2013 WL 4509534 (Pa.Com.Pl.) (Trial Pleading)
Court of Common Pleas of Pennsylvania.
Berks County

Jane L. HAHN, Plaintiff,
v.
5501 PERKIOMEN AVENUE OPERATIONS LLC, d/b/a Berkshire Center.
and
GENESIS HEALTHCARE, LLC, Defendants.

No. 13-19390.
August 13, 2013.

Complaint in Civil Action (Medical Professional Liability Action)

Ruben J. Krisztal, Esquire, Identification No.: 202716, Wilkes & McHugh, P.A., Three Parkway, 1601 Cherry Street, Suite 1300, Philadelphia, PA 19102, Telephone No.: (215) 972-0811, Email: rkrisztal@wilkesmchugh.com.

This is not An Arbitration, Case; An Assessment of, Damages is Required; Jury, Trial Demanded, Attorney for Plaintiff, Jane L. Hahn.

NOTICE TO DEFEND NOTIFICACION PARA DEFENDERSE

NOTICE	**AVISO**
You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.	Le han demandado a usted en el tribunal. St usted quiere defenderse de las demandas expuestas en las paginas siguientes, usted debe tomar accion en el plazo de veinte (20) dias a partir de la fecha en que se le hizo entrega de la demanda y la notificacion, al interponer una comparecencia escrita, en persona o por un abogado y registrando por escrito en el tribunal sus defensas o sus objeciones a las demandas en contra de su persona. Se le advierte que si usted no lo hace, el caso puede proceder sin usted y podria dictarse un fallo por el juez en contra suya sin notificacion adicional y podria ser por cualquier dinero reclamado en la demanda o por cualquier otro reclamo o desagravio en la demanda solicitado por el demandante. Usted puede perder dinero o sus propiedades u otros derechos importantes para usted.
YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW. THIS OFFICE CAN PROVIDE YOU WITH INFORMATION ABOUT HIRING A LAWYER.	USTED DEBE LLEVARLE ESTE DOCUMENTO A SU ABOGADO INMEDIATAMENTE. SI NO TIENE ABOGADO NO PUEDE CORRER CON LOS GASTOS DE UNO, VAYA O LLAME POR TELEFONO A LA OFICINA EXPUESTA ABAJO. ESTA OFICINA PUEDE POVEERLE INFORMACION RESPECTO A COMO CONTRATAR A UN ABOGADO.
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WITH INFORMATION ABOUT AGENCIES THAT MAY OFFER LEGAL SERVICES TO ELIGIBLE PERSONS AT A REDUCED FEE OR NO FEE.	PUDIERA PROVEERLE INFORMACION RESPECTO A INSTITUCIONES QUE PUEDAN OFRECER SERVICIOS LEGALES A PERSONAS QUE CALIFICAN PARA LA REDUCCION DE HONORARIOS O QUE NO TENGAN QUE PAGAR HONORARIOS.
Lawyers' Referral Service of the	Servicio de Recomendacion para Contratar Abogados
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Plaintiff, Jane L. Hahn, by and through her undersigned counsel, Wilkes & McHugh, P.A., files the instant Complaint in Civil Action, and in support thereof avers the following:

I. PARTIES

A. Plaintiff

1. Jane L. Hahn is an adult individual who was a resident at the skilled nursing facility commonly known as Berkshire Center (hereinafter “the Berkshire Facility”) from April 26, 2012 through May 21, 2012.

2. Jane L. Hahn is a citizen of the Commonwealth of Pennsylvania, residing at 300 Tranquility Lane, Liberty Building, Apt 201, Reading, Pennsylvania 19607.

B. Defendants, 5501 Perkiomen Avenue Operations, LLC, d/b/ a Berkshire Center; Genesis Healthcare, LLC (“Defendants”)

3. Defendant, 5501 Perkiomen Avenue Operations, LLC, d/b/a Berkshire Center, 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 5501 Perkiomen Avenue, Reading, Pennsylvania 19606.

4. Defendant, 5501 Perkiomen Avenue Operations, LLC, d/b/a Berkshire Center, is engaged in the business of owning, operating and/or managing nursing homes, including Berkshire Center (“the Facility”), providing healthcare, medical services, nursing care, assisted living/personal care to the public in Reading, Berks County, Pennsylvania, and, was at all times material hereto, duly licensed to operate same in the Commonwealth of Pennsylvania, 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 personally 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 Jane L. Hahn.

5. Defendant, Genesis Healthcare, LLC, is a corporation, duly licensed, organized and existing under and by virtue of the laws of the State of Delaware, with offices and a place of business located at 101 East State Street, Kennett Square, Pennsylvania 19348.

6. Defendant, Genesis Healthcare, LLC, is engaged in the business of owning, operating and/or managing nursing homes, including Berkshire Center ("the Facility"), providing healthcare, medical services, nursing care, assisted living/personal care to the public in Reading, Berks County, Pennsylvania, and, was at all times material hereto, duly licensed to operate same in the Commonwealth of Pennsylvania, 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 personally 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 Jane L. Hahn.

7. Upon present information and belief, at all times material hereto, Defendants individually and collectively, and/or through a joint venture, owned, operated, licensed and/or managed the Facility, and are individually and collectively engaged in the business of providing nursing care and assisted living/personal care services to the general public, which services are akin to the services that hospitals provide.

II. JURISDICTION AND VENUE

8. Jurisdiction and venue are proper in this Honorable Court in Berks County, Pennsylvania, insofar as Defendants regularly conduct business in this county, the cause of action arose in this county and/or the action is being brought in any county which venue may be laid against any defendant. See Pa.R.C.P. 1006 and 2179.

III. FACTUAL BACKGROUND

A. Conduct of the Defendants

9. On April 26, 2012, Jane L. Hahn was admitted to the care of the Facility.

10. During the course of her residency, Jane L. Hahn 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' Facility to obtain such care and protection. [1]

11. The Defendants, through advertising, promotional materials and information sheets, held out themselves and the Facility, as being able to provide skilled nursing and personal care to sick, **elderly** and frail individuals, including Jane L. Hahn.

12. At all times material hereto, the Defendants held themselves out as capable of being able to provide the requisite care to sick, **elderly**, and frail individuals, including, Jane L. Hahn's total health care, including care planning and the provision of medication, medical care and treatment, therapy, nutrition, hydration, hygiene and all activities of daily living.

13. 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 Jane L. Hahn, and promised that they would adequately care for her needs.

14. Defendants exercised complete and total control over the health care of all residents of the Facility, such as Jane L. Hahn.

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

16. At all times material hereto, the control exercised by Defendants included, inter alia: budgeting, marketing, human resource management, training, supervision of staff, staffing, and the creation and implementation of all policy and procedural manuals used by the Facility.

17. Defendants also exercised control over reimbursement, quality care assessment and compliance, licensure, certification, and all financial, tax, and accounting issues.

18. Defendants, by and through their board of directors and corporate officers, utilized survey results and quality indicators to monitor the care being provided at their personal care homes/residential health care/skilled nursing facilities, including the Facility.

19. Defendants exercised ultimate authority over all budgets and had final approval over the allocation of resources to their Facility.

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

21. 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 Facility, and to oversee their conduct in the matters set forth herein.

22. Defendants had an obligation to employ competent, qualified and trained staff so as to ensure that proper treatment was rendered to individuals having medical and nursing problems, such as those presented by Jane L. Hahn as set forth herein.

23. As a part of their duties and responsibilities, Defendants had an obligation to maintain and manage the Facility with adequate staff and sufficient resources to ensure the timely recognition and appropriate treatment of medical conditions suffered by residents, such as Jane L. Hahn, whether within the Facility, or obtained from other medical care providers.

24. Defendants made a conscious decision to operate and/or manage the Facility so as to maximize profits and/or excess revenues at the expense of the care required to be provided to its residents, including Jane L. Hahn.

25. In their effort to maximize profits and/or excess revenues, Defendants negligently, intentionally and/or recklessly mismanaged and/or reduced staffing levels below the level necessary to provide adequate care and supervision to the residents, which demonstrated a failure to comply with the applicable regulations and standards for personal care homes/skilled nursing facilities.

26. Defendants recklessly and/or negligently disregarded the consequences of their actions, and/or negligently caused staffing levels at the Facility to be set at a level such that the personnel on duty could not and did not meet Jane L. Hahn's needs.

27. Over the past several years, and at all times material hereto, Defendants intentionally increased the number of sick, **elderly** and frail residents with greater health problems requiring more complex medical and custodial care.

28. Defendants knew that this increase in the acuity care levels of the resident population would substantially increase the need for staff, services, and supplies necessary for the new resident population.

29. Defendants knew, or should have known, that the acuity needs of the residents in their Facility increased and, therefore, the resources necessary increased, including raising the amount of staffing required to meet the needs of the residents.

30. Defendants failed to provide resources necessary, including sufficiently trained staff, to meet the needs of the residents, including Jane L. Hahn.

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

32. Defendants knowingly disregarded resident 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 treatment.

33. The acts and omissions of Defendants were motivated by a desire to increase profits and/or excess revenues of the Facility, by knowingly, recklessly, and with total disregard for the health and safety of the residents, reducing expenditures for needed staffing, training, supervision, and care to levels that would inevitably lead to severe injuries, such as those suffered by Jane L. Hahn.

34. The actions of Defendants were designed to increase reimbursement by governmental programs.

35. Defendants' financial motives were evidenced by the fact that Jane L. Hahn was not transferred to the appropriate medical Facility and/or Facility with the appropriate level of health care when Defendants knew, or should have known, that they could not meet Jane L. Hahn's needs.

36. The aforementioned acts directly caused injury to Jane L. Hahn and were known by Defendants.

37. Defendants knowingly sacrificed the quality of care received by all residents, including Jane L. Hahn, by failing to manage, care, monitor, document, chart, prevent, diagnose and/or treat the injuries and illnesses suffered by Jane L. Hahn, as described herein, which included receiving toxic doses of Synthroid, delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain.

38. At the time and place of the incidents herein described, the Facility whereupon the incidents occurred was individually, collectively, and/or through a joint venture, owned, possessed, controlled, managed, operated and maintained under the exclusive control of Defendants.

39. At all times material hereto, 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 Defendants herein.

40. The aforementioned incidents were caused solely and exclusively by the negligence, carelessness, and recklessness of 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 Jane L. Hahn.

41. 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 the Plaintiff, Jane L. Hahn, is asserting professional liability claims against Defendants, their agents, servants, contractors, subcontractors, staff and/or employees.

42. In addition to all other claims and demands for damages set forth herein, Plaintiff is asserting claims for ordinary negligence, custodial neglect and corporate negligence against the Defendants herein, as each of the entities named as Defendants herein are directly and vicariously liable for their independent acts of negligence, for their acts of general negligence, and for their acts of general corporate negligence.

B. Injuries of Jane L. Hahn at the Facility

43. At the time of her admission to the care of the Facility on April 26, 2012, Jane L. Hahn had a past medical history including Irritable Bowel Syndrome (IBS).

44. Upon admission to the Facility, Jane L. Hahn, was dependent upon the staff for her mental, physical and medical needs, requiring assistance with activities of daily living, and had various illnesses and conditions that required evaluation and treatment.

45. Defendants knew or should have known that Jane L. Hahn was at risk for aggravation of her IBS and chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain.

46. The Defendants deprived Jane L. Hahn of adequate care, treatment, food, water and medicine and caused her to suffer numerous illnesses and injuries, which upon information and belief, included receiving toxic doses of Synthroid, delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain.

47. The severity of the negligence inflicted upon Jane L. Hahn by the Defendants 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.

48. These injuries, as well as the conduct specified herein, caused Jane L. Hahn to suffer a loss of personal dignity, together with degradation, anguish, emotional trauma, pain and suffering.

49. During her admission, Jane L. Hahn required assistance with care for all of her activities of daily living.

50. Prior to Mrs. Hahn's admission, the hospital had her on a dose of Synthroid 50 meq daily.

51. On 4/27/12, the Facility's physician wrote an order for Mrs. Hahn to have Synthroid 50 meq every day at 6:00. However, the Pharmacy Active Orders form showed that she was receiving Synthroid ***500 meq*** every day at 6:30, ***plus*** Synthroid 50 meq each day.

52. The Medication Administration Record shows that Mrs. Hahn received the toxic dose of Synthroid 550 meq for four days.

53. On 4/30/12, the Medication Administration Record shows that Mrs. Hahn was not receiving her pain medication as ordered.

54. On 5/1/12, Mrs. Hahn complained of low back pain.

55. On 5/10/12, a new order was written for a stool sample to check for C-Diff. A stool specimen was not collected until six days later, however. According to the records, one of the aides actually refused to take the sample because of the nature of the task.

56. On 5/10/12, an order was also made for Lactase tablets before meals. Mrs. Hahn is lactose intolerant and was experiencing diarrhea at the time these Lactase pills were ordered to be given to her.

57. On 5/15/12, her diet was changed to regular diet with chopped meat, despite her history of IBS.

58. On 5/16/12, the specimen of her stool was finally collected, and the report for the culture did not come in until 5/18/12. It was negative for C-Diff.

59. On 5/18/12, a new order was written for Immodium twice a day for two days, but no diagnosis is charted. The Facility failed to start her on Immodium until eight days after her symptoms of diarrhea started. The Facility also only administered one tab each day for three days, contrary to the doctor's orders.

60. According to the medical records, from 5/1-5/20, staff failed to shower or bathe Mrs. Hahn.

61. During her admission, staff had left her lying in her urine and she developed a urinary tract infection.

62. By 5/21/12, Mrs. Hahn had lost 6.6 pounds during her three week admission.

63. The Facility accepted Jane L. Hahn, as a resident fully aware of her medical history and understood the level of nursing care required to prevent the occurrence of her serious injuries.

64. Jane L. Hahn's chart included and evidenced missing and incomplete documentation, including Activities of Daily Living sheets, medication administration records, treatment administration records, and controlled medication utilization record.

65. The severity of the negligence inflicted upon Jane L. Hahn by the Defendants consisted of mismanagement, improper/ under-budgeting, understaffing of the Facility and lack of training of the Facility employees, failure to provide adequate and appropriate health care; engaging in incomplete, inconsistent and fraudulent documentation; failure to develop an appropriate therapeutic care plan; failure to provide proper medication; and failure to provide sufficient food and water to preclude receiving toxic doses of Synthroid, delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain, and failure to ensure the attainment of the highest level of physical, mental and psychosocial functioning.

66. As a result of the negligence, carelessness and recklessness of the Defendants herein described, Jane L. Hahn was caused to suffer serious and permanent injuries as described herein, to, in and about her body and possible aggravation and/or activation of any pre-existing conditions, illnesses, ailments, or diseases she had, and/or accelerated the deterioration of her health, physical and mental condition, and more particularly, receiving toxic doses of Synthroid, delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain, and other body pain and damage, and anxiety reaction and injury to her nerves and nervous system, some or all of which were permanent, together with other medical complications.

VII. COUNT ONE

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

68. 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.

69. At all times material hereto, Defendants had the ultimate responsibility of ensuring that the rights of the residents, including Jane L. Hahn were protected.

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

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

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

73. At all times material hereto, Defendants owed a duty and responsibility to furnish Jane L. Hahn with appropriate and competent nursing and/or total healthcare.

74. 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 Facility, including those suffered by Jane L. Hahn, Defendants failed to take steps to prevent the occurrence of said injuries, illnesses, and/or infections.

75. Defendants knew, or should have known, of the aforementioned problems that were occurring with the care of Jane L. Hahn, as they were placed on actual and/or constructive notice of said problems.

76. Defendants, as the corporate owners, board members and/or managers of the Facility, breached their duty and were, therefore, negligent, careless and reckless in their obligations to Jane L. Hahn.

77. The corporate conduct of Defendants was independent of the negligent conduct of the employees of the Facility, and was outrageous, willful, and wanton, and exhibited a reckless indifference to the health and well-being of the residents, including Jane L. Hahn.

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

79. At all times material hereto, the breach of duties, negligence, carelessness and recklessness of 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 Jane L. Hahn, 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 Defendants, consisted of the following acts and omissions in the care and treatment of Jane L. Hahn:
a. failure to hire appropriately trained staff and/or train, select and retain competent staff who failed to provide adequate nutrition, failed to prevent and engaged in incomplete, inconsistent and fraudulent documentation, failed to follow doctor's orders, failed to provide appropriate treatment and services to prevent receiving toxic doses of Synthroid, delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain, and failed to provide adequate assessments of Jane L. Hahn following a change in condition;

b. knowingly allowing and/or encouraging unskilled and untrained individuals to care for Jane L. Hahn who failed to prevent and engaged in incomplete, inconsistent and fraudulent documentation, failed to follow doctor's orders, failed to provide appropriate treatment and services and to prevent receiving toxic doses of Synthroid, delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain, and failed to provide adequate assessments of Jane L. Hahn following a change in condition;

c. failure to prevent and engage in incomplete, inconsistent and/or fraudulent documentation by failing to consistently complete Activities of Daily Living sheets, failing to document administration of medications, failing to consistently document Treatment Record, and failing to properly complete Medication Administration Records;

d. failure to provide adequate pain management;

e. failure to ensure that Jane L. Hahn did not develop serious and permanent injuries to, in and about her body and possible aggravation and/or activation of any pre-existing conditions, illnesses, ailments, or diseases she had, and/or accelerated the deterioration of her health, physical and mental condition, and more particularly, when she experienced delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain when the Defendants knew or should have known that she was at risk for the same;

f. failure to respond in a timely manner with appropriate medical care when Jane L. Hahn was injured, including when she experienced receiving toxic doses of Synthroid, suffered delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain, when Defendants knew or should have known that she was at risk for the same;

g. failure to provide adequate and appropriate health care by failing to keep Jane L. Hahn free from infection, failing to respond to a change in condition in a timely manner, failing to provide an adequate assessment following a change in condition, failing to provide adequate hygiene, failed to follow doctor's orders, failing to provide appropriate treatment and services to prevent receiving toxic doses of Synthroid, delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain, and failing to administer ordered medications and treatments;

h. failure to ensure complete, consistent documentation and avoid fraudulent documentation by failing to update MDS with significant changes in conditions, and failing to provide complete and consistent documentation;

i. failure to develop an appropriate therapeutic care plan by failing to develop a comprehensive care plan and revise it to reflect current conditions, and failing to provide social services such as physical therapy, occupational therapy and speech therapy in order to attain the highest practicable physical, mental, and social well-being;

j. failure to ensure that each resident received and that the Facility provided 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;

k. failure to ensure that the Facility used 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 included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are 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;

1. failure to ensure that the Facility had 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 twenty-four hour basis to provide nursing care to all residents in accordance with resident care plans;

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

n. failure to develop and implement written policies and procedures that prohibit mistreatment, neglect, and **abuse** of residents and misappropriation of the resident's property;

o. failure to ensure that the services provided or arranged by the Facility were provided by qualified persons in accordance with each resident's written plan of care;

p. failure to oversee and supervise all persons who practiced nursing and/or skilled healthcare in the Facility who failed to prevent receiving toxic doses of Synthroid, delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain;

q. failure to formulate, adopt and enforce adequate rules, procedures and policies to ensure quality healthcare for residents by failing to: follow doctor's orders, provide adequate and appropriate health care to prevent receiving toxic doses of Synthroid, delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain, and provide complete and consistent documentation, provide appropriate treatment, services and adequate assessments following change in condition to prevent receiving toxic doses of Synthroid, delays in obtaining medical treatment that aggravated her IBS and caused chronic diarrhea, urinary tract infection, weight loss, poor hygiene, and severe pain;

r. failure to undertake and/or implement the instructions provided by physicians and notify the physicians of change in the condition of Jane L. Hahn;

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

t. failure to provide Jane L. Hahn with the necessary care and services to allow her to attain or maintain the highest practicable physical, mental and psychological well-being;

u. failure to assist Jane L. Hahn in her personal hygiene;

v. failure to ensure that the Facility was properly funded;

w. failure to implement a budget that would allow the Facility to provide adequate and appropriate healthcare to Jane L. Hahn including adequate staff and supplies;

x. grossly understaffing the Facility;

y. failure to take appropriate steps to remedy continuing problems at the Facility that Defendants knew were occurring with Jane L. Hahn'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;

z. failure 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;

aa. failure to maintain open lines of communication with the governing body, department heads, Facility staff and its residents to ensure that resources were properly allocated and that resident care was maintained at a high level;

bb. failure to maintain compliance with governmental regulations;

cc. failure 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;

dd. failure to coordinate training programs to improve employee skills and to enhance employee performance;

ee. failure to develop a budget with an objective of the delivery of quality care; and,

ff. acting in a grossly negligent manner, with reckless indifference to the rights and safety of Jane L. Hahn.

80. Upon information and belief, the corporate officers of the Defendants were made aware of the governmental/state survey results and placed on notice of the issues with resident care at their Facility.

81. Upon information and belief, 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 failures at the Facility on: 9/19/08 failed to follow physician's orders relating to bowel management; 10/9/09 failed to provide care that maintained resident dignity on two of two nursing care units; failed to maintain complete and accurate clinical records for eight of 25 residents; failed to ensure sanitary practices were maintained to ensure the spread of infection; failed to ensure that its medication error rate was below five percent (it was over 16 percent); failed to ensure medical justification for the use of an antipsychotic medication; failed to revise and update comprehensive care plans; failed to follow physician's orders; 9/2/10 failed to ensure that the MDS assessments accurately reflected each resident's status for three of 24 sampled residents; failed to address unplanned weight loss; and 9/21/12 failed to address a resident's unplanned weight loss; failed to implement a policy to identify and control the spread of infection.

82. Defendants, knew that the violations were not isolated events and were, at times, described as repeat deficiencies, which placed them on notice of failures to provide proper care and treatment to residents, including Jane L. Hahn.

83. 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, Jane L. Hahn, suffered (a) severe permanent physical injuries resulting in severe 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 Facility, and (e) aggravation of her pre-existing medical conditions.

84. In causing the aforementioned injuries, Defendants knew, or should have known, that Jane L. Hahn, would suffer such harm.

85. The conduct of Defendants was intentional, outrageous, willful and wanton, and exhibited a reckless indifference to the health and well-being of Jane L. Hahn.

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

WHEREFORE, Plaintiff, Jane L. Hahn, respectfully requests that judgment be entered in her favor, and against 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.

IX. COUNT TWO

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

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

88. 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.

89. 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.

90. At all times pertinent hereto, Jane L. Hahn was a care dependent resident of the Defendants' Facility, 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 the Defendants' conduct.

91. 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 Jane L. Hahn sustained.

92. The Defendants, in accepting the responsibility for caring for Jane L. Hahn 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 Jane L. Hahn for whom they were responsible to provide care as specifically set forth in this Complaint;

93. As a direct result of the aforesaid negligence "per se" of the Defendants, Jane L. Hahn was caused to sustain serious personal injuries and damages as aforesaid.

94. The conduct of the Defendants, and each of them, as specifically set forth in this 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, Jane L. Hahn, respectfully requests that judgment be entered in her favor, and against 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.

IX. COUNT THREE

NEGLIGENCE PER SE FOR VIOLATIONS OF PENNSYLVANIA OLDER ADULTS PROTECTIVE SERVICES ACT, 35 P.S. §10225.101, et seq.

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95. Plaintiff incorporates herein by reference the preceding paragraphs as through the same were more fully set forth at length herein.

96. At all times pertinent hereto, there was in full force and effect 35 P.S. § 10225.101, *et seq.*, "Pennsylvania Older Adults Protective Services Act," which sets forth civil penalties, administrative penalties and other consequences for **abuse** of a care-dependent person.

97. 35 P.S. § 10225.102, expresses the policy of the Commonwealth of Pennsylvania that:

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

98. At all times pertinent hereto, Jane L. Hahn was an older person who was a resident of Defendants' Facility who lacked the capacity to protect herself and thus fell within the class of persons 35 P.S. § 10225.101, et seq. was intended to protect, thus entitling Plaintiff to adopt 35 P.S. § 10225.101, et seq. as the standard of care for measuring the Defendants' conduct.

99. Additionally, the Pennsylvania Older Adults Protective Services Act is directed, at least in part, to obviate the specific kind of harm which Jane L. Hahn sustained.

100. In addition to the aforesaid negligence, which said negligence is specifically incorporated herein, the Defendants, in accepting the responsibility for caring for Jane L. Hahn as aforesaid, were negligent “per se” and violated 35 P.S. § 10225.101, et seq. in that they had reasonable cause to suspect that Jane L. Hahn was the victim of **abuse** or neglect and failed to report said **abuse** and neglect to the appropriate agency and law enforcement officials.

101. As a direct result of the aforesaid negligence “per se” of the Defendants, Jane L. Hahn was caused to sustain serious personal injuries and damages as aforesaid.

102. The conduct of Defendants, and each of them, as specifically set forth in this 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, Jane L. Hahn, respectfully requests that judgment be entered in her favor, and against 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.

Dated: 8/12/2013

Respectfully submitted,

WILKES & McHUGH, P.A.

By:

Ruben J. Krisztal, Esquire

Attorney for Plaintiff

Footnotes

1 Plaintiff is not bringing any claim pursuant to Pa. St. 62 P.S. § 1407(c), and nothing in this Complaint should be interpreted as an attempt to recover damages pursuant to that statute.