**IN THE COURT OF COMMON PLEAS OF BUTLER COUNTY, PENNSYLVANIA**

**Civil Division**

MELINDA M. BROWN, Individually and as Administratrix of the Estate of NICHOLAS SYLVESTER CYMBOL, Deceased,

Plaintiff,

vs.

SUNNYVIEW NURSING AND REHABILITATION CENTER; and,

SUNNYVIEW OPERATING LLC d/b/a SUNNVIEW NURSING AND REHABILITATION CENTER;

Defendants.

No.:

PLAINTIFF'S COMPLAINT

Code:

Filed on Behalf of: Plaintiff, Melinda M. Brown, Individually and as Administratrix of the Estate of Nicholas Sylvester Cymbol, Deceased

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Plaintiff,

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SUNNYVIEW NURSING AND REHABILITATION CENTER and SUNNYVIEW OPERATING LLC d/b/a SUNNVIEW NURSING AND REHABILITATION CENTER,

Defendants.

No.:

**NOTICE TO DEFEND**

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

**YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, THEN YOU SHOULD GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP:**

Office of Prothonotary, Butler County
Butler County Government Center
124 West Diamond Street
Butler, PA 16001
(724) 284-5214

Butler County Bar Association
240 S. Main Street
Butler, PA 16001
(724) 841-0130

**YOU MUST RESPOND TO THIS COMPLAINT WITHIN TWENTY (20) DAYS OR A JUDGMENT FOR THE AMOUNT CLAIMED MAY BE ENTERED AGAINST YOU BEFORE THE HEARING. IF YOU DO NOT APPEAR FOR THE HEARING, THE CASE MAY BE HEARD IMMEDIATELY BEFORE A JUDGE. THERE IS NO RIGHT TO A TRIAL DE NOVO ON APPEAL FROM A DECISION ENTERED BY A JUDGE.**

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## PLAINTIFF'S COMPLAINT

AND NOW, comes the Plaintiff, Melinda M. Brown, Individually and as Administratrix of the Estate of Nicholas Sylvester Cymbol, Deceased, by and through her undersigned counsel, Robert N. Peirce, III, Esquire; Scott M. Simon, Esquire; David A. Martin, Esquire, and the law firm of Robert Peirce & Associates, P.C., and claims damages of the Defendants, Sunnyview Nursing and Rehabilitation Center and Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center, upon causes of action, the following which are statements.

## PARTIES

1. Plaintiff Melinda M. Brown is an adult individual with a mailing address of PO Box 12, Nu Mine, Armstrong County, Pennsylvania 16244.

2. Melinda M. Brown is the sister of the Decedent, Nicholas Sylvester Cymbol.

3. Melinda M. Brown was appointed Administratrix of the Estate of Nicholas Sylvester Cymbol by the Register of Wills of Armstrong County, Pennsylvania on February 27, 2024.

4. Plaintiff brings this action pursuant to 42 Pa. Const. Stat.§§ 8301-8302 and Pa. R.C.P. 2202(a) on her own behalf as the personal representative of the Estate of Nicholas Sylvester Cymbol and on behalf of all those entitled by law to recover damages for the wrongful death of Nicholas Sylvester Cymbol.

5. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Nicholas Sylvester Cymbol, and their relations to him, are as follows:

| **Name:** | **Address:** | **Relationship:** |
|---|---|---|
| Nicholas E. Cymbol | 21426 Beaverton Ave.<br>Port Charlotte, FL 33952 | Father |
| Linda Podobensky | 301 South McKean St.<br>Kittanning, PA 16201 | Mother |

6. Defendant Sunnyview Nursing and Rehabilitation Center is a Pennsylvania Corporation with a registered address and principal place of business located at 107 Sunnyview Circle, Butler, Butler County, Pennsylvania 16001.

7. Defendant Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center is a Pennsylvania Limited Liability Company with a registered address and principal place of business located at 107 Sunnyview Circle, Butler, Butler County, Pennsylvania 16001.

8. Collectively, Defendants Sunnyview Nursing and Rehabilitation Center and Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center operated a "long-term care" facility, as that term is defined by Pennsylvania's Health Care Facilities Act, 35 P.S. § 448.802(A), *et. seq.*, which "promote[s] the public health and welfare through the establishment and enforcement of regulations setting minimum standards in the construction, maintenance and

operation of health care facilities", under the fictitious business name "Sunnyview Nursing and Rehabilitation Center" at 107 Sunnyview Circle, Butler, Butler County, Pennsylvania 16001.

9. Additionally, Defendants Sunnyview Nursing and Rehabilitation Center and Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center operated Sunnyview Nursing and Rehabilitation Center as a "skilled nursing facility" as that term is defined by Title XVIII of the Social Security Act, 42 U.S.C. §1395i-3 (Medicare) and as a "nursing facility" as that term is defined in Title XIX of the Social Security Act, 42 U.S.C. §1396r (Medicaid).

10. Accordingly, Defendants Sunnyview Nursing and Rehabilitation Center and Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center are "healthcare providers", as that term is defined in the Medical Care Availability and Reduction of Error Act ("MCARE"), 40 P.S. § 1303.503.

11. As "healthcare providers" under the MCARE Act, Defendants Sunnyview Nursing and Rehabilitation Center and Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center are "licensed professionals" as defined by Pennsylvania Rule of Civil Procedure 1042.1, and, in addition to other claims asserted, Plaintiff is asserting professional liability claims against the Defendants.

12. At all times relevant hereto, Defendants Sunnyview Nursing and Rehabilitation Center and Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center acted independently and by and through their duly authorized agents, servants, and/or employees then and there acting within the course and scope of their employment.

13. Defendants Sunnyview Nursing and Rehabilitation Center and Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center will be collectively referred

to hereinafter as "Defendants", "Sunnyview Nursing and Rehabilitation Center", and/or "Sunnyview".

14. This Complaint is brought vicariously and directly against the Defendants for their managerial and operational negligence, carelessness, recklessness, and willful and wanton conduct.

## JURISDICTION AND VENUE

15. Venue is proper in this jurisdiction under Pa. R.C.P. 1006(a)(1) and MCARE, 40 P.S. §1303.501, *et seq.*, as Defendants do business in, and are thus capable of being served in, Butler County.

## FACTS COMMON TO ALL CAUSES OF ACTION

16. Nicholas "Nick" Cymbol was a 43-year-old man who resided at Sunnyview Nursing and Rehabilitation Center.

17. Mr. Cymbol's past medical history was significant for an anoxic brain injury, blindness, diabetes, and neuropathy.

18. As a result of his medical condition, Mr. Cymbol required around-the-clock skilled nursing care, resulting in his admission to Sunnyview Nursing and Rehabilitation Center.

19. On their website, Defendants promote that "Everyone deserves a place that feels like home . . . We put people first with attentive, high-quality care."

20. Trusting Sunnyview Nursing and Rehabilitation Center, Mr. Cymbol's family believed that he would receive the proper care he needed, relying on information provided by Sunnyview that the facility was appropriately staffed with credentialed healthcare providers and nurses.

21. Tragically, this was not the case.

22. In or about January 2023, Defendants hired Heather Pressdee as the Unit Manager of the Cardinal Unit at Sunnyview Nursing and Rehabilitation Center, where Mr. Cymbol had been residing.

23. At Sunnyview Nursing and Rehabilitation Center, Unit Managers are responsible for and supervise the delivery of medical care to all residents on a day-to-day basis, directing and coordinating the work of Registered Nurses ("RNs"), Licensed Practical Nurses ("LPNs"), and Nursing Assistants ("NAs") on their respective units.

24. In addition to their supervisory and direct-care roles, Unit Managers at Sunnyview Nursing and Rehabilitation Center serve as management representatives of the Defendants in dealings with facility residents, residents' families, and residents' physicians.

25. Further, Unit Managers at Sunnyview Nursing and Rehabilitation Center were expected to serve and function as leaders and mentors to the Sunnyview nursing and support staff at all times.

26. Additionally, Unit Managers at Sunnyview Nursing and Rehabilitation were tasked with enforcing facility safety rules, ensuring that any and all accidents or incidents were reported and investigated in a timely and accurate manner, and ensuring that all residents living in the facility remained free from abuse and neglect.

27. Accordingly, Defendants tasked Pressdee with addressing any resident care concerns, conducting internal investigations regarding resident and/or staff complaints, and investigating allegations of abuse, in addition to her duties in providing direct resident care.

28. Essentially, any complaints of abuse at Sunnyview Nursing and Rehabilitation Center would have to go through Pressdee herself.

29. Additionally, by retaining her as a Unit Manager, the Defendants provided Pressdee with direct and unfettered access to medication carts and locked medication storage areas and tasked her with monitoring and supervising unit-wide medication administration and access.

30. Prior to her hiring by Defendants, Pressdee worked at ten medical facilities during the corresponding timeframes:

| Facility | Start Date | End Date |
|---|---|---|
| Encompass Health Rehabilitation Hospital of Harmarville | 10/2018 | 04/2019 |
| Allegheny Valley Hospital | 04/2019 | 09/2019 |
| Platinum Ridge Center for Rehabilitation & Healing | 09/2019 | 01/2020 |
| Orchards of Saxonburg | 02/2020 | 04/2020 |
| UPMC Passavant – McCandless | 04/2020 | 10/2020 |
| Concordia at Rebecca Residence | 10/2020 | 04/2021 |
| Belair Healthcare and Rehabilitation Center | 04/2021 | 02/2022 |
| Woodhaven Care Center | 03/2022 | 05/2022 |
| Quality Life Services – Chicora | 05/2022 | 11/2022 |
| Premier Armstrong Rehabilitation | 11/2022 | 12/2022 |

31. In less than four years, Pressdee was forced to resign from or was terminated by each of the ten aforementioned facilities for exhibiting abusive tendencies and behavior toward residents and staff at each and every facility.

32. Sunnyview Nursing and Rehabilitation Center purportedly maintained an "Abuse Policy" specifically stating that all potential employees were to be screened for a history of abuse, neglect, or mistreating residents during the hiring process.

33. Despite her disturbing and alarming history of resident abuse at ten prior facilities, including causing the injuries and/or deaths of at least 16 residents at other facilities between December 2020 and December 2022, which Defendants knew or should have known, Defendants hired Pressdee in or about January 2023.

34. Defendants clearly failed to conduct an appropriate background check prior to hiring Pressdee in light of her concerning pattern of abusive behavior and the red flags that should have been raised when Defendants saw that she had worked at and been discharged from ten prior healthcare facilities within a less than four-year span.

35. Had Defendants conducted even the most cursory background investigation, they would have learned that Pressdee had been terminated or forced to resign from these ten facilities because of her abusive behavior towards residents and staff and would have learned that Pressdee would be a danger to their residents.

36. Instead, Defendants blatantly ignored their own Abuse Policy when hiring Pressdee and tasked her with supervisory duties in her position as a Unit Manager, gave her access to controlled medications, and allowed her to provide care to Sunnyview Nursing and Rehabilitation Center's vulnerable residents.

37. Over the course of Pressdee's employment at Sunnyview Nursing and Rehabilitation Center, she exhibited troubling and erratic behavior – just as she had done at each of the ten facilities that employed her in the four years prior to Sunnyview – and her conduct provided staff and administration of the Sunnyview facility with actual knowledge that she was a danger to Sunnyview residents.

38. Unfortunately, prior to and during Pressdee's employment there, Sunnyview Nursing and Rehabilitation Center consistently failed to train its staff with regard to recognizing,

communicating and reporting abuse, neglect, and exploitation of residents; and consequently, the Defendants allowed Pressdee's abuse and neglect to pervade throughout the facility.

39. After her arrival at Sunnyview Nursing and Rehabilitation Center on January 2, 2023, members of the Sunnyview nursing staff began to notice that the residents who Pressdee had access to were passing away unexpectedly and/or under suspicious circumstances, causing the nursing staff to believe Pressdee had involvement in their deaths.

40. However, as outlined below, Sunnyview Operating LLC and Sunnyview Nursing and Rehabilitation Center's Administration completely and repeatedly ignored the concerns of staff and residents pertaining to Pressdee's treatment of residents.

41. At some point shortly after her start date on January 2, 2023, Pressdee began providing care to a resident known as "M.L." – an 80-year-old mother who had recently been admitted to the facility for rehabilitation.[1]

42. It was M.L.'s goal to return home with her family.

43. After Pressdee started, she began spending an excessive amount of time treating and caring for M.L.

44. During this time, M.L.'s medical condition deteriorated significantly, and she often appeared overmedicated to family members and staff.

45. On or about January 19, 2023, M.L.'s son visited her at Sunnyview Rehabilitation and Nursing Center and discovered that she was bloody, appeared beaten, and had broken teeth and two black eyes.

46. These injuries occurred while M.L. was in the care of Pressdee.

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[1] The family of "M.L." has filed a separate lawsuit against the above-captioned Defendants in the Court of Common Pleas of Allegheny County at Docket No. GD-24-002778.

47. Neither Pressdee nor Sunnyview Rehabilitation and Nursing Center staff ever sent M.L. to the hospital despite her condition and these clear signs of abuse, nor did the Defendants ever launch an investigation into the cause of these injuries or report this incident to Pennsylvania state agencies.

48. Instead, the Defendants relied on Pressdee's story that M.L. "fell".

49. On January 21, 2023, Pressdee again provided direct care to M.L.

50. On January 21, 2023, Pressdee injected M.L. with 60 units of short-acting insulin.

51. Later that day, M.L. passed away.

52. Two months later, in March 2023, Pressdee began providing care to a resident known as "A.V." – a 104-year-old mother, grandmother, great-grandmother, and great-great-grandmother.

53. "A.V." was not diabetic.

54. Prior to Pressdee assuming care of A.V., A.V. was in good health and able to ambulate on her own.

55. Pressdee made numerous derogatory, insulting comments about A.V. to other members of the Sunnyview nursing staff, and had even commented, "When is she going to die already?"

56. Additionally, Pressdee had stated that A.V. "should not still be alive."

57. Sunnyview Nursing and Rehabilitation Center and Sunnyview Operating LLC took no action whatsoever to reprimand Pressdee or remove her from caring for A.V. despite these extremely inappropriate and disturbing comments.

58. On March 20, 2023, Pressdee cared for A.V. during her shift from 6:30 a.m. to 8:30 p.m.

59. At some point during her shift, Pressdee injected A.V. with 60 units of short-acting insulin.

60. The following morning, on March 21, 2023, a Sunnyview CNA found A.V. in her room in a hypoglycemic crisis and foaming at the mouth.

61. At approximately 9:25 a.m. on March 21, 2023, A.V. died.

62. Although A.V. died under suspicious circumstances, the Defendants did nothing to investigate or report this incident and allowed Pressdee to continue caring for residents.

63. Around the same time of A.V.'s passing, Pressdee also cared for a resident known as "I.S." – a 78-year-old mother, grandmother, and great-grandmother who was on hospice care at Sunnyview Nursing and Rehabilitation Center.

64. On March 24, 2023, I.S.'s daughter visited her mother at Sunnyview, who observed her mother to be "warm and oily" on that date.

65. Pressdee had been caring for I.S. that day.

66. During her visit, I.S.'s daughter ran out to her car in the parking lot of the facility for no more than 30 minutes.

67. Upon information and belief, while her daughter was outside in the parking lot, Pressdee injected I.S. with 60 units of short-acting insulin.

68. I.S.'s daughter returned to the room shortly thereafter to find her mother in distress.

69. I.S.'s daughter immediately notified Pressdee, who returned to I.S.'s room with a medicine cart.

70. While Pressdee was rendering care to I.S., I.S.'s daughter briefly left the room.

71. Upon information and belief, Pressdee administered an additional 60-unit injection of insulin to I.S. while her daughter was outside of the room.

72. When I.S.'s daughter returned to her mother's room, she discovered that her mother had died while alone with Pressdee.

73. On the same day as I.S.'s death, Pressdee provided direct care to a resident known as "G.S." – a 90-year-old father, grandfather, and great-grandfather.

74. Though G.S. was diabetic, he was not insulin dependent.

75. At some point during her shift on March 24, 2023, Pressdee administered an excessive dose of long-acting insulin to G.S.

76. Overnight, G.S.'s blood sugar dropped significantly.

77. At approximately 5:00 a.m. on March 25, 2023, G.S. was found in his room in a hypoglycemic crisis, unresponsive, and foaming at the mouth.

78. This marked the second time in three days that a Sunnyview resident was found foaming at the mouth while under the care of Pressdee.

79. Unbelievably, the staff and management at Sunnyview did nothing to investigate these very unusual occurrences in just a matter of three days.

80. At this time, Sunnyview Nursing and Rehabilitation Center staff checked G.S.'s blood sugar, discovering that it was 55 mg/dL, indicating that he was hypoglycemic.

81. A short time after, G.S.'s blood sugar had dropped to 37 mg/dL.

82. Sunnyview Nursing and Rehabilitation Center staff inserted an intravenous ("IV") port so that Dextrose could be administered to G.S. to raise his blood sugar.

83. Pressdee arrived for work on March 25, 2023 at approximately 7:00 a.m.

84. At this time, Pressdee and one other LPN were the only two nurses on staff on the unit.

85. Eventually, G.S.'s blood sugar stabilized.

86. Once this occurred, the LPN, who was the only other member of the nursing staff on shift at the time Pressdee arrived, left the room to take a break, leaving G.S. alone with Pressdee.

87. While the LPN was out of G.S.'s room, Pressdee administered two 10 mL flushes of air into G.S.'s IV port, resulting in an air embolism that caused G.S.'s death.

88. Inexplicably, despite the fact that at least three Sunnyview residents had died under highly-suspicious circumstances while under Pressdee's care within one week – two of whom exhibited hypoglycemia with foaming at the mouth shortly before death – the Defendants still did nothing.

89. Within the next few weeks following G.S.'s passing, Pressdee began caring for a resident known as "S.L." – an 82-year-old mother, grandmother, and great-grandmother.

90. Though S.L. was diabetic, she was not insulin dependent.

91. Upon information and belief, S.L. had late-stage cancer, and the plan was that she was to be transferred home on hospice.

92. Pressdee had previously made comments to other members of the Sunnyview Nursing and Rehabilitation staff that S.L. "needed to die."

93. Defendants did nothing to reprimand Pressdee or remove her from caring for S.L. despite this extremely inappropriate comment.

94. Prior to S.L.'s death on April 17, 2023, Pressdee administered an excessive dose of insulin to S.L. which did not immediately cause S.L.'s death.

95. Shortly thereafter, Pressdee administered one syringe of air into S.L.'s PICC line in an effort to create an air embolism.

96. Once Pressdee administered one syringe of air into S.L.'s PICC line, S.L. died.

97. By this time, several members of the Sunnyview Nursing and Rehabilitation Center nursing staff had come forward and expressed concerns to Sunnyview Operating LLC and Sunnyview Nursing and Rehabilitation Center Administration that Pressdee was responsible for the deaths of residents at the facility.

98. Some of these concerns were raised by Sunnyview staff members who had worked with Pressdee at prior facilities, including Belair Healthcare and Rehabilitation Center and Quality Life Services – Chicora, expressing concerns to Sunnyview Administration that Pressdee was responsible for the deaths of residents at these facilities as well.

99. When a Sunnyview CNA confronted management with these concerns and asked why Pressdee was allowed to continue working at Sunnyview and caring for residents in light of her erratic, disturbing, and inappropriate behavior, Sunnyview Nursing and Rehabilitation Center's Director of Nursing, Heidi Coyle, stated simply that Pressdee "does her work."

100. Sunnyview Nursing and Rehabilitation Center and Sunnyview Operating LLC Administration failed to take any action whatsoever to investigate Pressdee or remove her from direct nursing care.

101. Put simply, Sunnyview Nursing and Rehabilitation Center and Sunnyview Operating LLC Administration did not care that two residents died after foaming at the mouth and another two died from air embolisms.

102. Again, all of these deaths occurred while under the care of Pressdee.

103. After S.L.'s death on April 17, 2023, Pressdee set her sights on Nick Cymbol.

104. Mr. Cymbol was a brittle diabetic, meaning that he often experienced large swings in his blood glucose levels.

105. As a result, Mr. Cymbol treated regularly with an endocrinologist and required routine insulin administration to maintain his blood sugar.

106. Additionally, Mr. Cymbol wore a Dexcom device that measured and recorded his blood sugar on a cellular app that was accessible to his family and his medical care providers.

107. Mr. Cymbol's Dexcom device, which was essential in notifying his medical providers when his blood sugar was elevated or dropping, required periodic changing by the Sunnyview Unit Manager in order to provide accurate and timely blood sugar readings.

108. Pressdee, in her role as a Unit Manager at Sunnyview, was responsible for ensuring that Mr. Cymbol's Dexcom device was working.

109. Though Mr. Cymbol was well-liked by the staff at Sunnyview Nursing and Rehabilitation Center, Pressdee routinely insulted, berated, bullied, and abused Mr. Cymbol, just as she had done to other residents.

110. Staff at Sunnyview Nursing and Rehabilitation Center were aware that Pressdee disliked Mr. Cymbol and that she held the belief that people with a quality of life like Mr. Cymbol did not deserve to live.

111. On at least one instance, Pressdee yelled at Mr. Cymbol, in earshot of other Sunnyview staff members, to "get away from [Pressdee's] fucking desk" when he had approached the nurse's station.

112. Pressdee also routinely called Mr. Cymbol derogatory names such as "retarded" in reference to his anoxic brain injury in earshot of Sunnyview staff members.

113. Additionally, on several occasions, Pressdee prevented other nurses at Sunnyview Nursing and Rehabilitation Center from feeding or providing water to Mr. Cymbol.

114. On the occasions where Pressdee would take Mr. Cymbol to the communal dining area of the facility, she made him eat alone and would not allow him to interact with other residents.

115. In spite of their knowledge of Pressdee's pattern of bullying behavior, the Defendants did nothing to remove Pressdee from Mr. Cymbol's care.

116. Moreover, despite their knowledge, Defendants allowed Pressdee to remain in her supervisory role as Unit Manager.

117. On Friday, April 28, 2023, Holly Knox, a Sunnyview LPN, expressed to Mr. Cymbol the importance of compliance with medications, telling him that she wanted him to be around when she came back on shift the following Monday.

118. Overhearing this conversation, Pressdee pulled Nurse Knox aside and told her that the conversation she had had with Mr. Cymbol was "gross."

119. In fact, Pressdee had made explicit comments to other Sunnyview staff members that Mr. Cymbol was "going to be the next one to die anyway."

120. Despite Pressdee making this promise that Mr. Cymbol was "going to be the next one to die," Sunnyview administration and staff did absolutely nothing to separate her from or prevent her from harming Mr. Cymbol.

121. It is absolutely beyond the pale that no one did anything after Pressdee made this promise regarding Mr. Cymbol.

122. During the final week of Mr. Cymbol's life, Pressdee informed his family that he allegedly "seemed really depressed."

123. This was not true.

124. Pressdee was the only nurse from Sunnyview Nursing and Rehabilitation Center that ever told Mr. Cymbol's family that he was allegedly depressed.

125. On Sunday, April 30, 2023, Pressdee worked the morning shift and began work at 6:25 a.m.

126. Pressdee worked the medication cart that morning.

127. During morning rounds, Mr. Cymbol's LPN recorded his blood sugar as 167 mg/dL at approximately 6:30 a.m.

128. Notably, Mr. Cymbol's blood sugar was to be checked six times daily, per his physician's order.

129. However, just 30 minutes later, at 7:00 a.m., Pressdee documented that Mr. Cymbol's blood sugar had allegedly risen to 380 mg/dL.

130. At this time, Pressdee injected Mr. Cymbol with 60 units of insulin.

131. Shortly after Pressdee injected him with 60 units of insulin, Mr. Cymbol's blood sugar plummeted.

132. According to Pressdee, Mr. Cymbol "crashed faster than expected", and she tried to reverse his drop in blood sugar by administering multiple doses of Glucagon.

133. Initially, Pressdee refused to call 911 on Mr. Cymbol's behalf – it was not until staff members confronted her that 911 was called.

134. Mr. Cymbol was transferred by ambulance to Butler Memorial Hospital that morning.

135. Mr. Cymbol remained at Butler Memorial Hospital for much of the day, and he was eventually discharged back to Sunnyview Nursing and Rehabilitation Center later that evening.

136. Despite the fact that he was hospitalized earlier in the day for hypoglycemia, the Sunnyview nursing staff failed to monitor Mr. Cymbol's blood sugar or monitor his condition once he had returned from the hospital.

137. During the evening of April 30, 2023 and into the early morning of May 1, 2023, Mr. Cymbol's condition gradually declined.

138. The Sunnyview staff failed to notify Mr. Cymbol's physician of the gradual decline in his condition overnight.

139. In fact, the last time that Mr. Cymbol's blood sugar was documented was shortly after he arrived back at Sunnyview from Butler Memorial Hospital during the evening of April 30, 2023.

140. Contemporaneously with the overall decline in his condition, Mr. Cymbol's blood sugar plummeted overnight.

141. Because Sunnyview nursing staff failed to monitor Mr. Cymbol's blood sugar overnight, they failed to take any corrective measures to stabilize his blood sugar.

142. Shortly after 4:00 a.m. on the morning of May 1, 2023, a nurse at Sunnyview, Lori Barbieri, RN, found Mr. Cymbol in a hypoglycemic crisis and foaming at the mouth.

143. At this point, Nurse Barbieri went to check Mr. Cymbol's Dexcom device, which had not been tracking his blood sugar due to a "sensor error."

144. Nurse Barbieri checked Mr. Cymbol's blood sugar via finger stick and discovered that his blood sugar was 23 mg/dL, indicative of critical hypoglycemia.

145. It is unknown how long Mr. Cymbol was in this state, as the Sunnyview nursing staff failed to monitor his blood sugar or check on him throughout the night.

146. After finding Mr. Cymbol in this condition, Nurse Barbieri called Mr. Cymbol's sister, Melinda Brown, advising her that she should come to the facility as her brother's condition was rapidly deteriorating.

147. Ms. Brown immediately left for the facility after getting off the phone.

148. However, at approximately 4:30 a.m. on May 1, 2023, as she was walking out her front door to head to Sunnyview, Ms. Brown received a phone call from a nurse at the facility advising her that her brother had passed away.

149. Just days after Pressdee promised that he would be "the next one to die," Mr. Cymbol passed away.

150. After receiving this heartbreaking news, Ms. Brown drove to pick up her and Mr. Cymbol's mother on her way to Sunnyview.

151. Shortly after Mr. Cymbol passed away that morning, Holly Knox, LPN arrived for her shift.

152. Pressdee arrived for her shift that morning at approximately 6:00 a.m.

153. Pressdee approached Nurse Knox, smacked her on the back, and said to her, "Sorry to hear about Nick, but at least you got to say your final goodbye," as if she were boasting about killing Mr. Cymbol.

154. Additionally, Pressdee went up to Ms. Brown after she arrived at Sunnyview and gave her a hug, stating that she was sorry for her brother's passing.

155. Mr. Cymbol's cause of death was initially identified as myocardial infarction.

156. On the same date of Mr. Cymbol's death, May 1, 2023, Pressdee was terminated by Sunnyview for exhibiting abusive behavior towards residents and other staff and escorted off the premises.

157. Shortly after Mr. Cymbol's death, and even after she had been terminated by Sunnyview, Pressdee sent Mr. Cymbol's family a sympathy card expressing her condolences for his death.

158. Pressdee's sympathy card to Mr. Cymbol's family read: "*nick was one of a kind. he was an amazing sole (sic) with a great sense of humor. he will be missed. words cant not (sic) say how sorry I am.*"

159. In the days and weeks following Pressdee's termination, the Pennsylvania Department of Health conducted an investigation of the facility.

160. Sunnyview Operating LLC and Sunnyview Nursing and Rehabilitation Center terminated and/or reprimanded staff members who provided information to the Pennsylvania Department of Health regarding the aforementioned resident deaths or Pressdee's conduct at the facility.

161. On May 24, 2023, an arrest warrant was issued and Pressdee was taken into custody by authorities in relation to two resident deaths at Quality Life Services - Chicora from insulin-induced hypoglycemia.

162. Investigators from the Pennsylvania Office of the Attorney General ("PAOAG"), Bureau of Narcotics Investigations and Drug Control ("BNIDC") determined that Pressdee had injected two residents of Quality Life Services with deadly amounts of short-acting insulin which caused their deaths.

163. Pressdee admitted to doing so with the intention of taking these residents' lives.

164. On that date, Pressdee was charged with two counts of criminal homicide – counts that have since been upgraded to murder in the first-degree and third-degree.

165. In the months following Pressdee's arrest, PAOAG initiated an investigation into suspicious resident deaths at other facilities that Pressdee worked at, including Sunnyview Nursing and Rehabilitation Center.

166. Plaintiff and her family were eventually informed by an agent of the Pennsylvania Office of Attorney General, Bureau of Narcotics Investigations and Drug Control that Pressdee had confessed to administering an exogenous injection of an excessive and lethal dose of insulin to Mr. Cymbol.

167. Thereafter, on or about November 2, 2023, 17 additional counts of attempted homicide and 19 counts of neglect of care-dependent persons were filed against Pressdee for resident deaths at numerous facilities in Butler, Allegheny, Westmoreland, and Armstrong Counties.

168. Specifically, as it relates to Mr. Cymbol's case, Pressdee was charged with murder and criminal neglect of a care-dependent person.

169. Initially, the family of Nicholas Cymbol believed that their loved one had died from natural causes.

170. Thanks to the investigation by the Pennsylvania Office of Attorney General, the family now knows that Pressdee administered an excessive and lethal dose of insulin to Mr. Cymbol, thereby causing his death.

171. To date, the criminal investigation into Pressdee remains ongoing, and as such, limited information regarding these incidents has been made known to the public and families of the victims, including the Plaintiff and his family.

172. Unfortunately, Mr. Cymbol's family's attempts to obtain information from the Defendants as to how this series of events was allowed to happen have gone ignored.

173. Notably, the undersigned counsel attempted to request Mr. Cymbol's medical records from Sunnyview Nursing and Rehabilitation Center on numerous occasions.

174. On November 20, 2023, the undersigned requested Mr. Cymbol's complete medical records from Sunnyview.

175. Sunnyview ignored this request.

176. On December 13, 2023, the undersigned reached out to Sunnyview and had to leave a voicemail message requested production of Mr. Cymbol's medical records.

177. Sunnyview ignored this request.

178. On December 18, 2023, the undersigned once against contacted Sunnyview by telephone and left a voicemail message requesting production of Mr. Cymbol's medical records.

179. Sunnyview once again ignored this request.

180. On December 20, 2023, the undersigned attempted to contact Sunnyview on three separate occasions throughout the day demanding production of Mr. Cymbol's medical records. All three attempts at communication went ignored by Sunnyview.

181. It was not until December 21, 2023 that Sunnyview Nursing and Rehabilitation Center's Administrator, Tricia Kradel, finally contacted the undersigned – however, she advised that Sunnyview had actually sent the medical records for another decedent, I.S., to an incorrect address.

182. If Ms. Kradel is to be believed, this act represents a violation of I.S.'s HIPAA rights, as this individual's medical records were disclosed to an incorrect address.

183. It was not until January 4, 2024 that Sunnyview provided Plaintiff's counsel with any of Mr. Cymbol's medical records.

184. However, Sunnyview failed to provide Mr. Cymbol's full and complete medical records.

185. On January 17, 2024, the undersigned once again requested Mr. Cymbol's full and complete medical records from Sunnyview.

186. From that date forward, Sunnyview has ignored all of the undersigned's requests for Mr. Cymbol's full and complete medical records.

187. Due to the ongoing nature of this investigation, additional victims of Pressdee at Sunnyview Nursing and Rehabilitation Center and other facilities who may be identified are currently unknown.

## COUNT I

**Plaintiff, Melinda M. Brown, Individually and as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased vs. Sunnyview Nursing and Rehabilitation Center**

**CORPORATE NEGLIGENCE**

188. All of the preceding paragraphs of this Complaint are incorporated herein, as if set forth more fully at length.

189. Sunnyview Nursing and Rehabilitation Center had a non-delegable duty and responsibility to its residents and to the public to furnish appropriate and competent medical care that comported with standards of professional practice.

190. As part of its non-delegable duties and responsibilities, Sunnyview Nursing and Rehabilitation Center had an obligation to establish policies and procedures to maintain adequate care and have competent medical staff to ensure that appropriate medical care is delivered to its residents.

191. Acting through its administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, Sunnyview Nursing and Rehabilitation Center is responsible for the standard of professional practice by members of its staff.

192. Sunnyview Nursing and Rehabilitation Center failed to uphold these non-delegable duties of care in relation to the care provided to Nicholas Sylvester Cymbol.

193. Sunnyview Nursing and Rehabilitation Center, as well as its duly authorized administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff negligently breached their duties owed to Nicholas Sylvester Cymbol in the following particulars:

a. By failing to protect Nicholas Sylvester Cymbol from physical and psychological harm, injury, and abuse perpetrated by Heather Pressdee at Sunnyview Nursing and Rehabilitation Center, as pled herein;

b. By failing to provide a safe environment for Nicholas Sylvester Cymbol while he was a resident of Sunnyview Nursing and Rehabilitation Center, as pled herein;

c. By failing to recognize that Heather Pressdee posed a risk to residents of the facility, including Nicholas Sylvester Cymbol, based on her history of abusing residents, as pled herein;

d. By failing to properly investigate the prior employment activities of prospective employees before hiring them, particularly Heather Pressdee, as pled herein;

e. By failing to implement a policy and/or procedure that would prevent individuals with a history of abusing and harming residents from obtaining employment at the Defendant facility, as pled herein;

f. By hiring and retaining staff, including Heather Pressdee, who the Defendant knew, or should have known, was a danger to residents such as Nicholas Sylvester Cymbol at Sunnyview Nursing and Rehabilitation Center, as pled herein;

g. By failing to conduct a thorough background check on all employees, including Heather Pressdee, such that a predatory individual was employed to provide hands on care to vulnerable residents such as Nicholas Sylvester Cymbol, as pled herein;

h. By failing to monitor the behavior of Heather Pressdee while she was an employee of the facility and while she was providing care to residents, as pled herein;

i. By failing to develop and enforce adequate and sufficient policies and procedures regarding the responsibilities of employees witnessing misconduct, as pled herein;

j. By failing to adequately train employees to respond to misconduct of other staff members, as pled herein;

k. By failing to provide for the monitoring of all medications within the Sunnyview Nursing and Rehabilitation Center facility to ensure that they were properly accounted for at all times, as pled herein;

l. By failing to exercise reasonable care in selecting, supervising, and controlling employees, as pled herein;

m. By failing to investigate Heather Pressdee, in spite of the string of suspicious deaths of residents who were under her care, as pled herein;

n. By failing to report suspicious deaths and all other reportable incidents that occurred under Pressdee's care to the necessary Pennsylvania state agencies, as pled herein;

o. By failing to maintain a protocol for storing medications such as insulin on the premises such that staff members could not obtain it without a physician's order, as pled herein; and,

p. By failing to investigate Heather Pressdee, despite concerns voiced by other staff members at Sunnyview Nursing and Rehabilitation Center that Pressdee was harming residents, as pled herein.

194. At all times relevant hereto, Sunnyview Nursing and Rehabilitation Center had a duty to not violate the legal rights of any resident, and had a duty to comply with the provisions of Title 28 Pennsylvania Administrative Code, Chapter 211, and 42 C.F.R. § 483, *et seq.*

195. The regulations listed below are designed and intended to protect the interests of persons such as Nicholas Sylvester Cymbol, who are residing in facilities such as Sunnyview Nursing and Rehabilitation Center.

196. The regulations listed below are designed and intended to protect persons such as Nicholas Sylvester Cymbol against the hazards he encountered and the harm and death he suffered as a result of residing at Sunnyview Nursing and Rehabilitation Center.

197. Sunnyview Nursing and Rehabilitation Center, as well as its duly authorized administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, recklessly, negligently and carelessly violated the above-noted regulations in the following ways:

a. By failing to design and implement resident care policies to ensure that Mr. Cymbol received treatment, medication, and rehabilitative nursing care, as prescribed, as required by 28 Pa. Code. § 211.10(c), as pled herein;

b. By failing to meet minimum standards of operation of a long-term care facility, as required by 28 Pa. Code. § 201.14, as pled herein;

c. By failing to adopt and enforce effective rules for the health, care and safety of the residents, as well as the general operation of the facility, as required by 28 Pa. Code. § 201.18, as pled herein;

d. By failing to provide appropriate training and educational programs for Sunnyview Nursing and Rehabilitation Center's staff, as required by 28 Pa. Code. § 201.20(a), as pled herein;

e. By failing to provide appropriate orientation and training to staff on prevention, detection, and reporting of resident abuse, as required by 28 Pa. Code § 201.20(b), as pled herein;

f. By failing to provide adequate nursing services consistent with 28 Pa. Code. § 211.12, as pled herein;

g. By failing to develop systems and mechanisms for monitoring the performance of Heather Pressdee and communicating issues related to her administration of medical care to Mr. Cymbol and other residents of Sunnyview Nursing and Rehabilitation Center, as required by 28 Pa. Code § 211.2(d)(10), as pled herein;

h. By failing to develop and adhere to written policies and procedures regarding the rights and responsibilities of residents, as required by 28 Pa. Code. § 201.29(a);

i. By failing to develop policies identifying all treatments and medications which may not be prescribed or dispensed by way of verbal order, as well as all personnel authorized to take and transcribe verbal orders, as required by 28 Pa. Code. § 211.3(e), as pled herein;

j. By failing to develop policies and procedure that ensure that medications are administered by authorized persons, as required by 28 Pa. Code § 211.9(b), as pled herein;

k. By failing to develop policies and procedures relative to the disposition of medications that address timely and safe identification and removal of medications for disposition; identification of storage methods for medications awaiting final disposition; control and accountability of medications awaiting final disposition consistent with standards of practice, and documentation of actual disposition of medications, as required by 28 Pa. Code § 211.9(j.1) as pled herein;

l. By failing to develop policies and procedures for drug therapy, distribution, administration, control, accountability, and use of medications, as required by 28 Pa. Code § 211.9(k), as pled herein;

m. By failing to report all serious incidents involving Sunnyview residents to the Pennsylvania Department of Health, as required by 28 Pa. Code § 201.14(c), as pled herein;

n. By failing to develop policies and procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs within the facility, as required by 42 C.F.R. § 484.35(a), as pled herein;

o. By permitting unauthorized personnel to have access to locked drugs and biologicals, in violation of 42 C.F.R. § 483.45(h), as pled herein;

p. By failing to ensure that Heather Pressdee had the competencies and skills necessary to care for residents' needs, as required by 42 C.F.R. § 483.35(a), as pled herein; and,

q. By failing to ensure that Sunnyview Nursing and Rehabilitation Center was administered in a manner that enabled it to use its resources effectively and efficiently to allow Mr. Cymbol to maintain or attain the highest practicable level of physical, mental and psycho-social well-being, as required by 42 C.F.R. § 483.70, as pled herein.

198. Sunnyview Nursing and Rehabilitation Center had actual or constructive knowledge of defective policies and procedures related to hiring, retention, supervision, monitoring, quality assurance, coordination of care, administration of medication, drug therapy, training and orientation of staff, and record-keeping; defects of which were substantial factors in causing the harm and death of Nicholas Sylvester Cymbol.

199. As a direct and proximate result of the aforementioned acts and omissions of Sunnyview Nursing and Rehabilitation Center and its authorized administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, as set forth above, Nicholas Sylvester Cymbol was injured as described above, experienced conscious pain and suffering and died.

200. As a result of the previously described conduct of Sunnyview Nursing and Rehabilitation Center, Plaintiff Melinda M. Brown, as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased, seeks damages as follows:

a. Money expended for medical services and supplies incident to the treatment and death of Nicholas Sylvester Cymbol;

b. Pain, suffering, embarrassment, humiliation, inconvenience, anxiety, loss of enjoyment of life and nervousness that Nicholas Sylvester Cymbol experienced while residing at the Defendant facility and sustained injuries which contributed to his eventual death;

c. Any and all hospital, medical, surgical, and nursing expenses incurred; and,

d. Punitive damages as a result of the actions as detailed herein, where Defendants knew or should have known that their acts and/or failures to act, as more fully set forth herein, would – and did, in fact - create a high degree of risk of physical harm, when Defendants acted with deliberate indifference to the health and well-being of Nicholas Sylvester Cymbol in exposing him to Heather Pressdee, who Defendants knew or should have known presented a risk to residents at Sunnyview Nursing and Rehabilitation Center. Further, these actions detailed herein show a complete and total lack of care for Nicholas Sylvester Cymbol and other residents of Sunnyview Nursing and Rehabilitation Center with regard to his health, safety, well-being, and human dignity.

WHEREFORE, Plaintiff, Melinda M. Brown, Individually and as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased, claims damages of Defendant Sunnyview Nursing and Rehabilitation Center, and demands compensatory and punitive damages from the Defendant in an amount in excess of the jurisdictional arbitration limits, together with interest, costs of suit, and any other relief this Honorable Court deems appropriate to recover for which this suit is filed.

## COUNT II

**Plaintiff, Melinda M. Brown, Individually and as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased vs. Sunnyview Nursing and Rehabilitation Center**

## VICARIOUS LIABILITY

201. All of the preceding paragraphs of this Complaint are incorporated herein, as if set forth more fully at length.

202. At all relevant times, Sunnyview Nursing and Rehabilitation Center acted by and through its administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, including Heather Pressdee, who were then and there acting within the course and scope of their employment.

203. In particular, Heather Pressdee's actions were (1) of a kind and nature that she was employed to perform (*i.e.*, [1] the administration of medication and patient care); (2) occurred substantially within her employer's authorized time and space limits (while she was on the clock and at the Sunnyview Nursing and Rehabilitation Center); and (3) were actuated, at least in part, by purpose to serve her employer (by providing care to Sunnyview Nursing and Rehabilitation Center residents). [2]

204. Sunnyview Nursing and Rehabilitation Center's administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, including Heather Pressdee, had a duty to act prudently, and had a duty to provide reasonable and ordinary care and care services to residents such as Nicholas Sylvester Cymbol.

205. Sunnyview Nursing and Rehabilitation Center is vicariously liable for the acts and omissions of its administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, including Heather Pressdee, as it has a duty to provide protection for its patients based on the special relationship between a nursing facility and its residents, and it delegates this duty to its administrators, nurses, physicians,

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[2] *See Costa v. Roxborough Mem'l Hosp.*, 708 A.2d 490, 493 (Pa. Super. Ct. 1998) ("The conduct of an employee is considered "within the scope of employment" for purposes of vicarious liability if: (1) it is of a kind and nature that the employee is employed to perform; (2) it occurs substantially within the authorized time and space limits; (3) it is actuated, at least in part, by a purpose to serve the employer; and (4) if force is intentionally used by the employee against another, the use of force is not unexpected by the employer.")

therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff.[3]

206. Sunnyview Nursing and Rehabilitation Center's administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, including Heather Pressdee, recklessly, negligently and carelessly breached their duties owed to Nicholas Sylvester Cymbol in the following particulars:

a. By injecting Mr. Cymbol with an excessive and lethal dosage of insulin that was not ordered by a physician, as pled herein;

b. To the extent insulin was given to Mr. Cymbol pursuant to a physician's order, by administering insulin in an amount far exceeding the safe and appropriate dosage prescribed by his physician, as pled herein;

c. By attempting to hide the treatment of Mr. Cymbol in giving a lethal dose of insulin by failing to document the injection being given and the dosage amount, as pled herein;

d. By causing Mr. Cymbol's death as a result of improper insulin administration, as pled herein;

e. By failing to record the administration of insulin to Mr. Cymbol, as pled herein;

f. By failing to follow proper procedure for the administration, storing, withdrawal, and control of medications such as insulin, as pled herein;

g. By administering a medication in a manner inconsistent with its accepted usage, namely administering insulin to Mr.

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[3] *See* RESTATEMENT (SECOND) OF AGENCY § 214 (1958) "A master or other principal who is under a duty to provide protection for or to have care used to protect others or their property and who confides the performance of such duty to a servant or other person is subject to liability to such others for harm caused by them by the failure of such agent to perform the duty"; RESTATEMENT (THIRD) OF AGENCY § 7.05 (2006) "1. A principal who conducts an activity through an agent is subject to liability for harm to a third party caused by the agent's conduct if the harm was caused by the principal's negligence in selecting, training, retaining, supervising, or otherwise controlling the agent. 2. When a principal has a special relationship with another person, the principal owes that person a duty of reasonable care with regard to risks arising out of the relationship, including the risk that agents of the principal will harm the person with whom the principal has such a special relationship."

Cymbol in an amount far exceeding the safe and appropriate dosage, as pled herein;

h. By failing to prevent Pressdee from administering an excessive and lethal dose of insulin to Mr. Cymbol, as pled herein;

i. By failing to immediately inform Mr. Cymbol that he had been injected with a lethal dose of insulin, as pled herein;

j. By failing to note or record in Mr. Cymbol's medical chart that he had been given a lethal dose of insulin, as pled herein;

k. By failing to promptly inform authorities that Mr. Cymbol had been given a lethal dose of insulin, as pled herein;

l. By failing to ensure that Mr. Cymbol was kept free from harm during his treatment, as pled herein;

m. By failing to ensure that Mr. Cymbol was kept safe during his time as a resident, as pled herein;

n. By failing to promptly inform appropriate medical personnel that Mr. Cymbol had been given a lethal dose of insulin, as pled herein;

o. By failing to follow any emergency response procedures in place to address improper medical treatment by another employee, as pled herein;

p. By failing to follow appropriate policies and procedures regarding the handling and usage of medication, as pled herein; and,

q. By failing to treat Mr. Cymbol with dignity and respect, as pled herein.

207. At all times relevant hereto, Sunnyview Nursing and Rehabilitation Center and its duly authorized administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, had a duty to not violate the legal rights of any resident, and had a duty to comply with the provisions of Title 28 Pennsylvania Administrative Code, Chapter 211, and 42 C.F.R. § 483, *et seq.*

208. The regulations listed below are designed and intended to protect the interests of persons such as Nicholas Sylvester Cymbol, who are residing in facilities such as Sunnyview Nursing and Rehabilitation Center.

209. The regulations listed below are designed and intended to protect persons such as Nicholas Sylvester Cymbol against the hazards he encountered and the harm and death he suffered as a result of residing at Sunnyview Nursing and Rehabilitation Center.

210. Sunnyview Nursing and Rehabilitation Center, as well as its duly authorized administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff recklessly, negligently and carelessly violated the above-noted regulations in the following ways:

a. By failing to protect Mr. Cymbol from accidents, injuries, and abuse when Heather Pressdee administered an excessive and lethal dose of insulin to Mr. Cymbol, as required by 28 Pa. Code. § 211.10(d), as pled herein;

b. By failing to provide adequate nursing services consistent with 28 Pa. Code. § 211.12, as pled herein;

c. By failing to intervene when it became clear that Heather Pressdee's medical care of Mr. Cymbol and other residents was inconsistent with current standards of care, as required by 28 Pa. Code § 211.2(d)(9), as pled herein;

d. By failing to develop systems and mechanisms for monitoring the performance of Heather Pressdee and communicating issues related to her administration of medical care to Mr. Cymbol and other residents of Sunnyview Nursing and Rehabilitation Center, as required by 28 Pa. Code § 211.2(d)(10), as pled herein;

e. By failing to provide general supervision, guidance, and assistance to assure that preventive measures, treatments, medications, diet, and other health services prescribed are properly carried out and recorded, as required by 28 Pa. Code § 211.12(d)(5), as pled herein;

f. By failing to execute written policies and procedures that prohibit the mistreatment, neglect and abuse of residents, as required by 42 C.F.R. § 483.12, as pled herein;

g. By permitting unauthorized personnel to have access to locked drugs and biologicals, in violation of 42 C.F.R. § 483.45(h), as pled herein;

h. By failing to ensure that the Sunnyview nursing staff, including Heather Pressdee, had the competencies and skills necessary to care for residents' needs, as required by 42 C.F.R. § 483.35(a), as pled herein;

i. By failing to provide to Mr. Cymbol a safe environment, as required by 42 C.F.R. § 483.80, as pled herein; and,

j. By failing to provide Mr. Cymbol his rights, including the right to a dignified existence, as required by 42 C.F.R. § 483.10, as pled herein.

211. As a direct and proximate result of the negligent conduct of Sunnyview Nursing and Rehabilitation Center as set forth above, Nicholas Sylvester Cymbol was injured, experienced conscious pain and suffering and died.

212. As a result of the previously described conduct of the Defendants, Plaintiff Melinda M. Brown, as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased, seeks damages as follows:

a. Money expended for medical services and supplies incident to the treatment and death of Nicholas Sylvester Cymbol;

b. Pain, suffering, embarrassment, humiliation, inconvenience, anxiety, loss of enjoyment of life and nervousness that Nicholas Sylvester Cymbol experienced while residing at the Defendant facility and until the time of his death and sustained injuries which contributed to his death;

c. Any and all hospital, medical, surgical, and nursing expenses incurred; and,

d. Punitive damages as a result of the actions as detailed herein, where Defendants knew or should have known that their acts

and/or failures to act, as more fully set forth herein, would, and did – in fact - create a high degree of risk of physical harm, when they acted with deliberate indifference to the health and well-being of Nicholas Sylvester Cymbol in exposing him to Heather Pressdee, who they know or should have known presented a risk to residents at Sunnyview Nursing and Rehabilitation Center. Further, these actions detailed herein show a complete and total lack of care for Nicholas Sylvester Cymbol and other residents of Sunnyview Nursing and Rehabilitation Center with regard to his health, safety, well-being, and human dignity.

WHEREFORE, Plaintiff, Melinda M. Brown, Individually and as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased, claims damages of Defendant Sunnyview Nursing and Rehabilitation Center, and demands compensatory and punitive damages from the Defendant in an amount in excess of the jurisdictional arbitration limits, together with interest, costs of suit, and any other relief this Honorable Court deems appropriate to recover for which this suit is filed.

## COUNT III

**Plaintiff, Melinda M. Brown, Individually and as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased vs. Sunnyview Nursing and Rehabilitation Center**

**WRONGFUL DEATH**

213. All of the preceding paragraphs of this Complaint are incorporated herein, as if set forth more fully at length.

214. All of the actions and/or inactions of Sunnyview Nursing and Rehabilitation Center, as described above, as well as the breaches of the duty of care owed to Nicholas Sylvester Cymbol, increased the risk of harm to him and caused his death on May 1, 2023.

215. The persons entitled by law to recover damages for Nicholas Sylvester Cymbol's wrongful death, identified herein, have sustained the following damages and losses:

a. All money expended for surgical, hospital, and nursing expenses incurred prior to the death of Nicholas Sylvester Cymbol;

b. All money expended for funeral and estate expenses because of the death of Nicholas Sylvester Cymbol; and,

c. They have forever been denied and forever lost the services, society and comfort, as well as the assistance, guidance, counseling, companionship, solace and protection of the Decedent, Nicholas Sylvester Cymbol.

WHEREFORE, Plaintiff, Melinda M. Brown, Individually and as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased, claims damages of Defendant Sunnyview Nursing and Rehabilitation Center, and demands compensatory and punitive damages from the Defendant in an amount in excess of the jurisdictional arbitration limits, together with interest, costs of suit, and any other relief this Honorable Court deems appropriate to recover for which this suit is filed.

## COUNT IV

**Plaintiff, Melinda M. Brown, Individually and as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased vs. Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center**

## CORPORATE NEGLIGENCE

216. All of the preceding paragraphs of this Complaint are incorporated herein, as if set forth more fully at length.

217. As owner, operator, manager, and/or possessor of Sunnyview Nursing and Rehabilitation Center, Sunnyview Operating LLC a non-delegable duty and responsibility to its residents and to the public to furnish appropriate and competent medical care that comported with standards of professional practice.

218. As part of its non-delegable duties and responsibilities, Sunnyview Operating LLC had an obligation to establish, enforce and follow policies and procedures to maintain adequate care and have competent medical staff to ensure that appropriate medical care is delivered to its residents.

219. Acting through its administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, Sunnyview Operating LLC was responsible for the standard of professional practice by members of its staff.

220. Sunnyview Operating LLC failed to uphold these non-delegable duties of care in relation to the care provided to Nicholas Sylvester Cymbol.

221. Sunnyview Operating LLC, as well as its duly authorized administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff negligently breached their duties owed to Nicholas Sylvester Cymbol in the following particulars:

a. By failing to protect Nicholas Sylvester Cymbol from physical and psychological harm, injury, and abuse perpetrated by Heather Pressdee at Sunnyview Nursing and Rehabilitation Center, as pled herein;

b. By failing to provide a safe environment for Nicholas Sylvester Cymbol while he was a resident of Sunnyview Nursing and Rehabilitation Center, as pled herein;

c. By failing to recognize that Heather Pressdee posed a risk to residents of the facility, including Nicholas Sylvester Cymbol, based on her history of abusing residents, as pled herein;

d. By failing to properly investigate the activities of prospective employees before hiring them, particularly Heather Pressdee, as pled herein;

e. By failing to implement a policy and/or procedure that would prevent individuals with a history of abusing and harming residents from obtaining employment at the facility, as pled herein;

f. By hiring and retaining staff, including Heather Pressdee, who the Defendant knew, or should have known, was a danger to residents such as Nicholas Sylvester Cymbol at Sunnyview Nursing and Rehabilitation Center, as pled herein;

g. By failing to conduct a thorough background check on all employees, including Heather Pressdee, such that a predatory individual was employed to provide hands on care to vulnerable residents such as Nicholas Sylvester Cymbol, as pled herein;

h. By failing to monitor the behavior of Heather Pressdee while she was an employee of the facility and while she was providing care to residents, as pled herein;

i. By failing to develop and enforce adequate and sufficient policies and procedures regarding the responsibilities of employees witnessing misconduct, as pled herein;

j. By failing to adequately train employees to respond to misconduct of other staff members, as pled herein;

k. By failing to provide for the monitoring of all medications within the Sunnyview Nursing and Rehabilitation Center facility to ensure that they were properly accounted for at all times, as pled herein;

l. By failing to exercise reasonable care in selecting, supervising, and controlling employees, as pled herein;

m. By failing to investigate Heather Pressdee, in spite of the string of suspicious deaths of residents who were under her care, as pled herein;

n. By failing to report suspicious deaths and all other reportable incidents that occurred under Pressdee's care to the necessary Pennsylvania state agencies, as pled herein;

o. By failing to maintain a protocol for storing medications on the premises such that staff members could not obtain it without a physician's order, as pled herein; and,

p. By failing to investigate Heather Pressdee despite concerns amongst other staff members at Sunnyview Nursing and Rehabilitation Center that she was causing harm to residents, as pled herein.

222. At all times relevant hereto, Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center had a duty to not violate the legal rights of any resident, and had a duty

to comply with the provisions of Title 28 Pennsylvania Administrative Code, Chapter 211, and 42 C.F.R. § 483, *et seq.*

223. The regulations listed below are designed and intended to protect the interests of persons such as Nicholas Sylvester Cymbol, who are residing in facilities such as Sunnyview Nursing and Rehabilitation Center.

224. The regulations listed below are designed and intended to protect persons such as Nicholas Sylvester Cymbol against the hazards he encountered and the harm and death he suffered as a result of residing at Sunnyview Nursing and Rehabilitation Center.

225. Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center, as well as its duly authorized administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, negligently and carelessly violated the above-noted regulations in the following ways:

a. By failing to design and implement resident care policies to ensure that Mr. Cymbol received treatment, medication, and rehabilitative nursing care, as prescribed, as required by 28 Pa. Code. § 211.10(c), as pled herein;

b. By failing to meet minimum standards of operation of a long-term care facility, as required by 28 Pa. Code. § 201.14, as pled herein;

c. By failing to adopt and enforce effective rules for the health, care and safety of the residents, as well as the general operation of the facility, as required by 28 Pa. Code. § 201.18, as pled herein;

d. By failing to provide appropriate training and educational programs for Sunnyview Nursing and Rehabilitation Center's staff, as required by 28 Pa. Code. § 201.20(a), as pled herein;

e. By failing to provide appropriate orientation and training to staff on prevention, detection, and reporting of resident

abuse, as required by 28 Pa. Code § 201.20(b), as pled herein;

f. By failing to provide adequate nursing services consistent with 28 Pa. Code. § 211.12, as pled herein;

g. By failing to develop systems and mechanisms for monitoring the performance of Heather Pressdee and communicating issues related to her administration of medical care to Mr. Cymbol and other residents of Sunnyview Nursing and Rehabilitation Center, as required by 28 Pa. Code § 211.2(d)(10), as pled herein;

h. By failing to develop and adhere to written policies and procedures regarding the rights and responsibilities of residents, as required by 28 Pa. Code. § 201.29(a);

i. By failing to develop policies identifying all treatments and medications which may not be prescribed or dispended by way of verbal order, as well as all personnel authorized to take and transcribe verbal orders, as required by 28 Pa. Code. § 211.3(e), as pled herein;

j. By failing to develop policies and procedure that ensure that medications are administered by authorized persons, as required by 28 Pa. Code § 211.9(b), as pled herein;

k. By failing to develop policies and procedures relative to the disposition of medications that address timely and safe identification and removal of medications for disposition; identification of storage methods for medications awaiting final disposition; control and accountability of medications awaiting final disposition consistent with standards of practice, and documentation of actual disposition of medications, as required by 28 Pa. Code § 211.9(j.1) as pled herein;

l. By failing to develop policies and procedures for drug therapy, distribution, administration, control, accountability, and use of medications, as required by 28 Pa. Code § 211.9(k), as pled herein;

m. By failing to report all serious incidents involving Sunnyview residents to the Pennsylvania Department of Health, as required by 28 Pa. Code § 201.14(c), as pled herein;

n. By failing to develop policies and procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs within the facility, as required by 42 C.F.R. § 484.35(a), as pled herein;

o. By permitting unauthorized personnel to have access to locked drugs and biologicals, in violation of 42 C.F.R. § 483.45(h), as pled herein;

p. By failing to ensure that Heather Pressdee had the competencies and skills necessary to care for residents' needs, as required by 42 C.F.R. § 483.35(a), as pled herein; and,

q. By failing to ensure that Sunnyview Nursing and Rehabilitation Center was administered in a manner that enabled it to use its resources effectively and efficiently to allow Mr. Cymbol to maintain or attain the highest practicable level of physical, mental and psycho-social well-being, as required by 42 C.F.R. § 483.70, as pled herein.

226. Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center had actual or constructive knowledge of defective policies and procedures related to hiring, retention, supervision, monitoring, quality assurance, coordination of care, administration of medication, drug therapy, training and orientation of staff, and record-keeping; defects of which were substantial factors in causing the harm and death of Nicholas Sylvester Cymbol.

227. As a direct and proximate result of the aforementioned acts and omissions of Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center and its authorized administrators, nurses, physicians, therapists, agents, ostensible agents, servants, workers, employees, contractors, subcontractors, and/or staff, as set forth above, Nicholas Sylvester Cymbol was injured as described above, experienced conscious pain and suffering and died.

228. As a result of the previously described conduct of Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center, Plaintiff Melinda M. Brown, as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased, seeks damages as follows:

a. Money expended for medical services and supplies incident to the treatment and death of Nicholas Sylvester Cymbol;

b. Pain, suffering, embarrassment, humiliation, inconvenience, anxiety, loss of enjoyment of life and nervousness that Nicholas Sylvester Cymbol experienced while residing at the Defendant facility and sustained injuries which contributed to his eventual death;

c. Any and all hospital, medical, surgical, and nursing expenses incurred; and,

d. Punitive damages as a result of the actions as detailed herein, where Defendants knew or should have known that their acts and/or failures to act, as more fully set forth herein, would, and in fact did, create a high degree of risk of physical harm, when they acted with deliberate indifference to the health and well-being of Nicholas Sylvester Cymbol in exposing him to Heather Pressdee, who they know or should have known presented a risk to residents at Sunnyview Nursing and Rehabilitation Center. Further, these actions detailed herein show a complete and total lack of care for Nicholas Sylvester Cymbol and other residents of Sunnyview Nursing and Rehabilitation Center with regard to his health, safety, well-being, and human dignity.

WHEREFORE, Plaintiff, Melinda M. Brown, Individually and as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased, claims damages of Defendant Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center and Rehabilitation Center, and demands compensatory and punitive damages from the Defendant in an amount in excess of the jurisdictional arbitration limits, together with interest, costs of suit, and any other relief this Honorable Court deems appropriate to recover for which this suit is filed.

## COUNT V

### Plaintiff, Melinda M. Brown, Individually and as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased vs. Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center

### WRONGFUL DEATH

229. All of the preceding paragraphs of this Complaint are incorporated herein, as if set forth more fully at length.

230. All of the actions and/or inactions of Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center d/b/a Sunnyview Nursing and Rehabilitation Center, as described above, as well as the breaches of the duty of care owed to Nicholas Sylvester Cymbol, increased the risk of harm to him and caused and/or contributed to his death on May 1, 2023.

231. The persons entitled by law to recover damages for Nicholas Sylvester Cymbol's wrongful death, identified herein, have sustained the following damages and losses:

a. All money expended for surgical, hospital, and nursing expenses incurred prior to the death of Nicholas Sylvester Cymbol;

b. All money expended for funeral and estate expenses because of the death of Nicholas Sylvester Cymbol; and,

c. They have forever been denied and forever lost the services, society and comfort, as well as the assistance, guidance, counseling, companionship, solace and protection of the Decedent, Nicholas Sylvester Cymbol.

WHEREFORE, Plaintiff, Melinda M. Brown, Individually and as Executor of the Estate of Nicholas Sylvester Cymbol, Deceased, claims damages of Defendant Sunnyview Operating LLC d/b/a Sunnyview Nursing and Rehabilitation Center and demands compensatory and punitive damages from the Defendant in an amount in excess of the jurisdictional arbitration limits, together

with interest, costs of suit, and any other relief this Honorable Court deems appropriate to recover for which this suit is filed.

**A JURY TRIAL IS DEMANDED.**

Respectfully submitted,

ROBERT PEIRCE & ASSOCIATES, P.C.

By:________________________________

SCOTT M. SIMON, ESQUIRE
Counsel for Plaintiff

**IN THE COURT OF COMMON PLEAS OF BUTLER COUNTY, PENNSYLVANIA**

**Civil Division**

| | |
|---|---|
| MELINDA M. BROWN, Individually and as Administratrix of the Estate of NICHOLAS SYLVESTER CYMBOL, Deceased,<br><br>Plaintiff,<br><br>vs.<br><br>SUNNYVIEW NURSING AND REHABILITATION CENTER and SUNNYVIEW OPERATING LLC d/b/a SUNNVIEW NURSING AND REHABILITATION CENTER,<br><br>Defendants. | No.: |

**CERTIFICATE OF MERIT REGARDING**
**DEFENDANT SUNNYVIEW NURSING AND REHABILITATION CENTER**

I, Scott M. Simon, Esquire, certify that:

__X__ An appropriate licensed professional has supplied a written statement to the undersigned that there is a basis to conclude that the care, skill or knowledge exercised or exhibited by the defendant in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional standards and that such conduct was a cause in bringing about harm;

And

__X__ The claim that defendant deviated from an acceptable professional standard is based solely or in part on allegations that other licensed professionals for whom this defendant is responsible deviated from an acceptable professional standard and an appropriate licensed professional has supplied a written statement to the undersigned that there is a basis to conclude that the care, skill or knowledge exercised or exhibited by the other licensed professionals in the treatment, practice or work that is the subject of the Complaint, fell outside acceptable professional standards and that such conduct was a cause in bringing about the harm;

Or

_____ Expert testimony of an appropriate licensed professional is unnecessary for prosecution of the claim against these defendants.

Respectfully submitted,

ROBERT PEIRCE & ASSOCIATES, P.C.

By:

SCOTT M. SIMON, ESQUIRE
Counsel for Plaintiff

**IN THE COURT OF COMMON PLEAS OF BUTLER COUNTY, PENNSYLVANIA**

**Civil Division**

| | |
|---|---|
| MELINDA M. BROWN, Individually and as Administratrix of the Estate of NICHOLAS SYLVESTER CYMBOL, Deceased,<br><br>Plaintiff,<br><br>vs.<br><br>SUNNYVIEW NURSING AND REHABILITATION CENTER and SUNNYVIEW OPERATING LLC d/b/a SUNNVIEW NURSING AND REHABILITATION CENTER,<br><br>Defendants. | No.: |

**CERTIFICATE OF MERIT REGARDING DEFENDANT SUNNYVIEW OPERATING LLC d/b/a SUNNYVIEW NURSING AND REHABILITATION CENTER**

I, Scott M. Simon, Esquire, certify that:

__X__ An appropriate licensed professional has supplied a written statement to the undersigned that there is a basis to conclude that the care, skill or knowledge exercised or exhibited by the defendant in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional standards and that such conduct was a cause in bringing about harm;

And

__X__ The claim that defendant deviated from an acceptable professional standard is based solely or in part on allegations that other licensed professionals for whom this defendant is responsible deviated from an acceptable professional standard and an appropriate licensed professional has supplied a written statement to the undersigned that there is a basis to conclude that the care, skill or knowledge exercised or exhibited by the other licensed professionals in the treatment, practice or work that is the subject of the Complaint, fell outside acceptable professional standards and that such conduct was a cause in bringing about the harm;

Or

_____ Expert testimony of an appropriate licensed professional is unnecessary for prosecution of the claim against these defendants.

Respectfully submitted,

ROBERT PEIRCE & ASSOCIATES, P.C.

By: ______________________________
SCOTT M. SIMON, ESQUIRE
Counsel for Plaintiff

**IN THE COURT OF COMMON PLEAS OF BUTLER COUNTY, PENNSYLVANIA**

**Civil Division**

MELINDA M. BROWN, Individually and as Administratrix of the Estate of NICHOLAS SYLVESTER CYMBOL, Deceased,

Plaintiff,

vs.

SUNNYVIEW NURSING AND REHABILITATION CENTER and SUNNYVIEW OPERATING LLC d/b/a SUNNVIEW NURSING AND REHABILITATION CENTER,

Defendants.

No.:

**VERIFICATION**

I verify that the averments of fact made in the foregoing COMPLAINT are true and correct and based on my personal knowledge, information or belief. I understand that averments of fact in said document are made subject to the penalties of 18 Pa. C.S. §4904, relating to unsworn falsifications to authorities.

3/25/24
Dated

MELINDA M. BROWN

**IN THE COURT OF COMMON PLEAS OF BUTLER COUNTY, PENNSYLVANIA**

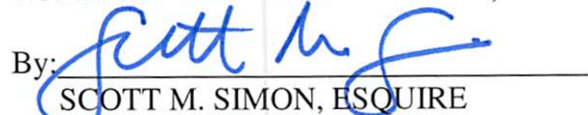
**Civil Division**

| | |
|---|---|
| MELINDA M. BROWN, Individually and as Administratrix of the Estate of NICHOLAS SYLVESTER CYMBOL, Deceased,<br><br>Plaintiff,<br><br>vs.<br><br>SUNNYVIEW NURSING AND REHABILITATION CENTER and SUNNYVIEW OPERATING LLC d/b/a SUNNVIEW NURSING AND REHABILITATION CENTER,<br><br>Defendants. | No.: |

**CERTIFICATE OF COMPLIANCE**

I certify that this filing complies with the provisions of the *Case Records Public Access Policy of the Unified Judicial System of Pennsylvania* that require filing confidential information and documents differently than non-confidential information and documents.

ROBERT PEIRCE & ASSOCIATES, P.C.



By: ________________________________
SCOTT M. SIMON, ESQUIRE
PA ID No.: 307559
Counsel for Plaintiff