2012 WL 12092411 (Pa.Com.Pl.) (Trial Pleading)
Court of Common Pleas of Pennsylvania.
Philadelphia County

Patrick J. MACPHERSON, Executor of the Estate of Richard Macpherson, Deceased, Plaintiff,
v.
THE MAGEE MEMORIAL HOSPITAL FOR CONVALESCENCE d/b/a Magee Rehabilitation Hospital,
and
JEFFERSON HEALTH SYSTEM, INC.,
and
Tjuh SYSTEM,
and
MANOR CARE OF YEADON PA, LLC, d/b/a, Manorcare Health Services-Yeadon,
and
HCR MANORCARE, INC.,
and
MANORCARE, INC.,
and
HCR HEALTHCARE, LLC,
and
HCR II HEALTHCARE, LLC,
and
HCR III HEALTHCARE, LLC, Defendants.

No. 111000191.
March 19, 2012.

October Term, 2011
This is not An Arbitration Case an Assessment of Damages is Required; Jury Trial Demanded

Amended Complaint

Wilkes & McHugh, P.A., Ruben J. Krisztal, Esquire, Attorney Identification No. 202716, 1601 Cherry Street, Suite 1300, Philadelphia, PA 19102, Tel No. (215) 972-0811, Email: rkrisztal@wilkesmchugh.com, for plaintiff, Patrick J. Macplers Executor of the Estate of Richard Macphrson, Deceased.

NOTICE TO DEFEND

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 in Civil Action and Notice to Defend 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 claim or relief requested by Plaintiffs. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE OR KNOW A LAWYER, THEN YOU SHOULD GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP.

PHILADELPHIA BAR ASSOCIATION

Lawyer Referral and Information Service

1101 Market Street, 11th Floor

Philadelphia, Pennsylvania 19107

(215) 238-1701

AVISO

Le han demandado a usteden la corte. Si usted quiere defenderse de estas demandas expuestas en las paginas siguientes, usted tiene veinte (20) dias de plazo al partir de la fecha de la demanda y la notificacion. Hace falta asentar una comparencia escrita o en persona o con un abogado y entregar a la corte en forma escrita sus defensas o sus objeciones a las demandas en contra de su persona. Sea avisado que si usted no se defiende, la corte tomara medidas y puede continuar la demanda en contra suya sin previo aviso o notificacion. Ademas, la corte puede decidir a favor del demandante y requiere que usted cumpla con todas las provisiones de esta demanda. Usted puede perder dinero o sus propiedades u otros derechos importantes para usted.

LLEVE ESTA DEMANDA A UN ABOGADO INMEDIATAMENTE. SI NO TIENE ABOGADO O SI NO TIENE EL DINERO SUFICIENTE DE PAGAR TAL SERVICIO, VAYA EN PERSONA O LLAME POR TELEFONO A LA OFICINA CUYA DIRECCION SE ENCUENTRA ESCRITA ABAJO PARA AVERIGUAR DONDE SE PUEDE CONSEGUIR ASISTENCIA LEGAL.

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AMENDED COMPLAINT IN CIVIL ACTION

(Medical Professional Liability Action)

Plaintiff, Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased, by and through counsel, Wilkes & McHugh, P.A., files the within Amended Complaint in Civil Action as follows:

I. PARTIES

a. Plaintiff

1. Richard MacPherson, was an adult individual and resident at Magee Rehabilitation Hospital, a hospital, located at 1513 Race St., Philadelphia, PA 19102, from August 20, 2009, through September 15, 2009, and a resident at ManorCare Health Services - Yeadon, a nursing home facility located at 14 Lincoln Ave., Yeadon, PA 19107, from September 15, 2009, through February 1, 2010, with the exception of hospitalizations.

2. Richard MacPherson, died on February 1, 2010.

3. Patrick J. MacPherson is the brother of Richard MacPherson, deceased, and is an adult individual and citizen of the Commonwealth of Pennsylvania, residing at residing at 341 Hanby Circle, Boothwyn, PA 19061.

4. Plaintiff, Patrick J. MacPherson, was appointed Executor of the Estate of Richard MacPherson, deceased, on February 18, 2010, by the Register of Wills of Delaware County.

A. Defendants, The Magee Memorial Hospital for Convalescence d/b/a Magee Rehabilitation Hospital; Jefferson Health System, Inc.; TJUH System ("Jefferson Defendants")

5. Defendant, The Magee Memorial Hospital for Convalescence d/b/a Magee Rehabilitation Hospital, 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 6 Franklin Plaza, Philadelphia, PA 19102 and 1513 Race Street, Philadelphia, PA 19102, respectively.

6. Defendant, The Magee Memorial Hospital for Convalescence d/b/a Magee Rehabilitation Hospital, is engaged in the business of owning, operating and/or managing hospital facilities, including Magee Rehabilitation Hospital (hereinafter "the Jefferson Facility"), providing health care, medical services, rehabilitation services, and assisted living/personal care/skilled nursing to the public in Philadelphia County, Pennsylvania and, was at all times material hereto, duly licensed to operate the Jefferson Facility, and was the employer, supervisor and/or partner of all other Jefferson Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the Jefferson Facility, out to the public as competent and skillful health care providers 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 Jefferson Defendants, all of whom played a role in the care of Richard MacPherson.

7. Defendant, Jefferson Health System, 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 259 N. Radnor Chester Rd, Radnor, Pennsylvania 19087.

8. Defendant, Jefferson Health System, Inc., is engaged in the business of owning, operating and/or managing hospital facilities, including Magee Rehabilitation Hospital (hereinafter "the Jefferson Facility"), providing health care, medical services, and assisted living/personal care/skilled nursing to the public in Philadelphia County, Pennsylvania and, was at all times material hereto, duly licensed to operate the Jefferson Facility, and was the employer, supervisor and/or partner of all other Jefferson Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the Jefferson Facility, out to the public as competent and skillful health care providers 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 Jefferson Defendants, all of whom played a role in the care of Richard MacPherson.

9. Defendant, TJUH System, 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 925 Chestnut Street, #311, Philadelphia, Pennsylvania 19107.

10. Defendant, TJUH System, is engaged in the business of owning, operating and/or managing hospital facilities, including Magee Rehabilitation Hospital (hereinafter "the Jefferson Facility"), providing health care, medical services, rehabilitation services, and assisted living/personal care/skilled nursing to the public in Philadelphia County, Pennsylvania and, was at all times material hereto, duly licensed to operate the Jefferson Facility, and was the employer, supervisor and/or partner of all other Jefferson Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the Jefferson Facility, out to the public as competent and skillful health care providers 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 Jefferson Defendants, all of whom played a role in the care of Richard MacPherson.

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

B. Defendants, Manor Care of Yeadon PA, LLC, d/b/a ManorCare Health Services - Yeadon; HCR ManorCare, Inc.; Manor Care, Inc.; HCR II Healthcare, LLC; HCR III Healthcare, LLC; and HCR Healthcare, LLC ("ManorCare Defendants")

12. Defendant, Manor Care of Yeadon PA, LLC, d/b/a ManorCare Health Services - Yeadon, 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 333 North Summit Street, Toledo, Ohio 43604 and 14 Lincoln Avenue, Yeadon, Pennsylvania 19050, respectively.

13. Defendant, Manor Care of Yeadon PA, LLC, d/b/a ManorCare Health Services - Yeadon, is engaged in the business of owning, operating and/or managing skilled nursing facilities, including ManorCare Health Services - Yeadon ("ManorCare Facility"), providing healthcare, medical services, nursing care, assisted living/personal care to the public in Yeadon, Delaware 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 ManorCare Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the ManorCare 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 ManorCare Defendants, all of whom played a role in the care of Richard MacPherson.

14. Defendant, HCR Manor Care, Inc., 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 333 North Summit Street, Toledo, Ohio 43604.

15. Defendant, HCR Manor Care, Inc., is engaged in the business of owning, operating and/or managing skilled nursing facilities, including ManorCare Health Services - Yeadon ("ManorCare Facility"), providing healthcare, medical services, nursing care, assisted living/personal care to the public in Yeadon, Delaware 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 ManorCare Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the ManorCare 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 ManorCare Defendants, all of whom played a role in the care of Richard MacPherson.

16. Defendant, Manor Care, Inc., 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 333 North Summit Street, Toledo, Ohio 43604.

17. Defendant, Manor Care, Inc., is engaged in the business of owning, operating and/or managing skilled nursing facilities, including ManorCare Health Services - Yeadon ("ManorCare Facility"), providing healthcare, medical services, nursing care, assisted living/personal care to the public in Yeadon, Delaware 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 ManorCare Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the ManorCare 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 ManorCare Defendants, all of whom played a role in the care of Richard MacPherson.

18. Defendant, HCR II 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 333 North Summit Street, Toledo, Ohio 43604.

19. Defendant, HCR II Healthcare, LLC, is engaged in the business of owning, operating and/or managing skilled nursing facilities, including ManorCare Health Services - Yeadon ("ManorCare Facility"), providing healthcare, medical services, nursing care, assisted living/personal care to the public in Yeadon, Delaware 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 ManorCare Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the ManorCare 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 ManorCare Defendants, all of whom played a role in the care of Richard MacPherson.

20. Defendant, HCR III 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 333 North Summit Street, Toledo, Ohio 43604.

21. Defendant, HCR III Healthcare, LLC, is engaged in the business of owning, operating and/or managing skilled nursing facilities, including ManorCare Health Services - Yeadon ("ManorCare Facility"), providing healthcare, medical services, nursing care, assisted living/personal care to the public in Yeadon, Delaware 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 ManorCare Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the ManorCare 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 ManorCare Defendants, all of whom played a role in the care of Richard MacPherson.

22. Defendant, HCR 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 333 North Summit Street, Toledo, Ohio 43604.

23. Defendant, HCR Healthcare, LLC, is engaged in the business of owning, operating and/or managing skilled nursing facilities, including ManorCare Health Services - Yeadon ("ManorCare Facility"), providing healthcare, medical services, nursing care, assisted living/personal care to the public in Yeadon, Delaware 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 ManorCare Defendants, noted herein, holding itself and its agents, employees, servants, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the ManorCare 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 ManorCare Defendants, all of whom played a role in the care of Richard MacPherson.

24. Upon present information and belief, at all times material hereto, ManorCare Defendants individually and collectively, and/or through a joint venture, owned, operated, licensed and/or managed the ManorCare 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

25. Jurisdiction and venue are proper in this Honorable Court in Philadelphia 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 Jefferson Defendants

26. On August 20, 2009, Richard MacPherson, was admitted to the care of the Jefferson Facility.

27. During the course of his admission, Richard MacPherson, was incapable of independently providing for all of his daily care and personal needs without reliable assistance. In exchange for monies, he was admitted to Jefferson Defendants' Facility to obtain such care and protection.

28. The Jefferson Defendants, through advertising, promotional materials and information sheets, held out themselves and the Jefferson Facility, as being able to provide medical, rehabilitation and nursing care to sick, **elderly** and frail individuals, including Richard MacPherson.

29. At all times material hereto, the Jefferson Defendants held themselves out as capable of being able to provide the requisite care to sick, **elderly**, and frail individuals, including, Richard MacPherson'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.

30. At the time of his admission, the Jefferson Defendants, individually and/or through their agents, employees, servants, contractors, subcontractors, staff and representatives, assessed the needs of Richard MacPherson, and promised that they would adequately care for his needs in accordance to the acceptable standards of care.

31. Jefferson Defendants exercised complete and total control over the health care of all patients of the Jefferson Facility, such as Richard MacPherson.

32. Upon information and belief, at all times hereto, Jefferson 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 Jefferson Facility.

33. At all times material hereto, the control exercised by Jefferson 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 Jefferson Facility.

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

35. Jefferson Defendants, by and through their board of directors and corporate officers, utilized survey results and quality indicators to monitor the care being provide at their hospital facilities, including the Jefferson Facility.

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

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

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

39. Jefferson Defendants had an obligation to employ competent, qualified and trained staff so as to ensure that proper treatment was rendered to individuals having medical problems, such as those presented by Richard MacPherson as set forth herein.

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

41. At all times material hereto, Jefferson Defendants made a conscious decision to operate and/or manage the Jefferson Facility so as to maximize profits and/or excess revenues at the expense of the care required to be provided to its patients, including Richard MacPherson.

42. In their effort to maximize revenues, Jefferson Defendants negligently, intentionally and/or recklessly mismanaged and/or reduced staffing levels below the level necessary to provide adequate care and supervision to the patients, which demonstrated a failure to comply with the applicable regulations and standards for hospitals.

43. Jefferson Defendants recklessly and/or negligently disregarded the consequences of their actions, and/or negligently caused staffing levels at the Jefferson 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 patients, including Richard MacPherson.

44. Over the past several years, and at all times material hereto, Jefferson Defendants had intentionally increased the number of sick, **elderly** and frail patients with greater health problems requiring more complex medical and nursing care.

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

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

47. Jefferson Defendants failed to provide resources necessary, including sufficiently trained staff, to meet the needs of the patients, including Richard MacPherson.

48. Jefferson Defendants knowingly established staffing levels that created recklessly high patient to staff ratios, including high patient to nurse ratios.

49. Jefferson 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 treatment.

50. The acts and omissions of Jefferson Defendants were motivated by a desire to increase revenues of the Jefferson Facility, by knowingly, recklessly, and with total disregard for the health and safety of the patients, reducing expenditures for needed staffing, training, supervision, and care to levels that would inevitably lead to severe injuries, such as those suffered by Richard MacPherson.

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

52. The aforementioned acts directly caused injury to Richard MacPherson and were known by Jefferson Defendants.

53. During the admission of Richard MacPherson at the Jefferson Facility, Jefferson Defendants knowingly sacrificed the quality of care received by all patients, including Richard MacPherson, by failing to manage, care, monitor, document, chart, prevent, diagnose and/or treat the injuries and illnesses suffered by Richard MacPherson, as described herein, which included development/worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, and severe pain.

54. At the time and place of the incidents herein described, the Jefferson 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 Jefferson Defendants.

55. At all times material hereto, Jefferson 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 Jefferson Defendants herein.

56. The aforementioned incidents were caused solely and exclusively by the negligence, carelessness, and recklessness of Jefferson 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 Richard MacPherson.

57. Richard MacPherson was a patient of the Jefferson Facility from August 20, 2009, through September 15, 2009, when during the relevant time period, a continuing course of conduct by Jefferson Defendants' actions and/or lack of actions, which included mismanagement, understaffing, and lack of training and supervision, were the cause of serious events involving Richard MacPherson and his serious and permanent injuries, and damages, hereinafter alleged by Plaintiff, Patrick J. MacPherson, that occurred at the Jefferson Facility.

58. Jefferson 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, Patrick J. MacPherson, is asserting professional liability claims against Jefferson Defendants, their agents, servants, contractors, subcontractors, staff and/or employees.

B. Injuries of Richard MacPherson at the Jefferson Facility

59. At the time of his admission to the care of the Jefferson Facility on August 20, 2009, Richard MacPherson, had a past medical history including hypertension, hyperlipidemia; Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Insulin Dependence Diabetes; Hepatitis C Virus; Depression; Neurogenic Bowel/Bladder (Incontinent); smoking; fractured right shoulder; IVDA (Cocaine/Heroin); Illicit Drug **Abuse** (Cannabis/Benzos); Chronic Pain Management Opiates; and malnourishment.

60. Upon admission to the Jefferson Facility, Richard MacPherson, was dependent upon the staff for his mental, physical, psychological and medical needs, requiring extensive to total assistance with activities of daily living, and had various illnesses and conditions that required evaluation and treatment.

61. Richard MacPherson was at risk for development/worsening of multiple pressure ulcers, urinary tract infections, weight loss, and severe pain.

62. Over the course of the admission of Richard MacPherson at the Jefferson Facility, Jefferson Defendants engaged in a pattern of care replete with harmful and injurious commissions, omissions and neglect as described herein.

63. The Jefferson Defendants deprived Richard MacPherson of adequate care, treatment, food, water and medicine and caused him to suffer numerous illnesses and injuries, which upon information and belief, included development/worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, and severe pain.

64. The severity of the recurrent negligence inflicted upon Richard MacPherson, while in the care of the Jefferson Defendants during his admission at the Jefferson Facility, accelerated the deterioration of his health and physical condition, and resulted in physical and emotional injuries that caused him severe pain, suffering and mental anguish.

65. These injuries, as well as the conduct specified herein, caused Richard MacPherson, to suffer a loss of personal dignity, together with degradation, anguish, emotional trauma, pain and suffering.

66. On his August 20, 2009 admission, Richard MacPherson required extensive to total care with all of his activities of daily living.

67. He weighed 159 pounds on admission, and was documented with several lesions, scrapes, and other skin injuries as follows: generalized body lesions, scrapes, and bruising; left foot and right foot lesions, neither staged nor measured; right gluteal fold wound, stage II, measuring 2x1cm; left heel deep tissue injury; right fifth toe blister; left axilla rash; low sacrum scabs/abrasions, not staged, measured as 4x4cm; and excoriated scrotum.

68. Skin assessments and wound care were ordered to be done twice daily.

69. On 8/21/09, Mr. MacPherson was identified with new wounds. These included: Right ischial wound, unstageable, unmeasured; and Fungal Dermatitis versus Excoriation to his bilateral buttocks/perineum/periwound. The bilateral buttocks skin injury was noted as 20 x 25 cm. He also had large bruises to his left elbow and right lateral flank.

70. On 8/22/09, Mr. MacPherson was noted to have fever of 101 degrees, pulmonary congestion, and decreased oxygen saturations. Updrafts were initiated every six hours for exacerbation of COPD.

71. On 8/23/09, he was noted to have severe anxiety and emotional issues, displayed by visible shaking and crying.

72. On 8/24/09, Mr. MacPherson was seen by nutrition due to inconsistent oral and nutritional intake.

73. On 8/25/09, labs revealed that his white blood count was down, his albumin was down, and his urinalysis was positive for bacteria. He was initiated on antibiotic for a urinary tract infection.

74. Spandaid boots were ordered to be worn at all times after physical therapy noted his left lateral foot with deep tissue injury. Lateral transfer training was placed on hold by the wound care nurse due to his skin wounds.

75. On 8/26/09, he continued with poor oral and nutritional intake. His lips, tongue, and mucous members were “very” dry - dehydrated. His Insulin was adjusted to fluctuating blood sugars.

76. The physician continued to note chronic decubitus ulcer over entirety of his buttocks. Mr. MacPherson expressed to nursing staff that he wanted “to die,” that he could not live like this. He was placed on 1:1 observation and psych consult requested.

77. Mr. MacPherson's nutritional intake remained poor.

78. On 9/1/09, labs revealed his white blood count was low, his platelet count was low, and his albumin was low.

79. On 9/1/09, Nursing noted his right foot and right plantar foot - 5th digit healed.

80. On this same day his sacral/coccyx worsened and described as a deep tissue injury, measuring 6.5 x 2.4cm.

81. His weight on 9/3/09 was noted at 142 pounds (a loss of 17 pounds) since admission.

82. On 9/09/09, a low grade temperature was noted. Labs revealed his white blood count and albumin was low.

83. 9/11/09, Nursing noted a new wound to the right heel, unstaged/unmeasured.

84. On 9/12/09, a new wound was noted to his right lateral foot, described as a deep tissue injury, with skin intact, and unmeasured.

85. His weight on 09/13/09 was noted at 134 pounds, a loss of 25 pounds since admission.

86. On 09/14/09, labs revealed that his albumin was again low.

87. At discharge on 09/15/09, he was noted as depressed with a flat affect with minimal insight to current circumstances and struggled to cope. His attitude was withdrawn/passive with impaired judgment, problem solving, and recall.

88. At discharge, the wound care nurse and staff nurse documented his wounds inconsistently: He had either an unstageable or a.5x.lcm Stage III sacral/coccyx wound, a left heel wound that was either healed or unknown stage, a right ischial wound that was neither described, measured or staged, and a buttocks wound.

89. The Jefferson Facility accepted Richard MacPherson, as a patient fully aware of his medical history and understood the level of nursing care required to prevent his serious injuries from occurring.

90. Throughout Richard MacPherson's chart there is missing and incomplete documentation, including Activities of Daily Living sheets, medication administration records, treatment administration records, and controlled medication utilization record.

91. The Jefferson Defendants deprived Richard MacPherson, of adequate and appropriate healthcare as a result of mismanagement, improper/under-budgeting, understaffing of the Jefferson Facility and lack of training of the Jefferson Facility

employees, in that they failed to provide adequate and appropriate health care; engaged in incomplete, inconsistent and fraudulent documentation; failed to develop an appropriate therapeutic care plan; provide proper medication; provide sufficient food and water to preclude malnutrition and dehydration, failed to prevent development/worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, and severe pain, and failed to ensure the highest level of physical, mental and psychosocial functioning was attained.

92. The severity of the recurrent negligence inflicted upon Richard MacPherson, while in the Jefferson Defendants' care consisted of mismanagement, improper/under-budgeting, understaffing of the Jefferson Facility and lack of training of the Jefferson Facility employees, in that they failed to provide adequate and appropriate health care; engaged in incomplete, inconsistent and fraudulent documentation; failed to develop an appropriate therapeutic care plan; provide proper medication; provide sufficient food and water to preclude malnutrition and dehydration, failed to prevent unnecessary falls; and, failed to ensure the highest level of physical, mental and psychosocial functioning was attained.

93. As a result of the negligence, carelessness and recklessness of the Jefferson Defendants herein described, Richard MacPherson, was caused to suffer serious and permanent injuries as described herein, to, in and about his body and possible aggravation and/or activation of any pre-existing conditions, illnesses, ailments, or diseases he had, and/or accelerated the deterioration of his health, physical and mental condition, and more particularly, development/worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, and severe pain, and other body pain and damage, and anxiety reaction and injury to his nerves and nervous system, some or all of which were permanent, together with other medical complications.

C. Conduct of the ManorCare Defendants

94. On September 15, 2009, Richard MacPherson, was admitted to the care of the ManorCare Facility.

95. During the course of his residency, Richard MacPherson, was incapable of independently providing for all of his daily care and personal needs without reliable assistance. In exchange for monies, he was admitted to ManorCare Defendants' Facility to obtain such care and protection.

96. The ManorCare Defendants, through advertising, promotional materials and information sheets, held out themselves and the ManorCare Facility, as being able to provide skilled nursing and personal care to sick, **elderly** and frail individuals, including Richard MacPherson.

97. At all times material hereto, the ManorCare Defendants held themselves out as capable of being able to provide the requisite care to sick, **elderly**, and frail individuals, including, Richard MacPherson' 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.

98. At the time of his admission, the ManorCare Defendants, individually and/or through their agents, employees, servants, contractors, subcontractors, staff and representatives, assessed the needs of Richard MacPherson, and promised that they would adequately care for his needs.

99. ManorCare Defendants exercised complete and total control over the health care of all residents of the ManorCare Facility, such as Richard MacPherson.

100. Upon information and belief, at all times hereto, ManorCare 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 ManorCare Facility.

101. At all times material hereto, the control exercised by ManorCare 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 ManorCare Facility.

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

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

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

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

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

107. ManorCare Defendants had an obligation to employ competent, qualified and trained staff so as to ensure that proper treatment was rendered to individuals having medical problems, such as those presented by Richard MacPherson as set forth herein.

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

109. At all times material hereto, ManorCare Defendants made a conscious decision to operate and/or manage the ManorCare Facility so as to maximize profits and/or excess revenues at the expense of the care required to be provided to its residents, including Richard MacPherson.

110. In their effort to maximize profits and/or excess revenues, ManorCare 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.

111. ManorCare Defendants recklessly and/or negligently disregarded the consequences of their actions, and/or negligently caused staffing levels at the ManorCare 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 Richard MacPherson.

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

113. ManorCare 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.

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

115. ManorCare Defendants failed to provide resources necessary, including sufficiently trained staff, to meet the needs of the residents, including Richard MacPherson.

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

117. ManorCare 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 treatment.

118. The acts and omissions of ManorCare Defendants were motivated by a desire to increase profits and/or excess revenues of the ManorCare 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 Richard MacPherson.

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

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

121. The aforementioned acts directly caused injury to Richard MacPherson and were known by ManorCare Defendants.

122. During the residency of Richard MacPherson at the ManorCare Facility, ManorCare Defendants knowingly sacrificed the quality of care received by all residents, including Richard MacPherson, by failing to manage, care, monitor, document, chart, prevent, diagnose and/or treat the injuries and illnesses suffered by Richard MacPherson, as described herein, which included development/worsening of multiple pressure ulcers, skin tears, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, and death.

123. At the time and place of the incidents herein described, the ManorCare 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 ManorCare Defendants.

124. At all times material hereto, ManorCare 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 ManorCare Defendants herein.

125. The aforementioned incidents were caused solely and exclusively by the negligence, carelessness, and recklessness of ManorCare 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 Richard MacPherson.

126. Richard MacPherson was a resident of the ManorCare Facility from September 15, 2009, through February 1, 2010, with the exception of hospitalizations, when during the relevant time period, a continuing course of conduct by ManorCare Defendants' actions and/or lack of actions, which included mismanagement, understaffing, and lack of training and supervision, were the cause of serious events involving Richard MacPherson and his serious and permanent injuries, damages, and death, hereinafter alleged by Plaintiff, Patrick J. MacPherson, that occurred at the ManorCare Facility.

127. ManorCare 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, Patrick J. MacPherson, is asserting professional liability claims against ManorCare Defendants, their agents, servants, contractors, subcontractors, staff and/or employees.

D. Injuries of Richard MacPherson at the ManorCare Facility

128. At the time of his admission to the care of the ManorCare Facility on September 15, 2009, Richard MacPherson, had a past medical history including that detailed in paragraph 60, supra, as well as the injuries sustained at the Jefferson Facility.

129. Upon admission to the ManorCare Facility, Richard MacPherson, was dependent upon the staff for his mental, physical and medical needs, requiring assistance with activities of daily living, and had various illnesses and conditions that required evaluation and treatment.

130. Richard MacPherson was at risk for falls, development/worsening of pressure ulcers, skin tears, weight loss, urinary tract infections, and death.

131. Over the course of the residency of Richard MacPherson at the ManorCare Facility, ManorCare Defendants engaged in a pattern of care replete with harmful and injurious commissions, omissions and neglect as described herein.

132. The ManorCare Defendants deprived Richard MacPherson of adequate care, treatment, food, water and medicine and caused him to suffer numerous illnesses and injuries, which upon information and belief, included development/worsening of multiple pressure ulcers, skin tears, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, and death.

133. The severity of the recurrent negligence inflicted upon Richard MacPherson, while in the care of the ManorCare Defendants during his residency at the ManorCare Facility, accelerated the deterioration of his health and physical condition, and resulted in physical and emotional injuries that caused him severe pain, suffering and mental anguish, together with unnecessary hospitalizations, and death.

134. These injuries, as well as the conduct specified herein, caused Richard MacPherson, to suffer a loss of personal dignity, together with degradation, anguish, emotional trauma, pain and suffering, and death.

135. On his September 15, 2009 admission, Richard MacPherson required assistance in care with all of his activities of daily living.

136. On 9/15/09, he weighed 136.8 pounds and was incontinent of bowel. He was documented with a left heel intact blister that measured 0.6 x 0.4cm without drainage; sacral/coccyx with intact skin and red tissue that measured 0.4 x 0.2cm; and right lateral foot with black tissue that measured 1.5 x 1.0cm. He scored a 16 (at risk) on the Braden Scale for Pressure Sore Risk.

137. By 9/19/09, he had lost almost six pounds in weight.

138. On 9/19/09, Mr. MacPherson was transferred to Mercy Fitzgerald Hospital, admitted with a diagnosis of Acute Coronary Syndrome.

139. Mercy Hospital documented his sacral wound as unstageable and measuring 4.5x5.6cm.

140. While at the hospital, he refused to return to the ManorCare facility due to the poor care he was receiving, and stated that he was fearful to return there.

141. After speaking with the Hospital Social Worker and the ManorCare Admissions Officer and Department Manager -who agreed to pass this information on to the ManorCare Facility Administrator, he was reluctantly transported back to ManorCare Facility on 9/24/09, where he was promised a follow-up with the Social Worker at ManorCare Facility.

142. Upon readmission to ManorCare Facility, it was noted that his sacral wound was assessed as an open area to his sacrum and left ischial area, unstaged/unmeasured.

143. On 09/28/09, he fell during a transfer from the chair to bed. The CNA failed to report this incident.

144. On 10/08/09, his sacrum wound worsened and increased to 10 x 5.0cm with 90% firm eschar; his left ischial wound measured 3.5 x 3.5cm with 80% necrotic tissue; his right heel worsened and measured 5.5 x 5cm; his left heel worsened; and his lumbar spine had multiple areas of transparent yellow tissue unstaged/unmeasured.

145. Orders noted to float heels while in bed, place cushion in wheelchair, and provide low air loss/alternating pressure mattress.

146. On 10/12/09, his right heel had bloody drainage, a new condition.

147. On 10/15/09, documentation evidenced that supplements (sandwiches and health shakes) were left sitting at Mr. MacPherson's bedside; and he was left for extended time in the wheelchair without off-loading of the sacral area.

148. Nutrition consult obtained from Jefferson Facility, noted blood sugars were elevated due to inappropriate supplements, with recommendations extended for diet appropriate supplements. Additional recommendation was made for PEG evaluation if poor healing of wounds continued.

149. On 10/19/09, Mr. MacPherson accused staff of not assisting him nutritionally and with off-loading to relieve pressure.

150. On 10/23/09, Mr. McPherson's bilateral fall mats by his beside bed were removed.

151. On 10/24/09, Mr. MacPherson developed a fever of 102.2 degrees and was transferred to Mercy Fitzgerald Hospital where he remained until 10/29/09.

152. On 10/29/09, he was readmitted to ManorCare Facility and the records describe his superior and inferior sacral wound both developed tunneling.

153. He resumed IV antibiotic via PICC for sacral wound sepsis and urosepsis.

154. On 11/02/09, Mr. MacPherson's inferior sacral ulcer now had bone exposed.

155. On 11/03/09, dietary supplements were ordered for weight gain and wound healing.

156. On 11/05/09, he complained that he received no hygiene.

157. On 11/9/09, his right ischial, left ischial, right heel, superior sacral, and inferior sacral wounds were noted with eschar.

158. On 11/10/09, labs revealed his Glucose, blood urea nitrogen, Albumin, and Pre-Albumin were all low. A urinalysis was also positive for infection, but no additional antibiotics ordered for his urinary tract infection.

159. Individual therapy with a Psych Nurse Specialist initiated on 11/11/09, documented Mr. MacPherson verbalized many complaints (clothing not laundered and desired to get out of bed), and requested sleeping medication and to be taught how to use bathroom by himself. Individual psych therapy was ordered on a weekly basis.

160. On 11/11/09 he sustained a skin tear to his right outer arm.

161. On 11/12/09, a nutritional consult from Jefferson Facility recommended gastrointestinal evaluation for PEG tube. The records do not indicate that there was follow-up on PEG placement.

162. On 11/19/09, now Mr. MacPherson's left lateral ankle and left heel had also developed eschar, and his superior sacral wound was now with 100% slough.

163. On 11/22/09, it was documented that Mr. MacPherson had a complaint of sacral pain, measured as a 7 out of 10, but ManorCare Defendants were unable to medicate him, as the pharmacy did not have medication.

164. On 11/30/09, Mr. MacPherson requested pain medication, but that was refused.

165. On 12/02/09, Mr. MacPherson complained about food, pain, inability to get out of bed, and lack of sleep.

166. On 12/06/09, Mr. MacPherson requested to be hospitalized several times. He was seen by hospice, and staff was instructed to call hospice before any hospitalization was approved.

167. Mr. MacPherson was ordered under hospice care as of 12/12/09.

168. This day was also the first time hygiene care was documented.

169. Morphine was ordered for every 12 hours.

170. On 12/14/09, his sacral and ischial wounds were noted as macerated and increased.

171. On 12/21/09, his left ischial wound was noted with heavy drainage and his sacral wound had a foul odor.

172. His morphine was increased to every 8 hours.

173. On 12/25/09, he fell on floor beside his bed.

174. On 12/27/09, he again fell out of bed.

175. Skin assessment noted on 1/04/10, documented that his sacrum now had bone exposure.

176. On 01/12/10, he fell out of bed again.

177. On 1/18/10, he still had the following wounds: right ischial, left ischial, left lateral ankle, right and left heel, sacrum, sacral area, and left inner 4th toe, and he developed an abrasion to his right buttock.

178. On 1/20/10, he again fell out of bed onto floor, with bolsters not in place.

179. On 1/25/10, his skin assessment documented additional injuries to his midspine, right trochanter, and left buttock.

180. On 1/26/10, he was prescribed Ativan for anxiety and shortness of breath.

181. On 1/27/10, he was administered comfort medications for pain and shortness of breath.

182. On 2/01/10, Mr. MacPherson passed away.

183. The ManorCare Facility accepted Richard MacPherson, as a resident fully aware of his medical history and understood the level of nursing care required to prevent his serious injuries from occurring.

184. Throughout Richard MacPherson's chart there is missing and incomplete documentation, including Activities of Daily Living sheets, medication administration records, treatment administration records, and controlled medication utilization record.

185. The ManorCare Defendants deprived Richard MacPherson, of adequate and appropriate healthcare as a result of mismanagement, improper/under-budgeting, understaffing of the ManorCare Facility and lack of training of the ManorCare Facility employees, in that they failed to provide adequate and appropriate health care; engaged in incomplete, inconsistent and fraudulent documentation; failed to develop an appropriate therapeutic care plan; provide proper medication; provide sufficient food and water to preclude malnutrition and dehydration, failed to prevent development/worsening of multiple pressure ulcers, skin tears, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, severe pain, and death, and failed to ensure the highest level of physical, mental and psychosocial functioning was attained.

186. The severity of the recurrent negligence inflicted upon Richard MacPherson, while in the ManorCare Defendants' care consisted of mismanagement, improper/under-budgeting, understaffing of the ManorCare Facility and lack of training of the ManorCare Facility employees, in that they failed to provide adequate and appropriate health care; engaged in incomplete, inconsistent and fraudulent documentation; failed to develop an appropriate therapeutic care plan; provide proper medication; provide sufficient food and water to preclude development/worsening of multiple pressure ulcers, severe weight loss, malnutrition, urinary tract infection, severe pain, sepsis, and death, and failed to ensure the highest level of physical, mental and psychosocial functioning was attained.

187. As a result of the negligence, carelessness and recklessness of the ManorCare Defendants herein described, Richard MacPherson, was caused to suffer serious and permanent injuries as described herein, to, in and about his body and possible aggravation and/or activation of any pre-existing conditions, illnesses, ailments, or diseases he had, and/or accelerated the deterioration of his health, physical and mental condition, and more particularly, development/worsening of multiple pressure ulcers, skin tears, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, death and other body pain and damage, and anxiety reaction and injury to his nerves and nervous system, some or all of which were permanent, together with other medical complications.

COUNT ONE

Patrick J. MacPherson, Administratrix of the Estate of Richard MacPherson, deceased v. The Magee Memorial Hospital for Convalescence d/b/a Magee Rehabilitation Hospital; Jefferson Health System, Inc.; TJUH System

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

189. At all times material hereto, Jefferson 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 Jefferson Defendants,

190. At all times material hereto, Jefferson Defendants had the ultimate responsibility of ensuring that the rights of the patients, including Richard MacPherson, were protected.

191. At all times material hereto, Jefferson Defendants owed a non-delegable duty to provide adequate and appropriate custodial care and supervision to Richard MacPherson, and other patients, such as reasonable caregivers would provide under similar circumstances.

192. At all times material hereto, Jefferson Defendants owed a non-delegable duty to Richard MacPherson, and other patients to hire, train, and supervise employees, so as to deliver healthcare and services to patients in a safe and reasonable manner.

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

194. At all times material hereto, Jefferson Defendants owed a duty and responsibility to furnish Richard MacPherson with appropriate and competent nursing and/or total healthcare.

195. Despite being made aware of the types and frequency of injuries, illnesses, and/or infections, many of which were preventable, sustained by the patients of the Jefferson Facility, including those suffered by Richard MacPherson, Jefferson Defendants failed to take steps to prevent the occurrence of said injuries, illnesses, and/or infections.

196. Jefferson Defendants knew, or should have known, of the aforementioned problems that were occurring with the care of Richard MacPherson, as they were placed on actual and/or constructive notice of said problems.

197. Jefferson Defendants, as the corporate owners, board members and/or managers of the Jefferson Facility, breached their duty and were, therefore, negligent, careless and reckless in their obligations to Richard MacPherson.

198. The corporate conduct of Jefferson Defendants was independent of the negligent conduct of the employees of the Jefferson Facility, and was outrageous, willful, and wanton, and exhibited a reckless indifference to the health and well being of the patients, including Richard MacPherson.

199. At all times material hereto, Jefferson Defendants owed and failed to fulfill the following duties to Richard MacPherson: 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 Jefferson Facility; and, formulate, adopt, and enforce rules, procedures and policies to ensure quality care and healthcare for all patients, contact physicians and/or follow doctor's recommendations.

200. At all times material hereto, the breach of duties, negligence, carelessness and recklessness of Jefferson 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 Richard MacPherson, 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 Jefferson Defendants, consisted of the following acts and omissions in the care and treatment of Richard MacPherson:
a. failure to hire appropriately trained staff and/or train, select and retain competent staff who failed to provide adequate preventative skin care allowing for the development and/or progression of multiple pressure sores, failed to provide adequate

nutrition and fluids to prevent malnutrition and dehydration, failed to prevent and engaged in incomplete, inconsistent and fraudulent documentation, failed to provide appropriate treatment and services to prevent the development/worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, severe pain and, and failed to provide adequate assessments of Richard MacPherson following a change in condition;

b. knowingly allowing and/or encouraging unskilled and untrained individuals to care for Richard MacPherson who failed to provide adequate preventative skin care allowing for the development and/or progression of multiple pressure sores, failed to provide adequate nutrition and fluids to prevent malnutrition and dehydration, failed to prevent and engaged in incomplete, inconsistent and fraudulent documentation, failed to provide appropriate treatment and services and to prevent the development/ worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, and severe pain, and failed to provide adequate assessments of Richard MacPherson 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 preventative skin care allowing for the development of multiple pressure wounds by failing to obtain and administer preventative pressure-relieving measures, failing to timely obtain order and consistently administer turning and repositioning Richard MacPherson at minimum every two hours or more often while in bed, and failing to properly follow wound care specialist instructions and administer wound care cleaning;

e. failure to provide adequate pain management;

f. failure to ensure that Richard MacPherson did not develop serious and permanent injuries to, in and about his body and possible aggravation and/or activation of any pre-existing conditions, illnesses, ailments, or diseases he had, and/or accelerated the deterioration of his health, physical and mental condition, and more particularly, when he experienced injuries including development/worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, and severe pain, when the Jefferson Defendants knew or should have known that he was at risk for the same;

g. failure to provide adequate and appropriate health care by failing to keep Richard MacPherson 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, preventative skin care, failing to provide adequate hygiene, failing to provide adequate nutrition impacting wound healing ability, failing to provide adequate hydration, failing to provide appropriate treatment and services to prevent when he experienced injuries including development/worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, and severe pain; failing to administer ordered medications and treatments; and failing to follow doctor's orders.

h. failure to ensure complete, consistent documentation and avoid fraudulent documentation by 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 receives and that the Jefferson 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;

k. failure to ensure that based on the comprehensive assessment of a resident, the Jefferson Facility must ensure that a resident who enters the Jefferson 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;

1. failure to ensure that the Jefferson 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 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;

m. failure to ensure that the Jefferson 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 twenty-four hour basis to provide nursing care to all patients in accordance with resident care plans;

n. failure of the Jefferson Facility to be administered 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;

o. failure of the Jefferson Facility to develop, implement and/or enforce written policies and procedures that prohibit mistreatment, neglect, and **abuse** of patients and misappropriation of the resident's property;

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

q. failure to oversee and supervise all persons who practiced nursing and/or skilled healthcare in the Jefferson Facility who failed to: development/worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, and severe pain;

r. failure to formulate, adopt and enforce adequate rules, procedures and policies to ensure quality healthcare for patients by failing to: provide adequate and appropriate health care to prevent falls, poor hygiene, and provide complete and consistent documentation, provide appropriate treatment, services and adequate assessments following change in condition to prevent development/worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, and severe pain;

s. acting in a grossly negligent manner, with reckless indifference to the rights and safety of Richard MacPherson;

t. failure to undertake and/or implement the instructions provided by physicians and notify the physicians of change in the condition of Richard MacPherson;

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

v. failure to provide Richard MacPherson with the necessary care and services to allow his to attain or maintain the highest practicable physical, mental and psychological well-being;

w. failure to provide Richard MacPherson with appropriate medication for pain management;

x. failure to assist Richard MacPherson in his personal hygiene;

y. failure to ensure that the Jefferson Facility was properly funded;

z. failure to implement a budget that would allow the Jefferson Facility to provide adequate and appropriate healthcare to Richard MacPherson including adequate staff and supplies;

aa. grossly understaffing the Jefferson Facility;

bb. failure to take appropiate steps to remedy continuing problems at the Jefferson Facility that Jefferson Defendants knew were occurring with Richard MacPherson'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;

cc. 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;

dd. failure to set in place a functional table of organization with standards of accountability and hold department heads accountable for the performance of their respective departments;

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

ff. 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;

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

hh. failure to develop a budget with an objective of the delivery of quality care.

204. As a direct and proximate result of the Jefferson Defendants' acts and/or omissions, and their breach of their duty of care, negligence, carelessness and recklessness, Richard MacPherson, 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 Jefferson Facility and (e) aggravation of his pre-existing medical conditions.

205. In causing the aforementioned injuries, Jefferson Defendants, knew, or should have known, that Richard MacPherson, would suffer such harm.

206. The conduct of Jefferson Defendants, was intentional, outrageous, willful and wanton, and exhibited a reckless indifference to the health and well being of Richard MacPherson.

207. The conduct of Jefferson Defendants, was such that an award of punitive damages is justified.

WHEREFORE, Plaintiff, Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased, respectfully requests that judgment be entered in his favor, and against Jefferson 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

Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased v. The Magee Memorial Hospital for Convalescence d/b/a Magee Rehabilitation Hospital; Jefferson Health System, Inc.; TJUH System

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

209. Plaintiff, Patrick J. MacPherson, 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.

210. The following persons are entitled to share under this cause of action in the estate of said decedent, Richard MacPherson: Patrick J. MacPherson (brother).

211. Plaintiff's decedent, Richard MacPherson, did not bring any action during his lifetime, nor has any other action been commenced on behalf of Plaintiff's decedent, Richard MacPherson, against the Jefferson Defendants herein.

212. Plaintiff, Patrick J. MacPherson, claims 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 Richard MacPherson, up to and including the time of his death, which was caused by the Jefferson Defendants' breach of duties, negligence, carelessness and recklessness.

213. Plaintiff, Patrick J. MacPherson, claims damages for the fright and mental suffering attributable to the peril leading to the physical manifestation of mental injuries, physical injuries, the development/worsening of multiple pressure ulcers, skin tear, urinary tract infection, severe weight loss, poor hygiene, and severe pain, occurring to Richard MacPherson, which were caused by the Defendant's breach of duties, negligence, carelessness and recklessness.

214. In causing the aforementioned injuries, the Jefferson Defendants knew, or should have known, that Richard MacPherson would suffer such harm.

215. The conduct of the Jefferson Defendants was intentional, outrageous, willful and wanton and exhibited a reckless indifference to the health and well-being of Richard MacPherson.

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

WHEREFORE, Plaintiff, Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased respectfully requests that judgment be entered in his favor, and against the Defendant, 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

Patrick J. MacPherson, Administratrix of the Estate of Richard MacPherson, deceased v. Manor Care of Yeadon PA, LLC, d/b/a ManorCare Health Services - Yeadon; HCR ManorCare, Inc.; Manor Care, Inc.; HCR II Healthcare, LLC; HCR III Healthcare, LLC; and HCR Healthcare, LLC

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

218. At all times material hereto, ManorCare 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 ManorCare Defendants.

219. At all times material hereto, ManorCare Defendants had the ultimate responsibility of ensuring that the rights of the residents, including Richard MacPherson, were protected.

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

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

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

223. At all times material hereto, ManorCare Defendants owed a duty and responsibility to furnish Richard MacPherson with appropriate and competent nursing and/or total healthcare.

224. 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 ManorCare Facility, including those suffered by Richard MacPherson, ManorCare Defendants failed to take steps to prevent the occurrence of said injuries, illnesses, and/or infections.

225. ManorCare Defendants knew, or should have known, of the aforementioned problems that were occurring with the care of Richard MacPherson, as they were placed on actual and/or constructive notice of said problems.

226. ManorCare Defendants, as the corporate owners, board members and/or managers of the ManorCare Facility, breached their duty and were, therefore, negligent, careless and reckless in their obligations to Richard MacPherson.

227. The corporate conduct of ManorCare Defendants was independent of the negligent conduct of the employees of the ManorCare Facility, and was outrageous, willful, and wanton, and exhibited a reckless indifference to the health and well being of the residents, including Richard MacPherson.

228. At all times material hereto, ManorCare Defendants owed and failed to fulfill the following duties to Richard MacPherson: 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 ManorCare Facility; and, formulate, adopt, and enforce rules, procedures and policies to ensure quality care and healthcare for all residents.

229. At all times material hereto, the breach of duties, negligence, carelessness and recklessness of ManorCare 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 Richard MacPherson, 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 ManorCare Defendants, consisted of the following acts and omissions in the care and treatment of Richard MacPherson:
a. failure to hire appropriately trained staff and/or train, select and retain competent staff who failed to provide adequate preventative skin care allowing for the development and/or progression of multiple pressure sores, failed to provide adequate nutrition and fluids to prevent malnutrition and dehydration, failed to prevent and engaged in incomplete, inconsistent and

fraudulent documentation, failed to provide appropriate treatment and services to prevent the development/worsening of multiple pressure ulcers, skin tears, failed to provide pain medication, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, and death, and failed to provide adequate assessments of Richard MacPherson following a change in condition; by neglecting Richard MacPherson.

b. knowingly allowing and/or encouraging unskilled and untrained individuals to care for Richard MacPherson who failed to provide adequate preventative skin care allowing for the development and/or progression of multiple pressure sores, failed to provide adequate nutrition and fluids to prevent malnutrition and dehydration, failed to prevent and engaged in incomplete, inconsistent and fraudulent documentation, failed to provide appropriate treatment and services and to prevent the development/worsening of multiple pressure ulcers, skin tears, multiple falls, failed to provide pain medication, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, and death, and failed to provide adequate assessments of Richard MacPherson following a change in condition; by neglecting Richard MacPherson.

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 preventative skin care allowing for the development of multiple pressure wounds by failing to obtain and administer preventative pressure-relieving measures, failing to timely obtain order and consistently administer turning and repositioning Richard MacPherson at minimum every two hours or more often while in bed, and failing to properly follow wound care specialist instructions and administer wound care cleaning;

e. failure to provide adequate pain management;

f. failure to ensure that Richard MacPherson did not develop serious and permanent injuries to, in and about his body and possible aggravation and/or activation of any pre-existing conditions, illnesses, ailments, or diseases he had, and/or accelerated the deterioration of his health, physical and mental condition, and more particularly, but without limitations, when he experienced development/worsening of multiple pressure ulcers, skin tears, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, and death, when the ManorCare Defendants knew or should have known that he was at risk for the same;

g. failure to respond in a timely manner with appropriate medical care when Richard MacPherson was injured, including when he experienced falls, fractures, and poor hygiene, when ManorCare Defendants knew or should have known that he was at risk for the same;

h. failure to provide adequate and appropriate health care by failing to keep Richard MacPherson 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, preventative skin care, failing to provide adequate hygiene, failing to provide adequate nutrition impacting wound healing ability, failing to provide adequate hydration, failing to provide appropriate treatment and services to prevent when he experienced development/worsening of multiple pressure ulcers, skin tears, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, and death, and failing to administer ordered medications and treatments;

i. 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;

j. 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;

k. failure to ensure that each resident receives and that the ManorCare 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;

1. failure to ensure that based on the comprehensive assessment of a resident, the ManorCare Facility must ensure that a resident who enters the ManorCare 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;

m. failure to ensure that the ManorCare 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 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;

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

o. failure of the ManorCare Facility to be administered 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;

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

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

r. failure to oversee and supervise all persons who practiced nursing and/or skilled healthcare in the ManorCare Facility who failed to prevent the development/worsening of multiple pressure ulcers, skin tears, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, and death;

s. failure 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/worsening of multiple pressure ulcers, skin tears, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, and sepsis, and provide complete and consistent documentation, provide appropriate treatment, services and adequate assessments following change in condition to prevent development/worsening of multiple pressure ulcers, skin tears, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, and death;

t. acting in a grossly negligent manner, with reckless indifference to the rights and safety of Richard MacPherson;

u. failure to undertake and/or implement the instructions provided by physicians and notify the physicians of change in the condition of Richard MacPherson;

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

w. failure to provide Richard MacPherson with the necessary care and services to allow his to attain or maintain the highest practicable physical, mental and psychological well-being;

x. failure to provide Richard MacPherson with appropriate medication for pain management;

y. failure to assist Richard MacPherson in his personal hygiene;

z. failure to ensure that the ManorCare Facility was properly funded;

aa. failure to implement a budget that would allow the ManorCare Facility to provide adequate and appropriate healthcare to Richard MacPherson including adequate staff and supplies;

bb. grossly understaffing the ManorCare Facility;

cc. failure to take appropriate steps to remedy continuing problems at the ManorCare Facility that ManorCare Defendants knew were occurring with Richard MacPherson'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;

dd. 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;

ee. failure to set in place a functional table of organization with standards of accountability and hold department heads accountable for the performance of their respective departments;

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

gg. failure to maintain compliance with governmental regulations;

hh. 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;

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

jj. failure to develop a budget with an objective of the delivery of quality care.

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

231. Upon information and belief, the ManorCare Defendants were aware that there were numerous problems at the ManorCare Facility, and that they had been cited by the Pennsylvania Department of Health for failures at the ManorCare Facility.

232. Upon information and belief, the ManorCare Defendants were aware that they had been cited by governmental units regarding additional failures at the ManorCare Facility on: 1/7/08 failed to provide adequate monitoring and supervision to ensure safety of resident; failed to develop a care plan to address and ensure the safety of resident; 3/13/08 failed to provide necessary rehabilitative services as required by a resident's comprehensive plan of care; 4/3/08 failed to insure that medication

was administered as ordered, that the physician was notified of this omission and failed to thoroughly monitor a resident for a change in condition; failed to consistently maintain complete and accurate documentation for care provided; 5/5/08 failed to obtain laboratory tests, weigh residents as ordered, enforce physician ordered fluid restrictions and ensure that residents received diets as ordered; 7/28/08 failed to ensure that pain medication was administered according to a physician's order; 8/21/08 failure to protect residents from mental anguish and indignity; failed to assess and monitor the development of pressure ulcers for three of six residents reviewed with pressure ulcers, resulting in actual harm for one resident; failed to ensure that residents were adequately monitored for pain management, to notify the physician of a resident's change in condition; facility failed to maintain accurate and complete documentation related to allegations of mistreatment of two residents, and assessment of one resident who had a fall; failed to provide adequate monitoring and supervision to ensure safety of a resident; 1/23/08 failed to follow procedure in reporting **abuse**; to provide follow-up action on pharmacy recommendations; facility failed to maintain/store a complete/accurate clinical record; failed to implement the facility's infection control policy and provide services consistent with the Center for Disease Control, national authority requiring contact precautions for specific infectious diseases and wound care; failed to notify the physician of an abnormal laboratory result; 9/4/09 failed to provide a safe and sanitary environment; failed to maintain resident's dignity regarding issues of personal care; failed to follow physician's orders for the application of skin protective devices; 10/29/09 failed to assess and develop interventions to address the psychosocial needs; 12/15/09 failed to ensure that pain medication was administered according to physician's orders; 8/12/10 failed to transcribe correctly and follow physician's orders; 10/5/10 facility failed to administer narcotic medication as ordered by the physician; and 10/12/10 administered medications without adequate monitoring or adequate indications for its need or usage.

233. Upon information and belief, the corporate officers of the ManorCare Defendants had been made aware in the past that the ManorCare Facility had been cited for the following failures' 1/7/08 failed to provide adequate monitoring and supervision to ensure safety of resident; failed to develop a care plan to address and ensure the safety of resident; 3/13/08 failed to provide necessary rehabilitative services as required by a resident's comprehensive plan of care; 4/3/08 failed to insure that medication was administered as ordered, that the physician was notified of this omission and failed to thoroughly monitor a resident for a change in condition; failed to consistently maintain complete and accurate documentation for care provided; 5/5/08 failed to obtain laboratory tests, weigh residents as ordered, enforce physician ordered fluid restrictions and ensure that residents received diets as ordered; 7/28/08 failed to ensure that pain medication was administered according to a physician's order; 8/21/08 failure to protect residents from mental anguish and indignity; failed to assess and monitor the development of pressure ulcers for three of six residents reviewed with pressure ulcers, resulting in actual harm for one resident; failed to ensure that residents were adequately monitored for pain management, to notify the physician of a resident's change in condition; facility failed to maintain accurate and complete documentation related to allegations of mistreatment of two residents, and assessment of one resident who had a fall; failed to provide adequate monitoring and supervision to ensure safety of a resident; 1/23/08 failed to follow procedure in reporting **abuse**; to provide follow-up action on pharmacy recommendations; facility failed to maintain/store a complete/accurate clinical record; failed to implement the facility's infection control policy and provide services consistent with the Center for Disease Control, national authority requiring contact precautions for specific infectious diseases and wound care; failed to notify the physician of an abnormal laboratory result; 9/4/09 failed to provide a safe and sanitary environment; failed to maintain resident's dignity regarding issues of personal care; failed to follow physician's orders for the application of skin protective devices; 10/29/09 failed to assess and develop interventions to address the psychosocial needs; 12/15/09 failed to ensure that pain medication was administered according to physician's orders; 8/12/10 failed to transcribe correctly and follow physician's orders; 10/5/10 facility failed to administer narcotic medication as ordered by the physician; and 10/12/10 administered medications without adequate monitoring or adequate indications for its need or usage.

234. ManorCare Defendants, knew that the violations described in the paragraphs above 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 Richard MacPherson.

235. As a direct and proximate result of the ManorCare Defendants' acts and/or omissions, and their breach of their duty of care, negligence, carelessness and recklessness, Richard MacPherson, 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 ManorCare Facility (e) aggravation of his pre-existing medical conditions, and (f) death.

236. In causing the aforementioned injuries, ManorCare Defendants, knew, or should have known, that Richard MacPherson, would suffer such harm.

237. The conduct of ManorCare Defendants, was intentional, outrageous, willful and wanton, and exhibited a reckless indifference to the health and well being of Richard MacPherson.

238. The conduct of ManorCare Defendants, was such that an award of punitive damages is justified.

WHEREFORE, Plaintiff, Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased, respectfully requests that judgment be entered in his favor, and against ManorCare 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 FOUR

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

Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased v. Manor Care of Yeadon PA, LLC, d/b/a ManorCare Health Services - Yeadon; HCR ManorCare, Inc.; Manor Care, Inc.; HCR II Healthcare, LLC; HCR III Healthcare, LLC; and HCR Healthcare, LLC

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

240. 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.

241. 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.

242. At all times pertinent hereto, Richard MacPherson was a care dependent resident of the ManorCare Defendants' Facility, ManorCare Health Services - Yeadon, 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 ManorCare Defendants' conduct.

243. 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 Richard MacPherson sustained.

244. The ManorCare Defendants, in accepting the responsibility for caring for Richard MacPherson 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 Richard MacPherson for whom they were responsible to provide care as specifically set forth in this Complaint;

245. As a direct result of the aforesaid negligence “per se” of the ManorCare Defendants, Richard MacPherson was caused to sustain serious personal injuries and damages as aforesaid.

246. The conduct of the ManorCare 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, Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased, respectfully requests that judgment be entered in his favor, and against the ManorCare 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 FIVE

Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased v. Manor Care of Yeadon PA, LLC, d/b/a ManorCare Health Services - Yeadon; HCR ManorCare, Inc.; Manor Care, Inc.; HCR II Healthcare, LLC; HCR III Healthcare, LLC; and HCR Healthcare, LLC

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

248. Plaintiff, Patrick J. MacPherson, 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.

249. The following persons are entitled to share under this cause of action in the estate of said decedent, Richard MacPherson: Patrick J. MacPherson (brother).

250. Plaintiff's decedent, Richard MacPherson, did not bring any action during his lifetime, nor has any other action been commenced on behalf of Plaintiff s decedent, Richard MacPherson, against the ManorCare Defendants herein.

251. Plaintiff, Patrick J. MacPherson, claims 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 Richard MacPherson, up to and including the time of his death, which was caused by the ManorCare Defendants' breach of duties, negligence, carelessness and recklessness.

252. Plaintiff, Patrick J. MacPherson, claims damages for the fright and mental suffering attributable to the peril leading to the physical manifestation of mental injuries, physical injuries, including the development/worsening of multiple pressure ulcers, skin tears, multiple falls, severe weight loss, malnutrition, urinary tract infection, poor hygiene, severe pain, sepsis, and death, occurring to Richard MacPherson, which were caused by the Defendant's breach of duties, negligence, carelessness and recklessness.

253. In causing the aforementioned injuries, the ManorCare Defendants knew, or should have known, that Richard MacPherson would suffer such harm.

254. The conduct of the ManorCare Defendants was intentional, outrageous, willful and wanton and exhibited a reckless indifference to the health and well-being of Richard MacPherson.

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

WHEREFORE, Plaintiff, Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased respectfully requests that judgment be entered in his favor, and against the Defendant, 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 SIX

Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased v. Manor Care of Yeadon PA, LLC, d/b/a ManorCare Health Services - Yeadon; HCR ManorCare, Inc.; Manor Care, Inc.; HCR II Healthcare, LLC; HCR III Healthcare, LLC; and HCR Healthcare, LLC

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

257. Plaintiff, Patrick J. MacPherson, brings this action on behalf of the decedent's estate under and by virtue of the Pennsylvania Judiciary Act 42 Pa.C.S. 8301, known as the Wrongful Death Statute, to recover all damages legally appropriate thereunder.

258. The following person is entitled to share under this cause of action in the estate of said decedent, Richard MacPherson: Patrick J. MacPherson (brother).

259. Plaintiffs decedent, Richard MacPherson, did not bring any action during his lifetime, nor has any other action been commenced on behalf of Richard MacPherson, deceased, against ManorCare Defendants herein.

260. Plaintiff, Patrick J. MacPherson, claims damages for the pecuniary loss suffered by the decedent's survivor by reason of the death of Richard MacPherson, deceased, as well as for the reimbursement of hospital, nursing, medical, and funeral expenses, and expenses of administration and other expenses incurred in connection therewith.

261. As a result of the death of Richard MacPherson, deceased, the survivor, as aforesaid, has been deprived of the companionship, comfort, aid, assistance, and society that they would have received from Richard MacPherson, deceased, for the remainder of his natural life.

WHEREFORE, Plaintiff, Patrick J. MacPherson, Executor of the Estate of Richard MacPherson, deceased, respectfully requests that judgment be entered in his favor, and against the Defendant, in an amount in excess of the compulsory arbitration limits and/or Fifty Thousand Dollars ($50,000.00) whichever is greater, together with costs, and any other relief that this Honorable Court deems appropriate given the circumstances. A jury trial is demanded.

Dated: 3-19-12

Respectfully submitted,

WILKES & McHUGH, P.A.

By

Ruben J. Krisztal, Esquire

Attorney for Plaintiff

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