2011 WL 2297771 (Ga.State Ct.) (Trial Pleading)
Georgia State Court.
Gwinnett County

Mary WIDEMAN, individually and as Executor of the Estate of William Wideman, deceased, Plaintiff,
v.
NEW LONDON HHS, LLC d/b/a New London Health Center, W. Mark McKettrick, William T. McKettrick, McKettrick Health Services, Inc., McKettrick Management, LLC, McKettrick Heritage Family, LP, McKettrick Sunrise Family, LP, Heritage Health Services, Inc., and Sunrise Medical Services, Inc., Defendants.

No. 10C131562.
February 15, 2011.

Civil Action

Amended Complaint for Damages

Perrotta, Cahn & Prieto, P.C., Michael A. Prieto, Georgia Bar No.: 587236, Robert W. Lamb, Georgia Bar No.: 631650, Travis J. Little, Georgia Bar No.: 568411, Attorneys for the Plaintiffs, The Bradley Building, 5 South Public Square, Cartersville, Georgia 30120, (770) 382-8900.

Now comes Mary Wideman, Individually and as Executor of the Estate of William Wideman, deceased, the Plaintiff in the above-styled civil action, and presents her Amended Complaint for Damages against Defendants as follows:

1.

In this action, Plaintiff Mary Wideman 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 lead directly and proximately to severe and life threatening infection, illness, pain, suffering, and the death of William Wideman. The Plaintiff in her capacity as Executor of Mr. Wideman's estate therefore seeks damages against the Defendants for Mr. Wideman's wrongful death, and seeks to recover upon Mr. Wideman's individual claims arising under tort and contract.

2.

Mary Wideman hereby subjects herself to the jurisdiction of this Court.

3.

Defendant NEW LONDON HHS, LLC D/B/A NEW LONDON HEALTH CENTER is a limited liability company formed under the laws of the State of Georgia with its principle place of business at 2020 McGee Road, Snellville, Gwinnett County, Georgia 30078-2992. This Defendants can be served with process by service upon its registered agent for service of process, William T. McKettrick, 454 Fury Ferry Road Suite C, Augusta, Columbia County, Georgia 30907- 8960.

4.

Defendants MCKETTRICK HEALTH SERVICES, INC. is a for-profit business corporation formed under the laws of the State of Georgia with its principle place of business in Augusta, Columbia County, Georgia. This Defendants can be served with process by service upon its registered agent for service of process, Judith A. Price, 454 Fury Ferry Road Suite C, Augusta, Columbia County, Georgia 30907- 8960.

5.

Defendants MCKETTRICK HERITAGE FAMILY, L.P. is a limited partnership formed under the laws of the State of Georgia with its principle place of business in Augusta, Columbia County, Georgia. This Defendants can be served with process by service upon its registered agent for service of process, William T. McKettrick, 454 Fury Ferry Road Suite C, Augusta, Columbia County, Georgia 30907- 8960.

6.

Defendants MCKETTRICK SUNRISE FAMILY, L.P. is a limited partnership formed under the laws of the State of Georgia with its principle place of business in Augusta, Columbia County, Georgia. This Defendants can be served with process by service upon its registered agent for service of process, William T. McKettrick, 454 Fury Ferry Road Suite C, Augusta, Columbia County, Georgia 30907- 8960.

7.

Defendants MCKETTRICK MANAGEMENT, LLC is a limited liability company formed under the laws of the State of Georgia with its principle place of business in Augusta, Columbia County, Georgia. This Defendants can be served with process by service upon its registered agent for service of process, William T. McKettrick, 454 Fury Ferry Road Suite C, Augusta, Columbia County, Georgia 30907- 8960.

8.

Defendants HERITAGE HEALTH SERVICES, INC. is a for-profit foreign corporation registered to transact business in the state of Georgia and maintains its registered office at 454 Fury Ferry Road Suite C, Augusta, Columbia County, Georgia 30907-8960. This Defendant is subject to the jurisdiction of this Court and may be served with process by serving its registered agent, Judith A. Price, at the address above.

9.

Defendants SUNRISE MEDICAL SERVICES, INC. is a for-profit foreign corporation registered to transact business in the state of Georgia and maintains its

15.

In all acts and at all times relevant hereto, Defendants owned and/or operated a long-term care facility doing business as New London Health Center ("NLHC"), located at 2020 McGee Road, Snellville, Gwinnett County, Georgia 30078-2992. Hereinafter, the term "NLHC" shall refer to these Defendants collectively.

16.

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The Defendants were charged with responsibility for the provision of residence, care, treatment and convalescent / rehabilitation services to William Wideman. These Defendants negligently failed at their responsibilities as described below.

17.

Venue is proper in this Court with regard to all Defendants.

18.

All Defendants are joint tortfeasors and are jointly and severally liable to the Plaintiff.

ONE COMPLAINT

19.

All Counts in this Complaint incorporate, and by reference include, the paragraphs found in all other Counts and portions of this Complaint.

FACTS

20.

Mr. Wideman entered NLHC for skilled nursing care, treatment and services for rehabilitation following surgery. NLHC had a duty to provide the care, treatment and services that Mr. Wideman needed in a skillful and non-negligent manner.

21.

However, NLHC staff failed in numerous ways to provide the care, treatment and services that Mr. Wideman needed in a skillful and non-negligent manner. As a result, Mr. Wideman endured severe infection and illness, tremendous pain and suffering, and death.

22.

Specifically, NLHC's staff failed to follow the requirements of federal and state law and regulations for the provision of proper care, treatment and services to a resident of a long-term care facility. NLHC's staff failed to follow standard nursing practices and protocols for provision of the care, treatment and services that Mr. Wideman needed. The staff failed to develop appropriate care plans and follow them and doctor's orders, failed to monitor Mr. Wideman to prevent infection and wound dehiscence, failed to keep Mr. Wideman clean at the sites of his wounds and to provide proper hygiene and assistance with voiding, failed to maintain Mr. Wideman's medical chart in accordance with professional standards and practices, failed to seek immediate emergency medical care and treatment for Mr. Wideman when he needed it, and failed to notify Mr. Wideman's treating physician of his condition needing immediate medical care and treatment. NLHC's failures are described in more detail below.

23.

Mr. William Wideman was 87 years-old when he presented to Dr. Peter H'Doubler with a non-healing ulcer of the right foot on August 26, 2008. Vascular occlusive disease was suspected. A few days later, Mr. Wideman was admitted to St. Joseph's Hospital for further diagnostic evaluation. Mr. Wideman's past medical history was noted to include coronary artery

disease, a 4-vessel coronary artery bypass graft in 1990, transient ischemic attacks, hypertension, atrial fibrillation, chronic renal insufficiency, urinary incontinence, dementia, and a remote history of smoking. He was also noted to have mild dementia. Mr. Wideman was cleared for open abdominal surgery to repair an abdominal aortic aneurysm" ("AAA").

24.

On September 8, 2008, Dr. Peter H'Doubler performed the AAA repair via an aortobifemoral bypass during which thrombectomies, angioplasty, an endarterectomy, and graft harvesting and implantation were also performed. On September 13, 2008, a stable Mr. Wideman was transferred out of the ICU. On September 15, 2008, discharge planning for rehabilitation placement began. On September 16, 2008, Mr. Wideman is again listed as "stable." On September 17, 2008, he is again listed as "stable" and "[i]ncisions healing." Later that day, as on the other days, the notes reflect "[n]o complaints" and "ok to go anytime," referring to discharge from the hospital for rehabilitation. On September 18, 2008, staff noted his continued progress, noting "no complaints." St. Joseph's records documented the thorough monitoring and cleaning of Mr. Wideman's incision sites. On September 19, 2008, staff again noted his progress, that he had no complaints, and approved his transfer from the facility to begin rehabilitation.

25.

At the time he was admitted to the hospital and later the NLHC for rehabilitation, Mr. Wideman resided in Monroe, Georgia on a seven-acre lot. He was born in Hogansville, Georgia and grew up in Birmingham, Alabama. He attended Princeton University as a young man in the 1940s. He served three and one-half years in Germany for the United States Army. He was happily married to the Plaintiff, Mary Wideman, for 65 years and he worked as an attorney. Mr. and Mrs. Wideman raised one daughter and were also blessed with one granddaughter. Prior to his surgery at St. Joseph's Hospital and subsequent infection at NLHC, Mr. Wideman was a relatively healthy 87 year-old male. He entered NLFIC for a few weeks of rehabilitation following AAA surgery. Mr. Wideman and his wife had their RV prepared and ready to carry them on a vacation to Florida upon his discharge. However, the Widemans were unable to carry out these plans after Mr. Wideman's sudden and unexpected infection at NLHC.

26.

Available NLHC documents indicate that, upon his admission to NLHC. he was noted to have scattered ecchymosis and open ulcers to his sacrum, left buttock, and right foot. His abdominal and groin wounds were noted to be dressed and draining reddish-brown fluid, and admission orders included daily dressing changes with Betadine. Mr. Wideman's chart contains no evidence that this care was provided as ordered. It is clear however that Mr. Wideman was incontinent of both urine and stool, and that diapers were utilized throughout his stay at NLHC.

27.

Mrs. Wideman stayed with her husband at NLHC as much as she could. She left the facility for one day on or about September 21, 2008 to take care of her own health, particularly some swollen feet. She returned to the facility the next day. When she returned to NLHC, she found her husband lying in bed. When she pulled back the sheets, she found her husband prostrate with thick padding across his stomach and lying in his own feces. She opened the bandage and on his legs found open festering wounds. She also found bed sores on his back.

28.

Mr. Wideman's bandages were soaking wet and needed to be changed. Witnesses from Mr. Wideman's room reported that staff had bathed Mr. Wideman by immersing him in a wooden tub of water multiple times between September 21, 2008 and

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September 22, 2010. Concerned about the possibility of infection. Mrs. Wideman demanded that his wet dressings be changed immediately. The nurse responded, “We don't have to. He can wait until next shift.”

29.

On or about September 24, 2008, Mr. Wideman began to have malodorous drainage from both groin wounds. This continued for several days. On September 25, 2008, an order was entered to culture the secretions from the left groin wound. It is unclear if this culture was obtained. If so, the results do not appear in the chart NLHC provided to Mr. Wideman's widow.

30.

By September 27, 2008, Mrs. Wideman began demanding NLHC transfer her husband to the hospital. The Defendants were reluctant to transfer Mr. Wideman. On September 28, 2008, Mr. Wideman was finally transferred to the emergency room at St. Joseph's Hospital. He was admitted to St. Joseph's with the diagnosis of bilateral groin wound dehiscence and likely infection.

31.

At St. Joseph's Mrs. Wideman was approached regarding continuing treatment for her husband and requested that all possible measures are taken to revive him and sustain his life.

32.

Upon admission to the nursing unit, Mr. Wideman was noted to be alert but confused, tachycardic, hypertensive, and incontinent. Cultures of the bilateral groin wounds and sacral ulcer were performed on September 29, 2008.

33.

On September 30, 2008, Dr. H'Doubler performed surgical debridement of the groin wounds as well as the abdominal incision during which “necrosis and infection” was noted to all 3 areas. On October 1, 2008, the bilateral groin wound cultures revealed “heavy growth” of Escherichia coli (“E. coli”), and the sacral ulcer culture revealed Methicillin-resistant Staphylococcus aureus (“MRSA”), E. coli, and Pseudomonas aeruginosa. Mr. Wideman was placed on contact isolation, and groin dressings were ordered to be performed with Dakin's solution irrigation.

34.

Due to the heavy growth of E. coli in Mr. Wideman's wound cultures, poor hygiene relating to stool incontinence while at New London was likely the root cause of the infection and dehiscence of his groin wounds.

35.

Mr. Wideman's condition quickly worsened. On October 11, 2008, a do not resuscitate (“DNR”) order was implemented which would spare Mr. Wideman any heroic measures to prolong his life.

36.

On October 13, 2008, Dr. H'Doubler performed a second surgical debridement of Mr. Wideman's abdominal and bilateral groin wounds during which "good granulation tissue" was noted. But Mr. Wideman continued to deteriorate and on October 23, 2008, the family decided to initiate comfort care measures and all medications and treatments were discontinued except for antibiotics. Hospice was consulted, and on October 24, 2008, Mr. Wideman was discharged to Embracing Hospice. Mr. Wideman passed away on October 27, 2008. Per the death certificate, the factors that contributed to Mr. Wideman's death included sepsis as the immediate cause of death, as well as end-stage renal failure and ischemic cardiomyopathy following AAA repair.

37.

Following her husband's death, Mary Wideman visited the nursing home to obtain the complete record of her husband's stay at the Defendants' facility. Despite Mr. Wideman's stay of only nine days at NLHC and despite the small number of records created, Defendants refused to produce the small stack of documents to Mrs. Wideman until spending three and one-half hours while she waited purportedly copying the records.

38.

The records NLHC ultimately produced to Mrs. Wideman appear incomplete. Either adequate records were not kept or certain records were removed from Mr. Wideman's chart before it was produced to his widow.

39.

Although certain notes from NLHC seem to indicate infection and skin breakdown concerns at the time of admission on September 19, 2008, NLHC failed to take any action whatsoever to address skin breakdown and infection until at least September 22, 2008. Specifically, all "Nursing Assessment" forms completed for Mr. Wideman for three days after admission show he received no care or treatment for ulcers, rashes, or bruises from September 19 through September 22, 2008.

40.

Under the heading "Skin" on the September 20, 2008 Nursing Assessment completed by "M. Okwaraoha, LPN," there are no check marks for "Rash___" "Bruise___" or "Ulcer___." The line, "If ulcer present: Location ___" is also left blank.

41.

Under the heading "Skin" on the September 21, 2008 Nursing Assessment completed by "A. Johnson, LPN," there are no check marks for "Rash___" "Bruise___" or "Ulcer ___." The line, "If ulcer present: Location ___" is also left blank.

42.

Under the heading "Skin" on the September 22, 2008 Nursing Assessment completed by "A. Johnson, LPN," there are no check marks for "Rash___" "Bruise___" or "Ulcer ___." The line, "If ulcer present: Location ___" is also left blank.

43.

Furthermore, the Dietary Progress Note completed by consultant Trent Thomason, MS. RD.LD based on information provided by NLHC staff on September 22, 2008 also indicates, under the heading "Skin," the following: "No pressure sores noted."

44.

However, two documents: (1) the Nurse's Progress Notes dated "9/19/08 200 pm" signed by "----M.--- RN" and (2) the Resident Data Collection "Status upon Admission" indicating a date of admission of "9/19/08" at "11:30 am" both include several specific comments purporting to refer to Mr. Wideman's deteriorated skin condition and susceptibility to infection upon admission.

45.

As a direct and proximate result of the Defendants' negligent acts and omissions outlined above, William Wideman suffered significant infection and illness, tremendous pain and suffering, and he died.

46.

As a result of the foregoing, the Plaintiff herein is entitled to an award of money damages on grounds more fully set out below.

COUNT I NEGLIGENCE PER SE BASED UPON VIOLATION OF REQUIREMENTS FOR LONG TERM CARE FACILITIES AT 42 CFR § 483.1 et seq.

47.

NLHC 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; NLHC receives funding under the Medicare and Medicaid programs.

48.

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

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

e) 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,

f) 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,

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

h) 42 CFR § 483.25.(c) requires the facility to take appropriate measures to prevent bed sores,

i) 42 CFR § 483.25.(c)(1) requires that facility ensure that a patient who enters the facility without bed sores does not develop bed sores after admission,

j) 42 CFR § 483.25.(c)(2) requires that facility ensure that a patient who develops bed sores gets appropriate treatment to promote healing and to prevent infection related to the wounds, and to prevent new bed sores from developing,

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

1) 42 CFR § 483.40.(a) requires the facility to ensure that each patient's medical care is supervised by a physician,

m) 42 CFR § 483.40. requires the facility to keep the resident's treating physician informed of their medical condition,

n) 42 CFR § 483.40.(d) requires the facility to provide or make available emergency medical care to residents at any and all times,

o) 42 CFR § 483.70(c)(1)-(2) requires the facility to have and maintain in safe operating condition all equipment necessary for staff to provide such treatment and services as are identified in each resident's plan of care,

p) 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.

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

r) 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, and

s) 42 CFR § 483.75.(h) requires the facility to obtain outside services that meet professional standards and principles.

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

49.

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

50.

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 Mr. Wideman,

b) Defendants failed to implement protocols to protect Mr. Wideman from **neglect**,

c) Defendants failed to operate and provide services to Mr. Wideman 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 Mr. Wideman that met professional standards of quality,

e) Defendants failed to maintain an adequate nursing staff to provide for Mr. Wideman's needs,

0 Defendants failed to provide properly trained, qualified and competent staff to care for Mr. Wideman,

g) Defendants failed to protect Mr. Wideman from **neglect**,

h) Defendants failed to properly train and supervise the nursing staff to provide the appropriate care, treatment and services that Mr. Wideman needed,

i) Defendants failed to communicate Mr. Wideman's medical conditions to his treating physician,

j) Defendants failed to provide prompt emergency medical treatment to Mr. Wideman when he needed it,

k) Defendants failed to implement an appropriate program for the prevention of bed sores,

1) Defendants failed to properly monitor Mr. Wideman for the development of pressure ulcers and infections.

m) Defendants allowed Mr. Wideman to develop pressure ulcers after he entered the facility,

n) Defendants failed to implement a program of turning Mr. Wideman, providing appropriate dressings, medicines and other care and treatment to alleviate Mr. Wideman's bed sores and to prevent infections,

o) Defendants failed to provide proper wound care at his surgical sites,

p) Defendants repeatedly failed to provide proper care and services to address Mr. Wideman's developing infections,

q) Defendants failed to maintain complete and accurate clinical records for Mr. Wideman in accordance with accepted professional standards and practices.

51.

The Defendants' acts and omissions constituting violation of the above-referenced federal regulations at 42 CFR § 483.1 *et seq.* constitute negligence *per se* or negligence as a matter of law pursuant to O.C.G.A. § 51-1-6.

52.

Defendants' failure to comply with the above federal mandates led directly to the serious infection, illness, pain, suffering and death of William Wideman.

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53.

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

COUNT II VIOLATION OF REQUIREMENTS OF THE GEORGIA BILL OF RIGHTS FOR RESIDENTS OF LONG-TERM CARE FACILITIES AT O.C.G.A. § 31-8-100 et seq.

54.

NLHC is a "long-term care facility" as that term is defined under O.C.G.A. § 31-8-102(3).

55.

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 seq.* which sets out requirements for those providing care, treatment and services to residents of long-term care facilities in this state. In particular, O.C.G.A. § 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.

56.

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).

57.

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 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 Mr. Wideman,

b) Defendants failed to implement protocols to protect Mr. Wideman from **neglect**,

c) Defendants failed to operate and provide services to Mr. Wideman 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 Mr. Wideman that met professional standards of quality,

e) Defendants failed to maintain an adequate nursing staff to provide for Mr. Wideman's needs,

f) Defendants failed to provide properly trained, qualified and competent staff to care for Mr. Wideman,

g) Defendants failed to protect Mr. Wideman from **neglect**,

h) Defendants failed to properly train and supervise the nursing staff to provide the appropriate care, treatment and services that Mr. Wideman needed,

i) Defendants failed to communicate Mr. Wideman's medical conditions to his treating physician,

j) Defendants failed to provide prompt emergency medical treatment to Mr. Wideman when he needed it,

k) Defendants failed to implement an appropriate program for the prevention of bed sores,

I) Defendants failed to properly monitor Mr. Wideman for the development of pressure ulcers and infections.

m) Defendants allowed Mr. Wideman to develop pressure ulcers after he entered the facility,

n) Defendants failed to implement a program of turning Mr. Wideman, providing appropriate dressings, medicines and other care and treatment to alleviate Mr. Wideman's bed sores and to prevent infections,

o) Defendants failed to provide proper wound care at his surgical sites,

p) Defendants repeatedly failed to provide proper care and services to address Mr. Wideman's developing infections,

q) Defendants failed to maintain complete and accurate clinical records for Mr. Wideman in accordance with accepted professional standards and practices.

58.

Pursuant to O.C.G.A. § 31-8-126(a), the Plaintiff has a cause of action for damages against the Defendants as a result of Defendants' violations of the rights granted under the *Georgia Bill of Rights for Residents of Long Term Care Facilities* such as those identified under O.C.G.A. § 31-8-108(a).

59.

Additionally, the Defendants' 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 pursuant to O.C.G.A. § 51-1-6.

60.

Defendant' 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 infection, illness, terrible pain, suffering, anguish, grief, and death of William Wideman.

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61.

As a result of the Defendants' acts and omissions constituting violation of the *Georgia Bill of Rights for Residents of Long Term Care Facilities* and negligence *per se,* and the resultant damages and harm, the Plaintiff is entitled to an award of damages in her representative capacity as set out below.

COUNT III STATUTORY REMEDIES FOR VIOLATION OF FEDERAL AND STATE STATUTES AND REGULATIONS IN THE OPERATION OF A PERSONAL CARE HOME

62.

NLHC is a "personal care home" as that term is defined under O.C.G.A. § 31-7-12.

63.

Pursuant to O.C.G.A. § 31-8-133, residents of personal care homes in Georgia have been granted certain rights which arc enumerated in the regulations promulgated by the Georgia Department of Human Resources at Ga. ADC § 290-5-35 et seq.

64.

Among the regulations promulgated by the Georgia Department of Human Resources for the operation of personal care homes is former Ga. ADC § 290-5-35-.18 (currently Ga. ADC § 111-8-62-.26) which provides that each resident of a personal care home must receive care and services which shall be adequate, appropriate and *in compliance with applicable federal and state law and regulations* (including the federal and state law and regulations identified in the preceding Counts of this Complaint).

65.

As described in detail above, the Defendants violated regulations of the U.S. Department of Health and Human Services at 42 CFR § 483.1 *et seq.,* the *Georgia Bill of Rights for Residents of Long Term Care Facilities* at O.C.G.A. § 31-8-100 *et seq.* and the regulations of the Georgia Department of Human Resources at Ga. ADC § 290-5-35 *et seq.* and 290-5-39-.07. in the following acts and omissions, among others:

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 Mr. Wideman,

b) Defendants failed to implement protocols to protect Mr. Wideman from **neglect**,

c) Defendants failed to operate and provide services to Mr. Wideman 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 Mr. Wideman that met professional standards of quality,

e) Defendants failed to maintain an adequate nursing staff to provide for Mr. Wideman's needs,

f) Defendants failed to provide properly trained, qualified and competent staff to care for Mr. Wideman,

g) Defendants failed to protect Mr. Wideman from **neglect**,

h) Defendants failed to properly train and supervise the nursing staff to provide the appropriate care, treatment and services that Mr. Wideman needed,

i) Defendants failed to communicate Mr. Wideman's medical conditions to his treating physician,

j) Defendants failed to provide prompt emergency medical treatment to Mr. Wideman when he needed it,

k) Defendants failed to implement an appropriate program for the prevention of bed sores,

I) Defendants failed to properly monitor Mr. Wideman for the development of pressure ulcers and infections.

m) Defendants allowed Mr. Wideman to develop pressure ulcers after he entered the facility,

n) Defendants failed to implement a program of turning Mr. Wideman, providing appropriate dressings, medicines and other care and treatment to alleviate Mr. Wideman's bed sores and to prevent infections,

o) Defendants failed to provide proper wound care at his surgical sites,

p) Defendants repeatedly failed to provide proper care and services to address Mr. Wideman's developing infections,

q) Defendants failed to maintain complete and accurate clinical records for Mr. Wideman in accordance with accepted professional standards and practices.

66.

Pursuant to O.C.G.A. § 31-8-136(a), Plaintiff in her capacity as the Executor of the Estate of William Wideman is entitled to an award of damages in the amount of $1,000.00 for each of the Defendant' individual violations of the regulations of the U.S. Department of Health and Human Services at 42 CFR § 483.1 *et seq.,* the provisions of the *Georgia Bill of Rights for Residents of Long Term Care Facilities* at O.C.G.A. § 31-8-100 *et seq.* and the regulations of the Georgia Department of Human Resources at Ga. ADC § 290-5-35 *et seq.* and 290-5-39-.07.

67.

Alternatively, pursuant to O.C.G.A. § 31-8-136(a) this Plaintiff is entitled to an award of actual damages for each of the Defendants' violations of the federal and state law and regulations identified herein.

68.

As permitted under O.C.G.A. § 31-8-136(c), the Plaintiff asserts her cause of action in this Count of the Complaint in addition to all other rights, remedies and causes of action stated in this complaint.

69.

Pursuant to O.C.G.A. § 31-8-136(a), Plaintiff in her capacity as the Executor of the Estate of William Wideman is entitled to an award of punitive damages for each of the Defendants' individual and numerous acts and omissions in violation of the Federal and state law and regulations cited in this Complaint.

COUNT IV GENERAL NEGLIGENCE

70.

William Wideman entered into a contract for the provision of residence, care, treatment and rehabilitative 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 care, treatment and services to Mr. Wideman. The Defendants failed to exercise reasonable care in a number of instances with respect to the care, treatment and services provided to Mr. Wideman, and he sustained serious infection, illness, great pain and suffering and died as a result as demonstrated below.

71.

Defendants failed to administer the nursing facility in such a way as to use its resources effectively and efficiently to provide proper care to Mr. Wideman.

72.

Defendants failed to implement protocols to protect Mr. Wideman from **neglect**.

73.

Defendants failed to provide or arrange services for Mr. Wideman that met professional standards of quality.

74.

Defendants failed to maintain sufficient nursing staff to provide for Mr. Wideman's needs.

75.

Defendants failed to provide properly trained, qualified and competent staff to care for Mr. Wideman.

76.

Defendants failed to protect Mr. Wideman from **neglect**.

77.

Defendants failed to properly train and supervise the nursing staff to provide the care, treatment and services that Mr. Wideman needed.

78.

Defendants failed to communicate Mr. Wideman's medical conditions to his treating physician.

79.

Defendants failed to seek prompt emergency medical treatment for Mr. Wideman when he needed it.

80.

Defendants failed to implement an appropriate program for the prevention of bed sores.

81.

Defendants failed to properly monitor Mr. Wideman for the development of pressure ulcers and infections.

82.

Defendants allowed Mr. Wideman to develop pressure ulcers after he entered the facility.

83.

Defendants failed to implement a program of turning Mr. Wideman, providing appropriate dressings, medicines and other care and treatment to alleviate Mr. Wideman's bed sores and to prevent infections,

84.

Defendants failed to provide proper wound care at his surgical sites,

85.

Defendants repeatedly failed to provide proper care and services to address Mr. Wideman's developing infections.

86.

Defendants failed to maintain complete and accurate clinical records for Mr. Wideman.

87.

Defendants failed to keep Mr. Wideman clean after voiding.

88.

Defendants failed to keep Mr. Wideman's urine and feces away from his surgical incision sites.

89.

Defendants failed to keep Mr. Wideman's surgical incision sites clean and dry.

90.

Defendants improperly immersed Mr. Wideman's surgical incision sites in water.

91.

Defendants delayed removing wet and soiled bandages from Mr. Wideman's surgical incision sites.

92.

Defendants failed to inspect and monitor Mr. Wideman's incision sites for signs of dehiscence.

93.

Defendants failed to timely seek treatment for Mr. Wideman's wound dehiscences.

94.

Defendants failed to follow Mr. Wideman's care plans and his doctors' orders necessary to maintain cleanliness and proper hygiene and to prevent skin breakdown, infection, and dehiscence.

95.

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.

96.

As a direct and proximate result of each one of the above-described negligent acts and omissions, Mr. Wideman suffered grave infection and illness, suffered tremendously, and died.

97.

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

COUNT V PROFESSIONAL NEGLIGENCE

98.

William Wideman entered into a contract with the Defendants for the provision of residence, care, treatment and rehabilitative services at the Defendants NLHC facility, and Defendants failed to provide that care, treatment and service as described herein.

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99.

Pursuant to the requirements of O.C.G.A. § 9-11-9.1, the Plaintiff has attached hereto the affidavit of Valerie A Jamison, RN, BSN, BS, CLNC, who is Nurse Jamison has prepared an affidavit which sets forth acts and omissions of the Defendants related to the care, treatment and services provided to William Wideman which proximately caused his severe infection, illness, suffering, and death, and which illustrate Defendants' staff's failure to provide the degree of care and skill required of the Defendants' staff in their professions, as set out below. Nurse Jamison's credentials and qualifications to render the opinions contained herein and in her professional affidavit are more fully described in her CV, which is attached to her affidavit as an exhibit. The Plaintiff hereby incorporates by this reference the entire contents of Nurse Jamison's affidavit and CV.

100.

Pursuant to her education, training and experience. Nurse Jamison is fully familiar with the preparation, development and implementation of nursing home resident care plans.

101.

She is fully familiar with the standards for properly and accurately maintaining a medical chart.

102.

Nurse Jamison is fully familiar with all aspects of post-surgical wound care, including the proper protocols for cleaning and monitoring the incision sites to prevent infection and dehiscence.

103.

Further, she is fully familiar with the signs and symptoms of infection in a patient in a nursing home and has been trained to contact the patient's treating physician to report any signs and symptoms of infection.

104.

Nurse Jamison has experience respecting care and treatment surrounding a resident's activities of daily living, including proper management of toileting and hygiene to prevent infection and skin breakdown.

105.

She is fully familiar with all aspects of care, treatment and services for the prevention and treatment of skin breakdown in patients and is also familiar with the development of illness and infection related to untreated and/or improperly treated skin breakdown.

106.

Based upon the foregoing, Nurse Jamison is fully competent to testify about the matters set forth below.

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The standard of care for professional and non-professional nursing staff in long term patient care facilities requires that the staff develop and then follow the resident patient's Care Plans and resident assessments, as well as doctors' orders, to the letter in all aspects.

107.

The standard of care for long term patient care facilities requires that the nursing staff provide appropriate care, treatment and services to residents who are susceptible to infection and who exhibit the signs and symptoms of infection, to notify the treating physician of the signs and symptoms of a serious infection, and to provide prompt and appropriate medical care to patients susceptible to infection who exhibit signs and symptoms of infection.

108.

The standard of care for long term patient care facilities requires that nursing and non-professional staff provide appropriate care, treatment and services to residents who have been found to have, or be at risk of developing, pressure ulcers.

109.

In caring for patients who have experienced skin breakdown and who are incontinent of bladder and bowel, the standard of care for staff at skilled nursing facilities requires that the staff monitor and record the patient's volume, frequency and pattern of voiding, that the staff regularly clean the patient with soap and water, that the staff dry the patient and provide a moisture barrier as ordered, that the staff clean, dry and provide a moisture barrier after incontinent episodes as ordered and that the staff bathe the patient and provide proper hygiene for the patient.

110.

For such patients, the standard of care further includes careful patient monitoring, proper charting of the condition of the skin breakdown, and proper charting of the course of treatment for skin breakdown. Measures also include following a program of turning the patient in bed, keeping pressure points dry and clean, providing appropriate and timely pressure relieving devises, and maintaining proper hygiene, wound care, medicines and dressings as ordered by the physician.

111.

When a resident patient has developed pressure ulcers, the standard of care for nursing care facilities requires that the staff develop and then properly follow the care plan and Resident Assessment Protocols. Nursing staff is further required to fully communicate the condition of the patient's skin to the treating physician, and to follow any physician's orders with respect to the proper measures for avoiding and addressing patient infection and proper prevention and treatment of bed sores.

112.

The standard of care for nursing staff in a long-term care facility caring for patients recuperating from AAA surgery requires that staff not allow the patients' surgical sites to be immersed in water until the incisions are completely healed, which can take six to eight weeks.

113.

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The standard of care for skilled nursing facilities requires that staff have proper training, knowledge, experience and supervision in the accurate recording of resident information and proper maintenance of a resident's chart.

114.

The standard of care for skilled nursing facilities requires that staff have proper training, knowledge, experience and supervision to recognize and fully communicate a resident's serious medical condition or injury, such as skin breakdown, wound dehiscence, or infection, to the treating physician so that the resident may receive appropriate care and treatment to address his changed medical condition.

115.

NLHC staff breached the standard of care for skilled nursing facilities when they failed to provide an adequate care plan for the avoidance of Mr. Wideman's pressure ulcers and for the monitoring of his surgical sites. As a result, Mr. Wideman suffered skin breakdown that put him at increased risk of infection and suffered dehiscence of his incision sites.

116.

NLHC staff breached the standard of care for skilled nursing facilities when they allowed Mr. Wideman to develop a significant infection while at NLHC.

117.

NLHC staff breached the standard of care for skilled nursing facilities when they failed to monitor Mr. Wideman for dehiscence and infection and failed to notice his signs and symptoms of infection, and thus failed to provide the necessary care and treatment to address his dehiscence and his infections before they became life-threatening.

118.

NLHC staff breached the standard of care for skilled nursing facilities when they failed to report Mr. Wideman's dehiscence and infection to his doctor and thus failed to allow his doctor to manage the care and treatment necessary to repel the infection and correct the dehiscence.

119.

NLHC staff breached the standard of care for skilled nursing facilities when they failed to follow doctor's orders and proper protocols for the care and treatment of Mr. Wideman's AAA surgical sites by fully immersing those sites in water on multiple occasions and exposing them to infection-causing bacteria.

120.

NLHC staff breached the standard of care for skilled nursing facilities each time NLHC nursing staff failed to contact Mr. Wideman's treating physician or to seek prompt medical attention to address the signs and symptoms of serious infection in the patient.

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121.

NLHC's nursing staff breached the standard of care when they failed to follow the appropriate measures for the prevention of skin breakdown, including when they failed to implement a program of turning and repositioning Mr. Wideman in his bed to prevent skin breakdown, failed to timely provide pressure relieving devises for Mr. Wideman, failed to properly monitor Mr. Wideman for the development of skin breakdown, and failed to adequately chart the condition of Mr. Wideman's skin to prevent skin breakdown.

122.

NLHC's nursing staff breached the standard of care when they failed to develop and follow resident assessment protocols and care plan for the care and treatment of skin breakdown, failed to implement a program of turning Mr. Wideman in his bed, failed to promptly provide pressure relieving devises and failed to properly maintain wound care and wound dressings. The staff also breached the standard of care expected of nursing staff when they failed to fully communicate the development of Mr. Wideman's skin breakdown to his treating physician, failed to follow physician's orders with respect to the care and treatment provided for Mr. Wideman's skin breakdown, failed to properly monitor Mr. Wideman's skin breakdown, failed to properly record information about Mr. Wideman's skin breakdown and failed to properly chart their course of care and treatment for Mr. Wideman's skin breakdown.

123.

NLHC breached the standard of care for skilled nursing facilities when staff failed to timely, accurately, and completely record relevant and/or required information in Mr. Wideman's chart and when it otherwise failed to properly maintain Mr. Wideman chart.

124.

As a direct and proximate result of each one of the above described failures to follow the acceptable standards of care, William Wideman sustained severe injury and illness, tremendous pain and suffering, and death.

125.

All of the Defendants' acts and omissions described above constitute professional negligence as a result of which the Plaintiff is entitled to recover from the Defendants as set out below.

COUNT VI BREACH OF CONTRACT

126.

William Wideman 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 Mr. Wideman. The Defendants failed to exercise reasonable care with respect to the care, treatment and services provided to Mr. Wideman, and he sustained serious infection, illness, pain and suffering and death as a result.

127.

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 William Wideman. The Defendants therefore breached the contract for services as set out herein.

128.

As a result of the foregoing, Plaintiff Mary Wideman in her capacity as Executor of William Wideman's estate is entitled to recover all amounts paid to obtain services under the contract and all consequential damages arising there from.

COUNT VII WRONGFUL DEATH

129.

As set out above, William Wideman sustained grievous infection, 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.

130.

As a result of the Defendants' violations of federal and state law, professional negligence, simple negligence and negligence per se and Mr. Wideman's resultant death as set out in detail above, Mrs. Wideman in her capacity as Executor of the Estate of William Wideman is entitled to recover damages against the Defendants for Mr. Wideman's wrongful death in an amount equal to the full value of the life of the deceased.

COUNT VIII ESTATE'S TORT CLAIMS

131.

Plaintiff Mary Wideman is the Executor of the Estate of William Wideman, and she prosecutes these claims in that capacity.

132.

As set out above, Mr. Wideman sustained grievous infection, illness, 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.

133.

In her capacity as the Executor of Mr. Wideman's estate, Plaintiff Mary Wideman is entitled to recover all damages to which Mr. Wideman would have been entitled had he survived. As a result of the Defendants' wrongful conduct, Mr. Wideman incurred medical and related expenses for her care, treatment and services prior to her death, and final expenses. Mr. Wideman also endured untold pain and suffering as a result of Defendants' negligent acts and omissions prior to her death.

134.

Based on the foregoing, Plaintiff Mary Wideman, as Executor of William Wideman's estate is entitled to recover from Defendants damages equal to all expenses incurred in the provision of medical care and treatment to Mr. Wideman resulting

from the Defendants' wrongful conduct, and to recover for Mr. Wideman's final expenses. This Plaintiff is also entitled to recover damages for Mr. Wideman's conscious pain and suffering prior to his death.

COUNT IX IMPUTED LIABILITY

135.

All of William Wideman's injuries, damages and his death were the direct result of the acts and omissions of the agents, servants and employees of the Defendants business entity conducted within the course and scope of each individual's employment with the Defendants business entity health care provider.

136.

The Defendant business entities are therefore vicariously liable for the individual employees' and agents' acts and omissions, and for each individual officer, director, employee, agent and servant's negligent acts and omissions, and the resultant injuries, damages and death of William Wideman by application of the doctrine of respondeat superior. The Plaintiffs are therefore entitled to recover damages from the Defendants as set out below.

COUNT X UNFAIR OR DECEPTIVE PRACTICES TOWARD THE ELDERLY

137.

At the time that the Defendants solicited William Wideman to become a resident at NLHC, and during the entire time that he remained a resident at the facility, he was an "**elderly**" person as that term is defined in O.C.G.A. § 10-1-850 (2).

138.

At the time that the Defendants solicited Mr. Wideman to become a resident at NLHC, and during the period that he remained a resident at the facility, he was a "disabled person" as that term is defined under both O.C.G.A. § 10-1-850 (1) (A) and (B).

139.

At the time that the Defendants solicited William Wideman to become a resident at NLHC, and during the period that he remained a resident at NLHC, the Defendants represented to the Widemans that the care, treatment, services and residence to be provided to Mr. Wideman would be of a sufficient standard and quality to provide for all of his needs. The Defendants' representations were false.

140.

The Defendants knowingly and intentionally made the false representations to the Widemans despite their actual knowledge that the care, treatment, services and residence that they would in reality provide would be substandard, and would not be of the quality necessary to meet Mr. Wideman's needs as fully demonstrated above. Defendants made the false representations in order to solicit Mr. Wideman to become a resident of their nursing home and for monetary gain.

141.

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The Defendants' conduct described in the preceding paragraphs constitutes a "deceptive trade practice" under the Uniform Deceptive Trade Practices Act at O.C.G.A. § 10-1-370 and 372 (a) (7). The Defendants' conduct also constitutes an "unlawful act or practice" under the Georgia Fair Business Practices Act of 1975 at O.C.G.A. § 10-1-390 and 393 (b) (7).

142.

William Wideman experienced extreme infection, illness, suffering and death as a direct result of Defendants' conduct in violation of the Georgia statutes listed above, as fully demonstrated in this Complaint.

143.

Based upon the foregoing, Plaintiff in her capacity as the Executor of William Wideman's estate has a cause of action against the Defendants, and in that capacity she is entitled to an award of actual damages, treble damages, punitive damages and attorney's fees as set out under O.C.G.A. § 10-1-853.

COUNT XI WILLFUL AND WANTON CONDUCT

144.

The conduct alleged herein demonstrates that Defendants and Defendants' employees, agents or servants have repeatedly committed acts of willful and heartless **neglect** and demonstrated wanton disregard for the life, health, safety and comfort of the residents of its facility, including Mr. Wideman, and is part and parcel of a repetitive pattern of such callous, wanton conduct for which Plaintiff is entitled to recover damages in an amount to be determined by a jury.

145.

The Defendants knew, or in the exercise of reasonable care, should have known that their staff and employees were **neglecting** and/or abusing the residents of its facility, including Mr. Wideman.

146.

The Defendants' repeated and continuous failure to take such reasonable steps available to them to prevent repetition of these acts, is itself willful, wanton and a reckless disregard and evidences an entire want of care which would raise a presumption of conscious indifference to the consequences. Defendants' heartless conduct is the functional equivalent of the intentional infliction of pain, cruelty and injury upon helpless victims, including Mr. Wideman. As such, Plaintiff is entitled to recover punitive damages from the Defendants in order to punish, penalize and deter the Defendants from further repetition of the conduct alleged herein above.

COUNT XII PIERCING THE CORPORATE VEIL

147.

The Defendants have misused and abused the corporate form, by engaging and conspiring in the furtherance of a civil conspiracy to perpetuate a fraud on the Plaintiff and to evade statutory, contractual and tort responsibility for their egregious conduct in this case.

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148.

Upon information and belief, the Defendants corporations have few or no identifiable assets and are intentionally undercapitalized in a deliberate attempt to evade tort responsibility.

149.

Upon information and belief, NLHC is knowingly operated with little or no liability insurance, leaving its victims without adequate resource for harms.

150.

At all times relevant hereto, the Defendants intended to, and did, abuse the corporate form, thereby warranting disregard of the corporate form.

151.

Upon information and belief, the Defendants failed to follow the corporate formalities, used the corporations herein as their alter ego, improperly commingled funds, and used the corporate form to perpetuate fraud.

152.

The corporate form should be set aside and the directors, officers and shareholders of the corporations herein should be personally liable, jointly and severally, for any judgment against the corporations.

153.

All of William Wideman's injuries, damages and his death were the direct result of the acts and omissions of the agents, servants and employees of the Defendants business entities conducted within the course and scope of each individual's employment with the Defendants business entities.

COUNT XIII JOINT ENTERPRISE

154.

At the time of the negligent acts and omissions and William Wideman's resultant injuries, damages and death described above, Defendants combined their property and labor in a joint undertaking for the provision of nursing home services to individuals such as William Wideman for a fee. Each had rights of mutual control over all aspects of the hiring, qualification, training, retention and supervision of NLHC employees, and each had rights of mutual control over all aspects of the care and services provided to NLHC residents.

155.

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

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COUNT XIV PRIVATE RIGHT OF ACTION UNDER MEDICARE SECONDARY PAYER ACT (MSP) AT 42 USCA §1395y(b)(3)(A)

156.

NLHC is a licensed and certified long-term care facility that provides skilled nursing care as a participant in the Medicare program; NLHC receives funding under the Medicare program.

157.

At the time of the events outlined in this complaint, William Wideman was the recipient of benefits under the Medicare program for the provision of medical care. treatment and services that he needed.

158.

It is anticipated that the U.S. Center for Medicare Services (CMS) will claim that Medicare benefits provided on behalf of William Wideman were conditional payments for covered services resulting from injury and illness that he sustained as the result of the negligent acts and omissions of the Defendants described in this action.

159.

To the extent that any such claim is correct, CMS was a "secondary payer" and the Defendants herein are the "primary payer" with respect to benefits provided on behalf of Mr. Wideman under the Medicare program.

160.

It is therefore anticipated that CMS will assert a Medicare lien upon the proceeds of any recovery from Defendants obtained by the Plaintiff in her capacity as Executor of the Estate of William Wideman to recover for amounts of any Medicare benefits CMS conditionally provided on behalf of Mr. Wideman in its capacity as secondary payer.

161.

It is further anticipated that judgment will be entered in this action in favor of the Plaintiff in her capacity as Executor of the Estate of William Wideman setting an award of money damages for which Defendants is responsible as a result of its wrongful acts and omissions outlined herein.

162.

To the extent that CMS demonstrates entitlement to recover upon its lien for Medicare benefits conditionally provided on behalf of William Wideman from amounts recovered by Plaintiff from Defendants, Plaintiff herein, in her capacity as Executor of the Estate of William Wideman, has a private cause of action against Defendants under the Medicare Secondary Payer Act (MSP) at 42 USCA §1395y(b)(3)(A) for double the amount of Medicare benefits conditionally provided on behalf of Mr. Wideman.

163.

Plaintiff hereby shows that no aspect of the present action forecloses her right to pursue her private right of action against the Defendants as provided pursuant to the MSP under 42 USCA §395y(b)(3)(A); and she herein expressly reserves the right to pursue her private cause of action there under following entry of final judgment, or other resolution of this action.

WHEREFORE: the Plaintiff prays for the following:
a) That service of process be had upon the Defendants,

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,

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

This 11 th day February, 2011.

End of Document

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