**IN THE SUPERIOR COURT OF GEORGIA COUNTY**

**STATE OF GEORGIA**

JOHN A. DOE, Individually as )

Surviving Son of Jane Doe, )

And JOHN B. DOE as )

Administrator of the Estate of )

JANE DOE, )

 )

 Plaintiffs, )

 )

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

 )

NURSING HOME; )

AGENT 1; and AGENT 2 )

 )

 Defendants. )

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

**COMPLAINT**

 **COME NOW** Plaintiffs and file this Complaint against Defendants Nursing Home; Agent 1; and Agent 2 (collectively, “Defendants”), showing the Court the following:

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

Plaintiff John A. Doe is a resident of Milledgeville, Georgia. Plaintiff is also a surviving child of Jane Doe, Deceased.

1.

Plaintiff John B. Doe is a resident of Cumming, Georgia. Plaintiff is also a surviving child of Jane Doe, Deceased. Plaintiff John B. Doe was lawfully appointed as Administrator of the Estate of Jane Doe, Deceased, on October 29, 2019, and brings this case as the appropriate representative of Jane Doe, Deceased, to recover all damages allowed by law.

1.

Defendant Nursing Home is a Domestic Limited Liability Company that transacts business in Georgia. Its principal office address is Address, Georgia, 30000. It may be served through its registered agent, Registered Agent, at Address, Georgia, 30000. It is subject to the venue and jurisdiction of this Court.

 At all material times, Nursing Home remained actively engaged in and transacted business in Georgia County, Georgia, by establishing, acquiring, owning, maintaining, and/or operating Nursing Home, a skilled nursing facility that is located at Address, Georgia, 30000.

1.

 During the period of time that Jane Doe resided at Nursing Home, which is detailed below in the “Facts” section, Nursing Home was staffed with nursing and professional and non-professional staff members and/or agents who at all times operated within the course and scope of their employment and/or agency with Defendants. As such, they are all 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.

 Defendant Agent 1. is a Domestic Nonprofit Corporation that transacts business in Georgia. Its principal office address is Address, Georgia, 30000. It may be served through its registered agent, Registered Agent, at Address, Georgia, 30000. It is subject to the venue and jurisdiction of this Court.

1.

At all material times, Agent 1 remained actively engaged in and transacted business in Georgia County, Georgia, by establishing, acquiring, owning, maintaining, and/or operating Nursing Home, a skilled nursing facility that is located at Address, Georgia, 30000.

1.

Defendant Agent 2 is a Domestic Nonprofit Corporation that transacts business in Georgia. Its principal office address is Address, Georgia, 30000. It may be served through its registered agent, Registered Agent, at Address, Georgia, 30000. It is subject to the venue and jurisdiction of this Court.

1.

 At all material times, Agent 2 remained actively engaged in and transacted business in Georgia County, Georgia, by establishing, acquiring, owning, maintaining, and/or operating Nursing Home, a skilled nursing facility that is located at Address, Georgia, 30000.

1.

Defendant Nursing Home is the governing body of D/B/A. Defendant Nursing Home manages, operates, and/or employs the facility at D/B/A located at Address, Georgia, 30000. Furthermore, it managed, owned and/or operated D/B/A at all relevant times herein during Jane Doe’s residency, and as such, is liable under Georgia law for the tortious conduct described herein of its agents and/or employees.

Defendant Agent 2 manages, operates, and/or employs the facility at Nursing Home located at Address, Georgia, 30000. Furthermore, it managed, owned and/or operated Nursing Home at all relevant times herein during Jane Doe’s residency, and as such, is liable under Georgia law for the tortious conduct described herein of its agents and/or employees.

 Defendant Agent 1 manages, operates, and owns the other corporate defendants and determines the financial and organizational structure for all corporate Defendants including their ability to properly staff and maintain sufficient employees and resources to meet relevant standards of care which govern their business practices.

1.

 Defendants are directly liable by virtue of their own conduct for the wrongful acts detailed herein. Defendants are also vicariously or indirectly liable and responsible for the wrongful conduct 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. Defendants conducted these entities, including Nursing Home, as if they were one by commingling them on an interchangeable basis or confusing separate properties, records, or control. Furthermore, Nursing Home was a subsidiary, affiliate, and/or alter ego of Defendants. Nursing Home was merely a conduit through which the Defendants did business. The management and operations of Nursing Home have so assimilated within the Defendants that Nursing Home was simply a name through which the Defendants conducted their business. The Defendants so dominated and controlled the operations of Nursing Home, and any assertions by the Defendants 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 the facility. Defendants share a common purpose and combined their property and labor in establishing, operating, managing, and/or controlling Nursing Home and combined their property and labor in Nursing Home for the purpose of making a profit. The Defendants each had a right of mutual control over the establishment operation, management, control, supervision and maintenance of Nursing Home.

 Whenever in this Complaint it is alleged that the Defendants did any act or failed to do any act, it is meant that the officers, agents, or employees of the designated Defendants respectively performed, participated in, or failed to perform such acts while in the course and scope of their employment or agency relationship with the Defendants. Acts and omissions of an officer or employee while acting within the scope of his or her employment or authority constitutes an act or omission of the corporation. Accordingly, Plaintiffs invoke the doctrine of *Respondeat superior*. Therefore, allegations of acts or omissions by any Defendants, or any requisite level of knowledge include officers, agents, servants, representatives, and/or employees who were: a) under the control of said Defendants; and b) acting in the course and scope of the employment relationship with said Defendants engaged in the act or omission or had the requisite level of knowledge.

Defendants are joint tortfeasors. Ga. Const. 1983, Art. VI, Sec. II, Para. 6; O.C.G.A. §§ 14-2-510, 14-3-510. Venue is proper as to all Defendants in Georgia County.

**FACTS**

1.

Jane Doe was 93 years old at the time of her admission to Nursing Home on or about June 16, 2016.

Jane Doe has a medical history that included Bradycardia, Hypertension, Hypothyroidism, Hyperlipidemia, Osteoporosis, Muscle weakness (generalized), Diverticulosis, Unspecified lack of coordination, difficulty in walking, Long term use of anticoagulants, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Chronic Constipation, Coronary Artery Disease, Sick Sinus Syndrome with a Pacemaker, Neuropathy, Dementia, Atrial Fibrillation, and Gastro-Esophageal Reflux Disease (GERD).

Ms. Doe’s initial plan of care noted that she was “at risk for falls and injuries from falls related to impaired mobility and medication regimen.” It also detailed a history of falls with a previous left femur fracture.

Ms. Doe’s initial plan of care dated June 16, 2016, described she was at risk for pressure sore development due to impaired mobility and the presence of pressure ulcers on her right knee and left posterior thigh. She was given an initial Braden score of 13.

The acute care plan included the following interventions with the goal of not developing a secondary infection: Provide treatment as ordered, Turn and reposition every 2 hours and as needed avoiding pressure to site, observe for signs and symptoms of wound infection, Cleanse after incontinent episodes and apply moisture barrier, pressure reducing mattress, provide heel protection, reposition or lift using turn/lift sheet, head of bed 30 degrees or less if consistent with medical condition, pressure reduction cushion when out of bed, use positioning devices such as pillows/wedges, refer to algorithm for nutritional support and refer to registered dietitian for dietary needs. Educate the resident and family, assess for pain, and treat as ordered.

On June 23, 2016, Nursing Home increased Ms. Doe’s Braden Score to 15.

On December 5, 2016, the Nursing Home nurse charted that Ms. Doe’s pressure ulcers on her right knee and left posterior thigh was resolved.

Ms. Doe’s care plans on June 2, 2017, and June 27, 2017, state that she is "[a]t risk for skin tears and bruising related to frail elderly skin and/or medications.” The June 27, 2017 care plan added the intervention of padding wheelchair arms even though it was to be implemented on June 2, 2017.

On August 12, 2017, Ms. Doe suffered an unwitnessed fall. A handwritten note by LPN states, "[h]eard resident yelling for help. Upon entering resident sitting on floor at bedside stated, ‘I slipped off the bed going to the bathroom.”

On August 21, 2017, Ms. Doe was admitted to Medical Center for altered mental status. Ms. Doe was sick for two weeks prior to admission. She was treated for UTI on August 12, 2017. She was weaker than normal and sleeping more. She had a urinalysis (UA) on August 20, 2017 that demonstrated the UTI had resolved.

 On August 31, 2017, Ms. Doe’s Care Plan Conference Sheet described the following: “[f]amily expresses displeasure with the nursing care of the mother. Found mother on the floor with a staff member right outside of the door. Son stated mother has been weak and not herself for a few weeks. Nurse and CNA unable to obtain vitals because the son suspected the mother had UTI. Family states linens are soiled and dirty. He also found black banana peel and strawberry juice stains on her linen. Nursing services aware of concerns.”

 On August 31, 2017, Ms. Doe was transferred back to Nursing Home via a stretcher. Admission documents from Nursing Home described that Ms. Doe “requires total care assist with ADLs and repositioning every 2 hours.”

1.

 On the September 7, 2017, an SBAR Communication form notifying \_\_\_\_\_\_\_, NP of a change in condition, stated, “[r]esident complaint of tiredness and sleeping most of the day. The resident decreased in therapy and needing several repeated cues to move the upper and lower extremities. Meal intake is poor and complaints of trouble breathing.” and “[Ms. Doe] requires more assistant with ADL care due to poor activity tolerance and weakness. Moderate assistance with ADLs and bed mobility, Max assistance with transfers, and with ADLs.”

1.

 On October 19, 2017, Ms. Doe complained of right hand and back pain. Her right hand was swollen and hot to the touch. There was no fracture in her right hand. No explanation was provided for the pain or injury-causing incident.

1.

 On November 3, 2017, Ms. Doe sustained a skin tear on her left lower extremity when she was transferred.

1.

 On February 6, 2018, Ms. Doe sustained another skin tear to her left lower leg while being transferred to a wheelchair by nursing home staff. The staff member was instructed to use a Sabina lift with all transfers as an intervention for the injury.

1.

 Ms. Doe started hospice care on June 5, 2018; hospice's comprehensive assessment stated the following: "[p]atient bed bound and unable to sit up in a wheelchair. No side rails on the bed due to family removing them—high risk for falls. Braden Score of 7 (Very high risk of impaired skin integrity) has had three falls in the past 18-24 months. Each fall resulted in an injury. Totally dependent on all ADLs, including the need to be fed. Very paranoid. Incontinent of bowel and bladder.”

 On October 13, 2018, Ms. Doe developed a new wound of unknown origin on left foot 2nd toe with redness and scab on top of the toe. Ms. Doe stated to the nurse that it hurt badly. She was referred to wound care.

 On January 17, 2019, Hospice Nurse, RN, notified Nursing Home that Ms. Doe might be discharged because of no decline in her health.

 On June 20, 2019, Ms. Doe developed a new wound on her left leg. She also had a wound on her right foot second toe that was covered with a dressing.

1.

 On June 24, 2019, Ms. Doe sustained a traumatic avulsion to her right lateral leg while being transferred from wheelchair to bed at the nursing home. Ms. Doe’s right leg came into contact with the bed rail or bed assist bar resulting in a deep cut. The wound measured 10cm length x 5cm depth width x 6cm wound depth. Her muscle and adipose tissue were exposed. The wound resulted in a large amount of blood loss. Ms. Doe was sent to Emergency Room.

1.

 An investigation by the Department of Community Health found that the “assist bar” was removed from the resident's bed. There was no evidence that a thorough investigation was conducted. Additionally, there was no documentation that other beds and assist bars were audited to ensure that potential rough areas did not exist that could cause injury to other residents.

1.

 At Emergency Room, Ms. Doe’s bleeding was controlled. She received 19 sutures to repair the laceration.

1.

 On June 25, 2019, Ms. Doe returned to Nursing Home from the hospital with a new order for Keflex 500mg every 6 hours for seven days and an order for sutures to be removed in 10-14 days.

1.

 On July 1, 2019, Nursing Home RN, placed the following note in Ms. Doe’s resident record: “[t]he black plastic piece that was on the right side of resident's bed on which her right leg was accidentally bumped causing a traumatic injury was removed. This was part of the intervention to prevent further injury. Family aware.”

1.

 On July 9, 2019, Ms. Doe’s sutures were removed from the location of the traumatic avulsion on her right leg. The wound bed was noted to have a purplish area with a small amount of bleeding. There were no signs or symptoms of infection.

1.

 On July 12, 2019, Doctor, MD, ordered care from Hospice.

1.

 On June 12, 2019, Nursing Home LPN, completed an MDS Assessment on Ms. Doe. The MDS assessment demonstrated that Ms. Doe required two-person assists for bed mobility, toilet use, including incontinence care, and when being transferred.

 On July 13, 2019, Ms. Doe developed a Deep Tissue Injury (DTI) with an intact blister to left heel. She had a history of wounds on the toes of both feet.

1.

 On July 17, 2019, a low air pressure mattress ordered by Hospice was delivered and successfully installed for Ms. Doe. Two days later, on July 19, 2019, Ms. Doe’s son complained that “staff didn’t know what they were doing with the air mattress and need someone to fix it.”

1.

 On July 29, 2019, a discolored area directly above Ms. Doe’s right heel, measuring 2x2cm, was discovered. Ms. Doe was receiving treatment to bilateral heels for bogginess. Her heels were floated with heel boots.

 On August 1, 2019, Ms. Doe suffered a new skin tear on her right shin, measuring 3x2x0.1 cm, due to leg positioning by staff while receiving wound care.

1.

 On August 2, 2019, Ms. Doe’s son complained that the staff does not encourage her to eat. They also wait until breakfast is cold before offering it to her.

1.

 On August 13, 2019, a Nursing Home CNA provided incontinence care while Ms. Doe was laying on her bed. This CNA turned Ms. Doe onto her side. The CNA then turned to get wipes and Ms. Doe fell out of the bed on the floor, injuring her head. On June 12, 2019, Nursing Home LPN, completed an MDS Assessment on Ms. Doe. The MDS assessment detailed that Ms. Doe required two-person assists for bed mobility, toilet use, including incontinence care, and when being transferred.

 Ms. Doe sustained a laceration above her right eye from the fall. Ms. Doe was admitted to Hospital.

1.

 At Hospital, Ms. Doe received nine sutures to repair the 4cm laceration above her right eye. Hospital discovered that Ms. Doe was bleeding within the brain parenchyma (intraparenchymal hemorrhage) due to trauma. Hospital transferred Ms. Doe to the trauma center at Hospital.

1.

 Ms. Doe was admitted to the neurointensive care unit at Hospital for treatment of an acute traumatic intraparenchymal hemorrhage, subarachnoid hemorrhage, and a nondisplaced spiral fracture of the distal shaft of the left tibia. Her brain bleed was monitored with coumadin discontinued, and a boot was placed on the tibia fracture.

1.

 On August 17, 2019, Ms. Doe was transferred back to Nursing Home. On August 18, 2019, Doctor, MD ordered hospice care for Ms. Doe because of her score on the Palliative Performance Scale (PPS) of 40%. A week later, August 25, 2019, Ms. Doe had a PPS of 20%.

 On August 30, 2019, Ms. Doe exhibited more signs of decline. Ms. Doe was gurgling on secretions and she was unable to cough the secretions up. Nursing Home CNAs had to reposition her side to side every two hours to prevent her from aspirating.

1.

 On September 10, 2019, Ms. Doe developed an open wound on her sacrum measuring 1 x 1 x 0.1cm.

1.

 On September 26, 2019, Nursing Home LPN observed that Ms. Doe’s wound to her left heel had partial eschar detaching.

1.

 On October 7, 2019, Ms. Doe’s son visited her and discovered that her bed was not lowered for fall precautions. He reported this to the Assistant Director of Nursing.

1.

On October 12, 2019, at approximately 7:00 am, Ms. Doe died.

**COUNT I**

**Claim for Professional Negligence**

1.

Plaintiffs restate and incorporate by reference the allegations set forth in Paragraphs 1 - 58 above.

1.

 At all times relevant hereto, Defendant’s nursing staff, the professional and non-professional staff at the subject skilled nursing facility owed a duty of care to Ms. Doe in accordance with the standard of care ordinarily exercised by skilled nursing facilities/long term care facilities and/or nursing homes generally under like conditions and similar surrounding circumstances.

 Defendants’ nursing staff, professional staff, and non-professional staff at the subject skilled nursing facility were negligent and breached their duty to Ms. Doe. More specifically, the nursing staff, professional staff, non-professional staff, and other healthcare providers, including Defendants’ agents and/or employees deviated from the standard of care between June 16, 2016, and October 12, 2019, by:

1. failing to prevent Ms. Doe from falling multiple times during her residency at Nursing Home (42 CFR 483.25(d));
2. failing to appropriately implement and change her individual service plan after multiple falls (42 CFR 483.21(b)(2));
3. failing to appropriately transfer Ms. doe on June 24, 2019, resulting in a traumatic skin avulsion requiring 19 sutures;
4. the staff of NURSING HOME failed on multiple occasions to provide treatment and care in accordance with basic professional standards of nursing practice (42 CFR 483.25);
5. failing to ensure Ms. Doe’s environment was free of accident hazards by allowing the bed rail to contain a sharp and dangerous edge that cut her leg on June 24, 2019, resulting in a traumatic skin avulsion requiring 19 sutures (42 CFR 483.25(d));
6. failing to prevent the development of multiple Deep Tissue Injuries (DTIs) and pressure wounds multiple times during her residency at Nursing Home (42 CFR 483.25(b)(1));
7. failing to maintain sufficient staffing to assist Ms. Doe on August 13, 2019, resulting in a fall causing an acute traumatic intraparenchymal brain hemorrhage, subarachnoid brain hemorrhage, and a nondisplaced spiral fracture of the distal shaft of the left tibia (42 CFR 483.35); and
8. failing to properly assist Ms. Doe on August 13, 2019, resulting in a fall causing an acute traumatic intraparenchymal brain hemorrhage, subarachnoid brain hemorrhage, and a nondisplaced spiral fracture of the distal shaft of the left tibia.

 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.

 Ms. Doe experienced bodily injury, severe pain, mental and emotional suffering, and untimely death as a direct and proximate result of the negligence by Defendants’ nursing staff and other professional and non-professional staff at the subject skilled nursing facility.

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

 If any of the acts or omissions alleged herein 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**

1.

Plaintiffs restate and incorporate by reference the allegations set forth in Paragraphs 1 - 65 above.

1.

Defendants had a duty to exercise ordinary and reasonable care in providing services to Ms. Doe, including, but not limited to, the following:

* 1. assisting Ms. Doe with activities necessary for daily living;
	2. providing Ms. Doe with appropriate assistance with bed mobility, transfers, and toileting and not mishandling Ms. Doe on August 13, 2019, resulting in a fall causing an acute traumatic intraparenchymal brain hemorrhage, subarachnoid brain hemorrhage, and a nondisplaced spiral fracture of the distal shaft of the left tibia;
	3. providing sufficient staffing to assist Ms. Doe on August 13, 2019, preventing a fall causing an acute traumatic intraparenchymal brain hemorrhage, subarachnoid brain hemorrhage, and a nondisplaced spiral fracture of the distal shaft of the left tibia;
	4. creating and following appropriate plans of care;
	5. ensuring proper fall precautions and interventions were in place;
	6. ensuring that Ms. Doe’s room was free of hazards, like the sharp edge on her bed on June 24, 2019, resulting in a traumatic skin avulsion requiring 19 sutures when Ms. Doe’s leg encountered the sharp edge while being transferred from her bed;
	7. observing, and documenting and reporting abnormal findings to nurses and physicians.

The nursing and other professional and nonprofessional staff members, including the certified nursing assistants (CNAs), at Nursing Home had a duty to exercise ordinary and reasonable care to protect Ms. Doe from injury while under Defendants’ care.

 The nursing and other professional and non-professional staff at Nursing Home breached their duty to exercise ordinary and reasonable care to protect Ms. Doe from injury while under Defendants’ care.

As alleged above, Defendants are vicariously liable for the negligent acts and omissions of the non-professional staff members at Nursing Home under the Doctrine of *Respondeat Superior* and other applicable laws.

**COUNT III**

**Violations of the Georgia Bill of Rights for Residents of Long-Term Care Facilities**

 Plaintiffs incorporate by reference the allegations from Paragraphs 1-70 as if set forth fully herein.

Plaintiffs are entitled to bring an action as a result of the Defendants' violations of Ms. Doe’s rights protected under the "Bill of Rights for Residents of Long-Term Care Facilities." O.G.G.A. § 31-8-100, et seq. These rights include, but are not limited to, reasonable care and skill, respect for dignity and privacy, and compliance with applicable laws and regulations.

The Georgia Bill of Rights for Long Term Care Residents was created to protect residents such as Ms. Doe from neglect and abuse and to create a safe environment for nursing home residents.

Defendants failed to properly care plan, assess, manage, and document Ms. Doe’s risk for falls which worsened during his residency at Nursing Home. Defendants further failed to provide Ms. Doe with reasonable care and skill in compliance with applicable laws and regulations which proximately caused his death. Among other violations, Defendants failed to provide quality of care, care that respected his dignity, and care, treatment, and services of a reasonable level of skill in failing to prevent, assess, and manage Ms. Doe’s risk for falls while at Nursing Home. These negligent actions and omissions constitute a violation of O.C.G.A. § 31-8-108 *et seq*.

By virtue of their conduct described in this Complaint, the Defendant, individually and while acting through the nurses and custodial staff employed by them at the facility, failed to comply with the requirements and provisions of the Official Code of Georgia§ 31-8-100, *et seq*., and violated Ms. Doe’s rights enumerated under the "Bill of Rights for Residents of Long Term Care Facilities."

These violations further constitute negligence per se as defined by Georgia law and in each and every violation constitutes a separate cause of action against Defendants for damages and such other relief this Court deems appropriate. O.C.G.A. § 31-8-126(a); Thurman v. Pruitt Corp., 212 Ga. App. 766, 422 S.E. 2d. 844 (1994).

As a direct and proximate result of Defendants' violations of the Georgia Bill of Rights for Residents of Long-Term Care Facilities, Ms. Doe suffered pain, injuries, an untimely death, and incurred medical expenses.

Plaintiffs are entitled to bring a wrongful death action for the death of their mother and is entitled to recover for the full value of the life of Jane Doe, for Defendant’s violations as set forth herein.

Additionally, Plaintiff John B. Doe, as Administrator of the Estate of Jane Doe, is entitled to recover for Jane Doe’s pain and suffering, as well as medical, funeral and burial expenses.

Plaintiffs are 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. § 31-8-100, et. seq. and 31-8-126(a).

**COUNT IV**

**Failure to Provide Sufficient and Proper Staffing and Nursing**

Plaintiffs incorporate by reference the allegations from Paragraphs 1-80 as if set forth fully herein.

Defendants had a duty to exercise ordinary and reasonable care in providing sufficient and competent staffing at Nursing Home.

Defendants were chronically understaffed, which put patients at the facility at risk and in danger.

Defendants breached their duty to exercise ordinary and reasonable care in providing sufficient and competent staffing at Nursing Home.

Defendants failed to provide sufficient and competent staffing at Nursing Home and caused the facility to be chronically understaffed.

Defendants’ acts and omissions caused permanent and debilitating injuries to Jane Doe including death.

As a result of the Defendants’ understaffing at Defendants are liable to Plaintiffs for the wrongful death of his mother.

Further, as a result of the Defendants’ understaffing at Nursing Home, Defendants are liable to Plaintiff John B. Doe, as Administrator of the Estate of Jane Doe, for Jane Doe’s pain and suffering, as well as medical, funeral and burial expenses.

**COUNT V**

**Punitive Damages**

 Plaintiffs incorporate by reference the allegations from Paragraphs 1-88 as if fully set forth herein.

 The wrongful acts, negligent acts and omissions, violations of Georgia Bill of Rights for Residents of Long Term Care Facilities, 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**, Plaintiffs requests the following:

1. That Defendants be served with process;
2. That Plaintiffs recover from Defendants the full value of Jane Doe’s life as determined by a fair and impartial jury;
3. That Plaintiff John B. Doe, as Administrator of the Estate of Jane Doe, Deceased recover from Defendants for Jane Doe’s, Deceased, pain and suffering, medical expenses, funeral expenses, punitive damages, and any other amount as determined by a fair and impartial jury;
4. That Plaintiffs have a trial by a jury of twelve on all issues on this action;
5. That Plaintiffs have such further relief to which she may be entitled.

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