VIRGINIA:

IN THE CIRCUIT COURT OF WINCHESTER

Carlos A. Bunting III, **Administrator of the Estate of** **Edna Marie Bunting** **Plaintiff,** **v.**	**Law No. CL 2013-13209**
Pinnacle Services Winchester, Inc d/b/a Evergreen Health and Rehabilitation Center 380 Millwood Ave Winchester, VA 22601 Serve: Registered Agent Robert J. Zelnick 12610 Lake Ridge Dr. Woodbridge, VA 22192 **Long Term Care Properties, LLC** P.O. Box 1394 Winchester, VA 22604 **Defendants.**	

COMPLAINT

COMES NOW Plaintiff, Carlos A. Bunting, as the Administrator of the Estate of Edna M. Bunting, by and through counsel and files this Complaint on behalf of the Estate and Statutory Beneficiaries against Defendants Pinnacle Services of Winchester Inc. d/b/a Evergreen Health and Rehabilitation Center and Long Term Care Properties, LLC and moves this Court for judgment based upon the following:

1. On or about August 15, 2016, Carlos A. Bunting III ("Carlos Bunting"), the son of Edna Bunting, was appointed as Administrator of his mother's Estate. Mr. Bunting currently resides at 1327 Berryville Ave, Winchester, Virginia.

2. On or about May 19, 2016 Edna Bunting was admitted to Evergreen Health and Rehabilitation Center of Winchester ("Evergreen"). Her medical history included pulmonary disease, a prior hip fracture with impaired gait, GIRD and elevated lipids. She had no documented skin breakdown on admission, but did have redness in the sacral area.

3. At the time of Edna Bunting's admission to Evergreen, Pinnacle Services Winchester Inc. operated this skilled nursing facility located at located at 380 Millwood Road, Winchester, Virginia. Defendant Long Term Care Properties, LLC owned the nursing facility.

4. At all relevant times alleged herein, Defendants Pinnacle Services Winchester Inc. and Long Term Care Properties, LLC were engaged in a joint venture as defined under Virginia law. By agreement, both Defendants participated in the nursing home's control and/or operation for their mutual benefits and shared in their joint venture's profits. Both Defendants had a voice in the nursing home's control and/or management.

5. At all times pertinent herein, Defendant Pinnacle Services of Winchester Inc. employed the nursing and nurse aides who cared for Ms. Bunting and further controlled the operation of the nursing home, operating under the trade name of Evergreen Health and Rehabilitation Center.

6. From the time of her admission until her discharge on or about June 23, 2016, Edna Bunting had a continuous and substantially uninterrupted course of treatment from Defendants and their agents/employees for the same conditions which prompted her admission.

Count I
(Negligence/Survivorship)

Plaintiff repeats and realleges each and every allegation set forth in the foregoing paragraphs 1 through 6 of this Complaint, as if fully set forth herein, and further states as follows:

7. At all times set forth herein, Defendants and their direct staff who cared for Edna Bunting were aware of her medical condition and history as reflected in her records. Defendants, through their agents/employees, represented to the Bunting family and to the Commonwealth of Virginia that they could adequately care for Ms. Bunting by providing nursing, rehabilitation and related care, that they could adequately monitor her medical care needs at the skilled care level and provide sufficient staff in numbers and training to meet the total care needs of their nursing home residents and specifically those of Edna Bunting.

8. Defendants and their agents/employees owed Ms. Edna a duty to provide reasonable care and to properly monitor, assess, treat, maintain and rehabilitate her. They further had a duty to take care of Ms. Bunting's needs and treat her with dignity. Furthermore, the duty to provide care, maintenance and protection of Ms. Bunting was a non-delegable duty; hence, Defendants are responsible for the conduct of any individuals to whom they delegated such duties.

9. Defendants, as owners and operators of a skilled care nursing facility, had a duty to provide staffing, including nursing, CNA and various specialists, in sufficient numbers and with sufficient training to meet Ms. Bunting's needs. Defendants before and during Ms. Bunting's nursing home residency at Evergreen were aware of staffing deficiencies yet persistently and in violation of applicable standards of care, provided insufficiently trained and

numbered staff to meet the needs of the nursing home residents, including Ms. Bunting. This proximately caused and/or contributed to substandard care which was provided to Ms. Bunting, in various healthcare areas, as described below.

10. Ms. Bunting was incontinent of bowel and bladder with compromised mobility. She required extensive assistance for bed mobility and transfers. Given these and other risk factors, Ms. Bunting was at high risk for the development of skin break-down.

11. Despite Ms. Bunting's high risk for the development of skin break-down, Defendants and their nursing and nurse aid staff breached applicable standards of care by failing to provide consistent and necessary off-loading and pressure prevention, including consistent turning and repositioning and other measures designed to prevent the development of skin break-down. Defendants and their staff breached applicable standards of care by failing to assess Ms. Bunting's wound at an earlier stage, that would have allowed successful treatment.

12. On June 18, 2016, Nurse [redacted] documented an open area surrounded by "angry red skin." On this date, the pressure wound was also noted to be unstageable because it was covered with necrotic tissue. Ms. Bunting's wound continued to deteriorate while Defendants, in breach of applicable standards of care, failed to adequately update her care plan.

13. Despite Ms. Bunting's high risk for the development of skin break-down, Defendants and their nursing and nurse aid staff breached applicable standards of care by failing to provide consistent and necessary off-loading and pressure prevention, including turning and repositioning and other measures designed to prevent the development of skin breakdown. Defendants and their staff breached applicable standards of care by failing to assess Ms. Bunting's wound at an earlier stage, which would have allowed successful treatment.

14. On or about June 23, 2016, Ms. Bunting was hospitalized because of a deep and infected pressure wound, that was malodorous. Necrotic tissue was present in the wound. Protein levels showed below normal protein levels consistent with malnutrition. On June 25, 2016, Ms. Bunting underwent debridement of her wound with the removal of muscle and subcutaneous tissue. After surgery, she was transferred to another facility, Golden Living, where she deteriorated further until her death.

15. Defendants and their staff, operating within the course and scope of their employment, breached applicable standards of care by failing to prevent Ms. Bunting's development of skin breakdown. Specifically, Defendants failed to undertake adequate daily assessments of her skin, failed to timely identify skin breakdown, failed to put in place an adequate care plan for preventive pressure relief and failed to provide adequate turning and repositioning.

16. In addition to the negligent acts described above, Defendants, through their agents/employees acting within the scope of their employment and during the course of a continued patient relationship, subjected Ms. Bunting to additional forms of substandard care in violation of accepted standards of care as follows:

a. Defendants failed to adequately monitor changes in Ms. Bunting's medical condition and otherwise failed to timely report such changes to Plaintiff's responsible party and attending physician;

b. Defendants failed to check on Ms. Bunting's skin status on a regular, daily basis and failed to document her status in the progress notes;

c. Defendants and their agents/employees negligently failed to provide adequate nutrition and hydration for Ms. Bunting;

d. Defendants and their agents/employees negligently failed to provide adequate care planning to maintain Ms. Bunting's highest practical mental, physical and psychosocial well-being and update the care planning when it became clear that Defendants' level of care was insufficient to prevent skin breakdown;

e. Defendants and their staff failed to keep Ms. Bunting's family advised of changes of condition, including the initial development of her pressure wound;

f. Because of administrative failures in adequate staffing and/or staff training, Ms. Bunting did not receive proper care to avoid skin breakdown and was neglected in multiple ways as more fully set forth herein;

f. Defendants and their agents/employees negligently failed to provide adequate assistance with daily living activities;

g. Defendants and their agents/employees negligently failed to provide adequate restorative and range of motion exercises; and

h. Defendants and their agents/employees negligently failed to provide adequate hygiene and proper toileting.

14. As a direct and proximate result of the aforesaid negligence and breaches in the applicable standards of care as outlined above, Edna Bunting sustained personal injuries, including but not limited to the onset of a large, infected pressure sore, decline in her physical and mental health, physical and mental suffering, and further incurred medical and related expenses in an effort to treat her injuries.

Count II
(Wrongful Death)

Plaintiff incorporates herein paragraphs 1 through 14 as if fully set forth herein and further alleges the following:

15. At the time of her nursing home admission, Edna Bunting had various risk factors for the development of skin breakdown and pressure sores. Defendants and their agents/employees operating within the course and scope of their employment breached applicable standards of care by failing to properly assess her risk factors, by failing to timely identifying skin breakdown and by failing to provide adequate care planning and pressure relief to prevent Ms. Bunting from developing pressure sores.

16. Defendants' staff negligently failed to monitor and address Plaintiff's change in condition leading up to her June 23, 2016 hospitalization including the progression of her sacral wound.

17. As a direct and proximate result of Defendants' negligence, Ms. Bunting developed a large, deep pressure wound in her sacral area that caused her to develop sepsis and other complications, resulting in her death on July 9, 2016.

18. Defendants' negligence in causing the pressure wound and resulting complications was the proximate cause of her death. Ms. Bunting is survived by statutory beneficiaries including her four children.

19. As a direct and proximate result of Ms. Bunting's wrongful death, said beneficiaries sustained damages including monetary losses, funeral expenses, and have further suffered sorrow, mental anguish, solace, loss of society, companionship, and comfort.

Count III – Punitive Damages

Plaintiff incorporates paragraphs 1 through 19 as if fully set forth herein and further alleges as follows:

20. During her residency at Defendants' nursing facility, Edna Bunting suffered from deficiencies and deficits which had affected her ability to care for herself. In such a condition, she was completely vulnerable and trusted Defendants to take care of her total healthcare needs.

21. Defendants Pinnacle and Long Term Care Properties LLC, through their staff, intentionally took advantage of Ms. Bunting's deficits and ability to protect herself by failing to provide the services, assistance and care necessary for her physical well-being. Defendants knew that this conduct would pose a serious risk of harm to Ms. Bunting. Despite this knowledge, Defendants, continued in their course of action and failed to properly manage Ms. Bunting's risk for pressure sores, compromised nutrition and other medical conditions.

22. On March 26, 2015, Defendants were cited for multiple violations of regulatory standards relating to the care of their residents, including *inter alia*, failing to provide proper treatment to prevent pressure wounds, failing to provide necessary devices to prevent skin break-down, failing to meet professional standards, failing to keep accurate, complete and organized clinical records, failing to meet proper infection control program, failing to follow physician orders, failing to ensure timely doctor visits, failing to advise resident's physician and family of change in condition (refusing medications), failing to develop policies to prevent mistreatment, neglect and abuse of residents (failing to perform pre-employment screening), failing to provide services to maintain the dignity of patients and failing to undertake proper resident assessments and document same.

23. On February 10, 2016, the Department of Health cited Defendants for, *inter alia*, failing to prevent development of pressure wounds and implement changes in treatment (5 day

delay it modifying treatment after development of open wound), failing to follow wound clinic recommendations, failing to maintain infection control practices to prevent the spread of infection, failing to maintain complete and accurate clinical records, failing to notify a treating physician about a resident's change in condition, failing to care for a resident in a manner that promotes dignity, failing to develop a complete care plan, failing to assure patients are free from significant medication errors, failing to revise a care plan to incorporate physician ordered care, failing to assure that services provided by nursing staff meet professional standards and failing to follow a patient's plan of care.

24. Defendants knew that the failure to provide vigilant pressure sore relief and monitoring for Ms. Bunting would place her at risk for developing skin breakdown and death. Defendants' corporate management staff recklessly failed to provide sufficient staffing for Ms. Bunting and other residents in an effort to increase their profits in the operation of this nursing facility.

25. At the time Ms. Bunting presented to the hospital on or about June 23, 2015, she had a very deep, foul smelling sacral pressure wound. When her wound was discovered at Evergreen on or about June 18, 2016, it was already covered with necrotic skin. Such a wound would have taken several days or longer to develop. Despite the high risk for skin breakdown that Ms. Bunting presented, Defendants' staff recklessly disregarded her rights despite their knowledge that not providing consistent and appropriate daily monitoring and pressure sore prevention would likely result in serious injury and/or death.

26. Defendants, through their corporate management staff, were well aware of wide-spread deficiencies in the care and treatment rendered to patients at this nursing facility before and during Ms. Bunting's nursing home residence. As noted above Defendants, through their

corporate and administrative management, were also aware of prior deficiencies involving, *inter alia*, failures to prevent pressure wounds. Despite the issuance of plans of correction suggesting that they were going to correct their deficient practices, Defendants continued to recklessly disregard the needs of their patients, including Ms. Bunting, despite knowledge that such conduct would likely cause injury. In summary, Defendants made conscious decisions on staffing and resource allocation which effectively sacrificed the needs of their patient population, including Ms. Bunting, who was completely reliant upon the staff to meet their daily care needs.

27. Defendants ratified the acts of their nursing and CNA staff, as their management staff and employees were aware of Ms. Bunting's health status and directly participated in the neglect and reckless conduct described above. Defendants also ratified their employees conduct by condoning it and failing to correct repeated instances of neglect of their residents including Ms. Bunting. Furthermore, as corporate management participated in the neglect of Ms. Bunting through the conduct of their Administrator and Director of Nurses, and as corporate management made the conscious business decision to maintain inadequate staffing levels in the face of an already deficiently performing facility, Defendants committed both direct and indirect acts of ratification making these corporate entities liable for punitive damages.

28. Defendants' management staff intentionally, and with reckless indifference to the consequences, ignored staffing complaints, inadequacies and other staffing problems even though they were aware that such deficiencies would lead directly to the harm of residents including Edna Bunting. Moreover, Defendants through their management staff, by failing to properly hire, train and monitor their staff and implement policies and procedures to correct institution-wide problems, and by making business decisions to sacrifice patient care for

increased income, committed direct acts of willful, wanton and reckless conduct that render these corporate Defendants directly liable for punitive damages.

29. As a direct and proximate result of the aforesaid willful, wanton and/or reckless conduct of Defendants and their staff, Edna Bunting sustained personal injuries as described above, suffered a serious decline in her mental health status leading to her untimely death, suffered great pain of body and mind and incurred medical and related out-of-pocket expenses and attorneys' fees.

WHEREFORE these and other premises considered, Carlos A. Bunting, as the Administrator of the Estate of Edna Bunting and on behalf of the statutory beneficiaries, moves this Court for judgment against Defendants, Pinnacle Services of Winchester Inc. d/b/a Evergreen Health and Rehabilitation Center and Long Term Care Properties, LLC jointly and severally, for the following relief:

a. $2,500,000.00 in compensatory damages plus costs and pre-judgment from June 18, 2016;

b. $500,000.00 in punitive damages with interest;

c. Any additional relief that this Court may deem appropriate.

JURY DEMAND

Plaintiff hereby demands a trial by jury as to all issues involved herein.

Date: January 30, 2018

Respectfully submitted,

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