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, this 18th day of March 2022, following argument held January 31, 2022 on Plaintiff's Motion for Reconsideration, Alternative Motion for Determination of Finality and/or Alternative Motion for Certification of Allowance of Appeal, the Court hereby issues the following OPINION and ORDER.

BACKGROUND

The procedural history of this case is discussed at length in this Court's December 30, 2021 Opinion and Order addressing Defendants' Motion to Remand to Compulsory Arbitration and Defendants' Motion for Partial Summary Judgment. In that Opinion and Order, the Court denied the Motion to Remand and granted in part the Motion for Partial Summary Judgment. Specifically, the Court denied the Motion as to negligence *per se* claims based on 18 Pa. C.S. § 2713, the breach of fiduciary duty claim, corporate negligence claims premised on a failure to train or supervise staff, and punitive damages claims arising from the August 1, 2014 incident. The Court granted the Motion as to negligence *per se* claims based on the Older Adults Protective Services Act, the aiding and abetting breach of fiduciary duty claim, all

corporate negligence claims not premised on failure to train or supervise, and all punitive damages claims not arising out of the August 1, 2014 incident.

On January 11, 2022, Plaintiff filed the instant Motion seeking reconsideration of the grant of summary judgment as to Plaintiff's corporate negligence claim premised on alleged understaffing of the facility (as well as related punitive damages claims). In the alternative, Plaintiff requested that this Court certify the issue for interlocutory appeal. Defendants filed an Answer to the instant Motion on January 27, 2022, and the Court heard argument on January 31, 2022.

ARGUMENTS

A. Plaintiff's Motion and Memorandum of Law in Support

Plaintiff seeks reconsideration of what it describes as a "*de facto* bar of Plaintiff's presentation of, at trial, evidence that the Facility in question was understaffed such that it could not meet the needs of the residents, including Mr. Stetts." Plaintiff notes that a trial court "has broad discretion to modify or rescind an order,"[1] and may do so where "intervening changes in facts or the law clearly warrant a new look at the question"[2] or "the prior holding was clearly erroneous and would create a manifest injustice if followed."[3]

Plaintiff's general contention is that the Court's "rejection of understaffing [based] on an alleged lack of expert testimony linking the Facility's understaffing to the harms incurred by Plaintiff" is "clearly contradicted by controlling Pennsylvania

[1] Motion for Reconsideration, ¶ 12 (*citing PNC Bank, N.A. v. Unknown Heirs*, 929 A.2d 219, 226 (Pa. Super. 2007)).
[2] *Id*. at ¶ 13 (*citing Ryan v. Berman*, 813 A.2d 792, 794 (Pa. 2002)).
[3] *Id*. (*citing Ryan*, 813 A.2d at 795).

law."[4] Plaintiff notes that understaffing is well-established as a basis for corporate negligence and related punitive damages.[5]

Plaintiff cites *Scampone v. Grane Healthcare Co.* as highly similar to this case.[6] In *Scampone*, the Superior Court concluded "the evidence of understaffing and insufficient care in question related to all residents of the nursing facility, including the decedent, and… the effects of understaffing were specifically connected to the decedent's care."[7] Plaintiff avers that, in *Scampone*, the Court "determined that 'evidence of understaffing' is not specialized knowledge and does not require expert testimony," and rejected the nursing home's argument that "expert testimony is required to establish both that: (1) the facility breached the industry standard of care by not having sufficient staff to meet the needs of the resident; and (2) the alleged understaffing in fact caused harm to the resident."[8] Plaintiff summarizes the relevant findings in *Scampone*, and ultimately argues that the evidence set forth in the record of this case is "[s]ubstantially similar" to that which was presented in *Scampone*.[9]

Plaintiff argues the evidence of record "demonstrates that the Facility staffed significantly below the expected staffing levels, the Facility's staff admitted that the Facility was understaffed, and the Facility's administration was aware of these complaints of understaffing," and that the "lay testimony of record from Mrs. Stetts' and Mark's deposition testimony, at the very least creates a genuine issue of material

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[4] *Id*. at ¶ 15.
[5] *Id*. at ¶ 16.
[6] *Scampone*, 11 A.3d 967 (Pa. Super. 2010).
[7] *Id*. at 991.
[8] Motion for Reconsideration, ¶¶ 18-19 (*citing Scampone*).
[9] *Id*. at ¶ 24. This Opinion discusses *Scampone* in detail *infra*.

fact as to whether the Facility's understaffing directly affected the care that Mr. Stetts received at the Facility."[10] Plaintiff further contends that her experts did in fact offer opinions that the facility was understaffed, even though they were not required to do so.[11] Additionally, Plaintiff respectfully contends that this Court overstepped its appropriate role at the summary judgment stage and made a credibility determination as to her expert opinions.[12]

Ultimately, Plaintiff argues that a manifest injustice would result if this Court precludes her from presenting a theory of corporate negligence premised on understaffing, and suggests that allowing such a ruling to stand would constitute reversible error.

B. Defendant's Answer to Plaintiff's Motion

Defendants first note that Plaintiff's Motion does not discuss or analyze her request, made in the alternative, to certify the Court's December 30, 2021 Order for interlocutory appeal. Defendants note that 42 Pa. C.S. § 702(b) provides for certification in the discretion of the trial court when the order "involves a controlling question of law as to which there is substantial ground for difference of opinion and… an immediate appeal from the order may materially advance the ultimate termination of the matter…." Defendants contend that the understaffing issue satisfies neither of these two prongs. With respect to the first prong, Defendants characterize the Court's holding as premised on a lack of factual support in the record, rather than a "controlling question of law." As to the second prong, Defendants note that many of

[10] *Id*. at ¶¶ 24-25.
[11] *Id*. at 26.
[12] *Id*. at 27. *See fn. 16, infra*.

their proposed grounds for summary judgment were rejected by this Court, and therefore the timing of trial and the ultimate termination of the matter will not be altered by an appellate determination.

On the merits of Plaintiff's request for reconsideration, Defendants contend that corporate negligence requires a plaintiff to establish not just that a healthcare entity owed a duty to a resident, but that the entity knew or should have known about a breach of that duty and actually caused harm to the resident.[13] Defendants argue that Plaintiff's theories of understaffing are overbroad and generalized, and that neither the proffered testimony of their experts, Mrs. Stetts, Mark Stetts, or any other lay witness concretely connects the alleged understaffing to any actual injury suffered by Mr. Stetts. Defendants argue that expert testimony is indeed necessary to establish some causal link between their alleged breach and the injuries Mr. Stetts sustained, and that this Court correctly concluded that no such link can be gleaned from the record, even when viewed in the light most favorable to Plaintiff.

In explaining what they view as a lack of evidence providing any causal connection between the alleged understaffing and Mr. Stetts's injuries, Defendants state "[Mrs.] Stetts and Mark Stetts spoke in generalized terms about alleged wait times when ringing the call bell for assistance…. Crucially, neither witness articulated any injury to Mr. Stetts whatsoever that resulted [from] these alleged call bell wait times. Moreover, there was no testimony from either that the assistance requested was not ultimately provided… Plaintiff makes no allegations that Mr. Stetts required additional care or treatment as a result of these alleged wait times."[14]

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[13] Answer, p. 4.
[14] *Id*. at p. 6.

Defendants also note, as they have previously, that Mr. Stetts is alleged to have often refused care, and contend that "Plaintiff [has] effectively conceded that the Facility met the minimum staffing requirements per the Pennsylvania regulations" by providing staffing figures that are greater than the minimum federal guidelines.

Finally, Defendants contend that Plaintiff has not adequately pled a punitive damages claim on this issue. Defendants note that one of Plaintiff's experts, Nurse Brzozowski, "does not once characterize the conduct of Defendants, including their alleged staffing levels, as 'willful,' 'wanton,' 'reckless,' 'egregious,' 'outrageous,' 'intentional,' or the like." They contend that Plaintiff's other expert, Dr. Dupee, "throws out the buzzwords 'reckless' and 'oppressive'" but "does not cite to any evidence of record of what exact conduct he reviewed to support this conclusion [and] subsequently admitted that he could not pinpoint the exact conduct, qualifying his conclusions with the equivocal statement that the Facility staff 'was either insufficient, incompetent, poorly trained or poorly supervised."[15]

C. Argument

At argument on the Motion for Reconsideration, counsel for Plaintiff argued that understaffing is a *theory* of corporate negligence which the jury is free to either believe or disbelieve. Therefore, inasmuch as Plaintiff has brought a claim of corporate negligence against the Defendants, any evidence of understaffing is merely one of many ways Plaintiff can support that claim. Counsel for Plaintiff agreed that the primary evidence in support of the understaffing theory consisted of the perceptions of Mrs. Stetts and Mark Stetts as well as statements made by

[15] Answer, p. 7.

unnamed staff members and overheard by Mrs. Stetts and Mark Stetts. Counsel for Plaintiff argued that, although some of those statements may be hearsay, this does not preclude the Court from relying on them as part of the record, and they are not all so obviously hearsay as to allow the Court to exclude them summarily.

Essentially, Plaintiff argues that she has made out a sufficient case to survive a motion for summary judgment, and therefore the appropriate procedure is to allow Plaintiff to present her case to the jury. Plaintiff notes that Defendant may then move for a directed verdict, and if the Court does not believe the evidence presented at trial was sufficient it may always grant a directed verdict or judgment n.o.v.

Counsel for Defendants largely reiterated Defendants' written argument, emphasizing their belief that the lack of a causal connection between alleged understaffing and the injuries suffered by Mr. Stetts is fatal to that claim of corporate negligence. Counsel also reiterated its belief that the record is devoid of any testimony that could support punitive damages for understaffing.

ANALYSIS

A. Summary of December 30, 2021 Opinion and Order Granting Partial Summary Judgment as to Corporate Negligence Claims Premised on Alleged Understaffing

This Court's ultimate holding on Defendants' Motion for Summary Judgment to Dismiss Corporate Negligence Claims, as stated in the December 30, 2021 Opinion and Order, was:

> "[T]he Court finds that Plaintiff has raised a genuine issue of material fact [sufficient to defeat a motion for summary judgment] 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 service.' 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… This theory of corporate liability is squarely addressed in Plaintiff's expert reports… [The conclusions of the experts are] sufficient to link the harms suffered by Mr. Stetts to the alleged duties of HCR ManorCare Services, LLC. Thus, the Court finds 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….

However, the Court grants summary judgment on all other theories of corporate liability… 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.

> fn. 70: Plaintiff… 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.[16]

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….

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."

The essence of the Court's holding is best demonstrated by contrasting the corporate negligence theory premised on a failure to supervise or train and the corporate negligence theory premised on understaffing.

With regard to the "failure to supervise or train" theory, Plaintiff's evidence clearly drew a line from the conduct of the corporate defendant to the injury suffered by Mr. Stetts. The record, taken in a light most favorable to Plaintiff, showed:

- Mr. Stetts suffered a significant and obvious injury on August 1, 2014 while being transferred by the staff of the Facility using a lift;

[16] Plaintiff interpreted this footnote as the Court "sua sponte assail[ing] [her] expert opinions based upon its assessment as to the credibility of these opinions." This is not correct. The Court recognizes that its use of the verb "believe" potentially created confusion, but the thrust of this footnote was the Court's determination that the expert reports did not state that the Facility was understaffed or explain how understaffing was connected to Mr. Stetts's injuries. It was not the case that the Court found a discussion of the connection between understaffing and Mr. Stetts's injuries in the expert reports but chose to disbelieve it; rather, the Court did not find those discussions present at all. At best, the handful of references to understaffing in Plaintiff's expert reports are fleeting and oblique. For instance, it is not obvious how a reduction in HPPD from 3.3005 to 3.17 is relevant to understaffing at the Facility, and Plaintiff has not explained how her expert opinions support her theory of understaffing or – more importantly – how that understaffing is in any way linked to the injuries suffered by Mr. Stetts.

- The injury was caused not by some mechanical issue with the lift or other unpreventable accident, but by a failure of the staff to properly utilize the lift;
- There was no documentation of the Facility's staff ever being trained in the use of the lift;
- HCR ManorCare Services, LLC was responsible for oversight of the care offered at the Facility; and
- HCR ManorCare Services, LLC would have or should have known that it did not train the staff at the Facility to use the lift, though it had a duty to do so.

Therefore, the evidence directly connected the actions of the corporate defendant to Mr. Stetts's injury – because the corporate defendant didn't train the staff, the staff didn't know how to use the lift; because the staff didn't know how to use the lift, Mr. Stetts suffered an injury on August 1, 2014.

With respect to the claim based on understaffing, the Court found Plaintiff's claim insufficient to defeat summary judgment in two ways, each of which would independently justify a grant of summary judgment. First, the Court found that Plaintiff had not established a link between the actions of HCR ManorCare Services, Inc. and alleged understaffing at the facility while Mr. Stetts was a resident there, between July 30, 2014 and August 25, 2014. Plaintiff claimed that the evidence of record showed that HCR ManorCare, Inc. set the Facility's budget at that time, but the Court found that the evidence presented consisted in significant part of deposition testimony and rulings from other cases, and did not establish that HCR ManorCare

Services, Inc. actually caused understaffing at the Facility in Williamsport between July 30, 2014 and August 25, 2014 by setting the Facility's budget at an inappropriately low level. Rather, even if the Court accepts without reservation deposition testimony in other cases, in other jurisdictions, concerning other time frames, the best the evidence shows is that HCR ManorCare, Inc. set the budget generally for some or all facilities under the HCR umbrella, and some plaintiffs at various times and places had been able to establish understaffing which could be linked back to HCR ManorCare, Inc. through certain facilities' budgets. It may certainly be true that understaffing at a facility in Northampton County in 2013 was caused by HCR ManorCare, Inc.'s budgeting decisions prior to that time. It does not follow, however, that there is a genuine issue of material fact on the record in this case as to whether HCR ManorCare, Inc.'s budgeting decisions led to understaffing at the Facility in Williamsport in July and August of 2014.

The Court also found Plaintiff's understaffing claim insufficient for failing to connect any alleged understaffing to injury suffered by Mr. Stetts. The injuries to Mr. Stetts pled in the Complaint consisted of a "skin tear to the right calf, a fluid-filled blister to the right heel, significant weight loss, poor hygiene, and severe pain." The record, in a light most favorable to Plaintiff, demonstrated:

- Mrs. Stetts sometimes "couldn't find anybody to help" Mr. Stetts, requiring her to walk down the halls to look for someone;
- Usually someone came and helped, but "a few times" she had to wait, and on one occasion she waited over an hour;
- Mr. Stetts "waited and waited and waited" for pain medication;

- Mark Stetts observed that Mr. Stetts would sometimes get assistance immediately when he pushed his call button but at other times had to wait longer than expected, and on one occasion Mark Stetts "had to go find somebody" after five or ten minutes;[17]
- Mark Stetts at one time considered the Facility to be "severely understaffed";
- An unnamed nurse told Mrs. Stetts the Facility was "shorthanded";
- Mark Stetts remarked to an unnamed nurse "it seems like you guys could use some more help," and the nurse replied "we always need more help";
- Dr. Dupee's isolated statement that the staff at the Facility was "apparently untrained, understaffed, unskilled, and under-supervised";
- Nurse Brzozowski's discussion of "Staffing, Staff Supervision, and Staff Training," which noted in relevant part that:
    - The number of beds at the Facility was near, but not at, the maximum it was licensed for;
    - There were 58 nurses' aides for 147 residents;[18] and

[17] Mark Stetts also indicated that nurses would ultimately assist his father with his needs, and stated "[a]s far as I know when I was there, it was pretty reasonable."
[18] There was no discussion of whether this ratio of aides to patients was inadequate, below the industry standard, or for some other reason objectionable.

- From July 30, 2014 through August 25, 2014, the number of "hours per patient day" worked by staff was 3.17, which was less than the "budgeted amounts" of 3.3005.[19,20]

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[19] Nurse Brzozowski stated that this showed "a decrease in HPPD" but did not explain whether either the 3.3005 or 3.17 figure was in any way insufficient, below the industry standard, or otherwise objectionable.

[20] The section of Nurse Brzozowski's report titled "Staffing, Staff Supervision, and Staff Training" reads, in its entirety (all formatting and emphasis in original):

Staffing, Staff Supervision, and Staff Training

Staff were aware of resident's on-going skin issues. Nursing care plans, staff supervision, and staff education were poorly documented or not documented at all. Many parts of resident's Nursing Care Plans were illegible and blurry.

Documented evidence from Facility Floor Plan documents at MCHS-WN revealed that there were 147 beds at MCHS-WN. MCHS-WN was licensed for no more than 152 beds and was a "for profit" facility.

Staffing documents showed that there were 58 nurses' aides which included full time, part time and PRN positions. Nurses' aides must provide for all ADL tasks for 147 residents, which included: feeding, transfers, repositioning, incontinence care, showering, grooming and bed baths, among other duties.

OF NOTE: 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 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.

According to the Centers of Medicare and Medicaid Services – Federal Regulations (2014) 483 Subpart D Requirements for State and Long-Term Care Facilities, specifically: 483.30: NURSING SERVICES: RN SERVICES: 8 CONSECUTIVE HOURS 7 DAYS A WEEK (SUPERVISION)…"

In addition, According to Chapter 21 of the State Board of Nursing: Responsibilities of an RN includes:

1. Collects complete and ongoing data to determine nursing care needs.
2. Analyzes the health status of the individuals and families and compares the data with the norm when possible, in determining nursing care needs.
3. Identifies goals and plans for nursing care.
4. Carries out nursing care actions which promote, maintain, and restore the well-being of individuals.

Taken in a light most favorable to Plaintiff, the evidence clearly establishes that Mr. Stetts suffered injury at the Facility; assistance at the 147-bed facility was not always immediate and was occasionally significantly delayed; Mrs. Stetts and Mark Stetts had the impression, as laypeople, that the facility was understaffed; and two unnamed staff members made statements suggesting they too believed the Facility was understaffed.[21] The Court found that Plaintiff did not present any evidence from

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5. Involves individuals and their families in their health promotion, maintenance, and restoration.
6. **Evaluates the effectiveness of the quality of nursing care provided. The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered.**

Additional nurses' aides were necessary for Mr. Stetts care due to the diagnosis of Morbid Obesity (weight ^448 pounds on admission), skin issues/multiple wounds, mobility and use of a Tenor Hoyer Lift for transfer issues from bed to motorized wheelchair. At MCHS-WN there was a need for multiple staff members to assist Mr. Stetts with safe transfers out of bed and with key ADLS. Prior documentation revealed that there were 4-5 staff needed to assist Mr. Stetts.

Mark Stetts Deposition Transcript on November 5, 2020 revealed complaints of inadequate staffing at MCHS-WN.

Documented evidence on a MCHS-WN report revealed that resident's wife called on 8/29/14 (after resident's discharge to home) and stated, "while a patient, toe was smashed, he was on a bedpan a long time, and was not clean when he came home…".

Mr. Gary E. Stetts was discharged from MCHS-WN on 8/25/14 back to his home with his wife via stretcher ambulance. He was discharged in stable condition.

Emergency records from Williamsport Medical Center and Milton Hershey Medical Center (9/18/15-9/19/15 revealed that Mr. Stetts had "abdominal pain secondary to an abdominal aneurysm with a high risk for rupture". CR scan of abdomen showed an Abdominal Aortic Aneurysm of 12.3 cm x 10.4 cm x 11.3 cm. He was transferred to Milton Hershey Medical Center via air ambulance and was admitted through the Emergency Department where he suffered a cardiac arrest, was successfully resuscitated and taken emergently to the operating room where he required CPR again. Mr. Stetts was taken post-op to the HVICU where he again went into cardiac arrest. He expired in the HVICU and was declared dead at 10:20am on 9/19/15.

[21] Although statements that the Facility is "shorthanded" and staff members "could always use more help" are both susceptible to interpretations that are unrelated to understaffing, a factfinder could find those statements to be evidence of the staff members' subjective beliefs that the facility is understaffed.

which a factfinder could conclude that any of the delays or perceived understaffing reported by Mrs. Stetts or Mark Stetts caused injury to Mr. Stetts. The Court similarly found that Plaintiff did not present evidence that any of the injuries allegedly suffered had understaffing as a contributing factor.

Ultimately, the Court's conclusion was that the record at summary judgment did not contain facts which established that HCR ManorCare, Inc.'s actions "[were] a substantial factor in causing the harm to the injured party."[22] This is because 1) the record was insufficient to demonstrate that HCR ManorCare, Inc. caused or otherwise allowed this Facility, in Williamsport, between July 30, 2014 and August 25, 2014, to be understaffed, and 2) the record was insufficient to demonstrate that alleged understaffing caused or contributed in any legally significant way to Mr. Stetts's injuries.

B. Plaintiff's Proposed Grounds for Reconsideration

In support of reconsideration, Plaintiff makes three related arguments. First, Plaintiff argues that, under Pennsylvania law, expert testimony is not necessary to establish corporate negligence due to understaffing. Second, Plaintiff contends that this Court misconstrued the evidence, and that the record is sufficient to establish all of the elements of a corporate negligence claim premised on understaffing. Third, Plaintiff contends that understaffing is not a distinct cause of action but is rather a theory of negligence, and it is improper to dismiss a theory of the case at the summary judgment stage. As these arguments are related, the Court will address them together.

[22] *See Welsh v. Bulger*, 698 A.2d 581, 585 (Pa. 1997).

1. Background Principles

Plaintiff contends that "[t]he Court premised its rejection of understaffing on an alleged lack of expert testimony linking the Facility's understaffing to the harms incurred by Plaintiff. Such premise is clearly contradicted by controlling law."[23] As explained above, the Court's December 30, 2021 Opinion and Order was not based solely on a lack of expert testimony, but on the lack of sufficient evidence in the entire record to link the alleged breach of corporate duty to injury suffered by Mr. Stetts; the lack of expert testimony was one facet of this absence of evidence. It is true, however, that the Opinion stressed the failure of Plaintiff's experts to link understaffing to injury suffered by Mr. Stetts as a primary cause of that gap between claim and evidence. Therefore, a full discussion of when expert testimony is required in corporate negligence cases is appropriate.

In *Thompson v. Nason*, 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."[24] The Court noted that for a hospital to be liable for corporate negligence "the hospital's negligence must have been a substantial factor in bringing about the harm to the injured party."[25]

The first published opinion to address what manner of proof was necessary to establish that a hospital's negligence was substantial factor in bringing about the injury was the Commonwealth Court's opinion in *Walls v. Hazleton State General*

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[23] Motion for Reconsideration, ¶ 15.
[24] *Thompson v. Nason Hosp.*, 591 A.2d 703, 707 (Pa. 1991).
[25] *Id*. at 708.

Hosp.[26] In *Walls*, the plaintiff's broken right leg was placed in an external fixation device to maintain alignment and allow the fracture to heal.[27] The plaintiff alleged the doctor responsible for his care failed to keep the device in alignment, causing his fracture to separate; the plaintiff also alleged the defendant hospital was directly liable on a theory of corporate negligence.[28] The jury ultimately entered a verdict against the hospital in the amount of $480,000.[29]

The Commonwealth Court vacated the jury's award, finding that "the corporate theory of negligence [was] inapplicable because there was no expert opinion evidence that the [defendant hospital's] conduct was either negligent under *Thompson* or was a substantial factor in causing [the plaintiff] harm."[30] The Commonwealth Court noted that in a medical malpractice action, "where it is not obvious that negligence occurred and that the doctrine of *res ipsa loquitur* should be applied, expert medical testimony is required to establish causation."[31] In the Court's judgment, "it was essential to present expert testimony regarding various aspects of the Wagner fixation device and the relationship between misuse of the device, the failure to follow hospital policies and any increased risk of harm to [the plaintiff]."[32] The Court ultimately concluded that although "there was some testimony about how [the plaintiff's] treatment could have been handled better, [there was no testimony]

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[26] *Walls v. Hazleton State General Hosp.*, 629 A.2d 232 (Pa. Cmwlth. 1993).
[27] *Id*. at 234.
[28] *Id*.
[29] *Id*. at 233.
[30] *Id*. at 235.
[31] *Id*., *citing Hamil v. Bashline*, 392 A.2d 1280 (Pa. 1978).
[32] *Id*.

that any mishandling on the part of the [defendant hospital] or its employees was a substantial cause of harm to him."[33]

The Supreme Court of Pennsylvania cited *Walls* with approval in *Welsh v. Bulger*, stating:

> "Although we set forth the elements of a cause of action for corporate negligence against a hospital in *Thompson*, we did not address the type of evidence necessary to prove this cause of action. In a traditional medical malpractice action, where the defendant's negligence is not obvious, a plaintiff must present expert testimony to establish to a reasonable degree of medical certainty that the defendant's acts deviated from an accepted medical standard, and that such deviation was the proximate cause of the harm suffered. The Commonwealth Court has determined that this expert testimony requirement is equally applicable to claims of corporate negligence where the hospital's negligence is not obvious. We believe the Commonwealth Court's determination is sound, and accordingly, we hold that, 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."[34]

In *Welsh*, the Supreme Court of Pennsylvania found that the expert's report was sufficient to meet this standard, because he "opined that the nurses breached the standard of care… [and] that this breach was a substantial factor in bringing about the harm to the deceased [because] if the nurses had notified the hospital of the need for a cesarean section, then the injury would not have occurred."[35]

The question of what would be sufficient to constitute "obvious" negligence of such a character as to not require expert testimony was addressed by the Superior Court of Pennsylvania in *Matthews v. Clarion Hosp.*[36] In *Matthews*, the unconscious

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[33] *Id*. at 236.
[34] *Welsh v. Bulger*, 698 A.2d 581, 585 (Pa. 1997) (internal citations omitted).
[35] *Id*. at 586.
[36] *Matthews v. Clarion Hosp.*, 742 A.2d 1111 (Pa. Super. 1999).

plaintiff fell from the operating table during a tubal ligation procedure in a manner that awkwardly stretched her right arm.[37] When she awoke, she immediately experienced severe pain in her right shoulder which was not present prior to the surgery.[38] The trial court granted the defendant hospital's motion for summary judgment when the plaintiff "failed to provide an expert report… [from] a medical expert who would opine to a reasonable degree of medical certainty that [the] hospital's acts deviated from an acceptable medical standard and that such deviation was the proximate cause of [the plaintiff's] harm."[39]

The Superior Court first summarized the principles underlying its review of the trial court's decision:

> "[A] claim of corporate negligence, like a claim of medical malpractice, requires that in cases where a hospital's negligence is not obvious, a plaintiff must establish through expert testimony that a hospital's acts deviated from an accepted standard of care and that the deviation was a substantial factor in causing plaintiff's harm. Expert testimony is not, however, required to establish a breach of duty 'where the matter under investigation is so simple, and the lack of skill or want of care so obvious, as to be within the range of the ordinary experience and comprehension of even nonprofessional persons.'
>
> Nor is expert testimony as to *causation* required 'where there is an *obvious* causal relationship' between the injury complained of and the alleged negligent act. 'An obvious causal relationship exists where the injuries are either an 'immediate and direct' or the 'natural and probable' result of the alleged negligent act."[40]

The Court noted that the plaintiff establish the breach of duty by "rel[ying] on Nurse Schubert's report to establish the standard of care for operating room nurses

[37] *Id*. at 1113, 1115.
[38] *Id*. at 1115.
[39] *Id*. at 1112.
[40] *Id*. (internal citations omitted; emphasis in original).

and a breach of that standard when a patient falls from an operating table."[41] On the issue of causation, the plaintiff presented medical record that showed "all of her extremities were found to be in normal condition" upon her admission to the hospital, but she "experienced significant right shoulder pain either when she awoke from surgery or almost immediately thereafter."[42] On this evidence, the Superior Court reversed the trial court's decision, finding the plaintiff's injury to be "so immediately and directly, or naturally and probably, the result of the accident that the connection between [the injury and the accident] does not depend solely on the testimony of professional or expert witnesses."[43]

2. *Scampone v. Grane Healthcare Co.*

Plaintiff cites *Scampone v. Grane Healthcare Co.*[44] as highly relevant, arguing the record in this case is "[s]ubstantially similar" to that in *Scampone*. In *Scampone*, the decedent was admitted to a nursing home in Pittsburgh in 1998 at age 88 and resided there until her death in 2004.[45] Upon admission, she had a number of chronic ailments, including dementia.[46] On December 15, 2003 she was diagnosed with a urinary tract infection, but was discharged from the hospital "in good condition" on December 18, 2003.[47] Between that date and her readmission to the hospital on

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[41] *Id*. at 1115.
[42] *Id*. at 1115-16.
[43] *Id*. at 1116.
[44] *Scampone v. Grane Healthcare Co*., 11 A.3d 967 (Pa. Super. 2010). *Scampone* was affirmed in part and remanded in part by the Supreme Court of Pennsylvania in *Scampone v. Highland Park Care Center, LLC*, 57 A.3d 582 (Pa. 2012); the portions of *Scampone v. Grane Healthcare Co.* relevant to this case were not at issue on appeal and remain binding precedent.
[45] Id. at 971.
[46] *Id*.
[47] *Id*.

January 30, 2004, she developed another urinary tract infection, severe dehydration, malnutrition, and bedsores; she died on February 9, 2004.[48] The plaintiff brought claims of both vicarious liability and corporate negligence against multiple corporate defendants, with the corporate negligence claim "premised upon the existence of chronic understaffing at the facility such that the employees were incapable of performing appropriate care to the nursing home residents, including [decedent]."[49]

The trial judge granted compulsory nonsuit to some of the corporate defendants, and "concluded that the evidence was insufficient to submit the question of punitive damages to the jury"; thus, the case was submitted to the jury against a single corporate defendant, Highland, on the theories of both vicarious liability and corporate negligence.[50] The jury found in favor of the plaintiff on both theories.[51] The plaintiff appealed the trial court's grants of nonsuit and bar of punitive damages; Highland appealed the trial court's refusal to grant it a compulsory nonsuit.[52]

On appeal, the Superior Court first concluded that corporate negligence may be brought against a nursing home as well as a hospital, and that understaffing is a valid ground upon which a corporate negligence claim may be based.[53]

The third significant issue addressed by the Superior Court in *Scampone* was Highland's claim that "[the] [p]laintiff's evidence was insufficient to support the jury's determination that it was liable under the corporate negligence cause of action

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[48] *Id*.
[49] *Id*.
[50] *Id*. at 971-72.
[51] *Id*. at 972.
[52] *Id*. at 972-73.
[53] *Id*. at 974-976. The Court held that a failure to ensure adequate staffing falls under the duty to "formulate, adopt, and enforce adequate rules and policies to ensure quality care for patients" as articulated in *Thompson*.

[because] there was no evidence either that it breached the industry standard of care by not having sufficient staff to meet the needs of its residents or that the alleged understaffing caused [the decedent's] death."[54] After summarizing the "general background information about the nursing home's operation," the Superior Court recounted the testimony and evidence presented by the plaintiff, which was overwhelming. The plaintiff presented the testimony of eleven staff members,[55] who collectively described the dire state of affairs at Highland during the final months of the decedent's life. They explained that Highland had received numerous, continuous complaints about not having enough nurses to provide patients with adequate care, and that the nurses on staff repeatedly informed their supervisors that they did not have enough time to perform such basic tasks as providing patients water and responding to call lights.[56] Numerous employees confirmed that Highland would receive advance notice of state inspections, but "avoided state sanctions for understaffing because it… would temporarily increase staff levels during state inspections…."[57] Multiple witnesses testified that their pleas to their supervisors for more help or resources resulted in no action.[58] At least one nurse testified that at

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[54] *Id*. at 978.
[55] Danny Toledo, RN unit manager at Highland for two years; Evelyn Johnson, LPN at Highland for five years; Karrin Holmes, CNA at Highland for two years; Zenobi Scott, CNA at Highland for one year; Christine Kopyleck, LPN at Highland for two years; Tammy Payne, nurse consultant employed by a previously-dismissed corporate defendant, who spent time at Highland each week as part of her job; Karolyn Knowlton, RN at Highland for one year; Michelle Dixon, nurse consultant employed by a previously-dismissed corporate defendant, who audited multiple facilities' federally mandated reports; Ed Francia and Bernard Erb, administrators at Highland; and Leonard Oddo, an employee of a previously-dismissed corporate defendant.
[56] *Id*. at 980-87.
[57] *Id*.
[58] *Id*.

any given time she had to take care of thirty-eight to forty residents, and was unable to complete her job responsibilities.[59]

Multiple nurses who provided care to the decedent noted that her water pitcher was "always empty," but there were "not enough [nurses]" to ensure that the decedent had adequate water.[60] These issues were consistently reported to supervisors, but nothing was done.[61] Other nurses complained about "holes in the records" kept by Highland, including gaps in patient charts; one nurse indicated that on many occasions she observed medications lying unadministered on patients' nightstands (or bodies) but the chart would reflect that these medications "were given."[62] One nurse observed employees of Grane, the previously-dismissed corporate defendant who owned Highland, falsifying records by "going back to the beginning of the month and putting their initials… in some empty spots on the documents to signify treatment that had not been performed had been."[63] Multiple witnesses, staff members and administrators alike, testified that these problems began or were intensified when Grane purchased Highland, and explained that Grane set the budget for Highland and had exclusive control over "all aspects of the operation of Highland," including staffing.

In addition to the eleven lay witnesses affiliated with Highland, the plaintiff in *Scampone* called two expert witnesses. The first was Nurse Kathleen A. Hill-O'Neill, who testified that the care of decedent fell below the standard of care with regard to

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[59] *Id*.
[60] *Id*.
[61] *Id*.
[62] *Id*.
[63] *Id*.

"following doctor's orders," "monitoring, assessing and preventing dehydration," "monitoring, assessing and preventing infections," "monitoring, assessing, and preventing malnutrition," "responding appropriately to significant changes in [the decedent's] condition," and "keeping up on an appropriate clinical record for [the decedent]."[64] Nurse Hill-O'Neill specifically opined that the decedent "was neglected and abused during her stay" at Highland, and "delineated specifically that [the decedent] was not properly assessed and monitored for dehydration and that it could have been prevented."[65] She based this on the evidence that 1) doctors ordered multiple tests for urinary tract infections that were not done, 2) the decedent began to display symptoms of dehydration, which should have triggered scrutiny but did not, 3) there was a nineteen-day period without a single nursing note entered into decedent's chart, 4) the day before the decedent was taken to the hospital for the final time she was "crying for water," and 5) the decedent had not been monitored for fluids and experienced "significant weight loss" in the weeks prior to her death.[66]

The plaintiff's second expert witness was Dr. Dean J. Nickles, who testified similarly to Nurse Hill-O'Neill as to Highland's failure to meet the appropriate standard of care, and offered these opinions to a reasonable degree of medical certainty.[67] Dr. Nickles also offered the following opinion to a reasonable degree of medical certainty:

> "Q: And in this case, did you come up with any opinions within the bounds of reasonable medical certainty as to whether or not the failures in providing care that you just discussed in a general fashion substantially or significantly contributed to needless injuries, suffering, and death with regard to Mrs. Scampone?

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[64] *Id*. at 984-85.
[65] *Id*. at 985.
[66] *Id*.
[67] *Id*. at 985-86.

A: I think that did occur.

Q: Do you think that within the bounds of reasonable medical certainty?

A: Yes, sir, I do.

Q: Can you explain that to the jury?

A: Well, specifically regarding her demise and death, I believe that the failures in the care at the nursing home resulted in conditions that ultimately led to her demise.

Q: What conditions are those?

A: Well, primarily two conditions. One was her urinary tract infection and, secondly, was her dehydration. Those were clear contributing factors in her ultimate demise."

Finally, the plaintiff presented the testimony of the decedent's son, who "frequently visited his mother and testified that she had difficulty getting water and pills and that her calls went unanswered," and the paramedic who took the decedent to the hospital on January 30, 2004, who testified to a number of symptoms she observed that demonstrated the decedent was suffering from profound dehydration.[68] The paramedic recounted that "[t]he RN on duty informed [her] that [the decedent] had not been given any fluid 'for quite a few days'" and "had been unable to swallow her medication for a 'couple days.'"[69]

The Superior Court of Pennsylvania found this evidence, viewed in the light most favorable to the verdict winner, more than sufficient to sustain the jury's verdict. In doing so, the Court addressed Highland's assertion "that there was no evidence either that it breached the industry standard of care by not having sufficient staff to meet the needs of its residents or that the alleged understaffing caused [the

[68] *Id*. at 986-87.
[69] *Id*. at 987.

decedent's] death."[70] The Court noted that the plaintiff's nursing expert testified that "Highland breached the standard of care applicable to nursing homes in various respects," and that the plaintiff

> "also presented evidence, which the jury chose to believe, that these failures were caused by understaffing. A number of witnesses established that CNAs, LPNs, and RNs were unable to perform their required functions due to a chronically insufficient number of personnel necessary to complete all the assigned work. This staffing deficiency occurred during the pertinent time frame. These witnesses worked on the fourth floor, where [the decedent] was located, and included [the decedent] within the parameters of this problem. As discussed *supra*, the existence of this persistent lack of adequate staffing constituted a violation of Highland's duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for its patient. The witnesses who established the existence of understaffing stated that the fact a problem existed in that regard was communicated to both Highland and Grane's nurse consultants."[71]

The Court further explained that "Ms. Hill-O'Neill clearly opined that the nursing home's failures led to [the decedent's] untreated [urinary tract infection], dehydration, and malnutrition," and "Dr. Nickles… stated that the [urinary tract infection], dehydration, and malnutrition were contributing factors in [the decedent's] death."[72]

The Court also rejected as "completely untenable" Highland's contention "that none of the evidence of understaffing was 'ever causally connected to the care and treatment' of [the decedent]."[73] The Court explained that "[t]he witnesses established the existence of a chronic lack of sufficient employees at [Highland] to provide sufficient care for all its residents," and various witnesses established that the

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[70] *Id*.
[71] *Id*. at 987-88.
[72] *Id*. at 988.
[73] *Id*.

decedent was not consistently given water, including for days leading up to the decedent being taken to the hospital.[74]

The Court also reversed the grant of nonsuit as to Grane, finding that as the entity "actually… in charge of managing the nursing home," overseeing "all aspects of the operation of Highland," it had breached a direct duty to the decedent to ensure adequate staffing at Highland.[75] As the Court explained:

> "While Highland employed the nursing staff, excluding the nursing consultants who were employed by and trained by Grane, Grane established and administered a quality assurance program to ensure the nursing facility provided quality nursing care to its residents. Part of this program included establishing an operating budget for Highland, which in turn would staff the nursing facility according to Grane's budget recommendations. Additionally, employees of Grane worked at the nursing facility and oversaw the daily operation of the nursing staff and the administration of the facility. Grane hired the RNs and appointed the directors of nursing. Further, any money remaining in Highland's bank account at the end of the month was transferred to Grane. Grane's involvement with the operation of the nursing facility and its sway over Highland garnered them control over the total health care of the residents similar to [a] hospital, HMO, [or] medical professional corporation.
>
> Based upon Grane's control over the total health care of the residents, it owed certain duties to those residents as outlined in *Thompson*. Of particular importance to Grane were the duties to use reasonable care in the maintenance of safe and adequate facilities and equipment and to formulate, adopt, and enforce adequate rules and policies to ensure quality care for the facility's residents. In order for [the plaintiff] to charge Grane with negligence, he must demonstrate that Grane had actual or constructive knowledge of the defect in procedures which created the harm and that Grane's negligence was a substantial factor in bringing about the harm. [The plaintiff] established a cause of action for corporate negligence based on Grane's governance of the care of the residents at the nursing facility. Hence, nonsuit was improperly entered in Grane's favor."[76]

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[74] *Id*. at 988-89.
[75] *Id*. at 989.
[76] *Id*. at 990-91. The Superior Court also reversed the trial court's judgment on punitive damages, holding that both Highland and Grane could be found to have "acted with reckless disregard to the rights of others and created an unreasonable risk of physical harm to the

C. Discussion

In *Scampone*, the Superior Court found (and the Supreme Court did not disagree) that the plaintiff had presented enough evidence to support the jury's verdict against Highland on the issue of corporate negligence based on understaffing, and had presented enough evidence against *Grane* on the issue of understaffing that the grant of a nonsuit on that claim was improper. Plaintiff seems to read the holding of *Scampone* to be this: *if* a plaintiff can demonstrate understaffing at the facility for which the corporation overseeing the facility is responsible, and plaintiff can establish that the facility's breaches in the standard of care caused harm to the resident, *then* the plaintiff may present the evidence of understaffing to the jury, who is free to accept or reject the plaintiff's contention that the understaffing was connected to the injury in such a way that the corporation's action or inaction is "a substantial factor in causing the harm to the injured party."

The testimony and evidence in *Scampone* deemed sufficient to support the claims of corporate negligence premised on understaffing can be summarized as:

- Lay testimony establishing that Grane controlled Highland's budget, including having final approval over its budget for staffing;

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residents of the nursing home." This is because Highland "was chronically understaffed and complaints from staff continually went unheeded. Grane and Highland employees not only were aware of the understaffing that was leading to improper patient care, they deliberately altered records to hide that substandard care… Staffing levels were increased during state inspections and then reduced after the inspection was concluded. Deliberately altering patient records to show care was rendered that was actually not is outrageous and warrants submission of the question of punitive damages to the jury. Other evidence supporting an award of punitive damages included [the decedent's] lack of nursing care for a critical nineteen days prior to her death and her deplorable condition on January 30, 2004. We also point to a note in her records that the poor woman was crying for water."

- Lay testimony establishing that, during the relevant time frame, the facility's staffing was insufficient in that nurses consistently did not have enough time to perform basic activities such as providing water, assisting with activities of daily living (such as monitoring a patient's intake of fluids and food), and keep consistent records;
- Lay testimony establishing that both Grane and Highland were aware of the staffing insufficiency, as the issues were consistently reported to employees of Grane and Highland;
- Lay testimony establishing that both Grane and Highland made conscious efforts to falsify records or otherwise hide the staffing insufficiency;
- Expert testimony establishing that the care at Highland breached the standard of care owed to the decedent in numerous ways;
- Lay testimony linking the insufficient staffing at Highland to the breaches of the standard of care;
- Expert testimony establishing that Highland's breaches were a substantial causal factor in the decedent's dehydration, malnutrition, and urinary tract infection; and
- Expert testimony establishing that the decedent's dehydration, malnutrition, and urinary tract infection caused her death.

Thus, a careful reading of *Scampone* shows that the Superior Court treated evidence of understaffing, evidence of a breach of the standard of care, evidence

that those breaches caused harm to the decedent, and evidence *connecting the understaffing to the decedent's care* as conceptually distinct.

Plaintiff argues, essentially, that the evidence presented in *Scampone* is substantially similar to the record in the instant case. Although Plaintiff has not always explicitly stated each of the steps in the chain connecting HCR ManorCare, Inc. to the injuries suffered by Mr. Stetts, the Court understand the Plaintiff to argue:

- The record demonstrates HCR ManorCare, Inc. controlled the Facility's budget, and had control over staffing levels during the relevant time frame;
- The facility was understaffed, as evidenced by both the record and the expert reports;
- The record demonstrates HCR ManorCare, Inc. was aware of the staffing insufficiency;
- The expert reports establish that the Facility breached the standard of care in multiple ways;
- The record is sufficient to link the insufficient staffing at the Facility to the breaches in the standard of care;
- Expert reports establish that the breaches were a substantial causal factor in Mr. Stetts's injuries.

Plaintiff stresses that "the Superior Court determined that 'evidence of understaffing' is not specialized knowledge and does not require expert testimony," but the Court's conclusion was never simply that Plaintiff had produced *no* evidence of understaffing or that expert testimony was strictly necessary to establish

understaffing (though it certainly would have been sufficient). Rather, the Court's conclusions were:

> "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**…
>
> Plaintiff has not produced evidence of understaffing at the Facility here **which led to injuries to Mr. Stetts**….
>
> 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**. [T]he Court finds that Plaintiff has done neither…."

The Court's first conclusion was that Plaintiff had not "allege[d] facts linking the actions of HCR ManorCare Services, Inc. to inadequate staffing at the Facility" during the 27 days Mr. Stetts was a resident there. The reasons for this conclusion are discussed *supra*, but can be summarized as: Plaintiff's proffered evidence demonstrated that HCR ManorCare Services, Inc. controlled the staffing at other facilities in other jurisdictions at other times, but the record in this case did not show that HCR ManorCare Services, Inc. controlled the staffing of *this Facility during the time Mr. Stetts was a resident there*. To so conclude from the evidence presented by Plaintiff would require a speculative leap beyond what was supported by the record.

The Court's second conclusion was that Plaintiff had not "allege[d] facts linking the inadequate staffing to the harm suffered by Mr. Stetts." In other words, Plaintiff had never established a causal connection between the alleged understaffing and the injuries suffered by Mr. Stetts, and therefore – even if all of Plaintiff's other contentions are accepted as true – Plaintiff cannot show that the corporate defendant's breach was "a substantial factor in causing the harm to" Mr. Stetts. Importantly, the Court did not hold that expert testimony is *always* required to establish a causal connection between understaffing and the harm to a patient, and therefore the failure to provide an expert opinion on that issue was *per se* dispositive regardless of what the lay witnesses said. Rather, the Court held that nothing of record – established by experts, lay witnesses, or otherwise – established that connection. Thus, Plaintiff's contention that "[t]he Court premised its rejection of understaffing on an alleged lack of expert testimony linking the Facility's understaffing to the harms incurred by Plaintiff," while not wholly incorrect, is not a full statement of the Court's holding.

The question at the heart of Plaintiff's request for reconsideration, then, is: if the record demonstrates understaffing, and demonstrates a breach of care, what showing is required to connect alleged understaffing to the alleged harm suffered by a resident prior to allowing the case to proceed to a jury?

The plain language of *Thompson* makes clear that *some* showing is required. Under *Thompson*, a plaintiff must show that the corporation's negligence was "a substantial factor in causing the harm to the injured party." If that negligence is alleged to be understaffing, but there is *no connection* between understaffing and the

breach that caused the injury, then the corporation's negligence cannot be said to be a factor, let alone a substantial one, in causing the harm to the injured party.

Further, although some connection must be established, it is apparent that expert testimony is not *always* required to establish this connection. In *Scampone*, the plaintiff presented expert testimony that Highland breached its duties, and those breaches caused the decedent's injuries and death, but only lay testimony established the existence of understaffing and the causal connection between the understaffing and the breaches. The Court in *Scampone* did not hold, however, that expert testimony is *never* required to establish a causal connection between understaffing and breaches of duties of care; it addressed whether the evidence presented in that case was sufficient to establish that connection, not whether *any* quantum of lay evidence presented in *any* case would necessarily be sufficient. Thus, the question becomes: when may the causal connection between understaffing and a breach of duty of care be shown by lay evidence, and when is expert testimony required?

As discussed in detail *supra*, the Pennsylvania courts have routinely held that "where it is not obvious that negligence occurred and that the doctrine of *res ipsa loquitur* should be applied, expert medical testimony is required to establish causation."[77] In *Scampone*, the Superior Court held that the plaintiff's lay testimony was sufficient to demonstrate a causal connection between the understaffing and the breaches (and thus the decedent's injuries). Therefore, one of two things must be true: *either* the Superior Court in *Scampone* determined the general principle that

[77] *Walls*, 629 A.2d at 235; *see also Welsh*, 698 A.2d at 585 (applying this principle firmly to both negligence and causation in the corporate negligence context).

expert testimony is generally required to establish causation does not apply to establishing a causal connection between understaffing and a patient's injuries, *or* the Court tacitly determined that the causal connection between the understaffing and the decedent's injuries in *Scampone* was obvious.

The first of these interpretations is not plausible, as it is extremely unlikely the Superior Court would carve out such a specific exception to a well-established principle of law *sub silentio* without at least discussing the reasons for doing so. The Court in *Scampone* reproduced a large excerpt from *Welsh*, which included *Welsh*'s directive that "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."[78] It is unlikely that the Court would quote this language and determine it inapplicable to the class of cases before it without any further explication or even mention.

Rather, the *Scampone* Court's discussion of the causal connection between understaffing and the treatment of the decedent shows that the Court found the link to be so obvious that it need not be stated explicitly. Eleven witnesses, including nurses caring for the decedent, testified that the understaffing at Highland was *the cause* of their failure to provide the decedent with water, monitor her food and fluid intake, and comply with doctor's orders to test her for infection. In light of this overwhelming, direct testimony, the jury needed nothing more to simply accept the testimony of the nurses providing care as to the causal link between the understaffing

[78] *Scampone*, 11 A.3d 967 (quoting *Welsh*, 698 A.2d at 685).

and the specific breaches, which in turn caused the specific injuries leading to the decedent's death.

Here, the link between the alleged understaffing at the Facility and Mr. Stetts's care is not obvious. Assuming *arguendo* that Plaintiff has provided lay testimony sufficient to establish understaffing at the Facility, the record still does not disclose any evidence – from lay witnesses, expert reports, or other sources – of a causal connection between understaffing and the August 1, 2014 incident involving the lift. There is no obvious link between a delay in call times or staff members remarking that they "could always use more help" and the failure of particular staff members to properly use the lift on that date. Nor is there any testimony or evidence showing any sort of direct link between the alleged understaffing and the fluid-filled blister, significant weight loss, poor hygiene, and severe pain allegedly suffered by Mr. Stetts. At best, Plaintiff's lay testimony may support an argument that "the outcome was bad, but it may not have been had more staff members been available." Nothing in the record, however, establishes how the alleged understaffing contributed in any *specific* way to the injuries suffered by Mr. Stetts.[79]

In the absence of an obvious connection between the alleged breach and the harm suffered, Pennsylvania case law requires expert testimony to provide the causal connection. That is what the Court found to be missing here.

[79] In *Scampone*, the evidence showed that the understaffing caused the staff to not provide decedent water, not monitor her food or fluid intake, and not check her for urinary tract infections; these had an obvious link to the dehydration, malnourishment, and urinary tract infection that led to the decedent's death. By contrast, Plaintiff has presented no evidence that understaffing led to staff using the lift improperly or to Mr. Stetts not being fed. Plaintiff can only ask the jury to speculate that, had more staff been available, the outcome may have been different in some indeterminate way.

Plaintiff contends that she has established understaffing at the Facility, and that she has established that the Facility breached duties of care to Mr. Stetts, resulting in harm. With this, the Court agrees – at the summary judgment stage, taking all evidence in a light most favorable to Plaintiff, there are material questions of fact as to whether the Facility was in fact understaffed and whether the Facility breached duties of care owed to Mr. Stetts. Plaintiff seems to argue, however, that these two showings are all that is necessary to submit evidence of understaffing to the jury, because it is in the province of the jury to accept or reject Plaintiff's theory that understaffing substantially contributed to these breaches. With this contention the Court cannot agree, as it entirely omits the requirement to demonstrate a causal connection between the alleged understaffing and the injuries suffered. *Thompson* requires that a corporate defendant's negligence be "a substantial factor in causing the harm to the injured party."

Ultimately, whether understaffing was a substantial factor in causing the injury is a question of causation, which, under *Welsh*, must be proved by expert testimony in a corporate negligence case unless the causal relationship is obvious. The record does not establish this connection by expert testimony, lay testimony, or other evidence, and therefore as a matter of law Plaintiff cannot show on the record that the alleged negligence of HCR ManorCare, Inc. was a "substantial factor in causing the harm to" Mr. Stetts. For this reason, the Court DENIES Plaintiff's Motion for Reconsideration of its December 30, 2021 Order.

D. Motion for Certification for Immediate Appeal

Under Pennsylvania Rule of Appellate Procedure 1311, an appeal may be taken from an interlocutory order only if that order is "certified under 42 Pa. C.S. § 702(b) or for which certification pursuant to 42 Pa. C.S. § 702(b) was denied," or "for which certification pursuant to Pa. R.A.P. 341(c) was denied…."

Under 42 Pa. C.S. § 702(b), "[w]hen a court… shall be of the opinion that [an] order involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the matter, it shall so state in such order. The appellate court may thereupon, in its discretion, permit an appeal to be taken from such interlocutory order." Under 42 Pa. C.S. § 702(c), "a petition for permission to appeal under this section shall not stay the proceedings before the lower court" unless either the lower court or appellate court so orders.

Rule of Appellate Procedure 341(c) provides that:

> "When more than one claim for relief is presented in an action, whether as a claim, counterclaim, cross-claim, or third-party claim, or when multiple parties are involved, the trial court or other government unit may enter a final order as to one or more but fewer than all of the claims and parties only upon an express determination that an immediate appeal would facilitate resolution of the entire case. Such an order becomes appealable when entered. In the absence of such a determination and entry of a final order, any order or other form of decision that adjudicates fewer than all the claims and parties shall not constitute a final order. In addition, the following conditions shall apply:
>
> (1) An application for a determination of finality under paragraph (c) must be filed within 30 days of entry of the order. During the time an application for a determination of finality is pending, the action is stayed.
>
> (2) Unless the trial court or other government unit acts on the application within 30 days after it is filed, the trial court or other

government unit shall no longer consider the application and it shall be deemed denied.

(3) A notice of appeal may be filed within 30 days after entry of an order as amended unless a shorter time period is provided in Pa.R.A.P. 903(c). Any denial of such an application is reviewable only through a petition for permission to appeal under Pa.R.A.P. 1311."[80]

Here, the Court does not believe either that an immediate appeal from its December 30, 2021 Order would materially advance the termination of the matter so as to justify a certification under 42 Pa. C.S. § 702(b) or that "an immediate appeal would facilitate resolution of the entire case" as is necessary for the Court to certify an order under Rule of Appellate Procedure 341. As Defendants point out, were the December 30, 2021 Order appealed, the timeline of the case on remand would be the same regardless of the result; trial would still proceed, with the only difference being which claims Plaintiff may present. A party who feels aggrieved by a decision they believe to be wrongly decided may always contend that immediate appeal would "advance the termination of the matter" or "facilitate resolution of the entire case," inasmuch as it would avoid the likely consequences of reversible error. Such a concern, however, lurks behind every adverse ruling, and the rules governing interlocutory appeals by allowance require something more. Thus,

[80] Plaintiff's Motion for reconsideration was filed on January 11, 2022. Under Rule 341(c)(2), therefore, Plaintiff's application for determination of finality was deemed denied on February 10, 2022, and after that date this Court no longer had the ability to grant Plaintiff the relief sought under this Rule. Under Rule 341(c)(3), Plaintiff had until Monday, March 14, 2022 to file a notice of appeal of this denial. The analysis in this section explains that, had the Court acted on the application for determination of finality, it would have denied the application for the reasons discussed *infra*.

the Court will DENY Plaintiff's Alternative Motion for Determination of Finality and/or Alternative Motion for Certification of Allowance of Appeal.

ORDER

AND NOW, this 18th day of March 2022, Plaintiff's Motion for Reconsideration, Alternative Motion for Determination of Finality and/or Alternative Motion for Certification of Allowance of Appeal is DENIED.

IT IS SO ORDERED.

By the Court,

_____
Eric R. Linhardt, Judge

cc: Michael T. Collis, Esq. and Kristin E. Hoffman, Esq.
Frick Building, Suite 912, 437 Grant Street, Pittsburg, PA 15219
William J. Mundy, Esq. and John M. Skrocki, Esq.
100 Four Falls, Suite 515, 1001 Conshohocken State Road, West Conshohocken, PA 19428
Gary Weber, Esq. (Lycoming Reporter)