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**NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS**



IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FOUR

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| SIMON D. CASTILLO,<br><br>Plaintiff and Appellant,<br><br>v.<br><br>SANTA FE HEALTHCARE, LLC, et al.,<br><br>Defendants and Respondents. | B279052<br><br>(Los Angeles County Super. Ct. No. TC027182) |

APPEAL from a judgment of the Superior Court for Los Angeles County, Brian Currey, Judge. Affirmed.

Ashton R. Watkins for Plaintiff and Appellant.

Cyndi K. Wong for Defendants and Respondents.

Plaintiff Simon D. Castillo appeals from a summary judgment entered in favor of defendants Santa Fe Healthcare, LLC, doing business as Villa Maria Elena Care Center (Villa Maria) and JPH Management, Inc. (JPH) (collectively, defendants) on Castillo's elder abuse and negligence claims. Those claims are based upon defendants' care of Castillo's mother, Eladia Daza Castillo (Decedent), while she was a resident of Villa Maria, a skilled nursing facility.

Decedent was in the care of Villa Maria because she was unable to care for herself due to dementia. She was ambulatory; she could walk (although she needed a walker or other assistance due to problems with her balance), and could wheel herself around in a wheelchair. However, because of her unsteadiness, lack of safety awareness, and dementia, she had a high risk of falling and injuring herself. Therefore, Villa Maria created a care plan to reduce her risk of falling. Despite that plan, Decedent fell three times while at Villa Maria and fractured her leg. Castillo's claims assert that either the care plan defendants developed was inadequate to protect Decedent from injury, or the care plan was adequate but defendants failed to adequately implement it. Defendants sought summary judgment on the ground that the care and services defendants rendered to Decedent were proper and in accordance with the prevailing standard of care in the community. Finding that Castillo failed to raise a disputed issue of fact, the trial court granted defendants' motion.

On appeal, Castillo contends the trial court erred by
(1) characterizing his claims as ones for medical malpractice;
(2) overruling his evidentiary objections to defendants' medical expert's

declaration; (3) finding that defendants met their burden on summary judgment; and (4) finding that Castillo failed to meet his burden in opposition to the summary judgment motion. We conclude that the trial court correctly found that Castillo's claims are based upon the provision of medical care, rather than the provision of custodial care. We also conclude that the trial court did not abuse its discretion in overruling Castillo's objections to defendants' medical expert's declaration. Finally, we conclude that, in light of defendants' admissible expert testimony that defendants' treatment of Decedent was within the applicable standard of care to a reasonable medical certainty, and Castillo's failure to provide any expert testimony (or other evidence) to the contrary, the trial court did not err in granting defendants' motion for summary judgment. Accordingly, we affirm the judgment.

## BACKGROUND

A. *The Complaint*

The original complaint was filed by Decedent on January 9, 2013; she filed the first amended complaint a month later. After she passed away (more than a year after the events at issue in this lawsuit), Castillo, as Decedent's successor-in-interest, filed the second amended complaint, which is the operative complaint.[1]

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[1] Defendants filed demurrers to both the first and second amended complaints on the ground that the claims failed because they were, in essence, insufficiently-alleged claims for professional negligence. Both demurrers were overruled (by different judges than the judge who issued the ruling at issue in this appeal).

The operative second amended complaint alleges as follows.

1. *Factual Allegations*

Decedent, who was 77 years old at the time of the incidents alleged, was transferred from Harbor UCLA Medical Center (Harbor UCLA) to Villa Maria on June 29, 2012[2] because she was unable to care for herself due to dementia. While at Harbor UCLA, doctors and/or nurses determined that Decedent needed a 24-hour bedside sitter to provide constant surveillance of Decedent because there was a significant risk that she might fall and/or injure herself. Thus, when Decedent was transferred to Villa Maria, the discharge summary stated that special precautions/safety measures were needed for her.

When Decedent was admitted to Villa Maria, her attending physician, Dr. Cadano, ordered that Decedent be placed in a supervised area, such as near a nursing station, and that she be monitored at all times once she was out of bed. Dr. Cadano also ordered that a "wander guard"[3] be placed on Decedent and that frequent visual checks be conducted.[4]

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[2] All dates are from the year 2012 unless otherwise indicated.

[3] A wander guard is a device that is placed on Alzheimer's or dementia patients to prevent them from leaving the facility or getting lost.

[4] The complaint alleged that no wander guard was placed on Decedent. But because the complaint does not allege that Decedent was injured as a result of getting lost or leaving the facility, this alleged fact is not material.

On July 22, Decedent had swelling and an abrasion on her hand, which Dr. Cadano examined. Because of her dementia, Decedent could not explain what happened to cause the injury. Villa Maria did not inform Castillo of the injury.

Three weeks later, on August 11, Decedent fell and was injured. Her medical records indicate that "the IDT"[5] recommended the following actions for Decedent's care: monitor Decedent's whereabouts with frequent visual checks; provide a mobility alarm; provide rehabilitation services; and follow-up treatment if indicated. Castillo was not notified of Decedent's fall during his visit with her on August 12. At that visit, Decedent complained of pain in her back and hips.

On August 15, Decedent was found sitting in front of her wheelchair; she told staff that she had slid from it. She was examined by a nurse, who found that she had sustained a skin tear between her middle and index fingers on her right hand. Dr. Cadano was notified, and Decedent was given appropriate treatment. To prevent this kind of incident from happening again, the IDT recommended: frequent visual checks; a mobility alarm as ordered to sound an alarm to nurses that Decedent is trying to get up from her wheelchair; and providing the wheelchair with a lap tray to prevent Decedent from standing up without assistance.

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[5] The IDT is an interdisciplinary team consisting of the director of nursing, a therapist, a member of the social services department, and the activity director.

During Castillo's visit with Decedent later that day, he noticed that Decedent was not able to walk or put weight on her left leg. Because of her dementia, Decedent could not explain to him what happened to her. When he asked staff about it, he was not given any information or explanation.

On September 8, a nurse saw that Decedent, who was in her wheelchair, was crying and holding her knee. She told the nurse that she was in a lot of pain. The nurse gave her pain medication and put her into her bed. The next morning, Decedent told the nurse that she had severe pain in her left leg; when asked what happened to cause the pain, Decedent said that she did not remember. The nurse called Dr. Cadano, who ordered X-rays of her left leg, as well as her right elbow (because there was a skin tear on her elbow and arm). The X-rays showed a nondisplaced fracture of Decedent's proximal fibula.[6] Dr. Cadano ordered that Decedent be transferred to Pacific Alliance Medical Center's (Pacific Alliance) urgent care for further evaluation. The records from Pacific Alliance indicate that Decedent was examined for fracture of the left tibia, contusion of the left [*sic*] hand and arm, and possible head trauma. The records also state that Decedent had severe pain in her left leg with swelling, and that she had suffered an acute fall injury and hit her leg against a hard object.

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[6] It appears the reference to a fracture of the fibula is a typographical error; the fracture was to Decedent's proximal tibia.

2. *The Causes of Action*

The second amended complaint alleged two causes of action, for elder abuse (i.e., violation of the Elder Abuse and Dependent Adult Civil Protection Act, Welf. & Inst. Code,[7] § 15600 et seq.), and negligence.

In his elder abuse claim, Castillo alleged that throughout Decedent's residence at Villa Maria, defendants "failed to provide the necessary medical care and protection to Decedent, [and] failed to report changes in her condition to her family." He alleged that despite Villa Maria's knowledge regarding Decedent's dementia and prior falls, "Defendants fail[ed] to ensure that a comprehensive continuing assessment of Decedent's mobility, medical and psychological conditions was done and then utilized to review, evaluate and update as necessary the plan of care and to develop effective approaches." Specifically, he alleged that defendants: "(1) failed to take the necessary precautions to protect Decedent from fall injury, and these failures caused her injury; [¶] (2) failed to provide Decedent with proper and adequate assessment and reassessment of her risk of fall injury; [¶] (3) failed to implement a medical care plan to prevent injury to Decedent; [¶] (4) failed to implement a fall prevention care plan requiring the facility to check and monitor Decedent's whereabouts at all time; [¶] (5) failed to secure Decedent with a mobility alarm for staff to be alarmed when Decedent tried to get up from [her] wheelchair unassisted; [¶] (6) failed to ensure

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[7] Further undesignated statutory references are to the Welfare and Institutions Code.

that Decedent was not left unattended for long periods of time; [¶] (7) failed to provide Decedent with a wheelchair with lap tray to prevent [her from] standing up unassisted; and [¶] (8) failed to [have] sufficiently trained staff to provide assistance to Decedent and/or did not have an adequate number of staff to provide the needed assistance."

In his negligence claim, Castillo alleged that defendants "had a duty to exercise a degree of care that a reasonable person in a like position would have exercised to protect Decedent from health and safety hazards," and identified the following specific duties: "(a) ensure that each care worker received adequate training before working with Decedent; [¶] (b) monitor, record and report changes in Decedent's health condition; [¶] (c) adequately and properly monitor and supervise Decedent's whereabouts when placed on her wheelchair; [¶] (d) adequately and properly monitor and supervise Decedent's whereabouts when once out of bed; [¶] (e) adequately and properly place Decedent in a supervised area at all times; [¶] (g) [*sic*] adequately and properly place [a] mobility alarm on Decedent for monitory and fall prevent; [¶] (f) [*sic*] adequately and properly place [a] mobility alarm on Decedent to prevent her from getting up from her wheelchair [un]assisted or unattended; [¶] (h) adequately and properly place [a] wander guard on Decedent to prevent injury or fall from occurring; [¶] (i) adequately and properly place Decedent in a wheelchair with lap tray to prevent Decedent from standing up unassisted or unattended from [her] wheelchair; [¶] (j) adequately and properly continue to monitor Decedent at all times to prevent injury or fall from occurring; [¶] (k) adequately conduct frequent visual checks

on Decedent to ensure she is [in] a safe place at all times; [¶] (l) note and properly react to emergent conditions and provide timely medical care to Decedent or otherwise act appropriately when conditions indicate; and [¶] (m) treat Decedent as an individual with respect, dignity, and without abuse."

B. *Motion for Summary Judgment*

1. *Defendants' Moving Papers*

Defendants moved for summary judgment or, in the alternative, summary adjudication.

As to the elder abuse claim, they argued (1) the fact that none of the medical practitioners who treated Decedent when she was brought to Pacific Alliance reported elder abuse or neglect, even though they are mandatory reporters, demonstrates that Castillo cannot establish elder abuse by clear and convincing evidence; (2) Castillo cannot establish that defendants, who are corporations, are liable for the alleged acts of their employees; (3) Castillo cannot establish that defendants' alleged negligence proximately caused Decedent's injury within a reasonable medical probability; and (4) Castillo cannot establish a breach of the standard of care for healthcare providers.

As to the negligence claim, defendants argued that (1) Castillo cannot establish, through expert medical testimony, that defendants breached the standard of care; and (2) Castillo cannot establish that defendants' conduct was a substantial factor in causing damages.

In support of their motion, defendants submitted, among other things, all of Decedent's medical records from Dr. Cadano, Villa Maria,

Harbor UCLA, Pacific Alliance, and Brotman Memorial Hospital Medical Center (where Decedent was treated from September 15 until September 21, when she was transferred to another skilled nursing facility). Defendants also submitted interrogatories propounded by Villa Maria and Castillo's supplemental responses to those interrogatories, as well as declarations from medical expert Dr. William Klein and Cynthia Galvez.[8]

a. *Dr. Klein's Declaration*

Because of the importance of Dr. Klein's declaration to the motion, we discuss it in detail.

Dr. Klein stated that he is a physician licensed to practice medicine in New York since 1967 and in California since 1968. He is Board-certified in internal medicine and internal medicine-pulmonary diseases. He is a clinical professor in the Department of Medicine, Chest Division, at the University of California at Irvine. He stated that he reviewed Decedent's medical records from Villa Maria, Harbor UCLA, Pacific Alliance, Brotman Medical Center, and Dr. Cadano, as well as the second amended complaint, Villa Maria's special interrogatories, and Castillo's supplemental responses to those interrogatories. Based upon his review of those documents, Dr. Klein declared the following.

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[8] Galvez is JPH's quality assurance nurse. Castillo objected to the declaration, and the trial court sustained the objection. Therefore, we do not consider or discuss the contents of that declaration.

Decedent was brought to Harbor UCLA in June 2012 for evaluation after her sole caregiver -- her daughter -- was arrested for elder abuse for allegedly hitting Decedent in the head. Decedent had a history of dementia, hypertension, arthritis, and anemia. She was transferred from Harbor UCLA to Villa Maria two weeks later, on June 29.

On the day of her admission to Villa Maria, several nursing assessments were performed and care plans were created. Among other things, it was determined that Decedent was at a high risk of falling. One of the care plans, ordered by Decedent's physician, Dr. Cadano, called for having both side rails up when Decedent was in bed to prevent her from falling out of bed. Another care plan addressed Decedent's gait imbalance, impaired cognition, and dementia. A "Physical Restraint Review" was conducted due to Decedent's poor safety awareness and statements by her that she wanted to leave the facility. Following that review, Dr. Cadano ordered that a wander guard be placed on her. A care plan was prepared with regard to Decedent's attempting to leave the facility; it called for frequent visual checks of Decedent, placing her in a supervised area, monitoring her whereabouts, assisting her in attending activities, and encouraging her to stay in the activity room.

As of July 1, a wander guard was in place, and Decedent was being monitored for her whereabouts. On July 10, it was determined that a care plan regarding falls was needed because Decedent was at risk for falling and injuring herself. The care plan was created on July 13. Because Decedent was noted to be getting up from her wheelchair

unassisted, a physician order was issued for a self-release seat belt for Decedent's wheelchair. Thereafter, a soft belt restraining device was installed. The care plan also called for monitoring Decedent closely for any changes in condition and to keep her comfortable.

On July 22, a change in condition assessment was prepared after Decedent's right hand was found to be swollen; Decedent was confused and did not know what had happened or why her hand was swollen. Dr. Cadano ordered an X-ray of her hand, and a care plan was created in which it was recognized that Decedent was at a high risk of spontaneous/pathological fractures due to osteoporosis.[9]

On August 11, Decedent was found sitting on the floor near her wheelchair. When she was asked what happened, Decedent said that she had been wheeling herself around, but then decided to remove her self-release belt and walk back into her room; she lost her balance or footing and fell. She said she did not hit anything, and she did not complain of pain. A complete body check was performed, and she was found to have a complete range of motion without pain. Dr. Cadano was notified. He ordered 72-hour neurologic checks and checks for vomiting or change in level of consciousness, and ordered the use of a "tab alarm" when Decedent was in a wheelchair.[10] The ordered checks

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[9] The final report from that X-ray, which is included in Villa Maria's records submitted in support of the summary judgment motion, states that there was no fracture or dislocation shown; instead, the X-ray showed mild degenerative disease.

[10] A tab alarm is attached to a patient's wheelchair and sounds an alarm when the patient leaves the wheelchair.

were performed without any negative finding or negative change in condition. A fall risk assessment was performed, and Decedent was deemed to be a high risk for falling. An IDT meeting was held to address the August 11 incident. The IDT recommended several actions, including monitoring Decedent's whereabouts, conducting frequent visual checks, and use of a mobility alarm for monitoring and fall prevention, as well as measures to try to lessen Decedent's restlessness.

On August 12, Decedent was assessed for ambulation and was found to be able to tolerate ambulation with hand-held assist utilizing a front wheel walker. On August 13, Dr. Cadano issued a new order for a tab alarm when Decedent was in her wheelchair; that order was carried out by staff.

Two days later, on August 15, Decedent was again found sitting on the floor. She said that she had slid down onto the floor from her wheelchair. A body check was performed, and a skin tear was found on her right middle finger. Dr. Cadano was notified, but no new orders were given. Another fall risk assessment was performed, and Decedent again was found to be at high risk for falling. An IDT meeting was held regarding the latest incident, at which the IDT recommended frequent visual checks, a mobility alarm as ordered, provision of a wheelchair with a lap tray, and continued monitoring.

A progress note dated August 17 indicated that a tab alarm was still in place, and that Decedent denied any pain or discomfort. Two days later, Decedent was assessed for ambulation and was found to be able to tolerate ambulation utilizing a front wheel walker, with no sign of pain; the same findings were made in another assessment a week

later. She was examined on August 31 by Dr. Cadano, who noted that she was doing well; he did not issue any new orders.

At 4:00 p.m. on the afternoon of September 6, Decedent was in a wheelchair with the self-release belt in place. She was observed to be agitated, and was removing her restraint and getting out of her wheelchair unassisted. Staff continued to monitor her, and she continued to be agitated and to be taking off her restraint and getting out of the wheelchair unassisted. At 8:00 p.m., she was in her wheelchair in her room when a certified nursing assistant (CNA) observed her removing her restraint and trying to walk away. The CNA tried assisting her back to her wheelchair, and asked another CNA for assistance. Decedent became more agitated, and started scratching them, cursing and screaming at them, and biting them because she did not want to go back to her wheelchair. Once she was returned to her wheelchair she started biting and scratching herself, drawing blood. She was brought to the charge nurse, who administered first aid despite Decedent's resistance. Later, when the charge nurse handed Decedent her evening medications, Decedent threw the cup, spilling out all of the medications.

Two days later, a CNA observed that Decedent was roaming around the facility. After dinner, the CNA moved Decedent to the nurse's station for her medication, but she refused to take it. She was taken to her room for changing, but was uncooperative and starting yelling, cursing, and pushing; the charge nurse had to come in to assist. She did not want to go to bed, so she was put in her wheelchair near the footboard of the bed. At 11:00 p.m., she complained to the CNA that her

knee hurt. The CNA alerted a nurse, who transferred Decedent to the bed and assessed her left knee; the nurse found no bruises or swelling. She was given Tylenol as ordered, and slept through the night.

At about 7:30 a.m. the next morning, a nursing assessment was performed; Decedent complaint of significant left knee pain, but there were no signs of bruising or swelling. When asked what happened, Decedent said that she could not remember but she might have hit her knee. She was given Tylenol for her pain, but the medication was found ineffective an hour later, so Dr. Cadano was called; he ordered an X-ray of her left leg. The X-rays were taken and Dr. Cadano was informed of the results. Upon receiving the results, Dr. Cadano ordered Decedent transferred to Pacific Alliance, an acute care facility.

When she arrived at Pacific Alliance, Decedent was examined by a physician, who noted that she had an acute left tibia fracture and abdominal pain. When she was admitted, an "abuse/neglect screen" was performed and found to be negative. She was discharged from Pacific Alliance on September 13 and transferred to Century Villa Skilled Nursing Center (Century Villa). She was transferred back to Pacific Alliance the following day due to disorientation and repeated attempts to get out of bed. She returned to Century Villa the next day, but was immediately transferred to Brotman Memorial Medical Center.

Based upon his review of Decedent's medical records, as well as his background, training, education, and clinical experience, Dr. Klein opined that, to a reasonable medical probability, (1) Villa Maria rendered health care services to Decedent in accordance with the prevailing standard in the community and provided proper care to

Decedent; (2) the care and services that Villa Maria staff and personnel rendered to Decedent, including the monitoring of Decedent, was not a substantial factor in causing or contributing to any injuries suffered by Decedent or to her death; (3) Villa Maria did not neglect the safety and well-being of Decedent; (4) Villa Maria did not neglect or physically abuse Decedent; (5) Villa Maria did not fail to follow, implement, and/or adhere to physician orders pertaining to the care and treatment of Decedent;[11] (6) Villa Maria did not fail to establish and implement a proper care plan(s) for Decedent; (7) Villa Maria did not fail to report to Dr. Cadano Decedent's medical status and any changes in that status; (8) at no time was Villa Maria's conduct careless, reckless, and/or in wanton disregard of Decedent's rights and safety, nor was Decedent physically abused; (9) Villa Maria did not ignore or otherwise neglect Decedent relative to her physical and mental health needs; and (10) Villa Maria did not subject Decedent to physical and/or mental abuse, nor did Villa Maria fail to treat Decedent with consideration, respect, and full recognition of dignity in caring for her personal needs.

b. *Villa Maria Medical Records*

Decedent's medical records from Villa Maria include the care plans and assessments discussed by Dr. Klein, as well as nurses' notes and progress reports showing that those plans were implemented.

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[11] Dr. Klein noted that although the IDT recommended providing a wheelchair with a lap tray, it was not ordered by a physician, which is required for restraints.

For example, the notes indicate that the wander guard had been placed as of July 1, and a lap belt was installed on Decedent's wheelchair no later than July 16.

The medical records also show that after Decedent removed her lap belt and fell when she tried to walk away from her wheelchair on August 11, Villa Maria received a physician order for a tab alarm. That order was received on August 13 and was carried out that same day.

The nurses' notes indicate that the tab alarm was in place on August 14, and on August 15, the day of her second fall. Notes from subsequent days also indicate that the tab alarm was in place. There also are several notes in which it was observed that Decedent kept removing her lap belt and tab alarm and trying to get up from her wheelchair.

Finally, Villa Maria's records show that personnel conducted frequent visual checks, monitoring, and assessments. Those assessments included ambulation assessments. In light of Castillo's allegation in the complaint that when he visited Decedent after her second fall she was not able to walk or put any weight on her left leg, we observe that all of the ambulation assessments that were carried out both before and after Decedent's falls on August 11 and August 15 state that Decedent was able to walk using a front wheel walker, with no sign of pain.[12]

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[12] As noted below, Castillo did not submit any evidence to support his allegation.

2. *Castillo's Opposition*

a. *Evidence*

The evidence Castillo submitted in opposition to defendants' summary judgment motion primarily consisted of certain pages from Decedent's medical records[13] and portions of the transcript from the deposition of Lorna Del Rosario.[14] Those deposition excerpts do not include any testimony about Del Rosario's background, expertise, or even her relationship with the events at issue, although it can be inferred from some of the questions she was asked that she was the director of nursing at Villa Maria during the time Decedent was a resident there.

In most of the submitted testimony, Del Rosario testified that she could not remember the events or did not know the answer to the

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[13] The documents submitted were: (1) a care plan and a fall risk management document prepared on Decedent's day of admission to Villa Maria; (2) a change in condition assessment and notes from the IDT meeting regarding Decedent's fall on August 11; (3) a change in condition assessment and notes from the IDT meeting regarding Decedent's fall on August 15; (4) the final reports for the X-rays taken on July 22 and September 9; (5) a change in condition assessment and transfer report from September 9, the day Decedent was transferred to Pacific Alliance; (6) three reports from Pacific Alliance; (7) a "Restorative Nursing Weekly Summary" from the week in August during which Decedent fell twice; and (8) a change in condition assessment from July 22.

[14] Castillo did not submit a declaration or testimony setting forth his observations regarding the care Decedent received, or his observations of Decedent while she was in the care of Villa Maria, including observations that are alleged in the complaint.

questions asked. The most potentially relevant testimony consisted of two exchanges.

In the first exchange, Del Rosario was asked whether anyone informed the staff at Villa Maria that they were to be making frequent visual checks on Decedent after her fall on August 11. Del Rosario responded that she could not remember. She then was asked, "whose responsibility would it have been to do that?" She responded, "As far as I know, it should be CNA and charge nurses." Counsel then asked, "So they failed to do that on this day of the fall, correct?" Following an objection, Del Rosario responded, "Yes."

The second exchange is somewhat ambiguous; therefore, we quote it in full:

"Q. Would you agree that Ms. Castillo was not protected from an avoidable injury when she fell on August 11th?

"[Defense counsel]: Same objections. Also assumes facts not in evidence. Same instruction [i.e., instruction not to answer].

"Q. Do you agree with that, ma'am?

"A. Yes.

"[Defense counsel]: Same objections; same instruction.

"Q. Do you agree with that, ma'am?

"A. Yes.

"[Defense counsel]: Same -- I'm instructing you not to answer. Don't answer his question. He's asking you an expert witness opinion.

"[Plaintiff's counsel]: She's already answered the question, and it's not an expert witness question.

"[Defense counsel]: I beg to differ.

"Q. Would you agree that Ms. Castillo was not protected from avoidable injury when she fell on . . . [The next page in the deposition was not included in the portion submitted by Castillo.]"

b. *Argument*[15]

Castillo argued that summary judgment could not be granted because "[t]he undisputed record is replete with example after example of how the Defendants consistently failed to exercise the degree of care applicable to Skilled Nursing Facilities for the Elderly . . . as defined by Title 22 Regulations. . . . [¶] In addition, the testimony of Defendant's Director of Nursing, Ms. Del Rosario, and accompanying documentary evidence clearly exhibits that Defendants recklessly failed to prevent Decedent from suffering at least three preventable falls, repeatedly failed to protect her from health and safety hazards, repeatedly failed to properly assess and reassess Decedent, and repeatedly failed to provide adequate and proper care to Decedent, resulting in her serious injuries." In support of this argument, Castillo cited to the testimony quoted above and other testimony in which Del Rosario said that she could not remember or did not know in response to questions about whether assessments were made or precautions were taken (which Castillo generally interpreted to mean that the assessments were not made or

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[15] Our discussion of Castillo's argument is limited to the portion of the argument contained in the first 20 pages of his opposition brief. Castillo's opposition brief exceeded the page limitation by five pages, and the trial court declined to consider the final five pages. Castillo does not challenge that portion of the trial court's ruling on appeal.

the precautions were not taken), and to the medical records related to Decedent's falls and fall risk assessments.

In addition, Castillo argued that defendants' assertion that his claims were for professional negligence was incorrect and had been rejected by previous judges in overruling defendants' demurrers to the first and second amended complaint. Rather, he contended that "[t]his is a classic elder abuse and neglect case . . . and one of the more egregious examples of a Skilled Nursing Facility . . . covering up mistakes."

Finally, Castillo argued that defendants were liable for the acts of their employees because they are a licensed facility, and therefore liable for the acts of their agents, and because they ratified their employees' acts by failing to discharge those employees who committed the allegedly wrongful act. There are, however, no citations to any evidence in the portion of this argument that was considered by the trial court (see fn. 11, *ante*).

c. *Separate Statement*

In defendants' separate statement in support of their motion, virtually all of the material facts are supported by citation to Dr. Klein's declaration. Castillo filed written objections to Dr. Klein's declaration on the ground that he was not qualified to render the expert opinions he provided, and asserted those objections in his separate statement. Castillo also purported to dispute most of the material facts with an extended summary of his contentions of neglect and/or abuse, supported by citations to Del Rosario's deposition testimony and unexplained

citations to the portions of Decedent's medical records that he submitted.[16]

3. *Trial Court's Ruling*

The trial court overruled Castillo's objections to Dr. Klein's declaration and granted defendants' summary judgment motion. The court noted that defendants' motion was based upon their contention that the nursing and non-physician employees at Villa Maria complied with the applicable standard of care with respect to their provision of medical care, treatment, and services to Decedent, and that no act or failure to act by Villa Maria caused Decedent's injuries. It found that Dr. Klein's declaration and Decedent's medical records were sufficient to meet defendants' initial burden in moving for summary judgment.

Addressing Castillo's opposition, the court noted that Castillo argued that "the record 'is replete with example after example of how the Defendants consistently failed to exercise the degree of care applicable to Skilled Nursing Facilities for the Elderly,'" and provided some examples, with citations to Del Rosario's deposition testimony. The court observed, however, that "[n]otably absent from Plaintiff's Opposition papers . . . is a physician expert declaration supporting Plaintiff's contention that Defendants breached their duty of care in treating Decedent." It found that Castillo's "reliance on the seemingly

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[16] This summary was almost 13 pages long, and was repeated in response to a majority of the material facts asserted by defendants, turning defendants' 20-page separate statement into a 219-page response.

inconsistent statements made by Defendants' PMK Lorna Del Rosario during her deposition is insufficient [to rebut the opinions proffered by Dr. Klein]; Plaintiff has not attached any testimony from Ms. Rosario's deposition that would establish Ms. Rosario's qualifications to opine on the quality of treatment provided by Defendants and, in any event, the Court has not found any express opinion by Ms. Rosario that Villa Maria failed to comply with the applicable standard of care and/or that such failure caused Decedent's injuries."

The trial court concluded: "As Plaintiff has failed to provide any expert evidence in response to the Klein Declaration, the Court finds that Plaintiff has failed to meet his burden of proof in establishing a triable issue on breach of any duty owed by Defendants to Decedent in connection with the medical services provided to Decedent, or that any purported breach of duty caused Decedent's damages."

Judgment was entered in favor of defendants, from which Castillo timely filed a notice of appeal.

## DISCUSSION

A. *Characterization of Castillo's Claims*

Castillo contends the trial court erred by characterizing his claims for elder abuse and negligence as medical malpractice claims. He asserts that he "is not claiming that a medical provider failed to exercise knowledge, skill and care in delivering medical services to Ms. Castillo." Instead, he asserts that his "lawsuit refers to Defendants' duty to provide for M[s]. Castillo's basic needs and comforts and their failure to carry out their custodial obligations."

In making this argument, Castillo relies upon *Delaney v. Baker* (1999) 20 Cal.4th 23 (*Delaney*), in which the Supreme Court discussed the difference between the conduct proscribed by the Elder Abuse and Dependent Adult Civil Protection Act (§ 15600 et seq., hereafter the Act) -- i.e., neglect -- and professional negligence, which is excluded from the Act (§ 15657.2). The Supreme Court explained that neglect as used in the Act "does not refer to the performance of medical services in a manner inferior to "'the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing'" [citation], but rather to the failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults, regardless of their professional standing, to carry out their custodial obligations." (*Delaney*, *supra*, 20 Cal.4th at p. 34.) As the Supreme Court explained in a subsequent case, "the statutory definition of 'neglect' speaks not of the *undertaking* of medical services, but of the failure to *provide* medical care." (*Covenant Care, Inc. v. Superior Court* (2004) 32 Cal.4th 771, 783.)[17]

The appellate court in *Carter v. Prime Healthcare Paradise Valley LLC* (2011) 198 Cal.App.4th 396 (*Carter*), provided the following review of cases showing the kind of conduct that constitutes neglect under the Act:

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[17] We note that throughout his appellant's opening brief Castillo treats his two causes of action -- for elder abuse and negligence -- as essentially the same. He makes no separate argument regarding his negligence claim.

"--A skilled nursing facility (1) failed to provide an elderly man suffering from Parkinson's disease with sufficient food and water and necessary medication; (2) left him unattended and unassisted for long periods of time; (3) left him in his own excrement so that ulcers exposing muscle and bone became infected; and (4) misrepresented and failed to inform his children of his true condition. [Citation.]

"--An 88-year-old woman with a broken ankle 'was frequently left lying in her own urine and feces for extended periods of time' and she developed pressure ulcers on her ankles, feet and buttocks that exposed bone, 'despite plaintiff's persistent complaints to nursing staff, administration, and finally, to a nursing home ombudsman.' [Citation.]

"--A facility caring for a dependent adult with a known condition causing progressive dementia, requiring nutrition and hydration through a gastrostomy tube, and subjecting her to skin deterioration, ignored a medical care plan requiring the facility to check the dependent adult's skin on a daily basis and failed to notify a physician when pressure ulcers and other skin lesions developed. [Citation.]

"--A 78-year-old man admitted to a skilled nursing facility 'was abused, beaten, unlawfully restrained, and denied medical treatment.' [Citation.]

"--The staff of a nursing home (1) failed to assist a 90-year-old, blind and demented woman with eating; (2) used physical and chemical restraints to punish the elder and prevent her from

obtaining help; and (3) physically and emotionally abused the elder by bruising her, 'withholding food and water, screaming at her, and threatening her.' [Citation.]

"--A skilled nursing facility (1) failed to provide adequate pressure relief to a 76-year-old woman with severe pain in her left leg and identified as at high risk for developing pressure ulcers; (2) dropped the patient; (3) left 'her in filthy and unsanitary conditions'; and (4) failed to provide her the proper diet, monitor food intake and assist her with eating. [Citation.]

"--A physician 'conceal[ed] the existence of a serious bedsore on a nursing home patient under his care, oppose[d] her hospitalization where circumstances indicate[d] it [was] medically necessary, and then abandon[ed] the patient in her dying hour of need.' [Citation.]" (*Carter*, *supra*, 198 Cal.App.4th at pp. 405-406.)

Based upon these cases and the provisions of the Act, the *Carter* court distilled the "factors that must be present for conduct to constitute neglect within the meaning of the Elder Abuse Act [as opposed to simple professional negligence] and thereby trigger the enhanced remedies available under the Act. The plaintiff must allege (and ultimately prove by clear and convincing evidence) facts establishing that the defendant (1) had responsibility for meeting the basic needs of the elder or dependent adult, such as nutrition, hydration, hygiene or medical care [citations]; (2) knew of conditions that made the elder or dependent adult unable to provide for his or her own basic needs [citations]; and (3) denied or withheld goods or services necessary to

meet the elder or dependent adult's basic needs, either with knowledge that injury was substantially certain to befall the elder or dependent adult (if the plaintiff alleges oppression, fraud or malice) or with conscious disregard of the high probability of such injury (if the plaintiff alleges recklessness) [citations]. The plaintiff must also allege (and ultimately prove by clear and convincing evidence) that the neglect caused the elder or dependent adult to suffer physical harm, pain or mental suffering." (*Carter*, *supra*, 198 Cal.App.4th at pp. 406-407.)

In the present case, the allegations of the complaint appear at first glance to assert a *failure* to provide medical services, which would fall under the Supreme Court's definition of "neglect" under the Act. (See *Covenant Care, Inc. v. Superior Court*, *supra*, 32 Cal.4th at p. 783.) For example, Castillo alleges that defendants "failed to provide the necessary medical care and protection to Decedent, [and] failed to report changes in her condition to her family," and gives specific examples of such alleged failures. But when examined more closely -- especially in light of Castillo's arguments and the evidence he relied upon in opposition to the summary judgment motion -- it becomes clear that what Castillo is, in fact, alleging is that defendants' professional assessments and decisions were inadequate or incorrect, and/or that the plans made to address Decedent's medical conditions were not properly carried out.

In essence, Castillo argues that not enough was done to prevent Decedent from falling and injuring herself while she was a resident at Villa Maria. But the determination of what was necessary to protect Decedent from falling and injuring herself required a *medical*

assessment of all of her medical issues -- not only her dementia, but also her osteoporosis, which put her at high risk of spontaneous/pathological fractures -- and development of a medical care plan, with orders from a physician if it was determined that any kind of restraints were needed. Thus, the inescapable conclusion is that Castillo's claims rest on allegations that the medical assessments and plans were inadequate (i.e., below the relevant standard of professional care), and/or that the medical services provided pursuant to those medical assessments and plans were below the relevant standard of professional care.

Indeed, Castillo's detailed summary of his claims of neglect and abuse that is found in his separate statement in opposition to the summary judgment motion, as well as his argument in his memorandum of point and authorities, confirms that his claims assert negligent performance of professional services rather than a failure to provide such services. The summary begins with the following statement: "Because VILLA MARIA did not *properly assess* and identify Decedent's needs, they did not generate and implement an *adequate* plan of care to meet those needs." (Italics added.) The summary goes on to discuss two "documented falls" and a third "undocumented" fall that Decedent suffered, which Castillo attributes to the inadequate plan or inadequate implementation of the plan. Similarly, in his memorandum of points and authorities, Castillo asserted that the "record is replete with example after example of how the Defendants consistently failed to exercise the degree of care applicable to Skilled Nursing Facilities for the Elderly," and that the record showed that defendants "repeatedly failed to properly assess and

reassess Decedent, and repeatedly failed to provide adequate and proper care to Decedent."

In light of Castillo's own arguments, which focus on the alleged inadequacy of the professional assessments, decisions, and plans to address Decedent's medical conditions, and the inadequate provision of services in carrying out those plans, we find that the trial court properly concluded that Castillo's claims allege negligence in the provision of medical services to Decedent.

B. *Objections to Dr. Klein's Declaration*

Castillo contends the trial court erred by overruling his objection to Dr. Klein's declaration. He argues that Dr. Klein was not qualified to give an expert opinion in this case because he "does not have any special knowledge, skill, experience, training or education relating to the operation of skilled nursing facilities" and he failed to demonstrate how he is familiar with the standard of care for skilled nursing facilities. We find no error.

"We are required to uphold the trial judge's ruling on the question of an expert's qualifications absent an abuse of discretion. [Citation.] Such abuse of discretion will be found only where '"the evidence shows that a witness clearly lacks qualification as an expert."'" (*People v. Chavez* (1985) 39 Cal.3d 823, 828.) "It is not critical whether a medical expert is a specialist. [Citation.] 'Where a duly licensed and practicing physician has gained knowledge of the standard of care applicable to a specialty in which he is not directly engaged but as to which he has an opinion based on education, experience, observation or association with

that specialty, his opinion is competent. [Citation.]' [Citation.] Thus, 'it is immaterial whether [an expert] is a . . . specialist providing he has knowledge of the standard of care in any given field.' [Citation.]" (*Fett v. Med. Bd. of California* (2016) 245 Cal.App.4th 211, 222.)

In this case, Dr. Klein stated in his declaration that he has been licensed to practice medicine since 1967, and is Board-certified in internal medicine and in internal medicine-pulmonary diseases. He also declared that he is "very familiar with the standard of care for the care and treatment of patients with conditions similar to that of [Decedent]." Whether Dr. Klein has specific experience with the care and treatment of patients while they are residents in skilled nursing facilities is not dispositive, as there is no suggestion that the medical care and treatment of patients with conditions similar to Decedent's varies depending upon where the patient resides. Certainly, Castillo did not produce any evidence, such as testimony from a medical professional, that the standard of care for patients with dementia and osteoporosis who reside in skilled nursing facilities is different than for those patients who reside elsewhere. Nor did Castillo produce any evidence that a physician with 50 years of experience in internal medicine does not have the expertise necessary to determine whether the medical assessments of and care provided to Decedent met the standard of professional care for patients with the medical issues affecting Decedent.

Based upon the evidence before the trial court, we cannot say that Dr. Klein clearly lacks the qualifications to provide expert testimony on the appropriate standard of care for the care and treatment of

Decedent. Therefore, we conclude the trial court did not abuse its discretion by overruling Castillo's objection to Dr. Klein's declaration.

C. *Defendants' Burden on Summary Judgment*

a. *Summary Judgment Law*

In determining a motion for summary judgment and on review of that judgment, both the trial court and the appellate court engage in the same three-step process. "'Because summary judgment is defined by the material allegations in the pleadings, we first look to the pleadings to identify the elements of the causes of action for which relief is sought.' [Citation.] [¶] 'We then examine the moving party's motion, including the evidence offered in support of the motion.' [Citation.] A defendant moving for summary judgment has the initial burden of showing that a cause of action lacks merit because one or more elements of the cause of action cannot be established or there is a complete defense to that cause of action. [Citations.] [¶] If the defendant fails to make this initial showing, it is unnecessary to examine the plaintiff's opposing evidence and the motion must be denied. However, if the moving papers make a prima facie showing that justifies a judgment in the defendant's favor, the burden shifts to the plaintiff to make a prima facie showing of the existence of a triable issue of material fact." (*Dollinger DeAnza Associates v. Chicago Title Ins. Co.* (2011) 199 Cal.App.4th 1132, 1144.)

"Although our review of a summary judgment is de novo, it is limited to issues which have been adequately raised and supported in [the appellant's] brief. [Citations.] Issues not raised in an appellant's

brief are deemed waived or abandoned." (*Reyes v. Kosha* (1998) 65 Cal.App.4th 451, 466, fn. 6.)

b. *Castillo's Contentions*

Castillo contends the trial court erred in finding that defendants satisfied their initial burden on summary judgment because (1) Dr. Klein was not qualified to give expert opinion testimony; (2) defendants failed to offer any evidence regarding whether defendants' conduct met the standard of care under title 22 of the California Code of Regulations; and (3) defendants did not submit any admissible evidence regarding JPH's liability.[18] None of these contentions prevail.

As discussed in section B., *ante*, the trial court overruled Castillo's objection that Dr. Klein was not qualified to render expert opinions in this case. We find there was no abuse of discretion in the court's ruling, and that Dr. Klein established his qualifications to testify as to whether the care and treatment provided to Decedent met the applicable standard of care.

With regard to Castillo's second contention regarding defendants' failure to offer evidence related to title 22 of the California Code of Regulations (the title 22 regulations), that failure was not fatal to their summary judgment motion. As noted, "'summary judgment is defined by the material allegations in the pleadings.'" (*Dollinger DeAnza*

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[18] As noted, defendants submitted a declaration from Cynthia Galvez, JPH's quality assurance nurse, regarding JPH's involvement with Villa Maria, but the trial court sustained Castillo's objection to that declaration. (See fn. 8, *ante*.)

*Associates v. Chicago Title Ins. Co.*, *supra*, 199 Cal.App.4th at p. 1144.) It is true that the second amended complaint makes reference generally to the fact that the standard of care for skilled nursing facilities is found in the title 22 regulations, and that defendants' conduct was contrary to that standard of care. (See, e.g., Second Amended Complaint, p. 4, ¶ 16 ["Defendants' negligent care, supervision and abuse of a 77 year old patient is highly egregious, and is without question, contrary to the standard of care provided for in sections 72000 through 72713 of Title 22 of the California Code of Regulations"].) But the complaint does not identify any specific regulation that was violated, the conduct that led to any specific violation, or, more importantly, how any specific violation caused injury to Decedent. Because the complaint did not adequately allege any cause of action arising from any specific violation of the title 22 regulations, defendants were not required to offer evidence related to those regulations.

Finally, Castillo's contention that defendants failed to meet their burden because they did not submit any admissible evidence regarding JPH's liability is factually incorrect. The complaint did not allege a separate cause of action against JPH. Rather, it alleged that JPH was Villa Maria's parent company, and that each defendant was responsible for the events and occurrences alleged and caused the alleged injuries. Thus, all the evidence that defendants submitted showing there was no breach of the applicable standard of care, no breach of duty, and no causation was relevant to the JPH's liability.

In short, defendants met their burden to show that Castillo's claims lacked merit, and the burden thus shifted to Castillo to make a prima facie showing of the existence of a triable issue of material fact.

D. *Castillo's Burden in Opposition to Summary Judgment*

Castillo contends the trial court erred in finding that he failed to meet his burden in opposition to summary judgment because he presented testimony from Del Rosario regarding the standard of care for, and duties of, skilled nursing facilities, as well as evidence that defendants failed to protect Decedent from health and safety hazards. He asserts the trial court improperly relied upon medical malpractice cases in finding that he was required to present expert witness testimony. We disagree.

First, as the trial court noted in its ruling, Castillo failed to provide evidence to establish Del Rosario's qualifications to opine on the standard of care for, and duties of, skilled nursing facilities.

Second, as discussed in Section A., *ante*, the trial court properly concluded that Castillo's claims alleged negligence in the provision of medical services to Decedent. Therefore, the trial court's reliance on medical malpractices cases was appropriate, and it correctly found that Castillo failed to meet his burden to establish a triable issue because he failed to provide any expert witness testimony in response to Dr. Klein's declaration. (See *Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 123 ["Whenever the plaintiff claims negligence in the medical context, the plaintiff must present evidence from an expert that the defendant breach his or her duty to the plaintiff and that the breach caused the

injury to the plaintiff"]; *Munro v. Regents of University of California* (1989) 215 Cal.App.3d 977, 984-985 ["'California courts have incorporated the expert evidence requirement into their standard for summary judgment in medical malpractice cases. When a defendant moves for summary judgment and supports his motion with expert declarations that his conduct fell within the community standard of care, he is entitled to summary judgment unless the plaintiff comes forward with conflicting expert evidence'"].)

Finally, even if Castillo was not required to present expert evidence regarding the standard of care, the fact of the matter is that he presented no evidence that Villa Maria failed to develop and implement appropriate care plans, and that that failure caused Decedent injury. Instead, he relies upon a kind of *res ipsa loquitur* argument, i.e., that because Decedent "fell multiple times in a short period of time . . . [t]he reasonable inference is that [defendants] consciously disregarded the safety of [Decedent] while she was under their care." But in light of the evidence that defendants submitted -- Dr. Klein's declaration and the medical records from Villa Maria -- to establish that the care plans Villa Maria developed were appropriate for a person with Decedent's medical conditions and that those care plans were implemented, Castillo was required on summary judgment to produce evidence to raise a disputed issue as to those facts. He could not rely upon mere conjecture to raise a triable issue. (*Brown v. Ransweiler* (2009) 171 Cal.App.4th 516, 525 ["'An issue of fact can only be created by a conflict of evidence. It is not created by "speculation, conjecture, imagination or guess work"'"].)

In light of Castillo's failure to produce evidence sufficient to raise a triable issue of fact regarding whether defendants' care of Decedent met the applicable standard of care or that any breach of the standard of care by defendants caused Decedent injury, the trial court properly granted summary judgment in favor of defendants.

## DISPOSITION

The judgment is affirmed. Defendants shall recover their costs on appeal.

**NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS**

WILLHITE, J.

We concur:

MANELLA, P. J.

DUNNING, J.*

*Judge of the Orange County Superior Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.