UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK
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LORI LAROCK, as Administratrix of the Estate of ROGER A. SANFORD,

Plaintiff,

JURY TRIAL DEMANDED

-against-

___ Civ. No. _____

ALBANY COUNTY NURSING HOME; THE COUNTY OF ALBANY; LARRY SLATKY; DEBBIE GOSSMAN; RHONDA LYGA; JOHN AND JANE DOES #1-5;

Defendants.
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Plaintiff Lori LaRock, as Administratrix of the Estate of her father, Roger A. Sanford, by and through her attorneys, Emery Celli Brinckerhoff & Abady LLP, for her Complaint alleges as follows:

THE CALLOUS AND CRUEL ALBANY COUNTY NURSING HOME

1. Imagine this nightmare: a daughter shows up at a nursing home. Her father is in a room. He is drenched in sweat. He is gasping for breath. His oxygen tube is dangling from his nose. No one is with him. No one is helping him. He is fighting for his life, alone.

2. The daughter runs into the hallway, screaming for help. No one helps. She finds nursing home staff, begging for help for her father. They offer none.

3. She runs back to his room. He is still alone, gasping for breath. She frantically calls 911. But it is too late. By the time the ambulance arrives, the emergency medical team cannot save his life.

4. This is no dream, but what actually happened on March 1, 2018, when Lori LaRock found her father Roger Sanford dying alone in the Albany County Nursing Home (the "Nursing Home").

5. Even worse, for months before Mr. Sanford's death, this taxpayer-funded facility left Mr. Sanford unchanged, unfed, unmedicated, unwashed, unshaven, and even covered in his own urine and feces.

6. Ms. LaRock had complained repeatedly about her father's mistreatment to the Executive Director of the Nursing Home, Larry Slatky. In response, Slatky told her any complaint to the New York State Department of Health ("DOH") would be "lost," because his employee had a relative at DOH. When Ms. LaRock said she took a photo of her father covered in vomit, Slatky screamed at her. When Ms. LaRock asked Slatky for his email address so she could email him the photo or a complaint of mistreatment, he refused. When Ms. LaRock managed to email Slatky anyway, he ignored the email.

7. Slatky did nothing to help Mr. Sanford. Slatky had only one concern: to cover-up the Nursing Home's misconduct.

8. After Mr. Sanford's death, the Department of Health conducted an investigation. It found that the Nursing Home and its staff violated not one, not two, but three separate federal laws. They failed to give Mr. Sanford "basic life support, including CPR." They failed to give him "treatment and care in accordance with professional standards of practice." They failed to provide "respiratory care."

9. They also failed to call 911, failed to invoke emergency protocols, and even failed merely to be in the same room with a man struggling for his own life.

10. Roger Sanford was the loving husband of Lois Sanford; father of Lori LaRock, Susan LaRock and John Sanford; and grandfather to seven grandchildren and three great-grandchildren. Mr. Sanford led a successful career working for the American Red Cross, Parsons Child and Family Center, and for multiple group homes for persons with disabilities. He did not deserve to die like this.

11. Now it is time this Nursing Home, its director Mr. Slatky, and its staff be held accountable for their callous and cruel treatment of this helpless man.

JURISDICTION AND VENUE

12. This Court has jurisdiction pursuant to 28 U.S.C. § 1331. This action arises under 42 U.S.C. § 1396, *et seq.* and under the Fourteenth Amendment to the Constitution of the United States pursuant to 42 U.S.C. § 1983.

13. Venue is proper in this district under 28 U.S.C. § 1391(b).

14. On May 25, 2018, Ms. LaRock filed a notice of claim pursuant to General Municipal Law § 50-i.

15. On July 19, 2018, Ms. LaRock testified at a hearing pursuant to General Municipal Law § 50-h.

THE PARTIES

16. Plaintiff LORI LAROCK resides in Saratoga County in Clifton Park, New York. She is the administratrix of her father Roger Sanford's estate. Before his death, Mr. Sanford resided at Albany County Nursing Home in Albany, New York.

17. Defendant ALBANY COUNTY NURSING HOME was at all relevant times the Nursing Home where Mr. Sanford resided. As such, the Nursing Home was responsible for Mr. Sanford's safety, security, well-being, and medical care.

18. Defendant the COUNTY OF ALBANY was at all relevant times a municipal corporation responsible for the administration of the Nursing Home. The County was the employer of all Nursing Home employees. As such, it was responsible for Mr. Sanford's safety, security, well-being, and medical care.

19. Defendant LARRY SLATKY was at all relevant times the Executive Director of the Nursing Home. As such, he was responsible for Mr. Sanford's safety, security, well-being, and medical care.

20. Defendant DEBBIE GOSSMAN was at all relevant times the nursing supervisor at the Nursing Home. As such, she was responsible for Mr. Sanford's safety, security, well-being, and medical care.

21. Defendant RHONDA LYGA was at all relevant times a licensed practical nurse at the Nursing Home. As such, she was responsible for Mr. Sanford's safety, security, well-being, and medical care.

22. Defendants JOHN AND JANE DOES #1-5 were at all relevant times Nursing Home employees responsible for Mr. Sanford's safety, security, well-being, and medical care.

23. Gossman, Lyga, and John and Jane Does #1-5 are referred to collectively as the "Staff Defendants." Slatky and the Staff Defendants are referred to collectively as the "Individual Defendants."

24. At all relevant times, all Defendants acted within the scope of their employment by Albany County Nursing Home and the County of Albany and acted under color of the laws, statutes, and ordinances, regulations, policies, customs, and usages of the State of New York.

FACTUAL ALLEGATIONS

25. In August 2017, Mr. Sanford's family placed him into Albany County Nursing Home.

26. Mr. Sanford was seventy-three years old. He suffered from Alzheimer's disease and multiple forms of heart disease.

27. Mr. Sanford was in poor health, and his Alzheimer's and overall worsening mental state had begun to prevent him from performing basic tasks, such as dressing himself, feeding himself, or taking his daily medications, without assistance. This need for constant assistance and supervision, beyond that which his elderly wife and daughter could provide, led Mr. Sanford's family to place him in a nursing home.

I. The Nursing Home Neglects Mr. Sanford

28. From the beginning of Mr. Sanford's stay at the Nursing Home, the home was chronically understaffed, and Mr. Sanford's most basic needs were neglected.

29. Ms. LaRock regularly arrived at the nursing home to find her father unwashed, unshaven, unchanged, and even covered in his own urine and feces.

30. On at least one occasion, Ms. LaRock found her father covered in his own urine only to be told that the Nursing Home was "short staffed" and that she would have to change him; otherwise, he would not be changed in the near future.

31. Another time, Ms. LaRock arrived to find her father only partially dressed—laying in bed with his shirt half on and hanging over the back of his neck with his chest and stomach exposed.

32. The Nursing Home often failed to feed Mr. Sanford. Ms. LaRock and her husband would frequently arrive to find Mr. Sanford sitting in bed with his dinner tray in front of him, unable to eat because no staff would assist him.

33. Mr. Sanford lost almost 20 pounds during his first four months at the Nursing Home.

34. Making matters worse, Nursing Home staff failed to treat Mr. Sanford's severe medical conditions.

35. Nursing Home staff would provide Mr. Sanford with a nebulizer to treat his chronic obstructive pulmonary disease, but often left before the treatment was complete.

36. Mr. Sanford was not capable of addressing or understanding his medical conditions.

37. Without staff supervision, Mr. Sanford would remove the nebulizer and would not complete his necessary medical treatment.

II. Defendant Slatky Threatens Ms. LaRock for Complaining about her Father's Treatment

38. On or around December 6, 2017, Ms. LaRock called a staff social worker, Amy Bennet, to complain about her father's inadequate care and neglect.

39. Ms. LaRock asked that the conversation be kept confidential for fear staff would retaliate against her father if they found out she had complained.

40. Ms. Bennet stated she would discuss Ms. LaRock's concerns with Nursing Director Maureen Tomisman.

41. Ms. LaRock's request for confidentiality was not honored. Instead, when Ms. LaRock came to the Nursing Home that very day, a staff member angrily confronted her and sniped: "you don't have to tell on us."

42. Having lost trust in Ms. Bennet and Ms. Tomisman, Ms. LaRock called Defendant Larry Slatky, the Executive Director of the home.

43. Ms. LaRock and Mr. Slatky spoke on the phone.

44. Ms. LaRock explained to Mr. Slatky her concerns with her father's care as described above, and her new fear of retaliation against her father.

45. Ms. LaRock told Mr. Slatky that she had already moved her father out of two prior nursing homes and she had called DOH due to his poor care at those homes.

46. Mr. Slatky suggested Ms. LaRock stop by the staff Christmas Party at the Nursing Home that night to discuss her father's care.

47. When she arrived at the Nursing Home that evening, Mr. Slatky took Ms. LaRock into the hallway to speak with her.

48. Mr. Slatky did not address Ms. LaRock's concerns about her father's care.

49. Instead, Mr. Slatky threatened that any paperwork would be "lost" if Ms. LaRock complained about the Nursing Home to DOH.

50. Mr. Slatky boasted that a relative of a Nursing Home employee worked in the DOH department that receives complaints, and no complaint against the Nursing Home would see the light of day.

51. As Executive Director of the Nursing Home, Slatky had a responsibility to ensure that the Nursing Home was in compliance with all state and federal regulations.

52. As Executive Director of the Nursing Home, Slatky had a responsibility to ensure that all Nursing Home residents receive adequate care.

53. As Executive Director of the Nursing Home, Slatky had a responsibility to address specific complaints regarding patient care, including Ms. LaRock's complaints.

54. Instead of doing anything to help Ms. LaRock's father or keep him safe, Mr. Slatky threatened Ms. LaRock.

55. Unsurprisingly given his response, this meeting with Mr. Slatky did nothing to improve Mr. Sanford's care.

56. Ms. LaRock continued to find her father unchanged, unfed, unmedicated, and drenched in his own bodily fluids.

III. Mr. Sanford's Health Deteriorates; Slatky Tries to Bury Ms. LaRock's Complaints

57. On February 24, 2018, one week before Mr. Sanford's death, Ms. LaRock noticed that her father did not seem like himself. He appeared to have vomited in his bed earlier that day (which, of course, had not been cleaned up); he seemed lethargic and was not getting out of bed; he coughed more than usual; and his breathing seemed raspy.

58. Ms. LaRock asked to speak to the head of nursing, Defendant Debbie Gossman.

59. Ms. LaRock asked Ms. Gossman to send her father to the hospital for further evaluation of his condition.

60. Ms. Gossman refused to send Mr. Sanford to the hospital.

61. Instead, Ms. Gossman stated that the Nursing Home had a chest x-ray machine and that all necessary testing and observation could be done at the Nursing Home.

62. The Nursing Home did not perform a chest x-ray on Mr. Sanford between February 24, 2018 and his death one week later.

63. On February 26, Ms. LaRock called Defendant Slatky on the phone.

64. Ms. LaRock told Slatky that she had found her father covered in vomit two days earlier and that he seemed ill.

65. Slatky seemed unconcerned about her Mr. Sanford's health.

66. Ms. LaRock then mentioned that she had taken a picture of her father covered in his own vomit, which she wanted to show him.

67. Slatky immediately became defensive.

68. Slatky shouted to Ms. LaRock that the picture "can't prove anything."

69. Ms. LaRock asked for Slatky's email address, so she could send him the picture and he could see her father's neglectful treatment.

70. Slatky refused to provide his email address.

71. Ms. LaRock figured out Slatky's email address on her own.

72. On February 26, 2018, at 2:01p.m., Ms. LaRock emailed Slatky the picture of her father covered in vomit.

73. Four minutes later, Slatky read Ms. LaRock's email, as confirmed by a read receipt sent to Ms. LaRock.

74. Slatky never responded to the email, orally or in writing.

75. Slatky never even acknowledged the email.

76. Slatky did nothing to protect or care for Mr. Sanford.

77. Slatky did not send Mr. Sanford to the hospital.

78. On information and belief, Slatky spoke with no Nursing Home staff about improving Mr. Sanford's care, or providing him further medical attention.

79. Slatky's only apparent concern was burying Ms. LaRock's complaints.

IV. The Nursing Home Leaves Mr. Sanford to Die

80. March 1, 2018 was one week after Ms. LaRock had first reported to the Nursing Home that her father seemed ill.

81. On March 1 at 6:10 p.m., Ms. LaRock received a voicemail from Defendant Gossman.

82. The voicemail stated that Mr. Sanford was ill and that Ms. LaRock should call her back so that Ms. Gossman could "let [Lori] know what's going on."

83. Panicked, Ms. LaRock called the Nursing Home immediately.

84. The Nursing Home security guard paged Ms. Gossman twice but received no response.

85. Ms. LaRock immediately left for the Nursing Home to see her father, an approximately twenty-minute trip.

86. Ms. LaRock arrived to a nightmare.

87. Her father was laying unattended in his room in agony as he struggled to stay alive.

88. No Nursing Home staff was with Mr. Sanford.

89. Mr. Sanford was drenched in sweat.

90. He was violently gasping for air.

91. An oxygen tube hung from Mr. Sanford's nose.

92. Mr. Sanford wasn't actually breathing through the oxygen tube, because no Nursing Home staff was there to administer the oxygen.

93. Ms. LaRock screamed for help.

94. No one responded.

95. Ms. LaRock left her father's room, desperate to find someone to help her father.

96. Ms. LaRock found a nurse, Defendant Lyga, in the dining room nonchalantly passing out medication.

97. Ms. LaRock told Lyga that her father needed urgent help and expressed amazement that he had been left in his present condition.

98. Lyga did not deny that Mr. Sanford was in urgent need of medical care.

99. Lyga stated "I didn't leave him there, Debbie Gossman did."

100. In short, Lyga knew that Mr. Sanford was alone in his room, unattended, while in desperate need of medical care.

101. Lyga made no effort to help Mr. Sanford or to get him emergency medical attention.

102. On her way back to her father's room, Ms. LaRock encountered at least two other John/Jane Doe Nursing Home staff in the hallway.

103. Neither helped her father.

104. On information and belief, additional John/Jane Doe staff in the Nursing Home knew about Mr. Sanford's grave medical condition, yet abandoned Mr. Sanford as he lay dying in his room.

105. Ms. LaRock returned to her father's room.

106. Mr. Sanford was still alone.

107. He was still gasping for breath.

108. Ms. LaRock immediately called 911.

109. At some point before the paramedics arrived, Ms. Gossman finally strolled in to Mr. Sanford's room.

110. Gossman reacted with no urgency to Mr. Sanford's declining health.

111. Gossman offered Mr. Sanford no medical assistance.

112. Gossman again left Mr. Sanford unattended by any medical personnel.

113. Contemporaneous records from emergency paramedics state that when they arrived, Mr. Sanford was "found laying in hospital bed unresponsive in obvious respiratory failure near respiratory arrest," was pale and sweating excessively, and "was in need of immediate airway support."

114. However, there was "no facility staff in the room" and "no report from facility staff available."

115. Mr. Sanford was transferred to Albany Medical Center, where he was treated in the Emergency Room and then the Intensive Care Unit.

116. Doctors at the hospital informed Ms. LaRock that her father likely aspirated on his own vomit and they would do their best to treat him.

117. This medical care was too late.

118. Mr. Sanford lived for another day and a half on a ventilator.

119. Mr. Sanford tragically passed away on March 3, 2018.

120. Autopsy results confirm that he died of aspiration pneumonia.

V. The DOH Investigation Uncovers a Nursing Home Meltdown

121. Following her father's death, Ms. LaRock filed a complaint with DOH. DOH conducted an investigation, reviewed medical records, and interviewed various Nursing Home staff.

122. DOH interviewed two Nursing Home nurses.

123. DOH interviewed at least one Nursing Home doctor.

124. DOH interviewed the Nursing Home's Medical Director.

125. DOH interviewed the Nursing Home's Respiratory Therapist/Director.

126. The DOH Report is attached as Exhibit A

127. DOH concluded that the Nursing Home violated federal law.

128. DOH concluded that the Nursing Home committed three violations of federal regulations.

129. First, DOH found that the Nursing Home violated 42 C.F.R. § 483.24 by failing to provide Mr. Sanford with "basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives." Ex. A at 1-5.

130. This DOH finding is true.

131. On March 1, 2018, the Nursing Home and its employees, including the Staff Defendants, did not provide Mr. Sanford CPR prior to the arrival of emergency medical personnel.

132. Second, DOH found that the Nursing Home violated 42 C.F.R. § 483.25 by failing to "ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices," *id.* at 5-14.

133. This DOH finding is true.

134. The Nursing Home and its employees, including the Staff Defendants, failed to ensure that Mr. Sanford received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and Mr. Sanford's choices.

135. Third, DOH found that the Nursing Home violated 42 C.F.R. § 483.25(i) by failing to provide "respiratory care" and failing to ensure "that a resident who needs

respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences," *id.* at 15-19.

136. This DOH finding is true.

137. The Nursing Home and its employees, including the Staff Defendants, failed to provide Mr. Sanford respiratory care consistent with professional standards of practice, the comprehensive person-centered care plan, or Mr. Sanford's goals and preferences.

138. In the course of their investigation leading to these conclusions, DOH uncovered a host of additional troubling facts.

139. For example, between 5:30-6:00 p.m. on March 1st, Defendant Gossman noted that Mr. Sanford's temperature had risen to 101.9 degrees and, by 6:04 p.m. had risen to 103.4 degrees. *Id.*at 3, 8.

140. Gossman also noted that Mr. Sanford's lungs were "congested with expiratory wheeze." *Id.* at 8.

141. At approximately 6:15 p.m.—roughly fifteen minutes before Ms. LaRock arrived—Defendant Lyga noticed that Mr. Sanford's breathing was "heavier than normal and faster." *Id.* at 18.

142. Despite these warning signs, Defendants Gossman and Lyga merely increased his oxygen and gave him an antibiotic before twice leaving him unattended.

143. Gossman, Lyga, and the other Staff Defendants did not follow numerous nursing home policies.

144. They failed to confer with a doctor to ensure that Mr. Sanford received the appropriate oxygen level. *Id.* at 15.

145. They failed to document how much oxygen they provided. *Id.* at 16-17.

146. They failed to provide an ongoing assessment of Mr. Sanford's respiratory status, including his response to oxygen therapy. *Id.* at 18.

147. The Nursing Home procedures provided a system for actions to be taken in the case of a medical emergency: a Code E.

148. When an emergency is ongoing, Nursing Home staff are supposed to (i) announce that a Code E is in place so other Nursing Home personnel can respond, and (ii) stay with the patient. *Id.* at 2.

149. Staff Defendants, including Defendants Gossman and Lyga, did not follow these procedures.

150. As Mr. Sanford lay dying in his bed, the Nursing Home and Staff Defendants failed to announce a Code E.

151. At no point on March 1, 2018 did any Nursing Staff announce a Code E for Mr. Sanford.

152. No Nursing Home staff stayed with the patient.

153. They left him to die alone.

154. The Nursing Home's Director of Nursing since admitted that had proper protocol been followed, they "certainly would have gotten staff to [Mr. Sanford] sooner" and "[t]hat's why we have a system in place." *Id.* at 14.

155. Gossman admitted to the DOH that she didn't even know whether Mr. Sanford was a "full code" (meaning all emergency services and CPR should be provided to preserve his life) or a "do not resuscitate" (for whom staff is not supposed to perform CPR) until she was making copies of his paperwork for EMS. *Id.* at 4.

156. Making matters worse, a medical doctor at the Nursing Home admitted to DOH that:

i. after learning that Mr. Sanford's temperature had risen to 101.3, he gave nursing staff instructions to "call the resident's family regarding their preferred hospital to send the resident out to";
ii. Defendants Gossman and Lyga did not inform him that Mr. Sanford's temperature had risen to 103.4 until after Ms. LaRock called EMS;
iii. Gossman and Lyga did not tell him that Mr. Sanford's condition had visibly worsened since the nurse's initial report to him; and
iv. Gossman and Lyga should have called a "Code E," and staff, including Gossman and Lyga, should have prepared to start CPR.

Id. at 14-15.

157. All of those statements by the Nursing Home medical doctor are, on information and belief, true.

158. The Staff Defendants, including Gossman and Lyga, should have performed CPR on Mr. Sanford.

159. No defendant performed CPR on Mr. Sanford.

160. Had they performed CPR, Mr. Sanford would likely have lived.

161. The Nursing Home Medical Director also acknowledged that "as a physician, I would have expected the code to be called. Then they'd get a rapid response team." *Id.* at 15.

162. The Staff Defendants, including Gossman and Lyga, should have called a Code E.

163. None of the defendants called a Code E.

164. Had they called a Code E, Mr. Sanford would likely have lived.

165. DOH also correctly concluded that the Nursing Home did not ensure that Mr. Sanford's emergency status was known during a significant change in Mr. Sanford's

respiratory condition; did not promptly identify and intervene for an emergent change in Mr. Sanford's condition; did not transcribe a physician order for Mr. Sanford to receive two liters of oxygen; did not monitor his respiratory condition; and did not document the oxygen therapy that he ultimately received. *Id.* at 5, 16.

166. The Staff Defendants, including Gossman and Lyga, were obligated to comply with these obligations.

167. None of them did.

168. As a result of Defendants' failures and misconduct set forth above, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, and lost life and enjoyment of life.

VI. Prior Allegations of Slatky's Corruption

169. Before assuming his role as Executive Director of Albany County Nursing Home, Slatky was the Chief Operating Officer of Nassau Health Care Corp, overseeing the operations at publicly operated care facilities.

170. Prosecutors criminally charged Slatky with directing subordinates to award bids to provide services at health care facilities to company's operated by his friends. Even then, Slatky put his own interests above patient care. Slatky was ultimately acquitted after a bench trial.

171. The Nursing Home hired Slatky while under indictment with these criminal charges pending.

VII. Slatky Takes a Victory Lap

172. Seven months after Mr. Sanford's death, the Nursing Home accepted a Bronze National Quality Award from the American Health Care Association and National Center for Assisted Living.

173. In response, Slatky said in a news release: "The transformation that is taking place at the Nursing Home is nothing short of miraculous."

174. On information and belief, neither the Nursing Home nor Slatky told the AHCA/NCAL about the mistreatment and death of Roger Sanford.

COUNT ONE

(42 U.S.C. § 1983—Violation of Mr. Sanford's Right to Substantive Due Process)
(Individual Defendants)

175. Plaintiff repeats and realleges as if fully set forth herein the allegations contained in the foregoing paragraphs.

176. Defendants were at all times responsible for Mr. Sanford's well-being and medical care, and at all times acted under color of New York State law.

177. By their conduct as set forth above, Defendants had actual knowledge of, yet disregarded, an obvious or excessive risk of Mr. Sanford's death, as well as obvious risks to his health and well-being over many months.

178. By failing to provide Mr. Sanford with necessary day-to-day care such as washing him, changing his clothes, and feeding him; failing to supervise Mr. Sanford's breathing treatments; refusing to remedy these deficiencies despite multiple complaints from Ms. LaRock; refusing to send Mr. Sanford to the hospital or even to conduct a chest x-ray in-house despite his persistent vomiting in the week leading up to his death; failing to take necessary steps to protect Mr. Sanford's life; violating multiple federal regulations designed to ensure patient health, life,

and safety, including Mr. Sanford's health, life, and safety; failing to help Mr. Sanford or call for emergency medical help as he lay dying under the Nursing Home's own roof; burying and threatening to bury complaints of mistreatment and poor care of Mr. Sanford; and by their other misconduct set forth above, Defendants shocked the conscience, violated any norm of professional judgment, and were deliberately indifferent to Mr. Sanford's health and safety and to a known risk of serious and immediate risk of harm to him. Defendants' actions all but assured Mr. Sanford would suffer a painful and gruesome death.

179. Because of Defendants' violations of Mr. Sanford's constitutional rights, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, and lost life and enjoyment of life.

180. As a consequence, Ms. LaRock, as the administratrix of Mr. Sanford's estate, is entitled to compensatory and punitive damages against Defendants.

COUNT TWO

(42 U.S.C. § 1983—Violation of Mr. Sanford's Rights under the Federal Nursing Home Reform Amendments, 42 U.S.C. §§ 1396 et seq., and OBRA regulations, 42 C.F.R. §§ 483.1 et seq.)
(All Defendants)

181. Plaintiff repeats and realleges as if fully set forth herein the allegations contained in the foregoing paragraphs.

182. Mr. Sanford was a recipient of Medicare and Medicaid and was, at all relevant times, a resident of Albany County Nursing Home and, therefore, within the class of persons protected and granted an enforceable right under 42 U.S.C. §§ 1396 *et seq*., and OBRA regulations, 42 C.F.R. §§ 483.1 *et seq*.

183. Defendants at all times acted under color of New York State law.

184. As already set forth by DOH, Defendants' failure to provide Mr. Sanford with treatment and care in accordance with professional standards of practice, to provide him

with basic life support, or to provide with adequate respiratory care on March 1, 2018 alone violated his federally protected rights under the Federal Nursing Home Reform Amendments 42 U.S.C. §§ 1396 *et seq*., and implementing OBRA regulations, 42 C.F.R. §§ 483.24-483.25.

185. By the above misconduct, including but not limited to the misconduct that led to the DOH findings, Defendants deprived Mr. Sanford of his federally protected rights under the Federal Nursing Home Reform Amendments 42 U.S.C. §§ 1396r and implementing OBRA regulations 42 C.F.R. § 483.10 and 42 C.F.R. § 483.12, including his right to live in an environment that promotes maintenance or enhancement of his quality of life; his right to services in his nursing facility that provide reasonable accommodation of his needs; the right to have a resident physician consulted upon a significant change in Mr. Sanford's physical health; the right to a sanitary and comfortable environment, including a clean bed; the right to have actions taken to prevent future violations of these rights while past complaints are being investigated; and the right to be free from abuse and neglect in a nursing home.

186. Because of Defendants' violations of Mr. Sanford's federally protected rights, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, and lost life and enjoyment of life.

187. As a consequence, Ms. LaRock, as the administratrix of Mr. Sanford's estate, is entitled to compensatory and punitive damages against Defendants.

COUNT THREE
(Nursing Home Bill of Rights, New York Public Health Law § 2801-d)
(All Defendants)

188. Plaintiff repeats and realleges as if fully set forth herein the allegations contained in the foregoing paragraphs.

189. Mr. Sanford was, at all relevant times, a resident of Albany County Nursing Home and, therefore, within the class of persons protected and granted an enforceable right under New York Public Health Law § 2801-d.

190. By the above misconduct, Defendants deprived Mr. Sanford of his rights under New York Public Health Law §§ 2803-c(3)(e) & (3)(g), including the right "to receive adequate and appropriate medical care" and the right "to receive courteous, fair, and respectful care and treatment."

191. The Nursing Home's treatment of Mr. Sanford also violates his rights under the New York Compilation of Codes Rules and Regulations, enforceable through New York Public Health Law § 2801–d, including his right to a nursing home that provides the "necessary services to maintain good nutrition, grooming, and personal and oral hygiene" to residents who are unable to carry out activities of daily living, 10 NYCRR § 415.12(a)(3), and his right to a nursing home that ensures proper "respiratory care" to its residents, 10 NYCRR § 415.12(k)(6).

192. Defendant Slatky, as the Executive Director of the Nursing Home, was responsible for the Nursing Home's compliance with state regulation. His failure to make sure that Federal and State laws and regulations were implemented and adhered to, failure to ensure the adequacy of the Nursing Home's facilities and staffing, and failure to ensure that adequate plans of care were developed for its residents likewise violated Mr. Sanford's rights under New York Public Health Law § 2801–d.

193. Because of Defendants' violations of Mr. Sanford's rights, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, and lost life and enjoyment of life.

194. In addition to being liable in their own right, Defendants Albany County Nursing Home and Albany County, as employers of each of the Individual Defendants—are responsible for their wrongdoing under the doctrine of *respondeat superior*.

195. As a consequence, Ms. LaRock, as the administratrix of Mr. Sanford's estate, is entitled to compensatory and punitive damages against Defendants.

COUNT FOUR
(Negligence)
(All Defendants)

196. Plaintiff repeats and realleges as if fully set forth herein the allegations contained in the foregoing paragraphs

197. Because Mr. Sanford was under Defendants' care, supervision, and control, Defendants had a special relationship with him, and owed him a duty of care.

198. Defendants had a duty to use the highest degree of care in monitoring Mr. Sanford's health and safety, and ensuring he received emergency medical treatment when needed. Defendants also had a duty to ensure that Mr. Sanford was adequately fed, dressed, and medicated on a daily basis.

199. Defendants breached this duty by their misconduct set forth above.

200. Defendants Albany County Nursing Home and Albany County, as employers of each of the Individual Defendants—are responsible for their wrongdoing under the doctrine of *respondeat superior*.

201. Because of Defendants' negligence, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, anxiety, and lost life and enjoyment of life.

202. As a consequence, Ms. LaRock, as the administratrix of Mr. Sanford's estate, is entitled to compensatory and punitive damages against Defendants.

COUNT FIVE
(Medical Malpractice)
(Defendants Albany County Nursing Home, Albany County, Staff Defendants)

203. Plaintiff repeats and realleges as if fully set forth herein the allegations contained in the foregoing paragraphs

204. At all times relevant to this Complaint, Defendants undertook to provide medical care to residents of Albany County Nursing Home including Mr. Sanford, and were legally obligated and had a special duty to do so effectively.

205. The Defendants held themselves out as possessing the proper degree of learning and skill necessary to render medical care, treatment, and services in accordance with good and accepted medical practice, and that they undertook to use reasonable care and diligence in the care and treatment of the residents of Albany County Nursing Home, including Mr. Sanford.

206. By their misconduct above, Defendants acted contrary to sound medical practice and committed acts of medical malpractice against Mr. Sanford.

207. Defendants Albany County Nursing Home and Albany County, as employer of each of the Staff Defendants—are responsible for their wrongdoing under the doctrine of *respondeat superior*.

208. Because of Defendants' negligence, Mr. Sanford endured pain and suffering, pre-death terror, mental anguish, and lost life and enjoyment of life.

209. As a consequence, Ms. LaRock, as the administratrix of Mr. Sanford's estate, is entitled to compensatory and punitive damages against Defendants.

210. A certificate of merit pursuant to Section 3012-a of the New York Civil Practice Law and Rules is annexed to Plaintiff's Complaint.

JURY TRIAL DEMANDED

211. Plaintiff demands a trial by jury.

WHEREFORE, Plaintiff respectfully request judgment against Defendants as follows:

a. compensatory damages in an amount to be determined at trial;

b. punitive damages in an amount to be determined at trial;

c. reasonable attorneys' fees, costs and disbursements pursuant to the Civil Rights Attorney's Fee Awards Act of 1976, 42 U.S.C. § 1988 and New York Public Health Law § 2801-d(6); and

d. such other and further relief as this Court deems just and equitable.

Dated: New York, New York
May 21, 2019

EMERY CELLI BRINCKERHOFF & ABADY LLP

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