IN THE COURT OF COMMON PLEAS OF LYCOMING COUNTY, PENNSYLVANIA

SELENA R. STETTS, as Administratrix of the Estate of GARY E. STETTS, Deceased, Plaintiff	:	No. 16-0983
vs.	:	Civil Action
MANOR CARE OF WILLIAMSPORT PA (NORTH), LLC d/b/a MANORCARE HEALTH SERVICES - WILLIAMSPORT NORTH; HCR MANORCARE, INC.; and HCR MANOR CARE SERVICES, LLC, Defendants	:	Professional Liability Action
	:	Defendants' Motion to Remand and Defendants' Motion for Partial Summary Judgment

OPINION AND ORDER

AND NOW, following argument held August 12, 2021 on Defendants' Motion to Remand to Compulsory Arbitration and Defendants' Motion for Partial Summary Judgment, the Court hereby issues the following OPINION and ORDER.

I. BACKGROUND

Plaintiff commenced this action by filing a Writ of Summons on June 28, 2016, followed by a Complaint on February 16, 2018. Defendants are Manor Care of Williamsport PA (North), LLC d/b/a ManorCare Health Services – Williamsport North ("Facility"), a skilled nursing facility, HCR ManorCare, Inc., and HCR Manor Care Services, LLC ("Corporate Defendants").[1] Plaintiff alleges that Decedent, Gary E. Stetts ("Mr. Stetts") was a resident at the Facility from July 30, 2014 through August 25, 2014, and that while there he suffered a "skin tear to the right calf, a fluid-filled blister to the right heel, significant weight loss, poor hygiene, and severe pain" attributable to the negligent, reckless, or intentional actions of Defendants. Plaintiff alleges numerous grounds for liability, including not only claims that individual

[1] On August 10, 2021, Plaintiff withdrew all claims against a number of previously-named Corporate Defendants. *See* fn. 49, *infra*.

employees of the Facility were negligent or reckless but also broad claims of corporate liability, including allegations that various policies and procedures of the Corporate Defendants resulted in understaffing and generally unsafe practices at the Facility.

Defendants filed Preliminary Objections to the Complaint on March 7, 2018; this Court ruled on the Preliminary Objections on March 15, 2019.[2] Plaintiff filed an Amended Complaint on March 28, 2019. The Amended Complaint includes four counts: breach of duty of care against all Defendants;[3] breach of fiduciary duty against the Facility; aiding and abetting breach of fiduciary duty against the Corporate Defendants; and a claim under the Survival Statute[4] against all Defendants.

Defendants filed an Answer and New Matter on April 23, 2019, and Plaintiff filed a Reply to New Matter on May 13, 2019. Following the close of discovery, Defendants filed the two instant motions: a Motion for Partial Summary Judgment, and a Motion to Remand to Compulsory Arbitration.

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[2] Shortly after Defendants filed preliminary objections, this matter was briefly stayed during the pendency of a collateral proceeding in another jurisdiction. Additionally, the Court granted the parties a period of discovery related solely to the resolution of the Preliminary Objections. These two factors accounted for the delay of over a year between the filing of Preliminary Objections and the Court's Order ruling on them.

[3] This count broadly encompasses claims of negligence against the Facility, claims of vicarious liability against the Corporate Defendants, claims of independent corporate negligence against the Corporate Defendants, and claims of negligence *per se* against all Defendants.

[4] 42 Pa. C.S. § 8302.

II. LEGAL STANDARD

Pennsylvania Rules of Civil Procedure 1035.1 through 1035.5 govern the filing of motions for summary judgment.[5] When deciding a motion for summary judgment, the Court must view the record in the light most favorable to the non-moving party, with all doubts as to whether a genuine issue of material fact exists being decided in favor of the non-moving party.[6] The party moving for summary judgment bears the burden of proving both the absence of an issue of material fact and its right to judgment as a matter of law.[7] Once the moving party has met its burden, if the non-moving party fails to produce sufficient evidence on an issue on which that party bears the burden of proof, the moving party is entitled to summary judgment as a matter of law.[8] The Court will only grant summary judgment, however, "where the right to such judgment is clear and free from all doubt."[9]

In a case in which the parties rely in significant part on affidavits, depositions, and expert reports, the Court is especially cognizant of its role in resolving a motion for summary judgment:

> The function of the summary judgment proceedings is to avoid a useless trial but is not, and cannot, be used to provide for trial by

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[5] Under Rule 1035.2, "[a]fter the relevant pleadings are closed, but within such time as to not unreasonably delay trial, any party may move for summary judgment in whole or in part as a matter of law (1) whenever there is no genuine issue of any material fact as to a necessary element of the cause of action or defense which could be established by additional discovery or expert report, or (2) if, after the completion of discovery relevant to the motion, including the production of expert reports, an adverse party who will bear the burden of proof at trial has failed to produce evidence of facts essential to the cause of action or defense which in a jury trial would require the issues to be submitted to a jury." Pa. R.C.P. 1035.2.
[6] *Keystone Freight Corp. v. Stricker*, 31 A.3d 967, 971 (Pa. Super. 2011).
[7] *Holmes v. Lado*, 602 A.2d 1389, 1391 (Pa. Super. 1992).
[8] *Id.* (citing *Young v. Pa. Dept. of Transp.*, 744 A.2d 1276, 1277 (Pa. 2000)).
[9] *Summers v. Certainteed Corp.*, 997 A.2d 1152, 1159 (Pa. 2010) (quoting *Toy v. Metro. Life Ins. Co.*, 928 A.2d 186, 195 (Pa. 2007)).

> affidavits or trial by depositions. That trial by testimonial affidavit is prohibited cannot be emphasized too strongly. In considering a motion for summary judgment, the lower court must examine the whole record, including the pleadings, any depositions, any answers to interrogatories, admissions of record, if any, and any affidavits filed by the parties. From this thorough examination the lower court will determine the question of whether there is a genuine issue as to any material fact. On this critical question, the party who brought the motion has the burden of proving that no genuine issue of fact exists. All doubts as to the existence of a genuine issue of a material fact are to be resolved against the granting of summary judgment.
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> In determining the existence or non-existence of a genuine issue of a material fact, courts are bound to adhere to the rule of [*Nanty–Glo*] which holds that a court may not summarily enter a judgment where the evidence depends upon oral testimony.

With regard to expert opinions in the context of summary judgment, our Supreme Court has said:

> It has long been Pennsylvania law that, while conclusions recorded by experts may be disputed, the credibility and weight attributed to those conclusions are not proper considerations at summary judgment; rather, such determinations reside in the sole province of the trier of fact….

> At the summary judgment stage, a trial court is required to take all facts of record, and all reasonable inferences therefrom, in a light most favorable to the non-moving party. This clearly includes all expert testimony and reports submitted by the non-moving party or provided during discovery; and, so long as the conclusions contained within those reports are sufficiently supported, the trial judge cannot *sua sponte* assail them in an order and opinion granting summary judgment. Contrarily, the trial judge must defer to those conclusions... and should those conclusions be disputed, resolution of that dispute must be left to the trier of fact.[10]

Defendants seek summary judgment on five issues. These are:

- "Motion for Summary Judgment to dismiss Count One negligence *per se* claims under criminal code 18 Pa. C.S. § 2713 and under 35 P.S. § 10225.101."
- "Motion for Summary Judgment to dismiss Count Two breach of fiduciary duty claims."
- "Motion for Summary Judgment to dismiss Count Three claims of aiding and abetting the Facility's alleged breach of fiduciary duty."
- "Motion for Summary Judgment to dismiss corporate negligence claims."
- "Motion for Summary Judgment to dismiss Plaintiff's claims for punitive damages."

[10] *DeArmitt v. New York Life Ins. Co.*, 73 A.3d 578, 594-96 (Pa. Super. 2013) (internal citations omitted).

III. MOTION FOR PARTIAL SUMMARY JUDGMENT

Because each portion of Defendants' Motion for Partial Summary Judgment, as well as Plaintiff's response, is heavily dependent on Plaintiff's expert reports, a review of the expert reports of Plaintiff's experts Richard M. Dupee, MD, MACP, AGSF, FRSM and Noreen Brzozowski, MSN, RN is helpful.

A. Plaintiff's Expert Reports

Plaintiff has produced two expert reports. The first is by Dr. Richard M. Dupee, MD, MACP, AGSF, FRSM. The second is by Nurse Noreen Brzozowksi, MSN, RN. In their Motion for Partial Summary Judgment, Defendants highlight numerous areas in which they allege Plaintiff's experts fail to support Plaintiff's claims. Plaintiff generally responds that the expert reports, when read contextually in their entirety, as opposed to granularly and out of context, support the claims made in the Amended Complaint, creating – at the very least – issues of fact sufficient to defeat a motion for summary judgment.

1. Dr. Dupee's Report

Dr. Dupee's written opinion is 13 pages. The first four pages of the opinion list the records Dr. Dupee reviewed and summarize Mr. Stetts's medical records from Williamsport Hospital, where he was located immediately prior to his transfer to the Facility. Pages 5 through 10 summarize Mr. Stetts's records from his 27 days at the facility, providing occasional comment.

On pages 5 and 6, Dr. Dupee discusses Mr. Stetts's initial intake plan and assessments, which identified numerous preexisting medical issues and areas of concern, including fall risk. Dr. Dupee opined that "[t]hese assessments, and

interventions needed, reflect[] the plan of care that was required for his care, a care plan that the entire staff knew or should have known."

Pages 7 and 8 of Dr. Dupee's opinion describe the August 1, 2014 incident during which Mr. Stetts suffered a "serious injury" to his leg during a transfer from his bed to an electric wheelchair. Dr. Dupee commented that "Mr. Stetts suffered an extremely painful injury due to carelessness by the ManorCare Williamsport North staff, in direct defiance of the facility mechanical lift policy," and "Mr. Stetts was morbidly obese, requiring at least a 3-person assistance with transfers. The failure to raise the arms on his motorized chair, which was the standard of care, directly resulted in this preventable injury, a result of carelessness and indifference by the ManorCare Williamsport North[11] staff."

Pages 9 and 10 describe the remainder of Mr. Stetts's time at the Facility, including notes related to skin changes on his right heel. Dr. Dupee notes that staff initially described this wound vaguely, as "a black, hard area," before providing a more specific description. This portion of the discussion noted that Mr. Stetts purportedly refused certain attempts by the Facility's staff to provide care. On these issues, Dr. Dupee commented:

> An area is hardly a reasonable description of a skin injury, as shortly after this notation, we find that Mr. Stetts suffered a deep tissue injury. Ms. Ladson[12] was required to completely identify and quantify this injury and chose not to do so.

[11] Throughout his report, Dr. Dupee refers to the Facility as "ManorCare Williamsport North."
[12] A nurse who described the "area" on Mr. Stetts's heel.

> Refusals, or non-compliance, by any patient, require an intense intervention as to the cause of such refusals. And the refusal should be defined; is it non-compliance, a rejection of advice, defiance, or a non-acceptance? In addition, is a refusal due to discomfort? We do know that Mr. Stetts was suffering with pain, and thus his refusal may have been due to poor pain management. The ManorCare Williamsport North staff was required to investigate all sources and causes of the "refusal," and yet failed to do so, a significant denial of reasonable care.… Mr. Stetts was allowed to suffer a deep tissue injury to his heel, as the ManorCare staff failed to provide him with pressure relief intervention.

Pages 11 through 13 of Dr. Dupee's Opinion provide his "Comment" and ultimate opinion on the totality of the care received by Mr. Stetts at the Facility. Dr. Dupee first notes some general issues with "the care provided in nursing facilities such as ManorCare Williamsport North," and describes how:

> [s]tructured comprehensive and individualized assessment and safety recommendations by care-teams can reduce injuries in nursing homes such as ManorCare Williamsport North by a substantial amount. Components of such teams include nursing, medicine, rehabilitation, and social service as well as those responsible for maintaining a safe environment including administration maintenance and housekeeping. Education of all staff regarding proper transfer critiques is critical in every nursing facility, using a continuous quality improvement (CQI)

> that is consistent with current efforts to improve care. Communication strategies, coordinating efforts to align staff should be a part of the care plan in reducing the risk for injury. This includes transfer of information so that the entire staff is informed and educated as to how to properly and safely transfer a patient such as Mr. Stetts.

Dr. Dupee gives his opinion that "ManorCare Williamsport North chose to deny such interventions, thus allowing Mr. Stetts to suffer painful injury to his leg which led to a worsening level of function, loss of dignity and loss of quality of life."

Dr. Dupee next discusses various federal regulations contained in the Nursing Home Reform Act, which he describes as providing "[t]he acceptable standard of care…." He explains that these regulations generally require facilities to strive for residents' conditions to improve or not worsen, to account for any lack of improvement or worsening, and to create comprehensive care plans that assess the totality of residents' needs in order to "attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being…." Dr. Dupee opines that, in contravention of these regulations:

> ManorCare Williamsport North failed to provide Mr. Stetts with "the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care," by failing to provide proper and safe transfers, thus allowing him to suffer [a] painful leg injury. ManorCare Williamsport North failed to properly

assess Mr. Stetts for his "refusals," thus allowing him to suffer a deep tissue injury to his heel.

Dr. Dupee next addresses the two statutory provisions serving as the basis for Plaintiff's negligence *per se* claims:

> The Commonwealth of Pennsylvania regulation 18 Pa. C.S.A. § 2713 "Neglect of Care Dependent Person" expressly states that older adults are not to be abused or neglected, particularly in health care facilities or by persons holding themselves out as trained professionals, and that if such abuse or neglect causes injury, either physical or mental, then such conduct is actionable. This regulation was designed to protect vulnerable adults, such as Mr. Stetts, from harm. Mr. Stetts was caused to suffer painful injury by the staff of ManorCare Williamsport North, holding themselves out as trained professionals, by failing to properly and safely transfer him to his wheelchair.
>
> The Commonwealth of Pennsylvania Regulation 35 P.S. §10225.101, "Pennsylvania Older Adults Protective Services Act," requires facilities such as Manor[C]are Williamsport North in caring for older adults such as Mr. Stetts, "who lack the capacity to protect themselves and are at imminent risk of abuse, neglect, exploitation or abandonment," to "have access to and be provided with services necessary to protect their health, safety and welfare."
>
> Mr. Stetts was denied services necessary to protect his health, safety and welfare, as he was allowed to suffer a painful leg injury due to

> neglectful care by the Manor[C]are Williamsport North by failing to properly and safely transfer him to his wheelchair.

Dr. Dupee concludes his report with his ultimate opinion concerning the Facility's care of Mr. Stetts:

> It is my opinion, to a reasonable degree of medical certainty that the owners, management, staff, agents and employees of ManorCare Williamsport North recklessly failed to comply with their duties of care for Mr. Stetts. It was the responsibility of the ownership, the management, governing body and administration of ManorCare Williamsport North to assure that the facility was adequately staffed for the acuity and care needs of its residents; that the staff had sufficient training, knowledge and ability to provide for the above care requirements by education, monitoring of the provision of care and constant re-evaluation of the staff's ability to perform tasks required by their professional training and that were in concert with the protocols and policies and procedures of ManorCare Williamsport North.
>
> Based upon the above, the records reviewed, my training and professional experience, it is my opinion, to a reasonable degree of medical certainty, that the above-cited failures of care, when taken together, constitute at times reckless indifference to Mr. Stetts'[s] circumstances, at times reckless and oppressive behavior, and inexcusable deviations from the standard of care by the apparently untrained, understaffed, unskilled, and under-supervised staff at

ManorCare Williamsport North, and all of which increased risk of harm and caused actual harm. The staff at this skilled nursing facility was either insufficient, incompetent, poorly trained or poorly supervised to provide the care required by reasonable standards, and as a direct result, allowed Mr. Stetts to suffer substantial harm.

2. Nurse Brzozowski's Report

Nurse Brzozowski's report is 12 pages. The first 3.5 pages discuss her credentials, list the records she reviewed, and briefly summarize Mr. Stetts's medical history prior to his time at the Facility. The remainder of the report is a general discussion of the care received by Mr. Stetts at the Facility; throughout this section, Nurse Brzozowski refers to applicable federal regulations.

Nurse Brzozowski begins by noting, generally, that her "[r]eview of [the] medical records from MCHS-WN[13] revealed several deviations from industry standards of practice and a pattern of inadequate and substandard care." She opines that "[s]taff knew or should have known that Mr. Stetts'[s] clinical diagnoses and multiple co-morbidities put him at risk for patient safety issues and clinical decline," and that "Mr. Stetts'[s] right to receive quality healthcare and to enjoy a quality of life were violated because of staffs' failures to ensure that he was provided with consistent, knowledgeable, and professional care necessary to maintain his highest level of well-being." Nurse Brzozowski describes her belief that "Mr. Stetts… was dependent upon the staff for his physical, mental, psycho-social, medical, nursing, and custodial needs, requiring assistance with activities of daily living as he

[13] Throughout her report, Nurse Brzozowski refers to the Facility as "MCHS-WN."

had various illnesses and conditions that required evaluation and treatment [and] required early detection and interventions from MCHS-WN staff for a vulnerable at-risk resident." She describes "MCHS-WN staff's failures to provide consistent nursing care for basic hygiene needs [and] assistance with all activities of daily living… failure to recognize and implement safety precautions during patient care and with patient transfers (out of bed)… failure to provide proper and documented staff training for nurses' aides for managing [the lift equipment], [and] failure for providing adequate levels of staffing and physician/nursing supervision."

Nurse Brzozowski addresses a number of specific issues in turn, beginning with "failure to provide quality care and prevent accidents." She noted that on two occasions in 2013,[14] the Facility was found to be out of compliance with certain Pennsylvania Department of Health requirements concerning fall prevention and provision of care. She further noted that the Facility "had a history of NON-COMPLIANCE with several [federal] requirements,"[15] but stated that "MCHS-WN did supply documents and plans for corrective actions for each non-compliant requirement in each of the DOH surveys." Nurse Brzozowski opined that "[s]taff failed to recognize and implement consistent safety precautions, during patient transfers, for the prevention of accidents, such as skin-related injuries." She discussed Mr. Stetts's weight, including how his size factored into his family's decision to rely on the Facility, as the Facility represented they could provide the appropriate level of care for a patient of Mr. Stetts's size.[16]

[14] The year prior to Mr. Stetts's stay at the Facility.
[15] Emphasis in original.
[16] Mr. Stetts weighed 448 pounds at the time of his admission to the Facility.

Nurse Brzozowski listed 11 skin issues that were present prior to Mr. Stetts's admission to the Facility, as well as the issues with his right heel that occurred after his admission. Regarding these issues, Nurse Brzozowski opined:

> MCHS-WN staff did provide wound care as ordered but there was inconsistent documentation and continuity of care issues addressing resident's needs in MCHS-WN records and nursing care plans for wound care and [activities of daily living] for basic hygiene/grooming, repositioning, transfers, and mobility needs. Staff documentation was very limited and sometimes records were illegible and blurry regarding consistent and scheduled repositioning, skin protection precautions, treatments, and medications. Although documented evidence did show that the resident did refuse Prevalon boots (to protect and elevate heels).
>
> In summary, based on documentation provided, it is my opinion that the care at MCHS-WN was deficient, fell below the standard of care, and resulted in harm to Mr. Stetts as detailed throughout this report.

The next subsection of Nurse Brzozowski's report addresses "Nurse Aid Training/Competency Evaluation Programs." She notes "[s]taff documentation in MCHS-WN records revealed extensive assistance (5 staff members for assist) for resident, Mr. Stetts," and details the various descriptions of the August 1, 2014 incident with the lift in Mr. Stetts's records and his family members' depositions. Nurse Brzozowski explained that she found "[n]o documented evidence… for nurses' aide training in the operation of specialty equipment," including the lift Mr. Stetts was

in when he suffered the skin tear. She also found "[n]o documented evidence that the mechanical lift procedure was followed by staff to prevent any accidents or skin related injuries," and opined "[c]onsistent staff supervision, staff protective oversight and competency training were found to be missing at MCHS-WN." She ultimately opined that "based on documentation provided and with my experience in caring for bariatric patients; it is my opinion that there should have been at least 6 staff members assisting and providing care to Mr. Stetts. It is also my opinion that the care at MCHS-WN was deficient, fell below the standard of care and resulted in harm to Mr. Stetts as detailed throughout this report."

Nurse Brzozowski's report next deals with "Staffing, Staff Supervision, and Staff Training." She notes that "[n]ursing care plans, staff supervision, and staff education were poorly documented or not documented at all," with many of the plans "illegible and blurry." Nurse Brzozowski discussed requirements and standards of care for nurse staffing schedules, detailing the statutory responsibilities of registered nurses, including "[e]valuat[ing] the effectiveness of the quality of nursing care provided." She noted that "[a]dditional nurses' aides were necessary for Mr. Stetts['s] care due to the diagnosis of Morbid Obesity… skin issues/multiple wounds, mobility and use of a [lift] for transfers from bed to motorized wheelchair," and that "[p]rior documentation revealed that there were 4-5 staff needed to assist Mr. Stetts." Nurse Brzozowski broadly noted "Mark Stetts['s][17] Deposition Transcript on November 5, 2020 revealed complaints of inadequate staffing at MCHS-WN." This section concludes with a brief summary of the emergency room records from September

[17] Mr. Stetts's son.

2015 concerning the medical emergency that ultimately led to Mr. Stetts's death.[18] Nurse Brzozowski concluded her expert report by stating:

> In conclusion, the staff at MCHS-WN and its owners, managers, consultants, and agents deviated from the standard of care in their care and treatment of Gary E. Stetts. Such deviations included: failure to provide (on a consistent and dependable basis): total healthcare for ADLs (including ordinary custodial and hygiene needs), failure to recognize and implement safety precautions during resident care and with resident transfers to out of bed with proper use of specialty equipment (Tenor Hoyer Lift) to prevent skin related injuries and accidents, skilled nursing services, physician and nurses oversight and supervision for a totally dependent resident that required extensive assistance from staff at MCHS-WN.
>
> Mr. Gary Stetts had a higher acuity level thus rendering these needs to be provided on a consistent, dependable, and professional manner by qualified healthcare staff at MCHS-WN.
>
> As a result of the failures, Mr. Stetts suffered from avoidable accidents and skin related injuries and inconsistent and inadequate care and nursing supervision related to activities of daily living.

[18] The report does not explain how the records of this event, which occurred approximately 13 months after Mr. Stetts's discharge from the Facility, are relevant.

B. Motion for Summary Judgment to Dismiss Negligence *Per Se* Claims under Criminal Code 18 Pa. C.S. § 2713 and 35 P.S. § 10225.101 *et sub.*

Negligence *per se* is a legal concept that "establishes both duty and the required breach of duty where an individual violates an applicable statute, ordinance or regulation designed to prevent a public harm."[19] A negligence *per se* claim has four elements: "(1) [t]he purpose of the statute must be, at least in part, to protect the interest of a group of individuals, as opposed to the public generally; (2) [t]he statute or regulation must clearly apply to the conduct of the defendant; (3) [t]he defendant must violate the statute or regulation; and (4) [t]he violation of the statute or regulation must be the proximate cause of the plaintiff's injuries."[20]

Among other theories of negligence, Plaintiff claims that Defendants have breached two statutes: the criminal code's prohibition on neglect of care dependent persons[21] and the Older Adults Protective Services Act.[22]

1. Neglect of Care-Dependent Person, 18 Pa. C.S. § 2713

Defendants make two arguments in support of their motion for summary judgment on negligence *per se* under 18 Pa. C.S. § 2713,[23] the first of which is

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[19] *Cabiroy v. Scipione*, 767 A.2d 1078, 1079 (Pa. Super. 2001).
[20] *Ramalingam v. Keller Williams Realty Grp., Inc.*, 121 A.3d 1034, 1042-43 (Pa. Super. 2015).
[21] 18 Pa. C.S. § 2713.
[22] 35 P.S. § 10225.101 *et seq*.
[23] 18 Pa. C.S. § 2713(a) reads:

> (a) Offense defined.—A caretaker is guilty of neglect of a care-dependent person if he:
>
> > (1) Intentionally, knowingly or recklessly causes bodily injury, serious bodily injury or death by failing to provide treatment, care, goods or services necessary to preserve the health, safety or welfare of a care-dependent person for whom he is responsible to provide care.

similar to one they raised in their third preliminary objection to the original Complaint. Defendants contend that 18 Pa. C.S. § 2713 "provide[s] an inappropriate basis for a negligence per se claim" because it "do[es] not prescribe particular acts that should or should not be done." For the reasons discussed in the Court's March 15, 2019 Opinion and Order addressing Defendants' Preliminary Objections, the Court believes § 2713 may properly serve as an appropriate basis for negligence *per se*.[24]

Defendants also argue that "Plaintiff's expert reports do not support" this basis for negligence *per se*. Defendants specifically contend that "Plaintiff's expert, Dr. Dupee, makes a one-sentence comment that § 2713 was allegedly violated by 'the staff of Manor Care Williamsport North… by failing to properly and safely transfer [Mr. Stetts] to his wheelchair,' with no further elaboration." Defendants argue that this opinion "is not only extremely overbroad, but it also fails to establish how the conduct of the staff was 'intentional,' knowing,' or 'reckless.'" Ultimately, Defendants argue that Plaintiff "will be unable to establish [her] prima facie case as to negligence *per se* and the same is proper for dismissal…."

Plaintiff responds that Defendants have mischaracterized Dr. Dupee's opinion, in that "Dr. Dupee specifically opines that the conduct of the Defendants *as described*

> (2) Intentionally or knowingly uses a physical restraint or chemical restraint or medication on a care-dependent person, or isolates a care-dependent person contrary to law or regulation, such that bodily injury, serious bodily injury or death results.
> (3) Intentionally, knowingly or recklessly endangers the welfare of a care-dependent person for whom he is responsible by failing to provide treatment, care, goods or services necessary to preserve the health, safety or welfare of the care-dependent person.

[24] The March 15, 2019 Opinion and Order explicitly overruled Defendants' Preliminary Objection in the nature of a demurrer to the negligence *per se* claim premised on 18 Pa. C.S. § 2713, explaining that "a private cause of action is not required for negligence *per se*, and the statute is sufficiently specific for negligence *per se*."

throughout his report constitutes a violation of [§ 2713]."[25] Plaintiff argues that there is no requirement that their expert provide separate opinions or testimony on the question of negligence *per se*, and that the "sufficient expert support to support [Plaintiff's] claims of professional negligence" is also sufficient to support Plaintiff's claims of negligence *per se*. Plaintiff further avers the record[26] contains a genuine issue of material fact on the issue of negligence *per se*, in that "the evidence of record demonstrates that the Defendants knowingly understaffed the facility… [and] knew that the personnel on duty would not be able to properly attend to the medical needs" of Mr. Stetts.

The Court agrees with Plaintiff that the record contains a genuine issue of material fact that precludes a grant of summary judgment on this claim. Dr. Dupee's expert report, when read as a whole, alleges conduct which, if proven at trial, could be found to violate the duty imposed by 18 Pa. C.S. § 2713. Dr. Dupee opines that the Facility "chose to deny" certain assessments and procedures, "thus allowing Mr. Stetts to suffer painful injury to his leg." He notes the need for "[e]ducation of all staff regarding proper transfer critiques" and "transfer of information so that the entire staff is informed and educated as to how to properly and safely transfer a patient such as Mr. Stetts." Specifically, he remarks "Mr. Stetts suffered an extremely painful injury due to carelessness by the ManorCare Williamsport North staff, in direct defiance of

[25] Emphasis in original.
[26] For the purposes of a Motion for Summary Judgment, the "record includes any pleadings, depositions, answers to interrogatories, admissions and affidavits, and reports signed by an expert witness that would, if filed, comply with Rule 4003.5(a)(1)…." Pa. R.C.P. 1035.1. An expert report complies with Rule 4003.5(a)(1) if it identifies the expert and states the subject matter on which the expert is expected to testify, the substance of the facts and opinions to which the expert is expected to testify, and a summary of the grounds for each opinion. Pa. R.C.P. 4003.5(a)(1).

the facility mechanical lift policy…. Mr. Stetts was morbidly obese, requiring at least a 3-person assistance with transfers. The failure to raise the arms on his motorized chair, which was the standard of care, directly resulted in this preventable injury, a result of the carelessness and indifference by the ManorCare Williamsport North staff." The language of Dr. Dupee's opinions, when read in a light most favorable to Plaintiff, could support a finding of intent, knowledge, or recklessness sufficient to allow a jury to conclude that the Facility violated 18 Pa. C.S. § 2713.[27]

The Court disagrees with Defendants that a failure to grant summary judgment "will create irreparable prejudice… by misleading and confusing a jury," as the duty of care imposed by 18 Pa. C.S. § 2713 appears to be largely or entirely subsumed within the duty of care owed generally to patients in a medical facility. Indeed, it is difficult to imagine a scenario in which a medical provider could be liable for "[i]ntentionally, knowingly, or recklessly caus[ing] bodily injury… by failing to provide treatment, care, goods or services necessary to preserve the health, safety or welfare of a care-dependent person" but not be liable for negligently causing said bodily injury in general. Plaintiff still bears the burden at trial of showing that the conduct alleged to violate the statute was the cause of Mr. Stetts's injuries.

The question before the Court is not whether the Court finds Plaintiff's factual averments convincing on the merits; rather, the Court must decide whether Defendants have met their burden of demonstrating the absence of an issue of material fact, establishing their clear right to judgment as a matter of law. Because

[27] Specifically, Dr. Dupee's allegations that the Facility "chose to deny" certain care, treated Mr. Stetts "careless[ly]" and "in direct defiance" of the relevant policies, and caused him injury through "carelessness and indifference" support levels of culpability beyond mere negligence.

Dr. Dupee's opinions, if accepted, could ostensibly support a finding that the Facility violated 18 Pa. C.S. § 2713, the Court cannot say that Defendants' right to judgment on this issue is so "clear and free from all doubt" as to allow a grant of summary judgment.

2. Older Adults Protective Services Act

Defendants first argue, as with 18 Pa. C.S. § 2713, that the Older Adults Protective Services Act provides an inappropriate basis for a negligence *per se* claim in light of its language and its purposes. Although Defendants also raised this argument in their preliminary objections to the original Complaint, they did so in the alternative to another argument: that Plaintiff's claims in the original Complaint in this regard should be stricken for a lack of specificity. It was this latter argument that was addressed – and credited – by the Court, which allowed Plaintiff to amend her claims to state with specificity which statutes served the basis of her claim.[28]

Plaintiff's Amended Complaint did not remove any language pertaining to the Older Adults Protective Services Act, retaining all references to 35 P.S. §10225.101 *et seq*. However, the Amended Complaint added the following paragraph: "35 P.S. § 10225.701 provides that an employee or an administrator of a facility who has reasonable cause to suspect that a resident is a victim of abuse shall immediately

[28] Paragraph Four of this Court's March 15, 2019 Order reads:

> *Preliminary Objection Four* is **SUSTAINED IN PART**. Defendants argue that Plaintiff's claims under Count I regarding negligence *per se* pursuant to 35 P.S. §10225.101 *et seq*. ("Older Adults Protective Services Act") should be stricken for the same reasons as expressed under their third preliminary objection [concerning 18 Pa. C.S. § 2713]. Alternatively, Defendants assert it should be stricken for lack of specificity. The Court agrees that Plaintiff cannot generally cite to the Act and claim specificity. Therefore, Plaintiff will be granted twenty (20) days to amend her complaint, stating the particular statutes applicable to her claims.

make an oral report to the appropriate agency and law enforcement officials, and within 48 hours shall make a written report to the agency."[29] The Amended Complaint also added language that "Defendants… were negligent 'per se' and violated… 35 P.S. §10225.701 in that they had reasonable cause to suspect that Gary E. Stetts was the victim of abuse or neglect and failed to report said abuse and neglect to the appropriate agency and law enforcement officials."[30]

Defendants did not file preliminary objections to the Amended Complaint, instead filing an Answer on April 23, 2019. Defendants specifically responded to the above claims by, *inter alia*, referencing the Court's March 15, 2019 ruling partially granting their fourth preliminary objection, noting "[p]ursuant to the Court's Order dated March 15, 2019, Plaintiff was ordered to cite to the specific statutes applicable to her claims. As such, any reference to '35 P.S. § 10225.101, *et seq.*' lacks specificity and is in violation of the Court's Order."[31]

Defendants also argue that the record is devoid of a genuine issue of fact concerning this claim. Defendants, averring that "[t]he [Older Adults Protective Services Act] is a reporting statute which has nothing to do with the provision of care

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[29] Amended Complaint, ¶118. 35 P.S. § 10225.701(a) states:

> (a) Mandatory reporting to agency.--
>
> (1) An employee or an administrator who has reasonable cause to suspect that a recipient is a victim of abuse shall immediately make an oral report to the agency. If applicable, the agency shall advise the employee or administrator of additional reporting requirements that may pertain under subsection (b). An employee shall notify the administrator immediately following the report to the agency.
>
> (2) Within 48 hours of making the oral report, the employee or administrator shall make a written report to the agency. The agency shall notify the administrator that a report of abuse has been made with the agency.
>
> (3) The employee may request the administrator to make or to assist the employee to make the oral and written reports required by this subsection.

[30] Amended Complaint, ¶121.

[31] Answer, ¶111-123.

and services by licensed healthcare personnel," argue that the record generally, and Dr. Dupee's report specifically, are "insufficient to establish any applicability of Plaintiff's claims" under the Older Adults Protective Services Act.

As with her claims for negligence *per se* under 18 Pa. C.S. § 2713, Plaintiff alleges "Dr. Dupee specifically opines that the conduct of the Defendants ***as described throughout his report*** constitutes a violation of the Older Adult[s] Protective Services Act."[32] Plaintiff argues "the evidence of record shows that Mrs. Stetts repeatedly raised concerns to the staff that Mr. Stetts was not getting the care he so desperately needed. Any one of the staff members or members of the Facility Administration that Mrs. Stetts raised these complaints to had every reason to suspect that Mr. Stetts was the victim [of] neglect and abuse and therefore was under the obligation to report it to the appropriate agencies and law enforcement officials."

Nonetheless, the Court grants Defendants' motion for summary judgment on this claim. The Court agrees with Defendants that the Amended Complaint's references to "35 P.S. §10225.101 *et seq*." are insufficiently specific in a manner already addressed in the preliminary objections and highlighted in Defendants' Answer. Broad averments to an Act with over twenty sections are insufficient to state a claim upon which relief can be granted.

Further, although Plaintiff has adequately and specifically stated a claim for negligence *per se* premised on a violation of §10225.701, the record fails to support such a claim. Section 10225.701 imposes a reporting requirement upon "[a]n employee or administrator who has reasonable cause to suspect that a recipient is a

[32] Emphasis in original.

victim of abuse…." Dr. Dupee's opinion on the Older Adults Protective Services Act claim was clearly not addressed to this requirement of "abuse", instead concluding "Mr. Stetts was denied services to protect his health, safety and welfare, as he was allowed to suffer a painful leg injury due to neglectful care by the Manor[C]are Williamsport North by failing to properly and safely transfer him to his wheelchair." Plaintiff points to Mrs. Stetts's deposition testimony indicating that she "repeatedly raised concerns to the staff that Mr. Stetts was not getting the care he so desperately needed," and essentially argues that any one of these communications between Mrs. Stetts and a staff member was sufficient to trigger the reporting requirement. The record, however, is devoid of any evidence, let alone expert opinion, to establish that these communications were sufficient to constitute "reasonable cause to suspect… abuse" as would be required to trigger the statute. The record is also devoid of any testimony or evidence linking the alleged failure to report potential abuse to any injury or damages sustained by Mr. Stetts; therefore, any causation element of the claim, on the record before the Court, is pure conjecture.

C. <u>Motion for Summary Judgment to Dismiss Breach of Fiduciary Duty Claims against the Facility</u>

Defendants next seek summary judgment on Count Two of the Amended Complaint, which alleges, *inter alia*, "the Facility… was a fiduciary of [Mr. Stetts]"; "[t]he Facility breached and violated their relationship of trust, special confidence, and their fiduciary obligations and duties owed to [Mr. Stetts]"; "the Facility acted in bad faith and used their position of trust and special confidence to [Mr. Stetts's] detriment and to their own advantage"; and "[t]he conduct of the Facility was intentional,

outrageous, willful and wanton and exhibited a reckless indifference to its fiduciary duties as it related to [Mr. Stetts]." Plaintiff seeks punitive damages on this claim.[33]

Defendants argue "[a] fiduciary relationship does not arise merely because one party relies on the specialized skill or expertise of the other party. The critical question is whether the relationship goes beyond mere reliance on superior skill, and into a relationship characterized by 'overmastering influence' on one side or 'weakness, dependence, or trust, justifiably reposed on the other side.'" Defendants describe the question of whether a nursing home has a fiduciary relationship with a patient as a "case by case" inquiry, and argue that because Mr. Stetts was alert, oriented, and able to make his own decisions, even going so far as to frequently reject attempted care and intervention, he was not in a fiduciary relationship with the Facility. Defendants aver that Plaintiff has offered no expert opinion on the question of whether a fiduciary duty existed between the Facility and Mr. Stetts.[34]

Plaintiff agrees with Defendants that the question of whether a nursing home has a fiduciary relationship with a resident must be determined on a case-by-case basis, but argues that such a relationship clearly existed between the Facility and Mr. Stetts. Plaintiff contends that both of her experts note that Defendants accepted Mr. Stetts into their facility and "expressly represented that they could and would provide Mr. Stetts with the care he so desperately needed," and that questions of Mr. Stetts'

[33] Defendants have filed a separate motion for summary judgment on the issue of punitive damages, which is addressed *infra*.

[34] Defendants also reiterate the argument, raised in their fifth preliminary objection to the original Complaint, that this count should be barred by the "gist of the action" doctrine. For the reasons stated in this Court's March 15, 2019 Order, the gist of the action doctrine is not applicable to this claim.

alleged non-compliance with Defendants are issues of fact that must be determined by a jury.

Both parties cite *Zaborowski v. Hospitality Care Ctr. Of Hermitage, Inc.*,[35] a 2002 case from the Court of Common Pleas of Mercer County, as describing the case-by-case inquiry a court must conduct to determine whether a fiduciary relationship exists between a nursing home and a resident. In *Zaborowski*, the decedent entered the resident facility, a skilled care nursing home, in 1997 and remained there until her death.[36] The plaintiff alleged that, following a management change in late 2000, the facility provided inadequate care leading to decedent's death in April 2001.[37] The plaintiff brought, *inter alia*, a count for breach of fiduciary duty, alleging that the defendants "breached their fiduciary duties to plaintiff's decedent with respect to her care and treatment."[38] The facility and the other defendants filed a preliminary objection in the nature of a demurrer, "assert[ing] that their relationship with… decedent was one of caregiver to patient and was not fiduciary in nature."[39]

The Court explained that "[u]nder Pennsylvania law, a fiduciary relationship exists 'when one person has reposed a special confidence in another to the extent that the parties do not deal with each other on equal terms, either because of an overmastering dominance on one side or weakness, dependence or justifiable trust,

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[35] *Zaborowski v. Hospitality Care Center of Hermitage, Inc.*, 60 Pa. D. & C.4th 474 (Pa. Com. Pl. Mercer Cty 2002).
[36] *Id*. at 477.
[37] *Id*.
[38] *Id*.
[39] *Id*. at 488.

on the other."[40] Under this standard, "a simple contract does not establish a fiduciary relationship. Instead, a fiduciary duty is created based upon the nature of the relationship between the parties involved."[41]

The Court held that, although a fiduciary relationship generally arises in a financial context, "the relationship between a nursing home and its residents can be fiduciary in nature," because

> [M]any if not most nursing home residents are in a vulnerable physical and/or mental state. Placing a loved one in such a facility necessarily entails trust on the part of the family as well as the resident. Since the residents reside in the home, the family has comparatively limited access and opportunity to learn if the resident is neglected or otherwise mistreated. If entrusting one's money to a receiver or conservator created a business relationship, one would hope at least in principle that entrusting a valued family member to the care of a business entity such as a nursing home would carry similar responsibilities.[42]

Holding that the inquiry must be case by case and that the burden of the establishing such a relationship rests with the plaintiff, the Court in *Zaborowski* dismissed the defendants' preliminary objection, because the plaintiff "alleged that [the] decedent 'was entrusted for her care and treatment into the exclusive care, custody, and control of'" the facility, and that "[a]s a result of this entrustment, a fiduciary duty was formed… which [the facility] subsequently breached by 'failing to

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[40] *Id*.
[41] *Id*.
[42] *Id*. at 489 (quoting *Schenck v. Living Centers-East Inc.*, 817 F. Supp. 432, 438 (E.D. La. 1996)).

use the highest standard of care in regard to the care and treatment of" the decedent.[43] The Court explained that the plaintiff would "have the burden of proving that a fiduciary duty existed between the… decedent and [the facility] at trial [by] adduc[ing] sufficient evidence showing that the… decedent was subject to the overmastering dominance of [the facility] or that her weakness, dependence or justifiable trust on [the facility] created a special confidence thereby imposing a fiduciary duty."[44]

Keeping in mind that the Court must scrupulously avoid substituting its own judgment for that of the factfinder, the Court cannot conclude at this time that the issue is "clear and free from all doubt" so as to justify a grant of summary judgment. Plaintiff has alleged that the Facility "entered into a special relationship with [Mr. Stetts] due to their voluntary assumption of an overmastering and domineering role over the destiny of [Mr. Stetts's] well-being, who was at all times a vulnerable individual requiring significant care and assistance." Neither party has provided a case indicating whether the proof of a fiduciary relationship requires an expert to explicitly conclude that such a relationship existed, and the Court has been unable to find such a case.[45] Plaintiff notes that her experts each suggest that the Facility knew or should have known, based on assessments conducted upon Mr. Stetts's intake, that he would require such comprehensive care as to render him essentially helpless. Indeed, Plaintiff alleges that the Facility was chosen due to its representations that it could handle the special care Mr. Stetts required, given his

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[43] *Id*. at 490.
[44] *Id*.
[45] Generally, an expert is not required to use "magic words," and courts should look to the substance of their testimony. *Welsh v. Bulger*, 698 A.2d 581, 585-86 (Pa. 1997).

weight and preexisting health conditions. The question of whether the Facility exercised an "overmastering influence" over Mr. Stetts during the relatively brief time he was a resident there, as opposed to merely being in a relationship of special knowledge and care, is highly dependent on which facts Plaintiff can prove at trial. Therefore, summary judgment on this issue is inappropriate.

D. Motion for Summary Judgment to Dismiss Aiding and Abetting Breach of Fiduciary Duty Claims against Corporate Defendants

Defendants next seek summary judgment on Plaintiff's claims for aiding and abetting the Facility's alleged breach of fiduciary duty. The elements of aiding and abetting a breach of a fiduciary duty are "(1) a breach of a fiduciary duty owed to another; (2) knowledge of the breach by the aider and abettor; and (3) substantial assistance or encouragement by the aider and abettor in effecting that breach."[46]

Defendants argue Plaintiff's experts "are… silent as to any involvement of the Corporate Defendants in a breach of any possible fiduciary relationship," and "[t]here are no direct facts in the evidentiary record showing that the Corporate Defendants aided or abetted any alleged breach of fiduciary duty by the Facility…." Plaintiff responds that she has alleged:

> [T]he corporate Defendants exercised dominance and control over the Facility's revenues, knowingly and intentionally created inter-company fees and transfers comprised of revenues obtained from the Facility's residents and transferred them to Corporate Defendants instead of allowing the Facility to use said resources to meet the needs of the

[46] *Koken v. Steinberg*, 825 A.3d 723, 732 (Pa. Cmwlth. 2003).

> residents, diverted funds necessary for patient care to corporate Defendants…, [and] structured the… business model of the Facility which constrained the Facility's ability to provide care to the Facility's residents.

Plaintiff contends that specific facts in the record support these allegations, namely that "ManorCare Health Services, LLC collected over $400,000 in 'home office fees'… [but] the Facility Administrator could not identify what, if any services were provided in exchange for these significant fees," and that "the evidence of record demonstrates that under the budget set by HCR ManorCare, Inc., the Facility was constrained to a designated staffing level, far below that which was required to meet the needs of the residents…."

Unlike Plaintiff's claim that the Facility allegedly breached a fiduciary duty to Mr. Stetts, which is supported by Plaintiff's expert reports, evidence in support of the claim that the Corporate Defendants aided or abetted the allege breach cannot be discerned from even a searching reading of the expert reports. Dr. Dupee's sole reference to the Corporate Defendants was his vague conclusion that:

> It was the responsibility of the ownership, the management, governing body and administration of ManorCare Williamsport North to ensure that the facility was adequately staffed for the acuity and care needs of its residents; that the staff had sufficient training, knowledge and ability to provide for the above care requirements by education, monitoring of the provision of care and constant re-evaluation of the staff's ability to perform tasks required by their professional training and that were in

> concert with the protocols and policies and procedures of ManorCare Williamsport North…. The staff at this skilled nursing facility was either insufficient, incompetent, poorly trained or poorly supervised to provide the care required by reasonable standards, and as a direct result, allowed Mr. Stetts to suffer substantial harm.

Nurse Brzozowski's report, similarly, does not contain any facts or opinions to support the claim that the Corporate Defendants knew of an alleged breach of fiduciary duty and provided substantial assistance or encouragement to the Facility in that breach. Rather, Nurse Brzozowski, like Dr. Dupee, merely opines in a conclusory fashion that "the staff at MCHS-WN *and its owners, managers, consultants, and agents* deviated from the standard of care in their treatment of Gary E. Stetts."[47] The vast majority of Nurse Brzozowski's conclusions and opinions relate to the Facility.

Plaintiff points to certain opinions of Nurse Brzozowski as directly implicating the Corporate Defendants in aiding and abetting a breach of fiduciary duty. Nurse Brzozowski, however, draws no such conclusions herself. For instance, Nurse Brzozowski notes:

> Nursing staffing schedules should include an RN supervisor, other RNs (as applicable and based on number of beds within the facility), LPNs and nurses' aides. HPPD (Hours Per Patient Day) documents revealed that totals for 7/30/14-8/25/14 time showed a decrease in total HPPD for the scheduled staff. Total hours worked during this time was 3.17

[47] Emphasis added.

but budgeted amounts revealed 3.3005. Thus, there was a decrease in HPPD. Time Punch report data showed that many of the staff's time punches did not complete an 8-hour shift.

Nurse Brzozowski's report provides no context for this statement. Importantly, she does not link the drop in HPPD to any policy or directive of the Corporate Defendants or to any injury suffered by Mr. Stetts. Nurse Brzozowski's report does baldly indicate she found a "failure [to provide] adequate levels of staffing" but does not otherwise elaborate on what would have been adequate or, more importantly, how this alleged inadequacy affected Mr. Stetts's care. Plaintiff argues, in response to the motion for summary judgment, that "the evidence of record demonstrates that under the budget set by HCR ManorCare, Inc., the Facility was constrained to a designated staffing level, far below that which was required to meet the needs of the residents," but Plaintiff's experts' reports do not in any way connect the budgeting or corporate structure of the Corporate Defendants to staffing in the Facility, let alone the care provided to Mr. Stetts.

Even taking "all facts of record, and all reasonable inferences therefrom, in a light most favorable to" Plaintiff, the record is devoid of evidence that any Corporate Defendant knew of an alleged breach of fiduciary duty or provided "substantial assistance or encouragement" to the Facility in effecting the Facility's alleged breach of fiduciary duty. Therefore, the Court grants Defendants' motion for summary judgment on this claim.

E. Motion for Summary Judgment to Dismiss Corporate Negligence Claims

Defendants next seek summary judgment on Plaintiff's corporate negligence claims. Noting that a corporate negligence claim requires more than an act of negligence by an individual for whom a corporate defendant is responsible, Defendants argue that Plaintiff has failed to demonstrate, for each Corporate Defendant, an individualized duty owed by that Defendant to Mr. Stetts. Defendants note "[i]n order to support a corporate liability theory, Plaintiff must produce expert testimony to establish that there was a deviation of the accepted standard of care and that the deviation was a substantial factor in causing harm."[48] Defendants characterize Plaintiff's experts as "silent to the relationship as well as the alleged duty, breach and causation between Mr. Stetts and [the various] named [corporate] entities," and argue that "in an attempt to circumvent the strict requirements for expert review, both of Plaintiff's expert reports each contain broad, all-encompassing language as to the 'owners' and 'managers' of the Facility without any factual basis or elaboration of the same." Defendants ultimately aver that Plaintiff's Amended Complaint "focuses on allegations that Moving Defendants provided inadequate care to Mr. Stetts resulting in his alleged injuries… [which] is clearly a direct negligence theory only" that can only be properly brought against the Facility and its staff.

In response, Plaintiff notes first that she "is agreeable to withdrawing her claims as to" most named Corporate Defendants, but asserts that "based upon the evidence of record, Plaintiff's claims against Defendants HCR ManorCare Services,

[48] Defendants cite *Welsh*, 698 A.2d at 585, for this proposition.

LLC and HCR ManorCare, Inc. **can** and **must** proceed to trial."[49] Plaintiff cites *Johnson v. ManorCare of Chambersburg, PA LLC d/b/a ManorCare Health Services—Chambersburg, et al.*, a Franklin County Court of Common Pleas case, as concerning "remarkably similar issues to those present here," and invites this Court to evaluate this case in a similar manner.[50]

The parties generally agree on the legal principles and cases applicable to the issues. In the seminal case *Thompson v. Nason Hosp.*, the Supreme Court of Pennsylvania recognized the doctrine of corporate negligence, "under which [a] hospital is liable if it fails to uphold the proper standard of care owed the patient, which is to ensure the patient's safety and well-being while at the hospital."[51] This doctrine "creates a nondelegable duty which the hospital owes directly to a patient. Therefore, an injured party does not have to rely on and establish the negligence of a third party."[52] This duty "ha[s] been classified into four general areas: (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment; (2) a duty to select and retain only competent physicians; (3) a duty to oversee all persons who practice medicine within its walls as to patient care; and (4)

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[49] Emphasis in original. On August 10, 2021, Plaintiff filed a Praceipe to Voluntarily Withdraw Any and All Claims against Defendants HCR MANORCARE, LLC; MANORCARE HEALTH SERVICES, INC., a/k/a MANORCARE HEALTH SERVICES, LLC; MANORCARE, INC; HCR IV HEALTHCARE; HCR III HEALTHCARE, LLC; HCR II HEALTHCARE, LLC; HCR HEALTCARE [sic], LLC; HCRMC OPERATIONS, LLC; HCR MANORCARE OPERATIONS II, LLC; HEARTLAND EMPLOYMENT SERVICES; and HCR MANORCARE HEARTLAND, LLC. As a result, the only remaining Defendants are Manor Care of Williamsport PA (North), LLC d/b/a ManorCare Health Services – Williamsport North (the Facility), HCR ManorCare, Inc., and HCR ManorCare Services, LLC.

[50] *Johnson v. Manor Care of Chambersburg PA LLC, d/b/a ManorCare Health Services – Chambersburg et al*., Franklin County C.C.P. No. 2018-2952 (J. Sponseller).

[51] *Thompson v. Nason Hosp*., 591 A.2d 703, 707 (Pa. 1991).

[52] *Id*.

a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients."[53]

The Supreme Court of Pennsylvania clarified "what type of evidence is necessary to establish a *prima facie* claim of corporate liability for negligence against a hospital" in *Welsh v. Bulger*.[54] The Court explained "[t]o establish a claim for corporate negligence against a hospital, a plaintiff must show that the hospital had actual or constructive knowledge of the defect or procedures that created the harm. The plaintiff also must establish that the hospital's negligence was a substantial factor in causing the harm to the injured party."[55] The Supreme Court held, in accordance with the general principle applicable to medical malpractice cases, "unless a hospital's negligence is obvious, a plaintiff must produce expert testimony to establish that the hospital deviated from an accepted standard of care and that the deviation was a substantial factor in causing the harm to the plaintiff."[56] The Court cautioned that experts are "not, however, require[d]… to use 'magic words' when expressing their opinions. Instead, we look at the substance of their testimony."[57]

In 2012, the Supreme Court of Pennsylvania held that nursing homes and other such skilled care facilities are subject to corporate liability in a manner similar to hospitals.[58] The Court explained that, to determine whether a facility is directly liable to a patient, the "proper question" is whether the plaintiff "offered sufficient evidence of the relationship with [the facility] to establish that duties of care exist, by application

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[53] *Id*. (internal citations omitted).
[54] *Welsh v. Bulger*, 698 A.2d 581 (Pa. 1997).
[55] *Id*. at 585.
[56] *Id*.
[57] *Id*. at 585-86.
[58] *Scampone v. Highland Park Care Center, LLC*, 57 A.3d 582 (Pa. 2012).

of Section 323 of the Restatement [(Second) of Torts] or by application of the *Althaus* factors. The inquiry is individual to each [corporate entity], although the duties of [entities] may be similar."[59]

Section 323 of the Restatement (Second) of Torts, expressly approved of by the Supreme Court of Pennsylvania in the corporate negligence realm, states:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if
>
> (a) his failure to exercise such care increases the risk of such harm, or
>
> (b) the harm is suffered because of the other's reliance upon the undertaking.

In *Althaus*, the Supreme Court of Pennsylvania enumerated five factors that should be considered when determining whether a defendant owes a plaintiff a duty of care: "(1) the relationship between the parties; (2) the social utility of the actor's conduct; (3) the nature of the risk imposed and foreseeability of the harm incurred; (4) the consequences of imposing a duty upon the actor; and (5) the overall public interest in the proposed solution."[60] The Court has described these two tests as "functional[ly] equivalent."[61]

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[59] *Id.* at 606 (citing *Althaus v. Cohen*, 756 A.2d 1166 (Pa. 2000)).
[60] *Althaus*, 756 A.2d at 1169.
[61] *Scampone*, 57 A.3d at 606.

As stated previously, Plaintiff invites this Court to consider *Johnson v. ManorCare of Chambersburg, PA LLC d/b/a ManorCare Health Services—Chambersburg, et al.*, a 2018 case from the Franklin County Court of Common Pleas, as persuasive, in that the issues addressed in that case are similar to those in the instant case.[62] In *Johnson*, the plaintiff alleged that the decedent "was deprived of 'adequate care, treatment, food, water, and medicine,'" and was subjected to abuse and neglect, while at a facility operated by some of these same Corporate Defendants.[63]

The Trial Court in *Johnson* first addressed the parties' interpretations of the corporate negligence standard. The Court rejected the defendants' position that "[the plaintiff] failed to meet the required standard because [the plaintiff's] expert reports do not state with specificity what misconduct was committed by any of the corporate [d]efendants, with each of the two expert reports focused on detailing the misconduct of the facility," noting "were [the Court] to accept [the defendants'] position, then [the plaintiff] would be required to retain experts who are not only capable of examining whether there was a violation of a standard of care in the medical context, but who are also capable of deciphering the corporate structure governing the [facility]."[64] Nonetheless, the Court also rejected the plaintiff's contention that "a plaintiff need not produce separate expert testimony applicable to corporate negligence and may rely upon the expert testimony pertaining to [the facility's] negligence and causation in support of claims for direct corporate negligence," holding that *Welsh* could not be

[62] *Johnson,* Franklin County C.C.P. No. 2018-2952.
[63] *Johnson* at 2.
[64] *Id*. at 12.

read so permissively.[65] Ultimately, the Court concluded that it "was not confined to read [the plaintiff's] expert reports as deficient simply because they do not discuss each corporate defendant with particularity," but made clear that a plaintiff "still must establish that the corporate [d]efendants are appropriate parties to the lawsuit."[66]

The *Johnson* Court then directly addressed the motion for summary judgment filed by the twelve corporate defendants in *Johnson*. Noting that "[the plaintiffs] opened a set of floodgates… when they named the twelve 'corporate' defendants as parties," the Court discussed Section 323 of the Restatement (Second) of Torts and the *Althaus* factors, ultimately deciding to apply the *Althaus* factors to the claims against the corporate defendants.[67] The *Johnson* Court then conducted an *Althaus* analysis for the various corporate defendants, dismissing motions for summary judgment as to some of them and granting as to others.

Here, Plaintiff argues that her causes of action for corporate negligence against HCR ManorCare Services, LLC and HCR ManorCare Inc. are clearly sufficient to survive a motion for summary judgment. Plaintiff notes that HCR ManorCare Services, LLC is the Facility's "home office," which is defined as "the

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[65] *Id*. at 13.
[66] *Id*.
[67] *Id*. at 16-17. Plaintiff urges this Court to apply the Restatement (Second) of Torts rather than *Althaus*, citing *Scampone v. Grane Healthcare Company*, 169 A.3d 600 (Pa. Super. 2017). In that case, the Superior Court of Pennsylvania described the *Althaus* analysis as "superfluous," in light of the Supreme Court of Pennsylvania's directive that "the *Althaus* factors… [are] more relevant to the creation of new duties than to the vindication of existing ones. It is not necessary to conduct a full-blown public policy assessment in every instance in which a longstanding duty imposed on members of the public at large arises in a novel factual scenario." *Scampone*, 169 A.3d at 617 (citing *Alderwoods (Pennsylvania), Inc. v. Duquesne Light Co.*, 106 A.3d 27 (Pa. 2014)). This Court believes that, based on the Supreme Court of Pennsylvania's description of the two tests as "functional equivalent[s]," the tests are synonymous, and thus it does not matter which the Court chooses; that is, any interpretation of the tests that produces divergent results is necessarily erroneous.

entity that provides centralized management and administrative services to the individual providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services."[68] The evidence of this relationship, Plaintiff argues, demonstrates that HCR ManorCare Services, LLC "furnishes services related to patient care," and Plaintiff argues that the motion for summary judgment as to HCR ManorCare Services, LLC should be denied on this basis alone.

Plaintiff makes much of Defendants' failure to produce "the contract evidencing the services provided to the Facility by Defendant, HCR ManorCare Services, LLC, which details the contractual obligations of this entity." Plaintiff argues that this Defendant should not be permitted to argue that Plaintiff cannot establish the nature of the contractual relationship between the Defendant and the Facility, while simultaneously withholding the document that details that relationship. Plaintiff cites multiple cases in which courts relied on the contract between a facility and its home office to support the existence of corporate negligence. Plaintiff notes that, in *Johnson*, "the defendants produced an 'Administrative Support Services Agreement' that revealed that HCR ManorCare Services, LLC contractually undertook to support the Facility in complying with regulatory requirements, develop policies and procedures to assist the Facility 'in maintaining quality clinical care,' both of which [the *Johnson Court*] found to support HCR ManorCare Services, LLC's 'hands-on involvement' in the operation of the facility at issue." Plaintiff suggests that, at the very least, this Court should not grant a motion for summary judgment as to HCR

[68] 42 C.F.R. § 421.404.

ManorCare Services, LLC before ordering Defendants to produce the contract between HCR ManorCare Services, LLC and the Facility.

As to HCR ManorCare, Inc., Plaintiff argues "[t]he evidence of record demonstrates that [the] Facility's budget, including its budgeted staffing levels, would be set and approved by the board of directors of HCR ManorCare, Inc. Given that Plaintiff has asserted that the Facility at issue was understaffed, this evidence is sufficient to create a genuine issue of material fact with respect to Defendant HCR ManorCare, Inc.'s liability for failure to ensure that the Facility maintained adequate staffing levels to meet the needs of the residents such that it may be liable under a theory of direct corporate negligence."[69]

Defendants filed a Sur-Reply to Plaintiff's Response in Opposition to Defendants' Motion for Partial Summary Judgment. Defendants essentially argue that portions of Plaintiff's evidence are from other cases in other counties, relating to other facilities and time periods, and should for that reason be disregarded. Defendant argues that, although Plaintiff's experts briefly discuss staffing levels, they

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[69] Plaintiff bases this contention in part on the deposition of Kathryn Hoops in an unrelated case, *Yetter v. Wilson*, a 2014 case in the Northampton County Court of Common Pleas. Ms. Hoops was an executive for HCR ManorCare, LLC, and testified as follows:

> Q: The budget for the facility, I know you've testified a little bit about the budget process before. Do you know if these facility budgets are rolled up into regional and divisional level?
> A: They are, yes.
> Q: And then the divisional level would be rolled up into a corporate leve?
> A: Yes.
> Q: And then the corporate budget for all these operating facilities, is that approved by the board of directors of HCR ManorCAre, Inc.?
> A: Yes.

In response, Defendants note that "the questions in [Ms. Hoops's] deposition focus around 2013, a year prior to Mr. Stetts's residency at Manor Care Williamsport North in 2014. Further, there was no testimony specifically directed to these entities' alleged role in the operation or management of… the facility at issue in this action."

do not address "how the staffing levels specifically affected the care Mr. Stetts received or any injuries resulting from the same."

Reviewing the record in the light most favorable to Plaintiff, the Court finds that Plaintiff has raised a genuine issue of material fact with respect to one particular theory of corporate negligence against HCR ManorCare Services, LLC. Plaintiff's evidence, if believed, could demonstrate that HCR ManorCare Services, LLC was the Facility's "home office" and thus responsible for "centralized management and administrative services… such as centralized… personnel services, management direction and control, and other similar services." In this capacity, HCR ManorCare Services, LLC arguably had "a duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for" the patients at the Facility. Plaintiff has sufficiently alleged that HCR ManorCare Services, LLC breached this duty by failing to ensure that its policies relating to patient transfers and the use of the lift were followed during the care of Mr. Stetts on August 1, 2014, either because the Facility's staff was not trained in the policy or because the staff was inadequately supervised. Applying Section 323 of the Restatement (Second) of Torts to the evidence, taken in the light most favorable to Plaintiff, Plaintiff's allegations are sufficient to establish that HCR ManorCare Services, LLC owed a duty of care to Mr. Stetts, failed to exercise that duty of care, and caused Mr. Stetts to suffer harm in reliance upon his belief that the Facility's staff would be properly trained and knowledgeable in the use of the lift and transfers generally.

This theory of corporate liability is squarely addressed in Plaintiff's expert reports. Nurse Brzozowski indicated that "[n]o documented evidence [was] located

for nurses' aide training in the operation of specialty equipment" such as the Hoyer lift, and referred to the deposition of Mrs. Stetts, who testified that during the August 1, 2014 incident involving the lift, the aides involved indicated they did not know how to use the lift, were not trained in its use, and ultimately were afraid to use it. Nurse Brzozowski concluded that, among the deviations of "the staff at MCHS-WN and its owners, managers, consultants, and agents" was "failure to… implement safety precautions during resident care and with resident transfers to out of bed with proper use of specialty equipment…." Similarly, Dr. Dupee opined that "[e]ducation of all staff regarding proper transfer critiques is critical in every nursing facility, using a continuous quality improvement (CQI) that is consistent with current efforts to improve care." Although he stated this generally, when considered in the context of his explicit conclusions that the mechanical lift policy was disregarded and violated, it is sufficient to link the harms suffered by Mr. Stetts to the alleged duties of HCR ManorCare Services, LLC. Thus, the Court finds that Plaintiff has made a showing sufficient to defeat summary judgment that HCR ManorCare Services, LLC had some responsibility for the oversight of staff at the Facility, and that Plaintiff's evidence, if believed, could demonstrate a causal connection between HCR ManorCare Services, LLC's failure to train or supervise the Facility's staff and Mr. Stetts's injuries. Therefore, the Court will deny Defendants' motion for summary judgment with respect to HCR ManorCare Services, LLC, on the theory that HCR ManorCare Services, LLC owed a direct duty to Mr. Stetts to ensure that the staff at the Facility was appropriately trained to operate the Facility's specialized equipment, including the Hoyer lift.

However, the Court grants summary judgment on all other theories of corporate liability as to the two remaining Corporate Defendants, HCR ManorCare Inc. and HCR ManorCare Services, LLC. Specifically, the Court finds that Plaintiff has not demonstrated a genuine issue of material fact related to alleged understaffing of the Facility; the Court agrees with Defendant's contention that Plaintiff's experts do not address "how the staffing levels specifically affected the care Mr. Stetts received or any injuries resulting from the same." Neither of Plaintiff's experts has explained how alleged understaffing affected Mr. Stetts's care at the Facility or otherwise caused him harm. Although Dr. Dupee referred to "inexcusable deviations from the standard of care by the apparently untrained, understaffed, unskilled, and under-supervised staff at ManorCare Williamsport North," he did not provide any link between the alleged understaffing and the injuries suffered by Mr. Stetts. Indeed, the Court is unable to find support in Dr. Dupee's report for his conclusion that the Facility was "apparently… understaffed…." Although Nurse Brzozowski's report discusses staffing levels, her report also does not contain any link between those staffing levels and the care received by Mr. Stetts.[70] In a light most favorable to Plaintiff, the record shows that, in other cases, at other times, staffing concerns were raised in facilities under the HCR umbrella. However, Plaintiff has not produced evidence of understaffing at the Facility here which led to injuries to Mr. Stetts. As such, the Court agrees with Defendants' argument that Plaintiff has

[70] Plaintiff, in her Brief in Opposition to the Motion for Partial Summary Judgment, repeatedly cites Nurse Brzozowski's expert report at page 11 and Dr. Dupee's report at pages 11 through 13, but the Court simply does not believe those portions of the expert reports – or any other portions – can be fairly read as articulating a theory of understaffing relevant to this case.

not satisfactorily addressed "how the staffing levels specifically affected the care Mr. Stetts received or any injuries resulting from the same."

To defeat summary judgment on this theory, Plaintiff would need to first allege facts linking the actions of HCR ManorCare Services, Inc. to inadequate staffing at the Facility, and then allege facts linking the inadequate staffing to the harm suffered by Mr. Stetts. Because the Court finds that Plaintiff has done neither, the Court will grant Defendants' motion for summary judgment as to corporate negligence claims premised on alleged understaffing of the Facility.

F. Motion for Summary Judgment to Dismiss Claims for Punitive Damages

Defendants' final motion for summary judgment seeks dismissal of Plaintiff's claims for punitive damages. Defendants aver that, under Pennsylvania case law and the MCARE Act,[71] "[a]n award of punitive damages must be supported by evidence of conduct more serious than the mere commission of an underlying tort." Defendants allege "Plaintiff has failed to discover any facts that suggest that the care provided to Mr. Stetts was willful, wanton or with reckless[] indifference." Defendants point to Mr. Stetts's pre-existing conditions, the prompt treatment of his injuries, and Mr. Stetts's non-compliance with his treatment in support of this contention. Defendants note that "Nurse Brzozowski does not once characterize the conduct of Moving Defendants as 'willful,' 'wanton,' 'reckless,' 'egregious,' 'outrageous,' 'intentional,' or the like," and suggest that Dr. Dupee's "overbroad and undefined conclusions that the Facility 'recklessly failed to comply with the duties of care for Mr.

[71] 40 P.S. §1303.101 *et seq.*

Stetts' and that the Facility's conduct 'constitute[d] at times reckless indifference to Mr. Stetts's circumstances'" are so ambiguous that they "cannot possibly support a basis for relief of punitive damages, and should be disregarded entirely."

Plaintiffs first argue that Defendants' motion for summary judgment as to punitive damages is procedurally improper, in that "[t]he right to punitive damages is merely an incident to a cause of action and not a cause of action in and of itself."[72] The Court rejects this argument. The Note to Pennsylvania Rule of Civil Procedure 1035.2 states "[p]artial summary judgment… may be rendered on one or more issues of liability, defense or damages." Additionally, the Supreme Court of Pennsylvania has suggested that motions for summary judgment on the issue of punitive damages must be evaluated on their own merits, with the court considering whether the plaintiff "ha[s] shown that [the defendants] ha[ve] acted in wanton fashion or engaged in willful misconduct."[73]

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[72] *Citing Shanks v. Alderson*, 585 A.2d 883, 885 (Pa. 1990).

[73] *Phillips v. Cricket Lighters*, 841 A.2d 1000, 1011 (Pa. 2003). In *Phillips*, the defendants in a products liability claim filed motions for summary judgment, seeking to dismiss each of the causes of action against them as well as the plaintiff's punitive damages claim. Each of these motions was granted by the trial court. The Superior Court reversed each grant of summary judgment; on the issue of punitive damages, "the Superior Court apparently understood the sole basis for the trial court's decision to be that the punitive damages claim could not be sustained where all other remaining tort claims have been dismissed." *Id*. The Supreme Court noted that this understanding of the trial court's opinion was incorrect, in that the trial court "found that summary judgment should enter on this claim because [the plaintiff] had failed to adduce sufficient evidence; namely, the [trial] court found that [the plaintiff] had not shown that [the defendants] had acted in wanton fashion or engaged in willful misconduct." *Id*. Although the Supreme Court affirmed the reversal of summary judgment on the independent claims, it remanded to the Superior Court to reconsider whether the trial court's grant of summary judgment on the issue of punitive damages was correct on the merits. In doing so, the Supreme Court of Pennsylvania appears to have recognized that a motion for summary judgment on punitive damages can validly exist as an independent motion, rising or falling on its own merits. *See also Johnson,* Franklin County C.C.P. No. 2018-2952 at 7-8.

On the merits, Plaintiff argues "the record is replete with evidence of understaffing and Defendants' reckless indifference to the Facility-wide systemic problems that affected Mr. Stetts's health and well-being." Additionally, Plaintiff cites *Dubose v. Quinlan* for the proposition that a nursing home awareness of a patient's propensity for bed sores is liable for punitive damages when it disregards that risk.[74] Plaintiff argues that because "Defendants knew or should have known that Mr. Stetts required an assistance of 4-5 during his hospitalization prior to the residency," Defendants' transfer of Mr. Stetts with only 3 staff members constituted active disregard of a known risk rising to the level of recklessness.

A "fact finder is permitted to award punitive damages when the plaintiff has established that the defendant 'acted in an outrageous fashion' due to either an evil motive or in 'reckless indifference to the rights of others.'"[75] Punitive damages are "an extreme remedy available only in the most exceptional cases," and "the court must determine whether the plaintiff has presented sufficient evidence to support a punitive damage award before submitting the issue of such damages to the jury."[76]

Although the Amended Complaint seeks punitive damages generally, at this stage Plaintiff has identified three distinct theories supporting an award of punitive damages. The first of these is the allegation of understaffing. As detailed above, the Court does not believe that Plaintiff has made a showing that the Facility was "chronically understaffed and complaints from the staff went unheeded," as is present

[74] 124 A.3d 1231 (Pa. Super. 2015).
[75] *Scampone v. Grane Healthcare Co.*, 11 A.3d 967, 991 (Pa. Super. 2010).
[76] *Doe v. Wyoming Valley Health Care System, Inc.*, 987 A.2d 758, 768 (Pa. Super. 2009).

in many cases in which Pennsylvania courts have found punitive damages claims appropriate. Plaintiff's expert reports similarly fail to provide support for this claim.

Plaintiff's second theory in support of punitive damages is her contention that "Defendants were aware of Mr. Stetts' risks of harm related to… the development of skin alterations and recklessly allowed him to develop the same." Plaintiff's expert reports, however, do not support an allegation that Mr. Stetts's development of skin alterations – specifically the "black area" on his right heel – was attributable to Defendants' recklessness, as opposed to mere negligence. Plaintiff essentially argues that, because Mr. Stetts had developed numerous skin issues at his prior hospitalization, the fact that he developed another skin issue while at the Facility is *per se* evidence of the Facility's recklessness.

Plaintiffs cite *Dubose v. Quinlan*[77] in support of this particular claim. In *Dubose*, a claim for punitive damages was properly allowed to go to the jury "where the plaintiff established the reckless neglect of the nursing home resident, Mrs. Dubose, leading to the development of numerous festering bedsores…."[78] In that case:

> [N]ursing home staff negligently followed a physician's order to frequently reposition the decedent on a 1-2 hour cycle, leading to a marked deterioration of existing bedsores. During her stay at Willowcrest, there was evidence that the decedent was malnourished, dehydrated, and suffered conscious pain from numerous bedsores. In addition, appellants used a licensed practical nurse to provide

[77] 125 A.3d 1231 (Pa. Super. 2015).
[78] *Id*. at 1240.

> advanced wound care in violation of the Nurse Practices Act. At the time of her death… the decedent suffered from at least 10 pressure ulcers as well as systemic infection. [The previous month], the decedent was hospitalized for acute renal failure caused by severe dehydration.[79]

On those facts, the Superior Court, "view[ing] the evidence in the light most favorable to the plaintiff, the verdict winner," determined that it was not error to allow punitive damages to go to the jury.[80]

Here, viewing the evidence in a light most favorable to Plaintiff, the vast majority of Mr. Stetts's skin issues predated his admission to the Facility, and there is insufficient evidence to conclude that his skin issues worsened in any systemic way. Plaintiffs have not alleged "sufficient evidence of substandard care to the point of reckless indifference" regarding Mr. Stetts's skin alterations.

Plaintiff's third theory in support of punitive damages is that "Defendants were… aware that Mr. Stetts was at risk for harm related to safety issues in transfers [and] knew or should have known that Mr. Stetts required an assistance of 4-5 during his hospitalization prior to residency." Thus, Plaintiff argues, because "Defendants recklessly failed to properly assess Mr. Stetts' needs for assistance with transfers, [they] allowed Mr. Stetts to suffer preventable injury and harm…."

For the reasons discussed in Section III.B.1 above, Dr. Dupee's export report, when read in the light most favorable to Plaintiff, could support a finding that Defendants were reckless, as opposed to merely negligent, in their transfer of Mr.

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[79] *Id*.
[80] *Id*.

Stetts. Plaintiff alleges, and Plaintiff's experts suggest, that the transfer was performed by an insufficient number of staff members, who either did not know or did not follow the appropriate transfer procedure, and that the Facility recklessly disregarded the need for special transfer procedures given Mr. Stetts's weight and health issues.

Plaintiff's Amended Complaint also requests punitive damages in Count II, Plaintiff's Breach of Fiduciary Duty claim against the Facility. Plaintiff does not make this specific argument in her Brief in Opposition to Defendants' Motion for Partial Summary Judgment, and has not otherwise developed this claim beyond the generic averment in the Amended Complaint that "[t]he conduct of the Facility was intentional, outrageous, willful and wanton and exhibited a reckless indifference to its fiduciary duties as it related to Gary E. Stetts." Plaintiff's experts provide no additional support for the contention that the Facility's alleged breach of fiduciary duty was of such character as to justify an award of punitive damages.

For the foregoing reasons, the Court will grant in part and deny in part Defendants' Motion for Partial Summary Judgment on Punitive Damages. The Court will deny the Motion as to the request for punitive damages relating to the August 1, 2014 incident, during which Mr. Stetts sustained injury in the course of an attempted transfer. The Court will grant the Motion as to all other theories of punitive damages.

IV. MOTION TO REMAND TO COMPULSORY ARBITRATION

Defendants' second motion is a Motion to Remand to Compulsory Arbitration. Defendants contend that, taking the evidence of record in the light most favorable to Plaintiff, Plaintiff has failed to demonstrate that the amount in controversy in this case

exceeds $50,000, which is the limit for compulsory arbitration. Defendants ask this Court to conclude, as a matter of law, that Plaintiff's recovery is necessarily less than $50,000, arguing that "[e]ven with the most generous calculation of damages, [Mr. Stetts's] alleged injuries cannot amount anywhere near to $50,000, particularly given that there are no medical liens…. [A]lleged injuries lasting mere days and without any evidence of long-term effects or significant associated medical costs cannot exceed $50,000."

Plaintiff responds that, generally, "it is entirely inappropriate for a judge to step in and play finder of fact to decide damages at this stage, as the duty of assessing damages is within the province of the jury." Plaintiff argues that, taking into account all damages – including non-economic and punitive damages – the amount in controversy in this case is well in excess of $50,000.

The Court agrees with Plaintiff that it is the province of the jury, not the Court, to determine in the first instance the amount of damages. The Court cannot conclude, as a matter of law, the maximum amount Plaintiff may recover is necessarily less than $50,000. Therefore, the Court denies Defendants' Motion to Remand to Compulsory Arbitration.

V. ORDER

For the foregoing reasons, the Court hereby ORDERS as follows:

Defendants' motion for summary judgment to dismiss Plaintiff's negligence *per se* claims is GRANTED IN PART and DENIED IN PART. The motion is GRANTED as to Plaintiff's claims of negligence *per se* based on an alleged violation of the Older

Adults Protective services Act. The motion is DENIED as to Plaintiff's claims of negligence *per se* arising out of alleged violations of 18 Pa. C.S. § 2713.

Defendants' motion for summary judgment to dismiss Plaintiff's breach of fiduciary duty claims against the Facility is DENIED.

Defendants' motion for summary judgment to dismiss Plaintiff's aiding and abetting breach of fiduciary duty claims against the Corporate Defendants is GRANTED.

Defendants' motion for summary judgment to dismiss Plaintiff's corporate negligence claims is GRANTED IN PART and DENIED IN PART. The motion is DENIED as to the claim that HCR ManorCare Services, LLC failed to ensure that its policies relating to patient transfers and the use of the lift were followed during the care of Mr. Stetts on August 1, 2014, either because the Facility's staff was not trained in the policy or because the staff was inadequately supervised. The motion is GRANTED as to all other claims of corporate negligence against both remaining Corporate Defendants.

Defendants' motion for summary judgment to dismiss Plaintiff's claims for punitive damages is GRANTED IN PART and DENIED IN PART. The motion is DENIED as to the request for punitive damages relating to the August 1, 2014 incident, during which Mr. Stetts sustained injury in the course of an attempted transfer. The motion is GRANTED as to all other claims for punitive damages.

Defendants' motion to remand to compulsory arbitration is DENIED.

IT IS SO ORDERED this 30th day of December 2021.

By the Court,

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Eric R. Linhardt, Judge

ERL/jcr
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