UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF TENNESSEE
CHATTANOOGA DIVISION

IN RE:	)	
	)	
NEW BEGINNINGS CARE, LLC,	)	CHAPTER 11
	)	CASE NO. 1:16-BK-10272-NWW
Debtor.	)	
	)	
	)	

NOTICE OF HEARING

Notice is hereby given that:

A hearing will be held Thursday, April 21, 2016 at 10:30 a.m. in the Historic U.S. Courthouse, Courtroom A, 31 East 11th Street, Chattanooga, TN 37402, on the following:

Motion for Relief From Automatic Stay Filed by the Estate of Vernell Hawkins, Jr.

If you do not want the court to grant the relief requested, you or your attorney must attend this hearing. If you do not attend the hearing, the court may decide that you do not oppose the relief sought in the Motion and may enter an order granting that relief.

THE ESTATE OF VERNELL HAWKINS, JR.'S
MOTION FOR PARTIAL RELIEF FROM THE AUTOMATIC STAY
TO ALLOW CIVIL LITIGATION TO PROCEED

COMES NOW, Carol Hawkins, as Personal Representative of the Estate of Vernell Hawkins, Jr., deceased, and on behalf of the wrongful death beneficiaries of Vernell Hawkins, Jr. ("Hawkins' Estate"), moves the Court to grant the estate relief from the automatic stay imposed by Section 362 of Title 11 of the United States Code (the "Bankruptcy Code") with respect to the Hawkins' Estate's personal injury action currently pending in the Circuit Court of Saline County, Arkansas. Said request for relief from stay is strictly limited to the amount of applicable insurance coverage of the Debtor, New Beginnings Care, LLC. In support of their Motion, the Hawkins' Estate respectfully submits the following:

Parties, Jurisdiction and Venue

1. On March 28, 2015, Debtor filed its petition with the Court for relief under Chapter 7 of the Bankruptcy Code.

2. This Motion is filed by the Hawkins' Estate pursuant to 11 U.S.C. § 362(d) to obtain relief from the automatic stay.

3. This Court has jurisdiction over this matter and over Debtor pursuant to 28 U.S.C. §§ 157 and 1334.

4. Venue over this matter is proper in this Court pursuant to 28 U.S.C. §§ 1408 and 1409.

5. This Motion constitutes a core proceeding which may be heard and determined by this Court pursuant to 28 U.S.C. §§ 157(b)(1) and 157(b)(2)(A) & (G).

Background

6. Prior to filing for relief under the Bankruptcy Code, Stoneybrook Healthcare & Rehab, LLC operated a nursing home known as Stoneybrook Health and Rehabilitation located at 3300 Military Road, Benton, Saline County, Arkansas.

7. Vernell Hawkins, Jr. was a resident of Stoneybrook Health and Rehabilitation from approximately September 25, 2013 until October 30, 2014. Mr. Hawkins died on December 22, 2014. New Beginnings Care, LLC actively participated in the ownership, operation, control, and management of Stoneybrook Health and Rehabilitation during the residency of Vernell Hawkins, Jr.

8. During his residency at Stoneybrook Health and Rehabilitation, Mr. Hawkins suffered numerous injuries resulting from the negligence of the Debtor including multiple

hospitalizations due to clogged PEG tube and tracheostomy; bedsores, including stage IV non-healing bedsore to sacrum; wound to right shoulder near trach collar; poor hygiene; UTIs; multiple infections; malnutrition; dehydration; pain; and death. As a result of these injuries, on November 19, 2015, the Hawkins' Estate filed a lawsuit against Stoneybrook Healthcare & Rehab, LLC, New Beginnings Care, LLC, and other related entities alleging negligence, medical negligence, breach of admissions agreement, breach of provider agreement, and violation of the Arkansas' Deceptive Trade Practices Act. *See* **Exhibit A**, file marked Complaint in the matter of *Carol Hawkins, as Personal Representative of the Estate of Vernell Hawkins, Jr., and on behalf of the wrongful death beneficiaries of Vernell Hawkins, Jr. v. Stoneybrook Healthcare & Rehab, LLC, New Beginnings Care, LLC, et. al.*; Saline County, Arkansas, Circuit Court Case No. 63CV-15-897.

9. After the Hawkins' Estate perfected service of the personal injury action against New Beginnings Care, LLC, New Beginnings served the Hawkins' Estate with an Answer as well as Notice of the instant bankruptcy action pending in this Court. *See* **Exhibit** B, Notice of Bankruptcy. Pursuant to 11 U.S.C. § 362, that matter is automatically stayed.

10. The claims asserted against New Beginnings Care, LLC by the Hawkins' Estate are covered by a Long Term Care Commercial Liability Policy issued by Columbia Casualty Company. *See* **Exhibit C**, policy declarations pages. The insurance policy provides coverage up to $1,000,000 for each claim and $3,000,000 aggregate. *Id.* at 2. New Beginnings Care, LLC is listed as the insured on the policy. *Id.* at 1.

Relief Requested

11. The Hawkins' Estate requests relief from the automatic stay to proceed with civil litigation in Saline County, Arkansas to determine the amount of and recover for the damages suffered by the Hawkins' Estate and for the purpose of allowing the entry of judgment up to the

amount of the insurance proceeds, as determined by the jury or otherwise agreed upon by the parties to that litigation.

12. With respect to the possibility of entry of judgment based on an award by a jury in excess of the insurance proceeds, the stay would remain in effect with respect to such excess judgment unless and until such time as this bankruptcy Court determines that the stay may be lifted to allow for the entry of said excess judgment.

13. Based on the above, the Hawkins' Estate seeks relief from the automatic stay "for cause" under 11 U.S.C. § 362(d)(1) to proceed to recover from Debtor's insurance coverage only and not from the bankruptcy estate.

14. Allowing the civil litigation to proceed and lifting the automatic stay with respect to entry of a judgment to the extent of the insurance coverage will cause no harm to the Debtor or the bankruptcy estate, as this Court would keep the stay in effect with respect to the entry of a judgment in excess of the available insurance coverage.

15. Section 362(d) authorizes relief from the stay if a party with an interest in property of the estate can demonstrate cause, or establish that the debtor has no equity in the property and that the property is not necessary to an effective reorganization. *In re Laguna Associates Ltd. P'ship*, 30 F.3d 734, 737 (6th Cir. 1994). "Cause" must be determined on a case-by-case basis. *Id.*; *See also In re Shivshankar Parnership, LLC*, 517 B.R. 812, 816-17 (Bankr. E.D. Tenn. 2014).

16. As the legislative history of Section 362 shows "it will often be more appropriate to permit proceedings to continue in their place of origin, when no great prejudice to the bankruptcy estate would result, in order to leave the parties to their chosen forum and to relieve the bankruptcy court from any duties that may be handled elsewhere." *In re Lamberiack*, 149 B.R. 467, 470 (Bankr. N.D. Ohio 1992) (citing Senate Report No., 989, 95'h Cong., 2d Sess., 50).

17. In determining whether "cause" exists to permit the Hawkins' Estate to proceed with their state court litigation is whether "the interests of the estate" are outweighed "by the hardships incurred by the creditor-plaintiff." *In re Indian River Estates, Inc.*, 293 B.R. 429, 433 (Bankr. N.D. Ohio 2003). Because no harm will result to New Beginnings Care, LLC by partially lifting the stay and the Hawkins' Estate will effectively be prejudiced by delaying their personal injury claims, a lifting of the stay is appropriate.

18. The Hawkins' Estate may effectively be harmed by delaying the civil court action. The mere existence of a bankruptcy action does not deny the Hawkins' Estate opportunity to prosecute their case. *In re Brock Laundry Machine Co.*, 37 B.R. 564, 566-67 (Bankr. N.D. Ohio 1984). In fact, courts have found that making a plaintiff wait to prosecute a claim puts them at a considerable disadvantage due to the preservation of evidence and loss of witnesses, as well as the length of time to receive a final award. *Id.* Therefore, courts may lift the stay under § 362(d) and allow movants/plaintiffs (in this case the Hawkins' Estate) to recover under any applicable insurance policy coverage. *Id.*

19. "The automatic stay was never intended to preclude a determination of tort liability and the attendant damages. It was merely intended to prevent a prejudicial dissipation of a Debtor's assets." *In re Brock Laundry Machine Co.*, 37 B.R. at 567. A partial lifting of the stay to allow the Hawkins' Estate to determine liability will not affect the estate. It will only allow the Hawkins' Estate to establish the amount of their claim. In this respect, a relief from the stay will not violate the purpose for which it was imposed. *Id.* Conversely, the interest of judicial economy will be served by lifting the stay to permit the state court to determine the underlying facts. For the reasons stated above, the Hawkins' Estate requests that this Court grant their Motion.

WHEREFORE, the Hawkins' Estate hereby requests that this Court enter an Order granting partial relief from automatic stay imposed by 11 U.S.C. § 362, permitting the Hawkins' Estate to proceed in the state court action and to proceed with entry of a judgment to the extent of any insurance coverage of the Debtor, and for all other relief to which they may be entitled.

Respectfully submitted,

REDDICK MOSS, PLLC

By: /s/ Robert W. Francis_________________
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Attorneys for the Hawkins' Estate

CERTIFICATE OF SERVICE

I hereby certify that on the 24th day of March, 2016, a copy of the foregoing *Motion for Partial Relief from Automatic Stay to Allow Civil Litigation to Proceed* and proposed order was served on the parties listed below by first-class mail, postage prepaid, unless said party is a registered CM/ECF participant who has consented to electronic notice, and the Notice of Electronic Filing indicates that Notice was electronically mailed to said party:

David J. Fulton
Scarborough & Fulton
701 Market Street
Suite 1000
Chattanooga, TN 37402
djf@sfglegal.com

United States Trustee
Historic U.S. Courthouse
31 E. Eleventh Street
Fourth Floor
Chattanooga, TN 37402

/s/ Robert W. Francis_________________
Robert W. Francis, *pro hac vice*
Reddick Moss, PLLC

Exhibit "A"

IN THE CIRCUIT COURT OF SALINE COUNTY, ARKANSAS
4 DIVISION

Carol Hawkins, as Personal Representative of the Estate of Vernell Hawkins, Jr., and on behalf of the wrongful death beneficiaries of Vernell Hawkins, Jr. PLAINTIFF

FILED
SALINE COUNTY CIRCUIT CLERK
11/19/15 12:05:38
BY OH

vs. CASE NO. 63CV-15-897

Stoneybrook Healthcare & Rehab, LLC d/b/a
Stoneybrook Health and Rehabilitation Center;
New Beginnings Care, LLC;
Trent Tolbert; and
Kathy Barnhill in her capacity as Administrator of
Stoneybrook Health and Rehabilitation Center DEFENDANTS

COMPLAINT

COMES NOW, the Plaintiff, Carol Hawkins, as Personal Representative of the Estate of Vernell Hawkins, Jr., deceased, and on behalf of the wrongful death beneficiaries of Vernell Hawkins, Jr., by and through her attorneys, Reddick Moss, PLLC, and for her causes of action against Defendants Stoneybrook Healthcare & Rehab, LLC d/b/a Stoneybrook Health and Rehabilitation Center; New Beginnings Care, LLC; Trent Tolbert; and Kathy Barnhill in her capacity as Administrator of Stoneybrook Health and Rehabilitation Center states as follows:

JURISDICTIONAL STATEMENT

1. Carol Hawkins is the Personal Representative of the Estate of Vernell Hawkins, Jr., pursuant to the Circuit Court of Pulaski County Order dated June 17, 2015, attached hereto as **Exhibit A**. Plaintiff brings this action on behalf of Vernell Hawkins, Jr.

2. Carol Hawkins is Vernell Hawkins, Jr.'s wife.

3. Other than hospitalizations, Vernell Hawkins, Jr. was a resident of Stoneybrook Health and Rehabilitation Center (sometimes referred to as "facility"), a nursing home located at

3300 Military Road, Benton, Saline County, Arkansas from approximately September 25, 2013 until October 30, 2014.

4. Defendant Stoneybrook Healthcare & Rehab, LLC d/b/a Stoneybrook Health and Rehabilitation Center is a foreign limited liability company that engaged in business in the state of Arkansas and owned, operated, managed, and held the license for the nursing home located at 3300 Military Road, Benton, Saline County, Arkansas known as Stoneybrook Health and Rehabilitation Center. The causes of action made the basis of this suit arise out of such business conducted by Defendant Stoneybrook Healthcare & Rehab, LLC d/b/a Stoneybrook Health and Rehabilitation Center in the ownership, operation, management, licensing and/or control of the facility during the residency of Vernell Hawkins, Jr. The agent for service of process for Defendant Stoneybrook Healthcare & Rehab, LLC is Incorp Services, Inc., 16 W. Center St., Fayetteville, Arkansas 72701.

5. Defendant New Beginnings Care, LLC is a foreign limited liability company that owned, operated, managed and/or provided services for Stoneybrook Health and Rehabilitation Center. The causes of action made the basis of this suit arise out of such business conducted by New Beginnings Care, LLC, Inc. in the ownership, operation, control, management, and provision of services for the facility during the residency of Vernell Hawkins, Jr. The agent for service of process for New Beginnings Care, LLC is Incorp Services, Inc., 16 W. Center St., Fayetteville, Arkansas 72701.

6. Upon information and belief, Defendant Trent Tolbert is a citizen and resident of Hixson, Tennessee. At certain times material to this action, Trent Tolbert was an owner and the Incorporator/Organizer of the licensee Defendant Stoneybrook Healthcare & Rehab, LLC. Upon information and belief, Trent Tolbert is an owner and/or member of separate Defendant New Beginnings Care, LLC. Trent Tolbert was a control person as defined in Ark. Code Ann. § 4-88-

113(d)(1) and is therefore jointly and severally liable for the Plaintiff's damages. Trent Tolbert's systematic and continuous contacts with the operations of Stoneybrook Health and Rehabilitation Center, specifically, and the State of Arkansas, generally, render him subject to the personal jurisdiction of this Court pursuant to Ark. Code Ann. § 16-4-101(B). Defendant Trent Tolbert may be served with process at his last known address: 4704 Hixson Pike, Hixson, Tennessee 37343.

7. Upon information and belief, Defendant Kathy Barnhill was the Administrator of Stoneybrook Health and Rehabilitation Center during the residency of Vernell Hawkins, Jr. The causes of action made the basis of this suit arise out of Mr. Barnhill's administration of Stoneybrook Health and Rehabilitation Center during the residency of Vernell Hawkins, Jr. Kathy Barnhill was a control person as defined in Ark. Code Ann. § 4-88-113(d)(1) and is therefore jointly and severally liable for the Plaintiff's damages. Defendant Kathy Barnhill may be served with process at her last known address: 6608 Verbena Drive, Little Rock, Arkansas 72209.

8. The Defendants collectively controlled the operation, planning, management, and staffing of the Facility. The authority exercised by the Defendants over the Facility included, but was not limited to, control of marketing, human resources management, training, staffing, creation and implementation of policies and procedures used by the 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.

9. The Defendants operated as a joint venture/enterprise for the purpose of streamlining and furthering their similar business interests, as Stoneybrook Healthcare & Rehab, LLC d/b/a Stoneybrook Health and Rehabilitation Center and New Beginnings Care, LLC were

owned by and controlled by the same owners, managers, and decision makers, including Trent Tolbert.

10. At all relevant times mentioned herein, the Defendants owned, operated and/or controlled the operation of the Facility, either directly or through the agency of each other and/or other agents, subsidiaries, servants, or employees.

11. Because the Defendants named herein and others were engaged in a joint venture/enterprise during relevant times, 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.

12. Whenever the term "Nursing Home Defendants" is used throughout this Complaint, that term collectively refers to and includes the following Defendants: Stoneybrook Healthcare & Rehab, LLC d/b/a Stoneybrook Health and Rehabilitation Center; New Beginnings Care, LLC; and Trent Tolbert.

13. Whenever the term "Administrator Defendant" is used throughout this Complaint that term refers to Defendant Kathy Barnhill.

14. Whenever the term "Defendants" is used throughout this Complaint, that term collectively refers to and includes all named Defendants.

15. This Court has jurisdiction over the subject matter and the parties to this action, and venue is proper in this Court.

Background and Factual Allegations

16. This case arises from Defendants' systemic failures to have sufficient staff at Stoneybrook Health and Rehabilitation Center to meet the needs of all of its residents which caused Vernell Hawkins, Jr. to suffer the injuries described in more detail below.

17. Persons admitted to a nursing facility have limitations caused by physical deterioration, cognitive decline, the onset or exacerbation of an acute or chronic illness or condition, or other related factors. They need nursing care, medical treatment, and rehabilitation to maintain functional status, increase functional status, or live safely from day to day. Many such residents are elderly, disabled, confined to their beds or unable to rise from a bed or chair independently, and unable to groom, feed, toilet, or clean themselves. Consequently, many nursing home residents rely upon nursing home staff for not only skilled nursing care and treatment, but also essential primary care (herein "Basic Care") including:

(a) toileting assistance;

(b) incontinence care and changing of wet and soiled clothing and linen;

(c) assistance transferring to and from bed and wheelchair;

(d) assistance with dressing and personal hygiene;

(e) assistance with bathing;

(f) assistance with turning and repositioning residents in bed or chair;

(g) feeding assistance; and

(h) exercises/passive range of motion ("ROM") exercises.

18. Basic Care is primarily delivered by Certified Nursing Aides or "CNAs."

19. Defendants limited the number of CNA staff on duty at Stoneybrook Health and Rehabilitation Center and rendered the facility incapable of delivering the Basic Care that residents needed. While the intent may have been to control costs, the effect on resident care was dramatic. With the limited budgets for CNA staffing, the supply of CNA hours fell far short of the demand for care by the resident population.

20. The profound difference between the amount of services that Defendants promised and claimed to provide and the amount of services that Stoneybrook Health and Rehabilitation Center could have provided is at the heart of this case.

21. Interviews with residents' families and former employees, and analysis of survey results reported by the Office of Long Term Care will all confirm the chronic understaffing of Stoneybrook Health and Rehabilitation Center and the Defendants failure to provide the Basic Care services that they were paid to provide.

22. More specifically, CNA understaffing led to a pattern and practice of failing to provide Basic Care Services at Stoneybrook Health and Rehabilitation Center throughout the residency of Vernell Hawkins, Jr. For example, Stoneybrook Health and Rehabilitation Center:

(a) Failed to regularly provide toileting, incontinence care, and basic hygiene care, leaving dependent residents in dirty diapers, dirty clothes, and dirty beds for hours at a time.

(b) Failed to timely respond to call lights rung by residents. Residents were left to soil themselves while waiting for assistance; others fell while attempting to walk to the bathroom unaided.

(c) Failed to re-position bed-bound and immobile residents; many residents remained in the same position for hours at a time, which can and sometimes did result in painful, infection-prone pressure sores.

(d) Failed to undertake ROM exercises – moving their joints and limbs, and assisting vulnerable residents who could walk or exercise. Without this assistance, residents lost mobility, rendering them even less independent.

(e) Failed to wash and bathe dependent residents.

(f) Failed to get dependent residents up, dressed, and out of bed.

(g) Failed to assist dependent residents with meals. Without help, some residents were unable to eat or drink in the time allotted, and some of them suffered weight loss and dehydration.

23. These tell-tale signs confirm that Stoneybrook Health and Rehabilitation Center did not provide the Basic Care that was required and paid for, and highlight the very human toll

of understaffing. Defendants' staffing practices saved them the cost of labor, but cost residents their dignity and comfort, and jeopardized their safety. Residents and their families and former employees will confirm that because CNAs were not available: residents at Stoneybrook Health and Rehabilitation Center were left for long periods in their own urine and waste; were not cleaned, repositioned, or moved, resulting in infections, pressure sores, and loss of mobility; were deprived of food and water; and suffered falls. The failure to provide this care not only violated the law and the promises made by Defendants, it also degraded residents and increased their risk of serious negative health consequences such as those suffered by Vernell Hawkins, Jr.

24. As even more specific proof of the pattern of failing to meet the Basic Needs of the residents at Stoneybrook Health and Rehabilitation Center, surveys conducted by the Office of Long Term Care provide proof that the Defendants were on notice and aware of problems with resident care. For example, in multiple surveys prior to, during, and immediately following Mr. Hawkins' residency, the facility was cited for numerous deficiencies relevant to the injuries of Vernell Hawkins, Jr., including:

a) Failure to give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores. (October 12, 2012, August 23, 2013, and again on October 2, 2014);

b) Failure to have a program that investigates, controls and keeps infection from spreading (August 23, 2013 and again on October 2, 2014);

c) Failure to provide necessary care and services to maintain the highest well being of each resident (January 10, 2013, August 23, 2013, May 9, 2014, and again on October 2, 2014); and

d) Failure to properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses (August 23, 2013)

25. The deficiencies cited in the surveys from the Office of Long Term Care, such as those referenced above specific to Stoneybrook Health and Rehabilitation Center, are for failures

to meet standards established by a comprehensive group of federal and state regulations that regulate all aspects of care in nursing homes.

A. Federal requirements.

26. As part of the Omnibus Budget Reconciliation Act of 1987, Congress enacted the Nursing Home Reform Act, 42 U.S.C. §§ 1395i-3, 1396r ("NHRA"), which establishes minimum standards for nursing facilities participating in, and seeking funding from, the Medicaid and Medicare programs.

27. Stoneybrook Health and Rehabilitation Center is a nursing facility as defined by the NHRA. 42 U.S.C. § 1396r(a).

28. The NHRA mandates that nursing facilities "operate and provide services in compliance with all applicable Federal, State, and local laws and regulations…and with accepted professional standards and principles which apply to professionals providing services in such a facility." 42 U.S.C. § 1396r(d)(4)(A). Likewise, 42 U.S.C. § 1320c-5(a)(2) requires all health care providers, including nursing facilities, to ensure that all services for which they submit claims for Medicaid payment are "of a quality which meets professionally recognized standards of health care."

29. Under the NHRA, nursing home operators that participate in Medicaid or Medicare must conduct comprehensive clinical assessments of each nursing home resident's needs, which are reflected in the MDS. 42 C.F.R. § 483.20(b)-(c). The MDS documents and scores each resident's level of impairment or infirmity, forms the foundation of the resident's care plan, and defines the day-to-day services the resident needs. 42 C.F.R. § 483.20(b). Given the MDS's importance to residents' assessment and care, various regulations ensure that an MDS accurately reflects each resident's status and needs – requiring that the MDS be signed and certified, and imposing penalties for falsifying an MDS. 42 C.F.R. § 483.20(g)-(k).

30. The MDS allows the nursing home to catalog exactly which Basic Care services are required by its residents with great specificity, as well as the number of staff members who assist when assistance is needed.

31. Federal regulations require that all nursing homes have sufficient numbers of nursing staff, including CNAs, "to provide nursing and related services to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care." 42 C.F.R. § 483.30(a). Further, every nursing home, as a condition of payment and participation in the Medicaid and Medicare program, 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: (i) ...licensed nurses; and (ii) [o]ther nursing personnel.

42 C.F.R. § 483.30(a)(1). "Other nursing personnel" includes CNAs, which are specifically included as "nurse aids" in 42 C.F.R. § 483.75(e)(1).

32. Thus, federal regulations make clear that: (a) a nursing home must provide sufficient nursing staff – including CNAs – to meet the needs documented in the MDS and care plans of its residents, and (b) the necessary level of staffing, therefore, depends upon the specific needs of and level of care required by the home's resident population.

B. State requirements.

33. Under Arkansas law, the Department of Human Services which licenses nursing facilities to operate, "shall not issue or renew a license of a nursing facility unless that facility employs the direct-care staff needed to provide continuous twenty-four-hour nursing care and service to meet the needs of each resident of the nursing facility and the staffing standards required by all state and federal regulations." Ark. C. Ann. § 20-10-1402(a).

34. Under Arkansas law, there are specific staffing standards regarding the minimum number of direct-care staff required in nursing facilities and "the staffing standard required...shall be the minimum number of direct-care staff required by nursing facilities and shall be adjusted upward to meet the care needs of residents." Ark. C. Ann. § 20-10-1402(b)(1). Therefore, a facility which provides staffing at the minimum number of direct caregivers required is not in compliance with Arkansas law as those staffing numbers "shall be adjusted upward to meet the care needs of residents." *Id.*

35. Under Arkansas law,

> ...all nursing facilities shall maintain the following minimum direct-care staffing-to-resident ratios:
>
> (1) One (1) direct-care staff to every six (6) residents for the day shift. Of this direct-care staff, there shall be at least one (1) licensed nurse to every forty (40) residents;
>
> (2) One (1) direct-care staff to every nine (9) residents for the evening shift. Of this direct-care staff, there shall be at least one (1) licensed nurse to every forty (40) residents;
>
> (3) One (1) direct-care staff to every fourteen (14) residents for the night shift. Of this direct-care staff, there shall be at least one (1) licensed nurse to every eighty (80) residents.

Ark. Code. Ann. § 20-10-1403(a).

36. Thus, like the federal regulations, Arkansas law makes clear that: (a) a nursing home must provide sufficient nursing staff – including CNAs – to meet the needs of its residents, and because the minimum staffing requirements "shall be adjusted upward to meet the care needs of residents," (b) the necessary level of staffing, therefore, depends upon the specific needs of and level of care required by the nursing facility's resident population.

Injuries Suffered by Vernell Hawkins, Jr.

37. Other than hospitalizations, Vernell Hawkins, Jr. was a resident of Stoneybrook Health and Rehabilitation Center from approximately September 25, 2013 until October 30, 2014. Vernell Hawkins, Jr. died on December 22, 2014.

38. Defendants were aware of Mr. Hawkins' medical condition and the care he required when they represented that they could adequately care for his needs.

39. In an effort to ensure that Vernell Hawkins, Jr. and other residents whose care was partially funded by the government were placed at Stoneybrook Health and Rehabilitation Center, Defendants held themselves out to the Arkansas Department of Human Services (DHS) and the public at large as being:

a) Skilled in the performance of nursing, rehabilitative and other medical support services;
b) Properly staffed, supervised and equipped to meet the total needs of their nursing home residents;
c) Able to specifically meet the total nursing home, medical and physical therapy needs of Vernell Hawkins, Jr. and other residents like him; and
d) Licensed by DHS and complying on a continual basis with all rules, regulations and standards established for nursing homes.

40. Defendants failed to discharge their obligations of care to Vernell Hawkins, Jr. with a conscious disregard for his rights and safety. At all times mentioned herein, Defendants, through their corporate officers and administrators, had knowledge of, ratified and/or otherwise authorized all of the acts and omissions that caused the injuries suffered by Mr. Hawkins, as more fully set forth below. Defendants knew that their facility could not provide the minimum standard of care to the weak and vulnerable residents of Stoneybrook Health and Rehabilitation Center. The severity of the recurrent negligence inflicted upon Mr. Hawkins while a resident of the facility accelerated the deterioration of his health and physical condition and resulted in physical and emotional injuries. While a resident at Stoneybrook Health and Rehabilitation

Center, Vernell Hawkins, Jr. sustained multiple injuries including, but not limited to, the following:

a) Multiple hospitalizations due to clogged PEG tube and tracheostomy;

b) Bedsores, including stage IV non-healing bedsore to sacrum;

c) Wound to right shoulder near trach collar;

d) Poor hygiene;

e) UTIs;

f) Multiple infections;

g) Malnutrition;

h) Dehydration;

i) Pain; and

j) Death.

41. The injuries sustained by Vernell Hawkins, Jr., as well as the conduct specified below, caused him to lose his personal dignity and to suffer extreme and unnecessary pain, anguish, and emotional trauma.

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

43. Defendants operated and managed Stoneybrook Health and Rehabilitation Center so as to maximize profits by reducing staffing levels below that needed to provide adequate care to residents that would comply with federal and state regulations governing skilled nursing facilities. Thus, Defendants knowingly and/or with reckless disregard for the consequences of their actions caused staffing levels at their facility to be set so that the personnel on duty at any given time could not reasonably tend to the needs of their assigned residents. Upon information and belief, Defendants knowingly established staffing levels that created recklessly high nurse/resident ratios and disregarded patient acuity levels as well as the minimal time required to perform essential functions. These acts of malfeasance directly caused injury to Vernell Hawkins Jr. and other residents of Stoneybrook Health and Rehabilitation Center and were known to Defendants.

44. The acts and omissions of Defendants were motivated by a desire to increase the profitability by reducing expenditures for needed staff, training, supervision and care to levels that would predictably lead to severe injury.

45. Plaintiff alleges that, during Mr. Hawkins' residency at Stoneybrook Health and Rehabilitation Center, Mr. Hawkins' was under the care, supervision and treatment of Defendants and that the injuries complained of were proximately caused by the acts and omissions of the Defendants.

46. Defendants were vicariously liable for the acts and omissions of all persons or entities under their control, either directly or indirectly, including employees, agents, consultants and independent contractors, whether in-house or outside entities, individuals, agencies or pools causing or contributing to the injuries of Vernell Hawkins Jr.

CAUSES OF ACTION AGAINST THE NURSING HOME DEFENDANTS

COUNT ONE: NEGLIGENCE

47. Plaintiff incorporates the allegations contained in Paragraphs 1 – 46 as if fully set forth herein.

48. The Nursing Home Defendants owed a non-delegable duty to residents, including Vernell Hawkins, Jr., to provide adequate and appropriate custodial care and supervision, which a reasonably careful nursing home would provide under similar circumstances.

49. The Nursing Home Defendants owed a non-delegable duty to their residents, including Vernell Hawkins, Jr., to exercise reasonable care in providing care and services in a safe and beneficial manner.

50. The Nursing Home Defendants owed a non-delegable duty to their residents, including Vernell Hawkins, Jr., to hire, train and supervise employees to deliver care and services to residents in a safe and beneficial manner.

51. The Nursing Home Defendants owed a non-delegable duty to residents, including Vernell Hawkins, Jr., to use reasonable care in treating their residents with the degree of skill and learning ordinarily possessed and used by nursing home facilities in the same or similar locality.

52. The Nursing Home Defendants owed a non-delegable duty to assist all residents, including Vernell Hawkins, Jr., in attaining and maintaining the highest level of physical, mental and psychosocial well-being.

53. The Nursing Home Defendants breached these duties by failing to exercise reasonable care and by failing to prevent the mistreatment, abuse and neglect of Vernell Hawkins, Jr. The negligence of Defendants includes, but is not limited to, the following acts and omissions:

a) The failure to ensure that Mr. Hawkins attained and maintained his highest level of physical, mental, and psychosocial well-being;

b) The failure to establish, publish and/or adhere to policies for nursing personnel concerning the care and treatment of residents with nursing, medical and psychosocial needs similar to those of Mr. Hawkins;

c) The failure to increase the number of nursing personnel to ensure that Vernell Hawkins, Jr. received timely and accurate care assessments, and proper treatment, medication and diet;

d) The failure to provide sufficient numbers of qualified personnel, including nurses, licensed practical nurses, certified nurse assistants and medication aides to meet the total needs of Mr. Hawkins throughout his residency;

e) The failure to increase the number of nursing personnel at the facility to ensure that Vernell Hawkins, Jr.:
   1) Received timely and accurate care assessments;
   2) Received proper treatment, medication, and diet; and
   3) Was protected from accidental injuries by the correct use of ordered and reasonable safety measures.

f) The failure to adequately screen, evaluate, and check references, test for competence and use ordinary care in selecting nursing personnel to work at the facility;

g) The creation of and/or the failure or refusal to identify and correct the injuries, conditions, and circumstances described in paragraph 17 and exhibited by Mr. Hawkins;

h) The failure to terminate employees at the facility assigned to Mr. Hawkins who were known to be careless, incompetent and unwilling to comply with the policies and procedures of the facility and the rules and regulations promulgated by the Arkansas Department of Human Services and the Office of Long Term Care;

i) The failure to assign nursing personnel at the facility duties consistent with their education and experience based on:
   1) Mr. Hawkins' medical history and condition, nursing and rehabilitative needs;
   2) The characteristics of the resident population residing in the area of the facility where Vernell Hawkins, Jr. was a resident; and,
   3) The nursing skills needed to provide care to such resident population.

j) The failure by the members of the governing body of the facility to discharge their legal and lawful obligation by (1) ensuring that the rules and regulations designed to protect the health and safety of residents, such as Vernell Hawkins, Jr., as promulgated by the Arkansas Department of Human Services and the Arkansas Office of Long Term Care, were consistently complied with on an ongoing basis and (2) ensuring appropriate corrective measures were implemented to correct problems concerning inadequate resident care;

k) The failure to adopt adequate guidelines, policies, and procedures of the facility for documenting, maintaining files, investigating and responding to any complaint regarding the quality of resident care or misconduct by employees at the facility, regardless of whether such complaint derived from a resident of the facility, an employee of the facility or any interested person;

l) The failure to maintain medical records on Vernell Hawkins, Jr. in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized with respect to diagnosis, treatment and assessment and establishment of appropriate care plans of care and treatment; and

m) The failure to properly in-service and orient employees to pertinent patient care needs to maintain the safety of residents.

54. A reasonably careful nursing home operating under similar circumstances would foresee that the failure to provide the ordinary care listed above would result in devastating injuries to Vernell Hawkins, Jr.

55. The Nursing Home Defendants further breached their duty of care to Vernell Hawkins, Jr. by violating certain laws and regulations in force in the State of Arkansas at the time of the occurrences discussed herein including, but not limited to, the following:

a) By failing to comply with rules and regulations promulgated by the Arkansas Department of Human Services, Division of Social Services, Office of Long Term Care, pursuant to authority expressly conferred by Act 28 of 1979 (Ark. Code Ann. § 20-10-202, *et seq.*) and published in the Long Term Care (LTC) Provider Manual on April 8, 1984, and the supplements thereto, and federal minimum standards imposed by the United States Department of Health and Human Services;

b) By failing to provide the necessary care and services to attain or maintain the highest practicable, physical, mental and psychosocial well-being of

Vernell Hawkins, Jr. in accordance with the comprehensive assessment and plan of care;

c) By failing to ensure a nursing care plan based on Mr. Hawkins' problems and needs was established that contained measurable objectives and timetables to meet his medical, nursing, and mental and psychosocial needs as identified in his comprehensive assessment;

d) By failing to review and revise Mr. Hawkins' nursing care plan when his needs changed;

e) By failing to treat Vernell Hawkins, Jr. courteously, fairly and with the fullest measure of dignity;

f) By failing to provide sufficient nursing staff and nursing personnel to ensure that Vernell Hawkins, Jr. attained and maintained his highest practicable physical, mental and psychosocial well-being;

g) By failing to provide a safe environment;

h) By failing to administer the facility in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident; and

i) By criminally abusing and neglecting Vernell Hawkins, Jr. and by failing to report that abuse in violation of the Adult and Long-Term Care Facility Resident Maltreatment Act, Ark. Code Ann. §§ 12-12-1701 *et seq.*

56. The Nursing Home Defendants were further negligent by infringing upon and depriving Vernell Hawkins, Jr. of the rights guaranteed by Ark. Code Ann. §§ 20-10-1201 *et seq.* including, but not limited to, the following:

a) The right to receive adequate and appropriate health care and protective and support services, including social services, mental health services, if available, planned recreational activities, and therapeutic and rehabilitative services consistent with the resident care plan for Vernell Hawkins, Jr., with established and recognized practice standards within the community, and with rules as adopted by federal and state agencies, such rights include:

1) The right to receive adequate and appropriate custodial service, defined as care for Vernell Hawkins, Jr. which entailed observation of diet and sleeping habits and maintenance of a watchfulness over his general health, safety, and well-being; and

2) The right to receive adequate and appropriate residential care plans, defined as a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, with participation from other facility staff and Mr. Hawkins or his designee or legal representative, which included a comprehensive assessment of the needs of Mr. Hawkins, a listing of services provided within or outside the facility to meet those needs, and an explanation of service goals;

b) The right to regular, consultative, and emergency services of physicians;

c) The right to appropriate observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care by nursing staff;

d) The right to access of dental and other health-related services, recreational services, rehabilitative services, and social work services appropriate to the needs and conditions of Mr. Hawkins, and not directly furnished by the licensee;

e) The right to a wholesome and nourishing diet sufficient to meet generally accepted standards of proper nutrition, guided by standards recommended by nationally recognized professional groups and associations with knowledge of dietetics, and such therapeutic diets as may be prescribed by attending physicians;

f) The right to a facility with its premises and equipment, and conduct of its operations maintained in a safe and sanitary manner;

g) The right to be free from mental and physical abuse, and from physical and chemical restraints;

h) The right of Mr. Hawkins to have privacy of his body in treatment and in caring for his personal needs;

i) The right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to resident care and the behavior of other residents;

j) The right to participate in social, religious, and community activities;

k) The right to the obligation of the facility to keep full records of the admissions and discharges of Mr. Hawkins and his medical and general health status, including:

1) medical records;

2) personal and social history;

3) individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals;

4) making it a criminal offense to fraudulently alter, deface, or falsify any medical or other long-term care facility record, or cause or procure any of these offenses to be committed; and

l) The right to be treated courteously, fairly, and with the fullest measure of dignity.

57. A reasonably prudent nursing home, operating under the same or similar conditions, would not have failed to provide the care listed above. Each of the foregoing acts of negligence on the part of the Nursing Home Defendants was a proximate cause of Vernell Hawkins, Jr.'s injuries as more specifically described herein. Mr. Hawkins suffered personal injury including extreme pain and suffering, mental anguish, disfigurement, disability, degradation, loss of personal dignity, emotional distress, and loss of life.

58. As a direct and proximate result of such grossly negligent, willful, wanton, reckless, malicious and/or intentional conduct, Plaintiff asserts a claim for judgment for all compensatory and punitive damages against the Nursing Home Defendants including, but not limited to, medical expenses, extreme pain and suffering, mental anguish, disfigurement, disability, degradation, loss of personal dignity, emotional distress, and loss of life in an amount exceeding that required by federal court jurisdiction in diversity of citizenship cases, to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

COUNT TWO: MEDICAL MALPRACTICE

59. Plaintiff incorporates the allegations contained in Paragraphs 1 – 58 as if fully set forth herein.

60. The Nursing Home Defendants are either medical care providers as defined by Ark. Code Ann. § 16-114-201(2) and/or liable for medical care providers as defined by Ark. Code Ann. § 16-114-201(2).

61. The Nursing Home Defendants owed a non-delegable duty to residents, including Vernell Hawkins, Jr., to use reasonable care in treating their residents with the degree of skill and learning ordinarily possessed and used by nursing home facilities in the same or similar locality.

62. The Nursing Home Defendants owed a non-delegable duty to assist all residents, including Vernell Hawkins, Jr., in attaining and maintaining the highest level of physical, mental and psychosocial well-being.

63. The Nursing Home Defendants failed to meet the applicable standards of care and violated their duty of care to Vernell Hawkins, Jr. through mistreatment, abuse and neglect. The Nursing Home Defendants failed to adequately supervise nurses and aides and failed to hire sufficient nurses and aides. As such, the nurses and aides were unable to provide Vernell Hawkins, Jr. the requisite care, and as a result, negligent acts occurred as set forth herein. The medical negligence of Defendants includes, but is not limited to, the following acts and omissions:

a) The failure to ensure that Vernell Hawkins, Jr. received the following:

    1) Timely and accurate care assessments;

    2) Proper treatment, medication and diet;

    3) Necessary supervision; and

    4) Timely nursing and medical intervention due to a significant change in condition.

b) The failure to provide, implement, and ensure adequate nursing care plan revisions and modifications as the needs of Vernell Hawkins, Jr. changed;

c) The failure to provide, implement and ensure that an adequate nursing care plan for Vernell Hawkins, Jr. was followed by nursing personnel;

d) The failure to provide Vernell Hawkins, Jr. with adequate and appropriate nursing care, treatments, and medications;

e) The failure to ensure that Vernell Hawkins, Jr. was assessed in order to receive adequate and proper nutrition, fluids, and therapeutic diet;

f) The failure to provide adequate care and treatment to Vernell Hawkins, Jr.; and

g) The failure to adequately and appropriately monitor Vernell Hawkins, Jr. and recognize significant changes in his health status.

64. A reasonably prudent nursing home, operating under the same or similar conditions, would not have failed to provide the care listed above. Each of the foregoing acts of negligence on the part of the Nursing Home Defendants was a proximate cause of Vernell Hawkins, Jr.'s injuries, which were foreseeable. Mr. Hawkins suffered personal injury, including excruciating pain and suffering, mental anguish, emotional distress, and loss of life.

65. The Nursing Home Defendants were negligent and reckless in breaching the duties owed to Vernell Hawkins, Jr. under the Medical Malpractice Act for the reasons specifically enumerated in this Complaint.

66. As a direct and proximate result of such grossly negligent, willful, wanton, reckless, malicious, and/or intentional conduct, Vernell Hawkins, Jr. suffered injuries as described herein. Plaintiff asserts a claim for judgment for all compensatory and punitive damages against the Nursing Home Defendants, including, but not limited to, medical expenses, extreme pain and suffering, mental anguish, emotional distress and loss of life in an amount exceeding that required for federal court jurisdiction in diversity of citizenship cases, to be determined by the jury, plus costs and all other relief to which Plaintiff is entitled by law.

COUNT THREE: BREACH OF THE ADMISSION AGREEMENT

67. Plaintiff incorporates the allegations contained in paragraphs 1–66 as if fully set forth herein.

68. Before being admitted to Stoneybrook Health and Rehabilitation Center, Vernell Hawkins, Jr. was required to enter into a Resident Admission Agreement, whereby the facility agreed to provide nursing and custodial care, necessary goods, services, and/or treatment to Mr. Hawkins in exchange for valuable consideration.

69. Vernell Hawkins, Jr., or those acting on his behalf, did what the Agreement for Care required of him in that valuable consideration was paid for the goods, services, care and treatment, including personal or custodial care, and professional nursing care the Nursing Home Defendants promised to provide.

70. The Nursing Home Defendants breached their contractual duties by failing to provide the care and services as described in the agreement, causing damage to Vernell Hawkins, Jr. As a result, the Plaintiff is entitled to, and seeks judgment for, the recovery of compensatory damages.

71. The Nursing Home Defendants are also liable for all consequential damages, because the Nursing Home Defendants knew, or should have known, that breaches of the admission agreement would result in consequential damages to Vernell Hawkins, Jr., and, under the circumstances, the Nursing Home Defendants should have understood that it had agreed to assume responsibility for any consequential damages caused by their breaches of the admission agreement. Plaintiff, therefore, seeks judgment for all foreseeable consequential damages, which flowed naturally from the failure of the Nursing Home Defendants to provide the care, goods, and services promised under the admission agreement, including but not limited to medical expenses, pain and suffering, mental anguish, and loss of life.

72. Plaintiff is entitled to seek punitive damages for breach of contract, because the Nursing Home Defendants knew or ought to have known, in the light of the surrounding circumstances, that their nonfeasance in breach of the admissions agreement would naturally and probably result in injury or damage, yet the Nursing Home Defendants breached the agreement in reckless disregard of the consequences from which malice may be inferred.

73. Plaintiff, for good cause, is unable to attach a copy of the actual admissions agreement upon which this claim is based, because it is in the possession of the Nursing Home Defendants.

COUNT FOUR: BREACH OF THE PROVIDER AGREEMENT

74. Plaintiff incorporates the allegations contained in paragraphs 1-73 as if fully set forth herein.

75. Upon becoming a resident of Stoneybrook Health and Rehabilitation Center, Mr. Hawkins, as a Medicare and/or Medicaid recipient, became a third-party beneficiary of the contract or provider agreement between the Nursing Home Defendants and the state and federal governments, an example of which is attached as **Exhibit B**.

76. For consideration duly paid by Mr. Hawkins, or on his behalf, the Nursing Home Defendants agreed to provide residents with personal and custodial care and professional nursing care in compliance with the requirements set forth in the provider agreements, as well as the minimum standards of care imposed by applicable law including the statutes and regulations set out herein. In addition, by entering into the agreement, the Nursing Home Defendants promised to "comply with all rules, regulations, changes in and additions thereto issued by the United States Department of Health and Human Services pertaining to nursing homes, and to comply with all rules, regulations, duly promulgated changes in and additions thereto issued by the State." The Nursing Home Defendants further agreed that "the rights and privileges of the

residents [were] of primary concern to the parties" and covenanted to "protect and preserve" the rights of the residents. The parties to the contract agreed "that failure to act in a manner consistent with those rights and privileges shall constitute an immediate breach of agreement."

77. As the name implies, the provider agreement exists to pay for and provide for resident, personal, or custodial care and professional nursing care. The provider agreements between the Nursing Home Defendants and the state and federal government were clearly intended to benefit the residents of Stoneybrook Health and Rehabilitation Center, including Vernell Hawkins, Jr.

78. In addition to the representations made by Nursing Home Defendants in the provider agreement, on the MDS that is submitted for each Medicaid recipient quarterly, the provider is required to certify the accuracy and truth of the MDS assessment as a condition of payment:

> I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated the collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

The provider agreement makes the submission of accurate MDSs a condition of payment for the Medicaid program.

79. The Nursing Home Defendants breached the provider agreement and committed multiple acts of nonfeasance in failing to provide the care, goods, and services to industry standards, as required by law and as agreed, including but not limited to:

a) Nonfeasance in failing to provide, as promised, the care and services for Mr. Hawkins to attain or maintain his highest practicable physical, mental, and psychosocial well-being, in accordance with a comprehensive assessment and plan of care;

b) Nonfeasance in failing to provide, as promised, dietary services, including special diets, supplemental feedings, special delivery preparation, assistance, and equipment required for preparing and dispensing oral feedings and special feeding devices;

c) Nonfeasance in failing to provide, as promised, personal or custodial services and nursing care;

d) Nonfeasance in failing, as promised, to implement policies and procedures so as to prevent infringement or deprivation of Mr. Hawkins' rights as a resident of a long term care facility;

e) Nonfeasance in failing to provide, as promised, assistance to Mr. Hawkins in developing and carrying out a plan of care;

f) Nonfeasance in failing to comply, as promised, with protections, duties and obligations imposed by applicable state and federal statutes and regulations as alleged herein; and

g) Nonfeasance in failing to staff Stoneybrook Health and Rehabilitation Center with sufficient personnel to adequately meet the needs of Mr. Hawkins, failing to comply with the rules and regulations promulgated by the state and federal governments, and in failing to provide staff qualified to meet the needs of the residents.

80. As a result of the Nursing Home Defendants' breach of the provider agreement, Plaintiff asserts a claim for judgment for all compensatory damages including the amount a jury determines is sufficient compensation for the loss of the benefit of promised services and care and treatment, in an amount that exceeds that required for federal court jurisdiction in diversity of citizenship cases.

81. The Nursing Home Defendants are also liable for all consequential damages, because the Nursing Home Defendants knew, or should have known, that breaches of the provider agreement would result in consequential damages to Vernell Hawkins, Jr., and, under the circumstances, the Nursing Home Defendants should have understood that it had agreed to assume responsibility for any consequential damages caused by their breaches of the provider agreement.

82. Plaintiff seeks judgment for all foreseeable consequential damages, which flowed naturally from the failure of the Nursing Home Defendants to provide the care, goods, and services promised under the provider agreement, including but not limited to medical expenses, pain and suffering, and mental anguish.

83. Plaintiff is entitled to seek punitive damages for breach of contract, because the Nursing Home Defendants knew or ought to have known, in the light of the surrounding circumstances, that their nonfeasance in breach of the provider agreement would naturally and probably result in injury or damage, yet the Nursing Home Defendants breached the agreement in reckless disregard of the consequences from which malice may be inferred.

84. Plaintiff, for good cause, is unable to attach a copy of the actual provider agreement upon which this claim is based, because it is in the possession of the Nursing Home Defendants.

<u>Count Five: Deceptive Trade Practices</u>

85. Plaintiff incorporates the allegations contained in Paragraphs 1–84 as if fully set forth herein.

86. At all times pertinent to this cause of action, Vernell Hawkins, Jr. was an "elder person" as defined by the Arkansas Deceptive Trade Practices Act, Ark. Code Ann. § 4-88-201(a). As an "elder person" within the meaning of the Deceptive Trade Practices Act, the

Plaintiff has a private cause of action to recover actual damages, punitive damages, and reasonable attorney's fees pursuant to Ark. Code Ann. § 4-88-204.

87. At all relevant times, the Arkansas Deceptive Trade Practices Act, codified at Ark. Code Ann. § 4-88-107(a) provides that it is unlawful to:

a. Knowingly take advantage of a consumer who is reasonably unable to protect his or her interest because of:

1) Physical infirmity; or

2) A similar factor; and

b. Engage in any other unconscionable, false, or deceptive act or practice in business, commerce, or trade.

88. Ark. Code Ann. § 4-88-108 provides that, when utilized in connection with the sale or advertisement of any goods, services, or charitable solicitation, it shall be unlawful for any person to (1) act, use or employ any deception, fraud or false pretense, or (2) conceal, suppress, or omit any material fact with intent that others rely on the concealment, suppression, or omission.

89. On information and belief, the Nursing Home Defendants made statements to Arkansas consumers regarding the services provided and quality of care at Stoneybrook Health and Rehabilitation Center that may have, tended to, or did deceive or mislead Arkansas consumers.

90. For example, the Nursing Home Defendants were required by federal and state regulations to devise a care plan for each resident based upon each resident's individual needs. On information and belief, the Nursing Home Defendants communicated these care plans to residents and their families, including Vernell Hawkins, Jr., which may have, tended to, or did lead them to believe that the Nursing Home Defendants would deliver – and had the staff and

resources to deliver – the care outlined in the plans. These representations were false and misleading.

91. Additionally, the Nursing Home Defendants made misrepresentations regarding the care they provide in marketing materials directed to consumers in Arkansas.

92. The Nursing Home Defendants' trade practices also are, and have been throughout the residency of Vernell Hawkins, Jr., unconscionable, because the nursing home residents, such as Mr. Hawkins, constitute a vulnerable population: they are elderly, ill, infirm, and often deteriorating. These residents often face the double burden of dependency and isolation. The Nursing Home Defendants accept these vulnerable residents for admission, and then knowingly fail to provide sufficient levels of staffing to provide the care required. Many nursing home residents require assistance with most or all of the ADLs or basic care needs. Once admitted, they lack the autonomy or ability to seek alternative care. Residents who are unable to get in and out of bed on their own, for example, have few options when the nursing home at which they are living fails to provide the care they need. Thus, residents cannot "vote with their feet," as consumers might in other contexts. Some residents are not even able to voice a complaint.

93. The Nursing Home Defendants also engage in, and have engaged in throughout the residency of Mr. Hawkins, substantively unconscionable trade practices by providing care that is so inadequate to meet the needs of residents that it results in a gross disparity between the value received by the residents for the services provided and the cost of the services.

94. The Nursing Home Defendants knew that they were not meeting, and did not have sufficient CNA staff to meet, the Basic Care needs of their residents as mandated by state and federal laws and regulations.

95. As described above, the Nursing Home Defendants received repeated deficiencies related to failures of Basic Care in Office of Long Term Care surveys. They received these deficiencies despite, on information and belief, taking steps to increase staffing and prepare staff for surveys ahead of time – steps that would lead surveyors to believe levels of care provided were higher than they actually were during non-survey times.

96. The conduct of the Nursing Home Defendants, as described herein, constitutes a deceptive practice in violation of the Deceptive Trade Practices Act. The Nursing Home Defendants engaged in an unconscionable, false, and/or deceptive act or practice in business, commerce and/or trade by marketing themselves and holding themselves out to the public and Vernell Hawkins, Jr. as being able to meet the needs of elder residents of Stoneybrook Health and Rehabilitation Center. The Nursing Home Defendants also violated numerous regulatory provisions governing the care and treatment of residents in nursing facilities, as well as provisions of the Arkansas Residents' Rights Statute, Ark. Code Ann. §§ 20-10-1201, et seq., which constitute unconscionable acts in violation of public policy and the Deceptive Trade Practices Act. The Nursing Home Defendants profited greatly as a result of their deceptive trade practices, but the Nursing Home Defendants were aware that Stoneybrook Health and Rehabilitation Center could not meet the needs of its residents, including Vernell Hawkins, Jr.

97. As a direct and proximate result of the Nursing Home Defendants' wrongful conduct, Plaintiff has suffered actual damages.

CAUSES OF ACTION AGAINST THE ADMINISTRATOR DEFENDANT

FACTUAL ALLEGATIONS

98. Plaintiff incorporates the allegations contained in Paragraphs 1–97 as if fully set forth herein.

99. Upon information and belief, Kathy Barnhill was the Administrator at Stoneybrook Health and Rehabilitation Center during the residency of Vernell Hawkins, Jr.

100. As administrator of Stoneybrook Health and Rehabilitation Center, Kathy Barnhill was responsible for ensuring that the facility complied with all state and federal regulations related to nursing facilities. Ms. Barnhill had a duty to administer the facility in a manner that enabled it to use resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident. The nursing facility, under the leadership of its administrator, is also required to 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 facilities. In addition, as a member of the facility's governing body, Ms. Barnhill had a duty to promulgate and implement policies and procedures for the operation and management of Stoneybrook Health and Rehabilitation Center. Defendant Kathy Barnhill breached the duty of care she owed to Vernell Hawkins, Jr.

NEGLIGENCE

101. Plaintiff incorporates the allegations contained in Paragraphs 1–100 as if fully set forth herein.

102. Kathy Barnhill owed a duty to the residents, including Vernell Hawkins, Jr., to provide services as a reasonable administrator within accepted standards for a nursing home administrator.

103. The Administrator Defendant breached the duties owed to the residents of Stoneybrook Health and Rehabilitation Center, including Vernell Hawkins, Jr., by failing to supervise nurses and nurses' aides and failing to hire sufficient nurses and nurses' aides, and as such, the nurses and nurses' aides were unable to provide Vernell Hawkins, Jr. the care he

required. The negligence of the Administrator Defendant includes, but is not limited to, the following acts and omissions:

a) Failure to adequately assess, evaluate, and supervise nursing personnel so as to ensure that Vernell Hawkins, Jr. received appropriate nursing care;

b) Failure to ensure that Vernell Hawkins, Jr. was provided with basic and necessary care and supervision;

c) Failure to adequately hire, train, supervise, and retain a sufficient amount of competent and qualified registered nurses, licensed vocational nurses, nurse assistants and other personnel in said facility to assure that Vernell Hawkins, Jr. received care, treatment, and services in accordance with state and federal law;

d) Failure to assign nursing personnel at Stoneybrook Health and Rehabilitation Center duties consistent with their education and experience based on:
   1) Vernell Hawkins, Jr.'s medical history and condition, nursing, and rehabilitative needs;
   2) The characteristics of the resident population residing in the area of the facility where Vernell Hawkins, Jr. was a resident; and
   3) Nursing skills needed to provide care to such resident population;

e) The failure to provide sufficient numbers of qualified personnel to ensure that Vernell Hawkins, Jr. was provided with a safe environment and was protected from abuse and mistreatment by the correct use of reasonable safety measures;

f) The failure to properly in-service and orient employees to pertinent resident care needs to maintain the safety of residents;

g) The failure to protect Vernell Hawkins, Jr. from abuse and neglect; and

h) The failure to provide adequate supervision to the nursing staff so as to ensure that Vernell Hawkins, Jr. received adequate and proper care.

104. A reasonably careful nursing home administrator would have foreseen that the failure to provide the ordinary care listed above would result in devastating injuries to Vernell Hawkins, Jr.

105. As a direct and proximate result of the Administrator Defendant's negligent conduct, Plaintiff asserts a claim for judgment for all compensatory damages against the Administrator Defendant, including, but not limited to, medical expenses, extreme pain and suffering, mental anguish, emotional distress and loss of life in an amount exceeding that required by federal court jurisdiction in diversity of citizenship cases, to be determined by the jury, plus costs and all other relief to which the Plaintiff is entitled by law.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, Carol Hawkins, as Personal Representative of the Estate of Vernell Hawkins, Jr., and on behalf of the wrongful death beneficiaries of Vernell Hawkins, Jr., prays for judgment against Defendants as follows:

1. For damages in an amount adequate to compensate the Plaintiff for the injuries and damages sustained and exceeding that required by federal court jurisdiction in diversity of citizenship cases.

2. For all general and special damages caused by the alleged conduct of Defendants.

3. For the costs of litigating this case.

4. For attorney's fees pursuant to Ark. Code Ann. § 16-22-308 and Ark. Code Ann. § 4-88-204.

5. For punitive damages sufficient to punish Defendants for their egregious and malicious misconduct in reckless disregard and conscious indifference to the consequences to Vernell Hawkins, Jr. and to deter Defendants and others from repeating such atrocities.

6. For all other relief to which Plaintiff is entitled.

Respectfully submitted,

Carol Hawkins, as Personal Representative of
the Estate of Vernell Hawkins, Jr.

By: ______________________

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Attorneys for the Plaintiff

J. To bill State Medicaid only after the service has been provided.

K. To accept Medicaid reimbursement rates determined by the State as full payment for all Medicaid eligible care and services required by the classification of each resident and rendered by the provider, and not to make additional charges to the resident, or to accept any additional payment from the resident, sponsor, or responsible parties for that service which is covered under the Medicaid Program.

L. To promptly refund to the resident or responsible party any unused portion of patient applied income collected in advance and not owed due to death, discharge or transfer. Resident income is to be prorated on a per diem basis according to the number of days in the month.

M. To promptly refund to a resident or other responsible person any deposit or advance fee collected while awaiting approval for Medicaid eligibility to the extent these days are covered by Medicaid payment.

N. To provide all services and specific items as defined in the Medical Assistance Reasonable Cost Related Reimbursement Manual for Long Term Care Facilities (MARCRRM-LTCF), or any revisions hereto or subsequent manuals. Receipt of Medicaid per diem reimbursement rates is considered payment in full for services and items included in the MARCRRM.

O. To accept assignment and file a claim in a timely and proper manner with all third party sources, and if said claim is collected from a third party, to reimburse Medicaid up to the amount Medicaid paid for said services.

P. The $30 Personal Needs Allowance which is provided for by the Medicaid Program for personal expenditures of a resident cannot and shall not be used for any other purpose except as approved in writing by the resident or responsible party.

Q. To comply with all State and/or Federal regulations pertaining to resident personal funds and to provide the State access to patient account records or any other financial records maintained by the provider for benefit of the patient. The new owner must specify in writing which owner will be responsible for unpaid Medicaid claims and facility accounts receivable balances resulting from dates of service prior to the ownership change.

Further Provider agrees that it will not prevent or interfere with the individual or responsible person, or the Office of Long Term Care in the transfer or discharging of a patient when same is appropriate.

II. The State agrees that it shall have the following responsibilities hereunder:

A. To make timely payments to Provider for the appropriate Medicaid services provided to eligible Medicaid recipients in accordance with the terms of the LTC Provider Manual or other appropriate regulations and procedures previously mentioned herein.

B. To notify Provider of any changes of rules or regulations to be followed hereunder as promptly as is practicable at all times.

C. To safeguard the confidentiality of any Medicaid records maintained for the State, its agents, under Federal confidentiality as specified in Federal and State regulations.

III. Mutual Covenants, Duties, Responsibilities, and Undertakings. [illegible]

A. State and Provider mutually agree to comply with all Federal and State laws, rules and regulations.

B. State and Provider agree that the rights and privileges of the residents are of primary concern to the parties and the parties expressly agree and covenant to protect and preserve these rights and privileges and that failure to act in a manner consistent with these rights and privileges shall constitute a material breach of agreement and may result in immediate termination of this agreement without recourse.

C. State and Provider agree and covenant that this written instrument constitutes the entirety of the agreement between both parties and no statements or representations not reduced to writing or incorporated herein by signed reference or not contained herein shall constitute any part of this agreement, and such statements or representations not incorporated herein by attached shall be binding upon the parties.

IV. This contract may be terminated in accordance with the following provisions:

A. This contract may be terminated by either party by giving 30 days written notice to the other party.

B. This contract may be terminated immediately by State for the following reasons:

1. Federal sanction of Provider.
2. Change of ownership.
3. Violation of any provision herein contained.
4. In accordance with termination procedures as set out in appropriate Federal and/or State regulations or rules by which Provider is bound hereunder.

Provider

By: ____________ (Signature)

Name: ____________ (Type Name)

Title: ____________

Date: ____________

Division of Economic and Medical Services
Office of Long Term Care

By: ____________ (Signature)

Name: ____________ (Type Name)

Title: ____________

Date: ____________

[illegible]

EVS-711 (R. [illegible])

J. To bill State (Medicaid) only after the service has been provided.

K. To accept Medicaid reimbursement rates determined by the State as full payment for all Medicaid eligible care and services required by the classification of each resident and rendered by the provider, and shall not collect charges to the resident, or to accept any additional payments from the resident, relative, or responsible party for that service which is covered under the Medicaid Program.

L. To promptly refund to the resident or responsible party any unused portion of resident applied income collected in advance and not owed due to death, discharge or transfer. Resident income is to be prorated on a per diem basis according to the number of days in the month.

M. To promptly refund to a resident or other responsible person any deposit or advance fee collected while pending approval for Medicaid eligibility to the extent those days are covered by Medicaid payments.

N. To provide all services and specific items as defined in the Medical Assistance Recipient Care Related Reimbursement Manual for Long Term Care Facilities (MARCRRM-LTCF), or any relevant bulletin or subsequent manuals. Receipt of Medicaid per diem reimbursement shall be considered payment in full for services and items included in the MARCRRM.

O. To accept assignment and file a claim in a timely and proper manner with all third party sources, and if said claim is collected from a third party, to reimburse Medicaid up to the amount Medicaid paid for said services.

P. The $30 Personal Needs Allowance which is provided for by the Medicaid Program for personal expenditures of a resident cannot and shall not be used for any other purpose except as requested in writing by the resident or responsible party.

Q. To comply with all State and/or Federal regulations pertaining to resident personal funds and to provide the State access to patient account records or any other financial records maintained by the provider for the benefit of the patient. The new owner must specify in writing which owner will be responsible for unpaid Medicaid claims and facility accounts receivable balances resulting from dates of service prior to the ownership change.

Further Provider agrees that it will not prevent or interfere with the individual or responsible person, or the Office of Long Term Care in the transfer or discharging of a patient when same is appropriate.

II. The State agrees that it shall have the following responsibilities hereunder:

A. To make timely payments to Provider for the appropriate Medicaid services provided to eligible Medicaid recipients in accordance with the terms of the LTC Provider Manual or other appropriate regulations and procedures previously mentioned herein.

B. To notify Provider of any changes of rules or regulations to be followed hereunder as promptly as is practicable at all times.

C. To safeguard the confidentiality of any Medicaid records maintained for the State, its agents, and/or facilities as specified in Federal and State regulations.

III. Mutual Covenants, Duties, Responsibilities, and Undertakings

A. State and Provider mutually agree to comply with all Federal and State laws, rules and regulations.

B. State and Provider agree that the rights and privileges of the residents are of primary concern to the parties and the parties expressly agree and covenant to protect and preserve those rights and privileges and that failure to act in a manner consistent with those rights and privileges shall constitute a material breach of agreement and may result in immediate termination of this agreement without recourse.

C. State and Provider agree and covenant that this written instrument constitutes the entirety of the agreement between both parties and no statement or representations not reduced to writing or incorporated herein by specific reference or not contained herein shall be binding upon the parties and such statements or representations not incorporated herein by attachment shall constitute no part of this agreement.

IV. This contract may be terminated in accordance with the following provisions:

A. This contract may be terminated by either party by giving 30 days written notice to the other party.

B. This contract may be terminated immediately by State for the following reasons:

1. Federal sanction of Provider.
2. Change of ownership.
3. Violation of any provision herein contained.
4. In accordance with termination procedures as set out in appropriate Federal and/or State regulations or rules by which Provider is bound hereunder.

Provider	Division of Economic and Medical Services Office of Long Term Care
By: ______ (Signature)	By: ______ (Signature)
Name: ______ (Type Name)	Name: ______ (Type Name)
Title: ______	Title: ______
Date: ______	Date: ______

EVS-711 (R. 1/01)

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60PR-15-1049
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IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF
VERNELL HAWKINS, JR., DECEASED NO. 60PR-15-1049

ORDER APPOINTING PERSONAL REPRESENTATIVE

The Petition of Carol Hawkins for appointment of a personal representative in the estate of Vernell Hawkins, Jr., deceased, is presented to the Court. Upon consideration of the Petition and the facts and evidence in support of it, the Court finds:

1) No demand for notice of proceedings for the appointment of a personal representative of the estate has been filed. The Petition is not opposed by any known person, and it may be heard without notice.

2) Vernell Hawkins, Jr., aged 47, who resided at 324 South Taylor, Little Rock, Arkansas, died intestate at St. Vincent's Infirmary Hospice in Little Rock, Arkansas, on or about December 22, 2014.

3) This Court has jurisdiction of this proceeding and venue properly lies in this County.

4) Carol Hawkins is a proper person by law to serve as personal representative of the estate.

5) It appears there are no unsecured claims against the decedent's estate.

6) The estate may have a potential personal injury/wrongful death action, and bond, therefore, is waived at this time. The Court will revisit the issue of bond should the estate acquire assets at any time.

IT IS THEREFORE ORDERED that administration is hereby opened in said estate and that Carol Hawkins be and they hereby is, named and appointed personal representative of the estate of the decedent; that the personal representative shall serve without bond; and that letters testamentary shall be issued to said personal representative.

DATED this 17th day of June, 2015.

CIRCUIT JUDGE

Submitted by:

/s/ H. Gregory Campbell
H. Gregory Campbell (#92001)
CAMPBELL LAW FIRM, P.A.
One Information Way, Box 101
Little Rock, Arkansas 72202
Telephone No. (501) 372-5659
Attorneys for Estate

EXHIBIT
A

Exhibit "B"

FILED SALINE COUNTY CIRCUIT CLERK
2016 FEB 29 AM 11:52
BY:

IN THE CIRCUIT COURT OF SALINE COUNTY, ARKANSAS
4TH DIVISION

CAROL HAWKINS, AS PERSONAL REPRESENTATIVE OF THE ESTATE OF VERNELL HAWKINS, JR., AND ON BEHALF OF THE WRONGFUL DEATH BENEFICIARIES OF VERNELL HAWKINS, JR. **PLAINTIFF**

v. **NO. 63CV-15-897**

STONEYBROOK HEALTHCARE & REHAB, LLC D/B/A STONEYBROOK HEALTH AND REHABILITATION CENTER; NEW BEGINNINGS CARE, LLC; TRENT TOLBERT; AND KATHY BARNHILL IN HER CAPACITY AS ADMINISTRATOR OF STONEYBROOK HEALTH AND REHABILITATION CENTER **DEFENDANTS**

NOTICE OF BANKRUPTCY

Separate Defendant New Beginnings Care, LLC hereby gives Notice that it filed bankruptcy under Chapter 11 of the United States Bankruptcy Code on or about January 22, 2016. See attached Notice of Bankruptcy Case Filing attached hereto as Exhibit A.

Respectfully submitted,

MITCHELL, WILLIAMS, SELIG, GATES & WOODYARD, P.L.L.C.
425 West Capitol Avenue, Suite 1800
Little Rock, Arkansas 72201-3525
(501) 688-8896 phone
(501) 918-7896 fax
smiller@mwlaw.com

By ______________________
Stuart P. Miller
Ark. Bar No. 88137

CERTIFICATE OF SERVICE

I, Stuart P. Miller, do hereby certify that I forwarded a copy of the foregoing to the below named persons via U.S. Mail on this 26 day of February, 2016.

Brian D. Reddick
Brent L. Moss
Robert W. Francis
Joshua C. Rovelli
Daniel K. Yim
Reddick Moss, PLLC
One Information Way, Suite 105
Little Rock, AR 72202

Robert M. Sexton
Rainwater Holt & Sexton
801 Technology Drive
Little Rock, AR 72223

Stuart P. Miller

Exhibit "C"

CNA

Long Term Care Commercial Liability Policy

New Business Declaration

POLICY NUMBER	COVERAGE PROVIDED BY	FROM - POLICY PERIOD - TO
6010508968	COLUMBIA CASUALTY COMPANY 333 S. WABASH CHICAGO, IL. 60604	03/15/2014 03/15/2015
	INSURED NAME AND ADDRESS NEW BEGINNINGS CARE LLC 4704 HIXSON PIKE HIXSON, TN 37343	
AGENCY NUMBER 974712	**AGENCY NAME AND ADDRESS** TIS INSURANCE SERVICES, INC. 1900 WINSTON RD #100 P. O. BOX 10328 (37939) KNOXVILLE, TN 37919 Phone Number: (865)691-4847	
BRANCH NUMBER 977	**BRANCH NAME AND ADDRESS** HPRO-LONG TERM CARE 333 S WABASH AVE, 19 SOUTH CHICAGO, IL 60604 Phone Number: (800)863-0341	

This policy becomes effective and expires at 12:01 A.M. standard time at your mailing address on the dates shown above.

The Named Insured is a Corporation.

Redacted

The Policy Premium is

Your Premium includes the following amount for Certified Acts of Terrorism Coverage

POLICY NUMBER
6010508968

INSURED NAME AND ADDRESS
NEW BEGINNINGS CARE LLC
4704 HIXSON PIKE
HIXSON, TN 37343

IMPORTANT NOTICE: THIS POLICY PROVIDES CLAIMS-MADE COVERAGE. PLEASE READ IT CAREFULLY, ESPECIALLY YOUR DUTIES IN THE EVENT OF A "CLAIM" AND "EXTENDED REPORTING PERIOD" SECTIONS.

RETROACTIVE DATE: 03/15/2014 See G-144037-A, For Additional Retroactive Dates That May Apply to Your Policy

In return for the payment of the premium, and subject to all the terms and conditions contained here-in, we agree to provide the insurance as stated.

COVERAGE PARTS: Only those "COVERAGE PARTS" for which a premium is indicated are included in this policy.

PROFESSIONAL LIABILITY -	CLAIMS MADE	**INCLUDED**
GENERAL LIABILITY -	CLAIMS MADE	**INCLUDED**

LIMITS OF LIABILITY:

POLICY AGGREGATE LIMIT OF LIABILITY:

PROFESSIONAL LIABILITY - CLAIMS MADE		GENERAL LIABILITY - CLAIMS MADE	
$1,000,000	Each Claim	$1,000,000	Each Occurrence Limit
$3,000,000	Aggregate	$3,000,000	General Aggregate Limit
	Deductible Each Incident Aggregate	INCLUDED	Products/Completed Operations Aggregate
		$5,000	Medical Expense Limit
	SIR Each Claim Aggregate	$1,000,000	Personal/Advertising Injury Limit
		$100,000	Damage to Premises Rented To You Limit
	Disciplinary Proceedings	$50,000	Legal Media Expenses
		$50,000	Emergency Evacuation Expenses
			Deductible Each Incident Aggregate
			SIR Each Claim Aggregate

POLICY NUMBER
6010508968

INSURED NAME AND ADDRESS
NEW BEGINNINGS CARE LLC
4704 HIXSON PIKE
HIXSON, TN 37343

SCHEDULE OF COVERAGES

POLICY LEVEL COVERAGES

Class Code C00610
Emergency Evacuation Expenses

Class Code C00007
Employee Benefits Liability

Class Code C00503
Punitive Damages Exclusion

Class Code C00504
Punitive Damages Exclusion

INSURED LOCATIONS SCHEDULE

Location 1
800 BROOKSIDE DR
LITTLE ROCK, AR 72205

Class Code 80908
Skilled Nursing; For Profit

Location 2
3300 MILITARY RD
BENTON, AR 72015

Class Code 80908
Skilled Nursing; For Profit

Location 3
1010 BARNES ST
LONOKE, AR 72086

Class Code 80908
Skilled Nursing; For Profit

POLICY NUMBER
6010508968

INSURED NAME AND ADDRESS
NEW BEGINNINGS CARE LLC
4704 HIXSON PIKE
HIXSON, TN 37343

FORMS AND ENDORSEMENTS SCHEDULE

Form Number		Form Title
CG0002	12/2007	Commercial General Liability Form
CG0435	10/2001	Employee Benefits Liability Coverage
GSL22746XX	01/2011	Disciplinary Proceedings Supplementary Payments
GSL2430XX	02/2013	Pre-Claim Assistance Endorsement
GSL2499XX	03/2008	Media Expenses Endorsement
GSL2500XX	10/2008	Emergency Evacuation Endorsement
GSL3842XX	01/2008	Coverage and Cap on Losses from Certified Acts of
GSL5752XX	01/2009	GL & PL per Location Endorsement
GSL6672XX	08/2009	LTC Bridge Endorsement
G141432B	07/2010	Common Conditions
G141433C	11/2012	LTC General Liability Amendatory Endorsement
G141442C	08/2009	LTC Professional Liability Coverage - Claims Made

***** PLEASE READ THE ENCLOSED IMPORTANT NOTICES CONCERNING YOUR POLICY *****

Form Number		Form Title
CNA77042XX	11/2013	Notification of Pending Law Change to Terr Risk
GSL5776XX	11/2013	Surplus Lines Licensing Information Form
G144233F	01/2008	Notice - Offer of Terrorism Disclosure of Premium

Countersignature

Jonathan Kantor
Secretary

Thomas F. Motamed
Chairman of the Board

UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF TENNESSEE
CHATTANOOGA DIVISION

IN RE:	)	
	)	
NEW BEGINNINGS CARE, LLC,	)	CHAPTER 11
	)	CASE NO. 1:16-BK-10272-NWW
Debtor.	)	
	)	
	)	

ORDER GRANTING THE HAWKINS' ESTATE'S MOTION FOR PARTIAL RELIEF FROM THE AUTOMATIC STAY

This matter came before the Court on the Motion of Carol Hawkins, as Personal Representative of the Estate of Vernell Hawkins, Jr., deceased, and on behalf of the wrongful death beneficiaries of Vernell Hawkins, Jr. ("Hawkins' Estate"), for partial relief from the automatic stay to pursue state court litigation in the matter of *Carol Hawkins, as Personal Representative of the*

Estate of Vernell Hawkins, Jr., and on behalf of the wrongful death beneficiaries of Vernell Hawkins, Jr. v. Stoneybrook Healthcare & Rehab, LLC, *New Beginnings Care, LLC*, *et. al.*; Saline County, Arkansas, Circuit Court Case No. 63CV-15-897. After review of all related pleadings and a hearing, the Court finds that the Motion is and should be GRANTED.

The Court hereby ORDERS as follows:

1. The automatic stay created by 11 U.S.C. § 362 is hereby lifted in the matter of *Carol Hawkins, as Personal Representative of the Estate of Vernell Hawkins, Jr., and on behalf of the wrongful death beneficiaries of Vernell Hawkins, Jr. v. Stoneybrook Healthcare & Rehab, LLC, New Beginnings Care, LLC, et. al.*; Saline County, Arkansas, Circuit Court Case No. 63CV-15-897.

2. The stay is lifted only up to the amount of applicable insurance coverage referenced in the Motion.

3. The automatic stay remains in effect as to judgment in any amount in excess of applicable insurance coverage referenced in the Motion pending further orders of this Court.

IT IS SO ORDERED.

###

APPROVED FOR ENTRY

REDDICK MOSS, PLLC

/s/ Robert W. Francis________________
Robert W. Francis, *pro hac vice*
Reddick Moss, PLLC
One Information Way, Suite 105
Little Rock, Arkansas 72202
Telephone: (501) 907-7790
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Attorneys for the Hawkins' Estate