2011 WL 9364991 (Iowa Dist.) (Trial Pleading)
District Court of Iowa.
Des Moines County

Mildred BOZARTH, and Wayne Bozarth, as Executor of the Estate of Gene Bozarth, Plaintiffs,
v.
DANVILLE CARE CENTER, Healthcare of Iowa, Inc., DC Health Partnership, L.C., Millennium Rehab & Consulting Group, Inc., Great River Therapeutics, P.C., Diversacare, L.L.C., Danville Development Company, Donald Chensvold, Tom Wagg, Amy Tressel and Teresa Minnis, Defendants.

No. LALA003599.
June 1, 2011.

Amended Petition at Law

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COME NOW the Plaintiffs in the above-entitled matter and for their causes of action state:
1. Plaintiff, Wayne Bozarth, is a duly appointed Personal Representative of the Estate of Gene Bozarth and is a resident of Oakland County, Michigan. Wayne Bozarth is authorized to pursue any and all claims on behalf of the Estate of Gene Bozarth, together with his sister, Carolyn Williams, co-executor of the Estate of Gene Bozarth.

2. Plaintiff, Mildred Bozarth, is an adult resident of Iowa, residing in Des Moines, County, IA, and is the wife of the decedent, Gene Bozarth at all times material to this action.

3. At the time of his death, Gene Bozarth was a resident of Des Moines County, Iowa.

4. At all times material to this action, Defendant Danville Care Center was a skilled nursing facility licensed by the State of Iowa, open to members of the general public (such as Gene and Mildred Bozarth), and had a principal place of business located at 401 S. Birch Street, Danville, IA.

5. At all times material to this action, Gene Bozarth was a resident at Danville Care Center.

6. At all times material to this action, Defendant Teresa Minnis was a resident of Iowa and/or worked in Iowa, and held herself out to be the Administrator of Danville Care Center, a skilled nursing facility open to members of the general public (such as Gene and Mildred Bozarth).

7. At all times material to this action, Teresa Minnis was an employee, agent, or apparent agent of Danville Care Center, and the other Defendants, acting within the course and scope of her employment, agency or apparent agency.

8. At all times material to this action, Defendants Donald Chensvold, Tom Wagg, and Amy Tressel were residents of Iowa and/or worked in Iowa. Mr. Chensvold was an owner and agent of Healthcare of Iowa, Inc., Millennium Rehab & Consulting Group, Inc. and DiversaCare LLC. Mr. Wagg and Mr. Tressel and were owners and agents of Healthcare of Iowa, Inc. At all times material to this action, Mr. Chensvold, Mr. Wagg, and Ms. Tressel were acting within the course and scope of their agency or apparent agency.

9. At all times material to this action, Defendant Healthcare of Iowa, Inc. was a domestic profit corporation having a principle place of business located at 4080 1st Ave. NE, Ste. 103, Cedar Rapids, IA 52402. Upon information and belief, Healthcare of Iowa, Inc. had an ownership, management, or other pecuniary interest in Danville Care Center.

10. At all times material to this action, Defendant DC Health Partnership, L.C., was a domestic profit limited company having a principle place of business located at 4080 First Ave. NE, Ste 103, Cedar Rapids, IA 52402. Upon information and belief, DC Health Partnership, L.C. had an ownership, management, or other pecuniary interest in Danville Care Center.

11. At all times material to this action, Defendant Millennium Rehab & Consulting Group, Inc. was a domestic profit corporation having a principle place of business located at 4725 Merle Hay Rd, Ste. 107, Des Moines, IA. Upon information and belief, Millennium Rehab & Consulting Group, Inc. had an ownership, management, or other pecuniary interest in Danville Care Center.

12. At all times material to this action, Defendant Great River Therapeutics, P.C. was a domestic professional corporation having a principle place of business located at 2807 Summer Street, Burlington, IA 52601. Upon information and belief, Great River Therapeutics, P.C. had an ownership, management, or other pecuniary interest in Danville Care Center.

13. At all times material to this action, Defendant DiversaCare, LLC was a domestic profit limited liability company having a principle place of business located at 4080 1st Ave. NE, Ste. 103, Cedar Rapids, IA 52402. Upon information and belief, DiversaCare, LLC had an ownership, management, or other pecuniary interest in Danville Care Center.

14. At all times material to this action, Defendant Danville Development Company was a domestic profit corporation having a principle place of business located at 15675 205th Ave, Danville, IA 52623. Upon information and belief, Danville Development Company had an ownership, management, or other pecuniary interest in Danville Care Center.

15. Based upon information and belief, at all times material to this Petition, all of the policies, procedures, protocols, staffing and budgeting decisions at Danville Care Center were promulgated and controlled by Healthcare of Iowa, Inc., a management company appointed and controlled by the Defendants, Donald Chensvold, Tom Wagg, Amy Tressel, and Teresa Minnis.

16. At all times material to this action, all acts by Danville Care Center and its respective employees, agents, or apparent agents, were done within the course and scope of their employment, agency or apparent agency.

17. At all times material to this action, all acts of staff at Danville Care Center were authorized, approved and ratified by Healthcare of Iowa, Inc., a management company appointed and controlled by the Defendants, Donald Chensvold, Tom Wagg, Amy Tressel, and Teresa Minnis.

18. On or around March 25, 2009, Gene and Mildred Bozarth entered into a contract with Danville Care Center, at which time Mr. and Mrs. Bozarth became residents of Danville Care Center. Mr. and Mrs. Bozarth, and their family, relied upon, and trusted, Danville Care Center to provide for their health and well-being.

19. The decision to enter Danville Care Center was not easily made. Gene and Mildred Bozarth had lived an independent life together, having been married for nearly 60 years. They met when they were teenagers, and eloped, because they were so in love and so eager to begin their life together.

20. Gene and Mildred have four children: Wayne, Carolyn, Charlette, and Nancy. Their family is close-knit, and communicates with one another constantly. Due to their close bond, the decision to admit Gene and Mildred into Danville Care Center was especially difficult. However, all realized that Gene and Mildred needed care that could only be provided by a skilled nursing facility. Danville Care Center promised such care; unfortunately, Danville did not keep its promise.

21. Prior to June 29, 2009, Danville Care Center knew or should have known that Gene Bozarth presented a risk of falling, and that Mr. Bozarth should not be left alone in his room without Mildred.

22. On or about June 29, Gene Bozarth was brought back to his room after dinner and left in his room, alone, by Sarah Wingate, an employee of Danville Care Center.

23. Because Gene Bozarth presented a known risk of falling, Danville Care Center had a duty to equip Gene Bozarth with an adequate alarm to notify Danville Care Center employees and staff when Gene Bozarth would attempt to get up from his chair, and had a duty to have enough staff, in close proximity, to respond to an alarm in a timely manner.

24. On said evening of June 29, 2009, those responsible for Gene Bozarth's care at Danville Care Center failed to properly fasten the alarm system to Mr. Bozarth, and likewise failed to adequately supervise Mr. Bozarth until his wife, Mildred Bozarth, could be brought back to the room they shared together. Additionally, those responsible for the care of Mr. Bozarth at Danville Care Center failed to bring Gene and Mildred back to his room together, all the while knowing Mr. Bozarth depended on his wife for support, and that he became anxious when they were not together.

25. On said evening of June 29, 2009, Gene Bozarth, while unattended and improperly alarmed, got up from him chair, exited his room, and began moving down the hallway to return to the dining hall where his wife, Mildred, remained.

26. No employee from Danville Care Center was close enough or able to see and restrain Gene Bozarth while he got out of his chair, nor did anyone attempt to help him while he moved down the hall. The first time Mr. Bozarth was seen (after being left unattended and without an alarm in his room) was as he fell.

27. Ultimately, Gene Bozarth tripped and fell at the end of the hallway, and struck his head on a wheelchair located in the hallway. This fall resulted in, among other things, a broken neck, fractured hand, fractured nose, fractured orbital wall, and other injuries, which led to his death.

28. Prior to June 29, 2009, Danville Care Center had been cited multiple times by the licensing authorities for maintaining an unsafe environment, and failing to prevent accidents.

29. Those responsible for Gene Bozarth at Danville Care Center failed to properly assess, diagnose and treat his injuries following his fall the night of June 29, 2009. The charge nurse on duty at the time of the fall, Linda Hampton, failed to follow Danville Care Center policy and procedure when she **neglected** to call the doctor on call to notify him of the significant change in Mr. Bozarth's condition. Staff at Danville Care Center left Mr. Bozarth to suffer overnight with his serious injuries.

30. The day following the fall, Gene Bozarth's primary care physician became aware of the incident, and ordered that Mr. Bozarth be taken to the Emergency Room. Rather than sending Mr. Bozarth by ambulance, the facility called Mr. Bozarth's daughter, Carolyn Williams, and informed her of the physician's orders. Ms. Williams informed Danville Care Center that she was in Iowa City, but that one of her sons could be at the facility within five minutes to take Mr. Bozarth to the ER. The facility responded that there was “no rush” for Mr. Bozarth to be taken to the Emergency Room, and that Mr. Bozarth could wait for Ms. Williams to return from Iowa City.

31. As a result of the injuries Gene Bozarth suffered due to his fall, Mr. Bozarth had to be hospitalized. As a result of complications from his injuries, as well as the necessary hospital stay, Gene Bozarth died on July 7, 2009.

32. Danville Care Center betrayed the trust of Gene and Mildred Bozarth, and their family, by failing to provide the promised level of care.

33. Gene Bozarth's death was proximately caused by his fall at Danville Care Center on June 29, 2009.

COUNT 1: CORPORATE NEGLIGENCE

34. Plaintiffs re-allege the above paragraphs.
35. The Defendants, by virtue of the contract and special relationship between Gene and Mildred Bozarth and Danville Care Center, owed a duty of reasonable care to Mr. and Mrs. Bozarth.

36. The Defendants breached their duty of reasonable care to Gene Bozarth, and were otherwise negligent in their care and treatment of Mr. Bozarth. Said negligence included, but was not limited to:

a. Failing to provide adequate staff, adequately paid staff, and adequately trained staff at Danville Care Center to care for residents such as Gene Bozarth, with the full knowledge that such inadequate staffing practices would place patients such as him at risk for injuries;

b. Negligently hiring, retaining and supervising staff at Danville Care Center, with the full knowledge that such negligent staffing practices would place patients such as Gene Bozarth at risk for injuries or death;

c. Failing to provide and implement proper care plans that would adequately meet Gene Bozarth's needs, including his risk of falling;

d. Failing to treat Gene Bozarth with dignity and respect;

e. Failing to have adequate and effective policies, procedures, staff and equipment to adequately care for Gene Bozarth;

f. Failing to follow policies and procedures currently in place;

g. Failing to provide appropriate medication to Gene Bozarth;

h. Failing to provide a safe living environment to Gene Bozarth;

i. Failing to provide humane care to Gene Bozarth;

j. Failing to ensure that Gene Bozarth was free from physical **neglect**;

k. Failing to keep truthful, complete and accurate medical records for Gene Bozarth;

l. Failing to appropriately notify physician and family of Gene's adverse change in condition;

m. Breaching their fiduciary duty to Gene Bozarth;

n. Failing to properly budget funds, so that money intended to be used to provide sufficient care to residents such as Gene Bozarth was instead diverted to Defendants as profit;

o. Employing a medical director in name only, who failed to fulfill any of the duties imposed on the medical director by law, and who misrepresented to the public and the public authorities that he had, indeed, fulfilled said duties; and

p. Failing to comply with state law and the Iowa Administrative Code with regard to the care provided to Gene Bozarth.

37. As a proximate result of the conduct and negligence of the Defendants, Gene Bozarth: (1) suffered injuries, including but not limited to a fractured neck, fractured hand, fractured nose, and fractured orbital wall, which ultimately resulted in his death; (2) required medical care and associated costs which otherwise would not have been necessary but for the misconduct of these Defendants; and (3) incurred all of the pain and suffering associated with these injuries and the pain and suffering associated with the indignity of not being properly cared for in a skilled nursing home setting.

38. As a proximate result of the negligence of these Defendants, Mildred Bozarth suffered emotional distress as she lay next to her dying husband, while he gasped for air, and she found herself unable to help him.

39. As a proximate result of this negligence, Gene Bozarth lost a measurable opportunity to survive.

COUNT 2: NEGLIGENCE AND NEGLIGENCE PER SE BY TERESA MINNIS

40. Plaintiffs re-allege the above paragraphs.
41. At all times material to this action, Teresa Minnis was the Administrator at Danville Care Center.

42. Pursuant to Iowa Administrative Code § 481-58.9(2), the administrator shall:

a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program;

b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position

c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants;

d. Make available the nursing facility payroll records for departmental review as needed;

e. Be required to maintain a staffing pattern for all departments.

43. In addition, Iowa Administrative Code § 441-81.13(19)(2)(2) states that the administrator is “responsible for management of the facility”,

44. Based upon information and belief, Ms. Minnis was negligent in the services, administration, and management of Danville Care Center by, among other things: (1) failing to ensure adequate care planning for Gene Bozarth; (2) failing to adequately staff and supervise the staff of Danville Care Center, (3) failing to adequately train staff; and (4) failing to have adequate policies and procedures in place to ensure the safety and wellbeing of Gene and Mildred Bozarth.

45. Based upon information and belief, Ms. Minnis promulgated and controlled all of the policies, procedures, protocols, staffing and budgeting decisions at Danville Care Center.

46. Based upon information, and belief, Ms. Minnis also authorized, approved, and/or ratified all acts of Danville Care Center staff.

47. As a proximate result of Ms. Minnis' actions, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 3: NEGLIGENCE OF CORPORATE ACTORS DONALD CHENSVOLD, TOM WAGG, AND AMY TRESSEL

48. Plaintiffs re-allege the above paragraphs.
49. Based upon information and belief, at all times material to this action, Donald Chensvold was the co-owner and/or president of Healthcare of Iowa, Inc., DiversaCare, and Millennium Rehab & Consulting Group, Inc. Based upon information and belief, at all times material to this action, Tom Wagg was a co-owner in Healthcare of Iowa, Inc., and the Vice President of Operations at Healthcare of Iowa, Inc. Based upon information and belief, at all times material to this action, Amy Tressel was the co-owner of Healthcare of Iowa, Inc., and the Vice President of Finance for Healthcare of Iowa, Inc.

50. Mr. Chensvold, Mr. Wagg and Ms. Tressel promulgated and controlled all of the policies, procedures, protocols, staffing and budgeting decisions at Danville Care Center.

51. Based upon information and belief, Mr. Chensvold, Mr. Wagg and Ms. Tressel also authorized, approved, and/or ratified all acts of Danville Care Center staff.

52. In doing the above, Mr. Chensvold, Mr. Wagg and Ms. Tressel knowingly and negligently violated state rules, regulations, and statutes in a number of ways, including, but not limited to (1) failing to have proper policies and procedures in place related to patient transfer from dining room to bedroom; (2) failing to have proper policies and procedures in place regarding staffing; (3) failing to adequately staff the nursing home, in an attempt to divert funds from patient care to profit; and (4) failing to employ a medical director who complies with state law and his medical director agreement.

53. As a proximate result of the knowing and negligent actions of Mr. Chensvold, Mr. Wagg and Ms. Tressel, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 4: NEGLIGENCE AND NEGLIGENCE PER SE BY DANVILLE CARE CENTER

54. Plaintiffs re-allege the above paragraphs.
55. Danville Care Center, by and through the acts of its employees and agents, was negligent in caring for Gene Bozarth. Said negligence included, but was not limited to:

a. Failing to prevent Mr. Bozarth's fall;

b. Failing to adequately respond to, assess, and treat Mr. Bozarth's injuries suffered as a result of the fall;

c. Failing to treat Mr. Bozarth with dignity and respect;

d. Failing to have adequate and effective policies, procedures, staff and equipment to adequately care for Mr. Bozarth;

e. Failing to follow policies and procedures currently in place;

f. Failing to provide appropriate medication to Mr. Bozarth;

g. Failing to provide a safe living environment to Gene Bozarth;

h. Failing to provide humane care to Gene Bozarth;

i. Failing to ensure that Gene Bozarth was free from physical **neglect**;

j. Failing to keep truthful, complete and accurate medical records for Gene Bozarth;

k. Failing to appropriately notify physician and family of Gene's adverse change in condition; and

l. Failing to comply with state law and the Iowa Administrative Code with regard to the care provided to Gene Bozarth.

56. Defendants were at all times relevant caretakers as described in Iowa Code § 235B.2(1).

57. Gene Bozarth was at all times relevant a dependent adult as described in Iowa Code § 235B.2(4).

58. The conduct of Danville Care Center is governed by the Iowa Code § 235B(5), which defines "dependent adult abuse" as "(1) any of the following as a result of the willful or negligent acts or omissions of a caretaker:.... (d) The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other necessary care to maintain a dependent adult's life or health."

59. The substandard nursing care and conditions that existed at Danville Care Center while Gene and Mildred Bozarth were patients constitutes inappropriate conduct that caused great harm to Gene and Mildred Bozarth.

60. The conduct of Danville Care Center is also governed by Iowa Administrative Code and more particularly the following Administrative Code Sections:

a. Iowa Administrative Code § 441-81.1 defines abuse as "any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee: ... (4) The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident's life or health."

b. Iowa Administrative Code § 441-81.13(5) "*Resident rights.* The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident..."

c. Iowa Administrative Code § 441-81.13(5) "*Resident rights.* (b) *Notice of rights and services.* (10) *Notification of changes.* (1) A facility shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

d. Iowa Administrative Code § 441-81.13(5) "*Resident rights.* (d) *Free choice.* The resident has the right to: (2) Be fully informed in advance about care and treatment and of any changes in the care or treatment that may affect the resident's well being.

e. Iowa Administrative Code § 441-81.13(6) "*Resident rights. Admission, transfer and discharge rights.* (a) *Transfer and discharge.* (2) Transfer *or discharge requirements.* The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: (1) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility."

f. Iowa Administrative Code § 441-81.13(7) "*Resident behavior and facility practices.* (b) Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

g. Iowa Administrative Code § 441-81.13(7) "*Resident behavior and facility practices.* (c) *Staff treatment of residents.* The facility shall develop and implement written policies and procedures that prohibit mistreatment, **neglect**, and abuse of residents and misappropriation of resident property.

h. Iowa Administrative Code § 441-81.13(8) "*Quality of Life.* A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. (a) *Dignity.* The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality."

i. Iowa Administrative Code § 441-81.13(8) "*Quality of Life.* (e) *Accommodation of needs.* A resident has the right to (1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered."

j. Iowa Administrative Code § 441-81.13(8) "*Quality of Life.* (h) Environment. The facility shall provide: (1) A safe, clean, comfortable and homelike environment."

k. Iowa Administrative Code § 441-81.13(9) "*Resident assessment.* The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability."

l. Iowa Administrative Code § 441-81.13(9) "*Resident assessment.* (c) *Accuracy of assessments.* The assessment shall accurately reflect the resident's status."

m. Iowa Administrative Code § 441-81.13(9) "*Resident assessment.* (d) *Comprehensive care plans.* (1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment."

n. Iowa Administrative Code § 441-81.13(10) "*Quality of care.* Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."

o. Iowa Administrative Code § 441-81.13(10) "*Quality of care.* (h) *Accidents.* The facility shall ensure that: (1) the resident environment remains as free of accident hazards as possible. (2) Each resident receives adequate supervision and assistive devices to prevent accidents."

p. Iowa Administrative Code § 441-81.13(10) "*Quality of care.* (i) *Nutrition.* Based on a resident's comprehensive assessment, the facility shall ensure that a resident: (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. (2) Receives a therapeutic diet when there is a nutritional problem."

q. Iowa Administrative Code § 441-81.13(10) "*Quality of care.* (m) *Medication errors.* The facility shall ensure that: (1) It is free of significant medication error rates of 5 percent or greater. (2) Residents are free of any significant medication errors."

r. Iowa Administrative Code § 441-81.13(11) *Nursing services.* The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident as determined by resident assessments and individual plans of care."

s. Iowa Administrative Code § 441-81.13(11) *Nursing services.* (a) *Sufficient staff.* (1) The facility shall provide services by sufficient numbers of ... personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans."

t. Iowa Administrative Code § 441-81.13(13)(d) "*Availability of physicians for emergency care.* The facility shall provide or arrange for the provision of physician services 24 hours a day in case of an emergency."

u. Iowa Administrative Code § 441-81.13(18) "*Physical environment.* The facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public." v. Iowa Administrative Code § 441-81.13(18) "*Physical environment.* (h) *Other environmental conditions.* The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public."

w. Iowa Administrative Code § 441-81.13(19) "*Administration.* A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."

x. Iowa Administrative Code § 441-81.13(19) "*Administration.* (a) *Licensure.* A facility shall be licensed under applicable state and federal law."

y. Iowa Administrative Code § 441-81.13(19) "*Administration.* (b) *Compliance with federal, state and local laws and professional standards.* The facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility."

z. Iowa Administrative Code § 441-81.13(19) "*Administration.* (d) *Governing body.* (1) The facility shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. (2) The governing body appoints the administrator who is: (1) Licensed by the state. (2) Responsible for the management of the facility."

aa. Iowa Administrative Code § 441-81.13(19) "*Administration.* (f) Proficiency *of nurse aides.* The facility shall ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for the residents' needs, as identified through resident assessments, and described in the plan of care."

bb. Iowa Administrative Code § 441-81.13(19) "*Administration.* (g) *Staff qualifications.* (1) The facility shall employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation."

cc. Iowa Administrative Code § 441-81.13(19) "*Administration.* (i) *Medical director.* (1) The facility shall designate a physician to serve as medical director. (2) The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility."

dd. Iowa Administrative Code § 441-81.13(19)(k) "*Radiology and other diagnostic services.* (1) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (2) The facility shall (3) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance."

ee. Iowa Administrative Code § 441-81.13(19)0) "*Clinical records.* (1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized."

ff. Iowa Administrative Code § 481-58.3 requires nursing facilities to "meet all of the rules, regulations, and standards contained in 481-Chapters 58 and 61" in order to make an application for licensure.

gg. Iowa Administrative Code § 481-58.10(6) "*General policies.* There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident which includes the individual to be contacted in case of emergency.

hh. Iowa Administrative Code § 481-58.11(135C) "*Personnel.* (j) There shall be an organized ongoing in-service educational and training program planned in advance for all personnel in all departments."

ii. Iowa Administrative Code § 481-58.12 (135C) "*Admission, transfer, and discharge,* (1) *General admission policies.* (a) No resident shall be admitted or retained in a nursing facility who is in need of greater services than the facility can provide."

jj. Iowa Administrative Code § 481-58.14(3) "*Medical services.* Arrangements shall be made to have a physician available to furnish medical care in case of emergency."

kk. Iowa Administrative Code § 481-58.14(5) "*Medical services.* The person in charge shall immediately notify the physician of any accident, injury, or adverse change in resident's condition."

ll. Iowa Administrative Code § 481-58.15(2) states specific requirements for a resident's clinical record. Specifically, § 481-58.15(2)(e) requires the record to contain "physician's orders for medication, treatment, and diet in writing and signed by the physician quarterly." § 481-58.15(2)(h)(2) requires the clinical record to contain a nurse's record, including, in relevant part, "routine notes including physician's visits, telephone calls to and from the physician; unusual incidents and accidents; change of condition....".

mm. Iowa Administrative Code § 481-58.18(2) "*Nursing care.* Residents shall be protected against hazards to themselves and others or the environment."

nn. Iowa Administrative Code § 481-58.19(135C) "*Required nursing services for residents.* The program plan for nursing facilities shall have the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules."

oo. Iowa Administrative Code §481-58.19(2) "*Medication and treatment.* (a) Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (b) Wound care; (c) Blood glucose monitoring; (d) Vital signs, blood pressure, and weights; (e) Ambulation and transfer, (f) Provision of restraints; (g) Administration of oxygen (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (h) Provision of all treatments; (i) Provision of emergency medical care, including arranging for transportation, in accordance with written policies and procedures of the facility; (j) Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition."

pp. Iowa Administrative Code § 481-58.28 (135C) "*Safety.* The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel."

qq. Iowa Administrative Code § 481-39(3): "*Residents' rights in general.* Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that: (a) Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts; and (b) As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities."

rr. Iowa Administrative Code § 481-58.39(9) (in relevant part): "*Residents' rights in general.* Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the

planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services... In the case of a confused or mentally retarded individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, [and] to be informed of the medical condition."

ss. Iowa Administrative Code § 481-58.40 (135C) "*Involuntary discharge or transfer.* (1) A facility shall not involuntarily discharge or transfer a resident from a facility except: For medical reasons. (a) 'Medical reasons' for transfer or discharge are based on the resident's needs and are determined and documented in the resident's record by the attending physician. Transfer or discharge may be required to provide a different level of care."

tt. Iowa Administrative Code § 481-58.43(135C) "*Resident abuse prohibited.* Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse.

uu. Iowa Administrative Code § 481-58.45(135C): "*Dignity preserved.* The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs."

61. These regulations were enacted for the benefit or protection of a class of the public, of which Gene and Mildred Bozarth were members at all times material to this action. These rules also set the minimum standard of care to be given to residents such as Gene and Mildred Bozarth.

62. Danville Care Center violated these regulations in negligently caring for Gene and Mildred Bozarth and other similarly situated patients at Danville Care Center.

63. As a proximate result of the violation of the regulations by Defendants' negligence *per se* against Gene and Mildred Bozarth resulted in pain, suffering, emotional distress and economic damages set forth in this Petition.

COUNT 5: NEGLIGENCE OF SARAH WINGATE

64. Plaintiffs re-allege the above paragraphs.
65. At all times material to this action, Sarah Wingate was an employee of Danville Care Center, employed as a CNA, and owed a duty of reasonable care to Gene and Mildred Bozarth.

66. All actions by Ms. Wingate, relative to this action, were done while she was an employee, or apparent employee, of Danville Care Center acting within the course and scope of her employment or apparent employment.

67. Based upon information and belief, Ms. Wingate was negligent in, among other things: (1) failing to properly install the necessary body alarm on Gene Bozarth; (2) failing to adequately supervise Gene Bozarth; and (3) leaving Gene Bozarth unattended in his room without an adequate alarm and without his wife, Mildred Bozarth, being present with him.

68. As a proximate result of Ms. Wingate's negligence, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 6: NEGLIGENCE OF LINDA HAMPTON

69. Plaintiffs re-allege the above paragraphs.

70. At all times material to this action, Linda Hampton was an employee of Danville Care Center, employed as a LPN, and had a duty of reasonable care to Gene and Mildred Bozarth.

71. All actions by Ms. Hampton, relative to this action, were done while she was an employee, or apparent employee, of Danville Care Center acting within the course and scope of her employment or apparent employment.

72. Based upon information and belief, Ms. Hampton was negligent in, among other things: (1) failing to adequately and accurately assess, diagnose, and treat Gene Bozarth's injuries as a result of his fall; (2) failing to call the doctor on call to discuss Gene Bozarth's condition; and (3) failing to call Gene Bozarth's emergency contacts.

73. As a proximate result of Ms. Hampton' negligence, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 7: NEGLIGENCE OF NICHELLE BERNAND

74. Plaintiffs re-allege the above paragraphs.
75. At all times material to this action, Nichelle Bernand was an employee of Danville Care Center, employed as a LPN, and had a duty of reasonable care to Gene and Mildred Bozarth.

76. All actions by Ms. Bernand, relative to this action, were done while she was an employee, or apparent employee, of Danville Care Center acting within the course and scope of her employment or apparent employment.

77. Based upon information and belief, Ms. Bernand was negligent in, among other things, failing to perform neurological examinations of Gene Bozarth during the hours after his fall and injury.

78. As a proximate result of Ms. Bernand's negligence, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 8: NEGLIGENCE OF DONNA WHITAKER

79. Plaintiffs re-allege the above paragraphs.
80. At all times material to this action, Donna Whitaker was an employee of Danville Care Center, employed as a RN, and had a duty of reasonable care to Gene and Mildred Bozarth.

81. All actions by Ms. Whitaker, relative to this action, were done while she was an employee, or apparent employee, of Danville Care Center acting within the course and scope of her employment or apparent employment.

82. Based upon information and belief, Ms. Whitaker was negligent in, among other things, failing to adequately and accurately assess Gene Bozarth's injuries as a result of his fall.

83. As a proximate result of Ms. Whitaker's negligence, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 9: NEGLIGENCE OF MASHELL BELZER

84. Plaintiffs re-allege the above paragraphs.
85. At all times material to this action, Mashell Belzer was an employee of Danville Care Center, employed as a director of nursing, and had a duty of reasonable care to Gene and Mildred Bozarth.

86. All actions by Ms. Belzer, relative to this action, were done while she was an employee, or apparent employee, of Danville Care Center acting within the course and scope of her employment or apparent employment.

87. Based upon information and belief, Mashell Belzer was negligent in, among other things: (1) failing to adequately and accurately assess Gene Bozarth's injuries as a result of his fall; and (2) failing to inform Gene Bozarth's family of the true extent of his injuries, indicating instead that his injuries were limited to his wrist and that there was no rush to take Mr. Bozarth to the emergency room.

88. As a proximate result of Ms. Belzer's negligence, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 10: NEGLIGENCE AND NEGLIGENCE PER SE OF HEALTHCARE OF IOWA, INC

89. Plaintiffs re-allege the above paragraphs.
90. The license for Danville Care Center, provided by the State of Iowa and produced by Defendants, is granted to Healthcare of Iowa, Inc., as Licensee, and lists Healthcare of Iowa, Inc. as the owner of Danville Care Center. The license is attached hereto as Exhibit “A”.

91. Iowa Administrative Code § 481-58.9(135C) requires a licensee to do the following:

a. Assume the responsibility for the overall operation of the nursing facility;

b. Be responsible for compliance with all applicable laws and with rules of the department; and

c. Establish written policies, which shall be available for review, for the operation of the nursing facility.

92. Additionally, Iowa Administrative Code § 481-58.28(135C) requires: “The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment.

93. Healthcare of Iowa, Inc., through Danville Care Center, has knowingly and negligently violated applicable rules and laws as stated above.

94. In addition, Healthcare of Iowa, Inc. has knowingly and negligently failed to comply with the state of Iowa's required duties of a nursing facility licensee. Such failures include, but are not limited to, the following: (1) failure to ensure the overall operation of Danville Care Center is in compliance with state and federal guidelines; (2) failure to establish appropriate written policies, including but not limited to policies pertaining to transfer of residents who require specific accommodations (such as needing to be transferred with a spouse); and (3) failure to ensure the provision and maintenance of a safe environment at Danville Care Center.

95. As a proximate result of Healthcare of Iowa, Inc.'s negligence, Gene and Mildred Bozarth suffered the harm set forth in this petition.

COUNT 11: NEGLIGENCE OF MILLENNIUM REHAB & CONSULTING GROUP. INC. and GREAT RIVER THERAPEUTICS. P.C.

96. Plaintiffs re-allege the above-paragraphs.

97. Upon information and belief, Millennium Rehab & Consulting Group, Inc. and Great River Therapeutics, P.C. provided physical therapy and occupational therapy to Gene and Mildred Bozarth.

98. Defendants Millennium Rehab & Consulting Group, Inc. and Great River Therapeutics, P.C. owed a duty of reasonable care to Gene and Mildred Bozarth. Such duty included, but was not limited to, informing Danville Care Center of the status of Mr. Bozarth's condition and progress, and informing Danville Care Center of observations relevant to Mr. Bozarth's health and safety.

99. Defendants Millennium Rehab & Consulting Group, Inc. and Great River Therapeutics, P.C. breached said duty of reasonable care to Gene and Mildred Bozarth, and was otherwise negligent. Said negligence included, but was not limited to failing to adequately instruct, inform, and otherwise warn Danville Care Center that Mr. Bozarth presented a risk of falling;

100. As a proximate result of Defendants Millennium Rehab & Consulting Group, Inc. and Great River Therapeutics, PC's negligence, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 12: NEGLIGENCE OF DIVERSACARE, LLC

101. Plaintiffs re-allege the above paragraphs.
102. Based upon information and belief, Defendant DiversaCare, LLC provided consulting services, including but not limited to nursing, dietary needs, Medicare consulting and billing, survey preparation, risk management and plan of correction implementation.

103. Defendant DiversaCare, LLC owed a duty of reasonable care to Gene and Mildred Bozarth. Such a duty included, but was not limited to: (1) ensuring nursing and dietary needs were met, and in accordance with state and federal regulations, laws, and statutes; (2) ensuring Danville Care Center was in compliance with state and federal regulations, laws and statutes pertaining to policies and procedures, plans of care, and environmental safety; and (3) ensuring Danville Care Center appropriately implemented plans of correction.

104. Defendant DiversaCare, LLC breached said duty of reasonable care to Gene and Mildred Bozarth, and was otherwise negligent. Said negligence included, but was not limited to: (1) failing to provide and implement proper care plans that would adequately meet Gene Bozarth's needs, including his risk of falling; (2) failing to have adequate and effective policies, procedures, staff and equipment to adequately care for Gene Bozarth; (3) failing to follow policies and procedures currently in place; (4) failing to ensure a safe living environment to Gene Bozarth; (5) failing to ensure that humane care was provided to Gene Bozarth; (6) failing to ensure that Gene Bozarth was free from physical **neglect**; (7) failing to ensure truthful, complete and accurate medical records were kept for Gene Bozarth; (8) failing to ensure compliance with state law and the Iowa Administrative Code with regard to the care provided to Gene Bozarth; and (9) failing to ensure appropriate plans of correction were implemented by Danville Care Center, in order to prevent incidents (such as the fall, and subsequent death, of Gene Bozarth) from occurring

105. As a proximate result of Defendant DiversaCare, LLC's negligence, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 13: BREACH OF FIDUCIARY DUTY

106. Plaintiffs re-allege the above paragraphs.

107. At all times material to this action, the decedent, Gene Bozarth, was entrusted to the care, treatment, and exclusive care, custody, and control of Danville Care Center. Moreover, Gene Bozarth, due to age and infirmity, was unable to care for himself, and was entirely dependent upon the care promised by Danville Care Center.

108. At all times material to this action, Danville Care Center was in a position of trust and influence over Gene Bozarth, and had a duty to care for and protect Gene Bozarth.

109. At all times material to this action, a fiduciary relationship existed between Danville Care Center and the Gene and Mildred Bozarth.

110. The Defendants breached their fiduciary duty to Gene and Mildred Bozarth.

111. As a proximate result of Defendants' wrongful conduct, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 14: FRAUD

112. Plaintiffs re-allege the above paragraphs.
113. On or around March 25, 2009, Gene and Mildred Bozarth entered into a contract with Danville Care Center, at which time Gene and Mildred Bozarth became residents of Danville Care Center.

114. Prior to and at the time of executing the above-mentioned contract on March 25, 2009, Danville Care Center made various representations to Gene and Mildred Bozarth, and their family, regarding the nature of the facility, as well as the type of care, treatment, and benefits they would receive as residents of Danville Care Center.

115. Such representations included, but were not limited to the contention that Danville Care Center was a fully licensed nursing home, in compliance with state and federal law, which would include having in its employ a medical director to fulfill all of the obligations set forth by law. In fact, Danville Care Center failed to employ a medical director that fulfilled required obligations. Instead, a medical director was employed in name only. This medical director ratified the actions of Danville Care Center without any investigation or personal verification that Danville Care Center was actually fulfilling its duties to residents and complying with the requirements of law.

116. Such representations were false, misleading, and untrue, and at the time such representations were made, Danville Care Center knew said representations were false, misleading, and untrue, and were made for the purpose of inducing persons, including Gene and Mildred Bozarth, to agree to become residents of Danville Care Center.

117. Such representations were material and were made by Danville Care Center with the intent to deceive Gene and Mildred Bozarth and their family.

118. In reasonable and actual reliance upon the truth of said representations, Gene and Mildred Bozarth, along with their family, entrusted Gene and Mildred Bozarth to the care, treatment, and benefits of Danville Care Center.

119. During the time of their stay at Danville Care Center, Gene and Mildred Bozarth shared a room together, and each paid approximately $4000 per month to Danville Care Center for the care, treatment, and benefits they were promised.

120. By virtue of the relationship between Gene Bozarth and the Defendants, a fiduciary duty existed. Said relationship formed because Mr. Bozarth was totally dependent and vulnerable, he reposed trust and confidence in Defendants' fidelity and adherence to their obligations to provide care and comply with all legal, contractual and statutory obligations. Defendants thereafter owed

to Mr. Bozarth a fiduciary duty of utmost good faith and fair dealing. In particular and without limiting the generality of the foregoing, Defendants owed to Mr. Bozarth the duty to use sums paid by him or on his behalf for his benefit and to pay for the costs of his care and necessities and to provide the level of care and treatment to which it represented it would do so as a licensed facility as reflected in the applicable statutes, regulations, and its own admission agreement.

121. Defendants breached the aforesaid duty, as alleged, and in doing so gained an advantage over Gene Bozarth having received compensation from, or on behalf of, Mr. Bozarth and diverted said sums to themselves as profit (bonus or otherwise), and thereby were able to reduce patient-care-related expenses and to increase profit, all at Mr. Bozarth's further injury. Defendants, and each of them, have (as described above) negligently, intentionally and/or recklessly obtained substantial advantage over Mr. Bozarth.

122. As a result of such fraud, Gene Bozarth paid fees for services at Danville Care Center to Defendants. In taking the acts herein alleged, and in misappropriating said fees on a fraudulent basis, Defendants engaged in fiduciary abuse and constructive fraud. Defendants realized a profit from the practice of fraud as alleged.

123. At the time Gene Bozarth was admitted to Danville Care Center, Defendants (including their employees/agents, and representatives) knew that, according to their plan to increase profit at the expense of patients like Mr. Bozarth, the operation of Danville Care Center was not designed, not administered and not funded to comply with its statutory and regulatory responsibilities. Instead, Defendants knew the operation of Danville Care Center was designed to circumvent the legal duty to comply with applicable regulations and its own policies and procedures so as to maximize its profitability. Said knowledge stems from Defendants having previously been cited by regulatory bodies for failure to provide legally adequate care as specifically signed for by Teresa Minnis and Donald Chensvold on numerous occasions, and their concurrent failure to take corrective measures as herein alleged. By not taking corrective measures, Defendants were able to minimize investment of funds in the management and administration of their facilities, and maximize their profits.

124. This knowledge was exclusively in the possession of the Defendants, and neither Gene Bozarth, nor those acting on his behalf, had such knowledge and opportunity to obtain true information. In particular, Defendants concealed and failed to advise Mr. Bozarth of their past citations for failure to provide legally adequate care, and their failure to take corrective measures. Mr. Bozarth, and those acting on his behalf, assumed that Defendants properly ran the business operations of Danville Care Center in compliance with the law, and that the care offered to patients met all legally required standards. Mr. Bozarth, and those acting on his behalf, further assumed that Defendants applied appropriate funds to the management and administration of their facilities so as to provide the legally required standard of care.

125. Defendants, through their employees, agents and representatives, had a duty, based in part on their superior and exclusive knowledge that the facility was unable and did not intend to provide legally adequate care to Gene Bozarth, and was not administered, financed, organized or staffed to provide reasonably adequate care. Based on Defendants' understanding that Gene Bozarth and those acting on his behalf were not positioned to determine the true facts, and were relying on Defendants in the operation of Danville Care Center as a purportedly licensed facility, Defendants failed to disclose the fact that they could not and would not provide legally adequate care to Mr. Bozarth.

126. Defendants breached their duty to disclose said facts to Gene Bozarth with the intent of leading Mr. Bozarth, and those acting on his behalf, into believing that he would be properly cared for, and into becoming, and remaining, a resident at Danville Care Center.

127. Gene Bozarth, and those acting on his behalf, relied upon the assurance of Defendants, that Mr. Bozarth would be properly cared for in accordance with the law, and in accordance with Danville Care Center's policies and procedures, and its admission agreement and Resident's Bill of Rights. Accordingly, Mr. Bozarth was placed, and remained, as a resident at Danville Care Center, in the care of Defendants, in ignorance of the true facts.

128. As a proximate result of Danville Care Center's fraud, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

129. By virtue of the foregoing, Defendants have acted for the benefit of Defendants in violation of provisions of Federal and state law setting standards for the care of their patients, and for the financing and administration of said nursing homes.

COUNT 15: NEGLIGENT MISREPRESENTATION

130. Plaintiffs re-allege the above-paragraphs.
131. On or around March 25, 2009, Gene and Mildred Bozarth became residents of Danville Care Center.

132. Prior to and at the time of admission on March 25, 2009, Defendants represented orally and in writing, expressly and implicitly to the family of Gene Bozarth and others, that during his residency, Defendants would be alert to Mr. Bozarth's medical requirements and that he would be provided care which met legal standards, and suggested as fact that he would be properly cared for. Some of these representations were made in the Danville Care Center Brochure, attached hereto as Exhibit "B", and the "Welcome to Our Facility" form, attached hereto as Exhibit "C".

133. Some of these representations include, but are not limited to, the following:

a. Danville Care Center Brochure

i. Our Golden Rule: Treat each resident with respect, dignity, and understanding with which we expect to be treated; give to each resident the love and kindness which we hope to receive."

ii. "Danville Care center is a... 24-hour skilled nursing facility."

iii. "**Elders** and families alike can have peace of mind knowing every room is linked to an emergency call system."

iv. "Our conscientious, caring staff is always here to lend a helping hand."

v. "The ultimate goal is to achieve the highest level of independence possible and attain or regain the highest possible quality of life for as long as possible."

b. Danville Care Center "Welcome to our Facility" form:

i. "Our purpose is to provide maximum quality of care so that life here will be comfortable and as much like home as possible."

ii. "We realize, as you do, that life here will never be exactly like home, but we will do all that we can to create an atmosphere of comfort and harmony. We care about you-your feelings and your needs, and through open communication these needs will be met."

iii. "Not all long-term care facilities offer the same care or facilities. We accept only those persons whose needs, as determined by a qualified physician, can be met by us."

iv. "Your dignity as a human being will be preserved. You will receive kind, considerate treatment and care at all times."

v. "You are to be aware of and fully informed of your medical condition unless your physician orders otherwise. You are encouraged to participate in the planning of your medical treatment and total care. Either through participation or your physician, you will always know what is going on."

vi. “We want you to like it here and we will do all that we can to attain this goal.”

134. Defendants additionally represented to the public at large (including Gene and Mildred Bozarth, and their family), and to the public by representations to the licensing and certification authorities, that they would comply with the laws, statutes and regulations governing nursing homes, when in fact they had no basis to reasonably believe this. In fact, based on their past record of citations, and the fact that their statutorily-required medical director performed none, or nearly none, of his required duties, Defendants could not reasonably believe that they would comply relevant statutes, regulations and laws.

135. Said representations and suggestions were false, known to be false when made, and were made without a reasonable basis for believing them to be true. Said falsity and knowledge of said falsity is reflected, in part, in the past record of violations and citations for similar conduct, and the failure of Defendants to take corrective measures after having received notice of deficiencies.

136. Said representations and suggestions were made for the purpose of inducing Gene Bozarth to become a resident at Danville Care Center, and keeping him as a resident, so that Defendants could earn fees paid by or on behalf of Mr. Bozarth for his care which would purportedly comply with the legal standards.

137. Gene Bozarth and his family relied upon said representations on the assumption that they were true. Accordingly, Mr. Bozarth became, and remained, a resident at Danville Care Center to his detriment. This detriment included paying fees to Defendants for a level of care he did not receive and subsequent demise due to the substandard care he did receive.

138. Defendants were in a superior position to know the true facts regarding their inability and unwillingness to comply with laws, statutes, and regulations, and the probable risk of harm that presented to Gene Bozarth.

139. As a legal result of the representations, Gene Bozarth has been damaged as alleged.

COUNT 16: BREACH OF CONTRACT BY DANVILLE CARE CENTER

140. Plaintiffs re-allege the above paragraphs.
141. At all times material to this action, Defendant Danville Care Center executed enforceable contracts with Gene and Mildred Bozarth, including, but not limited to, Contract Between Resident and Danville Care Center, Admission Agreement, and Resident's Bill of Rights. The Contract is attached hereto as “Exhibit D”, the Admission Agreement is attached hereto as Exhibit “E”, and the Resident's Bill of Rights is attached here to as Exhibit “F”.

142. Defendant Danville Care Center violated contracts with Gene and Mildred Bozarth. The violations include, but are not limited to:

a. Failure to provide appropriate services as required by state and federal law;

b. Failure to provide timely and adequate assessments;

c. Failure to develop an adequate care plan, including failing to update the care plan when indicated;

d. Failure to provide safe and appropriate surroundings;

e. Failure to provide adequate medical care;

f. Failure to employ a reasonably competent Medical Director;

g. Failure to install necessary bodily alarm(s) on Mr. Bozarth prior to the fall at issue in this action;

h. Failure to inform physician and family of adverse change in condition; and.

i. Failure to timely transfer Mr. Bozarth when his care could not be provided for at Danville Care Center.

143. The violations were willful, wanton and in reckless disregard for the safety and wellbeing of Gene Bozarth.

144. As a proximate result of Danville Care Center's breach of contract, Gene Bozarth suffered those damages set forth in this Petition.

COUNT 17: PREMISES LIABILITY

145. Plaintiffs re-allege the above-paragraphs.
146. Upon information and belief, and at all times material to this action, Defendant Danville Development Company owned the land and improvements that house Danville Care Center, located at 401 S. Birch Street, Danville, IA. Upon further information and belief, Danville Care Center operated its skilled care nursing home at said facility, and exercised some control over the premises, together with Danville Development Company.

147. In addition, according to Iowa Administrative Code § 481-58.28 (135C), Healthcare of Iowa, Inc., as licensee of Danville Care Center, was required to "be responsible for the provision and maintenance of a safe environment for residents and personnel."

148. Defendants Danville Care Center, Danville Development Company, and Healthcare of Iowa, Inc. had a duty to maintain the premises in a safe condition for residents, and in particular for those such as Gene Bozarth who were totally dependent on the staff for all of their needs.

149. Upon information and belief, Defendants Danville Care Center, Danville Development Company, and Healthcare of Iowa, Inc. knew or in the exercise of reasonable care should have known of a condition on the premises at 401 S. Birch Street, Danville, IA and that it involved an unreasonable risk of injury to a person in the position of Gene Bozarth. Such conditions included, but were not limited to, unsafe clutter and wheelchairs in the hallways of said facility.

150. Said Defendants knew, or in the exercise of reasonable care should have known, that Gene Bozarth would not discover the condition, or that he would not realize the condition presented an unreasonable risk of injury, or he would not protect himself from the condition.

151. Said Defendants were negligent in allowing the dangerous condition to exist, and in failing to properly and reasonably protect Gene Bozarth from such condition.

152. As a proximate result of said Defendants' negligence, Gene and Mildred Bozarth suffered the harm set forth in this Petition.

COUNT 18: LOSS OF CONSORTIUM

153. The Plaintiffs re-allege all of the above paragraphs.

154. At all times material to this action, the decedent, Gene Bozarth, was survived by his wife, Mildred Bozarth, and their natural born children, Carolyn Jean Williams, Charlette Ann Mendenhall, Nancy Vanderwier and Wayne Bozarth.

155. As a direct and proximate result of the wrongful and negligent conduct of the Defendants, described and set forth above, Gene Bozarth's widow and surviving children have been deprived of the society, comfort, support, companionship, services and consortium of their husband and father,

156. Mildred Bozarth is entitled to obtain damages for loss of support and consortium prior to the death of Gene Bozarth. Wayne Bozarth, as Executor of the Estate of Gene Bozarth, is duly authorized and entitled to obtain damages for loss of support and consortium on behalf of Mildred Bozarth, Carolyn Jean Williams, Charlette Ann Mendenhall, Nancy Vanderwier, and Wayne Bozarth, with the exception of pre-death loss of support and consortium for Mildred Bozarth, which she seeks on her own behalf.

COUNT 19: PUNITIVE DAMAGES

157. Plaintiffs re-allege all of the above paragraphs.
158. At all times material to this action, the conduct of the Defendants, described and set forth above, was outrageous and constituted a willful and wanton disregard for the rights and safety of others, including Gene and Mildred Bozarth.

159. The Defendants' outrageous, willful, and wanton conduct was a proximate cause of damage and injury to the Plaintiffs;

COUNT 20: CIVIL CONSPIRACY

160. Plaintiffs re-allege all of the above paragraphs.
161. At all times material to this action, each of the Defendants formed and participated in an agreement between each other to maintain a licensed nursing home facility for purpose of maximizing products at the expense of patient care and treatment. Said agreement included, but was not limited to, the following provisions: to inadequately hire, train, and employ necessary staffing, and to employee a medical director in name only, for a nominal amount, and whom was completely unaware of the day to day activities of Danville Care Center;

162. The Defendants committed the wrong(s) set forth above;

163. All of the Defendants conspired with Danville Care Center and actively participated in the conspiracy for the purpose of maximizing profits at the expense of patient care;

164. The above-mentioned conspiracy of the Defendants was a proximate cause of the damage and injury to the Gene and Mildred Bozarth, described more fully above.

JURY DEMAND

The Petitioners demand jury trial on all issues so triable under Iowa Law.

PRAYER

WHEREFORE, Plaintiffs hereby request the following relief against the above-mentioned Defendants, jointly and severally:

1. Compensatory damages in an amount to be determined at trial;

2. Punitive damages in an amount to be determined at trial

3. Plaintiffs' costs, pre and post judgment interest, attorneys fees, and for such other relief as the Court deems just and equitable.

Dated April 22, 2011.

By: <<signature>>

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