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STATEMENT OF CLAIM

Mিনny Mallery (hereinafter referred to as, (“Ms. Mallery”), hereby sues Peacehealth Peacehealth at Riverbend, Eugene Emergency Physicians, P.C., and Mckenzie Medical Center (collectively, and hereinafter referred to as “Health Care Providers or Defendants”). In support of Plaintiff’s causes of action, Ms. Mallery states as follows:

INTRODUCTION

1. This is primarily a complaint for failure to treat under the federal law EMTALA, (The Emergency Treatment and Active Labor Act) lack of informed consent, health care discrimination, healthcare fraud (Kepro) from an entity which accepts government funds, intentional torts from health care providers, and a contract action arising from the acts and omissions related to the medical care and treatment of Ms. Mallery by the Health Care Provider Defendants, including the physicians, residents, nurses, technicians, and staff including but not limited to the providers contracted and or employed by Peacehealth Sacred Heart, LLC, Mckenzie Medical Center, and Eugene Emergency Physicians, P.C.; each of whom were responsible for rendering medical care and treatment to Ms. Mallery.

2. Minny Mallery also known as Minny Frank is a well-known 51 year-old patient of the Health Care Providers with the following documented list of medical diagnoses including but not limited to, symptomatic cholelithiasis, Neutropenia, Elevated erythrocyte sedimentation rate, low folic acid, Hepatic steatosis, Leukopenia, Elevated bilirubin, low serum haptoglobin, Hemolysis, Chronic acute pancreatitis, Cirrhosis of the liver, Autoimmune Hepatitis, Esophagitis, Gastritis, Thiamin deficiency, Impaired fasting glucose, peripheral neuropathy, peroneal nerve injury, abnormal weight loss of over 85 pounds, chronic anemia with history of multiple blood transfusions, history of multiple iron infusions, Gastroesophageal reflux disease, chronic

occlusion of the splenic vein, gastric varices, history of Upper GI Bleed, Melena, Hemochromatosis (one allele), history of tachycardia, Temporomandibular joint disorder, chronic fatigue, arthritis, Anxiety disorder, post-traumatic stress disorder, Celiac disease, Alopecia, Psoriasis, Systemic Lupus, Low magnesium level, chronic low potassium, Hypokalemia, and Hypocalcemia, and several vitamin deficiencies including but not limited to Vitamin A, Vitamin K, Vitamin D, Vitamin B1, liver failure, acute brain encephalopathy. This list is not all inclusive. Ms. Mallery is often very ill requiring hospitalization in order to get medically stabilized. Due to Ms. Mallery's multiple health conditions she is considered disabled and meets the definition of a protected individual under Section 1755 of the Patient Protection and Affordable Care Act and Section 504, part of the Rehabilitation Act of 1943. Ms. Mallery is a Medicare recipient based on disability.

3. Ms. Mallery visited the Defendants' hospital including but not limited to the following dates which are pertinent, 7/10/23, 9/7/23, 11/27-11/30/23 (inpatient), 2/5/24, 2/15/24(inpatient), 3/7/24-3/14/24, 4/26/24 (inpatient) 4/29/24-5/4/24, (inpatient), 5/7/24/ 5/20/24, 5/24/24-6/4/24, (inpatient) 6/27/24,2/14/2025, 4/30/2025, 5/3/2025. Due to Ms. Mallery's frequent visits to the Emergency room requiring urgent medical attention the Health Care Providers were aware of Ms. Mallery's documented history and were aware that she suffered from a myriad of maladies, most significant, Ms. Mallery's history of upper and lower gastrointestinal bleeding related to her previously diagnosed chronic liver failure and her cardiac condition, which is a QT prolongation. Despite the Defendants' awareness and Ms. Mallery's complaint of pain and worsening symptoms, the Defendants failed to properly treat, evaluate and diagnose Ms. Mallery due to their personal preconceived beliefs about her. The Defendants treat Ms. Mallery differently than other patients similarly situated as her due to her diagnoses of Bipolar-Disorder,

Alcohol use disorder, as well the frequency of her visits to the Emergency room department. The discriminatory behavior committed against Ms. Mallery is compounded by the fact that the employees and agents of the Defendants are aware that Ms. Mallery had filed several complaints internally against them and externally to Kepro (a quality care organization serving Medicare beneficiaries) complaining about the consistent deviation from the standard of care in the Defendants' hospital and Emergency room Department. The Defendants' behavior on or about May 7, 2024, May 20, 2024, May 24 through June 4, 2024, May 2, 2025 and June 27, 2024 can only be described as retaliatory in nature, acts committed solely with the intent and purpose of harming Ms. Mallery.

4. As a result of the Defendants' failure to properly and timely evaluate, treat and diagnose Ms. Mallery, she struggles with the aftereffects of the coma she experienced, is at an increased risk of premature death, and has suffered immense physical and emotional pain all of which for she rightfully seeks compensation.

5. As a result of the coma Ms. Mallery experienced over the course of a year and ongoing, permanent brain damage which consists of memory loss, cognitive deficits, loss of physical coordination, loss of dexterity of the hands and fingers and a notable decline in mental acuity. Ms. Mallery has a law degree and works in the legal field. Other permanent injuries have yet to be determined and or assessed. However a recent MRI performed on Plaintiff's brain shows loss of volume and brain atrophy which was directly caused by Plaintiff's coma as her MRI brain scans prior to the coma did not show these significant findings. The Defendants' position on the matter is that Plaintiff suffered a withdrawal seizure, and that she became encephalopathic after she was admitted to the hospital due to gastrointestinal bleeding. Defendant SHMC claims that Plaintiff experienced a seizure

because of alcohol withdrawal, however this is a fallacy and regardless, Plaintiff was still under the direct control and care of Defendant Peacehealth. Plaintiff has never suffered a withdrawal seizure or encephalopathy while under the medical care of well-trained nurses, CNAs, and physicians that are competent enough to follow the reasonable standard of care while treating patients such as Plaintiff. Plaintiff has been through alcohol withdrawal multiple times during her five decades of living and has never had a seizure or coma related to alcohol, including but not limited to:

1993- Plaintiff suffered from alcoholism and alcohol poisoning as diagnosed by a physician at Frederick Memorial Hospital in Frederick, Md, but never had a withdrawal coma when she stopped cold turkey after that event. She never had a seizure or coma.

1994- Plaintiff had been drinking at least a pint of vodka a day and then stopped cold turkey when she found out she was pregnant. She never had a seizure or coma.

2005- Plaintiff had been drinking a half of gallon of vodka a day and then stopped cold turkey when she found out she was pregnant. She never had a seizure or coma.

2010-Plaintiff had been drinking a bottle of wine a day. She stopped cold turkey she found out she was pregnant. She never had a seizure or a coma.

2012- Plaintiff started drinking heavily again when her son shot himself, she stopped cold turkey in 2013 when her children were removed from her care. She never had a seizure or a coma.

2021-Plaintiff sought treatment at two places which were unsuccessful, one of which was Orenda in Maryland and another one in Emmitsburg, MD, however at both locations, Plaintiff was inpatient and under the care of nurses. She had been drinking nearly a gallon of

vodka a day (Plaintiff's son passed away in late 2020), she went through withdrawal but never had a seizure or a coma.

2022 Plaintiff sought treatment for medical detox at John's Hopkins Hospital; she suffered major withdrawal symptoms which were severe. However, she never had a seizure or a coma.

2023 Plaintiff sought treatment at Serenity Lane in Eugene, OR (after finding out her daughter was raped) and finished their 30-day program. And she stopped cold turkey, but she was under the competent care of medical staff, thus, she never suffered a seizure or a coma.

2026 Plaintiff sought detox and treatment at Buckley House in Eugene, OR and Willamette Family. She never had a seizure or a coma

2026 Plaintiff had begun drinking wine again, more than a bottle a day but through her motivation to remain sober and engage in recovery she sought detox at Adapt Crossroads in Roseburg, Oregon. She had minor withdrawal symptoms but was treated adequately. She never suffered a seizure or a coma. It should be noted that Plaintiff has had multiple brain MRI's over the years and they were always completely normal until AFTER the coma. Res Ipsa Loquitur is most fitting in this scenario. There is no other explanation of Plaintiff's coma if not negligence of the Defendants.

6. The Defendants' pure negligence (*Ms. Mallery was under the care and control of the Defendants and admitted as a patient for two days before she fell into her coma*), Two days is enough time to stabilize patients in a similar condition. Defendant Peacehealth's contractual breach of their duties owed to Ms. Mallery including their violation of Federal anti-discrimination statutes and from their deviation from the general standards of medical care have caused Ms. Mallery conscious physical and mental pain and suffering, severe mental anguish and

economic losses, including but not limited to, lost wages and extraordinary medical expenses and other damages. The injuries and permanent cognitive deficiencies sustained by Ms. Mallery were the direct and proximate result of the negligent and intentional actions of the Defendants as well as the breaches of the applicable standards of medical care by and through their employees/servants/agents, without any act or omissions on the part of Ms. Mallery directly thereunto contributing.

JURISDICTION AND VENUE

7. This Court has jurisdiction as the matter relates to a matter pursuant to a question of federal law involving EMTALA. This court also has jurisdiction pursuant to Plaintiff's claims related to the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12131(2), Section 504 of the Rehabilitation Act ("Section 504" or "RA"), 29 U.S.C. § 794. This court has supplemental jurisdiction over Plaintiff's state claims pursuant to section 1367(a) of 28 U.S. C.

8. Venue in this district is proper pursuant to 28 U.S.C. § 1391(b) and divisional venue is appropriate in the Eugene Division pursuant to local rule 3-2 because the claims arise in this district.

THE PARTIES

9. At all relevant times pertinent hereto, Plaintiff Ms. Mallery was residing in Eugene, Oregon, and is considered a protected individual under the relevant statute, Section 1557 of the Patient Protection and Affordable Care Act (Subpart A, Part 92) and Section 504 part of the Rehabilitation Act of 1973.¹ Ms. Mallery is a Medicare recipient based upon disability.

¹ Section 1557 of the Patient Protection and Affordable Care Act (ACA) (42 U.S.C. 18116), prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs and activities. Section 1557 provides that, except as otherwise provided in title I of the ACA, an individual shall not, on the grounds prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is

10. At all relevant times pertinent hereto, Health Care Provider Peacehealth at Riverbend, (hereinafter referred to as PeaceHealth) is a business entity organized under the laws of the State of Oregon, held itself out to the public as competent to provide medical services and treatment for patients with health conditions such as Ms. Mallery and did provide such services to Ms. Mallery directly and by and through its actual and/or apparent agents, servants, and/or employees, each of whom acted within the scope of his/her authority at all times. Peacehealth is a recipient for purposes of Section 1557 of the Patient Protection and Affordable Care Act and Section 504 of the Rehabilitation Act of 1973.

11. At all relevant times pertinent hereto, Eugene Emergency Physicians, P.C. is a business entity organized under the laws of the State of Oregon and under the laws of the State of Oregon, held itself out to the public as competent to provide medical services and treatment for patient with health conditions such as Ms. Mallery and did provide such services to Ms. Mallery directly and by and through its actual and/or apparent agents, servants, and/or employees, each of whom acted within the scope of his/her authority at all times. Eugene Emergency Physicians is a recipient for purposes of Section 1557 of the Patient Protection and Affordable Care Act and Section 504 of the Rehabilitation Act of 1973.

12. At all relevant times pertinent hereto, Mckenzie Willamette Medical Center. is a business entity organized under the laws of the State of Oregon and under the laws of the State of Oregon, held itself out to the public as competent to provide medical services and treatment for patient with health conditions such as Ms. Mallery and did provide such services to Ms. Mallery

receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an executive agency or any entity established under title I of the ACA. This part applies to health programs or activities administered by recipients of Federal financial assistance from the Department, Department-administered health programs or activities, and title I entities that administer health programs or activities.

directly and by and through its actual and/or apparent agents, servants, and/or employees, each of whom acted within the scope of his/her authority at all times. Mckenzie Willamette Medical Center is a recipient for purposes of Section 1557 of the Patient Protection and Affordable Care Act and Section 504 of the Rehabilitation Act of 1973

13. At all relevant times pertinent hereto, the Defendants acted as the principals, and/or actual and/or apparent agents, servants and/or employees or each other, and within the scope of their authority. All of the injuries and damages sustained by Ms. Mallery were the direct and proximate result of the negligent actions, omissions, failure to treat, and breaches of the applicable standards of medical care by the Health Care Providers, by and through their employees/servants, without any act or omission on the part of Ms. Mallery directly thereunto contributing. All agents of the Defendants are considered recipients for purposes of Section 1557 of the Patient Protection and Affordable Care Act and Section 504 of the Rehabilitation Act of 1973.

FACTUAL BACKGROUND

14. Ms. Mallery incorporates by reference the factual allegations of the foregoing paragraphs of this Statement of Claim 1-13 as if fully set forth herein:

15. On or about May 20, 2024, Ms. Mallery visited the Emergency room due to complaints of abdominal pain, nausea, and vomiting over the past week. Ms. Mallery disclosed to the intake medical professional that she suspected upper GI bleeding again and wasn't feeling quite well as she had vomited blood and was unable to keep food or liquids down for several days.

16. On March 20, 2024, The Defendants drew Ms. Mallery's blood, left the vials of blood in Ms. Mallery's possession and then later discharged Ms. Mallery from care over her objections. Ms. Mallery requested further evaluation or a second opinion but was discharged after waiting

several hours to see a Physician. Ms. Mallery has photo evidence of the blood vials left in her possessions and videos. This was a deviation from the standard of care to leave two blood vial with a patient and then discharge the patient. There is no clear way to guarantee that the blood tested that day or any day is indicative of Plaintiff's correct blood test results. Plaintiff was suffering from hyperammonemia at the time, a condition which is life threatening and can lead to coma and death. Defendants failed to order an ammonia test which could have detected this condition much sooner, before it led to Plaintiff's coma.

17. The Defendants were aware through their medical training, hands-on work experience, and overall general medical knowledge as demonstrated by their professional degree(s), that a patient with a history of severe to moderate substance abuse attempting to stop drinking alcohol is ill advised to do so without medical intervention and or medical assistance. The reasoning is such that stopping cold turkey increases the chances of coma and or death due to the body's physical dependence on the substance. This is the very reason for the CIWA protocol to be immediately implemented. The Defendants were also aware that ammonia levels should be checked in a patient with liver cirrhosis, and that patients' blood should also be tested for acidosis which is a dangerous condition. The last time Defendant Peacehealth checked Plaintiff's lactic acid was February 20, 2024. Defendant Peacehealth did not run the appropriate tests in time before Plaintiff fell into a coma. This deviation from the standard of care caused Plaintiff's coma. Had the Defendant hospital Peacehealth run the appropriate tests at the time that Plaintiff required emergent assistance, her coma would have been prevented.

18. The Defendants were aware that Ms. Mallery had a history of alcohol use disorder due to self-reporting and her medical record, (history of alcoholic pancreatitis requiring in patient hospitalization over 10 times within the past three years, chronic liver failure requiring liver

transplant). The Defendants were also aware based upon Ms. Mallery's myriad of medical conditions found in the medical record and also based upon self-reporting that she has a history of atypical seizures and this places her at higher risk for seizure or stroke during detox from alcohol. This history made it even more paramount that the Defendants run a blood test for ammonia levels to rule out the potential of hyperammonemia.

19. The Defendants are aware that suffering alcoholics attempting to seek treatment are struggling to find detox centers or residential treatment centers in this geographical area that accept the state's insurance plan and that the hospital is often times the patient's only sanctuary for detox and or treatment for medical emergencies and the symptoms resulting therefrom. Yet the Defendants' hospital has failed to implement policies to keep patients safe who might otherwise have no place to go during a time of acute substance abuse withdrawal or toxic /hepatic encephalopathy.

20. On May 24, 2024, Plaintiff returned to the Defendant's emergency room where it is well known in the community that the wait to see a physician is 5 to 12 hours or longer.² Ms. Mallery returned after her visit from May 20, 2024 and was complaining again of abdominal pain specifically her pancreas and liver, feelings of general malaise, and severe fatigue. While waiting in a bed during admission for treatment, Ms. Mallery fell into a coma, and was diagnosed with alcoholic withdrawal delirium, hyperammonemia, and hepatic encephalopathy. At the time Ms. Mallery was admitted to the Defendants' hospital she was suffering from internal bleeding related to her condition, requiring a blood transfusion, complications related to liver failure

² On the occasions Ms. Mallery visited the Defendants' hospital she waited over 5 hours, often more than 10 hours to see a physician or get a bed to be seen in the Emergency room department.

including gastric varices, hepatic portal hypertension, and an enlarged spleen. Had the Defendant Hospital not turned Plaintiff away just days before, this could have been prevented.

21 Triage notes taken on May 24, 2024, at 12:49pm in part state: Complains of upper abdominal pain, nausea, vomiting, and headache. Patient has end-stage liver disease and chronic pancreatitis/ Patient was told she doesn't have much longer to live and would like to talk to someone about that."

22. Triage notes taken on May 24, 2024 at 12:56pm in part state: "Patient seen on 5/20 for same, patient history of pancreatitis. Patient also has end stage liver disease. Patient states her pain is uncontrolled and nausea is not helped by Zofran."

23. Priority Nursing note on May 24, 2024 at 10:08pm in part states, " Patient reports stabbing right upper quadrant pain, ascites, constipation, last bm 5/22. History of lupus, gastral and esophageal varices. Patient has notable abdominal ascites and states if possible she would like to have her abdomen drained during this visit." Having "notable ascites" is one symptom that the liver is failing and not filtering out toxins in the body, one of which is ammonia.

24. Alcoholic withdrawal delirium, hyperammonemia and hepatic encephalopathy are both considered medical emergencies, and the Defendants failed to diagnose and treat these conditions on May 20, 2024, which contributed or directly led to an eventual hepatic comatose state of Ms. Mallery on May 24, 2025, which she endured a myriad of intensive and invasive medical procedures resulting in economic and non-economic damages.

25. On May 24, 2024, Benjamin Huneycutt noted in Plaintiff's chart at 11:31pm, "CIWA, will give Ativan 2mg IV now, pt appears to be entering DT's when I see her.." **Yet the Dr did not order a test for ammonia levels until the very next day in the afternoon when it was**

too late. Because of this failure to order an ammonia test inter alia, this agent of the hospital committed pure negligence by deviating from the reasonable standard of care, as a result Plaintiff's ammonia level kept rising until she fell into a coma. During Ms. Mallery's admission on or about May 30 through June 3, 2024, the Defendants intentionally traumatized Ms. Mallery by putting a video camera in her room to observe video and audio record her 24/7. This was done without Ms. Mallery's consent and continued even after Ms. Mallery complained to staff that it was offensive. This event was particularly traumatizing for Ms. Mallery as she had previously complained about such tactics to the Defendants quality assurance department in March 2024. One camera was in the bathroom and watched Ms. Mallery's every move and because it was equipped with audio the person could hear Ms. Mallery's private telephone conversations. This invasion of privacy while attempting to recuperate from a comatose state was very unsettling and disturbing for Ms. Mallery. Ms. Mallery was unable to shower and care for her sanitary needs due to her reluctance to have an unknown audience while caring for such needs.

26. On or about May 31, 2024, an agent of the Defendants informed Ms. Mallery that she was being discharged from the hospital to a Skilled Nursing Facility, Ms. Mallery disputed the release as she felt it was premature and filed a verbal complaint with Kepro a Medicare Quality Assurance Contractor for Medicare. Ms. Mallery's complaint was denied, and she was discharged from the hospital on or about June 4, 2024.

27. On or about June 27, 2024, Ms. Mallery attempted to get medical help and treatment at the Defendants' hospital, however an agent of the Defendants called Security before Ms. Mallery was even checked in or seen at the hospital. The security guards searched Ms. Mallery's bags

and asked if she had thoughts of harming herself or others. Ms. Mallery was later released the same night after being briefly seen.

28. The Defendant hospital did not previously have a policy in place which would require assistance from its Security department. Nor did the hospital have a policy in place which would require assistance from its Security department based upon any previous acts and or statements made by Ms. Mallery to the Defendants or their agents. This was completely an unprovoked invasion of privacy.

28. There are no other patients whose bags are checked by agents from the Security Department upon entry into the Defendants' Emergency Room Department of the hospital. Ms. Mallery was indeed targeted by the Defendants in an effort to humiliate, intimidate and eradicate Ms. Mallery from seeking emergency medical treatment at the hospital.

COUNT I

(MEDICAL NEGLIGENCE- RES IPSA LOQUITOR

(Claims as to Peacehealth and Eugene Emergency Physicians

29. Ms. Mallery repeats and re-alleges each and every allegation set forth in paragraphs 1-28 of this Statement of Claim, as if each allegation was fully set forth herein, and incorporates each preceding allegation by reference, and further allege as follows:

30. Health Care Providers Peacehealth, and Eugene Emergency Physicians, directly and by and through their actual/and or apparent agents, servants and/or employees, individually owed Ms. Mallery the non-delegable duty to exercise that degree of care and skill which reasonably competent like health care providers would have exercised under the same or similar

circumstances. At the time of Plaintiff's coma, she was under the exclusive control of the Defendant and their agents, the coma would not have occurred if not for the Defendants' and their agents' actions and or omissions. Plaintiff was incapacitated during her admission, mentally and physically and the coma was not a result of her own actions.

31. Health Care Provider Peacehealth and Eugene Emergency Physicians directly and by and through their actual/and or apparent agents, servants breached their duty to Plaintiff to provide competent medical services and were negligent by failing to exercise such degree of skill and diligence required of healthcare providers acting under the same or similar circumstances in the community of the health care providers or a similar community and by failing in the following particulars, among others, as may be determined through legal discovery in this action:

- a. Failing to be knowledgeable and stay up to date on the proper medical treatment of patients experiencing alcohol withdrawal delirium and or hepatic encephalopathy.
- b. Failing to appreciate the risks of substance abuse for chemically dependent patients waiting over 5 or more hours in the waiting room to be seen.
- c. Failing to initiate timely interventions and treatments and diagnostic testing that would have prevented Ms. Mallery's deteriorating condition which resulted in a hepatic coma.
- d. Failing to have appropriate staff, employees and other healthcare providers available to patients waiting for a room to open and to be timely seen by a provider.
- e. Failing to timely notify and sufficiently communicate with the other health care providers about Ms. Mallery's deteriorating condition.

- f. Failing to adequately instruct, train, and/or supervise its agents, servants and/or employees about CIWA protocols and the appropriate time to initiate such procedure.
- g. Failing to provide appropriately trained and skilled personnel to care for Ms. Mallery.
- h. Failing to establish and/or follow and/or enforce appropriate policies, procedures and/or protocols for the management of patients in the same or similar circumstances as Ms. Mallery.
- i. Failing to properly credential, supervise, and/or provide adequate training to agents, servants, and/or employees.
- j. Failing in other ways to implement and enforce policies, procedures, guidelines, drills, and training to adequately and competently diagnose patients with diseases of the pancreas and chronic liver disease who present to the hospital with abdominal pain with a previous history of pancreas and liver disease who may be in active detox and is experiencing active alcohol withdrawal delirium, hyperammonia or encephalopathy.

32. The above negligence of the Health Care Providers directly and through their actual and/or apparent agents, servants, and/or employees, jointly and severally, without any negligence on the part of Ms. Mallery contributing thereto, proximately caused Ms. Mallery to suffer continuous brain deterioration and cognitive defects, physical and emotional pain including but not limited to:

- a. Severe emotional and physical pain and suffering and mental anguish, fear of medical professionals which will place a limitation on Ms. Mallery's future medical treatment.
- b. Worsened liver encephalopathy which led to a coma due to Defendant's failure and refusal to diagnose and treat alcoholic withdrawal delirium days prior.

c. extraordinary past, present and future medical expenses, and other injuries which may become apparent throughout the course of discovery.

d. failing to have a policy in place to enhance patient health and safety by issuing CIWA (Clinical Institute of Withdrawal Assessment) protocol to those patients who complain of symptoms related to moderate to severe drug or alcohol detox and or patients who admit to being in a state of detox.

e. Other damages as permitted by law.

33. The Defendants knew or should have known that Ms. Mallery could have gone into a coma due to her condition on May 20, 2024, and May 24, 2024, and was suffering from the effects of alcohol detox or hyperammonemia or acted so recklessly and in disregard as to Ms. Mallery's deteriorating condition as to have seriously contributed thereto. On both dates of service, Ms. Mallery informed the nurses and physicians that she had been cutting alcohol down and limiting her intake on her own due to an inability to find a detox center. Yet on both days the health care providers failed to timely diagnose Ms. Mallery's alcohol withdrawal detox and or hepatic encephalopathy, and or failed to timely treat her condition, which led to her comatose state. This possibly occurred due to the failure to initiate the CIWA protocol, during her blood transfusion or the Defendants' failure to run an ammonia blood test. Ms. Mallery, based on her history and complaint of symptoms similar to those experiencing active alcohol detox or hyperammonemia was a patient who qualified for the initiation of the CIWA protocol and further blood testing specific for persons with liver cirrhosis. The lack of CIWA initiation of the protocol and lack of blood testing was a deviation from the standard of care and potentially the direct and proximate cause of Ms. Mallery's hepatic coma and further injuries resulting therefrom. The lack of timely attention of the nurses call button or alerts of the monitor at the

nurses station was a deviation from the standard of care. The Plaintiff has been told by nurses that they block out the sound of the alarms just to survive their shift, so patients go unmanaged and sometimes suffer the ill consequences of inadequate training and or hiring. At all times during Ms. Mallery's injuries and coma she was under the nursing care and medical supervision of the agents of the Defendants, they owed her a duty to care for her and to provide reasonable and competent medical services, however, they failed and under their direct supervision, Plaintiff fell into a coma, loss oxygen to her brain long enough to suffer lifelong damages. These damages affect her memory, her cognitive skills, her thinking processes and gravely impact on her ability to be employed or engage in legal activities which she once enjoyed. The Defendants never tested Plaintiff's ammonia levels after multiple hospital visits and her known diagnosis of end stage liver failure. This failure to order a test for Plaintiff's ammonia levels and acidosis levels, directly caused Plaintiff's coma. As of 5/8/2025 a recent MRI of Plaintiff's brain shows a decline in cognitive efficiency. The brain MRI compared to previous ones taken prior to the coma shows, "There is mild diffuse cortical volume loss. "Even this mild of a change greatly impacts Plaintiff's Day to day life. The Plaintiff now has to employ assistance with daily living which prior to the coma she did not have to do. Plaintiff has made several changes which have greatly impacted on her day to day functions which she now seeks rightful compensation.

34. As a further direct and proximate cause of the individual, successive, concurrent, joint and several negligence of these Health Care Providers, Ms. Mallery has received and will continue to receive various types of therapies, occupational, psychological, and pharmaceutical, all for which significant sums of money have been and will continue to be expended. Had these Health Care Providers adhered to the applicable standard of care, Ms. Mallery would not have

suffered as she has in the past and will continue to suffer in the future, both economically, non-economically and other damages.

WHEREFORE, Ms. Mallery has suffered brain damage, cognitive deficits, neurological deficits which may be permanent due to the coma while in the Defendants' care, Ms. Mallery requests that judgment be entered against the Health Care Provider Defendants in the amount of (\$2.500,000 thousand dollars) individually, jointly and severally, in an amount that is fair, adequate and just.

COUNT II

INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS
DISCRIMINATION

35. Ms. Mallery repeats and re-alleges each and every allegation set forth in paragraphs 1-34 of this Statement of Claim, as if each allegation was fully set forth herein, and incorporates each preceding allegation by reference, and further allege as follows:

36. On or about March 14, 2024, Ms. Mallery received a letter from Kepro, a Beneficiary and Family Centered Care Quality Improvement Organization authorized by the Medicare program to review inpatient services provided by Medicare. Kepro reviewed Ms. Mallery's complaint that she was being released from the hospital too soon and their decision was that they agreed with Ms. Mallery. On or about June 3, 2024, Ms. Mallery filed a similar complaint with Kepro regarding her May 24, 2024, admission.

37. On or about May 17, 2024, Ms. Mallery received a letter from Defendant Peacehealth's risk management department that they had received her complaint to their office about date of service May 7, 2024 where Ms. Mallery was held under video observation in the emergency room department. In the letter the Defendants' agent stated that a thorough review had been

conducted including staff interviews. The Defendant hospital apologized for the use of the video camera because it triggered Ms. Mallery's PTSD. Yet with knowledge of Ms. Mallery's mental health disability the Defendants placed Ms. Mallery under video and audio observation once again on May 30-June 4, 2024. The Defendants were aware that Ms. Mallery is a person with a qualified disability.

38. The placement of the video cameras was intentional and meant to cause Ms. Mallery emotional distress which it did. Those other similarly situated patients such as Ms. Mallery do not endure 24/7 audio and video surveillance. As a result of the cameras Ms. Mallery suffered severe emotional distress including nightmares, flashbacks, hypervigilance, anger, depression, grief and sadness during her time in the Defendants' care. The Defendants knew of Ms. Mallery's PTSD trigger in regard to the camera; thus, their action was intentional and meant to harm Ms. Mallery, which it did.

39. On or about May 20, 2024, Ms. Mallery sought care and emergent medical treatment at the Defendant hospital but was treated with hostility and basically kicked out of the hospital by the agents of the Defendants due to her prior written and verbal grievances she had filed against the Hospital, and due to their discrimination against the mentally ill with substance abuse issues. This was a retaliatory measure. All the while Ms. Mallery was suffering from internal bleeding and an inflamed brain due to her condition and due to the rising level of ammonia in her blood. The behavior of the Defendants refusal to treat would be considered shocking, outrageous and socially intolerable in a civilized community.

40. Due to an unknown reason on May 20, 2024, the agents of the Defendants left Ms. Mallery with her own blood after it was drawn instead of keeping the blood in their custody. Leaving a patient with their own blood is a deviation from the professional standard of care. Ms.

Mallery's overall treatment on May 20, 2024, was substandard and this failure to treat and diagnose Ms. Mallery led to a rapid deterioration of her medical condition which occurred over the next several days.

41. Due to the targeting behavior of the Defendants on or about June 27, 2024, the agents of the Defendants immediately contacted their Security department to search Plaintiff's personal items and belongings as she was checking in. This was humiliating for Ms. Mallery as no other patient was being searched upon entry to the hospital and she had not done anything to require such treatment. The Defendants knew that this would be unsettling for Ms. Mallery and wanted to cause her emotional distress.

42. On or about April 25, 2025, after Plaintiff suffered a heart attack due to Defendant's negligence, she sought treatment at the Defendant Peacehealth and they placed her immediately in isolation for a period of over 8 hours. The provider notes states the emergency room assessment as, "Chest pain, unspecified type, history of Mallory-Weiss syndrome, Anemia, unspecified..."

43. The acts and omissions described herein can only be explained by negligence, discrimination and intentional malicious behavior committed by the Defendants and against Ms. Mallery. As a further direct and proximate cause of the individual, successive, concurrent, joint and several negligence and intentional acts of these Health Care Providers, Ms. Mallery has received and will continue to receive various types of therapies, occupational, psychological, and pharmaceutical, all for which significant sums of money have been and will continue to be expended. Had these Health Care Providers adhered to the anti-discrimination provisions in section 1557 of the Patient Protection and Affordable Care Act and Section 504 of the

Rehabilitation Act of 1973³, Ms. Mallery would not have suffered as she has in the past and will continue to suffer in the future, both economically, non-economically and other damages.

WHEREFORE, Ms. Mallery was harmed by the intentional discriminatory behavior of the Defendants in that the delay in treatment contributed to Ms. Mallery's coma which led to brain damage which may be permanent, therefore, Ms. Mallery requests that judgment be entered against the Health Care Provider Defendants in the amount of \$2,500,000 individually, jointly and severally, in an amount that is fair, adequate and just.

COUNT III INTENTIONAL MISREPRESENTATION
NEGLIGENT MISREPRESENTATION

(Claim against Peacehealth)

44. Ms. Mallery repeats and re-alleges each and every allegation set forth in paragraphs 1-43 of this Statement of Claim, as if each allegation was fully set forth herein, and incorporates each preceding allegation by reference, and further allege as follows:

45. On or about May 31, 2024, an agent of the Defendant hospital contacted Ms. Mallery and informed her about the discharge plan to a Skilled Nursing Facility. Ms. Mallery had only been awake from a comatose state at this time for about 3 or 4 days. The agent informed Ms. Mallery that she would be cared for 24/7 and have access to proper medical treatment to assist with ameliorating her symptoms and taking the next steps for her condition to improve. Ms. Mallery

³ Section 794. Nondiscrimination under Federal grants and programs; promulgation of rules and regulations

(a) Promulgation of rules and regulations

No otherwise qualified individual with a disability in the United States, as defined in section 705 (20) of this title, shall, solely by reason of his or her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.

had a similar discussion with an agent of the Defendants' working within the physical therapy department and was promised that she would be taken good care of once discharged to the facility. The agent that visited Ms. Mallery on May 31, 2024, also left her with the names and phone numbers of facilities to contact to gather more information for her discharge.

46. On or about June 4, 2024, Ms. Mallery received notification that Kepro had denied her claim and agreed with the hospital that she should be discharged. It wasn't until she returned home that Ms. Mallery understood the reasoning behind Kepro decision. The letter received by Ms. Mallery dated June 4, 2024, states in part:

On 6/3/2024, you contacted Kepro because you were concerned that you were being discharged too soon from an inpatient level of care from Peacehealth Riverbend Hospital. Our QIO physician reviewer has evaluated your current medical condition and the plan for discharge. According to our interpretation of Chapter 1 of the Medicare Benefit Policy Manual guidelines and after reviewing the medical record and any additional information provided, Kepro agrees with the discharge plan. This means that in the opinion of the physician reviewer, it is appropriate for you to be discharged from inpatient level of care. ***The reason for our decision is as follows: You are being discharged to a Skilled Nursing Facility...***

47. The Defendants represented to Ms. Mallery and agents of Kepro that she was being discharged from the hospital on June 4, 2024 only because she was being handed off by the Defendants directly to a Skilled Nursing Facility for the remainder of her treatment and care for brain encephalopathy, internal bleeding and acute liver failure. This representation was material in that Ms. Mallery and Kepro relied upon this information in making decisions affecting Ms. Mallery's medical care and discharge plan.

48. Ms. Mallery would not have left the hospital if not for Defendant's false statement which at the time it was made Defendants knew or should have known it was false. The Defendants intended for Ms. Mallery to rely upon the information given to her and she did, to her detriment.

49. Kepro relied upon the Defendants' discharge plan and statements of the Defendants to make their decision to deny Ms. Mallery's claim of leaving the hospital too soon on June 4, 2024. Kepro would not have agreed with the Defendants' discharge plan had they not relied upon the Defendants' statement that Ms. Mallery would be discharged to a Skilled Nursing Facility.

50. As a result of Ms. Mallery and Kepro's reliance upon Defendants' promise, Ms. Mallery went home and suffered the consequences of attempting to be cared for in home. The home health plan is comprised only of employees and contractors of the Defendants. The in-home health discharge plan that the Defendants 'implemented was not helpful to Ms. Mallery's condition and likely set in place only for information seeking and self-serving purposes.

51. Ms. Mallery required 24/7 nursing care but instead was forced to endure navigating her serious health conditions at home alone including but not limited to the emotional and physical maladies related to:

(a) severe fatigue related to severe anemia/ Ms. Mallery required a second blood transfusion at the time of discharge on June 4, 2024, per the opinion of three doctors and based upon labwork. However, Ms. Mallery was booted out of the hospital before she could receive one.

(b) severe mental disturbances, moderate to severe disorientation as to time and place, confusion, memory loss (Upon discharge Ms. Mallery was suffering from acute encephalopathy). This condition is critical and a patient suffering from this condition requires frequent monitoring. Ms. Mallery requested a second brain scan and the attending Defendants' hospitalist agreed, but Ms. Mallery was booted out of the hospital before she could obtain one.

(c) electrolyte imbalances requiring IV (Upon discharge Ms. Mallery was unable to metabolize Potassium or Magnesium to normal levels, both electrolytes are critical to brain and heart function)

The hospital agents gave Ms. Mallery some potassium tablets upon discharge knowing that Ms. Mallery is unable to physically absorb certain vitamins and electrolytes orally.

(d) Ms. Mallery required assistance walking and maneuvering around her home and required assistance with feeding and remembering to take her medications. Ms. Mallery's mobility was so affected she required assistance using the facilities and making it on time due to new medications she was required to start taking including but not limited to lactulose. Taking this medication resulted in Ms. Mallery soiling herself on more than one occasion and she required assistance from nursing staff to clean up.

(e) liver failure - (Upon discharge Ms. Mallery was still experiencing the effects of chronic liver failure for which she had no relief including but not limited to IV fluids and IV medications, which would have assisted Ms. Mallery in feeling less physical pain and general malaise.)

52. The initial decision to discharge Ms. Mallery to a Skilled Nursing Facility was appropriate and met the standard of care. The decision to send Ms. Mallery home alone without adequate nursing supervision and access to 24/7 nursing assistance was a deviation from that standard of care and as a direct and proximate result of the change in the discharge plan, Ms. Mallery suffered harm, harm which could have easily been avoided by following the initial discharge plan.

53. When the Defendants made the statements to Ms. Mallery and to the representatives at Kepro they knew the statements were false or the Defendants made the statements in blatant reckless disregard of the truth. The Defendants intended Ms. Mallery and Kepro to rely upon the false or misrepresentations in regard to Ms. Mallery's discharge plan yet changed the plan without cause because of reasons unrelated to Ms. Mallery's medical condition.

WHEREFORE, Ms. Mallery was injured by the Defendants' negligent or intentional misrepresentation and suffered damages she requests that judgment be entered against the Health

Care Provider Defendants in the amount of \$2,500,000 individually, jointly and severally, in an amount that is fair, adequate and just.

COUNT V NEGLIGENCE-LACK OF INFORMED CONSENT

(Plaintiff's heart attack)

(Claims against Peacehealth and Eugene Emergency Physicians)

54. Ms. Mallery repeats and re-alleges each and every allegation set forth in paragraphs 1-53 of this Statement of Claim, as if each allegation was fully set forth herein, and incorporates each preceding allegation by reference, and further allege as follows:

55. On or about 4/4/2025 Plaintiff had a heart attack due to the pure negligence of the Defendants. The preventable heart attack caused Plaintiff excruciating pain, emotional distress, compensatory damages, and potentially lifelong damages. The benefits of administering Zofran did not outweigh the risk of a heart attack when there were many other alternatives the health care providers could have administered, for example Reglan. No alternative was offered to Plaintiff and no explanation of the potential side effects of Zofran was explained to Plaintiff as she was administered Zofran by the Defendant Peacehealth for a period of 2 years. Plaintiff was not made aware that Zofran would cause her to have a heart attack or clearly she would not have taken the medication.

56. Administering Zofran to a patient with long QT syndrome is contradicted, however, for a period of 2 years, the Defendants and its agents administered Zofran to the Plaintiff on the following dates which led to her eventual heart attack on April 4, 2025. The nurses, doctors and agents of the Defendants were well aware that Plaintiff suffered from long QT syndrome and deviated from the reasonable standard of care when there were other options to administer to Plaintiff for nausea which would have not caused her heart attack and the ensuing damages which occurred therefrom. Testimony will show that this is not a fact in dispute. The following dates are

times when Plaintiff was experiencing long QT syndrome via Defendant Peacehealth's monitor yet despite this they administered Zofran to Plaintiff, despite other alternatives to spare her from having an eventual cardiac event which could have ended her life:

57. 2/5/2024 Plaintiff was prescribed Zofran previously, however, on date of service 2/5/2024 an agent of Defendant Sacred Heart Medical noted that Patient took an (ondansetron) Zofran around 1230 while waiting in the lobby. At this time Plaintiff was not aware that taking Zofran could cause a heart attack.. Had Plaintiff had known that there was an alternative medication for her severe nausea she would have opted for the medication that would not have increased her risk of a heart attack.

58. On 2/5/24 ED provider an agent of the Defendants, Scott C. Williams again noted in his report, in the narrative section "when compared to November 28, 2023, QT has lengthened" which can indicate a condition of dangerous heart rhythms.

59. On 2/6/2024 Progress notes by Rajeev L. Alexander, an agent of the Defendants diagnosed Plaintiff with QT prolongation, a condition where the QT interval, the time it takes for the heart to fully recharge between beats, is longer than normal. This extended interval can increase the risk of abnormal heart rhythms and potentially cause sudden cardiac arrest. No physician will testify that Zofran is NOT contraindicated in patients diagnosed with QT prolongation. This is an undisputable fact. Plaintiff's primary care physician had advised her of such; however, it was too late, Plaintiff had already been administered Zofran by the Defendants on multiples occasions over the course of the years and the damages had already taken its toll, resulting in Plaintiff's heart attack.

60. On 2/7/2024, Eva Pradham, an agent of the Defendant Peacehealth noted on 2/7/24 noted in her progress notes “active problems, QT prologation.”

61. On 2/13/2024 during a different hospital admission an agent of the Defendants Jenna L. Shenk noted as a critical care note, one of the admitting diagnoses was “QT prolongation (R94.31). Home medications and inpatient medications are listed in the Defendants medical record which states that patient should take ondansetron (Zofran) 8 Mg, disintegrating tablet as needed for nausea.

62. Plaintiff was discharged on 2/15/2024 and the medication on the discharge summary signed by an agent of the Defendants Preetivi Ellis stated, “medications to continue include ondansetron 8 mg tablet, take 1 table by mouth every 8 hours as need for nausea and vomiting.

63. Plaintiff was discharged after an admission on 3/14/2024 and diagnosed by an agent of the Defendants Saroj Shrestha with QTc prolongation QTC 554 as of 3/11. Repeat EKG 515 as of 3/13, 531 today, yet still sent home with “Medications to continue including but not limited to, Ondansetron (zofran) 8MG 1 tablet by mouth every 8 hours as need for nausea or vomiting.

64. Plaintiff was admitted to the hospital and went into a coma because of the defendants’ negligence. On May 24, 2024, an agent of Defendants Joel Valencia noted, “She says that she has not been able to stop vomiting and has been trying her Zofran at home without any improvement.” At no time was Plaintiff advised to stop taking Zofran or it could cause a heart attack. She was only aware after her heart attack occurred. Had she known that taking the medication would have caused her heart attack she would have actively sought other alternatives, and this would have avoided the heart attack.

65. On 6/3/2024 after Plaintiff had suffered from a several day coma she was discharged and her discharge summary states and signed by an agent of the Defendant Bibhuti Neupane that Plaintiff suffered from among other things, "Prolonged QTc, chronic, QTc was elevated as high as 587 on 5/26 however now has returned back to her apparent baseline of around low 500's (510 6/1)." Despite this continued diagnosis of prolonged QT Plaintiff was sent home with the medications to continue including, "Ondansetron (zofran).

66. Plaintiff was seen by the Defendants Peacehealth on February 6, 2025 and diagnosed with "an irregular heartbeat". Yet still administered medication contradicted for Plaintiff's condition.

67. Plaintiff was seen and kicked out of the hospital on 4/24/2025, she was experiencing chest pain after her recent heart attack on 4/4/2025. An agent of the Defendants Adam Sykes, Do wrote in the medical record, " chief complaint, chest pain" ... yet in the discharge paperwork it notes, "irregular heartbeat", post heart attack on 4/4/2025, yet the discharge instructions state, " CONTINUE these medications which have NOT CHANGED,, ondansetron (zofran), take 1 tablet (4mg total) every 8 hours as needed for nausea or vomiting.."

68. On April 26, Plaintiff was administered Zofran by the Defendant hospital Mckenzie Medical Center and On April 30, 2025, Plaintiff presented to the emergency department at Peacehealth and they were aware her previous heart attack, yet once again administered Zofran.

69. Plaintiff had been receiving the medication Zofran via IV fluids by the paramedics and the Defendants each and every time she went to the hospital complaining of nausea despite her diagnosis of prolonged QT.

70. As a direct and proximate result of giving Plaintiff the incorrect medication which is clearly contraindicated in patients with Plaintiff's heart condition, Plaintiff suffered a near fatal heart attack and suffered both non economical and economical damages.

WHEREFORE, Ms. Mallery was injured by the Defendants' negligence and suffered damages she requests that judgment be entered against the Health Care Provider Defendants in the amount of \$2,500,000 individually, jointly and severally, in an amount that is fair, adequate and just.

COUNT VI- EMTALA (FAILURE TO PROVIDE EMERGENCY MEDICAL SERVICES)

(Claims All Defendants)

71. Ms. Mallery repeats and re-alleges each and every allegation set forth in paragraphs 1-70 of this Statement of Claim, as if each allegation was fully set forth herein, and incorporates each preceding allegation by reference, and further alleges as follows:

72. Plaintiff alleges that prior to her coma Defendant Mckenzie Willamette failed to treat her due to the discriminatory things written in her medical record and her history of alcohol use disorder, which led to days later Plaintiff lapsing into a coma on 5/24/2024.

73. On 4/4/25 Plaintiff suffered a heart attack, sepsis, kidney injury and a rupture of her esophagus due to internal bleeding and vomiting of blood. All of these injuries were due to the failures of health care providers to assist Plaintiff and to provide the proper care and treatment.

74. After traveling 3,000 miles during a heart attack on April 4, 2025, Plaintiff sought treatment at both Defendant hospitals and brought her medical records with her to both hospitals in addition both Defendant hospitals and agents were able to access Plaintiff's medical records from April 4, 2025 and they refused to treat her, although she was suffering from a very painful kidney infection,

experiencing chest pain, abdominal pain, recovering from sepsis, a torn esophagus and bloody stools. Plaintiff's diagnoses at the time were including, but not limited to:

- a. Hematemesis
- b. Liver cirrhosis, decompensated
- c. Esophageal/Gastric varices s/p PARTO
- d. Coffee ground emesis
- e. Hyperammonemia
- f. Stress (Takasubo) cardiomyopathy
- g. Elevated troponin
- h. Acute kidney injury
- i. High anion gap metabolic acidosis
- j. Lactic acidosis
- k. Proteinuria in the setting of SLE (systemic lupus)
- l. Diabetes mellitus type 2

75. The Plaintiff was in severe pain and emotional turmoil and had just travelled 3,000 miles to seek proper medical attention, yet she was placed in isolation in the hospital (Peacehealth) based upon the hospital's past experiences with Plaintiff and they refused to treat her emergency condition due to her disability and inability to communicate effectively while under emotional and physical extreme stress.

76. On April 25, 2025, Defendant Peacehealth refused to admit a patient who required emergency treatment and inpatient care and stated in part the following in the medical record for the reason: "Sat April 26, 2025, I was notified by charge RN that patient was becoming verbally aggressive with staff. It was noted that patient was taking pictures security and posting on Facebook Considered escalation of care: **admission but not done due to patient's behavior...** Social drivers of health which affected care: mental health and transportation barriers which significantly affect care by limiting ability to follow up and remain in ED for further workup..." Plaintiff clearly needed to be admitted to the hospital for further evaluation, management and

treatment but was denied this right because she was accused of posting the Defendants on Facebook.

76. The Defendant Peacehealth Provider Notes state, clinical impression, “ chest pain, history of Mallory-Weiss syndrome, Anemia...” There was no treatment or assessment of these symptoms by either Defendant Hospitals. Plaintiff had just suffered a heart attack, diabetic ketoacidosis, sepsis, near kidney failure and she suffers from end stage liver cirrhosis, yet no treatment was given to Plaintiff due to her disability of substance abuse disorder (currently in recovery), her social media personality and her prior complaints against the Defendant Peacehealth to their risk management department in the past, and quality assurance department (more than 5 times). This is clearly against federal rules and discriminatory. An agent of the Defendant Peacehealth notes on April 25, 2025, “ Pt agitated, calling numerous people to complain about her alleged poor treatment here and is now shouting obscenities in the lobby.” However, the Plaintiff is in possession of the audio and she was not shouting at all, she actually was speaking in a low tone and this was AFTER she was refused treatment and was recording her purse and her own voice, then she was wheeled out into the freezing cold (Plaintiff is colder than others due to her anemia) by security guards, stalked by security guards driving by to check on her every few minutes while she was sitting in her wheelchair waiting for a taxi for over an hour.

77. Prior to Plaintiff being wheeled out by security because she was upset, she was being refused treatment, nursing staff noted in the medical record...” Pt had an episode of vomiting during lab draw.” This was blood and it was evident that Plaintiff was vomiting blood. The nurses had to clear the room because it was a hazard, yet the Defendant hospital and agents did nothing to help Plaintiff. Nurse Brenton then noted, “Pt has a plethora of complaints including chest pain, bloody stools, as well as “12 or 13 out of 10 kidney pain”, yet Defendant Peacehealth kicked her

out of the hospital after placing her in isolation for over 8 hours and Plaintiff recorded them because they were simultaneously recording her. A kind security guard offered Plaintiff a blanket while she was in isolation from the rest of the hospital. During this time, the Plaintiff received no treatment which related to her chief complaints which were emergent and requiring of emergency services.

78. As a result of Defendant's actions and omissions and breach of their duties to Plaintiff, was then left to suffer in severe excruciating pain with a kidney infection for weeks with no medication or relief as both the Defendant hospitals refuse to treat Plaintiff in violation of Federal law.

79. On 4/30/2025 Plaintiff was still suffering from an active kidney infection and sepsis and recovering from her heart attack on 4/4/2025, she went to seek treatment at Peacehealth once again. There are few options available in Plaintiff's hometown. There are only two hospitals in the town in which Plaintiff resides, and both have refused to treat her. The Defendant hospitals have a monopoly in the town in which Plaintiff resides, and she is left with no other options to seek medical care. Even the hospital in Cottage Grove is run by the agents of the Defendant Hospital Peacehealth.

80. On 4/30/2025 Plaintiff felt assaulted by a nurse and emotionally traumatized by an agent of the Defendant Peacehealth. The medical records states in part, " This is a 51 y.o who presents with multiple complaints including back pain, kidney pain, PTSD, anxiety, tearful, abdominal pain, chest pain..... She has alcohol on board" There was never any proof or evidence that Plaintiff's clear water bottle contained alcohol, nor should it have been removed from her hands by a medical professional when she was seeking emergent care. The removal of the water bottle

from Plaintiff was a deviation from the reasonable standard of care as there was no medical reason for a nurse to accost Plaintiff with her suspicions that she was drinking alcohol. This is discrimination on its face.

81. On 4/30/2025, the anniversary of Plaintiff's deceased son's birthday, she did relapse and drink alcohol, however alcohol use disorder is not a reason for failure to treat an emergent condition which Plaintiff did have. The Plaintiff was recovering from a recent heart attack, had been continuing to experience chest pains, was vomiting blood and had dark tarry stools, was a hospice patient in February 2025 and has been diagnosed with decompensated liver cirrhosis. Plaintiff clearly meets the medical standard of a patient who requires critical care, regardless of her complaints of patient care, facebook posts and social media. Plaintiff deserves objective medical treatment, not treatment that clearly deviates from the reasonable standard of care.

82. An agent of Peacehealth surmised after diagnosing Plaintiff with a kidney infection, he wrote, "I will think she has mesenteric ischemia... oh like she has a bowel obstruction... However, the physician failed to admit Plaintiff, failed to order further tests to rule out his suspicions, however, ordered ZOFRAN (injection 4mg 4mg IV) *contraindicated in patients with cardiomyopathy such as Plaintiff* and failed to treat Plaintiff based in part on the nurse's discrimination of Plaintiff. Wherein Dr. Vince Huntsberger writes in his note:

...the nurse was concerned that she was drinking alcohol in the room. I think she is fine to be discharged home."

83. An agent of Peacehealth wrote: PT came in the ER with a water bottle. Bottle smells heavily of ETOH. MD aware. It is **NOT** the policy of the Defendants to confiscate water bottles from patients. This was a clear deviation from the standard of care. Plaintiff's urine and blood had

already been tested for alcohol. This was merely a tactic to humiliate, intimidate and limit Plaintiff's access to medical care.

84. On 4/30/2025 an agent of the Defendants, Dr. Vincent Huntsberger noted in the emergency department encounter note his assessment of Plaintiff including the following: “Differential diagnosis considered include but not limited to Acute coronary syndrome, pulmonary embolism, aortic dissection, kidney pain, kidney infection, lupus flare, Mallory Weiss tear, esophageal rupture, pneumonia, pancreatitis, acute cholecystitis, choledocholithiasis, small bowel obstruction, mesenteric ischemia, UTI, kidney stone...”

85. Dr. Huntsberger administered Zofran on this date at this time, despite this medication being contraindicated due to Plaintiff's dire medical condition.

86. Dr. Huntsberger noted in the record, “Patient was very concerned that she had a lupus flare. I do not think this is a lupus flare. I think it is likely the kidney infection.” Of note Dr. Huntsberger is not a licensed physician in the field of Rheumatology and therefore would not be able to diagnose a “lupus flare”. It is a deviation from the standard of care to fail to consult with a specialist in the area of Rheumatology with a patient with kidney pain, a recent history (4/4/2025 of “acute kidney injury) and with a known history of systemic Lupus. The same agent of the Defendant hospital incorrectly stated in the medical record that Plaintiff refused additional testing. Plaintiff is a well known patient of the Defendant hospital Peacehealth and if anything, she demands additional testing and NEVER denies additional testing. This is why Plaintiff has been deemed a problematic patient. Despite being an advocate for herself, Plaintiff deserved to be treated as others similarly situated as her during the time of her emergency medical health situation.

87. Dr. Huntsberger further notes in the subjective portion of the record in part:

Patient is very frustrated and tearful due to previous visits. This is a 51 y.o history of alcohol use disorder, cystitis, GI bleed, arthritis, autoimmune hepatitis, COPD, chronic pain, coagulopathy, dysphagia, hypertension, hypokalemia, hypomagnesemia, cervical spine pain, irregular heartbeat, paresthesia, bipolar hepatic encephalopathy who presents for low back pain since April 4 (*when Plaintiff was diagnosed with "acute kidney injury"*), and no relief from Robaxin, (*a muscle relaxant*). Patient is worse now. No recent injury. History of Lupus and AKI recently chronic back issues. Also complains of chest pain and multiple other complaints at this time. Who presents to the Emergency department with multiple issues. She was seen on 4/26/2025. She was diagnosed with chest pain, Mallory-Weiss, anemia, alcohol intoxication without complication and low potassium, (*low potassium can cause heart arrhythmias and chest pain*). ... he continues noting in the record falsities about Plaintiff that Plaintiff can prove are not accurate.

88. At one point during the visit Plaintiff became so distressed about the encounter, Dr. Huntsberger noted in the record, "Difficult to assess she is laying in a fetal position, she will lay flat on her back and let me really pressed on her abdomen, whenever I touch it hurts, there is no specific tenderness she has some guarding I could not test for rebound, there is no pulsatile mass that I can feel but again very limited she got distally in her feet good pulses."

89. Also on this date an agent of the Defendant Peacehealth, "Hanna" noted in the medical record in the nurse's priority note, "Pt came into the ER with a water bottle. Bottle smells heavily of ETOH. MD aware.

90. On May 1, 2025, Plaintiff returned to the Defendant Peacehealth's Emergency department and was diagnosed with Pyelonephritis. The Defendants' agents knew or should have known that Plaintiff required inpatient treatment for her medical condition of a kidney infection

especially due to her underlying conditions of Systemic Lupus and her recent diagnosis on April 4, 2025 of an “acute kidney injury”.

91. The Defendant Peacehealth’s agents knew that due to Plaintiff’s condition of gastritis and end stage liver cirrhosis and a recent diagnosis of gastric enteritis that giving her oral medications would not be effective. Plaintiff is well known by the Defendant Hospitals as a patient who does not tolerate oral medications due to her physical condition yet sent her home with a prescription for limited pain medication and limited antibiotics. Because of this failure to properly treat, Plaintiff suffered intense pain lasting several weeks which was debilitating. Plaintiff was unable to make her physician appointments, was unable to grocery shop, was unable to walk, was unable to function or maintain daily tasks without being in excruciating pain from the kidney infection which was being left untreated.

92. Plaintiff complained to the nursing staff that she felt her medical needs were not being adequately addressed. An agent of the Defendant Peacehealth Sean noted in the chart, “BIBA from home for back pain. Pt was seen and evaluated yesterday for same. Pain worse today. Pt was prescribed Abx but has not picked them up. . Another agent Leah, noted in the chart, SW met with pt briefly. SW practiced actively listening as pt spoke of her frustration with healthcare system....”

93. On May 2, 2025, the agents of Defendant Peacehealth reversed their prior written and documented diagnosis of a kidney infection as documented by an agent of the Defendant Peacehealth via the notes in the medical record by provider Margaret Pattison wherein she notes in part, “ low probability of pyelonephritis... plan to discharge home.” Ms. Mallery was diagnosed by this provider with “back pain”, completely contradicting the diagnosis that was

previously made by the same hospital and without further examination or proper screening for kidney infection.

94. Plaintiff was in such excruciating pain that she went to the only other hospital in the town in which she resides, the Defendant Mckenzie Willamette Medical Center. On May 3, 2025, Plaintiff arrived at Mckenzi Medical Center complaining of pain from a previously diagnosed kidney infection and had medical records in hand.

95. The Defendant Mckenzi Willamette Medical Center refused to run any tests to rule out kidney infection or a lupus flare up and only tested for back pain by doing an MRI of Plaintiff's spine (unnecessary test), which did show that Plaintiff was suffering from a tear in her back from a bulging disc, however this is pain in addition to the underlying untreated kidney infection.

96. The Defendant Mckenzi Willamette Medical Center discharged Plaintiff with diagnoses including but not limited to: Diarrhea, Radiculopathy, lumbar region, alcoholic cirrhosis of liver.

97. During this visit several nurses witnessed Plaintiff having dark tarry stools which clearly indicated that she was bleeding internally, which is a medical emergency. The Plaintiff has videos and photos of the black tarry stools taken while she was actually in the hospital. The nurses disclosed that the Defendant hospital does not have the staff to address Plaintiffs' needs, for example, an agent of the Defendant Mckenzie Willamette Medical Center stated in part that she felt sorry for Plaintiff and that the hospital just doesn't have the resources to treat her conditions. Due to the hospital's lack of funding and financial resources, the medical providers were not able to access a Gastroenterologist to consult on Plaintiff's condition, therefore she was left untreated and left in excruciating pain and left to suffer internal bleeding which lasted for several weeks leaving her fatigued and unable to perform daily tasks and manage her life in a

way in which she would have been able to manage had she been properly treated for her emergency medical condition.

98. Plaintiff's condition was not stabilized as required under EMTALA as she was still internally bleeding and still had a kidney infection she could not manage at home. The Defendants knew that due to Plaintiff's bleeding ulcers and gastritis that pills would not assuage her pain nor her kidney infection. The plaintiff suffered for weeks due to disability discrimination, which is a violation under ADA, and also a failure to treat her which is a violation under the Federal laws of EMTALA.

99 As further proof that Plaintiff's condition was not stabilized as required by EMTALA, Plaintiff's urine tested positive for blood as she was seeking assistance with her Rheumatologist on May 7, 2025. Plaintiff's Rheumatologist noted, "Billirubin Urine, Ketones Abnormal, Blood UA abnormal, Protein, Abnormal, Nitrate, Abnormal, Leukocytes, Abnormal. It was clear by the urinalysis that Plaintiff was still suffering from an untreated kidney infection.

100. Plaintiff reserves the right to amend this complaint to seek punitive damages against the Defendants for their intentional torts and potentially add other Defendants. Plaintiff has very little information as the Defendants' have concealed the medical records, intentionally fabricated information in the medical records and she does not have enough information pre discovery to make an exact determination as to the damages and the persons responsible for her injuries.

WHEREFORE, Plaintiff requests that this court:

- a. Find that Defendants violated their obligations to Plaintiff under the federal laws pursuant to the EMTALA.

- b. Find that the Defendants violated federal laws as Medicare recipients and committed fraud upon Kepro which enticed Plaintiff to discharge too soon, and find that the Defendants discriminated against Plaintiff for reasons unassociated with her medical condition
- c. Award reasonable costs and expenses incurred in the prosecution of this action including reasonable attorney's fees, pursuant to 28 U.S.C § 1920 and 42 U.S.C. 188 and Federal rules of civil procedure 23(3) and (h):
- d. Award compensatory damages to Plaintiff for her injuries, monetary damages not less than \$2,500,000 for each count and for pain and suffering which is ongoing, loss of income, lost wages over Plaintiff's lifetime, severe emotional distress and general economic losses related to her illnesses caused by the Defendants' negligence and any other such evidence Plaintiff can show to prove her damages.
- e. And any other relief this court deems necessary and proper in the interest of justice.

Respectfully Submitted,

/s/ Minny Mallery

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