MISSOURI CIRCUIT COURT
TWENTY-FIRST JUDICIAL CIRCUIT
ST. LOUIS COUNTY

ANGELA THOMPSON as surviving granddaughter of decedent NELLIE WILKS on her claim for wrongful death	)	
	)	Cause No. _____
vs.	)	
	)	Division No. _____
THE WOODLANDS OF MARYLAND HEIGHTS, LLC d/b/a PARKWOOD SKILLED NURSING AND REHABILITATION CENTER, Serve: Greg S. Spence 1749 Gilsinn Lane Fenton, MO 63026	)	
and	)	
RILEY-SPENCE MANAGEMENT COMPANY, L.L.C. Serve: Greg S. Spence 1749 Gilsinn Lane Fenton, MO 63026	)	**JURY TRIAL DEMANDED**
and	)	
RILEY-SPENCE PROPERTIES NO. 2, L.L.C. Serve: Charles J. Riley 1749 Gilsinn Lane Fenton, MO 63026	)	
and	)	
RILEY-SPENCE & ASSOCIATES, INC. Serve: Greg S. Spence 1749 Gilsinn Lane Fenton, MO 63026	)	
and	)	
RILEY-SPENCE PROPERTIES, L.L.C. Serve: Charles J. Riley 1749 Gilsinn Lane Fenton, MO 63026	)	
and	)	

RILEY-SPENCE PROPERTIES NO. 3, L.L.C.)
Serve: Greg S. Spence)
1749 Gilsinn Lane)
Fenton, MO 63026)
and)
)
MID-AMERICA HEALTH CARE LIMITED)
PARTNERSHIP,)
Serve: Greg S. Spence)
1749 Gilsinn Lane)
Fenton, MO 63026)
and)
)
CHARLES J. RILEY)
Serve: 1749 Gilsinn Lane)
Fenton, MO 63026)
and)
)
GREG S. SPENCE)
Serve: 1749 Gilsinn Lane)
Fenton, MO 63026)
and)
)
C. ELAINE SPENCE)
Serve: 1749 Gilsinn Lane)
Fenton, MO 63026)
)
Defendants.)

PETITION

COMES NOW Angela Thompson, by and through her attorney, DAVID W. TERRY of the TERRY LAW FIRM, L.L.C., and for her causes of action against defendants, states:

THE PARTIES

1. Nellie Wilks died on October 26, 2008 as a result of negligent care she received at Parkland Skilled Nursing & Rehabilitation Center ("hereinafter Parkwood Skilled Nursing and

Rehabilitation Center"), specifically the development of pressure sores that became deep and infected.

2. Plaintiff Angela Thompson is the granddaughter of Nellie Wilks and is a qualified claimant to pursue a wrongful death cause of action pursuant to Section 537.090 of the Missouri Revised Statutes.

3. Defendant The Woodlands of Maryland Heights, L.L.C. ("The Woodlands"), is a corporation doing business as Parkwood Skilled Nursing and Rehabilitation Center, which is located at 3201 Lane, Maryland Heights, Missouri 63043. At all relevant times, The Woodlands provided services to Parkwood Skilled Nursing and Rehabilitation Center, operated or had an ownership interest in and/or management responsibilities at Parkwood Skilled Nursing and Rehabilitation Center, a proprietary nursing home operating under Missouri's Omnibus Nursing Home Act as a skilled nursing facility. At all relevant times, The Woodlands of Maryland Heights, L.L.C. was in business for the care and treatment of persons in need of nursing home care.

4. Defendant Riley-Spence Management Company, L.L.C. provided services to Parkwood Skilled Nursing and Rehabilitation Center, operated or had an ownership interest in and/or management responsibilities at Parkwood Skilled Nursing & Rehabilitation Center, a proprietary nursing home operating under Missouri's Omnibus Nursing Home Act and subject to state and federal regulations. At all relevant times, Riley-Spence Management Company, L.L.C. was in business for the care and treatment of persons in need of nursing home care.

5. Defendant Riley-Spence Properties No. 2, L.L.C. provided services to Parkwood Skilled Nursing and Rehabilitation Center, operated or had an ownership interest in and/or management responsibilities at Parkwood Skilled Nursing and Rehabilitation Center, a proprietary

nursing home operating under Missouri's Omnibus Nursing Home Act and subject to state and federal regulations. At all relevant times, Riley-Spence Properties No. 2, L.L.C. was in business for the care and treatment of persons in need of nursing home care.

6. Defendant Riley-Spence & Associates, L.L.C. provided services to Parkwood Skilled Nursing and Rehabilitation Center, operated or had an ownership interest in and/or management responsibilities at Parkwood Skilled Nursing and Rehabilitation Center, a proprietary nursing home operating under Missouri's Omnibus Nursing Home Act and subject to state and federal regulations. At all relevant times, Riley-Spence & Associates, L.L.C. was in business for the care and treatment of persons in need of nursing home care.

7. Defendant Riley-Spence Properties, L.L.C. provided services to Parkwood Skilled Nursing and Rehabilitation Center, operated or had an ownership interest in and/or management responsibilities at Parkwood Skilled Nursing and Rehabilitation Center, a proprietary nursing home operating under Missouri's Omnibus Nursing Home Act and subject to state and federal regulations. At all relevant times, Riley-Spence Properties, L.L.C. was in business for the care and treatment of persons in need of nursing home care.

8. Defendant Riley-Spence Properties No. 3, L.L.C. provided services to Parkwood Skilled Nursing and Rehabilitation Center, operated or had an ownership interest in and/or management responsibilities at Parkwood Skilled Nursing and Rehabilitation Center, a proprietary nursing home operating under Missouri's Omnibus Nursing Home Act and subject to state and federal regulations. At all relevant times, Riley-Spence Properties No. 3, L.L.C. was in business for the care and treatment of persons in need of nursing home care.

9. Defendant Mid-America Healthcare Limited Partnership ("Mid-America") provided services to Parkwood Skilled Nursing and Rehabilitation Center, a proprietary nursing home operating under Missouri's Omnibus Nursing Home Act and subject to state and federal regulations. At all relevant times, Mid-America Health Care Limited Partnership was in business for the care and treatment of persons in need of nursing home care. Moreover, Mid-America Healthcare Limited Partnership is considered the "Home Office" for the Parkwood facility as well as other nursing home and assisted living businesses owned, operated, and/or managed by defendants Charles J. Riley, Gregory S. Spence, and C. Elaine Spence and their myriad of corporate interests, including the defendant companies named herein.

10. Upon information and belief, defendant Charles J. Riley is a resident of the state of Missouri. At certain times material to this action, Charles J. Riley formed The Woodlands of Maryland Heights, L.L.C. d/b/a Parkwood Skilled Nursing and Rehabilitation Center, Riley-Spence Management Company, L.L.C., Riley-Spence Properties No. 2, L.L.C., Riley-Spence & Associates, Inc., Riley-Spence Properties, L.L.C., Riley-Spence Properties No. 3, L.L.C., and Mid-America Healthcare Limited Partnership (hereinafter collectively referred to as the "Corporate Defendants") to further the business of his nursing home operations in Missouri.

11. Defendant Charles J. Riley was an equity owner, was the sole or substantial majority owner, chief executive officer, the sole member or sole managing member, an employee, and a member of the governing boards of the Corporate Defendants.

12. Defendant Charles J. Riley negotiated with himself for management services provided by Riley-Spence Management Company, L.L.C., to The Woodlands of Maryland Heights,

L.L.C. d/b/a Parkwood Skilled Nursing and Rehabilitation Center. He also negotiated with himself for favorable terms associated with the building lease between Riley-Spence Properties No. 2, L.L.C. and The Woodlands of Maryland Heights, L.L.C. d/b/a Parkwood Skilled Nursing and Rehabilitation Center.

13. The agreements defendant Charles J. Riley negotiated with himself are solely for the benefit of himself and the other individual and Corporate Defendants named herein except The Woodlands of Maryland Heights, L.L.C. d/b/a Parkwood Skilled Nursing and Rehabilitation Center, where residents such as Nellie Wilks are to receive care.

14. In fact, the agreements defendant Charles J. Riley negotiated with himself are designed to decrease the financial resources available to the Parkwood facility where residents such as Nellie Wilks are to receive care.

15. While exercising control of the Parkwood Skilled Nursing and Rehabilitation Center facility, Charles J. Riley periodically visited the facility and other facilities he owns in whole or in part.

16. Charles J. Riley retained the power to hire and terminate at will employees of the Parkwood Skilled Nursing and Rehabilitation Center facility and the other facilities he owns in whole or in part.

17. Charles J. Riley received additional compensation for his role as a member of the Corporate Defendants and was responsible for overall management and planning of the operations of Parkwood Skilled Nursing and Rehabilitation Center. Charles J. Riley directly participated in creating conditions at Parkwood Skilled Nursing and Rehabilitation Center, which

led to the injuries incurred by Nellie Wilks by directing or authorizing the manner in which the facility's cost-cutting, budget and staffing was instituted with no regard for the discretion and the interest of Parkwood Skilled Nursing and Rehabilitation Center or its residents, including Nellie Wilks. Charles J. Riley created a budgetary and staffing strategy, which minimized employee quantity, employee quality, safety, training, and supervision in order to maximize profits.

18. The direct participation and control of the Corporate Defendants and Charles J. Riley over Parkwood Skilled Nursing and Rehabilitation Center went beyond mere oversight and commission of acts consistent with any investor or owner.

19. Upon information and belief, Charles J. Riley has also worked as administrator of the Parkwood Skilled Nursing and Rehabilitation Center facility in the past.

20. Upon information and belief, defendant Gregory S. Spence is a resident of the state of Missouri. At certain times material to this action, Gregory S. Spence was an ownership partner, along with defendant Charles J. Riley in the Corporate Defendants to further the business of his nursing home operations in Missouri.

21. Defendant Gregory S. Spence was a part owner, member, an employee, and a member of the governing boards of the Corporate Defendants.

22. In his various capacities with these entities, defendant Gregory S. Spence was responsible for overall management and planning of the operations of Parkwood Skilled Nursing and Rehabilitation Center. Gregory S. Spence directly participated in creating conditions at Parkwood Skilled Nursing and Rehabilitation Center, which led to the injuries incurred by Nellie Wilks by directing or authorizing the manner in which the facility's cost-cutting, budget and

staffing was instituted with no regard for the discretion and the interest of Parkwood Skilled Nursing and Rehabilitation Center or its residents, including Nellie Wilks. Gregory S. Spence created a budgetary and staffing strategy, which minimized employee quantity, employee quality, safety, training, and supervision in order to maximize profits.

23. While exercising control of the Parkwood Skilled Nursing and Rehabilitation Center facility, Gregory S. Spence periodically visited the facility and other facilities he owns in whole or in part in Missouri.

24. Gregory S. Spence retained the power to hire and terminate at will employees of the Parkwood Skilled Nursing and Rehabilitation Center facility and the other facilities he owns in whole or in part.

25. Gregory S. Spence received additional compensation for his role or resident care function as a member of the Corporate Defendants and was responsible for overall management and planning of the operations of Parkwood Skilled Nursing and Rehabilitation Center.

26. The direct participation and control of the Corporate Defendants and Gregory S. Spence personally over Parkwood Skilled Nursing and Rehabilitation Center went beyond mere oversight and commission of acts consistent with any investor or owner.

27. Upon information and belief, Gregory S. Spence has also worked as administrator of the Parkwood Skilled Nursing and Rehabilitation Center facility in the past.

28. Upon information and belief, defendant C. Elaine Spence is a resident of the state of Missouri. At certain times material to this action, C. Elaine Spence was an ownership partner,

along with defendants Charles J. Riley and Gregory S. Spence in the Corporate Defendants to further the business of her nursing home operations in Missouri.

29. Defendant C. Elaine Spence was a part owner, member, an employee, and a member of the governing boards of the Corporate Defendants.

30. In her various capacities with these entities, defendant C. Elaine Spence was responsible for overall management and planning of the operations of Parkwood Skilled Nursing and Rehabilitation Center. C. Elaine Spence directly participated in creating conditions at Parkwood Skilled Nursing and Rehabilitation Center, which led to the injuries incurred by Nellie Wilks, by directing or authorizing the manner in which the facility's cost-cutting, budget and staffing was instituted with no regard for the discretion and the interest of Parkwood Skilled Nursing and Rehabilitation Center or its residents, including Nellie Wilks. C. Elaine Spence created a budgetary and staffing strategy, which minimized employee quantity, employee quality, safety, training, and supervision in order to maximize profits.

31. While exercising control of the Parkwood Skilled Nursing and Rehabilitation Center facility, C. Elaine Spence periodically visited the facility and other facilities she owns in whole or in part in Missouri.

32. C. Elaine Spence retained the power to hire and terminate at will employees of the Parkwood Skilled Nursing and Rehabilitation Center facility and the other facilities she owns in whole or in part.

33. C. Elaine Spence received additional compensation for her role or resident care function as a member of the Corporate Defendants and was responsible for overall management and planning of the operations of Parkwood Skilled Nursing and Rehabilitation Center.

34. The direct participation and control of the Corporate Defendants and C. Elaine Spence personally over Parkwood Skilled Nursing and Rehabilitation Center went beyond mere oversight and commission of acts consistent with any investor or owner.

35. At all times relevant herein, defendants received payment from Medicare and Medicaid to provide nursing home care, treatment, and related services and was subject to the requirements of 42 USCA §1396r (1990) et seq., as amended by The Omnibus Budget Reconciliation Act of 1987 ("OBRA") and Volume 42, Code of Federal Regulations, Part 483 setting forth Medicare and Medicaid requirements for long-term facilities ("OBRA Regulations"), as effective on October 1, 1990.

36. At all times relevant to this Petition, Parkwood Skilled Nursing and Rehabilitation Center was a "nursing facility" as defined by 42 U.S.C.A. **§**1396r.

37. At all relevant times, defendants controlled or had the right to control the clinical and financial aspects of operation of Parkwood Skilled Nursing and Rehabilitation Center. Moreover, defendants exercised consistent oversight of Parkwood Skilled Nursing and Rehabilitation Center in the form of daily, weekly, monthly, and annual reporting and monitoring.

38. At all relevant times, defendants received funds and profited from the funds received by Parkwood Skilled Nursing and Rehabilitation Center from residents either by private pay, Medicare, Medicaid or other payor sources.

39. At all relevant times herein mentioned, defendants acted by and through their agents, servants and employees who acted within the scope and course of their agency and employment.

40. Defendants were engaged in a joint venture-enterprise during Nellie Wilks' residency at Parkwood Skilled Nursing and Rehabilitation Center. Each defendant had a shared community of interest in the object and purpose of the undertaking for which the nursing home known as Parkwood Skilled Nursing and Rehabilitation Center was being operated/used. Each defendant had an equal right to share in the control of the operation of the nursing home during Nellie Wilks' residency regardless of whether such right was actually exercised.

41. The defendants controlled the operation, planning, management, and quality control of the nursing home facility. The authority exercised by the defendants over the nursing facility included, but was not limited to, control of marketing, human resources management, training, staffing, creation and implementation of policy and procedure manuals used by the nursing home facility, federal and state Medicare and Medicaid reimbursement, quality care assessment and compliance, licensure and certification, legal services, and financial, tax, and accounting control through fiscal policies established by the defendants.

42. These companies operated as a joint venture/enterprise for the purpose of streamlining and furthering their similar business interests, as all entities were ultimately controlled by the same corporation or individuals.

43. At all relevant times mentioned herein, the defendants owned, operated and/or controlled, either directly or through the agency of each other and/or other diverse subalterns,

agents, subsidiaries, servants, or employees the operation of the Parkwood Skilled Nursing and Rehabilitation Center facility.

44. Because the Defendants named herein were engaged in a joint venture/enterprise before and throughout Nellie Wilks' residency, the acts and omissions of each participant in the joint venture/enterprise are imputable to all other participants. The actions of the defendants and each of its servants, agents and employees as set forth herein, are imputed to each of the defendants, jointly and severally.

COUNT I – WRONGFUL DEATH

45. Plaintiff incorporates by reference each and every allegation set forth in paragraphs 1 – 44 as though fully set forth herein.

46. On or about July 7, 2008, Nellie Wilks became a resident of Parkwood Skilled Nursing and Rehabilitation Center.

47. When admitted to Parkwood Skilled Nursing and Rehabilitation Center, Ms. Wilks had no pressure sores and no open areas on her skin. She was completely dependent upon the defendants for all of her needs, including proper nourishment, hydration, and turning and repositioning to remain free of pressure sores.

48. Upon her admission to Parkwood Skilled Nursing and Rehabilitation Center, Ms. Wilks's was able to feel pain and remained able to feel pain to the day of her death.

49. Upon her arrival at the facility, employees determined that Ms. Wilks would benefit from restorative care and a repositioning program although defendants failed to complete these processes in a timely and meaningful way.

50. Ms. Wilks was completely dependent upon defendants to provide her with sufficient nourishment through the gastric tube she had in place upon her arrival at Parkwood Skilled Nursing and Rehabilitation Center. On July 16, 2008, nine days after her admission to Parkwood Skilled Nursing and Rehabilitation Center, defendants completed a dietary evaluation that determined that her current diet was insufficient to meet her daily caloric or nutritional needs. Despite this finding, no changes were made to Ms. Wilks diet at that time.

51. In fact, no follow-up dietary assessment was done for Ms. Wilks until August 20, 2008 which is 35 days after defendants determined that Ms. Wilks was not receiving her daily nutritional needs. During these 35 days, Parkwood records reflect that Ms. Wilks had lost approximately 24 pounds and developed a serious sacral pressure ulcer.

52. In direct violation of state and federal regulations, Ms. Wilk's physician and family members were not notified that she was not receiving proper nutrition or of her significant weight loss.

53. Thirteen days after her arrival, defendants prepared a Care Plan that, among other things, identified that Ms. Wilks was a risk for developing pressure sores due to decreased mobility and incontinence of bowel and bladder. Defendants failed or refused to regularly complete the approaches they identified that would keep Ms. Wilks from developing pressure ulcers.

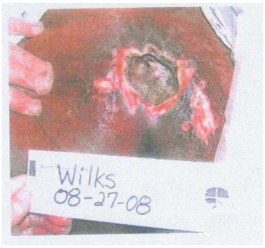
54. Due to the location of Ms. Wilks sacral pressure sores and the propensity for urine and feces to enter the wound, defendants had a duty to regularly keep Ms. Wilks clean and dry. Defendants failed in this duty and left Ms. Wilks to languish in urine and feces, causing skin breakdown and infection.

55. In addition to being a significant risk for developing pressure sores, Ms. Wilks was at risk for developing urinary tract infections. Defendants failed or refused to complete the steps necessary to prevent Ms. Wilks from developing a urinary tract infection.

56. As a direct result of defendants actions and omissions, Ms. Wilks developed a urinary tract infection, lost significant weight, developed two pressure sores on her sacrum, with one or both becoming infected, and developed osteomylitis.

57. On August 27, 2008, Nellie Wilks was transferred to Select Specialty Hospital where she was determined to be suffering from malnutrition and a large infected pressure sore measuring 3 ½ inches x 3 inches with black necrotic material and a very foul odor.

58. Upon her arrival at Select Specialty Hospital the pressure sores on Ms. Wilks looked as pictured here:



59. Due to the location of Ms. Wilks' pressure sores and the propensity for urine and feces to enter the wound, Ms. Wilks underwent a diverting colostomy procedure on September 23, 2008. At the time of this surgery, Ms. Wilks' wound was a deep stage IV sacral wound with exposed sacral bone.

60. Ms. Wilks remained at Select Specialty Hospital until her death on October 26, 2008.

DEFENDANTS OWED DUTIES TO NELLIE WILKS

61. At all relevant times, defendants had a duty to provide Nellie Wilks with appropriate and reasonable levels of medical attention within the established professional standards of care.

62. At all relevant times, defendants owed Nellie Wilks as their patient and nursing home resident, the duty to exercise that degree of care and learning ordinarily exercised under the same or similar circumstances by members of the community of duly licensed health care providers, nursing home owners, operators, managers, agents and employees, and in particular, defendants owed Nellie Wilks the duty to take steps necessary to prevent Nellie Wilks from:

a. Developing pressure sores;

b. Becoming malnourished and losing significant weight;

c. Developing a urinary tract infection;

d. Developing wound infections;

e. Developing osteomylitis; and

f. Experiencing severe pain as a result of her injuries.

63. At all relevant times, defendants had a duty to refrain from abusing or neglecting Nellie Wilks.

64. At all relevant times, defendants had a duty to prevent Nellie Wilks from being inflicted with physical injury or harm.

65. Defendants owed Nellie Wilks a duty to keep her free from mental and/or physical abuse.

66. Defendants also owed Nellie Wilks a duty to treat her with consideration and respect and with full recognition of her dignity and individuality.

67. At all relevant times, defendants had a duty to hire, retain and supervise employees and agents who knew of and were competent to comply with the state and federal requirements associated with nursing home care.

68. At all relevant times, the defendants and their agents were required to follow state and federal rules and regulations in the care and treatment of Nellie Wilks.

69. At all relevant times, defendants had a duty to provide sufficient financial resources to the Parkwood facility so the facility could meet its regulatory obligations to its residents, such as Nellie Wilks.

70. The defendants and their agents had a non-delegable duty to provide appropriate medical care to Nellie Wilks and to ensure that their employees and agents exercised that degree of skill and learning ordinarily exercised by members of the employees' professions.

71. During the 2007 annual survey, Parkwood Skilled Nursing and Rehabilitation Center was cited for failing to give professional services that meet a professional standard of quality. That citation was purportedly corrected in 2007, however, the facility was cited for that same problem in the 2008 annual survey.

72. During the 2007 annual survey, Parkwood Skilled Nursing and Rehabilitation Center was cited for failing to give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores. That citation was purportedly corrected in 2007, however, the facility was cited for that same problem in the 2008 annual survey.

73. During the 2007 annual survey, Parkwood Skilled Nursing and Rehabilitation Center was cited for failing to make sure residents who cannot care for themselves receive help with eating/drinking, grooming and hygiene. That citation was purportedly corrected in 2007, however, the facility was cited for that same problem in the 2008 annual survey.

74. During the 2008 annual survey, Parkwood Skilled Nursing and Rehabilitation Center was cited for failing to make sure that each resident's nutritional needs were met.

75. During the 2008 annual survey, Parkwood Skilled Nursing and Rehabilitation Center was cited for failing to make sure residents with reduced range of motion get proper treatment and services to increase range of motion.

76. During her residency at Parkwood Skilled Nursing and Rehabilitation Center, Nellie Wilks did not receive professional services that met a professional standard of quality, did not receive proper treatment to prevent new bed (pressure) sores or heal existing bed sores, did not receive assistance with eating/drinking, grooming and hygiene to the level she required, did not have her nutritional needs met and did not get proper treatment and services to increase range of motion.

77. As a result of the prior deficiencies received by Parkwood Skilled Nursing and Rehabilitation Center, defendants had sufficient notice to know that they had problems in the very areas in which Ms. Wilks subsequently suffered. Yet, despite this notice, defendants failed or refused to correct the deficient care.

78. Defendants and their agents had a non-delegable duty to provide management services to Nellie Wilks and, in the operation, management and supervision of Parkwood Skilled

Nursing and Rehabilitation Center, to place resident safety above profit, to provide sufficient resources and training to permit Parkwood Skilled Nursing and Rehabilitation Center, its agents and employees to:

a. Provide each resident with twenty-four hour protective oversight, personal attention and medical care in accord with his/her condition;

b. Provide medical care consistent with acceptable practice;

c. Provide sufficient personnel properly trained in their duties;

d. Provide each resident an environment free from mental and physical abuse; and

e. Provide each resident with consideration, respect and full recognition of his/her dignity and individuality.

79. In addition to the general duties with which defendants failed to comply, defendants and their agents breached their duties to Nellie Wilks and were guilty of acts of negligence in violating regulations governing skilled nursing facilities, including, but not limited to one or more of 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). All facilities shall develop policies and procedures to insure the residents' health and safety;

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

e. 19 C.S.R. 30-85.042(16). All persons who have contact with residents 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 education 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 the problems, needs, care of residents and infection control and is sufficient to ensure staff's continuing competency;

h. 19 C.S.R. 30-85.042(23). Facilities shall conduct at least annual in-service education for nursing personnel including training in restorative nursing. This training by a registered nurse or qualified therapist shall include: turning and repositioning for the bedridden resident, rang of motion (ROM) exercises, ambulation assistance, transfer procedures, bowel and bladder training and self-care activities of daily living;

i. 19 C.S.R. 30-85.042(34). All facilities shall employ a director of nursing on a full time basis who shall be responsible for the quality of patient care and supervision of personnel rendering patient care;

j. 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;

k. 19 C.S.R. 30-85.042(38). Nursing personnel shall be on duty at all times on each resident-occupied floor;

l. 19 C.S.R. 30-85.042(42). Each facility resident shall be under the medical supervision of a Missouri-licensed physician who has been informed of the

facility's emergency medical procedures and is kept informed of treatments or medications prescribed by any other professional lawfully authorized to prescribe medications;

m. 19 C.S.R. 30-85.042(43). Facilities shall ensure that at the time the resident is admitted, the facility obtains from a physician the resident's primary diagnosis along with current medical findings and written orders for the immediate care of the resident;

n. 19 C.S.R. 30-85.042(44). The facility shall ensure that the resident's private physician, the physician's designee, the facility's supervising physician or an alternative physician shall examine the resident at least annually, and shall examine the resident as often as necessary to ensure proper medical care;

o. 19 C.S.R. 30-85.042(45). For each medical examination, the physician must review the resident's care, including medications and treatments; write, sign and date progress notes; and sign and date all orders. The facility shall establish a policy requiring the physician to sign orders and to complete all other documentation required if the physician does not visit the resident routinely;

p. 19 C.S.R. 30-85.042(46). No medication, treatment or diet shall be given without a written order from a person lawfully authorized to prescribe such and the order shall be followed;

q. 19 C.S.R. 30-85.042(66). Each resident shall receive twenty-four (24) hour protective oversight and supervision;

r. 19 C.S.R. 30-85.042(67). Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice;

s. 19 C.S.R. 30-85.042(70). Residents who are physically or mentally incapable, or both, of changing their own positions shall have their positions changed at least every two (2) hours and shall be provided supportive devices to maintain good body alignment;

t. 19 C.S.R. 30-85.042(71). The facility must provide each resident the opportunity to access sufficient fluids to maintain proper hydration in accordance with the resident's medical condition and goals of treatment as documented in the medical record;

u. 19 C.S.R. 30-85.042(73). Facilities shall provide each resident, according to his/her needs, with restorative nursing to encourage independence, activity and self-help to maintain strength and mobility;

v. 19 C.S.R. 30-85.042(74). Each resident shall have skin care including the application of oil, lotion and cram as needed to prevent dryness and scaling of skin;

w. 19 C.S.R. 30-85.042(75). Facilities shall keep residents free from avoidable pressure sores, taking measures toward prevention. If sores exist, staff shall give adequate treatment;

x. 19 C.S.R. 30-85.042(79). In the event of accident, injury or significant change in the resident's condition, facility staff shall notify the resident's physician in accordance with the facility's emergency treatment policies which have been approved by the supervising physician;

y. 19 C.S.R. 30-85.042(80). In the event of accident, injury or significant change in the resident's condition, facility staff shall immediately notify the person designated in the resident's record as the designee or responsible party;

z. 19 C.S.R. 30-85.042(81). Staff shall inform the administrator of accidents, injuries or unusual occurrences which adversely affect, or could adversely affect, the resident. The facility shall develop and implement responsive plans of action;

aa. 19 C.S.R. 30-85.042(83). Facilities shall provide equipment and nursing supplies in sufficient number to meet the needs of the residents;

bb. 19 C.S.R. 30-85.042(93). The facility shall designate an employee to be responsible for the activity program. The designated personal shall be capable of identifying activity needs of residents, designing and implementing programs to maintain or increase, or both, the resident's capability in activities of daily living. Facilities shall provide activity programs on a regular basis. Each resident shall have a planned activity program which includes individualized activities, group activities and activities outside the facility as appropriate to his/her needs and interests;

cc. 19 C.S.R. 30-85.042(99)(B). Facilities shall ensure that the clinical record contains sufficient information to – Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident;

dd. 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) Changes(s) in physical, mental and psychosocial condition;
(C) Reasons for changes in treatment;

ee. 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 unity and systematically organized;

ff. 19 C.S.R. 30-85.052(1). Nutritional needs of residents shall be met and shall be based on the individual's circumstances, medical condition and goals and treatment as determined and justified by the physician. A qualified professional, such as a dietitian or registered nurse, shall regularly assess these needs and shall keep the physician informed of the nutritional status of the resident;

gg. 19 C.S.R. 30-88.010(20). Each resident shall be free from mental and physical abuse;

hh. 19 C.S.R. 30-88.010(24). Each resident shall be treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and care of his/her personal needs;

ii. 42 C.F.R. 483.10(b)(11)(i)(B). Notification of changes. A facility must 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 – 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);

jj. 42 C.F.R. 483.15. A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each residents quality of life. (a) Dignity. The facility must 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 his or her individuality;

kk. 42 C.F.R. 483.20(b)(1). Resident assessment. The facility must conduct initially and periodically as comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity….A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the state. The assessment must include at least the following:

(vi) Mood and behavior patterns;
(viii) Physical functioning and structural problems;
(ix) Continence;
(xi) Nutritional status; and
(xv) Special treatments and procedures;

ll. 42 C.F.R. 483.20(g). Accuracy of assessment. The assessment must accurately reflect the resident's status;

mm. 42 C.F.R. 483.25(a)(1)(2)(3). Quality of Care. Each resident must receive and the facility must 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.

(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that –

(1) A resident's abilities in activities of daily living to not diminish unless circumstances of the individuals clinical condition demonstrate that diminution was unavoidable…..;
(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and
(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal oral hygiene;

nn. 42 C.F.R. 483.25(c). Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that –

(1) A resident who enters the facility without pressure sores dos not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing;

oo. 42 C.F.R. 483.25(e). Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that –

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion;

pp. 42 C.F.R. 483.25(f)(1) . Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that --

(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem;

qq. 42 C.F.R. 483.25(i). Nutrition. Based on a resident's comprehensive assessment, the facility must 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; and

(2) Receives a therapeutic diet when there is a nutritional problem;

rr. 42 C.F.R. 483.25(j). Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health;

ss. 42 C.F.R. 483.30(a)(1). Nursing services. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident, as determined by resident assessments and individual plans of care….The facility must provide services by sufficient numbers of each of the following types of personnel on a 24 hour basis to provide nursing care to all residents in accordance with resident care plans…;

tt. 42 C.F.R. 483.75(b). Administration. A facility must 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….The facility must 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; and

uu. 42 C.F.R. 483.75(l)(i)(ii). Clinical records. The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented.

80. Defendants failed to provide a sufficient number of employees to care for Nellie Wilks and the other residents of Parkwood Skilled Nursing and Rehabilitation Center.

81. Defendants failed to provide sufficient training and supervision of employees to provide the care required by state and federal regulations as well as the local community.

82. Defendants failed to provide sufficient funding to the Parkwood facility so that it could provide sufficient care to Nellie Wilks and other residents. In fact, defendants actively defunded the facility through a series of related party transactions designed solely to enrich the individual defendants at the expense of the Parkwood residents.

83. As a direct and proximate result of the negligence of defendants as set forth in the above numbered paragraphs, Ms. Wilks suffered a lack of dignity, serious, permanent, debilitating and disfiguring bodily injuries; malnutrition, pressure sores, infection, osteomylitis, severe pain, and ultimately death.

84. The deprivations Ms. Wilks suffered was the result of actions or omissions by the defendants – and each of them – all of which caused the physical pain and suffering to Ms. Wilks.

85. Plaintiff also incurred expenses for Ms. Wilks, funeral and burial all as a direct result of defendants' negligence.

86. Such conduct by defendants justifies exemplary or punitive damages.

WHEREFORE, plaintiff requests judgment against defendants in an amount that is fair and reasonable in excess of the jurisdictional minimum, for actual damages, for exemplary/punitive damages, attorney fees, costs, prejudgment interest, and for such other relief as this Court deems just and proper.

COUNT II - NEGLIGENCE PER SE

87. Plaintiff incorporates by reference each and every allegation set forth in paragraphs 1 – 86 as though fully set forth herein.

88. As the owners, operators, managers and/or medical director of skilled nursing care and residential care facilities licensed by the State of Missouri and accepting Medicare and Medicaid funds, defendants were subject to regulations promulgated by the Missouri Division of Social Services and under the Social Security Act.

89. Nellie Wilks was a member of the class of persons intended to be protected by the enactment of these regulations.

90. The negligence of the defendants in violating the regulations was willful, wanton, and outrageous, constituted gross negligence, and demonstrated conscious and reckless disregard for the rights of Nellie Wilks, thereby allowing the consideration of aggravating and punitive damages.

91. Parkwood Skilled Nursing and Rehabilitation Center is a licensed nursing home as that term is understood in law, therefore Parkwood Skilled Nursing and Rehabilitation Center, its owners, operators, managers, employees and agents were at all times material to this lawsuit, required by statute to comply with the rules and regulations set forth above.

92. As a result of said violations, which are negligent per se, Nellie Wilks was injured, suffered, and died.

WHEREFORE, plaintiff requests judgment against defendants in an amount that is fair and reasonable in excess of the jurisdictional minimum, for actual damages, for exemplary/punitive damages, attorney fees, costs, prejudgment interest, and for such other relief as this Court deems just and proper.

COUNT III- NEGLIGENT SUPERVISION

93. Plaintiff incorporates by reference each and every allegation set forth in paragraphs 1 – 92 as though fully set forth herein.

94. Defendants had a duty to supervise the agents and employees that provided care to Nellie Wilks.

95. The actions taken by defendants with respect to Nellie Wilks were within the area of defendants duty to supervise.

96. Defendants failed to use ordinary care in performing their duties to supervise the agents and employees that were providing care and services to Nellie Wilks.

97. It was foreseeable to defendants that its failure to supervise their agents and employees would result in the type of damages incurred by Nellie Wilks all as identified above and incorporated herein.

98. Defendants failure to supervise amounted to negligence that directly caused Nellie Wilks' damages.

99. As a direct and proximate result of defendants' repeated wrongful acts and

omissions while Nellie Wilks was a resident at Parkwood Skilled Nursing and Rehabilitation Center, Ms. Wilks suffered the following serious and permanent damages:

a. Pressure sores;

b. Malnourished and losing significant weight;

c. Urinary tract infection;

d. Wound infections;

e. Osteomylitis; and

f. Severe pain.

100. Defendant's conduct justifies punitive or exemplary damages.

WHEREFORE, plaintiff requests judgment against defendants in an amount that is fair and reasonable in excess of the jurisdictional minimum, for actual damages, for exemplary/punitive damages, attorney fees, costs, prejudgment interest, and for such other relief as this Court deems just and proper.

COUNT IV- PUNITIVE/EXEMPLARY DAMAGES

101. Plaintiff incorporates by reference each and every allegation set forth in paragraphs 1 – 100 as though fully set forth herein.

102. Defendants' acts and omissions were, willful, wanton, malicious, so reckless as to be in utter disregard to the consequences and in conscious disregard to the health and well-being of Nellie Wilks.

103. Defendants' intentional acts or omissions caused Nellie Wilks to suffer a lack of dignity, serious, permanent, debilitating and disfiguring bodily injuries; malnutrition, pressure sores, infection, osteomylitis, severe pain, and ultimately death.

104. Such conduct justifies punitive or exemplary damages.

WHEREFORE, plaintiff requests judgment against defendants in an amount that is fair and reasonable in excess of the jurisdictional minimum, for actual damages, for exemplary/punitive damages, attorney fees, costs, prejudgment interest, and for such other relief as this Court deems just and proper.

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