IN THE STATE COURT OF DEKALB COUNTY
STATE OF GEORGIA

KEITH MITCHELL, Individually and as Administrator of the Estate of CHRISTINE MITCHELL, Deceased,	)	
Plaintiff,	)	**CIVIL ACTION FILE NO.:** 17A65415
v.	)	
TUCKER INVESTMENTS & ASSOCIATES, LLC d/b/a GRACE HEALTHCARE OF TUCKER; GRACE HEALTHCARE, LLC; ABC CORPORATIONS; and JOHN/JANE DOES I and II,	)	
Defendants.	)	

COMPLAINT FOR DAMAGES

Now comes, Keith Mitchell (hereinafter "Plaintiff"), Individually and as the Administrator of the Estate of Christine Mitchell, (hereinafter "Ms. Mitchell"), deceased, and presents his complaint for damages against Defendants Tucker Investments & Associates, LLC d/b/a Grace Healthcare of Tucker; Grace Healthcare, LLC; ABC Corporations; and John/Jane Does I and II and as follows:

1.

In this action, Plaintiff Keith Mitchell shows that the Defendants' violations of federal and state law and regulations in the operation of a long-term care facility, negligence per se, professional negligence, simple negligence and breach of contract in the provision of nursing home care, treatment and services led directly and proximately to severe and life threatening injuries, illness, pain, suffering and the death of Christine Mitchell. At all times material to this lawsuit, Ms. Mitchell received care, treatment and supervision while residing at Grace

Healthcare of Tucker, which is located in Dekalb County, Georgia. The Plaintiff, individually and in his capacity as the Administrator of the Estate of Christine Mitchell, therefore seeks damages to recover upon claims arising under tort and contract.

JURISDICTION AND VENUE

2.

Plaintiff, Keith Mitchell, is an individual over the age of nineteen (19) years and brings this lawsuit individually and in his capacity as the Administrator of the Estate of Christine Mitchell. Plaintiff hereby subjects himself to the jurisdiction of this Court.

3.

Defendant Tucker Investments &Associates, LLC d/b/a Grace Healthcare of Tucker is a domestic Limited Liability Company formed under the laws of the State of Georgia with its principle place of business at 801 Broad Street, Suite 200, Chattanooga, Tennessee, 37402. This Defendant owns, operates, and/or manages a skilled nursing facility Grace Healthcare of Tucker in Tucker, Dekalb County, Georgia 30084. This Defendant can be served with process by service upon its registered agent for service of process in this State: National Registered Agents, Inc., 289 S. Culver Street, Fulton County, Lawrenceville, Georgia 30046-4805.

4.

Defendant, Grace Healthcare, LLC is a foreign Limited Liability Company formed under the laws of the State of Delaware, authorized to do business in the State of Georgia, with its principle place of business at 801 Broad Street, Suite 200, Chattanooga, Tennessee, 37402. This Defendant owns, operates, and/or manages a skilled nursing facility called Grace Healthcare of Tucker in Tucker, Dekalb County, Georgia 30084. This Defendant can be served with process by

service upon its registered agent for service of process in this State: National Registered Agents, Inc., 289 S. Culver Street, Fulton County, Lawrenceville, Georgia 30046-4805.

5.

Defendant ABC, Inc., is a corporate entity whose correct name is not known at the current time, but is known to Defendants. Upon information and belief, Defendant ABC, Inc. is an entity capable of being sued in Georgia and is subject to the jurisdiction and venue of this Court. Once the true and correct identity of Defendant ABC, Inc., has been established, it will be substituted into this action by amendment and pursuant to Georgia law.

6.

Upon proper service of process, and based on the foregoing, jurisdiction is proper in this Court. Venue is proper in this Court under OCGA § 9-10-31.

PARTIES

7.

Plaintiff Keith Mitchell is the son of Christine Mitchell, deceased. Plaintiff seeks to recover upon Ms. Mitchell's individual claims against Defendants arising in tort and contract in his individual capacity and in his capacity as the Administrator of his mother's estate.

8.

The Defendant Tucker Investments & Associates, LLC d/b/a Grace Healthcare of Tucker owned, operated, and/or managed a Nursing Home called Grace Healthcare of Tucker, located at 2165 Idlewood Road, Tucker, Georgia, 30084 at the time of Christine Mitchell's residency. The Defendant entity was contractually charged with responsibility for the provision of residence, care, treatment and convalescent/rehabilitation services to Ms. Christine Mitchell. The Defendants negligently failed at their responsibilities as described below.

9.

The Defendant Grace Healthcare, LLC owned, operated, and/or managed the Nursing Home called Grace Healthcare of Tucker, located at 2165 Idlewood Road, Tucker, Georgia, 30084 at the time of Christine Mitchell's residency. The Defendant entity was contractually charged with responsibility for the provision of residence, care, treatment and convalescent/rehabilitation services to Ms. Christine Mitchell. The Defendants negligently failed at their responsibilities as described below.

10.

Defendant John/Jane Doe I at all relevant times was the Administrator at Grace Healthcare of Tucker. Defendant John/Jane Doe II at all relevant times was the Director of Nursing Services at Grace Healthcare of Tucker. In these capacities, each of these Defendants was responsible for ensuring that Ms. Christine Mitchell received the medical and nursing care, treatment and services necessary to address her medical and nursing needs and her needs with respect to her activities of daily living. These Defendants were also responsible for discovering, investigating, preventing and correcting all instances of resident abuse, mistreatment, and neglect. They were responsible for proper and timely communication of Ms. Mitchell's medical condition and needs to her doctor when necessary, and providing prompt medical care when it was necessary.

FACTS

11.

Christine Mitchell was 67-years-old when she was admitted to Grace Healthcare of Tucker on January 18, 2012. At the time, Ms. Mitchell had a history of dementia with

behavioral disturbances, diabetes, seizures, hypertension, cardiovascular disease, GERD and encephalopathy.

12.

On admission, Ms. Mitchell's care plan included assistance with all activities of daily living; frequent monitoring for optimal health and functioning, and interventions for her psychosis.

13.

Ms. Mitchell was admitted for care and safety due to her increasing seizures as the family could no longer keep her at home. The MDS of January 30, 2012, determined that Ms. Mitchell had a BIMS score of 7. She was unstable with walking and needed a one person assist. She was noted to be a fall risk and required frequent reminding and redirecting for safety. Ms. Mitchell had a chair alarm on her wheel chair to reduce falls.

14.

On January 28, 2012, the care plan was updated to include falls. There was also a chair alarm to be utilized when Ms. Mitchell was up in a wheelchair.

15.

On February 9, 2012, Ms. Mitchell was found by the evening staff sitting straight up next to her bed. Ms. Mitchell stated she fell out of bed. No injuries were noted at that time. This was her first documented fall. The fall care plan was not updated.

16.

On February 12, 2012, Ms. Mitchell was found sitting on the footrest of her wheelchair. Her right foot was bent backward. Ms. Mitchell did not complain of pain. An x-ray was ordered

by the nurse practitioner. The x-rays of the ankle were negative. This was her second documented fall.

17.

On March 25, 2012, Ms. Mitchell complained of her foot hurting and stated the bedside table fell on her foot on March 22, 2012. Her foot was swollen. An x-ray was obtained that was negative for any injury.

18.

On March 26, 2012, Ms. Mitchell was found lying on the floor on her back beside the wheel chair. She had no complaints of pain, and said she was trying to find her walker. The care plan was updated for two- person assist. This was her third documented fall.

19.

The 60-day Minimum Data Set was completed on April 16, 2012, which showed a BIMS of 7. It was also determined that Ms. Mitchell now needed extensive assistance for mobility with the assistance of 2 staff members. She could be in a wheel chair in the hallway and propel herself. Ms. Mitchell continued to have more confusion at night.

20.

On April 12, 2012, Ms. Mitchell was found lying on the floor on her hands and knees. She stated she was trying to go to the bathroom. She denied hitting her head. No injuries were noted. Ms. Mitchell was not on a toileting program at this time. This was her fourth documented fall.

21.

On June 16, 2012, as the hospice nurse was entering the building, Ms. Mitchell, eloped out the front entrance. She was immediately brought back without incident. The care plan has her listed as not an elopement risk. There was not a care plan completed for elopement.

22.

On June 19, 2012, Ms. Mitchell had a witnessed fall by the CNA. She was transferring herself from the wheel chair to the bed, and she fell on the floor. No injuries were noted. An x-ray of the right wrist was performed, and no new fracture was noted. There was a fracture at the end of the radius but the age could not be determined. No new interventions were noted to the care plans. This was her fifth documented fall.

23.

On July 2, 2012, Ms. Mitchell was found on the floor by the staff at 8:30 p.m. with no apparent injury. There was no documentation that the chair alarm was in place prior to the fall. This was her sixth documented fall.

24.

On July 4, 2012, the staff noted Ms. Mitchell had fallen on July 3, 2012 and was found on the floor of the bathroom. Ms. Mitchell had a loose bowel movement which went from her room into the bathroom, and the resident had slipped in her own stool. A repeat x-ray was ordered for the right foot due to swelling. This was her seventh documented fall.

25.

On September 18, 2012 Ms. Mitchell was found on the floor next to the toilet after attempting to transfer unassisted. Prior to this fall, Ms. Mitchell had been agitated and was

medicated with Ativan. There was no apparent injury noted. The care plan was not updated. This was her eighth documented fall.

26.

On November 6, 2012, Ms. Mitchell fell while attempting to sit on her bed. She had poor vision which complicated her mobility. She complained of pain to her right hand after this fall. No other injuries were noted. An x-ray was taken and no injuries were noted to the right hand. This was her ninth documented fall.

27.

On December 17, 2012, Ms. Mitchell was found sitting on her bathroom floor. She stated she lost her balance and sat down on her buttocks. X-rays were ordered and no injuries noted. This was her tenth documented fall.

28.

On December 31, 2012, Ms. Mitchell was sitting on the side of the bed when she dropped her water cup. She reached over to get it and fell to the floor and landed on her right side. She also said she hit her head. No injuries were noted. Neurological checks were initiated with no abnormal findings. This was her eleventh documented fall.

29.

On April 4, 2013, the yearly MDS was completed and determined a BIMS score of 5. It was noted that Ms. Mitchell continued to need extensive, 2-person assistance for mobility, which now included bed mobility.

30.

On April 17, 2013, Ms. Mitchell was found lying on her left side in front of the bathroom door. She was trying to get to the bathroom and did not call for assistance. She complained of pain from the shoulder to her knee on the left side. Ms. Mitchell had normal range of motion and no injuries noted. She was given Tylenol for pain. This was her twelfth documented fall.

31.

On May 13, 2013, Ms. Mitchell was found on the floor trying to go to the bathroom. The assessment findings were negative. A toilet program was still not initiated. This was her thirteenth documented fall.

32.

On September 22, 2013, Ms. Mitchell had another fall. She was assisted back to bed by two staff members. The care plan was changed, and she would now have a clip alarm on her wheel chair when up. This was her fourteenth documented fall.

33.

On November 15, 2013, Ms. Mitchell was discussed at an interdisciplinary team meeting. She was noted to be a fall risk with interventions noted. However, the bed and chair alarm would be removed at this time. This was the first initiation of a toileting program for Ms. Mitchell. She would be toileted 4 times a day and as needed. Ms. Mitchell was educated on the importance of not getting up by herself.

34.

On December 23, 2013, Ms. Mitchell was found on the floor by her roommate's bed. There was vomit on the floor. Ms. Mitchell stated she was trying to find the door. No injuries were noted and the assessment was normal. This was her fifteenth documented fall.

35.

On December 31, 2013, Ms. Mitchell was found lying in the hallway on her stomach. She stated she was trying to get up out of the wheelchair and fell. She had a scratch to her knee. The chair alarm was removed at the last interdisciplinary meeting on November 15, 2013. This was her sixteenth documented fall.

36.

On January 8, 2014, the MDS for her two-year admission assessment determined a marked decline in her lack of ability to ambulate. She was now required to have two plus person assist for all physical mobility, including bed mobility. She had no ability to ambulate at this time. She was also noted to be incontinent of bowel and bladder at all times. Ms. Mitchell was unable to participate in a toileting program. The MDS does not state why she could not participate in a toileting program.

37.

On January 9. 2014, Ms. Mitchell was found sitting on the floor in her room. She was assisted back to bed. No injuries were noted at this time. This was her seventeenth documented fall.

38.

On January 12, 2014, Ms. Mitchell was found sitting on the floor with her wheelchair behind her. She was trying to go to the bathroom. No injuries were noted, and Ms. Mitchell was assisted back to bed. Ms. Mitchell later complained of pain in her right arm. An x-ray determined there were no injuries. This was her eighteenth documented fall.

39.

On January 18, 2014, Ms. Mitchell was heard yelling and was found sitting on the floor by the toilet. She stated she was trying to go to the toilet and slid down on her buttocks. The chair alarm was not on. Ms. Mitchell was assisted to the toilet and then helped back to bed. Her family was notified. This was her nineteenth documented fall.

40.

On February 3, 2014, Ms. Mitchell was found on the floor by a CNA. Ms. Mitchell stated she was going to the bathroom. No injuries were noted. Ms. Mitchell was assisted back to bed. This was her twentieth documented fall.

41.

On February 15, 2014, Ms. Mitchell fell in the bathroom while only one CNA was with her when the care plan stated two plus staff members for any mobility. When she fell, Ms. Mitchell lacerated her forehead above the eyebrow. She was taken to the ER, and the laceration was sutured. She had episodes of vomiting and was returned to the ER later that evening. Her blood pressure was 152/110 at this time. This was her twenty-first documented fall.

42.

On March 14, 2014, the chair alarm sounded and the CNA found Ms. Mitchell on the floor between the bed and the wheelchair. Ms. Mitchell tried to stand up and sit on her bed but missed the bed. No injuries were noted. She was put back to bed. This was her twenty-second documented fall.

43.

On March 14, 2014, Ms. Mitchell was found on the floor in the dining room. She reached down to get something off the floor and fell out of the wheelchair face down. She had a small laceration in the middle of her forehead with a small hematoma present. Vital signs were stable with no complaints of pain. The laceration was cleansed and pressure applied. An ice pack was applied to the hematoma. This was her twenty-third documented fall.

44.

On September 13, 2014, Ms. Mitchell was found lying on the floor at 11:00 p.m. She was moving all extremities. Her vital signs were stable. Ms. Mitchell complained of pain on the right side. No injuries noted. This was her twenty-fourth documented fall.

45.

On January 12, 2015, Ms. Mitchell's three year MDS showed a BIMS score of 8. This was better than her earlier BIMS score. Ms. Mitchell was now confined to bed or a chair. She could not ambulate and had to be transferred only with two plus assistance. She needed extensive assistance with all ADL's. She had no pressure ulcers.

46.

On August 23, 2015, Ms. Mitchell was admitted to St. Joseph's Hospital of Emory Healthcare for a fever of unknown etiology. She was diagnosed with pneumonia. She also had high sodium and low potassium level. Both of these are indicative of dehydration. Ms. Mitchell was no longer verbally responsive and was confused and not following commands. During this hospital visit an order was given for Mepilex for a right hip wound treatment. The wound was not staged at this time and was not noted in the Grace Healthcare of Tucker records.

47.

On September 6, 2015, Ms. Mitchell was readmitted to Grace Healthcare of Tucker. The diagnosis was resolved pneumonia, PEG tube feedings, and severe cardiac issues. She was to receive 55 cc per hour of Glucerna tube feeding.

48.

On Ms. Mitchell's return from St. Joseph's Hospital the nurse listed her as non-verbal and unable to follow commands. On room air her pulse ox was 85% and with 2 liters of nasal cannula the pulse ox was 92%. She was unable to sit without a wedge pillow for support. Her muscle strength was only a 1/5, with 5 being full muscle strength.

49.

On September 9, 2015, Ms. Mitchell was admitted to DeKalb Medical Center for respiratory distress. During this admission to DeKalb she was treated for a DVT with a vena cava filter placed. On her readmission to Grace Healthcare on September 12, 2015, she was noted as a failure to thrive. Her son did not want her to return to Grace Healthcare of Tucker for additional treatment.

50.

On September 14, 2015, Ms. Mitchell was rolled off the edge of bed while one of the CNA's was changing the sheets according to the description of the incident. Only one CNA was changing her bed. She pulled on the sheet, and Ms. Mitchell rolled over the edge of the bed onto the floor. She hit her face on the floor. She had an open area to the right side of her forehead with a hematoma. The bleeding was stopped and a steri-strip was applied by the nurse practitioner. Ms. Mitchell was awake, alert, and screaming. 911 was called and the EMS transported Ms. Mitchell to DeKalb Medical Center. This was her twenty-fifth documented fall.

51.

The EMS report noted Ms. Mitchell was having an upward, fixed stare, and her only response was to pain. She did not follow any commands and did not talk. A large hematoma from the right eye to the middle of the forehead was present. A laceration was present to the forehead.

52.

In the emergency room, a CT of the head was performed that showed a right frontal subdural hematoma. The CT also showed multiple infarctions from her previous strokes. A repair was made to a 5-centimeter stellate lesion to the middle of the forehead. Flaps of the wound were repaired with five separate simple interrupted sutures.

53.

On September 18, 2015, the discharge summary stated she would return to a skilled nursing facility. She had a traumatic subdural hematoma. Neurologically she was unresponsive.

She did not move any extremities. She opened her eyes spontaneously but the pupils did not move synchronously. Ms. Mitchell only moaned to pain.

54.

On September 24, 2015, Ms. Mitchell was transferred to Golden Living in Dunwoody. She was flaccid in all extremities and had contractures on the right side. She was being tube fed at 55 cc/hour of Glucerna.

55.

On October 14, 2015, Ms. Mitchell was admitted to Amedisys Hospice for comfort care although she remained a Full Code per her son's decision.

56.

On October 15, 2015, Ms. Mitchell became unresponsive and was having periods of apnea. CPR was initiated and maintained until EMS arrived to transport Ms. Mitchell to Northside Hospital. She arrived in the Emergency Room with CPR being continued. She was intubated and ventilated with an ambu bag and then a ventilator.

57.

Ms. Mitchell remained apneic and was pronounced dead at 1.54 p.m.

58.

The death certificate listed the cause of Ms. Mitchell's death as: Cardiopulmonary arrest; Cerebrovascular disease and Chronic Kidney Disease Stage 3.

COUNT I
VIOLATION OF FEDERAL STATUTES AND REGULATIONS
OF 42 CFR §483.1 et seq.

59.

Grace Healthcare of Tucker is a licensed and certified long-term care facility that provides skilled nursing care as a participant in the Medicare program and that provides nursing care as a participant in the Medicaid program; Grace Healthcare of Tucker receives funding under the Medicare and Medicaid programs.

60.

The U.S. Department of Health & Human Services has promulgated a number of regulations pursuant to its authority under OBRA at 42 USCA § 1395i-3 related to the care, treatment and services provided to residents of skilled nursing facilities participating in the Medicare program and nursing facilities participating in the Medicaid program. Among those regulations are the following:

a) 42 CFR §483.10 and 15(a) provide that the resident has a right to live a dignified existence,

b) 42 CFR §483.13(c) requires the facility to implement protocols to protect the resident from neglect,

c) 42 CFR §483.13(c)(2) requires that all instances of patient neglect be reported to the facility administrator and other officials in accordance with state law,

d) 42 CFR §483.13(c)(3) requires that the facility maintain evidence of its investigation into patient neglect and must prevent future neglect of patients,

e) 42 CFR §483.13(c)(4) requires that results of neglect investigation be reported to the administrator and appropriate state authorities,

f) 42 CFR §483.15 requires the facility to care for its residents in a manner that maintains and enhances the resident's quality of life,

g) 42 CFR §483.15(e)(1) requires that each resident be provided services in the facility to accommodate their individual needs,

h) 42 CFR §483.20(b) and (g) require the facility to maintain a comprehensive and accurate assessment of the resident's medical needs, including the resident's general health and physical functioning,

i) 42 CFR §483.20(k)(1) requires that the facility prepare an accurate comprehensive care plan that addresses the patient's medical and nursing needs,

j) 42 CFR §483.20(k)(3) requires that services provided or arranged by the facility meet professional standards of quality and be provided by qualified persons,

k) 42 CFR §483.25. requires the facility to provide services to attain and maintain the highest practicable physical, mental and psychosocial well-being in accordance with the resident's assessments and Care Plan,

l) 42 CFR §483.25(a)(3) requires the facility to provide a resident who is unable to carry out the activities of daily living necessary services to maintain good nutrition, hygiene, grooming and oral hygiene,

m) 42 CFR §483.30 requires the facility to maintain an adequate nursing staff,

n) 42 CFR §483.75 requires that the facility be administered in such a way as to use its resources effectively and efficiently to maintain the highest practicable physical, mental and psychosocial well-being of each resident,

o) 42 CFR §483.75 requires properly trained, qualified and competent staff.

p) 42 CFR §483.75(b) requires the facility to operate and provide services in

compliance with law and acceptable professional standards and principles that apply to professionals providing said services,

q) 42 CFR §483.75(k)(1) requires the facility to maintain clinical records in accordance with accepted professional standards and practices which are complete and accurate.

61.

As a licensed and certified long-term care facility which receives funding under the Medicare and Medicaid programs, the Defendant long term care facility is subject to the above federal regulations for the provision of care, treatment and services to residents of the facility.

62.

As described in this complaint, the Defendants violated the above regulations of the U.S. Department of Health and Human Services in the following acts and omissions, among others to be demonstrated by the evidence:

a) Defendants failed to administer the nursing facility in such a way as to use its resources effectively and efficiently to maintain the highest practicable physical, mental and psychosocial well-being of Christine Mitchell,

b) Defendants failed to implement protocols to protect Christine Mitchell from neglect,

c) Defendants failed to operate and provide services to Christine Mitchell in compliance with law and acceptable professional standards and principles that apply to professionals providing said services,

d) Defendants failed to provide or arrange services for Christine Mitchell that met professional standards of quality,

e) Defendants failed to maintain an adequate nursing staff to provide for Christine Mitchell's needs,

f) Defendants failed to provide properly trained, qualified and competent staff to care for Christine Mitchell,

g) Defendants failed to maintain complete and accurate clinical records related to the care and treatment of Christine Mitchell in accordance with accepted professional standards and practices,

h) Defendants failed to protect Christine Mitchell from neglect,

i) Defendants failed in their duty to report all instances of Christine Mitchell's neglect to the facility administrator and appropriate state authorities,

j) Defendants failed to report results of any neglect investigation to the Administrator and appropriate state authorities,

k) Defendants failed to properly train and supervise the nursing staff to provide the appropriate care, treatment and services that Christine Mitchell needed,

l) Defendants failed to follow physician's orders with respect to the care and treatment that Christine Mitchell needed.

63.

Defendants are liable to Keith Mitchell, as Administrator of the Estate of Christine Mitchell, deceased, for all damages recoverable, including but not limited to pain and suffering, medical expenses, and funeral expenses.

64.

Defendants are liable to Keith Mitchell, as the son of Christine Mitchell for all damages recoverable, including but not limited to the full value of her life.

COUNT II
NEGLIGENCE PER SE BASED UPON VIOLATION OF REQUIREMENTS OF THE GEORGIA BILL OF RIGHTS FOR RESIDENTS OF LONG-TERM CARE FACILITIES AT OCGA §31-8-100 et seq.

65.

The State of Georgia has promulgated the *Bill of Rights for Residents of Long-term Care Facilities* at OCGA §31-8-100 et seq. which sets out requirements for those providing care, treatment and services to residents of long-term care facilities in this state. In particular, OCGA § 31-8-108(a) requires that residents of long-term care facilities receive care, treatment and services that are adequate and appropriate and which must be provided with reasonable care and skill and in compliance with all applicable laws and regulations (including those listed in the preceding Count of this complaint), and with respect for the resident's personal dignity, among other requirements.

66.

Pursuant to its authority granted by statute, the Georgia Department of Human Resources has promulgated a number of regulations for the provision of care, treatment and services to residents of long-term care facilities. In particular, GA ADC 290-5-39-.07 requires that each resident be provided with care, treatment and services which are adequate and appropriate for the condition of the resident as determined by the resident's developing care plan. The regulation also requires that services be provided with reasonable care and skill and in compliance with all applicable laws and regulations (including the state laws and federal regulations identified above).

67.

The Defendants violated the provisions of the *Georgia Bill of Rights for Residents of Long Term Care Facilities* and the regulations of the Georgia Department of Human

Resources identified above in all of the acts and omissions that are described in this Complaint for Damages. Among the acts and omissions constituting violation of the *Georgia Bill of Rights for Residents of Long Term Care Facilities* are the following:

a) Defendants deviated from the standard of care when they failed to provide Ms. Mitchell care in a safe manner.

b) Defendants deviated from the standard of care by failing to provide adequate number of staff members during care as indicated in the nurse's notes.

c) Defendants deviated from the standard of care by failing to maintain Ms. Mitchell's highest practicable physical, mental, and psychosocial well-being.

68.

The Defendant's violations of the *Georgia Bill of Rights for Residents of Long Term Care Facilities* and the regulations of the Georgia Department of Human Resources set out above constitute negligence per se or negligence as a matter of law.

69.

Defendants' failure to comply with the *Georgia Bill of Rights for Residents of Long Term Care Facilities* and the regulations of the Georgia Department of Human Resources set out above lead directly to the serious injury, illness, terrible pain, suffering, anguish, grief, and death of Christine Mitchell.

70.

As a result of the Defendants' acts and omissions constituting negligence per se, and the resultant damages and harm, the Plaintiff is entitled to an award of damages in his representative capacity as set out below.

COUNT III
STATUTORY REMEDIES AGAINST DEFENDANTS FOR VIOLATION OF FEDERAL AND STATE STATUTES AND REGULATIONS IN THE OPERATION OF A NURSING HOME

71.

Grace Healthcare of Tucker is a "nursing home" as that term is defined under O.C.G.A. § 31-7-1(1)(B).

72.

Nursing homes in Georgia must be licensed by the DHR/DCH and are required to comply with all applicable state and federal laws governing the administration of long term care facilities, including, but not limited to the *Bill of Rights for Long Term Care Facilities* and its rules and regulations.

73.

Pursuant to O.C.G.A. §§ 31-8-100 through 31-8-127, residents of nursing homes in Georgia have been granted certain rights which are enumerated in the regulations promulgated by the Georgia Department of Human Resources at GA ADC 111-8-50, et seq.

74.

Among the regulations promulgated by the Georgia Department of Human Resources for the operation of nursing homes is GA ADC 111-8-50-.02 and 111-8-50-.07 which provide that each resident of a nursing home must receive care and services which shall be adequate, appropriate and *in compliance with applicable federal and state law and regulations*.

75.

The State of Georgia has promulgated the *Bill of Rights for Residents of Long-term Care Facilities* at O.C.G.A. § 31-8-100 et eq., which sets out requirements for those providing care,

treatment and services to residents of long-term care facilities in this state, including personal care homes.

76.

Defendants' conduct which is described in great detail above constitutes numerous individual violations of the *Georgia Bill of Rights for Residents of Long-term Care Facilities* at O.C.G.A. § 31-8-100 et seq., the regulations of the Georgia Department of Human Resources at GA ADC § 111-8-50 et seq. and the regulations of the U.S. Department of Health and Human Services at 42 CFR § 483.1 et seq.

77.

Defendants are liable to Plaintiff for all damages recoverable.

COUNT IV
GENERAL NEGLIGENCE

78.

Christine Mitchell entered into a contract for the provision of long-term residence, care, treatment and services with the Defendants in this action, and pursuant to their agreement the Defendants had a duty to exercise ordinary care in the provision of that care, treatment, and services to Ms. Mitchell. The Defendants failed to exercise reasonable care in a number of instances with respect to the care, treatment and services provided to Ms. Mitchell, and she sustained serious injury, great pain and suffering, and premature death as a result as demonstrated below.

79.

Upon information and belief, Defendants failed to establish and implement policies and procedures designed to provide appropriate care, treatment and services to Grace Healthcare of Tucker residents including Christine Mitchell.

80.

Upon information and belief, Defendants failed to properly prepare Grace Healthcare of Tucker's budget so as to use its resources effectively and efficiently to maintain appropriate care treatment and services to its residents including Christine Mitchell.

81.

Upon information and belief, Defendants failed to implement policies, practices and protocols to protect residents, including Christine Mitchell from neglect.

82.

Defendants failed to operate and provide services to Christine Mitchell in compliance with acceptable professional standards and principles that apply to professionals providing said services.

83.

Upon information and belief, Defendants failed to maintain an adequate nursing and non-professional staff to provide for Christine Mitchell's needs.

84.

Defendants failed to provide properly trained, qualified and competent staff to care for Christine Mitchell.

85.

Upon information and belief, Defendants failed to properly train and supervise the Grace Healthcare of Tucker's staff that was responsible for the provision of care, treatment and services to Christine Mitchell.

86.

Defendants failed to properly monitor and chart Christine Mitchell's condition and the

course of care provided to address her medical conditions.

87.

Defendants' staff was negligent in a number of other ways identified herein and to be further demonstrated by the evidence.

88.

As a direct and proximate result of each one of the above-described negligent acts and omissions, Ms. Mitchell suffered grave injury, suffered tremendously, and suffered premature death.

89.

Many of the Defendants' acts and omissions described herein are ministerial in nature and constitute simple negligence for which the Defendants are liable to the Plaintiff.

90.

As a result of the foregoing acts and omissions and the resultant injuries, pain and suffering, and death of Ms. Mitchell, the Plaintiff is entitled to recover from the Defendants as set out below.

COUNT V
PROFESSIONAL NEGLIGENCE

91.

Christine Mitchell entered into a contract with the Defendants for the provision of long-term residence, care, treatment and services at the Defendants' facility, and Defendants failed to provide that care, treatment and service as described herein.

92.

Defendants were negligent and failed to exercise that degree of care required of the long- term care and skilled nursing home profession in general under similar conditions

and like circumstances. To the extent that this Count may be considered a medical malpractice action as defined in O.C.G.A. § 9-11-8 or O.C.G.A. § 9-3-70, see the Affidavit and CV of Nancy J. Urff, RN, attached hereto as Exhibit "A" to pursuant to O.C.G.A. § 9-11-9.1(a), to the extent that this statute may apply, if at all, to this action, and which Affidavit is hereby incorporated herein by reference. The Affidavit specifies at least one negligent act or omission on the part of Defendants and/or their staff, and the factual basis for such negligent act or omission that caused injury to Christine Mitchell. The Affidavit is not inclusive of each act, error, or omission that has been committed by Defendants, and Plaintiff reserves the right to contend and prove additional acts, errors, and omissions on the part of Defendants that reflects a departure from the requisite standard of care required by law.

93.

Pursuant to Nurse Urff's education, training and experience, Nurse Urff is familiar with the guidelines and regulations of Long Term Care Facilities including the requirement to maintain patient's safety during any intervention.

94.

Also pursuant to Nurse Urff's education, training and experience, Nurse Urff is familiar with the proper care of patients who had medical conditions similar to Christine Mitchell, including but not limited to, dementia, diabetes, hypertension, and seizures.

95.

Pursuant to Nurse Urff's education, training and experience, Nurse Urff is fully aware of the circumstances under which a resident is in need of increased safety measures when there is a decline in functional ability. My Nurse Urff's experience includes provision of emergency medical care when the resident needs it.

96.

As a result of Nurse Urff's education, training and experience outlined above, Nurse Urff is well qualified to testify as to the acceptable standards of care with respect to the below referenced aspects of nursing care, both for nursing care that occurs at a nursing home, assisted living facility and/or any type of long-term care setting as well as nursing care that occurs in a hospital setting.

97.

The standard of care for staff in the long term care setting requires that the staff provide appropriate monitoring and update care plans when the needs of a resident has changed substantially.

98.

The standard of care for staff in the long term care setting requires that the staff recognize significant changes in a resident and notify the physician and family regarding the changes as well as initiate a resident's transfer to an acute care center sufficient to meet the resident's needs.

99.

The standard of care for staff in the long-term care setting requires that the staff obtain immediate emergency or hospital care when the resident's condition requires it.

100.

Notwithstanding the duty owed to Christine Mitchell by Defendants as described above, Defendants were negligent and failed to exercise that degree of care, skill and diligence required of the medical and nursing home profession in general under similar conditions and like circumstances. The negligence of Defendants included, but was not limited to, the

following:

1. Grace Healthcare of Tucker failed to provide care to prevent Ms. Mitchell from a significant number of falls through updating care plans and interventions to decrease the number of falls.
2. Grace Healthcare of Tucker failed to implement a toileting program to prevent Ms. Mitchell from suffering a substantial number of falls as she tried to go to the bathroom.
3. Grace Healthcare of Tucker staff failed to utilize basic safety measures by raising the side rails on the bedside to which the resident is being turned. As per the agencies care plan 2 plus staff members were to be assisting the bed mobility per the care plan. The other staff member should have been present to stand on the side of the bed, to prevent the resident from rolling off.
4. Grace Healthcare of Tucker staff failed to closely monitor, revise care plans and implement adequate interventions for a resident with deteriorating conditions.
5. Grace Healthcare of Tucker staff failed to maintain Ms. Mitchell's highest practicable physical, mental, and psychosocial well-being.

101.

Defendants also have vicarious liability for the negligent acts and omissions of all persons or entities under Defendants' control either direct or indirect, including its respective employees, agents, and consultants.

102.

As a direct and proximate result of the negligence of Defendants as described herein, Christine Mitchell lacked appropriate health care, causing tremendous struggle, suffering, and death.

COUNT VI
BREACH OF CONTRACT

103.

Christine Mitchell entered into a contract for the provision of long term nursing care, treatment, and services with the Defendants in this action, and pursuant to that agreement the Defendants had a duty to exercise ordinary care in the provision of care, treatment and services to Christine Mitchell. The Defendants failed to exercise reasonable care in a number of instances with respect to the care, treatment and services provided to Christine Mitchell, and she sustained serious illness, injury, pain and suffering, and premature death as a result.

104.

In the wrongful acts and omissions described in detail above and in the insufficiency of care, treatment and services outlined herein, the Defendants failed to provide the services that they promised to provide pursuant to the contract for services entered between the Defendants and Christine Mitchell. The Defendants therefore breached the contract for services as set out herein.

105.

As a result of the foregoing, Plaintiff Keith Mitchell, in his individual capacity and in his capacity as the Administrator of Estate of Christine Mitchell, is entitled to recover all amounts paid to obtain services under the contract and all consequential damages arising therefrom.

COUNT VII
FAILURE TO PROVIDE SUFFICIENT AND PROPERLY TRAINED STAFF

106.

Defendants had a duty to exercise ordinary and reasonable care in providing sufficient staffing and properly trained staff at Defendants' facility.

107.

Defendants were chronically understaffed, which put patients at the facility at risk and in danger. In addition, the staff at Defendants' facility was inadequately and improperly trained.

108.

The Defendants' facility Defendants breached their duty to exercise reasonable and ordinary care in providing sufficient and quality staffing.

109.

The Defendants failed to provide sufficient staffing at Defendants' facility and caused the facility to be chronically understaffed, and failed to properly train said staff. Defendants' acts and omissions proximately caused Christine Mitchell serious injury, pain, suffering, and death.

110.

As a further result of the Defendants' failure to provide sufficient staff at Defendants' facility and failure to properly train its staff, Plaintiff Keith Mitchell Individually and as Administrator of the Estate of Christine Mitchell is entitled to recover damages for the pain and mental anguish, death, suffering, medical expenses, and funeral and burial expenses.

COUNT VIII
IMPUTED LIABILITY

111.

All of Christine Mitchell's injuries and damages were the direct result of the acts and

omissions of the agents, servants and employees of the Defendant business entities conducted within the course and scope of each individual's employment with the Defendant business entity health care providers.

112.

The Defendant business entities are therefore vicariously liable for the individual employee and agent's acts and omissions, and for each individual officer, director, employee, agent and servant's negligent acts and omissions, and the resultant injuries, and damages of Christine Mitchell by application of the doctrine of respondent superior. The Plaintiff is therefore entitled to recover damages from the Defendants as set out herein.

COUNT IX
ESTATE'S TORT CLAIMS
AS TO ALL DEFENDANTS

113.

Plaintiff Keith Mitchell is the Administrator of the Estate of Christine Mitchell, and he prosecutes these claims in that capacity.

114.

As set out above, Ms. Mitchell sustained grievous injuries, pain, suffering, and death as a direct result of Defendants' acts and omissions which constitute violations of federal and state law, professional negligence, general negligence, and negligence per se.

115.

In his capacity as the Administrator of Ms. Mitchell's estate, Plaintiff Keith Mitchell is entitled to recover all damages to which Ms. Mitchell would have been entitled had she survived. As a result of the Defendants' wrongful conduct, Ms. Mitchell incurred medical expenses and related expenses for her care, treatment and services prior to her death, and final expenses. Ms.

Mitchell also endured untold pain and suffering as a result of Defendants' negligent acts and omissions prior to her death.

116.

Based on the foregoing, Plaintiff Keith Mitchell, as the Administrator of Ms. Mitchell's estate is entitled to recover from Defendants damages equal to all expenses incurred in the provision of medical care and treatment to Ms. Mitchell resulting from the Defendant's wrongful conduct and to recover for Ms. Mitchell's final expenses. The Plaintiff is also entitled to recover damages for Ms. Mitchell's conscious pain and suffering prior to her death.

COUNT X
JOINT ENTERPRISE

117.

At the time of the negligent acts and omissions and Christine Mitchell's resultant injuries and damages described above, the Defendants combined their property and labor in a joint undertaking for the provision of long-term nursing home care, treatment and services for a fee. Each had rights of mutual control over all aspects of the residence, care, treatment and services provided to Christine Mitchell while she was a resident at Grace Healthcare of Tucker.

118.

By virtue of the foregoing, all of the Defendants are liable to the Plaintiff herein for money damages as set out below by application of the joint enterprise theory of recovery.

COUNT XI
WRONGFUL DEATH
AS TO ALL DEFENDANTS

119.

As set out above, Ms. Mitchell sustained grievous illness, suffered tremendously and ultimately died as a direct result of the Defendants' acts and omissions in the provision of care,

treatment and services to her which constituted violations of federal and state law, professional negligence, simple negligence, and negligence per se.

120.

Ms. Mitchell is survived by her son, Keith Mitchell, the Plaintiff herein.

121.

As a result of the Defendants' violations of federal and state law, professional negligence, simple negligence and negligence per se and Ms. Mitchell's resultant death as set out in detail above, Plaintiff is entitled to recover damages against the Defendants for Ms. Mitchell's wrongful death in an amount equal to the full value of the life of the deceased.

COUNT XI
PUNITIVE DAMAGES

122.

As described and set forth herein, Defendants actions, inactions, and omissions demonstrate willful misconduct, malice, wantonness, oppression, and an entire want of care giving rise to the presumption of Defendants' conscious indifference to the consequences of their actions.

123.

As a result of the foregoing, Plaintiff is entitled to an award of punitive damages from the Defendants in an amount sufficient to punish Defendants and deter the Defendants from similar conduct in the future.

WHEREFORE: the Plaintiff prays for the following:

a) That service of summons and process be had upon each Defendant,

b) That this case be tried before 12 fair and impartial jurors on all issues so triable,

c) That judgment be entered against the Defendants in amounts in excess of $10,000.00 with all costs to be taxed against the Defendants, for all special damages, pain, and suffering of Christine Mitchell,

d) That Plaintiff recovers a judgment against Defendants for punitive damages in an amount sufficient to punish Defendants and deter the Defendants from similar conduct in the future;

e) That the Court grant the Plaintiff all other relief that it deems appropriate.

This18th day of July, 2017.

Respectfully submitted,

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