(1)

COMMONWEALTH OF MASSACHUSETTS

BERKSHIRE, ss.

SUPERIOR COURT
CASE NO.: 2576CV00134

ALLISON PFISTER AS THE PERSONAL REPRESENTATIVE OF THE ESTATE OF THERESA MARIE PFISTER
PLAINTIFF,

v.

GAHCR II PITTSFIELD MA SNF TRS SUB, LLC doing business as SPRINGSIDE REHABILITATION AND SKILLED CARE CENTER; CAREERSTAFF UNLIMITED, LLC; BANE CARE MANAGEMENT, LLC;
DEFENDANTS.

FILED
THE COMMONWEALTH OF MASSACHUSETTS
BERKSHIRE S.S. SUPERIOR COURT
AUG 01 2025
Lisa A. Denault-Viale

COMPLAINT AND JURY DEMAND

PRELIMINARY STATEMENT

Springside Rehabilitation and Skilled Nursing Center mission statement reads they are "*committed to enhancing the lives of our residents*". On May 28, 2023, Theresea Marie Pfister died after succumbing to injuries related to being dropped from a Hoyer lift [also known as a patient lift which is a mechanical device used to safely transfer individuals who have limited mobility from one surface to another, such as from a bed to a chair or wheelchair]. At the time of Ms. Pfister's fall out of the Hoyer lift, the certified nurse's aide (CNA) assisting in the transfer operated the patient lift by herself without the assistance of another aide or nurse due to the Springside was short staffed. Operation of a Hoyer Lift requires two or more people to operate at all times. This wrongful death action seeks to hold the Defendants responsible for their carelessness, recklessness, and gross negligence.

PARTIES

Plaintiff

1. Plaintiff is Allison Pfister as the duly appointed Personal Representative of the Estate of Theresa Pfister.

2. Allison Pfister is the daughter and "next of kin" to Theresa Pfister.

3. At all times pertinent hereto, decedent Theresa Pfister was a resident or patient of Springside Rehabilitation and Skilled Care Center at 255 Lebanon Avenue, Pittsfield, Berkshire County, Massachusetts.

4. Theresa Pfister died on May 28, 2023, at the age of 70.

EC

Defendants

5. Springside Rehabilitation and Skilled Care Center (hereinafter "Springside") is located at 255 Lebanon Avenue, Pittsfield, Berkshire County, Massachusetts.

6. Defendant CareerStaff Unlimited LLC is a foreign limited liability company organized under the laws of the state of Delaware with a principal office at 7925 Jones Branch Drive, Unit 1100, McLean, Virginia.

7. Defendant CareerStaff Unlimited LLC is not a medical provider.

8. Defendant Bane Care Management, LLC (hereinafter "Bane Care") is a domestic limited liability company organized under the laws of Massachusetts with a principal office at 350 Granite Street, Suite 2203, Braintree, Norfolk County, Massachusetts.

9. Defendant Bane Care Management LLC is not a medical provider.

10. Defendant Bane Care Management, LLC was the management company for Springside Rehabilitation and Skilled Care Center located at 255 Lebanon Avenue, Pittsfield, Berkshire County, Massachusetts in May 2023.

11. At all times relevant hereto, Defendant GAHCR II Pittsfield MA SNF TRS Sub, LLC, was the licensee of Springside Rehabilitation and Skilled Care Center.

12. Defendant GAHCR II Pittsfield MA SNF TRS Sub, LLC, is a foreign Limited Liability Company.

13. Defendant GAHCR II Pittsfield MA SNF TRS Sub, LLC, principal place of business is 350 Granite Street Suite 2304, Braintree, Massachusetts.

Mass. Gen. Laws cc. 231 sec. 60L Requirement has been met

14. On June 11, 2024, a formal letter was served to Springside Rehabilitation and Skilled Care Center, pursuant to the provisions of M.G.L. c. 231, §60L. (Exhibit A).

15. On June 11, 2024, out of an abundance of caution, but not required, a formal letter was served to CareerStaff Unlimited, LLC in Irving, Texas.

16. The notice statute, M.G.L. c. 231, §60L was enacted to give medical providers such as Springside Rehabilitation and Skilled Care Center an opportunity to evaluate claims early on and respond to them appropriately. The statute was designed to promote early resolution without the need for expensive litigation.

17. On November 4, 2024 Springside Rehabilitation and Skilled Care Center responded to Plaintiff's M.G.L. c. 231 §60L letter denying liability and no offer was made.

FACTUAL BACKGROUND

18. Plaintiff hereby realleges and repeats paragraphs 1 through 17 of this Amended Complaint, in the same manner and fashion if expressly set forth herein.

19. Springside Rehabilitation and Skilled Care Center claims that it "*is situated in the heart of the beautiful Berkshires and has earned a reputation of excellence in providing a range of rehabilitation and skilled nursing care. Our experienced staff of compassionate caregivers, therapists, clinical experts and dietary personnel are focused on one goal: providing an exceptional experience for our residents and patients. Our range of services includes post-acute, short-term rehabilitation for individuals needing to recover from a hospital stay to long term care. This includes goal-oriented rehabilitation following an elective joint replacement, recovering from a stroke or another serious illness. As a skilled nursing facility, our traditional long-term care services are a vital part of our mission. We strive to provide the highest possible quality of life and an active daily routine for our long-term residents*".

20. Springside Rehabilitation and Skilled Care Center claim they "*are committed to enhancing the lives of our residents, whether they need short-term rehabilitation, or traditional long-term care. At Springside we recognize the difference is in the details and we invest as much time and energy in our setting as we do in the care we provide. Our mission is to provide a bridge between inpatient care and home for our short-term residents, and to achieve and maintain the highest possible level of functioning for each of our long-term residents*".

21. Despite what Springside claim, Springside's State Survey and "Deficiencies" issued by the Massachusetts Department of Public Health have at all times relevant hereto, shown consistently substandard quality of care to its residents. This is indicative of a systemic problem of lack of quality of care and quality of life to the residents. This lack of quality of care was known to the administration, owners and management of Springside.

22. The following Deficiencies documented by the state of Massachusetts put Springside on notice of substandard care performed by its administration and staff:

    a. March 6, 2023, State surveys resulted in deficiency citations for "Administration" for failure to establish "the facility conducts, initially and periodically, a comprehensive, accurate, standardized reproducible assessment of each residents functional capacity from direct observation and communication with the resident and direct care staff."

    b. March 6, 2023, State surveys resulted in deficiency citations for "Administration" for failure to establish "The facility ensures that residents continent of bladder and bowel on admission receive services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. The facility ensures residents incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder

function as possible, specifically not catheterizing residents incontinent of urine who enter the facility without an indwelling catheter and assessing residents who enter with an indwelling catheter for removal of the catheter as soon as possible."

c. July 15, 2021, State surveys resulted in deficiency citations for "Administration" for failure to establish that "The facility ensures that its medication error rates are not 5 percent or greater."

23. At all relevant times, Springside exhibited a pattern of poor substandard care that was below the applicable standards for a nursing home.

24. At all relevant times, Springside's owners, administration, employees, administrators, license holders and corporate officers, were aware of the widespread pattern of substandard resident care and failed to correct it.

25. At all times pertinent hereto, Springside represented to Ms. Pfister that it would provide her with competent and quality care.

26. At all times relevant hereto, Defendant Bane Care Management LLC was the management company for Springside.

27. Defendant Bane Care Management LLC owns, operates and, or manages twelve (12) skilled nursing and assisted living locations across Massachusetts.

28. Defendant BaneCare hold itself out as a "*proud of the dedicated, seasoned and compassionate teams at each of our facilities. You will find that it is not unusual for our clinicians, therapists, nursing assistants and administrative staff to have over 20 or even 30 years of professional experience with BaneCare, which differentiates us from our competition. The staff and their unmatched ability to provide top quality care is the foundation of the BaneCare family*".

29. BaneCare's mission states: "*we are driven to create an environment built on compassion, dignity, and respect for our residents and their extended families, for our community, and for our staff members. We strive to achieve the highest possible quality of life for each resident by providing quality skilled nursing and post-acute rehabilitation care, delivered sensitivity, deep respect, and genuine hospitality. We are focused every day on caring for our residents just as we would want to be cared for ourselves. When families are no longer able to care for their loved ones, we will be there for them, understanding how difficult it is to make the decision to utilize a skilled nursing facility.*"

30. CareerStaff Unlimited is a per-dem and contract managed service provider based in Irving, Texas. It ranks No. 14 of largest per diem nurse staffing firms in the US.

31. CareerStaff, was founded in 1989, provides healthcare organizations with access to more than 1,000 staffing companies nationwide. (Acquired by ShiftMed in April 2024).

32. On June 15, 2018, Theresa Pfister was admitted to Springside for long term care.

33. At all times pertinent hereto, the Defendants operating Springside held themselves out to be a nursing home skilled in the custodial care, services and supervision to the residents of Springside in a safe environment, in a manner conforming to accepted rules, standards and established practices of the nursing home industry.

34. Ms. Pfister was dependent on her caregivers for all activities of daily living (ADLs).

35. Ms. Pfister used a wheelchair for mobility and required a mechanical lift for transfers.

36. At all times relevant hereto, the following care plan was in place for Ms. Pfister.

    i. Theresea requires 2 staff for Hoyer lift transfers using a medium (purple) full-body sling

37. On August 2, 2022, Ms. Pfister was injured when transferred using a Hoyer Lift: "Resident being transferred this am with Hoyer lift- lift pad straps ripped and resident fell onto floor- hitting left side top/post head- small lump present ice pack applied.

38. On May 16, 2023, while being cared for by an employee of Defendant CareerStaff Unlimited Ms. Pfister fell (dropped) out of a Hoyer Lift onto her face and head. 911 was then called at 5:22am.

39. Emergency Medical Services (EMS) found Ms. Pfister lying on the floor on her back with a 2-inch laceration to the right side of her forehead.

40. Reported to EMS by staff was that Ms. Pfister had been moved by Aide using Hoyer lift and that Ms. Pfister had fallen forward out of the Hoyer Lift from approximately 3 feet high, striking her head on the floor. Reported to have occurred 10 minutes prior to calling EMS. On EMS assessment Ms. Pfister's airway was open, there was dried/drying blood in both nostrils, her breathing non-labored, skin cool dry and of normal coloring. Laceration on forehead had coagulated and was no longer actively bleeding but with a large amount of drying blood in her hair on right side of head with 6-7 cm. laceration to head.

41. Ms. Pfister was placed in C-collar, moved to stretcher from floor by EMS. Ms. Pfister appeared to be in discomfort but remained calm and relaxed throughout the duration of transport to the hospital. The Glasgow Coma score was 9.

42. The Glasgow Coma Scale (GCS) is a neurological scale that assesses the level of consciousness in individuals following a traumatic brain injury. It evaluates three key aspects: eye-opening, verbal response, and motor response, each scored separately to provide a total GCS score ranging from 3 (deep coma or death) to 15 (fully alert).

43. At 5:52AM Ms. Pfister was admitted to the emergency department of the Berkshire Medical Center (BMC): *"Patient presents from Springside SNF after flipping out of a Hoyer lift landing face first on the floor* - Patient fell from approximately 3 feet".

44. BMC noted that there was no loss of consciousness, but that Ms. Pfister suffered a 3 cm laceration on the right side of forehead. Ms. Pfister was alert, crying and screaming. There was visible trauma, a 3 cm gaping diagonal laceration on left side of the forehead and cervical spine tenderness was noted. On physical examination the left leg had limited range of mobility secondary to pain. Ms. Pfister became quite agitated and resistant with range of motion of the left leg.

45. The following imaging was obtained and revealed Ms. Pfister additional injuries because of the drop/fall:

    a. Catscan of the chest, abdomen, and pelvis revealed an acute nondisplaced fracture of the posterior wall of the left acetabulum, and a few patchy ground glass and airspace infiltrates in the right upper lobe concerning for pneumonia.

    b. Catscan scan of the cervical spine revealed an acute nondisplaced type II odontoid fracture.

    c. Catscan of the face revealed an acute nondisplaced fracture of the anterior nasal bones and anterior nasal septum, and right frontal scalp laceration.

46. Labs revealed a slightly elevated white blood cell count of 11.2 *(normal 4.0-11.0)*

47. Ms. Pfister was given lorazepam 0.5 mg. IV, morphine 4 mg. IV, and tetanus prophylaxis.

48. The forehead laceration involved muscle layers and was closed with 5 staples under local lidocaine anesthesia.

49. A neurosurgical consultation was obtained. The recommendation was to use an Aspen collar and to follow up on an outpatient basis, as Ms. Pfister was not considered a surgical candidate.

50. An orthopedic consultation was obtained resulting in recommendation for conservative fracture treatment of the acetabular fracture and follow up as an outpatient.

51. At approximately 12:00PM Ms. Pfister was transferred back to Springside Rehabilitation and Nursing Center.

52. When Ms. Pfister returned from the hospital via ambulance she was sleeping but yelled out in pain when transferred to her bed. She appeared comfortable following positioning in bed.

53. At 1426 a late entry by Angela Williams RN stated, "resident returned from bmc er via stretcher at 12p- aspen collar in place-5 staples to right forehead, right hip fx[1]-odontoid fx-nasal fx- pna[2]-antibiotic given in er, returned with order for levofloxacin 750 mg po daily x 5 days-bruising noted to chin-red/blanchable buttocks-vss[3]- neuro checks in place-continue to monitor.

54. According to the Springside Rehabilitation and Nursing Center incident report: "at 0500 the patient was being transferred via mechanical lift when she fell out of the lift and onto the floor. The nurse was notified immediately and responded to the resident. Upon assessment, the nurse identified a laceration to the resident's right forehead. Bleeding was controlled, the resident was not moved, staff remained with her and 911 was called for transport to the ED.

55. The ED diagnosed the resident with 2 non-displaced nasal fractures, non-displaced C2 fracture, non-displaced left acetabulum fracture, and pneumonia. Her laceration was repaired with 5 staples, and an Aspen collar was applied to stabilize her neck.

56. She returned to Springside at noon 5/16/23 with recommendations for Tylenol and Ibuprofen for pain, orders to keep Aspen collar in place except for care until follow up with neurology/ weight bearing as tolerated with follow up with ortho, staple removal in 5 days, and antibiotics for her pneumonia. [The CNA] reported that she was transferring the resident via mechanical lift by herself and that she forgot to cross the leg straps. The resident fell forward out of the lift once the lift was away from the bed. The resident fell 3 feet to the floor, hitting her head on the mechanical lift and floor.

57. On May 25, 2023, DPH intake notes regarding the May 16, 2023, incident stated, "The resident was being transferred via Hoyer lift when she slid out and fell to the floor. A full investigation is underway, and a full report will follow. All staff (including CNAs, nurses, and rehab staff) have been notified that they can NOT use any lift until they successfully complete competency test."

58. On May 27, 2023, Jeremy Jones RN noted at approximately 10:00 pm Ms. Pfister appeared to have respiratory distress with mild to moderate secretions in her oral pharynx.

59. Her oxygen level was found to be low at 86%. Oxygen was administered with minimal effect.

60. The family was called, and a decision was made to transfer Ms. Pfister to the hospital. 911 was called and she was transferred to the emergency room.

61. Ms. Pfister was transported by ambulance at 10:37pm to the Berkshire Medical Center emergency department and was admitted to the Berkshire Medical Center ICU.

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[1] fx- fracture

[2] pna-pneumonia

[3] vss- vital signs stable

62. The medical assessment was sepsis with acute respiratory failure, multifocal pneumonia, hypernatremia, odontoid fracture, and hip fracture. Due to her worsening condition and requirement for increasing oxygen and blood pressure support, and after discussion with the healthcare proxy, Ms. Pfister was transitioned to comfort measures only.

63. She started on morphine and Ativan as needed.

64. Ms. Pfister died on May 28, 2023, at 7:51PM at the age of 70 years with family at her bedside.

65. The Death Certificate stated the death as:

    a. immediate cause COMPLICATIONS OF SECOND CERVICAL VERTEBRA, LEFT ACETABULUM

    b. due to or a consequence of AND NASAL BONE FRACTURES – DAYS.

    c. Place of injury SKILLED NURSING FACILITY

66. The interval between onset and death was 12 days.

67. On June 7, 2023, DHS conducted a survey at the Springside Rehabilitation and Nursing Center and issued citations for past non-compliance with Federal regulations related to 42 CFR 483.25 Quality of Care and 42 CFR 483.35 Nursing Services because of what happened to Ms. Pfister.

68. The survey revealed that the CNA assigned to Ms. Pfister had begun working at the facility only a few nights before the incident.

69. The CNA was a traveling CNA, and she said she had not received orientation from Springside on the use of the mechanical lift.

70. The CNA did not recall signing off on the Mechanical Lift Policy.

71. This CNA also said that she had not crossed the straps of the divided leg style lift pad when she fastened them to the lift, prior to initiating the transfer.

72. Springside Rehabilitation and Nursing Center's response to Plaintiff's M.G.L. c. 231, §60L presentment letter states that "*the .....fall forming the basis of the claim occurred ..... While she was being care for by an employee of CareerStaff Unlimited.*" It goes on to say that "*CareerStaff Unlimited was responsible for ensuring this employee was competent to provide care to Springside's residents before she began caring for people at the facility.*"

73. Once the Aide was placed by her employer CareerShift Unlimited, LLC at Springside Rehabilitation and Nursing Center on May 16, 2023, the Aide is under the direction and control, guidance and supervision of Springside Rehabilitation and Nursing Center.

74. In 2023 Springside was significantly RN understaffed coupled with CNA understaffing.

75. For the year 2023 Springside saved $1,926,455 from Staffing below the Hybrid Recommended, and $356,252 Savings from Staffing below Anticipated Minimum.

76. Springside knew or should have known that inadequate staffing leads to incidents like Ms. Pfister's death.

77. Bane Care knew that inadequate staffing leads to incidents like Ms. Pfister's death and has been in the business for 66 years!

78. At all times pertinent hereto, Ms. Pfister was wholly reliant on the Springside and Bane Care's staff for her supervision, care and safety.

CLAIMS

COUNT I
Negligence
GAHCR II PITTSFIELD MA SNF TRS SUB, LLC doing business as SPRINGSIDE REHABILITATION AND SKILLED CARE CENTER

79. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein.

80. At all times pertinent hereto, the Defendant Springside held out to be a nursing home skilled in the custodial care and supervision of nursing home residents, able to provide said custodial care, services and supervision to residents of the facility in a safe environment, in a manner conforming to accepted rules, standards and established practices of the nursing home industry.

81. On August 2, 2022, Springside failed to safely transfer Ms. Pfister using a Hoyer Lift and she was injured.

82. On or about May 16, 2023, the Defendant Springside, by and through their employees, agents, servants, negligently failed to adequately supervise and assist Ms. Pfister while at Springside, causing her to fall mid-transfer from the Hoyer lift, suffering serious injury and ultimately death.

83. On or about August 2, 2022, and then again on May 16, 2023, Springside by and through their employees, agents, servants, negligently failed to provide or obtain adequate custodial care, supervision, and monitoring to prevent Ms. Pfister from suffering harm.

84. On or about August 2, 2022, and then again on May 16, 2023, Springside by and through their employees, agents, servants, officers, directors, partners, corporate parent, and/ or

subsidiaries, negligently failed to hire enough sufficient competent staff to care for, supervise, and/or monitor Ms. Pfister.

85. On or about May 16, 2023, Springside by and through their employees, agents, servants, officers, directors, partners, corporate parent, and/ or subsidiaries, negligently failed to properly train its staff and that of CaeerStaff Unlimited, LLC's Aide in caring for, supervising or monitoring Ms. Pfister.

86. On or about August 2, 2022, Springside by and through their employees, agents, servants, officers, directors, partners, corporate parent, and/or subsidiaries, negligently failed to properly train its staff in caring for, supervising or monitoring Ms. Pfister.

87. On or about May 16, 2023, Springside by and through their employees, agents, servants, officers, directors, partners, corporate parent, and/ or subsidiaries, negligently failed to properly supervise its staff and that of CaeerStaff Unlimited, LLC's Aide in caring for Ms. Pfister.

88. On or about August 2, 2022, Springside by and through their employees, agents, servants, officers, directors, partners, corporate parent, and/ or subsidiaries, negligently failed to properly supervise its staff in caring for Ms. Pfister.

89. On August 2, 2022, Springside failed to maintain and keep the Hoyer Lift and, or it's pads in proper working condition.

90. Springside was required under both state and federal law, and by contract, to provide safety to Ms. Pfister as a consumer of its services and to render appropriate care and treatment in accordance with standards specified in both the Commonwealth of Massachusetts Regulations for Long Term Care Facilities, 105 CMR 150.000 – 159.000 and the Federal Nursing Home Regulations, 42 CFR 483.5 – 483.95. These failures are evidence of neglect under CMR 155.003 and 42 CFR 483.25.

91. As a direct and proximate result of the negligence on the part of Springside, Ms. Pfister suffered personal injuries, disfigurement, loss of dignity, conscious pain and suffering, leading up to her ultimately death on May 28, 2023.

92. As a direct and proximate result of negligence on the part of Springside, Ms. Pfister suffered personal injuries, loss of dignity, conscious pain and suffering on August 2, 2022.

93. As a direct and proximate result of the negligent acts by Springside Ms. Pfister was neglected per 105 CMR 155. Neglect. Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. In determining whether or not neglect has occurred, the following standards shall apply: (1) A patient or resident has been neglected if: (a) An individual has failed to provide appropriate care, treatment or service to the patient or resident; (b) The individual's failure to provide the treatment, care or service to the patient or resident is either intentional or the result of carelessness; and (c) As a result of the failure to provide the treatment, care or service, the individual has failed

to maintain the health or safety of the patient or resident, as evidenced by harm to the patient or resident, or a deterioration in the patient or resident's physical, mental or emotional condition.

WHEREFORE, Plaintiff, the Personal Representative of the Estate of Theresea M. Pfister, prays that judgment be entered in its favor and against Springside in an amount just and appropriate together with interest, attorney's fees, cost of suit, and for such other relief as the Court may award.

COUNT II
Wrongful Death
Pursuant to M.G.L. c. 229 §2
GAHCR II PITTSFIELD MA SNF TRS SUB, LLC doing business as
SPRINGSIDE REHABILITATION AND SKILLED CARE CENTER

Plaintiff hereby reasserts and repeats the allegations, inclusively, as if set forth fully herein

94. The Defendant was at all times required to have sufficient numbers of competent and trained staff. The Defendant failed to properly screen, hire, and supervise, monitor and train agents, agency staff, agents, servants or employees in the proper care of Theresa Pfister and the proper methods for transferring Thersea Pfister as well as the proper use of Hoyer lifts.

95. At all relevant times, the Defendant had sufficient monetary funds, resources and supplies to provide the residents of Springside, including Ms. Pfister, with adequate equipment, care, monitoring, supervision, staffing, and management but failed to do so and as a result the licensee Springside, was ill equipped to provide adequate equipment, care, monitoring, supervision, protection, sufficient competent staff, resources and services necessary to meet all the needs of their residents, including Ms. Pfister, and a direct result neglect occurred which led to her untimely death.

96. At all relevant times, Springside was responsible for ensuring that the Aide involved with the May 16, 2023, transfer of Ms. Pfister was familiar with, trained in Springside's policy and procedures and the resident needs for each resident the Aide would be caring for. That included Ms. Pfister.

97. At all relevant times, Springside had an obligation to supervise the CareerStaff Unlimited, LLC's Aide in the building.

98. Springside failed to supervise the CareerStaff Unlimited, LLC Aide on May 16, 2023.

99. Springside failed to ensure that the Aide involved with the May 16, 2023, transfer of Ms. Pfister was familiar with, trained on Springside's policy and procedures and the resident needs for each resident the Aide would be caring for.

100. On May 16, 2023, Defendant failed to educate, train and supervise its employees, staff, agents, servants (particularly the CareerStaff Unlimited, LLC Aide) and workers on the proper use of the Hoyer lift.

101. At all times relevant, the direct and indirect owners of "Springside" had sufficient monetary funds, resources, and supplies to provide the residents Springside including Theresa Pfister, with adequate monitoring, supervision, staffing, and management but the direct owner and, or management failed to do so and as a result the licensee, GAHCR II Pittsfield MA SNF TRS SUB, LLC, was ill equipped to provide the care, protection sufficient competent staff, resources, and services necessary to meet all the needs of their residents, including Theresa, and a result negligence occurred.

102. At all times pertinent hereto, Springside failed to hire sufficient numbers of adequately trained and equipped staff to care for, supervise, and/or monitor Ms. Pfister.

103. At all times relevant, Springside held and does hold itself out to the general public, including Thersea Pfister, other residents and both the State of Massachusetts and Federal Governments as a skilled nursing home facility which claims to provide quality care and is competent and qualified to provide the necessary care and services expected of a nursing home facility.

104. At all times pertinent hereto, Springside, with the management advice of Bane Care, significantly reduced its RN and CNA staffing levels in an effort to save money.

105. By doing so resulted in a decline in Springside's quality of care, as evidenced by the surveys the Department of Health and Human Services conducted and issued against Springside (See paragraph 22 of this Complaint).

106. Springside Rehabilitation and Nursing Center staff failed in their duty to keep Ms. Pfister safe from harm.

107. Although an adequate care plan was in place for ensuring her safety during transfers, the CNA directly involved in her care did not adhere to the care plan.

108. The established care plan specifically called for two+ staff for all transfers and certain other care activities but the CNA performed the transfer alone.

109. Further, the DHS survey found there was no evidence that Springside Rehabilitation and Nursing Center ensured the CNA had been properly trained on using the mechanical lift.

110. Unfortunately, Ms. Pfister suffered significant harm related to these breaches in regulations, policy violations, and care standards.

111. She experienced pain not only at the time of injury, but also when undergoing subsequent procedures and care activities that caused pain in movement.

112. She exhibited evidence of anxiety and fear as well, crying and yelling out during her evaluation and treatment in the emergency room.

113. Finally, the medical documentation revealed that although not symptomatic at the time, x-ray evidence of pneumonia was noted during the May 16, 2023 emergency room visit.

114. In the subsequent days following Ms. Pfister's fall/ drop, her respiratory status worsened, and she developed multifocal pneumonia with acute sepsis.

115. This sequence of events is consistent with respiratory compromise that can occur in immobile patients.

116. Respiratory complications from immobility include decreased ventilation, atelectasis, and pneumonia.

117. The care plan initiated on May 18, 2023 for pneumonia did not include an intervention for frequent repositioning and the CNA documentation shows numerous gaps in repositioning interventions for the month of May 2023.

118. The immobility resulting from the traumatic injuries on May 16, 2023, including odontoid and hip fractures, made movement difficult and further compromised Ms. Pfister's respiratory status.

119. Defendant Springside, through its agents, servants and/or employees, held itself out to be a specialist in the field of nursing care with the expertise to maintain the health and safety of people unable to care for themselves, such as Theresa Marie Pfister.

120. As Decedent Theresa Marie Pfister was a paying resident of Springside, said nursing home, by and through its agents, servants, and/or employees, owed duties, contractual and otherwise, to decedent to provide competent nursing and other care as required by law and consistent with community standards.

121. Defendant Springside also had a duty to secure competent custodial and medical care for its residents, including decedent, when it was not equipped to treat or stabilize any particular medical condition.

122. Defendant Springside also had a duty to always provide safety for its residents, including decedent.

123. Defendant Springside also had a duty to refrain from injuring and harming its residents, including decedent.

124. Defendant Springside also had a duty to properly train its staff (and that of any agency staff) in caring for decedent and others like her who were unable to attend to their own health and safety, and were confined to a nursing home.

125. On or about May 16, 2023, the Springside, by and through their employees, agents, servants, officers, directors, partners, corporate parent, and/or subsidiaries negligently failed to provide necessary safe working equipment to assist and protect Ms. Pfister while at Springside, causing her to fall or be dropped mid transfer from the Hoyer lift.

126. Defendant Springside breached said duties and was negligent by:

a. Causing decedent to be exposed to risk of personal injury from abuse, neglect, and lack of supervision.
b. Failing to properly provide adequate supervision and appropriate care for decedent in accordance with her needs.
c. Failing to provide qualified and trained staff.
d. Failing to provide adequate resources to enable quality care to be given.
e. Failing to take necessary and appropriate measures to avoid accident hazards.
f. Failing to follow nursing care plans responsive to the care of the decedent.
g. Failing to perform the above actions willfully and knowingly.

127. The Defendant was negligent in that they violated the regulations for licensing of long term care health facilities of both the Health Care Financing Administration U.S. Department of Health and Human Services, 42 CFR Part 483 and the Massachusetts Department of Public Health, 105 C.M.R. §150.00, et seq., as they failed to provide a sufficient number of trained, experienced and competent personnel; negligently hired and retained incompetent staff, failed to ensure that their personal needs are met and that they remain free of accidents; and failed to ensure dignity.

128. The Defendant failed to comply with federal and state laws, rules, regulations, and guidelines designed to protect the health and safety of patients and residents such as Ms. Pfister. The Defendnat was negligent per se in violating the following regulations: (including but not limited to)

a. 42 CFR 483.10 which relates to Resident Rights and several of its subparts;
b. 42 CFR 483.20 which relates to Resident Assessment and several of its subparts;
c. 42 CFR 483.25 which relates to Quality of Care and several of its subparts;
d. 42 CFR 483.15 which relates to Quality of Life and several of its subparts;
e. 42 CFR 483.30 which relates to Nursing Services and several of its subparts;
f. 42 CFR 483.75 which relates to Administration and several of its subparts.

129. In addition to the foregoing, the Defendant was negligent per se in violating 105 C.M.R. §150.000-159.000 (subparts thereof) standards for Long Term Care Facilities, as promulgated by the Commonwealth of Massachusetts Department of Public Health.

130. At all times pertinent hereto, Theresa Pfister, was unable to care for herself and was under the exclusive control and care of the Defendants.

131. At all times pertinent hereto, the decedent, Theresa Pfister, was in the exercise of due care under the circumstances and was otherwise free from any and all comparative negligence.

132. As a direct and proximate result of the Defendant's wrongful and negligent acts and omissions, as aforesaid, Theresa Pfister was severely injured, was caused to endure extreme conscious pain and suffering for an extended period of time, suffered bodily injury, incurred expenses for his medical treatment, died on May 28, 2023, and was otherwise injured and damaged. The plaintiff also incurred funeral expenses as a direct and proximate result of these acts and omissions.

133. Defendant Springside was negligent in failing to comply with federal and state laws, rules, regulations and guidelines designed to protect the health and safety of residents such as decedent Theresa Marie Pfister. Violations include:

a. Federal regulation 42 CFR §483.25 Quality of Care §483.25(d) Accidents The facility must ensure that §483.25(d)(1) the resident environment remains as free of accident hazards as is possible; §483.25(d)(2) each resident receives adequate supervision and assistance devices to prevent accidents.

b. Federal regulation 42 CFR §483.35 Nursing Services §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning, and implementing resident care plans and responding to resident's needs.

c. Federal regulation 42 CFR §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

d. Federal regulation 42 CFR §483.21(b)(1) Comprehensive Care Plans specifies that the facility must develop and implement a comprehensive person-centered care plan for each resident that is based on a comprehensive assessment of the resident's medical, nursing, and mental and psychological needs. The facility must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

e. Regulations from the State of Massachusetts; 105 CMR 150.007 (D)(2)(a) specifies: Nursing Care Plan: The nursing care plan shall be an organized, written daily plan of care for each patient. It shall include: diagnoses, significant conditions or impairments, medication, treatments, special orders, diet, safety measure, mental condition, bathing and grooming schedules, activities of daily living, the kind and amount of assistance needed, long-term and short-term goals, planned patient teaching programs, encouragement of patient's interests and desirable activities. It shall indicate what nursing care is needed, how it can best be accomplished, and what methods and

approaches are most successful. This information shall be summarized on a cardex and be available for use by all personnel involved in patient care.

f. Regulations from the State of Massachusetts; 105 CMR 150.007 (D)(2) (d) specifies: All personnel who provide care to a patient shall have a thorough knowledge of the patient's condition and the nursing care plan.

134. Springside Rehabilitation and Nursing Center staff failed in their duty to keep Ms. Pfister safe from harm.

135. Defendant Springside, through its agents, servants and employees, disregarded its duties as aforesaid and failed to exercise said level of care in that said defendant negligently failed to properly render and recommend appropriate services to decedent.

136. Defendant Springside, through its agents, servants and employees, disregarded its duties as aforesaid and failed to exercise said level of care in that said defendant negligently failed to recommend adequate, proper and necessary treatment and care.

137. Defendant Springside, through its agents, servants and employees, disregarded its duties as aforesaid and failed to exercise said level of care in that said defendant negligently failed to properly supervise plaintiff.

138. Defendant Springside, through its agents, servants and employees, disregarded its duties as aforesaid and failed to exercise said level of care in that said defendant was otherwise negligent.

139. Defendant Springside's acceptance of a CNA from a staffing agency such as Defendant CareerStaff Unlimited, LLC constitutes an acceptance of responsibility to supervise, train, and familiarize that CNA with policies and procedures.

140. Defendant Springside's acceptance of a CNA from a staffing agency such as Defendant CareerStaff Unlimited, LLC constitutes an acceptance to monitor that CNA.

141. Defendant Springside's acceptance of a CNA from a staffing agency such as Defendant CareerStaff Unlimited, LLC constitutes an acceptance of the CNA from Defendant CareerStaff Unlimited, LLC and Defendant Springside is responsible for her actions and negligence that occurred under (Springside's) building and supervision.

142. Harm "includes but is not limited to death, physical injury, pain or psychological injury" 105 C.M.R §155.003.

143. Ms. Pfister's injuries were the result of neglect by Springside and its staff that were insufficient in both quantity and quality to care for her and were the foreseeable result of the acts of Bane Care.

144. As a direct and proximate cause of the negligence of Defendant Springside, decedent Thersea Marie Pfister was dropped from a Hoyer lift, suffered for days before succumbing to her injuries and ultimately died.

145. As a direct and proximate cause of Defendant Springside's wrongful and negligent acts and omissions, as aforesaid, decedent Theresa Marie Pfister sustained injuries and died, was caused to endure extreme conscious pain and suffering, suffered bodily injury, incurred expenses for additional and otherwise unnecessary medical treatment, suffered a loss of dignity, and was otherwise injured and damaged.

WHEREFORE, the Estate of Theresa Marie Pfister prays that judgment be entered in their favor and against Defendant GAHCR II Pittsfield MA SNF TRS SUB, LLC in an amount deemed, just and fair by this Honorable court, together with interest, attorney fees, cost of suit, and for such other relief as this Honorable court may award.

COUNT III
Conscious Pain and Suffering
Pursuant to M.G.L. c. 229 §2 and to M.G.L. c. 229 §6
GAHCR II PITTSFIELD MA SNF TRS SUB, LLC doing business as
SPRINGSIDE REHABILITATION AND SKILLED CARE CENTER

146. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein.

147. As a direct and proximate cause of the negligence, and / or willful and / or intentional conduct of Defendant, GAHCR II Pittsfield MA SNF TRS SUB, LLC as foresaid, decedent Thresa Marie Pfister endured extreme and prolonged conscious pain and suffering.

WHEREFORE, the Plaintiff, the Estate of Thresa Marie Pfister, prays that judgment be entered in it's favor and against Defendant GAHCR II Pittsfield MA SNF TRS SUB, LLC in an amount deemed, just and fair by this Honorable court, together with interest, attorney fees, cost of suit, and for such other relief as this Honorable court may award for the conscious pain and suffering caused by the Defendant GAHCR II Pittsfield MA SNF TRS SUB, LLC.

COUNT IV
Punitive Damages
Pursuant to M.G.L. c. 229 §2
GAHCR II PITTSFIELD MA SNF TRS SUB, LLC doing business as
SPRINGSIDE REHABILITATION AND SKILLED CARE CENTER

148. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein.

149. All the forementioned acts and or omissions of Defendant GAHCR II Pittsfield MA SNF TRS SUB, LLC constitute gross negligence, and or arise to the level of willful, wanton and / or reckless behavior within the meaning of the Wrongful Death Statute, so as to merit an

award of punitive damages against the Defendant GAHCR II Pittsfield MA SNF TRS SUB, LLC.

150. As a direct and proximate cause of the negligence, and / or gross negligence and / or willful and / or intentional conduct of Defendant GAHCR II Pittsfield MA SNF TRS SUB, LLC as foresaid, decedent Theresa Marie Pfister endured extreme and prolonged conscious pain and suffering and death.

WHEREFORE, the Plaintiff the Estate of Theresa Marie Pfister prays that judgment be entered in its favor and against Defendant GAHCR II Pittsfield MA SNF TRS SUB, LLC in an amount of punitive damages deemed just and fair by this Honorable Court, together with interest, attorney fees, costs of suit, and for such other relief the Court may award.

COUNT V
Negligence
BANE CARE MANAGEMENT, LLC

151. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein.

152. At all times pertinent hereto, Bane Care Management, LLC was the management company for Springside.

153. Springside represents to the community that it is Bane Care facility.

154. At all times pertinent hereto, Bane Care was knowledgeable and sophisticated about the business of the management and operation of Long Term Care facilities such as Springside.

155. At all times pertinent hereto, Bane Care was knowledgeable and sophisticated with respect to regulatory requirements and obligations owed to nursing home residents such as Ms. Pfister.

156. At all times pertinent hereto, Bane Care knew or should have known of the many deficient practices occurring at the Springside facility as set forth throughout this complaint.

157. At all times pertinent hereto, Bane Care knew or should have known how the lack of administration involvement by Bane Care contributed to the deficient practices occurring at the Springside facility.

158. At all times pertinent hereto, Bane Care failed to take adequate action to remedy the deficient practices occurring at the Springside facility.

159. At all times pertinent hereto, Bane Care was knowledgeable and sophisticated with respect to the standards and duties of care owed to nursing home residents such as Ms. Pfister.

160. At all times pertinent hereto, Bane Care owed a duty of care to Ms. Pfister.

161. At all times pertinent hereto, the duty of care owed by Bane Care to Ms. Pfister included the duty to adopt and implement policies or procedures designed to ensure appropriate care was delivered to Ms. Pfister.

162. Bane Care, by and through its employees, agents, and/or servants, breached its duty of care to Ms. Pfister by failing to adopt and implement policies or procedures designed to ensure that the appropriate care was delivered to Ms. Pfister.

163. At all times pertinent hereto, the duty of care owed by Bane Care to Ms. Pfister included the duty to hire, or arrange for, sufficient numbers of adequately trained and equipped staff to care for, supervise, and/or monitor Ms. Pfister.

164. Bane Care, by and through its employees, agents, and/or servants, breached its duty of care to Ms. Pfister by failing to hire, or arrange for, adequately trained and equipped staff to care for, supervise, and/or monitor Ms. Pfister.

165. Bane Care and its owners, managers, and operators knew or should have known that inadequate staffing leads to incidents like the one that led to Ms. Pfister's death.

166. At all times pertinent hereto, upon information and belief and upon industry standards, Bane Care generated revenue from Springside by providing various services, including, but not limited to, participation in the management of budgets, operations, staffing, and training.

167. At all times pertinent hereto, the duty of care owed by Bane Care to Ms. Pfister included the duty to properly train the staff in caring for, supervising, and/or monitoring Ms. Pfister.

168. Bane Care by and through its employees, agents, and/or servants, breached its duty of care to Ms. Pfister by failing to properly train the staff in caring for, supervising, and/or monitoring Ms. Pfister.

169. At all times pertinent hereto, the duty of care owed by Bane Care to Ms. Pfister included the duty to properly supervise the staff in caring for and supervising Ms. Pfister.

170. At all times pertinent hereto, Bane Care had a nurse on staff to oversee the provision of care at Springside.

171. Bane Care by and through its employees, agents, and/or servants, breached its duty of care to Ms. Pfister by failing to properly supervise the staff in caring for and supervising Ms. Pfister.

172. At all times pertinent hereto, the duty of care owed by Bane Care to Ms. Pfister included the duty to administer the Springside facility in a manner that enabled the facility to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, including Ms. Pfister.

173. Bane Care, by and through its employees, agents and/or servants, breached its duty of care to Ms. Pfister by failing to administer the Springside facility in a manner that enabled the facility to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of Ms. Pfister.

174. Bane Care, by and through its employees, agents, and/or servants, breached its duty of care to Ms. Pfister when it made the deliberate decision to increase their profits by decreasing the number of RNs and CNAs at Springside.

175. Bane Care, by and through its employees, agents, and/or servants, breached its duty of care to Ms. Pfister when it made the deliberate decision to increase their profits by decreasing the number of LPNs at Springside.

176. Bane Care and its owners, managers, and operators acted wantonly and maliciously with regard to Ms. Pfister.

177. As a direct and proximate result of the fault of Bane Care, Ms. Pfister suffered preventable harm and damages including but not necessarily limited to physical injuries, loss of dignity, and conscious pain and suffering.

178. As a direct and proximate result of the fault of Bane Care, Ms. Pfister suffered preventable harm and damages which caused her untimely death on May 28, 2023.

179. As a direct and proximate result of the fault of Bane Care, Ms. Pfister suffered preventable harm and damages on August 2, 2022.

180. At all times pertinent hereto, Bane Care exercised pervasive control over the operations at the Springside facility.

181. At all times pertinent hereto, Bane Care oversaw key areas of nursing center operations, including: clinical issues and quality concerns, sales and marketing efforts, nursing, dietary services, federal and state reimbursement, human resources management, maintenance, and financial services.

182. At all times pertinent hereto, Bane Care determined the policies and procedures that govern the clinical care at each facility including the Springside facility.

183. At all times pertinent hereto, Bane Care exercised pervasive control over the nursing practices at the Springside facility.

184. At all times pertinent hereto, Bane Care reviewed nursing practices at the Springside facility.

185. At all times pertinent hereto, Bane Care directed initiatives concerning resident care at the Springside facility.

186. At all times pertinent hereto, Bane Care coordinated training programs for the nurses and nursing assistants at the Springside facility.

187. At all times pertinent hereto, Bane Care exercised pervasive control over the administration of the Springside facility.

188. At all times pertinent hereto, Bane Care was responsible for the supervising of executive directors and administrators of the Springside facility.

189. At all times pertinent hereto, Bane Care coordinated training programs for nursing center executive directors, the business office, and other department managers at the Springside facility.

190. At all times pertinent hereto, Bane Care was responsible for ensuring that the administrator of Springside hired competent and qualified staff.

191. At all times pertinent hereto, Bane Care exercised pervasive control over the operating budget for the Springside facility.

192. At all times pertinent hereto, Bane Care exercised pervasive control over the fees charged at the Springside facility.

193. At all times pertinent hereto, the Springside facility had no discretion as to the amount of money paid to Bane Care.

194. At all times pertinent hereto, Bane Care had no other source of income other than monies paid by Springside.

195. At all times pertinent hereto, Bane Care was responsible for setting the budget for the Springside facility.

196. At all times pertinent hereto, the budget set by Bane Care affected the staffing levels at the Springside facility.

197. At all times pertinent hereto, when Bane Care exercised its pervasive control over both the operation of and the flow of money from the Springside facility, Bane Care did so know

that its activities would impact the quality and quantity of care available to Ms. Pfister and others like her.

198. At all times pertinent hereto, Bane Care knew that Ms. Pfister and others like her would be induced to place themselves under the care of the Springside facility.

199. Ms. Pfister, and others like her, relying on the promise of skilled competent care, did in fact place themselves under the care of the Springside facility.

200. Ms. Pfister's injuries were the result of neglect by the Springside staff that were insufficient in both quantity or quality to care for her and were the foreseeable result of the acts of Bane Care.

201. As a direct and proximate result of the willful, wanton, and reckless conduct on the part of Bane Care, Ms. Pfister suffered preventable injuries and an untimely death.

202. The death of Ms. Pfister was a foreseeable result of the actions taken by Bane Care in directing and controlling the operations of the Springside facility.

203. At all times pertinent hereto, Bane Care manifested an intent to associate with the Springside facility for mutual profit arising from the skilled nursing services provided to Ms. Pfister and others like her at the Springside facility.

204. At all times pertinent hereto, Bane Care contributed money, property, effort, knowledge, skill, or other assets to the common undertaking with the Springside facility.

205. At all times pertinent hereto, Bane Care maintained a joint property interest with the Springside facility in all or parts of the subject matter of the venture.

206. At all times pertinent hereto, Bane Care possessed a right to participate in the control or management of the enterprise.

207. At all times pertinent hereto, Bane Care exercised its right to participate in the control or management of the enterprise.

208. At all times pertinent hereto, Bane Care had an expectation of profit from the enterprise.

209. At all times pertinent hereto, Bane Care had a right to share in the profit from the enterprise, including any profit derived from the services rendered to Ms. Pfister.

210. At all times pertinent hereto, Bane Care shared responsibility for any losses from the enterprise, including any losses related to the services rendered to Ms. Pfister.

211. Wherefore, the Defendants, Springside and Bane Care were acting as a joint venture.

212. As a direct and proximate cause of the negligence of Defendant Bane Care, decedent Thersea Marie Pfister was dropped from a Hoyer lift on May 16, 2023, suffered for days before succumbing to her injuries and ultimately died on May 28, 2023.

213. As a direct and proximate cause of the negligence of Defendant Bane Care, decedent Thersea Marie Pfister was dropped from a Hoyer lift on August 2, 2022, suffered for days thereafter and was otherwise injured.

214. As a direct and proximate cause of Defendant Bane Care's wrongful and negligent acts and omissions, as aforesaid, decedent Theresa Marie Pfister sustained injuries and died, was caused to endure extreme conscious pain and suffering, suffered bodily injury, incurred expenses for additional and otherwise unnecessary medical treatment, suffered a loss of dignity, and was otherwise injured and damaged.

WHEREFORE, Plaintiff, the Personal Representative of the Estate of Theresea M. Pfister, prays that judgment be entered in its favor and against Bane Care in an amount just and appropriate together with interest, attorney's fees, cost of suit, and for such other relief as the Court may award

COUNT VI
Wrongful Death
Pursuant to M.G.L. c. 229 §2
BANE CARE MANAGEMENT, LLC

215. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein.

216. As a direct and proximate cause of the negligence of Defendant Bane Care, decedent Thersea Marie Pfister was dropped from a Hoyer lift on May 16, 2023, suffered for days before succumbing to her injuries and ultimately died on May 28, 2023.

217. As a direct and proximate cause of Defendant Bane Care's wrongful and negligent acts and omissions, as aforesaid, decedent Theresa Marie Pfister sustained injuries and died, was caused to endure extreme conscious pain and suffering, suffered bodily injury, incurred expenses for additional and otherwise unnecessary medical treatment, suffered a loss of dignity, and was otherwise injured and damaged.

WHEREFORE, the Estate of Theresa Marie Pfister prays that judgment be entered in their favor and against Defendant Bane Care Management, LLC in an amount deemed, just and fair by this Honorable court, together with interest, attorney fees, cost of suit, and for such other relief as this Honorable court may award.

COUNT VII
Conscious Pain and Suffering
Pursuant to M.G.L. c. 229 §2 and to M.G.L. c. 229 §6
BANE CARE MANAGEMENT, LLC

218. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein.

219. As a direct and proximate cause of the negligence, and / or willful and / or intentional conduct of Defendant, Bane Care Management, LLC as foresaid, Decedent Thresa Marie Pfister endured extreme and prolonged conscious pain and suffering.

WHEREFORE, the Plaintiff, the Estate of Thresa Marie Pfister, prays that judgment be entered in it's favor and against Defendant Bane Care Management, LLC in an amount deemed, just and fair by this Honorable court, together with interest, attorney fees, cost of suit, and for such other relief as this Honorable court may award for the conscious pain and suffering caused by the Defendant Bane Care Management, LLC.

COUNT VIII
Punitive Damages
Pursuant to M.G.L. c. 229 §2
BANE CARE MANAGEMENT, LLC

220. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein.

221. All the forementioned acts and or omissions of Defendant Bane Care Management, LLC constitute gross negligence, and or arise to the level of willful, wanton and / or reckless behavior within the meaning of the Wrongful Death Statute, so as to merit an award of punitive damages against the Defendant Bane Care Management, LLC.

222. As a direct and proximate cause of the negligence, and / or gross negligence and / or willful and / or intentional conduct of Defendant Bane Care Management, LLC as foresaid, decedent Theresa Marie Pfister endured extreme and prolonged conscious pain and suffering and death.

WHEREFORE, the Plaintiff the Estate of Theresa Marie Pfister prays that judgment be entered in its favor and against Defendant Bane Care Management, LLC in an amount of punitive damages deemed just and fair by this Honorable Court, together with interest, attorney fees, costs of suit, and for such other relief the Court may award.

COUNT IX
Wrongful Death
Pursuant to M.G.L. c. 229 §2
CAREERSTAFF UNLIMITED, LLC

223. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein.

224. At all times relevant hereto, "CareerStaff" contracted with the Defendant Bane Care and , or Springside, to provide skilled competent nursing and, or certified nursing aide care at Springside to care for residents including Theresa Pfister.

225. Defendant Careerstaff at all times pertinent hereto, was the nurse pool and placement agency for Springside when the injuries which are the subject matter of this complaint were occasioned.

226. Defendant Careerstaff had contractual and other duties to provide competent nursing and other care at Springside in which Ms. Pfister was a third-party beneficiary.

227. Careerstaff also had a duty to secure competent medical care for the residents they were assigned, including Ms. Pfister, when it was not equipped to treat or stabilize any particular medical condition.

228. CareerStaff held itself out to be a specialist in the field of nursing placement with the expertise to maintain the health and safety of people unable to care for themselves, such as Ms. Pfister

229. CareerStaff also had a duty to provide nurses and aides to Springside that were adequately trained, supervised and monitored in the act of transferring residents as well as being familiar and knowledgeable about transfer using Hoyer lifts.

230. Notwithstanding said duties, on or about May 16, 2023, CareerStaff, though its agents, servants, employees, failed to timely and adequately provide adequate care and treatment while Ms. Pfister was receiving rehabilitative and skilled nursing care.

231. When Ms. Pfister was injured on May 16, 2023, she was being transferred and cared for by CareerStaff employees, placements or personnel.

232. CareerStaff employees negligently dropped or failed to transfer Theresa Pfister safely on May 16, 2023.

233. As a direct and proximate cause of the negligence of Defendant CareerStaff, decedent Thersea Marie Pfister was dropped from a Hoyer lift on May 16, 2023, suffered for days before succumbing to her injuries and ultimately died on May 28, 2023.

WHEREFORE, Plaintiff, the Personal Representative of the Estate of Theresea M. Pfister, prays that judgment be entered in its favor and against CareerStaff in an amount just and appropriate together with interest, attorney's fees, cost of suit, and for such other relief as the Court may award

COUNT XI
Conscious Pain and Suffering
Pursuant to M.G.L. c. 229 §2 and to M.G.L. c. 229 §6
CAREERSTAFF UNLIMITED, LLC

234. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein.

235. As a direct and proximate cause of the negligence, and / or willful and / or intentional conduct of Defendant CareerStaff Unlimited, LLC, as foresaid, decedent Thresa Marie Pfister endured extreme and prolonged conscious pain and suffering.

WHEREFORE, the Plaintiff, the Estate of Thresa Marie Pfister, prays that judgment be entered in it's favor and against Defendant CareerStaff Unlimited, LLC in an amount deemed, just and fair by this Honorable court, together with interest, attorney fees, cost of suit, and for such other relief as this Honorable court may award for the conscious pain and suffering caused by the Defendant CareerStaff Unlimited, LLC.

COUNT XII
Punitive Damages
Pursuant to M.G.L. c. 229 §2
CAREERSTAFF UNLIMITED, LLC

236. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein

237. All the forementioned acts and / or omissions of Defendant CareerStaff Unlimited, LLC constitute gross negligence, and or arise to the level of willful, wanton and / or reckless behavior within the meaning of the Wrongful Death Statute, so as to merit an award of punitive damages against the Defendant CareerStaff Unlimited, LLC.

WHEREFORE, the Estate of Thresa Marie Pfister, prays that judgment be entered in it's favor and against Defendant CareerStaff Unlimited, LLC in an amount deemed, just and fair by this Honorable court, together with interest, attorney fees, cost of suit, and for such other relief as this Honorable court may award

COUNT XIII
VICARIOUS LIABILITY
CAREERSTAFF UNLIMITED, LLC

238. Plaintiff hereby reasserts and repeats the allegations, inclusive, as if set forth fully herein

239. CareerStaff Unlimited, LLC is liable for the negligent actions of their employee placed at Springside on May 16, 2023who was involved with the transfer via Hoyer Lift of Ms. Pfister because those actions and inactions occurred within the scope of her employment.

WHEREFORE, Plaintiff, the Personal Representative of the Estate of Theresea M. Pfister, prays that judgment be entered in its favor and against CareerStaff in an amount just and appropriate together with interest, attorney's fees, cost of suit, and for such other relief as the Court may award

JURY DEMAND

A Jury Trial is hereby DEMANDED by the Plaintiff.

Respectfully Submitted,
For the Plaintiff,
By its counsel,

/s/ David J. Hoey

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Exhibit "A"
Attachment to Complaint

June 11, 2024

Springside Rehabilitation and Skilled
Care Center
Attn: Ms. Christina Pringle, Administrator
255 Lebanon Avenue
Pittsfield, MA 01201

Re: The Estate of Theresa Marie Pfister v. Springside Rehabilitation and Skilled Care Center

Dear Ms. Pringle:

Our office represents the Estate of Theresa Marie Pfister with respect to her injuries and wrongful death caused by the lack of care and services by staff and administration of Springside Rehabilitation and Skilled Care Center and CareerStaff Unlimited, LLC on or about May 16, 2023. **This letter shall serve as a formal presentment pursuant to the provision of M.G.L. c. 231 §60L. A copy of this letter and all documents referenced herein should be forwarded to your attorney or insurer for the purpose of a response.**

On May 16, 2023 an employee of CareerStaff Unlimited, LLC, who was placed at Springside Rehabilitation and Skilled Care Center, attempted to use a hoyer lift to transfer Theresa. This employee who was never property trained on the use of this particular hoyer lift failed to secure Theresa properly. As a result, Theresa fell from the hoyer lift and sustained grievous injuries that ultimately resulted in her death on May 28, 2023. According to Theresa's care plan, as well as the specifications for this particular hoyer lift, Theresa's transfer with the lift should have been performed by two people. However, as noted above, the aide that attempted to perform the transfer did so by herself.

The notice statute, M.G.L. c 231, §60L gives medical providers an opportunity to evaluate claims early and respond to them appropriately in cases where liability is clear as in this case, the statute was designed to promote early resolution without the need for costly and time-consuming litigation.

It is our opinion and that of our preliminary expert, Christine Rheaume, RN (a copy of her report is enclosed herewith), based on her education, training, skill, knowledge and experience, to a reasonable degree of professional and nursing certainty, that the staff at Springside Rehabilitation and Skilled Care Center as well as the employee of CareerStaff Unlimited, LLC failed to meet

regulatory requirements and minimum care stands in among other acts and omissions, failing to adhere to the established plan of care to ensure Theresa's safety. Contrary to the established care plan, the aid attempted to perform a one person hoyer transfer. Additionally, Springside Rehabilitation and Skilled Care Center failed to properly supervise and/or train the aide.

In June of 2018, 65 year old Theresa Pfister was admitted to Springside Rehabilitation and Skilled Care Center for long term care due to a diagnosis of dementia. As a skilled nursing facility, Springside Rehabilitation and Skilled Care Center is required, at a minimum, to provide care and services in compliance with state and federal regulation. In particular, based on the comprehensive assessment of a resident Springside Rehabilitation and Skilled Care Center was required to ensure that the residents receive treatment and care in accordance with professional standards of practice and their comprehensive care plan (see 42 CFR 483.25). Additionally, such facilities are required to ensure that residents receive adequate supervision to prevent accidents (see 42 CFR 483.25 (d)(1-2). Springside Rehabilitation and Skilled Care Center and CareerStaff Unlimited, LLC's failed to meet these minimum requirements which led to Theresa's injuries and untimely death.

As a result of the negligence and gross negligence of Springside Rehabilitation and Skilled Care Center and CareerStaff Unlimited LLC, Theresa was transported by ambulance to the hospital. She was diagnosed with a nasal fracture, C2 fractures, a laceration to her forehead and an acetabulum fracture. On May 28, 2023 Theresa died as a result of these injuries. Theresa's Death Certificate states that the immediate cause of death was complication of the second cervical vertebra, left acetabulum and nasal fractures, as a result of accidental injury. Theresa suffered with the severe pain of her injuries for twelve days before ultimately dying as result of these injuries.

This being a wrongful death case, there are allegation of negligence and gross negligence. Accordingly the issue of punitive damages is implicated , and is a question for the jury. Springside Rehabilitation and Skilled Care Center accepted Theresa knowing they did not have the skill, capability, staffing, resources or adequate funds to meet all of her, and other patients' needs. As a result, Theresa was neglected as per Massachusetts' definition of neglect. [1] Springside Rehabilitation and Skilled Care Center failed to adequately train staff and monitor the residents' safety.

The Defendant CareerStaff Unlimited, LLC, as the employer of the aide that improperly operated the hoyer lift, is vicariously liable for the negligence of its employee. In this situation, where Springside Rehabilitation and Skilled Care Center and CareerStaff Unlimited LLC both owe a duty of care to the resident, both entities are liable for Theresa's injuries and her death.

Liability in this case is clear. Springside Rehabilitation and Skilled Care Center failed to enforce the established care plan regarding Theresa being a two person transfer when utilizing the hoyer lift. The egregious conduct of Springside Rehabilitation and Skilled Care Center goes well

[1] Neglect: a failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. 105 C.M.R. 155.003.

beyond mere negligence. Its conduct was grossly negligent. Springside Rehabilitation and Skilled Care Center knowingly allowed a contract aide employed by CareerStaff Unlimited LLC to operate a hoyer lift without adequate training or supervision. Despite there being a high risk resident, and her documented need for a high level of care, Springside Rehabilitation and Skilled Care Center chose not to provide sufficient staff to ensure that Theresa received the minimum care and services required. These failures directly caused Theresa's death.

I have enclosed a written statement prepared by Theresa's only daughter, Allison. The death of her mother has had a profound effect on her and the untimely loss of her mother and best friend will continue to affect her indefinitely. Allison entrusted her mother to Springside Rehabilitation and Skilled Care Center to provide adequate safety and medical care for her when she was no longer able to do so herself due to the progressing dementia. She never expected that her mother would meet her demise so prematurely and live her last days with completely avoidable pain and suffering. Her demise under the circumstances in which they occurred was truly unnecessary, appalling and disgraceful to the entire health care industry.

Presentment letters can be very effective in procuring resolution of those claims where liability is clear, thus avoiding the unnecessary expenditures of significant sums of money and substantial time typical in litigating these matters. We believe this case to be one of those which is ripe for such and early resolution based on the egregious violation of the standard of care, the reckless disregard of her neds and risk for harm, the injuries sustained by Ms. Pfister, her subsequent medical treatment, associated medical expenses, conscious pain and suffering, and her wrongful death, as well as the beneficiary's loss of consortium. Compensatory, punitive, and special damages will be sought. Special damages known at this time include the following:

- Action Ambulance $480.63
- Berkshire Health Systems $41,326.83
- Berkshire Faculty Services $720.00

We have provided a DropBox link below (Joseph M. Desmond, Esquire and Derek T. Gratza-Wells) or an original thumb drive (Springside Rehabilitation and CareerStaff Unlimited, LLC) which contains copies of the above-referenced records and bills, as well as our preliminary expert report for your review. We will await your response within the statutory time limit.

https://www.dropbox.com/scl/fo/z4rn7trjsxppn868yfxpa/AOEZoDTblcKOwtlMmOptDzU?rlkey=y1vfgjdjcso5cmpmgif897p7p&st=4dj792ce&dl=0

Very truly yours,

CAMPOLI, MONTELEONE & MOZIAN, P.C.

Scott W. Ellis

SWE/bh
Enclosures

cc: CareerStaff Unlimited, LLC
Joseph M. Desmond, Esquire
Derek T. Gratza-Wells, Esquire

CERIFIED MAIL NO. 7017 2400 0000 1440 1809