Case No. 79396

In the Supreme Court of Nevada

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

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,

Respondents.

APPEAL

from the Eighth Judicial District Court, Clark County
The Honorable JACQUELINE M. BLUTH, District Judge
District Court Case No. A-19-790152-C

RESPONDENTS' APPENDIX
VOLUME 1
PAGES 1–250

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CERTIFICATE OF SERVICE

I certify that on April 20, 2020, I submitted the foregoing RESPONDENTS' APPENDIX for filing *via* the Court's eFlex electronic filing system. Electronic notification will be sent to the following:

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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

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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

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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

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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.

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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

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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

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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.*

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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

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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

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

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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

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CLERK OF THE COURT

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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.

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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.

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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.

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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.

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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.

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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.

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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
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Las Vegas, Nevada 89145

-and-

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

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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

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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.

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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

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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

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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

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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.*

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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

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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

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[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

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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

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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

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[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

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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]

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_____, 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

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EXHIBIT C

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NEO

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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
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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*
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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-
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Las Vegas, NV 89106
Attorney for Plaintiff

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

4810-8067-4857, v. 1

ORDR
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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,

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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.

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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:

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Approved as to form and content:

/s/: James Ream, Esq.

Clay R. Treese, Esq.
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4830-1822-3913, v. 1

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CLERK OF THE COURT

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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

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DATED this 22nd day of March 2018.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By /s/ Amanda J. Brookhyser
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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.
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/s/ Nicole Etienne
By:_____
Employee of Lewis Brisbois Bisgaard & Smith, LLP

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Attorneys for Stanley Kidiavayi, RN,
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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:

////

LEWIS BRISBOIS

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.

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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

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Approved as to Form and Content by:

HALL PRANGLE SCHOONVELD

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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_____
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Attorneys for Plaintiff

EXHIBIT D

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CLERK OF THE COURT

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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

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DATED this 19 day of December, 2011.

LEWIS BRISBOIS BISGAARD & SMITH LLP

By: _____
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BRIANNA SMITH
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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

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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

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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;

JEROME TAO
DISTRICT JUDGE
DEPARTMENT XX
LAS VEGAS, NEVADA 89155

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

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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

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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

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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

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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"

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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

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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

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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").

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(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

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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

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EXHIBIT E

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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.

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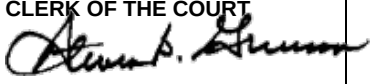

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DISTRICT COURT

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.

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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

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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,

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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 -

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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.

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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.

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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.

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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;

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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.

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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.

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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

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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

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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.

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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

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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.

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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

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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

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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.

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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.

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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.

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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.

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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

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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.

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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

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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

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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

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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

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"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).

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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

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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.

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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

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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.

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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

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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' RESPONSE TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT** Date: October 24, 2018 Time: 8:30 a.m.
Estate of MARY CURTIS, deceased; LAURA LATRENTA, as Personal Representative of the Estate of MARY CURTIS; and LAURA LATRENTA, individually, Plaintiffs,	

vs.

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

Defendant.

PLAINTIFFS' RESPONSE TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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

DATED this 4th day of October, 2018.

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MEMORANDUM OF POINTS AND AUTHORITIES

I. ISSUE

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

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

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

II. LEGAL ARGUMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. LCCPV's Argument Is Mistaken and Omissive.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Id. at 560.

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

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

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

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

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

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

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III. CONCLUSION

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

DATED this 4th day of October, 2018.

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

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CERTIFICATE OF SERVICE

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

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

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

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EXHIBIT 1

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

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

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

Amendment 1

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

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

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

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

For background information, NRS 449.0151 reads as follows:

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

1. A surgical center for ambulatory patients;

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Exhibit begins with:	H1 thru: H5

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

PROPOSED AMENDMENT 1:

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

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

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

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

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

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

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

Amendment 2

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

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

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

PROPOSED AMENDMENT 2:

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

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

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

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

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

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

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

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

(a) "Abuse" means willful and unjustified:

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

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

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

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

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

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

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

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

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

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

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

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

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

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EXHIBIT 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2016
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295076	A. BUILDING _____ B. WING _____	04/21/2016

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

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

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

5-17-16

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

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

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

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

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

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

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 8 did not read the medication order prior to the administration. The LPN believed all pain medications such as oxycodone had to be administered every four hours. Facility policy titled, "Policies for Medication Administration" revised October 2004, documented that prior to the administration of a medication, the nurse had to check the Medication Administration Record (MAR), read the order entirely, read the label three times and check the Physician order if a discrepancy was detected between the medication label and the MAR. Resident #21 Resident #21 was admitted to the facility on 3/2/16 with diagnoses that included neoplasm and pressure ulcer. On 3/6/16 Resident #21's physician ordered Morphine Sulfate ER (Extended Release) 60 milligrams two tablets, to be given by mouth every 8 hours with orders to hold for sedation or confusion. Resident #20 Resident #20 was admitted to the facility on 3/2/16 with diagnoses that included falls, syncope & collapse, chronic obstructive pulmonary disease and hypertension. The documentation indicated Resident #20's prescribed medications did not include Morphine Sulfate. Review of a facility document dated 3/7/16 indicated Resident #20 was given Morphine	F 329		

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

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

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

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

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

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

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

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

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

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

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

BEFORE THE HONORABLE MICHAEL P. VILLANI, DISTRICT COURT JUDGE

WEDNESDAY, OCTOBER 31, 2018

RECORDER'S TRANSCRIPT OF HEARING:
ALL PENDING MOTIONS

APPEARANCES:

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

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

APPEARANCES CONTINUED ON PAGE 2.

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For Defendant Saxena: VINCENT VITATOE, ESQ.

Also appearing by CourtCall: BENNIE LAZZARA, ESQ.

RECORDED BY: CYNTHIA GEORGILAS, COURT RECORDER

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Las Vegas, Nevada, Wednesday, October 31, 2018

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

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

MR. VITATOE: Cross motions; correct. Yeah.

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

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

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

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

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

THE COURT: All right, thank you.

MR. LAZZARA: Thank you, Judge.

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

MR. DAVIDSON: No.

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

THE COURT: All right, thank you.

All right, Counsel.

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

THE RECORDER: Yes.

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THE COURT: If you could.

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

THE COURT: Do you want to –

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

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

MR. VOGEL: Okay. Okay.

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

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

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THE COURT: All right, thank you.

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

[Colloquy]

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

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

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

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healthcare covered under 41A.

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

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

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

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

MS. BOSSIE: That is true.

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

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

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

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

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

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

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

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

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

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

MR. VOGEL: The gravamen.

MS. BOSSIE: The gravamen.

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

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

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

MR. VOGEL: That was my case.

MS. BOSSIE: That was your case.

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

THE COURT: Okay. Go ahead, Counsel.

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

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

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

THE COURT: Okay, well, let –

MR. VOGEL: -- says and its --

THE COURT: -- Counsel finish.

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. BOSSIE: No, no. Actually, the –

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

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MS. BOSSIE: No, under abuse –

THE COURT: -- clear on.

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

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

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

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

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

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

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

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

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

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

MS. BOSSIE: Okay.

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

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

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

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

THE COURT: All right, thank you.

Counsel.

MR. VOGEL: Yes, thank you.

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

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

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law that's not allowed.

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

MR. VOGEL: Well, you can't waive –

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

MR. VOGEL: Sure.

THE COURT: -- here and –

MR. VOGEL: You can't –

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

MR. VOGEL: Yeah.

MS. BOSSIE: We are.

THE COURT: Okay.

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

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

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

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

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

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

THE COURT: All right, thank you.

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

MR. VOGEL: Thank you.

THE COURT: -- on this issue.

All right. Thank you.

MR. DAVIDSON: Thank you, Your Honor.

MS. BOSSIE: Thank you, Your Honor.

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

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

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

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

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

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

MS. BOSSIE: Oh, is the –

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

MR. DAVIDSON: He was here.

MR. VOGEL: He was here earlier.

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

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

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

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

THE COURT: Okay.

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

MR. VOGEL: When is the next stack?

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

MR. VOGEL: The 29th.

[Colloquy between Court, Defense counsel and clerk]

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

MR. VOGEL: Right.

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

MR. VOGEL: Yeah.

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

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

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

THE COURT: Yes.

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

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

THE COURT: The November –

MS. BOSSIE: November.

THE COURT: Okay.

MS. BOSSIE: So, --

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

MR. VOGEL: Okay.

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

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

THE COURT: Yes.

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

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

MS. BOSSIE: Thank you, Your Honor.

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

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

MR. VOGEL: Keep it on.

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

MR. VOGEL: Okay.

THE COURT: All right.

MR. VOGEL: Okay, that – yeah.

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

THE COURT: Yes.

MR. DAVIDSON: -- housekeeping stuff done.

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

MS. BOSSIE: Two weeks before.

THE COURT: All right.

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MR. DAVIDSON: Thank you, Your Honor.

THE COURT: Thank you.

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

* * * * * *

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

Cynthia Georgilas

CYNTHIA GEORGILAS
Court Recorder/Transcriber
District Court Dept. XVII

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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, Appellants, vs. 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; SOUTH LAS VEGAS INVESTORS LIMITED PARTNERSHIP; LIFE CARE CENTERS OF AMERICA, INC.; AND CARL WAGNER, ADMINISTRATOR, Respondents.	Supreme Court Case No. 77810 District Court Case No. A-750520 **DOCKETING STATEMENT CIVIL APPEALS**

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DOCKETING STATEMENT CIVIL APPEALS

Appellants, Laura Latrenta, as Personal Representative of The Estate of Mary Curtis, and Laura Latrenta, Individually, by and through the undersigned counsel, hereby submit this Docketing Statement.

1. Judicial District: Eighth Judicial District

Department: XVII

County: Clark Judge: Michael P. Villani

District Ct. Case No.: A-17-750520-C

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2. Attorney filing this docketing statement:

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Attorney for Appellants

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Clients: Estate of Mary Curtis, Deceased; Laura Latrenta, As Personal Representative of the Estate of Mary Curtis; and Laura Latrenta, Individually

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If this is a joint statement by multiple appellants, add the names and addresses of other counsel and the names of their clients on an additional sheet accompanied by a certification that they concur in the filing of this statement.

3. Attorney(s) representing respondents(s):

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Attorney for Respondents

Client(s): 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; South Las Vegas Investors Limited Partnership; Life Care Centers Of America, Inc.; and Carl Wagner

4. Nature of disposition below (check all that apply):

☐ Judgment after bench trial	☐ Dismissal:
☐ Judgment after jury verdict	☐ Lack of jurisdiction
☑ Summary judgment	☐ Failure to state a claim
☐ Default judgment	☐ Failure to prosecute
☐ Grant/Denial of NRCP 60(b) relief	☐ Other (specify): .....
☐ Grant/Denial of injunction	☐ Divorce Decree:
☐ Grant/Denial of declaratory relief	☐ Original ☐ Modification
☐ Review of agency determination	☐ Other disposition (specify): .....

5. Does this appeal raise issues concerning any of the following? No

☐ Child Custody

☐ Venue

☐ Termination of parental rights

6. **Pending and prior proceedings in this court.** List the case name and docket number of all appeals or original proceedings presently or previously pending before this court which are related to this appeal:

N/A

7. **Pending and prior proceedings in other courts.** List the case name, number and court of all pending and prior proceedings in other courts which are related to this appeal (*e.g.*, bankruptcy, consolidated or bifurcated proceedings) and their dates of disposition:

Case consolidated with Case No. A-17-750520-C:
Estate of Mary Curtis v. Samir Saxena, M.D, et al.
Case No. A-17-754013-C
Eighth Judicial District Court (Clark County)

Case No. A-17-754013-C is currently pending in the Eighth Judicial District Court of the State of Nevada in and for the County of Clark.

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8. **Nature of the action.** Briefly describe the nature of the action and the result below:

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On February 2, 2017, in Case No. A-17-750520-C, Appellants filed a Complaint against Respondents 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 ("the facility"); Life Care Centers Of America, Inc.; and Carl Wagner ("Life Care Respondents" or "Respondents") alleging causes of action for (1) abuse/neglect of an older person pursuant to N.R.S. § 41.1395, (2) wrongful death (by the Estate), (3) wrongful death (by Ms. Curtis' surviving daughter), and (3) bad faith tort.

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In short, Appellants' claims against Life Care Respondents are based upon the injuries Ms. Curtis sustained during her residency at Respondents facility. The facility admitted Ms. Curtis on March 2, 2016. Mary Curtis was 90 years old at the time of her admission and therefore was considered an "older person" under NRS 41.1395. Within a week of her admission, Life Care Respondents twice permitted her to fall. Additionally and outrageously, Life Care Respondents administered a drug to Mrs. Curtis that had not been prescribed for her—morphine, in fact. As found by the District Court, Ms. Curtis was administered "a dose of morphine prescribed to another resident." Life Care Respondents knew they had wrongly administered morphine to Ms. Curtis yet failed to act timely upon that discovery, instead retaining Ms. Curtis as a resident until March 8, 2016. Only after Ms. Curtis' daughter discovered Ms. Curtis in distress on March 8, 2016, did Life Care Respondents call 911 and emergency personnel transport Ms. Curtis to the hospital. At hospital she was diagnosed with anoxic brain encephalopathy. Ms. Curtis died three days later of morphine intoxication.

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On September 10, 2018, almost two years after Appellants filed the Complaint against the Life Care Respondents, the Life Care Respondents filed their Motion for Summary Judgment arguing that Appellants' allegations were essentially allegations of professional negligence under 41A.015 and, so, Appellants had been required to file an expert affidavit at the time the Complaint was Appellants initially filed. Life

Care Respondents argued that pursuant to NRS 41A.017, the case must be dismissed because an affidavit of merit was not included. In the alternative, Life Care Respondents argued that if the District Court did not want to apply the entirety of Chapter 41A to Appellants' claims, then the District Court should still apply 41A.035 to limit Appellants' pain and suffering damages to $350,000.

On October 4, 2018, Appellants filed a Response to Life Care Respondents' Motion for Summary Judgment.

On October 31, 2018, the District Court held a hearing on Respondents' Motion for Summary Judgment.

On December 7, 2018, the District Court entered its Order Granting Respondents' Motion for Summary Judgment.

On December 11, 2018, Life Care Respondents filed the Notice of Entry of Order Granting Respondents' Motion for Summary Judgment. In the Order Granting Respondents' Motion for Summary Judgment, the District Court directed entry of judgment in accordance with NRCP 54(b).

9. Issues on appeal. State concisely the principal issue(s) in this appeal (attach separate sheets as necessary):

This appeal poses multiple questions of statewide public importance, including the obvious inconsistency between the decision of the District Court and the language of Nevada's statutes. The District Court improperly applied Chapter 41A to the case by expanding the plain meaning of NRS 41A.015 ("Professional

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negligence" defined") and NRS 41A.017 ("Provider of health care" defined). A nursing home is not included in the definition of "provider of health care" and, in fact, was intentionally and deliberately excluded from the definition in the most recent 2015 amendment to the statute. However, the District Court expanded the meaning to include the Life Care Respondents and, in effect, eviscerated NRS 41.1395, the statute enacted in 1997 to protect the State's older and vulnerable persons from abuse, neglect or exploitation. The legislative history establishes that nursing homes were contemplated by the legislature as being included under NRS 41.1395.

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In addition to ignoring the language of the statutes and eviscerating the State's statute intended to protect the vulnerable elderly population, the issues in this appeal are of statewide public importance because non-health care providers (*e.g.*, management, making resource decisions)—the conduct of which cannot realistically be the subject of an expert affidavit—can hereafter use a health care provider as a shield to demand the expert affidavit. Further, here the District Court, contrary to public policy, essentially ruled that nursing homes can avoid liability for their own conduct by hiring and hiding behind nurses (which are included in the definition of "provider of health care") when management makes it impossible for those nurses to do their jobs competently. Ms. Curtis, an older person, would not have been allowed to fall or been given the morphine but for the fact that management (*i.e.* the

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Life Care Respondents that are not providers of health care) created, promoted and maintained a toxic environment that predictably and inevitably led to her death.

In addition to the decision of the District Court and the language of the statutes outlined above, in the event Chapter 41A applies to some of Appellants' causes of action, the District Court's decision is inconsistent with the language of 41A.100 and with the published decision of the Supreme Court in *Szydel v. Markman*, 121 Nev. 453, 117 P.3d 200 (2005). In *Szydel*, the Supreme Court held that an expert affidavit in a *res ipsa loquitur* case under NRS 41A.100(1) is unnecessary. NRS 41A.100 provides that a plaintiff may condemn a licensed facility with its own regulations instead of using expert testimony. In this case, the Life Care Respondents' own regulations and the federal regulations required the staff to ensure that the right resident receives the right medication and the staff to provide residents adequate care and attention. Therefore, even if some of the claims were considered professional negligence claims, no expert affidavit was required and it would be unreasonable to require Appellants to expend unnecessary effort and expense to obtain an affidavit from a medical expert when expert testimony was not necessary to succeed at trial.

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Another question of statewide public importance, should the Supreme Court find that some or all of Appellants' claims were subject to the affidavit requirement, is whether there can ever be closure on the affidavit question; or whether, to the

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contrary, all litigation at any stage may be challenged for the lack and/or insufficiency of an expert affidavit. In the District Court, the Life Care Respondents raised noncompliance with NRS 41A.071 as an affirmative defense. This point notwithstanding, the Life Care Respondents litigated the case vigorously for years, engaging in extensive briefing, filing various motions, and conducting discovery—including receiving expert reports supporting the case and deposing the experts who authored them. Only then, almost two years into litigation and with trial in sight, did Respondents file a motion for summary judgment raising the expert affidavit defense. While it is conceivable that some cases first require exploration of the available medical testimony in order to determine the necessity of the affidavit, this is not one of those cases. The facility gave Ms. Curtis morphine prescribed for another nursing home resident. Whether such a circumstance as a matter of law requires an expert affidavit, is not an issue requiring two years of depositions to raise to the trial court. Nonetheless, and despite the wasted years in the trial court and the prejudice suffered by Appellants, the District Court held that the Life Care Respondents did not waive the defense.

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Finally, the principal issues on appeal are questions of statewide public importance because the decision of the District Court flouts the published decision of the Supreme Court in *Szymborski v. Spring Mountain Treatment Ctr.*, 403 P.3d 1280 (Nev. 2017), thereby putting the continued precedential authority of

Szymborski into question. In *Szymborski*, the Supreme Court instructed that "the medical malpractice claims that fail to comply with NRS 41A.071 must be severed and dismissed, while allowing the claims for ordinary negligence to proceed." 403 P.3d at 1285. Although Appellants brought four separate causes of action (including ordinary negligence claims) based upon the direct liability and vicarious liability of the Respondents, the District Court failed to follow precedent by failing to distinguish between the various causes of actions and theories of liability and, instead, dismissed the entire complaint for want of an expert affidavit in support of any professional negligence claims.

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10. Pending proceedings in this court raising the same or similar issues. If you are aware of any proceedings presently pending before this court which raises the same or similar issues raised in this appeal, list the case name and docket numbers and identify the same or similar issue raised:

N/A

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11. Constitutional issues. If this appeal challenges the constitutionality of a statute, and the state, any state agency, or any officer or employee thereof is not a party to this appeal, have you notified the clerk of this court and the attorney general in accordance with NRAP 44 and NRS 30.130?

☑ N/A ☐ Yes ☐ No

If not, explain:

12. Other issues. Does this appeal involve any of the following issues?

☑ Reversal of well-settled Nevada precedent (identify the case(s))

☐ An issue arising under the United States and/or Nevada Constitutions

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☑ A substantial issue of first impression

☑ An issue of public policy

☑ An issue where en banc consideration is necessary to maintain uniformity of this court's decisions

☐ A ballot question

If so, explain:

Reversal of well-settled Nevada precedent (identify the case(s))

- *Szymborski v. Spring Mountain Treatment Ctr.*, 403 P.3d 1280 (Nev. 2017). The District Court failed to follow (and, in essence, attempts to annul) the well-settled Nevada precedent stated in *Szymborski* by failing to distinguish between the various causes of actions and theories of liability and, instead, dismissed the entire complaint for want of an expert affidavit in support of any professional negligence claims. In addition to defying *Szymborski*, the District Court's ruling is in direct contradiction to the unambiguous language of Chapter 41A and NRS 41.1395, as well as the legislative history of Chapter 41A and NRS 41.1395.

A substantial issue of first impression

- Does Chapter 41A effectively pre-empt NRS 41.1395, when the causes of action for abuse or neglect of an older person are brought against a nursing home and the nursing home's parent and management companies?

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Issues having secondary effects on public policy

- If Chapter 41A effectively eviscerates NRS 41.1395 when the causes of action for abuse or neglect of an older person are brought against a nursing home (and the nursing home's parent and management companies), then the State's vulnerable elderly population is no longer protected. Rather, nursing homes may avoid liability for their own conduct in neglecting and abusing older persons by hiring and hiding behind nurses or other providers of health care when management makes it impossible for those providers of health care to do their jobs competently.
- If a defendant is allowed to continue to litigate a case for years, and only belatedly raise the defense of failure to file an expert affidavit in accordance with NRS 41A.071, then defendants will effectively be allowed to waste judicial resources and time, manipulate the judicial system (*e.g.*, engage in other substantive defenses first, while holding on to this procedural defense as a last resort), as well as be allowed to prejudice the opposing party, contrary to public policy. Furthermore, such a circumstance in Nevada law will invite affidavit challenges to extend to any stage of litigation in the future.

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13. Assignment to the Court of Appeals or retention in the Supreme Court. Briefly set forth whether the matter is presumptively retained by the Supreme Court or assigned to the Court of Appeals under NRAP 17, and cite the subparagraph(s) of the Rule under which the matter falls. If appellant believes

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that the Supreme Court should retain the case despite its presumptive assignment to the Court of Appeals, identify the specific issue(s) or circumstance(s) that warrant retaining the case, and include an explanation of their importance or significance:

The matter is presumptively retained by the Supreme Court under NRAP 17(a)(12) as the matters on appeal raise questions of statewide public importance and are upon which there is an inconsistency between the published decision of the Supreme Court and the District Court's rulings.

14. Trial. If this action proceeded to trial, how many days did the trial last?

N/A

Was it a bench or jury trial?

N/A

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15. Judicial Disqualification. Do you intend to file a motion to disqualify or have a justice recuse him/herself from participation in this appeal? If so, which Justice?

No.

TIMELINESS OF NOTICE OF APPEAL

16. Date of entry of written judgment or order appealed from:

December 7, 2018

17. Date written notice of entry of judgment or order was served

December 11, 2018

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Was service by:

☐ Delivery
☑ Mail/electronic/fax

18. If the time for filing the notice of appeal was tolled by a post-judgment motion (NRCP 50(b), 52(b), or 59)

(a) Specify the type of motion, the date and method of service of the motion, and the date of filing.

N/A

☐ NRCP 50(b) ☐ NRCP 52(b) ☐ NRCP 59

NOTE: Motions made pursuant to NRCP 60 or motions for rehearing or reconsideration may toll the time for filing a notice of appeal. *See AA Primo Builders v. Washington*, 126 Nev. 578, 245 P.3d 1190 (2010).

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(b) Date of entry of written order resolving tolling motion

N/A

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(c) Date written notice of entry of order resolving tolling motion was served

N/A

19. Date notice of appeal filed

December 27, 2018

If more than one party has appealed from the judgment or order, list the date each notice of appeal was filed and identify by name the party filing the notice of appeal:

N/A

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20. Specify statute or rule governing the time limit for filing the notice of appeal, e.g., NRAP 4(a) or other

NRAP 4(a)

SUBSTANTIVE APPEALABILITY

21. Specify the statute or other authority granting this court jurisdiction to review the judgment or order appealed from:

(a)

☑ NRAP 3A(b)(1) ☐ NRS 38.205

☐ NRAP 3A(b)(2) ☐ NRS 233B.150

☐ NRAP 3A(b)(3) ☐ NRS 703.376

☐ Other (specify)

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(b) Explain how each authority provides a basis for appeal from the judgment or order:

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NRAP 3A(b)(1) applies because Appellants are appealing the final judgment entered in the action or proceeding commenced in the court in which the judgment was rendered.

22. List all parties involved in the action or consolidated actions in the District Court:

(a) Parties:

Estate of Mary Curtis

Laura Latrenta (as Personal Representative of the Estate and individually)

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

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South Las Vegas Investors Limited Partnership

Life Care Centers Of America, Inc.

Bina Hribik Poretello

Carl Wagner

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.

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(b) If all parties in the District Court are not parties to this appeal, explain in detail why those parties are not involved in this appeal, *e.g.*, formally dismissed, not served, or other:

The parties stipulated to the dismissal of Bina Hribik Poretello. On July 17, 2017, the District Court entered an order dismissing Bina Hribik Portello pursuant to the stipulation.

Appellants settled claims with Samir Saxena, M.D. The District Court approved the settlement on July 2, 2018.

Annabelle Socaoco, N.P., IPC Healthcare, Inc. aka The Hospitalist Company, Inc., Inpatient Consultants of Nevada, Inc., IPC Healthcare Services of Nevada, Inc., and Hospitalists of Nevada, Inc. (the "IPC Defendants") are not parties to the appeal

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because the final judgment was entered against only the Respondents of Case No. A-17-750520-C. The case involving the IPC Defendants was consolidated with Case No. A-17-750520-C but contain separate allegations that were not adjudicated in the final judgment on appeal.

23. Give a brief description (3 to 5 words) of each party's separate claims, counterclaims, cross-claims, or third-party claims and the date of formal disposition of each claim.

N/A

24. Did the judgment or order appealed from adjudicate ALL the claims alleged below and the rights and liabilities of ALL the parties to the action or consolidated actions below?

☐ Yes ☑ No

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25. If you answered "No" to question 24, complete the following:

(a) Specify the claims remaining pending below:

Wrongful Death by Estate against the IPC Defendants

Wrongful Death by Individual against the IPC Defendants

Medical Malpractice against the IPC Defendants

(b) Specify the parties remaining below:

All IPC Defendants: 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.

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(c) Did the District Court certify the judgment or order appealed from as a final judgment pursuant to NRCP 54(b)?

☑ Yes ☐ No

(d) Did the District Court make an express determination, pursuant to NRCP 54(b), that there is no just reason for delay and an express direction for the entry of judgment?

☑ Yes ☐ No

26. If you answered "No" to any part of question 25, explain the basis for seeking appellate review (*e.g.*, order is independently appealable under NRAP 3A(b)):

N/A

27. Attach file-stamped copies of the following documents:

- The latest-filed complaint, counterclaims, cross-claims, and third-party claims
- Any tolling motion(s) and order(s) resolving tolling motion(s)
- Orders of NRCP 41(a) dismissals formally resolving each claim, counterclaims, cross-claims and/or third-party claims asserted in the action or consolidated action below, even if not at issue on appeal
- Any other order challenged on appeal
- Notices of entry for each attached order

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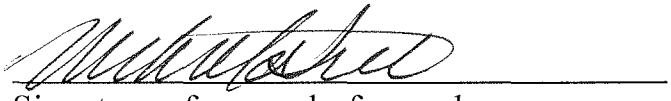
VERIFICATION

I declare under penalty of perjury that I have read this docketing statement, that the information provided in this docketing statement is true and complete to the best of my knowledge, information and belief, and that I have attached all required documents to this docketing statement.

Estate of Mary Curtis, Laura Latrenta, as Personal Representative and Individually	Michael D. Davidson, Esq. Kolesar & Leatham
Name of Appellants	Name of counsel of record
January 24, 2019	
Date	Signature of counsel of record

Nevada, Clark County
State and county where signed

CERTIFICATE OF SERVICE

I certify that on the 24th day of January, 2019, I served a copy of this completed docketing statement upon all counsel of record:

☐ By personally serving it upon him/her; or

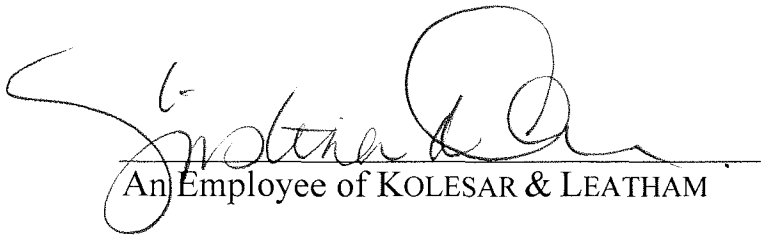
☑ By mailing it by first class mail with sufficient postage prepaid to the following address(es):

S. Brent Vogel, Esq.
Amanda J. Brookhyser, Esq.
LEWIS BRISBOIS BISGAARD & SMITH
6835 S. Rainbow Blvd, Suite 600
Las Vegas, Nevada 89118

Attorneys for Respondent

Israel L. Kunin, Esq.
KUNIN LAW GROUP
3551 East Bonanza Rd # 110
Las Vegas, Nevada 89110

Settlement Judge



An Employee of KOLESAR & LEATHAM

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EXHIBIT 1

Complaint for Damages (Case No. A-17-750520-C) filed on 02/02/2017

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EXHIBIT 1

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

Landlord/Tenant
- ☐ Unlawful Detainer
- ☐ Other Landlord/Tenant

Title to Property
- ☐ Judicial Foreclosure
- ☐ Other Title to Property

Other Real Property
- ☐ Condemnation/Eminent Domain
- ☐ Other Real Property

Torts

Negligence
- ☐ Auto
- ☐ Premises Liability
- ☑ Other Negligence

Malpractice
- ☐ Medical/Dental
- ☐ Legal
- ☐ Accounting
- ☐ Other Malpractice

Other Torts
- ☐ Product Liability
- ☐ Intentional Misconduct
- ☐ Employment Tort
- ☐ Insurance Tort
- ☐ Other Tort

Probate

Probate *(select case type and estate value)*
- ☐ Summary Administration
- ☐ General Administration
- ☐ Special Administration
- ☐ Set Aside
- ☐ Trust/Conservatorship
- ☐ Other Probate

Estate Value
- ☐ Over $200,000
- ☐ Between $100,000 and $200,000
- ☐ Under $100,000 or Unknown
- ☐ Under $2,500

Construction Defect & Contract

Construction Defect
- ☐ Chapter 40
- ☐ Other Construction Defect

Contract Case
- ☐ Uniform Commercial Code
- ☐ Building and Construction
- ☐ Insurance Carrier
- ☐ Commercial Instrument
- ☐ Collection of Accounts
- ☐ Employment Contract
- ☐ Other Contract

Judicial Review/Appeal

Judicial Review
- ☐ Foreclosure Mediation Case
- ☐ Petition to Seal Records
- ☐ Mental Competency

Nevada State Agency Appeal
- ☐ Department of Motor Vehicle
- ☐ Worker's Compensation
- ☐ Other Nevada State Agency

Appeal Other
- ☐ Appeal from Lower Court
- ☐ Other Judicial Review/Appeal

Civil Writ

Civil Writ
- ☐ Writ of Habeas Corpus
- ☐ Writ of Mandamus
- ☐ Writ of Quo Warrant
- ☐ Writ of Prohibition
- ☐ Other Civil Writ

Other Civil Filing

Other Civil Filing
- ☐ Compromise of Minor's Claim
- ☐ Foreign Judgment
- ☐ 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.

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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

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

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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.

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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.

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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.

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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.

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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.

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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.

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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.
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-and-

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

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EXHIBIT 2

Amended Complaint for Damages filed on 05/01/2018

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EXHIBIT 2

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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 **AMENDED COMPLAINT FOR DAMAGES** **1. Abuse/Neglect of an Older Person** **2. Wrongful Death by Estate** **3. Wrongful Death by Individual Medical Malpractice**
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	

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NEVADA, INC.; HOSPITALISTS OF NEVADA, INC.; and DOES 51–100,

Defendant.

AMENDED COMPLAINT FOR DAMAGES

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 Amended Complaint against Defendants Samir Saxena, M.D., Annabelle Socaoco, N.P., IPC Healthcare, Inc. aka IPC The Hospitalist Company, Inc., Inpatient Consultants of Nevada, Inc., IPC Healthcare Services of Nevada, Inc., Hospitalists of Nevada, Inc., and Does 51 through 100, and allege as follows:

GENERAL ALLEGATIONS

1. Decedent Mary Curtis suffered while a resident at Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley significant physical injury 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. She died on March 11, 2016 in Las Vegas.

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 Samir Saxena, M.D. was a licensed physician who provided medical care at Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley and was Ms. Curtis's treating physician thereat.

4. Defendant Samir Saxena, M.D., was and is a resident of the State of Nevada.

5. Plaintiffs are informed and believe and thereon allege that at all relevant times Defendant Annabelle Socaoco, N.P., was a licensed nurse practitioner who provided medical care under Defendant Saxena's supervision at Life Care Center of South Las Vegas f/k/a Life

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Care Center of Paradise Valley.

6. Defendant Annabelle Socaoco, N.P., was and is a resident of the State of Nevada.

7. Defendant IPC Healthcare, Inc., a Delaware corporation aka The Hospitalist Company, Inc., and/or its affiliated entities Inpatient Consultants of Nevada, Inc., a California corporation; IPC Healthcare Services of Nevada, Inc., a California corporation; and Hospitalists of Nevada, Inc., a Missouri corporation, was at all relevant times employer of Defendants Samir Saxena, M.D., and Annabelle Socaoco, N.P.

8. Defendant IPC Healthcare, Inc., and/or its affiliated entities Inpatient Consultants of Nevada, Inc.; IPC Healthcare Services of Nevada, Inc.; and Hospitalists of Nevada, Inc., as employer of Defendants Saxena and Socaoco, who were at all relevant times acting within the course and scope of their employment, is vicariously liable for the acts, omissions, and failures of Defendants Saxena and Socaoco.

9. Plaintiffs are informed and believe and thereon allege that Defendants Does 51 through 100 are other individuals or entities that caused or contributed to injuries suffered by Ms. Curtis as discussed below. (Hereinafter "IPC Defendants" refers to Samir Saxena, M.D., Annabelle Socaoco, N.P., IPC Healthcare, Inc., Inpatient Consultants of Nevada, Inc., IPC Healthcare Services of Nevada, Inc., Hospitalists of Nevada, Inc., and Does 51 through 100.)

10. 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.

11. 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.

12. 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

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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.

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

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

13. Plaintiffs hereby incorporate the allegations in all the foregoing paragraphs as though fully set forth herein.

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

15. 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.

16. 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 immediately 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 care.

17. During her Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley residency Ms. Curtis was dependent on IPC Defendants for medical care.

18. IPC Defendants knew that Ms. Curtis relied on them for her medical care and that without that care she would be susceptible to injury and death.

19. Life Care Center staff on 7 March 2016 administered to Ms. Curtis, who had not been prescribed morphine, morphine prescribed to another resident.

20. Despite Dr. Saxena's notice and knowledge that Life Care Center of South Las Vegas staff had wrongly administered morphine to Ms. Curtis resulting in a morphine overdose, and although a reasonably trained physician would have recognized that she required treatment in an acute care setting, he failed to timely order that she be sent to an acute care setting, leading

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to Ms. Curtis's retention at Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley until 8 March 2016 and contributing to her injuries and death.

21. Despite Dr. Saxena's notice and knowledge of Ms. Curtis's morphine overdose, and although a reasonably trained physician would have recognized that she required a Narcan IV drip (or ongoing dosages of Narcan equivalent thereto), he failed to order such a treatment. He also knew or should have known that she required the close observation that an acute care hospital would provide. These failures contributed to her injuries and death.

22. Despite NP Socaoco's notice and knowledge that Life Care Center of South Las Vegas staff had wrongly administered morphine to Ms. Curtis resulting in a morphine overdose, and although a reasonably trained nurse practitioner would have recognized that she required treatment in an acute care setting, NP Socaoco failed to timely order that she be sent to an acute care setting, leading to Ms. Curtis's retention at Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley until 8 March 2016 and contributing to her injuries and death. NP Socaoco instead ordered that Ms. Curtis be given Narcan.

23. Despite NP Socaoco's notice and knowledge of Ms. Curtis's morphine overdose, and although a reasonably trained nurse practitioner would have recognized that she required a Narcan IV drip (or ongoing dosages of Narcan equivalent thereto), she failed to order such a treatment. She also knew or should have known that Ms. Curtis required the close observation that an acute care hospital would provide. These failures contributed to her injuries and death.

24. Life Care Center of South Las Vegas staff eventually called 911 and emergency personnel transported Ms. Curtis to Sunrise Hospital, where she was diagnosed with anoxic brain encephalopathy and put on a Narcan IV drip. She was later transferred to Nathan Adelson Hospice on 11 March 2016 and died shortly thereafter.

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

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

27. IPC Defendants' actions were abuse under N.R.S. § 41.1395(4)(a) and neglect

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under N.R.S. § 41.1395(4)(c).

28. IPC 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.

29. 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.

30. 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.

31. Despite IPC Defendants' notice and knowledge that Ms. Curtis was dependent on them for her medical care, 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.

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

SECOND CAUSE OF ACTION

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

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

34. IPC Defendants, in providing medical care for Ms. Curtis, had a duty to exercise the level of knowledge, skill, and care of medical professionals in good standing in the community.

35. IPC Defendants breached their duties to Ms. Curtis and were negligent and careless in their actions and omissions as set forth above.

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

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37. 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.

38. Despite IPC Defendants' notice and knowledge that Ms. Curtis was dependent on them for her medical care, 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 IPC Defendants)

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

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

41. IPC Defendants, in providing medical care to Ms. Curtis, had a duty to exercise the level of knowledge, skill, and care of medical professionals in good standing in the community.

42. IPC Defendants breached their duties to Ms. Curtis and were negligent and careless in their actions and omissions as set forth above.

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

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

45. As a further direct and proximate result of IPC 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.

46. 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.

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FOURTH CAUSE OF ACTION

(Medical malpractice by all Plaintiffs against IPC Defendants)

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

48. Upon Ms. Curtis's admission to Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley, IPC Defendants assumed responsibility for her medical care and had a duty to use such skill, prudence, and diligence as other similarly situated medical professionals in providing medical care to dependent and elderly residents such as Ms. Curtis.

49. Ms. Curtis was dependent on IPC Defendants for her medical care while at Life Care Center of South Las Vegas f/k/a Life Care Center of Paradise Valley.

50. Despite IPC Defendants' knowledge of Ms. Curtis's dependence on them for medical care, they failed to provide adequate medical care to her, as alleged above.

51. IPC Defendants failed to meet the applicable standard of care in their medical care for Ms. Curtis, including by (1) failing to order that she be sent to an acute care hospital in response to her morphine overdose; (2) failing to order that she receive a Narcan drip (or ongoing dosages of Narcan equivalent thereto); and (3) failing to recognize or to act on their recognition that she required the close observation that an acute care hospital would provide.

52. IPC Defendants' medical care of Ms. Curtis fell below the standard of care and was a proximate cause of her injuries and damages, including by contributing to her death. This allegation is supported by the Affidavit of Loren Lipson, MD, *see* Ex. 1, Lipson Aff., and by the Affidavit of Kathleen Hill-O'Neill, RN, DNP, MSN, NHA. *See* Ex. 2, Hill-O'Neill Aff.

53. Ms. Curtis's injuries and death were therefore the result of IPC Defendants' negligence.

54. The damages and injuries directly and proximately caused by IPC Defendants' malpractice were permanent.

55. As a direct and proximate result of IPC Defendants' malpractice and Ms. Curtis's resulting death, Laura Latrenta incurred damages of grief, sorrow, companionship, society, comfort and consortium, and damages for pain and suffering, mental anguish, hospitalizations,

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and medical and nursing care and treatment.

56. The damages and injuries directly and proximately caused by IPC Defendants' malpractice were permanent, including future pain and suffering, loss of companionship, and mental anguish from Ms. Curtis's untimely death.

57. Plaintiffs' past and future damages exceed $10,000.

58. Wherefore, Plaintiffs pray for judgment against IPC Defendants 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 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 1st day of May, 2018.

KOLESAR & LEATHAM

By */s/ Michael D. Davidson, Esq.*
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CERTIFICATE OF SERVICE

I hereby certify that I am an employee of Kolesar & Leatham, and that on the 1st day of May, 2018, I caused to be served a true and correct copy of foregoing **AMENDED COMPLAINT FOR 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

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EXHIBIT 3

Stipulation to Dismiss Bina Hribik Poretello Without Prejudice filed on 07/18/2017

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EXHIBIT 3

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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 **STIPULATION TO DISMISS BINA HRIBIK PORETELLO WITHOUT PREJUDICE**

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COME NOW, the parties, by and through their undersigned attorneys, and respectfully requests the Court enter an Order dismissing Bina Hribik Portello without prejudice, each party to bear its own costs. The parties further stipulate to the withdrawal of Defendant Bina Hribik Portello's Motion for Summary Judgment and to vacate the hearing, currently scheduled for July 25, 2017.

This Stipulation shall not affect the status of Plaintiff's claims against the remaining Defendants.

DATED this 6 day of July, 2017

KOLESAR & LEATHAM

By:_____
MICHAEL D. DAVIDSON, ESQ.
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-and-

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Arizona Bar No. 022825
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15333 N. Pima Rd., Ste. 300
Scottsdale, Arizona 85260

Attorneys for Plaintiff

DATED this ___ day of July, 2017

LEWIS BRISBOIS BISGAARD & SMITH LLP

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

Attorneys for Defendants

IT IS SO ORDERED.

DATED this ____ day of June, 2017.

See next page

_____
DISTRICT COURT JUDGE

Submitted by:
KOLESAR & LEATHAM

By:_____
MICHAEL D. DAVIDSON, ESQ.
Nevada Bar No. 000878
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Attorneys for Plaintiffs

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Las Vegas, Nevada 89145
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COME NOW, the parties, by and through their undersigned attorneys, and respectfully requests the Court enter an Order dismissing Bina Hribik Portello without prejudice, each party to bear its own costs. The parties further stipulate to the withdrawal of Defendant Bina Hribik Portello's Motion for Summary Judgment and to vacate the hearing, currently scheduled for July 25, 2017.

This Stipulation shall not affect the status of Plaintiff's claims against the remaining Defendants.

DATED this __ day of July, 2017

KOLESAR & LEATHAM

By:_____
MICHAEL D. DAVIDSON, ESQ.
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Attornevs for Plaintiff

DATED this 12 day of July, 2017

LEWIS BRISBOIS BISGAARD & SMITH LLP

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

Attorneys for Defendants

IT IS SO ORDERED.

DATED this 17 day of June, 2017.

_____
DISTRICT COURT JUDGE

JUDGE STEFANY A. MILEY

Submitted by:
KOLESAR & LEATHAM

By:_____
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Attorneys for Plaintiffs

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EXHIBIT 4

Order Granting Defendants' Motion for Summary Judgment filed on 12/07/2018

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

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

Plaintiffs,

Vs.

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

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

ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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SAMIR SAXENA , M.D.,

Defendant

ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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

FINDINGS OF FACT

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

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

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

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

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

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

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Brown, at *8.

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

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

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

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

IT IS SO ORDERED

DATED this 3 day of Dec., 2018.

DISTRICT COURT JUDGE

JM

Submitted by:

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