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 I (APP001-213)

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

CHRONOLOGICAL INDEX

Date Filed	Description	Volume	Page Nos.:
02/02/2017	Complaint for Damages	I	APP001-008
03/03/2017	Affidavit of Service of Summons and Complaint for Carl Wagner	I	APP009-011
03/03/2017	Defendants' Answer to Plaintiffs' Complaint	I	APP012-019
03/09/2017	Affidavit of Service – South Las Vegas Investors Limited Partnership	I	APP020-022
03/09/2017	Affidavit of Service – South Las Vegas Medical Investors, LLC	I	APP023-025
05/26/2017	Affidavit of Service – Life Care Centers of America, Inc.	I	APP026-028
9/10/2018	Defendants' Motion for Summary Judgment	I	APP029-125
09/21/2018	Plaintiffs' Motion for Prima Facie Claim for Punitive Damages	I	APP126-158
9/21/2018	Excerpts of the Appendix of Exhibits to Plaintiffs' Motion for Prima Facie Claim for Punitive Damages	I	APP159-213
10/04/2018	Plaintiffs' Response to Defendants' Motion for Summary Judgment	II	APP214-256
10/17/2018	Defendants' Reply to Plaintiffs' Opposition to Motion for Summary Judgment	II	APP257-264
10/31/2018	Recorder's Transcript of Hearing: All Pending Motions	II	APP265-288

Date Filed	Description	Volume	Page Nos.:
12/07/2018	Order Granting Defendants' Motion for Summary Judgment	II	APP289-297
12/11/2018	Notice of Entry of Order Granting Defendants' Motion for Summary Judgment	II	APP298-309
12/27/2018	Plaintiffs' Notice of Appeal of the Order Granting Defendants' Motion for Summary Judgment	II	APP310-312

ALPHABETICAL INDEX

Date Filed	Description	Volume	Page Nos.:
12/27/2018	Plaintiffs' Notice of Appeal of the Order Granting Defendants' Motion for Summary Judgment	II	APP310-312
10/04/2018	Plaintiffs' Response to Defendants' Motion for Summary Judgment	II	APP214-256
10/31/2018	Recorder's Transcript of Hearing: All Pending Motions	II	APP265-288

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 I (APP001-213)** 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

COMP
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

-and-

MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice Pending*
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

Attorneys for Plaintiffs

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 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,

Defendants.

CASE NO. A-17-750520-C

DEPT NO. XXIII

COMPLAINT FOR DAMAGES

1. **Abuse/Neglect of an Older Person**
2. **Wrongful Death by Estate**
3. **Wrongful Death by Individual**
4. **Bad Faith Tort**

Plaintiffs Estate of Mary Curtis, deceased; Laura Latrenta, as Personal Representative of the Estate of Mary Curtis; and Laura Latrenta, individually, by and through their attorneys of record, Kolesar & Leatham and Wilkes & McHugh, P.A., hereby submit this Complaint against

Defendants 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; Carl Wagner; and Does 1 to 50, inclusive, and allege as follows:

GENERAL ALLEGATIONS

1. Decedent Mary Curtis suffered significant physical injury while a resident at Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley and ultimately a painful death. At all times relevant she resided in the city of Las Vegas in the County of Clark, Nevada and was an "older person" under N.R.S. § 41.1395. Ms. Curtis died on March 11, 2016 in Las Vegas, Nevada.

2. At all times material Plaintiff Laura Latrenta was a natural daughter and surviving heir of Ms. Curtis. At all relevant times she was an individual and resident of Harrington Park, New Jersey.

3. Plaintiffs are informed and believe and thereon allege that at all relevant times Defendant South Las Vegas Medical Investors, LLC dba Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley was a limited liability company duly authorized, licensed, and doing business in Clark County, Nevada and was at all relevant times in the business of providing care to residents while subject to the requirements of federal and state law, located at 2325 E. Harmon Ave., Las Vegas, NV 89119.

4. Plaintiffs are informed and believe and thereon allege that at all relevant times Defendants Life Care Centers of America, Inc.; South Las Vegas Investors Limited Partnership; South Las Vegas Medical Investors, LLC; and Does 1 through 25, and each of them, were and are owners, operators, and managing agents of South Las Vegas Medical Investors, LLC dba Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley, such that they controlled the budget for said Defendant which impacted resident care, collected accounts receivable, prepared audited financial statements, contracted with various vendors for services, and provided direct oversight for said Defendants in terms of financial and patient care responsibility.

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

5. Plaintiffs are informed and believe and thereon allege that at all relevant times Defendants Bina Hribik Portello and Carl Wagner were and are administrators of Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

6. Plaintiffs are informed and believe and thereon allege that Defendants Does 26 through 50 are other individuals or entities that caused or contributed to injuries suffered by Ms. Curtis as discussed below. (Hereinafter "Defendants" refers to 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; Carl Wagner; and Does 1 through 50.)

7. Plaintiffs will ask leave of Court to amend this Complaint to show such true names and capacities of Doe Defendants when the names of such defendants have been ascertained. Plaintiffs are informed and believe and thereon allege that each defendant designated herein as Doe is responsible in some manner and liable herein by reason of negligence and other actionable conduct and by such conduct proximately caused the injuries and damages hereinafter further alleged.

8. Plaintiffs are informed and believe and thereon allege that at all relevant times Defendants and each of them were the agents, servants, employees, and partners of their co-Defendants and each of them; and that they were acting within the course and scope of employment. Each Defendant when acting as principal was negligent in the selection, hiring, training, and supervision of each other Defendant as its agent, servant, employee, and partner.

9. Every fact, act, omission, event, and circumstance herein mentioned and described occurred in Clark County, Nevada, and each Defendant is a resident of Clark County, has its principal place of business in Clark County, or is legally doing business in Clark County.

10. Each Defendant, whether named or designated as Doe, was the agent, servant, or employee of each remaining Defendant. Each Defendant acted within the course and scope of such agency, service, or employment with the permission, consent, and ratification of each co-Defendant in performing the acts hereinafter alleged which gave rise to Ms. Curtis's injuries.

///

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

FIRST CAUSE OF ACTION – ABUSE/NEGLECT OF AN OLDER PERSON

(Abuse/Neglect of an older person by the Estate of Mary Curtis against all Defendants)

11. Plaintiffs hereby incorporate the allegations in all the foregoing paragraphs as though set forth at length herein.

12. Mary Curtis was born on 19 December 1926 and was therefore an "older person" under N.R.S. § 41.1395.

13. On approximately 2 March 2016 Ms. Curtis was admitted to Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley, a nursing home, for care and supervision. Defendants voluntarily assumed responsibility for her care and to provide her food, shelter, clothing, and services necessary to maintain her physical and mental health.

14. Upon entering Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley Ms. Curtis's past medical history included dementia, hypertension, COPD, and renal insufficiency. She had been hospitalized after being found on her bathroom floor on 27 February 2016; during her hospitalization it was determined that she would not be able to return to her previous living situation and so following her hospital course she was transferred to Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley for continuing subacute and memory care.

15. During her Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley residency Ms. Curtis was dependent on staff for her basic needs and her activities of daily living.

16. Defendants knew that Ms. Curtis relied on them for her basic needs and that without assistance from them she would be susceptible to injury and death.

17. Despite Defendants' notice and knowledge of Ms. Curtis's fall risk they permitted her to fall (causing her injuries) shortly after she entered Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

18. Despite Defendants' notice and knowledge that Ms. Curtis was dependent on them for proper medication administration, they on 7 March 2016 administered to her a dose of morphine prescribed to another resident. Ms. Curtis was not prescribed morphine.

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

19. 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 8 March 2016.

20. Defendants eventually called 911 and emergency personnel transported Ms. Curtis to Sunrise Hospital, where she was diagnosed with anoxic brain encephalopathy. She was later transferred to Nathan Adelson Hospice on 11 March 2016 and died shortly thereafter.

21. Ms. Curtis's death certificate records that her immediate cause of death was morphine intoxication.

22. As a result of Defendants' failures and conscious disregard of Ms. Curtis's life, health, and safety, she suffered unjustified pain, injury, mental anguish, and death.

23. The actions of Defendants and each of them were abuse under N.R.S. § 41.1395(4)(a) and neglect under N.R.S. § 41.1395(4)(c).

24. Defendants' failures were made in conscious disregard for Ms. Curtis's health and safety and they acted with recklessness, oppression, fraud, or malice in commission of their neglect or abuse of Ms. Curtis.

25. As a direct and legal result of Ms. Curtis's injuries and death, her estate's personal representative is entitled to recover double her actual damages under N.R.S. § 41.1395.

26. As a direct and legal result of Ms. Curtis's injuries and death, her estate's personal representative is entitled to attorney fees and costs under N.R.S. § 41.1395.

27. Despite Defendants' notice and knowledge that Ms. Curtis was dependent on them for her basic needs and safety, they willfully and deliberately ignored and failed to avoid the substantial risk and probability that she would suffer injury and death, so that Plaintiff is entitled to punitive damages under N.R.S. § 42.001.

28. As a direct and proximate result of Defendants' willful negligence and intentional and unjustified conduct, Ms. Curtis suffered significant injuries and death. Defendants' conduct was a direct consequence of the motive and plans set forth herein, and Defendants are guilty of malice, oppression, recklessness, and fraud, justifying an award of punitive and exemplary damages.

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

SECOND CAUSE OF ACTION

(Wrongful Death by the Estate of Mary Curtis against all Defendants)

29. Plaintiff re-alleges and incorporates by reference the allegations in the foregoing paragraphs as though fully set forth herein.

30. Defendants, their staff, and employees, in caring for Ms. Curtis, had a duty to exercise the level of knowledge, skill, and care of those in good standing in the community.

31. Defendants had a duty to properly train and supervise their staff and employees to act with the level of knowledge, skill, and care of nursing homes in good standing in the community.

32. Defendants and their agents and employees breached their duties to Ms. Curtis and were negligent and careless in their actions and omissions as set forth above.

33. As a direct and proximate result of Defendants' breaches Ms. Curtis died on 11 March 2016 in Las Vegas, Nevada.

34. As a direct and legal result of Ms. Curtis's death, her estate's personal representative is entitled to maintain all actions on her behalf and is entitled under N.R.S. § 41.085 to recover special damages, including medical expenses incurred by Ms. Curtis before her death, as well as funeral and burial expenses according to proof at trial.

35. Despite Defendants' notice and knowledge that Ms. Curtis was dependent on them for her basic needs and safety, they willfully and deliberately ignored and failed to avoid the substantial risk and probability that she would suffer injury and death, so that Plaintiff is also entitled to punitive damages under N.R.S. § 42.001.

THIRD CAUSE OF ACTION

(Wrongful Death by Laura Latrenta individually against all Defendants)

36. Plaintiffs re-allege and incorporate by reference the allegations in the foregoing paragraphs as though fully set forth herein.

37. Plaintiff Laura Latrenta is a surviving daughter and natural heir of Mary Curtis.

38. Defendants, their staff, and employees, in caring for Ms. Curtis, had a duty to exercise the level of knowledge, skill, and care of those in good standing in the community.

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

39. Defendants had a duty to properly train and supervise their staff and employees to act with the level of knowledge, skill, and care of those in good standing in the community.

40. Defendants, and their agents and employees, breached their duties to Ms. Curtis and were negligent and careless in their actions and omissions as set forth above.

41. As a direct and proximate result of Defendants' breaches Ms. Curtis died on 11 March 2016 in Las Vegas, Nevada.

42. Before her death, Ms. Curtis was a faithful, loving, and dutiful mother to her daughter Laura Latrenta.

43. As a further direct and proximate result of Defendants' negligence Plaintiff Laura Latrenta has lost the love, companionship, comfort, affection, and society of her mother, all to her general damage in a sum to be determined according to proof.

44. Under N.R.S. § 41.085 Plaintiff Laura Latrenta is entitled to recover pecuniary damages for her grief, mental anguish, sorrow, physical pain, lost moral support, lost companionship, lost society, lost comfort, and mental and physical pain and suffering.

FOURTH CAUSE OF ACTION

(Bad Faith Tort by the Estate of Mary Curtis against all Defendants)

45. Plaintiffs re-allege and incorporate by reference the allegations in the foregoing paragraphs as though fully set forth herein.

46. A contract existed between Mary Curtis and Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

47. The contract, like every contract, had an implied covenant of good faith and fair dealing.

48. Mary Curtis's vulnerability and dependence on Defendants created a special relationship between her and Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

49. Mary Curtis's vulnerability and dependence on Defendants meant that she had a special reliance on Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

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

50. Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley's betrayal of this relationship goes beyond the bounds of ordinary liability for breach of contract and results in tortious liability for its perfidy.

51. Defendants' perfidy constitutes malice, oppression, recklessness, and fraud, justifying an award of punitive and exemplary damages.

52. Wherefore, Plaintiffs pray for judgment against all Defendants and each of them as follows:

A. For compensatory damages in an amount in excess of $10,000;

B. For special damages in an amount in excess of $10,000;

C. For punitive damages in an amount in excess of $10,000:

D. For reasonable attorney's fees and costs incurred herein;

E. For additional damages pursuant to NRS Chapter 41;

F. For pre-judgment and post judgment interest; and

G. For such other and further relief as the Court may deem just and proper in the premises.

DATED this 2 day of February, 2017.

KOLESAR & LEATHAM

By _____
MICHAEL D. DAVIDSON, ESQ.
Nevada Bar No. 000878
400 South Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145

-and-

MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice Pending*
WILKES & MCHUGH, P.A.
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260

Attorneys for Plaintiffs

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

Electronically Filed
03/03/2017 02:55:17 PM

AFFIDAVIT OF SERVICE

State of Nevada **County of Clark** **District Court**

CLERK OF THE COURT

Case Number: A-17-750520-C

Plaintiff:
Estate of Mary Curtis, deceased; Laura Latrenta, as Personal Representative of Estate of Mary Curtis; and Laura Latrenta, individually

vs.

Defendant:
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; et al.

Received by AM:PM Legal Solutions on the 14th day of February, 2017 at 3:59 pm to be served on **Carl Wagner, 9345 Grand Sky Ave., Las Vegas, NV 89178**.

I, Michelle Roeder, being duly sworn, depose and say that on the 28th day of February, 2017 at 6:30 pm, I:

at all times herein, pursuant to NRCP 4(c), was and is a citizen of the United States, over 18 years of age, not a party to or interested in the proceeding in which this affidavit is made and **served the Defendant** by leaving a true and correct copy of the **Summons and Complaint for Damages** on the date and hour of service endorsed thereon by me, at the aforementioned address which is the within named person's dwelling house or usual place of abode, to a person residing therein who is 18 years of age or older to wit: Brittney Wagner (Wife/Co-Occupant) and informing said person of the contents thereof.

Description of Person Served: Age: 28+, Sex: F, Race/Skin Color: Caucasian, Height: 5'7", Weight: 130, Hair: Black, Glasses: N

I declare under penalty of perjury under the law of the State of Nevada that the foregoing is true and correct, signed and dated this:
3 day of March, 2017.

Michelle Roeder

Michelle Roeder

AM:PM Legal Solutions
520 S. 7th St., Ste. B
Las Vegas, NV 89101
(702) 385-2676

Our Job Serial Number: AMP-2017000549

SUMM

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

-and-

MELANIE L. BOSSIE, ESQ. – *Pro Hac Vice Pending*
WILKES & MCHUGH, P.A.
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260
Telephone: (602) 553-4552
Facsimile: (602) 553-4557
Email: Melanie@wilkesmchugh.com

Attorneys for Plaintiffs

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 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, Defendants.	CASE NO. A-17-750520-C DEPT NO. XXIII

SUMMONS – DEFENDANT, CARL WAGNER

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 20 DAYS. READ THE INFORMATION BELOW.

TO THE DEFENDANT: A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

CARL WAGNER

1. If you intend to defend this lawsuit, within 20 days after this Summons is served on you exclusive of the day of service, you must do the following:

a. File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.

b. Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the plaintiff and this Court may enter a judgment against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. This action is brought against you for abuse/neglect of an older person; wrongful death, and bad faith tort as described in the Complaint.

4. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

5. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators, each have 45 days after service of this summons within which to file an answer to the Complaint.

Issued at the direction of:

KOLESAR & LEATHAM

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

Attorneys for Plaintiffs

CLERK OF COURT

By: _____ FEB 0 6 2017
Deputy Clerk Date
Regional Justice Center SHIMAYA LADSON
200 Lewis Avenue
Las Vegas, Nevada 89101

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

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., and 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.

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

DEFENDANTS' ANSWER TO PLAINTIFFS' COMPLAINT

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 (collectively "Defendants"), by and through their

counsel, S. Brent Vogel, Esq. and Amanda J. Brookhyser, hereby answers Plaintiffs' Complaint as follows:

GENERAL ALLEGATIONS

1. In answering Paragraphs 1, 2, and 4 of the section entitled General Allegations of Plaintiffs' Complaint, Defendants are without sufficient information or knowledge to form a belief as to the truth or falsity of the allegations contained therein and upon that basis, deny the allegations contained there.

2. Defendants admit the allegations as set forth in Paragraph 3 of the section entitled General Allegations of Plaintiffs' Complaint.

3. Defendants deny each and every allegation set forth in Paragraphs 6, 7, 8, 9, and 10 of the section entitled General Allegations of Plaintiffs' Complaint.

4. In answering Paragraph 5 of the section entitled General Allegations of Plaintiffs' Complaint, Defendant admit that Carl Wagner was Administrator of Life Care Center of Paradise Valley at all relevant times but deny each and every remaining allegation set forth therein.

FIRST CAUSE OF ACTION – ABUSE/NEGELCT OF AN OLDER PERSON

(Abuse/Neglect of an order person by the Estate of Mary Curtis against all Defendants)

5. In answering Paragraph 11 of the First Cause of Action of Plaintiffs' Complaint, Defendants repeat and reallege as though fully set forth herein their answers to Paragraphs 1 through 10 of the section entitled General Allegations of Plaintiffs' Complaint.

6. In answering Paragraphs 12, 13, 14, 15, 16, 20, and 21 of the First Cause of Action of Plaintiffs' Complaint, Defendants are without sufficient information or knowledge to form a belief as to the truth or falsity of the allegations contained therein and upon that basis, deny the allegations contained therein.

7. Defendants deny each and every allegation as set forth in Paragraphs 17, 18, 19, 22, 23, 24, 25, 26, 27 and 28 of the First Cause of Action of Plaintiffs' Complaint.

SECOND CAUSE OF ACTION

(Wrongful Death by the Estate of Mary Curtis against all Defendants)

8. In answering Paragraph 29 of the Second Cause of Action of Plaintiffs' Complaint,

Defendants repeat and reallege as though fully set forth herein their answers to Paragraphs 1 through 10 of the section entitled General Allegations and Paragraphs 11 through 28 of the First Cause of Action of Plaintiffs' Complaint.

9. Defendants deny each and every allegation as set forth in Paragraphs 30, 31, 32, 33, 34, and 35 of the Second Cause of Action of Plaintiffs' Complaint.

THIRD CAUSE OF ACTION

(Wrongful Death by Laura Latrenta individually against all Defendants)

10. In answering Paragraph 36 of the Third Cause of Action of Plaintiffs' Complaint, Defendants repeat and reallege as though fully set forth herein their answers to Paragraphs 1 through 10 of the section entitled General Allegations, Paragraphs 11 through 28 of the First Cause of Action, and Paragraphs 29 through 35 of the Second Cause of Action of Plaintiffs' Complaint.

11. In answering Paragraph 37 of the Third Cause of Action of Plaintiffs' Complaint, Defendants are without sufficient information or knowledge to form a belief as to the truth or falsity of the allegations contained therein and upon that basis, deny the allegations contained therein.

12. Defendants deny each and every allegation as set forth in Paragraphs 38, 39, 40, 41, 42, 43, and 44 of the Third Cause of Action of Plaintiffs' Complaint.

FOURTH CAUSE OF ACTION

(Bad Faith Tort by the Estate of Mary Curtis against all Defendants)

13. In answering Paragraph 45 of the Fourth Cause of Action of Plaintiffs' Complaint, Defendants repeat and reallege as though fully set forth herein their answers to Paragraphs 1 through 10 of the section entitled General Allegations, Paragraphs 11 through 28 of the First Cause of Action, Paragraphs 29 through 35 of the Second Cause of Action, and Paragraphs 36 through 44 of the Third Cause of Action of Plaintiffs' Complaint.

14. Defendants deny each and every allegation as set forth in Paragraphs 46, 47, 48, 49, 50, 51, and 52 of the Fourth Cause of Action of Plaintiffs' Complaint.

CONCLUDING ANSWER TO ALL ALLEGATIONS

15. All allegations not specifically addressed above due to the nature of the language and construction of the allegations, or for any other reason, are specifically denied.

AFFIRMATIVE DEFENSES

1. Plaintiffs' Complaint on file herein fails to state a claim against Defendants upon which relief can be granted.

2. Plaintiffs' Complaint on file herein is barred by the applicable statute of limitations.

3. The injuries, if any, allegedly suffered by Plaintiffs as set forth in the Complaint were caused in whole or in part by the negligence of a third party or third parties over which Defendants had no control.

4. The damages, if any, alleged by Plaintiffs were not the result of any acts of omission, commission, or negligence, but were the result of a known risk, which was consented to by Plaintiffs.

5. Pursuant to NRS 41A.110, Defendants are entitled to a conclusive presumption of informed consent.

6. The incident alleged in the Complaint, and the resulting damages, if any, to Plaintiffs, was proximately caused or contributed to by the Plaintiffs' own negligence, and such negligence was greater than the negligence, if any, of these Defendants.

7. The damages, if any, incurred by Plaintiffs were not attributable to any act, conduct, or omission on the part of the Defendants. Defendants deny that they were negligent or otherwise culpable in any matter or in any degree with respect to the matters set forth in Plaintiffs' Complaint.

8. That it has been necessary for Defendants to employ the services of an attorney to defend this action and a reasonable sum should be allowed Defendants for attorneys' fees, together with costs of suit incurred herein.

9. Pursuant NRS 41A.035 Plaintiffs' non-economic damages, if any, may not exceed $350,000.

10. Defendants are not jointly liable with any other entities that may or may not be

named in this action, and will only be severally liable for that portion of Plaintiffs' claims that represent the percentage of negligence attributable to Defendants, if any.

11. Plaintiffs' damages, if any, were not proximately caused by Defendants.

12. Plaintiffs' injuries and damages, if any, are the result of forces of nature over which Defendants had no control or responsibility.

13. Plaintiffs are barred from asserting any claims against Defendants because the alleged damages were the result of one or more unforeseeable intervening and superseding causes.

14. Plaintiffs failed to mitigate damages, if any.

15. Plaintiffs failed to allege facts in support of any award of pre-judgment interest.

16. The incident alleged in the Complaint, and the resulting damages, if any, to Plaintiffs, were proximately caused or contributed to by the Plaintiffs' own negligence, and such negligence was greater than the negligence, if any, of Defendants.

17. Pursuant to NRCP 11, as amended, all applicable Affirmative Defenses may not have been alleged herein insofar as sufficient facts were not available after reasonable inquiry upon the filing of Defendants' Answer and, therefore, Defendants reserve the right to amend their Answer to allege additional Affirmative Defenses if subsequent investigation warrants.

18. Each service rendered to Plaintiffs by these Defendants was expressly and impliedly consented to and authorized by the Plaintiffs on the basis of full and complete disclosure.

19. Plaintiffs failed to substantively comply with NRS 41A.071.

20. At all times mentioned herein, Defendants acted reasonably and in good faith with regard to the acts and transactions which are the subject of this lawsuit.

21. To the extent Plaintiffs have been reimbursed from any source for any special damages claimed to have been sustained as a result of the incidents alleged in Plaintiffs' Complaint, these Answering Defendants may elect to offer those amounts into evidence and, if these Answering Defendants so elect, Plaintiffs' special damages shall be reduced by those amounts pursuant to NRS 42.021.

22. Defendants hereby incorporate by reference those affirmative defenses enumerated

in NRCP 8 as if fully set forth herein. In the event further investigation or discovery reveals the applicability of such defenses, Defendants reserve the right to seek leave of the court to amend this Answer to assert the same. Such defenses are incorporated herein by reference for the purpose of not waiving the same.

23. Defendants avail themselves of all affirmative defenses and limitations of action as set out in NRS 41.085, 41A.035, 41A.045, 41A.061, 41A.071, 41A.097, 41A.100, 42.005, 42.021, 41.141, and all applicable subparts.

24. NRS Chapters 41 and 41A limit damages that may be collectable against these Answering Defendants.

25. The facts as alleged in the Complaint do not entitle Plaintiffs to punitive damages.

26. The facts as alleged in the Complaint do not state a claim for punitive damages under NRS 42.005.

27. The facts as alleged in the Complaint do not state a claim for double damages under NRS 41.1395.

28. The facts as alleged in the Complaint do not adequately state a claim of injury under NRS 41.1395.

WHEREFORE, Defendants pray for judgment as follows:

1. That Plaintiffs take nothing by way of the Complaint on file herein;

2. For reasonable attorneys' fees and costs of suit incurred herein;

3. For trial by jury, and;

4. For such other and further relief as the Court may deem just and proper in the premises.

DATED this 3rd day of March, 2017

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., and Carl Wagner

CERTIFICATE OF SERVICE

I hereby certify that on this 3rd day of March, 2017, a true and correct copy of **DEFENDANTS' ANSWER TO PLAINTIFFS' COMPLAINT** 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/ Nicole Etienne
an Employee of
LEWIS BRISBOIS BISGAARD & SMITH LLP

Electronically Filed
03/09/2017 04:04:54 PM

AFFIDAVIT OF SERVICE

State of Nevada **County of Clark** **District Court**

CLERK OF THE COURT

Case Number: A-17-750520-C

Plaintiff:
Estate of Mary Curtis, deceased; Laura Latrenta, as Personal Representative of Estate of Mary Curtis; and Laura Latrenta, individually

vs.

Defendant:
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; et al.

Received by AM:PM Legal Solutions on the 14th day of February, 2017 at 3:59 pm to be served on **South Las Vegas Investors Limited Partnership c/o CSC Services of Nevada, Inc., as a Registered Agent, 2215-B Renaissance Dr., Las Vegas, NV 89119**.

I, Stan McGrue, being duly sworn, depose and say that on the 16th day of February, 2017 at 12:14 pm, I:

at all times herein, pursuant to NRCP 4(c), was and is a citizen of the United States, over 18 years of age, not a party to or interested in the proceeding in which this affidavit is made and **served** the within named individual or entity by delivering a true and correct copy of the **Summons and Complaint for Damages** on the date and hour of service endorsed thereon by me, at the aforementioned address, to, Frances Gutierrez (Admin), as a person of suitable age and discretion at the above address, which is the address of the Registered Agent as shown on the current certificate of designation filed with the Secretary of State, to receive service of legal process pursuant to NRS 14.020.

Description of Person Served: Age: 33+, Sex: F, Race/Skin Color: Hispanic, Height: 5'4", Weight: 140, Hair: Black, Glasses: N

I declare under penalty of perjury under the law of the State of Nevada that the foregoing is true and correct, signed and dated this:
8 day of March, 2017.

Stan McGrue
NV License [illegible]

AM:PM Legal Solutions
520 S. 7th St., Ste. B
Las Vegas, NV 89101
(702) 385-2676

Our Job Serial Number: AMP-2017000550

SUMM

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

-and-

MELANIE L. BOSSIE, ESQ. – *Pro Hac Vice Pending*
WILKES & MCHUGH, P.A.
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260
Telephone: (602) 553-4552
Facsimile: (602) 553-4557
Email: Melanie@wilkesmchugh.com

Attorneys for Plaintiffs

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 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, Defendants.	CASE NO. A-17-750520-C DEPT NO. XXIII

SUMMONS – DEFENDANT, SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 20 DAYS. READ THE INFORMATION BELOW.

TO THE DEFENDANT: A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP

1. If you intend to defend this lawsuit, within 20 days after this Summons is served on you exclusive of the day of service, you must do the following:

a. File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.

b. Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the plaintiff and this Court may enter a judgment against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. This action is brought against you for abuse/neglect of an older person; wrongful death, and bad faith tort as described in the Complaint.

4. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

5. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators, each have 45 days after service of this summons within which to file an answer to the Complaint.

Issued at the direction of:

KOLESAR & LEATHAM

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

Attorneys for Plaintiffs

CLERK OF COURT

By: _____ FEB 0 6 2017
Deputy Clerk Date
Regional Justice Center
200 Lewis Avenue
Las Vegas, Nevada 89101
SHIMAYA LADSON

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

Electronically Filed
03/09/2017 04:04:17 PM

AFFIDAVIT OF SERVICE

State of Nevada **County of Clark** **District Court**

CLERK OF THE COURT

Case Number: A-17-750520-C

Plaintiff:
Estate of Mary Curtis, deceased; Laura Latrenta, as Personal Representative of Estate of Mary Curtis; and Laura Latrenta, individually

vs.

Defendant:
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; et al.

Received by AM:PM Legal Solutions on the 12th day of February, 2017 at 3:59 pm to be served on **South Las Vegas Medical Investors, LLC dba Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley c/o CSC Services of Nevada, Inc, as Registered Agent, 2215-B Renaissance Dr., Las Vegas, NV 89119**.

I, Stan McGrue, being duly sworn, depose and say that on the 13th day of February, 2017 at 11:38 pm, I:

at all times herein, pursuant to NRCP 4(c), was and is a citizen of the United States, over 18 years of age, not a party to or interested in the proceeding in which this affidavit is made and **served** the within named individual or entity by delivering a true and correct copy of the **Summons and Complaint for Damages** on the date and hour of service endorsed thereon by me, at the aforementioned address, to, Frances Gutierrez (Admin), as a person of suitable age and discretion at the above address, which is the address of the Registered Agent as shown on the current certificate of designation filed with the Secretary of State, to receive service of legal process pursuant to NRS 14.020.

Description of Person Served: Age: 33+, Sex: F, Race/Skin Color: Hispanic, Height: 5'4", Weight: 140, Hair: Black, Glasses: N

I declare under penalty of perjury under the law of the State of Nevada that the foregoing is true and correct, signed and dated this:
8 day of March, 2017.

Stan McGrue
NV License #190

AM:PM Legal Solutions
520 S. 7th St., Ste. B
Las Vegas, NV 89101
(702) 385-2676

Our Job Serial Number: AMP-2017000546

SUMM

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

-and-

MELANIE L. BOSSIE, ESQ. – *Pro Hac Vice Pending*
WILKES & MCHUGH, P.A.
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260
Telephone: (602) 553-4552
Facsimile: (602) 553-4557
Email: Melanie@wilkesmchugh.com

Attorneys for Plaintiffs

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 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, Defendants.	CASE NO. A-17-750520-C DEPT NO. XXIII

SUMMONS – DEFENDANT, SOUTH LAS VEGAS MEDICAL INVESTORS, LLC d/b/a LIFE CARE CENTER OF SOUTH LAS VEGAS f/k/a LIFE CARE CENTER OF PARADISE VALLEY

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 20 DAYS. READ THE INFORMATION BELOW.

TO THE DEFENDANT: A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

SOUTH LAS VEGAS MEDICAL INVESTORS, LLC d/b/a LIFE CARE CENTER OF SOUTH LAS VEGAS f/k/a LIFE CARE CENTER OF PARADISE VALLEY

1. If you intend to defend this lawsuit, within 20 days after this Summons is served on you exclusive of the day of service, you must do the following:

a. File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.

b. Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the plaintiff and this Court may enter a judgment against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. This action is brought against you for abuse/neglect of an older person; wrongful death, and bad faith tort as described in the Complaint.

4. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

5. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators, each have 45 days after service of this summons within which to file an answer to the Complaint.

Issued at the direction of:

KOLESAR & LEATHAM

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

Attorneys for Plaintiffs

CLERK OF COURT

FEB 06 2017

By: _____
Deputy Clerk Date
Regional Justice Center
200 Lewis Avenue
Las Vegas, Nevada 89101

SHIMAYA LADSON

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

Electronically Filed
5/26/2017 1:54 PM
Steven D. Grierson
CLERK OF THE COURT

AFFIDAVIT OF SERVICE

State of Nevada County of Clark District Court

Case Number: A-17-750520-C

Plaintiff:
Estate of Mary Curtis, deceased; Laura Latrenta, as Personal Representative of Estate of Mary Curtis; and Laura Latrenta, individually

vs.

Defendant:
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; et al.

Received by AM:PM Legal Solutions on the 12th day of February, 2017 at 3:59 pm to be served on Life Care Centers of America, Inc c/o CSC Services of Nevada, Inc., as Registered Agent, 2215-B Renaissance Dr., Las Vegas, NV 89119.

I, Stan McGrue, being duly sworn, depose and say that on the 13th day of February, 2017 at 11:38 pm, I:

at all times herein, pursuant to NRCP 4(c), was and is a citizen of the United States, over 18 years of age, not a party to or interested in the proceeding in which this affidavit is made and served the within named individual or entity by delivering a true and correct copy of the **Summons and Complaint for Damages** on the date and hour of service endorsed thereon by me, at the aforementioned address, to, Frances Gutierrez (Admin), as a person of suitable age and discretion at the above address, which is the address of the Registered Agent as shown on the current certificate of designation filed with the Secretary of State, to receive service of legal process pursuant to NRS 14.020.

Description of Person Served: Age: 33+, Sex: F, Race/Skin Color: Hispanic, Height: 5'4", Weight: 140, Hair: Black, Glasses: N

I declare under penalty of perjury under the law of the State of Nevada that the foregoing is true and correct, signed and dated this:

17 day of February, 2017.

Stan McGrue
NV License #1990

AM:PM Legal Solutions
520 S. 7th St., Ste. B
Las Vegas, NV 89101
(702) 386-2976

Our Job Serial Number: AMP-2017000547

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

SUMM

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

-and-

MELANIE L. BOSSIE, ESQ. – *Pro Hac Vice Pending*
WILKES & MCHUGH, P.A.
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260
Telephone: (602) 553-4552
Facsimile: (602) 553-4557
Email: Melanie@wilkesmchugh.com

Attorneys for Plaintiffs

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 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, Defendants.	CASE NO. A-17-750520-C DEPT NO. XXIII

SUMMONS – DEFENDANT, LIFE CARE CENTERS OF AMERICA, INC.

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 20 DAYS. READ THE INFORMATION BELOW.

TO THE DEFENDANT: A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

LIFE CARE CENTERS OF AMERICA, INC.

1. If you intend to defend this lawsuit, within 20 days after this Summons is served on you exclusive of the day of service, you must do the following:

a. File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.

b. Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the plaintiff and this Court may enter a judgment against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. This action is brought against you for abuse/neglect of an older person; wrongful death, and bad faith tort as described in the Complaint.

4. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

5. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators, each have 45 days after service of this summons within which to file an answer to the Complaint.

Issued at the direction of:

KOLESAR & LEATHAM

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

Attorneys for Plaintiffs

CLERK OF COURT

By: _____ FEB 06 2017
Deputy Clerk Date
Regional Justice Center
200 Lewis Avenue
Las Vegas, Nevada 89101

SHIMAYA LADSON

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

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.: XXIII

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

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

LEWIS BRISBOIS

SAMIR SAXENA , M.D., Defendant	**DEFENDANTS' 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 Motion for Summary Judgment.

This Motion 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 10th day of September, 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,

NOTICE OF MOTION

TO: All Parties and their respective attorneys of record.

PLEASE TAKE NOTICE that the undersigned will bring the foregoing **DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** on for hearing in Department ~~XVIII~~ XVII on the 17 day of Oct., 2018, at the hour of 8:30 am or as soon thereafter as counsel may be heard.

DATED this 10th day of September, 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,

/ / / /

/ / / /

LEWIS BRISBOIS

MEMORANDUM OF POINTS AND AUTHORITIES

I.

INTRODUCTION

This case concerns the residency of Mary Curtis at Life Care Center of Paradise Valley ("LCCPV")[1] from March 2, 2016 through March 8, 2016. Plaintiff alleges that on March 7, 2016 Ms. Curtis was erroneously given a dose of Morphine that was meant for another patient. Plaintiff alleges that it was this nursing error that lead to Ms. Curtis' death. Plaintiff's Complaint against these Defendants was filed on February 2, 2017. See Complaint attached hereto as **Exhibit A**. Plaintiff asserted causes of action for (1) abuse/neglect of an older person; (2) wrongful death; and (3) bad faith. The gravamen of Plaintiff's Complaint- and, indeed, the focus of the depositions conducted by Plaintiff as well as her expert reports- is negligent nursing care. Plaintiff argues and alleges that Ms. Curtis' death was caused by the negligent administration of Morphine as well as the lack of follow-up by the nurses for the next approximately twenty-four (24) hours. These allegations are the very definition of professional negligence under 41A.015. Additionally, as the mechanism of injury at issue in this case was the injection of Morphine- by an employee of LCCPV for which it may be vicariously liable- LCCPV's liability is derivative of the liability of the nurses who cared for Ms. Curtis. In other words, if a Jury were to find that the nursing care was not negligent, there would not be independent basis upon which to hold LCCPV liable. Thus, the causes of action against LCCPV must be covered under the umbrella of Chapter 41A, which includes a requirement of an affidavit of merit. Nev.Rev.Stat.§41A.100. According to NRS 41A.017, if that affidavit of merit is not included with the instituting Complaint, the case must be

[1] Plaintiff has also named as Defendants Life Care Centers of America and Carl Wagner as the Administrator of Life Care Center of Paradise Valley. For purposes of this Motion, "LCCPV" shall refer to all Defendants.

dismissed.

Furthermore, according to the Nevada Supreme Court in *Zhang v. Barnes*, Dkt. No. 67219, LCCPV's exposure cannot be higher than the potential exposure of its nursing employees due to the fact that the only basis for liability on the part of LCCPV is the allegedly negligent acts of its nursing personnel. As such, NRS 41A.035 specifically would apply to the claims against LCCPV consistent with the Nevada Supreme Court's analysis in *Zhang*. If 41A.035 specifically applies, the rest of the Chapter must apply as well. Therefore, Plaintiff's Complaint must be dismissed as it is *void ab initio* and Plaintiff may not be given leave to amend. Alternatively, if the Court is not inclined to apply the entirety of Chapter 41A to Plaintiff's claims, 41A.035 should still apply to limit Plaintiff's pain and suffering damages to $350,000 consistent with the *Zhang* decision and other decisions by this District Court.

II.

STATEMENT OF FACTS

The papers, pleadings, and depositions that make up the record of this case make clear that the emphasis, goal, and focus of Plaintiff's allegations and discovery efforts was and is to put forth and prove that breaches of the standard of care- or nursing negligence- killed Mary Curtis. The questioning in the over a dozen[2] nursing depositions in this case is demonstrative of this effort:

> Q. So the standard of care in nursing and the policy and procedures at Life Care is, in determining that you have the right person, that you would have to use two identifiers to ensure the right person, am I correct?

[2] For brevity's sake, Defendants will not quote from every deposition in this case as there have been over two dozen. This is a sampling of the kind of questioning that is consistent across the board in these depositions.

A. Correct.

Q. And as we know, Ershiela didn't even do one of those identifiers. Am I correct?

A. Correct.

Chatman, 22:21-25, 23:1-4

Q. And I take it the standard of care and protocol would be, if you do an assessment of a resident, that would need to be documented within the clinical record?

A. Correct.

Chatman, 49:24-5, 50:1-3.

Q Now, the standard of care in nursing would be that if Ms. Curtis experienced a fall resulting in injury, that the circumstances of that fall and injury would and should be documented in her clinical record?

A Correct.

Socaoco, 33:15-9.

Q And the standard of care in nursing when you're providing extended relief morphine is not to crush that medication; am I correct?

THE WITNESS: I'm not sure.

Socaoco, 37:14-19

Q Now I take it the standard of care in nursing is if the staff at Life Care Centers of Paradise Valley are monitoring the vital signs of Mary, that that should be documented within the clinical records?

A Correct.

Socaoco, 69:15-19

Q And there's certain standards of care in medication administration that would need to be adhered to?

A Yes.

Sansome, 22:17-20

Q And I would also take it that it would be the standard of care in nursing to also ensure that a resident is free from unnecessary drugs or medications?

A Well, we try to do that, but, you know, it's the doctor's orders. We nurses could not alter or change any orders without the doctor's order.

Sansome, 25:2-8

Q I do want to talk a little bit about controlled narcotics because in dealing with controlled narcotics, there is a heightened standard of care in administering controlled narcotics; am I correct?

THE WITNESS: Yes.

Sansome, 34:10-16

Q The bottom line, if the standard of care was being followed, "this," being the morphine, should not have been given to Mary; true?

THE WITNESS: Yes.

Sansome, 55:8-13

Q Now, with your monitoring of Mary's vital signs, that's something that the standard of care in nursing would dictate to be within her clinical record; am I correct?

THE WITNESS: Yes.

Sansome, 65:10-16

The standard of care in nursing is in order to ensure that you have the right patient, that you have two identifiers to make sure that you have the right resident; am I correct?

A Yes.

Dawson, 27:8-12

Q Bottom-line standard practice in nursing, if you do an assessment of a resident, it would need to be documented within their clinical record?

A Correct.

Dawson, 39:6-9

Q Do you agree that the standards of nursing that are in place, of being the seven rights of medication administration, and to have carts set up appropriately so the right medication's given to the right patient, is in place to ensure what happened to Mary does not happen?

THE WITNESS: I don't know what happened to Mary. I mean, the standard of care was provided. I did everything that was in my nursing scope to do, and I don't know what happened after that.

Dawson, 53:18-25, 54:1-3

Q Well, if you're adhering to the seven rights, which are minimum standards, this would have never have happened; true?

A No.

Dawson, 97:5-8

Q And do you have an expectation of the nursing staff at the Paradise Valley location to adhere to the standard of care in nursing?

A Yes.

Olea, 22:2-5

Q So the bottom line to this question is any licensed nurse would have the knowledge and awareness, or should have the knowledge and awareness of what the standard of care in nursing would be for residents in a nursing home?

A Yes.

Olea, 28:14-19

Q Because as we've gone through this morning, if the standard of care was met and the medication administration rights were complied with, this would have never happened, true?

THE WITNESS: It's true. It's true.

Olea, 49:16-22

15. During her Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley residency Ms. Curtis was dependent on staff for her basic needs and her activities of daily living.

Complaint at ¶15

19. 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 8 March 2016.

Complaint at ¶19

30. Defendants, their staff, and employees, in caring for Ms. Curtis, had a duty to exercise the level of knowledge, skill, and care of those in good standing in the community.

Complaint at ¶30

III.

LEGAL ARGUMENT

A. LEGAL STANDARD FOR SUMMARY JUDGMENT

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any disputed material fact and that the moving party is entitled to a judgment as a matter of law." N.R.C.P. 56(c). In other words, a motion for summary judgment shall be denied when the evidence, taken together, shows a genuine issue as to any material fact. In the milestone case *Wood v. Safeway, Inc.*, 121 Nev. 724, 731 (2005), the Supreme Court of Nevada held that "[t]he substantive law controls which factual disputes are material" to preclude summary judgment, and that "[a] factual dispute is genuine when the evidence is such that a rational trier of fact could return a verdict for the nonmoving party." *Id*.

When applying the above standard, the pleadings and other proof must be construed in a light most favorable to the nonmoving party. *Id*. at 732. However, the nonmoving party, in this case, Plaintiffs, "may not rest upon general allegations and conclusions," but shall "by affidavit or otherwise, set forth specific facts demonstrating the existence of a genuine issue for trial." *Id*. at 731-32. The nonmoving party "bears the burden to 'do more than simply show that there is some metaphysical doubt' as to the operative facts in order to avoid summary judgment being entered in the moving party's favor." *Id*. at 732. "The nonmoving party 'is not entitled to build a case on the gossamer threads of whimsy, speculation and conjecture.'" *Id*. But, "the nonmoving party is entitled to have the evidence and all reasonable inferences accepted as true." *LeasePartners Corp. v. Robert L. Brooks Trust Dated Nov. 12, 1975*, 113 Nev. 747, 752 (1997).

B. DEFENDAANTS ARE ENTITLED TO THE PROTECTIONS OF NRS CHAPTER 41A

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.

First, in *DeBoer v. Senior Bridges at Sparks Family Hospital,* 282 P. 3d 727, 732 (Nev. 2012), the Supreme Court distinguished between medical malpractice and traditional negligence claims, not on the basis of the plaintiff's legal theory, but on the basis of whether the medical provider allegedly injured the plaintiff through the provision of medical services – i.e. "medical diagnosis, judgment, or treatment" – or nonmedical services, which would give rise to ordinary negligence claims. Here, there can be no genuine question that LCCPV's liability, if any, arises from the nurses' alleged medical malpractice. The nurses' conduct is the only possible source of LCCPV's liability. In other words, had the nurse not given Ms. Curtis the dose of Morphine at issue, there would be no injury and source of liability against LCCPV. Since plaintiff's claim against LCCPV is based on its nursing personnel's provision of medical services to Ms. Curtis, it is a medical malpractice claim and the provisions of NRS Chapter 41A apply.

A recent decision by the Nevada Supreme Court regarding the determination of whether a claim is one for professional negligence or general negligence sheds further light on the analysis. In Szymborski v. Spring Mountain Treatment Ctr., 403 P.3d 1280 (Nev. 2017), Appellant Lee Szymborski's adult son, Sean Szymborski (Sean), was admitted to Spring Mountain Treatment Center (Spring Mountain) for care and treatment due to self-inflicted wounds. *Id.* at 1282-83. When it came time to discharge Sean, licensed social workers undertook the discharge planning, but also delegated some tasks to a Masters of Arts (MA). *Id.* Szymborski and Sean had a turbulent relationship, and Sean was discharged with diagnoses of psychosis and spice abuse. *Id.* A social worker documented that **S**zymborski directed a case manager not to release Sean to Szymborski's home upon discharge and that the case manager would help Sean find alternative housing. *Id.*

Spring Mountain nurses also documented that Sean did not want to live with his father, noting that he grew agitated when talking about his father and expressed trepidation about returning to his father's home. *Id.* However, on the date discharge, Sean was put into a cab and sent to his father's house anyway. It was alleged that Sean vandalized the house and caused significant property damage. *Id.*

In his complaint, Szymborski asserted four claims against Spring Mountain, its CEO, Daryl Dubroca, and various social workers and MAs (collectively, Spring Mountain): negligence (count I); professional negligence (count II); malpractice, gross negligence, negligence per se (count III); and negligent hiring, supervision, and training (count IV). *Id.* Szymborski attached a report to his complaint, but not an expert medical affidavit. *Id.* Spring Mountain moved to dismiss the complaint because Szymborski failed to attach an expert medical affidavit pursuant to NRS 41A.071. The district court granted Spring Mountain's motion to dismiss, finding that the claims in the complaint were for medical malpractice and required an expert medical affidavit. *Id.*

In their review of whether Szymborski had indeed asserted causes of action that required support by an expert affidavit, the Nevada Supreme Court engaged in the following analysis:

> Allegations of breach of duty involving medical judgment, diagnosis, or treatment indicate that a claim is for medical malpractice. *See Papa v. Brunswick Gen. Hosp.*, 132 A.D.2d 601, 517 N.Y.S.2d 762, 763 (App. Div. 1987) ("When the duty owing to the plaintiff by the defendant arises from the physician-patient relationship or is substantially related to medical treatment, the breach thereof gives rise to an action sounding in medical malpractice as opposed to simple negligence."); *Estate of French v. Stratford House*, 333 S.W.3d 546, 555 (Tenn. 2011) ("**If the alleged breach of duty of care set forth in the complaint is one that was based upon medical art or science, training, or expertise, then it is a claim for medical malpractice."),** *superseded by statute* Tenn. Code. Ann. 29-26-101 *et seq.* (2011), as *recognized in Ellithorpe v. Weismark*, 479 S.W.3d 818, 824-26 (Tenn. 2015). **By extension, if the jury can only evaluate the plaintiff's claims after presentation of the standards of care by a medical expert, then it is a medical malpractice claim.** See *Bryant*, 684 N.W.2d at 872; *Humboldt Gen. Hosp. v. Sixth Judicial Dist. Court*, 132 Nev., Adv. Op. 53, 376 P.3d 167, 172 (2016) (reasoning that a medical expert affidavit was required where the scope of a patient's

informed consent was at issue, because medical expert testimony would be necessary to determine the reasonableness of the health care provider's actions). If, on the other hand, 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. *See Bryant*, 684 N.W.2d at 872.

The distinction between medical malpractice and negligence may be subtle in some cases, and parties may incorrectly invoke language that designates a claim as either medical malpractice or ordinary negligence, when the opposite is in fact true. *See Weiner v. Lenox Hill Hosp.*, 88 N.Y.2d 784, 673 N.E.2d 914, 916, 650 N.Y.S.2d 629 (N.Y. 1996) ("[M]edical malpractice is but a species of negligence and no rigid analytical line separates the two.") (internal quotation marks omitted). Given the subtle distinction, a single set of circumstances may sound in both ordinary negligence and medical malpractice, and an inartful complaint will likely use terms that invoke both causes of action, particularly where, as here, the plaintiff is proceeding pro se in district court. *See Mayo v. United States*, 785 F. Supp. 2d 692, 695 (M.D. Tenn. 2011)("The designations given to the claims by the plaintiff or defendant are not determinative, and a single complaint may be founded upon both ordinary negligence principles and the medical malpractice statute."). **Therefore, we must look to the gravamen or "substantial point or essence" of each claim rather than its form to see whether each individual claim is for medical malpractice or ordinary negligence.** *Estate of French*, 333 S.W.3d at 557 (citing *Black's Law Dictionary* 770 (9th ed. 2009)); *see State Farm Mut. Auto. Ins. Co. v. Wharton*, 88 Nev. 183, 186, 495 P.2d 359, 361 (1972) (in determining whether an action is for contract or tort, "it is the nature of the grievance rather than the form of the pleadings that determines the character of the action"); *Benz-Elliott v. Barrett Enters., LP*, 456 S.W.3d 140, 148-49 (Tenn. 2015) (the gravamen of the claims rather than the gravamen of the complaint determines statute of limitations issues because "parties may assert alternative claims and defenses and request alternative relief in a single complaint, regardless of the consistency of the claims and defenses"). Such an approach is especially important at the motion to dismiss stage, where this court draws every reasonable inference in favor of the plaintiff, and a complaint should only be dismissed if there is no set of facts that could state a claim for relief. *Deboer*, 128 Nev. at 409, 282 P.3d at 730.

Here, Szymborski's complaint alleges four claims for relief. Our case law declares that a medical malpractice claim filed without an expert affidavit is "void *ab initio*." *Washoe Med. Ctr. v. Second Judicial Dist. Court*, 122 Nev. 1298, 1304, 148 P.3d 790, 794 (2006); *but cf. Szydel v. Markman*, 121 Nev. 453, 458-59, 117 P.3d 200, 204 (2005) (determining that an NRS 41A.071 medical expert affidavit is not required when the claim is for one of the res ipsa loquitur circumstances set forth in NRS 41A.100).

> Under this precedent, 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. *See Fierle v. Perez*, 125 Nev. 728, 740, 219 P.3d 906, 914 (2009), *as modified* (Dec. 16, 2009), *overruled on other grounds by Egan*, 129 Nev. 239, 299 P.3d 364. Therefore, with the above principles in mind, we next determine which of Szymborski's claims must be dismissed for failure to attach the required medical expert affidavit, and which claims allege facts sounding in ordinary negligence. Because the district court's sole basis for dismissal was Szymborski's failure to attach a medical expert affidavit, the question before us is not the validity, sufficiency, or merit of Szymborski's claims. Instead, the issue is whether the claims are for medical malpractice, requiring dismissal under NRS 41A.071, or for ordinary negligence or other ostensible tort.
> *Id.* at 1284-85 (emphasis added).

In this case, the *Szymborski* analysis makes clear that Plaintiff's claims against LCCPV are for professional negligence. The very root of the allegations against LCCPV is medical decision-making. Plaintiff's sole focus in discovery in this case- and, indeed, in the portions of the depositions cited for the Court above- is the five rights of medication, how that process is the standard of care in nursing, how it is the process that every nurse should understand and abide by when administering medication, and how the nurse's failure in this case to abide by that standard is what injured Ms. Curtis. There can be no clearer argument of professional negligence than that. Plaintiff will have to put on expert testimony to explain to the Jury what the five rights of medication are, how a nurse goes about complying with them, what the "checks and balances" are, and how that standard of care was not complied with in this case. A lay juror is not going to have the knowledge of the five rights of medication or how to comply with them; Plaintiff will have to put on expert testimony in order to meet her burden of proof on the duty and breach elements of her claims. Therefore, all of Plaintiff's claims against LCCPV must be deemed as grounded in professional negligence and, thus, subject to the protections of NRS Chapter 41A.

In *Fierle v. Perez*, 219 P. 3d 906, 910-11 (2009), this Court cited, quoted and relied on NRS 89.060 and NRS 89.220 in holding that NRS Chapter 41A provisions --- specifically, NRS

41A.071's affidavit requirement for "medical malpractice or dental malpractice" actions – applies to malpractice actions against a professional medical corporation and professional negligence actions against a provider of health care alleging inter alia negligent supervision. Thus, the argument that NRS Chapter 41A provisions do not protect LCCPV fails regardless of whether plaintiff's claims are characterized as being for medical malpractice or for professional negligence. Plaintiff asserted four causes of action in her Complaint: 1) Abuse/neglect of an older person; 2). Wrongful Death by the Estate; 3). Wrongful Death by Plaintiff; and 4) Bad Faith. Thus, Plaintiff cannot in good faith argue that her claims against LCCPV are anything but covered by NRS Chapter 41A as each of her claims stem from the one act by the nurse of administering Morphine and then the subsequent follow-up by the nursing personnel. Even Plaintiff's Bad Faith cause of action, which will be addressed below, is a professional negligence claim masquerading as a contract claim.

Specifically, in *Fierle,* Justice Pickering agreed that NRS 41A.071's affidavit requirement applies to malpractice actions against a medical corporation and for negligent supervision, but dissented from the Court's holding that it also applies to all professional negligence claims, asserting that medical malpractice is a type of professional negligence such that the professional negligence statutes apply to medical malpractice but the reverse is not true, i.e. the malpractice statutes do not apply to all professional negligence actions. *Fierle*, 219 P. 3d at 914-16. In *Egan v. Chambers*, 299 P. 3d 364 (2013) this Court essentially adopted Justice Pickering's position in *Fierle,* holding that NRS 41A. 071 does not apply to professional negligence claims against a provider of health care not covered by the malpractice statute and overruled *Fierle,* but only "in part."

As other states have recognized, there is no common law respondeat superior liability for entities such as LCCPV, since such entities cannot be licensed to practice medicine and thus

cannot control professional decision making. See., e.g. *Harper ex rel. Al-Harmen v. Denver Health*, 140 P. 3d 273(Colo. App. 2006); *Daly v. Aspen Center for Women's Health*, 134 P. 3d 450 (Colo. App. 2006). The same rationale precludes an entity from being liable for inadequate training or supervision. Rather, this matter is controlled by statute in each state under what has come to be known as the "corporate practice of medicine" doctrine. *Id.*

The Nevada Supreme Court has never expressly addressed the "corporate practice of medicine" doctrine, but the Nevada Attorney General has twice opined that in Nevada, the doctrine limits medical professionals to practicing through entities and associations formed pursuant to NRS Chapter 89 (with exceptions not relevant to our case). See Nev. AGO 2002-10 (2002). Thus, LCCPV did not – and legally could not – do anything that injured plaintiff; LCCPV acts through its licensed personnel and does not, itself, practice medicine. *Id.* Therefore, any argument that improper care was rendered can only be based upon a nurse's actions as LCCPV cannot, itself, render care.

The Nevada Supreme Court recently addressed a similar issue in *Zhang v. Barnes*, Dkt. No. 67219. See Order attached hereto as **Exhibit B.** In *Barnes* the question was whether Nevada Surgery & Cancer Care (NSCC), which employed the co-Defendant surgeon Dr. Zhang, was covered under the damages cap in 41A.035 even though it did not fall under the definition of a "provider of healthcare." The Court held as follows:

> "In cases such as this, when a negligent hiring, training, and supervision claim is based upon the underlying negligent medical treatment, the liability is coextensive. Negligent hiring, training, and supervision claims cannot be used as a channel to allege professional negligence against a provider of healthcare to avoid the statutory caps on such actions. **While a case-by-case approach is necessary because of the inherent factual inquiry relevant to each claim, it is clear to us, in this case, that the allegations against NSCC were rooted in Zhang's professional negligence.** Thus, Barnes' negligent hiring, training, and supervision claim is subject to the statutory caps under NRS 41A.035."

Ex. B, at 17-18 (emphasis added).

The present case is even more straightforward than *Barnes* because Plaintiff did not allege negligence hiring, supervision, or training against LCCPV; rather, Plaintiff asserted causes of action that inherently require a finding of professional negligence on the part of a nurse if there is to be liability on the part of LCCPV. Therefore, the claims against LCCPV are straight forward vicarious liability claims and any liability on the part of LCCPV would be rooted in the nurses' alleged misconduct. As such, the allegations against LCCPV are derivative of the claims against the nurses and must fall under the protections of NRS Chapter 41A. NRS 41A.071 stands for the proposition that a Complaint that makes allegations of professional negligence must be accompanied by an affidavit of merit. If it is not, the Complaint must be dismissed and leave to amend is not provided as the Complaint is *void ab initio.* See *Fierle v. Perez*, 219 P. 3d 906, (2009). Indeed, two departments in this District have found similarly that the provisions of NRS Chapter 41A must apply to an employer when the employer's negligence is derivative of the professional negligence of its employee. See Orders, attached hereto as **Exhibit C.**

Specifically, Judge Tao in Estate of Willard Ferhat, et al, v. TLC Long Term Care, LTd., Case No. A562984, addressed this very issue of applying NRS Chapter 41A's protections to a skilled nursing facility. The only defendant in that matter from TLC Long Term Care, a skilled nursing facility. Judge Tao noted that "improper administration of prescription drugs and the alleged failure to diagnose and treat a medical condition are acts that unequivocally fall within the scope of medical malpractice." See Order, attached hereto as **Exhibit D**¸ at 19, ¶61. Judge Tao further determined that the allegations against the employees who were nurses or physicians would indisputably require an expert affidavit for support under NRS 41A.017. *Id.* at 20, ¶63. Therefore, given that the Plaintiff's Complaint dis not name those individuals, but only named the skilled nursing facility that employed them, a determination whether the provisions of NRS

Chapter 41A applied to the cause of action against the employer was necessary. 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 vicariously against employers of physicians and nurses. *Id.*, at 20, ¶¶66-67. This is still the case. Based upon that ambiguity, the Court looked to the intent of NRS Chapter 41A. The Court found as follows:

> "**It appears logical to the Court that the fundamental legislative purposes of NRS Chapter 41A would be defeated if a plaintiff could circumvent the affidavit requirement by simply omitting the physicians or nurses who actually committed the malpractice from the complaint and yet lodge the very same allegations vicariously against the employer of those physicians and nurses.** In most cases, the employer would likely respond by filing a third-party claim for indemnity or contribution against those doctors or nurses, with the practical result that those doctors and nurses would end up as defendants in the lawsuit without any affidavit ever having been filed by the plaintiff. Such a result would be absurd and illogical and would provide a considerable loophole through which a plaintiff could easily circumvent both the letter and spirit of the affidavit requirement. As the Supreme Court noted in *Fierle*, courts must consider 'the policy and spirit of the law and will seek to avoid an interpretation that leads to an absurd result'"

Id., at 21, ¶68 (internal citations omitted) (emphasis added).

The scenario that was presented to Judge Tao in the *Ferhart* case is the exact situation that is presented to this Court at present; whether Plaintiff will be allowed to circumvent the affidavit requirement because she did not name any of the nurses at LCCPV as defendants even though her causes action are very clearly based upon nursing negligence and the sole basis of liability on the part of LCCPV is the "improper administration of prescription drugs and the alleged failure to diagnose and treat a medical condition." *Id.*, at 19, ¶61. There can be no other conclusion but that the provisions of NRS Chapter 41A must apply to LCCPV upon that basis.

Plaintiff will attempt to argue that her fourth cause of action for Bad Faith is a contract-based claim and, therefore, cannot be subject to NRS Chapter 41A. However, that analysis is

mistaken. Plaintiff alleges that there was an agreement between LCCPV and Curtis that was somehow breached when Ms. Curtis was allegedly injured. However, as was true for all of Plaintiff's other claims, her allegations are rooted in professional negligence.

In State Farm Mut. Auto. Ins., Co. v. Wharton, the Nevada Supreme Court held:

> In determining whether an action is on the contract or in tort, we deem it correct to say that it is the nature of the grievance rather than the form of the pleadings that determines the character of the action. **If the complaint states a cause of action in tort, and it appears that this is the gravamen of the complaint, the nature of the action is not changed by allegations in regard to the existence of or breach of a contract.** In other words, it is the object of the action, rather than the theory upon which recovery is sought that is controlling.

State Farm Mut. Auto. Ins., Co. v. Wharton, 88 Nev. 183, at 186; 495 P.2d 359, at 361 (1972)(citations omitted)(emphasis added); see also Hartford Ins. Statewide Appliances, 87 Nev. 195, 197, 484 P.2d 569, 571 (1971)(explaining that the object of the action, rather than the legal theory under which recovery is sought, governs when determining the type of action for statute of limitations purposes). Other jurisdictions are in accord. Specifically, California Courts have held that:

> A plaintiff may not, however, circumvent the statute of limitations merely by pleading an action which is in substance a tort as a contract. It is settled that an action against a doctor arising out of his negligent treatment is an action sounding in tort and not one based upon a contract.

Christ v. Lipsitz, 99 Cal.App.3d 894, 899, 160 Cal. Rptr. 498, 501 (1979)(held that the plaintiff's cause of action for breach of contract arises solely from the physician's alleged negligent vasectomy and sounds in tort); See also Bellah v. Greenson, 81 Cal.App.3d 614, 625, 146 Cal.Rptr. 535, 542 (1978) (plaintiff's "negligent breach of contract" claim against physician sounded in tort not contract).

The Nevada Supreme Court more recently took up a case with a similar set of facts. In Alvarez v. Garcia (Eighth Judicial District Court, Case No. A533914), Plaintiff alleged that the Defendant Physician negligently and tortiously injected saline into her breasts without her consent

during a liposuction procedure. Plaintiff's Complaint alleged both tort-based causes of action for, amongst other things, Negligence and Medical Malpractice, while also pleading contract-based causes of action based upon the same tortious conduct. Defendants moved for judgment as a matter of law on Plaintiff's contract-based causes of action (after Plaintiff's tort-based causes of action were dismissed on the basis that the Statute of Limitations had expired) arguing that Plaintiff's "contract" claims did not sound in contract, but rather sounded in tort and, therefore, were also barred by the applicable Statute of Limitations. The District Court denied Defendants' Motion for Summary Judgment and, subsequently, the Defendants filed an Emergency Writ with the Nevada Supreme Court arguing, in part, that denial of Defendants' Motion for Summary Judgment, thereby erroneously extending the applicable statute of limitations, was an improper decision warranting the issuance of a Writ. See Garcia v. Eighth Judicial District Court of the State of Nevada In and For the County of Clark, et al. (Nevada Supreme Court, Docket No.58686). The Nevada Supreme Court agreed with the Defendants and issued a Writ of Mandamus on November 22, 2011, dismissing Plaintiff's case as to all Defendants. *See* Writ, attached hereto as **Exhibit E.** Specifically, the Nevada Supreme Court stated:

> The district court also was required to grant Garcia's motion for summary judgment. Alvarez alleged claims for breach of contract and breach of the implied covenant of good faith and fair dealing; **however, the basis for her claims are the saline injections that are also the basis for her tort claims.** Alvarez argues that the informed consent for that she signed, but that Dr. Garcia did not sign, was a contract for her liposuction procedure. In determining whether an action is on a contract or in tort, this court looks at the nature of the grievance to determine the character of the action, not the form of the pleadings. "It is settled that an action against a doctor arising our of his negligent treatment of a patient is an action sounding in tort and not one based upon a contract. Accordingly, Alvarez's breach of contract claims sound in tort, and are subject to a two-year statute of limitation.

(emphasis added).

As such, while Plaintiff attempts to style her Bad Faith claim as one based upon a breach

of an alleged contract, the basis for her claim is the Morphine injection and negligent nursing care. That is the very definition of a professional negligence claim.

As Plaintiff did not file her Complaint against LCCPV with an accompanying affidavit, her Complaint must be dismissed in its entirety. Such a determination is supported by jurisprudence from this District Court as well as the Nevada Supreme Court, as cited herein.

IV.

CONCLUSION

Based upon the foregoing, Defendants respectfully request this Honorable Court grant this Motion for Summary Judgment and dismiss Plaintiff's claims in their entirety without leave to amend.

DATED this 10th day of August, 2018

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Amanda 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,

EXHIBIT A

DISTRICT COURT CIVIL COVER SHEET

A-17-750520-C

County, Nevada

XXIII

Case No. _____
(Assigned by Clerk's Office)

I. Party Information *(provide both home and mailing addresses if different)*

Plaintiff(s) (name/address/phone):	Defendant(s) (name/address/phone):
Estate of Mary Curtis, deceased; Laura LaTrenta, as	South Las Vegas Medical Investors, LLC d/b/a Life
Personal Representative of the Estate of Mary Curtis; and	Care Center of South Las Vegas, f/k/a Life Care
Laura LaTrenta	Center of Paradise Valley; South Las Vegas Investors
	Limited Partnership; Life Care Centers of America, Inc.
Attorney (name/address/phone):	Attorney (name/address/phone):
Michael D. Davidson Esq. - Kolesar & Leatham	
400 S. Rampart Blvd., Suite 400, Las Vegas, NV 89145	
(702) 362-7800, telephone	
(702) 362-9472, facsimile	

II. Nature of Controversy *(please select the one most applicable filing type below)*

Civil Case Filing Types

Real Property	Torts	
Landlord/Tenant	**Negligence**	**Other Torts**
☐ Unlawful Detainer	☐ Auto	☐ Product Liability
☐ Other Landlord/Tenant	☐ Premises Liability	☐ Intentional Misconduct
Title to Property	☑ Other Negligence	☐ Employment Tort
☐ Judicial Foreclosure	**Malpractice**	☐ Insurance Tort
☐ Other Title to Property	☐ Medical/Dental	☐ Other Tort
Other Real Property	☐ Legal	
☐ Condemnation/Eminent Domain	☐ Accounting	
☐ Other Real Property	☐ Other Malpractice	

Probate	Construction Defect & Contract	Judicial Review/Appeal
Probate *(select case type and estate value)*	**Construction Defect**	**Judicial Review**
☐ Summary Administration	☐ Chapter 40	☐ Foreclosure Mediation Case
☐ General Administration	☐ Other Construction Defect	☐ Petition to Seal Records
☐ Special Administration	**Contract Case**	☐ Mental Competency
☐ Set Aside	☐ Uniform Commercial Code	**Nevada State Agency Appeal**
☐ Trust/Conservatorship	☐ Building and Construction	☐ Department of Motor Vehicle
☐ Other Probate	☐ Insurance Carrier	☐ Worker's Compensation
Estate Value	☐ Commercial Instrument	☐ Other Nevada State Agency
☐ Over $200,000	☐ Collection of Accounts	**Appeal Other**
☐ Between $100,000 and $200,000	☐ Employment Contract	☐ Appeal from Lower Court
☐ Under $100,000 or Unknown	☐ Other Contract	☐ Other Judicial Review/Appeal
☐ Under $2,500		

Civil Writ		Other Civil Filing
Civil Writ		**Other Civil Filing**
☐ Writ of Habeas Corpus	☐ Writ of Prohibition	☐ Compromise of Minor's Claim
☐ Writ of Mandamus	☐ Other Civil Writ	☐ Foreign Judgment
☐ Writ of Quo Warrant		☐ Other Civil Matters

Business Court filings should be filed using the Business Court civil coversheet.

February 2, 2017
Date

Signature of initiating party or representative

See other side for family-related case filings.

Nevada AOC - Research Statistics Unit
Pursuant to NRS 3.275

Form PA 201
Rev 3.1

Electronically Filed
02/02/2017 03:42:58 PM

CLERK OF THE COURT

COMP
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

-and-

MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice Pending*
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

Attorneys for Plaintiffs

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

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 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,

Defendants.

CASE NO. A-17-750520-C

DEPT NO. XXIII

COMPLAINT FOR DAMAGES

1. **Abuse/Neglect of an Older Person**
2. **Wrongful Death by Estate**
3. **Wrongful Death by Individual**
4. **Bad Faith Tort**

Plaintiffs Estate of Mary Curtis, deceased; Laura Latrenta, as Personal Representative of the Estate of Mary Curtis; and Laura Latrenta, individually, by and through their attorneys of record, Kolesar & Leatham and Wilkes & McHugh, P.A., hereby submit this Complaint against

Defendants 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; Carl Wagner; and Does 1 to 50, inclusive, and allege as follows:

GENERAL ALLEGATIONS

1. Decedent Mary Curtis suffered significant physical injury while a resident at Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley and ultimately a painful death. At all times relevant she resided in the city of Las Vegas in the County of Clark, Nevada and was an "older person" under N.R.S. § 41.1395. Ms. Curtis died on March 11, 2016 in Las Vegas, Nevada.

2. At all times material Plaintiff Laura Latrenta was a natural daughter and surviving heir of Ms. Curtis. At all relevant times she was an individual and resident of Harrington Park, New Jersey.

3. Plaintiffs are informed and believe and thereon allege that at all relevant times Defendant South Las Vegas Medical Investors, LLC dba Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley was a limited liability company duly authorized, licensed, and doing business in Clark County, Nevada and was at all relevant times in the business of providing care to residents while subject to the requirements of federal and state law, located at 2325 E. Harmon Ave., Las Vegas, NV 89119.

4. Plaintiffs are informed and believe and thereon allege that at all relevant times Defendants Life Care Centers of America, Inc.; South Las Vegas Investors Limited Partnership; South Las Vegas Medical Investors, LLC; and Does 1 through 25, and each of them, were and are owners, operators, and managing agents of South Las Vegas Medical Investors, LLC dba Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley, such that they controlled the budget for said Defendant which impacted resident care, collected accounts receivable, prepared audited financial statements, contracted with various vendors for services, and provided direct oversight for said Defendants in terms of financial and patient care responsibility.

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

5. Plaintiffs are informed and believe and thereon allege that at all relevant times Defendants Bina Hribik Portello and Carl Wagner were and are administrators of Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

6. Plaintiffs are informed and believe and thereon allege that Defendants Does 26 through 50 are other individuals or entities that caused or contributed to injuries suffered by Ms. Curtis as discussed below. (Hereinafter "Defendants" refers to 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; Carl Wagner; and Does 1 through 50.)

7. Plaintiffs will ask leave of Court to amend this Complaint to show such true names and capacities of Doe Defendants when the names of such defendants have been ascertained. Plaintiffs are informed and believe and thereon allege that each defendant designated herein as Doe is responsible in some manner and liable herein by reason of negligence and other actionable conduct and by such conduct proximately caused the injuries and damages hereinafter further alleged.

8. Plaintiffs are informed and believe and thereon allege that at all relevant times Defendants and each of them were the agents, servants, employees, and partners of their co-Defendants and each of them; and that they were acting within the course and scope of employment. Each Defendant when acting as principal was negligent in the selection, hiring, training, and supervision of each other Defendant as its agent, servant, employee, and partner.

9. Every fact, act, omission, event, and circumstance herein mentioned and described occurred in Clark County, Nevada, and each Defendant is a resident of Clark County, has its principal place of business in Clark County, or is legally doing business in Clark County.

10. Each Defendant, whether named or designated as Doe, was the agent, servant, or employee of each remaining Defendant. Each Defendant acted within the course and scope of such agency, service, or employment with the permission, consent, and ratification of each co-Defendant in performing the acts hereinafter alleged which gave rise to Ms. Curtis's injuries.

///

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

FIRST CAUSE OF ACTION – ABUSE/NEGLECT OF AN OLDER PERSON

(Abuse/Neglect of an older person by the Estate of Mary Curtis against all Defendants)

11. Plaintiffs hereby incorporate the allegations in all the foregoing paragraphs as though set forth at length herein.

12. Mary Curtis was born on 19 December 1926 and was therefore an "older person" under N.R.S. § 41.1395.

13. On approximately 2 March 2016 Ms. Curtis was admitted to Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley, a nursing home, for care and supervision. Defendants voluntarily assumed responsibility for her care and to provide her food, shelter, clothing, and services necessary to maintain her physical and mental health.

14. Upon entering Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley Ms. Curtis's past medical history included dementia, hypertension, COPD, and renal insufficiency. She had been hospitalized after being found on her bathroom floor on 27 February 2016; during her hospitalization it was determined that she would not be able to return to her previous living situation and so following her hospital course she was transferred to Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley for continuing subacute and memory care.

15. During her Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley residency Ms. Curtis was dependent on staff for her basic needs and her activities of daily living.

16. Defendants knew that Ms. Curtis relied on them for her basic needs and that without assistance from them she would be susceptible to injury and death.

17. Despite Defendants' notice and knowledge of Ms. Curtis's fall risk they permitted her to fall (causing her injuries) shortly after she entered Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

18. Despite Defendants' notice and knowledge that Ms. Curtis was dependent on them for proper medication administration, they on 7 March 2016 administered to her a dose of morphine prescribed to another resident. Ms. Curtis was not prescribed morphine.

19. 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 8 March 2016.

20. Defendants eventually called 911 and emergency personnel transported Ms. Curtis to Sunrise Hospital, where she was diagnosed with anoxic brain encephalopathy. She was later transferred to Nathan Adelson Hospice on 11 March 2016 and died shortly thereafter.

21. Ms. Curtis's death certificate records that her immediate cause of death was morphine intoxication.

22. As a result of Defendants' failures and conscious disregard of Ms. Curtis's life, health, and safety, she suffered unjustified pain, injury, mental anguish, and death.

23. The actions of Defendants and each of them were abuse under N.R.S. § 41.1395(4)(a) and neglect under N.R.S. § 41.1395(4)(c).

24. Defendants' failures were made in conscious disregard for Ms. Curtis's health and safety and they acted with recklessness, oppression, fraud, or malice in commission of their neglect or abuse of Ms. Curtis.

25. As a direct and legal result of Ms. Curtis's injuries and death, her estate's personal representative is entitled to recover double her actual damages under N.R.S. § 41.1395.

26. As a direct and legal result of Ms. Curtis's injuries and death, her estate's personal representative is entitled to attorney fees and costs under N.R.S. § 41.1395.

27. Despite Defendants' notice and knowledge that Ms. Curtis was dependent on them for her basic needs and safety, they willfully and deliberately ignored and failed to avoid the substantial risk and probability that she would suffer injury and death, so that Plaintiff is entitled to punitive damages under N.R.S. § 42.001.

28. As a direct and proximate result of Defendants' willful negligence and intentional and unjustified conduct, Ms. Curtis suffered significant injuries and death. Defendants' conduct was a direct consequence of the motive and plans set forth herein, and Defendants are guilty of malice, oppression, recklessness, and fraud, justifying an award of punitive and exemplary damages.

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

SECOND CAUSE OF ACTION

(Wrongful Death by the Estate of Mary Curtis against all Defendants)

29. Plaintiff re-alleges and incorporates by reference the allegations in the foregoing paragraphs as though fully set forth herein.

30. Defendants, their staff, and employees, in caring for Ms. Curtis, had a duty to exercise the level of knowledge, skill, and care of those in good standing in the community.

31. Defendants had a duty to properly train and supervise their staff and employees to act with the level of knowledge, skill, and care of nursing homes in good standing in the community.

32. Defendants and their agents and employees breached their duties to Ms. Curtis and were negligent and careless in their actions and omissions as set forth above.

33. As a direct and proximate result of Defendants' breaches Ms. Curtis died on 11 March 2016 in Las Vegas, Nevada.

34. As a direct and legal result of Ms. Curtis's death, her estate's personal representative is entitled to maintain all actions on her behalf and is entitled under N.R.S. § 41.085 to recover special damages, including medical expenses incurred by Ms. Curtis before her death, as well as funeral and burial expenses according to proof at trial.

35. Despite Defendants' notice and knowledge that Ms. Curtis was dependent on them for her basic needs and safety, they willfully and deliberately ignored and failed to avoid the substantial risk and probability that she would suffer injury and death, so that Plaintiff is also entitled to punitive damages under N.R.S. § 42.001.

THIRD CAUSE OF ACTION

(Wrongful Death by Laura Latrenta individually against all Defendants)

36. Plaintiffs re-allege and incorporate by reference the allegations in the foregoing paragraphs as though fully set forth herein.

37. Plaintiff Laura Latrenta is a surviving daughter and natural heir of Mary Curtis.

38. Defendants, their staff, and employees, in caring for Ms. Curtis, had a duty to exercise the level of knowledge, skill, and care of those in good standing in the community.

39. Defendants had a duty to properly train and supervise their staff and employees to act with the level of knowledge, skill, and care of those in good standing in the community.

40. Defendants, and their agents and employees, breached their duties to Ms. Curtis and were negligent and careless in their actions and omissions as set forth above.

41. As a direct and proximate result of Defendants' breaches Ms. Curtis died on 11 March 2016 in Las Vegas, Nevada.

42. Before her death, Ms. Curtis was a faithful, loving, and dutiful mother to her daughter Laura Latrenta.

43. As a further direct and proximate result of Defendants' negligence Plaintiff Laura Latrenta has lost the love, companionship, comfort, affection, and society of her mother, all to her general damage in a sum to be determined according to proof.

44. Under N.R.S. § 41.085 Plaintiff Laura Latrenta is entitled to recover pecuniary damages for her grief, mental anguish, sorrow, physical pain, lost moral support, lost companionship, lost society, lost comfort, and mental and physical pain and suffering.

FOURTH CAUSE OF ACTION

(Bad Faith Tort by the Estate of Mary Curtis against all Defendants)

45. Plaintiffs re-allege and incorporate by reference the allegations in the foregoing paragraphs as though fully set forth herein.

46. A contract existed between Mary Curtis and Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

47. The contract, like every contract, had an implied covenant of good faith and fair dealing.

48. Mary Curtis's vulnerability and dependence on Defendants created a special relationship between her and Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

49. Mary Curtis's vulnerability and dependence on Defendants meant that she had a special reliance on Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

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

50. Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley's betrayal of this relationship goes beyond the bounds of ordinary liability for breach of contract and results in tortious liability for its perfidy.

51. Defendants' perfidy constitutes malice, oppression, recklessness, and fraud, justifying an award of punitive and exemplary damages.

52. Wherefore, Plaintiffs pray for judgment against all Defendants and each of them as follows:

A. For compensatory damages in an amount in excess of $10,000;

B. For special damages in an amount in excess of $10,000;

C. For punitive damages in an amount in excess of $10,000:

D. For reasonable attorney's fees and costs incurred herein;

E. For additional damages pursuant to NRS Chapter 41;

F. For pre-judgment and post judgment interest; and

G. For such other and further relief as the Court may deem just and proper in the premises.

DATED this 2 day of February, 2017.

KOLESAR & LEATHAM

By _____
MICHAEL D. DAVIDSON, ESQ.
Nevada Bar No. 000878
400 South Rampart Boulevard, Suite 400
Las Vegas, Nevada 89145

-and-

MELANIE L. BOSSIE, ESQ. - *Pro Hac Vice Pending*
WILKES & MCHUGH, P.A.
15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260

Attorneys for Plaintiffs

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

EXHIBIT B

27428.92 A

IN THE SUPREME COURT OF THE STATE OF NEVADA

REN YU ZHANG, M.D.; AND NEVADA SURGERY AND CANCER CARE, LLP, A NEVADA LIMITED PARTNERSHIP,
Appellants/Cross-Respondents,
vs.
DILLON MATHEW BARNES,
Respondent/Cross-Appellant.

No. 67219

FILED

SEP 12 2016

TRACIE K. LINDEMAN
CLERK OF SUPREME COURT
BY S. Young
DEPUTY CLERK

ORDER AFFIRMING IN PART, REVERSING IN PART, AND REMANDING

This is an appeal and cross-appeal from an amended judgment on a jury verdict in a medical malpractice action and from an order denying a motion for judgment as a matter of law or a new trial. Eighth Judicial District Court, Clark County; James M. Bixler, Judge.

I.

In May 2012, respondent/cross-appellant Dillon Barnes sued appellant/cross-respondent Dr. Ren Yu Zhang and his employer, appellant/cross-respondent Nevada Surgery and Cancer Care, LLP (NSCC), for medical malpractice and negligent hiring, training, and supervision, after a surgery left Barnes with severe burns. A jury found in favor of Barnes, awarding him $2,243,988 in damages, of which $2,000,000 consisted of noneconomic damages for past and future pain and suffering. Barnes sued others, including the hospital at which the surgery took place, but settled with them before trial.

A series of post-judgment motions followed entry of judgment on the jury verdict. Through a post-trial juror interview, defense counsel

discovered that an insurance declaration page showing Zhang's $1,000,000/$3,000,000 policy limits was inadvertently included as part of an exhibit the jury reviewed. Zhang and NSCC moved for a new trial on this basis.

In addition to moving for a new trial, Zhang and NSCC moved for judgment as a matter of law (JMOL) under NRCP 50(b) and to conform the verdict to the law pursuant to NRCP 59(e). The motion for JMOL disputed the imposition of liability on NSCC, while the motion to conform sought to apply the $350,000 cap on noneconomic damages to both Zhang and NSCC and to offset sums Barnes received from settlements. The district court denied the motions for new trial and JMOL. It applied the $350,000 statutory noneconomic damages cap to Zhang but not NSCC and applied settlement and collateral source offsets. As a result of these rulings, the district court entered an amended judgment awarding Barnes $411,579.09 from Zhang and $1,243,988.00 from NSCC.

II.

Zhang and NSCC appeal several substantive issues, including whether the prejudicial insurance information the jury accidentally received warrants a new trial, whether a professional medical association such as NSCC can claim the benefit of the $350,000 cap on noneconomic damages provided in NRS 41A.035, and whether appellants/cross-respondents are entitled to settlement offsets. In his answering brief and cross-appeal, Barnes raises two procedural challenges that must be addressed first because, if we credit either challenge, it may eliminate in whole or in part the substantive issues presented on appeal.

A.

Barnes challenges the timeliness of Zhang and NSCC's post-trial motions, arguing that EDCR 8.06(c) prohibits parties from extending service by three days for mail or electronic means when filing a motion for a new trial. The language in EDCR 8.06(c) is more restrictive than its counterpart, NRCP 6(e). There is no restrictive language in NRCP 6(e) that would exclude certain types of motions from adding three days for electronic service. *Cf. Winston Prods. Co. v. DeBoer*, 122 Nev. 517, 524, 134 P.3d 726, 731 (2006) ("[W]e hold that the 10-day time period for filing motions for judgment as a matter of law and for a new trial should be calculated first under NRCP 6(a), excluding intermediate Saturdays, Sundays and nonjudicial days. If service was made by mail or electronic means, 3 days should thereafter be added pursuant to NRCP 6(e)."). Under NRCP 83, local rules may "not [be] inconsistent with these rules." Thus, NRCP 6(e) controls. *See W. Mercury, Inc. v. Rix Co.*, 84 Nev. 218, 222-23, 438 P.2d 792, 795 (1968) ("The district courts have rule-making power, but the rules they adopt must not be in conflict with the Nevada Rules of Civil Procedure." (footnote omitted)). Accordingly, Zhang and NSCC's post-trial motions were timely.

B.

Barnes also challenges as procedurally defective NSCC's argument that the district court erred in denying its NRCP 50(b) renewed motion for JMOL on Barnes' claim of negligent hiring, training, and supervision. This court reviews an order under either NRCP 50(a) or 50(b) de novo. *Nelson v. Heer*, 123 Nev. 217, 223, 163 P.3d 420, 425 (2007). Before trial, NSCC moved for summary judgment under NRCP 56 on Barnes' claim of negligent hiring, training, and supervision, which the

district court denied. At the close of Barnes' case-in-chief, NSCC moved for JMOL under NRCP 50(a) as to punitive damages, but did not mention the negligent hiring, training, and supervision claim. Post-trial, NSCC filed an NRCP 50(b) motion for JMOL on the negligent hiring, training, and supervision claim, which Barnes challenged as procedurally deficient in that NSCC did not move for JMOL under NRCP 50(a) as to that claim. The district court did not address the procedural issue and denied the NRCP 50(b) motion on the merits. On appeal, Barnes contends that, despite NSCC's motion for summary judgment, NSCC's failure to move for JMOL during trial under NRCP 50(a) on the issue of negligent hiring, training, and supervision precluded its post-trial NRCP 50(b) motion on that issue.

Under NRCP 50(b), a party "may renew its request for judgment as a matter of law by filing a motion no later than 10 days after service of written notice of entry of judgment." A party must make the same arguments in its pre-verdict NRCP 50(a) motion as it does in its post-verdict NRCP 50(b) motion. *See Price v. Sinnott*, 85 Nev. 600, 607, 460 P.2d 837, 841 (1969) ("It is solidly established that when there is no request for a directed verdict, the question of the sufficiency of the evidence to sustain the verdict is not reviewable. A party may not gamble on the jury's verdict and then later, when displeased with the verdict, challenge the sufficiency of the evidence to support it." (citations omitted)). A pretrial motion for summary judgment is not a substitute for the NRCP 50(a) motion needed to preserve issues for review in a NRCP 50(b) renewed motion for judgment as a matter of law. *See, e.g., Jones ex rel. United States v. Mass. Gen. Hosp.*, 780 F.3d 479, 488-89 (1st Cir. 2015) (rejecting the argument that "a party satisfies Rule 50(b) by raising the

same grounds in his pretrial motion for summary judgment under Rule 56, and consequently, no separate Rule 50(a) motion is required" (internal quotations and alterations omitted)); *Sykes v. Anderson*, 625 F.3d 294, 304 (6th Cir. 2010) ("[E]ven if a defendant raises qualified immunity at summary judgment, the issue is waived on appeal if not pressed in a Rule 50(a) motion." (alteration in original) (quoting *Parker v. Gerrish*, 547 F.3d 1, 12 (1st Cir. 2008)); *Sharp Structural, Inc. v. Franklin Mfg., Inc.*, 283 F. App'x 585, 588 (9th Cir. 2008) ("[R]aising an issue in a motion for summary judgment is not sufficient to preserve it for review in a Rule 50(b) motion unless the argument is reiterated in a Rule 50(a) motion.").

Though some courts have recognized an exception to the rule that motions for summary judgment do not serve as a basis for a Rule 50(b) motion, the exception is limited to motions for summary judgment that present pure issues of law. *See, e.g., Frank C. Pollara Grp., LLC v. Ocean View Inv. Holding, LLC*, 784 F.3d 177, 185 (3d Cir. 2015) ("There is an exception to this general rule, however, for an order denying summary judgment on a 'purely legal issue' capable of resolution 'with reference only to undisputed facts.'" (quoting *Ortiz v. Jordan*, 562 U.S. 180, 190 (2011))); *Varghese v. Honeywell Int'l, Inc.*, 424 F.3d 411, 423 (4th Cir. 2005) (recognizing that some courts have allowed an exception for "appeals from a denial of summary judgment after a trial where the summary judgment motion raised a legal issue and did not question the sufficiency of the evidence"). Both in its motion for summary judgment and in its NRCP 50(b) motion, NSCC challenged the sufficiency of the evidence to establish Barnes' claim of negligent hiring, training, and supervision. Thus, because these issues are fact-based, even applying the exception for pure questions of law that some federal courts have made, NSCC's pretrial

motion for summary judgment does not excuse its failure to move for JMOL under NRCP 50(a). Though the district court should have denied the NRCP 50(b) motion for its procedural defect instead of addressing it on the merits, the district court reached the correct result in denying JMOL, so we affirm its decision in that respect. *See Saavedra-Sandoval v. Wal-Mart Stores, Inc.*, 126 Nev. 592, 599, 245 P.3d 1198, 1202 (2010).

C.

Zhang and NSCC argue that a new trial is warranted based on testimony mentioning Zhang had malpractice insurance and the inadvertent submission to the jury of Zhang's insurance declaration page. "This court reviews a district court's decision to grant or deny a motion for a new trial for an abuse of discretion." *Gunderson v. D.R. Horton, Inc.*, 130 Nev., Adv. Op. 9, 319 P.3d 606, 611 (2014). A district court may, in its discretion, order a new trial if there has been "plain error or manifest injustice," which exists "where 'the verdict or decision strikes the mind, at first blush, as manifestly and palpably contrary to the evidence.'" *Kroeger Props. & Dev., Inc. v. Silver State Title Co.*, 102 Nev. 112, 114, 715 P.2d 1328, 1330 (1986) (quoting *Price*, 85 Nev. at 608, 460 P.2d at 842).

In this case, the first two references to insurance occurred with NSCC's own witness, Dr. Stephanie Wishnev, who mentioned insurance twice in a general way while discussing how physicians become qualified for employment at NSCC. The third reference to insurance occurred with Barnes' expert, Dr. Stephen McBride. During direct examination, Barnes' counsel asked McBride to list everything he reviewed in forming his opinion. McBride listed over 60 documents, including "Dr. Zhang's insurance policy." Although Zhang and NSCC immediately approached the bench, asking for a mistrial, which the

district court ultimately denied, both parties and the district court recognized that a limiting instruction may draw more attention to the fact that Zhang had malpractice insurance and, thus, decided against the instruction. However, the district court admonished counsel and the witness to omit all references to insurance.

Also, pre-trial, the parties stipulated to admit a number of exhibits, some of which were voluminous. Among those exhibits was Zhang's hospital credentialing file, which apparently included as an attachment an insurance declaration page showing Zhang had malpractice insurance. This exhibit was submitted to the jury and, by inadvertence, neither party noticed the insurance declaration page. After Zhang's counsel discovered the existence of the insurance declaration page in a post-trial interview with jurors, she supplemented her motion for a new trial with a declaration from a juror that, during deliberations, the juror saw the insurance information with the policy limits. When ruling on Zhang's motion for a new trial, the district court made a specific finding of fact that the insurance declaration page was admitted into evidence and it showed that Zhang had a policy limit of $1,000,000. Nevertheless, the district court denied Zhang's motion for a new trial, concluding in part that Zhang and NSCC had relied on the credentialing file during trial, they received a fair trial, and "[t]here was no accident or surprise which ordinary prudence could not have guarded against. Both parties were given the opportunity to review the evidence binders that were given to the jury."

We conclude that the few references to insurance—two of them to the concept of insurance generally and one specific to Zhang—do not rise to the level of prejudice necessary to warrant a new trial. *Cf.*

Silver State Disposal Co. v. Shelley, 105 Nev. 309, 313, 774 P.2d 1044, 1047 (1989) (allowing mention of insurance in voir dire because, "in an age of mandatory automobile insurance, we recognize that even unsophisticated jurors are often aware of the fact that insurance coverage may exist and thus, some prejudice may be unavoidable" (footnote omitted)); *Stackiewicz v. Nissan Motor Corp.* 100 Nev. 443, 453, 686 P.2d 925, 931 (1984) (citing *Holden v. Porter*, 405 F.2d 878 (10th Cir. 1969), for the proposition that "mention of insurance coverage [is] not misconduct").

The inadvertent submission to the jury of Zhang's insurance declaration page, on the other hand, had the potential to prejudice the trial. As challengers to the district court's decision, Zhang and NSCC carried the burden to show that the district court abused its discretion in denying their motion for a new trial. *See Gunderson*, 130 Nev., Adv. Op. 9, 319 P.3d at 611. On appeal, Zhang and NSCC failed to include exhibit 32, Zhang's credentialing file, which contained the insurance declaration page(s) the jury received. NRAP 30(d) provides, "Copies of relevant and necessary exhibits shall be clearly identified, and shall be included in the appendix as far as practicable." Clearly, it was error for this exhibit to go to the jury, but without the exhibit in the record on appeal, this court is deprived of the opportunity to fully assess prejudice and, so, whether the district court abused its discretion in denying a new trial on this basis. Without the exhibit, this court cannot understand precisely what the jury saw and how that information appeared in the context of the exhibit as a whole. We therefore affirm the district court's denial of Zhang and NSCC's motion for a new trial. *See Cuzze v. Univ. & Cmty. Coll. Sys. of Nev.*, 123 Nev. 598, 603, 172 P.3d 131, 135 (2007) ("When an appellant

fails to include necessary documentation in the record, we necessarily presume that the missing portion supports the district court's decision.").

D.

Of the $2,243,988 the jury awarded Barnes in damages, $2,000,000 was for pain and suffering, which NRS 41A.011 denominates "noneconomic damages." NRS 41A.035 limits the noneconomic damages recoverable in a professional negligence action to $350,000. The district court applied the $350,000 cap to Zhang but not to NSCC, a ruling NSCC appeals. Whether NRS 41A.035 limits NSCC's liability for noneconomic damages to $350,000 as it does Zhang's presents a question of law and statutory interpretation that we review de novo. *See Zohar v. Zbiegien*, 130 Nev., Adv. Op. 74, 334 P.3d 402, 405 (2014).

As written before its amendment in 2015,[1] NRS 41A.035 (2004) read as follows:

> In an action for injury or death against a provider of health care based upon professional negligence, the injured plaintiff may recover noneconomic damages, but the amount of noneconomic damages awarded in such an action must not exceed $350,000.

"Provider of health care" and "professional negligence" are both defined terms. As written before their 2015 amendment, NRS 41A.017 (2011) defined "provider of health care" to mean "a physician licensed under

---

[1]The 2015 amendments to NRS 41A.035 added the phrase "regardless of the number of plaintiffs, defendants or theories upon which liability may be based," to the end of the sentence. 2015 Nev. Stat., ch. 439, § 3, at 2526. This amendment did not change NRS 41A.035; it clarified it. *See Tam v. Eighth Judicial Dist. Court*, 131 Nev., Adv. Op. 80, 358 P.3d 234, 240 (2015).

chapter 630 or 633 of NRS, dentist, licensed nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, licensed dietitian or a licensed hospital and its employees," while NRS 41A.015 (2004) defined "[p]rofessional negligence" to mean "a negligent act or omission to act by a provider of health care in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death. The term does not include services that are outside the scope of services for which the provider of health care is licensed or services for which any restriction has been imposed by the applicable regulatory board or health care facility."

NSCC argues that, as a professional medical association, its liability is derivative from Zhang's and, therefore, its liability should not exceed his. Barnes counters that NSCC does not fit into the statutory definition of "provider of health care" and that liability for negligent hiring, training, and supervision is not "based upon professional negligence." As the claims in this case were for professional negligence arising out of Zhang's services, we agree with NSCC.

1.

On the question of applying NRS 41A.035 to a defendant-doctor's professional medical association, this court confronted an analogous issue in *Fierle v. Perez*, 125 Nev. 728, 219 P.3d 906 (2009), *overruled on other grounds in Egan v. Chambers*, 129 Nev., Adv. Op. 25, 299 P.3d 364, 365, 367 (2013). *Fierle* addressed the expert affidavit requirement in NRS 41A.071, rather than the cap on noneconomic damages imposed by NRS 41A.035. *Id.* at 734-35, 219 P.3d at 910. As in this case, though, the plaintiff in *Fierle* argued that, while NRS Chapter 41A protected the defendant-doctor by requiring an expert affidavit, the

statutes did not by their terms extend the protection to the doctor's professional medical corporation, whom the plaintiff had also sued. *See id.* at 734, 219 P.3d at 910 ("Appellants argue that under these statutes an affidavit from a medical expert is not required in suits against a professional medical corporation."). At the time, NRS Chapter 41A required an expert affidavit to support "an action for medical malpractice," *see* NRS 41A.071 (2002), while NRS 41A.009 (1985) defined "medical malpractice" as "the failure of *a physician, hospital or employee of a hospital*, in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances." 1985 Nev. Stat., ch. 620, § 4, at 2006 (emphasis added).[2] Recognizing 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, *Fierle*, 125 Nev. at 734, 219 P.3d at 910, we nonetheless looked to NRS Chapter 89, addressing professional business associations, and extended NRS Chapter 41A's affidavit requirement to the doctor's professional medical corporation, equally with the doctor himself. *Id.* at 735, 219 P.3d at 910-11; *see also id.* at 741, 744, 219 P.3d at 914, 916 (Pickering, J., concurring and dissenting) (noting cases supporting the extension of medical malpractice protections to a physician's corporate entity as well as the physician where the claim arises out of medical treatment of a patient). In doing so, we stated "NRS Chapters 41A and 89 must be read in harmony" and that, so read, "the provisions of NRS

---

[2]The 2015 Legislature amended NRS 41A.071 to substitute "professional negligence" for "medical malpractice" and repealed NRS 41A.009. *See* 2015 Nev. Stat., ch. 439, §§ 6, 12, at 2527, 2529.

Chapter 41A must be read to include professional medical corporations." *Id.* at 735, 219 P.3d at 910-11.

At the time *Fierle* was decided, NRS 41A.071's affidavit requirement only applied to "medical malpractice" rather than "professional negligence" actions. *See supra* note 2. In addition to requiring an affidavit to bring suit against a professional medical corporation, *Fierle* equated "medical malpractice" with "professional negligence," using this logic to extend NRS 41A.071's affidavit requirement to nurses and nurse practitioners. *Id.* at 736-38, 219 P.3d at 911-12. In *Egan*, 129 Nev., Adv. Op. 25, 299 P.3d 364, this court overruled *Fierle* to the extent it deemed "medical malpractice" and "professional negligence" to be one and the same. The *Egan* court therefore reversed an order dismissing a suit against a podiatrist and the medical group that employed him for want of an NRS 41A.071 affidavit. *Egan* held that, because a podiatrist was not a "physician" as defined in NRS 41A.013, the action was for "professional negligence," not for "medical malpractice," and NRS 41A.071 did not apply. *Id.* at 366-67.

Barnes urges us to disregard *Fierle* because it was overruled in *Egan*. But *Egan* did not address *Fierle*'s holding with respect to professional medical associations and the need to read NRS Chapters 41A and 89 together. While *Egan* reversed the order of dismissal against both the podiatrist and the medical group that employed him, it did so on the basis the claim asserted was for professional negligence, not medical malpractice, so NRS 41A.071 did not apply. This case, by contrast, presents no issue as to the distinction between "medical malpractice" and "professional negligence." The cap in NRS 41A.035 applies to all actions

for "professional negligence," not just the subset of actions for medical malpractice.

Under 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 actions.[3] In 2015, in fact, the Legislature amended the definition of "provider of healthcare" in NRS 41A.017 to expressly so state.[4] This 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*. Much as in *Tam*, 131 Nev., Adv. Op. 80, 358 P.3d at 240, we view the 2015 amendments to NRS 41A.017 and NRS 41A.035 as confirming our reading of the applicable statutory scheme. We therefore

---

[3]We reject Barnes' argument that a professional medical corporation is not a "person" for purposes of NRS Chapter 89. *See* NRS 0.039 (defining "person" to encompass "any form of business or social organization . . . including, but not limited to, a corporation, partnership, association, trust or unincorporated organization").

[4]The 2015 amendments to NRS 41A.017 (2011) are shown in italics:

> "'Provider of healthcare' means a physician licensed ~~[under]~~ *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 or technician, licensed dietitian or a licensed hospital, *clinic, surgery center, physicians' professional corporation or group practice that employs any such person* and its employees.

2015 Nev. Stat., ch. 439, § 2, at 2526.

reject Barnes' argument that the 2015 amendment to NRS 41A.017 signified the Legislature's view that, before its amendment, NRS 41A.017 implicitly excluded professional medical corporations from NRS Chapter 41A.

2.

There remains the question whether Barnes' claims against NSCC were for "professional negligence," a requirement that also must be met before NRS 41A.035 can apply. This court has interpreted the term "professional negligence" broadly, concluding that it encompasses the term "medical malpractice." *Tam*, 131 Nev., Adv. Op. 80, 358 P.3d at 242. Given this broad definition, a case-by-case approach is appropriate to determine whether a professional negligence statute applies to claims grounded on legal theories besides malpractice. *See Smith v. Ben Bennett, Inc.*, 35 Cal. Rptr. 3d 612, 615 (Ct. App. 2005) ("[W]hen a cause of action is asserted against a health care provider on a legal theory other than medical malpractice, the courts must determine whether it is nevertheless based on the 'professional negligence' of the health care provider so as to trigger [the Medical Injury Compensation Reform Act (MICRA)]. The answer is sometimes yes and sometimes no, depending on the particular cause of action and the particular MICRA provision at issue.").

In declining to apply NRS 41A.035 to cap NSCC's liability, the district court relied on our unpublished decision in *McQuade v. Ghazal Mountain Dental Group, P.C.*, Docket Nos. 61347, 61846 (Order of Reversal and Remand, September 24, 2014), for the proposition that "McQuade did not have to comply with NRS 41A.071[']s affidavit requirement] because the action was based on respondeat superior and negligent hiring, not medical or dental malpractice." While this assertion

is correct, *McQuade* interpreted NRS 41A.071, which, as noted above, only applied to "an action for medical malpractice or dental malpractice," not professional negligence, prior to 2015. *See* 2015 Nev. Stat., ch. 439, § 6, at 2527. Here, on the other hand, NRS 41A.035 (2004) applied to actions "based upon professional negligence," which, as articulated in *Tam*, 131 Nev., Adv. Op. 80, 358 P.3d at 242, is broader than and encompasses medical malpractice.

Based on the complex factual inquiry in each case-by-case claim of whether negligent hiring, training, and supervision amounts to professional negligence, it is no surprise that courts have split on whether such claims are independent of medical malpractice or professional negligence. *Compare James v. Kelly Trucking Co.*, 661 S.E.2d 329, 331 (S.C. 2008) (noting that an "employer's liability under [a negligent hiring, training, and supervision] theory does not rest on the negligence of another, but on the employer's own negligence"), *with Blackwell v. Goodwin*, 513 S.E.2d 542, 545-46 (Ga. Ct. App. 1999) (determining that the statute of repose for medical malpractice claims applies to plaintiff's claims against the nurse's employer for negligent hiring, retention, supervision, and entrustment because the claims arose out of the nurse's administration of an injection, which involved the exercise of her professional skill and judgment).

A case-by-case analysis of whether claims asserted by a plaintiff are grounded in professional negligence will avoid a rule of pleading and ensure a rule of substance. Thus, the threshold issue is whether Barnes' negligent hiring, training, and supervision claim is truly an independent tort or whether it is related and interdependent on the underlying negligence of Zhang.

Although in the context of an insurance coverage dispute, some courts have held that claims of negligent hiring, training, and supervision that are inherently interdependent on and an intricate part of the negligent rendering of professional medical treatment are subject to the "professional services exclusion," just like medical malpractice. *See Duncanville Diagnostic Ctr., Inc. v. Atl. Lloyd's Ins. Co. of Tex.*, 875 S.W.2d 788, 791 (Tex. Ct. App. 1994). For example, in *Duncanville*, an insurance company for a professional medical corporation sought a declaratory judgment that it did not have a duty to defend under its policy after the medical corporation's radiological technicians administered too much sedative to a 4-year old girl, leading to her ultimate death. *Id.* at 790. The insurance policy contained what is known as a "professional services exclusion," "providing that coverage does not apply to bodily injury 'due to the rendering or failure to render any professional service.'" *Id.* The plaintiffs argued that the professional services exclusion did not apply to their claim of negligent hiring, training, and supervision. *Id.* at 791. The Texas Court of Appeals rejected that argument:

> There would have been no injury in this case and no basis for the [plaintiffs'] lawsuit without the negligent rendering of professional medical treatment. Stated more specifically, Erica's death could not have resulted from the negligent hiring, training, and supervision or from the negligent failure to institute adequate policies and procedures without the negligent rendering of professional medical services. The negligent acts and omissions were not independent and mutually exclusive; rather, they were related and interdependent. Therefore, the professional services exclusion operated to exclude coverage not only for the claims of negligence in rendering the professional services but also for the related

> allegations of negligent hiring, training, and supervision . . . .

Id. at 791-92.

When negligent hiring claims are inextricably linked to the underlying professional negligence, courts have held that the negligent hiring claim is more akin to vicarious liability than an independent tort. *See Am. Registry of Pathology v. Ohio Cas. Ins. Co.*, 461 F. Supp. 2d 61, 70 (D.D.C. 2006) ("Even though the complaints allege that [the American Registry of Pathology] was negligent in hiring Ms. Stevens, [a cytotechnologist,] the injuries in question were caused by—*i.e.* 'arose out of'—Ms. Steven's failure to perform the cytopathology tests properly. In that sense, the negligent hiring claims are similar to the vicarious liability claims because they seek to hold the employer responsible for the negligent acts of the employee."); *Holmes Reg'l Med. Ctr., Inc. v. Dumigan*, 151 So. 3d 1282, 1285 (Fla. Dist. Ct. App. 2014) (citing *Martinez v. Lifemark Hosp. of Fla., Inc.*, 608 So. 2d 855, 856-57 (Fla. Dist. Ct. App. 1992) for the proposition that "the case should be handled under the [Florida Medical Malpractice Act] because plaintiff's asserted claims of negligent hiring and retention, fraud and misrepresentation, and intentional tort were necessarily and inextricably connected to negligent medical treatment").

In cases such as this, when a negligent hiring, training, and supervision claim is based upon the underlying negligent medical treatment, the liability is coextensive. Negligent hiring, training, and supervision claims cannot be used as a channel to allege professional negligence against a provider of health care to avoid the statutory caps on such actions. While a case-by-case approach is necessary because of the inherent factual inquiry relevant to each claim, it is clear to us, in this

case, that the allegations against NSCC were rooted in Zhang's professional negligence. Thus, Barnes' negligent hiring, training, and supervision claim is subject to the statutory caps under NRS 41A.035. And, in light of this court's holding in *Tam*, under NRS 41A.035 (2004), Barnes is only entitled to receive a total of $350,000 for noneconomic damages "per incident, regardless of how many plaintiffs, defendants, or claims are involved." 131 Nev., Adv. Op. 80, 358 P.3d at 240.

E.

Our holding that NSCC is a provider of health care and therefore entitled to have its liability for noneconomic damages capped at $350,000 requires remand to the district court for recalculation of the judgment as to NSCC. To the extent that, as a provider of health care being held liable for professional negligence, NSCC is severally liable, it does not appear to be entitled to a settlement offset. *See* NRS 41A.045 (stating that providers of health care will only be liable severally, not jointly); *Piroozi v. Eighth Judicial Dist. Court*, 131 Nev., Adv. Op. 100, 363 P.3d 1168, 1172 n.4 (2015) ("[B]ecause the petitioners are only severally liable for their portion of the apportioned negligence damages, they are not entitled to an offset."); *see also* Appellants' Opening Brief, p. 36, note 4 ("Defendants recognize that the District Court's failure to offset the settlement against Dr. Zhang's liability is harmless error so long as his liability is capped under NRS 41A.035 . . . ."). As between Zhang and NSCC, the apportionment of liability is unclear. The verdict form refers "Dr. Zhang" and "All Others," without specifically apportioning NSCC's liability, yet, as a defendant held liable on a theory of negligent hiring for the same injury Zhang caused, including the capped $350,000 in noneconomic damages, NSCC's liability appears vicarious. As this issue

was not adequately briefed or developed, it is inappropriate to address it for the first time on appeal.

In remanding, we decline to disturb the district court's collateral source offset for the portion of Barnes' medical bills forgiven by Southern Hills Hospital. *See* NRS 42.021(1). Barnes' challenge on cross-appeal to the district court's offset of $84,813.80 under NRS 42.021 was limited to the sufficiency of evidence presented. Barnes argued that the district court erred by relying solely on an interrogatory answer. This was not the only evidence presented to the district court, however, as Zhang and NSCC attached to their NRCP 59(e) motion a hospital bill showing the amount the district court credited. Accordingly, we

ORDER the judgment of the district court AFFIRMED IN PART AND REVERSED IN PART AND REMAND this matter to the district court for proceedings consistent with this order.[5]

_____, J.
Hardesty

_____, J.
Douglas

_____, J.
Cherry

_____, J.
Gibbons

_____, J.
Pickering

[5]The Honorable Ron Parraguirre, Chief Justice, did not participate in the decision of this matter.

cc: Hon. James M. Bixler, District Judge
Lansford W. Levitt, Settlement Judge
Maupin Naylor Braster
Lewis Brisbois Bisgaard & Smith, LLP/Las Vegas
David N. Frederick
Kravitz, Schnitzer & Johnson, Chtd.
Eighth District Court Clerk

EXHIBIT C

NEO
KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
JONQUIL L. WHITEHEAD, ESQ.
Nevada Bar No. 10783
HALL PRANGLE & SCHOONVELD, LLC
1160 North Town Center Drive, Suite 200
Las Vegas, NV 89144
(702) 889-6400 – Office
(702) 384-6025 – Facsimile
kwebster@hpslaw.com
jwhitehead@hpslaw.com
Attorneys for Defendant
El Jen Medical Hospital, Inc.

Electronically Filed
10/15/2015 10:48:07 AM

CLERK OF THE COURT

DISTRICT COURT

CLARK COUNTY, NEVADA

SCOTT RULAND, individually, and as Special Administrator for the estate of the decedent, ELEANOR SUSAN RULAND, Plaintiff, vs. EL JEN MEDICAL HOSPITAL, INC., and DOES I through X, and ROE CORPORATIONS I through X, inclusive; Defendants.	CASE NO. A695709 DEPT NO. XXXI

NOTICE OF ENTRY OF ORDER

HALL PRANGLE & SCHOONVELD, LLC
1160 NORTH TOWN CENTER DRIVE
SUITE 200
LAS VEGAS, NEVADA 89144
TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

PLEASE TAKE NOTICE that an Order Denying Plaintiff's Motion to Amend the Complaint and Plaintiff's Motion for Declaratory Relief Under NRS 30.040 was entered in the above-entitled Court on the 13th day of October, 2015, a copy of which is attached hereto.

DATED this 15th day of October, 2015.

HALL PRANGLE & SCHOONVELD, LLC

By: */s/: Jonquil Whitehead*
KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
JONQUIL L. WHITEHEAD, ESQ.
Nevada Bar No. 10783
HALL PRANGLE & SCHOONVELD, LLC
1160 North Town Center Drive, Suite 200
Las Vegas, NV 89144
Attorneys for Defendant
El Jen Medical Hospital, Inc.

HALL PRANGLE & SCHOONVELD, LLC
1160 NORTH TOWN CENTER DRIVE
SUITE 200
LAS VEGAS, NEVADA 89144
TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of HALL PRANGLE & SCHOONVELD, LLC; that on the 15th day of October, 2015, I served a true and correct copy of the foregoing **NOTICE OF ENTRY OF ORDER** via E-Service on Wiznet pursuant to mandatory NEFCR 4(b) to the following parties:

Clay R. Treese, Esq.
THE LAW OFFICE OF CLAY R TREESE
2272-1 South Nellis Boulevard
Las Vegas, NV 89142
-and-
James J. Ream, Esq.
333 North Rancho, Suite 530
Las Vegas, NV 89106
Attorney for Plaintiff

/s/: Diana Cox
An employee of HALL PRANGLE & SCHOONVELD, LLC

4810-8067-4857, v. 1

ORDR
KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
JONQUIL L. WHITEHEAD, ESQ.
Nevada Bar No. 10783
HALL PRANGLE & SCHOONVELD, LLC
1160 North Town Center Drive, Suite 200
Las Vegas, NV 89144
(702) 889-6400 – Office
(702) 384-6025 – Facsimile
kwebster@hpslaw.com
jwhitehead@hpslaw.com
Attorneys for Defendant
El Jen Medical Hospital, Inc.

DISTRICT COURT

CLARK COUNTY, NEVADA

SCOTT RULAND, individually, and as Special Administrator for the estate of the decedent, ELEANOR SUSAN RULAND, Plaintiff, vs. EL JEN MEDICAL HOSPITAL, INC., and DOES I through X, and ROE CORPORATIONS I through X, inclusive; Defendants.	CASE NO. A695709 DEPT NO. XXXI

ORDER DENYING
PLAINTIFF'S MOTION TO AMEND THE COMPLAINT AND
PLAINTIFF'S MOTION FOR DECLARATORY RELIEF UNDER NRS 30.040

PLAINTIFF filed a Motion for Leave to Amend the Complaint on August 10, 2015 and a Motion for Declaratory Relief Under NRS 30.040 on August 27, 2015. DEFENDANT filed oppositions to both motions on August 27, 2015 and September 14, 2015, respectively. PLAINTIFF filed his replies to DEFENDANT's oppositions on September 15, 2015 and September 23, 2015, respectively. This matter having come on for hearing on September 29,

HALL PRANGLE & SCHOONVELD, LLC
1160 NORTH TOWN CENTER DRIVE
SUITE 200
LAS VEGAS, NEVADA 89144
TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

2015, before Honorable Judge Joanna S. Kishner. Jonquil Whitehead, Esq., of the law offices of HALL PRANGLE & SCHOONVELD, LLC, appeared for Defendant. James J. Ream, Esq., and Clay R. Treese, Esq., appeared for Plaintiff.

The Court having reviewed the papers and pleadings on file, argument by all counsel and being fully advised in the premises, and other good cause appearing, hereby renders the following:

IT IS HEREBY ORDERED that PLAINTIFF'S MOTION FOR DECLARATORY RELIEF UNDER NRS 30.040 is DENIED.

IT IS FURTHER HEREBY ORDERED that the claim of "Professional Negligence" against DEFENDANT, a skilled nursing facility, in this case is governed by NRS 41A. The Court finds this based on the nature of the claim of "Professional Negligence" pled as a failure to meet the standard of care by a professional covered by NRS 41A ("a licensed nurse"), there is no case law or statute that exempts a skilled nursing facility from NRS 41A, and this matter has been part of three medical malpractice status checks and treated as a medical malpractice case since its filing on February 6, 2014.

...

...

...

...

...

...

...

...

HALL PRANGLE & SCHOONVELD, LLC
1160 NORTH TOWN CENTER DRIVE
SUITE 200
LAS VEGAS, NEVADA 89144
TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

IT IS FURTHER HEREBY ORDERED that PLAINTIFF'S MOTION FOR LEAVE TO AMEND THE COMPLAINT is DENIED pursuant to *Nutton v. Sunset Station*, 131 Nev. Advanced Opinion 34 (June 2015) as PLAINTIFF failed to demonstrate good cause for this untimely request to amend the Complaint after the deadline.

IT IS SO ORDERED.

DATED this 8 day of October, 2015.

JOANNA S. KISHNER

DISTRICT COURT JUDGE JOANNA S. KISHNER

Respectfully Submitted by:

KENNETH M. WEBSTER, ESQ.
Nevada Bar No. 7205
JONQUIL L. WHITEHEAD, ESQ.
Nevada Bar No. 10783
HALL PRANGLE & SCHOONVELD, LLC
1160 North Town Center Drive, Suite 200
Las Vegas, NV 89144
Attorneys for Defendant
El Jen Medical Hospital, Inc.

Approved as to form and content:

/s/: James Ream, Esq.

Clay R. Treese, Esq.
THE LAW OFFICE OF CLAY R TREESE
2272-1 South Nellis Boulevard
Las Vegas, NV 89142
-and-
James J. Ream, Esq.
333 North Rancho, Suite 530
Las Vegas, NV 89106
Attorney for Plaintiff

HALL PRANGLE & SCHOONVELD, LLC
1160 NORTH TOWN CENTER DRIVE
SUITE 200
LAS VEGAS, NEVADA 89144
TELEPHONE: 702-889-6400 FACSIMILE: 702-384-6025

4830-1822-3913, v. 1

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
Stanley M. Kidiavayi, RN
and Staffing Specialist, Inc.

DISTRICT COURT

CLARK COUNTY, NEVADA

SAMANTHA HULME aka SAMANTHA MARSHALL, Plaintiff, vs. SUNRISE HOSPITAL AND MEDICAL CENTER, LLC d/b/a SUNRISE HOSPITAL, STANLEY M. KIDIAVAYI, RN; STAFFING SPECIALISTS, INC.; DOES I through X, inclusive, and ROE CORPORATIONS I through X, inclusive, ROE Limited Liability Company I through X, inclusive, , Defendant.	CASE NO. A-15-724332-C Dept. No.: VI **NOTICE OF ENTRY OF ORDER**

PLEASE TAKE NOTICE that an Order Granting in Part and Denying in Part Defendant Staffing Specialists' Motion for Summary Judgment and Granting Plaintiff's Countermotion to Amend Complaint was entered on the 21st day of March 2018. A copy of which is attached hereto.

LEWIS BRISBOIS BISGAARD & SMITH LLP ATTORNEYS AT LAW

DATED this 22nd day of March 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
LEWIS BRISBOIS BISGAARD & SMITH LLP
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
Attorneys for Defendants Stanley Kidiavayi, RN and Staffing Specialist, Inc.

CERTIFICATE OF SERVICE

I hereby certify that on this 22nd day of March 2018, a true and correct copy of **NOTICE OF ENTRY OF ORDER** to be served via the Court's electronic filing and service system (wiznet) to all parties on the current service list:

Michael Paul Wood, Esq.
MICHAEL PAUL WOODS LAW OFFICE
601 S. 10th Street, Suite 103
Las Vegas, NV 89101
Attorney for Plaintiff

Ken Webster, Esq.
HALL PRANGLE & SCHOONVELD
1160 North Town Center Drive, Suite 200
Las Vegas, NV 89144

/s/ Nicole Etienne
By:
Employee of Lewis Brisbois Bisgaard & Smith, LLP

S. BRENT VOGEL
Nevada Bar No. 006858
AMANDA J. BROOKHYSER
Nevada Bar No. 11526
LEWIS BRISBOIS BISGAARD & SMITH LLP
6385 S. Rainbow Boulevard, Suite 600
Las Vegas, Nevada 89118
702.893.3383
FAX: 702.893.3789

Attorneys for Stanley Kidiavayi, RN,
and Staffing Specialists, Inc.

DISTRICT COURT

CLARK COUNTY, NEVADA

SAMANTHA HULME aka SAMANTHA MARSHALL, Plaintiff, vs. SUNRISE HOSPITAL AND MEDICAL CENTER, LLC dba SUNRISE HOSPITAL; STANLEY KIDIAVAYI, RN; STAFFING SPECIALISTS, INC.; DOES I through X, inclusive, and ROE CORPORATIONS I through X, inclusive, ROE Limited Liability Company I through X, inclusive, Defendants.	CASE NO. A-15-724332-C Dept. No.: VI **ORDER GRANTING IN PART AND DENYING IN PART DEFENDANT STAFFING SPECIALIST'S MOTION FOR PARTIAL SUMMARY JUDGMENT AND GRANTING PLAINTIFF'S COUNTERMOTION TO AMEND COMPLAINT**

THIS MATTER, having come on for hearing on the 23rd day of January, 2018, Amanda J. Brookhyser, Esq., of the Law Firm LEWIS BRISBOIS BISGAARD & SMITH, appearing on behalf of Defendants Stanley Kidiavayi, RN, and Staffing Specialists; William Brenske, Esq., of the Law Firm BRENSKE & ANDREVSKI, appearing on behalf of Plaintiff; and James Fox, Esq., of the Law Firm HALL PRANGLE SCHOONVELD, appearing on behalf of Defendant Sunrise Hospital and Medical Center, and the court having reviewed all applicable pleadings and having heard and considered oral argument, does order and find as follows:

////

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Defendant's Motion for Partial Summary Judgment is DENIED in part and GRANTED in part. To the extent that the Motion for Partial Summary Judgment sought to have the pain and suffering damages cap in NRS 41A.035 apply to Staffing Specialists should it be found that the claims against Stanley Kidiavayi, RN, are for professional negligence, the Motion is GRANTED. To the extent that the Motion sought to have the court find that the claims against Stanley Kidiavayi, RN are for professional negligence, the Motion is DENIED without prejudice as the court cannot make a determination at this point whether or not, as a matter of law, the claims against Stanley Kidiavayi, RN are for professional negligence or if they are for general negligence.

////

////

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff's Countermotion to Amend Complaint is hereby GRANTED.

IT IS SO ORDERED, ADJUDGED AND DECREED.

DISTRICT COURT JUDGE

Submitted by:

LEWIS BRISBOIS BISGAARD & SMITH

By

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 Stanley Kidiavayi, RN, and Staffing Specialists.

Approved as to Form and Content by:

HALL PRANGLE SCHOONVELD

#13122

JOHN F. BEMIS, ESQ.
Nevada Bar No. 9509
SARAH SILVERMAN, ESQ.
Nevada Bar No. 13624
Attorneys for Sunrise Hospital and Medical Center

BRENSKE & ANDREVSKI

WILLIAM R. BRENSKE, ESQ.
Nevada Bar No. 1806
RYAN D. KRAMETBAUER, ESQ.
Nevada Bar No. 12800
Attorneys for Plaintiff

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff's Countermotion to Amend Complaint is hereby GRANTED.

IT IS SO ORDERED, ADJUDGED AND DECREED.

_____
DISTRICT COURT JUDGE

Submitted by:

LEWIS BRISBOIS BISGAARD & SMITH

By_____
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 Stanley Kidiavayi. RN. and Staffing Specialists.

Approved as to Form and Content by:

HALL PRANGLE SCHOONVELD

_____
JOHN F. BEMIS, ESQ.
Nevada Bar No. 9509
SARAH SILVERMAN, ESQ.
Nevada Bar No. 13624
Attorneys for Sunrise Hospital and Medical Center

BRENSKE & ANDREVSKI

_____
WILLIAM R. BRENSKE, ESQ.
Nevada Bar No. 1806
RYAN D. KRAMETBAUER. ESQ.
Nevada Bar No. 12800
Attorneys for Plaintiff

EXHIBIT D

50013-615 CT

Electronically Filed
12/21/2011 09:05:22 AM

CLERK OF THE COURT

NOE
S. BRENT VOGEL
Nevada Bar No. 006858
BRIANNA SMITH
Nevada Bar No. 11795
LEWIS BRISBOIS BISGAARD & SMITH LLP
6385 S. Rainbow Blvd., Suite 600
Las Vegas, Nevada 89118
702.893.3383 - Main
702.893.3789 - Facsimile
bvogel@lbbslaw.com
bgsmith@lbbslaw.com
Attorneys for TLC Holdings, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

THE ESTATE OF WILLARD FERHAT, JOSEPHINE FERHAT, SPECIAL ADMINISTRATOR, Plaintiff, v. TLC HOLDINGS, LLC d/b/a TLC LONG TERM CARE CENTER and JOHN DOES I through X, inclusive, Defendant.	CASE NO. A562984 DEPT NO.: XX **NOTICE OF ENTRY OF ORDER**

PLEASE TAKE NOTICE that an Order Granting TLC Holdings, LLC d/b/a TLC Long Term Care Center's Motion to Dismiss was entered on the 19th day of December 2011. A copy of which is attached hereto.

LEWIS BRISBOIS BISGAARD & SMITH LLP ATTORNEYS AT LAW

4814-5189-4794.1

DR062712090

DATED this 19 day of December, 2011.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By: _____

S. BRENT VOGEL
Nevada Bar No. 006858
BRIANNA SMITH
Nevada Bar No. 111795
6385 S. Rainbow Blvd., Suite 600
Las Vegas, Nevada 89118
Attorneys for Defendant TLC Holdings, LLC

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of LEWIS BRISBOIS BISGAARD & SMITH LLP and that on this 21 day of December, 2011, I did cause a true copy of **NOTICE OF ENTRY OF ORDER** be placed in the United States Mail, with first class postage prepaid thereon, and addressed as follows:

Victor Lee Miller, Esq.
Law Office of Victor Lee Miller
935 S. Decatur Blvd.
Las Vegas, NV 89107
Attorneys for Plaintiff

By _____
An Employee of
LEWIS BRISBOIS BISGAARD & SMITH LLP

LEWIS BRISBOIS BISGAARD & SMITH LLP

Electronically Filed
12/19/2011 03:26:39 PM

ORDR

CLERK OF THE COURT

CLERK OF THE COURT

DISTRICT COURT

CLARK COUNTY, NEVADA

ESTATE OF WILLARD FERHAT, et al.,

Plaintiff(s),

v.

TLC LONG TERM CARE, LTD.,

Defendant(s).

CASE NO.: A562984
DEPT. XX

ORDER GRANTING DEFENDANT'S MOTION TO DISMISS WITHOUT PREJUDICE

This matter having come on for hearing on December 14, 2011, Victor Lee Miller, Esq., appearing for and on behalf of Plaintiffs; Brent S. Vogel, Esq., appearing for and on behalf of Defendant, and the Court having heard arguments of counsel, and being fully advised in the premises, finds:

(1) This matter comes before the Court on a Motion to Dismiss filed by the Defendant, TLC Holdings LLC, pursuant to Rule 12(b)(5) of the Nevada Rules of Civil Procedure (NRCP). The Defendant alleges that the Complaint must be dismissed because it alleges a cause of action sounding in medical malpractice pursuant to NRS 41A.017 yet fails to include an affidavit of a medical expert as required by NRS 41A.071.

(2) Summary judgment was previously granted by the Court (via Judge Togliatti), but on appeal the Nevada Supreme Court reversed and remanded, finding that additional discovery was necessary pursuant to NRCP 56(f). *See* Order of Reversal and

JEROME TAO
DISTRICT JUDGE
DEPARTMENT XX
LAS VEGAS, NEVADA 89101

Remand, No. 55347, issued August 3, 2011. However, in its Order, the Supreme Court expressly left open the question now before this Court. In footnote 2 of its Order, the expressly left open the question now before this Court. In footnote 2 of its Order, the Supreme Court stated as follows:

> "[Plaintiff] also contends that TLC improperly argues for the first time on appeal that this case falls within the purview of NRS Chapter 41A's expert affidavit requirement. We conclude that TLC waived the issue by failing to raise it below....While TLC correctly argues that [the Plaintiff] was required to provide expert testimony concerning causation, we conclude that [Plaintiff] is not barred from doing so because summary judgment was improperly granted at an early stage in the proceedings. *See* NRS 41A.100; see also *Bronneke v. Rutherford*, 120 Nev. 230, 235 n. 9 (2004) ("The recent version of NRS 41A.100(1) continues to require expert medical testimony to prove medical negligence.")."

(3) The parties originally supplied briefing on this Motion to this Court for a hearing scheduled on November 9, 2011. After reviewing the original briefing, this Court issued an Order dated November 8, 2011, requesting additional briefing by the parties regarding certain legal issues. This Court heard oral argument on the additional briefing on December 14, 2011.

(4) Plaintiff Josephine Ferhat is the Special Administrator of the Estate of Willard Ferhat, the co-Plaintiff. The Defendant operates a residential care facility known as the TLC Long Term Care Center.

(5) The Plaintiffs' Complaint was filed on May 13, 2008. The Court notes that the allegations of the Complaint are pled generally. The Plaintiffs allege that the decedent was lawfully on the Defendant's premises when he developed multiple decubitis ulcers while unsupervised or turned (Paragraph VI); the Defendant, through its officers, agents, servants and employees committed certain acts of negligence, namely Paragraph VII, which alleges that the Defendant:

A. Failed to keep [decedent] safe while in their care;

B. Failed to properly supervise [decedent] during his stay;

C. Failed to properly inspect [decedent] so as to provide a proper sleeping surface and skin care;

surface and skin care;

D. Failed to warn Plaintiffs of a dangerous condition;

E. Permitted [decedent] to remain in a defective and unsafe condition when Defendant knew of said condition or reasonably should have known of the unsafe condition

Finally, the Complaint alleges that the Plaintiffs were permanently injured as a proximate cause of the Defendant's negligence (Paragraphs VIII and IX).

(6) The general allegations of the Complaint have been supplemented by the parties during discovery and during the briefing of this Motion. According to the Plaintiffs' Brief, Willard Ferhat resided in the Defendant's facility in connection with rehabilitation following a stroke. According to the Plaintiffs, the Defendant was supposed to provide a clean and safe living environment for Mr. Ferhat and to care for his personal needs, including his personal hygiene. Allegedly, the Defendant was negligent (through its officers, agents, servants and employees) in providing those services and left Mr. Ferhat sitting in dirty diapers, failed to properly operate a special mattress designed to prevent pressure sores from developing, and failed to regularly reposition him in order to prevent bedsores from forming, all of which caused him to develop decubitus ulcers and eventually sepsis (a blood infection) which hastened his death.

(7) Additionally, in its Supplemental Brief, the Defendant has supplied medical records and copies of Responses to Interrogatories which they assert add detail to the allegations of the Complaint and demonstrate that the acts/omissions listed in the Complaint actually fall within the scope of NRS 41A.017.

(8) For example, Defendant's Interrogatory No. 13 requests: "describe in detail the injuries, complaints and symptoms which you claim [the decedent] suffered as a

result of the incident out of which this action arose." The Plaintiffs' Response to this Interrogatory cites a variety of incidents and allegations, including such things as failing to use clean gloves while handling the decedent, failing to regularly turn the decedent so that he developed bed sores, and allowing him to sit in soiled diapers for long periods of time. As the Plaintiffs note, some of these allegations are, at least arguably, not activities normally performed by a licensed nurse or physician or which involve the exercise of professional medical judgment.

(9) However, the same Response to this Interrogatory also includes the following statements which appear to recite instances of alleged professional negligence committed by nurses and physicians:

> "[the decedent] didn't have his oxygen. Traci...call[ed] the doctor about the oxygen....The charge nurse came in about 15 minutes later and put oxygen on my husband and he did calm down."
>
> "The staff also would not turn my husband. They would say that he was too heavy. He ended up with a stage III ulcer on his left heel. My son spoke to Dr. Jorgensen regarding this issue. He also spoke to him regarding these medications my husband was taking, specifically the Remeron and Neurontin. My husband was so sedated he could not go to physical therapy. Dr. Jorgensen said they gave it to [the decedent] because he was depressed. We asked if he could be off of it but they would not take him off."
>
> "We brought up the medications and did not receive an answer....As for the medications, [the decedent] had not been on those medications at St. Rose or before the stroke. He was so sleepy during the day that when he would be in the wheel chair he would just sit with his head on his chest and not be able to wheel himself like he could at St. Rose. He was able to wheel himself up and down the hall and now he couldn't move at all. Because he was so sedated he began to deteriorate and lose all of the function he had gained back at St. Rose....After being on these medications, he was unable to complete any of these tasks. He began having trouble swallowing, he was too sedated to wheel himself, he had to be fed, he became a complete transfer and he had to have help grooming. Also because of the sedation he began to silently aspirate his own secretions."

(10) By this Motion, the Defendant alleges that the allegations of the

Complaint, while pled in terms of general negligence, actually constitute a cause of action for medical malpractice under chapter 41A of the NRS. In its original Motion, the Defendant averred that it operates a licensed skilled nursing facility which is legally licensed to provide "continuous skilled nursing and related care as prescribed by a physician" (NRS 449.0039) and therefore that its employees are "providers of health care" pursuant to NRS 41A.017. Accordingly, because the Complaint alleges that the Defendant's employees performed professional medical services in a negligent manner, the Defendant asserts that the Complaint must be dismissed because its allegations are not supported by an affidavit as required by NRS 41A.071.

(11) In Opposition, the Plaintiffs aver that the provisions of NRS 41A.071 do not govern their Complaint. First, the Plaintiffs note that NRS 41A.015 expressly states that the requirements of Chapter 41A are limited to acts or omissions by "providers of health care." The Plaintiffs assert that NRS 41A.017 does not define "provider of health care" to include facilities such as that operated by the Defendant. Therefore, the Plaintiffs conclude that no expert affidavit is required because NRS 41A.071 simply does not apply to the cause of action alleged in the present Complaint.

(12) In its November 8, 2011 Order, this Court requested additional briefing on the following additional questions: (a) whether the allegations contained in the Plaintiffs' Complaint fall within the scope of NRS 41A.017 to the extent that the acts or omissions listed in the Complaint were committed by licensed nurses at the Defendant's facility, and (b) if so, then whether the allegations of vicarious liability against the facility are also void to the extent that they arise from underlying allegations that would have been void *ab initio* had they been asserted individually.

(13) In its Supplemental Brief, the Plaintiffs aver that, since this motion was originally brought pursuant to NRCP 12(b)(5), and since the matter now involves the consideration of facts and evidence which lie outside of the pleadings, the Defendant's

motion must be considered a motion for summary judgment under NRCP 56. The Plaintiffs assert that summary judgment cannot be granted because genuine issues of material fact exist, and furthermore, additional discovery is required under NRCP 56(f).

(14) Therefore, the first question before the Court is the precise procedural posture of this Motion. If this Motion has indeed become a motion for summary judgment pursuant to NRCP 56, then the Supreme Court's Order of Reversal and Remand would remain in effect and summary judgment cannot be granted since discovery is still at a relatively early stage.

(15) The Defendant's Motion is styled as a motion brought pursuant to NRCP 12(b)(5). It is well-settled that, in considering a Motion to Dismiss pursuant to NRCP 12(b)(5), the Court must accept all allegations of the Complaint to be true and view those allegations in the light most favorable to the non-moving party. In reviewing the sufficiency of a Complaint under NRCP 12(b)(5), the Court's analysis would normally be limited to the allegations contained within the four corners of the Complaint. Normally, the Court's role would be to determine whether those allegations, by themselves, without supplementation, meet the notice pleading requirements of NRCP 12 and other relevant rules. If the Court considers evidence outside of the pleadings, then pursuant to the express provisions of NRCP 12, the motion should be automatically converted to a motion for summary judgment and reviewed under the standards of NRCP 56. The Plaintiffs assert that this is what has happened here.

(16) However, in this case, the Defendant does not allege that the Plaintiffs have failed to adequately plead all of the elements setting forth a cause of action for which relief can be granted. Rather, the Defendant appears to concede that the basic elements of a cause of action lying in negligence are sufficiently pled within the Complaint to satisfy the notice pleading requirements of NRCP 12. Instead, the Defendant's Motion avers that the Plaintiffs' cause of action is actually a veiled cause of

action for medical malpractice because of the nature of the Defendant's facility and the type of care that it actually rendered to the decedent. In other words, the focus of the Motion is not upon the technical sufficiency of the allegations contained within the Complaint, but rather upon the nature of the Defendant's conduct which the Defendant asserts brings the Complaint within the scope of NRS Chapter 41A.

(17) Thus, in substance, it appears that NRCP 12(b)(5) does not actually govern this Motion. By this Motion, the Defendant is actually challenging whether the Plaintiff has complied with certain specific requirements regarding expert affidavits imposed by a separate statute that exists outside of the Nevada Rules of Civil Procedure.

(18) The Court notes that, even under the express terms of NRCP 12, only NRCP 12(b)(5) motions are treated as NRCP 56 motions if evidence outside of the pleadings is considered. Other types of NRCP 12(b) motions may be based upon facts and evidence outside of the pleadings without becoming NRCP 56 motions. For example, in resolving NRCP 12(b)(2) motions alleging lack of personal jurisdiction, courts necessarily look outside of the pleadings to determine such things as whether a party has demonstrated sufficient minimum contacts with the forum state; indeed the Nevada Supreme Court has required that courts hold evidentiary hearings to resolve such motions. *See, e.g., Trump v. Eighth Judicial District Court*, 109 Nev. 687, 692-94 (1993). The Court also notes that NRCP 12 is not the sole or exclusive basis for bringing a motion requesting dismissal of a complaint; by way of example, motions seeking dismissal may also be brought pursuant to NRCP 11 or NRCP 37, to name only two examples.

(19) Thus, the Defendant's Motion should be treated as a NRCP 56 motion only if it can be fairly said that it was originally brought as a NRCP 12(b)(5) motion. As noted, it appears quite clear that it was not. The Defendant's Motion asserts a failure to comply with a separate statutory requirement that exists outside of the rules of

procedure. Thus, it appears to the Court that the Defendant's Motion was not originally brought pursuant to NRCP 12(b)(5) (even though it was originally styled as such), and brought pursuant to NRCP 12(b)(5) (even though it was originally styled as such), and therefore it need not be treated as a NRCP 56 motion merely because its disposition requires consideration of facts and evidence that lie outside of the four corners of the Complaint.

(20) Therefore, the Court deems that this Motion is ripe for consideration notwithstanding the Plaintiffs' assertion that additional discovery is needed. Although the Plaintiffs have asserted that additional discovery is necessary pursuant to NRCP 56(f), such an assertion would only be relevant if the Defendant's Motion can fairly be labeled a motion seeking summary judgment under NRCP 56. Here, the Defendant's Motion is not such a motion. A response seeking a continuance based upon NRCP 56(f) is inapposite to a motion that seeks dismissal based upon the failure to comply with the affidavit requirement of a statute.

(21) The Court also incidentally notes that, even if this were a NRCP 56 motion, the Plaintiffs have not technically complied with the requirements of NRCP 56(f) because they failed to supply the Court with the required affidavit. *See, Choy v. Ameristar Casinos*, 127 Nev. Adv. Op. 78 (November 23, 2011) (NRCP 56(f) relief cannot be granted if respondent failed to comply with its express terms by supplying an affidavit).

(22) Turning to the merits of the Defendant's argument, the Defendant first avers that an affidavit is required because its facility must be considered a "hospital" within the meaning of NRS 41A.017 and 41A.071.

(23) NRS 41A.071 states as follows:

> **NRS 41A.071 Dismissal of action filed without affidavit of medical expert supporting allegations.** If an action for medical malpractice or dental malpractice is filed in the district court, the district court shall dismiss the action, without prejudice, if the action is filed without an

affidavit, supporting the allegations contained in the action, submitted by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged similar to the type of practice engaged in at the time of the alleged malpractice.

(24) In the present case, the parties do not dispute that the allegations of the Complaint are not supported by any affidavit that meets the requirements of NRS 41A.071. The question before the Court is whether the Plaintiffs' Complaint asserts a cause of action for "professional negligence" which requires such an affidavit pursuant to NRS 41A.071.

(25) NRS 41A.015 defines "professional negligence" as follows:

> **NRS 41A.015 "Professional negligence" defined.** "Professional negligence" means a negligent act or omission to act by a provider of health care in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death. The term does not include services that are outside the scope of services for which the provider of health care is licensed or services for which any restriction has been imposed by the applicable regulatory board or health care facility.

(26) The Nevada Supreme Court has expressly held that a cause of action for "professional negligence" against a physician or nurse is legally identical (at least for purposes of the affidavit requirement of NRS 41A.071) to a cause of action for "medical malpractice." *See, Flerle v. Peres*, 125 Nev. Adv. Op. 54 (2009).

(27) NRS 41A.017 defines "provider of health care" as follows:

> **NRS 41A.017 "Provider of health care" defined.** "Provider of health care" means a physician licensed under chapter 630 or 633 of NRS, dentist, licensed nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, or a licensed hospital and its employees.

(28) Thus, under Nevada's statutory scheme, to constitute a cause of action for medical malpractice or professional negligence that falls within the scope of NRS Chapter 41A and requires the submission of an expert affidavit, the Complaint must allege: (a) a negligent act or omission was committed (b) by a "provider of health care"

JEROME TAN
DISTRICT JUDGE
DEPARTMENT XX
LAS VEGAS, NEVADA 89155

as defined in NRS 41A.017, (c) "in the rendering of professional services," (d) which act or omission is the proximate cause of the injury or death. *See, Fierle v. Perez*, 125 Nev. Adv. Op. 54 (2009). In the present case, the parties appear to agree that the Complaint adequately alleges most of these elements, but disagree with respect to whether the Defendant's facility is a "provider of health care" as defined in NRS 41A.071.

(29) In connection with their Motion, the Defendant has supplied the Court with a copy of a license issued by the State of Nevada Department of Health and Human Services, Division of Health, Bureau of Licensure and Closure (attached to the Defendant's Reply Brief). In its November 8 Order, the Court noted that the license has not been properly authenticated by any affidavit, and it does not appear to be a certified copy of a public record but rather merely an informal photocopy. However, the Court accepted the authenticity of the license for purposes of resolving the present Motion. In their Supplemental briefing following the November 8 Order, the Plaintiffs make no attempt to challenge the authenticity of this document. Therefore, the Court finds that the Plaintiffs have waived any challenge to the document and deems it admissible for the Court's consideration for the limited purposes of resolving the present Motion.

(30) The document indicates that the Defendant's facility has been licensed by the State of Nevada as a "facility for skilled nursing" pursuant to Chapters 439 and 449 of the Nevada Revised Statutes and the Nevada Administrative Code. The Defendant's argument essentially is that, as a licensed "facility for skilled nursing," its facility is legally analogous to a "licensed hospital" as defined in NRS 41A.017 and therefore should be considered to fall within the scope of NRS Chapter 41A. Thus, the question before the Court is one of statutory interpretation, namely, whether NRS 41A.017 should be read to encompass a licensed "facility for skilled nursing."

(31) In interpreting the scope and meaning of a statute, the Court looks first to the words of the statute. If the Legislature has independently defined any word or phrase

contained within a statute, the Court must apply the definition created by the Legislature. If, and only if, the Court determines that the words of the statute are ambiguous when given their ordinary and plain meaning, then reference may be made to other sources such as the legislative history of the statute in order to clarify the ambiguity.

(32) In this case, several statutes are relevant to the Court's analysis. NRS 41A.017 defines "provider of health care" for purposes of Chapter 41A, including (among other things not relevant here) licensed physicians, licensed nurses, or a licensed hospital and its employees. NRS 449.0039 defines a "facility for skilled nursing." NRS 449.012 defines a "hospital."

(33) The Defendant asserts that the phrase "licensed hospital" as defined in NRS 41A.017 should be read broadly to encompass a "facility for skilled nursing." However, the Court notes that this interpretation appears to have been expressly rejected by the Nevada Legislature. The Nevada Legislature has defined a "hospital" as follows:

> **NRS 449.012 "Hospital" defined.** "Hospital" means an establishment for the diagnosis, care and treatment of human illness, including care available 24 hours each day from persons licensed to practice professional nursing who are under the direction of a physician, services of a medical laboratory and medical, radiological, dietary and pharmaceutical services.

(34) On its face, NRS 449.012 appears to exclude the Defendant's facility, which does not, among other things, operate under the direction of a physician and does not include the services of a medical laboratory. The Court particularly notes that NRS 41A.017 expressly refers not merely to a "hospital," but to a "licensed hospital." There is no dispute that the Defendant's facility is not "licensed" as a "hospital" pursuant to NRS Chapter 449 or any other provision of the NRS.

(35) Furthermore, NRS 449.0039 expressly states that a facility for skilled nursing "does not include a facility which meets the requirements of a general or any other special hospital":

NRS 449.0039 "Facility for skilled nursing" defined.

1. "Facility for skilled nursing" means an establishment which provides continuous skilled nursing and related care as prescribed by a physician to a 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.

2. "Facility for skilled nursing" does not include a facility which meets the requirements of a general or any other special hospital.

(36) As a matter of law, the Court must, whenever possible, interpret statutes in a manner such that they are meaningful and consistent with other statutes. Therefore, the Court concludes that NRS 41A.017 must be interpreted so that it expressly does not encompass a facility for skilled nursing as defined in NRS 449.0039.

(37) The Court notes that it is possible that the Legislature intended section 2 of NRS 449.0039 to draw a distinction between a "hospital" and a "facility for skilled nursing" only for licensing purposes, and not for purposes of tort liability. However, while this is an argument that perhaps can be made, the Court notes the absence of any specific language supporting it either in the text of the statutes or within their legislative history. Therefore, the Court concludes that the Legislature intended that the term "licensed hospital" as used in NRS 41A.017 cannot be read to include a facility licensed only for skilled nursing pursuant to NRS 449.0039.

(38) In its brief, the Defendant argues that Chapter 41A must be read broadly to give meaning to the intended purpose of the Legislature. In particular, the Defendant relies upon broad language contained in the case *Fierle v. Perez*, 125 Nev. Adv. Op. 54 (2009). However, the Court notes that, under well-settled principles of statutory interpretation, a statute's legislative history is only relevant if the text of the statute itself is unclear or ambiguous. In such cases, the legislative history of an enactment may be referenced in order to resolve the ambiguity. There does not appear to be any ambiguity between NRS 41A.107, NRS 449.021, and NRS 449.0039.

(39) Additionally, it is another well-settled principle of statutory construction that express statutory language cannot be read out of existence based upon general

statements of legislative intent. *See generally, Union General Life Ins. Co. v. Wernick*, 777 F.2d 499 (9th Cir. 1985) ("it is a fundamental rule of statutory construction that
777 F.2d 499 (9th Cir. 1985) ("it is a fundamental rule of statutory construction that
specific statutory language prevails over general provisions"). Thus, the fact that the Legislature may have intended to act broadly cannot justify ignoring the specific language that it actually chose to enact (or not to enact).

(40) Moreover, the Court has reviewed the legislative history of NRS Chapter 41A. Chapter 41A was enacted as Assembly Bill 1 in 2002 during a special session of the Legislature in order to address skyrocketing medical malpractice insurance premiums that were effectively forcing physicians to leave Nevada for other states. During consideration of the bill, numerous witnesses testified that the purpose of the bill was to ensure that Nevada citizens would continue to have affordable access to physicians and hospitals by lowering the insurance premiums that physicians and hospitals would have to pay. *See, for example*, Assembly Hearing on Medical Malpractice Issues, July 29, 2002 and July 30, 2002; Remarks made during session of the Senate Committee of the Whole, July 30, 2002.

(41) The Court notes that the legislative history specific to the affidavit provision is sparse. During the consideration of this provision, the focus of the Legislature was upon ensuring that the affidavit be provided by an expert in a field that was sufficiently closely related to the alleged malpractice. There was also some debate regarding whether dentists were included within the affidavit requirement, as well as upon possible revisions to the statute of limitations period. *See*, Assembly Hearing on Medical Malpractice Issues, July 30, 2002.

(42) During the legislative debate, there was no indication that the Legislature intended to expand the definition of "hospital" as defined in the NRS. There was also no indication that the Legislature intended Assembly Bill 1 to apply to non-hospital facilities which do not employ physicians, such as "facilities for skilled nursing" under

NRS 449.0039, which only employ nurses and other staff. Indeed, to the extent that the purpose of the bill was to ensure continued and affordable access to physicians and
purpose of the bill was to ensure continued and affordable access to physicians and
hospitals by reducing the insurance premiums paid by physicians and hospitals, the bill logically should not apply to non-hospital facilities which do not employ physicians and in which physicians do not provide care.

(43) Subsequent to its 2002 initial enactment, certain provisions of Chapter 41A were amended through an initiative petition enacted in 2004. As described by the Nevada Supreme Court, the 2004 amendments operated as follows: "In duplicating the definition of medical malpractice and expanding it to include nurses and other non-hospital employees, it is fair to assume that the people...wanted to extend the legislative shield that protects doctors from frivolous lawsuits and keep doctors practicing medicine in this state." *Fierle*, 125 Nev. Adv. Op. at ---. Relying upon this broad language, the Defendant asserts that it must have been the intent of the 2004 amendments to expand the scope of 41A.017 so broadly as to include its non-hospital facility.

(44) However, there is a considerable difference between expanding a statute to include non-hospital employees on the one hand, and expanding it to include non-hospital facilities on the other. One does not necessitate the other. More important, while it appears clear that the intent of the 2004 amendments was to achieve the former, there is no indication that the voters intended the latter. The 2004 amendments simply did not change the actual language of either NRS 41A.107, NRS 449.021, or NRS 449.0039 in any manner that would make this interpretation tenable.

(45) NRS 41A.017 was expressly amended in 2004 to include nurses and other practitioners such as chiropractors, Doctors of Oriental Medicine, physical therapists, and the like. Notably, the definition of "licensed hospital" was not amended or expanded in any way. In reviewing a statutory amendment, the Court must consider not only what was changed, but also what the voters chose not to change. If the Legislature (or the

voters) chose to leave a portion of a statute alone while changing other portions, that choice must be deemed to have been intentional. Therefore, the 2004 amendments must choice must be deemed to have been intentional. Therefore, the 2004 amendments must be interpreted such that the voters specifically chose not to expand the definition of "licensed hospital." Furthermore, the express words of a statute cannot be read in a manner inconsistent with their plain meaning simply because one party asserts that the Legislature or the voters may have subjectively intended something else. Where the words of the statute are clear, as they are here, the legislative history is of little importance.

(46) Therefore, the Court finds that, based both upon the plain language of the statute as well as the legislative history (to the extent relevant), NRS 41A.017 does not encompass a "facility for skilled nursing" as defined in NRS 449.0039.

(47) However, the Court notes that the analysis does not end there. In its November 8 Order, the Court requested additional briefing regarding two issues. The Court noted that an expert affidavit might nevertheless be required if (a) the acts or omissions at issue were committed by licensed nurses or physicians, who are expressly included within the scope of NRS 41A.017, and (b) if the affidavit requirement also applies, as a matter of law, to claims asserted against the facility that employed those nurses or physicians under principles of vicarious liability.

(48) Although neither party originally raised this issue, the Court notes that NRS 41A.017 expressly defines "provider of health care" to include "licensed nurses." As noted above, NRS 449.0039 defines "facility for skilled nursing" as a facility which provides continuous "skilled nursing and related care as prescribed by a physician to a patient in the facility...." Thus, NRS 449.0039 expressly contemplates that a "facility for skilled nursing" may employ both nurses and non-nurses and may offer care rendered by nurses and well as services that are not required to be rendered by a licensed nurse ("related care").

(49) Therefore, in this case, it is possible that the Plaintiffs' Complaint is based upon care that was required to be rendered to the decedent in the Defendant's facility by a licensed nurse. If so, then it appears to the Court that the Complaint asserts an underlying cause of action against a "provider of health care" expressly recognized in NRS 41A.017.

(50) The Court notes that a potential ambiguity exists in that NRS 449.0039 incorporates the term "skilled nurse" while NRS 41A.017 applies to "licensed nurses." The Court notes that NRS Chapter 449 contains a definition of "registered nurse" but does not independently define the term "skilled nurse." Indeed, the phrase "skilled nurse" appears nowhere else within NRS Chapter 449. However, because nurses must be licensed in order to render patient care (whether they are skilled or not), the Court finds that this potential dilemma is easily resolved since a "skilled nurse" under NRS 449.0039 must also be a nurse that is licensed by the appropriate state boards and agencies. Therefore, for purposes of this Motion, the phrase "skilled nurse" and "licensed nurse" are legally equivalent and may be used interchangeably.

(51) In any event, as the Court has noted, to the extent that liability in this case is premised upon any act or omission by a licensed nurse, then those allegations would arguably fall within the scope of NRS 41A.017 and an expert affidavit would be required.

(52) The Court notes that the Plaintiffs' Complaint does not assert causes of action against the individual employees who were responsible for rendering care to the decedent. Rather, only the facility itself is named as a defendant, under a theory of vicarious liability. However, if the Complaint had asserted individual causes of action against individual licensed nurses, then the Complaint would have been void *ab initio* pursuant to NRS Chapter 41A at least with respect to those individual tortfeasors. If the underlying allegations of negligence are void *ab initio*, then a question exists regarding

whether the allegations of vicarious liability against a third-party defendant could legally stand on their own.

(53) Therefore, the next question before the Court is whether the acts or omissions at issue were actually committed by licensed nurses or physicians. If so, then the analysis turns to whether NRS 41A.071 applies to claims asserted vicariously against the facility but not against those nurses.

(54) As noted hereinabove, the Complaint in this case is pled very generally. The Complaint at hand does not incorporate the words "malpractice" or "professional negligence," and it does not expressly assert any claims against individual nurses or physicians. Instead, it generally avers that the Defendant was liable because it employed people who acted negligently (paragraph VII, Defendants "were negligent through their officers, agents, servants and employees") and because the decedent's injuries occurred on the premises owned by the Defendant (paragraph VI, decedent "was lawfully on the aforementioned property").

(55) NRS 41A was drafted in response to what was perceived as a legislative emergency. Therefore, the Court deems that its provisions are directed toward practical reality rather than legal technicalities. Accordingly, even if a Complaint does not expressly contain the exact words "medical malpractice" or "professional negligence," the provisions of NRS 41A.017 and 41A.071 would still apply if, as a matter of practical reality rather than artful pleading, it asserts a cause of action that in actuality is premised on medical malpractice. In other words, if a Complaint asserts a negligent act or omission that involves the exercise of professional medical judgment by a licensed nurse or physician (or another medical professional listed in the statute), then NRS 41A would apply regardless of whatever words are actually stated in the Complaint. Thus, the Court's inquiry is not limited to the words used in the Complaint, but rather looks to the substantive reality behind the allegations asserted therein.

(56) In the present case, the Defendant has supplied medical records and copies of Responses to Interrogatories which they assert add detail to the allegations of the of Responses to Interrogatories which they assert add detail to the allegations of the Complaint and demonstrate that the acts/omissions listed in the Complaint actually fall within the scope of NRS 41A.017.

(57) For example, Defendant's Interrogatory No. 13 asked the Plaintiff to describe in detail the injuries, complaints and symptoms which the decedent suffered as a result of the incident out of which this action arose. The Plaintiffs' Response to Interrogatory No. 13 recites instances of alleged professional negligence committed by nurses and physicians. Some of these allegations are quoted verbatim hereinabove at paragraph 9, supra. Included were such allegations as the improper or excessive administration of prescription drugs (such as Remeron and Neurontin), the failure to diagnose or treat a stage III decubitis ulcer, and the failure to administer oxygen.

(58) Moreover, these assertions closely match allegations specifically contained in the Complaint. For example, the Complaint alleges a failure "to properly inspect" the decedent and "to warn Plaintiffs of a dangerous condition," which appear to allege that the physicians and nurses failed to apprise the decedent of the development of the stage III decubitis ulcer that eventually led to his death. Similarly, the Complaint also alleges that the Defendant permitted the decedent to remain in a dangerous and unsafe condition, which appears to allege that the Defendant failed to diagnose and treat that stage III decubitis ulcer before it became infected and killed him.

(59) These allegations unquestionably involve the exercise of professional judgment by nurses and physicians. Indeed, the persons alleged to have committed those acts are specifically identified as Dr. Craig Jorgensen (a physician) and the "charge nurse."

(60) The Court notes that the Plaintiffs' discovery responses appear to allege a variety of different kinds of negligence, some of which appear to fall within the scope of

medical malpractice and some of which do not. For example, the discovery responses include allegations of negligence in the performance of relatively menial activities, such include allegations of negligence in the performance of relatively menial activities, such as the failure to use clean gloves, to turn the decedent regularly, or to clean his diapers appropriately. As the Plaintiffs note, at least some of these allegations relate to relatively menial or mechanical acts which at least arguably do not involve the exercise of professional medical judgment by physicians or nurses.

(61) However, the Complaint asserts only one cause of action, for general negligence, and only one defendant is named. Furthermore, in reviewing the discovery responses and the description of the case contained in the Plaintiffs' briefing, it appears that these relatively menial errors are not alleged to be the proximate cause of the decedent's death. According to the Plaintiffs' own assertions, while the failure to use clean gloves, to turn the decedent properly, or clean his diapers regularly eventually caused him to develop ulcers, there was no assertion that those acts were, in and of themselves, fatal. Rather, they appear to have been far less proximate along the chain of causation than (or they are at least equal with) the alleged over-use of sedatives and the subsequent failure to diagnose or treat those ulcers before they became infected. The Court notes that improper administration of prescription drugs and the alleged failure to diagnose and treat a medical condition are acts that unequivocally fall within the scope of medical malpractice. Thus, in this case, the acts/omissions that might not have been committed by medical professionals are inextricably interfwined in the chain of causation with acts/omissions that were necessarily performed by physicians and nurses which necessarily constitutes professional negligence.

(62) Because the various allegations of negligence are factually intertwined and furthermore are not separated into different counts or against different defendants, the Court can see no logical way to separate the allegations of malpractice from the allegations that are non-professional in nature. Because only one cause of action has

been asserted, it appears to the Court that all of the allegations must be treated as one for purposes of determining whether the Complaint requires the support of an affidavit pursuant to NRS 41A.071.

(63) In short, the Court finds that the Plaintiffs' Complaint alleges instances of medical malpractice against physicians and nurses who indisputably fall within the statutory definition of "providers of health care." These allegations would normally require the support of an expert affidavit pursuant to NRS 41A.071 if the claims had been asserted individually against those physicians and nurses.

(64) However, as noted, the instant Complaint does not actually assert claims against any individual nurses or physicians. Rather, it only asserts a cause of action in negligence against the facility which employed those physicians and nurses and where the acts/omissions occurred. Thus, the next question is whether the provisions of NRS 41A would apply to such a cause of action against the employer instead of the individual actors.

(65) As noted, NRS Chapter 41A was enacted in response to a public policy crisis in an attempt to keep physicians practicing in Nevada by reducing their medical malpractice insurance premiums and limiting frivolous lawsuits against them. The Defendant argues that NRS 41A should be construed generously in order to effectuate that broad legislative purpose.

(66) As noted hereinabove, this Court found that NRS 41A did not encompass "facilities for skilled nursing" because such facilities appeared to be expressly excluded by statute. Statements of general legislative purpose or intent cannot supersede the express language enacted within the statute.

(67) However, the Court can find no such specific exclusion for claims brought vicariously against employers of physicians and nurses. In the absence of such express language, then an ambiguity exists regarding the scope of the statute. When such an

ambiguity exists, then the legislative intent plays a larger role in determining the scope of the statutory language.

(68) It appears logical to the Court that the fundamental legislative purposes of NRS Chapter 41A would be defeated if a plaintiff could circumvent the affidavit requirement by simply omitting the physicians or nurses who actually committed the malpractice from the complaint and yet lodge the very same allegations vicariously against the employer of those physicians and nurses. In most cases, the employer would likely respond by filing a third-party claim for indemnity or contribution against those doctors or nurses, with the practical result that those doctors and nurses would end up as defendants in the lawsuit without any affidavit ever having been filed by the plaintiff. Such a result would be absurd and illogical and would provide a considerable loophole through which a plaintiff could easily circumvent both the letter and spirit of the affidavit requirement. As the Supreme Court noted in *Fierle*, courts must consider "the policy and spirit of the law and will seek to avoid an interpretation that leads to an absurd result." 125 Nev. Adv. Op. at ---.

(69) Furthermore, this situation appears to be akin to that considered by the Nevada Supreme Court in *Fierle v. Perez*, 125 Nev. Adv. Op. 54 (2009). In that case, the Court held that NRS 41A applied to professional medical corporations even though such professional medical corporations were not named anywhere within the statute. The Court found that omitting such corporations would create an illogical result that would allow plaintiffs to circumvent the affidavit requirement. The same logic appears to apply to claims asserted vicariously against the employers of physicians and nurses.

(70) The Court notes that a possible exception to this principle might exist if such an employer were alleged to be liable on grounds that are legally independent of any negligence committed by the nurse or physician employed by them. For example, an employer may be liable for negligent hiring, training, or supervision of doctors or

nurses, but that question is not before this Court and therefore need not be addressed within this Order.

(71) As a final matter, the Court wishes to state that, by this result, it is expressly not condoning the actions or behavior of any of the nurses or physicians identified in the discovery responses. If the Plaintiffs' allegations are true, then the decedent suffered both terribly and unjustly, and the last days of his life were tragically darkened and cut short by the carelessness of medical professionals who should have done much, much more to relieve his suffering. There is no way to know, but it is possible that Mr. Ferhat might still be alive today but for what is alleged to have occurred in this case.

(72) Nonetheless, the Legislature has made the fundamental policy decision that judicial complaints asserting medical malpractice must be accompanied by an expert affidavit or be dismissed. This Court is well aware that the statute of limitations period for filing a new complaint against the Defendant may have already expired. This Court is bound to apply the law even when the result is distasteful to the Court.

(73) Therefore, the Court concludes that the allegations of the Plaintiffs' Complaint fall within the scope of NRS 41A.017 and 41A.071. Since no expert affidavit accompanied the Complaint as required by NRS 41A.071, the Complaint must be dismissed without prejudice.

(74) The Defendant's Motion is therefore GRANTED and the Complaint is hereby DISMISSED without prejudice against re-filing with the support of an expert affidavit as required by NRS 41A.071.

DATED: December 19, 2011

JEROME T. TAO
DISTRICT COURT JUDGE

JEROME TAO
DISTRICT JUDGE
DEPARTMENT XX
LAS VEGAS, NEVADA 89155

CERTIFICATE OF SERVICE

I hereby certify that I served a copy of the foregoing, by placing copies in the attorney folder's in the Clerk's Office or faxing as follows:

Victor Lee Miller, Esq. - Via Facsimile: 877-0487
Brent S. Vogel, Esq. - Via Facsimile: 893-3789

Paula Walsh

Paula Walsh, Executive Assistant

JERIMIE TAO
DISTRICT JUDGE
DEPARTMENT XX
LAS VEGAS, NEVADA 89155

EXHIBIT E

A533914

IN THE SUPREME COURT OF THE STATE OF NEVADA

JULIO GARCIA, M.D., F.A.C.S.; AND JULIO GARCIA, M.D., LTD., A NEVADA CORPORATION,
Petitioners,
vs.
THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK; AND THE HONORABLE RON ISRAEL, DISTRICT JUDGE,
Respondents,
and
YESENIA "JESSIE" ALVAREZ,
Real Party in Interest.

No. 58686

FILED

NOV 22 2011

TRACIE K. LINDEMAN
CLERK OF SUPREME COURT
BY
DEPUTY CLERK

ORDER GRANTING PETITION FOR WRIT OF MANDAMUS

This original petition for a writ of mandamus challenges a district court order denying petitioners' motion for summary judgment and granting real party in interest's countermotion to reinstate previously dismissed claims.

Real party in interest, Yesenia Alvarez, was employed as an aesthetician in the office of petitioner Dr. Julio Garcia, a plastic surgeon. As part of Alvarez's compensation she received two free liposuction procedures from Dr. Garcia on August 28, 2002, and July 2, 2003. Alvarez alleges that during the second of these procedures, Dr. Garcia injected her breasts with saline without her consent. Dr. Garcia admits that he injected Alvarez's breasts with saline, but contends that the injections took place during the first procedure.[1]

[1]In her original and first amended complaints, Alvarez alleged that the saline injections occurred during the first procedure, on August 28, 2002, but she alleges in her second amended complaint that the injections took place during the second procedure, on July 2, 2003.

Alvarez admits that she became aware of the saline injections immediately upon waking after the procedure, and was aware at least within days after the procedure that Dr. Garcia had shown her breasts to other employees while she was still under sedation. Alvarez testified at deposition on January 4, 2005, in a previous, unrelated action between the parties, that as of that date she had knowledge of all of her causes of action against Dr. Garcia related to the injections. Alvarez filed her complaint in this case on January 4, 2007, more than three and a half years after she alleges the injections took place and two years after her deposition in the unrelated action.

Alvarez alleged 15 causes of action against Dr. Garcia: medical malpractice/negligence, medical malpractice/negligence per se, negligence-res ispa loquitur, breach of contract, contractual and tortious breach of implied covenant of good faith and fair dealing, civil assault, civil battery, negligent/intentional infliction of emotional distress, fraudulent concealment, unreasonable intrusion upon seclusion of plaintiff, unreasonable publicity given to private facts, negligent misrepresentation, fraudulent concealment, breach of fiduciary duty, and declaratory relief. On May 17, 2007, the district court dismissed all of Alvarez's causes of action other than her two breach of contract and the declaratory relief causes of action. On January 18, 2011, Dr. Garcia filed a motion for summary judgment on Alvarez's remaining causes of action, arguing that her breach of contract claims were really tort claims that were time-barred. Alvarez opposed the motion and filed a countermotion for summary judgment regarding the same causes of action as well as a countermotion to reinstate all of her previously dismissed causes of action. The district court denied both the motion and countermotion for summary judgment, but granted Alvarez's motion to reinstate her previously dismissed causes of action. Dr. Garcia challenges the denial of his motion

for summary judgment and the grant of Alvarez's countermotion to reinstate previously dismissed claims in his petition.

A writ of mandamus is available to compel the performance of an act that the law requires or to control an arbitrary or capricious exercise of discretion. International Game Tech. v. Dist. Ct., 124 Nev. 193, 197, 179 P.3d 556, 558 (2008). A writ of mandamus is an extraordinary remedy, and whether a petition for extraordinary relief will be considered is solely within this court's discretion. See Smith v. District Court, 107 Nev. 674, 677, 818 P.2d 849, 851 (1991). The right to appeal following a final judgment generally constitutes an adequate legal remedy, precluding writ relief. International Game Tech., 124 Nev. at 197, 179 P.3d at 558. When a case is in the early stages of litigation, however, and judicial economy and administration are taken into consideration, an appeal is not always an adequate remedy, making writ relief appropriate. Id. at 198, 179 P.3d at 559. Although we generally will not exercise our discretion to consider mandamus petitions that challenge district court orders denying summary judgment, an exception to this general rule exists when judgment in petitioners' favor is clearly required by statute. Smith v. District Court, 113 Nev. 1343, 1344-45, 950 P.2d 280, 281 (1997). Here, having considered the writ petition, answer, and reply, as well as the supporting documents, we conclude that our intervention by way of mandamus is warranted and we grant the petition.

Alvarez's motion to reinstate previously dismissed claims

Our review of the petition, answer, and supporting documents, including the hearing transcript, shows that the district court erred in granting Alvarez's motion to reinstate her previously dismissed claims, as neither the hearing transcript nor the district court order provided any legal basis to reinstate the claims. Alvarez asserted in her countermotion that the statute of limitations for her claims were tolled by her cause of

action for fraudulent concealment. A fraudulent concealment defense, however, requires a showing both that Dr. Garcia used fraudulent means to keep Alvarez unaware of her cause of action and that Alvarez was, in fact, ignorant of the existence of her cause of action. Wood v. Santa Barbara Chamber of Commerce, Inc., 705 F.2d 1515, 1521 (9th Cir. 1983). The record here shows that Alvarez was aware of Dr. Garcia's actions upon waking from her surgery; therefore, the fraudulent concealment doctrine is not applicable to toll the statute of limitations for any of her claims. Id.

Dr. Garcia's motion for summary judgment

The district court also was required to grant Garcia's motion for summary judgment. Alvarez alleged claims for breach of contract and breach of the implied covenant of good faith and fair dealing; however, the basis for her claims are the saline injections that are also the basis for her tort claims. Alvarez argues that the informed consent form that she signed, but that Dr. Garcia did not sign, was a contract for her liposuction procedure. Dr. Garcia asserts that Alvarez's contract actions are in fact tort claims and the tort statute of limitation should be applied to them.

In determining whether an action is on a contract or in tort, this court looks at the nature of the grievance to determine the character of the action, not the form of the pleadings. State Farm Mut. Auto. Ins. v. Wharton, 88 Nev. 183, 186, 495 P.3d 359, 361 (1972). "'It is settled that an action against a doctor arising out of his negligent treatment of a patient is an action sounding in tort and not one based upon a contract.'" Christ v. Lipsitz, 160 Cal. Rptr. 498, 501 (Ct. App. 1979) (quoting Bellah v. Greenson, 146 Cal. Rptr. 535, 542 (Ct. App. 1978)). Accordingly, Alvarez's breach of contract claims sound in tort, and are subject to a two-year statute of limitation. NRS 11.190(4)(e). Since Alvarez was aware of Dr.

Garcia's actions upon waking from her procedure in 2003, her claims, which were not brought until 2007, are time-barred.

As Alvarez has no remaining causes of action that were brought timely, her declaratory relief claim must be dismissed. Builders Ass'n v. City of Reno, 105 Nev. 368, 369, 776 P.2d 1234, 1234 (1989) (holding that "[t]he Uniform Declaratory Judgments Act does not establish a new cause of action or grant jurisdiction to the court when it would not otherwise exist"). Accordingly, we

ORDER the petition GRANTED AND DIRECT THE CLERK OF THIS COURT TO ISSUE A WRIT OF MANDAMUS instructing the district court to vacate its order granting Alvarez's countermotion to reinstate previously dismissed claims and to grant petitioners' motion for summary judgment.[2]

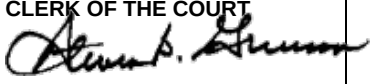
_____, C.J.
Saitta

_____, J.
Douglas

_____, J.
Hardesty

cc: Hon. Ron Israel, District Judge
Lewis Brisbois Bisgaard & Smith, LLP/Las Vegas
Bowen Law Offices
Eighth District Court Clerk ✓

[2]In light of this decision, we vacate the stay imposed by our September 15, 2011, order.



MOT
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

* * *

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 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, Defendants.	CASE NO. A-17-750520-C DEPT NO. XVII Consolidated with: CASE NO. A-17-754013-C **PLAINTIFFS' MOTION FOR PRIMA FACIE CLAIM FOR PUNITIVE DAMAGES**
Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually, 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' MOTION FOR PRIMA FACIE CLAIM FOR PUNITIVE DAMAGES

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 move for an order that the jury will be permitted to consider awarding punitive damages. This motion is brought under Rule 56(c) and is supported by the following memorandum of points and authorities, the appendix of exhibits filed herewith, and any argument presented at the time of hearing.

DATED this 21st day of September, 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

NOTICE OF MOTION

PLEASE TAKE NOTICE that the undersigned will bring the foregoing Motion on for hearing on the 24th day of October, 2018, in Department XVII of the above-entitled Court at the hour of In Chambers.m., or as soon thereafter as counsel may be heard.

DATED this 21st day of September, 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.

If a plaintiff adduces sufficient evidence that a defendant had knowledge of the probable harmful consequences of a wrongful act yet failed to act to avoid those consequences then the issue of punitive damages is for the jury. Laura herein adduces sufficient evidence (1) that Defendants knew that LCCPV had insufficient staff; knew that that insufficiency was compromising resident care; knew that a nurse had erroneously given Mary a potentially fatal dose of morphine; and knew that Mary needed to be closely monitored for signs of morphine overdose; and (2) that Defendants nevertheless ignored her, leaving her to decline unnoticed and to be found unresponsive by her daughter, by which time it was too late to salvage her life. She died of morphine intoxication a few days later. Is the issue of punitive damages for the jury?

II. STATEMENT OF FACTS.

Mary's Condition on Entering LCCPV

1. Mary Curtis had been living alone in an apartment; she could dress, bathe, cook,

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

clean, and do laundry without difficulty, and used a cane for ambulation around the apartment. Ex. 1, Photo; Ex. 2, OT Plan of Tx.

2. Mary entered Life Care Center of Paradise Valley on 2 March 2016 following hospitalization after a fall at her apartment. Ex. 3, Prog. Notes LCC-133; Ex. 4, Disch. Summ.; Ex. 5, Floor Plan.

3. She was alert with clear speech and regular respiration. Ex. 6, Nursing Assess. LCC-113.

4. She required extensive assistance with her activities of daily living, including bed mobility, transfers, locomotion, and toilet use. Ex. 7, MDS Sect. G LCC-86.

5. Her balance during transitions and walking was not steady and she could stabilize only with staff assistance. Ex. 7, MDS Sect. G LCC-87.

6. She had no condition or disease such as would have resulted in a life expectancy of under six months. Ex. 7, MDS Sect. J LCC-92.

7. On 3 March Mary was friendly and "concerned about leaving our facility, wanting to go back home." Ex. 8, Chatman Dep. 17:3–10.

Mary's First Days at LCCPV

8. Mary on 3 March was found lying on the floor in the bathroom, and reported that she had got out of bed to use the bathroom, lost her balance, fell, and hit her head on the wall. Ex. 9, LCC Fall Incident Rpt-00001; Ex. 3, Prog. Notes LCC-133.

9. Her blood pressure after her fall was 165/75. Ex. 9, LCC Fall Incident Rpt-00002.

10. Actions taken post-fall were to continue falling star intervention, tab alarm, bed in lowest position, and non-skid socks. *Id.* at -00003.

11. Mary's gait was unsteady; she was incontinent; her toileting program was prompted voiding. *Id.* at -00004.

12. Alert charting was initiated; interventions in place upon Mary's fall were tab alarm and fall risk bracelet; thereafter were to be in place tab alarm and bed in lowest position. *Id.* at -00005.

13. Mary had fallen within the last 30 days; a bed alarm had been in place. *Id.* at -

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

00004.

14. She had a right leg bruise of 5 x 7 cm and a left leg bruise of 15 x 7 cm. Ex. 10, Non-Pressure Skin Condition R. LCC-138, -142.

15. She should not have been left unattended in the bathroom. Ex. 11, Ramos Dep. 46:7–18.

16. LCCPV created an interim care plan on 3 March for Mary's being "[a]t risk for physical injury from falls"; her fall risk score was 22; the sole intervention identified was to educate resident/family (on what was left unidentified). Ex. 12, Interim Care Plan LCC-126.

17. On 4 March Mary was alert and verbally responsive with no ill effects from the fall recorded. Ex. 3, Prog. Notes LCC-133.

18. Mary fell on 6 March. Ex. 13, LCC Dawson Stmt-00001.

19. There was not but should have been an incident report for Mary's second fall; that fall should have been documented in the clinical record. Ex. 8, Chatman Dep. 16:6–17:2; Ex. 14, Werago Dep. 18:22–19:16.

20. DON Tessie Hecht told LPN Ershiela Dawson that Mary's second fall was not recorded because it was just on the word of the roommate. Ex. 15, Dawson Dep. 87:1–6.

21. LCCPV failed to complete the MDS section concerning Mary's falls. Ex. 7, MDS Sect. J LCC-93.

Mary's Last Days at LCCPV

22. LPN Ersheila Dawson was assigned to Mary only on 7 March and knew neither her nor her care needs. Ex. 15, Dawson Dep. 10:6–12.

23. Nurse Dawson, who had been called in that morning because LCCPV was short a nurse, felt a bit behind the eight-ball, as normally the shift would have begun at 7:00 a.m. but she did not arrive until 8:00 or 9:00 a.m.—the normal time for the morning medication pass, which requires significant preparatory work. *Id.* at 10:18–24; 11:20–12:22; 14:19–23.

24. She testified that "[t]hat morning was very chaotic . . . . I was urged to take care of these three persons immediately. I started in order and then [ADON] Thelma [Olea] came back to me and reiterated that I needed to get these three people done." *Id.* at 42:13–17.

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

25. Nurse Dawson testified that she had no opportunity to review Mary's clinical record before providing her medication. *Id.* at 37:12–25.

26. She testified that she did check the medication administration record but that her cart was out of order, and that "the meds that were in the narc box were out of order also, because I had taken meds from two different nurses and they weren't going to match. . . . So I put it in order the best way that I knew how." *Id.* at 48:18–23; 49:19–24.

27. She then, according to her testimony, "got reprimanded again to take care of these three people. And so at that point, I want to get these three people taken care of, so that that can get back into the flow of regular med pass." *Id.* at 50:21–23.

28. At approximately 10:00 a.m. Nurse Dawson popped out two pills, crushed them, put them in applesauce, and gave them to Mary. Ex. 16, LCC Med Incident Rpt-00001; Ex. 17, Dawson Emp File-00104.

29. She then went to room 312A and began looking for the medications for that room's resident, at which point she realized that she had given 312A's morphine to Mary. Ex. 17, Dawson Emp File-00104.

30. Nurse Dawson then realized that Mary had been given the wrong medication; that it was morphine; that it was a significant dose (120 milligrams); and that without action that dose could be fatal. Ex. 15, Dawson Dep. 59:16–60:10.

31. Nurse Dawson "said that 'I did not read the name in the medication package, did not double check the MAR, and was my first time to be in 300 hall and did not know the patients.'" Ex. 17, Dawson Emp File-00104.

32. Nurse Dawson testified that she "really just messed this up. It was unbelievable. I was very concerned. I was overwhelmed that I may have had harmed somebody. So, yeah, I was pretty upset too." Ex. 15, Dawson Dep. 65:7–11.

33. According to Nurse Dawson's employee file documentation, at this point she reported her error to ADON Olea, who told her to call the physician, who (not the physician Dr. Samir Saxena but Nurse Practitioner Annabelle Socaoco) ordered that Narcan be administered. Ex. 17, Dawson Emp File-00104.

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

34. Nurse Dawson testified that she asked Nurse Socaoco whether she should prepare to send Mary out because of the high dose of morphine and was told no; that because she did not know Mary's baseline or how morphine would affect Mary her "thought process would have been to send her out"; and that she expected that Mary would be sent to the hospital: "With that much morphine, yeah, I . . . thought that we would send her out." *Id.* at 78:4–18; 137:11–22.

35. Nurse Dawson testified that she reported as follows to Nurse Socaoco: "Hey, I just fucked up, and I just gave this lady 120 milligrams of morphine. What am I going to do?" *Id.* at 115:22–116:8.

36. DON Hecht, with whom Nurse Dawson spoke before leaving for the day, told her that "She'll be fine" and that "It happens." *Id.* at 84:20–22; 86:8–17.

37. Nurse Dawson informed ADON Olea of Mary's narcotic overdose at around noon; ADON Olea did not know how much or when it was given, nor did she know what Mary's baseline was. Ex. 18, Olea Dep. 52:12–16; 53:3–13.

38. ADON Olea became upset when she was told that Mary had been given the wrong medication, one reason for which is that she was just made aware of it shortly before noon. *Id.* at 47:8–20; Ex. 19, Sansome Dep. 106:3–6.

39. ADON Olea could see that Mary was nauseated. Ex. 18, Olea Dep. 53:19.

40. ADON Olea did not know that the medication was morphine (only that it was a narcotic), when it was given to Mary, how much was given, or whether it was short- or long-acting (although that would make a difference in how a resident is affected). *Id.* at 54:17–55:2; 57:5–17.

41. ADON Olea testified that Nurse Dawson did not tell her that Mary's blood pressure after the incident was 170/78. *Id.* at 66:1–6.

42. ADON Olea did not take Mary's vitals when she checked on her, nor was she aware of Mary's ongoing high blood pressures, or that she was nauseated and vomiting. *Id.* at 66:13–25.

43. The adverse reaction noted for Mary post-morphine was increased blood pressure and lethargy. *Id.* at 74:16–75:2.

44. ADON Olea asked herself how in the world 120 milligrams of morphine could have been given to Mary. *Id.* at 49:10–22.

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

45. When RN Cecilia Sansome came on shift at noon, ADON Olea informed her about Mary's situation; Nurse Sansome asked if the physician had been notified and was told no; ADON Olea then asked her to call and get an order. Ex. 19, Sansome Dep. 18:3–7; 45:25–46:9.

46. Nurse Sansome was asking herself how in the world this could have happened, especially with all the procedures in place to prevent it. *Id.* at 54:19–55:1.

47. ADON Olea did not assess Mary before Nurse Sansome arrived. *Id.* at 59:7–12.

48. At 1:00 p.m. Nurse Socaoco ordered that Mary receive 0.4 mg of Narcan once with repetition allowed in three minutes; also, staff was to monitor Mary's vital signs every four hours and to call the nurse practitioner with any changes. Ex. 20, Tel. Orders LLC-52.

49. Nurse Socaoco became aware of Mary's overdose when Nurse Sansome called her around noon: she does not recall Nurse Dawson's speaking to her at 10:30 a.m. regarding Mary's situation and believes given the situation's gravity that if Nurse Dawson had done so she would recall it. Ex. 21, Socaoco Dep. 34:24–35:1; 36:8–20.

50. Nurse Sansome gave Mary Narcan at 1:29 p.m. and (as Mary was still groggy) again at 1:32 p.m., then assumed her regular duties as admitting nurse. Ex. 19, Sansome Dep. 63:13–15; 64:8–10; 106:7–15.

51. Nurse Sansome was not made aware that the drug was morphine, how much of it was given, whether it was extended release, or whether it had been crushed; neither did she know that Mary was vomiting. *Id.* at 62:11–63:8; 67:2–9.

52. When Mary's daughter Laura Latrenta arrived at around noon, a nurse told her, "You're not going to be smiling when we tell you what happened"; the nurse told her that Mary had been given the wrong medication and that "you're going to have your mother back in six hours"; Laura stayed with her mother until approximately 2:30 p.m. Ex. 22, Latrenta Dep. 50:1–13; 109:5–16.

53. Staff was to continue to monitor Mary overnight, with vital signs taken every fifteen minutes for one hour and then every four hours; Mary's blood pressure had risen that afternoon, measuring 177/46. Ex. 23, Post Acute Prog. Note LCC-61.

54. Mary was alert and verbally responsive with confusion at 5:00 p.m. on 7 March;

vital signs monitoring was to continue. Ex. 3, Prog. Notes LCC-132.

55. Occupational therapy was withheld on 7 March per nursing and was withheld on 8 March because of a change in Mary's medical status. Ex. 24, OT Daily Tx. Note.

56. Physical therapy on 8 March withheld Mary's therapy owing to her change in status; PT had been unable to arouse her that day despite multiple attempts; nursing was notified. Ex. 25, PT Daily Tx. Note.

57. Laura returned to LCCPV on 8 March at around 11:00 a.m. and found her mother unresponsive; Mary's roommate told Laura that "your mom has been out of it. No one has come to check her all day." Ex. 22, Latrenta Dep. 70:22–71:9.

58. Laura then took out her phone and videoed her mother in her unresponsive state and herself trying to wake her. *Id.* at 71:14–25.

59. Mary's mouth was open; her tongue was sticking out; her eyes were rolling in the back of her head. *Id.* at 71:25–72:8.

60. Laura hurried to the nurses' station and told them that there was something wrong with her mother; the attendant replied that there was nobody on the floor but that she would get someone; Laura then ran back to her mother and, seeing someone walk by, told her that she needed to come into her mother's room; she responded, "In a minute." *Id.* at 72:22–73:5.

61. Laura then began screaming that someone needed to come in now; this produced the desired staff response. *Id.* at 73:5–11.

Mary's Last Days

62. According to a nursing note of 11:47 a.m., at 11:00 a.m. on 8 March Laura called DON Hecht into Mary's room, where she found Mary with oxygen saturation showing 84%, desaturating 77%. Ex. 3, Prog. Notes LCC-132.

63. EMS was called at 11:19 a.m. and arrived to find Mary "[u]nconscious but wakes to verbal stimuli, nonverbal and does not follow commands"; she was neither alert nor oriented; her Glasgow Coma Scale total was 11; she had "decreased respiratory effort and rate"; Laura informed EMS that she "attempted to have facility staff assess patient but no staff would come to room for appx 5-10 min." Ex. 26, EMS Report.

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

64. Mary was transferred non-responsive out of LCCPV with an order reading "Transfer 911 – respiratory distress." Ex. 29, Transfer Form LCC-3; Ex. 20, Tel. Orders LCC-53.

65. At 11:30 a.m. on 8 March LCCPV recorded that Mary had decreased level of consciousness, decreased mobility, and labored or rapid breathing; she was full code. Ex. 27, SBAR Commc'n Form LCC-54, -55.

66. DON Hecht does not know for how long Mary had been unarousable before she called 911. Ex. 28, Hecht Dep. 91:17–22.

67. Mary's presentation was completely different on 6 March from her presentation on 8 March. Ex. 28, Hecht Dep. 90:2–91:16.

68. Mary was admitted to Sunrise Hospital with altered mental status and was "[o]verdosed with morphine." Ex. 30, Sunrise Hosp. & Med. Ctr. H&P.

69. She was started on a Narcan drip and IV fluid, but became more unresponsive and her creatinine increased to 3.9; she also developed respiratory failure owing to altered mental status and COPD exacerbation. Ex. 31, Sunrise Hosp. & Med. Ctr. Disch. Summ.

70. On 9 March Mary was on BIPAP and was somnolent, opening her eyes only to painful stimuli. Ex. 32, Neuro. Consult. 1 of 7.

71. She was lethargic, sedated, and in no acute distress; she did not follow commands; her altered mental status was "[d]ifficult to evaluate due to decreased level of consciousness." *Id.* at 3 of 7.

72. Mary's physician talked to Laura "regarding gravity of situation and that in order to reverse situation there would need to be heroic efforts including likely intubation and mechanical ventilation, dialysis and multiple IV medications"; she "[d]iscussed decreased likelihood of patient being extubated given advanced age and history of COPD as well as no guarantee that patient would survive and likely low quality of life if she did survive." *Id.* at 6 of 7.

73. Mary "had not wanted heroic life efforts including life support and CPR." *Id.*

74. Mary was discharged from Sunrise Hospital on 11 March; her discharge diagnoses included altered mental status due to overdose, opiate overdose, and acute respiratory failure with hypercapnia secondary to narcotic overdose. Ex. 31, Sunrise Hosp. & Med. Ctr. Disch. Summ.

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

75. Mary died on 11 March at Nathan Adelson Hospice. Ex. 33, Death Cert.

76. Her sole immediate cause of death was morphine intoxication. *Id.*

77. She was to have an autopsy; her case was referred to the coroner. *Id.*

The Autopsy Report

78. The coroner opined that Mary "died as a result of morphine intoxication with the other significant conditions of atherosclerotic and hypertensive cardiovascular disease, and dementia." Ex. 34, Autopsy Report.

79. According to the coroner, "there was reportedly one nurse charged with dispensing medications to forty patients. Due to an error, the decedent received an oral dose of 120 mg of morphine, which had been ordered for another patient. The decedent's regular medication orders did not include morphine. The decedent became excessively sedated, and a physician was called to examine the decedent; and that afternoon the physician administered Narcan and Clonidine, with follow-up physician order for close observation and monitoring every 15 minutes for one hour, and every 4 hours thereafter." *Id.*

80. According to the coroner, Mary "reportedly remained somnolent." *Id.*

81. According to the coroner, "[t]he hospital admission urine toxicology screen was positive for opiates. The decedent's neurological condition did not improve, and following discussion with the family she was made Category 3. She was comatose, with agonal breathing." *Id.*

82. According to the coroner, "[t]oxicological examination of blood obtained on admission to the acute care hospital, following transfer from the skilled nursing facility, showed morphine 20 ng/ml." *Id.*

83. According to the forensic toxicologist, "[i]n 15 cases where cause of death was attributed to opiate toxicity (heroin, morphine or both), free morphine concentrations were 0–3700 ng/mL (mean = 420 +/- 940)"; positive findings were morphine – free, 20 ng/mL. Ex. 35, Tox. Report.

Additional LCCPV Documentation on Mary's Morphine Overdose

84. Nurse Dawson recorded at approximately 4:00 p.m. on 7 March that an incident

report had been given to the DON and that the ADON was notified of the medication error; that Narcan was given twice three minutes apart; that Mary had elevated blood pressure; and that Mary had had some nausea and vomiting. Ex. 3, Prog. Notes LCC-132.

85. Life Care's incident report records that the medication error was a Level 1 incident that had happened at 10:00 a.m.; that Mary's blood pressure immediately thereafter was 170/78; that Nurse Socaoco had been notified at 10:30 a.m. and new orders had been received; that family had been notified in person at 11:00 a.m.; that Nurse Sansome had provided the first aid; that the LPN had been educated; and that Mary was stable and improving. Ex. 16, LCC Med Incident Rpt-00001, -00002.

86. Life Care's incident report records that Mary had an adverse reaction: increased blood pressure and lethargy. Ex. 16, LCC Med Incident Rpt-00003.

87. Nurse Dawson recorded in her handwritten statement that she had given Mary two tablets of morphine (120 milligrams); that the ADON was made aware; that Mary's vitals were checked every 15 to 20 minutes; and that a family member was bedside, had been made aware of the error, was not upset, and said that as long as Mary was awake then she was okay. Ex. 13, LCC Dawson Stmt-00001.

88. On 11 March Nurse Dawson was educated on the medication administration policy. Ex. 17, Dawson Emp File-00104.

The Quality of LCCPV's Monitoring

89. Although clinical records and incident reports must be accurate, truthful, and complete, Mary's clinical record is not: for example, there is no note for 5 March, and staff's failure to record assessments in Mary's clinical record on 7 March is especially concerning as Mary had just been given 120 milligrams of morphine. Ex. 28, Hecht Dep. 74:2–75:19.

90. CNAs know that if they take vital signs they must document them in the clinical record. Ex. 36, Reyes Dep. 17:11–18.

91. CNAs who observe a change in a resident's condition have the duty and obligation to record it and to give the record to the nurse. *Id.* at 18:3–19:1.

92. If a nurse had done an assessment but had not so recorded in the record that would

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

indicate that she lacked the time to do her complete job. Ex. 19, Sansome Dep. 113:8–18.

93. Mary's blood pressure was last recorded on her neurological assessment flowsheet on 5 March. Ex. 37, Neuro. Assess. Flow Sheet LLC-116, -117.

94. Mary's vital signs were last recorded on her vital sign flowsheet on 6 March. Ex. 38, Vital Sign Flow Sheet LLC-178.

95. The gap in Mary's nursing notes between 5:00 p.m. on 7 March and 11:00 a.m. on 8 March concerns DON Hecht, as the standard of care required notes, especially after an event such as Mary's. Ex. 28, Hecht Dep. 57:2–16.

96. ADON Olea does not know if each nurse and CNA assigned to Mary was apprised of her condition and of what to look for. Ex. 18, Olea Dep. 125:6–12.

97. Mariver Delloro, a CNA assigned to Mary, does not recall having been instructed to closely monitor a resident who had potentially overdosed on morphine; to her knowledge, she never had such a resident. Ex. 39, Delloro Dep. 20:10–19; 22:19–23:4.

98. Had CNA Delloro been instructed to take a resident's vitals on the night shift, she would have entered her results on the vital sign flow sheet. *Id.* at 21:24–22:3.

99. LPN Debra Johnson does not recall monitoring Mary on the night of 7 March. Ex. 40, Johnson Dep. 43:10–12.

100. LPN Regina Ramos does not recall an event where Nurse Dawson gave 120 milligrams of morphine to the wrong resident. Ex. 11, Ramos Dep. 20:19–22.

101. CNA Isabella Reyes, who was assigned to Mary on the morning of 8 March, was never informed while working at LCCPV of any resident's ever being given morphine erroneously. Ex. 36, Reyes Dep. 21:2–9.

102. If CNA Reyes had been monitoring Mary's vital signs, she would have documented in the flow sheet, but there are no vital signs recorded for Mary on 8 March. *Id.* at 25:18–24.

103. CNA Reyes received no training regarding signs and symptoms of a morphine overdose. *Id.* at 35:14–23.

104. CNA Reyes has at Life Care never been told that a resident was wrongly given morphine nor what to look for in that circumstance. *Id.* at 35:24–36:8.

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

105. CNA Cherry Uy, another CNA assigned to Mary after her overdose, was never informed that Mary had been given morphine intended for another resident, nor was she told of the need to closely monitor and supervise her owing to a morphine overdose. Ex. 41, Uy Dep. 19:14–20:3.

106. If CNA Uy had been monitoring Mary's vital signs she would have so documented on the flowsheet. *Id.* at 22:5–15.

107. CNA Meseret Werago, whose assignment included Mary's room, does not know what to look for to see if someone may be suffering from an overdose of morphine. Ex. 14, Werago Dep. 16:25–17:4; 25:15–18.

108. If nursing staff is closely monitoring Mary then it should be staff that recognizes a change in Mary and not her daughter. Ex. 19, Sansome Dep. 109:9–17.

109. That Laura had to find Mary in the condition reflected in the video upsets Nurse Sansome; "there should be documentation, close monitoring when they found out." *Id.* at 109:19–110:12.

The Regional Director's Visitations

110. Performance areas covered during the regional director of clinical services' visit of January 2016 included medication management and nursing labor review; issues included nurses not signing out medications. Ex. 42, Facility Visit Report (Jan. 18, 2016).

111. Performance areas covered during the regional director of clinical services' visit of February 2016 included medication management, quality of life, and bounce-backs to hospitals; issues included that LCCPV "has been talking with physician's and inservicing staff in an effort to decreased bounce back rate" and that "[t]he Dietician needs to be spoken to about writing notes that incriminate the facility." Ex. 43, Facility Visit Report (Feb. 25, 2016).

112. Performance areas covered during the regional director of clinical services' visit of 8 March 2016 included medication management; issues included "[m]edication error noted. Facility to follow-up, education." Ex. 44, Facility Visit Report (Mar. 8, 2016).

113. Of patients who had recently had a change in condition, sixty percent had documentation to support that the nurse was notified of the change; twenty percent had

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

documentation in nurse's notes to reassess for condition changes and response to interventions/treatments; none had evidence to support that all components of INTERACT 3 were in place. Ex. 45, Change of Condition.[1]

The State's Surveys of LCCPV

114. The State cited LCCPV for failing to ensure that a narcotic pain medication was administered following the prescribed schedule for one resident and for failing to prevent a narcotic pain medication from being given to the wrong resident, i.e., Mary. Ex. 46, Survey 7–8 (Apr. 21, 2016).

115. Corrective actions to be accomplished by LCCPV included education "on med pass administration policy and procedure" and for "[m]ed pass observations [to] be conducted weekly x4, monthly x2/ until 100% threshold is met." *Id.* at 7.

116. As to the resident whose medication schedule was not observed, "[t]he LPN acknowledged she did not read the medication order prior to the administration." *Id.* at 8–9.

117. The State found that Mary "was given Morphine Sulfate that was not ordered for the resident"; that Mary's condition "before the incident was alert and confused"; and that her "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." *Id.* at 9–10.

118. The morphine-administering nurse said that "during the morning medication pass she was told by a [CNA] [that Mary] was in pain. About the same time Resident #21 indicated to the nurse she was in pain." *Id.* at 10.

119. "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 [Mary]." *Id.*

120. "The nurse indicated she had only worked on other units before and the Medication Administration Record . . . did not have pictures of Residents #20 [i.e., Mary] and #21." *Id.*

[1] Life Care's regional director of nursing testified that LCCPV's overall score of 67 percent on this audit equated to getting a D in school. Ex. 52, Blackmore Dep. 59:15–60:6.

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

121. Mary became nauseated and her blood pressure increased; Clonidine was ordered; "[t]he nurse reported she went home that afternoon and the resident was 'fine' at the time of the departure." *Id.*

122. The DON reported that the offending nurse "was working in the 300 and 400 unit"; that "usually two nurses worked on these units, but the census was higher than usual, so three nurses were assigned to about 16 residents each"; and that "the day after the medication error, [Mary] became unresponsive, a Code Blue was called and the resident was immediately transferred to the Emergency Room at an acute care hospital." *Id.* at 11.

123. Mary's nurse documented that at 3:59 p.m. on 7 March "hourly vital signs and hydration were offered." *Id.*

124. The DON at 11:47 a.m. on 8 March "documented the resident's blood saturation dropped to 77% (normal is above 90%) and a Code Blue was called." *Id.*

125. LCCPV's policies required that a nurse administering medication "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." *Id.* at 12.

126. The State also cited LCCPV for its medication error rate of 7.14%. *Id.*

127. The State in its survey of 13 March 2015 cited LCCPV for failing to implement fall prevention strategies for two residents and for failing to ensure care plans were updated in accordance with fall policies for four residents. Ex. 47, Survey 22 (Mar. 13, 2015).

128. The State in its survey of 13 March 2015 recorded that "the facility had a medication error rate of 10%." *Id.* at 30.

Staff's Knowledge

129. DON Hecht expected that her nursing staff would comply with LCCPV's nursing policy and procedures, which were in line with the standard of care in nursing. Ex. 28, Hecht Dep. 15:4–12.

130. According to DON Hecht, the standard of care means that "the nurses will provide

everything from medication administration, evaluation, change of condition, communicate to the doctor whatever the change of conditions are in a timely manner," and "[t]hat the patient will not fall, that the patient will not have any other injuries while they are in the facility." *Id.* at 15:16–16:3.

131. Every nurse coming out of nursing school should know what the five rights of medication administration are. *Id.* at 20:16–19.

132. Nurse Dawson knew the five rights of medication: the right patient, the right medication, the right dose, the right route, and the right time. Ex. 15, Dawson Dep. 26:8–20.

133. There are at least three opportunities to ensure that the right medication is given to the right resident: matching the orders, matching the MAR, and (if it is a controlled narcotic) matching by reading the label. Ex. 19, Sansome Dep. 34:1–9.

134. It is well known in nursing that giving the wrong medication to the wrong resident could harm or kill her. Ex. 18, Olea Dep. 34:25–35:5; Ex. 15, Dawson Dep. 25:25–26:7.

135. A heightened awareness should prevail when providing a resident controlled narcotics. Ex. 28, Hecht Dep. 23:24–24:2.

136. It is well known in nursing that a significant dose of morphine given to someone—especially an elderly person—unaccustomed to morphine can be potentially dangerous or fatal. *Id.* at 24:21–25:10.

137. Nurses are trained that a morphine overdose is potentially fatal, and everyone in nursing knows that 120 milligrams of morphine given to a resident for whom it is not meant is potentially harmful or fatal. Ex. 19, Sansome Dep. 45:10–13; Ex. 18, Olea Dep. 59:17–60:1.

138. It is standard knowledge in nursing that extended release morphine should not be crushed without consulting the provider. Ex. 18, Olea Dep. 76:17–21.

139. Morphine is an opioid and a controlled narcotic, meaning a heightened responsibility for nursing staff to observe the five rights of medication; morphine administered inappropriately or to the wrong person could be harmful or fatal; there is an extra step with controlled narcotics, i.e., reading the label thrice and comparing it to the controlled narcotic log and to the order; if the steps of the standard of care or rights of medication administration are

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

complied with there should be no excuse to give morphine to a resident for whom it is not intended. *Id.* at 45:1–46:1.

140. What opiate was given, how much, when, and whether it was extended release or short-acting should have been relayed to Nurse Socaoco, as those data were necessary for Mary's appropriate care and treatment. Ex. 28, Hecht Dep. 68:6–25.

141. DON Hecht would not want to place an LPN into a chaotic situation because that is when problems happen, nor would she want to put an LPN in a situation where she was starting a med pass at 8:00 or 8:30 instead of 6:30 or 7:00 as that is when dangerous situations happen; moreover, if a managing nurse is aware that a nurse is already behind schedule then DON Hecht would hope that the managing nurse would help set up the cart accurately. *Id.* at 27:9–13; 76:2–21.

142. If a facility through its staff members knows, as LCCPV did, that this is a potentially fatal event for Mary, then it can call 911 itself. *Id.* at 63:13–18.

143. An acute care hospital is better equipped to closely monitor one who has overdosed on morphine: a hospital has a lower ratio of nurses to patients, more monitoring devices, and physicians present. Ex. 19, Sansome Dep. 82:20–83:16.

Staff's Conclusions

144. Life Care Centers of America has the duty and responsibility to provide enough time for nursing staff both to comply with the standard of care and to go through the checks of the rights of medication administration in order to ensure that a resident not be given an inappropriate medication. Ex. 18, Olea Dep. 30:18–31:4.

145. Life Care Centers of America has the duty and responsibility to ensure that LCCPV provides one-on-one staff for a period of time for a resident requiring such supervision. *Id.* at 31:22–32:4.

146. What happened to Mary exceeds everyday carelessness. *Id.* at 99:21–25.

147. It was reckless to Mary's health and wellbeing that the appropriate controlled narcotics were not lined up to be appropriately administered to her. Ex. 15, Dawson Dep. 94:8–12.

148. Nursing staff's knowing that Mary could not be aroused and doing nothing about it would constitute conscious disregard of her health and wellbeing. Ex. 28, Hecht Dep. 82:13–83:4.

149. A resident's receiving a significant dose of morphine not meant for her is inexcusable. *Id.* at 29:4–9.

150. That the five rights of medication were not observed in Mary's situation is inexcusable and if better systems were in place and the medication administration rights were being adhered to this never would have happened. *Id.* at 94:25–95:4; 95:11–23; Ex. 18, Olea Dep. 134:12–25; Sansome Dep. 76:21–77:2.

151. That this was Nurse Dawson's first time on the unit was no excuse for not verifying the right patient and the right medication. Ex. 18, Olea Dep. 80:10–19.

152. That there is no note recorded for Mary from 5:00 p.m. until Laura summoned DON Hecht the next day at 11:00 a.m. concerns DON Hecht and is below the standard of care for monitoring after a significant event like Mary's. Ex. 28, Hecht Dep. 77:7–20.

153. There was no RN supervisor at night and so it would have been prudent to send Mary to the hospital for close monitoring by an RN and a physician. *Id.* at 85:1–11.

154. That there is no note for 5 March, no note regarding Mary's fall and injury on 6 March, no clinical assessment in the record post-morphine overdose, and no assessment in the record on 8 March of Mary's being unarousable, is clearly a pattern of violation of the standard of care in nursing in monitoring and assessing Mary. *Id.* at 87:11–23.

155. LCCPV's deficiency for unnecessary drugs being provided to Mary was warranted. *Id.* at 96:16–97:11.

156. That there is no indication in the nursing notes that Mary, who was given an excessive dose of morphine and was to have been closely monitored, was unresponsive prior to her daughter's stopping the DON to alert her to her mother's unresponsiveness is unacceptable. Ex. 18, Olea Dep. 98:4–12.

Life Care's Focus on Bounce-Backs

157. Life Care closely monitors bounce-backs and resident length of stay at LCCPV. Ex. 18, Olea Dep. 117:9–12; Ex. 19, Sansome Dep. 81:16–22.

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

158. LCCPV was monitoring 30-day readmissions closely because it would not want the hospital—its biggest referral source—to be penalized. Ex. 48, Saxena Dep. 34:6–14.

159. Life Care corporate educated DON Hecht and LCCPV staff on the need to decrease the bounce-back rate to hospitals (i.e., ensuring that a resident discharged from the hospital to LCCPV not return to acute care within thirty days). Ex. 28, Hecht Dep. 32:2–8.

160. DON Hecht was educated that bounce-backs can lead to financial penalties to hospitals, thereby endangering resident referrals from such hospitals. *Id.* at 33:6–20.

161. Management instructed nurses via in-services that LCCPV preferred to maintain residents there rather than transferring them to the hospital. Ex. 11, Ramos Dep. 72:5–10.

162. Management instructed nursing that re-hospitalization within the bounce-back period of 30 days was to be avoided. *Id.* at 75:2–6.

Life Care's Pressure on Census

163. Significant census growth was emphasized from the top of Life Care's corporate structure. Ex. 49, Harris Dep. 30:11–15.

164. Life Care corporate wanted LCCPV to increase its census. Ex. 28, Hecht Dep. 34:23–35:1.

165. LCCPV's census increased from 78 on 17 January to 92 on 8 March. *Id.* at 34:7–16.

Life Care's Control of LCCPV's Labor and Budget

166. Life Care Centers of America expected LCCPV to operate within its corporate-established budget. Ex. 50, Wagner Dep. 12:22–13:16; 15:23–16:1.

167. LCCPV has from corporate a certain PPD within which it must operate. Ex. 18, Olea Dep. 126:4–10.

168. DON Hecht had been in compliance with the corporate expectation of staying under the labor PPD. Ex. 28, Hecht Dep. 48:7–10.

169. DON Hecht at times had concerns that she was constrained by the corporate PPD for nursing labor but had no say on LCCPV's nursing PPD budget. *Id.* at 54:15–22.

/ / /

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

LCCPV's Known Understaffing and Compromised Care

170. DON Hecht recalled being made aware that nurses and CNAs were sharing their concerns about the need for more help to provide resident care; recalled that Nurse Sansome sometimes reported to management that nurses were not following the nursing standard of care; and recalled that acuity was high and that more help was needed to meet residents' needs. Ex. 28, Hecht Dep. 52:18–53:17.

171. DON Hecht testified that although she heard concerns at nurses' meetings that staff had too many residents to care for her hands were tied to an extent because she had to operate LCCPV within the nursing labor established by corporate. *Id.* at 54:2–14.

172. DON Hecht testified that she had been having issues with staff turnover and that managing nurses had been pulled to the floor frequently to fill vacant nursing spots, so any managing nurse had the ability to step in, provide medications, and do assessments. *Id.* at 48:11–25.

173. Nurses and CNAs at times told ADON Olea that additional CNAs or nurses were needed. Ex. 18, Olea Dep. 125:20–25.

174. Nurse Sansome would observe that nurses were not following the standard of care and would bring it to management's attention because of her concerns that residents' health and wellbeing would be affected. Ex. 19, Sansome Dep. 15:3–21.

175. Even before 7 March Nurse Sansome had seen employees not meeting the standard of care and would warn management that something bad could happen. *Id.* at 70:21–71:18.

176. Nurses or CNAs would sometimes come to Nurse Sansome with their concerns that more staff members were needed, which concerns she would pass on to management; for example, CNAs or nurses would tell her that the acuity of care was so high that they needed more help to meet residents' needs. *Id.* at 78:13–79:6.

177. CNA Uy regularly worked the 300 unit on the night shift and was responsible for up to 25 residents, which was "a lot" and "[t]oo many." Ex. 41, Uy Dep. 10:15–11:4.

178. She discussed with her supervisor that she had too many residents, and CNAs discussed among themselves the difficulties of having 25 residents. *Id.* at 11:5–8; 12:7–12.

179. The excessive number of residents to be cared for is one of the reasons that CNA Uy left LCCPV. *Id.* at 13:3–16.

180. Some CNAs would say at CNA meetings that they needed more help. *Id.* at 13:25–14:15.

181. At CNA meetings complaints or concerns about the CNA shortage were raised, a shortage that "[o]f course" would affect resident care. *Id.* at 16:6–12.

182. CNAs requested that fewer residents be assigned to them so that they would be able to provide more care to their residents. Ex. 14, Werago Dep. 29:4–24.

LCCPV's Known Ongoing Medication Error Issues

183. LCCPV had a pattern of medication administration problems and was aware of its ongoing problem with patients not receiving the right medication. Ex. 28, Hecht Dep. 37:25–38:15.

184. LCCPV had an ongoing issue with patients not receiving the right medication between 2014 and 2015. *Id.* at 38:21–39:2.

185. It was cited by the State for a medication error rate of ten percent. *Id.* at 39:8–14.

186. Its medication error rate as it continued into January, February, and March 2016 concerned DON Hecht. *Id.* at 39:17–24.

187. DON Hecht testified that there was an ongoing problem with nursing staff providing the wrong medication to residents, that there were quite a few medication errors, and that that was very concerning to her as managing nurse. *Id.* at 44:10–25.

188. ADON Olea recalls that before Mary's being overdosed LCCPV's medication error rate was over five percent and was "one of the challenges we have that is being addressed, an ongoing concern that we are addressing, and we addressed, continuous education." Ex. 18, Olea Dep. 104:21–105:14.

189. Appropriate medication administration was an ongoing challenge at LCCPV before Mary's overdose. *Id.* at 106:19–24; Ex. 28, Hecht Dep. 51:16–24.

190. Medication error reports go to the regional nurse and to the DON. Ex. 18, Olea Dep. 123:9–15.

191. Nurse Sansome at times saw wrong medications being given to residents and would

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

pass that on to the administration. Ex. 19, Sansome Dep. 68:23–69:2.

LCCPV's Medical Director's Opinions

192. Morphine given or used inappropriately is known to lead to serious harm or death. Ex. 48, Saxena Dep. 62:6–10.

193. 120 milligrams of morphine is a significant amount to a 120-pound opiate-naïve octogenarian, and is in fact a significant dose in itself. *Id.* at 66:20–67:10.

194. Mary's dying of morphine intoxication after receiving 120 milligrams of morphine not meant for her would not surprise Dr. Saxena. *Id.* at 108:21–109:4.

195. Crushing extended-release morphine causes uncontrolled morphine delivery that may lead to overdose and death. *Id.* at 67:11–18.

196. A nurse administering extended-release morphine is expected to know not to crush it. *Id.* at 67:24–68:3.

197. Although life-threatening or fatal respiratory depression can occur at any time during extended-release morphine's use, the risk is greater during the initiation of therapy or following a dosage increase. *Id.* at 68:7–13.

198. Life-threatening respiratory depression is more likely to occur in elderly, cachetic, or debilitated patients as they may have altered pharmacokinetics or altered clearance compared to younger, healthier individuals. *Id.* at 68:14–20.

199. Narcan is a short-acting medication, and 0.4 milligrams is the starting dose. *Id.* at 68:25–69:17.

200. For Nurse Dawson not to read the name on the medication and compare and double-check it with the medication administration record would be unacceptable. *Id.* at 93:25–94:11.

201. For a nurse not to ensure the right person and the right medication is reckless, which recklessness is heightened when dealing with potentially life-threatening morphine. *Id.* at 96:2–22.

202. If Nurse Socaoco became aware that a patient of Dr. Saxena's was given 120 milligrams of unprescribed morphine then she should call him if that is beyond the scope of her practice. *Id.* at 98:6–11.

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

203. LCCPV's being issued a deficiency for failing to prevent a narcotic pain medication from being administered to Mary would be warranted. *Id.* at 110:8–17.

204. Dr. Saxena testified that had he known that Mary, an opiate-naïve older adult, had been given 120 milligrams of morphine, he would have transferred her to the hospital—a setting with around-the-clock physicians and the equipment to appropriately monitor her; he does not know why she was not sent to the hospital. *Id.* at 123:17–124:17.

205. Staff's failure to ensure that they were giving the right medication to the right patient was inexcusable. *Id.* at 125:19–126:3.

What Nurse Socaoco Did Not Know

206. Nurse Socaoco is "not well versed" concerning dosage and the difference between short- and long-acting; whether crushing pain medication is appropriate is also outside her knowledge base. Ex. 21, Socaoco Dep. 38:7–39:3.

207. Nurse Socaoco knew only that Mary had been given a narcotic: she did not know what medication, how much, whether short- or long-acting, or whether crushed; her knowledge before providing orders for Mary was "just the narcotic and oxycodone." *Id.* at 39:22–41:1; 47:12–15.

208. She was not told that Mary was having increased blood pressure. *Id.* at 41:23–25.

209. She knows that 0.4 milligrams of Narcan is a minimal dosage to be given initially to a patient, but does not know Narcan's lifespan, i.e., she does not know if the Narcan given will be effective three, four, or five hours later. *Id.* at 51:15–52:3; 52:24–53:15.

210. She testified that this was an unusual circumstance for her as a new nurse practitioner. *Id.* at 74:25–75:3.

What Life Care's CEO Did Know

211. On 16 December 2015 a letter addressed to Life Care CEO Forrest Preston and Life Care president Beecher Hunter was received by the President's Office. Ex. 51, Preston/Hunter Letter 1 (Dec. 8, 2015).

212. It was written anonymously "because of fears of the repercussions or retaliation"; alleged "many critical issues," of which many were "still occurring with staff and patients at Life

Care Paradise Valley Las Vegas"; raised "the poor leadership and the cover up of many incidents by Tessie Hecht, RN/DON"; and requested that Messrs. Preston and Hunter "investigate and take the appropriate actions to ensure the safety of our patients." *Id.*

213. It informed them that "one of our previous patients had an incident that was never reported"; that a resident "suffered a fall in the presence of his handicapped CNA," who was a family member of DON Hecht; that "[t]he CNA tried to lift the patient off the floor by himself and did not call anyone to alert or assist him as per our protocol, nor did he report the incident until he knew he was seen by another non-medical staff member"; that "Crystal the on duty RN and Tessie Hecht were notified"; that DON Hecht "did not do anything throughout the day and tried covering the fall to prevent an incident report even though nurses brought to her attention many times that [resident] 'looked grayish' and was not doing well"; that "staff members continued to see that [resident's] health was deteriorating and [he] was finally sent to the emergency room where he subsequently expired"; that DON Hecht "has been covering up many incidents such as having staff file false documents or write false statements"; and that DON Hecht "has known for a long time that Crystal has made many errors such as giving wrong doses or wrong medications to patients and always covers it up for her." *Id.*

214. It urged them "to also look into the following patients care where Tessie has covered up many mistakes," *id.* at 1–2; requested that they "[p]lease investigate patient [name] where the same situation occurred"; and alleged that "[s]taff members noticed [resident] was not looking good and expressed their concerns to Tessie," whose "orders were to do nothing unless she was gravely ill to prevent a bounce back to the hospital"; that "[e]ventually [resident] worsened hours later and was sent to the hospital where again patient expired"; that "Crystal gave [a current] patient wrong medications and admitted to doing so"; and that "Tessie was informed but once more no action was taken." *Id.* at 2.

215. It advised that "[t]hese are some of the many issues that occur on a daily basis at our facility"; warned that "[o]ur director of nursing is endangering our patients lives and will continue to do so unless action is taken"; and advised that if the letter did not result in changes then the writer "will be forced to report to the pertinent authorities and agencies and risk my future

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

employment with your company in order to prevent anymore abuse and deaths of people we are in trusted to protect, our patients." *Id.*

III. LEGAL ARGUMENT.

"[T]he court has the responsibility to determine whether, as a matter of law, the plaintiff has offered sufficient evidence of oppression, fraud, or malice to support a punitive damages instruction." *Hester v. Vision Airlines, Inc.*, 687 F.3d 1162, 1172 (9th Cir. 2012). But "[o]nce the district court makes a threshold determination that a defendant's conduct is subject to this form of civil punishment, the decision to award punitive damages rests entirely within the jury's discretion." *Countrywide Home Loans, Inc. v. Thitchener*, 124 Nev. 725, 740 (2008).

Punitive damages are available "where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud or malice, express or implied." NRS 42.005(1). Oppression is "despicable conduct that subjects a person to cruel and unjust hardship with conscious disregard of the rights of the person," NRS 42.001(4), while implied malice is "despicable conduct which is engaged in with a conscious disregard for the rights or safety of others." NRS 42.001(3). So the statute "defines implied malice as a distinct basis for punitive damages in Nevada and establishes a common mental element for implied malice and oppression based on conscious disregard." *Thitchener*, 124 Nev. at 729. This conscious disregard is "the knowledge of the probable harmful consequences of a wrongful act and a willful and deliberate failure to act to avoid those consequences." NRS 42.001(1).

The *Thitchener* court affirmed a punitive damages award against Countrywide, which had misidentified and foreclosed on plaintiffs' condo and had disposed of their personal belongings. 124 Nev. at 729–30. The district court had submitted the issue of punitive damages to the jury "based on evidence that Countrywide ignored numerous warning signs that likely would have led it to discover its error in misidentifying [plaintiffs'] condominium unit"; the jury "awarded punitive damages on alternative theories of implied malice and oppression." *Id.* at 740.

Countrywide argued that plaintiffs had "failed to prove that it consciously disregarded their rights because there was no direct evidence that it actually knew that it was proceeding against the wrong condominium unit." *Id.* Indeed, it presented the case "as a convergence of undetected

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

mistakes and therefore contend[ed] that there was insufficient evidence that it acted with 'an actual knowledge, equivalent to the intent to cause harm.'" *Id.* at 744 n.55. But "intent to cause harm . . . is the mental element of express malice and plays no role in analyzing a defendant's conscious disregard for purposes of implied malice or oppression." *Id.* And plaintiffs had "presented evidence of multiple ignored warning signs suggesting that Countrywide knew of a potential mix-up, as well as evidence indicating that Countrywide continued to proceed with the foreclosure despite knowing of the probable harmful consequences of doing so." *Id.* at 744.

For example, Countrywide's foreclosure specialist had reviewed the appraisal report and understood that plaintiffs owned the property but "did not consider this to be problematic in preparing the property for resale"; she "was similarly indifferent regarding the broker price opinion, which she also admittedly ignored"; and "[a]lthough the preliminary title report was available for this property, [she] did not review it, leaving that task to a subordinate." *Id.* This was "sufficient evidence to infer that Countrywide knew that it may have been proceeding against the wrong unit." *Id.* And its foreclosure specialist "presumably understood that proceeding in the face of these warning signs involved an imminent, as opposed to merely a theoretical, risk of harm to this particular unit's lawful owner." *Id.* So "the jury reasonably could have inferred that Countrywide's casual attempts at verification indicated a willful and deliberate failure on its part to avoid that harm," and thus "could have logically concluded that Countrywide consciously disregarded [plaintiffs'] rights." *Id.* at 744–45. Submitting plaintiffs' punitive damages claim to the jury was therefore proper. *Id.* at 745.

Similarly, our supreme court affirmed a punitive damages award of almost $58 million against a drug manufacturer in *Wyeth v. Rowatt*, 126 Nev. 446 (2010). Plaintiffs had been diagnosed with breast cancer after taking Wyeth's drugs, *id.* at 451, i.e., they "all developed a debilitating disease, breast cancer, as a result of Wyeth's actions, or lack thereof." *Id.* at 471. Wyeth "presented evidence that its drug label warned women and physicians that there was a risk of breast cancer, [but] these warnings were inadequate because they were misleading." *Id.* at 468. Indeed, Wyeth had "financed and manipulated scientific studies and sponsored medical articles to downplay the risk of cancer while promoting certain unproven benefits." *Id.* Still, there was

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

"evidence that Wyeth provided a breast cancer warning, although arguably inadequate, and that it sponsored some limited testing." *Id.* at 470. Nevertheless, "[b]ased on the warning's language and Wyeth's actions . . . a jury could reasonably determine that while Wyeth warned of breast cancer, it also tried to hide any potential harmful consequences of its products," so "substantial evidence supports the jury's conclusion that Wyeth acted with malice when it had knowledge of the probable harmful consequences of its wrongful acts and willfully and deliberately failed to act to avoid those consequences such that punitive damages were warranted." *Id.* at 474.[2]

Life Care Centers of America knew that LCCPV had serious medication issues, SOF ¶ 110, including that its 2015 medication error rate was ten percent, SOF ¶ 128, and that its ongoing problems with residents not receiving the right medications antedated Mary's overdose, SOF ¶¶ 183–91; knew that cover-ups were happening at LCCPV, including false documentation and cover-ups of medication errors, SOF ¶¶ 213–14; knew that residents were dying because of Life Care's desire to avoid bounce-backs, SOF ¶ 214, i.e., for the sake of Life Care's profit margin, SOF ¶¶ 158, 160; and knew that the lives of LCCPV's residents remained at risk. SOF ¶ 215. Yet despite this knowledge Life Care Centers of America continued to pressure LCCPV to retain residents fit for hospitalization, SOF ¶¶ 159, 161–62; and continued to pressure LCCPV to increase its census, SOF ¶¶ 163–64, resulting in an increase from 78 residents in January to 92 by 8 March, SOF ¶ 165; while continuing to force LCCPV to operate within its corporate-imposed budget and corporate-capped labor, SOF ¶¶ 166–68, thereby tying the DON's hands even though she knew that residents were suffering because of LCCPV's lack of staff. SOF ¶¶ 169–71. And so the probable harmful consequences of these wrongful acts occurred: yet another resident, in this case Mary, needlessly suffered and died because of LCCPV's Life Care-mandated lack of staff. This is sufficient evidence of Life Care Centers of America's conscious disregard for punitive damages

[2] *See also Austin v. C & L Trucking, Inc.*, 610 F. Supp. 465, 472 (D. Nev. 1985) ("Malice in fact may be inferred from a conscious disregard of an accepted safety procedure by the defendant."); *Evans v. Dean Witter Reynolds, Inc.*, 116 Nev. 598 (2000) (affirming $6 million punitive damages award against brokerage firm that had enabled financial exploitation of widow who was "dependent upon nursing assistance for all of the activities of daily living"); *Clark v. Lubritz*, 113 Nev. 1089 (1997) (holding that partners' decision not to tell other partner that they had reduced his year-end distribution constituted clear and convincing evidence of malice).

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

to reach the jury.

LCCPV and its staff knew that LCCPV was short of nurses and that Nurse Dawson, who was being rushed by the ADON and did not know her residents of 7 March, SOF ¶¶ 22–24, 27, was set up for failure, SOF ¶ 141; knew that Nurse Dawson gave Mary a potentially fatal dose of morphine, SOF ¶¶ 30, 136–37; knew that Mary was thereafter nauseated, SOF ¶ 39, with increased blood pressure and lethargy, SOF ¶ 43; knew that they were ignorant of basic facts such as what narcotic was given, when, how much, or whether it was extended release, SOF ¶ 40; knew that Nurse Socaoco needed that information for Mary's appropriate care and treatment, SOF ¶ 140; knew the importance of Mary's clinical record, SOF ¶ 89; knew that Mary needed to be monitored overnight, SOF ¶ 53; knew that a hospital was better equipped to monitor Mary than was LCCPV, SOF ¶ 143; knew that they could call 911, SOF ¶ 142; knew that Mary did not receive OT on 8 March because of a change in her medical status, SOF ¶ 55; and knew that Mary did not receive PT on 8 March because of her change in status and that PT could not rouse her that day despite multiple attempts. SOF ¶ 56.

Yet despite this knowledge LCCPV and its staff failed to monitor Mary's blood pressure, SOF ¶ 93, or vitals, SOF ¶ 94; failed to assess Mary after 5:00 p.m. on 7 March, SOF ¶¶ 89, 95, or on 8 March before Laura arrived and insisted on staff's attention upon finding Mary unresponsive and being told by her roommate that "[n]o one has come to check her all day," SOF ¶ 57, which attention even then was rendered—after Laura hunted down a staff member—with no particular sense of urgency, SOF ¶¶ 60, 63; failed to even tell CNAs to monitor Mary, much less why and how, SOF ¶¶ 97–107; and failed to simply pick up the phone and call 911 in order to secure aid for their unconscious and helpless but still profitable resident until Laura's presence made their doing so unavoidable. SOF ¶¶ 62–64. And so the probable harmful consequences of these wrongful acts occurred: Mary, having been overdosed on morphine and thereafter ignored, died of morphine intoxication. As LCCPV's DON observed, "It happens." SOF ¶ 36. This is sufficient evidence of LCCPV and its staff's conscious disregard for punitive damages to reach the jury.[3]

[3] As to Nurse Dawson specifically, she knew how to ensure that the right resident would receive the right medication, i.e., the five rights of medication, SOF ¶¶ 131–33; knew the need for heightened vigilance with controlled narcotics, SOF

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

Nurse Socaoco knew that Mary had been overdosed, SOF ¶ 49; knew that she did not know necessary details of the overdose such as what the narcotic was, how much was given, whether it was extended release, or whether it had been crushed, SOF ¶¶ 51, 207; knew that she was "not well versed" in narcotics matters, including dosage, the difference between short- and long-acting, and whether crushing them is appropriate (although even LCCPV's nurses knew not to crush such medications, ¶¶ 125, 138), SOF ¶ 206; knew that she was ignorant of Narcan's lifespan and of its efficacy hours after it was given, SOF ¶ 209; knew that she should call Dr. Saxena if presented with a situation beyond the scope of her practice, SOF ¶ 202; and knew that Mary's situation was beyond the scope of her practice as a new nurse practitioner. SOF ¶ 210. Yet despite this knowledge she simply prescribed Narcan and called it a day. And so the probable harmful consequences of these wrongful acts occurred: the Narcan's effectiveness waned; Mary declined; Mary died. This is sufficient evidence of Nurse Socaoco's conscious disregard for punitive damages to reach the jury.

Thitchener counsels the same result. As in *Thitchener*, Defendants here may wish to present this case as a convergence of undetected mistakes in order to claim insufficient evidence of actual knowledge. But as in *Thitchener* that wish will go ungranted, for actual knowledge plays no role in analyzing a defendant's conscious disregard for implied malice and oppression purposes (and in any event Defendants did have actual knowledge that LCCPV's lack of staff was harming residents and of LCCPV's widespread and persistent medication errors). And as in *Thitchener* plaintiffs could point to evidence of multiple warning signs ignored by Countrywide before it foreclosed on their condo (for example, its foreclosure specialist was "indifferent regarding the broker price opinion, which she . . . admittedly ignored," 124 Nev. at 744), so too here Laura's record is rich in evidence that Defendants ignored the warning signs of the compromised care that residents were receiving because of the lack of staff, of the dangerously chaotic situation conductive to the medication errors for which LCCPV is known in which Nurse Dawson had been

¶¶ 135, 139; and knew not to crush medications unless she had first consulted the provider, SOF ¶¶ 125, 138; yet despite this knowledge she, as she said, "fucked up." SOF ¶ 35. LCCPV did get around to educating her on its medication administration policy a few days after the fuck-up. SOF ¶ 88.

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

placed, and of Mary's decline—indeed, they declined even to record her vital signs or blood pressure or to assess her at all until her daughter's presence foreclosed their further neglect of Mary. This is sufficient evidence to infer that Defendants knew that Mary could have been suffering from morphine-induced harm ultimately arising from LCCPV's understaffing and breakdown in medication administration. And as in *Thitchener* Countrywide's foreclosure specialist "presumably understood that proceeding in the face of these warning signs involved an imminent, as opposed to merely a theoretical, risk of harm," *id.*, so too here Defendants understood that continued inattention to LCCPV's understaffing, to its medication blunders, and to Mary's condition despite her morphine overdose involved an imminent risk of harm or death to Mary. The jury is therefore entitled to conclude that Defendants' casual to nonexistent attempts to verify Mary's wellbeing after they themselves placed her at risk of harm or death by morphine overdose indicated a willful and deliberate failure on their part to avoid Mary's harm or death, and so may conclude that they consciously disregarded Mary's rights. *Thitchener* therefore requires submitting Laura's punitive damages claim to the jury.

Wyeth is likewise. As in *Wyeth* plaintiffs had suffered a debilitating disease as a result of Wyeth's actions or lack thereof, so too here Mary suffered harm and death as a result of Defendants' actions or lack thereof. And as Wyeth financed and manipulated scientific studies to downplay the risk of harm from their drug, so too here Defendants have for the sake of profit maximization manipulated their census by clinging to potential "bounce-back" residents and have engaged in cover-ups of the injuries and deaths that LCCPV's residents have suffered—in particular here Nurse Dawson's employee file and Life Care's incident report loudly clash with other evidence regarding the timeline of the events of 7 March (for example, as to when Nurse Socaoco and the ADON were notified). Indeed, Wyeth's actions were less culpable than Defendants' here: Wyeth "provided a breast cancer warning, although arguably inadequate, and . . . sponsored some limited testing," 126 Nev. at 470, thus showing some slight concern for its customers, while Defendants here—although extremely zealous to claim and retain residents—made no effort to address the warning signs that Nurse Dawson had been placed in an untenable position or to apprise themselves of Mary's condition (even failing to tell LCCPV's night staff that

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

she was to be monitored or what to look for) before Laura's forceful presence made acknowledging Mary's existence and condition inescapable. So as in *Wyeth* defendant's warning and actions constituted substantial evidence supporting the jury's conclusion that Wyeth acted with malice, so too here Defendants' failures to address the warning signs of error-inducing chaos on the morning of 7 March or to warn staff to monitor Mary and their failure to take any action to salvage her life until forced to do so (by which time it was too late to save her) would support a jury's conclusion that they acted with malice. *Wyeth* therefore requires submitting Laura's punitive damages claim to the jury.

In sum, Laura has adduced sufficient evidence of Defendants' conscious disregard for the rights and safety of her mother, who shortly before entering LCCPV was at home and shortly after leaving LCCPV was in the ground, for the jury to weigh punitive damages on theories of implied malice and oppression. An order that the jury will be permitted to do so is therefore now justified.

IV. CONCLUSION.

Laura requests that the Court order that the jury will be permitted to consider awarding punitive damages.

DATED this 21st day of September, 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 21st day of September, 2018, I caused to be served a true and correct copy of foregoing **PLAINTIFFS' MOTION FOR PRIMA FACIE CLAIM FOR PUNITIVE DAMAGES** 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

APEN
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

* * *

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 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, Defendants.	CASE NO. A-17-750520-C DEPT NO. XVII Consolidated with: CASE NO. A-17-754013-C **APPENDIX OF EXHIBITS TO PLAINTIFFS' MOTION FOR PRIMA FACIE CLAIM FOR PUNITIVE DAMAGES**
Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually, 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.

APPENDIX TO PLAINTIFFS' MOTION FOR PRIMA FACIE CLAIM FOR PUNITIVE DAMAGES

Exhibits	Document Description	Page No(s).
1.	Photograph	1–2
2.	OT Plan of Treatment	3–4
3.	Progress Notes	5–7
4.	Discharge Summary	8–9
5.	Floor Plan	10–11
6.	Nursing Assessment	12–14
7.	MDS	15–19
8.	Deposition of Loretta Chatman	20–23
9.	LCC Fall Incident Report	24–29
10.	Non-Pressure Skin Condition Record	30–32
11.	Deposition of Regina Ramos	33–37
12.	Interim Care Plan	38–39
13.	Dawson Statement	40–41
14.	Deposition of Meseret Werago	42–49
15.	Deposition of Ersheila D. Dawson	50–59
16.	LCC Medical Incident Report	60–63
17.	Dawson Employee File	64–65
18.	Deposition of Thelma B. Olea	66–85

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

APPENDIX TO PLAINTIFFS' MOTION FOR PRIMA FACIE CLAIM FOR PUNITIVE DAMAGES		
Exhibits	**Document Description**	**Page No(s).**
19.	Deposition of Cecilia Sansome	86–102
20.	Telephone Orders	103–105
21.	Deposition of Annabelle Socaoco, N.P.	106–112
22.	Deposition of Laura Latrenta	113–118
23.	Post Acute Treatment Note	119–120
24.	OT Daily Treatment Note	121–122
25.	PT Daily Treatment Note	123–124
26.	EMS Report	125–128
27.	SBAR Communication Form	129–131
28.	Deposition of Tessie Hecht	132–154
29.	Transfer Form	155–156
30.	Sunrise Hospital and Medical Center History and Physical	157–159
31.	Sunrise Hospital and Medical Center Discharge Summary	160–161
32.	Neurological Consultation Note	162–169
33.	Death Certificate	170–171
34.	Autopsy Report	172–174
35.	Toxicology Report	175–178
36.	Deposition of Isabella Reyes	179–182
37.	Neurological Assessment Flow Sheet	183–185
38.	Vital Sign Flow Sheet	186–187
39.	Deposition of Mariver Delloro	188–192
40.	Deposition of Debra Johnson	193–195
41.	Deposition of Cherry Uy	196–201
42.	Regional Director of Clinical Services Facility Visit Report (Jan. 18, 2016)	202–203

APPENDIX TO PLAINTIFFS' MOTION FOR PRIMA FACIE CLAIM FOR PUNITIVE DAMAGES		
Exhibits	**Document Description**	**Page No(s).**
43.	Regional Director of Clinical Services Facility Visit Report (Feb. 25, 2016)	204–205
44.	Regional Director of Clinical Services Facility Visit Report (Mar. 8, 2016)	206–207
45.	Change of Condition	208–210
46.	Survey (Apr. 21, 2016)	211–224
47.	Survey (Mar. 13, 2015)	225–236
48.	Deposition of Samir Saxena, M.D.	237–240
49.	Deposition of Machelle Lynette Harris	241–243
50.	Deposition of Carl Wagner	244–249
51.	Preston/Hunter Letter (Dec. 8, 2015)	250–252
52.	Deposition of Connie Blackmore	253–256

DATED this 21st day of September, 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 21st day of September, 2018, I caused to be served a true and correct copy of foregoing **APPENDIX OF EXHIBITS TO PLAINTIFFS' MOTION FOR PRIMA FACIE CLAIM FOR PUNITIVE DAMAGES** 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 9

INCIDENT/ACCIDENT DATA ENTRY QUESTIONNAIRE

LIFE CARE CENTERS OF AMERICA, INC.

Report Author : Regina S Ramos
Facility : Paradise Valley (NV)

Date/Time : 3/3/2016 2:00:00 PM
Incident ID : 1242261

Preliminary

Preliminary Information	
Last Name	Curtis
First Name	Mary
Gender	Female
Assigned Room Number	313A
Type of Incident Alleged	Fall
Level of Incident	Level I

Outside Care	
Was outside care needed to treat and/or diagnose this injury?	No

Incident

Incident Location	
Did Incident Occur Inside or Outside the Facility?	Inside

Inside Location	
Unit where Incident/Accident occurred	Skilled Nursing
Wing where Incident/Accident occurred	East
Floor where Accident/Incident occurred	First

Occurrence?	
Full Description of Incident/Accident	Called by staff in patient room ,this writer came ASAP in patient room. Found patient laying on the floor on left side position in the bathroom. When asked what happened patient stated"I got out from bed to use the bathroom lost my balance then I fell. Pt. said she hit her head on the wall but not to much.Body assessment was done. NO noted lump or bump on head at this time.Rom+ to all extremities. No injuries noted.

Witness	
Was Incident witnessed?	No

Report Author : Regina S Ramos
Facility : Paradise Valley (NV)

Date/Time : 3/3/2016 2:00:00 PM
Incident ID : 1242261

Discovery	
Person who discovered Incident - Last Name	Carlson
Person who discovered Incident - First Name	Jan
Person who discovered Incident - Title	Resident at the faci
Resident Condition Before	
Resident's Mental Function before Incident/Accident	Alert/confused
Was Resident non-compliant with care or transfers?	Yes
What is the Resident's functional mobility?	Transfers - Need Assistance
Resident Activity	
Activity at the time of the incident? Check all that apply.	Going to the bathroom
Assistive Devices	
What Resident Assistive Device was in use at the time of the incident?	Other
Restraints	
Were any Restraints in use at the time of the incident?	No
Resident Condition	
Resident's Mental Function after Incident/Accident	Alert/Confused
Vital Signs	
What was the Resident's temperature immediately after the incident?	98
What was the Resident's Pulse immediately after the incident?	73
What was the Resident's Respiratory Rate?	22
What was the Resident's Blood Pressure immediately after the incident?	165/75
Describe the Resident's Intensity of Pain after the incident. (using the pain scale)	0 - 3
Physician/NP Info	
Physician Notified/NP - Last Name	Samir
Physician Notified/NP - First Name	Saxena
Date/Time of Physician/NP Notification	Mar 3 2016 2:00PM
Brief Summary of Physician's/NP's Response or Orders	no new orders
Representative Info	
Family/Legal Representative Notified - Last Name	Curtis

Report Author : Regina S Ramos
Facility : Paradise Valley (NV)

Date/Time : 3/3/2016 2:00:00 PM
Incident ID : 1242261

Family/Legal Representative Notified - First Name	Laura
Family Relationship to Resident	Daughter
Date/Time Family /Representative Notified	Mar 3 2016 7:45PM
Method of Notification	Spoke with someone
Was any other Family Member notified?	No

First Aid

Was first aid administered at the facility?	No

Actions

What immediate actions were taken to provide safety for the resident and/or others?	continue falling star intervention. Tab -alarm ,put bed in lowest position.Non-skid socks.

Supervisor Info

Supervisor Last Name	Olea
Supervisor First Name	Thelma
Supervisor Title	ADON

Investigation

Occurrence Detail

Specific Location (check all that apply)	Resident's Bathroom
Was an associate involved or providing care at time of the incident?	No

Data Entry

Person Entering Ida Data - Last Name	Ramos
Person Entering Ida Data - First Name	Regina
Person Entering Ida Data - Title	LPN

Current Status of Resident

How is Resident now?	Observation

Diagnoses

Primary Diagnosis	Hypertention

Medication Usage

Were any one of the following medications in use at the time of the incident?	No Medication
List any drugs and date started within the last 14 days.	all meds. upon admission

Report Author : Regina S Ramos
Facility : Paradise Valley (NV)

Date/Time : 3/3/2016 2:00:00 PM
Incident ID : 1242261

Falls

Resident's Mobility Status? Check all that apply	Unsteady Gait
Is the Resident Incontinent? (If yes, what type of toileting program)	Yes, without Urgency

Toileting Program

What type of toileting program is in place?	Prompted voiding

Barriers

What if any, of the following barriers potentially contributed to the Incident?Check all that apply	No Barriers Noted
Was the floor wet? (If yes, with what substance?)	No

Resident Fall Detail

Fall Category As Defined By CMS	Found on floor with or w/o inj
Was fall Attended/Unattended?	Unattended
What position was the Resident in when you found them? (e.g.,Resident found flat on back)	laying on the floor left side position
Did the Resident have access to a call light when he/she fell?	No
Was call light on at time of incident?	No
When was the last Fall Risk Assessment done?	After last incident
What was the Fall Risk Assessment score?	22
What fall reduction measures were in place at time of incident?	Bed alarm
Has resident fallen previously?	Yes

Previous Fall History

Resident has fallen in past? (Number of days)	0 - 30 days

Found on Floor

Is finding this Resident on the floor an expected behavior?	Yes
Was a head injury suspected?	No

Hip Protectors

Is the resident a candidate for hip protectors?	No
If resident is not a candidate for hip protectors, reasons why. (Choose all that apply.)	Other
Were hip protectors on at the time of the fall?	No
If refused, reasons for refusal. (Check all that apply)	
If refused, was waiver signed?	

Consciousness

Report Author : Regina S Ramos	Date/Time : 3/3/2016 2:00:00 PM
Facility : Paradise Valley (NV)	Incident ID : 1242261
Was there a loss in Consciousness?	No
Were neuro-checks completed per protocol?	Yes

Care Plan/Chart

Date care plan reviewed and updated	3/3/2016
Date alert charting initiated	3/3/2016
What interventions were in place at the time of the Incident?	Tab-alarm ,fall risk bracelet
What interventions are in place now?	tab-alarm, put bed on lowest position.

EXHIBIT 15

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.	)	Case No. A-17-750520-C
SOUTH LAS VEGAS MEDICAL INVESTORS, LLC dba LIFE CARE CENTERS OF SOUTH LAS VEGAS f/k/a LIFE CARE CENTER OF PARADISE VALLEY; SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP; et al.,	)	
Defendants.	)	

DEPOSITION OF ERSHEILA D. DAWSON
THURSDAY, MARCH 1, 2018
LAS VEGAS, NEVADA

REPORTED BY:
KENDALL D. HEATH
NEV. CCR NO. 475
CALIF. CSR NO. 11861
JOB NO.: 2811353
PAGES 1 - 143

Q If you could just describe for me just your vague recollection of Mary, what do you remember?

A I know she was up in age, I think 90-plus years of age, and she came to Life Care I believe because failure to be able to care for herself.

Q Now, I believe you were only assigned to Mary on one occasion?

A One day.

Q So I take it you were not familiar with Mary and her care needs; is that fair?

A For a day, I can't -- you can't say yes, so it would be a no.

Q Now, it's my understanding that you were not normally assigned to the 3- or 400 units at Life Care Centers of Paradise Valley; am I correct?

A No, I was usually on the 1- or the 200 hall.

Q On the one day that you were assigned to Mary, who was on the 300 unit, how did it come to be that you got assigned to that unit from management at Life Care?

A Wow. I believe I got called into work. They were short a nurse, and I got called in. They were short a nurse, and I got called in.

Q Do you know why they did not call in a nurse

A Absolutely.

Q And the five -- now seven rights of medication, is the standard of care in nursing in providing a medication administration to a resident; am I correct?

A Yes.

Q I also take it, it takes time to go through the different steps of the seven rights of medication administration in order to ensure the right medication is given to the right resident?

A Yes.

Q In I believe the five rights -- strike that.

Back in 2016, it was the seven rights of medication administration; am I correct?

A Yes.

Q The seven rights of medication administration is a standard of care that's in place to ensure that the right medication is given to the right resident?

A Yes.

Q And in the seven rights of medication is also in place in order to ensure the health and the well-being of the residents receiving the medication; am I correct?

A Yes.

Q Because it is well-known in nursing that if a

wrong medication is given to the wrong patient, and depending on what that medication is, it can be life-threatening and sometimes fatal --

MS. BROOKHYSER: Foundation.

BY MS. BOSSIE:

Q -- agreed?

A That's true.

Q And as a licensed practical nurse, you had knowledge of each of those five rights of medication?

A Yes.

Q So I just want to talk a little bit about them, if you don't mind.

Now, I take it that these seven rights of medication administration to residents are in place to have basically the checks and balances that you have the right patient, the right medication, the right dose, the right route, and the right reason; am I correct?

A The right time, yes.

Q And we'll go through each of them, but each step of ensuring that you've got the right medication with the right patient is a checks and balances to ensure that the health and safety and the well-being of the resident is being adhered to; am I correct?

came out, we immediately called the PCP that was on for Mary, and the first two or three phone calls, they didn't pick up. We had their cell phone, they didn't pick up. But I kept calling until she picked up.

And I -- she was like, It must be something. We were very loose in association, so it wasn't like a stern phone call. I immediately told her what I -- what I had done, and she immediately gave me an order. I gave the order to the unit secretary. The unit secretary drew up the order and it was administered. It wasn't even 20 minutes that elapsed that we swang into action to make sure that the effects of the morphine wouldn't be detrimental.

Q Let me go through some of -- you just covered a lot of information.

So I take it, you realized that the wrong medication was given to Mary?

A Correct.

Q And then did you determine that it was morphine?

A Yes.

Q And then did you determine that it was a significant dose of morphine, being 120 milligrams?

A Correct.

Q And clearly, 120 milligrams is a significant

dose of morphine?

A Absolutely.

Q And I believe you realized that Mary should not have gotten morphine?

A Yes.

Q And since 120 milligrams of morphine is a significant dose of morphine, there was this conscious awareness that, Hey, we need to do something about it because it could be life-threatening or fatal?

A Correct.

Q Now, after you realize this, you go and you go find --

A After I realized it, I called the attending.

Q Okay.

A I didn't get an answer. I put the phone down. I went and got -- knocked on the door for the director of nursing, but they were in a meeting. But I told Ms. Thelma, I said, I really got to talk to you.

Q Okay.

A So she stepped out and I told her. She did come down with me, we did go in. Mary was no reaction to the morphine as of yet. That was notable. Took her vital signs. She was within normal range of her vital signs, and so we start calling the attending

was coming into town that day. That was the urgency about getting her medicated, so she wouldn't be in kind of a complaintive state. So she was pretty -- pretty upset. I was upset.

Q Did you also say to yourself, How in the world could this have happened?

A No, I felt like I really just messed up. I really just messed this up. It was unbelievable. I was very concerned. I was overwhelmed that I may have had harmed somebody. So, yeah, I was pretty upset too.

Q Now, did Thelma know what had taken place prior to you talking with Victoria?

A Yeah, because we -- we went to the phone together. She was in her office calling, I was on the station calling. And then when we got the pick-up, the unit secretary, I believe her name is Cecile, she wrote down the order as I called it out. And she went and pulled the Narcan and she administered it.

Q And is Cecile, I believe it's Cecilia Samson -- Samson?

A I don't know the last name.

Q Cecilia is an RN; am I correct?

A Correct.

Q And I know you may not be able to give me

Q I believe earlier you had also talked to the director of nursing regarding your concerns of why the fall the day before was not in the record?

A I asked that. I said -- and it was because no one had seen it. It wasn't witnessed. It was just the word of the roommate.

Q I take it, though, if someone experiences a fall and it's reported that the resident had fallen, it should indicate within the clinical records or an incident report pertaining to the interview of what happened?

A I -- my thought, she said just vaguely, like they were going to call the nighttime nurse and question her about it, but it was just the word of the roommate, no one had seen it.

Q Okay.

A And Mary herself didn't ever say she fell.

Q Did you specifically talk to Mary about the fall and the injury that she experienced the night before?

A No. I asked her if she was in pain.

Q Just want to ask you a couple of questions, if you don't mind.

Now, I believe you -- the note that I believe you're authoring at the end of the day is regarding

When that was one of her daughter's and the two housekeepers that came in to visit her that day, had also noted that she hadn't been eating very much, that she was probably dehydrated. The housekeepers were trying to push fluids too, and that she had fallen a lot of times inside of her apartment.

BY MS. BOSSIE:

Q You do agree, though, that it is reckless to Mary's health and well-being that the appropriate controlled narcotics were not lined up to be appropriately administered to her?

A I do.

MS. BROOKHYSER: Incomplete hypothetical; foundation; speculation; and calls for a legal conclusion.

BY MS. BOSSIE:

Q Did management ever inform you that the cause of death by the coroner for Mary was acute morphine intoxication?

A They did not. I was never told that.

Q Were you made aware that Life Care of Paradise Valley, by the State of Nevada, was cited for the deficiency pertaining to the unnecessary medication of the morphine being given to Mary?

A I was never told that they were cited.

EXHIBIT 22

DISTRICT COURT

CLARK COUNTY, NEVADA

Estate of MARY CURTIS, deceased; LAURA LATRENTA, a 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.	CASE NO. A-17-750520-C DEPT NO. XXIII

DEPOSITION OF LAURA LATRENTA

Taken on Wednesday, November 29, 2017

At 9:01 a.m.

At Kolesar & Leatham

400 South Rampart Boulevard, Suite 400

Las Vegas, Nevada

REPORTED BY: CINDY MAGNUSSEN, RDR, CCR NO. 650

A. I walked in to the facility. And whenever I see my mother, I try to put on a happy face. I'm sure she was unhappy being there. And I came in, and I went, Hi, Mom.

And somebody said to me, You're not going to be smiling when we tell you what happened.

Q. Okay.

A. I look at her, and I said, What are you talking about? She says, Don't worry. Now, I don't know if this phrase came before or after this next sentence, but she said, Don't worry, you're going to have your mother back in six hours. I think first she said, She was given the wrong medication.

I said -- and then she didn't offer anything after that. So I said, What medication? She said, Morphine. Nothing after that. Morphine, I repeated. These things I know exactly. How much morphine? By that time, my heart is racing.

And she says, Don't worry. You will have your mother back in six hours. And I believe she said, 120 milligrams. I know enough about morphine to know that that is a terrible dose.

At that point, the nurse started to cry. And say, I'm so sorry. I've never done this. And there was a lot of chaos. And during this whole time, my

what six hours was. But I felt I would be able to go home because frankly, what would I be doing to help her staying? So I went home to bed.

Q. When you went home, was she awake?

A. I don't recall if she was drowsy or like -- I know she wasn't like, Bye, Mom. Bye, Laura. It wasn't that. That was no more.

Q. But you can't remember if she was awake or asleep at that point?

A. I can't remember.

Q. Did you have any other conversations that day with any other Life Care Center personnel that we have not talked about?

A. I don't recall, but I might have said something to people walking in to checking her, How is she doing? What's going on? I might have had comments and questions like that.

Q. Sure. But no other conversations stand out in your mind?

A. No sitdown conversations about my mother. Other than, Oh, she's going to be fine.

Q. Okay. So when was the next time that you came back to Life Care Center?

A. The next day.

Q. Okay. Do you recall about what time you came?

A. I want to say like 11, 11:15.

Q. And you went straight to your mom's room?

A. Oh, yeah.

Q. And tell me how she looked when you got there.

A. She wasn't responsive. And there is this lady, Jen, who was this person who has been there for -- I don't know anything about her, but she was, like, her bedmate. And she said, You know, your mom has been out of it. No one has come to check her all day.

Q. When you say bedmate, you're talking about another resident?

A. There were two beds in the room. Yeah. Yeah. She was in the other bed. And I went, Mom, Mom.

Q. So you were touching her?

A. Yeah. And she wasn't responsive. And I don't know why I did this, but I took my phone out, and I videoed her not being responsive. Because I was used to seeing Ileana's videos of the bruises on her leg and how she was doing. Because Ileana always sent me videos of my mother in the grocery store or pictures of my mother.

Q. Sure.

A. So she actually taught me that. Back and forth we would send videos and pictures.

I took my phone out, and I videoed me trying to wake her. I went, Mom, Mom. Her mouth was open,

A. Are you asking me if another doctor told me that he did something wrong?

Q. That Saxena did something wrong?

A. No.

Q. There's a note in the Life Care Paradise Valley chart March 7, 2016 at 3:59 p.m. indicating that they notified you of the fact that morphine had been administered to your mother.

Do you remember learning that around that time?

A. No. I learned that when I walked in the door.

Q. Okay. Do you know what time of day that was?

A. I walked in about 12.

Q. Okay. And then were you basically in the room from 12 on that day?

A. I was in the room until maybe 2:30.

Q. Okay.

A. I went home to get the pasta, the macaroni, and I came back about 90 minutes later, to the best of my recollection.

Q. In the note, they indicate that your mother had some nausea and vomiting, less than 1 ounce. Did you see anything more than just 1 ounce of vomit?

A. I can't recall what was in the garbage can. But they made me hold it.

EXHIBIT 28

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,	CASE NO. A-17-750520-C DEPT NO. XVII Consolidated with: CASE NO. A-17-754013-c
Plaintiffs,	
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.; BINA HRIBIK PORTELLO, Administrator; CARL WAGNER, Administrator; and DOES 1-50, inclusive,	
Defendants.	
And Consolidated Action.	

DEPOSITION OF TESSIE HECHT

SATURDAY, AUGUST 4, 2018, 10:10 a.m.

SAN RAMON, CALIFORNIA

Reported by: DEBORAH WONG BROOKS, CSR, License No. 5223

their loved one would be meeting the nursing standard of care in providing that care. True?

A Yes.

Q Now I would take it, as a management nurse did you also have an expectation that the nursing staff would comply with the nursing policy and procedures that were in place at the facility?

A Yes.

Q And just from your recollection pertaining to the nursing department policy and procedures, were they in line with the standard of care in nursing?

A Yes.

Q And I take it you know what I mean by "the standard of care in nursing." Am I correct?

A Yes.

Q And if you could, in your words, just tell me what your understanding of what standard of care in nursing means.

A That the patient will receive the care that is -- quality of care which has, as according to their diagnosis when they came -- they come to the facility, the quality of care, and the nurses will provide everything from medication administration, evaluation, change of condition, communicate to the doctor whatever the change of conditions are in a timely manner.

A Yes.
Q Going on to making sure we've got the right medication, within that right there's multiple checks and balances, especially when you're dealing with controlled narcotics. Am I correct?
A Yes.
Q And let me just go through some of those checks and balances.
One, when you pull a controlled narcotic out of the locked unit, you need to look at the controlled narcotic log, make sure you've got the right medication for the right resident, and then subtract that controlled narcotic from the log.
A Yes.
Q That's the first checks and balances.
Then you would like to compare it to the medication administration record to make sure you've got the right medication and order. Am I correct?
A Yes.
Q So again, there's even more checks and balances ensuring the right medication's going to the right patient.
A Yes.
Q Now I take it that there is or should be a heightened awareness when you're providing controlled

narcotics to a resident.
A Yes.
Q That's why there's the extra steps of looking at what the medication is, comparing it to the controlled narcotic log, comparing it to the MAR, because you don't want to give a controlled narcotic to a resident that it's not meant for.
A Yes.
Q And as is well known in nursing, if you give a resident a significant dose of controlled narcotics that wasn't meant for that resident, it could potentially be not only dangerous for them. It could potentially be fatal.
MS. BROOKHYSER: Foundation. Calls for speculation.
BY MS. BOSSIE:
Q Am I correct?
A I don't know. It can. It can be. It cannot be, you know. Depends on what is the situation of the resident.
Q It is well known in nursing if you give a significant dose of morphine to someone who's not used to morphine, especially in the elderly, that it can potentially be dangerous for them or potentially be fatal.

A Yes.
Q Now, did that come from corporate to you all at the facility, that you all would need to decrease the bounce back rate to hospitals, which would mean a resident who is discharged from the hospital to the nursing home, that they don't bounce back or return to acute within that 30-day window?
A We were educated in that. Yes.
Q And I take it coming from corporate, there was an expectation to reduce the bounce back rate for the return to hospital.
MS. BROOKHYSER: Foundation.
THE WITNESS: Yes and no.
BY MS. BOSSIE:
Q And I'll get to some of the reports later. But from what I was reviewing -- well, strike that.
Did you receive the reports on the bounce back or return to acute?
A I don't know what report.
Q But you know the bounce back to hospitals were tracked.
A Tracked. Yes.
Q And there was an expectation to lower the bounce back to hospitals.
A Yes.

percent compliance." Do you see that?
A Yes.
Q So again, up until February 25th, the facility is still having issues pertaining to medication management.
A Yeah. According to this.
Q Going for a moment to March 8th of 2016.
A Yes.
Q Now, here do you see where the census is up to 92?
A Yes.
Q I'm just going back and comparing it for a moment.
Back on January 18th, do you see where the census was 78?
A Yes.
Q And then going into February 25th, the census had increased to 85?
A Yes.
Q And then going into March 8th of 2016, the census has now increased to 92. Am I correct?
A Yes.
Q Now, it's also my understanding that corporate wanted the facility to increase the census at the Paradise Valley facility.

A Yes.
Q And again, as of March 8th, medication management is an issue.
A Yes.
Q And that's where we see a medication error has now, in fact, happened.
A Yes.
Q I just want to next go back, and let me just -- give me two seconds to locate it.
This is just the one document I haven't made copies of, but we'll just kind of go through it together, and I'll put the Bates stamp numbers on the record.
MS. BROOKHYSER: Perfect. That works.
BY MS. BOSSIE:
Q Let me just ask a general question.
First of all, I take it if a medication error is being -- not "being made" -- that's probably -- strike that.
If a medication error happens at the facility, there was an expectation that the nursing staff would complete an incident report on it.
A Yes.
Q And would you, as the director of nursing, receive that incident report to review?
A Yes.

incident report in which Ativan was given without an order, and let me just show that to you.
A I see it on here.
Q And obviously a psychotropic medication should not be given to a resident without the order to do so.
A Yes.
Q And again, the facility would be on notice through the incident reports of these medication errors that we're covering. Am I correct?
A Yes.
MS. BROOKHYSER: Foundation.
BY MS. BOSSIE:
Q Just going to August 1st of 2014 where the nurse gave Xanax three tablets at 10:00 p.m. on July 31st of '14 and on August 1st of 2014 at 6:00 a.m. instead of methadone 10 milligrams three tablets. Do you see that?
A I see it. Yes.
Q So, again, the facility is on notice that there is the issue of providing the wrong medication to patients.
A I see that --
MS. BROOKHYSER: Foundation.
THE WITNESS: -- from the report.
BY MS. BOSSIE:
Q It's starting to appear to be that there is a

pattern of medication administration problems at the facility. Am I correct?

MS. BROOKHYSER: Speculation.

THE WITNESS: Yeah.

BY MS. BOSSIE:

Q Going to August 3rd of 2015, the wrong medication given to patient. The patient's room number was 108, but patient received 116 resident's medication.

A I see that from the report.

Q And again, the facility being aware that there's an ongoing problem with patients not receiving the right medication. Am I correct?

MS. BROOKHYSER: Foundation. Calls for speculation.

THE WITNESS: Yes.

BY MS. BOSSIE:

Q Going to August 9th of 2015, RN charge nurse, while providing pain IVP, noted that the stock on hand is not the same as the pain IVP on the label.

A Yes, I see it.

Q Again, we've covered 2014, and then to 2015, that there is an ongoing issue with the medication administration, and specifically patients not receiving the right medication. Am I correct?

MS. BROOKHYSER: Foundation. Calls for

was nursing labor review.
A Yes. Yes.
Q And then down below on the nursing labor review, it indicates "Connie discussed staffing with the director of nursing," whom I take is you.
A Yes.
Q "She has been staying under PPD."
So, I take it you were in compliance with the corporate expectation of staying under the labor PPD.
A Yes.
Q Then, "She has had some challenges with nurses as they have had a higher than normal turnover since the previous ED resigned." Do you see that?
A I see that.
Q Does that help refresh your recollection that you were having some issues with the turnover of staff?
A Yes.
Q Now it goes on, "Unit managers, night supervisor, SDC and ADON have been pulled to the floor frequently to fill vacant nursing spots."
A I see that.
Q So, clearly any of the managing nurses have the ability to step in and provide medications and do assessments.
A Yes.

I correct?
A Yes.
Q And then Christy is forwarding it to you and Carl so you would be aware of it. Do you see that?
A Yes.
Q And Christy even indicates "We are trying to be more vigilant with the medications as this is a high priority for our patients -- and understandably so, specially when it pertains to pain medications."
A Yes.
Q The pile is dwindling. Give me just two seconds.
Now, I believe we talked about earlier that Thelma Olea was your assistant director of nursing?
A Yes.
Q And she has testified in this matter that there was an ongoing challenge regarding appropriate medication administration prior to the events that happened to Mary Curtis. Obviously, I take it --
A Yes.
Q -- you agree with that --
A I see it.
Q -- statement, based on what we've covered.
A Yes.
Q Give me two seconds.

Thelma also had testified in this matter that at times, both nurses and CNAs would come to her and share their concerns that they needed additional CNAs and nurses. Do you remember that being passed on to you?

A I can't remember, but there might be sometimes, yeah, that it's being said to me that they need more help.

Q Now, we do know it takes people being employees to adequately and appropriately supervise residents, but also to give them adequate and appropriate and timely care.

A Yes.

Q And we have talked about that there was an ongoing issue with the turnover of staff --

A Yes.

Q -- at the Paradise Valley facility.

A Yes.

Q And I take it you can't give me specifics, but you do remember being made aware that nurses and CNAs were sharing their concerns for the need for more help to provide resident care.

MS. BROOKHYSER: Misstates her testimony.

THE WITNESS: Yes. And some patients not every day. Not all the time. Some occasions. Yes.

/ / /

BY MS. BOSSIE:

Q Do you remember Cecilia Sansome?

A Yes.

Q And she was a registered nurse. Am I correct?

A Yes.

Q And she's testified in this matter that she would observe nurses not following the standard of care in nursing, and that she was a vocal nurse, and that she reported it to management. Do you remember that?

A Yeah. Sometimes.

Q And Cecilia Sansome also testified that the acuity of care was high for the facility, and that they needed more help to meet the residents' needs.

A Yes. Acuity is high.

Q Do you remember Cecilia also bringing that to your attention?

A I remember on some occasions. Yes.

Q And I believe -- do you remember Cherry Yu, Y-U? She was a CNA.

MS. BROOKHYSER: U-Y. That's how you spell the last name.

MS. BOSSIE: First name Cherry.

THE WITNESS: Cherry.

BY MS. BOSSIE:

Q Mm-hmm. C-H-E-R-R-Y.

I kind of reviewed and read really, yeah, closely.
Q Were you concerned in any manner that there was a gap from 5 o'clock all the way to the next note, which was done by yourself at approximately 11 o'clock on the 8th?
A I did not see a documentation of the night shift, the 11:00 to 7:00, and the 7:00 to before 11:00 o'clock.
Q And I take it since you are a managing nurse and you were made aware of what happened to Mary, that you found it very concerning that there were no notes by those shifts. True?
A Yes.
Q Because as we know, the standard of care, there should be, especially after an event like this.
A Yes.
Q Now, I want to go to go March 7th, which was the day that the morphine was given to Mary when it was not meant for her. Do you have an independent recollection of, that day, being made aware of that?
A After reviewing the record, I remember the assistant director of nursing, together with the staff, came to me and told me about it.
Q Do you remember approximately when that was?
A I know it was before lunch. I can't even

THE WITNESS: I don't know. I don't know what happened. I'm trying to recollect, but it's really hard. I can't remember. I don't know what was relayed to Annabelle, you know.

BY MS. BOSSIE:

Q Well, what should be relayed to Annabelle is all of the items I've just talked about.

A I --

MS. BROOKHYSER: Same objection.

MR. VITATOE: Join.

BY MS. BOSSIE:

Q What specifically was given. What opiate. True?

A Yes.

Q How much opiate was given.

A Yes.

Q When it was given.

A Yes.

Q Whether it was extended release or short acting.

A Yes.

Q Because through your experience as a registered nurse, you would need all of that data to appropriately care and treat for Mary.

A Yes.

BY MS. BOSSIE:

Q Now, I would take it to be in compliance with the regulations governing clinical records, that clinical records and incident reports would need to be accurate, truthful, and complete.

A Yes.

Q Well, one we're starting down that we know Mary's clinical record is not complete because, first of all, there's no note for March 5th. Am I correct?

A Mm-hmm. Yes.

Q There's no note in her clinical record to specifically what was given to her, at what time, at what dose, and whether it was extended release or short acting.

A Yes.

Q That should be all contained in the clinical record so it can be a communication tool to the oncoming nurses and then the nurse the next day.

A Yes.

Q Now, just going back for a moment to the nurses' progress notes which is marked as 7 for the record.

Now, for March 7th during the day shift, there's only one note by Ms. Dawson. Am I correct? That was entered at 3:59 p.m.

A Yes.
Q If you, yourself, had done an assessment of Mary, this is where you would document the assessment.
A I would document in this.
Q And this is where Thelma, if she's doing an assessment of Mary, this is where she would be documenting.
A Yes.
Q And the same with Cecilia.
A Yes.
Q And I take it that you don't see any entry notes from Thelma or Cecilia?
A I don't see any.
Q Is that concerning to you as a managing nurse, that if you have your assistant director of nursing who is assessing along with Cecilia, that they're not putting their assessments in the clinical record so it could be passed on to the next shift and then the shift after?
A Yes.
Q Now, it's especially concerning given the fact that Mary had just been given 120 milligrams of morphine.
A Yes.
Q Ershiela Dawson had indicated that that morning was a chaotic morning. Do you remember it being a chaotic morning?

note at 8:00, but she actually just saw Mary at 5 o'clock. Do you see?

A 8:06 p.m.

Q She wrote it, but she basically testified that she saw Mary just at 5 o'clock.

A I see that.

Q And then we don't have any note on Mary Curtis from 5 o'clock in the afternoon until you're called by the daughter the next day at 11:00.

A I don't see any notes. Yes.

Q I take it as we've talked about earlier, where everyone has notice and actual knowledge of what's going on with Mary, and there's no note for over 15 to 16 hours on her, is that concerning to you?

A Yes.

Q And that's below the standard of care in nursing in monitoring after a significant event like this taking place for Mary.

MS. BROOKHYSER: Foundation.

THE WITNESS: Yes.

BY MS. BOSSIE:

Q And that's when bad things happen.

MS. BROOKHYSER: Incomplete hypothetical.

BY MS. BOSSIE:

Q Strike that.

nursing staff member is involved after being told that Mary was unarousable, you would take it to meet the standard of care that nursing would have done something about it --

A Yes.

Q -- at that time.

A Yes.

Q Not leave it to waiting till the daughter comes to the facility, walks into the room, and then sees her mom being unresponsive, and having to go out and flag down a nursing staff.

A Yes.

Q And in essence, if the nursing staff is aware that she's unable to be aroused, and they have not done anything about it, so they're aware and conscious of this information and not doing anything about it is, in essence, a conscious disregard to the health and well being of Mary Curtis, is it not?

MS. BROOKHYSER: Foundation. Incomplete hypothetical. Calls for a legal conclusion.

THE WITNESS: Can be.

BY MS. BOSSIE:

Q Not only can be. It was.

A Well --

MS. BROOKHYSER: Same objections.

BY MS. BOSSIE:
Q It was, was it not?
MS. BROOKHYSER: Same objections.
THE WITNESS: It -- it is.
BY MS. BOSSIE:
Q Do you know which nurse was assigned to Mary that morning when you were grabbed?
A I can't remember.
Q Now, going back for one moment on the night before, obviously if the facility makes the decision to keep Mary at the facility, I would take it that you would want an RN being assigned to Mary to be able to do assessments of her based on what just happened to her.
A I would. Yes.
Q Now, let me just show you for a moment which I've marked as Exhibit 5, and I believe -- first of all, we know Ershiela is just a licensed practical nurse. Am I correct?
A Yes.
Q Regina is just a licensed practical nurse.
A Yes.
Q Same with Bernadette.
A Yes.
Q And same with Deborah.
A Deborah? Yes.

BY MS. BOSSIE:
Q Let me show you a video of Mary the night before she was provided the overdose of morphine.
(Video played.)
THE WITNESS: Oh, she was talking.
BY MS. BOSSIE:
Q And seeing Mary --
A That was before the --
Q The overdose.
A Oh, okay. That was before. She's awake. Alert.
Q Conversant?
A Sounds like. Yes.
Q Wanting to get out of there. True?
A I heard that. Yes.
Q We're talking completely different than the video --
A Than the video before. Yes. I can see the difference.
Q Because going the night before Mary was overdosed on morphine -- I mean, she was alert and oriented. Able to converse. Wanting to go home. Her friend, caregiver, said "You've got to wait till tomorrow" till her daughter got there. Correct?
MS. BROOKHYSER: Compound.

THE WITNESS: I don't know. I don't know who was that lady.

MS. BOSSIE: It was compound. I agree. Let me bottom line it.

Q The person you see in the video on the night of March 6 of 2016 is completely different than the Mary that you saw at 11 o'clock on March 8th of 2016.

A So, this is March 6th.

Q Correct.

A And that's -- okay. Yes.

Q And the previous video was March 8th.

A Yes. I saw that.

Q So, clearly how she presented in the video on March 8th and to you on March 8th is completely different than how she is on March 6th.

A Yes.

Q And it was to the point that you called a code blue and 911 for Mary.

A Yes.

Q Do you know how long Mary had been non-arousable?

A I don't know.

MS. BOSSIE: Let's just take a bathroom break.

MS. BROOKHYSER: Sure.

(Off the record from 12:49 p.m. to 12:54 p.m.)

EXHIBIT 33

STATE OF NEVADA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
VITAL STATISTICS

CERTIFICATE OF DEATH

CASE FILE NO. 3883679

2016006866
STATE FILE NUMBER

TYPE OR PRINT IN PERMANENT BLACK INK

DECEDENT

1a. DECEASED-NAME (FIRST, MIDDLE, LAST, SUFFIX)		2. DATE OF DEATH (Mo/Day/Year)	3a. COUNTY OF DEATH
Mary Therese	CURTIS	March 11, 2016	Clark

3b. CITY, TOWN, OR LOCATION OF DEATH	3c. HOSPITAL OR OTHER INSTITUTION -Name(If not either, give street a	3e. If Hosp. or Inst. indicate DOA, OP/Emer Rm Inpatient(Specify)	4. SEX
Las Vegas	Nathan Adelson Hospice	Hospice Facility (HFS)	Female

5. RACE (Specify)	6. Hispanic Origin? Specify	7a. AGE-Last Birthday (Years)	7b. UNDER 1 YEAR MOS / DAYS	7c. UNDER 1 DAY HOURS / MINS	8. DATE OF BIRTH (Mo/Day/Yr)
White	No - Non-Hispanic	89			December 19, 1926

IF DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS

9a. STATE OF BIRTH (If not US/CA, name country)	9b. CITIZEN OF WHAT COUNTRY	10. EDUCATION	11. MARITAL STATUS (Specify)	12. SURVIVING SPOUSE'S NAME (Last name prior to first marriage)
New York	United States	11	Widowed	

13. SOCIAL SECURITY NUMBER	14a. USUAL OCCUPATION (Give Kind of Work Done During Most of	14b. KIND OF BUSINESS OR INDUSTRY	Ever in US Armed Forces?
132-14-1745	Homemaker	Own Home	No

15a. RESIDENCE - STATE	15b. COUNTY	15c. CITY, TOWN OR LOCATION	15d. STREET AND NUMBER	15e. INSIDE CITY LIMITS (Specify Yes or No)
Nevada	Clark	Las Vegas	1055 E Flamingo Rd #1024	Yes

PARENTS

16. FATHER/PARENT - NAME (First Middle Last Suffix)	17. MOTHER/PARENT - NAME (First Middle Last Suffix)
Jack DI CHIARA	Rose VALENTINO

18a. INFORMANT- NAME (Type or Print)	18b. MAILING ADDRESS (Street or R F D. No, City or Town, State, Zip)
Laura LATRENTA	45 Greenway Harrington Park, New Jersey 07640

DISPOSITION

19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	19b. CEMETERY OR CREMATORY - NAME	19c. LOCATION City or Town State
Entombment	Palm Valley View Cemetery	Las Vegas Nevada 89123

20a. FUNERAL DIRECTOR - SIGNATURE (Or Person Acting as Such)	20b. FUNERAL DIRECTOR LICENSE NUMBER	20c. NAME AND ADDRESS OF FACILITY
CELENA DILULLO SIGNATURE AUTHENTICATED	FD862	Palm Mortuary-Eastern 7600 S Eastern Las Vegas NV 89123

TRADE CALL — TRADE CALL - NAME AND ADDRESS

CERTIFIER

To Be Completed by CERTIFYING PHYSICIAN

21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature & Title)

21b. DATE SIGNED (Mo/Day/Yr)	21c. HOUR OF DEATH

21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

To Be Completed by CORONER'S OFFICE

22a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature & Title)
TIMOTHY DUTRA M.D.
SIGNATURE AUTHENTICATED

22b. DATE SIGNED (Mo/Day/Yr)	22c. HOUR OF DEATH
April 15, 2016	14:58
22d. PRONOUNCED DEAD (Mo/Day/Yr)	22e. PRONOUNCED DEAD AT (Hour)
March 11, 2016	14:58

23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print): Timothy Dutra M.D. 1704 Pinto Lane Las Vegas, NV 89106 — 23b. LICENSE NUMBER: 13502

REGISTRAR

24a. REGISTRAR (Signature)	24b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr)	24c. DEATH DUE TO COMMUNICABLE DISEASE
NANCY BARRY SIGNATURE AUTHENTICATED	April 18, 2016	YES ☐ NO ☒

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)

PART I
(a) Morphine Intoxication — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(b) — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(c) — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(d)

PART II OTHER SIGNIFICANT CONDITIONS-Conditions contributing to death but not resulting in the underlying cause given in Part 1. Atherosclerotic And Hypertensive Cardiovascular Disease, Dementia

26. AUTOPSY (Specify Yes or No): Yes — 27. WAS CASE REFERRED TO CORONER (Specify Yes or No): Yes

28a. ACC., SUICIDE, HOM., UNDET OR PENDING INVEST. (Specify)	28b. DATE OF INJURY (Mo/Day/Yr)	28c. HOUR OF INJURY	28d. DESCRIBE HOW INJURY OCCURRED
ACCIDENT	March 07, 2016	0800	Ingestion Of Morphine

28e. INJURY AT WORK (Specify Yes or No)	28f. PLACE OF INJURY- At home, farm, street, factory, office building, etc. (Specify)	28g. LOCATION STREET OR R F D No	CITY OR TOWN	STATE
No	Care Center	2325 E Harmon Ave	Las Vegas	Nevada

LOCAL REGISTRAR

"CERTIFIED TO BE A TRUE AND CORRECT COPY OF THE DOCUMENT ON FILE WITH THE REGISTRAR OF VITAL STATISTICS, STATE OF NEVADA." This copy was issued by the Southern Nevada Health District from State certified documents authorized by state Board of Health pursuant to NRS 440.175.

VRS-Rev-20120523a

254877

DATE ISSUED: APR 18 2016

Registrar of Vital Statistics
By:

This copy not valid unless prepared on watermarked security paper displaying date, seal and signature of Registrar.
SOUTHERN NEVADA HEALTH DISTRICT • P.O. Box 3902 • Las Vegas, NV 89127 • 702-759-1010 • Tax ID # 88-0151573

SOUTHERN NEVADA HEALTH DISTRICT

EXHIBIT 51

12-08-2015

Dear Mr Preston & Mr Hunter;

I am writing this letter anonymously to you because of fears of the repercussions or retaliation that may arise against me and my fellow co workers.
There has been many critical issues and many of these issues are still occurring with staff and patients at Life Care Paradise Valley Las Vegas.
I want to bring light into the real operations at our facility and the poor leadership and the cover up of many incidents by Tessie Hecht, RN/DON.
I pray that you will investigate and take the appropriate actions to ensure the safety of our patients and save Life Care and it's reputation.
[redacted] one of our previous patients had an incident that was never reported.
[redacted] suffered a fall in the presence of his handicapped CNA. It is well known to us that this CNA is a family member of our director of nursing Tessie Hecht.
The CNA tried to lift the patient off the floor by himself and did not call anyone to alert or assist him as per our protocol, nor did he report the incident until he knew he was seen by another non medical staff member.
Crystal the on duty RN and Tessie Hecht were notified.
Tessie Hecht did not do anything through out the day and tried covering the fall to prevent an incident report even though nurses brought to her attention many times that [redacted]" looked grayish" and was not doing well.
Towards the late hours of the day, staff members continued to see that Mr [redacted] ealth was deteriorating and was finally sent to the emergency room where he subsequently expired.
Tessie Hecht has been covering up many incidents such as having staff file false documents or write false statements in order for her not to be discovered.
Tessie Hecht has known for a long time that Crystal has made many errors such as giving wrong doses or wrong medications to patients and always covers it up for her.

I urge you to also look into the following patients care where Tessie has covered

up many mistakes in order to protect the employees of her same ethnicity who speaks in the same native language in front of other staff, families, patients and doctors so we can't understand what is occurring or being said.
Please investigate patient [redacted] where the same situation occurred.
Staff members noticed Mts [redacted] was not looking good and expressed their concerns to Tessie our DON early one day. Tessie's orders were to do nothing unless she was gravely ill to prevent a bounce back to the hospital. Eventually Mrs [redacted] worsened hours later and was sent to the hospital where again patient expired.
[redacted] currently a patient at our facility, Crystal gave the patient wrong medications and admitted to doing so. Tessie was informed but once more no action was taken by our director of nursing.
These are some of the many issues that occur on a daily basis at our facility.
Our director of nursing is endangering our patients lives and will continue to to do so unless action is taken.
I will be at my outmost attention to see if my letter has any impact on our facility. If not, I will be forced to report to the pertinent authorities and agencies and risk my future employment with your company in order to prevent anymore abuse and deaths of people we are in trusted to protect, our patients.

Sincerely,

A loyal employee