**IN THE STATE COURT OF GEORGIA COUNTY**

**STATE OF GEORGIA**

JOHN DOE, as Executor )

of the Estate of JACK DOE, )

 )

 Plaintiff, )

 )

v. ) Civil Action File No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 )

ASSISTED LIVING FACILITY )

and SENIOR LIVING, )

 )

 Defendants. )

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**COMPLAINT**

 **COMES NOW** Plaintiff and files this Complaint against Defendants Assisted Living Facility and Senior Living showing the Court the following:

**Parties, Jurisdiction, Venue, and Service of Process**

 Plaintiff John Doe is a resident of City, Georgia. Plaintiff is also a surviving brother of Jack Doe, Deceased. Plaintiff John Doe was lawfully appointed as Executor of the Estate of Jack Doe, Deceased, on February 28, 2018, and brings this case as the appropriate representative of Jack Doe, Deceased, to recover all damages allowed by law.

2.

Under O.C.G.A. §51-4-5, Plaintiff John Doe, as Executor of the Estate of Jack Doe brings this action for wrongful death on behalf of himself and his brothers Brother and Brother Doe.

3.

Defendant Assisted Living Facility is a domestic for-profit corporation that transacts business in Georgia. Its principal office address is Address, City, GA 30000. It may be served through its registered agent, Registered Agent at Address, City, GA 30000. It is subject to the venue and jurisdiction of this Court.

4.

 Defendant Assisted Living Facility does business as “Assisted Living Facility.”

5.

Defendant Assisted Living Facility is operated as an Assisted Living Center under O.C.G.A. § 31-8-130 et. seq.; O.C.G.A. § 31-7-12; O.C.G.A. § 31-7-12.2; and the Georgia Department of Community Health, Health Care Facility Regulations, Chapters 111-8-62.01, et seq. and 111-8-63.01 et seq.

6.

 During the period of time that Mr. Doe was a resident, Defendant Assisted Living Facility was required to comply with all applicable laws and regulations pertaining to Defendant Assisted Living Facility, including but not limited to Georgia’s Bill of Rights for Personal Care Residents, O.C.G.A. § 31-8-131, et. seq.; Rules of Department of Community Health, 111-8-62.01, et seq.; and Rules of Department of Community Health, 111-8-63.01, et seq.

7.

 Defendant Senior Living is a domestic for-profit corporation that transacts business in Georgia. Its principal office address is Address, City, GA 30000. It may be served through its registered agent, Registered Agent at Address, City, GA 30000. It is subject to the venue and jurisdiction of this Court.

8.

 Defendant Senior Living owns, operates and/or manages assisted living facilities such as Assisted Living Facility throughout the State of Georgia.

9.

 Defendants are directly liable by virtue of their own conduct for the wrongful acts and omissions detailed herein. Defendants are also vicariously or indirectly liable and responsible for the wrongful acts and omissions detailed herein under one or more of the following alternative legal theories:

1. Alter Ego: at all material times, Defendants were alter egos of one another. Defendant Senior Living controlled and/or managed Defendant Assisted Living Facility, as if they were one by commingling the two companies on an interchangeable basis or confusing separate properties, records, or control. Further, Defendant Assisted Living Facility was a subsidiary, affiliate, and/or alter ego of Defendant Senior Living. Defendant Assisted Living Facility was merely a conduit through which Defendants did business. The management and operations of Defendant Assisted Living Facility were so assimilated within Defendant Senior Living that Defendant Assisted Living Facility was simply a name through which Defendants conducted their business. Defendant Senior Living. so dominated and controlled the operations of Defendant Assisted Living Facility, and any assertions by Defendant Senior Living that each was a separate corporate fiction with an independent and separate existence is a sham and part of a scheme to perpetrate fraud, promote injustice and evade existing legal and fiduciary obligations.
2. Agency: at all material times, Defendants acted as agents for one another and each ratified or authorized the acts or omissions of the other.
3. Joint Venture/Enterprise: in the alternative, Defendants are each liable for the acts and omissions of the other because they were engaged in a joint venture and enterprise and acted in concert in the establishment, operation, management and control of Defendant Assisted Living Facility. Defendants share a common purpose and combined their property and labor in establishing, operating, managing, and/or controlling Defendant Assisted Living Facility and combined their property and labor in Defendant Assisted Living Facility for the purpose of making a profit. Defendants each had a right of mutual control over the establishment operation, management, control, supervision and maintenance of Defendant Assisted Living Facility.

10.

 During the period of time that Mr. Doe was a resident, Defendant Assisted Living Facility was staffed with nursing and other professional and non-professional staff members who at all times operated within the course and scope of their employment and/or agency with Defendants such that they are liable for the staff members’ wrongful acts and omissions under the doctrine of *Respondeat Superior* and/or other legal theories of vicarious liability applicable under Georgia law.

11.

Defendants are joint tortfeasors.

12.

Defendants are subject to the venue and jurisdiction of this Court pursuant to Ga. Const. Art. IV, § II, ¶ IV, O.C.G.A. §§ 9-10-31, 14-2-510, and other applicable law.

13.

 Jack Doe’s resident records and documents from Defendant Assisted Living Facility include the following relevant information: Jack Doe was a 78-year old man with multiple co-morbidities including progressive dementia with altered mental status, generalized weakness and limited communication because of progressive aphasia. He was right hand dominant with right upper extremity weakness thought to be related to a chronic rotator cuff issue. On October 23, 2017 Mr. Doe was admitted to Assisted Living Facility and specifically to the Memory Care Unit. Mr. Doe was placed on a regular diet. Dietary preferences were addressed, and the initial plan of care indicated that Mr. Doe could feed himself and had no prior history of aspiration or dietary precautions.

14.

 Mr. Doe was a high fall risk upon admission and sustained an initial fall approximately 3 weeks afterwards.

15.

 On November 17, 2017 Mr. Doe fell and was treated for a right eyebrow laceration and back pain.

16.

 On November 23, 2017 he suffered an additional fall which may have been from a wheelchair. No significant injuries were identified, and he was treated and released from the emergency room.

17.

 On December 9, 2017 Mr. Doe suffered a third fall and was again sent to the emergency room for treatment of a forehead laceration. A head CT was negative, and no acute injuries were identified.

18.

 On December 31, 2017 during lunch in the dining room at approximately 11:34 a.m., Mr. Doe began choking while apparently eating roast beef.

19.

 Defendant Assisted Living Facility CNA performed a finger sweep of his mouth followed by an incorrect attempt of the Heimlich maneuver. Ms. CNA reported that she was able to clear his airway and asked an available aid to go and get a nurse on duty from another unit.

20.

 LPN arrived as Ms. CNA was sweeping Mr. Doe’s mouth and described liquid and food on Mr. Doe’s shirt following the procedure.

21.

 LPN indicated upon arrival that Mr. Doe did have a pulse and was barely breathing. She also described that the staff turned him on his side, and no further objects were coming out of his mouth.

22.

 LPN later stated in an incident report to the County Sheriff’s Office that she “observed CNA sweeping the mouth area and noted liquid and food on the resident’s mouth.” She also described that Mr. Doe had a pulse and was breathing “very shallow” while lying on the floor.

23.

 LPN then indicated that she left to contact the EMS, and when she returned, Mr. Doe was not breathing and without a pulse.

24.

 Defendant Assisted Living Facility staff describe that they moved Mr. Doe to his room to “clean him up.” LPN later indicated in her voluntary statement to the County Sheriff’s Office that she was uncertain of the choking protocol and had to obtain advice from other Assisted Living Facility staff members. A medical aid suggested that they move Mr. Doe from the dining room back to his resident room to “clean him up.”

25.

 Defendant Assisted Living Facility staff called “911” at 11:51 p.m.

26.

 At 12:09 p.m., EMS arrived and described that Defendant Assisted Living Facility staff was cleaning up Mr. Doe in his room.

27.

 EMS personnel asked Defendant Assisted Living Facility staff to stop cleaning Mr. Doe and exit the room until the coroner arrived upon the scene.

28.

 The County Sheriff’s Office was contacted to investigate the incident, and Mr. Doe’s body was transported to the county morgue.

29.

 An autopsy was performed by GBI Pathologist, and she found that the presence of a mass of food matter (16 x 5 cm) completely occluded Mr. Doe’s upper airway. She determined that Mr. Doe died as a result of asphyxia due to choking. The manner of death was classified as accidental.

30.

 On January 8, 2018, the State of Georgia Department of Community Health made a visit to Assisted Living Facility. Investigators reviewed Mr. Doe’s records. The investigators found that Mr. Doe choked on food during his lunch at approximately 11:34 a.m. on December 31, 2017. Assisted Living Facility staff attempted to perform the Heimlich maneuver and partially cleared the obstruction. Mr. Doe had a pulse at that time. After staff requested assistance, Mr. Doe lost consciousness and had no pulse. CPR was allegedly initiated.

31.

 The DCH investigator’s review of the County EMS trip record demonstrated that a 911 call was received at 11:51 a.m. and that a time lapse of 17 minutes occurred between the report of the resident choking and the call out to 911.

32.

 The State of Georgia cited Defendant Assisted Living Facility. The summary of the statement of deficiencies included that in the case of an accident or sudden adverse change in a resident’s change or adjustment, an assisted living community must immediately take actions appropriate to the specific circumstances to address the needs of the resident, including notifying the representative or legal surrogate, if any. The assisted living community must also retain a record of all such adverse changes and the assisted living community’s response in the resident’s files.

33.

 The State of Georgia investigator further found that Defendant Assisted Living Facility failed to immediately take actions appropriate to the specific circumstances to address Mr. Doe’s needs while he was choking.

**COUNT I**

**Claim for Professional Negligence**

34.

 Mr. Doe restates and incorporates by reference his allegations set forth in Paragraphs 1- 33 above.

35.

 At all times relevant hereto, the nursing staff and other professional and non-professional staff at Defendant Assisted Living Facility owed a duty of care to Mr. Doe in accordance with the standard of care ordinarily exercised by assisted living facilities and/or personal care homes, and nurses, CNAs, and others generally under like conditions and similar and surrounding circumstances.

36.

 The nursing staff and other professional and non-professional staff at Assisted Living Facility were negligent and breached the applicable standard of care by failing to:

 a) appreciate Jack Doe’s increased risk for choking;

 b) to prevent Jack Doe from choking; and

 c) failing to properly clear a foreign object obstruction and also failing to call EMS in a timely fashion.

37.

 Attached hereto as Exhibit “A” is the Affidavit of Expert, RN, which satisfies the requirements of O.C.G.A. §§ 9-11-9.1 and 24-7-702.

38.

 Mr. Doe experienced bodily injury, severe pain, suffering and an untimely death as a direct and proximate result of the negligence by the nursing staff and other professional and non-professional staff at Defendant Assisted Living Facility.

39.

As alleged above, Defendants individually and collectively are vicariously liable for the negligent acts and omissions of the nursing and other professional and nonprofessional staff members at Defendant Assisted Living Facility under the Doctrine of *Respondeat* *Superior* and other applicable laws.

40.

 If any of the acts or omissions alleged in Paragraphs 1 through 39 are deemed by the Court to involve ordinary negligence rather than professional negligence, they are alternatively incorporated and averred as part of Count II of this Complaint.

**COUNT II**

**Ordinary Negligence**

41.

 Plaintiff restates and incorporates by reference his allegations set forth in Paragraphs 1- 42 above.

42.

 Defendants had a duty to exercise ordinary and reasonable care to protect Mr. Doe from choking on or about December 31, 2017. Said duty included, but was not limited to:

a. ensuring that Defendant Assisted Living Facility was adequately staffed with nursing and other professional and nonprofessional staff members who could supervise and assist Mr. Doe while eating; and

b. ensuring that Defendant Assisted Living Facility ’s nursing and other professional and nonprofessional staff were adequately trained in how to supervise, assist residents such as Mr. Doe, and prevent them from choking and/or injuring themselves.

43.

Defendants breached their duty to exercise ordinary and reasonable care to protect Mr. Doe from choking and/or injuring himself throughout his admission to Defendant Assisted Living Facility.

44.

 The nursing and other professional and nonprofessional staff members at Defendant Assisted Living Facility had a duty to exercise ordinary and reasonable care to protect Mr. Doe from choking on December 31, 2017.

45.

 The nursing and other professional and nonprofessional staff at Defendant Assisted Living Facility breached their duty to exercise ordinary and reasonable care to protect Mr. Doe from choking on December 31, 2017.

46.

As alleged above, Defendants are vicariously liable for the negligent acts and omissions of the nonprofessional staff members at Defendant Assisted Living Facility under the Doctrine of *Respondeat Superior* and other applicable laws.

47.

 If any of the acts or omissions alleged in Paragraphs 1 through 46 are deemed by the Court to involve professional negligence rather than ordinary negligence, they are alternatively incorporated and averred as part of Count I of this Complaint.

**COUNT III**

**Violation of Georgia’s Remedies for Residents of Personal Care Homes,**

**O.C.G.A. § 31-8-130, et. seq., and the Department of Community Health’s Rules and Regulations for Assisted Living Communities**

***(Negligence per se)***

48.

 Plaintiff incorporates by reference his allegations from Paragraphs 1-47 as if set forth fully herein.

49.

 As a resident of Defendant Assisted Living Facility, an assisted living/personal care facility, Mr. Doe was entitled to the rights afforded him under Georgia’s Remedies for Residents of Personal Care Homes, O.C.G.A. § 31-8-130, et. seq. These rights included, but are not limited to, reasonable care and skill, care and services that are appropriate, adequate staffing based on resident needs, and compliance with applicable laws and regulations. O.C.G.A. § 31-8-133; the Department of Community Health’s (the “DCH’s”) Rules and Regulations for Personal Care Homes, Chapter 111-8-62; DCH Rules and Regulations for Assisted Living Communities, Chapter 111-8-63.

50.

 Georgia’s Remedies for Residents of Personal Care Homes was created to protect residents such as Mr. Doe from neglect and abuse, and to create a safe environment for personal care home and/or Assisted Living Community residents. O.C.G.A. § 31-8-131; DCH Rules and Regulations, Chapters 111-8-62 and 111-8-63.

51.

 Resident rights are enumerated in the DCH’s Rules and Regulations for Personal Care Homes chapter 111-8-62 and Assisted Living Communities chapter 111-8-63. See also, O.C.G.A. § 31-2-1 et. seq., which gives the DCH rule making authority to issue regulations.

52.

Defendants’ employees and/or agents at Defendant Assisted Living Facility wrongfully and negligently cared for Mr. Doe by failing to provide him with dignity, appropriate care services, and appropriate staffing based on his needs and the needs of the other residents. O.C.G.A. §31-8-133; DCH Rules and Regulations, Chapters 111-8-62-.12; 111-8-62-.25; 111-8-62-.26; 111-8-63-.25.

53.

Defendants’ professional and/or non-professional staff, agents and employees, among other negligent acts and omissions, failed to provide Mr. Doe with reasonable care and skill and in compliance with applicable laws and regulations which proximately caused his choking and resulting injuries on December 31, 2017. These negligent acts and omissions constitute a violation of O.C.G.A. § 31-8-133; DCH Rules, Chapters 111-8-62-.12; 111-8-62-.25; 111-8-62-.26; and 111-8-63-.25. For instance, among other violations, Mr. Doe did not receive quality of care; care that respected his dignity; and care, treatment and services that used reasonable level of skill when Defendants’ personal care staff and other non-professional staff failed to prevent him from choking and/or becoming injured during his residency.

54.

 These failures, violations, and omissions caused, pain, suffering, injury and Mr. Doe’ untimely and wrongful death. DCH Rules and Regulations for Assisted Living Communities, Chapter 111-8-63.03.

55.

 These violations of Georgia’s Remedies for Residents of Personal Care Homes further constitute negligence *per se* as defined by Georgia law and each and every violation constitutes a separate cause of action against Defendants, their agents and employees, for damages and such other relief as this Court deems appropriate*.*  O.C.G.A. § 31-8-136(6)(d); Thurman v. Pruitt Corp., 212 Ga. App. 766, 422 S.E. 2d. 844 (1994); O.C.G.A. § 31-2-1 et. seq.

56.

 As a direct and proximate result of all of the Defendants’ violations of Georgia’s Remedies for Residents of Personal Care Homes and the DCH’s Rules and Regulations for Personal Care Homes and/or Assisted Living Facilities, Mr. Doe suffered injuries, an untimely and wrongful death, and experienced severe pain and anguish.

57.

 Defendants’ agents and employees, are jointly and severally responsible for any and all violations pursuant to O.C.G.A. § 31-8-100(a), et. seq., for damages from those violations as defined by this act.

58.

 Defendants are vicariously liable for all of the wrongful acts, negligent acts and/or omissions described herein of its agents or employees.

59.

 Plaintiff is entitled to recover all allowable damages for violations of these rights including, but not limited to, pain and suffering and medical expenses pursuant to O.C.G.A. §§ 31-8-131, et. seq.; and 31-8-136.

**COUNT IV**

**Breach of Contract**

60.

 Plaintiff incorporates by reference his allegations from Paragraphs 1-59 as if set forth fully herein.

61.

 To the extent that the Resident Admission Agreement that Brother Doe, as Power of Attorney, and Jack Doe entered into with Defendants is a valid and enforceable contract, Defendants breached the contract by failing to provide Jack Doe with basic assisted living services, assistance in activities of daily living, and by failing to uphold his resident rights.

62.

 Jack Doe suffered injuries physical pain and suffering, and mental and emotional pain and suffering, and/or untimely death as a result of Defendants’ breach of the Resident Admissions Agreement.

**COUNT V**

**Punitive Damages**

63.

 Plaintiff incorporates by reference his allegations from Paragraphs 1-62 as if fully set forth herein.

64.

 The wrongful acts, negligent acts and omissions, violations of Georgia Remedies for Residents of Personal Care Homes, aforementioned Rules of the Department of Community Health Rules and Regulations, and breaches of standards of care by Defendants, by and through their agents and/or employees, evince wantonness and are such gross deviations from the appropriate standards of care that they justify the inference of a conscious indifference to the consequences as defined by O.C.G.A. § 51-12-5.1, and which justify an award of punitive and exemplary damages against Defendants to punish, penalize, and deter these Defendants and others similarly situated from repeating such egregious conduct in the future.

 **WHEREFORE**, Plaintiff requests the following:

1. That Defendants be served with process;
2. That Plaintiff John Doe, as Administrator of the Estate of Jack Doe, Deceased, recover from Defendants the full value of Jack Doe’s life as determined by a fair and impartial jury in excess of Ten Thousand Dollars ($10,000.00);
3. That Plaintiff John Doe as Administrator of the Estate of Jack Doe, recover from Defendants for Jack Doe, Deceased’s pain and suffering, medical expenses, funeral expenses, punitive damages, and any other amount as determined by a fair and impartial jury;
4. That Plaintiff has a trial by a jury of twelve on all issues on this action;
5. That Plaintiff has such further relief to which she may be entitled.

 This \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_, 2021.