2013 WL 3430290 (Ariz.Super.) (Trial Motion, Memorandum and Affidavit)
Superior Court of Arizona.
Pima County

Ernest H. BLACKBURN, Personal Representative of the Estate of Billie JO Blackburn, on behalf of the Estate of Billie JO Blackburn, Plaintiff,

v.

Ensign SABINO, L.L.C., a Nevada limited liability company doing business as Sabino Canyon Rehabilitation and Care Center; Bandera Healthcare, Inc., a California corporation; The Ensign Group, Inc., a Delaware corporation; Ensign Facility Services, Inc., a Nevada corporation: Christine Jones, Administrator; Cornerstone Hospital of Southeast Arizona, L.L.C., a Delaware limited liability company; CS Healthcare Arizona, L.L.C., a Delaware limited liability company; Cornerstone Healthcare Group Holding, Inc., a Delaware corporation, Christine Hansen, Chief Executive Officer/Adminstrator and John Does 1-250, Defendants.

No. C2010-1401.
January 9, 2013.

Plaintiff's Response to Defendants' Motion in Limine Re: DHS Surveys and Regulations

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Honorable James Marner.

[MOTION IN LIMINE NO. 3]

(Trial Date: January 23, 2013)

Plaintiff, by and through counsel undersigned, hereby responds to Defendants' Motion in Limine #3 to preclude evidence of Arizona Department of Health Services surveys and state or federal regulations.

MEMORANDUM OF POINTS AND AUTHORITIES

I. PLAINTIFF IS ENTITLED TO USE EVIDENCE OF STATE AND FEDERAL HOSPITAL REGULATIONS AS A BASIS FOR THE STANDARD OF CARE.

Billie Blackburn's family admitted her to Defendants' facility, Cornerstone Hospital, believing she would receive proper and appropriate care that conformed to the standards set for hospitals by federal law and those laws enacted by the State of Arizona. A violation of a regulation is evidence of negligence and is admissible under the Arizona Adult Protective Services Act to establish proof of **elder** **abuse** and neglect.

It is well settled that violation of a regulation or a statute is evidence of negligence. See *RAJI* (Civil) 4th, Negligence I. The court in *Brand v. J.H. Rose Trucking Co.*, 102 Ariz. 201, 205, 427 P.2d 519, 523 (1967), stated, "[f]rom the failure to heed a statute or regulation, the law conclusively infers a want of reasonable care." *See also Good v. City of Glendale*, 150 Ariz. 218, 221, 722 P.2d 386, 389 (App. 1986), "a person who violates a statute enacted for the protection and safety of the public is guilty of negligence per se." Other states have similarly held that violations of statutes and regulations are evidence of negligence.

See, e.g., *Bridgforth v. Vandiver*, 225 Ark. 702, 284 S.W.2d 623 (1955); *Bussell v. Missouri Pac.c R. Co.*, 237 Ark. 812, 376 S.W.2d 345 (1964); *Dunn v. Brimer*, 259 Ark. 855, 537 S.W.2d 164 (1976).

In the California case of *In re Convervatorship of Gregory*, 80 Cal. App. 4th 514, 522, 95 Cal. Rptr. 2d 336 (2000), "[d]efendants argue[d] that although the regulations have nothing to do with the [California] **Elder Abuse** Act, and involve only the regulation of federal Medicaid payments, [plaintiff] effectively used them to create a private cause of action. They also complain the instructions were too vague to provide meaningful guidance to the jury." The court found, "the question before us is not whether violation of these regulations gives rise to a private right of action, but whether the duly authorized regulations can be used to describe the care required under an *existing* statutory right of action for **elder abuse**. *Id.* (Emphasis added).

The *Gregory* trial court instructed the jury in the language of California Welfare & Institutions Code § 15610.07 with regard to the **abuse** of an **elder**, and described how " '[p]atients of skilled nursing facilities shall be treated and cared for" by reading portions of state statutes, and state and federal regulations governing patients" rights and patient care in skilled nursing facilities." *Id.* at 19. The court also instructed the jury about the term "reckless neglect." The *Gregory* court found that the instructions given "provided concrete examples which amplified the instruction on **elder abuse** based on Welfare and Institutions Code § 15610.07." *Id.* at 20.

Likewise in the California case of *Norman v. Life Care Centers of Am., Inc.*, 107 Cal. App.4th 1233, 132 Cal. Rptr. 2d 765 (2003), the issue was whether or not California Code of Regulations, Title 22 fin large part modeled after and incorporating the federal regulations], serves as a proper regulation to warrant a negligence per se instruction. The *Norman* court held:
[W]e conclude the regulations in question impose on Life Care duties of care, and a breach by Life Care of those duties of care constitutes "[t]he negligent failure ... to exercise that degree of care that a reasonable person in a like position would exercise." Accordingly, a violation by Life Care of those regulations in caring for an **elder** constitutes **elder abuse** neglect under the (California **Elder Abuse**] Act.

Id. at 1246 (Emphasis added) (citations omitted). The court went on to say:

> Furthermore, the regulations clearly were intended to protect the health and safely of nursing home residents by requiring the initial development and updating of appropriate care plans for them and notification of their physicians if there is any change in conditions.

Id. at 1247. The conclusion of the court was, that by refusing an instruction on negligence per se, the trial court precluded Norman from arguing that Life Care's alleged regulatory violations were presumed to constitute negligence and therefore neglect under her **elder abuse** cause of action. *Id.* at 1250.

Defendants' argument here views the regulations in isolation and outside the context of this case. Plaintiff will provide expert testimony from Dr. Joyce Black, who possesses the necessary expertise to explain to the jury the deficiencies in the standard of care in this case. The jury will not be read a set of regulations without context to them. Rather, the jury will be given extensive testimony regarding the standard of care and the deviations from it in this case, and will then be directed to the regulations that create a basis for the standard of care. In addition, Plaintiff is entitled to ask Defendants own employees about their knowledge of the regulations, whether they arc required to follow them and whether the facility complied with the regulation. As an example, Christine Hansen testified that she was familiar with the slate and federal regulations governing long-term care facilities such as Cornerstone and it would he her expectation that her staff members would comply with these regulations. (Exhibit 1, Deposition of Christine Hansen, p.49, line 13-24)

For example, Defendants' documentation in Mrs. Blackburn's clinical record fails to comply with 42 CFR § 482.24, *Condition of Participation: Medical Records Services*, based upon the numerous omissions and inconsistencies found in her chart. This federal regulation provides in relevant part:

...A medical record must be maintained for every individual evaluated or treated in the hospital...

(b) Standard: Form and retention of record. The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible.

In sum, Cornerstone failed to provide Billie Blackburn with the necessary care and services to maintain her health and well-being. Plaintiff's expert, Dr. Joyce Black, will provide the support for her opinions that Defendants violated the regulations based on her education, training, and experience. The appropriate foundation will be provided at the trial of this matter not only for the introduction of the regulations as evidence of the standard of care, but also how they arc relevant in this case. The regulations create a standard of care to be provided by hospital operators to their patients and failure to meet this standard of care is evidence of negligence.

II. THE DHS DOCUMENTS ARE RELEVANT AND ADMISSIBLE.

The State of Arizona Department of Health Services (DHS) conducts inspections of every nursing home and long-term care hospital licensed by the state in order to determine the degree of compliance with minimum standards established by the state and federal governments for the quality and adequacy of care and services provided to residents. At the conclusion of the survey process, DHS issues a Statement of Deficiencies reporting deficiencies found during the survey. In response to the report, the facility files a Plan of Correction, which sets forth the action pledged to be taken by the facility to correct these deficiencies so that they do not happen to other residents or patients in the future, DHS also performs investigations in the aftermath of complaints made to the agency about care in nursing homes and long-term care hospitals. These survey reports and the plans of correction are public documents, intended for public inspection.

There are no appellate cases in Arizona directly on point regarding the admissibility of DHS surveys. However, courts in several states have expressly held that stale inspection reports are admissible in civil actions against long term care facilities. *Advocat, Inc. v. Sauer,* 353 Ark. 29, 11 S.W.3d 346 (2003); *Horizon/CMS Healthcare Corp. v. Auld,* 34 S.W.3d 887 (Tex. 2000).

Courts have held that evidence of the prevalence of conditions in a nursing home were relevant and admissible at trial to show motive, intent, and the absence of mistake of the nursing home operator. *Mitchell v. State,* 491 So. 2d 596, 599 (Fla. Dist. Ct. App. 1986) (holding testimony regarding mistreatment of other residents, and testimony regarding the general conditions of the facility, including roach infestation, failure to follow nutritional guidelines, and lack of staff training, was admissible to show knowledge on the part of the defendant); *See also Sauer,* 353 Ark. at 60, 11 S.W.3d at 364.

Inspection reports have also been expressly held admissible at trial as evidence of prior notice of a dangerous condition existing on the premises which causes harm. *Brown v. Sims,* 538 So. 2d 901 (Fla. Dist. Ct. App. 1989), reversed on other grounds, *Sims v. Brown.* 574 So. 2d 131 (Fla. 1991).

Finally, it is axiomatic that evidence that tends to show “an evil mind” and “aggravated and outrageous conduct” is clearly relevant to making a case for punitive damages. *Linthicum v. Nationwide Life Ins. Co.,* 150 Ariz. 326, 723 P.2d 675 (1986). This is because evidence to the effect that the defendant knew from previous experience that the alleged conduct on its part would probably result in injury to the plaintiff, because it knew that such carelessness on its part in the past had resulted in similar injuries to others, but continued in this course of conduct in utter indifference to the consequences, has a legitimate tendency to show that the defendant acted with conscious or reckless disregard. *Gunthorpe v. Daniels,* 150 Ga. App. 113, 257 S.E.2d 199 (1979).

A. ***Prior Rulings Expressly Hold That State Surveys are Admissible at Trial.***

While Arizona has no case directly on point, cases from Alabama and Arkansas that hold that state survey reports are admissible a(trial against a long-term care facility. For example, in *Flint City Nursing Home, Inc. v. Depreast*, 406 So. 2d 356, 361 (Ala. 1981), the court held that 12 out of 16 deficiencies contained in a nursing home state survey were admissible for the purpose of "showing notice to the nursing home of dangerous conditions existing at the nursing home and inadequate policies and procedures relative to the care and well-being of the residents."

In *Montgomery Health Care Facility, Inc. v. Ballard*, 565 So. 2d 221, 223 (Ala. 1990), the Alabama Supreme Court expressly held that "this evidence was admissible":

The defendants argue that the trial court incorrectly admitted into evidence survey and complaint reports regarding the nursing home. These reports, compiled by the Alabama Department of Public Health, contained information about deficiencies found in the nursing home.

The deficiencies admitted into evidence were inadequate documentation of treatment given for decubitus ulcers; 23 patients found with decubitus ulcers, 10 of whom developed those ulcers in the facility; dressings on the sores were not changed as ordered; nursing progress notes did not describe patients' ongoing conditions, particularly with respect to descriptions of decubitus ulcers; worsening of decubitus ulcers; ineffective policies and procedures with respect to sterile dressing supplies; lack of nursing assessments; incomplete patient care plans or lack of such plans; inadequate documentation of doctors visits, orders, or progress notes; a.m. care not consistently documented; inadequate documentation of turning patients; incomplete "activities of daily living" sheets; "range of motion" exercises not documented; orders for placing patient up in chair not consistently documented; patients found wet and soiled with dried fecal matter; lack of bowel and bladder retraining programs; incomplete documentation of ordered force fluids; inaccessible water pitchers; monthly weighing of patients was not done; incomplete documentation of food consumption; tube feeders were not receiving their feedings as ordered; linen was not handled properly to prevent the spread of infection; vital signs not checked as ordered; inadequate staffing; the director of nursing was not responsible for the standards of nursing practice; charge nurses had not been responsible for the supervision of nursing activities; the governing body in its management through the administrator had not enforced rules and regulations concerning patients' health and safety due to deficiencies noted in nursing services such as bowel and bladder training, activities of daily living, ambulation, patient care planning, and infection control. There was evidence that all of these deficiencies contribute to the development or worsening of pressure sores.

Because the jury could find that the deficiencies noted were deficiencies that proximately caused Mrs. Stovall's death, this evidence was admissible and the trial judge did not **abuse** his discretion in admitting it.

The Arkansas Court of Appeals in *Rose Cure, Inc. v. Ross*, 91 Ark. App. 187, 209 S.W.3d 393 (2005) also upheld the admissibility of surveys. The defendants there claimed that the trial court's admission of a survey was erroneous because the survey was conducted before the resident was admitted to defendants' facility and involved issues relating to residents other than Mrs. Givens. The Court of Appeals disagreed, finding that the surveys showed evidence of problems with turning/repositioning such as Mrs. Givens experienced, as well as that the facility was on notice of such problems. *Id.* at 406. Also, in determining the appropriateness of punitive damages, the Arkansas Supreme Court in *Sauer* relied on OLTC records, which are the equivalent of the DHS records in Arizona: "... the OLTC's findings that Rich Mountain was not meeting OLTC's requirements regarding adequate nursing staff were relevant as to whether the Sauer Estate's allegations of lack of patient care were true." *Saner*, 353 Ark. at 59, 111 S.W.3d at 363. The court further found the surveys were admissible:

> Each OLTC survey notified appellants of examples of the manner in which Rich Mountain tailed to meet the needs of its patients due to inadequate staffing. Whether the patients at Rich Mountain suffered from inadequate nurse staffing pertaining to personal hygiene, feeding, and treatment would certainly have a bearing on whether the allegations made by the Sauer Estate about the lack of quality care afforded to Mrs. Sauer were more or less probable. Moreover, the surveys are probative of the fact that the appellants were on notice of dangerous conditions in the nursing home due to understaffing....

Id. at 364 (citations omitted).

B. *Plans of Corrections are Admissible as Admissions.*

The plan of correction section of the report is a statement prepared by the long-term care facility, and publicized as set forth above. Because that section of the report is a "party's own statement in either an individual or representative capacity" it is admissible under section 803 (6) of the *Arizona Evidence Code* (concerning admissions of a party opponent), as long as the statements "lend to prove or disprove" any material fact in the case. *Ariz.R.Evid.*, section 401 (defining relevant evidence).

C. *Public Records are Admissible.*

Arizona Evidence Code section 803 (8) stales that public records are admissible "unless the sources of information or other circumstances indicate lack of trustworthiness." Records, reports, and data of public offices or agencies setting forth "(B) matters observed pursuant to duty imposed by law, as to which matters there was a duly to report" or "(C) factual findings resulting from an investigation made pursuant to authority granted by law." Here, Plaintiff seeks to admit into evidence reports and data from the Department Health Services resulting from annual surveys and complaint investigations authorized by Title 9 of the *Arizona Administrative Code.* In *Parsons v. Smithey,* 109 Ariz. 49, 504 P.2d 1272 (1973) (citing *Snyder v. Beers,* 1 Ariz. App. 497, 405 P.2d 288 (1965)) the Supreme Court of Arizona held that similar records, specifically school records and police records, may properly be admitted under the business record exception,

A similar result can be found in Florida. There, in *Desmond v. Medic Ayers Nursing Home,* 492 So. 2d 427 (Fla. Dist. Ct. App. 1986), the court held that the report of a state epidemiologist was admissible at trial *because it was part of the nursing home state survey report.* As to the State Survey, the court held that:
[T]he report was admissible under the "public records" exception to the hearsay rule, since it was prepared pursuant to a "duty imposed by law as to matters which there was a duty to report." In this case, Dr. Sack's duty to report was imposed by Section 400.19(3), Florida Statutes, which requires the Department of Health and Rehabilitative Services to conduct at least one unannounced annual inspection of nursing homes, and in the event of a deficiency, to conduct any necessary subsequent inspections to insure nursing home compliance with department standards. Thus, by statute Dr. Sacks was obligated to report the results of field investigators' findings concerning conditions at [the nursing home] to the HRS licensing office together with his recommendations pursuant to those investigations.

Id. at 430, 431. (Emphasis added) (citations omitted)

Accordingly, the survey results from the inspection of nursing homes has been specifically held to be admissible at trial to prove the truth of the matters asserted therein under the "pubic records" exception to the hearsay rule.

D. *The Surveys are Admissible to Prove Intent. Knowledge, and Absence of Mistake.*

In addition to being admissible as public records and admissions, these survey reports are also admissible to show knowledge and absence of mistake on the part of the nursing home. *Mitchell,* 491 So.2d at 599. In *Mitchell,* the State of Florida brought criminal charges of **abuse** and exploitation of the **elderly** against Mitchell, the operator of the nursing home. On appeal, Mitchell asserted that evidence relating to the general conditions at the nursing home, including roach infestation, failure to follow dietary menus and nutritional guides, inadequacies in the facilities, lack of adequate staff or training, and specific references of poor care to other residents of the nursing home, were inadmissible.

The appellate court disagreed:

> We are of the view that the evidence in this category was admissible to show knowledge and absence of mistake on the part of Mitchell. The defense pointed to testimony that bedsores can occasionally develop in a properly supervised facility. Evidence of the prevalence of the conditions and improper treatment throughout the [home] was relevant to counter an inference that the conditions giving rise to the named victims' injuries were isolated instances beyond the defendant's knowledge and control.

Id. at 599.

In this case, it is relevant for Plaintiff to show that the failures on the part of Cornerstone Hospital were not simple mistakes, and that Defendants knew of the dangerous conditions existing on the premises. Here, the DHS surveys are of consequence to determine that Defendants had notice and knowledge of the deficiencies within the Facilities and yet failed to correct them, resulting in harm to their residents, including Mrs. Blackburn. In addition, the DHS surveys that were conducted at Cornerstone Hospital in 2008 covered conditions that were present during Mrs. Blackburn's admission.

E. ***Examples of Relevant Cornerstone Department of Health Services Surveys***

1. June 2008 Survey

The state of Arizona conducted a survey of Cornerstone Hospital between June 20 and June 23, 2008, which is a period of time when Ms. Blackburn was a patient at the facility. This survey includes a finding that the nurse executive failed to require that the registered nurses assigned to “patient no. 1” assessed, directed, and monitored the patient's skin care to prevent and treat skin breakdown. [Exhibit 2, June 23, 2008 Survey] The survey also indicates that the hospital's policies and procedures were not followed for wound care, assessment, treatment, and documentation for “patient no. 1.” [*Id.*] The June, 2008 survey further notes that a physical therapist indicated that a particular patient would benefit from a pressure-relieving mattress, but documentation is lacking that this information was communicated to the physician or nursing staff or that the patient was actually provided an air mattress. [*Id.*] There is also reference that a physician ordered EPC cream to be applied to the patient's perineum and buttocks twice daily but the nursing staff provided a different treatment for which there was no order. [*Id.*] The surveyors documented that Cornerstone's Wound Care Nurse went on vacation after “patient no. 1” was admitted and, thus, was not aware that the patient developed pressure ulcers during her stay. [*Id.*]

Cornerstone Chief Executive Officer Christine Hansen conceded to the surveyors that the hospital's policies and procedures were not followed for wound care assessment, treatment, and documentation with respect to that particular patient. [*Id.*] The survey also addressed the fact that the nurse executive failed to require that there be a care plan in place for that patient which included the prevention of skin breakdown which is something that the CEO would expect to be in place. [*Id.*]

The deficiencies and issues noted in the June 23, 2008 surveys were virtually identical to many of the failures of the Defendants with respect to the care provided to Mrs. Blackburn who was a patient in the facility at the time and subsequent to when the survey was conducted. For example, here Plaintiff contends that Cornerstone failed to follow its own policies and procedures with respect to wound care and failed to provide certain physician-ordered wound treatments to Mrs. Blackburn. [Exhibit 3, Affidavit of Joyce Black,] Additionally, Plaintiff's standard of care expert has opined that Cornerstone neglected to provide a physician ordered Roho cushion (which is a pressure-relieving device) for Mrs. Blackburn's wheelchair. [Exhibit 4, Deposition of Plaintiff's expert, Dr. Joyce Black at 151] Finally, many of the failures on the part of Cornerstone with respect to the wound care provided to Mrs. Blackburn occurred during the wound care nurse's vacation. [Id at 153, 161] Additionally, even after being told by the state what was deficient in their practice regarding pressure sore treatment and documentation, the same acts and omissions continued in regard to Mrs. Blackburn. Here, in addition to the surveys being admissible as public records and admissions,

Plaintiff can demonstrate that the failures on the part of Cornerstone were not simple mistakes but rather that Defendants were well aware of the dangerous conditions in their facility. The DHS surveys are of consequence to determine that Defendants had notice and knowledge of the deficiencies within their long term care hospital and yet failed to correct them, resulting in harm to their residents, including Mrs. Blackburn. In addition, the DHS survey that was conducted at Cornerstone Hospital in June 2008 clearly covered conditions that were present during Mrs. Blackburn's admission.

2. December 2008 Survey

The State of Arizona also conducted a survey of Cornerstone Hospital that was dated December 19, 2008. Although the survey is dated December 19, 2008, it specifically addresses issues which occurred earlier that year that took place either before or during Mrs. Blackburn's admission. For example, the survey references a Cornerstone meeting on February 28, 2008. which indicated that the nursing admission assessment at the Tucson facility was only 83% compliant. [Exhibit 5, December 19, 2008 Survey] The survey also references March 13, 2008 meeting minutes which indicate that chart audit results were not submitted. [*Id.*] The survey references that the March 13, 2008 meeting minutes revealed that medication reconciliation was at 20% and had been reported in January at 30% and in February at 50%, but no actions or follow up notes were recorded. [*Id.*] The survey references that no meeting was conducted in April, 2008. The survey references that the May 16, 2008 meeting minutes indicate that medication documentation was 50%. [*Id.*] Furthermore, the survey references June 2008 meeting minutes which indicate that medication documentation was even lower at 45%. [*Id.*]

The December survey references an interview of Christine Hansen, NR/CEO, who will be testifying at trial where she acknowledged that with the change in QA directors, *many of the identified problem areas at the hospital were not consistently monitored;* the QA director resigned in May 2008 and another QA director was hired but only stayed a short time; a third QA director was hired in August 2008 and resigned in November, 2008. [*Id.*]

The December survey resulted in a citation related to the nurse executive's failure to acquire an acuity plan that included an accurate assessment of all patients' needs as evidenced by not ensuring that all wound care treatments were performed following physician orders for eight patients with skin breakdown. [*Id.*] The survey also referenced that a patient who was to be turned and repositioned every two hours and sacral wound wet to dry dressing changed twice daily yet the dressing was changed only once on 7/17 and 7/19, not at all on 7/20, and once on 7/27 and with respect to turning and repositioning the patient was turned only three times on 6/29 and not at all on 6/30, 7/1, and 7/2/09. *Id.*

Cornerstone Hospital was also cited in the December 2008 survey in that the Chief Clinical Officer failed to provide the number of nursing personnel to provide nursing care to the patients on multiple days in July 2008 as evidenced by patients not being fed, medications not administered timely, wound care treatments not being done, and call lights not being responded to in a timely manner. [*Id.*]

In connection with the December 2008 survey, a minimum of four nurses interviewed acknowledged that nurses had been assigned six or seven patients in the past and that it was difficult to provide all patients' needs when there were so many patients assigned with high acuity levels. [*Id.*] Eight of ten patients expressed concerns with slow response to call lights, especially on the evening shift and one patient and his wife stated they waited 45 minutes for someone to respond. [*Id.*] In connection with the December 2008 survey, two former Cornerstone Hospital employees were interviewed via telephone on December 17, 2008 and stated that assignments were heavy on the 100 unit and frequently the nurses were unable to complete all the nursing tasks assigned. [*Id.*] The Department of Health Services determined that the hospital's quality management program failed to evaluate the patients' quality of care in the following areas: wound care, call light response time, and sufficient staffing to meet patient needs. [*Id.*] The survey indicates that the CEO acknowledged she was aware call lights had been an issue and it was addressed at the nurses' monthly meetings. [*Id.*]

Again, the December 2008 survey findings mirror the failures that occurred in Mrs. Blackburn's care at Cornerstone Hospital and were happening at the same time that Mrs. Blackburn was a resident. Plaintiff here has alleged the same deficiencies

as were present in the survey: understaffing, inadequate documentation, failure to provide physician-ordered treatments and inadequate pressure relief through turning and repositioning. [Exhibit 6, P's 3rd Supplemental Disclosure of Expert Witnesses and Opinions at pp. 11-16] The December 2008 DHS survey clearly demonstrates that Defendants had notice and knowledge of the deficiencies within their long term care hospital and yet failed to correct them, resulting in harm to their residents, including Mrs. Blackburn. In addition, the DHS survey that were conducted at Cornerstone Hospital in December 2008, without question covered conditions and references that were present during Mrs. Blackburn's admission and throughout her admission.

F. ***The Records are Admissible to Support Punitive Damages.***

In *Gurule v. Illinois Mut. Life & Cas. Co.*, 152 Ariz. 600, 602, 734 P.2d 85, 87 (1987), the court discussed instances where the wrongful conduct was not a single instance but was part of a pattern or practice. While a single piece of evidence, taken alone, may not be clear and convincing evidence of an "evil mind" "several pieces of such evidence, taken together, might clear the evidentiary hurdle." *Id.*

Here, Plaintiff intends to introduce evidence contained in the DHS surveys that Defendants knew of deficiencies involving understaffing, woefully inadequate documentation and improper wound care and failed to correct them resulting in injury to Mrs. Blackburn. This evidence is clearly relevant in support of Plaintiff's request for punitive damages. [1]

G. ***Survey Results Are Neither Irrelevant Nor Unfairly Prejudicial.***

Arizona Rules of Evidence, Rule 403 permits a court to exclude relevant evidence "if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." In *Shotwell v. Donahoe*, 207 Ariz. 287. 85 P.3d 1045 (2004), the Arizona Supreme Court held:

A proper Rule 403 balancing of probative value and prejudicial effect begins with a proper assessment of the "probative value of the evidence on the issue for which it is offered." *Stale v. Gibson*, 202 Ariz. 321, 324, 44 P.3d 1001, 1004 (2002) (quoting Joseph M. Livermore, et. al., *Arizona Practice: Law of Evidence* §403, at 82-83, 84-86 (4th ed. 2000) (footnotes omitted). "The greater the probative value, ... and the more significant in the case to which it is addressed, the less probable that the factors of prejudice or confusion can substantially outweigh the value of the evidence." [2]

Id. at 296.

In the instant case, what the Defendants knew about deficiencies at the nursing home prior to and during Mrs. Blackburn's admission and promised the Department of Health Services through their Plans of Correction that these deficiencies would be corrected so that no other patients would be harmed in the future. Thus, the actions they failed to take as a result of this knowledge is critical testimony on issues of their violation of the *Adult Protective Services Act* and the harm that befell Mrs. Blackburn. This evidence is highly probative, and thus will outweigh any prejudice to the Defendants.

It is equally well settled that just because the surveys will hurt the position of the Defendants here does not make it inadmissible. In *State v. Schurz*, 176 Ariz. 46, 52, 859 P.2d 156, 162 (1993) the court held that relevant evidence will generally adversely affect the party against whom it is offered, but that is not the type of prejudice to which Rule 403 speaks.

IV. CONCLUSION.

For the foregoing reasons. Plaintiff respectfully requests this Court deny Defendants' Motion in Limine to preclude Plaintiff from offering regulations as evidence of the standard of care and to exclude DHS surveys.

Dated: January 8, 2013.

WILKES & MCHUGH, P.A.

By: <<signature>>

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Footnotes

1 In *Gunthorpe v. Daniels*, 150 Ga. App. 113, 257 S.E.2d 199 (1979), the Court noted that evidence that the dentist knew his carelessness in the past had caused similar injuries to others, but nevertheless continued his conduct with an indifference to the consequences would be admissible on the issue of malice or wanton conduct or whether the act itself was negligent.

2 In *Advocat, Inc. v. Sauer*, 353 Ark. 29, 60, 11 S.W.3d 346, 364 (2003), the probative value of the OLTC surveys was great. Not only did the surveys show that Rich Mountain was understaffed during the relevant time period, but they also served as evidence that Rich Mountain was put on notice of its failure to address adequacy-of-staff issues in 1997. Although the surveys undoubtedly were prejudicial to appellants, that prejudice did not outweigh the strong probative value of the surveys."

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