**IN THE SUPREME COURT OF THE STATE OF NEVADA**

Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually, Plaintiffs/Appellants,

Appellants,

vs.

SOUTH LAS VEGAS MEDICAL INVESTORS, LLC dba LIFE CARE CENTER OF SOUTH LAS VEGAS f/k/a LIFE CARE CENTER OF PARADISE VALLEY; SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP; LIFE CARE CENTERS OF AMERICA, INC.; and CARL WAGNER, Administrator inclusive,

Respondents.



**Supreme Court No. 77810**
District Court Case No. A750520

# APPELLANTS' APPENDIX – VOLUME II (APP00214-312)

Michael Davidson, Esq.
Kolesar & Leatham
400 S. Rampart Blvd., Suite 400
Las Vegas, Nevada 89145
Telephone No.: (702) 362-7800
Facsimile No.: (702) 362-9472

Melanie L. Bossie, Esq.
Bossie Reilly & Oh, P.C.
15333 N. Pima Road, Suite 300
Scottsdale, AZ 85260
Telephone No.: (602) 553-4552
Facsimile No.: (602) 553-4557

Bennie Lazzara, Jr., Esq.
Wilkes & McHugh, P.A.
One North Dale Mabry Hwy., Ste. 700
Tampa, Florida 33609
Telephone No.: (813) 873-0026
Facsimile No.: (813) 286-8820

*Attorneys for Plaintiffs/Appellants, The Estate of Mary Curtis, Laura Latrenta, as Personal Representative of the Estate, and Laura Latrenta, individually*

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## CERTIFICATE OF SERVICE

Pursuant to NRAP 25(c)(1)(B), I certify that I am an employee of Kolesar & Leatham and on the 17th day of July, 2019, I submitted the foregoing **APPELLANTS' APPENDIX – VOLUME II (APP00214-312)** to the Supreme Court of Nevada's electronic docket for filing and service upon the following:

S. Brent Vogel, Esq. and Amanda J. Brookhyser, Esq.
Lewis Brisbois Bisgaard & Smith
6835 S. Rainbow Blvd., Suite 600
Las Vegas, Nevada 89118

*/s/ Kristina R. Cole*
An Employee of KOLESAR & LEATHAM

**OMSJ**
MICHAEL D. DAVIDSON, ESQ.
Nevada Bar No. 000878
**KOLESAR & LEATHAM**
400 South Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Telephone: (702) 362-7800
Facsimile: (702) 362-9472
E-Mail: mdavidson@klnevada.com
MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice*
**WILKES & MCHUGH, P.A.**
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260
Telephone: (602) 553-4552
Facsimile: (602) 553-4557
E-Mail: Melanie@wilkesmchugh.com
BENNIE LAZZARA, JR., ESQ. - *Pro Hac Vice*
**WILKES & MCHUGH, P.A.**
One North Dale Mabry Highway, Suite 700
Tampa, FL, 33609
Telephone: (813) 873-0026
Facsimile: (813) 286-8820
Email: bennie@wilkesmchugh.com
*Attorneys for Plaintiffs*



**DISTRICT COURT**

**CLARK COUNTY, NEVADA**

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|---|---|
| Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually,<br><br>Plaintiffs,<br>vs.<br><br>SOUTH LAS VEGAS MEDICAL INVESTORS, LLC dba LIFE CARE CENTER OF SOUTH LAS VEGAS f/k/a LIFE CARE CENTER OF PARADISE VALLEY; SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP; LIFE CARE CENTERS OF AMERICA, INC.; BINA HRIBIK PORTELLO, Administrator; CARL WAGNER, Administrator; and DOES 1-50, inclusive,<br><br>Defendants. | Case No. A-17-750520-C<br><br>Dept No. Xvii<br><br>Consolidated With:<br>Case No. A-17-754013-C<br><br>**PLAINTIFFS' RESPONSE TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**<br><br>Date: October 24, 2018<br>Time: 8:30 a.m. |
| Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually,<br><br>Plaintiffs, | |

vs.

SAMIR SAXENA, M.D.; ANNABELLE SOCAOCO, N.P.; IPC HEALTHCARE, INC. aka THE HOSPITALIST COMPANY, INC.; INPATIENT CONSULTANTS OF NEVADA, INC.; IPC HEALTHCARE SERVICES OF NEVADA, INC.; HOSPITALISTS OF NEVADA, INC.; and DOES 51–100,

Defendant.

**PLAINTIFFS' RESPONSE TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

Plaintiffs Estate of Mary Curtis, deceased; Laura Latrenta, as Personal Representative of the Estate of Mary Curtis; and Laura Latrenta, individually ("Plaintiffs"), by and through their attorneys at the law firms of Kolesar & Leatham and Wilkes & McHugh, P.A., hereby respond to Defendants' Motion for Summary Judgment filed by the Life Care Defendants.

DATED this 4th day of October, 2018.

**KOLESAR & LEATHAM**

By */s/ Melanie L. Bossie, Esq.*
MICHAEL D. DAVIDSON, ESQ.
Nevada Bar No. 000878
400 South Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice*
**WILKES & MCHUGH, P.A.**
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260
BENNIE LAZZARA, JR., ESQ. - *Pro Hac Vice*
**WILKES & MCHUGH, P.A.**
One North Dale Mabry Highway, Suite 700
Tampa, FL, 33609
*Attorneys for Plaintiffs*

**MEMORANDUM OF POINTS AND AUTHORITIES**

**I. ISSUE**

- The affirmative defense of lack of expert affidavit is waived by a defendant's substantially participating in litigation. LCCPV has for almost two years vigorously

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

litigated this case. The case is to be tried next month. May LCCPV now assert an expert affidavit defense?

- If and only if a complaint states a professional negligence claim against a provider of health care then an expert affidavit must accompany it. Laura's complaint is for elder abuse, wrongful death, and bad faith tort. LCCPV is a nursing home. Is Laura's complaint void for lack of expert affidavit?

## II. LEGAL ARGUMENT

Chapter 41A and its expert affidavit requirement do not apply to elder abuse claims under NRS 41.1395. And in any event Life Care Center of Paradise Valley waived its expert affidavit defense and so cannot now complain of the lack of expert affidavit. Nor is LCCPV a provider of health care, so that professional negligence claims against providers of health care are to be accompanied by an expert affidavit would be of no consequence here in any event. But even if LCCPV were a provider of health care two exceptions to the affidavit requirement (i.e., the exception provided by NRS 41A.100(1) and that for ordinary negligence claims) would apply here, such that the absence of an expert affidavit would still be harmless.

### A. LCCPV Has Waived Enforcement of the Expert Affidavit Requirement.

The right to assert NRS 41A.071's expert affidavit requirement as a defense is waivable. *See Estate of Ferhat v. TLC Holdings, LLC*, 127 Nev. 1133, at *1 n.2 (table) (Nev. 2011) (refusing to consider whether the expert affidavit requirement applied because defendant had waived the issue). The Arizona Supreme Court considered whether an analogous defense had been waived in *City of Phoenix v. Fields*, 201 P.3d 529 (Ariz. 2009). At issue was a statute requiring that "[b]efore suing a public entity, a plaintiff must file a notice of claim that includes 'a specific amount for which the claim can be settled.'" *Id.* at 531 (citation omitted). Defendants in 2007 moved for summary judgment on the grounds that the 2002 notice had not included such an amount. *Id.* The trial court found that defendants had not waived the notice of claim statute defense. *Id.* at 534. It erred.

The supreme court first observed that "[a]n assertion that the plaintiff has not complied with the notice of claim statute is an affirmative defense." *Id.* at 535. It then assumed without

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

deciding that defendants had preserved the defense in their answer. *Id.* But "[e]ven when a party preserves an affirmative defense in an answer or a Rule 12(b) motion . . . it may waive that defense by its subsequent conduct in the litigation." *Id.* Moreover, "[a]ny defense a public entity may have as to the sufficiency of a notice of claim is apparent on the face of the notice" and is "a matter that courts can quickly and easily adjudicate early in the litigation." *Id.* at 536. So "[g]iven that a government entity may entirely avoid litigating the merits of a claim with a successful notice of claim statute defense, waiver of that defense should be found when the defendant 'has taken substantial action to litigate the merits of the claim that would not have been necessary had the entity promptly raised the defense.'" *Id.* (citation omitted). Defendants had "engaged in extensive briefing," had "filed various motions," had "engaged in discovery," and had only filed their "motion for summary judgment finally raising the absence of a settlement demand . . . more than three years after class certification." *Id.* So "[b]y any measure, [defendants] substantially participated in this litigation before raising their notice of claim statute defenses." *Id.* They therefore "waived this defense . . . by their subsequent conduct." *Id.*[1]

Here, LCCPV did raise noncompliance with NRS 41A.071 as an affirmative defense. *See* Life Care Answer: Affirmative Defenses ¶ 19. But LCCPV could of course waive that affirmative defense by its subsequent conduct. As the defense in *Fields* was apparent on the face of the notice, so here the expert affidavit defense's applicability vel non was—according to LCCPV—apparent on the face of Laura's complaint. *See* Defs.' Mot. Summ. J. 10 (citing allegations in the complaint as evidence of the need for an expert affidavit). The Court could thus have quickly and easily adjudicated the expert affidavit defense early in the litigation. So given that LCCPV could have entirely avoided litigating this case's merits with a successful expert affidavit defense, waiver of that defense exists if LCCPV has taken substantial action to litigate the merits that would have been unnecessary had it promptly raised the defense. Has LCCPV done so? Of course: it has

[1] This was so even though "[t]ypically, waiver is 'a question of fact,'" as "in this case, waiver by conduct is apparent from the extensive litigation record below." *Id.* (citation omitted). *Cf. Nev. Gold & Casinos, Inc. v. Am. Heritage, Inc.*, 121 Nev. 84, 89 (2005) ("Waiver is generally a question of fact. But when the determination rests on the legal implications of essentially uncontested facts, then it may be determined as a matter of law.") (footnotes omitted).

litigated the case vigorously, engaging in extensive briefing, filing various motions, and engaging in discovery—including receiving expert reports supporting Laura's case and deposing the experts who authored them—and only now, almost two years into litigation and with trial in sight, filing a motion for summary judgment finally raising the expert affidavit defense. It has therefore waived this defense by its subsequent conduct.

The same result obtains by analogizing to waiver of arbitration cases.[2] Our supreme court has taught that "a waiver may be shown when the party seeking to arbitrate (1) knew of his right to arbitrate, (2) acted inconsistently with that right, and (3) prejudiced the other party by his inconsistent acts," which prejudice "may be shown . . . when [the parties] litigate substantial issues on the merits." *Nev. Gold & Casinos, Inc. v. Am. Heritage, Inc.*, 121 Nev. 84, 90–91 (2005). It thus found waiver in *Nevada Gold* where the party seeking arbitration, after having "initially sought to arbitrate its dispute," then "proceeded to vigorously litigate the matter in the Texas court for eighteen months without moving the Texas court to compel arbitration," and then "[o]nly on the eve of trial, and after litigating substantial issues, did [it] belatedly seek an order . . . to compel arbitration." *Id.* at 91.

Here, LCCPV (1) knew of its right to assert the expert affidavit defense—it raised the defense in its answer and even now points to Laura's complaint as evidence that the defense applies; (2) acted inconsistently with that right—it did not seek dismissal of Laura's complaint on expert affidavit grounds; and (3) prejudiced Laura by those inconsistent acts—as shown by the parties' litigating substantial issues for almost two years before LCCPV with trial nearing roused itself to raise the defense. LCCPV therefore waived its expert affidavit defense under *Nevada Gold*, and so its motion for summary judgment based on that defense must fail.

Happily, however, LCCPV is unharmed by having waived the affidavit requirement, because that requirement never applied in this case anyway, as will now be seen.

/ / /

[2] *Fields* suggests this approach. *See* 201 P.3d at 536 n.4 (observing that "[c]ases involving arbitrable disputes provide a useful analogy," as "[i]t is widely recognized that even when a dispute is subject to arbitration, that right may be waived by a party who participates substantially in litigation without promptly seeking an order from the court compelling arbitration").

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

**B. LCCPV Is Not Sheltered by Chapter 41A Because It Is Not a Provider of Health Care.**

**1. LCCPV Is Not a Provider of Health Care Under NRS 41A.017.**

NRS 41A.071 provides for dismissal without prejudice of a complaint in "an action for professional negligence" unaccompanied by a medical expert affidavit. Professional negligence is "the failure of a provider of health care, in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health care." NRS 41A.015. A provider of health care is "a physician licensed pursuant to chapter 630 or 633 of NRS, physician assistant, dentist, licensed nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director of technician, [or] licensed dietician," as well as "a licensed hospital, clinic, surgery center, physicians' professional corporation or group practice that employs any such person and its employees." NRS 41A.017.[3]

LCCPV is a skilled nursing facility. I.e., it is "an establishment which provides continuous skilled nursing and related care as prescribed by a physician to a patient in the facility who is not in an acute episode of illness and whose primary need is the availability of such care on a continuous basis." NRS 449.0039(1). It is "not . . . a facility which meets the requirements of a general or any other special hospital." NRS 449.0039(2). Is LCCPV then one of the entities identified as providers of health care under NRS 41A.017? No. It is a different thing. It is therefore not a provider of health care. Because it is not, Laura's claims against it are not claims of professional negligence; because they are not, her complaint need not be accompanied by an expert affidavit. So that her complaint was without such an affidavit is without legal significance.

**2. LCCPV's Argument Is Mistaken and Omissive.**

LCCPV, however, argues that its liability derives from its nurses' liability and that since those nurses are providers of health care it too is entitled to the protections granted to providers of

[3] Before the statute's 2015 amendment the latter group explicitly included only "a licensed hospital and its employees." NRS 41A.017 (amended 2015).

health care under chapter 41A, including the expert affidavit requirement.[4] The argument fails for three reasons.

First, the premise that LCCPV's liability is solely vicarious is erroneous. For example, LCCPV itself had and knew that it had an ongoing problem with its residents not receiving the right medication, Pls.' Mot. Prima Facie Claim SOF ¶¶ 183–91, and knew that its understaffing was compromising resident care, *id.* ¶¶ 170–82—conditions that it declined to remedy and that being unremedied led to Mary's morphine overdose and then to her death. So LCCPV is directly liable for its own acts and omissions.[5]

Second, even if LCCPV's liability were solely vicarious, LCCPV would not partake of its nursing staff's status as providers of health care under *Zhang v. Barnes*, 382 P.3d 878 (table) (Nev. 2016).[6] The *Zhang* court held that a surgeon's professional medical association qualified as a provider of health care entitled to NRS 41A.035's noneconomic damages cap. *Id.* at *7.[7] It relied on *Fierle v. Perez*, 125 Nev. 728 (2009),[8] observing that in *Fierle*, "[r]ecognizing that professional medical entities were not mentioned in NRS 41A.009's list of persons who could commit medical malpractice protected by NRS 41A.071's affidavit requirement," the court had "nonetheless looked to NRS Chapter 89, addressing professional business associations, and extended NRS

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

[4] *See* Defs.' Mot. Summ. J. 11–12 ("These Defendants are entitled to the protections of Chapter 41A as LCCPV's liability is totally derivative of that of its nursing staff. LCCPV's liability is based solely on the acts and omissions of its nursing staff, as no other officer, employee or agent of LCCPV was involved in the events in question in any way. Therefore, any claims against LCCPV are derivative claims."). Although LCCPV appears not to claim otherwise, Laura notes for clarity's sake that even were LCCPV correct the claims against the other Life Care Defendants would remain uncompromised and so dismissal of her complaint in its entirety is not at issue. *See Szymborski v. Spring Mountain Treatment Ctr.*, 403 P.3d 1280, 1285 (Nev. 2017) (instructing that "the medical malpractice claims that fail to comply with NRS 41A.071 must be severed and dismissed, while allowing the claims for ordinary negligence to proceed").

[5] *See, e.g.*, *Estate of Ray ex rel. Ray v. Forgy*, 744 S.E.2d 468 (N.C. Ct. App. 2013) (holding that an expert certification requirement did not apply to a corporate negligence claim against a hospital because the claim arose out of the policy, management, or administrative decisions of hospital and so was of ordinary negligence). LCCPV in fact says that it "cannot, itself, render care," Defs.' Mot. Summ. J. 17, so if it speaks truth its direct liability can only be for ordinary negligence.

[6] LCCPV with admirable optimism claims *Zhang* as support for its position. *See* Defs.' Mot. Summ. J. 15–16. Laura also notes that Judge Tao's order, which LCCPV waves frantically, *see id.* at 18–19, antedates *Zhang* by several years.

[7] The complaint in *Zhang* was filed before the 2015 amendment to NRS 41A.017. *See id.* at *1.

[8] So does LCCPV. *See* Defs.' Mot. Summ. J. 15–16.

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400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

Chapter 41A's affidavit requirement to the doctor's professional medical corporation, equally with the doctor himself." *Zhang*, 382 P.3d 878, at *4. In so doing, the *Fierle* court said that "'NRS Chapters 41A and 89 must be read in harmony' and that, so read, 'the provisions of NRS Chapter 41A must be read to include professional medical corporations.'" *Id.* (quoting *Fierle*, 125 Nev. at 735). So "[u]nder NRS 89.060 and NRS 89.220, as interpreted in *Fierle*, a physician's professional corporation, equally with the physician himself, can be a 'provider of healthcare' for purposes of the cap NRS 41A.035 imposes on noneconomic damages in professional negligence cases." *Id.* at *5. Indeed, in 2015 "the Legislature amended the definition of 'provider of healthcare' in NRS 41A.017 to expressly so state," which amendment "did not change but clarified the law, stating in express statutory terms the result reached on the issue of the interplay between NRS Chapters 40 and 89 in *Fierle*." *Id.* The *Zhang* court therefore "view[ed] the 2015 amendments to NRS 41A.017 and NRS 41A.035 as confirming [its] reading of the applicable statutory scheme." *Id.* at *5.

Indeed, the legislature's rejection of nursing homes as providers of health care is perfectly pellucid, for the nursing home industry openly asked the legislature during its deliberations on the 2015 amendment to add "skilled nursing facility" to § 41A.017's list of providers of health care—a request that the legislature denied. *See* Ex. 1, Prop. Amend. to S.B. 292. So that the legislature's excluding nursing homes from § 41A.017's list of providers of health care is intentional is undeniable. And to that legislative intent attention must be paid.

Under *Zhang*, then, (1) the entities read into § 41A.017 by the supreme court in addition to the providers of health care explicitly identified therein were in order to harmonize Chapters 41A and 89, and thus do not include nursing homes, which are defined in Chapter 449; and (2) such reading-in is now impermissible, as the legislature in 2015 by amendment explicitly identified in § 41A.017 the entities that the supreme court had previously read in, making § 41A.017's list now exhaustive. Nursing homes are not among those explicitly identified entities. So their liability arising from the liability of a provider of health care does not make them providers of health care.

Third, even if LCCPV's liability were solely vicarious, and even if LCCPV did (contra *Zhang*) participate in its staff's status as providers of health care vel non, it still would not be a provider of health care as to its CNAs' acts and omissions. CNAs are not providers of health care.

*See* NRS 41A.017 (listing licensed nurses but not CNAs).[9] Here is LCCPV's omission, of course: LCCPV somewhat rudely ignores the important contributions made by its CNAs to Mary's injuries and death, treating only its nurses as worthy of attention.[10] Yet neglecting Mary to death was a team effort: for example, CNAs' failure to monitor Mary between the night of 7 March and Laura's arrival to find her mother unresponsive on 8 March is a critical part of the story of Mary's decline and death. *See* Pls.' Mot. Prima Facie Claim SOF ¶¶ 89–109. For these failures LCCPV is vicariously liable, and that liability of course could not threaten to make LCCPV a provider of health care as its CNAs are not themselves providers of health care.[11]

**3. NRS 41.1395 and Chapter 41A Are Mutually Exclusive Here.**

The federal district court in *Brown v. Mt. Grant General Hospital*, No. 3:12-CV-00461, 2013 WL 4523488 (D. Nev. Aug. 26, 2013) held that NRS 41.1395 and Chapter 41A conflict. *See id.* at *6 (holding that "these statutes conflict, at least as applied to the facts here," as Chapter 41A's "regime contains a restriction on compensable damages, and a shorter than normal limitations period," while "§ 41.1395 provides for double damages and the default limitations period") (citations omitted). So the court ruled that plaintiffs, who had brought elder abuse and medical malpractice claims against a hospital and physicians, "may not allege an elder abuse claim under the present circumstances." *Id.* It believed that "the elder abuse statute was not intended as a remedy for torts that sound in medical malpractice," *id.*, as "both the plain language of § 41.1395 and its legislative history suggest that the statute targets the relationship between long-term caretakers and their charges." *Id.* at *7. Indeed, "the statute's text and legislative history primarily

[9] *See also Myers v. Heritage Enters., Inc.*, 820 N.E.2d 604, 610 (Ill. App. Ct. 2004) ("Given the minimal training requirements and the fact that nursing assistants provide primarily personal care, the nursing assistant position is not a professional position requiring the professional negligence instruction.").

[10] *See, e.g.*, Defs.' Mot. Summ. J. 5 ("[T]he only basis for liability on the part of LCCPV is the allegedly negligent acts of its nursing personnel."); *id.* at 12 ("LCCPV's liability is based solely on the acts and omissions of its nursing staff, as no other officer, employee or agent of LCCPV was involved in the events in question in any way.").

[11] *See also Greene Cty. Hosp. Auth. v. Turner*, 421 S.E.2d 715, 716 (Ga. Ct. App. 1992) ("In the complaint, the only claim stated against the hospital is that the hospital 'was negligent in that its staff failed to meet the standard of care required of medical professionals generally in screening, observing, and treating [appellee]. . . . While that language may state a claim of malpractice against [physician] since he is a professional, the language states only a claim of ordinary negligence against the hospital to the extent that the members of the hospital 'staff' referred to in appellee's complaint are non-professionals . . . .").

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

address the regulation of longterm care for the elderly." *Id.* For example, "[t]he statute speaks of liability in the event a person fails to 'maintain the physical or mental health of an older person' or 'exploit[s]' the elderly by gaining their 'trust and confidence'"—phrases that "invoke continuing and long-term relationships." *Id.* And "during hearings on § 41.1395, several legislators addressed the statute's potential impact on 'nursing homes,' 'managed care facilities,' 'long-term care facilities,' 'group homes,' caretaking family members, even homeless shelters, yet no legislator mentioned hospitals or clinics." *Id.* Indeed, "[t]he entities discussed by the legislators share a common attribute: they are all, in one way or another, long-term care facilities." *Id.* Yet "[u]nlike long-term care facilities, hospitals are typically acute care facilities—places one goes to receive short-term treatment for treatable ailments." *Id.* So "confronted with a choice between applying the elder care statute 'to facts only at its outer reaches,' and applying the medical malpractice statutes to a clear case of alleged medical malpractice," the court chose the latter and dismissed the elder abuse claim. *Id.* at *8 (citation omitted).

Under *Brown*, then, elder abuse per NRS 41.1395 and medical malpractice per Chapter 41A are mutually exclusive: § 14.1395 governs claims against long-term care facilities such as nursing homes, while Chapter 41A governs claims against (inter alia) hospitals. This Court has adopted *Brown*'s reasoning and in accordance with it has already granted summary judgment to Dr. Saxena on Laura's elder abuse claim, *see* Court Minutes (Mar. 21, 2018) ("The Complaint in question is for professional negligence against a healthcare provider and, therefore, governed by NRS 41A."); and has already dismissed the elder abuse claim against Nurse Socaoco, *see* Court Minutes (Aug. 13, 2018) ("NRS 41A.017 provides the definition of provider of health care. The Court FINDS IPC Defendants fall within this definition, and therefore, the elder abuse causes of action are improper in the instant matter.").[12]

[12] *See also* Order ¶¶ 4–10 (Apr. 11, 2018) (finding that Laura's complaint against Dr. Saxena and her proposed amended complaint "concern professional negligence against a provider of health care, and, therefore, are governed by NRS 41A"; finding that "there is neither legislative purpose nor intent to carve out an exception for elderly patients for negligent conduct within the purview of 41A"; finding *Brown*'s reasoning "persuasive as related to causes of action brought pursuant to NRS 41.1395 and NRS 41A when both causes of action are premised upon the provision of health care by a provider of health care"; finding Dr. Saxena a provider of health care and that Laura's claims against him sound in professional negligence; and concluding that "[a]s such, Plaintiffs may only pursue causes of action premised

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

That § 14.1395 and Chapter 41A are mutually exclusive has therefore already been decided. That proposition is accordingly the law of the case and so not now to be undermined for LCCPV's benefit, *see Recontrust Co. v. Zhang*, 130 Nev. 1, 7–8 (2014) ("[A] court involved in later phases of a lawsuit should not re-open questions decided (i.e., established as law of the case) by that court or a higher one in earlier phases.'") (citation omitted), especially given the Court's already having dismissed claims based on its adoption of the mutual exclusivity interpretation. *See Askins v. U.S. Dep't of Homeland Sec.*, 899 F.3d 1035, 1042 (9th Cir. 2018) ("A court may also decline to revisit its own rulings where the issue has been previously decided and is binding on the parties—for example, where the district court has previously entered a final decree or judgment."). Indeed, given that § 41.1395 and Chapter 41A are here mutually exclusive, granting LCCPV's request for shelter under Chapter 41A would lead to a remarkable result: the elder abuse statute, which as its text and legislative history show primarily targets long-term care facilities such as nursing homes, would be unavailable against nursing homes. But that would make § 41.1395 a nullity and mock the legislature's intent in enacting it. So granting LCCPV's request to eviscerate § 41.1395 could not be right.

### C. NRS 41A.100 Would Obviate the Need for an Expert Affidavit Even ifLCCPV Were a Provider of Health Care.

"The object of NRS 41A.071's affidavit-of-merit requirement . . . is 'to ensure that parties file malpractice cases in good faith, *i.e.*, to prevent the filing of frivolous lawsuits." *Baxter v. Dignity Health*, 357 P.3d 927, 930 (Nev. 2015) (citation omitted). NRS 41A.071 is a "procedural rule of pleading" that courts "must liberally construe." *Id.* In accordance with these principles, our supreme court held that notwithstanding NRS 41A.071's plain language res ipsa loquitur claims require no expert affidavit in *Szydel v. Markman*, 121 Nev. 453 (2005). The court observed that "NRS 41A.100(1) provides an exception to the basic requirement that expert testimony or evidence from a recognized medical text or treatise is required to prove negligence and causation in a

upon alleged professional negligence under NRS 41A to the exclusion of causes of action premised upon NRS 41.1395").

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

medical malpractice lawsuit," *id.* at 457, and that NRS 41A.071 and NRS 41A.100(1) "conflict because NRS 41A.100(1) permits a jury to infer negligence without expert testimony at trial, whereas NRS 41A.071 requires dismissal whenever the expert affidavit requirement is not met." *Id.* at 458. So "requiring an expert affidavit at the start of a malpractice action, while permitting the plaintiff to proceed at trial without the need to produce expert testimony under the res ipsa loquitur doctrine, leads to an absurd result" and "would do little to advance the primary goal of the expert affidavit requirement, which is to deter frivolous litigation and identify meritless malpractice lawsuits at an early stage." *Id.* at 458–59. And so "requiring an expert affidavit in a res ipsa case under NRS 41A.100(1) is unnecessary," as "[t]hese are factual situations where the negligence can be shown without expert medical testimony," and as "[i]t would be unreasonable to require a plaintiff to expend unnecessary effort and expense to obtain an affidavit from a medical expert when expert testimony is not necessary for the plaintiff to succeed at trial." *Id.* at 459–60.

NRS 41A.100(1) provides that, except in res ipsa cases,

> [l]iability for personal injury or death is not imposed upon any provider of health care based on alleged negligence in the performance of that care unless evidence consisting of expert medical testimony, material from recognized medical texts or treatises *or the regulations of the licensed medical facility wherein the alleged negligence occurred is presented to demonstrate the alleged deviation from the accepted standard of care* in the specific circumstances of the case and to prove causation of the alleged personal injury or death.

(Emphasis added.) Res ipsa cases are not, then, the only professional negligence cases not requiring expert testimony; a plaintiff may instead of using expert testimony condemn a licensed facility with its own regulations. *See Luke* 19:22 ("Out of thine own mouth will I judge thee, thou wicked servant."). The reason underlying dispensing with the expert testimony requirement in both res ipsa-based cases and regulation-based cases is the same: a defendant has made the case against itself.[13] And "[a]s the ancient Romans once said, *ubi eadem ratio, ibi idem jus*—'where there is the same reason, there is the same law.'" *Murakami v. United States*, 52 Fed. Cl. 232, 241 (2002). So in regulation-based cases too no expert affidavit is needed.

[13] Indeed, LCCPV has admitted throughout this litigation that its giving Mary morphine was in error, thereby satisfying the object of NRS 41A.071's affidavit-of-merit requirement, i.e., to prevent the filing of frivolous lawsuits.

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400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

Here, LCCPV's own regulations no doubt require, inter alia, that staff ensure that the right resident is receiving the right medication and that staff provide residents adequate care and attention (instead of, say, ignoring a resident until her daughter finds her unresponsive).[14] Indeed, federal regulations exist in order to ensure nursing homes' compliance with minimum standards, which compliance was absent in Mary's case, leading to LCCPV's being cited for failing to ensure that her drug regimen was free from unnecessary drugs—a citation that recorded that LCCPV's own "policy titled 'Policies for Medication Administration' . . . stated when administering medication, to identify a resident by comparing the name on the arm band with the name on the MAR and the photo of the resident." Ex. 2, Survey 7 and 12 of 15. As in *Szydel*, then, negligence here can be shown without expert medical testimony and so it would be unreasonable to require Laura to expend unnecessary effort and expense to obtain an affidavit from a medical expert when expert testimony is not necessary for her to succeed at trial. So as in *Szydel* no expert affidavit was required as the plaintiff could make her case without expert testimony under NRS 41A.100(1), so too here even if this were a professional negligence action no expert affidavit would be required as Laura could make her case without expert testimony under NRS 41A.100(1).

**D. That Laura's Claims Partake of Ordinary Negligence Would Obviate the Need for an Expert Affidavit Even if LCCPV Were a Provider of Health Care.**

"[W]hen a hospital performs nonmedical services, it can be liable under principles of ordinary negligence." *Szymborski v. Spring Mountain Treatment Ctr.*, 403 P.3d 1280, 1284 (Nev. 2017). Now "[a]llegations of breach of duty involving medical judgment, diagnosis, or treatment indicate that a claim is for medical malpractice." *Id.* But if "the reasonableness of the health care provider's actions can be evaluated by jurors on the basis of their common knowledge and experience, then the claim is likely based in ordinary negligence." *Id.* at 1285. This "distinction between medical malpractice and negligence may be subtle in some cases," and in fact "a single

[14] LCCPV's director of nursing testified that the facility's policies and procedures were in line with the standard of care in nursing, including that nurses provide medication administration, that nurses timely communicate to the physician a change in a resident's condition, and that a resident neither fall nor "have any other injuries while they are in the facility." Pls.' Mot. Prima Facie Claim SOF ¶¶ 129–30.

set of circumstances may sound in both ordinary negligence and medical malpractice." *Id.* In sum, "[a] claim is grounded in medical malpractice and must adhere to NRS 41A.071 where the facts underlying the claim involve medical diagnosis, treatment, or judgment and the standards of care pertaining to the medical issue require explanation to the jury from a medical expert at trial." *Id.* at 1288.[15]

Using this standard, the *Szymborski* plaintiff's claim against a hospital employee (a licensed social worker) labeled by plaintiff "malpractice, gross negligence, and negligence per se" did not require an expert affidavit. *Id.* at 1287.[16] Plaintiff alleged that the social worker was "entrusted to provide medical care owed to patients and [had] a duty to provide adequate medical treatment, to protect the patient and the public at large,'" and that she "breached the duty of care by discharging the patient, paying for a taxi only to Plaintiff's address . . . in violation of discharge policies and procedures, pursuant to NAC 449.332.'" *Id.* The court reckoned that "[a]lthough [plaintiff] uses terms like 'medical care' and 'medical treatment' in the description of the duty of care owed, the gravamen of this claim is that the social worker committed malpractice and was grossly negligent because the social worker discharged [patient] to [plaintiff's] home." So "[t]his breach of the standard of care was not based on the social worker's medical judgment." *Id.* And although for negligence per se plaintiff alleged that the medical treatment center violated NAC 449.332 (governing hospital discharge planning)—for example, by not discharging patient to a safe environment, by not documenting that he had made living arrangements (NAC 449.332 requires inter alia that evaluation of the patient's needs in discharge planning and the discharge plan be documented), and by failing to follow its own discharge policies—nevertheless "[t]he factual allegations underlying these specific regulatory violations do not involve medical diagnosis, treatment, or judgment," and so "do not sound in medical malpractice and, therefore, do not require a medical expert affidavit." *Id.*

[15] For example, "[a] medical malpractice statute will not apply to claims for negligent supervision, hiring, or training where the underlying facts of the case do not fall within the definition of medical malpractice." *Id.*

[16] Although LCCPV relies on and discusses at length *Szymborski*, including offering a magnificent *Szymborski* block quotation luxuriantly sprawling over three pages of its motion, it never does quite get around to considering how the *Szymborski* court in fact handled the claims before it. *See* Defs.' Mot. Summ. J. 12–15.

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

Yet, as the dissenting justice noted, the complaint referenced several documents "including the patient continuing care plan, the nursing progress note, and the acute physician discharge progress note," in which documents were discussed patient's discharge plans, and "[i]t appears these documents were prepared by physicians." *Id.* at 1289 (Hardesty, J., dissenting). To him this "demonstrate[d] that the decisions regarding [patient's] discharge involved medical judgment or treatment," such that "the claims [plaintiff] alleges are breaches of that judgment or treatment and are grounded in medical malpractice," thereby making an affidavit necessary. *Id.* The majority, however, declined to adopt that approach, i.e., notwithstanding physicians' apparent involvement in patient's discharge plaintiff's claim remained one of ordinary negligence.

Given *Szymborski*'s reliance on it, *see id.* at 1284–85, it is well to consider as well *Estate of French v. Stratford House*, 333 S.W.3d 546 (Tenn. 2011).[17] In *Estate of French*, the Tennessee Supreme Court held that because an administratrix of a nursing home resident's estate "alleged violations of the standard of care pertaining to both medical treatment and routine care, she has made claims based upon both medical malpractice and ordinary negligence." *Id.* at 550. Like the *Szymborski* court, the *French* court recognized that "a single complaint may be founded upon both ordinary negligence principles and the medical malpractice statute." *Id.* at 557. It therefore first segregated the medical malpractice claims: "the claims . . . that [nursing home] was negligent in assessing [resident's] condition, developing her initial plan of care, and properly updating that plan to conform to changes in her condition do indeed sound in medical malpractice." *Id.* at 558. But plaintiff also alleged that staff "failed to administer basic care in compliance with both the established care plan and doctors' subsequent orders regarding [resident's] treatment." *Id.* And "those staff members who allegedly failed to follow the care plan were CNAs," who "are not medical professionals and [whose] qualifications do not approach the more extensive and specialized training of a doctor or registered nurse." *Id.* Moreover, plaintiff "claims that the failure of the CNAs to provide basic services resulted, at least in part, from chronic understaffing of which senior management . . . was aware." *Id.* These allegations "pertain to basic care" and so "this

[17] *Superseded by statute as recognized in Ellithorpe v. Weismark*, 479 S.W.3d 818 (Tenn. 2015).

component of the claim sounds in ordinary negligence." *Id.* In other words, "allegations that the CNAs failed to comply with the care plan's instructions due to a lack of training, understaffing, or other causes, constitute claims of ordinary, common law negligence." *Id.* at 559. In sum,

> not all care given to patients at nursing home facilities is necessarily related to the rendering of medical care by a medical professional. The assessment of a patient's condition and the development of a plan of care that determines how often and when a patient needs to be fed, hydrated, bathed, turned or repositioned may require specialized medical skills, and thus should proceed under the [medical malpractice act]. A nursing home's failure to ensure that its staff, including certified nursing assistants, actually complies with the plan of care and performs services that, however necessary, are routine and nonmedical in nature, falls into the category of ordinary negligence.

*Id.* at 560.

Given *Szymborski*'s teaching that a single set of circumstances may sound in both ordinary negligence and medical malpractice, it is well to analyze separately (1) Mary's overdosing itself and (2) the subsequent general failure to follow orders regarding monitoring Mary and the broad neglect of her needs before Laura's arrival.[18] The latter is a straightforward failure to follow orders. No medical judgment was involved (and in the case of the CNAs no medical judgment could have been involved). True, physician (well, nurse practitioner) orders were involved, but according to *Szymborski* that involvement does not convert ordinary negligence into medical malpractice. So

[18] Of course, as noted above, *see supra* Section II.B.2., LCCPV itself is (in addition to being vicariously liable for its staff's ordinary negligence) also directly liable in ordinary negligence for its own dysfunction, and as to that liability there is naturally no question of an affidavit's necessity. *See, e.g.*, *Iodice v. United States*, 289 F.3d 270, 277 (4th Cir. 2002) (concluding that plaintiffs alleging that VA owed them duties regarding its staff's training, monitoring, and supervision, that it had an obligation to maintain appropriate policies and procedures to provide proper treatment of patients, and that it failed to promulgate adequate policies and procedures and to follow existing policies and procedures "clearly do not assert only medical malpractice claims," but "also seek to hold the VA liable in ordinary negligence"); *Harris v. Extendicare Homes, Inc.*, 829 F. Supp. 2d 1023, 1029 (W.D. Wash. 2011) ("[D]ecisions regarding training, hiring, and staffing are typically business/operational decisions, not health care decisions as defendants invite the Court to assume."); *Bleiler v. Bodnar*, 479 N.E.2d 230, 236 (N.Y. 1985) (holding that plaintiff's "claims that the hospital failed to provide competent medical personnel and to promulgate and enforce appropriate regulations and procedures" sounded in ordinary negligence); *Tracy v. Vassar Bros. Hosp.*, 13 N.Y.S.3d 226, 228 (App. Div. 2015) (holding that allegations that hospital "failed to investigate or respond to warnings and complaints from its employees regarding [physician's] practices generally" were of ordinary negligence); *Carthon v. Buffalo Gen. Hosp. @ Deaconess Skilled Nursing Facility Div.*, 921 N.Y.S.2d 746 (App. Div. 2011) (holding that claims against nursing home based on staff's failures to carry out directions of physicians responsible for resident's care plan were of ordinary negligence); *Estate of Waters v. Jarman*, 547 S.E.2d 142, 145 (N.C. Ct. App. 2001) (reversing trial court's dismissal of corporate negligence claim against hospital unaccompanied by expert certification because "where the corporate negligence claim arises out of policy, management or administrative privileges, such as . . . failing to monitor or oversee performance of the physicians, credentialing, and failing to follow hospital policies, the claim is instead derived from ordinary negligence principles").

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

the failures of staff (both nurses and CNAs) to obey orders and to provide basic care is easily ordinary negligence under *Szymborski*.

The overdosing itself, on which LCCPV would like the Court to exclusively focus, is a closer question. It of course violated regulations and LCCPV's own policies and procedures, but so did defendant's negligently discharging the patient in *Szymborski*. And as in *Szymborski* those violations involved no medical judgment, neither was medical judgment implicated here: no medical judgment is needed to know that not verifying the right resident and the right medication when administering a narcotic may cause overdosing and death. There was a clear confirmation process to be followed not as a matter of medical judgment but as a matter of necessity, and Nurse Dawson, thrown into a chaotic situation and feeling herself behind the eight ball, did not follow it. So the overdosing too is ordinary negligence under *Szymborski*.

*Estate of French* confirms this result. Laura alleges that staff failed to administer to her mother basic care in compliance with Mary's care plan and with subsequent orders regarding her treatment; that some of those who failed to follow the care plan and orders were CNAs, who are not medical professionals; and that staff's failures to provide basic services resulted at least in part from understaffing of which management was aware—allegations pertaining to basic care and so sounding in ordinary negligence. *Estate of French* therefore corroborates the conclusion reached by reviewing *Szymborski*: no affidavit would be required even if LCCPV were a provider of health care as the claims against LCCPV would partake of ordinary negligence.

In sum, (1) LCCPV waived its expert affidavit defense; (2) no expert affidavit was required in any event because LCCPV is clearly not a provider of health care; and (3) no expert affidavit would have been required even if LCCPV were arguably such a provider because (a) NRS 41A.100(1)'s affidavit exception for claims supported by a facility's regulations would apply, and (b) *Szymborski*'s affidavit exception for claims of ordinary negligence would apply. LCCPV's motion should therefore be denied.

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KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

## III. CONCLUSION

Laura requests that the Court deny LCCPV's motion for summary judgment.

DATED this 4th day of October, 2018.

**KOLESAR & LEATHAM**

By */s/ Melanie L. Bossie, Esq.*

MICHAEL D. DAVIDSON, ESQ.
Nevada Bar No. 000878
400 South Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice*
**WILKES & MCHUGH, P.A.**
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260
BENNIE LAZZARA, JR., ESQ. - *Pro Hac Vice*
**WILKES & MCHUGH, P.A.**
One North Dale Mabry Highway, Suite 700
Tampa, FL, 33609

*Attorneys for Plaintiffs*

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

**CERTIFICATE OF SERVICE**

I hereby certify that I am an employee of Kolesar & Leatham, and that on the 4th day of October, 2018, I caused to be served a true and correct copy of foregoing **PLAINTIFFS' RESPONSE TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** in the following manner:

(ELECTRONIC SERVICE) Pursuant to Administrative Order 14-2, the above-referenced document was electronically filed on the date hereof and served through the Notice of Electronic Filing automatically generated by that Court's facilities to those parties listed on the Court's Master Service List.

*/s/ Kristina R. Cole*
An Employee of KOLESAR & LEATHAM

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

# EXHIBIT 1

# SKILLED NURSING FACILITIES –
# PROPOSED AMENDMENT TO SENATE BILL NO. 292

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) ***green bold italic underlining*** is new language proposed in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill that is proposed to be retained in this amendment; and (6) **green bold** is newly added transitory language.

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We enthusiastically support SB292. Our two proposed changes are simply intended to further the goals of SB292, by streamlining and harmonizing Nevada's statutes dealing with civil actions for negligence.

**Amendment 1**

Our first proposed amendment is intended to add further clarity to this bill by enhancing the language in Section 2 to ensure that all health care providers are specifically included in the definition of "provider of health care" in NRS 41A.017. These changes would help to make it clear that NRS Chapter 41A applies to all providers of health care, whether the care in question was provided by a medical professional in a hospital, a surgical center, an obstetric center, a skilled nursing facility, or any other medical facility.

There are three key NRS sections dealing with professional negligence in the medical field with definitions of "provider of health care" – NRS 41A.017, NRS 42.021 (8)(d), and NRS 629.031(1). With this bill amending the definition of "provider of health care" in one of these, NRS 41A.017, we wanted to ensure that any changes are made across the board. Our amendment proposes to cross-cite the definitions between the relevant statutes, and syncs the language across these definitions, to make it clear that they cover the same entities and individuals.

We also added a citation to the definition of "medical facility" in NRS 449.0151 to each of the definitions, to clarify that these medical professionals are covered whether or not they work in a licensed hospital or another form of licensed medical facility.

These clarifications are essential to our skilled nursing facilities, to protect them from having to spend hundreds of thousands of dollars litigating this basic fact - that we are a provider of health care covered under NRS 41A. It will also harmonize the professional negligence statutes in the medical field to the benefit of all medical professionals and entities.

For background information, NRS 449.0151 reads as follows:

**NRS 449.0151 "Medical facility" defined.** "Medical facility" includes:

1. A surgical center for ambulatory patients;

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2. An obstetric center;
3. An independent center for emergency medical care;
4. An agency to provide nursing in the home;
5. A facility for intermediate care;
6. A facility for skilled nursing;
7. A facility for hospice care;
8. A hospital;
9. A psychiatric hospital;
10. A facility for the treatment of irreversible renal disease;
11. A rural clinic;
12. A nursing pool;
13. A facility for modified medical detoxification;
14. A facility for refractive surgery;
15. A mobile unit; and
16. A community triage center.

**PROPOSED AMENDMENT 1:**

**Sec. 2.** NRS 41A.017 is hereby amended to read as follows:

41A.017 "Provider of health care" means ***a "provider of health care" as defined in NRS 629.031(1) and NRS 42.021 (8)(d),*** a physician licensed ~~[under]~~ ***pursuant to*** chapter 630 ***, 630A*** or 633 of NRS, ***physician assistant,*** dentist, licensed nurse, dispensing optician, optometrist, ***practitioner of respiratory care,*** registered physical therapist, ***occupational therapist,*** podiatric physician, licensed psychologist, ***licensed marriage and family therapist, licensed clinical professional counselor, music therapist,*** chiropractor, ***athletic trainer, perfusionist,*** doctor of Oriental medicine ~~[,]~~ ***in any form,*** medical laboratory director or technician, ***pharmacist or*** licensed dietitian or a licensed hospital ***, clinic, surgery center, skilled nursing facility, medical facility as defined in NRS 449.0151 or other entity that employs any such person*** and its employees.

**Sec. 2A.** NRS 42.021 (8)(d) is hereby amended to read as follows:

8. (d) "Provider of health care" means ***a "provider of health care as defined in NRS 41A.017 and NRS 629.031(1),*** a physician licensed ~~under~~ ***pursuant to*** chapter 630***, 630A*** or 633 of NRS, ***physician assistant,*** dentist, licensed nurse, dispensing optician, optometrist, ***practitioner of respiratory care,*** registered physical therapist, ***occupational therapist,*** podiatric physician, licensed psychologist, ***licensed marriage and family therapist, licensed clinical professional counselor, music therapist,*** chiropractor, ***athletic trainer, perfusionist,*** doctor of Oriental medicine ***in any form,*** medical laboratory director or technician, ***pharmacist or*** licensed dietitian or a licensed hospital***, skilled nursing facility, medical facility as defined in NRS 449.0151 or other entity that employs any such person*** and its employees.

**Sec. 2B. NRS 629.031(1) is hereby amended to read as follows:**

NRS 629.031 "Provider of health care" defined. Except as otherwise provided by a specific statute:

1. "Provider of health care" means ***a "provider of health care as defined in NRS 41A.017 and NRS 42.021 (8)(d),*** a physician licensed pursuant to chapter 630, 630A or 633 of NRS, physician assistant, dentist, licensed nurse, dispensing optician, optometrist, practitioner of respiratory care, registered physical therapist, occupational therapist, podiatric physician, licensed psychologist, licensed marriage and family therapist, licensed clinical professional counselor, music therapist, chiropractor, athletic trainer, perfusionist, doctor of Oriental medicine in any form, medical laboratory director or technician, pharmacist, licensed dietitian or a licensed hospital***, skilled nursing facility, medical facility as defined in NRS 449.0151 or other entity that employs any such person and its employees*** ~~as the employer of any such person~~.

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**Amendment 2**

Our second proposed amendment is intended to add further clarity to Nevada's statutes regarding professional negligence in the medical realm by making clear that a plaintiff cannot circumvent the limitations of NRS 41A by improperly bringing an additional claim under NRS 41.1395 (the elder abuse statute).

Our skilled nursing facilities have repeatedly had to defend themselves against attorneys bringing what should be clear 41A claims under the auspices of NRS 41.1395 as well. This puts our facilities in jeopardy of being forced to pay out significant damages under NRS 41.1395 for causes that are rightfully included under the limits of NRS 41A. Skilled nursing facilities are forced to expend hundreds of thousands of dollars engaging in extensive discovery and pretrial motion practice defending NRS 41.1395 claims that are rightfully included under NRS 41A.

Allowing attorneys to pursue health care "neglect" or "abuse" claims under NRS 41.1395 renders the cap provided by NRS 41A.035 meaningless. Damages under NRS 41.1395 are not capped and then doubled in addition to attorney fees and costs.

**PROPOSED AMENDMENT 2:**

**Sec. 11. NRS 41.1395 is hereby amended to read:**

NRS 41.1395 Action for damages for injury or loss suffered by older or vulnerable person from abuse, neglect or exploitation; double damages; attorney's fees and costs.

1. Except as otherwise provided in subsection 3, if an older person or a vulnerable person suffers a personal injury or death that is caused by abuse or neglect or suffers a loss of money or property caused by exploitation, the person who caused the injury, death or loss is

liable to the older person or vulnerable person for two times the actual damages incurred by the older person or vulnerable person.

2. If it is established by a preponderance of the evidence that a person who is liable for damages pursuant to this section acted with recklessness, oppression, fraud or malice, the court shall order the person to pay the attorney's fees and costs of the person who initiated the lawsuit.

3. The provisions of this section do not apply to a person who caused injury, death or loss to a vulnerable person if the person did not know or have reason to know that the harmed person was a vulnerable person.

***4. The provisions of this section do not apply to an act of professional negligence as covered under NRS 41A.***

~~4.~~ **5.** For the purposes of this section:

(a) "Abuse" means willful and unjustified:

(1) Infliction of pain, injury or mental anguish; or

(2) Deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of an older person or a vulnerable person.

(b) "Exploitation" means any act taken by a person who has the trust and confidence of an older person or a vulnerable person or any use of the power of attorney or guardianship of an older person or a vulnerable person to:

(1) Obtain control, through deception, intimidation or undue influence, over the money, assets or property of the older person or vulnerable person with the intention of permanently depriving the older person or vulnerable person of the ownership, use, benefit or possession of that person's money, assets or property; or

(2) Convert money, assets or property of the older person with the intention of permanently depriving the older person or vulnerable person of the ownership, use, benefit or possession of that person's money, assets or property.

As used in this paragraph, "undue influence" does not include the normal influence that one member of a family has over another.

(c) "Neglect" means the failure of a person who has assumed legal responsibility or a contractual obligation for caring for an older person or a vulnerable person, or who has voluntarily assumed responsibility for such a person's care, to provide food, shelter, clothing or services within the scope of the person's responsibility or obligation, which are necessary to maintain the physical or mental health of the older person or vulnerable person. For the purposes of this paragraph, a person voluntarily assumes responsibility to provide care for an older or vulnerable person only to the extent that the person has expressly acknowledged the person's responsibility to provide such care.

(d) "Older person" means a person who is 60 years of age or older.

(e) "Vulnerable person" means a person who:

(1) Has a physical or mental impairment that substantially limits one or more of the major life activities of the person; and

(2) Has a medical or psychological record of the impairment or is otherwise regarded as having the impairment.

The term includes, without limitation, a person who has an intellectual disability, a person who has a severe learning disability, a person who suffers from a severe mental or emotional illness or a person who suffers from a terminal or catastrophic illness or injury.

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**Contact:**
Jennifer J. Gaynor, Dickinson Wright, PLLC, (702) 550-4462, jgaynor@dickinsonwright.com

# EXHIBIT 2

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295076 | A. BUILDING _____ B. WING _____ | 04/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENT-PARADISE VALLEY | 2325 E. HARMON AVE. LAS VEGAS, NV 89119 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>This Statement of Deficiencies was generated as a result of a Medicare recertification survey in your facility on 4/12/16 through 4/21/16, in accordance with 42 Code of Federal Regulations (CFR), Chapter IV, Part 483 - Requirements for Long Term Care Facilities.<br><br>The census at the time of the survey was 88 residents.<br><br>The sample size was 18 sampled residents and 3 unsampled residents.<br><br>There were two complaints investigated.<br><br>Complaint #NV00045334 was substantiated.<br><br>The allegation a resident was seen by a physician assistant for two months instead of an actual doctor was substantiated (See Tag F387).<br><br>The following allegations could not be substantiated.<br>Allegation #1 a resident weighed at least a dozen pounds less than when she went in.<br>Allegation #2 a resident developed ulcers on her body.<br>Allegation #3 a resident was hurt during physical therapy.<br>Allegation #4 a resident was discharged because her insurance benefits ran out.<br><br>The investigation included:<br><br>A review of the clinical record of the resident of concern in addition to four other records. | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



APP240

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| F 000 | Continued From page 1<br>Interviews were conducted with the Director of Nursing, the Director of Physical Therapy, the Administrator, the Occupational Therapist, the Director of Medical Records, the Registered Nurse, the Dietician and the Licensed Practical Nurse.<br><br>Observations were made of residents throughout the facility in addition observation were made of residents receiving physical therapy and wound care.<br><br>Complaint #NV00045765 was substantiated.<br><br>The allegation a medication was not administered as ordered was substantiated (See Tag F329).<br><br>The following allegation could not be substantiated:<br><br>Allegation #1 the facility staffing was inadequate.<br><br>The investigation into the allegation included:<br><br>Observations of care during the survey.<br><br>Interviews with residents, family members and a group interview.<br><br>Interviews with direct care staff.<br><br>Interview with the Director of Nursing.<br><br>Interview with the Staff Development Nurse.<br><br>Review of the facility's staffing sheet.<br><br>The findings and conclusions of any investigation by the Division of Public and Behavioral Health | F 000 | | |

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| F 000 | Continued From page 2<br>shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.<br><br>The following regulatory deficiencies were identified: | F 000 | Correction (POC) does not constitute admission agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The POC is prepared or executed solely because it is required by the provisions of federal and state laws. | |
| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update | F 157 | Tag F 157<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>The resident is no longer in the facility and will not be affected by the deficient practice.<br><br>How will you identify other residents having the same potential to be affected by the same practice and what anticipated corrective action will be taken:<br><br>The residents with the same potential to be affected will be identified by auditing the MAR's to identify any refusals of medication and if the reason(s) for refusal are documented. | |

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| F 157 | Continued From page 3<br>the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, observation and clinical record review, the facility failed to ensure a Physician was notified about an adverse pain medication reaction for 1 of 18 sampled residents (Resident #4).<br><br>Findings included:<br><br>Resident #4<br><br>Resident #4 was admitted on 3/2/16, with diagnoses including status post motor vehicle accident, pelvic fracture and large ulcers at the left lower extremity.<br><br>Review of Resident #4's clinical record revealed a physician order dated 4/5/16, for lidocaine patch 5% to be applied daily to the left lower back for pain management.<br><br>On 4/12/16 at 8:45 AM, a medication pass observation was conducted with a Registered Nurse. During the procedure, the resident refused the application of the lidocaine patch. The resident indicated the patch caused a painfully burning sensation and the last time that was applied, the patch had to be removed by a nurse due to the adverse reaction.<br><br>Medication Administration Record (MAR) revealed that from 4/9/16 to 4/14/16, nurses' initials were circled in the spots corresponding to the administration of the lidocaine patch. The | F 157 | What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:<br><br>The audit will occur weekly and brought to PI until 100% threshold is met. Education on medication administration and refusals will be provided to all Licensed Nurses.<br><br>How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:<br><br>The audits of the MAR will be monitored in the performance improvement process, until 100% compliance is achieved and quarterly audits will be performed by our Pharmacy services as preventive measures from recurrence.<br><br>Individual responsible: DON, ADON, DSD<br><br>Date of completion: June 8, 2016 | |

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| F 157 | Continued From page 4<br>medication notes in the back of the MAR documented that on 4/12/16 and 4/14/16, the medication was not administered because the resident refused.<br><br>On 4/14/16 at 3:00 PM, the Director of Nursing (DON) explained if a medication was not administered, the nurse must circle the initial in the MAR and document the reason for not administering the medication. The DON indicated if a medication was not administered becasue of an adverse reaction, the Attending Physician must be notified and the nature of the reaction documented in the clinical record. The DON acknowledged the nurses did not document the reasons why the lidocaine patch was not administered. The record lacked documented evidence the Attending Physician was notified about the adverse reaction to the lidocaine patch. | F 157 | Correction (POC) does not constitute admission agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The POC is prepared or executed solely because it is required by the provisions of federal and state laws. | |
| F 322 SS=D | 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that --<br><br>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and<br><br>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. | F 322 | Tag F 322<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>The LPN involved with the deficient practice was educated and given competency testing regarding enteral tube feeding placement and verification. | |

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| F 322 | Continued From page 5<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and policy review, the facility failed to ensure nursing staff verified proper positioning of feeding tube prior starting a tube feeding for 1 of 18 sampled residents (Resident #7).<br><br>Findings include:<br><br>Resident #7<br><br>Resident #7 was admitted to the facility on 9/16/15 with diagnoses including history of renal cell carcinoma, high blood pressure, chronic gastric ulcer, depression, gastrostomy, diabetes, stroke and blindness.<br><br>On 4/12/16 at 4:00 PM, the Licensed Practical Nurse (LPN) was observed setting up a new gastrostomy tube feeding to be infused via a pump for Resident #7. The LPN connected the primed feeding tube infusion to the resident's gastrostomy tube (g-tube) was ready to start the feeding pump. The inspector requested the LPN not start the feeding pump and asked if the gastrostomy tube placement should be assessed prior to starting the feeding. The LPN confirmed the g-tube placement should be checked prior to starting the tube feeding.<br><br>Facility policy titled, "Tube Feeding Administration" (no revision date) indicated staff | F 322 | How will you identify other residents having the same potential to be affected by the same practice and what anticipated corrective action will be taken:<br><br>We will identify all residents receiving tube feeding and perform ongoing med pass observations to ensure proper procedure is being followed on all peg tube feedings.<br><br>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:<br><br>Education of all Licensed Nurses will be performed on peg tube medication administration policy and procedure. LPNs will receive competency evaluations regarding enteral tube feeding placement and verification upon hire and annually thereafter. Med Pass and enteral tube feeding placement and verification observations will be conducted to ensure substantial compliance.<br><br>How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:<br><br>Random peg tube med pass observations will continue to be done weekly x4, monthly x2/until 100% threshold is met. The observations will be included in our performance improvement process. | |

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| F 322 | Continued From page 6<br>was to verify proper positioning of a g-tube before connecting primed feeding bag tubing to the resident's g-tube. | F 322 | Individual responsible: DON, ADON, DSD<br><br>Date of Completion: June 8, 2016 | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, interview and document review, the facility failed to ensure a narcotic pain medication was administered following the prescribed schedule for 1 of 18 | F 329 | Correction (POC) does not constitute admission agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The POC is prepared or executed solely because it is required by the provisions of federal and state laws.<br><br>Tag F 329<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>The residents (#4, #20 and #21) affected by the deficient practice are no longer in the facility<br><br>How will you identify other residents having the same potential to be affected by the same practice and what anticipated corrective action will be taken:<br><br>All residents have the potential to be affected by the deficient practice, education will be performed with all Licensed Nurses on med pass administration policy and procedure. Med pass observations will be conducted weekly x4, monthly x2/ until 100% threshold is met. | |

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| F 329 | Continued From page 7<br>sampled residents (Resident #4) and did not prevent a narcotic pain medication from administration to the wrong resident for 1 unsampled resident (Resident #20).<br><br>Findings include:<br><br>Resident #4<br><br>Resident #4 was admitted on 3/2/16, with diagnoses including status post motor vehicle accident, pelvic fracture and large ulcers at the left lower extremity.<br><br>Review of Resident #4's clinical record revealed a physician order dated 3/21/16, for oxycodone 5 milligrams (mg) to be administered as needed every six hours for pain management.<br><br>On 4/14/16 at 10:35 AM, two nurses attempted to provide wound care to the resident. During the assessment prior to the wound treatment, the resident complained of lower extremities pain with an intensity of eight over ten (8/10). The resident indicated a pain medication was administered at 5:00 AM per request due to the pain.<br><br>Review of the controlled drug record revealed one tablet of oxycodone 5 mg was removed from the medication cart at 5:00 AM and another at 9:00 AM.<br><br>On 4/14/16 at 10:49 AM, a Licensed Practical Nurse (LPN) explained oxycodone 5 mg was administered at 9:00 AM because the resident complained of pain. The LPN confirmed the medication was administered at 5:00 AM and 9:00 AM, every four hours instead of every six hours as ordered. The LPN acknowledged she | F 329 | What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:<br><br>The LPNs involved in the med pass errors were educated. First LPN #4 was educated April 14, 2016. LPN #11 was educated March 11, 2016. A med pass observation was conducted on March 12, 2016. The LPN was found to be in substantial compliance with medication administration policy and procedure.<br><br>All Licensed Nurses were educated on medication administration following the error on March 11, 2016 on the date<br><br>How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:<br><br>Med pass observation is conducted quarterly with pharmacy services and will be ongoing. Random med pass observation is being done monthly.<br><br>Individual responsible: DON, ADON, SDS<br><br>Date of Completion: June 8, 2016 | |

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| F 329 | Continued From page 8<br>did not read the medication order prior to the administration. The LPN believed all pain medications such as oxycodone had to be administered every four hours.<br><br>Facility policy titled, "Policies for Medication Administration" revised October 2004, documented that prior to the administration of a medication, the nurse had to check the Medication Administration Record (MAR), read the order entirely, read the label three times and check the Physician order if a discrepancy was detected between the medication label and the MAR.<br><br>Resident #21<br><br>Resident #21 was admitted to the facility on 3/2/16 with diagnoses that included neoplasm and pressure ulcer. On 3/6/16 Resident #21's physician ordered Morphine Sulfate ER (Extended Release) 60 milligrams two tablets, to be given by mouth every 8 hours with orders to hold for sedation or confusion.<br><br>Resident #20<br><br>Resident #20 was admitted to the facility on 3/2/16 with diagnoses that included falls, syncope & collapse, chronic obstructive pulmonary disease and hypertension. The documentation indicated Resident #20's prescribed medications did not include Morphine Sulfate.<br><br>Review of a facility document dated 3/7/16 indicated Resident #20 was given Morphine | F 329 | | |

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| F 329 | Continued From page 9<br>Sulfate that was not ordered for the resident. The condition of the resident before the incident was alert and confused. The resident's physician was notified immediately and an order for Narcan (a narcotic antagonist) 0.4 milligrams was ordered to be given intramuscularly with orders "may" repeat in 3 minutes twice. The resident's family member was subsequently notified.<br><br>On 4/21/16 the licensed nurse that administered the medication stated, during the morning medication pass she was told by a Certified Nursing Assistant (CNA) Resident #20 was in pain. About the same time Resident #21 indicated to the nurse she was in pain. The nurse indicated she administered what she thought was Resident #20's pain medication to the resident. The nurse stated the tablets were crushed and given in applesauce. Afterward when the nurse tried to administer Resident #21's medication the nurse realized she had mistakenly given Resident #21's Morphine Sulfate to Resident #20. The nurse reported the error immediately and the physician was notified. The resident was assessed and monitored. The nurse indicated she had only worked on other units before and the Medication Administration Record (MAR) did not have pictures of Residents #20 and #21.<br><br>Documentation in the clincial record read that the resident continued to be stable. The nurse indicated Narcan was ordered and it made the resident nauseated. The resident remained stable until about two hours later when the resident's blood pressure increased. The physician was notified and the medication Clonidine was ordered. The nurse reported she went home that afternoon and the resident was "fine" at the time of the departure. | F 329 | | |

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| F 329 | Continued From page 10<br><br>On 4/21/16 the Director of Nursing stated the licensed nurse that gave the wrong medication to Resident #20 was working in the 300 and 400 unit. The Director indicated usually two nurses worked on these units, but the census was higher than usual, so three nurses were assigned to about 16 residents each. The Director stated subsequent training was given to nurses after the incident. The Director indicated the day after the medication error, Resident #20 became unresponsive, a Code Blue was called and the resident was immediately transferred to the Emergency Room at an acute care hospital.<br><br>Review of the clinical record revealed on 3/7/16 at 3:59 PM the resident's nurse documented, hourly vital signs and hydration were offered, the resident was receiving Oxygen at 2 liters per minute, the resident was in no distress, had no shortness of breath and was arousable.<br><br>On 3/7/16 at 8:06 PM the resident's nurse documented the Oxygen was ongoing, the resident was alert and verbally responsive and confused. Vital signs were monitored every hour and the resident had received Clonidine for elevated blood pressure. The resident continued to be frequently monitored.<br><br>On 3/8/16 at 11:47 AM the Director of Nursing documented the resident's blood saturation dropped to 77% (normal is above 90%) and a Code Blue was called. A non-rebreather mask was started with 15 liters per minute of Oxygen. The resident was able to open eyes to verbal stimuli. The resident was taken to the Emergency Room by paramedics. | F 329 | | |

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| | 295076 | A. BUILDING _____ B. WING _____ | 04/21/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENT-PARADISE VALLEY | 2325 E. HARMON AVE. LAS VEGAS, NV 89119 |

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| F 329 | Continued From page 11<br>The document "Nursing Home To Hospital Transfer Form" indicated the resident was transferred at 11:30 AM on 3/8/16.<br><br>The facility policy titled "Policies for Medication Administration", dated 10/14 stated when administering medication, to identify a resident by comparing the name on the arm band with the name on the MAR and the photo of the resident. If there is no photo or armband, to verify the resident's identity with staff that knows the resident. The policy further stated medications should only be crushed after checking with the pharmacist or supervisor in case they are time released. | | Correction (POC) does not constitute admission agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The POC is prepared or executed solely because it is required by the provisions of federal and state laws.<br><br>Tag F 332<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>The resident #19 is no longer in the facility.<br><br>How will you identify other residents having the same potential to be affected by the same practice and what anticipated corrective action will be taken:<br><br>All residents have the potential to be affected by the deficient practice. The corrective action is to educate all licensed nurses on medication administration policy and procedure. A written audit will be done on Med Pass observations. Med Pass observations will be written on pharmacy observation forms. Random med pass observation is being done monthly and being reported to monthly Performance Improvement Committee. | |
| F 332 SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to maintain a medication error rate of 5% or less for one unsampled resident (Resident #19).<br><br>Findings include:<br><br>On 4/12/16 and 4/14/16, 28 medication passes were observed with two medication errors identified. The medication error rate was 7.14 %.<br><br>On 4/14/15 at 7:35 AM, a medication administration pass was observed with a | F 332 | | |

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| F 332 | Continued From page 12<br>Licensed Practical Nurse (LPN). The LPN administered medications to Resident #19 that included lisinopril 40 milligrams (mg) one tablet and senokot 8.5 mg one tablet.<br><br>Review of resident #19's clinical record revealed a physician order for senokot 8.5 mg two tablets every eight hours for constipation. During the medication pass, the LPN administered one tablet of senokot instead of two tablets as prescribed.<br><br>In addition, the clinical record documented an order dated 4/13/16, to discontinue the medication lisinopril 40 mg. During the medication pass, the LPN administered the medication lisinopril.<br><br>On 4/14/16 at 1:26 PM, the LPN acknowledged she did not read the medication orders.<br><br>The facility policy titled "Policies for Medication Administration" revised October 2004, documented that prior to the administration of a medication, the nurse had to check the MAR, read the order entirely, read the label three times and check the Physician order if a discrepancy was detected between the medication label and the MAR. | F 332 | What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:<br><br>Education will be performed with all licensed nurses on medication administration policy and procedure. Sessions include medication administration policy and procedure, and the five rights of medication administration. Random med pass observation is being done monthly and reviewed by Performance Improvement Committee.<br><br>How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:<br><br>Med pass observation is conducted quarterly with pharmacy services and will be ongoing. Random medication pass observations are being done monthly to maintain threshold of 95% and discussed monthly at QAPI.<br><br>Individual responsible: DON, ADON, SDS<br><br>Date of Completion: June 8, 2016 | |
| F 387 SS=D | 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT<br><br>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.<br><br>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was | | | |

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| F 387 | Continued From page 13<br>required.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, policy review and interview, the facility failed to ensure 1 of 18 residents (Resident #17) was seen by a physician at least every thirty days for the first 90 days after admission.<br><br>Findings include:<br><br>Resident #17<br><br>Resident #17 was admitted to the facility on 10/19/15 and discharged on 1/27/16, with diagnoses including adult failure to thrive, severe protein- calorie malnutrition, abdominal pain, high blood pressure, anxiety and difficulty walking.<br><br>Resident #17's medical record documented the primary care physician assistant was providing care between the dates of 10/19/15 through 12/20/15. The physician signed progress note dated 12/21/15 indicated the first visit made by the primary care physician was 60 days after the initial admission.<br><br>Facility Policy titled "Physician Services Guidelines" [Last Revised: 1/4/2013] indicated the physician must visit the resident at least every 30 days for the first 90 days after admission.<br><br>On 4/14/16 at 2:20 PM, the Director of Medical Records confirmed Resident #17's record indicated no visits were performed by the primary care physician until 12/21/15. | F 387 | Correction (POC) does not constitute admission agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The POC is prepared or executed solely because it is required by the provisions of federal and state laws.<br><br>Tag F 387<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>The resident #17 is no longer in the facility and will not be affected by the deficient practice.<br><br>How will you identify other residents having the same potential to be affected by the same practice and what anticipated corrective action will be taken:<br><br>All residents have the potential to be affected by the deficient practice. The anticipated corrective action will be to audit all resident charts for timely physician visits and notify all Physicians of required timely visits. | |

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| F 387 | Continued From page 14<br>On 4/14/16 at 3:00 PM, the Director of Nursing (DON) indicated the primary care physician should see a newly admitted resident within 72 hours of the admission. The DON further indicated the facility had identified problems with a group of certain physicians not seeing residents within the required time frames. | F 387 | What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:<br><br>The Audits performed by Health Information Manager will be conducted at 72 hours, 15 days, 60 days and 90 days, then every 60 days thereafter.<br><br>How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:<br><br>We will monitor this system by entering it into the performance improvement process and will monitor timely visits each month to ensure threshold of 100%.<br><br>Individual responsible: Health Information Manager<br><br>Date of Completion: June 8, 2016 | |

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| F 387 | Continued From page 13<br>required.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, policy review and interview, the facility failed to ensure 1 of 18 residents (Resident #17) was seen by a physician at least every thirty days for the first 90 days after admission.<br><br>Findings include:<br><br>Resident #17<br><br>Resident #17 was admitted to the facility on 10/19/15 and discharged on 1/27/16, with diagnoses including adult failure to thrive, severe protein- calorie malnutrition, abdominal pain, high blood pressure, anxiety and difficulty walking.<br><br>Resident #17's medical record documented the primary care physician assistant was providing care between the dates of 10/19/15 through 12/20/15. The physician signed progress note dated 12/21/15 indicated the first visit made by the primary care physician was 60 days after the initial admission.<br><br>Facility Policy titled "Physician Services Guidelines" [Last Revised: 1/4/2013] indicated the physician must visit the resident at least every 30 days for the first 90 days after admission.<br><br>On 4/14/16 at 2:20 PM, the Director of Medical Records confirmed Resident #17's record indicated no visits were performed by the primary care physician until 12/21/15. | F 387 | Accepted LSC PC 4/29/16<br>Tag K 018<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>The blood pressure stand was moved and the clean cart was moved and labeled appropriately to prevent any further impedance.<br><br>How will you identify other residents having the same potential to be affected by the same practice and what anticipated corrective action will be taken:<br><br>All residents that have the potential to be affected by the same practice. The blood pressure stands have been moved from impeding any doorway and the clean carts have been labeled to be appropriately place so as to not obstruct the doorway. | |

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| F 387 | Continued From page 14<br>On 4/14/16 at 3:00 PM, the Director of Nursing (DON) indicated the primary care physician should see a newly admitted resident within 72 hours of the admission. The DON further indicated the facility had identified problems with a group of certain physicians not seeing residents within the required time frames. | F 387 | What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:<br><br>Moved any blood pressure stands and labeled the clean carts for proper placement and provide ongoing education.<br><br>How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:<br><br>The facility staff will monitor the placement of items during Grand Rounds and staff rounds. Staff has been educated on proper storage of clean carts and blood pressure stands.<br><br>Individual responsible: Sr. Environmental Director<br><br>Date of completion: June 8, 2016 | |

S. BRENT VOGEL
Nevada Bar No. 6858
Brent.Vogel@lewisbrisbois.com
AMANDA J. BROOKHYSER
Nevada Bar No. 11526
Amanda.Brookhyser@lewisbrisbois.com
LEWIS BRISBOIS BISGAARD & SMITH LLP
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Telephone: 702.893.3383
Fax: 702.893.3789
*Attorneys for Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., Carl Wagner*

DISTRICT COURT

CLARK COUNTY, NEVADA

Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually,

Plaintiffs,

vs.

SOUTH LAS VEGAS MEDICAL INVESTORS, LLC dba LIFE CARE CENTER OF SOUTH LAS VEGAS fka LIFE CARE CENTER OF PARADISE VALLEY; SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP; LIFE CARE CENTERS OF AMERICA, INC.; BINA HRIBIK PORTELLO, Administrator; CARL WAGNER, Administrator; and DOES 1-50 inclusive,

Defendants.

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Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually,

Plaintiffs,

Vs.

CASE NO. A-17-750520-C
Dept. No.: XXIII

Consolidated with:
CASE NO. A-17-754013-C

**DEFENDANTS' REPLY TO PLAINTIFFS' OPPOSITION TO MOTION FOR SUMMARY JUDGMENT**

LEWIS BRISBOI

| | |
|---|---|
| SAMIR SAXENA , M.D.,<br><br>Defendant. | **DEFENDANTS' REPLY TO PLAINTIFFS' OPPOSITION TO MOTION FOR SUMMARY JUDGMENT** |

COMES NOW, Defendants SOUTH LAS VEGAS MEDICAL INVESTORS, LLC dba LIFE CARE CENTER OF SOUTH LAS VEGAS fka LIFE CARE CENTER OF PARADISE VALLEY; SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP; LIFE CARE CENTERS OF AMERICA, INC., and CARL WAGNER, ("Defendants"), by and through their counsel of record S. Brent Vogel, Esq., and Amanda J. Brookhyser, Esq., of the Law Firm LEWIS BRISBOIS BISGAARD & SMITH, and hereby file this Reply to Plaintiffs' Opposition to Motion for Summary Judgment.

This Reply is based upon the papers and pleadings on file in this case, the Memorandum of Points and Authorities submitted herewith and any argument adduced at the time of hearing on this matter.

DATED this 17th day of October, 2018.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Amanda J. Brookhyser

S. BRENT VOGEL
Nevada Bar No. 6858
Brent.Vogel@lewisbrisbois.com
AMANDA J. BROOKHYSER
Nevada Bar No. 11526
Amanda.Brookhyser@lewisbrisbois.com
LEWIS BRISBOIS BISGAARD & SMITH llp
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Telephone: 702.893.3383
Fax: 702.893.3789
*Attorneys for Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., Carl Wagner*

## MEMORANDUM OF POINTS AND AUTHORITIES

The arguments posed in Plaintiffs' Opposition fail for several reasons. First, the affidavit requirement found in NRS 41A.071 is jurisdictional and cannot be waived. Second, Defendants are considered a provider of healthcare based upon the vicarious nature of their liability in this case, the lack of statutory language removing them from such a definition, and the absurd result should they not be included. Third, NRS 41A.100 does not save Plaintiffs from their failure to comply with NRS 41A.071. And, fourth, even if this court declines to dismiss Plaintiffs' Complaint outright, the damage cap in NRS 41A.035 would still apply to Plaintiffs' causes of action.

### A. The Affidavit Requirement is Jurisdictional and Cannot be Waived

While Plaintiffs' argument that Defendants waived the expert affidavit issue is creative, it is nonsensical and disingenuous. In support of Plaintiff's dubious argument, she cites to Estate of Ferhat v. TLC Holdings, and erroneously argues that it stands for the proposition that the right to assert NRS 41A.017's expert affidavit requirement is waivable. That is not what the Nevada Supreme Court determined; Rather, the Court, in dicta, stated that because the Defendant had not raised the issue of the expert affidavit requirement in the District Court, the Nevada Supreme Court could not consider it on appeal. That is a far cry from the implied holding in Plaintiffs' Opposition and inapposite to the facts of this case as Defendants are currently raising the issue at the District court level.

Additionally, given that the expert affidavit requirement is jurisdictional, it cannot be waived. See, e.g., Jasper v. Jewkes, 50 Nev. 153, 254 P. 698 (1927); Liberty Mut. v. Thomasson, 317 P.3d 831 (2014); Padilla Constr.Co. v. Burley, 2016 Nev. App. Unpub. LEXIS 10 (May 10, 2016); Finley v. Finley, 65 Nev. 113 (1948).

**B. Defendants Are Considered Providers of Healthcare**

Plaintiffs do nothing to convince this court that the primary basis for liability on the part of Defendants is not vicarious and not centered upon Nurse Dawson's administration of Morphine to Ms. Curtis. Plaintiffs spend a great deal of time arguing about staffing levels and other collateral issues that are irrelevant. The primary basis of liability on the part of all these Defendants is the actions of Nurse Dawson and the subsequent monitoring nurses. Plaintiffs attempt to cloud the issues by offering histrionic arguments to adduce an emotional reaction from this court. The issue is really quite simple: Could Plaintiffs have sued Defendants for inadequate staffing levels if Ms. Curtis had not been given the dose of Morphine? The answer is a resounding No. Arguments regarding staffing levels and budgets may be relevant to punitive damages, but they are not a basis for liability. The basis for liability- and, indeed the entire reason that this case was even commenced- was the administration of Morphine. Plaintiffs do not even attempt to argue that such action does not fall under the definition of medical care and cannot reasonably argue that Nurse Dawson is not a provider of healthcare[1].

Incredibly, Plaintiffs do nothing to address the prior order from Judge Tao on this very issue, likely because it is detrimental to their arguments. Plaintiffs do not argue that Judge Tao's Order can be factually distinguished or that his legal reasoning was in error. Rather, Plaintiffs ignore it completely. And while this court is not beholden to Judge Tao's analysis, it certainly is informative and likely sheds light on what the Nevada Supreme Court would do if presented with this issue. Plaintiffs do not dispute that had they named Nurse Dawson as a Defendant, they would have had to include an expert affidavit to support their arguments against her. Why, then, do

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[1] Plaintiffs take a stab at implying that Nurse Dawson may not be a provider of healthcare because she is a CNA. They even go so far as to accuse Defendants of "rudely" diminishing the part that CNAs played in this case. All blustering aside, CNAs are covered under NRS 41A.017. They are "licensed nurses." There is no question that CNAs are providers of healthcare.

Plaintiffs get to make an end-run around that statutory requirement simply by naming her employer instead when her actions are what created the claim? Plaintiffs have no answer.

Additionally, Judge Tao addressed the very argument that Plaintiff makes in her Opposition concerning the lack of mention of skilled nursing facilities in the language of NRS 41A.017. The Court recognized that while the definition of "providers of healthcare" did not include "facilities for skilled nursing," there was no specific exclusion for claims brought against them. That is still the case. Moreover, NRS 41A.017 does not apply a definition to "hospitals." Plaintiffs attempt to affix a statutory definition, but the Legislature did not assign a specific statutory section to define what is included in the term "hospital" for purposes of NRS 41A.017.

What this issue comes down to is common sense. Does it make common sense that an entity, whose primary basis of liability stems from the medical actions and decision-making of an employee nurse, could be liable for more in damages than the nurse would be if she were named as a Defendant in the lawsuit? Of course not. Plaintiffs shy away from this argument and ignore it completely because common sense, in this respect, is their enemy. Plaintiffs want to rely upon emotion and to paint the Defendants as monsters who deserve to be punished. While that kind of affected language may play well in front of a Jury, in this context, those arguments are misplaced and add nothing. Defendants Motion concerns a jurisdictional requirement, borne from statute, that if a Plaintiff is going to make professional negligence arguments- be it from a vicarious standpoint or otherwise- they must include an expert affidavit, otherwise their Complaint is *void ab initio*. That is the case here.

**C. NRS 41A.100 does not Save Plaintiffs from the Expert Affidavit Requirement.**

NRS 41A. 100 provides, in pertinent part:

> Liability for personal injury or death is not imposed upon any provider of health care based on alleged negligence in the performance of that care unless evidence consisting of expert medical testimony, material from

> recognized medical texts or treatises or the regulations of the licensed medical facility wherein the alleged negligence occurred is presented to **demonstrate the alleged deviation from the accepted standard of care in the specific circumstances of the case and to prove causation of the alleged personal injury or death[.]**

Nev.Rev.Stat. §41A.100 (emphasis added).

Plaintiffs attempt to convince this court that LCCPV's policies and procedures are an appropriate substitute for expert medical testimony. However, in order to comply with the plain language of NRS 41A.100, if Plaintiff is going to use "the regulations of the licensed medical facility wherein the alleged negligence occurred," Plaintiffs must be able to point to those regulations to prove breach **and** causation. A policy concerning medication administration has nothing to do with causation in this case. The same standard would apply to any federal regulations to which Plaintiffs may refer. Plaintiffs cannot use LCCPV's policies or any regulations to prove causation; that is left to expert testimony. As such, NRS 41A.100 cannot save Plaintiffs failure to comply with NRS 41A.071.

/ / / /

/ / / /

## CONCLUSION

Based upon the foregoing, Defendants respectfully request this Honorable Court grant Defendants' Motion for Summary Judgment.

DATED this 17 day of October, 2018

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Amanda J. Brookhyser

S. BRENT VOGEL
Nevada Bar No. 006858
AMANDA J. BROOKHYSER
Nevada Bar No. 11526
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Tel. 702.893.3383

Attorneys for Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., Carl Wagner

**CERTIFICATE OF SERVICE**

I hereby certify that on this 17th day of October, 2018, a true and correct copy of **DEFENDANTS' REPLY TO PLAINTIFFS' OPPOSITION TO MOTION FOR SUMMARY JUDGMENT** was served by electronically filing with the Clerk of the Court using the Electronic Service system and serving all parties with an email-address on record, who have agreed to receive Electronic Service in this action.

By /s/ Nicole Etienne
an Employee of LEWIS BRISBOIS BISGAARD & SMITH LLP

Electronically Filed
4/25/2019 10:01 AM
Steven D. Grierson
CLERK OF THE COURT

**RTRAN**

DISTRICT COURT

CLARK COUNTY, NEVADA

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| ESTATE OF MARY CURTIS, et al,<br><br>Plaintiffs,<br><br>vs.<br><br>SOUTH LAS VEGAS MEDICAL INVESTORS, LLC, et al,<br><br>Defendants.<br><br>And all related claims | CASE: A-17-750520-C<br><br>Con/w: A-17-754013-C<br><br>DEPT. XVII |

BEFORE THE HONORABLE MICHAEL P. VILLANI, DISTRICT COURT JUDGE

WEDNESDAY, OCTOBER 31, 2018

***RECORDER'S TRANSCRIPT OF HEARING:***
***ALL PENDING MOTIONS***

APPEARANCES:

For the Plaintiff: MELANIE BOSSIE, ESQ.
MICHAEL D. DAVIDSON, ESQ.

For Defendant Life Care: STEPHEN B. VOGEL, ESQ.

APPEARANCES CONTINUED ON PAGE 2.



Case Number: A-17-750520-C

For Defendant Saxena: VINCENT VITATOE, ESQ.

Also appearing by CourtCall: BENNIE LAZZARA, ESQ.

RECORDED BY: CYNTHIA GEORGILAS, COURT RECORDER

Las Vegas, Nevada, Wednesday, October 31, 2018

[Hearing begins at 8:44 a.m.]

THE COURT: All right, Mary Curtis versus South Las Vegas Medical Investors. It's Defendant's motion for summary judgment and then motion by the Plaintiff on the punitive damage – there was a motion on each side for punitive –

MR. VITATOE: Cross motions; correct. Yeah.

THE COURT: -- damages but let's deal with the summary judgment motion as far as the liability issue.

MR. VOGEL: All right. Do we need to come up –

MR. LAZZARA: Your Honor, before we begin, --

MR. DAVIDSON: And, Your Honor, we have Mr. Lazzara on the phone.

MR. LAZZARA: Your Honor, before we begin I wanted to announce my presence. This is Bennie Lazzara, Jr. I'm appearing and I'm grateful via CourtCall on behalf of the Plaintiffs.

THE COURT: All right, thank you.

MR. LAZZARA: Thank you, Judge.

THE COURT: Will you be handling the argument, sir?

MR. DAVIDSON: No.

MR. LAZZARA: No, Your Honor. Ms. Bossie is there.

THE COURT: All right, thank you.

All right, Counsel.

MR. VOGEL: Do we need to come up to the microphone or –

THE RECORDER: Yes.

THE COURT: If you could.

MR. VOGEL: And, Your Honor, I don't know how much argument you want to entertain. I know some judges don't like us to reiterate everything --

THE COURT: Do you want to –

MR. VOGEL: -- that's already in the moving papers or what not, but I'm happy to hit kind of the high points.

THE COURT: Just hit the highlights. I've reviewed this numerous times.

MR. VOGEL: Okay. Okay.

You know, our point is, is look, this is a straight medication error and the nurse, Ms. Dawson testified it was an error. It wasn't due to anything other than she just made a mistake. And she is a licensed practical nurse. She's covered by NRS 41A. And if you're going to sue a corporation like South Las Vegas Medical Investors, who is the employer of this person, you can't get around the statutory construct of 41A.

So that's the – you know that's basically it in a nutshell is they didn't attach an affidavit saying, hey, this is you know below the standard of care. Yet, all of the discovery in the case has been about the nursing care and how they fell below the standard of care in the medication administration error as well as the follow up in following PA's orders. That's all medical decision making by the nursing staff. They're all covered by 41A and you can't sue the employer in an effort to get around 41A's protections that were put into place. So that, in a nutshell, is what the motion for summary judgment is based on.

THE COURT: All right, thank you.

Ms. Bossie, if you can come a little closer to make sure Counsel hears you on the phone.

[Colloquy]

MS. BOSSIE: Judge, what the Defense wants to do in this case is in essence eviscerate the elder abuse statute in this state. And when we go through, they really don't rely on any evidence to ask this Court to treat my elder abuse claim as a claim under 41A. They completely glean over and don't mention the legislative intent.

When the nursing home industry, in 2015, -- and I think it's right on point of what the Defense is asking you to do here today, it's my pleading – this is exactly what they asked the Legislature, who as we know create the laws that we all need to follow -- skilled nursing facility proposed amendment in 2015. This post – it postdates Judge Taos' order. It postdates Fierle. It even postdates Egan. So, the amendment to the Legislature by the skilled nursing facility, they want to add to further clarify to this Bill by enhancing the language on who is a provider of healthcare and they want to ensure that all healthcare providers are specifically included in the definition of provider of healthcare. And these changes would help to make it clear under Chapter 41A what providers are providers of healthcare. And their amendment that they want to add in is a skilled nursing facility. That was their amendment.

They go on to say: These clarifications are essential to our skilled nursing facilities to protect them from having to spend hundreds of thousands of dollars litigating this basic fact that we are providers of

healthcare covered under 41A.

What do you think the Legislature did with this language? Purposely omitted licensed nursing homes from 41A and the definition of provider of healthcare. You can't get any more straightforward than this. And this is what the Defense wants the Court is to go and be the Legislature and put nursing homes into that category. And the proposed amendment -- you see how they wrote them in and then the Legislature, when you read the current definition, purposely left them out, even with their arguments of why they wanted to be in. And the reason why is if nursing homes are included under 41A you would eviscerate the elder adult statute. And the case law that I can go to and I cited to says obviously the elder adult statute in even the Brown opinion, in which we've been before you on previous motions, all talk about that in the Brown opinion, the purpose of the elder adult statute is for private attorneys to come forward to protect the older adults that have been abused and neglected and litigate those cases. And the Brown opinion goes on to say that that's why you have two distinct statutes. And I know you know – I could pull it here, but I mean the Brown goes through the whole litany that they're two exclusive causes of action.

So, going to – and I've got to enlighten the Court. You probably know by reading my punitive damage motion, this case is not about one nurse giving 120 milligrams of morphine to a resident it wasn't meant for. There's a whole cascade of incidents that are part of this cause of action from Life Care Centers of America. My client, yes, was there for a short period of time. But in that short period of time, she

experienced two falls. One of the falls, not even being documented within the clinical record which we'll go and I'll argue that more before my punitive damage motion, but then as the daughter is flying from New Jersey to take mom home they overdoes her on 120 milligrams of morphine. What do they do after that? They don't send her to the hospital. They don't put her on IV drip. They keep her at that facility because they want her head in that bed for that census at that facility and they don't want to have her bounce back to the hospital because she left the hospital within a 30 day period of time and they've been commanded by corporate that you got to reduce those bounce backs, so they don't send her to the hospital. They also don't communicate to the CNA's from shift to shift, hey, we just overdosed this woman on morphine. Can you closely monitor and take care of her. None of them even remember the event. And there's no notes in the record reflecting the assessment of Mary subsequent to being overdosed to the point the egregiousness keeps going. So the next morning physical therapy has a note that – and I know I'm getting –

THE COURT: Right, I think we're getting into the punitive damage claim. I mean it's – I know it's tied in to a certain point. I pulled the Complaint. It says that – I mean one of the claims is they were administered a dose of morphine and they shouldn't have.

MS. BOSSIE: That is true.

THE COURT: Isn't that a medical treatment giving her morphine?

MS. BOSSIE: It is not a medical treatment giving her

morphine. I mean obviously in any nursing home setting or skilled nursing facility it's going to rely on nurses and CNA's for the cause of action for the older adult statute. I mean you're not going to have a cause of action – well, for vicarious, but you also have a direct cause of action against the corporation. But actually just providing a medication actually is almost like *res ipsa loquitur*. We all know that you know you don't give someone medication that wasn't meant for them. So, it really is not a medical treatment or a medical diagnosis or assessment. But obviously, when the Legislature leaves skilled nursing facilities out of it, the liability is going to be based on -- for abuse and neglect has to be based on CNA's, nurses, etcetera, for that cause of action. So that is also inferred into it.

THE COURT: Defense argues about the vicarious liability that they're only – the facility is only liable because of the sub-standard nursing care, giving morphine to someone who is allegedly allergic to the morphine.

MS. BOSSIE: No. There's more than one theory of liability in this case and that's' what they failed to address is, first of all, I've got a theory of direct liability for Life Care Centers of America for – and I've cited the case law that all supports the Morrow case, that you can have both vicarious and direct, that they purposely, you know, added the heads to the beds. They go from 78 to 92 residents in the face of having complaints and concerns that they did not have enough employees to provide appropriate care to the residents. So obviously, they add more to it. And they also had the corporate control to keep the facility under

budget, under labor, in order to make a profit. So, there's direct liability for the corporations regarding their direct conduct. Yes, obviously then there's a vicarious liability for Life Care Centers of America when you know based on their acts or admissions of their staff, but it's not solely a vicarious liability case.

So, bottom line, though, Judge, the 41A does not apply to the elder abuse claim no matter how hard the Defense attempt to apply it and that's by the Legislature, that's by the definition. And the one avenue of giving the wrong medication to the wrong patient is not an exercise of medical judgment, so that does not qualify.

THE COURT: How is this different than the, if I'm pronouncing correct, Szymborski case, that's S-Z-Y-M-B-O-R-S-K-I?

MS. BOSSIE: Well, first of all, the Szymborski case you're dealing with a hospital, not a skilled nursing facility, so you can't really use – let me pull that case for a moment. Szymborski was in a hospital that's under the providers of healthcare. And even in –

THE COURT: Well, in Szymborski didn't Justice Pickering say there's – it was just general negligence, you don't need a – I mean they actually – she specifically addressed the fact that, correct, you don't need an affidavit if it's just general negligence. But then part of the case was you did need an affidavit for the medical care and its says don't look to the title that you're given, look to – or she said –

MR. VOGEL: The gravamen.

MS. BOSSIE: The gravamen.

THE COURT: -- substantial point or essence of each claim.

MS. BOSSIE: But, Judge, in this case Spring Mountain Treatment Center is a hospital. So, using the logic in – and I'm not going to be able to pronounce it, Szymborski, I mean part of it would come under 41A because it's under the definition of provider of healthcare. So, you can't really take a hospital setting that comes under the definition and now apply it to a skilled nursing facility which was purposely left out because of the abuse and neglect issue of it and to rely on that for legal argument that this case would fall under 41A.

Now, I do want to talk a little bit about waiver 'cause the Defense knows -- and you can waive a requirement. We are now 3 weeks from trial. Every expert's been – has the report, has been deposed. The affidavit requirement it's just to ensure that there's not a frivolous lawsuit. I find it concerning that they wanted to know whether this was a frivolous lawsuit and it's just a threshold thing, why didn't they come in right when I filed my Complaint and say – and bring it to your attention and say, okay, Ms. Bossie, do that? You know what they do? They wait till the statute of limitations pass in order to try to get this entire case thrown out. And this threshold matter to show if it's a frivolous case or not can be waived and I cited some of those cases. The Ferhat, I think it was Lewis Brisbois case. They didn't bring it up –

MR. VOGEL: That was my case.

MS. BOSSIE: That was your case.

MR. VOGEL: [Indiscernible] and I did bring it up.

THE COURT: Okay. Go ahead, Counsel.

MS. BOSSIE: And the Appellate Court said he waived that

argument because he didn't bring it up you know on the lower level. So that issue –

MR. VOGEL: That's not – what – that's not what [indiscernible] –

THE COURT: Okay, well, let –

MR. VOGEL: -- says and its --

THE COURT: -- Counsel finish.

MR. VOGEL: -- quite clear [indiscernible] says.

THE COURT: All right. Let Ms. Bossie, finish. Go ahead.

MS. BOSSIE: And next, looking -- I cited City of Phoenix versus Fields. It – same thing as a notice of claim against a governmental entity, and again the Defense – it was a deficient notice of claim. But instead of bringing it up saying it's a noticed deficient claim against a governmental entity, they waited till the eve of trial once the statute of limitations had run and the court in that case said that they waived that defense by its subsequent conduct and litigation. And that is exactly what the Defense did here. I mean two years of litigation, every deposition except our 30(b)(6) is done. Experts were all done. Depositions done. We are ready for trial at the end of the month. So it is ingenuous, I believe, to wait till the end of the case. So, there is clear case law to support that this was – that this initial affidavit to show the case is not frivolous has been waived. I cite Nevada Gold.

THE COURT: How about Washoe Medical it says its void *ab initio* if you don't have an affidavit.

MS. BOSSIE: Well, one, we don't even come –

THE COURT: Assuming that – assuming some of the claims are covered under medical malpractice, Washoe Medical says its void *ab initio*.

MS. BOSSIE: Well, I don't believe any of the claims come under the medical malpractice or 41A, but I still think that can be waived. Any affirmative defense can be waived. And by their own conduct, you can't sit and wait after two years of litigation to bring this forth.

So, Your Honor, obviously 41A.071 speaks for itself. Same with what the nursing home intended to do in the amendments in 2015 and they were purposely left out. And anyone knows if you're going to have an abuse and neglect action against an older adult in a nursing home, it's going to be based on nursing conduct. That's common sense. They're not in the definition of provider of healthcare. The Defense wants you to write them in, you know, take the statute, let's write in skilled nursing facility. That's the Legislature's job and they purposely did not do it. And since this case is not solely vicarious liability, there's direct liability, there – and they already said that Life Care is not providing healthcare, you know those claims are still part of this action.

Now, I – last, -- I mean they cite to Zhang. Zhang's a 2009, again prior to the amendment, Zhang relied on Fierle, then – which got overturned by Egan – and look at Egan. That's a podiatrist. That's more medical care than in a skilled nursing facility. And because a podiatrist, who is, you know, a physician, was not specifically in the provider of healthcare, Egan said that they overstepped their bounds in Fierle and basically said you got to look at what the statute and who's listed there.

And they said – Egan and the Supreme Court said 41A.071 did not apply to the podiatrist and his organization because he's not listed there.

This is straight statutory construction, Your Honor, and the Defense is trying to eviscerate an older abuse statute that is there to protect the vulnerable in this state. That's why there's double compensatory in attorneys' fees 'cause they want people to litigate these cases. And if every skilled nursing facility falls under the 41A, you eviscerate the statute 'cause the next thing they're going to come in and say, oh, no, now we're subject to the cap of $350,000.00. So that would eviscerate the double damages of the older adult statute.

Now, when the Legislature is doing the amendment and having skilled nursing facilities in, they are aware of the other statute 'cause they could have put in the other statute specific language – actually in the amendment they wanted to. They wanted it to be under the definition of provider of healthcare and then they wanted to be in the older adult statute saying that does not apply to skilled nursing facilities and the Legislature did not do it because I think their intent is to protect the older people from being abused and neglect in this county.

THE COURT: Under your elder abuse claim, isn't elder abuse that you didn't provide the proper you know safety, housing, clothing, food, etcetera? Here, I mean isn't the gravamen in the claim that you gave her morphine and she was allergic to it?

MS. BOSSIE: No, no. Actually, the –

THE COURT: Who – what else did they do wrong? That's what I'm not –

MS. BOSSIE: No, under abuse –

THE COURT: -- clear on.

MS. BOSSIE: -- and I'm trying to find – here we go, the definition for you is – no, that – give me one second -- and I'll paraphrase it, but under the statute for the older abuse it goes to not providing in essence services that is needed for the resident. And under neglect, yes, it goes to you know heating, water, shelter, and services to maintain the health and well-being of the older adult. So, that's written into the definition of what abuse and neglect is under that statute. So the portion – obviously, she was given shelter. She was given water. But she wasn't given you know the services that she needed in order to ensure her safety and her health and well-being, and that is the essence to an abuse and neglect claim so that's built into the definition.

THE COURT: Well, with every senior citizen Plaintiff wouldn't they fall under your theory? Wouldn't they fall under elder abuse?

MS. BOSSIE: If you're an older adult and if you're abused or neglected and if you fall under those elements, then you could potentially have an older –

THE COURT: No, [indiscernible] they perform surgery on the wrong arm with a senior citizen, is that elder abuse?

MS. BOSSIE: It depends on if that is considered abuse or neglect, so you have to would meet those definitions, so – [indiscernible]. I had it right here. Let me – no, that's true, Mr. – there has to be the relationship between the older adult and the caregiver. And you know how Brown goes through that analysis – let me pull Brown for

a moment. Here we go. And Brown, which is the case that you had used beforehand for the older adult statute, second: …the statute's text and legislative history primarily addresses the regulation of long term care for the elderly. The statute speaks of liability in the event a person fails to maintain the physical or mental health of an older adult, or exploits an older adult in their trust and confidence. And then it goes that's:…both the plain language of the older adult statute and its legislative history suggests that the statute targets the relationship between long term caregivers and their charges. This is contra distinction to the type of relationship that exists between hospitals and their patients. So, you could have an older – if you had a guardian that may have financially exploited -- or you could have it under the statute if you even had a family member at home that abused or neglected an older adult you could bring a cause of action under that statute. But the intent of it is older adults being abused in skilled nursing facilities.

So, bottom line, reading the strict language of who is a provider of healthcare and who is not and what the Legislature intended, I would ask this Court to deny their summary judgment on, one, that it clearly does not go under that statute by the plain language, then the legislative intent, clearly not part of it.

And this case is not just about giving 120 milligrams of morphine that she was allergic to. I mean everybody, including our treating physicians, said 120 milligrams of morphine is a significant dose and can be fatal and life threatening 'cause she's opiate naive and she's 89 and you know a little over 100 pounds. So, it wasn't like she was

allergic to it. I mean this was just a complete inexcusable you know act that took place, you know, and it wasn't her morphine so it's really –

THE COURT: All right. I under – I know that.

MS. BOSSIE: Okay.

THE COURT: It was for another patient because that patient may have died.

MS. BOSSIE: That patient may have been in pain by not getting their morphine, but – so – and I also, just to finish up, there are exceptions even under 41A if it's based on a regulation, and there is a federal regulation of providing someone unnecessary drugs and they actually cited for giving Mary unnecessary drugs according to that regulation. So, that's under 41A.100 if the Court does not find that the 41A does not apply, then the next that they didn't waive it by their actions and inactions at this late stage of the game, and then there's also the exception. There are federal regulations that govern skilled nursing facilities that a minimum you know standards that they have to meet or there's a deviation. One of the exceptions under 41A.100 is regulations of a licensed medical facility. Obviously, I don't think 41A applies 'cause it's not a medical facility, it's a nursing facility. But there's an exception that you don't need an affidavit for that. And in this case they did find a violation of a regulation pertaining to giving Mary the unauthorized 120 milligrams of morphine. And actually, even their own employees and managing agents all agreed that it was a warranted deficiency for what happened.

So, bottom line, Judge, for all those reasons, if you rule in the

way the Defense wants you to rule, there's no older adult statute left in this state and I think if this is going to apply to a skilled nursing facility it needs to be left to the Legislature to make that determination. Therefore, I would ask the Court to deny the Defendants motion for summary judgment.

THE COURT: All right, thank you.

Counsel.

MR. VOGEL: Yes, thank you.

Briefly, first of all, the reference to legislation that was introduced in 2015 does not change the case law that existed before and after it. And under the framework of the statute that we have now, whether or not the Legislature agreed to amend the statute or not really doesn't change anything 'cause the issue here is what is the case law and how does it apply, which means Ferhat, Zhang, Egan, all those cases still apply in the way they are. And there's absolutely no doubt that the administration of medication by a licensed nurse is under 41A. Its – you know it talks about decision making and treatment and there can be no dispute that administering a medication from a nurse to a patient is medical treatment. That is clearly under 41A.

And we have all this case law that talks about vicarious liability and you can't basically make 41A null and void by suing the principle and ignoring the agent. You know, you can't – the principle can't be more liable than the agent in this type of situation. It doesn't make any sense 'cause otherwise you'd never sue the healthcare provider, you just sue whoever employed them and we've already seen from the case

law that's not allowed.

THE COURT: Well, the issue of waiver that Counsel brings up.

MR. VOGEL: Well, you can't waive –

THE COURT: We are 2-3 years down the road –

MR. VOGEL: Sure.

THE COURT: -- here and –

MR. VOGEL: You can't –

THE COURT: -- we have calendar call today I think; aren't we?

MR. VOGEL: Yeah.

MS. BOSSIE: We are.

THE COURT: Okay.

MR. VOGEL: Well, there's a couple of issues on that. First of all, you can't waive a jurisdictional requirement and as Washoe points out its void *ab initio*. It never existed so it can't be waived. And, we did plead an affirmative defense so they're on notice. If they were worried about it they could have amended their Complaint. They could have done something about it. They didn't, so you know – and here's the other reality of litigation. If we had filed a motion off the bat they would have said, oh, you know, 56(f), we need to do discovery, we need to do this, that, the other thing. You know, it doesn't matter. You know, Washoe and – you know Washoe its void *ab initio*. You can't waive a jurisdictional issue.

As to the 41.1395, the elder abuse statute, it still -- the whole

gravamen of that Complaint, you know, that issue still arises out of the morphine administration. That's what it comes out of. That is – you know and let's not forget what the elder abuse statute's purpose is. It was designed to give a private cause of action for things that were crimes. If you look at the legislative history of that statute it talks about, hey, you know the DA's office doesn't have enough resources to prosecute true elder abuse – you know, the failure to provide – you know true neglect, true exploitation. I mean that's why that statute was created. It – literally, it's for crimes. And I think we cited in a prior motion, I can't remember if we did in this, but you know that's what the purpose of that statute is so it's not going to be eviscerated by anything. In this case, they're trying to boot strap an elder abuse claim simply because she's over the age of 70 for a morphine administration. So, it's not eviscerated in any way, shape, or form, and it's still a derivative claim.

Then finally their last cause of action is this bad faith claim. Egan versus Chambers you know in their CliffsNotes No. 2 talks about – you know and it cites some cases we cited to, State Farm versus Wharton that you cannot disguise a contract claim – you know, you can't disguise a tort claim as a contract claim. And that's what they're trying to do here 'cause even that still, in their Complaint, arises out of the claim of morphine administration so it's still all malpractice by the nurse, Ms. Dawson, in giving the wrong medication to the wrong patient.

So, at the end of the day, they still can't get around the fact that Ms. Dawson is a covered entity under 41A and all the claims flowing up to you know Life Care are all derivative of that and vicariously of that.

And you know, based on all the case law that we've discussed here today, you know their Complaint's void *ab initio* on all counts and it should be dismissed.

THE COURT: All right, thank you.

I do have a – I reviewed both sides' briefs on the punitive damages issues and I have sufficient information in that regard. I want to review this matter further. You will have a written decision this week –

MR. VOGEL: Thank you.

THE COURT: -- on this issue.

All right. Thank you.

MR. DAVIDSON: Thank you, Your Honor.

MS. BOSSIE: Thank you, Your Honor.

[Hearing concludes at 9:15 a.m.]

[Case recalled at 10:00 a.m.]

THE COURT: Next up is Mary Curtis. And we do have it says 8 to 10 days; is that still accurate if it depends on the issues and how the Court rules?

MR. VOGEL: That would depend on how many people you're planning on calling.

MS. BOSSIE: I'm pretty quick. I think we can –

MR. DAVIDSON: [Indiscernible] isn't here.

MS. BOSSIE: Oh, is the –

MR. VOGEL: Oh, we don't have a co-defendant.

MR. DAVIDSON: He was here.

MR. VOGEL: He was here earlier.

THE COURT: All right. Well, how many days is it expected to take?

MS. BOSSIE: I think we can try it in two weeks in the 10 days.

THE COURT: Unfortunately, we only have one week left unless you want to trail this other case that we just had to see if they settle, but – the one we just had that's taken up two and half weeks or three weeks.

MR. VOGEL: I would rather not be sitting waiting.

THE COURT: Okay.

MS. BOSSIE: I'd rather try the case now 'cause we are ready to go.

MR. VOGEL: When is the next stack?

THE COURT: I just gave them, the other case, April 22nd; is that correct?

MR. VOGEL: The 29th.

[Colloquy between Court, Defense counsel and clerk]

THE COURT: Okay. You know as you know I have a split calendar so that's why we can't –

MR. VOGEL: Right.

THE COURT: -- give you every month here. We can – if this is going to go a week plus a couple of days; is that what it sounds like?

MR. VOGEL: Yeah.

THE COURT: We'll put you on the April 15th stack shooting for a May 6th date. It's not a firm setting but – oh, this is a medmal, so – well, its listed as medmal, so we'll give you May 6 for the – it's the May –

excuse me, April 15 stack for five weeks -- May 6, that will give you two weeks. So, we'll give you your calendar call date is --

THE CLERK: Do you want it for the April 15th setting?

THE COURT: Yes.

THE CLERK: Okay. That will be April 3rd, 9:00 a.m.

MS. BOSSIE: Judge, though, if I just make for the record. Obviously since we just have one case ahead of us, if we could at least trail that one case for like the next 10 days and at least have a cut off 'cause if it does go away your whole stack opens up.

THE COURT: The November –

MS. BOSSIE: November.

THE COURT: Okay.

MS. BOSSIE: So, --

THE COURT: Sure, if you want, – or you want to contact the attorneys that were just here or see if it settles --

MR. VOGEL: Okay.

THE COURT: -- and then put it back – you know contact chambers.

MS. BOSSIE: But in the meantime, you're setting it for May 6th date?

THE COURT: Yes.

MS. BOSSIE: Okay. 'Cause I do have a trial that is definitely going April 8th. It's a retrial on punitive damages that was a directed verdict that's going to go to trial, but if – I can – that will be done by May 6. I was just concerned about the April 15th date.

THE COURT: Okay. All right. Great. Thank you.

MS. BOSSIE: Thank you, Your Honor.

MR. VOGEL: Will our motion in limine date for the 14th of November stand or are you going to continue this?

THE COURT: Sure. We'll keep it on.

MR. VOGEL: Keep it on.

THE COURT: Let's get it – wrap them up. I don't want to kick the can down the street.

MR. VOGEL: Okay.

THE COURT: All right.

MR. VOGEL: Okay, that – yeah.

MR. DAVIDSON: And then for purposes of the local rules, Your Honor, we'll decide on April the 3rd, the calendar call date, when you want all of the other –

THE COURT: Yes.

MR. DAVIDSON: -- housekeeping stuff done.

THE COURT: Right. Usually its two weeks – it would be two weeks before.

MS. BOSSIE: Two weeks before.

THE COURT: All right.

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MR. DAVIDSON: Thank you, Your Honor.

THE COURT: Thank you.

[Hearing concludes at 10:04 a.m.]

* * * * * *

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.

Cynthia Georgilas

CYNTHIA GEORGILAS
Court Recorder/Transcriber
District Court Dept. XVII

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Steven D. Grierson
CLERK OF THE COURT

S. BRENT VOGEL
Nevada Bar No. 06858
Brent.Vogel@lewisbrisbois.com
AMANDA J. BROOKHYSER
Nevada Bar No. 11526
Amanda.Brookhyser@lewisbrisbois.com
LEWIS BRISBOIS BISGAARD & SMITH LLP
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
702.893.3383
FAX: 702.893.3789
*Attorneys for Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., Carl Wagner,*

DISTRICT COURT

CLARK COUNTY, NEVADA

Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually,

Plaintiffs,

vs.

SOUTH LAS VEGAS MEDICAL INVESTORS, LLC dba LIFE CARE CENTER OF SOUTH LAS VEGAS fka LIFE CARE CENTER OF PARADISE VALLEY; SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP; LIFE CARE CENTERS OF AMERICA, INC.; BINA HRIBIK PORTELLO, Administrator; CARL WAGNER, Administrator; and DOES 1-50 inclusive,

Defendants.

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Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually,

Plaintiffs,

Vs.

CASE NO. A-17-750520-C
Dept. No.: XVII

Consolidated with:
CASE NO. A-17-754013-C

**ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

SAMIR SAXENA , M.D.,

Defendant

**ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

THIS MATTER, having come on for hearing the 31st day of October, 2018 on Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., and Carl Wagner's Motion for Summary Judgment, S. Brent Vogel, Esq., of the Law Firm Lewis Brisbois Bisgaard & Smith, appearing on behalf of Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., and Carl Wagner ("Defendants"); Vincent Vitatoe, Esq., of the Law Firm John H. Cotton & Associates, Ltd., appearing on behalf of Annabelle Socaoco, N.P.; IPC Healthcare, Inc. aka The Hospitalist Company, Inc.; INPATIENT CONSULTANTS OF NEVADA, INC.; IPC Healthcare Services Of Nevada, Inc.; Hospitalists Of Nevada, Inc. (collectively, "IPC Defendants"); and Melanie Bossie, Esq., of the Law Firm Wilkes & McHugh, and Michael Davidson, Esq., of the Law Firm Kolesar and Leatham, appearing on behalf of Plaintiffs Estate of Mary Curtis and Laura Latrenta, the Court, having considered the papers and pleadings in this matter and after hearing oral argument, finds as follows:

**FINDINGS OF FACT**

1). Mary Curtis was a resident at Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley (LCCPV) from March 2, 2016 through March 8, 2016.

2). On March 7, 2016, Ersheila Dawson, LPN, administered to Ms. Curtis a dose of morphine prescribed to another resident.

3). On March 8, 2016, Ms. Curtis was transferred from LCCPV to Sunrise Hospital.

4). On March 11, 2016 Ms. Curtis passed away.

5). On February 2, 2017, Plaintiffs filed their Complaint in CASE NO. A-17-750520-C against Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., and Carl Wagner. The Complaint included causes of action for wrongful death, abuse/neglect of an older person, and bad faith tort. The Complaint did not include an affidavit of merit.

6). On April 14, 2017, Plaintiffs filed their Complaint in CASE NO. A-17-754013-C against Samir Saxena, MD. A Motion to Consolidate was filed on July 6, 2017 and was granted on August 24, 2017.

**CONCLUSIONS OF LAW**

1). Summary Judgment is appropriate when the pleadings and other evidence on file demonstrates no genuine issue as to any material fact remains and the moving party is entitled to judgment as a matter of law. Nev.R.Civ.Pro56(c); Wood v. Safeway, Inc., 121 Nev. 724, 121 P.3d 1026, 1031 (2005). In ruling upon a motion for summary judgment, the Court must view all evidence and inferences in the light most favorable to the non-moving party. Torrealba v. Kesmetis, 124 Nev. 95, 178 P.3d 716 (2008). To rebut a motion for summary judgment, the non-moving party must present some specific facts to demonstrate that a genuine issue of material fact exists. Forouzan, Inc. v. Bank of George, 128 Nev. 896, 381 P.3d 612 (2012).

2). Defendants brought their Motion for Summary Judgment on the basis that although Plaintiffs' causes of action are titled abuse/neglect of an older person, wrongful death, and bad faith tort, the claims are actually professional negligence covered under NRS 41A.015. Further, since the claims involve professional negligence, there is an affidavit of merit requirement pursuant to NRS 41A.071 and since an affidavit was not attached to the complaint, summary judgment should be

granted. Plaintiffs state that by filing such a Motion after two years of litigation, the Defendants have waived their objection to the affidavit requirement but more importantly, the claim is one of abuse/neglect of an older person and not professional negligence under Chapter 41A, which does not require an expert affidavit.

3). NRS 41A.015 defines professional negligence as a failure of a provider of healthcare, in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced health care professionals. NRS 41A.071 provides that for any action sounding in professional negligence, there is a requirement of an affidavit of merit. Without such an affidavit, the case must be dismissed. If a complaint for professional negligence fails to have attached thereto an affidavit of merit, the complaint is void *ab initio*. Washoe Medical Center v. Second Dist. Court, 122 Nev. 1298, 1300 (2006).

4). The Court does not find the claim that Defendants waived the affidavit requirement by filing their Motion after two years of litigation. If Plaintiffs' claims are based upon professional negligence, there is an affidavit requirement. Such a complaint without an affidavit must be dismissed since it is void *ab initio*. Additionally, given that the expert affidavit requirement is jurisdictional, it cannot be waived. See, e.g., Jasper v. Jewkes, 50 Nev. 153, 254 P. 698 (1927); Liberty Mut. v. Thomasson, 317 P.3d 831 (2014); Padilla Constr.Co. v. Burley, 2016 Nev. App. Unpub. LEXIS 10 (May 10, 2016); Finley v. Finley, 65 Nev. 113 (1948).

5). Defendants contend that they are entitled to the protections of Chapter 41A because their liability is derivative of its nursing staff. In Deboer v. Senior Bridges at Sparks Family Hospital, 282 P.3d 727 (Nev. 2012), the Supreme Court distinguished between medical malpractice and traditional negligence on the basis of the provision of medical services provided to the plaintiff, i.e., medical diagnosis, judgment or treatment. *Id.* at 732.

6). The Court finds that Defendants' liability is based on the acts (LPN Dawson's

administration of morphine to Mary Curtis) and omissions (failure to monitor Mary Curtis thereafter) of its nursing staff. LPN Dawson and the other nursing staff monitoring Ms. Curtis are providers of health care pursuant to NRS 41A.017. Said acts and omissions are a provision of medical services which give rise to Defendants' liability. Therefore, the provisions of NRS Chapter 41A apply.

7). More fundamental to the determination by the Court is whether or not the allegations are for general negligence resulting from non-medical services or for negligent medical treatment which calls for an affidavit of merit. Szymborski v. Spring Mountain Treatment Ctr., 403 P.3d 1280 (Nev. 2017). Szymborski holds that a plaintiff's complaint can be based upon both general negligence and professional negligence. The Nevada Supreme Court stated that the Court is to look beyond the title to a particular cause of action and determine whether or not the claims actually involve professional negligence or general negligence. *Id.* at 1284.

8). Abuse/neglect of an older person is codified in NRS 41.1395 as willful and unjustified infliction of pain, injury or mental anguish or deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of an older person or a vulnerable person. Nev.Rev.Stat.41.1395. As stated in Szymborski and Egan v. Chambers, 299 P.3d 364, 366 (Nev. 2013), the courts should look to the nature of the grievance to determine the character of the action, not the form of the pleadings. Cited with approval in Brown v. Mt. General Hospital, 3:12-CV-00461-LRH, 2013 WL 4523488 (D. Nev., Aug. 2013).

9). Although Plaintiffs use language from NRS 41.1395 in their complaint, the underlying basis of the complaint is for medical malpractice. See Complaint, ¶18. Plaintiffs allege that despite Defendants' notice and knowledge that Ms. Curtis was dependent on them for proper medication administration, they, on March 7, 2016, administered to her a dose of morphine prescribed to another resident. Ms. Curtis was not prescribed morphine. See Complaint, ¶19.

10). Plaintiffs further allege that, despite Defendants' notice and knowledge that they had wrongly administered morphine to Ms. Curtis, they failed to act timely upon that discovery, instead retaining Ms. Curtis as a resident until March 8, 2016.

11). The administration of morphine by an LPN and failure to monitor the effects of the administration of morphine is a claim of professional negligence requiring an affidavit pursuant to NRS 41A.071. In other words, Plaintiffs allege that but for LPN Dawson's alleged nursing conduct of improperly administering morphine and subsequent lack of nursing monitoring of Ms. Curtis, she would not have died. As the gravamen of Plaintiffs' allegations sounds in professional negligence, NRS Chapter 41A applies to all of Plaintiffs' claims to the exclusion of NRS 41.1395.

12). A claim is grounded in professional negligence and must adhere to NRS 41A.071 where the facts underlying the claim involve medical diagnosis, treatment, or judgment and the standards of care pertaining to the medical issue require explanation to the jury from a medical expert. Szymborski at 1288. This Court finds persuasive the holding in Brown v. Mt. Grant Gen. Hosp, 3:12-CV-00461-LRH, 2013 WL 4523488 (D.Nev. Aug.26, 2-13), which sets forth the following:

> "Moreover, the Nevada Supreme Court has signaled a disapproval of artful pleading for the purposes of evading the medical malpractice limitations. For example, the Court concluded that medical malpractice claims extend to both intentional and negligence-based actions. Fierle, 219 P.2d at 913 n. 8. This means that a plaintiff cannot escape the malpractice statues damages or timeliness limitations by pleadings intentional tort battery, say instead of negligence. If the Nevada Supreme Court casts an jaundiced eye on the artful pleading of intentional torts, it is likely to view the artful pleading of elder abuse similarly. In the end, it seems, Nevada courts look to the nature of the grievance to determine the character of the action, not the form of the pleadings. Egan v. Chambers, 299 P.3d 364, 366 n.2 (Nev. 2013 (citing State Farm Mut. Auto. Ins. Co. v. Wharton, 88 Nev. 183, 495 P.2d 359, 361 (1972))."

Brown, at *8.

13). Plaintiffs' Complaint is grounded in and involves medical treatment and the standard

of care (administration of morphine and the failure to monitor). Thus, the gravamen of the Complaint, and all claims therein, sounds in professional negligence, which requires an affidavit.

IT IS THEREFORE HEREBY ORDERED, ADJUDGED, AND DECREED, that Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., and Carl Wagner's Motion for Summary Judgment is hereby GRANTED.

It is further determined and ordered pursuant to Nev. R. Civ. P. 54(b), this is a final judgment and there is no just reason for delay of entry of judgment in favor of Defendants.

IT IS SO ORDERED

DATED this 3 day of Dec., 2018.

DISTRICT COURT JUDGE

JM

Submitted by:

**LEWIS BRISBOIS BISGAARD & SMITH LLP**

By: _____

S. BRENT VOGEL, ESQ.
Nevada Bar No. 006858
AMANDA J. BROOKHYSER, ESQ.
Nevada Bar No. 011526
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118

*Attorneys for Life Care Defendants*

LEW IS

Approved as to form by:

**KOLESAR & LEATHAM**

By:_____
MICHAEL DAVIDSON, ESQ. (NV Bar No. 000878)
400 South Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145

-and-

MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice*
Arizona Bar No. 022825
**WILKES & MCHUGH, P.A.**
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260

*Attorneys for Plaintiffs*

Approved as to form and content by:

**JOHN H. COTTON & ASSOCIATES, LTD.**

By:_____
JOHN H. COTTON, ESQ.
Nevada Bar No. 005262
VINCENT J. VITATOE, ESQ
Nevada Bar No. 012888
7900 West Sahara Avenue, Suite 200

*Attorneys for IPC Defendants*

LEWIS

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By:_____
MICHAEL DAVIDSON, ESQ. (NV Bar No. 000878)
400 South Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145

-and-

MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice*
Arizona Bar No. 022825
**WILKES & MCHUGH, P.A.**
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260

*Attorneys for Plaintiffs*

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By:_____
JOHN H. COTTON, ESQ.
Nevada Bar No. 005262
VINCENT J. VITATOE, ESQ
Nevada Bar No. 012888
7900 West Sahara Avenue, Suite 200

*Attorneys for IPC Defendants*

LEW IS

S. BRENT VOGEL
Nevada Bar No. 006858
Brent.Vogel@lewisbrisbois.com
AMANDA J. BROOKHYSER
Nevada Bar No. 11526
Amanda.Brookhyser@lewisbrisbois.com
LEWIS BRISBOIS BISGAARD & SMITH LLP
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
702.893.3383
FAX: 702.893.3789
*Attorneys for Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., Carl Wagner,*

DISTRICT COURT

CLARK COUNTY, NEVADA

Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually,

Plaintiffs,

vs.

SOUTH LAS VEGAS MEDICAL INVESTORS, LLC dba LIFE CARE CENTER OF SOUTH LAS VEGAS fka LIFE CARE CENTER OF PARADISE VALLEY; SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP; LIFE CARE CENTERS OF AMERICA, INC.; BINA HRIBIK PORTELLO, Administrator; CARL WAGNER, Administrator; and DOES 1-50 inclusive,

Defendants.

---

Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually,

Plaintiffs,

Vs.

CASE NO. A-17-750520-C
Dept. No.: XVII

Consolidated with:
CASE NO. A-17-754013-C

**NOTICE OF ENTRY OF ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

| | |
|---|---|
| SAMIR SAXENA , M.D.,<br><br>Defendant | **NOTICE OF ENTRY OF ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** |

PLEASE TAKE NOTICE that an **ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** was entered with the Court in the above-captioned matter on the 7th day of December, 2018, a copy of which is attached hereto.

DATED this 11th day of December, 2018

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Amanda J. Brookhyser

S. BRENT VOGEL
Nevada Bar No. 006858
AMANDA J. BROOKHYSER
Nevada Bar No. 11526
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Attorneys for Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., Carl Wagner,

**CERTIFICATE OF SERVICE**

I hereby certify that on this 11th day of December, 2018, a true and correct copy of **NOTICE OF ENTRY OF ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** was served by electronically filing with the Clerk of the Court using the Wiznet Electronic Service system and serving all parties with an email-address on record, who have agreed to receive Electronic Service in this action.

By /s/ *Johana Whitbeck*
an Employee of
LEWIS BRISBOIS BISGAARD & SMITH LLP

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Steven D. Grierson
CLERK OF THE COURT

S. BRENT VOGEL
Nevada Bar No. 06858
Brent.Vogel@lewisbrisbois.com
AMANDA J. BROOKHYSER
Nevada Bar No. 11526
Amanda.Brookhyser@lewisbrisbois.com
LEWIS BRISBOIS BISGAARD & SMITH LLP
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
702.893.3383
FAX: 702.893.3789
*Attorneys for Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., Carl Wagner,*

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**ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

RECEIVED BY DEPT 17 ON DEC 03 2018

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SAMIR SAXENA , M.D.,

Defendant

**ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

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**FINDINGS OF FACT**

1). Mary Curtis was a resident at Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley (LCCPV) from March 2, 2016 through March 8, 2016.

2). On March 7, 2016, Ersheila Dawson, LPN, administered to Ms. Curtis a dose of morphine prescribed to another resident.

3). On March 8, 2016, Ms. Curtis was transferred from LCCPV to Sunrise Hospital.

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5). On February 2, 2017, Plaintiffs filed their Complaint in CASE NO. A-17-750520-C against Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., and Carl Wagner. The Complaint included causes of action for wrongful death, abuse/neglect of an older person, and bad faith tort. The Complaint did not include an affidavit of merit.

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**CONCLUSIONS OF LAW**

1). Summary Judgment is appropriate when the pleadings and other evidence on file demonstrates no genuine issue as to any material fact remains and the moving party is entitled to judgment as a matter of law. Nev.R.Civ.Pro56(c); Wood v. Safeway, Inc., 121 Nev. 724, 121 P.3d 1026, 1031 (2005). In ruling upon a motion for summary judgment, the Court must view all evidence and inferences in the light most favorable to the non-moving party. Torrealba v. Kesmetis, 124 Nev. 95, 178 P.3d 716 (2008). To rebut a motion for summary judgment, the non-moving party must present some specific facts to demonstrate that a genuine issue of material fact exists. Forouzan, Inc. v. Bank of George, 128 Nev. 896, 381 P.3d 612 (2012).

2). Defendants brought their Motion for Summary Judgment on the basis that although Plaintiffs' causes of action are titled abuse/neglect of an older person, wrongful death, and bad faith tort, the claims are actually professional negligence covered under NRS 41A.015. Further, since the claims involve professional negligence, there is an affidavit of merit requirement pursuant to NRS 41A.071 and since an affidavit was not attached to the complaint, summary judgment should be

granted. Plaintiffs state that by filing such a Motion after two years of litigation, the Defendants have waived their objection to the affidavit requirement but more importantly, the claim is one of abuse/neglect of an older person and not professional negligence under Chapter 41A, which does not require an expert affidavit.

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4). The Court does not find the claim that Defendants waived the affidavit requirement by filing their Motion after two years of litigation. If Plaintiffs' claims are based upon professional negligence, there is an affidavit requirement. Such a complaint without an affidavit must be dismissed since it is void *ab initio*. Additionally, given that the expert affidavit requirement is jurisdictional, it cannot be waived. See, e.g., Jasper v. Jewkes, 50 Nev. 153, 254 P. 698 (1927); Liberty Mut. v. Thomasson, 317 P.3d 831 (2014); Padilla Constr.Co. v. Burley, 2016 Nev. App. Unpub. LEXIS 10 (May 10, 2016); Finley v. Finley, 65 Nev. 113 (1948).

5). Defendants contend that they are entitled to the protections of Chapter 41A because their liability is derivative of its nursing staff. In Deboer v. Senior Bridges at Sparks Family Hospital, 282 P.3d 727 (Nev. 2012), the Supreme Court distinguished between medical malpractice and traditional negligence on the basis of the provision of medical services provided to the plaintiff, i.e., medical diagnosis, judgment or treatment. *Id.* at 732.

6). The Court finds that Defendants' liability is based on the acts (LPN Dawson's

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9). Although Plaintiffs use language from NRS 41.1395 in their complaint, the underlying basis of the complaint is for medical malpractice. See Complaint, ¶18. Plaintiffs allege that despite Defendants' notice and knowledge that Ms. Curtis was dependent on them for proper medication administration, they, on March 7, 2016, administered to her a dose of morphine prescribed to another resident. Ms. Curtis was not prescribed morphine. See Complaint, ¶19.

10). Plaintiffs further allege that, despite Defendants' notice and knowledge that they had wrongly administered morphine to Ms. Curtis, they failed to act timely upon that discovery, instead retaining Ms. Curtis as a resident until March 8, 2016.

11). The administration of morphine by an LPN and failure to monitor the effects of the administration of morphine is a claim of professional negligence requiring an affidavit pursuant to NRS 41A.071. In other words, Plaintiffs allege that but for LPN Dawson's alleged nursing conduct of improperly administering morphine and subsequent lack of nursing monitoring of Ms. Curtis, she would not have died. As the gravamen of Plaintiffs' allegations sounds in professional negligence, NRS Chapter 41A applies to all of Plaintiffs' claims to the exclusion of NRS 41.1395.

12). A claim is grounded in professional negligence and must adhere to NRS 41A.071 where the facts underlying the claim involve medical diagnosis, treatment, or judgment and the standards of care pertaining to the medical issue require explanation to the jury from a medical expert. Szymborski at 1288. This Court finds persuasive the holding in Brown v. Mt. Grant Gen. Hosp, 3:12-CV-00461-LRH, 2013 WL 4523488 (D.Nev. Aug.26, 2-13), which sets forth the following:

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Brown, at *8.

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of care (administration of morphine and the failure to monitor). Thus, the gravamen of the Complaint, and all claims therein, sounds in professional negligence, which requires an affidavit.

IT IS THEREFORE HEREBY ORDERED, ADJUDGED, AND DECREED, that Defendants South Las Vegas Medical Investors LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., and Carl Wagner's Motion for Summary Judgment is hereby GRANTED.

It is further determined and ordered pursuant to Nev. R. Civ. P. 54(b), this is a final judgment and there is no just reason for delay of entry of judgment in favor of Defendants.

IT IS SO ORDERED

DATED this 3 day of Dec., 2018.

DISTRICT COURT JUDGE

JM

Submitted by:

**LEWIS BRISBOIS BISGAARD & SMITH LLP**

By: _____

S. BRENT VOGEL, ESQ.
Nevada Bar No. 006858
AMANDA J. BROOKHYSER, ESQ.
Nevada Bar No. 011526
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118

*Attorneys for Life Care Defendants*

LEWIS

Approved as to form by:

**KOLESAR & LEATHAM**

By:_____
MICHAEL DAVIDSON, ESQ. (NV Bar No. 000878)
400 South Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145

-and-

MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice*
Arizona Bar No. 022825
**WILKES & MCHUGH, P.A.**
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260

*Attorneys for Plaintiffs*

Approved as to form and content by:

**JOHN H. COTTON & ASSOCIATES, LTD.**

By:_____
JOHN H. COTTON, ESQ.
Nevada Bar No. 005262
VINCENT J. VITATOE, ESQ
Nevada Bar No. 012888
7900 West Sahara Avenue, Suite 200

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LEWIS

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MICHAEL DAVIDSON, ESQ. (NV Bar No. 000878)
400 South Rampart Boulevard, Suite 400
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**WILKES & MCHUGH, P.A.**
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260

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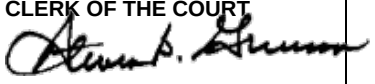
JOHN H. COTTON, ESQ.
Nevada Bar No. 005262
VINCENT J. VITATOE, ESQ
Nevada Bar No. 012888
7900 West Sahara Avenue, Suite 200

*Attorneys for IPC Defendants*

LEW IS



**NOAS**
MICHAEL D. DAVIDSON, ESQ.
Nevada Bar No. 000878
**KOLESAR & LEATHAM**
400 South Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Telephone: (702) 362-7800
Facsimile: (702) 362-9472
E-Mail: mdavidson@klnevada.com
MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice*
**WILKES & MCHUGH, P.A.**
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260
Telephone: (602) 553-4552
Facsimile: (602) 553-4557
E-Mail: Melanie@wilkesmchugh.com
BENNIE LAZZARA, JR., ESQ. - *Pro Hac Vice*
**WILKES & MCHUGH, P.A.**
One North Dale Mabry Highway, Suite 700
Tampa, FL, 33609
Telephone: (813) 873-0026
Facsimile: (813) 286-8820
Email: bennie@wilkesmchugh.com
*Attorneys for Plaintiffs*



**DISTRICT COURT**

**CLARK COUNTY, NEVADA**

* * *

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|---|---|
| Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually,<br><br>Plaintiffs,<br>vs.<br><br>SOUTH LAS VEGAS MEDICAL INVESTORS, LLC dba LIFE CARE CENTER OF SOUTH LAS VEGAS f/k/a LIFE CARE CENTER OF PARADISE VALLEY; SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP; LIFE CARE CENTERS OF AMERICA, INC.; BINA HRIBIK PORTELLO, Administrator; CARL WAGNER, Administrator; and DOES 1-50, inclusive,<br><br>Defendants. | Case No. A-17-750520-C<br><br>Dept No. XVII<br><br>Consolidated With:<br>Case No. A-17-754013-C<br><br>**PLAINTIFFS' NOTICE OF APPEAL OF THE ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** |
| Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually,<br><br>Plaintiffs, | |

vs.

SAMIR SAXENA, M.D.; ANNABELLE SOCAOCO, N.P.; IPC HEALTHCARE, INC. aka THE HOSPITALIST COMPANY, INC.; INPATIENT CONSULTANTS OF NEVADA, INC.; IPC HEALTHCARE SERVICES OF NEVADA, INC.; HOSPITALISTS OF NEVADA, INC.; and DOES 51–100,

Defendant.

**PLAINTIFFS' NOTICE OF APPEAL OF THE ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

Notice is hereby given that the Estate of MARY CURTIS, deceased, LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS, and LAURA LATRENTA, individually, plaintiffs above named, hereby appeal to the Supreme Court of Nevada the Order Granting Defendants' Motion for Summary Judgment entered in this action on the 7th day of December, 2018.

DATED this 27th day of December, 2018.

**KOLESAR & LEATHAM**

By */s/ Michael D. Davidson, Esq.*
MICHAEL D. DAVIDSON, ESQ.
Nevada Bar No. 000878
400 South Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice*
**WILKES & MCHUGH, P.A.**
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260
BENNIE LAZZARA, JR., ESQ. - *Pro Hac Vice*
**WILKES & MCHUGH, P.A.**
One North Dale Mabry Highway, Suite 700
Tampa, FL, 33609

*Attorneys for Plaintiffs*

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

KOLESAR & LEATHAM
400 S. Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145
Tel: (702) 362-7800 / Fax: (702) 362-9472

**CERTIFICATE OF SERVICE**

I hereby certify that I am an employee of Kolesar & Leatham, and that on the 27th day of December, 2018, I caused to be served a true and correct copy of **PLAINTIFFS' NOTICE OF APPEAL OF THE ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** in the following manner:

(ELECTRONIC SERVICE) Pursuant to Administrative Order 14-2, the above-referenced document was electronically filed on the date hereof and served through the Notice of Electronic Filing automatically generated by that Court's facilities to those parties listed on the Court's Master Service List and to those parties listed below:

S. Brent Vogel, Esq.
Amanda J. Brookhyser, Esq.
**LEWIS BRISBOIS BISGAARD & SMITH, L.L.P.**
6385 S. Rainbow Blvd., Suite 600
Las Vegas, Nevada 89118

*Attorneys for Defendants South Las Vegas Medical Investors, LLC dba Life Care Center of South Las Vegas fka Life Care Center of Paradise Valley, South Las Vegas Investors, LP, Life Care Centers of America, Inc., and Carl Wagner*

Vincent J. Vitatoe, Esq.
John H. Cotton, Esq.
**JOHN H. COTTON & ASSOCIATES, LTD.**
7900 W. Sahara Avenue, Suite 200
Las Vegas, Nevada 89117

*Attorneys for Defendants Samir Saxena, MD, Annabelle Socaoco, NP, IPC Healthcare, Inc. aka The Hospitalist Company, Inc., Inpatient Consultants of Nevada, Inc., IPC Healthcare Services of Nevada, Inc., Hospitalists of Nevada, Inc.*

*/s/ Kristina R. Cole*
An Employee of KOLESAR & LEATHAM