IN THE STATE COURT OF COBB COUNTY
STATE OF GEORGIA

VIRGINIA SPEARS, Individually As A Surviving Child And As the Executrix of The Estate of CLARA BELL BARNETT, and EARL BARNETT, JAMES BARNETT And DON BARNETT, Individually As Surviving Children of CLARA BELL BARNETT,	)	Civil Action No. _____
Plaintiffs,	)	
vs.	)	
THE A.G. RHODES HOME-COBB INC., and A.G. RHODES HOMES,	)	
Defendants.	)	

FIRST AMENDED COMPLAINT FOR DAMAGES

Plaintiffs Virginia Spears, As A Surviving Child and as the Executrix of The Estate of Clara Bell Barnett, and Earl Barnett, James Barnett and Don Barnett, as Surviving Children of Clara Bell Barnett, bring this Complaint for Damages against defendants, showing the Court as follows:

PARTIES, JURISDICTION, AND VENUE

1.

Plaintiff Virginia Spears is both the natural daughter of and executrix for the Estate of Clara Bell Barnett, who died on February 6, 2003. Plaintiffs Earl Barnett, Don Barnett and James Barnett are the natural sons of Clara Bell Barnett.

2.

Defendant The A.G. Rhodes Home-Cobb, Inc., is a Georgia corporation duly organized and existing under the laws of the State of Georgia and at all times material hereto was doing business at 900 Wylie Road, Marietta, Georgia, 30067. Defendant A.G. Rhodes-Cobb's registered agent is Corporation Process Company, located at 180 Cherokee Street, Marietta, Georgia 30060. Likewise, Defendant A.G. Rhodes Homes is a Georgia corporation duly organized and existing under the laws of the State of Georgia and at all times material hereto was doing business at 350 Boulevard S.E., Atlanta, Georgia 30312. Defendants have agreed to accept service in this case via their attorney Craig Brookes, Finley & Buckley, P.C., 2931 North Druid Hills Road, Suite C, Atlanta, Georgia 30329. Defendants are subject to the jurisdiction and venue of this Court.

PRELIMINARY ALLEGATIONS

3.

At all times mentioned herein, Defendant A.G. Rhodes Home-Cobb Inc., was owned, operated, controlled and managed by Defendant A.G. Rhodes Homes.

4.

At all times mentioned herein, defendants were engaged in the proprietary business of operating a licensed long-term nursing home facility located 900 Wylie Road, Marietta, Georgia 30067, and held themselves out to both the general public and specifically Ms. Clara Bell Barnett, Plaintiffs Virginia Spears, Earl Barnett, Don Barnett and James Barnett and Clara Bell Barnett's family members as a specialist in the area of adult nursing care.

5.

At all times mentioned herein, defendants operated a licensed nursing home facility that participated in the Medicare and Medicaid programs. Defendants are subject to the requirements for long-term health care as set forth in both the United States Code of Federal Regulations, 42 CFR 483, and O.C.G.A. §31-8-103 through §31-8-121, collectively known as the "Bill of Rights For Residents Of Long-Term Care Facilities."

6.

At all times mentioned herein, defendants held themselves out to be a specialist in the area of assisted care living, and represented that they employ a trained and competent staff of employees that maintains the type of safe environment necessary to provide for the health, safety, and well-being of persons unable to care for themselves.

7.

The cause and/or causes of action giving rise to this lawsuit concern the care, treatment, and errors and omissions arising therefrom, as well as the willful and wanton actions on the part of defendants and their employees, agents, officers and representatives which pertain to Ms. Clara Bell Barnett while she was a resident at defendants' nursing home facility at 900 Wylie Road, Marietta, Georgia 30067.

8.

At all times mentioned herein, defendants were engaged in the business of operating a nursing home facility and were responsible to the residents of the facility, including Clara Bell Barnett, for the provision of their custodial care, and the provision of nursing home

services, including but not limited to, the provision of residents' rights.

9.

The duties defendants owed Clara Bell Barnett while she was a resident at their nursing home facility included the duty to provide her with that degree of care, skill and diligence usually exhibited by nursing homes generally in the community and nationally, and as such defendants are governed by the provision and standards set out by O.C.G.A. § 51-1-27.

10.

Defendants' nursing home facility located at 900 Wylie Road, Marietta, Georgia 30067 is a regulated business and constitutes a "facility" or "long term care facility" within the meaning and purview of O.C.G.A. § 31-8-102(3).

11.

Defendants' nursing home facility located at 900 Wylie Road, Marietta, Georgia 30067 is a "nursing home" within the meaning of the rules of the Department of Human Resources, Public Health § 290-5-8-.01(a).

12.

Defendants' nursing home facility located at 900 Wylie Road, Marietta, Georgia 30067 is subject to the

standards required of long-term facilities pursuant to 42 CFR § 438, et seq.

13.

Defendants' nursing home facility located at 900 Wylie Road, Marietta, Georgia 30067 is a "nursing facility" within the meaning of 42 USC § 1396(r)(a).

14.

Defendants' nursing home facility located at 900 Wylie Road, Marietta, Georgia 30067 is a "skilled nursing facility" as defined at 42 USC § 1395 I-3(1)(A).

15.

Each and every act or omission to act on the part of defendants' employees, agents, supervisors, managers, representatives, etc., alleged within this Complaint was done within the course of their employment and the scope of their duties as defendants' employees. Accordingly, defendants are liable and/or responsible for the negligence and/or reckless and/or intentional conduct of its employees, agents, supervisors, managers, representatives, etc., pursuant to the doctrines of *respondeat superior* and agency.

FACTS

16.

Ms. Clara Bell Barnett and her family enrolled Ms. Barnett into defendants' nursing home facility on June 22, 2002. Ms. Barnett was a resident of defendants' nursing home facility and under the care of defendants, its agents, officers, and employees up until and including approximately October or November of 2002.

17.

Ms. Barnett and her family enrolled Ms. Barnett into defendants' facility as a patient and resident based upon the representations defendants held out and made to the Barnett family as outlined in Paragraphs 4-6 of this Complaint.

OVERMEDICATION

18.

When Ms. Barnett was admitted to defendants' nursing home facility on June 22, 2002, she was on the psychotropic drug Haldol per the instructions of Wellstar Kennestone Hospital. She was soon switched to Zyprexia.

19.

Psychotropic drugs such as Haldol and Zyprexia are used to treat conditions such as acute psychosis, memory loss and agitation. However, these drugs also have

numerous side effects, including weight loss, anxiety, depression, lethargy and deep vein thrombosis (DVT).

20.

Once defendants admitted Ms. Barnett to their facility it became their duty to provide Ms. Barnett with on-going patient evaluations and monitoring to ensure that the psychotropic drugs remained appropriate for her long-term care.

21.

Defendants failed to properly monitor and evaluate Ms. Barnett to determine if her clinical condition warranted the continued use of psychotropic drugs.

22.

Defendants failed to look for alternatives to psychotropic drugs for treating Ms. Barnett.

23.

Defendants continued to give Ms. Barnett psychotropic drugs even after her clinical condition no longer warranted the use of these drugs.

24.

Ms. Barnett suffered many known side effects as the proximate result of defendants' continued administration of psychotropic drugs that were not warranted for her clinical condition. The side effects Ms.

Barnett suffered included, but were not limited to, weight loss, agitation, confusion, lethargy, deep vein thrombosis (DVT) and incontinence.

25.

Defendants' failure to properly evaluate Ms. Barnett's continued need for psychotropic drugs and failure to seek alternative treatments are a deviation from the applicable standard of care, as well as a violation of both federal and state regulations for nursing home facilities such as defendants.

MALNUTRITION

26.

When Ms. Barnett arrived at defendants' nursing home facility on June 22, 2002, she had "red-flag" signs and symptoms that indicated she might be at-risk to suffer malnutrition.

27.

Defendants failed to recognize Ms. Barnett's "red-flag" signs and symptoms indicating the possibility of future malnutrition when she was admitted to their nursing home facility.

28.

Defendants failed to develop and implement a patient Care Plan for Ms. Barnett that adequately addressed her individual nutritional needs.

29.

Ms. Barnett suffered nutritional problems and weight loss as the proximate result of defendants' failure to provide adequate nutritional care.

30.

Defendants failed to properly monitor and evaluate Ms. Barnett's nutritional and weight status, and failed to follow physician's orders regarding Ms. Barnett's nutritional care.

31.

Defendants failed to recognize that their continued use of psychotropic drugs on Ms. Barnett was having adverse, avoidable effects on her nutritional and weight status.

32.

Defendants failed to give Ms. Barnett dietary evaluations and interventions even though her declining weight and nutritional status warranted investigation.

33.

Ms. Barnett suffered physical and emotional injury, including but not limited to continuing nutritional problems and further weight loss, as the proximate result of defendants' actions and omissions as set forth in Paragraphs 27 through 32 of this Complaint.

34.

Defendants' actions and omissions as set forth in Paragraphs 27 through 32 are a deviation from the applicable standard of care, as well as a violation of both federal and state regulations for nursing home facilities such as defendants.

PRESSURE SORES

35.

When Ms. Barnett arrived at defendants' nursing home facility on June 22, 2002, she already had some pressure sores.

36.

When Ms. Barnett arrived at defendants' nursing home facility on June 22, 2002, she had "red-flag" signs and symptoms that indicated that she may be at-risk to have additional problems with pressure sores.

37.

Defendants failed to recognize Ms. Barnett's "red-flag" signs and symptoms indicating the possibility of future pressure sores when she was admitted to their nursing home facility.

38.

Defendants failed to create and implement a patient Care Plan that adequately addressed Ms. Barnett's skin care needs.

39.

Defendants failed to provide Ms. Barnett with the proper skin and nutritional care necessary to facilitate the healing of existing pressure sores.

40.

Defendants failed to provide Ms. Barnett with the proper skin and nutritional skin care necessary to prevent new pressure sores from developing.

41.

Ms. Barnett's suffered physical and emotional injury, including but not limited to the worsening of existing pressure sores and the development of new pressure sores, as the proximate result of defendants' actions and inactions as set forth in Paragraphs 37 through 40 of this Complaint.

42.

Defendants' actions and inactions as set forth in Paragraphs 37 through 40 of this Complaint are a deviation from the applicable standard of care, as well as a violation of both federal and state regulations for nursing home facilities such as defendants.

PHYSICAL ABUSE BY STAFF AND DEFENDANTS' "COVER-UP" ATTEMPT

43.

On October 18, 2002, Ms. Barnett was admitted to Wellstar Kennestone Hospital with a spiral fracture in her right ankle.

44.

Ms. Barnett was non-ambulatory at the time her ankle was fractured.

45.

Upon admission to the hospital Ms. Barnett informed the hospital staff that "someone [one of defendants' staff] grabbed me by my leg and pulled me." See Exhibit A.

46.

Wellstar Kennestone Hospital physicians labeled the spiral fracture as consistent with "elder abuse" and reported the incident to social services. See Exhibit A.

47.

The Department of Human Resources (DHR) investigated the incident and found that defendants had failed to properly notify Ms. Barnett’s family of the situation and additionally had failed to do a proper investigation into the events surrounding the alleged abuse.

48.

As the proximate result of defendants’ failure to do a proper investigation of the incident and failure to maintain and preserve evidence, the DHR was unable to determine who fractured Ms. Barnett’s ankle.

49.

The spiral fracture in Ms. Barnett’s ankle was consistent with an incident of acute trauma or abuse given her clinical condition.

50.

Defendants’ failed to respond in a timely manner to Ms. Barnett’s complaints of ankle pain and failed to adequately investigate the cause of her ankle pain.

51.

Ms. Barnett suffered physical and emotional injury, including but not limited to a fractured ankle and

emotional trauma, as the proximate result of defendants' abusive actions and omissions.

52.

Defendants abusive actions and omissions as set forth in Paragraphs 45 through 50 of this Complaint are a deviation from the applicable standard of care, a violation of both federal and state regulations for nursing home facilities such as defendants, and constitute deliberate and recklessly indifferent actions intended to both harm Ms. Barnett and prevent others from discovering the harmful acts.

NEGLIGENT RECORD-KEEPING LEADS TO KNEE INJURY AND SURGERY

53.

When Ms. Barnett was admitted to defendants' nursing home facility on June 22, 2002, she had just undergone knee surgery at Wellstar Kennestone Hospital.

54.

Per Ms. Barnett's doctor's orders, Ms. Barnett was on "touch-down weight-bearing status" due to her knee. This meant that Ms. Barnett needed defendants' staff to provide her with assistance walking and moving around so that she did not put any weight on her knee.

55.

Ms. Barnett’s doctor’s orders for her to be on “touch-down weight-bearing status” was included in Ms. Barnett’s transfer records from Wellstar Kennestone Hospital to defendants’ nursing home facility.

56.

Upon Ms. Barnett’s admission, defendants failed to properly document her weight-bearing status in defendants’ charts and records.

57.

As the proximate result of defendants’ failure to properly document Ms. Barnett’s weight-bearing status, defendants failed to consistently provide Ms. Barnett with the assistance she needed in order to follow her doctor’s orders regarding her weight-bearing status. In other words, defendants caused Ms. Barnett to put too much weight and strain on her surgically repaired knee.

58.

When Ms. Barnett’s doctor examined her in July 2002 he noted that the pins in Ms. Barnett’s knee had become dislodged, and that Ms. Barnett would need corrective surgery.

59.

Defendants' failure to properly document Ms. Barnett's weight-bearing status and failure to carry out the doctor's orders regarding Ms. Barnett's weight-bearing status proximately caused the pins in Ms. Barnett's knee to become dislodged and proximately caused Ms. Barnett to undergo corrective surgery.

60.

Following Ms. Barnett's corrective surgery her doctor once again placed her on "touch-down weight-bearing status" due to her knee.

61.

Defendants again failed to properly document Ms. Barnett's doctor's orders on weight-bearing status following this corrective surgery.

62.

Ms. Barnett's corrective knee revision surgery was a proximate cause in her later developing deep vein thrombosis (DVT).

63.

Defendants' actions and omissions as set forth in Paragraphs 56 through 63 of this Complaint are a deviation from the applicable standard of care, as well as a

violation of both federal and state regulations for nursing home facilities such as defendants.

FRAUDULENT RECORD-KEEPING

64.

Defendants' medical records for July 31, 2002, claim that Ms. Barnett had a Foley catheter and that it was "draining well." See Exhibit B.

65.

Ms. Barnett did not have a Foley catheter on July 31, 2002. It had been removed five days earlier, on July 26, 2002. See Exhibit C.

66.

Defendants' medical records for September 22, 2002, indicate that defendants' had examined Ms. Barnett and that a cast on her right leg was "intact." See Exhibit D.

67.

Ms. Barnett did not have a cast on her right leg on September 22, 2002. It had been removed nine days earlier on September 12, 2002. See Exhibit F.

68.

Defendants knew when they made their record-entries as set forth in Paragraphs 64 through 67 of this

Complaint that they had not in fact provided the care they claimed to be providing.

69.

Defendants made the record-entries as set forth in Paragraphs 64 through 67 of this Complaint with the intent of misleading Ms. Barnett, her family and state and federal regulatory inspectors to believe that defendants were providing medical care to Ms. Barnett that met the standard of care.

70.

Ms. Barnett and her family relied upon defendants' representations and misrepresentations regarding Ms. Barnett's care in allowing her to enroll and remain at defendants' facility.

71.

As a proximate result of defendants' representations and misrepresentations as to patient care, Ms. Barnett's family allowed Ms. Barnett to enroll and remain at defendants' nursing home facility and thereby incur physical and emotional injury and trauma.

72.

Defendants' actions and omissions as set forth in Paragraphs 54 through 71 of this Complaint are a deviation from the applicable standard of care, as well as a

violation of both federal and state regulations for nursing home facilities such as defendants.

WRONGFUL DEATH

73.

Ms. Barnett died on February 6, 2003. Defendants' actions, inactions and omissions as set forth in this Complaint proximately caused and contributed to Ms. Barnett's overall decline, deterioration in function, and eventual death.

COUNT ONE-ORDINARY NEGLIGENCE

74.

Plaintiffs adopt and re-allege Paragraphs One through Seventy-Three as if fully set out herein.

75.

Defendants' non-professional employees, and/or professional employees whose negligent acts or omissions did not require the exercise of professional skill and judgment, owed a duty to Ms. Barnett to exercise reasonable and ordinary care so as to prevent harm and injury to Ms. Barnett.

76.

Defendants' non-professional employees, and/or professional employees whose negligent acts or omissions did not require the exercise of professional skill and

judgment, breached their duty to exercise ordinary and reasonable care to Ms. Barnett.

77.

Defendants' failure to exercise ordinary and reasonable care toward Ms. Barnett proximately caused Ms. Barnett to suffer physical and emotional injury.

COUNT TWO-PROFESSIONAL NEGLIGENCE

78.

Plaintiffs adopt and re-allege Paragraphs One through Seventy-Seven as if fully set out herein.

79.

Defendants owed a duty to their nursing home residents, including Ms. Barnett, to provide care, treatment and services in a manner consistent with the accepted standards of care for nursing homes.

80.

Defendants breached the duty of professional care owed to its nursing home residents, including Ms. Barnett, and negligently ignored an ongoing pattern of neglect and disdain for the most fundamental basic needs of its residents, including Ms. Barnett. Defendants' breaches of the standard of care are set forth throughout this Complaint and further include but are not limited to the following:

(a) Failure to properly evaluate Ms. Barnett for the appropriateness of the mediation she was on, and negligently prescribed inappropriate medication on a continuing basis;

(b) Failure to implement, carry out, and document an adequate and reasonable care plan for Mr. Barnett to prevent the development of pressure sores, and failure to properly treat and document the treatment of pressure sores that did develop or were already present;

(c) Overall failure to adequately document the care and treatment provided to Ms. Barnett;

(d) Failure to provide adequate nutritional care;

(e) Failure to adequately and reasonably keep Ms. Barnett’s family properly notified of her physical, mental and medical condition;

(f) Failure to adequately and reasonably implement and maintain a proper supervision program for a patient who was at high risk to fall and required assistance with daily life activities;

(g) Failure to provide adequate psychological care and counseling for a patient in Ms. Barnett’s clinical condition;

(h) Failure to adequately and reasonably provide care and assistance in ensuring that Ms. Barnett maintained “touch-down weight-bearing” status for her knee;

(i) Failure to adhere to applicable state and federal regulations regarding the care and treatment of Ms. Barnett, and failure to consisting and accurately document such care and treatment;

(j) Failure to carry out orders for care and treatment for Mr. Barnett as prescribed by outside doctors and physicians;

(k) Failure to provide proper care and treatment in ensuring that Ms. Barnett remained continent;

(l) Failure to timely evaluate and diagnose injury to ankle, as well as likely causing injury to Ms. Barnett through physical abuse.

(m) Failure to maintain and deploy adequate levels of staffing and nursing employees to meet the nursing standards of care;

(n) Negligent hiring and retention of professional and non-professional employees;

(n) Failure to supervise and adequately train its staff and nursing employees;

(o) Failure to provide adequate and timely

nursing intervention to alleviate Ms. Barnett's pain and suffering;

(p) Failure to update Ms. Barnett's Care Plan upon changes in her condition; and

(q) Failure to adequately report and investigate an alleged incident of physical abuse.

81.

Defendants' care and treatment of Ms. Barnett negligently and recklessly fell below the nursing home industry's accepted standard of care required for treating residents and patients. Pursuant to O.C.G.A. § 9-11-9.1, attached as Exhibit G is the affidavit of Diane Nelson, R.N., outlining some examples of defendants' failure to meet the requisite standard of care in its treatment of Ms. Barnett. This affidavit is incorporated by reference into this Complaint.

82.

Ms. Barnett suffered physical and emotional injury and trauma, and death, as the proximate result of defendants' actions and omissions as set forth in Paragraphs Seventy-Eight through Eighty-One of this Complaint.

COUNT THREE-STATUORY VIOLATIONS AND NEGLIGENCE PER SE

83.

Plaintiffs adopt and re-allege Paragraphs One through Eighty-Two as if fully set out herein.

84.

As a licensed nursing home in Georgia and as otherwise set forth in Paragraphs Four through Six of this Complaint, Defendants had a duty to adhere to and comply with various state and federal rules and regulations in providing care to its nursing home residents, including Ms. Barnett.

85.

By and through the actions and omissions as set forth throughout this Complaint, defendants have failed to adhere to and comply with various state and federal rules and regulations, including but not limited to the following:

(a) Violation of resident rights per 42 CFR § 483.10 et seq;

(b) Violation of admission, transfer and discharge rights, per 42 CFR § 483.12 et seq;

(c) Mistreatment and neglect, per 42 CFR § 483.13 et seq;

(d) Quality of life, per 42 CFR § 483.15 et seq;

(e) Resident assessment, per 42 CFR § 483.20 et seq;

(f) Quality of Care, per 42 CFR § 483.25 et seq;

(g) Nursing Services, per 42 CFR § 483.30 et seq;

(h) Dietary Services, per 42 CFR § 483.35 et seq;

(i) Pharmacy Services, per 42 CFR § 483.60 et seq;

(j) Physical Environment, per 42 CFR § 483.70 et seq

(k) Administration, per 42 CFR § 483.75 et seq;

(l) Required Care, Treatment and Services, per O.C.G.A. 31-8-108 et seq;

(m) The rules, regulations, policies and procedures of The A.G. Rhodes Home-Cobb Inc.; and

(n) Rules of the Department of Human Resources, including but not limited to:

1. Nursing Service, Chapter 290-5-8-.04 et seq;
2. Professional Service, Chapter 290-5-8-.05 et seq;
3. Dietary Service, Chapter 290-5-8-.06 et seq;
4. Medical and Nursing Care, Chapter 290-5-8-.10 et seq;
5. Records, Chapter 290-5-8-.11 et seq; and
6. Safety, Chapter 290-5-8-.13 et seq;

86.

Defendants' violations of the various state and federal rules and regulations as set forth above constitute a violation of the generally accepted standard of care within the nursing home industry.

87.

Defendants' violations of the various state and federal rules and regulations as set forth above constitute negligence per se.

88.

Ms. Barnett suffered physical and emotional injury and trauma, and death, as the proximate result of defendants' actions and omissions as set forth in

Paragraphs Eighty-Three through Eighty-Seven of this Complaint.

COUNT FOUR-BREACH OF CONTRACT

89.

Plaintiffs adopt and re-allege Paragraphs One through Eighty-Eight as if fully set out herein.

90.

Defendants entered into an express written contract to provide nursing and personal care to Ms. Barnett, and to exercise such reasonable care toward Ms. Barnett as her medical condition(s) required.

91.

The terms of this contract included expressly, by implication, or by operation of law that in return for payment defendants would provide care, services and supplies with the highest practicable standard of nursing care and through a team of trained professionals in compliance with all statutes and regulations governing the operation and management of licensed nursing home facilities in the State of Georgia.

92.

Defendants failed to provide Ms. Barnett with the quantity and quality of care, services and supplies to which Ms. Barnett was entitled under the contract, and

thereby breached the contract as more specifically set forth throughout this Complaint.

93.

Ms. Barnett at all times fulfilled her obligations under the contract, or defendants waived such obligations or defendants are estopped to assert such obligations as a defense.

94.

Ms. Barnett and plaintiffs suffered contract, special and consequential damages as the proximate result of defendants' breach of contract.

COUNT FIVE-BREACH OF THIRD-PARTY CONTRACT

95.

Plaintiffs adopt and re-allege Paragraphs One through Ninety-Four as if fully set out herein.

96.

Defendant is a party to a contract with the Georgia Department of Community Health, Division of Medical Assistance, to provide skilled nursing services, long-term care, treatment and other services to nursing home residents according to state plan. At all times mentioned in this Complaint, defendants were required pursuant to 42 USC § 1396(a)(23)(a) to satisfy sections (b)-(d) of §

1396(r) and to comply with federal regulations to qualify for reimbursements for long-term care and nursing services.

97.

Defendants are reimbursed from the Department of Community Health, Division of Medical Assistance for providing skilled nursing services, long-term care, treatment and other services to residents, including Ms. Barnett.

98.

Ms. Barnett was an intended third-party beneficiary of the contract between defendants and the Department of Community Health, Division of Medical Assistance.

99.

Defendant has breached its contract with the Department of Community Health, Division of Medical Assistance by failing and refusing to comply with the nursing, nutritional, environmental, sanitary, rehabilitative and humanitarian requirements and standards of care under federal and state laws and regulations.

100.

As the proximate result of the breaches of contract as set forth throughout this Complaint, Ms.

Barnett suffered physical and emotional injury and trauma, death, and contract and special damages.

COUNT SIX-BREACH OF FIDUCIARY DUTY AND FRAUD

101.

Plaintiffs adopt and re-allege Paragraphs One through One Hundred as if fully set out herein.

102.

The relationship between Ms. Barnett and defendants was one of trust and confidence, and defendants had a higher duty to affirmatively speak the truth to Ms. Barnett and her family because of Ms. Barnett's medical condition(s).

103.

Defendants owed Ms. Barnett a fiduciary duty of loyalty and care pursuant to O.C.G.A. §23-2-58. This fiduciary duty included, but was not limited to, defendants' duty to ensure that Ms. Barnett was not injured or abused by defendants' other patients and/or employees.

104.

Defendants engaged in intentional fraud and/or willful misrepresentation and/or reckless disregard by concealing and failing to disclose to Ms. Barnett, her family and state and federal regulatory inspectors material

facts within defendants' knowledge regarding Ms. Barnett's care and clinical condition.

105.

Defendants' intentional and/or willful and/or reckless misrepresentations were made in order to induce Ms. Barnett to remain as a resident at defendants' facility and to induce state and federal regulatory inspectors to not cite defendants for various state and regulatory patient care violations.

106.

Ms. Barnett suffered physical and emotional injury and trauma, and death, and the proximate result and consequence of defendants' intentional and/or willful and/or reckless conduct as set forth throughout this Complaint.

COUNT SEVEN-PUNITIVE DAMAGES

107.

Plaintiffs adopt and re-allege Paragraphs One through One Hundred and Six as if fully set out herein.

108.

Defendants had notice of the substandard care they were providing to Ms. Barnett and other residents of its nursing home facilities by virtue of repeated

notification it received that Ms. Barnett's and other patients' nursing and treatment needs were not being met.

109.

Defendants had notice of the substandard care they were providing to Ms. Barnett and other residents of their nursing home facilities by virtue of numerous other complaints and lawsuits filed against them by other residents regarding defendants' poor and substandard care that proximately resulted in severe physical and emotional injuries and death to other patients.

110.

Defendants had notice of the substandard care they were providing to Ms. Barnett and other residents by virtue of its statewide, systemic shortcomings and failings that have resulted in numerous complaints and lawsuits against it statewide, as well as citations and fines by regulatory agencies statewide.

111.

Defendants had notice of the substandard care they were providing to Ms. Barnett and other residents by virtue of repeated citations by local and state regulatory agencies for various deficiency violations.

112.

Defendants intentionally withheld information and failed to properly report the circumstances of the care it provided to Ms. Barnett, along with the resulting injuries, to the proper state and federal regulatory agencies, and Ms. Barnett's family.

113.

Defendants, by and through their employees and staff, intentionally and/or recklessly fractured Ms. Barnett's ankle in an incident of physical abuse, failed to report the incident, failed to adequately investigate the incident, and failed to take necessary steps to ensure that a similar incident would not happen again.

114.

Defendants' actions and omissions as set forth throughout this Complaint demonstrate an entire want of care and indifference to consequences. Likewise, defendants' intentional and willful attempt to mislead regulatory agencies, outside health care providers and others regarding Ms. Barnett's clinical condition and the medical care, or lack thereof, that defendants provided to Ms. Barnett demonstrate an entire want of care and indifference to consequences. Defendants' level of misconduct is such that punitive damages are warranted

under O.C.G.A. §51-12-5.1 in order to penalize and punish defendant for its misconduct, to deter defendant from engaging in such aggravating conduct in the future, and to deter other nursing homes and corporations from engaging in similar misconduct.

WHEREFORE, plaintiffs ask for the following relief:

(a) That plaintiffs have a trial by jury;

(b) That plaintiffs recover from defendants compensatory damages in such amount as shall be proven upon the trial of this case, representing the medical bills and expenses incurred as a result of defendants' negligence, recklessness and breach of fiduciary duty, and any amounts paid pursuant to the contract for defendants to care for Ms. Barnett;

(c) That plaintiffs recover from defendants general damages for the pain and suffering of Ms. Barnett that occurred as a proximate result of defendants' negligence, recklessness, and breach of fiduciary duty in such amounts as will be determined by the enlightened conscience of a fair and impartial jury;

(d) That plaintiffs recover from defendants the

full value of the life of Ms. Barnett in an amount as determined in the enlightened conscience of a fair and impartial jury;

(e) That plaintiffs recover from defendants punitive damages in an amount as determined in the enlightened conscience of a fair and impartial jury in sufficient sums to punish defendants and deter defendants and others similarly situated from engaging in similar conduct in the future; and

(f) That plaintiffs have such other and further relief as this Court deems just and proper.

DATED: August ___, 2004.

Respectfully submitted,

DAWSON MANTON & CRUMPLER, LLP

BY:_____
Patrick A. Dawson
Georgia Bar No. 005620
Jason R. Manton
Georgia Bar No. 469898
Joan G. Crumpler
Georgia Bar No. 005590

328 Alexander Street
Marietta, Georgia 30060
(770) 919-7554
(770) 499-05020 fax

FLOURNOY MORGAN & SCHNATMEIER

By:_____
Matthew C. Flournoy
Georgia Bar No.

Suite 700
244 Roswell Street
Marietta, Georgia 30060-2000
(770) 427-9094
(770) 427-6847 fax