2011 WL 9716860 (Pa.Com.Pl.) (Trial Pleading)
Court of Common Pleas of Pennsylvania.
Dauphin County

Linda F. LAFF, Executor of the Estate of Lillian Glass deceased, Plaintiff,
v.
JEWISH HOME OF GREATER HARRISBURG, INC., d/b/a the Residence Jewish Home of Greater Harrisburg Senior Real Estate Holdings, LLC, d/b/a the Hollinger Group, Defendants.

No. 2009CV10920.
September 22, 2011.

This is not an Arbitration Matter. an Assessment of Damages Hearing is Required.

Amended Complaint in Civil Action (Professional Malpractice Action)

Ruben J. Krisztal, Esquire, Attorney Identification No. 202716, Wilkes & McHugh, P.A., 400 Market Street, Suite 1250, Pennsylvania, Pennsylvania 19106, 215-972-0811, 215-972-0580 (fax), Email: rkrisztal@wilkesmchugh.com, Attorneys for Plaintiff, Linda F. Laff, Executor of the Estate of Lillian Glass, deceased.

Plaintiff, Linda F. Laff, Executor of the Estate of Lillian Glass, deceased, by and through her counsel, Wilkes & McHugh, P.A., files the within Amended Complaint in Civil Action as follows:

PARTIES

1. Lillian Glass was an adult individual and resident at Jewish Home of Greater Harrisburg, d/b/a The Residence, an assisted living facility, located at 4004 Linglestown Road, Harrisburg, Pennsylvania 17112, from June 6, 2005 to August 24, 2008.

2. On August 29, 2008, Lillian Glass was transferred to the Jewish Home of Greater Harrisburg nursing home unit, located at 4000 Linglestown Road, Harrisburg, Pennsylvania 17112, where she remained until October 2,2008. Lillian Glass died on November 1,2008

3. Linda F. Laff, is the daughter of Lillian Glass, deceased, and is an adult individual and citizen of the Commonwealth of Pennsylvania, residing at 31 Fairfax Lane, Anville, Pennsylvania 17003.

4. Linda F. Laff was appointed Executor of the Estate of Lillian Glass, deceased, on March 9, 2009, by the Register of Wills of Dauphin County.

5. Defendant, Jewish Home of Greater Harrisburg, Inc., d/b/a The Residence, upon information and belief, is a corporation, duly licensed, organized and existing under and by virtue of the laws of the Commonwealth of Pennsylvania, with offices and a place of business located at 4000 Linglestown Road, Harrisburg, Pennsylvania 17112.

6. Defendant, Jewish Home of Greater Harrisburg, Inc., d/b/a The Residence, (hereinafter “The Residence”) is engaged in the business of owning, operating and/or managing nursing homes and assisted living facilities, including The Residence, providing healthcare, medical services, nursing care, assisted living/personal care to the public in Pennsylvania, Dauphin County, and, was at all times material hereto, duly licensed to operate The Residence, and was the employer, supervisor and/or partner of all other Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners,

and those persons granted privileges at The Residence, out to the public as competent and skillful long-term healthcare providers and practitioners of medicine and which is directly and vicariously liable, among other things for the acts and omissions of themselves, their agents, employees, servants, contractors, subcontractors, staff and/or partners and all other Defendants, all of whom played a role in the care of Lillian Glass.

7. Defendant, Jewish Home of Greater Harrisburg, Inc., upon information and belief, is a corporation, duly licensed, organized and existing under and by virtue of the laws of the Commonwealth of Pennsylvania, with offices and a place of business located at 4000 Linglestown Road, Harrisburg, Pennsylvania 17112.

8. Defendant, Jewish Home of Greater Harrisburg, Inc. (hereinafter "the Facility"), is engaged in the business of owning, operating and/or managing nursing homes, including the Facility, providing healthcare, medical services, nursing care, assisted living/personal care to the public in Pennsylvania, Dauphin County, and, was at all times material hereto, duly licensed to operate the Facility, and was the employer, supervisor and/or partner of all other Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the Facility, out to the public as competent and skillful long-term healthcare providers and practitioners of medicine and which is directly and vicariously liable, among other things for the acts and omissions of themselves, their agents, employees, servants, contractors, subcontractors, staff and/or partners and all other Defendants, all of whom played a role in the care of Lillian Glass.

9. Defendant, Senior Real Estate Holdings, LLC, d/b/a The Hollinger Group, upon information and belief, is a corporation, duly licensed, organized and existing under and by virtue of the laws of the State of Florida, with offices and a place of business located at 4550 Lena Drive, Mechanicsburg, PA 17055.

10, Defendant, Senior Real Estate Holdings, LLC, d/b/a The Hollinger Group, (hereinafter "The Hollinger Group") is engaged in the business of owning, operating and/or managing nursing homes and assisted living facilities, including The Residence, providing healthcare, medical services, nursing care, assisted living/personal care to the public in Pennsylvania, Dauphin County, and, was at all times material hereto, duly licensed to operate The Residence, and was the employer, supervisor and/or partner of all other Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at The Residence, out to the public as competent and skillful long-term healthcare providers and practitioners of medicine and which is directly and vicariously liable, among other things for the acts and omissions of themselves, their agents, employees, servants, contractors, subcontractors, staff and/or partners and all other Defendants, all of whom played a role in the care of Lillian Glass.

11. Upon present information and belief, at all times material hereto, the Defendants individually, collectively, and/or through a joint venture, owned, licensed, operated and/or managed both The Residence and the Facility, and are collectively engaged in the business of providing medical, nursing care and assisted living/personal care services to the general public, akin to a hospital.

JURISDICTION AND VENUE

12. Jurisdiction and venue are proper in this Honorable Court insofar as Defendants regularly conduct business in Dauphin County, Pennsylvania, and/or the cause of action arose therein. *See* Pa.R.C.P. 1006 and 2179.

FACTUAL BACKGROUND

Conduct of the Defendants

13. On June 6, 2005, Lillian Glass was admitted to Jewish Home of Greater Harrisburg's care at the assisted living facility, The Residence, where she remained in residence until August 24, 2008. She was transferred to the skilled nursing facility, the Facility, on August 29, 2008, where she remained until October 2, 2008. Lillian Glass died on November 1, 2008.

14. During the course of her residency at The Residence and the Facility, Lillian Glass was incapable of independently providing for all of her daily care and personal needs without reliable assistance. In exchange for monies, she was admitted to Defendants' care to obtain such care and protection.

15. The Defendants, through advertising, promotional materials and information sheets, held out themselves, The Residence and the Facility, as being able to provide nursing and assisted living care to sick, **elderly** and frail individuals, including Lillian Glass.

16. At all times material hereto, the Defendants held themselves out as capable of providing assisted living, nursing care and total healthcare, akin to a hospital, and assumed responsibility for Lillian Glass's total healthcare, including care planning and the provision of medication, medical care and treatment, therapy, nutrition, hygiene and all activities of daily living.

17. At the time of her admission, the Defendants, individually and/or through their agents, employees, servants, contractors, subcontractors, staff and representatives assessed the needs of Lillian Glass and promised that they would adequately care for her needs.

18. Upon information and belief, at all times material hereto, the Defendants were a vertically integrated corporation controlled by the same board of directors, who were responsible for the operation, planning, management and quality control of The Residence and the Facility.

19. Defendants entered into a Management Agreement with Senior Real Estate Holdings, LLC, d/b/a The Hollinger Group to perform certain services. The Agreement is attached hereto and made a part hereof as if fully set forth herein, and referred to as Exhibit “A”.

20. At all times material hereto, the control exercised over The Residence and the Facility by the Defendants included, inter alia: budgeting, marketing, human resource management, training, staffing, and the creation and implementation of all policy and procedure manuals used by The Residence and the Facility.

21. The Defendants also exercised control over reimbursement, quality care assessment and compliance, licensure, certification, and all financial, tax and accounting issues through control of the fiscal policies of The Residence and the Facility.

22. The Defendants, by and through their board of directors and corporate officers, received and utilized survey results and quality indicators to monitor the care being provided at their nursing home and assisted living facilities, including The Residence and the Facility.

23. The Defendants exercised ultimate authority over all budgets and had final approval over the allocation of resources to their nursing and assisted living facilities, including The Residence and the Facility.

24. As a part of their duties and responsibilities, the Defendants had an obligation to establish policies and procedures that addressed the needs of the residents of The Residence and the Facility, including Lillian Glass, with respect to the recognition and/or treatment of medical and nursing conditions, such as those experienced by Lillian Glass, so as to ensure that timely and appropriate care will be provided for such conditions whether provided within The Residence and the Facility, or obtained from other medical providers.

25. The Defendants, acting through their administrators, various boards, committees, and individuals, were responsible for the standard of professional practice by members of their staff at The Residence and the Facility.

26. The Defendants had an obligation to employ competent, qualified staff so as to ensure that proper treatment was rendered to individuals having medical problems, such as those presented by Lillian Glass as set forth herein.

27. As a part of their duties and responsibilities, the Defendants had an obligation to maintain The Residence and the Facility with adequate staff and sufficient resources to ensure the timely recognition and appropriate treatment of medical conditions suffered by residents, such as Lillian Glass, whether rendered within The Residence and the Facility, or obtained from outside medical providers.

28. At all times material hereto, the Defendants made a conscious decision to operate and/or manage The Residence and the Facility so as to maximize excess revenues at the expense of the care required and needed by their residents, including Lillian Glass,

29. In their efforts to maximize excess revenues/profits, the Defendants negligently, intentionally and/or recklessly reduced staffing levels below the level necessary to provide adequate care to residents, which demonstrates a failure to comply with the applicable regulations and standards for assisted living and nursing home facilities.

30. The Defendants recklessly and/or negligently disregarded the consequences of their actions, and/or negligently caused staffing levels at The Residence and the Facility to be set at a level such that the personnel on duty at any given time could not reasonably tend to the needs of their assigned residents, including Lillian Glass.

31. Over the past several years, and at all times material hereto, the Defendants have intentionally increased the census at The Residence and the Facility, and their other facilities, with residents who suffer from greater health problems requiring more complex medical care.

32. The Defendants knew, or should have known, that this increase in the acuity of the resident population would substantially increase the need for staff, services, and supplies necessary for the new resident population.

33. The Defendants failed to provide the necessary resources, including but not limited to supplies, equipment, and sufficient staff to meet the needs of their residents, including Lillian Glass.

34. The Defendants were aware of complaints from certified nursing aides regarding short staffing, which were reported to defendants by the Director of Nursing, and did not correct the problem prior to causing harm to Ms. Glass.

35. The Defendants were aware of complaints from registered nurses regarding short staffing, which were reported to defendants by the Director of Nursing, and did not correct the problem prior to causing harm to Ms. Glass.

36. The Defendants were aware of complaints from residents and residents' family members regarding short staffing, which were reported to defendants by the Director of Nursing, and did not correct the problem prior to causing harm to Ms. Glass.

37. The Defendants were aware that the budget was not adequate to maintain a level of sufficient staffing to provide adequate care to the residents, but did nothing to correct the problem prior to causing harm to Ms. Glass.

38. The Defendants were aware that residents were left lying in their own urine due to the understaffing at the Facility and did not correct the problem prior to causing harm to Ms. Glass.

39. The Defendants were aware that call bells were left unanswered for fifteen to twenty minutes, despite a Facility policy that they should be answered in three to five minutes and did not correct the problem prior to causing harm to Ms. Glass.

40. The Defendants intentionally increased the number of staff at the Facility during state inspections to deceive the Department of Health.

41. The Defendants were aware that the Facility was placed on provisional license, meaning they could not accept Medicare admissions, due to the numerous citations they received.

42. The Residence and the Facility were not properly managed by Seth Levy, the CEO and Nursing Home Administrator, among others.

43. Payment of agency for nursing was excessive, reckless and outrageous in that agency nursing lacks continuity of care for residents.

44. Management of the Facility and Residence by Defendants was fiscally irresponsible.

45. The Defendants knowingly established staffing levels that created recklessly high resident to staff ratios, including high resident to nurse ratios.

46. The Defendants knowingly disregarded patient acuity levels while making staffing decisions; and, also knowingly disregarded the minimum time required by the staff to perform essential day-to-day functions and treatments.

47. The acts and omissions of the Defendants were motivated by a desire to increase the excess revenues of their assisted living facilities and nursing homes, including The Residence and the Facility, by knowingly, recklessly, and with total disregard for the health and safety of their residents, reducing expenditures for needed staffing, training, supervision, and care to levels that would inevitably lead to severe injuries, such as those suffered by Lillian Glass.

48. The actions of the Defendants were designed to increase reimbursements by governmental programs, which, upon information and belief, are the primary source of income for The Residence and the Facility.

49. The aforementioned acts directly caused injury to Lillian Glass and were known by the Defendants.

50. During the residency of Lillian Glass at The Residence, the Defendants knowingly sacrificed the quality of care received by all residents, including Lillian Glass, by failing to manage, care, monitor, document, chart, prevent, diagnose and/or treat the injuries and illnesses suffered by Lillian Glass, as described herein, which included falls, right hip fracture, two fractured metatarsals, dehydration, weight loss, skin breakdown, poor hygiene and severe pain.

51. During the residency of Lillian Glass at the Facility, the Defendants knowingly sacrificed the quality of care received by all residents, including Lillian Glass, by failing to manage, care, monitor, document, chart, prevent, diagnose and/or treat the injuries and illnesses suffered by Lillian Glass, as described herein, which included urinary tract infections, dehydration, weight loss, malnutrition, skin breakdown, pressure ulcers, osteomyelitis, poor hygiene and severe pain.

52. At the time and place of the incidents hereinafter described, The Residence and the Facility whereupon the incidents occurred was individually, in concert, and/or through a joint venture, owned, possessed, controlled, operated, managed and/or maintained under the exclusive control of the Defendants.

53. At all times material hereto, the Defendants were operating personally or through their agents, servants, workers, employees, contractors, subcontractors, staff, and/or principals, who acted with actual, apparent and/or ostensible authority, and all of whom were acting within the course and scope of their employment and under the direct and exclusive control of the Defendants herein.

54. The theories of negligence in this matter involve both direct liability and vicarious liability. The incidents aforementioned were caused solely and exclusively by reason of the negligence, carelessness and recklessness of the Defendants, their agents, servants, contractors, subcontractors, staff and/or employees and was due in no part to any act or omission to act on the part of Lillian Glass.

55. Lillian Glass was a resident of The Residence on or about June 6, 2005 through August 24, 2008, and a resident of the Facility on or about August 29, 2008 through October 2, 2008, when during that time period, the Defendants' continuing actions and/or omissions, which included mismanagement, understaffing and lack of training, were the cause of serious events involving Lillian Glass and caused her serious and permanent injuries and damages hereinafter alleed by Plaintiff.

56. The Defendants, their agents, servants, contractors, subcontractors, staff and/or employees are/were, at all times material hereto, licensed professionals/ professional corporations and/or businesses and Plaintiff asserts, in part, professional liability claims against all of the Defendants, their agents, servants, contractors, subcontractors, staff and/or employees.

Injuries of Lillian Glass

57. Upon admission to The Residence and the Facility, Lillian Glass was dependent upon the staff for her mental, physical and medical needs, requiring some assistance with activities of daily living, and had various illnesses and conditions that required evaluation and treatment.

58. The staff, administration and ownership of The Residence and the Facility were on notice of Lillian Glass's past medical history.

59. Over the course of the residency of Lillian Glass at The Residence and the Facility, Defendants engaged in a pattern of care replete with harmful and injurious commissions, omissions and neglect as described herein.

60. The Defendants deprived Lillian Glass of adequate care, treatment, pressure relieving devices, food, water and medicine at The Residence and as a result of Defendants' conduct, Lillian Glass suffered numerous illnesses and injuries, which upon information and belief, included but were not limited to falls, right hip fracture, two fractured metatarsals, dehydration, weight loss, skin breakdown, poor hygiene and severe pain.

61. The Defendants deprived Lillian Glass of adequate care, treatment, pressure relieving devices, food, water and medicine at the facility and as a result of Defendants' conduct, Lillian Glass suffered numerous illnesses and injuries, which upon information and belief, included but were not limited to urinary tract infections, dehydration, weight loss, malnutrition, skin breakdown, pressure ulcers, osteomyelitis, poor hygiene and severe pain.

62. As detailed within, the severity of the recurrent negligence inflicted upon Lillian Glass, while in the care of the Defendants during her residency at The Residence and The Facility, accelerated the deterioration of her health and physical condition, and resulted in physical and emotional injuries that caused her severe pain, suffering and mental anguish, together with unnecessary hospitalizations.

63. These injuries, as well as the conduct specified herein, caused Lillian Glass to suffer a loss of personal dignity, together with degradation, anguish and emotional trauma.

64. Upon admission to The Residence on June 6, 2005, Ms. Glass was 4 feet, 6 inches tall and weighed 117 pounds.

65. On June 6, 2007, Ms. Glass was assessed with stable peripheral vascular disease to her lower extremities.

66. On June 16, 2007, Ms. Glass weighed 109 pounds.

67. On March 18, 2008, Ms. Glass was assessed with peripheral vascular disease and ordered wider therapeutic shoes for her due to a pre-ulceration to her right fifth toe.

68. By April 18, 2008, Ms. Glass had developed a decubitus ulcer to her right fifth toe and a painful callus to her left great toe.

69. On May 9, 2008, her left great toe was debrided of callus formations.

70. On May 21, 2008, Ms. Glass' left foot was assessed as slightly bruised on top by the second and third toes, but she denied bumping it on anything.

71. On June 4, 2008, lab results were indicative of dehydration with a BUN of 44 mg/d1 and creatinine of 1.32 mg/d1.

72. On June 1, 2008, Ms. Glass' left great toe became red and swollen. There was no vidence that it was previously assessed and the Facility had not alerted anyone.

73. On June 6, 2008, Ms. Glass' left great toenail was debrided due to an in-grown toenail.

74. Subsequently, per the medical records provided, there was no apparent follow up by nursing personnel as to the issues with Ms. Glass' toes.

75. By July 25, 2008, the left great toenail developed pre-ulceration with keratosis to the nail bed.

76. Ms. Glass' toes worsened, and on August 8, 2008 were noted to be oozing and opened up. There were potential signs of infection, which had been ignored.

77. Ms. Glass' family was not informed of the progression of her toe injury.

78. On August 8, 2008, Ms. Glass suffered a fall in the bathroom and was found with her legs stretched out. There was no evidence of toileting schedule instituted.

79. Defendants failed to prevent falls though Defendants were aware that there were safety issues.

80. Defendants failed to properly assess and follow through her functioning post her August 8, 2008 fall.

81. Defendants should have consulted with the doctor about transfers after her August 8, 2008 fall, but there is no evidence in the medical records that this was done.

82. On August 24, 2008, Ms. Glass suffered a fall after sliding off the bench at the foot of her bed, which caused her to sustain a right hip fracture. She was transferred to the hospital for evaluation and treatment.

83. On August 29, 2008, Ms. Glass was admitted to The Jewish Home of Greater Harrisburg's skilled nursing unit as a Full Code with a diagnosis of right hip fracture status post ORIF, weighing 122.3 pounds, according to the admission assessment, and was started on a regular diet with a poor appetite noted.

84. The Admission Assessment noted that Ms. Glass had a scattered rash to her chest, bruising to her hands bilaterally, and 14 staples to her right hip but no other skin breakdown. She was assessed as alert and oriented x3 and able to make her needs known.

85. Due to 2 fractured metatarsals from a fall earlier in the month, Ms. Glass had a CAM boot to her right foot.

86. Upon admission to the Facility, Ms. Glass could feed herself with supervision, but required an extensive to total assist for all other activities of daily living; CNAs were to assess her skin routinely and notify the appropriate staff person of any changes; she was on a static air mattress and was to be turned every 2 hours and wear moon boots while in bed; weekly skin

assessments were to be completed on Wednesdays, during the 10:00 am to 6:00 pm shift; and she was started on physical and occupational therapy.

87. There were no activities of daily living sheets provided for the months of September and October of 2008.

88. On September 2, 2008, Ms. Glass' Foley was discontinued and a urinalysis was collected, which returned positive for a urinary tract infection, and the culture grew out E-coli. She was started on a course of Cipro and a daily bladder scan was ordered.

89. On September 2, 2008, the registered dietitian met with Ms. Glass and discussed her food preferences. Ensure supplements were to be offered if she ate les than 50% of her meals.

90. Also on September 2, 2008, lab work obtained was significant for low albumin and chloride levels, which were 2.7 g/L and 96 respectively, and an elevated white blood cell count.

91. The September 3, 2008, skin assessment noted the right hip incision, but no other skin problems and it also stated her toenails were okay.

92. On September 4, 2008, Dr. Saacks examined Ms. Glass and noted that her right hip incision was healing well.

93. On September 5, 2008, scheduled toileting every hour was ordered, but discontinued later that day in favor of a Foley catheter.

94. On September 8, 2008, the Facility informed Ms. Glass' daughter that Ms. Glass weighed 115 pounds.

95. On September 9, 2008, the registered dietitian met with Ms. Glass again after being alerted to poor oral intake and she agreed to drink one healthshake in the afternoons.

96. The September 10, 2008, minimum data set indicated that Ms. Glass weighed 108 pounds.

97. The September 10, 2008, skin assessment, noted no new skin problems and described her toenails were okay.

98. On September 11, 2008, during a care plan meeting, Ms. Glass' poor appetite was discussed with her daughter.

99. Ms. Glass informed social services that she was very thirsty throughout the day and would like for the staff to make sure that her water pitcher was full, cold and within reach.

100. On September 12, 2008, the registered dietitian completed a nutritional assessment, noting that Ms. Glass needed 1650 Kcals and 1650 ccs of fluid per day to maintain a weight of 122.3 pounds and also noted insufficient nutrient intake due to eating less than 25% of meals. Recommendations included a regular diet, offering Ensure supplements as ordered, obtaining the pending psych consult and monitoring her food intake and body consumtion.

101. On September 12, 2008, Ms. Glass insisted on the removal of her moon boots and TED hose due to pain, which were removed later that day.

102. On September 12, 2008, Ms. Glass scored a 10 out of 21 on a Mini-Mental State Evaluation and she was confused, according to the psychiatrist. She was started on Zyprexa and was to be changed to Lexapro seven days later.

103. By September 13, 2008, the right hip incision was healed and dressing changes were discontinued.

104. On September 15, 2008, a urinalysis was collected and the culture grew out coagulase negative staphylococcus by September 17, 2008, and she was started on a course of Macrobid and Floristar.

105. On September 17, 2008, Ms. Glass' Foley catheter was discontinued with ongoing urinary bladder scans thereafter due to urinary retention.

106. The September 24, 2008, skin assessment was blank and unsigned.

107. On September 25, 2006, the Facility care planned a Stage II blister on her left heel and noted that she was noncompliant with prevention.

108. The September 26, 2008, minimum data set indicated that Ms. Glass weighed 101 pounds and had no skin problems aside from a rash.

109. On September 26, 2008, nursing called Ms. Glass' daughter to let her know that the left heel was worse, which had not been mentioned in the nursing notes before.

110. Also, on September 26, 2008, depression was added to Ms. Glass' diagnosis and she was started on Lexapro and Zyprexa.

111. The registered dietitian met with Ms. Glass during meals on September 26, 2008, and encouraged her to eat. Ms. Glass was notably confused during these encounters.

112. The registered dietitian was aware of skin breakdown to her heel and Ms. Glass was started on healthshakes with Prosource three times a day, multivitamins with minerals every day and Vitamin C supplements.

113. On September 26, 2008, the Facility was instructed to encourage fluids between meals and Ms. Glass was to be offered an evening snack and Ensure if she ate less than 50% of her meals.

114. On September 29, 2008, nursing noted a 2 x 2.5 cm old blistered area to the left heel with a small area of darkened skin that was painful to the touch and thought to possibly represent deep tissue injury. The area was nonblanchable and the left heel was described as “mushy”. Elsewhere in the chart, it was assessed as a black Stage IV pressure sore.

115. Skin prep was ordered to the heels bilaterally and Ms. Glass was encouraged to elevate her feet on a pillow when she didn't want to wear her protective boots.

116. On September 29, 2008, Ms. Glass' care plan was updated that the left heel blister was now a reabsorbed Stage I pressure ulcer that was nonblanchable with a Stage IV present.

117. On September 30, 2008, podiatrist, Dr. Crispell, assessed Ms. Glass for her complaints of a painful left hallux and she was assessed with a non-healing ulcer to her left hallux and peripheral vascular disease.

118. The site had previously been reported as healing per medical records, but was now macerated with a small amount of exposed bone.

119. Orders included daily Acquacel dressing changes to her toe, as well as left foot x-rays and a course of Keflex.

120. No assessments of Ms. Glass' condition were documented after 6:00 a.m. on September 30, 2008, until nursing staff was unable to arouse her to administer her bedtime medications at 9:35 p.m.

121. Her vital signs were: temperature 98.2, pulse 145, respiratory rate 16 and blood pressure 80/65. The physician was notified and ordered her transfer to the hospital for evaluation.

122. On October 1, 2008, Ms. Glass returned to the Facility with a diagnosis of urinary tract infection and dehydration. The emergency room had administered IV fluids and taken x-rays of her left great toe.

123. The October 1, 2008, skin assessment was blank and unsigned.

124. On October 2, 2008, the left toe x-ray returned indicative of osteomyelitis, prompting orders for a comprehensive medical plan and consult with Dr. Blake for the left great toe.

125. On October 2, 2008, Ms. Glass' BUN was elevated at 33 mg/dl, while her albumin was low at 3.0 g/L.

126. On October 2, 2008, a wound care nurse assessed Ms. Glass' left toe, noting that on September 25, 2009, Ms. Glass had told an aid her toe looked funny. A nurse reportedly had applied a bandaid to the toe at that time noting no drainage or unusual tissue other than the pink nail bed (None of these events were documented in the chart prior to October 2, 2008).

127. When the nurse took the dressing off of the left great toe on October 2, 2008, she found some dried blood and a pinpoint area of exposed bone at the nail bed. Ms. Glass also had a 1.5 x 2.5 x.4 cm purple blister on her right heel and negative pedal pulses and there was a .4 x 2 cm Stage IV area in the center of the blister.

128. The wound care nurse requested and the physician ordered, Silvasorb dressing changes to the right heel every three days, bilateral arterial Doppler studies to her legs, a prealbumin level, and checking for placement of the left great toe dressing every shift.

129. On October 2, 2008, Dr. Saacks recommended having Ms. Glass directly admitted to Community General Osteopathic Hospital for IV antibiotics for osteomyelitis of her left great toe.

130. After being discharged from the hospital, Ms. Glass was transferred to a different facility.

131. Throughout Lillian Glass's chart there is frequent and widespread missing and incomplete documentation, including but not limited to medication administration records, treatment administration records and nurses notes.

COUNT ONE

Linda F. Laff, Executor of the Estate of Lillian Glass, deceased v. All Defendants

132. Plaintiff hereby incorporates by reference the preceding paragraphs as though the same were fully set forth at length herein.

133. At all times material hereto, Defendants were acting through their agents, servants and employees, who were in turn acting within the course and scope of their employment under the direct supervision and control of the Defendants.

134. At all times material hereto, Defendants had the ultimate responsibility of ensuring that the rights of the residents, including Lillian Glass, were protected.

135. At all times material hereto, Defendants owed a non-delegable duty to provide adequate and appropriate custodial care and supervision to Lillian Glass and other residents, such as reasonable caregivers would provide under similar circumstances.

136. At all times material hereto, Defendants owed a non-delegable duty to Lillian Glass and other residents to hire, train, and supervise employees, so as to deliver healthcare and services to residents in a safe and reasonable manner.

137. At all times material hereto, Defendants, by and through their agents, employees, and/or servants owed a duty of care to Lillian Glass to exercise the appropriate skill and care of licensed physicians, nurses, directors of nursing, and/or nursing home administrators.

138. At all times material hereto, Defendants owed a duty and responsibility to furnish Lillian Glass with appropriate and competent nursing and/or total healthcare.

139. Despite being made aware of the types and frequency of injuries, illnesses, and/or infections, many of which were preventable, sustained by the residents of The Residence and the Facility, including those suffered by Lillian Glass, the Defendants failed to take steps to prevent the occurrence of said injuries, illnesses, and/or infections.

140. The Defendants knew, or should have known, of the aforementioned problems that were occurring with the care of Lillian Glass, as they were placed on actual and/or constructive notice of said problems.

141. The Defendants, as the corporate owners, board members and/or managers of The Residence and the Facility, breached their duty and were, therefore, negligent, careless and reckless in their obligations to Lillian Glass.

142. The corporate conduct of the Defendants was independent of the negligent conduct of the employees of The Residence and the Facility, and was outrageous, willful, and wanton, and exhibited a reckless indifference to the health and well being of the residents, including Lillian Glass.

143. At all times material hereto, Defendants owed and failed to fulfill the following duties to Lillian Glass: use reasonable care in the maintenance of safe and adequate facilities and equipment, including lifts and beds; select and retain only competent staff; oversee and supervise all persons who practiced nursing and/or skilled healthcare within The Residence and the Facility; and, formulate, adopt, and enforce rules, procedures and policies to ensure quality care and healthcare for all residents.

144. At all times material hereto, the breach of duties, negligence, carelessness and recklessness of the Defendants, individually and/or acting by and through their officers, board members, physicians, physicians' assistants, nurses, certified nurses' aides and office staff who examined, treated and/or communicated the condition of Lillian Glass, and through the administrative personnel responsible for hiring, retaining and/or dismissing staff, staff supervision and policy-making and enforcement, as well as any agents, servants, employees, contractors, subcontractors and/or consultants of the Defendants consisted of the following acts and omissions in the care and treatment of Lillian Glass:
a. failed to hire appropriately trained staff who failed to provide adequate preventative skin care allowing for the development and progression of pressure sores, including infected toe, failed to prevent and engaged in incomplete, inconsistent and fraudulent documentation, failed to provide appropriate treatment and services to prevent development and worsening of pressure sores and failed to provide adequate assessments of Ms. Glass following a change in condition;

b. failed to appropriately train staff members who failed to provide adequate preventative skin care allowing for the development and progression of pressure sores, including infected toe, failed to prevent and engaged in incomplete, inconsistent and fraudulent documentation, failed to provide appropriate treatment and services to prevent development and worsening of pressure sores and failed to provide adequate assessments of Ms. Glass following a change in condition;

c. knowingly allowed and/or encouraged unskilled and untrained individuals to care for Ms. Glass who failed to provide adequate preventative skin care allowing for the development and progression of pressure sores, including infected toe, failed to prevent and engaged in incomplete, inconsistent and fraudulent documentation, failed to provide appropriate treatment and services

to prevent development and worsening of pressure sores and failed to provide adequate assessments of Ms. Glass following a change in condition;

d. failed to ensure accurate, complete and consistent documentation and avoid fraudulent documentation;

e. failed to provide adequate preventative skin care allowing for the development of infected toe;

f. failed to provide adequate preventative skin care allowing for the development of multiple pressure wounds by failing to timely obtain order and administer preventative measures;

g. failed to provide adequate preventative skin care allowing for the development and worsening of pressure ulcers/wounds by failing to provide proper hygiene for Ms. Glass;

h. failed to ensure that Ms. Glass did not develop serious and permanent injuries to her body and possible aggravation and/or activation of any preexisting conditions, illnesses, ailments, or diseases she had, and/or accelerated the deterioration of her health, physical and mental condition, and more particularly, but without limitations, when she experienced falls, right hip fracture, two fractured metatarsals, dehydration, weight loss, skin breakdown, poor hygiene and severe pain while a resident at The Residence and urinary tract infections, dehydration, weight loss, malnutrition, skin breakdown, pressure ulcers, osteomyelitis, poor hygiene and severe pain, while a resident at the Facility, when Defendants knew or should have known that she was at risk for the same;

i. failed to respond in a timely manner with appropriate medical care when Ms. Glass was injured, including when she experienced multiple pressure wounds when Defendants knew or should have known that she was at risk for the same;

j. failed to provide adequate and appropriate health care by failing to keep Ms. Glass free from infection, failing to provide adequate preventative skin care allowing for the development and progression of pressure sores, failed to prevent and engaged in incomplete, inconsistent and fraudulent documentation, failed to provide appropriate treatment and services to prevent development and worsening of pressure sores and failed to provide adequate assessments of Ms. Glass following a change in condition;

k. failed to develop an appropriate therapeutic care plan by failing to develop a comprehensive care plan and revise it to reflect current conditions;

1. failed to ensure that all alleged violations involving mistreatment, neglect, or **abuse**, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the Facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency);

m. failed to ensure that each resident receives and that The Residence and the Facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care;

n. failed to ensure that a resident who enters The Residence and the Facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing;

o. failed to ensure that The Residence and the Facility provides for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment the interests and the physical, mental, and schosocial well-being of each resident;

p. failed to ensure that The Residence and the Facility uses the results of the assessment to develop, review and revise the resident's comprehensive plan of care, developing a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, describing the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; failed to ensure that The Residence and the Facility has sufficient nursing

q. failed to ensure that The Residence and the Facility has sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical; mental, and psychosocial well-being of each resident, as determined by the resident assessments and individual plans of care, providing services by sufficient number of each of the required types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans;

r. failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public;

s. failed to administer The Residence and the Facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

t. failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and **abuse** of residents and misappropriation of the resident's property;

u. failed to ensure that the services provided or arranged by The Residence and the Facility must be provided by qualified persons in accordance with each resident's written plan of care;

v. failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality;

w. failed to ensure that the resident's right to reside and receive services with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered, providing sufficient space and equipment in dining, health services, recreation, and program areas to enable the staff to provide residents with needed services as required by the standards and as identified in each resident's plan of care;

x. failed to use reasonable care in the maintenance of safe and adequate facilities and equipment;

y. failed to select and retain only competent staff who failed to provide adequate and appropriate health care to prevent the development and progression of multiple pressure sores, falls, right hip fracture, two fractured metatarsals, dehydration, weight loss, skin breakdown, urinary tract infections, dehydration, weight loss, malnutrition, skin breakdown, pressure ulcers, osteomyelitis, poor hygiene and severe pain, incomplete, inconsistent and fraudulent documentation;

z. failed to oversee and supervise all persons who practiced nursing and/or skilled healthcare in The Residence and the Facility who failed to provide adequate and appropriate health care to prevent multiple pressure wounds, properly notify physicians in a timely manner, follow physician orders; failed to develop and revise appropriate care plans; failed to provide complete and consistent documentation; failed to provide appropriate treatment, services and adequate assessments following change in condition to prevent multiple pressure wounds;

aa. failed to formulate, adopt and enforce adequate rules, procedures and policies to ensure quality healthcare for residents by failing to provide adequate and appropriate health care to prevent development and progression of pressure sores and properly notify physicians in a timely manner, provide safe transfers, follow physician orders; failed to develop and revise appropriate care plans; failed to provide complete and consistent documentation; failed to provide appropriate treatment, services and adequate assessments following change in condition to prevent multiple pressure wounds;

bb. failed to provide competent agents, servants, workmen and/or employees who would perform the duties required by law of the Defendants; including the timely response to call lights;

cc. acting in a grossly negligent manner, with reckless indifference to the rihts and safety of Ms. Glass;

dd. failed to undertake and/or implement the instructions provided by physicians and notify the physicians of change of Ms. Glass's condition;

ee. failed to refer Ms. Glass to the necessary medical specialists in a timely manner who would have properly diagnosed and/or treated Ms. Glass's condition due to failure to notify treating physicians and follow up on physicians instructions;

ff. failed to provide Ms. Glass with the necessary care and services to allow her to attain or maintain the highest practicable physical, mental and psychological well-being;

gg. failed to provide Ms. Glass with appropriate medication for pain management;

hh. failed to assist Ms. Glass in her personal hygiene;

ii. failed to treat Ms. Glass with human decency and respect;

jj. failed to ensure that The Residence and the Facility was properly funded;

kk. failed to implement a budget that would allow The Residence and the Facility to provide adequate and appropriate healthcare to Ms. Glass including adequate staff and supplies;

ll. grossly understaffing The Residence and the Facility;

mm. failed to take appropriate steps to remedy continuing problems at The Residence and the Facility that Defendant knew were occurring with Ms. Glass's care, which included the need to increase the number of employees, hiring skilled and/or trained employees, adequately training the current employees, monitoring the conduct of the employees, and/or changing the current policies and procedures to improve resident care;

nn. defendants were aware of complaints from certified nursing aides regarding short staffing, which were reported to defendants by the Director of Nursing, and did not correct the problem prior to causing harm to Ms. Glass;

oo. defendants were aware of complaints from registered nurses regarding short staffing, which were reported to defendants by the Director of Nursing, and did not correct the problem prior to causing harm to Ms. Glass;

pp. defendants were aware of complaints from residents and residents family members regarding short staffing, which were reported to defendants by the Director of Nursing, and did not correct the problem prior to causing harm to Ms. Glass;

qq. defendants were aware that the budget was not adequate to maintain a level of sufficient staffing to provide adequate care to the residents, but did nothing to correct the problem prior to causing harm to Ms. Glass;

rr. defendants were aware that residents were left lying in their own urine due to the understaffing at the Facility and did not correct the problem prior to causing harm to Ms. Glass;

ss. defendants were aware that call bells were left unanswered for fifteen to twenty minutes, despite a Facility policy that they should be answered in three to five minutes and did not correct the problem prior to causing harm to Ms. Glass;

tt. defendants intentionally increased the number of staff at the Facility during state inspections to deceive the Department of Health;

uu. failed to evaluate the quality of resident care and efficiency of services, identify strengths and weaknesses, set in place measures for improvements where necessary, and, evaluate progress and institute appropriate follow-up activities;

vv. failed to set in place a functional table of organization with standards of accountability and hold department heads (such as the Administrator and DON) accountable for the performance of their respective departments;

ww. failed to maintain open lines of communication with the governing body, department heads, Facility staff and its residents to assure resources are properly allocated and that resident care is maintained at a high level;

xx. failed to maintain compliance with governmental regulations and assure that the nondiscriminatory policy and policy on resident rights of The Residence and the Facility are available for inspection by the public;

yy. defendants were aware that the Facility was placed on provisional license, meaning they could not accept Medicare admissions, due to the numerous citations they received;

zz. failed to implement personnel policies and procedures that define job responsibilities, accountability and the performance appraisal process and emphasize the importance of the health care team in the delivery of quality resident care;

aaa. failed to assure that a formal program is in place to provide for the recruitment, hiring and development of competent department managers and other staff at The Residence and the Facility;

bbb. failed to coordinate training programs to improve employee skills and to enhance employee performance;

ccc, failed to develop a budget with an objective of the delivery of quality care;

ddd. failed to maintain sanitary and structural integrity of the premises at The Residence and the Facility, for the health and welfare of the residents, such as Ms. Glass;

eee. failed to provide adequate assessment following a change in the medical condition of Ms. Glass;

fff. failed to implement physicians' orders and to keep physicians informed, resulting in delay of treatment and harm to residents which was contrary to the health and welfare of the residents, such as Ms. Glass;

ggg. failed to provide an ongoing activity program to reduce social isolation, which was contrary to the health and welfare of the residents, such as Ms. Glass;

hhh. failed to obtain the necessary psychosocial treatment and services for the residents;

iii. failed to turn and reposition Ms. Glass to prevent the development and worsening of the pressure ulcers; failed to monitor the progress of the pressure ulcer(s); failed to communicate to the doctor the changes of the status of the pressure ulcers in a timely manner; and failed to adjust the nutritional intake to assist in the healin of the pressure ulcers;

jjj. failed to respond to documented signs and symptoms of pain and suffering during Ms. Glass's residency; and

kkk. failed to communicate to Ms. Glass's family changes in Ms. Glass's condition, and failed to notify them of various deficiencies issued against The Residence and the Facility, including those listed below.

145. The Defendants were aware that there were numerous problems at the Facility, and that they had been cited by the Pennsylvania Department of Health for: failing to provide services in accordance with each resident's written plan of care; failing to provide care in a manner and in an environment that maintained a resident's dignity; failing to provide the necessary care and services; failing to ensure that residents receive adequate supervision and assistance to prevent accidents; failing to ensure privacy and confidentiality of resident clinical records; failing to implement their written policies and procedures that prohibit mistreatment, neglect, and **abuse** for residents; failing to ensure that acceptable parameters of nutritional status were maintained; failing to ensure that each resident received adequate supervision and assistance devices to prevent accidents; failing to maintain an environment free of accident hazards as evidenced by the placement of cleaning products on the top of housekeeping carts, meal trays from the previous day containing leftover food items being stored in a resident dining room, and a resident call bell in need of repair; failing to ensure that the call bell was accessible for residents; failing to respond, in a timely manner, to the call bells activated; failing to maintain complete clinical record documentation; failing to provide timely care and services to residents who experienced a change in medical condition; failing to provide each resident with sufficient fluid intake to maintain proper hydration and health; failing to ensure residents were cared for in a manner that maintained their dignity; failing to ensure that food was stored at appropriate temperatures for refrigerators in the nursing unit dining rooms; failing to provide services in accordance with the written plan of care; failing to ensure food was palatable; failing to provide medications as ordered by the physician in a timely manner; failing to notify the Department of Health of a reportable event in a timely manner; failing to ensure that each resident maintained acceptable weight parameters; failing to implement its policies to reduce dehydration risks, and to ensure adequate intake; failing to provide timely and necessary foot care; failing to promptly resolve grievance; failing to provide the necessary care and services to maintain the highest practicable physical well-being for residents that did not receive medications as ordered by the physician; failing to ensure that the physician was notified of a change in condition for residents and that cardiopulmonary resuscitation was done for residents; and failing to ensure that all alleged violations were immediately reported to the administrator, the police, and the Department of Health; that the allegations were thoroughly investigated with the results of the investigation reported to the Department of Health within five working days of the incident; and that measures were implemented to prevent further neglect while the investigation was in progress.

146. That Defendants were aware that multiple deficiencies were repeat deficiencies.

147. As a direct and proximate result of the Defendants' acts and/or omissions, and their breach of their duty of care, negligence, carelessness and recklessness, Lillian Glass suffered (a) severe permanent physical injuries resulting in pain, suffering and disfigurement, (b) mental anguish, embarrassment, humiliation, degradation, emotional distress, and loss of personal dignity, (c) loss of capacity for enjoyment of life, (d) expense of otherwise unnecessary hospitalizations, medical expenses and residency at The Residence and the Facility, and (e) aggravation of her pre-existing medical conditions.

148. In causing the aforementioned injuries, the Defendants knew, or should have known, that Lillian Glass would suffer such harm.

149. The conduct of the Defendants was intentional, outrageous, willful and wanton, and exhibited a reckless indifference to the health and well being of Lillian Glass.

150. The conduct of the Defendants was such that an award of punitive damages is justified.

WHEREFORE, Plaintiff, Linda F. Laff, Executor of the Estate of Lillian Glass, deceased, respectfully requests that judgment be entered in her favor, and against all Defendants, in an amount in excess of the compulsory arbitration limits and/or Fifty Thousand Dollars ($50,000.00) whichever is greater, together with punitive damages, costs, and any other relief that this Honorable Court deems appropriate given the circumstances. A jury trial is demanded.

COUNT TWO

NEGLIGENCE PER SE FOR VIOLATIONS OF NEGLECT OF CARE-DEPENDENT PERSON, 18 Pa.C.S.A. §2713

Linda F. Laff, Executor of the Estate of Lillian Glass, deceased v. All Defendants

151. Plaintiff incorporates herein by reference each and every preceding paragraph of this Amended Complaint as if the same were more fully set forth herein.

152. At all times pertinent hereto, there was in full force and effect 18 Pa.C.S.A. § 2713 "Neglect of Care Dependent Person," which set forth penal consequences for neglect of a care-dependent person.

153. 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person" expresses the fundamental public policy of the Commonwealth of Pennsylvania that **elders**, like children, are not to be **abused** or neglected, particularly in health care facilities or by persons holding themselves out as trained professionals, and that if such **abuse** or neglect causes injury, either physical or mental, then such conduct is actionable.

154. At all times pertinent hereto, Lillian Glass was a care dependent resident of Defendants and thus fell within the class of persons 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person" was intended to protect, thus entitling Plaintiff to adopt 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person" as the standard of care for measuring Defendants' conduct.

155. Additionally, 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person" is directed, at least in part, to obviate the specific kind of harm which Lillian Glass sustained.

156. Defendants, in accepting the responsibility for caring for Lillian Glass as aforesaid, were negligent "per se" and violated 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person" in that they:

> a. failed to provide treatment, care, goods and services necessary to preserve the health, safety or welfare of Lillian Glass for whom they were responsible to provide care as specifically set forth in this Amended Complaint.

157. As a direct and proximate result of the aforesaid negligence "per se" of defendants, Lillian Glass was caused to sustain serious personal injuries and damages as aforesaid.

158.The conduct of Defendants, and each of them, as specifically set forth in this Amended Complaint, was outrageous, inconsistent with and intolerable given the norms of modern society and as such, Plaintiff requests punitive damages in addition to all other damages as aforesaid.

WHEREFORE, Plaintiff, Linda F. Laff, Executor of the Estate of Lillian Glass, deceased, respectfully requests that judgment be entered in her favor, and against all of the Defendants, in an amount in excess of the compulsory arbitration limits and/or Fifty Thousand Dollars ($50,000.00), whichever is greater, together with punitive damages, costs, and any other relief that this Honorable Court deems appropriate given the circumstances. A jury trial is demanded.

COUNT THREE

Linda F. Laff, Executor of the Estate of Lillian Glass, deceased v. All Defendants

147. Plaintiff hereby incorporates by reference the preceding paragraphs as though the same were fully set forth at length herein.

148. Plaintiff, Linda F. Laff, Executor of the Estate of Lillian Glass, deceased, brings this action on behalf of the decedent's estate under and by virtue of the Pennsylvania Judiciary Act 42 Pa.C.S. 8302, known as the Survival Statute, to recover all damages legally appropriate thereunder.

149. The following person is entitled to share under this cause of action in the estate of said decedent: Linda F. Laff, her daughter.

150. Plaintiff decedent, Lillian Glass, did not bring any action during her lifetime, nor has any other action been commenced on behalf of plaintiffs' decedent, Lillian Glass, against the Defendants herein.

151. Plaintiff, Linda F. Laff, Executor of the Estate of Lillian Glass, deceased, claim damages for the conscious pain and suffering including mental and physical pain, suffering and inconvenience, loss of life's pleasures and aggravation of pre-existing medical conditions, and expense of otherwise unnecessary hospitalizations undergone by Lillian Glass, up to the time of her death, which was caused by the Defendants' breach of duties, negligence, carelessness and recklessness.

152. Plaintiff, Linda F. Laff, Executor of the Estate of Lillian Glass, deceased, claim damages for the fright and mental suffering attributable to the peril leading to the physical manifestation of mental injuries, physical injuries, falls, right hip fracture, two fractured metatarsals, dehydration, weight loss, skin breakdown, urinary tract infections, malnutrition, pressure ulcers, osteomyelitis, poor hygiene and severe pain, which was caused by the Defendants' breach of duties, negligence, carelessness and recklessness.

153. In causing the aforementioned injuries, the Defendants knew, or should have known, that Lillian Glass, would suffer such harm.

154. The conduct of the Defendants was intentional, outrageous, willful and wanton and exhibited a reckless indifference to the health and well-being of Lillian Glass.

155. The conduct of the Defendants was such that an award of punitive damages is justified.

WHEREFORE, Plaintiff, Linda F. Laff, Executor of the Estate of Lillian Glass, deceased, respectfully requests that judgment be entered in her favor, and against all Defendants, in an amount in excess of the compulsory arbitration limits and/or Fifty Thousand Dollars ($50,000.00) whichever is greater, together with punitive damages, costs, and any other relief that this Honorable Court deems appropriate given the circumstances. A jury trial is demanded.

Dated: *9/20/2011*

Respectfully submitted,

WILKES & McHUGH, P.A.

By:

Ruben J. Krisztal, Esquire

Attorney for laintiff

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