IN THE CIRCUIT COURT OF ST. LOUIS COUNTY, MISSOURI

DINA FARRAR,

Plaintiff,

v.

BETHESDA LONG TERM CARE, INC. d/b/a BETHESDA MEADOW, et al.

NEWLY ADDED DEFENDANT

MIDWEST STAFFING SOLUTIONS, LLC
Serve: Registered Agent
Barbara Pohl
10016 Office Center Ave.
St. Louis, MO 63128

Defendants.

CASE NO. 19SL – CC01553

Division: 15

JURY TRIAL DEMANDED

FIRST AMENDED PETITION FOR DAMAGES

PLAINTIFF

1. Lucia Payne ("Lucia") died on March 22, 2017. Before her death, Lucia was a resident at Bethesda Meadow, a Missouri licensed nursing home located at 322 Old State Road, Ellisville, MO 63021. She resided at the facility from approximately February 11, 2017 until she left the facility on or about March 21, 2017.

2. Plaintiff Dina Farrar is Lucia Payne's niece and the only surviving relative of Lucia Payne, and therefore, a member of the class of individuals authorized to pursue a wrongful death claim pursuant to R.S.Mo. § 537.080. At all relevant times, Plaintiff was a resident of St. Louis County, Missouri.

DEFENDANTS

Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow

3. Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow is and was at all times

EXHIBIT A

herein, an active Missouri nonprofit corporation in good standing which may be sued in its own name with its principal place of business located at 1630 Des Peres Road, Suite 290, St. Louis, Missouri 63131.

4. Upon information and belief Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow is the sole or primary owner and operator of the long-term care facility known as Bethesda Meadow which is and was at all times located at 322 Old State Road, Ellisville, Missouri 63021.

5. Upon information and belief defendant Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow maintained operational and managerial control over the Bethesda Meadow facility.

6. At all relevant times, Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow held itself out as a proprietary nursing home operating under Missouri's Omnibus Nursing Home Act as a skilled nursing facility.

7. At all relevant times, Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow held itself out to the public as providing 24-hour care from a professional and well-trained staff.

8. At all relevant times, Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow as well as its owners, operators, managers, agents, servants, consultants and employees were required to act within the standards of care set forth in the federal regulatory rules that apply to skilled nursing home facilities, specifically those found in the Omnibus Budget Reconciliation Act at 42 C.F.R. 483, *et seq.*

9. At all relevant times, Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow as well as its owners, operators, managers, agents, servants, consultants and employees were required to act within the standards of care set forth in the Missouri regulations that apply to skilled nursing home facilities, specifically those found at 19 C.S.R. 30, *et seq.*

10. At all relevant times, Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow acted by and through its owners, members, operators, managers, agents, servants, representatives, consultants and employees all of whom acted within the scope of their ownership, agency and employment.

11. At all relevant times, Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow provided centralized management and support services to the Bethesda Meadow facility, such as operational support for preparing budgets, accounting, financial services, cash management, training, and other services all of which are provided to the Bethesda Meadow facility.

12. At all relevant times, Bethesda Long Term Care, Inc. d/b/a Bethesda Meadow was also responsible for the daily operation of Bethesda Meadow facility, including but not limited to: providing capital, determining dollar budgets, determining per patient per day (PPD) budgets, hiring and firing staff, determining the number of staff, determining the staffing levels, determining the staff-to-resident ratio, staff training, safety of residents, licensure, auditing resident care, reviewing and approving computer systems, facility maintenance, facility licensing, contracting for services, and other operations controlling resident care.

Bethesda Health Group, Inc.

13. Bethesda Health Group, Inc. is an active Missouri non-profit corporation with its principal place of business located at 1630 Des Peres Road, Suite 290, St. Louis, Missouri 63131.

14. At all relevant times defendant Bethesda Health Group, Inc. held itself out as owner, operator and/or managing entity for several skilled nursing facilities, including Bethesda Meadow and maintained operational and managerial control over the Bethesda Meadow facility.

15. At all relevant times, Bethesda Health Group, Inc. held itself out to the public as providing 24-hour care from a professional and well-trained staff.

16. At all relevant times, Bethesda Health Group, Inc. as well as its owners, operators, managers, agents, servants, consultants and employees were required to act within the standards of care set forth in the federal regulatory rules that apply to skilled nursing home facilities, specifically those found in the Omnibus Budget Reconciliation Act at 42 C.F.R. 483, *et seq.*

17. At all relevant times, Bethesda Health Group, Inc. as well as its owners, operators, managers, agents, servants, consultants and employees were required to act within the standards of care set forth in the Missouri regulations that apply to skilled nursing home facilities, specifically those found at 19 C.S.R. 30, *et seq.*

18. At all relevant times, Bethesda Health Group, Inc. acted by and through its owners, members, operators, managers, agents, servants, representatives, consultants and employees all of whom acted within the scope of their ownership, agency and employment.

19. At all relevant times, Bethesda Health Group, Inc. provided centralized management and support services to the Bethesda Meadow facility. The management and support services include operational support for preparing budgets, accounting, financial services, cash management, training, and other services all of which are provided to the various healthcare facilities by the Bethesda Health Group, Inc. d/b/a Bethesda Meadow centralized home office.

20. At all relevant times, Bethesda Health Group, Inc. was also responsible for the daily operation of Bethesda Meadow facility, including but not limited to: providing capital, determining dollar budgets, determining per patient per day (PPD) budgets, hiring and firing staff, determining the number of staff, determining the staffing levels, determining the staff-to-resident ratio, staff training, safety of residents, licensure, auditing resident care, reviewing and approving computer systems, facility maintenance, facility licensing, contracting for services, and other operations controlling resident care.

Midwest Staffing Solutions, LLC

21. Midwest Staffing Solutions, LLC is a Missouri limited liability company with it principal 10016 Office Center Ave., St. Louis, Missouri 63128.

22. At all relevant times, Midwest Staffing Solutions, LLC held itself out as a staffing agency that providing qualified nurses and nursing assistants to skilled nursing facilities like Bethesda Meadows.

23. At all relevant times, Midwest Staffing Solutions, LLC provided temporary employees to skilled nursing facilities each of whom was to have been properly trained in the care of nursing home residents before they were assigned to a skilled nursing facility.

24. At all relevant times, Midwest Staffing Solutions, LLC employees were required to act within the standards of care set forth in the federal regulatory rules that apply to skilled nursing home facilities, specifically those found in the Omnibus Budget Reconciliation Act at 42 C.F.R. 483, *et seq.*

25. At all relevant times, Midwest Staffing Solutions, LLC employees were required to act within the standards of care set forth in the Missouri regulations that apply to skilled nursing home facilities, specifically those found at 19 C.S.R. 30, *et seq.*

26. At all relevant times, Midwest Staffing Solutions, LLC employees were required to follow the policies and procedures of each nursing home in which they were working, including Bethesda Meadows.

27. At all relevant times, Midwest Staffing Solutions, LLC employees were required meet the needs of the residents of each nursing home in which they were working, including Bethesda Meadows.

28. Upon information and belief, the owners of Midwest Staffing Solutions, LLC during the time of this event were Dennis Pohl and Barbara Pohl.

DEFENDANTS' JOINT ENTERPRISE DEFENDANTS
(Bethesda Health Group, Inc. and Bethesda Long Term Care, Inc. d/b/a Bethesda Meadows)

29. Bethesda Health Group, Inc. and Bethesda Long Term Care, Inc. d/b/a Bethesda Meadows (later jointly referred to as the "Bethesda Defendants") were engaged in a joint enterprise in that:

a. Defendants had an agreement, express or implied, to operate and manage the Bethesda Meadow facility located at 322 Old State Road, Ellisville, Missouri 63021

b. Defendants had a common purpose to operate and manage the Bethesda Meadow facility located at 322 Old State Road, Ellisville, Missouri 63021

c. Defendants had a joint monetary interest in the operation of the Bethesda Meadow facility located at 322 Old State Road, Ellisville, Missouri 6302.

d. Defendants had an equal right to a voice in the direction of the operation of the Bethesda Meadow facility located at 322 Old State Road, Ellisville, Missouri 63021which gave the defendants equal right of control.

30. As a consequence of the joint enterprise, defendants owed a joint duty to Lucia to adequately monetize the facility, budget for sufficient staffing levels, provide sufficient staffing levels, provide sufficient supervision, provide sufficient training, provide a safe environment, to hire quality employees and to use reasonable care for her safety while she was under their care and supervision at the Bethesda Meadow facility.

31. There has been a close relationship between the defendants at all times relevant.

32. Defendants exercised substantial control over significant aspects of the operation and management of the Bethesda Meadow during Lucia's period of residency therein, including but not limited to the creation, setting, funding and/or implementation of budgets; the hiring and training of staff; the monitoring of resident acuity levels and staffing sufficiency to meet each resident's needs; control over resident admissions and discharge to and from the facility; the supervision and monitoring of residents; and the creation and enforcement of written policies and procedures pertaining to the rules that provide for the safety and well-being of residents.

33. Each of these managerial and operational functions had a direct impact on the quality of care delivered to Lucia and other residents at Bethesda Meadow nursing home facility and were taken in furtherance of an operational and managerial objective over the licensee Bethesda Meadow.

JURISDICTION AND VENUE

34. Venue and jurisdiction are proper in this Court because the tortious acts complained of occurred in St. Louis County, Missouri.

AGENCY

35. The acts hereinafter described were performed by the owners, managers, agents, representatives, servants, and employees of defendants and were performed either with the full knowledge and consent of defendants, and/or were performed by their agents, representatives, servants, or employees during the scope of their ownership, management, agency, representation, or employment with the defendants.

FACTUAL BACKGROUND

36. Lucia Payne was resident at Bethesda Meadow beginning February 11, 2017 and remained a resident at the facility until March 21, 2017.

37. Upon her admission to Bethesda Meadow, Lucia suffered from a severe cognitive defect, required extensive assistance for bed mobility, dressing and hygiene, had a known fall history with fractures and was designated as a high fall risk.

38. During her residency at Bethesda Meadow Lucia was known to move around a lot in bed, did not lay still which often resulted in her sheets and pillows requiring adjustment or being found on the floor.

39. According to her care plan, Lucia's bed was to remain in a low position while she was in it with a cushioned mat on the floor next to the bed.

40. During her admission at Bethesda Meadow, Lucia suffered several falls and was known to throw herself out of her wheelchair.

41. On March 17, 2017 Lucia fell out of her bed at Bethesda Meadow.

42. On March 18, 2017 Lucia fell from her a chair in her bedroom.

43. On March 19, 2017 Lucia fell from a chair in the dining room.

44. On March 21, 2017 during a shift change, an Agency Employee with no previous experience with Lucia was assigned to provide her care for that shift.

45. That Agency Employee was obtained through defendant Midwest Staffing Solutions, LLC.

46. Even though there were other employees on the same wing of the Bethesda Meadow facility that knew Lucia, had provided care for her in the past and knew her tendencies to be unsettled, the Bethesda Defendants made the choice to assign an Agency Employee from Midwest Staffing Solutions, LLC who had no knowledge of Lucia or her care needs.

47. The Bethesda Defendants made the decision to permit the Agency Employee from defendant Midwest Staffing Solutions, LLC to work at the Bethesda Meadow facility and provide care for Lucia and other residents without supervision.

48. Other employees knew the level of care Lucia required and told state investigators that Lucia was “very quick” and that they would “never walk away from [Lucia] during care.” This critical information was not provided to the Agency Employee and he was permitted to provide care for Lucia and other residents without supervision.

49. On March 21, 2017, the Agency Employee approached Lucia to provide incontinence care and to dress her. Before providing care, the Agency Employee did not leave the bed in a low position while Lucia was in the bed, instead he raised the bed to make it easier for him to provide Lucia with care.

50. In the process of providing care to Lucia, the Agency Employee walked away from Lucia's bed during which time Lucia fell out of the bed which was now in a much higher position than what was safe for her.

51. Lucia's head hit the bare, hard floor while the rest of her body landed halfway on the mat next to her bed. Rather than seek help from the nursing staff, the Agency Employee picked Lucia up and put her back in her bed.

52. In this fall, Lucia suffered multiple facial fractures, trauma to her left eye, a cervical compression fracture, severe swelling, bruises and was cuts that were bleeding.

53. Lucia was taken to a local hospital where she died the following day of craniocerebrospinal trauma directly caused by the negligent care she received at the Bethesda Meadow facility.

54. While holding Bethesda Meadow out to Lucia, her family and other members of the public as providing excellent care, the Bethesda Defendants failed to provide sufficient care to Lucia which resulted in severe pain, injuries and death.

55. Further, while holding its employees out to nursing home facilities like Bethesda Meadow as being trained to provide excellent care, follow facility policies and procedures and to provide care in accordance with the state and federal regulatory rules, Midwest Staffing Solutions, LLC's Agency Employee failed to provide sufficient care to Lucia which resulted in severe pain, injuries and death.

COUNT I – WRONGFUL DEATH
(The Bethesda Defendants)

56. Plaintiff incorporates by reference all of the foregoing allegations in this Petition as though fully set forth herein.

57. At all times material hereto, Lucia was in a defenseless and dependent condition.

58. As a result of her defenseless and dependent condition, Lucia relied upon

defendants to hire and employ quality to staff members with sufficient training and knowledge to provide for her safety, protection, medical care and treatment.

59. At all relevant times, defendants had a duty to act in accordance with the standards of care required of those owning, operating, managing, maintaining, and/or controlling a skilled nursing facility.

60. These duties required defendants to implement and enforce policies and procedures to ensure the proper care for, and treatment of, residents such as Lucia.

61. These duties required defendants to have sufficient and qualified staff at Bethesda Meadow nursing home to ensure that residents of the nursing home receive proper care, supervision, monitoring, treatment and compliance with care plan requirements.

62. These duties required defendants to ensure that the nurses and other staff at Bethesda Meadow provided the care and supervision required by the resident.

63. These duties required defendants to ensure that Bethesda Meadow's nurses and other staff were educated and trained to provide proper supervision, care and treatment for the residents, like Lucia.

64. These duties required defendants to ensure that defendants ensure that agency employees are properly supervised and educated on how to meet the needs of all residents for whom they are assigned.

65. These duties required defendants to ensure that Lucia was cared for by individuals knowledgeable of her condition and medical needs.

66. These duties required defendants to ensure that Bethesda Meadow was properly capitalized to ensure that the residents received quality caretakers, proper supervision, and quality care and treatment.

67. Specifically, with respect to Lucia, defendants and their agents, servants and/or

employees breached their duties and were guilty of the following acts of negligence and carelessness by failing to measure up to the requisite standard of due care, skill, and practice ordinarily exercised by members of their profession under the same or similar circumstances, including:

a. By failing to enact and carry out an adequate care plan regarding Lucia's high fall risk;

b. By failing to recognize changes in Lucia's physical and mental conditions;

c. By failing to provide Lucia with proper supervision;

d. By failing to provide an agency employee with proper supervision and information about Lucia's care needs;

e. By failing to timely transfer Lucia to a facility that could provide her adequate care;

f. By failing to provide adequate staff to ensure Lucia's 24-hour protective oversight, supervision and care;

g. By failing to properly supervise and train the employees, agents and/or servants of defendants who were responsible for the care and treatment of Lucia;

h. By failing to have and/or implement appropriate policies and procedures regarding how to provide the care needs Lucia required;

i. By failing to ensure that Lucia received proper supervision, care and treatment to prevent her from falling and suffering devastating head and neck injuries that caused her death;

j. By failing to properly capitalize the facility so it could have enough staff members to provide Lucia with the supervision and safety she required;

k. By failing to meet Lucia's medical and care needs; and

l. By failing to take required precautions to prevent a fall.

68. Defendants, as the owners, operators, and/or managers of skilled care nursing facilities licensed by the State of Missouri and accepting Medicare and Medicaid funds, were subject to regulations promulgated by the Missouri Division of Social Services and

under the Social Security Act.

69. While providing care and treatment to Lucia, defendants and their agents, servants and/or employees breached their duty to Lucia and were guilty of acts of negligence and negligence, *per se*, in violating regulatory rules governing skilled care facilities including but not limited to the following:

a. 19 C.S.R. 30-85.042(3). The operator shall be responsible to assure compliance with all applicable laws and rules. The administrator shall be fully authorized and empowered to make decisions regarding the operation of the facility and shall be held responsible for the actions of all employees. The administrator's responsibilities shall include the oversight of residents to assure that they receive appropriate nursing and medical care;

b. 19 C.S.R. 30-85.042(6). The facility shall not knowingly admit or continue to care for residents whose needs cannot be met by the facility directly or in cooperation with outside resources. Facilities which retain residents needing skilled nursing care shall provide licensed nurses for these procedures;

c. 19 C.S.R. 30-85.042(13). The facility shall develop policies and procedures applicable to its operation to insure the residents' health and safety and to meet the residents' needs. At a minimum there shall be policies covering personnel practices, admission, discharge, payment, medical emergency treatment procedures, nursing practices, pharmaceutical services, social services, activities, dietary, housekeeping, infection control, disaster and accident prevention, residents' rights and handling residents' property;

d. 19 C.S.R. 30-85.042(15). All personnel shall be fully informed of the policies of the facility and of their duties;

e. 19 C.S.R. 30-85-14.042(16). All persons who have any contact with the residents in the facility shall not knowingly act or omit any duty in a manner which would materially and adversely affect the health, safety, welfare or property of a resident;

f. 19 C.S.R. 30-85.042(20). The facility shall develop and offer an in-service orientation and continuing educational program for the development and improvement of skills of all the facility's personnel, appropriate for their job function;

g. 19 C.S.R. 30-85.042(22). The facility must ensure there is a system of in-service training for nursing personnel which identifies training needs

related to problems, needs, and care of residents and sufficient to ensure staff's continuing competency;

h. 19 C.S.R. 30-85.042(37). All facilities shall employ nursing personnel in sufficient numbers and with sufficient qualifications to provide nursing and related services which enable each resident to attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Each facility shall have a licensed nurse in charge who is responsible for evaluating the needs of the residents on a daily and continuous basis to ensure there are sufficient trained staff present to meet those needs;

i. 19 C.S.R. 30-85.042(38). Failing to ensure that all nursing personnel shall be on duty at all times on each resident-occupied floor;

j. 19 C.S.R. 30-85.14.042(66). Each resident shall receive twenty-four (24)-hour protective oversight and supervision;

k. 19 C.S.R. 15-14.042(67). Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice;

l. 19 C.S.R. 30-85.042(99). Facilities shall ensure that the clinical record contains sufficient information to—
   a) Identify the resident;
   b) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and
   c) Identify the discharge or transfer destination;

m. 19 C.S.R. 30-85.042(100). Facilities shall ensure that the resident's clinical record must contain progress notes that include, but are not limited to:
   a) Response to care and treatment;
   b) Change(s) in physical, mental and psychosocial condition;
   c) Reasons for changes in treatment; and
   d) Reasons for transfer or discharge;

n. 19 C.S.R. 30-85.042(103). The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices. These records shall be complete, accurately documented, readily accessible on each nursing unit and systematically organized;

o. 19 C.S.R. 30-88.010(20). Failing to keep each resident free from mental and physical abuse; and

p. 42 C.F.R. 483.70(g) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to

> residents by a person or agency outside the facility… (2) Arrangements …or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for - (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services.

70. Lucia was a member of the class of persons intended to be protected by the enactment of the aforementioned regulatory rules.

71. The physical injuries Lucia incurred were the type of injuries that the regulatory rules were enacted to prevent.

72. As a direct and proximate result of the individual and collective acts of negligence of defendants as described above, Lucia suffered severe pain, anxiety, mental distress, and death.

73. As a direct and proximate result of the individual and collective acts of negligence of all defendants as described above, Plaintiff also suffered damages including, but not limited to, loss of companionship, loss of comfort, loss of guidance, loss of counsel and loss of instruction, pain, suffering, bereavement and mental anguish.

74. The actions of defendants were malicious, wanton, grossly negligent and reckless, and performed in reckless disregard of the welfare and safety of Lucia and others, such that, in addition to damages for pain and suffering, defendants are liable for punitive and exemplary damages for their grossly negligent care of Lucia.

75. At the time defendants failed or refused to recognize the significant changes in Lucia's condition and failed to properly respond to those changes, they knew that their conscious disregard to providing adequate care to Lucia created a high degree of probability of injury to residents, like Lucia.

76. Accordingly, defendants showed a complete indifference to, or conscious disregard, for the safety of the Bethesda Meadow residents, including Lucia, and warrants punitive and/or exemplary damages be assessed against defendants in an amount that is fair and

reasonable and will punish defendants and deter them and others from similar conduct.

77. As a direct and proximate result of defendants' negligence, and complete indifference to, or conscious disregard, for the care and safety of others, Lucia was harmed and suffered damages, including but not limited to pain, suffering, mental anguish, loss of enjoyment of life and death.

WHEREFORE, Plaintiff in her capacity as a member of the wrongful death class of claimants pursuant to RSMO § 537.080, pray for judgment against the Bethesda Defendants in an amount a jury deems fair and reasonable under the circumstances, including, but not limited to, actual damages, damages for aggravating circumstances (exemplary/punitive damages), the costs of this action, and for such other and further relief as the Court deems just and proper.

COUNT II – WRONGFUL DEATH
(Midwest Staffing Solutions, LLC)

78. Plaintiff incorporates by reference all of the foregoing allegations in this Petition as though fully set forth herein.

79. At all times material hereto, Lucia was in a defenseless and dependent condition.

80. Defendant Midwest Staffing Solutions, LLC provided an Agency Employee to Bethesda Meadow at the request of the Bethesda Defendants to provide quality care to Bethesda Meadow residents, including Lucia Payne.

81. At all relevant times, defendant had a duty to provide a properly trained Agency Employee to provide resident care act in accordance with the standards of care required at a Missouri skilled nursing facility, like Bethesda Meadow.

82. These duties required defendant to properly train their Agency Employee in all types of care, including but not limited to, providing care to residents while the resident remains in bed, as well as all precautions that are to be taken during this time.

83. These duties required defendant to ensure that its agency employees properly

supervised the residents for whom they are caring.

84. These duties required defendant to ensure that its agency employees would be knowledgeable of the care needs of those for whom they are caring.

85. Specifically, with respect to Lucia, defendant and its agents, servants and/or employees breached their duties and were guilty of the following acts of negligence and carelessness by failing to measure up to the requisite standard of due care, skill, and practice ordinarily exercised by members of their profession under the same or similar circumstances, including:

a. By failing to recognize changes in Lucia's physical and mental conditions;

b. By failing to provide Lucia with proper supervision;

c. By failing to provide an agency employee with proper supervision and information about Lucia's care needs;

d. By failing to provide adequate oversight, supervision and care;

e. By failing to ensure that Lucia received proper supervision, care and treatment to prevent her from falling and suffering devastating head and neck injuries that caused her death;

f. By failing to determine what Lucia's care needs were before providing care;

g. By failing to meet Lucia's medical and care needs; and

h. By failing to take required precautions to prevent a fall.

86. Defendant, as the owners of a staffing agency to skilled care nursing facilities were required to provide agency nurses who provided care to residents in accordance with the regulatory rules promulgated by the Missouri Division of Social Services and under the Social Security Act.

87. While providing care and treatment to Lucia, defendant's employee breached their duty to Lucia and were guilty of acts of negligence by failing to provide her a safe

environment and proper supervision.

88. As a direct and proximate result of the acts of negligence of defendant and its employees as described above, Lucia suffered severe pain, anxiety, mental distress, and death.

89. As a direct and proximate result of the negligence of defendant and its employees as described above, Plaintiff also suffered damages including, but not limited to, loss of companionship, loss of comfort, loss of guidance, loss of counsel and loss of instruction, pain, suffering, bereavement and mental anguish.

90. The actions of defendant and its employees were malicious, wanton, grossly negligent and reckless, and performed in reckless disregard of the welfare and safety of Lucia and others, such that, in addition to damages for pain and suffering, defendants are liable for punitive and exemplary damages for their grossly negligent care of Lucia.

91. At the time defendant and its employees failed to provide quality care to Lucia as described above, they knew that their conscious disregard to providing adequate care to Lucia created a high degree of probability of injury to residents, like Lucia.

92. Accordingly, defendant and its employees showed a complete indifference to, or conscious disregard, for the safety of Lucia, and warrants punitive and/or exemplary damages be assessed against defendant in an amount that is fair and reasonable and will punish defendant and deter them and others from similar conduct.

93. As a direct and proximate result of defendant's negligence, and complete indifference to, or conscious disregard, for the care and safety of others, Lucia was harmed and suffered damages, including but not limited to pain, suffering, mental anguish, loss of enjoyment of life and death.

WHEREFORE, Plaintiff in her capacity as a member of the wrongful death class of claimants pursuant to RSMO § 537.080, pray for judgment against defendant Midwest Staffing

Solutions, LLC in an amount a jury deems fair and reasonable under the circumstances, including, but not limited to, actual damages, damages for aggravating circumstances (exemplary/punitive damages), the costs of this action, and for such other and further relief as the Court deems just and proper.

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