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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN DIEGO

Dean Takahashi II, a minor, by and through his Guard Ad Litem, Cheryl Kay Daily; **Lani Takahashi**, an individual and as Successor-in-Interest to **Dean Takahashi**

v.

Prime Healthcare Paradise Valley LLC, a limited liability company, et al.,

Defendants.

Case No.: 37-2019-00020065-CU-MM-CTL

Plaintiffs' Memorandum in Opposition to Prime Healthcare Paradise Valley LLC's Motion for Summary Adjudication

Judge: Hon. Kenneth J. Medel
Dept.: C-66

Complaint Filed: April 9, 2019
Trial Date: n/a

Hearing Date: December 4, 2020
Time: 9:30 a.m.

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INTRODUCTION

This is a wrongful-death and successor-in-interest action by the widow (Lani Takahashi) and surviving son (Dean Takahashi II) of Dean Takahashi ("Dean"), arising out of Dean's preventable suicide while he was a patient at a psychiatric facility owned and operated by Prime Healthcare Paradise Valley, LLC ("Prime").

Dean Takahashi was initially brought to Prime's facility on a so-called "5150 hold" for, among other things, "suicidal ideations with command auditory hallucinations." Specifically, Dean verbalized a suicidal intent, which he attributed to voices in his head.

As a psychiatric facility engaged in the treatment of individuals who suffer from acute suicidal ideation, Prime was well aware that it had to take steps to ensure that Dean did not act out his impulse to kill himself. In particular, the agency that granted accreditation to Prime had begun issuing bulletins in 2007 directing Prime and other similar facilities to use special doors, hardware, and linens in patient rooms to eliminate the risk that a patient like Dean would hang himself. In addition, in view of the suicide risk that he posed, the physician who admitted Dean to Prime's facility had specifically ordered Prime to perform visual checks on Dean every 15 minutes, 24 hours a day.

But as it turns out, Prime had made no modifications to the doors, hinges, and sheets in its patient rooms to prevent hanging incidents since the facility was built in 1988. And rather than check on Dean every 15 minutes as required, Prime's personnel left Dean unattended for at least **105 minutes**. When they eventually checked on Dean, he was found hanging from a bedsheet he had wedged between the door and the door frame.

Plaintiffs brought this lawsuit to hold Prime accountable for its conscious disregard of its patients' safety in general and Dean's safety in particular. Among other things, Plaintiffs allege that Prime's conduct amounts to "neglect" under the Elder and Dependent Abuse Act, and seek punitive damages for Prime's misconduct.

Prime now seeks summary adjudication of Plaintiffs' "neglect" claim and prayer for punitive damages. But as set forth below, Prime's conduct met the definition of "neglect" under California law, Prime exhibited a "conscious disregard" for Dean's safety, and Prime's misconduct caused Dean's death. Accordingly, this Court should deny Prime's motion for summary adjudication in its entirety.

BACKGROUND

1. Prime exhibits a conscious disregard for patient welfare.

Prime operates a 24-hour custodial facility that specializes in the treatment of individuals with severe mental-health issues. (PAMF #5.)[1] With a brief exception (discussed below), Prime's facility was accredited by the Joint Commission, a national organization that issues accreditation to hospitals and acute care facilities like Prime. (PAMF #21)

The Joint Commission found that 75% of suicides in acute, in-patient psychiatric facilities are hangings. (PAMF #29.) With that in mind, from 2007 through 2018, the Joint Commission issued numerous bulletins and standards directing its accredited psychiatric care facilities to remove so-called "ligature points" from their patient rooms. (PAMF #20, 21, 24–26, 31–35.) In particular, the Joint Commission stressed that accredited care facilities "must" make psychiatric patient rooms "ligature-resistant" by removing common ligature points (e.g., door frames, door knobs, handles, and hinges) "where a cord, rope, bedsheet, or other fabric material can be looped or tied to create a sustainable point of attachment" which a patient could use to hang oneself. (PAMF #25, 31–33.) In their place, the Joint Commission directed their accredited facilities to retrofit patient rooms in their facilities with special doors and hardware that could not be used as a ligature point. (PAMF #34, 35.) In addition to removing ligature points, the Joint Commission directed facilities to equip patient rooms with special linens designed to tear under strain. (PAMF #31–34, 45.)

The Joint Commission also emphasized that the danger a psychiatric patient would commit suicide by hanging was greatly amplified if the patient is left alone in a ligature-laden room without regular monitoring. (PAMF #24, 30.)

Despite these clear guidelines, from 1988 (when it was built) through 2019, Prime made absolutely no effort to address the many ligature points in the psychiatric patient rooms at its facility. (PAMF #44.) As a result, Prime had a "near miss" in May 2015 when a patient attempted to commit suicide by hanging from a curtain rod in her room with a bed sheet. (PAMF #41.) But despite that close call, Prime made no efforts to address the ligature points in its patients' rooms. (PAMF #44.)

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[1] Citations to Plaintiff's "Additional Material Facts" in their separate statement appear as **(PAMF #X)**. Citations to Prime's memorandum brief appear as **(Def. Memo. at X)**.

2. Prime's conscious disregard for patient welfare results in Dean's death.

On May 2, 2018, Dean's wife called 911 because Dean was in a psychotic state. She asked that Dean be brought to a medical facility that could protect Dean from himself. San Diego Sheriffs brought Dean to Paradise Valley Hospital's emergency room on a 5150 hold. Despite a history of bipolar and schizoaffective disorder (PAMF #9), Dean was a loving husband and father to a 13-year-old son for whom he was the primary caretaker. But on this occasion, Dean was in the throes of a psychotic episode and was experiencing vivid visual and auditory hallucinations that were commanding him to attempt to kill himself by stabbing himself in the eye with a pencil. (PAMF #6, 7.) Dean was unable to resist his command hallucinations, and had already acted out on an auditory hallucination command to eat dog feces. (PAMF #8.)

Dr. Kugel, the on-call psychiatrist who treated Dean, immediately recognized that Dean was a danger to himself in the absence of custodial care. (PAMF #1, 3, 11.) With that in mind, Dr. Kugel had Dean transported to Prime's facility on a "5150" psychiatric hold. (*Ibid.*) Because Dean was suicide risk, Dr. Kugel ordered Prime to perform visual "line-of-sight" checks on Dean **every 15 minutes**, 24 hours a day. (PAMF #11.)

But in the early morning hours of May 4, 2018, Prime employees allowed at least **105 minutes** to elapse without checking on Dean, who was behind a closed door in his patient room. When someone finally did open the door to Dean's room, he was hanging from a bedsheet that he had wedged between the door and doorframe of his room's private bathroom. (PAMF #13–15.) When first responders arrived, Dean was already cold to the touch. (PAMF #16.) He was eventually pronounced dead at the hospital.

3. Prime continues to disregard patient welfare until its revenue is put in jeopardy.

Were Prime concerned with patient welfare, Dean's death would have prompted a massive, facility-wide investigation, and would have motivated Prime to finally update patient rooms by removing the many ligature points therein. And if Prime cared for its patients' welfare, it would have fired the employees who left Dean unmonitored for at least 105 minutes despite explicit orders to perform line-of-sight visual checks on Dean every 15 minutes. (PAMF #63, 64.)

But because Prime does *not* care for its patients' welfare, it made absolutely no effort to address ligature points in its patient rooms. (PAMF #42–45.) And rather than terminate the employees who abandoned Dean for at least 105 minutes, Prime simply issued a warning to a single nurse. (PAMF #68, 69.) As a result, Prime's facility continued to present a clear and present danger to the welfare of its in-patient psychiatric patients.

Even worse, Prime did nothing to address the fact that its employees—apparently at the direction of Prime's officers—had falsified Dean's patient records to make it appear that they had diligently conducted the requisite 15-minute welfare checks. (PAMF #65, 67.) But video from the surveillance camera outside Dean's room confirmed that the staff had not checked on Dean and had therefore falsified their records. And Prime actually destroyed some of that surveillance footage: Although Prime had **12 hours'** worth of video from the camera outside Dean's room, a high-ranking Prime administrator instructed Prime's Regional Security Manager not to preserve most of it (PAMF #73), ostensibly because it further demonstrated Prime's failure to check on Dean.[2]

Naturally, the fact that Prime made no changes to its facility, did not terminate the employee who failed to check on Dean, and had actually engaged in efforts to conceal evidence of its misconduct, directly fostered an environment where patient welfare was not taken seriously. (PAMF #79–81.)

Thus, it is perhaps no surprise that in 2019, yet *another* patient was found hanging from a bedsheet on a door in his room. (PAMF #49.) As with Dean, this patient had been left unattended for over 42 minutes despite orders to conduct wellness checks every 15 minutes. (PAMF #77.) Shockingly, even this predictable death did not force any changes to ligature points in Prime's patient rooms. (PAMF #51, 53.)

Indeed, Prime likely would have continued to put its psychiatric patients at risk had the Joint Commission not intervened: In March 2019, the Joint Commission preliminarily denied Prime's accreditation and notified Prime that it would not be reinstated until Prime made its patient rooms

[2] When Prime initially produced the surveillance video in discovery, the video only showed eight minutes of footage immediately before Dean's body was discovered hanging. Months later, on the eve of the deposition of Prime's Regional Security Manager (the "person most knowledgeable" regarding the video) Prime produced 105 minutes of video before Dean was discovered. It showed that no Prime employee checked on Dean during that entire time.

ligature-resistant. (PAMF #53.) Without accreditation, Prime would not be able to seek insurance reimbursement for patient care, effectively stopping its revenue stream. (PAMF #54.)

While its patients' welfare was never sufficient motivation for Prime to make necessary safety changes, the threat to Prime's profits did the trick, and within four months Prime spent $50,000 to retrofit its psychiatric patient rooms with special ligature-resistant doors and hardware. (PAMF #55.)

STANDARD OF REVIEW

The party seeking summary judgment has the burden of persuasion and production, and must make a prima facie showing that there are no triable issues of material fact. (*Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 850.) It is not enough to simply point out "an absence of evidence to support" an element of the plaintiffs' cause of action. (*Id*. at 854, n.23.) The moving party must initially "present facts to establish a defense." (*Archdale v. American Intern. Specialty Lines Ins. Co.* (2007) 154 Cal.App.4th 449, 462.) Only if the defendant succeeds in doing so does the burden shift to "demonstrate the existence of a triable, material issue of fact" as to that defense. (*Ibid*.) A court reviewing a motion for summary judgment must strictly scrutinize the moving party's evidence. (*McDonald v. Antelope Valley Community College Dist.* (2008) 45 Cal.4th 88, 96–97.)

Summary judgment should be "used with caution" so it does not become a substitute for trial. (*Molko v. Holy Spirit Ass'n.* (1988) 46 Cal.3d 1092, 1107.) "In ruling on the motion the court must consider all of the evidence and all of the inferences reasonably drawn therefrom and must view such evidence in the light most favorable to the opposing party." (*Aguilar*, *supra*, 25 Cal.4th at 843, internal citations omitted.) This Court's role is to determine whether such issues of fact exist, "not to decide the merits of the issue themselves." (*Walsh v. Walsh* (1941) 18 Cal.2d 439, 441). All doubts as to whether there are any triable issues of fact are resolved in favor of the party opposing summary judgment. (*Zelda, Inc. v. Northland Ins. Co.* (1997) 56 Cal.App.4th 1252, 1259.)

Finally, a party seeking summary judgment may not rely on new facts or evidence in its reply papers. (*San Diego Watercrafts, Inc. v. Wells Fargo Bank* (2002) 102 Cal.App.4th 308, 316.)

Points & Authorities

1. Plaintiffs' have a viable claim for abuse of a dependent adult.

1.1 This Court already found that Plaintiffs' allegations meet the definition of "neglect."

Prime's first argument is essentially a demurrer: It argues that Plaintiffs' "alleged acts/omissions were not neglect or abuse" under Welfare and Institutions Code section 15600. (Def. Memo. at p. 13, capitalization omitted.)

If that argument sounds familiar, it's because it is the exact same argument Prime made in a motion to strike this Court denied in January 2020. (See ROA #88, 92.) Indeed, rather than dispute whether Plaintiffs can *prove* a "neglect" claim, Prime disputes whether Plaintiffs' *allegations* meet the definition of "neglect." (E.g., Def. Memo. at p. 7 ["Plaintiffs allegations lie solely in medical malpractice/wrongful death."]; *ibid.* ["Plaintiffs are attempting to expand what is at most a claim … based on alleged medical negligence to include a cause of action for elder/dependent adult abuse."]; *id.* at p. 12 ["Plaintiffs' allegations are clearly allegations of professional negligence and medical in nature, rather than neglect and custodial in nature."]; *id.* at p. 15 ["Plaintiff's allegations amount to a failure to follow orders correctly, or a failure to take every necessary precaution. This is not neglect or abuse pursuant to the EADACPA."].)

There is no reason to re-visit this settled issue, and this Court should summarily reject this aspect of Prime's motion as an improper and untimely motion for reconsideration. But in an abundance of caution—and to provide context and support for Plaintiffs' opposition to Prime's motion more generally—Plaintiffs gratuitously demonstrate that they have a viable claim for "neglect."

Under the Elder Abuse Act, "neglect" is the "failure of those responsible for attending to the basic needs and comforts of ... dependent adults." (*Delaney v. Baker* (1999) 20 Cal.4th 23, 34.)

In *Carter v. Prime Healthcare* (2011) 198 Cal.App.4th 396, 406, the court identified "[three] factors that must be present for conduct to constitute neglect within the meaning of the Elder Abuse Act."

- First, the plaintiff must show that the defendant "had responsibility for meeting the basic needs of the elder or dependent adult, such as nutrition, hydration, hygiene or medical care." (*Id*. at p. 405.)

- Second, the plaintiff must show that the defendant "knew of conditions that made the elder or dependent adult unable to provide for his or her own basic needs." (*Ibid.*)
- Third, the plaintiff must show that the defendant "denied or withheld goods or services necessary to meet the elder or dependent adult's basic needs." (*Ibid.*)

Here, Plaintiffs easily satisfy all three elements.

Regarding the **first** element, the plaintiff must show that the defendant "assumed a significant measure of responsibility for attending to one or more ... basic needs that an able-bodied and fully competent adult would ordinarily be capable of managing without assistance." (*Winn v. Pioneer Medical Group, Inc.* (2016) 63 Cal.4th 148, 158.)

Prime's facility is a 24-hour custodial facility that specializes in the treatment of individuals with severe mental-health issues. (PAMF #5.) Dean was brought there on a so-called "5150" hold because he was a danger to himself. (PAMF #1, 3; Welf. & Inst. Code, § 5150, subd. (a) [providing for custodial hold of a person who presents "a danger … to himself" as "a result of a mental health disorder"].)

At the time Dean was admitted to Prime's facility, Prime knew he was suffering from visual hallucinations and auditory hallucinations that were commanding him to kill himself. (PAMF #6, 7.) Prime also knew that Dean was unable to resist his command hallucinations, and had already acted out on an auditory hallucination command to eat dog feces. (PAMF #8.)

In short, whereas a "fully competent adult would ordinarily be capable" of refraining from conscious acts of self-harm, Dean was admitted to Prime's custodial facility specifically because he could not, and therefore would not be safe from himself in the absence of acute, custodial care. (PAMF #11.) Thus, Dean can easily establish the first element of a "neglect" claim (i.e., that the defendant "had responsibility for meeting the basic needs of the elder or dependent adult").

Prime attempts several counter-arguments; all fail.

First, Prime argues it "never had any custodial relationship" with Dean. (Def. Memo. at p. 17.) But mere "admission to an acute care facility ... standing alone," is "sufficient to make [one] a dependent adult who would be entitled to the Act's protection." (*Stewart v. Superior Court* (2017) 16 Cal.App.5th 87, 102.)

1 Second, Prime implies that Dean was not a "dependent adult" because he "needed no … assistance from [Prime] beyond psychiatric support." (Def. Memo. at p. 17.) But the Elder Abuse Act expressly defines "basis needs" as the "care for ... mental health needs," and "protect[ion] from ... safety hazards." (Welf. & Inst. Code, § 15610.57, subd. (b)(1)–(2).) Thus, Prime's argument that Dean would not have needed to rely on Prime if he "were mentally healthy" only underscores Plaintiffs' point.

Third, Prime implies that Dean was not a "dependent adult" because, when he was not in the grips of a mental-health crisis, Dean was "independent" insofar as he "cooked, cleaned, drove, … bathed himself, [and] dressed himself." (Def. Memo. at p. 17.) That may be true, but it is a moot point because, again, Dean was admitted to Prime's facility because he was in the midst of a mental-health crisis in which he lacked the ability to resist powerful commands inside his brain to harm himself. (PAMF #1, 3, 6, 7, 8, 11.)

For the **second** element of a "neglect" claim, Plaintiffs must show that Prime "knew of conditions that made the elder or dependent adult unable to provide for his or her own basic needs." (*Carter*, *supra*, 198 Cal.App.4th at p. 405.)

As a custodial facility specializing in mental-health disorders (PAMF #5), Prime knew that those suffering from mental-health disorders are at an increased risk of self-harm as a general matter. (PAMF #23.) And here, Prime had ample knowledge that Dean in particular was at great risk of self-harm or suicide in the absence of adequate custodial care.

Prime knew that Dean had a history of bipolar disorder and schizoaffective disorder. (PAMF #9.) Prime knew that, on this occasion, Dean was suffering from visual hallucinations and auditory hallucinations that were commanding him to kill himself. (PAMF #6, 7.) Prime also knew that Dean was unable to resist his command hallucinations, and had already acted out on an auditory hallucination command to eat dog feces. (PAMF #8.) And Prime knew that the physician who sent Dean to Prime's facility did so specifically because Dean was at risk of self-harm and suicide if he was not placed into an acute custodial care facility where he would be unable to act out on his suicidal impulses. (PAMF #1, 3, 11.) Thus, a jury could easily find that Prime "knew of conditions that made" Dean "unable to provide for his or her own basic needs."

For the **third** element of a "neglect" claim, Plaintiffs must show that Prime "denied or withheld goods or services necessary to meet" Dean's "basic needs." (*Carter*, *supra*, 198 Cal.App.4th at p. 405.)

Here, Dean was brought to Prime's facility specifically because he was unable to restrain powerful impulses to commit acts of self-harm or suicide. (PAMF #11.) Thus, Dean's "basic need" was to be put into a position where he could not hurt himself. (PAMF #19; Welf. & Inst. Code, § 15610.57, subd. (b)(1)–(2) [defining "basic needs" as "care for ... mental health needs," and "protect[ion] from ... safety hazards"].)

Putting Dean in a position where he could not harm himself required the following goods or services:

First, regarding "goods," Dean needed to be kept in a room that was free of instrumentalities that Dean could use to hurt or kill himself. (PAMF #20, 26.)

At a minimum, this meant putting Dean in a room without the means to hang himself. (PAMF #24, 29.) According to the Joint Commission—a national entity that promulgates accreditation standards for care facilities including Prime (PAMF #21)—this meant putting Dean in a room that did not feature so-called "ligature points." (PAMF #32, 34.) Ligature points include hard-points—such as door frames, door knobs, handles, and hinges—"where a cord, rope, bedsheet, or other fabric material can be looped or tied to create a sustainable point of attachment" which can be used to hang oneself. (PAMF #25, 31–33.) To make their rooms "ligature-resistant," the Joint Commission recommends that in-patient acute psychiatric facilities like Prime use special doors and hardware in their patient rooms. (PAMF #34, 35.)

Second, Dean needed to be vigilantly monitored to ensure that he was not engaging in an act of self-harm or suicide.

Indeed, the Joint Commission advises that the risk of suicide from ligature points is amplified when a high-risk patient (like Dean) is left alone in a private room without frequent monitoring. (PAMF #24, 30.) And here, the physician who admitted Dean to Prime's facility wrote orders that Dean be monitored with direct line-of-sight every 15 minutes, 24 hours a day in order to prevent him from committing suicide. (PAMF #11.)

But Prime provided neither of the things Dean needed to fulfill his basic needs.

First, to state the obvious, Prime did *not* place Dean in a ligature-free room. (PAMF #42, 43, 46.) Whereas removing ligature points would have called for special door hinges that cannot be used to create "a sustainable point of attachment" and using special linens designed to tear under strain (PAMF #31–34, 45), Dean was found unresponsive hanging from a standard bedsheet that he had wedged between the doorframe and the bathroom door in his room. (PAMF #13–15.)

Second, Prime did not monitor Dean with line-of-sight observation every 15 minutes. The first emergency personnel who arrived at Prime's facility found that Dean was already cold to the touch, suggesting he had been hanging for quite a while. (PAMF #16.) And, indeed, the video from the surveillance camera outside Dean's room shows that before Dean's body was finally discovered, some **105 minutes** elapsed without anyone checking on him. (PAMF #63, 64.)

Despite its manifest failure to provide Dean's most basic needs—an environment where Dean, a suicidal patient, would be safe from himself—Prime argues it was not guilty of "neglect" because it provided *some* of the care Dean needed. (Def. Memo. at p. 17.) That argument rests on Prime's assumption that "[o]nly a total failure to attend to the needs of a … dependent adult is sufficient" to establish "neglect" under the Elder Abuse Act. (Def. Memo. at p. 13; see also *id*. at p. 20 ["Case law is clear that absent a complete and total abandonment of the patient, the allegations cannot rise to the level of elder or dependent adult abuse."].)

But California law expressly rejects the premise that "a care facility cannot be held liable for dependent abuse unless there is a total absence of care." (*Sababin v. Superior Court* (2006) 144 Cal.App.4th 81, 90.) To the contrary, even "[i]f some care is provided, that will not necessarily absolve a care facility of dependent abuse liability. For example, if a care facility knows it must provide a certain type of care on a daily basis but provides that care sporadically, *or is supposed to provide multiple types of care but only provides some of those types of care*, withholding of care has occurred." (*Ibid.*, italics added.)

Thus, the fact that Prime may have provided *some* of Dean's care does not absolve Prime of "neglect" for failing to provide the most important care Dean needed—diligent observation and a room free of ligature points. This should be obvious: Despite Prime providing Dean with "3 medical examinations from 3 different specialists, orders for therapy, orders for medication, labs, vital signs,

treatment plans, [and] consultation," Dean was still found hanging from a bedsheet over a traditional door in his room at Prime's facility. (PAMF #13, 14.) Clearly, then, the most critical aspects of Dean's care were neglected, and thus there is no question Prime "denied or withheld goods or services necessary to meet" Dean's "basic needs." (*Carter*, *supra*, 198 Cal.App.4th at p. 405.)

1.2 A reasonable jury could find that Prime showed a conscious disregard for patient safety.

To make a claim for "neglect," Plaintiffs must not only show that Prime denied or withheld goods or services necessary to meet Dean's basic needs; they must also show that Prime did so "with conscious disregard of the high probability of … injury." (*Carter*, *supra*, 198 Cal.App.4th at p. 405.)

To show a "conscious disregard" for the safety of others, the plaintiff must establish [1] that the defendant was aware of the probable dangerous consequences of his conduct, and [2] he willfully and deliberately failed to avoid those consequences." (*Taylor v. Superior Court* (1979) 24 Cal.3d 890.)

Ultimately, whether a defendant exhibited a conscious disregard for the safety of others "is a question of fact to be determined at trial." (*Belgen v. Superior Court* (1981) 125 Cal.App.3d 959, 964.) And here, a reasonable jury could easily find that Prime exhibited a "conscious disregard" for Dean's safety.

The **first** element requires a finding that Prime "was aware of the probable dangerous consequences of its conduct."

Here, there is ample evidence Prime was acutely aware of the probable dangerous consequences when patients like Dean are (1) left in rooms with ligature points and (2) are not closely monitored.

As an entity accredited by the Joint Commission (PAMF #21), Prime was aware since at least 2007 that ligature points presented a risk of patient suicide from numerous bulletins issued by the Joint Commission. (PAMF #40.) In those bulletins, the Joint Commission advised acute, in-patient psychiatric facilities like Prime that they "must" remove ligature points from rooms where psychiatric patients are kept. (PAMF #20, 21, 24–26, 31–35.) The stated purpose was to reduce the risk of suicide given that 75% of suicides by patients at in-patient acute care psychiatric facilities are hangings accomplished with ligature points. (PAMF #29.)

And Prime knew from first-hand experience that ligature points in patient rooms presented a significant suicide risk: In May 2015, three years before Dean's suicide, a patient attempted to hang herself in one of Prime's patient rooms using a standard bedsheet and a curtain rod. (PAMF #42.)

And Prime knew the risk of suicide from ligature points is amplified when a patient at high risk for suicide (like Dean) is left alone in a private room without frequent monitoring. (PAMF #24, 30.) Indeed, Prime had express policies recognizing the critical need to fulfill physician orders to provide line-of-sight visual monitoring (PAMF #57–59), and express policies prohibiting closed doors on psychiatric units at night. (PAMF #58.) And here Prime knew that the physician who admitted Dean to Prime's facility wrote orders that Dean be monitored with direct line-of-sight every 15 minutes, 24 hours a day specifically to prevent him from committing suicide. (PAMF #11, 56.)

Ultimately, a jury could reasonably conclude that Prime knew that suicide was a "probable dangerous consequence" of placing patients at high risk for suicide in private rooms with ligature points and leaving them unmonitored for extended periods. (PMAF #30, 47.)

The **second** element requires a finding that, despite the knowledge that its acts or omissions had a probable dangerous consequence, Prime "willfully and deliberately failed to avoid those consequences."

Here, there is ample evidence that despite knowing the probable dangerous consequences of ligature points in its patient rooms, Prime made absolutely no effort to remove them.

Indeed, the evidence shows that despite numerous bulletins and directives from the Joint Commission that patient rooms "must be ligature free" (PAMF #35), Prime had not made *any* changes to the doors or door hinges in the patient rooms at its facility since it was built in **1988**. (PAMF #44.)

Even after the near suicide in May 2015 in which a patient attempted suicide by using a bed sheet and a curtain rod (PAMF #41), Prime made no effort to remove even the most obvious ligature points from the patient rooms in its psychiatric unit. (PAMF #22.)

Thus, when Dean was admitted to Prime's facility in 2018, none of the doors in the psychiatric unit had breakaway hinges or handles. (PAMF #43.) In addition, all of the linens in the rooms in Prime's psychiatric unit were standard linens instead of breakaway linens recommended by the Joint Commission that would tear if forced to bear weight. (PAMF #45.)

Prime's willful and deliberate indifference to the hazards posed by ligature points in its patient rooms is underscored by Prime's behavior after Dean's death.

Under guidelines issued by the Joint Commission, a patient suicide—even an attempted suicide—in an acute, in-patient care facility like Prime is a so-called "sentinel event" that indicates something is amiss in the facility, and which requires a root-cause analysis to identify the problem and a solution. (PAMF #36.) According to the Joint Commission, in the case of a patient suicide in a behavioral unit, the facility should form an investigative unit comprised of managerial personnel who have the authority to make changes to the facility and/or staffing as needed to rectify the problem(s) giving rise to the suicide. (PAMF #37.) In the case of a suicide by hanging, the root-cause investigation should include an inventory of fixtures throughout the patient rooms to identify and eliminate ligature points. (PAMF #38.) But despite the foregoing requirements, Prime made no effort to remove the ligature points throughout the patient rooms in its psychiatric unit. (PAMF #48.)

In **January 2019**, yet another patient committed suicide at Prime's facility by hanging himself from a door in his room. (PAMF #49.) But even though ligature points had now resulted in two patients' deaths within an eight-month period, Prime *still* made no effort to address the problem. (PAMF #53.)

Indeed, Prime likely would have continued to ignore the obvious risk presented by the ligature points in its patient rooms had the Joint Commission not preliminary denied Prime's accreditation in March 2019 due to this very issue. The loss of Joint Commission accreditation would have effectively prevented Prime from operating by jeopardizing insurance-reimbursement money. (PAMF #54.) Of course, faced with a threat to its revenue, Prime—a for-profit entity—finally spent $50,000 to retrofit its facility with special doors and hinges to reduce ligature points. (PAMF #55.)

In short, even though Prime was well aware of the hazards posed by ligature points in patient rooms in psychiatric facilities both as a general matter (from Joint Commission bulletins and standards) and from its own first-hand experience (with attempted and completed suicides), Prime made absolutely *zero* effort to remove ligature points until the Joint Commission put Prime's profits in jeopardy.

Similarly, Prime was well aware that the danger a patient will successfully attempt suicide by hanging from a ligature point is greatly amplified any time when a patient at high risk for suicide (like Dean) is left alone in a private room without frequent monitoring. (PAMF #24, 30, #57–59.) And Prime knew that Dean in particular required direct line-of-sight monitoring every 15 minutes, 24 hours a day because he was a suicide risk. (PAMF #11, 56.) But despite that knowledge, Prime left Dean unattended in a room full of ligature points for *at least* **105 minutes**. (PAMF #63, 64.)

Ultimately, a reasonable jury could conclude that these facts demonstrate that Prime exhibited a "conscious disregard" of its psychiatric patients' safety in general, and of Dean's safety in particular.

1.3 A reasonable jury could find that Prime *itself* engaged in a conscious disregard of patient safety and/or ratified the conduct of Prime employees who did.

Under Welfare and Institutions Code section 15657, subdivision (c), an employer cannot be held liable for acts of "neglect" committed by an employee unless the plaintiff makes the showing required by Civil Code section 3294, subdivision (b). Under Civil Code section 3294, subdivision (b), "[a]n employer" may be liable for punitive damages resulting from "acts of an employee" if the employer "ratified … the wrongful conduct."

Prime argues that Plaintiffs' "neglect" claim necessarily fails because "there is no evidence to establish a triable issue of material fact as to [ratification]." (Def. Memo. at p. 21.)

There are at least three problems with that argument.

First, Prime failed to carry its threshold burden of production to show that there are no triable issues regarding ratification.

Under California law, "the party moving for summary judgment bears an initial burden of production to make a prima facie showing of the nonexistence of any triable issue of material fact." (*Aguilar*, *supra*, 25 Cal.4th at p. 850.) Only when the moving party "carries [its] burden of production" does the burden "shift" to "the opposing party … to make a prima face showing of the existence of a triable issue of material fact." (*Ibid.*; see also *Certain Underwriters at Lloyd's of London v. Superior Court* (1997) 56 Cal.App.4th 952, 956.)

And California law is clear that a moving party's conjecture that "there is no evidence to establish a triable issue of material fact" on a given issue (Def. Memo. at p. 21), is not sufficient to

fulfill its burden of production: "Summary judgment law in this state … continues to require a defendant moving for summary judgment to present evidence, and not simply point out that the plaintiff does not possess, and cannot reasonably obtain, needed evidence." (*Aguilar*, *supra*, 25 Cal.4th at p. 854, italics added; see also *Hagen v. Hickenbottom* (1995) 41 Cal.App.4th 168, 186 ["We cannot agree with those who may be understood to suggest that a moving defendant may shift the burden simply by suggesting the possibility that the plaintiff cannot prove its case."], superseded by statute on other grounds as stated in *Rice v. Clark* (2002) 28 Cal.4th 89, 96–98.) Thus, Prime's argument regarding ratification fails right out of the gate.

Second, Prime is mistaken in its assertion that there is no evidence Prime "ratified" the conscious disregard of its employees. In support of that premise, Prime argues that "[r]atification requires *advanced knowledge* of the behavior by the employer … or *authorization* of the wrongful conduct by the employer." (Def. Memo. at p. 22, italics added.)

In fact, case law holds that "an employer may be liable for an employee's act where the employer *either* authorized the tortious act *or subsequently ratified an originally unauthorized tort*." (*C.R. v. Tenet Healthcare Corp.* (2009) 169 Cal.App.4th 1094, 1110, italics added.) Ultimately, then, Prime may be held liable for its employee's "neglect" if it ratified the employee's conduct *after the fact*. (Black's Law Dict. (8th ed. 2004) p. 1290, col. 1 [defining "ratification" as "[a] person's binding adoption of an act already completed"].)

"Whether an employer has ratified an employee's conduct is generally a factual question." (*C.R.*, *supra*, 169 Cal.App.4th at p. 1110) Ratification can be inferred "where an employer fails to investigate" employee misconduct. (*C.R.*, *supra*, 169 Cal.App.4th at p. 1110.) Also, "[t]he failure to discharge an employee who has committed misconduct may be evidence of ratification." (*Ibid*.)

Here, a Prime employee (Nurse Olivar) was responsible for diligently monitoring Dean by direct line-of-sight every 15 minutes. But instead, Dean was left unattended for at least **105 minutes** (PAMF #63, 64), during which he hanged himself with a bedsheet. (PAMF #13, 14.)

In any facility that cared about patient safety, the failure to diligently monitor a patient as required by physician's direct orders and Prime's own policies—and which ultimately resulted in the patient's death—would have been grounds for *immediate* termination. (PAMF #82.) But Prime gave

Olivar a written warning. (PAMF #69.) And in her very next performance review for the time period covering Dean's death, Olivar's supervisors indicated that she "meets or exceeds" her job duties. (PAMF #71.)

But it gets worse: Because diligently discharging doctors' orders to provide line-of-sight monitoring is so critical, Prime has a written policy that its employees must document each and every time they perform a 15-minute visual wellness check. (PAMF #59.) And even though the video surveillance indisputably shows that no Prime employee checked on Dean for at least **105 minutes** before he was found hanging from a bedsheet in his room (PAMF #63, 64), Prime employees *falsified their logs* to make it appear as though they had diligently checked on Dean every 15 minutes. (PAMF #65, 67.) And while Prime *claims* that accurate medical records are of paramount importance and that it is both illegal and a terminable offense to falsify medical records (PAMF #60, 61), no Prime employees were terminated for altering Dean's medical records (PAMF #68, 70), and the records themselves were never corrected. (PAMF #66.)[3]

Of course, given that the executive-level management and the governing board participated in the "investigation" into Dean's death (PAMF #84), there are only two ways to explain Prime's failure to correct the records or to fire the employees responsible for falsifying them: Either Prime's executive-level management was so apathetic about its patients' welfare that they did not even do a cursory investigation into Dean's death, or Prime executive-level management *knew* that the records were falsified and actually condoned its employees' lack of integrity and failure to protect patient welfare. Either way, a reasonable jury could find that Prime ratified its employees' misconduct (*C.R.*, *supra*, 169 Cal.App.4th at p. 1110), and fostered an environment where the welfare of its psychiatric patients was taken lightly, thereby exposing all of them to a significantly increased risk of harm. (PAMF #72.)

But there's still more: Although Prime had **12 hours'** worth of video from the camera outside Dean's room, a high-ranking Prime administrator instructed Prime's Regional Security Manager not

[3] A staff-assignment document from the night Dean died indicates there was a staffing shortage at Prime, supporting an inference that nurses who should have otherwise been terminated were retained due to staffing issues. (PAMF #74.)

to preserve the entire footage (PAMF #73), ostensibly because it portrayed Prime in an even worse light than the footage Prime *did* produce in this case.

In short, consistent with the adage that the cover-up is worse than the crime, a jury could easily find that Prime ratified its employees' conscious disregard of Dean's safety by failing to perform (and concealing their failure to perform) the diligent visual monitoring on which Dean's safety depended.

Third, Prime is mistaken in its assertion that to establish "neglect," Plaintiffs must necessarily show that Prime ratified an *employee's* misconduct. (Def. Memo. at p. 21.)

But under Civil Code section 3294, subdivision (b), in addition to *indirect* liability from misconduct of an employee, an employer may be held liable for punitive damages—and, thus, "neglect" under Welfare and Institutions Code section 15657—if it "was *personally* guilty of oppression, fraud, or malice." (Italics added.) Thus, if the evidence establishes that Prime engaged in conscious disregard of patient welfare *as an institution*, then Prime is liable for "neglect" (and, for that matter, punitive damages).

This concept has particular relevance here given that Dean's death was attributable to the conscious disregard of patient safety stemming from long-standing deficiencies in Prime's physical plant (i.e., the presence of numerous ligature points in Dean's room). A reasonable jury could conclude that Prime's failure to make any effort to address ligature points in its patient rooms between 1988 and 2019 despite the well-known risks to patient safety posed by those ligature points (PAMF #20, 21, 24–26, 29, 31–35, 40, 42, 45), was an *institutional decision*, and thus reflects Prime's *personal* misconduct.

Here it is notable that the decision to spend $50,000 to ultimately retrofit Prime's facility with special hardware to reduce/remove ligature points was approved by the Chief Financial Officer. (PAMF #55.) It thus follows that the failure to implement those measures earlier was the fault of Prime's officers and directors themselves, not low-level employees. Indeed, Prime's Chief Nursing Officer and Chief Executive Officer both conceded that they were required them to stay current on all Joint Commission standards, and both claimed that they did so. (PAMF #40.) And yet, neither one had instructed Prime's "Safety Officer" to remove ligature points until the Joint Commission denied Prime's accreditation in March 2019. (PAMF #48–50.)

Of course, even if Plaintiffs need to show that Prime ratified the failure to remove ligature points, they can do so: Following the attempted suicide from hanging in 2015, Dean's suicide in 2018, and the suicide from hanging in 2019, Prime's leadership never undertook efforts to assess ligature points in patient rooms with revised ligature-reduction policies or employee training. (PAMF #49–51.) Of course, the failure of corporate leadership to investigate and rectify an obvious safety risk is itself evidence of ratification. (*C.R.*, *supra*, 169 Cal.App.4th at p. 1110.) And the evidence shows that Prime's leadership still would have continued to ignore the obvious risk presented by the ligature points in its patient rooms but for the fact that, in March 2019, the Joint Commission suspended Prime's accreditation until Prime agreed to address the problem. (PAMF #53.)

In short, whether through ratification of egregious employee misconduct reflecting a conscious disregard for patient safety, or Prime's own institutional disregard for patient safety, a jury could find that Prime itself is liable for "neglect" (and, for that matter, punitive damages).

1.4 A reasonable jury could find that Prime's misconduct caused Dean's death.

Prime next argues that its "acts or omissions did not cause … [Dean]'s death." (Def. Memo. at p. 21.)

Causation is a highly fact-intensive issue that typically "cannot be resolved by summary judgment." (*Lawrence v. La Jolla Beach & Tennis Club, Inc.* (2014) 231 Cal.App.4th 11, 33.)

Prime's brief discussion of causation appears to raise two counter-arguments. Both fail.

First, Prime seems to suggest that because Dean killed himself, Prime is somehow absolved of any liability for Dean's death. (Def. Memo. at p. 21 ["It is without dispute that Decedent took his own life and was the actual cause of his own death."].)

But "[i]f the likelihood that a … person may act in a particular manner is the hazard or one of the hazards which makes the actor negligent, such an act whether innocent, negligent, intentionally tortious, or criminal does not prevent the actor from being liable for harm caused thereby." (*Bigbee v. Pacific Tel. & Tel. Co.* (1983) 34 Cal.3d 49, 58, quoting Rest.2d Torts, § 449.) Here, the very reason a physician put Dean in Prime's custody was the expectation that Prime would fulfill a duty of custodial care to prevent Dean from killing himself. Thus, the fact that Dean took his own life while in Prime's custody is precisely the reason to hold Prime liable, not a reason to absolve it.

Second, Prime asserts that a "suicide can occur in a matter of minutes." (Def. Memo. at p. 21.) Presumably, this is to suggest that even if Prime had performed the requisite 15-minute checks, Dean might have still succeeded in committed suicide.

But whether it took Dean 20 minutes to hang himself or only a few, the fact remains that he hanged himself. And Dean was only able to do so because Prime's rooms were egregiously substandard insofar as they featured ligature points that could easily be used for that purpose. By contrast, had Prime taken care to remove ligature points from its rooms, Dean would probably still be alive today.

2. Plaintiffs have a viable claim for punitive damages.

Prime also argues that Plaintiffs' prayer for punitive damages must be struck because "there are no facts that show [Prime] is guilty of oppression, fraud, or malice." (Def. Memo. at p. 23.)

But "a conscious disregard for the safety of others may constitute the malice required to sustain a claim for punitive damages." (*Belgen*, *supra*, 125 Cal.App.3d at p. 962.) And as explained above regarding Plaintiffs' "neglect" claim, a reasonable jury could find that Prime itself engaged in a conscious disregard of patient safety, or ratified the conduct of Prime employees who did. Accordingly, a reasonable jury could find Prime liable for punitive damages.

3. The motion for summary adjudication should be denied as to Prime Healthcare Management, Inc. and Prime Healthcare Services, Inc.

Prime's motion for summary adjudication was originally filed February 26, 2020. "Prime Health Care Paradise Valley, LLC" was the sole moving party in those papers.

On November 13, 2020—just a week before Plaintiffs' opposition was due—Prime then filed an "amended" motion for summary adjudication. This time, two additional Prime entity-defendants were listed as moving parties: "Prime Healthcare Management, Inc." and "Prime Healthcare Services, Inc."

But there are three fundamental problems with treating Prime Healthcare Management, Inc. and Prime Healthcare Services, Inc. as moving parties here:

First, the amended notice of motion and motion was not timely. A notice of a motion for summary adjudication must "be served … at least **75 days** before the time appointed for hearing."

(Code Civ. Proc., § 437c, subd. (a)(2), (f)(2), boldface added.) The hearing on the motion for summary adjudication is December 4, 2020. But the amended notice of motion and motion was served on November 13, 2020, only **21 days** beforehand. This late service was prejudicial, too, insofar as it came just **seven days** before Plaintiffs' opposition to the pending motion for summary adjudication was due.

Second, there are no allegations specific to either Prime Healthcare Management, Inc., or Prime Healthcare Services, Inc., in the operative separate statement (which remains as it was originally filed in February 2020). This is fatal to a summary adjudication as to both entities because the law requires that "[e]ach moving party shall support their motion for summary judgment with a separate statement." (*Frazee v. Seely* (2002) 95 Cal.App.4th 627, 636.)

Third, no Defendant (neither the original "Prime" or the newcomers) submitted additional evidence that might shed light on the liability of either of the new Prime entities. Accordingly, neither Prime Healthcare Management, Inc., nor Prime Healthcare Services, Inc., has even attempted—much less succeeded—in meeting their burdens of production.

Of course, to the extent the liability of Prime Healthcare Management, Inc., and Prime Healthcare Services, Inc., is coterminous with that of Prime Healthcare Paradise Valley, LLC, the motion for summary adjudication can be denied on *substantive* grounds as to Prime Healthcare Management, Inc., and Prime Healthcare Services, Inc., for the same reasons the motion should be denied as to Prime Healthcare Paradise Valley, LLC.

But to the extent Defendants intend to argue on reply that the liability analysis differs as to Prime Healthcare Management, Inc., and Prime Healthcare Services, Inc., from that of Prime Healthcare Paradise Valley, LLC, this Court should deny the motion for summary adjudication as to Prime Healthcare Management, Inc., and Prime Healthcare Services, Inc., on one or more of the three *procedural* grounds set forth above.

CONCLUSION

For the foregoing reasons, Plaintiffs urge this Court to **deny** Defendants' motion for summary adjudication in its entirety.

Dated: November 20, 2020 Respectfully submitted:

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