pressure ulcers are the most serious and are full thickness wounds with extensive destruction, tissue necrosis, or damage to the muscle, bone or supporting structures. Frequently, adjacent tissue is undermined and sinus tracts are present. *See National Pressure Ulcer Advisory Panel, “Pressure ulcers: incidence, economics, risk assessment. Consensus development conference statement.”* Decbitis 1989; 2:24-28.
- 8 Nurse Antoinette's Report, p.3.
- 9 *Id.*
- 10 Dr. Williams' Report, p. 2; Nurse Antoinette's Report, p. 3.

11 Dr Williams' Report, pp.4-5; Nurse Antoinette's Report,p.3.
12 *Id.*
13 *Id.*
14 Nurse Antoinette's Report, p.3.
15 Dr. Williams' Report, p. 2; Nurse Antoinette's Report, p. 3.
16 Dr. Williams' Report, p.3.
17 *Id.*
18 *Id.* at. 5-6
19 *Id.* at 6.
20 Nurse Antoinette's Report, p. 6.
21 *Id.*
22 *Id.* at 14.
23 *Id.* at 7 (emphasis added).
24 Dr. Williams' Report, p. 4.
25 Dr. Williams' Report, p. 4 (emphasis added).
26 *Id.* at 5.
27 *Id.*
28 *Id.*
29 *Id.*
30 *Id.*
31 *Id.*
32 Dr. Williams' Report, pp.8, 10-11; Nurse Antoinette's Report, pp. 9-12.
33 Dr. Williams' Report, p. 8.
34 Dr. Williams' Report, p. 2; Nurse Antoinette's Report, p. 3.
35 Dr. Williams' Report, p. 2.
36 Nurse Antoinette's Report, p. 12.
37 *Id.*
38 *Id.* at 3.
39 Dr. Williams' Report, p. 3; Nurse Antoinette's Report, p.11.
40 Dr. Williams' Report, pp. 3-4 (emphasis added); Nurse Antoinette's Report, p. 11.
41 Dr. Williams' Report, p. 4 (emphasis added).
42 Nurse Antoinette's Report, p. 11.
43 *Id.*
44 Dr. Williams' Report, p. 3; Nurse Antoinette's Report, p. 11.
45 Nurse Antoinette's Report, p. 11.
46 Nurse Antoinette's Report, p. 12.
47 *Id.* at 15.
48 *Id.* at 14.
49 Dr. Williams' Report, p. 11.
50 *Id.*
51 Dr. Williams' Report, p. 11; Nurse Antoinette's Report, p.4.
52 Nurse Antoinette's Report, p. 15.
53 A copy of Janine McClosky's deposition transcript is attached hereto as Exhibit "F"
54 McClosky, pp. 20-21, 38.
55 *Id.* at 28
56 *Id.* at 170-71.
57 *Id.* at 77-78.
58 *Id.* at 46-48.
59 *Id.* at 59-60.

60 *Id.* at 47, 65-66.
61 McClosky, pp. 64-66.
62 *Id.* at 47-50.
63 *Id.* at 57-58.
64 *Id.* at 172-73.
65 *Id.* at 67-70.
66 *Id.* at 181 (emphasis added).
67 *Id.* at 167-68.
68 *Id.* at 171.
69 A copy of Jacqueline Ficklin's deposition transcript is attached hereto as Exhibit "G"
70 Ficklin, p. 32.
71 *Id.* at 38, 39.
72 *Id.* at 40.
73 *Id.* at 37.
74 *Id.* at 43.
75 *Id.* at 43, 75.
76 *Id.* at 69-70.
77 *Id.* p. 73.
78 *Id.* at 44-45, 62.
79 *Id.* at 71-72.
80 Ficklin, pp. 71-72.
81 *Id.* at 66-67 (emphasis added).
82 *Id.* at 47-48.
83 *Id.* at 50.
84 *Id.* at 51.
85 *Id.* at 52.
86 *Id.* at 52-53.
87 *Id.* at 62-65.
88 *Id.* at 60-61.
89 A copy of Annette S. Opoku's deposition transcript is attached hereto as Exhibit "H"
90 Opoku, p. 17.
91 Opoku, p. 18.
92 *Id.* at 19-20.
93 *Id.* at 20.
94 *Id.* at 21.
95 *Id.* at 22.
96 *Id.* at 23.
97 *Id.* at 31.
98 A copy of Linda Ann Callan's deposition transcript is attached hereto as Exhibit "I"
99 Callan, pp. 53-54.
100 *Id.* at 147.
101 *Id.*
102 Callan, at 48.
103 *Id.* at 50-51 (emphasis added).
104 *Id.* at 35-37.
105 *Id.* at 35 (emphasis added).
106 A copy of John Paolini's deposition transcript is attached hereto as Exhibit "J"
107 Paolini, p. 13.
108 *Id.* at 32-33.

109 Paolini, p. 33 (emphasis added).
110 *Id.* at 41.
111 *Id.*
112 A copy of Barbara Anne Redheffer's deposition transcript is attached hereto as Exhibit "K"
113 Redheffer, p. 15.
114 *Id.* at 14.
115 *Id.* at 21 (emphasis added).
116 A copy of Cynthia Davis Jackson's deposition transcript is attached hereto as Exhibit "L"
117 Jackson, p. 19.
118 *Id.* at 24.
119 *Id.* at 27.
120 *Id.* at 37.
121 *Id.* at 40.
122 *Id.* at 41.
123 *Id.* at 44.
124 *Id.* at 54.
125 *Id.*
126 *Id.* at 55-56.
127 *Id.* at 54.
128 Jackson, pp. 54-55.
129 *Id.* at 55.
130 A copy of Scott Miller's deposition transcript is attached hereto as Exhibit "M"
131 Miller, pp. 96-97.
132 *Id.* at 99-100.
133 *Id.* pp. 119-120.
134 *Id.* at 23.
135 Miller, p. 107.
136 *Id.* at 11, 15.
137 *Id.* at 11-13.
138 A copy of Joanna Stuck's deposition transcript is attached hereto as Exhibit "N"
139 Stuck, pp. 10-11.
140 Stuck, pp. 36, 38, 40, 43, 49, 54-55, 59, 61, 62-63, 68, 70, 94.
141 *Id.* at 130-131.
142 *Id.* at 31-33.
143 *Id.* at 30.
144 *Id.* at 30-31.
145 *Id.* at 33.
146 *Id.* at 38-41.
147 *Id.* at 44.
148 *Id.* at 52.
149 *Id.* at 46-48 (emphasis added) (Of note, the RDO and Administrator provide recommendations to the budget process).
150 Stuck, pp. 49-50.
151 *Id.* at 43.
152 *Id.* at 90.
153 *Id.* at 67-74.
154 *Id.* at 71.
155 *Id.* at 75.
156 *Id.* at 76.
157 *Id.*, at 99-101, 19.

158 *Id.* at 20.
 159 Stuck, pp. 101-102 (emphasis added).
 160 A copy of Gretchen Mangone's deposition transcript is attached hereto as Exhibit "O"
 161 Mangone, pp. 25, 26.
 162 *Id.* at 67-69.
 163 *Id.* at 70.
 164 *Id.* at 81.
 165 Mangone, p. 88.
 166 *Id.* at 89.
 167 A copy of Carmella Grazel Kennedy's deposition transcript is attached hereto as Exhibit "P"
 168 Kennedy, pp. 27-28.
 169 *Id.* at 62-63.
 170 *Id.* at 66-68 (emphasis added).
 171 A copy of Kathleen Doud's deposition transcript is attached hereto as Exhibit "Q"
 172 Douds, pp. 22-24 (emphasis added).
 173 *Id.* at 25.
 174 Douds, pp. 28-29 (emphasis added).
 175 *Id.* at 56-57.
 176 *Id.* at 59.
 177 *Id.* at 58.
 178 *Id.* at 47-49.
 179 Douds, pp. 45-46.
 180 *Id.* at 74.
 181 *Id.* at 74-75.
 182 *Id.* at 75.
 183 *Id.* at 94.
 184 *Id.* at 99-100.
 185 *Id.* at 18-20.
 186 A copy of Ruth Thomas's deposition transcript is attached hereto as Exhibit "R"
 187 Thomas, pp. 10, 16-17.
 188 Thomas, pp. 19-20.
 189 *Id.* at 17, 21 (Sister Mary Anne Basil, Kathy Clark, Ruth Thomas, representing Mercy Health Systems and the Sisters of Mercy, and Sue Morey, Eastern Division VP, Scott Miller, RDO, and Ken Kang, Assistant Treasurer, representing Manor Care, were members of the Partnership Board and all attended these meetings).
 190 Outrageous conduct is an "act done with a bad motive or with reckless indifference to the interests of others." *Focht v. Rabada*, 217 Pa. Super. 35, 38, 268 A.2d 157, 159 (1970). The punitive damage provisions of the Medical Care Availability and Reduction of Error (MCARE) Act, 40 P.S. § 1303.101 *et seq.*, also utilizes the same standard. The Act, which includes "nursing home" within the definition of -healthcare provider, provides:
 191 Willful misconduct, on the other hand, "means that the actor desired to bring about the result that followed, or at least that he was aware that it was substantially certain to ensue." *Arnold v. Leamy*, 67 Pa. D.&C.4th 370, 376-77 (C.P. Lancaster 2004) (citing *Evans v. Philadelphia Transp. Co.*, 418 Pa. 567, 212 A.2d 440 (1965)). Simply put, "[it is a step beyond 'wanton misconduct.'" *Pursel v. Parkland Sch. Dist.*, 70 Pa. D.C.4th 129, 136 (C.P. Lehigh 2005).
 (a) AWARD. -- Punitive damages may be awarded for conduct that is the result of the health care provider's willful or wanton conduct or reckless indifference to the rights of others...
 40 P.S. § 1303.505.
 192 The *Scampono* court's application of punitive damages to nursing home **abuse** and neglect cases is discussed more fully below.
 193 Our Supreme Court has noted that neither law nor logic "prevent[s] the plaintiff in a case sounding in negligence from undertaking the additional burden of attempting to prove, as a matter of damages, that the defendant's conduct not only was negligent but that the conduct was also outrageous, and warrants a response in the form of punitive damages." *Hutchinson*, 582 Pa. at 124-25.

- 194 The type of conduct that will support a claim for punitive damages is exemplified in *McCain v. Beverly Health and Rehabilitation Services, Inc.*, 2002 WL 1565526 (E.D. Pa. July 15, 2002), another nursing home neglect and **abuse** case. There, the court held that under Pennsylvania law, allegations that a nursing home transported a resident in an ill-fitting wheelchair that caused pressure sores, despite the resident's high risk for developing pressure sores, was sufficient to allege willful or wanton conduct or reckless indifference to meet the standard for seeking punitive damages. *Id.* at *2. Likewise, in *Capriotti v. Beverly Enterprises Pennsylvania Inc.*, 72 Pa. D. & C.4th 564 (C.P. Fayette 2004), another nursing home neglect and **abuse** case, the court considered similar allegations of **abuse** and neglect, including "that the corporate defendants knowingly, and with reckless disregard for the health and well-being of the facility residents, grossly understaffed and under-funded the facility; failed to appropriately train the staff; and knowingly permitted Ms. Capriotti to be neglected." *Id.* at 572. After considering these allegations, the court had no trouble finding that these allegations, "if believed, would entitle the plaintiff to punitive damages." *Id.* at 576. See also *Hoffman v. Mem'l Osteopathic Hosp.*, 342 Pa. Super. 375, 383, 492 A.2d 1382, 1386 (1985) (reversing the trial court and holding that evidence that a physician allowed a patient to remain crying and immobile for no more than two hours was sufficient to establish *prima facie* reckless indifference); *Wimer v. Macielak*, 47 Pa. D. & C.4th 364, 368-69 (C.P. Crawford 2000) (holding that "a material issue of fact remains to be determined as to whether the defendant [doctor] acted with reckless indifference to the medical condition of the plaintiff in failing to respond to the messages sent to the defendant's beeper."); *Medvecz v. Choi*, 569 F.2d 1221, 1227-30 (3d Cir. 1987) (anesthesiologist who left the operating room for a lunch break without securing a suitable replacement could be liable for exemplary damages to a patient who suffered complications during his absence).
- 195 *McCain*, at *1, citing *Fallowfield Development Corp. v. Strunk*, 1990 WL 52745, at *19 (E.D. Pa. 1990) (emphasis added).
- 196 Under § 2713, a caretaker is defined as "an owner, operator, manager or employee of a nursing home," and a care-dependent person is defined as "any adult who, due to physical or cognitive disability or impairment, requires assistance to meet his needs for food, shelter, clothing, personal care or health care." Defendants and Ms. Paolini clearly fall under the respective definitions of caretaker and care-dependent person.
- 197 See Stuck, pp. 43, 44, 46-48, 49-50; Mangone, pp. 67-70, 81; Douds, p. 58-59; Opoku, pp. 20-22.
- 198 See Opoku, p. 23; Ficklin, pp. 44-45, 62; McClosky, pp. 67-70, 181.
- 199 See Mangone, p. 88; Jackson, p. 40; Ficklin, pp. 43, 51, 53-55, 73, 75.
- 200 *Reilly v. Tiergarten, Inc.*, 633 A.2d 208, 210, 430 Pa. Super. 10 (1993) (stating the four elements a party must prove in order to recover in an action for negligence).
- 201 Mercy Health Corporation formed Mercy Adult Services so as to enter a joint venture with Manor Care of Delaware County, Inc. In 2003, Mercy Management of Southeastern Pennsylvania was substituted for Mercy Adult Services as a partner in the joint venture agreement. Of note, the caption in this matter was amended to reflect the reality that Mercy Adult Services ceased to exist in 2003.