2008-CA-00067

T

Reply

TABLE OF CONTENTS

TABLE OF CONTENTS i

TABLE OF AUTHORITIES ii

ARGUMENT 1

I. Plaintiff's Experts Testified As To Numerous Acts And Omissions Of The Defendants' Employees That Directly And Proximately Caused Mr. Guillotte's Injuries And Death 1

A. Vicarious Liability 1

1. Nutrition 3
2. Glucose Control 2
3. Contractures 2
4. Skin Lesions 4
5. Multiple Falls 7
6. Recurrent Infections 7
7. Documentation Deficiencies 8

B. Corporate Negligence 8

II. Expert Testimony As To The Standard Of Care Is Not Necessary For Plaintiff's Claims Of Ordinary Negligence 13

A. Plaintiff's Allegations of Ordinary Negligence 15

B. Most Care Provided at White House is Not a Professional Service 16

CONCLUSION 21

CERTIFICATE OF FILING 22

CERTIFICATE OF SERVICE 23

CERTIFICATE OF VIRUS-FREE COMPUTER DISK 24

TABLE OF AUTHORITIES

CASES

Advocat v. Sauer, 111 S.W.3d 346 (2003).....12, 13, 19

Affiliated Investments, Inc. v. Turner,
337 So.2d 1263, 1267 (Miss. 1976).....8

Alcoy v.Valley Nursing Homes, Inc., 630 S.E.2d 301 (Va. 2006).....13, 19

Bailey v. Rose Care Center, 307 Ark. 14, 817 S.W. 2d 412 (1991).....18

Burton v. Choctaw, 730 So.2d 1, 7-8 (Miss. 1999).....14, 17

Covenant Health Rehab of Picayune, L.P. v. Brown,
949 So.2d 732, ¶ 20 (Miss. 2007).....17

Foster v. Evergreen Healthcare, Inc., 716 N.E.2d 19 (Ind. Ct. App. 1999).....14

Jenkins v. Pensacola Health Trust, Inc., 933 So.2d 923 (Miss. 2006).....17

Jordan v. Wilson, 20085 WL 2894366, *4 (Miss. Ct. App. 2008).....14

McQuay v. Guntharp, 336 Ark. 534, 986 S.W. 2d 850 (1999),.....19

Owens v. Manor Healthcare Corp., 512 N.E.2d 820 (Ill. Ct. App. 4th Dist. 1987).....20

Partin v. North Mississippi Medical Center, Inc.,
929 So. 2d 924, 933 (Miss. Ct. App. 2005).....15

Saucier ex rel. Saucier v. Biloxi Reg'l Med. Ctr.,
708 So. 2d 1351, 1354 (Miss. 1998).....15

Strong v. Commericial Carpet Co., Inc,. 322 N.E.2d 387 (Ind. Ct. App. 1976).....14

STATUTES

Miss. Code Ann. §15-1-36(2).....13

Miss. R. Civ. P. 56(c).....15

Miss. Code Ann. § 15-1-49.....17

Medical Malpractice Act, Code §§ 8.01-581.1 through --581.20:1.....19

42 C.F.R. § 409.33(d).....18

42 U.S.C. §§ 1395 18

42 U.S.C. §§ 1395i-3(b)(5)(A), (F)-(G).....18

OTHER

Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes – Report to Congress, Ch. 6.; Elder Abuse in Residential Long-Term Care Facilities: What is Known About Prevalence, Cause and Prevention: Testimony Before the U. S. Senate Committee on Finance, Statement of Catherine Hawes, Ph.D. (June 18, 2002).....9

Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes – Report to Congress Ch. 6 (July, 2000).....10

Elder Abuse in Residential Long-Term Care Facilities: What is Known About Prevalence, Cause and Prevention: Testimony Before the U.S. Senate Committee on Finance, Statement of Catherine Hawes, Ph.D. (June 18, 2002).....10

Nursing Home Expenditures and Quality, GAO-02-431R (June 13, 2002).....11

I. Plaintiff's Experts Testified As To Numerous Acts And Omissions Of The Defendants' Employees That Directly And Proximately Caused Mr. Guillotte's Injuries And Death.

A. Vicarious Liability

Defendants maintain that Plaintiff cannot continue this action because Plaintiff's expert has stated that he will not identify individual caregivers that breached the standard of care. See Def. Brief at p. 17, 19, 22, 23, 24, 25, 27. Defendants then stretch this claim to state that Plaintiff "admitted that no staff members breached the standard of care." Def. Brief at 27. With all due respect, Defendants fail to acknowledge that Plaintiff's experts testified in their depositions as to numerous, specific acts and omissions of the Defendants' employees that directly and proximately caused Mr. Guillotte injuries and death. Admittedly, both Plaintiff's and Defendants' experts were unable to ascertain all of the names of the Defendants' employees who breached the standard of care. The nursing home record provided to the Plaintiff and maintained by Defendants makes the task of naming each breaching caregiver impossible. R. at 1772-75, 1784-1801, 1833, 1838, 1841-43, 1845, 1847-51, 1854-55, 2271, 2276. On many occasions, the individuals responsible for providing Mr. Guillotte's care and treatment on a daily basis are unidentified or their signatures or initials are illegible. *Id.* However, the specific naming of the employees is not required by Mississippi precedent.

Even without the names of specific caregivers who provided care on each shift, Plaintiff's experts clearly testified as to the failures of care that occurred. Defendants wrongly criticize Plaintiff's expert's failure to identify each specific breach by employee's name, rank and serial number. Similarly, the Circuit Court incorrectly concluded that Plaintiff's medical experts "will not be providing testimony at trial regarding specific acts or omissions of the Defendants' employees and whether or not said acts or omissions were a proximate cause of Guillotte's injuries and/or death." R. at 1882.

Plaintiff's case is not about a specific incident that occurred to Hamilton Guillotte. Instead, his story involves months of a slow, gradual deterioration that Plaintiff's experts testified was caused by daily, repeated failures by Defendants' staff.

Hamilton Guillotte was admitted to Dixie White House on October 26, 2001 and remained until September 21, 2002. R. 24, 123. During his residency at Dixie White House, Hamilton Guillotte suffered from physical and emotional trauma, including, but not limited to: multiple falls, urinary tract infections, bronchial infections, dehydration, malnutrition, uncontrolled glucose levels, functional decline, contractures, multiple pressure sores, sepsis, and death. R. at 29, 1720, 1721, 1739, 1745, 1751, 1760, 1763. Mr. Guillotte's quality of life was diminished by the Defendants' repeated failures to recognize what care, services, and treatment he needed. R. at 2231.

Instead of there being one, glaring incident that caused harm to Mr. Guillotte, it was the cumulative effect of Defendants' day in and day out failures and omissions that resulted in devastating effects to his well-being, causing his excruciating, preventable death. Dr. Timothy Hammond explained the ongoing nature of these failures,

> Q. And whatever caregiver was wither documenting the record for those specific instances which you either charted or discussed, then that would be the respective caregiver who fell below the standard of care?
>
> A. Yes.
>
> Q. And for the ones that are not indicated anywhere in the chart who failed to delivery that care, you would never be able to identify that person?
>
> A. No, sir.
>
> ***
>
> A. There are so many—because there are so many nurses involved and so many staff, I didn't specifically look at he specific caregivers. What I see

is a systematic pattern. There are a large number of people involved and a number of them are recurrent.

***

A. Most of the names are illegible.

R. at 1772-73.

Defendants' own documentation makes it impossible to reach the illusionary bar Defendants require- specifying which employee on which date did the specific act that caused the ultimate injury to Mr. Guillotte. Indeed, a number of critical entries in Mr. Guillotte's activities of daily living (ADL's) contain no signatures of the staff providing the care, or responsible for providing care, nor do they contain the signatures of the nurses supervising the individuals providing or failing to provide care. R. at 1782- 1803. Defendants' expert, Dr. Robert Kelly, agreed that identifying specific nurses or caregivers was often impossible given the poor documentation. R. at 1833, 1838, 1841-42. Instead, the identity "would be generic by the nurses." R. at 1843. Still, Dr. Hammond was specific that, "it is the people who breached the standard of care." R. at 1774.

Nurse Trahant agreed that Mr. Guillotte's injuries and suffering "could have been controlled by the nursing home staff." R. at 2232 (emphasis added). Instead, he suffered from severe pain that had to be controlled by Morphine patches, caused by a combination of "pressure ulcers, contractures, his arthritis, [and] being immobile." *Id.* There was not one, specific incident that caused these injuries. Instead, Defendants' repeated failures and omissions resulted in the eventual breakdown and failure of his body and its systems.

1. Nutrition

According to Plaintiff's physician expert, Dr. Timothy Hammond, Mr. Guillotte had continuing deterioration and needed nutritional parameters. Yet, "he does not have an adequate assessment and reassessment and care-plan to continue to deal with it, and he has continued

malnutrition and dehydration, which is ongoing and increasing in severity." R. at 1720. Indeed, Mr. Guillotte was malnourished several months into his admission. R. at 1722. According to Dr. Hammond, "[t]hey should have been telling the doctor that his weight was still below ideal weight." R. at 1720. Yet, the nursing home "[f]ailed to assess, reassess and make a care plan to realize they had an ongoing nutritional deficit." R. at 1723; see also, R. at 1725.

> [I]f they had acted appropriately, reassessed him and gotten adequate nutrition through the PEG tube, then it would have helped, yes. I believe it would have prevented the skin problems and he would have healed them faster, and it would have put him at less risk for the sepsis that led to his death. And the dehydration issue goes along with the nutrition issues on that.
>
> ...
>
> You do not look at nutrition alone. The nutrition and dehydration condition go together.
>
> ...
>
> This poor man is dehydrated consistently. On occasion, he's dramatically dehydrated.

R. at 1732.

Nurse Trahant describes a concerning inconsistency in the documentation regarding Mr. Guillotte's nutrition. R. at 2204. As explained by Nurse Luanne Trahant, in April, 2002, someone was charting that Mr. Guillotte was consuming 100% of his meals, yet he had to be sent to the hospital for a PEG tube to be placed due to malnourishment. R. at 2216, 2221. A review of the records cited by Ms. Trahant shows that there are no signatures by the individual charting that Mr. Guillotte was consuming 100% of his meals. R. at 1807-08, 1809, 1813.

Similarly, Defendants were responsible for providing fluids to Mr. Guillotte, yet he became dehydrated on more than one occasion. There is no documentation of his input and output prior to June 2002. Even then, the documentation does not reveal who monitored his intake and output. R. at 1818 (showing initials but no signatures for the documentation of Mr. Guillotte's intake and output in June 2002), 1841-43, 2204. Still, Nurse Trahant testified that

"once they began documenting his intake and output in May and all through September, it was very evident to me that they consistently were not providing him with the amount of fluid that had been recommended by the dietition." R. at 2204. Dr. Hammond also testified that the root of Mr. Guillotte's dehydration was his not getting adequate fluid through his PEG feedings. R. at 1733. "You have to really work to get a sodium of 166, by not giving someone anywhere near adequate water." *Id.*

2. Glucose Control.

Mr. Guillotte had Type II diabetes. R. at 1744. Yet, according to Dr. Hammond, "[t]hey don't get the job done and the patient's diabetic control gets worse over time, not better, for the periods that we have documentation. There is one period we do not." R. at 1745. Dr. Hammond opined, "[t]hey don't have to manage it, they just have to know they have a problem and ask for help." R. at 1746.

3. Contractures.

Dr. Hammond was critical of the fact that the hospital records document Mr. Guillotte's contractures before the nursing home even seems to realize they exist. R. at 1739, 1750-51, 1754, 1757. According to Dr. Hammond, the nursing home "needed to document why their documentation of contractures, or rather of range of motion and voluntary movement is so different to the hospital." R. at 1757.

Dr. Hammond and Nurse Trahant both opined that the onset and progression of contractures could have been delayed with appropriate therapy. R. at 1758, 2216. According to Nurse Trahant, "Mr. Guillotte would have benefited from being picked back up by restorative in June. There were no documented reasons why they couldn't pick him up." R. at 2215. Indeed, Nurse Trahant testified that Mr. Guillotte's mobility and pain "could have been addressed appropriately by the staff through interventions." R. at 2218 (emphasis added). "[A]s he started

developing changes, the staff didn't change or intervene appropriately as they had in the past." *Id.*(emphasis added). In Nurse Trahant's opinion, restorative range of motion exercises would have prevented his contractures, improved circulation, and decreased his pain. R. at 2216.

4. Skin Lesions.

Mr. Guillotte's skin lesions also were not consistently or reliably documented. On the same day, Mr. Guillotte is noted in one document as having 10 lesions and in another document 7 lesions are recorded. R. at 1763, 1770. The nursing home documentation is conflicting—both internally and with what the wound care center in the hospital reported. R. at 1763. Given this conflicting documentation, Dr. Hammond wondered, "[h]ow can you look after lesions when you have conflicting reports of how many there are and where they are?" R. at 1765. "I think it is very hard to adequately deal with lesions when you are uncertain how many there are, what they are and what the status is." R. at 1769.

Luanne Trahant agreed. She was unable to decipher the nurses' notes with regard to whether comprehensive skin assessments were done. There were no body audits prior to February 2002. The documentation was "very incomplete and very much below standard as far as keeping up with his skin condition." This violated Defendants' own policy as well as the standard of care. R. at 2201-02.

Nurse Trahant specifically stated that the reasons Mr. Guillotte developed wounds were: "he did not receive enough hydration", "he was losing important nutritional elements", "the turning and positioning during that time was poorly documented." R. at 2222-23. Further, the staff failed "to change the plan to address his nutritional problems or skin problems." R. at 2231. Dr. Hammond also opined that, with appropriate nutrition and adequate hydration, more likely than not, these wounds would not have developed. R. at 1767.

5. Multiple Falls.

Mr. Guillotte suffered from numerous falls at Dixie White House. He was found lying on the floor on at least five occasions, the last fall resulting in a contusion to his left forehead. R. at 1751, 1753. According to Dr. Hammond, "[t]hey didn't do anything that prevented the outcome of the return falls." R. at 1752. Indeed, "the pattern of being found on the floor and not making new interventions, particularly with the wheelchair, does breach the standard of care... All I see is a recurrent pattern where they do not adequately address it." R. at 1752; see also, R. at 1653. Dr. Hammond explained that Mr. Guillotte "should not be put in a situation where he was likely to fall... There are a variety of ways of going about it, and I would not criticize them for which ones they did, but they need to assess, reassess and care-plan to make sure they deal with it." R. at 1753.

6. Recurrent Infections.

Mr. Guillotte suffered from recurrent infections, including three episodes of urosepsis, urinary tract infections, and some secondary elements of pneumonia while at Dixie White House. R. at 1760. According to Dr. Hammond, Mr. Guillotte's malnutrition and dehydration predisposed him to infections. R. at 1762.

With regard to Mr. Guillotte's urinary tract infections, Nurse Trahant testified that "the hygiene practices of the staff were not well documented in the records." R. at 2227. She felt that it "would have been important for the staff to evaluate . . . if taking out the catheter affected any of the wounds or the ability to take care of those wounds." R. at 2227 (emphasis added).

Nurse Trahant stated plainly that it was the staff's responsibility to inform the doctor of Mr. Guillotte's condition, but the staff failed to assess his bladder function and failed to notify the doctor. R. at 2229.

7. Documentation Deficiencies.

In addition to the substantial testimony provided by Plaintiff's experts regarding the impossibility of reading the illegible names, initials, and signatures on Mr. Guillotte's chart, not to mention the complete absence of documentation on many occasions, Defendants' own expert conceded that Defendants' records are unreliable. R. at 1848-51, 1854-55. Dr. Kelly testified:

> Q. Is it fair to say that you have seen, though, evidence here at least to suggest that the record in some places is incomplete and inaccurate?
>
> A. Yes.

R. at 2276. Because the documents themselves are unclear, Dr. Hammond testified that "whatever caregiver was either documenting the record for those specific instances... then that would be the respective caregiver who fell below the standard of care." R. at 1772.

Clearly, Plaintiff's experts have testified regarding numerous breaches of the standard of care. It is both unnecessary and impossible for Plaintiff to specify the individuals responsible for each and every single breach, as Defendants' own records are insufficient and inaccurate in this regard. For each of these reasons, the Circuit Court's order should be reversed and Plaintiff's cause of action reinstated.

B. Corporate Negligence

"A corporation can act only through its agents." *Affiliated Investments, Inc. v. Turner*, 337 So.2d 1263, 1267 (Miss. 1976). As acknowledged by Defendants, Plaintiff has asserted a corporate negligence claim against Defendants arising from what Dr. Hammond described as,

> I think the major problem is a systemic failure of the home. The home is not monitoring the care and doesn't have the policies and procedures in place to assess, reassess and deliver a care plan.
>
> ...
>
> But if you are asking me was there one nurse in particular, there were many nurses and many staff who did not manage to convey adequate information.

R. at 1775. Defendants try to downplay this testimony by calling it a "gut a feeling." Def. Brief at p. 27. Instead, these were opinions substantiated by Defendants' own records and properly made by Plaintiff's experts as to the actions of Defendants in running their facilities.

Dr. Hammond was critical of the staff's failure to accurately assess, reassess, care plan and advise the physician with regard to the ongoing issues. R. at 1739 (dehydration), 1745 (diabetes), 1746 (diabetes), 1751 (falls), 1753 (falls), 1765 (skin lesions), 1767 (skin lesions), 1762 (urinary infections). Dr. Hammond views this failure a "pattern." R. at 1746.

Further, Dr. Hammond testified that he believed these failures were the result of a staffing problem: "Many of the failures we see here today are consistent with a lack of staffing." R. at 1773. He further explained, "reasonable staff will clean up soiled patients if they have the time to do it." R. at 1773. Dr. Hammond opined that surveys conducted at the home just prior to Mr. Guillotte's residence were "consistent with a systemic problem at the home, that the environment is unable to provide the resources the patient needs." *Id.* "What I see is a systematic pattern. There are a large number of people involved and a number of them are recurrent." R. at 1773. "I think it is a systemic failure, meaning that there are many individuals that breached the standard of care, all right? And that they share a responsibility with the home." R. at 1774. "It is a matter of the chain of command. Each person is charged to give the right information up the chain of command... The chain of command failed, and that happened several times." R. at 1774.

Defendants' understaffing is central to Plaintiff's theory of corporate negligence. R. at 1429. Staffing is a major expense of nursing facilities. Lower staffing increases profits, but it also decreases care and causes death and serious injury. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes – Report to Congress, Ch. 6.*; *Elder Abuse in Residential Long-Term Care Facilities: What is Known About Prevalence, Cause and Prevention: Testimony*

Before the U. S. Senate Committee on Finance, Statement of Catherine Hawes, Ph.D. (June 18, 2002).

The understaffing of a facility has a direct negative impact on all the nursing home's residents. According to a report issued by the Center for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, in July of 2000, 54 percent of all nursing homes are understaffed to the point that residents do not get the minimal two hours of care by nurses' aides per day necessary to keep them from being endangered. See Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes – Report to Congress, Ch. 6 (July, 2000).

The fewer nurses and nurses' aides on staff, the less individual attention the residents get, and the more bedsores, malnutrition, falls, abnormal weight loss and dehydration they suffer. In a sizeable number of nursing homes, government inspectors continue to find residents who are malnourished, left soaking in their own urine and feces and physically abused by underpaid, poorly trained staffers. *Ibid.*

Additionally, testimony in hearings before the United States Senate Finance Committee show that one of the most significant and preventable causes of abuse and neglect in a nursing home setting is inadequate staffing levels. *Elder Abuse in Residential Long-Term Care Facilities: What is Known About Prevalence, Cause and Prevention: Testimony Before the U.S. Senate Committee on Finance*, Statement of Catherine Hawes, Ph.D. (June 18, 2002) ("I should note that if I were going to do only one thing to reduce abuse and neglect, it would be to increase staffing in the nation's nursing homes."). A GAO report to the Senate Finance Committee and Special Committee on Aging issued in June, 2002, found that nursing homes providing more nursing hours were less likely to be cited for quality of care problems than homes providing

fewer nursing hours. See *Nursing Home Expenditures and Quality,* GAO-02-431R (June 13, 2002).

The precedents emphasize the importance and relevance of this evidence. For example, in *Beverly Enterprises – Florida, Inc. v. Spilman*, 661 So. 2d 867 (Fla. Ct. App. 1995), the evidence showed:

1. Spilman lost an excessive amount of weight, became increasingly confused and agitated, and became non-ambulatory.

2. He was seen restrained in a geri-chair (in a vest with ropes which tied in the back) almost everyday for hours at a time.

3. If the nursing home was understaffed, he was often left sitting in soiled clothing, and on a number of occasions he attempted to untie his restraints to escape his chair. When he was unsuccessful, he dragged the chair around with him.

4. He was supposed to receive help eating, but if the nursing home was understaffed, he received no help and his tray was thrown away. At times his chart was documented to show that he was fed when he was not.

5. When a stomach tube was placed in his stomach to provide him nourishment, on many occasions nurses did not properly refill it for hours at a time. An employee who worked on Spilman's wing of the nursing home during the day shift testified that when the stomach tube was in place, he was supposed to receive 30-minute feedings, two times per shift. When she was rushed, however, she had to give the feeding in five to eight minutes. She stated that the tube site looked "nasty" and was draining and that Spilman suffered from deep draining pressure sores. His bandages were supposed to be changed and initialed on every shift. Sometimes the bandages were changed from day-to-day; other times they were not.

6. Spilman had deep bedsores on his hips and buttocks and the odor was strong outside his room.

7. Each wing of the nursing home contained sixty patients to be cared for by one charge nurse, one regular nurse and three certified nursing assistants.

8. A certified nursing assistant was also required to perform a nurse' job.

9. The head nurse was unavailable for hours at a time.

10. The nursing staff knew when the state would come to inspect and on those occasions increased staff.

11. The nursing home was understaffed.

12. A treating physician testified that Spilman suffered from one of the worst cases of bedsores he had ever seen. The physician stated that he "couldn't believe it" when he first examined Spilman. He discovered that the tissue in Spilman's hip was rotted well into both hip joints, surrounding muscles, tendons and ligaments. His post-operative diagnosis was osteomyelitis, a bone infection, which was indicated by bone coated in fluid. The periosteum rotted away from the bone, and the bone was gray and non-viable. When he saw Spilman in the hospital, his injuries were beyond repair.

Id. at 870-71.

Likewise, in *Advocat v. Sauer,* 111 S.W.3d 346 (2003), the Arkansas Supreme Court upheld the admission of such evidence, writing;

> Here, Mrs. Sauer died in the care of Rich Mountain from severe malnutrition and dehydration. There was evidence presented that she was found at times with dried feces under her fingernails from scratching herself while lying in her own excrement. At other times, she was not "gotten up" out of her bed as she should have been. Often times, Mrs. Sauer's food tray was found in her room, untouched because there was no staff member at the nursing home available to feed her. She was not provided with "range of motion" assistance when the facility was short of staff.
>
> ***
>
> Mrs. Sauer was often times found wet without being changed in four hours. She had pressure sores on her back, lower buttock, and arms on days she was found sitting in urine and excrement. . . . at times she had no water pitcher in her room; nor did she receive a bath for a week or longer, due to there not being enough staff at the facility. . . . at the time she was hospitalized prior to her death, she had a severe vaginal infection. When she was in the geriatric chair, she was not "let loose" every two hours, as required by law. Finally, Mrs. Sauer was found to suffer from poor oral hygiene with caked food and debris in her mouth.

Id. at 353-354.

The Arkansas Supreme Court concluded, "There was ample testimony and evidence presented to demonstrate that Mrs. Sauer suffered considerably and was not properly cared for, that Rich Mountain was short-staffed, and that the Appellants' tried to cover this up by "false-charting" and by bringing in additional "employees" on State-inspection days." *Id.* at 354. "All of this serves to support the Sauer estate's case that the nursing home, under the auspices of the

Appellants, knew it had staffing problems and committed negligence as to Mrs. Sauer, because it was short-staffed due to cutbacks." *Ibid.*

The evidence in *Spilman* and *Sauer* is remarkably and tragically similar to that in this case. Plaintiff's experts have opined that Defendants understaffed their facility to the point that it was dangerous. Defendants accepted Hamilton Guillotte as a resident knowing full well that he required significant and intense care. They simply did not have adequate staff to provide that care. The result was malnourishment, dehydration, multiple infections, contractures, pressure sores, and pain so severe that it had to be controlled by Morphine patches. R. at 2232. The damage caused by Defendants' conduct was horrendous. Accordingly, the Circuit Court's grant of summary judgment to Defendants should be reversed.

II. Expert Testimony As To The Standard Of Care Is Not Necessary For Plaintiff's Claims Of Ordinary Negligence.

The basic premise of Defendants' brief is that, because this case arose from care in a nursing home, only the Mississippi medical malpractice statute applies. Likewise, the Circuit Court incorrectly concluded that, "[w]ithout such expert medical testimony, Plaintiff cannot survive a motion for summary judgment." R. at 1882.

The premise that Plaintiff's case is strictly a medical malpractice case is incorrect. Miss. Code Ann. §15-1-36(2) is only applicable where an allegation directly involves, first, an act or omission "arising out of the course of medical, surgical or other professional services," and, second, the act or omission is performed by a designated health-care provider. If one of these requirements is not met, then the wrongful conduct falls outside the scope of the medical malpractice statute and within the scope of ordinary negligence or some other cause of action. Thus, Defendants' and the Circuit Court's basic premise motion is flawed. See *Alcoy v. Valley Nursing Homes, Inc.,* 630 S.E.2d 301 (Va. 2006)(rejecting the notion that all claims against a nursing home are subject to the provisions of the Medical Malpractice Act).

Plaintiff's complaint, as amended, alleges against all Defendants causes of action for negligence, medical malpractice, malice and/or gross negligence, fraud, breach of fiduciary duty, and for the wrongful death of Mr. Guillotte. R. at 24-91. It is commonly recognized that plaintiffs may maintain actions for both ordinary negligence and medical malpractice within the same action. See *Turner v. Steriltek, Inc.*, __ S.W.2d __, Slip Copy, 2007 WL 4523157 (Tenn. Ct. App.). Indeed, a plaintiff can plead and go forward on as many distinct claims as she has, even if the remedies for such overlap. *See, e.g., Foster v. Evergreen Healthcare, Inc.*, 716 N.E.2d 19 (Ind. Ct. App. 1999). In the *Foster* case, the Indiana court ruled that Rule 8 expressly permitted an estate of a nursing home resident, who suffered severe burns upon being lowered into scalding water, to plead and to seek relief under more than one theory and upon as many separate causes of action as desired or pleaded in the alternative. *Id.* "[I]t was entirely proper . . . to seek recovery in both tort and contract." *Id.* (citing *Strong v. Commercial Carpet Co., Inc.*, 322 N.E.2d 387 (Ind. Ct. App. 1975)).

This reasoning is consistent with the Mississippi Supreme Court's statement that not every activity engaged by a physician, dentist, nurse or lawyer is a professional service. *See Burton v. Choctaw County,* 730 So.2d 1, 7-8 (Miss. 1999). Moreover, it is consistent with Mississippi precedent that a plaintiff may plead multiple or alternative theories of liability in one complaint. See *Jordan v. Wilson*, 2008 WL 2894366, *4 (Miss. Ct. App. 2008). Plaintiff has alleged in her Complaint that Defendants failed to provide Mr. Guillotte with adequate nutrition, hydration and other custodial care, causing him harm, and ultimately his death. Plaintiff has sufficiently stated claims for ordinary negligence, survival and wrongful death. Accordingly, he should be permitted to present these claims before a jury.

It is well settled that summary judgment shall be granted by a court only if "the pleadings, depositions, answers to interrogatories and admissions on file, together with

affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Miss. R. Civ. P. 56(c); *Saucier ex rel. Saucier v. Biloxi Reg'l Med. Ctr.*, 708 So. 2d 1351, 1354 (Miss. 1998). When the evidence in this matter is viewed under this standard, it is clear that, even if this Court finds Plaintiff's expert testimony to be insufficient to support Plaintiff's medical malpractice claims, the Circuit Court erred in dismissing Plaintiff's non-medical negligence claims, as Plaintiff has established that genuine issues of material fact exist with regard to her claims of ordinary negligence. *See Partin v. North Mississippi Medical Center, Inc.*, 929 So. 2d 924, 933 (Miss. Ct. App. 2005).

A. Plaintiff's Allegations of Ordinary Negligence.

With regard to Plaintiff's ordinary negligence claim, Plaintiff alleged that Defendants owed a duty to Hamilton Guillotte to provide adequate and appropriate custodial care and supervision, which a reasonably careful person would provide under similar circumstances. Plaintiff specifically alleged that Defendants failed to provide at least the following basic, custodial care to Mr. Guillotte:

a) The failure to provide necessary and adequate continence care and assistance with toileting;

b) The failure to provide adequate and appropriate hygiene care, including the failure to bathe him daily after each incontinent episode so as to prevent urine and fecal contact with his skin for an extended period of time, thereby preventing pressure sores and infections from developing and progressing;

c) The failure to provide clean bed linens as needed to prevent urine and fecal contact for an extended period of time, thereby preventing pressure sores and infections from developing and progressing;

d) The failure to provide even the minimum number of staff necessary to assist

the residents with their needs;

e) The failure to provide adequate supervision for Mr. Guillotte to prevent him from falling and being injured by falls within the facility;

f) The failure to protect Mr. Guillotte from harm within the facility;

g) The failure to adopt adequate guidelines, policies, and procedures for documenting, maintaining files, investigating, and responding to any complaint regarding the quantity of resident care, the quality of resident care, or misconduct by employees, irrespective of whether such complaint derived from a state survey agency, a resident of said facility, an employee of the facility or any interested person;

h) The failure to provide a safe environment;

i) The failure to protect Mr. Guillotte from verbal abuse within the facility; and

j) The failure to protect Mr. Guillotte from physical abuse within the facility.

R. at 64-69.

Many of the acts and omissions Plaintiff has alleged in this case are outside the scope of the Mississippi medical malpractice statute, and, thus, do not require expert testimony as to the standard of care. Simply put, nothing in providing food and water, cleaning people up when they are incontinent, providing good hygiene and grooming, protecting residents from verbal and physical abuse, providing clean linens, and providing sufficient budget, staff, supplies and supervision involves the exercise of professional medical care and judgment.

B. Most Care Provided at White House is Not a Professional Service.

The majority of the employees of Defendants' facility who provide the majority of the care are not licensed or professional medical-care providers and, thus, cannot perform "professional services." Most of the staff are low-wage and fairly unskilled and untrained laborers, laundry staff, kitchen staff, janitorial staff, CNAs, and, perhaps, "feeders" or "turners."

Indeed, the Mississippi Supreme Court has acknowledged that ordinary negligence can apply to a plaintiff's nursing home negligence case. See *Jenkins v. Pensacola Health Trust, Inc.*, 933 So.2d 923 (Miss. 2006)(applying the three-year statute of limitations for ordinary negligence to the plaintiff's nursing home negligence case); see also, *Covenant Health Rehab of Picayune, L.P. v. Brown*, 949 So.2d 732, ¶ 20 (Miss. 2007). In *Jenkins,* the plaintiff brought a wrongful death suit against a nursing home and its owner for personal injuries sustained by the decedent at the defendants' facility. 933 So.2d at 924. The Supreme Court determined that the plaintiff's complaint against the nursing home defendants sounded in ordinary negligence and, accordingly, the court applied the three-year statute of limitations for ordinary negligence, codified at Miss. Code Ann. § 15-1-49, to the plaintiff's wrongful death claim. *Id.* at 925-26.

Non-professional services such as dressing, grooming, toileting, feeding, budgeting, staffing, and hydration fall outside of the scope of professional negligence. When confronted with the issue of defining "professional services" in the content of an exclusionary clause involving an insurance dispute for a claim against a governmentally owned and operated nursing home, the Mississippi Supreme Court wrote:

> In determining whether or not a particular act or failure to act is of a professional nature we should look not to the title or character of the party performing the act but to the act itself." *Marx*, 157 N.W.2d at 872. Inevitably, every service performed, or activity engaged in, by a physician, dentist, nurse or lawyer is not a "professional" service. Here we are presented not with a nurse but with a nurse's aide, which the State of Mississippi does not require to be licensed. The State Board of Nursing only provides a certification process for nurse's aides.
>
> Simply because a nurse's aide may usually be associated with nurses, and because the aide may be exposed to certain activities performed by nurses while trained, does not necessarily mean that bathing is a "nursing treatment" which constitutes "professional service".

Burton v. Choctaw County, 730 So.2d 1, 7-8 (Miss.1999).

> Various state guidelines treat bathing as a personal care skill, not as a basic nursing skill. It is unrealistic to say that the average lay person could not be

> expected to know personal skills such as bathing, grooming, dressing and toileting.

Id. at 8.

The Medicare regulations applicable to nursing homes also distinguish between assistance with or provision of activities of daily living to residents and more advanced care requiring the application of professional medical judgment or skills. Under Medicare regulations, "personal care services" are those which do not require "skills of qualified technical or professional personnel" such as bathing, dressing, eating, periodic turning and positioning in bed, getting in and out of bed or a chair, moving around, using the bathroom, and routine care for incontinence, among others. 42 C.F.R. § 409.33(d). Moreover, the Social Security Act, codified at 42 U.S.C. §§ 1395 *et seq.*, omits CNAs from the definition of a "licensed health professional," which is limited by federal law to "a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician." 42 U.S.C. §§ 1395i-3(b)(5)(A), (F)-(G). Therefore, the failures occasioned by CNAs' inability to perform their tasks are not professional negligence.

Similarly, the officers or other administrative or decision-making personnel of the corporate defendants are not all medical-care professionals. These personnel are incapable of committing medical malpractice because they are not the sort of licensed professionals who can be sued for medical malpractice. Because none of these persons may be sued for medical malpractice, the nursing home's liability for their actions must lie in ordinary negligence.

Like the Mississippi Supreme Court, many courts in other states have recognized that not all wrongful conduct that occurs in a nursing home is medical malpractice. *See Bailey v. Rose Care Center,* 307 Ark. 14, 817 S.W. 2d 412 (1991). (Arkansas Medical Malpractice Act did not

apply when the patient left the nursing home unnoticed and was substantially struck and killed by a vehicle. Although, the patient was under a doctor's care, the patient's death was not the result of a doctor's treatment or order, but the allegedly improper supervision of the nurse's aide on duty that night); see also, *Turner v. Steriltek, Inc.*, __ S.W.2d __, Slip Copy, 2007 WL 4523157, at *5 (Tenn. Ct. App.)(recognizing a viable claim for ordinary negligence against Vanderbilt University Hospital when the claim was based upon policy or institution-wide decisions affecting every patient at the defendant hospital).

In the case of *McQuay v. Guntharp,* 336 Ark. 534, 986 S.W. 2d 850 (1999), the Arkansas Supreme Court wrote:

> The distinction between ordinary negligence and malpractice turns on whether the acts or omissions complained of involving matters of medical science or art requiring special skills not ordinarily possessed by lay persons or whether the conduct complained of can instead be assessed on the basis of the common every day experience of the trier or of facts. *Where the matter requires the consideration of the professional skill and knowledge of the practitioner of the medical facility, the more specialized theory of medical malpractice applies.*

Id. at 540, 986 S.W.2d at 852-53 (citing *Borrillo v. Deekman Downtown Hosp.,* 146 A.D.2d 734 (N.Y. App. Div. 1989)). See also, *Advocat, Inc. v. Sauer,* 353 Ark. 29, 111 S.W.3d 346 (2003) (holding that separate jury instructions, verdict forms and damage awards against a nursing home for ordinary negligence and medical negligence stemming from the care a nursing home resident received is appropriate).

In *Alcoy v. Valley Nursing Homes, Inc.,* 630 S.E.2d 301 (Va. 2006), the Virginia Supreme Court considered whether causes of action for "negligence and sexual assault and battery, based on the failure of nursing home personnel to ensure the safety of one of their residents, are subject to the provisions of the Medical Malpractice Act, Code §§ 8.01-581.1 through --581.20:1." *Id.* at 302. It was alleged "that Alcoy was sexually assaulted because of Valley's failure to ensure her

safety by providing adequate and proper personnel, visitor screening, and security systems for the Woodbine facility." *Id.* at 304.

Considering the unique factual context of a tort occurring in a nursing home, the Virginia Supreme Court held "that these alleged omissions do not involve the provision of health care or professional services as contemplated by the Act. Instead, the alleged omissions involve administrative, personnel, and security decisions related to the operation of the Woodbine facility, rather than to the care of any particular patient." *Id.*

Similarly, in *Owens v. Manor Healthcare Corp.*, 512 N.E.2d 820 (Ill. Ct. App. 4th Dist. 1987), a nursing home resident fell from a wheelchair because he was not properly supervised by nurses and nurse's aides. The Illinois Court of Appeals noted, "Custodial shelter care must be distinguished from medical treatment. The specific act alleged does not arise from medical diagnosis or treatment." *Id.* at 823. The court went on, "Expert testimony from a health-care professional is not required to assess the acts of the defendant. The determination to be made is not inherently one of medical judgment." *Id.*

Similarly, the bulk of Mr. Guillotte's injuries for which Plaintiff seeks recovery were the result of ordinary, not professional, negligence. For example, he lost weight and became malnourished and dehydrated while in the care of Defendants because they did not give him food or water. This led to infections that required hospitalization. R. at 1721, 1765, 2204, 2221. Mr. Guillotte became so contracted from being left to lie unattended for hours on end that he could not extend his limbs. R. at 1739, 1750-51, 1754. Dr. Hammond testified that Defendants' failures ultimately contributed to Mr. Guillotte's death. R. at 1721.

While expert testimony may be required to prove that these failures caused Mr. Guillotte's death, this is basic care that is regularly provided by any parent to a child. There is nothing medical about Defendants' failure to provide this type of custodial care. As Plaintiff's

claims sound in ordinary negligence, the Circuit Court should not have granted summary judgment based on what it perceived to be omissions from Plaintiff's expert testimony.

Conclusion

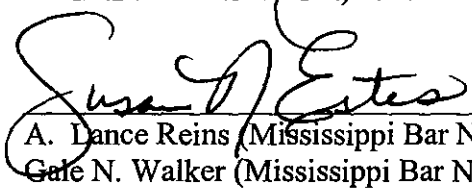
Hamilton Guillotte starved slowly and wasted away in agony while in Defendants' care. Defendants knew he needed care and they also knew they lacked the staff to give it.

Plaintiff respectfully requests that this Court reverse the Circuit Court of Harrison County's grant of summary judgment in favor of the Defendants, remand the case for trial, and for all other relief, both general and specific, to which she is entitled.

Respectfully submitted,

The Estate of Hamilton Peter Guillotte
By and through Edith Jordan, Individually
and as Administratrix of the Estate of Hamilton
Peter Guillotte

WILKES & McHUGH, P.A.



A. Lance Reins (Mississippi Bar No. [redacted]
Gale N. Walker (Mississippi Bar No. [redacted]
Susan N. Estes (Mississippi Bar No. [redacted]
Wilkes & McHugh, P.A
11 North Towne Dr., Suite 220
Jackson, MS 39211

AND

Donald J. Rafferty
P.O. Box 4252
2118 18th Street
Gulfport, MS 39502

Attorneys for Plaintiff/ Appellant

CERTIFICATE OF FILING

I hereby certify that I, Susan Nichols Estes, counsel for the Plaintiff/Appellant, on this 24th day of October, 2008, deposited with Federal Express, with delivery prepaid via Priority Next Day Delivery, to be delivered to the Mississippi Supreme Court Clerk's Office, the following original documents and copies:

The original and five (5) copies of the above Appellant's Reply Brief.

This certificate of filing is made pursuant to Rule 25(a) of the Mississippi Rules of Appellate Procedure.

Susan Nichols Estes

Attorney for Plaintiff/Appellant

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing was served by First Class Mail on the following, this 24th day of October, 2008:

Lynda C. Carter
Nicole C. Huffman
WISE CARTER CHILD & CARAWAY
2781 C.T. Switzer Sr. Drive
Suite 307
Biloxi, MS 39531

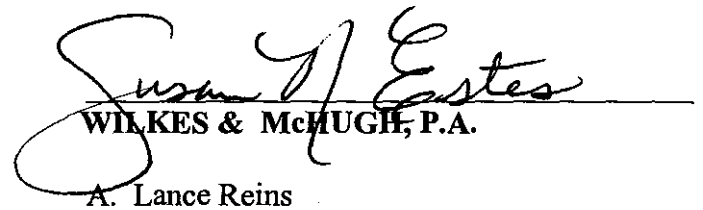
Daniel E. Dias
Mancuso and Dias, PA
2002 North Lois Avenue
Suite 510
Tampa, FL 33607

Honorable Jerry O. Terry
Harrison Circuit Judge
P.O. Box 1461
Gulfport, MS 39502

Susan M. Estes
Attorney for Plaintiff/Appellant

CERTIFICATE OF VIRUS-FREE COMPUTER DISK

I certify that the computer disk accompanying this brief has been scanned and is virus free.



WILKES & McHUGH, P.A.

A. Lance Reins
Mississippi Bar No. [redacted]
Gale N. Walker
Mississippi Bar No. [redacted]
Susan N. Estes
Mississippi Bar No. [redacted]
Wilkes & McHugh, P.A
11 North Towne Dr., Suite 220
Jackson, MS 39211

Attorneys for Plaintiff/ Appellant