# Supreme Court of Pennsylvania Court of Common Pleas Civil Cover Sheet

For Prothonotary Use Only: Docket No:

County

The information collected on this form is used solely for court administration purposes. This form does not

Commencement of Action:  Complaint Writ of Sur Transfer from Another Jurisdiction		Petition Declaration of Taking	
Lead Plaintiff's Name: Lois McCallister, An Incapacitated P	erson, By Mary Frenc	Lead Defendant's Name Sunrise Senior Liv	
Are money damages requested?	ĭ Yes ☐ No	Dollar Amount Re (check one)	
Is this a Class Action Suit?	□ Yes ⊠ No	Is this an MDJ	JAppeal? ☐ Yes ⊠ No
Name of Plaintiff/Appellant's Attor  Check here if y	•	(are a Self-Represen	ted [Pro Se] Litigant)
PRIMARY C			ost accurately describes your e of claim, check the one that
TORT (do not include Mass Tort)  Intentional Malicious Prosecution Motor Vehicle Nuisance Premises Liability Product Liability (does not include mass tort) Slander/Libel/ Defamation Other: Asbestos Tobacco Toxic Tort - DES	CONTRACT (do not be a super Plaintiff Debt Collection Debt Collection Debt Collection Debt Collection Discrimination Discrimination Demployment Demplo	n: Credit Card n: Other	Administrative Agencies Board of Assessment Board of Elections Dept. of Transportation Statutory Appeal: Other Zoning Board Other:
Toxic Tort - Implant Toxic Waste Other:  PROFESSIONAL LIABLITY Dental Legal Medical Other Professional: Nursing Home Negligence	Ground Rent Landlord/Tenar Mortgage Fored	in/Condemnation	MISCELLANEOUS  Common Law/Statutory Arbitrat Declaratory Judgment Mandamus Non-Domestic Relations Restraining Order Quo Warranto Replevin Other:

# IN THE COURT OF COMMON PLEAS OF DELAWARE COUNTY, PENNSYLVANIA CIVIL ACTION - LAW

LOIS MCCALLISTER, An Incapacitate	ed
Person, By MARY FRENCH, Guardian	

Plaintiff

v.

SUNRISE SENIOR LIVING, INC.

And
SUNRISE CONTINUING CARE, LLC
And
THE QUADRANGLE
And
SAMIRAH TRAYNHAM
And
TYRINA GRIFFIN
And
AYESHA MUHAMMAD

Defendants

# DELAWARE COUNTY COURT OF COMMON PLEAS LAW DIVISION

TERM, 2011

NO. \_\_\_\_\_

JURY TRIAL DEMANDED

2011 OCT 12 RM 9: 53

## PRAECIPE FOR APPEARANCE

To the Office of Judicial Support, Court of Common Pleas of Delaware County:

Please enter our appearance for the Plaintiffs, Lois Mccallister, An Incapacitated Person, By Mary French, Guardian, in the above entitled proceeding.

SALTZ, MONGELUZZI, BARRETT & BENDESKY, P.C.

BY: 2

Robert J. Mongeluzzi, Esquire, I.D. No. 36283 Carmen P. Belefonte, Esquire, I.D. No. 08608 Andrew R. Duffy, Esquire, I.D. No. 77121

One Liberty Place, 52<sup>nd</sup> Floor 1650 Market Street Philadelphia, PA 19103 215-496-8282

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E-mail: <u>rmongeluzzi@smbb.com</u> <u>cbelefonte@smbb.com</u> <u>arduffy@smbb.com</u>

#### SALTZ, MONGELUZZI, BARRETT & BENDESKY, P.C.

BY: ROBERT J. MONGELUZZI/CARMEN BELEFONTE/ANDREW R. DUFFY

IDENTIFICATION NO.: 36283/08608/77121

52ND FLOOR

1650 MARKET STREET

PHILADELPHIA, PA 19103

(215) 496-8282

# LOIS MCCALLISTER, An Incapacitated DELAWARE CO Person, By MARY FRENCH, Guardian COURT OF COMM

Plaintiff

v.

SUNRISE SENIOR LIVING, INC.

And

SUNRISE CONTINUING CARE, LLC

And

THE QUADRANGLE

And

SAMIRAH TRAYNHAM

And

TYRINA GRIFFIN

And

AYESHA MUHAMMAD

Defendants

DELAWARE COUNTY
COURT OF COMMON PLEAS
LAW DIVISION

ATTORNEYS FOR PLAINTIFFS

**TERM, 2011** 

NO. \_\_\_\_\_

JURY TRIAL DEMANDED

2011 OCT 12 MM 9: 53

OFFICE OF

JUDICIAL SUSTIONT
DELIVERS TO PA

#### JURY TRIAL DEMAND

To the Office of Judicial Support:

Plaintiffs, Lois McCallister, An Incapacitated Person, By Mary French, Guardian, hereby demands a jury trial in the present action composed o twelve (12) members.

SALTZ, MONGELUZZI, BARRETT, & BENDESKY, P.C.

BY:

Robert J. Mongeluzzi, Esquire

Carmen P. Belefonte, Esquire

Andrew R. Duffy, Esquire

Attorneys for Plaintiff(s)

# SALTZ, MONGELUZZI, BARRETT & BENDESKY, P.C.

BY: ROBERT J. MONGELUZZI/CARMEN

BELEFONTE/ANDREW R. DUFFY

IDENTIFICATION NO.: 36283/08608/77121

52ND FLOOR

1650 MARKET STREET

PHILADELPHIA, PA 19103

(215) 496-8282

ATTORNEYS FOR PLAINTIFFS

# LOIS MCCALLISTER, An Incapacitated Person, By MARY FRENCH, Guardian

1846 Rose Tree Lane Havertown, PA 19083

**Plaintiff** 

 $\mathbf{v}$ 

#### SUNRISE SENIOR LIVING, INC.

7900 Westpark Drive McLean, VA 22102

And

#### SUNRISE CONTINUING CARE, LLC

7900 Westpark Drive McLean, VA 22102

And

#### THE QUADRANGLE

3300 Darby Road Haverford PA 19041

And

#### SAMIRAH TRAYNHAM

824 Whitney Ave Lansdowne, PA 19050

And

#### **TYRINA GRIFFIN**

3207 W Susquehanna Ave Philadelphia, PA 19121

### DELAWARE COUNTY COURT OF COMMON PLEAS LAW DIVISION

TERM, 2011

NO. \_\_\_\_\_

JURY TRIAL DEMANDED

7011 OCT 12 AM 9: 53
OFFICE OF JUDICIAL SUPPORT

And

## **AYESHA MUHAMMAD** 1335 N 49<sup>th</sup> ST Philadelphia, PA 19131

#### Defendants

#### "NOTICE

"You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by an attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgement may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.

"YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER (OR CANNOT AFFORD ONE), GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP. THIS OFFICE CAN PROVIDE YOU WITH INFORMATION ABOUT HIRING A LAWYER. IF YOU CANNOT AFFORD TO HIRE A LAWYER, THIS OFFICE MAY BE ABLE TO PROVIDE YOU WITH INFORMATION ABOUT AGENCIES THAT MAY OFFER LEGAL SERVICES TO ELIGIBLE PERSONS AT A REDUCED FEE OR NO FEE.

PHILADELPHIA BAR ASSOCIATION LAWYER REFERRAL and INFORMATION SERVICE One Reading Center Philadelphia, Pennsylvania 19107 (215) 238-1701"

#### "AVISO

"Le han demandado a usted en la corte. Si usted quiere defenderse do estas demandas expuestas en las páginas siguients, usted tiene veinte (20) dias, de plazo al partir de la fecha de la demanda y la notificatión. Hace falta asentar una comparenca escrita o en persona o con un abagado y entregar a la corte en forma escrita sus defensas o sus objecciones a las demandas en contra de su persona. Sea avisado que si usted no de defiende, la corte tomará medidas y puede continuar la demanda en contra suya sin previo aviso o notificaion. Además, la corte puede decidir a favor del demandante y requiere que usted cumpla con todas las provisiones de esta demanda. Usted puede perder dinero o sus propiedades u otros derechos importantes para usted.

"TLEVE ESTA DEMANDA A UN ABOGADO INMEDIATAMENTE. SI NO TIENE ABAGADO O SI NO TIENE EL DINERO SUFICIENTE DE PARGAR TAL SERVICO, VAYA EN PERSONA O LLAME POR TELEFONO A LA OFICINA CUYA DIRECCION SE ENCUENTRA ESCRITA ABAJO PARA AVERIGUAR DONDE SE PUEDE CONSEGUIR ASISTENCIA LEGAL. ESTA OFICINA PUEDE PROPORCIONARLE LA INFORMACION SOBRE CONTRATAR A UN ABOGADO. SI USTED NO TIENE DINERO SUFICIENTE PARA PAGAR A UN ABOGADO. ESTA OFICINA PUEDE PROPORCIONARLE INFORMACION SOBRE AGENCIAS QUE OFRECEN SERVICIOS LEGALES A PERSONAS QUE CUMPLEN LOS REQUISITOS PARA UN HONORARIO REDUCIDO O NINGUN HONORARIO,

ASSOCIACION DE LICENDIADOS DE FILADELFIA SERVICO DE REFERENCA E INFORMACION LEGAL One Reading Center Filadelfia, Pennsylvania 19107 Telefono: (215) 238-17017

#### **CIVIL ACTION – COMPLAINT**

- 1. Lois McCallister is an adult citizen of the Commonwealth of Pennsylvania.
- 2. Mary French, Lois McCallister's daughter, is an adult citizen of the Commonwealth of Pennsylvania.
- 3. Mary French resides at 1846 Rose Tree Lane, Havertown, PA 19083 with her husband, Paul French.

- 4. Since April 3, 2011, Lois McCallister has resided with Mary and Paul French at 1846 Rose Tree Lane, Havertown, PA 19083.
- 5. Lois McCallister, suffers from profound neurocognitive and neurobehavioral deficits as a result of dementia/Alzheimer's disease.
- 6. On June 7, 2011, the Court of Common Pleas of Delaware County, Orphans' Court Division, determined Lois McCallister to be incapacitated and named Mary French the Plenary Guardian of the Estate of Lois McCallister.
- 7. Defendant, Sunrise Senior Living, Inc. and/or Defendant, Sunrise Continuing Care, LLC, are Delaware Corporations with their principle office located at 7900 Westpark Drive, McLean, VA.
- 8. Defendant, Sunrise Senior Living, Inc. and/or Defendant, Sunrise Continuing Care, LLC, operate seventeen (17) facilities across the Commonwealth of Pennsylvania.
- 9. Defendant, The Quadrangle, is a corporation or other business entity organized and existing under the laws of the Commonwealth of Pennsylvania with its principal place of business located at 3300 Darby Road, Haverford, PA 19041.
- 10. Defendants, Sunrise Senior Living, Inc., Sunrise Continuing Care, LLC and The Quadrangle, are collectively referred to hereinafter as "SUNRISE".
- 11. Defendant, SUNRISE, is engaged in the business of owning, operating and/or managing assisted living facilities, including The Quadrangle (hereinafter referred to as "the Facility"), located at 3300 Darby Road, Haverford, PA 19041, providing healthcare, medical

services, assisted living care, nursing care, and/or certified nurse assistant/aide care to the public in Delaware County, Pennsylvania, and, at all times material hereto, was duly licensed to operate the same in the Commonwealth of Pennsylvania, and was the employer, supervisor and/or partner of co-Defendants, noted herein, holding itself and its agents, employees, contractors, subcontractors, staff and/or partners, and those persons granted privileges at the Facility, out to the public as competent and skillful healthcare, assisted living, and/or nursing care providers and practitioners of medicine and/or nursing and which is personally and vicariously liable for the acts and omissions of themselves, their agents, employees, contractors, subcontractors, staff and/or partners and all other Defendants, all of whom played a role in the care, supervision, oversight and/or assistance of Lois McCallister.

- 12. At all relevant times, defendant, SUNRISE, was acting by and through its employees, agents, workers, and/or staff, all of whom were acting within the course and scope of their employment for and on behalf of defendant, SUNRISE.
- 13. At all relevant times, defendant, SUNRISE, carried on substantial business activities within Delaware County and Commonwealth of Pennsylvania.
- 14. Defendant, Samirah Traynham, is an adult citizen of the Commonwealth of Pennsylvania, residing at 824 Whitney Ave, Lansdowne, PA 19050.
- 15. At all relevant times, Defendant Traynham was an employee and/or agent of SUNRISE, working in the course and scope of her employment while interacting with Lois McCallister.

- 16. Defendant, Tyrina Griffin, is an adult citizen of the Commonwealth of Pennsylvania, residing at 3207 W Susquehanna Ave, Philadelphia, PA 19121.
- 17. At all relevant times, Defendant Griffin was an employee and/or agent of SUNRISE, working in the course and scope of her employment while interacting with Lois McCallister.
- 18. Defendant, Ayesha Muhammad, is an adult citizen of the Commonwealth of Pennsylvania, residing at 1335 N 49<sup>th</sup> ST, Philadelphia, PA 19131.
- 19. At all relevant times, Defendant Muhammad was an employee and/or agent of SUNRISE at the time of Plaintiff's residency, working in the course and scope of her employment while interacting with Lois McCallister.
- 20. In 2008, Lois McCallister was diagnosed with dementia and moved into the Independent Living unit at the Facility in Haverford, PA.
- 21. On or about January 6, 2011, Lois McCallister's dementia worsened and she was moved to the Assisted Living unit at the Facility.
- 22. At the advice of the staff at the Quadrangle Facility, Mary French moved her mother, Lois McCallister, into the dementia unit of the Facility called the Reminiscence Living unit.
- 23. Shortly after moving into the Reminiscence Living unit, Lois McCallister told her daughter, Mary French, that staff members at the Facility were hurting her and performing other abusive behavior.

- 24. Mary French reported the abuse to a director of the Facility.
- 25. The director of the Facility told Mary French that abuse did not occur and her mother's complaints were a product of her dementia.
- 26. After her conversation with the director of the Facility, Mary French discovered bruises on Lois McCallister's hands.
- 27. These bruises were noticeable or should have been noticeable to the staff at SUNRISE.
- 28. Thereafter, Lois McCallister's family purchased a clock radio with a video camera in it. The camera did not have sound capabilities.
- 29. On or about March 25, 2011, Lois McCallister's family placed the camera in Lois McCallister's room in the Facility and set the video camera to record.
- 30. On or about March 31, 2011, Mary French retrieved the video recording from the camera.
- 31. The video from Lois McCallister's room shows three staff members of the Facility, Defendants, Samirah Traynham, Tyrina Griffin and/or Ayesha Muhammad, physically abusing Lois McCallister over the course of days, including striking Lois McCallister in the head; violently shoving Lois McCallister into her bed; forcefully pulling off Lois McCallister shirt and bra and forcing her to stand while she was mocked, taunted and humiliated; and grabbing, pushing and striking Lois McCallister as she tried to escape from the employees/agents of the Defendant, SUNRISE.

- 32. On April 3, 2011, Mary French removed Lois McCallister from the Facility.
- 33. On April 4, 2011, Paul French, Mary French's husband, reported the abuse to the Haverford Police.
- 34. Thereafter, defendants Samirah Traynham, Tyrina Griffin and Ayesha Muhammad were arrested and charged with aggravated assault, simple assault, criminal conspiracy, harassment, neglect of a care dependent person and recklessly endangering another person.
- 35. In December 2009, Sunrise received notice from the Pennsylvania Department of Public Welfare ("DPW") that the license to operate Sunrise's Newtown Square Facility would not be renewed due to numerous violations of law related to resident mistreatment.
- 36. As a result, Sunrise and the DPW entered into a Settlement Agreement dated April 2, 2010 setting forth specific terms to which Sunrise must comply.
- 37. Among other terms, Sunrise was ordered to close five (5) of its twenty-two (22) personal care homes in Pennsylvania.
- 38. Sunrise was also ordered to have all staff, including direct care staff persons and management, "participate in an active and ongoing program of culture change, beginning June 1, 2010. Culture change will focus on a 'resident-first' approach to each job function. . .". See, April 2, 2010 Settlement Agreement attached as Exhibit "A".
- 39. After the horrific abuse of Lois McCallister, the DPW conducted Licensing Inspections at the Quadrangle.

- 40. As a result of those inspections, the DPW found numerous violations of 55 Pa. C.S. § 2600 (relating to personal care homes) as well as violations of the April 2, 2010 Settlement Agreement.
- 41. On April 29, 2011, the DPW revoked the Quadrangle's license. In doing so, the DPW stated: "the pattern of interconnected negligent acts committed by multiple levels of management at Quadrangle Assisted Living as described on the enclosed Violation Report and Settlement Violation Report demonstrate GROSS INCOMPETENCE, NEGLIGENCE, AND MISCONDUCT in the operation of Quadrangle Assisted Living by Sunrise Continuing Care, LLC. . ." See, April 29, 2011 letter from the DPW to Sunrise Continuing Care attached as Exhibit "B" [emphasis in original].
- 42. The DPW specifically cited Sunrise for: (1) violating the law by failing to report alleged and/or actual abuse; (2) violating the April 2, 2010 Settlement Agreement by failing to provide the required culture change; and (3) obstructing the investigation of the abuse of Lois McCallister.
- 43. The DPW stated "[t]hese events are indicative of the culture of abuse and intimidation inconsistent with Sunrise's agreement to implement and promote an active, ongoing, resident-first program of culture change.
  - 44. SUNRISE failed to rid itself of pervasive abuse and neglect in its facilities.
- 45. On September 15, 2010, prior to the physical abuse suffered by Lois McCallister, the Facility was cited by the DPW for failure to report an incident where a resident sustained

serious bodily injury requiring admission to the hospital. The Facility was required to take correction action and report future incidences.

- 46. To have its license at the Quadrangle provisionally reinstated, Sunrise entered into another legal Settlement Agreement with the DPW requiring Sunrise to make major changes to its operation of the Quadrangle.
- 47. These changes included, among other terms: (1) a designated manager for each shift responsible for managing the dementia care unit; (2) mandatory performance evaluation of dementia unit staff to assess their skills and empathy toward patients; and (3) new hiring policies.
- 48. Defendants are jointly and severally liable for the injuries and damages suffered by Lois McCallister.

WHEREFORE, Plaintiff claims of Defendants, jointly and severally, a sum in excess of Fifty Thousand Dollars (\$50,000) in compensatory damages and punitive damages, delay damages pursuant to Pa. R.C.P. 238, interest, allowable costs of suit and brings this action to recover the same.

#### COUNT I – NEGLIGENCE

#### PLAINTIFF v. DEFENDANT SUNRISE

- 49. Plaintiff incorporates herein by reference all proceeding paragraphs of this complaint as if fully set forth hereinafter.
- 50. At all times material hereto, Defendants knew or should have known that their residents/patients were elderly and/or disabled and in need of particular care and supervision.

- 51. At all times material hereto, Defendants had the ultimate responsibility of ensuring that the rights of the residents/patients, including Lois McCallister, were protected.
- 52. At all times material hereto, Defendants owed a non-delegable duty to provide adequate and appropriate custodial care and supervision to Lois McCallister and other residents/patients, such as reasonable caregivers would provide under similar circumstances.
- 53. At all times material hereto, Defendants, by and through their agents and/or employees owed a duty of care to Lois McCallister to exercise the appropriate skill and standard of care of licensed assisted care facilities, directors of assisted living, and/or assisted living home administrators.
- 54. At all times material hereto, Defendants had a duty to furnish Lois McCallister with appropriate and competent assisted living, medical, and/or total care. Defendants deviated from generally accepted standards of care and violated Pennsylvania law.
- 55. Despite being constructively and/or actually made aware of the abuse suffered by Lois McCallister, Defendants failed to take steps to prevent the occurrence of said abuse.
- 56. Defendants knew, or should have known, of the aforementioned problems that were occurring with the care of Lois McCallister, as they were placed on actual and/or constructive notice of said problems.
- 57. Defendants, as the corporate owner, board member and/or managers of the Facility, breached their duty and were, therefore, negligent, careless and reckless in their obligations to Lois McCallister.
  - 58. At all times material hereto, the breach of duties, negligence, gross negligence,

carelessness, and recklessness of Defendants, individually, vicariously and/or acting by and through their officers, board members, physicians, physicians' assistants, nurses, certified nurses' aides, directors, administrators, and direct staff who cared for or oversaw the care of Lois McCallister, and through the administrative personnel responsible for hiring, retaining and/or dismissing staff, staff supervision and policy-making and enforcement, as well as any agents, employees, contractors, subcontractors and/or consultants of Defendants consisted of the following acts and omissions in the care and treatment of Lois McCallister:

- a. Failure to hire appropriately trained staff to care for the residents/patients of the Facility to prevent the horrific, demeaning and degrading mistreatment of their residents/patients;
- b. Failure to appropriately train staff members to care for the residents/patients of the Facility to prevent the horrific, demeaning and degrading mistreatment of their residents/patients;
- c. Knowingly allowing/or encouraging unskilled and untrained individuals to care for Lois McCallister;
- d. Failure to appropriately act upon the report of abuse received from Lois McCallister's family;
- e. Failure to report abuse to the DPW to enable the DPW to investigate and prevent ongoing abuse;
- f. Failure to provide a safe environment by failing to ensure adequate supervision of direct care staff to prevent the horrific, demeaning and degrading mistreatment of their residents/patients;

- g. Failure to ensure that each resident receives and that the facility provides the necessary care and service to attain or maintain the highest practicable physical and mental well-being, in accordance with the comprehensive assessment and plan of care;
- h. Failure to ensure that the facility has sufficient assisted living staff to provide assisted living and related services to attain or maintain the highest practicable physical and mental well-being of each resident, as determined by the resident assessments and individual plans of care, providing services by sufficient number of each of the required types of personnel on a twenty-four hour basis to provide assisted living care to all residents/patients in accordance with resident care plans;
- i. Failure of the facility to provide a safe, functional, and comfortable environment for residents/patients;
- j. Failure of the facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents/patients;
- k. Failure to implement and supervise internal company policy of a "resident-first" approach to each job function;
- 1. Failure of the facility to ensure that the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care;

- m. Failure of the facility to promote care for residents/patients in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality;
- n. Failure to select and retain only competent staff who provide adequate and appropriate care to prevent the horrific, demeaning and degrading mistreatment of residents/patients;
- o. Failure to oversee and supervise all persons who practiced assisted living and/or direct care in the Facility who failed to provide adequate and appropriate care to prevent the horrific, demeaning and degrading mistreatment of their residents/patients;
- p. Failure to formulate, adopt and enforce adequate rules, procedures and policies to ensure quality care for residents/patients;
- q. Failure to provide competent agents, workers and/or employees who would perform the duties required by law of the Defendant;
- r. Acting in a grossly negligent manner with reckless indifference to the rights and safety of Lois McCallister by failing to oversee and supervise her direct care;
- s. Failure to undertake and/or implement the DPW mandates set forth in the April 2, 2010 Settlement Agreement;
- t. Failure to provide Lois McCallister with the necessary care and services to allow her to attain or maintain the highest practicable physical, mental and psychological well-being;

- u. Failure to treat Lois McCallister with human decency and respect;
- v. Failure to ensure that the Facility was properly funded;
- w. Failure to implement a budget that would allow the Facility to provide adequate and appropriate direct care to Lois McCallister including adequate staff;
- x. Grossly understaffing the Facility;
- y. Failure to take appropriate steps to remedy continuing problems at the Facility that Defendant knew or should have known were occurring with Lois McCallister's care, which included the need to increase the number of employees, hiring skilled and/or trained employees, adequately training the current employees, monitoring the conduct of the employees, and/or changing the current policies and procedures to improve resident care;
- z. Failure to evaluate the quality of resident care and efficiency of services, identify strengths and weaknesses, set in place measures for improvements where necessary, and, evaluate progress and institute appropriate follow-up activities;
- aa. Failure to hire proper direct care staff;
- bb. Failure to maintain compliance with governmental regulations;
- cc. Failure to assure that a formal program is in place to provide for the recruitment, hiring and development of competent department managers and other staff at the Facility;

- dd. Failure to coordinate training programs to improve employee skills and to enhance employee performance;
- ee. Failure to provide adequate assessment following a change in the medical condition of Lois McCallister;
- ff. Allowing a culture of abuse and intimidation to exist in the dementia unit;
- gg. Failure to properly hire, train, supervise, and monitor staff within the Dementia unit;
- hh. Violating the law by failing to report alleged or actual abuse;
- ii. Vicarious liability for the actions of employee/agents, including, but not limited to, the physical and mental abuse of Lois McCallister; and
- jj. Permitting a passive response to the abuse of Lois McCallister as part of a culture that condoned abuse of the elderly residents of the dementia unit and made repetitive abuse events more likely.
- 59. As a direct and proximate result of Defendants' acts and/or omissions, and their breach of duty of care, negligence, carelessness and recklessness, Lois McCallister suffered (a) severe physical injuries resulting in pain and suffering, (b) mental anguish, embarrassment, humiliation, degradation, emotional distress, and loss of personal dignity, (c) loss of capacity for enjoyments of life, (d) expense of otherwise unnecessary hospitalization, medical care and residency at the Facility; (e) a financial loss as a result of Sunrise's failure to provide contracted, bargained-for, and/or implied care.
- 60. In causing the aforementioned injuries and damages, Defendants knew, or should have known, that Lois McCallister would suffer such harm.

- 61. The conduct of Defendants was intentional, outrageous, willful and wanton, and exhibited a reckless indifference to the health and well-being of Lois McCallister.
- 62. The conduct of Defendants was such that an award of punitive damages is justified.

# COUNT II – CORPORATE NEGLIGENCE

#### PLAINTIFF v. DEFENDANT SUNRISE

- 63. Plaintiff incorporates herein by reference all proceeding paragraphs of this complaint as if fully set forth hereinafter.
- 64. The corporate conduct of Defendants was independent of the negligent conduct of the employees of the Facility, and was outrageous, willful, and wanton, and exhibited a reckless indifference to the health and well-being of the residents/patients, including Lois McCallister.
- 65. At all times material hereto, Defendants owed and failed to fulfill the following duties to Lois McCallister: use reasonable care in the maintenance of safe and adequate facilities; select and retain only competent staff; oversee and supervise all person who practiced assisted living, direct care and/or skilled care within the Facility; and, formulate adopt and enforce rules, procedures and policies to ensure quality care for all residents/patients.

- a. At all times material hereto, the breach of duties, negligence, carelessness and recklessness of Defendants, individually, vicariously and/or acting by and through their officers, board members, physicians, physicians' assistants, nurses, certified nurses' aides and staff who cared for Lois McCallister, and through the administrative personnel responsible for hiring, retaining and/or dismissing staff, staff supervision and policy-making and enforcement, as well as any agents, employees, contractors, subcontractors and/or consultants of Defendants consisted of the following acts and omissions:
- Failure to hire appropriately trained staff to care for the residents/patients of the
  Facility to prevent the horrific, demeaning and degrading mistreatment of their
  residents/patients;
- Failure to appropriately train staff members to care for the residents/patients of the Facility to prevent the horrific, demeaning and degrading mistreatment of their residents/patients;
- Knowingly allowing/or encouraging unskilled and untrained individuals to care for Lois McCallister;
- d. Failure to appropriately act upon the report of abuse received from Lois McCallister's family;
- e. Failure to report abuse to the DPW to enable the DPW to investigate and prevent ongoing abuse.

- f. Failure to provide a safe environment by failing to ensure adequate supervision of direct care staff to prevent the horrific, demeaning and degrading mistreatment of their residents/patients;
- g. Failure to ensure that each resident receives and that the facility provides the necessary care and service to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care;
- h. Failure to ensure that the facility has sufficient assisted living staff to provide assisted living and related services to attain or maintain the highest practicable physical and mental well-being of each resident, as determined by the resident assessments and individual plans of care, providing services by sufficient number of each of the required types of personnel on a twenty-four hour basis to provide assisted living care to all residents/patients in accordance with resident care plans;
- Failure of the facility to provide a safe, functional, and comfortable environment for residents/patients;
- j. Failure of the facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents/patients and misappropriation of the resident's property;
- k. Failure to implement and supervise internal company policy of a "resident-first" approach to each job function;

- Failure of the facility to ensure that the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care;
- m. Failure of the facility to promote care for residents/patients in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality;
- n. Failure to select and retain only competent staff who provide adequate and appropriate care to prevent the horrific, demeaning and degrading mistreatment of residents/patients;
- o. Failure to oversee and supervise all persons who practiced assisted living and/or direct care in the Facility who failed to provide adequate and appropriate care to prevent the horrific, demeaning and degrading mistreatment of their residents/patients;
- Failure to formulate, adopt and enforce adequate rules, procedures and policies to ensure quality care for residents/patients;
- q. Failure to provide competent agents, workers and/or employees who would perform the duties required by law of the Defendant;
- r. Acting in a grossly negligent manner with reckless indifference to the rights and safety of Lois McCallister by failing to oversee and supervise her direct care;
- s. Failure to undertake and/or implement the DPW mandates set forth in the April 2, 2010 Settlement Agreement;

- t. Failure to provide Lois McCallister with the necessary care and services to allow her to attain or maintain the highest practicable physical, mental and psychological well-being;
- u. Failure to treat Lois McCallister with human decency and respect;
- v. Failure to ensure that the Facility was properly funded;
- w. Failure to implement a budget that would allow the Facility to provide adequate and appropriate direct care to Lois McCallister including adequate staff;
- x. Grossly understaffing the Facility;
- y. Failure to take appropriate steps to remedy continuing problems at the Facility that Defendant knew or should have known were occurring with Lois McCallister's care, which included the need to increase the number of employees, hiring skilled and/or trained employees, adequately training the current employees, monitoring the conduct of the employees, and/or changing the current policies and procedures to improve resident care;
- z. Failure to evaluate the quality of resident care and efficiency of services, identify strengths and weaknesses, set in place measures for improvements where necessary, and, evaluate progress and institute appropriate follow-up activities;
- aa. Failure to hire proper direct care staff;
- bb. Failure to maintain compliance with governmental regulations;
- cc. Failure to assure that a formal program is in place to provide for the recruitment, hiring and development of competent department managers and other staff at the Facility;

- dd. Failure to coordinate training programs to improve employee skills and to enhance employee performance;
- ee. Failure to provide adequate assessment following a change in the medical condition of Lois McCallister;
- ff. Allowing a culture of abuse and intimidation to exist in the dementia unit;
- gg. Failure to properly hire, train, supervise, and monitor staff within the Dementia unit;
- hh. Violating the law by failing to report alleged or actual abuse; and
- ii. Permitting a passive response to the abuse of Lois McCallister as part of a culture that condoned abuse of the elderly residents of the dementia unit and made repetitive abuse events more likely.
- 66. Defendants knew or should have known, of the aforementioned problems that were occurring with the care of Lois McCallister, as they were placed on actual and/constructive notice of said problems.
- 67. Defendants, individually and by and through corporate officers of Defendants were aware that they had been cited by governmental units regarding the Facility for deficiencies.
- 68. On September 15, 2010, the Director of Assisted Living at the Facility was notified of a violation of Regulation 55 Pa. Code § 2600, specifically subsection 16(c) stating, "The home shall report the Incident or condition to the Department's personal care home regional office or the person care home complaint hotline within 24 hours in a manner designated by the Department."

- 69. On February 4, 2011, a follow-up letter containing this violation was sent to Mr. David Haddock, the Vice President and Secretary of Defendant.
  - 70. Defendants took no corrective action after being put on notice of its violation.
- 71. Seven (7) months later, Defendants committed the same violation when they failed to report the egregious abuse of Lois McCallister.
- 72. As a direct and proximate result of Defendants' acts and/or omissions, and their breach of duty of care, negligence, carelessness and recklessness, Lois McCallister suffered the injuries and damages set forth above.
- 73. In causing the aforementioned injuries, Defendants knew, or should have known, that Lois McCallister would suffer such harm.
- 74. The conduct of Defendants was intentional, outrageous, willful and wanton, and exhibited a reckless indifference to the health and well-being of Lois McCallister.
- 75. The conduct of Defendants was such that an award of punitive damages is justified.

#### **COUNT HI - NEGLIGENCE PER SE**

#### PLAINTIFF v. ALL DEFENDANTS

- 76. Plaintiff incorporates herein by reference all proceeding paragraphs of this complaint as if fully set forth hereinafter.
- 77. At all pertinent hereto, there was in full force and effect 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person," which set fourth penal consequences for neglect of care-dependent person.
- 78. 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person" expresses the fundamental public policy of the Commonwealth of Pennsylvania that elders, like children, are not to be abused or neglected, particularly in health care facilities or by person holding themselves out as trained professionals, and that if such abuse or neglect causes injury, either physical or mental, then such conduct is actionable.
- 79. At all times pertinent hereto, Lois McCallister was a care dependent resident of Defendant's Facility, The Quadrangle, and thus fell within the class of persons 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person" was intended to protect, thus entitling Plaintiff to adopt 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person" as the standard of care for measuring the Defendant's conduct.
- 80. Additionally, 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person" is directed, in part, to obviate the specific kind of harm which Lois McCallister sustained.
- 81. Defendants, in accepting the responsibility for caring for Lois McCallister as aforesaid, were negligent "per se" and violated 18 Pa.C.S.A. §2713 "Neglect of Care Dependent Person".

- 82. Defendants are also liable for the negligence 'per se" of any criminal charges to which they/their employees plead guilty or are found guilty.
- 83. As a direct result of the aforesaid negligence "per se" of Defendants, Lois McCallister was caused to sustain serious personal injuries and damages as set forth above.
- 84. The conduct of Defendants, and each of them, as specifically set forth in this Complaint, was outrageous, inconsistent with and intolerable given the norms of modern society and as such, Plaintiff requests punitive damages in addition to all other damages as aforesaid.

#### **COUNT IV – NEGLIGENCE PER SE**

#### PLAINTIFF v. ALL DEFENDANTS

- 85. Plaintiff incorporates herein by reference all proceeding paragraphs of this complaint as if fully set forth hereinafter.
- 86. At all times pertinent hereto, there was in full force and effect 35 P.S. §10225.101, et seq., "Pennsylvania Older Adults Protective Services Act," which sets forth civil penalties, administrative penalties and other consequences for abuse of a care-dependent person.
- 87. 35 P.S. §10225.101, expresses the policy of the Commonwealth of Pennsylvania that:

- ...older adults who lack the capacity to protect themselves and are at imminent risk of abuse, neglect, exploitation or abandonment shall have access to and be provided with services necessary to protect their health, safety and welfare. It is not the purpose of this act to place restrictions upon the personal liberty of incapacitated older adults, but this act should be liberally construed to assure the availability of protective services to all older adults in need of them. Such services shall safeguard the rights of incapacitated older adults while protecting them from abuse, neglect, exploitation and abandonment, and to establish a program of protective services for older adults in need of the.
- 88. At all times pertinent hereto, Lois McCallister was an older person, seventy-eight (78) years old at the time the abuse occurred, who was a resident of Defendants' facility, The Quadrangle, who lacked the capacity to protect herself and thus fell within the class of persons 35 P.S. §10225.101, et seq. was intended to protect, thus entitling Plaintiff to adopt 35 P.S. §10225.101, et seq. as the standard of care for measuring the Defendants' conduct.
- 89. Additionally, the Pennsylvania Older Adults Protective Services Act is directed, at least in part, to prevent the specific kind of harm which Lois McCallister sustained.
- 90. In addition to the aforesaid negligence, which said negligence is specifically incorporated herein, Defendants, in accepting the responsibility for caring for Lois McCallister as aforesaid, were negligent "per se" and violated 35 P.S. §10225.101, et seq. in that they abused or had reasonable cause to suspect that Lois McCallister was the victim of abuse and neglect and failed to report said abuse and neglect to the appropriate agency and law enforcement officials.
- 91. As a direct result of the aforesaid negligence "per se" of Defendants, Lois McCallister was caused to sustain serious personal injuries and damages as aforesaid.
- 92. The conduct of Defendants, and each of them, as specifically set forth in this Complaint, was outrageous, inconsistent with and intolerable given the norms of modern society and as such, Plaintiff requests punitive damages in addition to all other damages as aforesaid.

#### COUNT V - NEGLIGENCE

### PLAINTIFF v. DEFENDANTS TRAYNHAM, GRIFFIN AND MUHAMMAD

- 93. Plaintiff incorporates herein by reference all proceeding paragraphs of this complaint as if fully set forth hereinafter.
- 94. Between March 25, 2011 and March 31, 2011, Defendants Trayham, Griffin and Muhammad negligently and/or recklessly physically abused Lois McCallister, including striking her in the head; violently shoving her into her bed; forcefully pulling off her shirt and bra and forcing her to stand while she was mocked, taunted and humiliated; and grabbing, pushing and striking her as she tried to escape from the Defendants. Other physical and emotional abuse was likely perpetrated. Defendants failed to exercise independent skill and judgment in their role as Lois McCallister's caretakers.
- 95. The negligent, reckless and careless acts of the Defendants Trayham, Griffin and Muhammad, were performed while in the course and scope of their employment and with actual and/or constructive knowledge of the SUNRISE Defendants. Defendants' actions deviated from generally accepted standards of care and violated Pennsylvania administrative and criminal law.
- 96. As a direct result of the aforesaid negligence of the Defendants, Lois McCallister was caused to sustain serious personal injuries and damages set forth above.

#### **COUNT VI - INTENTIONAL ACTS**

### PLAINTIFF v. DEFENDANTS TRAYNHAM, GRIFFIN AND MUHAMMAD

- 97. Plaintiff incorporates herein by reference all proceeding paragraphs of this complaint as if fully set forth hereinafter.
- 98. Between March 25, 2011 and March 31, 2011, Defendants Trayham, Griffin and Muhammad intentionally made physical contact with Lois McCallister by striking her in the head; violently shoving her into her bed; forcefully pulling off her shirt and bra and forcing her to stand while she was mocked, taunted and humiliated; and grabbing, pushing and striking her as she tried to escape from the Defendants.
- 99. As a direct result of the aforesaid negligence of the Defendants, Lois McCallister was caused to sustain serious personal injuries and damages set forth above.

WHEREFORE, Plaintiff claims of Defendants, jointly and severally, a sum in excess of Fifty Thousand Dollars (\$50,000) in compensatory damages and punitive damages, delay damages pursuant to Pa. R.C.P. 238, interest, allowable costs of suit and brings this action to recover the same.

#### **COUNT V – PUNITIVE DAMAGES**

#### PLAINTIFF v. ALL DEFENDANTS

- 100. Plaintiff incorporates herein by reference all proceeding paragraphs of this complaint as if fully set forth hereinafter.
- 101. Defendants, knowingly, willfully and intentionally exposed Lois McCallister to degrading, humiliating and painful treatment.
- 102. Defendants, by and through their employees/agents, knowingly, willfully, and intentionally physically and mentally abused Lois McCallister.
- 103. Defendants put profits over people and exposed their residents/patients to unsafe conditions and horrific abuse to improve their bottom line.
- 104. Defendants' conduct rises to the level of outrageous conduct by willfully and recklessly ignoring the warnings of abuse given to them by Plaintiff's family and ignoring the physical signs of abuse and neglect.
- 105. Defendants acted in a willful, wanton and reckless disregard for the well being and safety of their residents/patients. This and other misconduct constituted outrageous, willful and/or wanton misconduct, and manifested a reckless indifference to the rights of others to support an award of punitive damages.

SALTZ, MONGELUZZI, BARRETT & BENDESKY, P.C.

BY:

10-12-11

ROBERT I MONGELUZZY CARMEN BELEFONTE

ANDREW R. DUFFY

Attorneys for Plaintiff

#### <u>VERIFICATION</u>

The averments or denials of fact contained in the foregoing document are true based upon the signer's personal knowledge or information and belief. If the foregoing contains averments which are inconsistent in fact, signer has been unable, after reasonable investigation, to ascertain which of the inconsistent averments are true, but signer has knowledge or information sufficient to form a belief that one of them is true. This Verification is made subject to the penalties of 18 Pa. C.S. §4904, relating to unsworn falsification to authorities.

DATE:	Mary French

#### COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE BUREAU OF HEARINGS AND APPEALS

IN THE APPEAL OF:

Sunrise of Newtown Square v. Adult Residential Licensing BHA ID No. 9999 BHA Docket No. 034-09-0077 Personal Care Home Licensure

#### SETTLEMENT AGREEMENT

This Settlement Agreement (Agreement) is entered into this day of 2010, by and between the Department of Public Welfare Adult Residential Licensing (Department) and Newtown Squere Assisted Living, LLC, its subsidiary entitles and any related entitles and Sunrise Senior Living Management, Inc. and Sunrise Senior Living Services, Inc. and their subsidiary entitles and any related entitles (collectively, referred to as Appellant, unless otherwise indicated), for the purpose of resolving the matter set forth herein.

WHEREAS, the Department is the Commonwealth agency entrusted with the oversight and administration of the licensing of personal care homes (homes) in the Commonwealth of Pennsylvania;

WHEREAS, Appellant operates twenty-two (22) personal care homes in Pennsylvania as identified in the Appendix and that are licensed under statutes and regulations administered by the Department;

WHEREAS, Appellant operates the personal care home known as Sunrise of Newtown Square located at 333 South Newtown Street Road, Newtown Square, Pennsylvania 19073 and that is the subject of this appeal and that is licensed under statutes and regulations administered by the Department:

WHEREAS, by letter of December 15, 2009 the Department advised Appellant that the Department was refusing to renew Appellant's Provisional License to operate Sunrise of Newtown Square;

WHEREAS, Appellant timely filed an administrative appeal of the Department's nonrenewal action on December 22, 2010 and the Bureau of Hearings and Appeals (BHA) timely scheduled a hearing for February 11, 2010;

WHEREAS, the Department and Appellant entered into a Stipulation of Settlement and Agreement on April 24, 2008 relating to BHA Docket Number 34-07-040 relating to Sunrise Assisted Living of Westlown and applicable to all personal care homes operated by Appellant as listed in the Appendix;

WHERAS, the Department and Appellant wish to continue the applicable provisions of the April 24, 2008 Stipulation of Settlement and Agreement and extend the effective dates for some of the provisions of the April 24, 2008 Stipulation of Settlement and Agreement;

WHEREAS, the Department and Appellant both wish to resolve this matter amicably and avoid the uncertainties of further litigation of this matter; AND,

WHEREAS, the Parties have reached a mutually agreeable means of resolving the matter that will settle and end this appeal.

NOW, THEREFORE, the Parties, Intending to be legally bound, do hereby mutually agree to the Terms of the Agreement as follows:

#### **Terms of Agreement**

- 1. All terms of this Agreement shall remain in effect for three (3) years from the date of this Agreement, unless otherwise specified in this Agreement, effective upon execution by the Parties. The execution of this Agreement by all Parties shall be promptly completed. The execution of this Agreement triggers the time period for actions required in this Agreement.
- 2. The execution of this Agreement terminates the Stipulation of Settlement and Agreement signed by both Parties on April 24, 2008. The applicable provisions of the April 24, 2008 Stipulation of Settlement and Agreement have been continued in this Agreement. The effective dates for some of the provisions of the April 24, 2008 Stipulation of Settlement and Agreement have been extended in this Agreement.
- 3. Appellant agrees not to: a) request an increase in ilcensed capacity in any of its personal care homes as listed in the Appendix, b) request an increase in ilcensed capacity for any existing secured dementia care unit in any of its personal care homes as listed in the Appendix, c) request to open any new secured dementia care unit in Pennsylvania, OR, d) apply for a license to operate any new personal care home/assisted living residence in Pennsylvania, for the duration for this Agreement.
- 4. Appellant will cease operation of five (5) of its twenty-two (22) personal care homes located in Pennsylvania as listed in the Appendix. The five personal care homes to be closed or sold/leased will be selected by the Appellant, with consideration given to close or self/lease those personal care homes operating on Provisional licenses and those operating pending appeal of ficense revocations or nonrenewals. Two personal care homes will be closed or sold/leased by July 1, 2010. Three additional personal care homes will be closed or sold/leased by January 1, 2011. In negotiating a sale or lease, Appellant will

allow for the timeline for the potential buyer/lessee to complete the Department's process to apply for and receive a new license, which takes approximately 60 days from the submission of a completed licensure application.

- 5. Appellant will fully implement the plans of correction contained in all Violation Reports issued by the Department prior to and after the execution of this Agreement for all personal care homes operated by Appellant as listed in the Appendix.
- 6. Appellant will comply with 55 Pa.Code Ch. 2600 (relating to personal care homes) for all personal care homes operated by Appellant as listed in the Appendix.
- 7. By May 1, 2010, Appellant will develop a revised description of services and criteria for admission and discharge, taking into account the health care and behavioral health needs of residents who can be safely served at the home, applicable to all personal care homes operated by Appellant as listed in the Appendix. The revised description of services and criteria for admission and discharge will significantly reduce the acuity needs of the residents who will be served in all personal care homes operated by Appellant as listed in the Appendix, by May 1, 2011. The revised description of services and criteria for admission and discharge will be in effect for a period of three (3) years from the effective date of this Agreement. The description of services and criteria for admission and discharge will include the following conditions for which Appellant will not admit, and for which Appellant will discharge if such needs develop after a resident moves into the home:

(a) Need for sliding scale insulin for a period exceeding 21 consecutive days

(b) Unmanaged psychosis

(c) Use of catheter requiring any staff assistance

(d) Unstable chronic health condition

(e) Dementia with frequent unmanaged aggressiveness

(f) Need for three-person transfer

(g) Need for a bedrall of any length

- (h) Unable to leave his/her bed for more than 14 days, except for residents who are receiving hospice care and services
- (i) Need for special feeding equipment that cannot be used independently by the resident

(j) One or more decubitus ulcers of stage 3 or stage 4

(k) Mental Illness accompanied by self-injurious, aggressive or predatory behaviors

(I) Tracheotomy

8. Between March 1, 2010 and June 1, 2010, Appellant will complete a new assessment for each resident who resides in a secured care dementia unit in any of the personal care homes operated by Appellant as listed in the Appendix.

Between December 1, 2009 and June 1, 2010, Appellant will complete a new assessment for each resident who does not reside in a secured care dementia unit in any of the personal care homes operated by Appellant as listed in the Appendix. A complete and detailed support plan will be developed for each resident within fifteen (15) days of completion of the assessment. The assessment and support plan shall be completed with the consultation and input of a physician, physician's assistant, certified registered nurse practitioner, or registered nurse, and in cooperation with the resident, the resident's family and friends who wish to participate, community service staff and direct care staff persons assigned to provide direct care services for the resident as specified in Provision 10 of this Agreement. Subsequent to the completion of the new assessments and support plans, Appellant will complete new assessments and support plans for each resident at least every three (3) months for residents who reside in a secured care dementia unit and every six (6) months for residents who do not live in a secured care dementla unit. Appellant will provide an opportunity for the resident and his/her family and friends to meet with Appellants' staff persons at a time and place convenient for those who wish to participate. Appellant will invite the resident's physician, community service agencies and medical/behavioral health care specialists to all assessments and support plan meetings.

- 9. By July 1, 2010, Appellant will employ a Life Enrichment Manager who is physically present in each of Appellant's licensed secured dementia care units for at least 40 hours each week. The Life Enrichment Manager will engage residents in familiar routines of daily living through personalized approaches designed to address the resident's interests and maximize the resident's abilities.
- 10. Appellant will maintain the following minimum direct care staff to resident ratios in all personal care homes operated by Appellant as listed in the Appendix:

Residents who live in and require secured dementia care Sleeping hours – 1:16 Awake hours – 1:8

Residents with mobility needs who do not require secured dementia care Sleeping hours -- 1:20

Awake hours -- 1:10

Resident without mobility needs Sleeping hours – 1:24 Awake hours – 1:16

Staff persons who are counted in the direct care staffing ratios must be physically present with the residents and providing direct care to the residents at all times they are counted in the staffing ratios.

Staff persons who are assigned to direct care duties must be assigned to provide direct care services to a specified, fixed group of residents, not to exceed a group size of 24 residents.

- 11. Appellant will use all of the Department's required and model forms, except for the Department's Resident-Home Contract.
- 12. All requests for regulatory walvers will be submitted by Appellant's regional management team, rather than by personal care home administrators.
- 13. Appellant will employ a full-time administrator who is on-site performing administrator duties at least 40 hours per week for all personal care homes operated by Appellant as specified in the Appendix.
- 14. All staff persons, including ancillary, management, administrative, maintenance and direct care staff persons employed by any personal care home operated by Appellant as listed in the Appendix, will participate in an active and ongoing program of culture change, beginning June 1, 2010. Culture change will focus on a "resident-first" approach to each job function, and include formal and regular labor-management meetings, as well as formal and regular opportunities for labor and management staff persons to meet with families to explore problems and identify innovative and practical solutions to improve the quality of care and services. Such opportunities will be planned and scheduled so that the direct care staff persons, who are assigned to provide direct care services for the resident as specified in Provision 10 of this Agreement, may interact with the resident's family and friends.
- 15. The Department will issue a Second Provisional License to Appellant to operate a personal care home for Sunrise of Newtown Square for a six-month period, to begin the date of the execution of this Agreement.
- 16. This Agreement shall not be construed to reduce, limit or restrict the Department's authority to enforce applicable statues and regulations, including but not limited to 62 P.S. § 1001 et seq., 55 Pa.Code § 20.1 et seq. and 55 Pa.Code § 2600.1 et seq.
- 17. Any violation by Appellant of any of the terms of this Agreement or of any other applicable requirement, including but not limited to Article X of the Public Welfare Code, 62 P.S. § 1001 et seq., 55 Pa. Code § 20.1 et seq. and 55 Pa. Code § 2600.1 ot seq, which is not cured within a reasonable time after notice, shall be deemed a material breach of the Agreement and the Department shall have the right to take any action determined to be appropriate; said right is subject to the Appellant's right to hearing before the Department's Bureau of Hearing and Appeals (BHA) to determine the appropriateness of the Department's action. Any violation by Appellant of any of the terms of this Agreement or of any other applicable requirement, may result in licensure action

against any or all of the personal care homes operated by Appellant as listed in the Appendix.

- 18. Each Party agrees that this Agreement shall not constitute an admission of wrongdoing, liability or fault by either Party.
- 19. The BHA shall have exclusive original jurisdiction, subject to appellate judicial review of its Order, over any dispute that may arise with respect to the interpretation, application or enforcement of the terms of this Agreement.
- 20. Each individual signing this Agreement on behalf of a Party represents that the individual is duly authorized to sign this Agreement on behalf of the Party. The undersigned represents that each Party has obtained all necessary approvals to bind the Party she/he represents.
- 21. This Agreement is based upon facts unique to this case and does not establish a precedent or otherwise bind the Department in any other action and shall not be construed as evidence of Department practice, policy or interpretation with respect to any dispute or issue.
- 22. The effective and execution date of this Agreement is the date set forth on page one of this Agreement, which will be completed by counsel for the Department on the date the Department's counsel signs this Agreement.
- 23. The Parties to this Agreement agree that they have read and fully understand this Agreement. This Agreement is entered into knowingly, voluntarily and intelligently with the advice of their respective legal counsel.
- 24. This Agreement constitutes the entire Agreement and understanding between the Parties relating to the specific matter contained herein, and supersedes any prior Agreements, whether oral or written, with respect thereto. This Agreement may not be amended or modified in any respect whatsoever except in writing duly executed by an authorized representative of each of the Parties. In the spirit of continuing to provide quality care to the residents, the consent of the Department to amend or modify the terms of this Agreement shall not be unreasonably withheld.
- 25. Once this Agreement is executed, either Party shall file this Agreement with BHA and such filing will constitute Appellant's withdrawal of its appeal.
- 26. This Agreement is public information in accordance with 65 P.S. § 67.101 et seq.

WHEREFORE, the Padles hereby slipulate and agree to the above			
conditions and terms of settlement.			
Rt-C.	pari V. Casey		
Appellant	Kevin Casey, Deputy Secretary		
Ron Jeanneault	533 Health & Welfare Bullding		
President	Harrisburg, PA 17120		
Sunrise Senior Living Services, Inc.			
Sunrise Senior Living Management, Inc.	•		
Date: 3-30-10	Date: 4/1/16		
And:	And:		
Linker of Stiller, Esquire	Many Consus Wall Esquire Counsel for		
Counsel for	Counsel for		
Logal Entity	Department of Public Welfare		
Data: 4/1/12	Date: 4/2/10		



#### COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE PO BOX 2675 HARRISBURG, PENNSYLVANIA 17105-2675

ADULT RESIDENTIAL LICENSING

PHONE: (717) 783-3670 FAX: (717) 783-5662

# CERTIFIED MAIL - RETURN RECEIPT REQUESTED MAILING DATE: APR 29 2011

Mr. David Haddock, Vice President and Secretary Sunrise Continuing Care, LLC Quadrangle Assisted Living 3300 Darby Road Haverford, Pennsylvania 19041

Dear Mr. Haddock:

As a result of the Department of Public Welfare's (Department) licensing inspection on April 5, 2011, April 7, 2011, April 11, 2011, April 12, 2011 and April 13, 2011 of the above personal care home, the violations specified on the enclosed Violation Report were found. Additionally, on April 2, 2010 the enclosed Settlement Agreement (Agreement) was signed by the Department, Sunrise Senior Living Management, Inc., and Sunrise Senior Living Services, Inc. and their subsidiary entities and any related entities (Sunrise). Quadrangle Assisted Living and Sunrise Continuing Care, LLC are subject to the provisions of the Agreement. During the Department's April 5, 2011, April 7, 2011, April 11, 2011, April 12, 2011 and April 13, 2011 inspection, violations with the Agreement were found as specified on the enclosed Settlement Violation Report.

As a result of violations with 55 Pa.Code Ch. 2600 (relating to personal care homes) and as a result of violations with the April 2, 2010 Agreement as documented in the enclosed Violation Report and Settlement Violation Report, the Department is REVOKING your Regular License #125740 to operate the above personal care home. This decision to REVOKE is made pursuant to 55 Pa. Code § 20.71(a)(6) (relating to conditions for denial, nonrenewal, or revocation) and 62 P.S. § 1026 (b)(4) and (5). The pattern of interconnected negligent acts committed by multiple levels of management at Quadrangle Assisted Living as described on the enclosed Violation Report and Settlement Violation Report demonstrate GROSS INCOMPETENCE, NEGLIGENCE, and MISCONDUCT in the operation of Quadrangle Assisted Living by Sunrise Continuing Care, LLC as follows:

Provision #14 of the April 2, 2010 Agreement required "all staff persons, including ancillary, management, administrative, maintenance and direct care staff persons employed by any personal care home operated by Sunrise to "participate in an active and ongoing program of culture change, beginning June 1, 2010." The culture change was to "focus on a 'resident-first' approach to each job function, and include formal and regular labor-management meetings, as well as formal and regular opportunities for labor and management staff persons to meet with families to explore problems and identify innovative and practical solutions to improve the quality of care and services." Moreover, these opportunities were to "be planned and scheduled so that the direct care staff persons, who are assigned to provide direct care services for the resident" had the opportunity to "interact with the resident's family and friends." Between June 1, 2010 and April 13, 2011, Sunrise Continuing Care, LLC did not provide the required cultural change program to fifty-two employees at Quadrangle Assisted Living, including direct care staff persons A, B, and C. Additionally, the cultural change program developed by Sunrise required Sunrise to send training suggestions to each Sunrise-operated facility on a monthly basis. Quadrangle Assisted Living did not receive training suggestions from Sunrise at any time between January 1, 2011 and April 13, 2011.

Resident #1 was admitted to Quadrangle Assisted Living's secured dementia care unit on February 2, 2011. On March 14, 2011, Resident #1's designated person reported to the director of the secured dementia care unit that Resident #1 had been hit, punched, and cut by direct care staff. The director of the secured dementia unit reported the allegations of abuse to the administrator of the home. The administrator did not report the alleged abuse to the Department or to the local Area Agency on Aging as required by regulation at any time. Had the report of the incident been made to the Department, an investigation of the alleged abuse by the Department would have been initiated within 24 hours.

On March 28, 2011, Resident #1 was forcibly pushed onto the resident's bed by direct care staff person B. Furthermore, between 8:02 PM and 8:14 PM on March 31, 2011, Resident #1 was physically assaulted, bullied, taunted, and mocked by staff persons A, B, and C. During this abuse, the resident was naked from the waist up. During this abuse, the resident attempted to leave the room, but was physically restrained from doing so by direct care staff persons A, B, and C. During a criminal investigation of the abuse incidents by municipal police on April 4, 2011, the home's administrator was made aware of additional abuse allegations relating to Resident #1. These allegations were not reported to the Department as required.

Finally, on April 5, 2011, the Department informed the Executive Director of the home that interviews would be conducted with staff persons who were present in the home during the abuse events. Staff person A was present in the building on April 5, 2011, but was not made available for interview. Although the failure to make Staff person A available was discussed with the Executive Director at 9:00 on April 7, 2011, staff person D was interviewed and terminated from employment by the home's Executive Director and left the premises sometime after 9:00 AM and before Department staff could interview the staff person. These events are indicative of a culture of abuse and intimidation inconsistent with Sunrise's agreement to implement and promote an active, ongoing, resident-first program of culture change.

The decision to REVOKE your license is also made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa.Code § 20.71(a)(2) (relating to conditions for denial, nonrenewal or revocation).

In accordance with 55 Pa.Code § 2600.269 (a)(3) (relating to ban on admissions) no resident admissions are permitted after the date of this letter.

If you disagree with the decision to REVOKE your license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Public Welfare in accordance with 1 Pa.Code Part II, Chs. 31-35. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

Jacob Herzing, Enforcement Manager Adult Residential Licensing Department of Public Welfare 423 Health and Welfare Building Seventh and Forster Streets Harrisburg, Pennsylvania 17120

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

The enclosed Violation Report and Settlement Violation Report specify plans of correction and dates by which corrections must be made. If you choose to appeal, these plans of correction must be followed during your operation pending your appeal.

Sincerely,

Ronald Melusky Acting Director

Enclosure Violation Reports Settlement Agreement