SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ONONDAGA

MICHAEL FARRUGGIO, as Administrator of the Estate of THERESA FARRUGGIO, and SUSAN KARPEN, individually and on behalf of all others similarly situated,

Plaintiffs,

v.

918 JAMES RECEIVER, LLC; RIVER MEADOWS, LLC; JAMES SQUARE NURSING HOME, INC.; CLINTON SQUARE OPERATIONS, LLC; LIBERTY SENIOR HOLDINGS, LLC; EXCELERATE HEALTHCARE SERVICES, LLC; JUDY KUSHNER; ABRAHAM GUNICKI; ELIEZER FRIEDMAN; and DOES 1-25;

Defendants.

Index No. 003831/2017

THIRD AMENDED CLASS ACTION COMPLAINT

DEMAND FOR JURY TRIAL

Plaintiffs Michael Farruggio, as Executor of the Estate of Theresa Farruggio, and Susan Karpen (collectively, "Plaintiffs"), individually and on behalf of all others similarly situated (also referred to as "Patients" or "Residents" or the "Class"), by and through their undersigned attorneys, Finkelstein, Blankinship, Frei-Pearson & Garber, LLP, as and for their class action complaint, allege, with personal knowledge as to their own actions and based upon information and belief as to those of others, as follows:

NATURE OF THE ACTION

1. Plaintiffs bring this class action against James Square Nursing Home, Inc.; 918 James Receiver, LLC; River Meadows, LLC; Liberty Senior Holdings, LLC; Excelerate Healthcare Services, LLC; Abraham Gutnicki; Judy Kushner; Eliezer Friedman; and Clinton Square Operations, LLC (collectively, "Defendants"), the former and current operators and owners of James Square Nursing and Rehab Centre, renamed the Bishop Rehabilitation and Nursing Centre in December 2017 (the "Facility"), on behalf of themselves and a class of

similarly situated nursing home patients who were victimized by unsafe and inadequate care in the Facility from August 25, 2014, to June 13, 2018 (the "Class Period"). Defendants' unlawful conduct was negligent and violates Section 2801-d of New York's Public Health Law ("PHL").

2. Defendants are entrusted to provide care to the elderly and infirm nursing home patients in their custody. Unfortunately, Defendants betrayed that trust in many ways. For example, Defendants failed to properly staff the Facility. Among many other shocking failures, this understaffing caused Defendants to fail to regularly wash patients, often resulting in patients, including Ms. Farruggio and Ms. Karpen, lying in their own fecal matter and urine for hours at a time. Indeed, there was typically no nurse or certified nurse assistant ("CNA") on Ms. Karpen's floor of the Facility through the entire night, and Ms. Karpen has been left in her own waste on many occasions and frequently went entire nights without being changed.

3. Understaffing at the Facility also resulted in the death of Ms. Farruggio. On or about December 28, 2015, as a result of understaffing, Ms. Farruggio was left unattended and suffered a fall. After discovering her on the floor with her bed alarm sounding, the staff at the Facility, instead of taking her vital signs, investigating the cause of the fall, reviewing her care plan, or referring her to a hospital, simply returned her to her bed, put her on oxygen, gave her a Xanax, and left her to fend for herself. When her son, Plaintiff Michael Farruggio, arrived at the Facility subsequent to the fall, he discovered for the first time that she had been put on oxygen and saw that her oxygen mask was only half-on and that she was not secure in her bed. Based on her surprisingly bad condition, he called 911, and Ms. Farruggio was removed to a hospital, where she was diagnosed on admission with respiratory failure, pneumonia, and acute renal failure. Ms. Farruggio also had a urinary tract infection, likely due to having been left in her

own urine and feces for extended periods of time by the staff at the Facility. The hospital put Ms. Farruggio on comfort care, and, on January 7, 2016, Ms. Farruggio died at the hospital.

4. The understaffing at the Facility and its harm to residents was extensively documented during an inspection in January 2017 by the New York State Department of Health ("DOH").[1] In its report, the DOH noted that the Facility failed to provide sufficient nursing staff, that the understaffing problem was widespread, and that the understaffing had the potential to cause significant harm. The inspection found that there were so few certified nurse aides at the Facility that residents had to eat meals in bed and could not get up until late in the day. According to the inspection report, the shortage of nurses and aides led to medication errors, delays in people getting showers and incontinence care, a woman falling out of a wheelchair and fracturing her shoulder, and many other problems. The report concluded that "inadequate staffing levels contributed to deficiencies cited in the areas of [dignity, comprehensive care plan, quality of care, activities of daily living, accident supervision, nutrition, hydration, specialty care, significant medication errors, and outside professional resources], as adequate staffing levels were not available on a frequent basis to meet residents' needs in a manner and in an environment which promoted each residents' physical, mental[,] and psychosocial well-being."

5. The quality of care at the Facility suffered to such an extent that, on June 13, 2017, investigators from the New York Attorney General's Office raided the Facility and seized documents pursuant to a search warrant issued as part of an investigation into patient care at the Facility.

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[1] *See* January 31, 2017 DOH Inspection Report (available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335338&SURVEYDATE=01/31/2017) (accessed August 18, 2017) (relevant portion of which is annexed hereto as Exhibit 1).

6. As the Facility has had approximately 440 beds and is operating at a high occupancy rate, many have languished in these unsafe and inadequate conditions.

7. Recognizing that there was no defense for the dangerous conditions in the Facility, the current owners, Defendant Clinton Square Operations, LLC, have already settled. The settlement provides injunctive relief that helps current residents by making the Facility safe and also provides the Class with monetary relief.

8. However, upon information and belief, the remaining Defendants have chosen to try to escape accountability by withholding documents, repeatedly delaying this action, and siphoning revenue away from the Facility in an effort to make it more difficult for the residents to collect on a judgment for the poor care they received at the Facility

9. Accordingly, Plaintiffs, individually and on behalf of the Class, assert claims against Defendants for negligence and violation of PHL § 2801-d and seek monetary damages in an amount to be determined at trial, statutory damages in accordance with PHL § 2801-d(2), and injunctive relief prohibiting further wrongful conduct, as well as any other available relief at law or in equity.

PARTIES

Plaintiffs

10. Plaintiff Michael Farruggio is the son of Theresa A. Farruggio, who was a resident of the Facility from approximately January 2012 until her death on January 7, 2016.

11. Mr. Farruggio is a citizen and resident of Onondaga County, New York. He is the administrator of Ms. Farruggio's estate.

12. Plaintiff Susan Karpen has been a resident of the Facility from approximately August 21, 2015, to the present.

13. Ms. Karpen is a citizen and resident of Onondaga County, New York.

Defendants

14. Defendant James Square Nursing Home, Inc. ("JSNH") is a New York corporation with its principal place of business in Onondaga County, New York. JSNH was owned and operated by Edward Leffler until his death in 2007. From at least as early as 1984 until 2007, JSNH owned as well as operated, managed, inspected, controlled, supervised, staffed, and maintained the Facility, which is located at 918 James Street, Syracuse, New York. Starting in 2007, as a result of Mr. Leffler's death, the Facility entered receivership, at which point JSNH ceased direct operation of the Facility, but maintained an ownership interest the Facility until its sale in 2015.

15. Defendant 918 James Receiver, LLC ("918 James") is a New York limited liability company with its principal place of business in Onondaga County, New York. From 2007 to 2015, 918 James was the receiver for the Facility and operated, managed, inspected, controlled, supervised, staffed, and maintained the Facility.

16. Defendant Liberty Senior Holdings, LLC ("Liberty") is a New York limited liability company with its principal place of business located in Kings County, New York. Liberty is owned and operated by Eliezer Friedman. Liberty bought the building and land for the Facility in 2014 or 2015. Liberty selected River Meadows, LLC as the operator of the Facility. Liberty leased the building and land to River Meadows, LLC. Upon information and belief, Liberty owned as well as operated, managed, inspected, controlled, supervised, staffed, and maintained the Facility, until it was sold to Defendant Clinton Square Operations, LLC in December 2017.

17. Defendant Eliezer Freidman resides in Ocean County, New Jersey. Mr. Friedman operates and has an ownership interest in Liberty and River Meadows, LLC. Mr. Friedman selected River Meadows, LLC to operate the Facility. Mr. Friedman managed, inspected,

controlled, supervised, staffed, and maintained the Facility until it was sold to Clinton Square Operations, LLC in December 2017.

18. Defendant River Meadows, LLC ("River Meadows") is a New York limited liability company with its principal place of business in Onondaga County, New York. Starting in or around 2014 or 2015, River Meadows owned, operated, managed, inspected, controlled, supervised, staffed, and maintained the Facility until December 2017 when it sold the Facility to Clinton Square Operations, LLC. River Meadows is owned and operated by Abraham Gutnicki and Judy Kushner. Eliezer Friedman and Liberty also operate and have an ownership interest in River Meadows.

19. Defendant Excelerate Healthcare Services, LLC ("Excelerate") is a Delaware limited liability company with its principal place of business in Ocean County, New Jersey. Starting in or around 2014 or 2015, Excelerate owned, operated, managed, inspected, controlled, supervised, staffed, and maintained the Facility until December 2017 when the Facility was sold to Clinton Square Operations, LLC. Upon information and belief, Excelerate is owned and operated by Abraham Gutnicki and Judy Kushner.

20. Defendant Judy Kushner, is a nursing home administrator and a resident of Ocean County, New Jersey. Ms. Kushner owned, operated, managed, inspected, controlled, supervised, staffed, and maintained the Facility from in or around 2014 or 2015 until Clinton Square Operations, LLC purchased the Facility in December 2017.

21. Defendant Abraham Gutnicki is a lawyer and a resident of Cook County, Illinois. Since in or around 2014 or 2015, Mr. Gutnicki owned, operated, managed, inspected, controlled, supervised, staffed, and maintained the Facility until it was sold to Clinton Square in December 2017.

22. Defendant Clinton Square Operations, LLC ("Clinton Square") is a New York limited liability company with its principal place of business in Onondaga County, New York. Starting in December 2017, Clinton Square owned and operated, managed, inspected, controlled, supervised, staffed, and maintained the Facility. Clinton Square is owned by Edward Farbenblum, a New York lawyer, and Orly Lieberman, a New York psychotherapist. Clinton Square entered into a settlement agreement and is making good faith efforts to fix the horrible conditions at the Facility that were created by the other Defendants' conduct.

23. In addition to the Defendants identified with particularity, Plaintiffs allege all claims against Doe Defendants 1-25, with addresses and names unknown. Investigation of the claims alleged in this action demonstrates a web of relatedness that cannot be readily untangled at this time, especially in light of Defendant River Meadows's failure to comply with its discovery obligations.

JURISDICTION AND VENUE

24. This Court has jurisdiction over all causes of action asserted herein. Defendants are subject to the personal jurisdiction of this Court pursuant to CPLR 301.

25. Defendants have conducted and do conduct business in the State of New York, including through operation of the Facility.

26. Venue is proper in this County pursuant to CPLR 503(a) because Plaintiffs reside in this County.

27. Venue is also proper in this County pursuant to CPLR 503(d) because several Defendants maintain their principal places of business in this County.

FACTUAL BACKGROUND

I. The Nursing Home Crisis Leads To Legislation Granting Patients A Right To Bring Class Actions Against Operators And Owners For Improper Care And To Federal Databases Tracking Nursing Home Ratings.

28. In an effort to protect the vulnerable nursing home population, ensure that their rights are enforced, and provide them with a form of legal recourse which would not otherwise be economically feasible, the New York State Legislature enacted PHL §§ 2801-d and 2803-c.

29. Predating the enactment of PHL §§ 2801-d and 2803-c, "the public's confidence in the State's ability to protect its most defenseless citizens, the aged and infirm, had been destroyed by a series of dramatic disclosures highlighting the abuses of nursing home care in their State." *See* Governor's Memoranda, Nursing Home Operations, McKinney's 1975 Session Laws of New York, p.1764. In Governor Carey's letter to the Legislature accompanying the bills for PHL §§ 2801-d and 2803-c, he stated that these bills were "designed to deal directly with the most serious immediate problems which have been uncovered with respect to the nursing home industry."[2] The Sponsor's Memorandum relating to PHL § 2803-c and the transcripts of the Senate debates indicate that the purpose of the statute was to establish certain minimum standards for the care of nursing home patients. *See* Governor's Bill Jacket for Chapter 648 of the Laws of 1975; Senate Debate Transcripts, 1975, Chapter 648 Transcripts, pp.4521, 4525. The term "residential health care facility" was intentionally used by the Legislature in an effort to curb abuses in the nursing home industry.[3]

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[2] *Morisett v. Terence Cardinal Cooke Health Care Ctr.*, 8 Misc.3d 506, 509 (Sup. Ct. N.Y. Cnty. 2005).

[3] *See Town of Massen v. Whalen*, 72 A.D.2d 838 (3rd Dep't 1979).

30. The Commission's Summary Report specifically indicated that PHL § 2801-d creates a cause of action for a patient of a facility which deprived the patient "of rights or benefits created for his well-being by federal or state law or pursuant to contract" which resulted in injury to the patient. The Commission stated that this statute "introduce[s] a degree of equality between nursing homes and their otherwise vulnerable and helpless patients and, through private litigation brought by patients either in individual or class action lawsuit, provides a supplemental mechanism for the enforcement of existing standards of care."

31. The Legislative Memorandum "Nursing Home–Health Care Facilities–Actions by Patients" relating to PHL § 2801-d observes that nursing home patients "are largely helpless and isolated," that many are "without occasional visitors," and that "[m]ost cannot afford attorneys," and therefore the bill provides nursing home patients "with increased powers to enforce their rights to adequate treatment and care by providing them with a private right of action to sue for damages and other relief and enabling them to bring such suits as class actions." *See* McKinney's Session Laws of New York, 1975 pp.1685-86. That memorandum states that the proposed PHL § 2801-d "creates incentives which would encourage private non-governmental parties (*i.e.*, plaintiffs' attorneys) to help protect the rights of nursing home patients." *Id.*

32. This statutory cause of action was created as an additional remedy, separate and distinct from other available traditional tort remedies, which may be also asserted in conjunction with common law causes of action based upon the same alleged facts.[4]

33. PHL § 2808-a(1) provides that "[e]very person who is a controlling person of any residential health care facility liable under any provision of this article to any person or class of

[4] *Kash v. Jewish Home & Infirmary of Rochester, N.Y. Inc.*, 61 A.D.3d 146, 150 (4th Dep't 2009).

persons for damages or to the state for any civil fine, penalty, assessment or damages, shall also be liable, jointly and severally, with and to the same extent as such residential health care facility, to such person or class of persons for damages or to the state for any such civil fine, penalty, assessment or damages." "[A] 'controlling person' of a residential health care facility shall be deemed to mean any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of said facility." PHL § 2808-a(2). It is not necessary to "show[] that the individual defendants participated in the alleged wrongful conduct; rather, such controlling persons need only possess the ability to direct or cause the direction of the management or policies of the facility[.]"[5]

34. In the wake of an emphasized focus on the adequacy of care provided by skilled nursing home facilities, in December of 2008, the Centers for Medicare & Medicaid Services ("CMS") enhanced its Nursing Home Compare public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The primary goal of this rating system is to provide residents and their families with an easy way to assess nursing home quality, in order to make meaningful distinctions between high and low performing nursing homes. The rating system features an overall five-star rating based on facility performance in three areas, each of which has its own five-star rating: (1) health inspections, which is measured based on outcomes from State health inspections; (2) staffing, which is a

[5] *Peters v. Nesconset Ctr. for Nursing & Rehab.*, 47 Misc. 3d 1211(A), (Sup. Ct. Queens Cnty. Apr. 15, 2015) (internal quotations, citations, brackets, ellipses omitted).

measure based on nursing home staffing levels (which is comprised of (i) the Registered Nurse ("RN") hours per resident per day and (ii) the total staffing hours for the combined hours of RN, Licensed Practitioner Nurse ("LPN") and nurse aide hours per resident per day); and (3) quality measures.

35. This class action seeks to address the injustices that caused the Legislature to enact PHL § 2801-d. As alleged in more detail below, Defendants have violated and continue to violate their statutory and common law obligations by failing to provide, among other things, adequate staffing, supervision, treatment, hygiene, and medical attention to the Class.

II. Defendants Disregard The Regulatory Framework That Protects Nursing Home Patients.

36. The Facility was founded in 1970 and, until his death in 2007, was owned and operated by Edward Leffler. By at least 1984, Mr. Leffler was operating the Facility via his corporation, Defendant JSNH.

37. In March 30, 2007, Mr. Leffler died, and the Facility entered into receivership.

38. In 2007, Defendant 918 James was approved to become the voluntary receiver and operator of the Facility, while JSNH would continue to retain ownership of the Facility.

39. On information and belief, 918 James was experienced in residence care, but lacked the resources and support needed to maintain and/or grow the number of residents at the Facility.

40. On information and belief, during 2011 and 2012, the principal of 918 James, Mr. Mark J. Squire, contemplated selling the Facility and, as a result, fewer resources were devoted to the Facility. Unsurprisingly, the staffing at the Facility received a two star ("below average") rating on CMS's Nursing Home Compare website for 2011 and 2012.

41. In or around July 2012, Mr. Squire passed away, leaving the Facility without an executive manager or clear management authority.

42. Upon information and belief, in or around 2013, Eliezer Friedman, Abraham Gutnicki, and Judy Kushner pursued a deal to take over the operation and ownership of the Facility. They established and/or utilized Liberty, River Meadows, Excelerate, and Does 1-25 for this purpose. They purposefully structured the deal in a way that was intended to transfer revenue from the Facility and River Meadows to Liberty, Excelerate, themselves, and Does 1-25 in order to protect it from lawsuits brought by or on behalf of residents who were harmed by the poor care they received at the Facility.

43. On June 11, 2013, River Meadows entered into an Operational Transfer Agreement with JSNH for the sale and acquisition of the operating interest of the Facility. Eliezer Friedman signed the June 11, 2013 Operational Transfer Agreement on behalf of River Meadows, and Abramah Gutnicki was identified as one of the contact people at River Meadows. On February 1, 2014, Mr. Friedman signed an amendment to that agreement on behalf of River Meadows. On information and belief, Mr. Friedman, Mr. Gutnicki, Ms. Kushner, and Liberty had the ability to control and in fact did control the operations of River Meadows and the Facility.

44. As part of the same deal, a separate entity, Liberty, purchased the real estate interest in the Facility in 2014 or 2015 and leased it back to River Meadows. On information and belief, Liberty overcharged River Meadows to lease the Facility in order to transfer revenue out of the Facility and River Meadows in an effort to insulate Defendants' ill-gotten gains from lawsuits that could be brought by or on behalf of residents who were harmed by the poor care they received at the Facility.

45. In or around February 2014, Excelerate Healthcare Services, LLC entered into an agreement with JSNH to provide them with consulting services.

46. In or around April 2014, River Meadows applied to the New York Public Health and Health Planning Council ("NYPHHPC"), an arm of the DOH, for approval of the sale and transfer.

47. As part of its application, River Meadows stated that it would reduce overall staffing at the Facility by 27 full time employees, despite representing to the NYPHHPC that the Facility's resources had already been reduced by the receiver.[6]

48. In 2015, the NYPHHPC conditionally approved River Meadows's application to take over the Facility.

49. In June 2015, Excelerate entered into an agreement with the Facility to provide it with consulting services. Pursuant to this agreement, Excelerate would, *inter alia*: 1) help to supervise staffing at the Facility; 2) maintain and manage the accounts receivables, accounts payable, employee compensation, payroll tax requirements and benefit programs, cash, and all other income, expenses, assets and liabilities in connection with the Facility; 3) cause to be paid before due all expenses, costs, taxes, utilities and other charges incurred by or on behalf of the Facility; 4) procure and provide replacements, repairs, and additions to, and the personal property used in the operation of the Facility, and cause the Facility to obtain and maintain sufficient liability insurance; 5) handle the accounting for the Facility; 6) handle the administrative services for the Facility; 7) make repairs, replacements, or capital improvements

[6] *See* State of New York Public Health and Health Planning Council Committee Day Agenda pp.118-129, Exhibit 7, Project # 141153-E at 5, 11(Mar. 26, 2015) (available at https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2015-03-26/docs/agenda.pdf) (accessed August 18, 2017) (relevant portion of which is annexed hereto as Exhibit 2).

at the Facility; 8) assist in survey preparation and management for the Facility; 9) develop and implement marketing and business development procedures; 10) perform other acts to maintain the Facility; and 11) negotiate and enter into contracts for the Facility.

50. As compensation, Excelerate would receive a percentage of the Facility's revenue. The agreement was signed by Ms. Kushner on behalf of Excelerate and Mr. Gutnicki on behalf of the Facility. Upon information and belief, the Facility overpaid for these services in order to transfer revenue out of the Facility and River Meadows in order to protect it from lawsuits that could be brought by or on behalf of residents who were harmed by the poor care they received at the Facility.

51. Notwithstanding that River Meadows is wrongfully withholding relevant documents from discovery, documents produced by River Meadows to Plaintiffs on August 31, 2018, also evidence that Excelerate represented that they were the owners of the Facility.

52. Upon information and belief, River Meadows, Excelerate, Liberty, the Facility, Mr. Friedman, Mr. Gutnicki, Ms. Kushner, and Does 1-25 transferred revenue from the Facility and River Meadows to themselves in order to insulate their ill-gotten gains from lawsuits that could be brought by or on behalf of residents who were harmed by the poor care they received at the Facility.

53. In light of River Meadows's promises to reduce the already thinly-stretched staffing, the Facility has had a high number of reported complaints and deficiencies arising from inadequate care of its elderly and disabled residents, as reflected in records maintained by CMS and DOH and in media reports.

54. For example, between March 1, 2013, and February 28, 2017, the DOH issued 110 citations to the Facility -- 75 more than the state average.

55. In January 2017, a DOH inspection found that the Facility failed to provide sufficient nursing staff, that the problem was widespread, and that the understaffing had the potential to cause significant harm.[7] The inspection found there were so few certified nurse aides at the Facility that residents had to eat meals in bed and could not get up until late in the day. A shortage of nurses and aides led to medication errors, delays in people getting showers and incontinence care, a woman falling out of a wheelchair and fracturing her shoulder, and many other problems, according to the inspection.

56. Indeed, the DOH inspection report indicated that the Facility was incapable of meeting even its own, subpar staffing goals. The inspection report said fewer nurses and aides were working in January than shown by the Facility's own staffing schedules. The inspection found discrepancies between those schedules and documented time clock and time sheet records.

57. Unsurprisingly, CMS's records show that throughout much of the Class Period the Facility received a rating of one star ("much below average") out of a five star scale in (i) staffing, (ii) health & fire safety inspections, and (iii) overall, further evidencing the lack of adequate care and staffing provided by the Facility.[8]

58. Moreover, CMS's records reveal that during the Class Period the total number of licensed nurse staff hours per resident per day fell well below the national and New York State averages. According to the Facility's Medicare Nursing Home Care profile, the Facility provided a total of 43 minutes of licensed nurse staff hours per resident per day whereas the national average is 1 hour and 42 minutes and the New York State average is 1 hour and 37

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[7] See Exhibit 1, January 31, 2017 DOH Inspection Report.

[8] *See* Nursing Home Compare Profile for the Facility (available at https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=335338) (accessed August 18, 2017) (copy annexed as Exhibit 3).

minutes.[9] Remarkably, the Facility provided a mere 9 minutes of registered nurse hours per resident per day whereas the national average was 50 minutes and the New York State average was 45 minutes.[10]

59. Indeed, the inadequate patient care at the Facility drew the attention of the New York State Attorney General's office. On June 13, 2017, investigators from the New York Attorney General's Office raided the Facility and seized records pursuant to a search warrant issued as part of an investigation into patient care at the Facility.[11]

60. And media reports of problems at the Facility indicate its management was aware that it was understaffed. When the family of residents complained about the substandard care -- so substandard that, in one case, a resident's spouse complained of needing to visit the Facility every morning to clean him up because he was routinely being left in his own urine overnight and not cleaned in the morning -- the only thing they were told was that the Facility was "short-staffed."[12]

61. On October 4, 2017, Clinton Square entered into an Asset Purchase Agreement ("APA") with River Meadows for the sale and acquisition of the operating interests of the facility. In conjunction with the APA, Liberty Senior Holdings, LLC, entered into a Real Estate Purchase Agreement ("REPA") with Clinton Square Realty, LLC for the sale and acquisition of

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[9] *Id.*

[10] *Id.*

[11] *See* http://cnycentral.com/news/local/ags-office-gathers-records-from-james-square-health-as-part-of-ongoing-investigation (accessed August 18, 2017).

[12] *See* http://www.syracuse.com/health/index.ssf/2017/06/families_tell_horror_stories_of_syracuse_nursing_home_under_investigation.html (accessed August 18, 2017)

the real estate interest in the Facility. Clinton Square will lease the Facility's real estate interest from Clinton Square Realty, LLC.

62. In October 2017 James Square applied to the NYPHHPC for approval of the sale and transfer.

63. On December 7, 2017 the NYPHHPC conditionally approved Clinton Square's application to take over the Facility. Clinton Square took over the Facility on December 15, 2017.

III. Throughout The Class Period The Facility Was Unsafe And The Conditions To Which Its Patients Were Subjected Violated Numerous Statutes.

64. Throughout the Class Period conditions at the Facility were unsafe and violative of applicable laws, rules, and regulations, and the care provided to Plaintiffs and the Class was inadequate.

65. Among other things, Defendants failed to satisfy applicable provisions of the Life Safety Code of the National Fire Protection Association, resulting in an unreasonable risk to the safety and well-being to Patients.

66. Defendants failed to promote the care for its residents in a manner that maintained or enhanced each resident's dignity and respect in full recognition of their individuality and in contravention of applicable federal and New York State laws, rules, and regulations.

67. Defendants failed to fail to provide sufficient nursing staff to provide the nursing and related services necessary to attain and maintain the highest practicable physical and psycho-social well-being of the Patients.

68. Defendants' failure to properly staff the Facility was particularly egregious because understaffing is one of the primary causes of inadequate care and often unsafe conditions in nursing facilities. Numerous studies have shown a direct correlation between

inadequate staffing and serious care problems including, but not limited to, a greater likelihood of falls, pressure sores, significant weight loss, incontinence, and premature death. Although the dangers caused by understaffing are common knowledge in the nursing home industry, Defendants nonetheless chose not to provide adequate staffing levels.

69. Defendants failed to provide each Patient with food that was palatable and provided at a proper temperature, and Defendants failed to provide food prepared by methods that conserve nutritive value, flavor, and appearance, resulting in harm to residents, including the Plaintiff and other members of the Class.

70. Plaintiffs clearly communicated a history of various complaints, signs, symptoms, pains, sensations, and other physical and/or mental occurrences to the Facility.

71. Defendants were negligent in their care of Plaintiffs and the other members of the Class. This negligence included: failing to use reasonable care in services and care rendered to Plaintiffs and the Class; departing from good and accepted medical practice in treating Plaintiffs and the Class; failing to perform required procedures; improperly performing medical procedures; failing to take proper medical histories and physical examinations before providing treatment; failing to properly nourish and hydrate Plaintiffs and the Class; failing to possess the knowledge and skill required for the proper treatment of Plaintiffs and the Class; failing to perform routine and/or required testing; failing to provide adequate nursing care and supervision; failing to provide Patients with proper treatment to prevent new pressure sores or heal existing pressure sores; failing to properly clean Patients; failing to conduct initial and periodic assessments of each Patients' functional capacity; failing to provide care by qualified persons according to each Patients' written plan of care; failing to develop a complete care plan that meets a resident's needs, with timetables and actions that can be measured; failing to provide the

necessary care and services to maintain or improve the highest well-being of each Patient; failing to provide Patients with adequate and proper assistance with eating/drinking, grooming, and personal and oral hygiene; and in otherwise being careless, negligent, reckless, and grossly negligent.

72. Defendants have subjected Plaintiffs and the Class to indignities and other harms that directly resulted from inadequate nurse staffing levels at the Facility, including but not limited to: infrequent and inadequate turning and repositioning; no response or long response times to call lights; failure to provide adequate showers; lack of assistance with grooming and bathing; inadequate attention to toileting needs, resulting in Plaintiffs and the Class remaining in their own urine and fecal matter for extended periods of time; lack of assistance with eating; failure to provide fluids as needed; lack of assistance with dressing; and being confined to their beds without removal for long periods. Indeed, Plaintiffs and their families have often found no nurses or doctors present on the floor for hours at a time or indeed for an entire evening.

73. The care and treatment rendered by Defendants to Ms. Karpen was negligent, careless, reckless, and grossly negligent. Defendants' acts and omissions towards Ms. Karpen constituted and constitute professional negligence and were deviations from accepted medical standards and practices in the community.

74. As a result, Ms. Karpen has sustained severe and permanent personal injuries; became sick, sore, lame, and disabled; and suffered mental anguish. Additionally, Ms. Karpen suffered extreme, conscious pain and anguish throughout the Class Period.

75. The care and treatment rendered by Defendants to Ms. Farruggio was negligent, careless, reckless, and grossly negligent. Defendants' acts and omissions towards Ms. Farruggio

constituted professional negligence and were deviations from accepted medical standards and practices in the community.

76. As a result, Ms. Farruggio sustained severe and permanent personal injuries; became sick, sore, lame, and disabled; suffered mental anguish; and ultimately contracted pneumonia and a urinary tract infection, leading to respiratory and renal failure and ultimately her death, as a result of Defendants' inadequate care. Additionally, Ms. Farruggio suffered extreme and conscious pain and anguish for a substantial period of time prior to her demise.

77. Upon information and belief, the care and treatment rendered by Defendants to the other members of the Class was negligent, careless, reckless, and grossly negligent. Defendants' acts and omissions towards the Class constitute professional negligence and are deviations from accepted medical standards and practices in the community. These deviations have resulted in the other members of the Class sustaining serious and permanent physical injury, rendering each of them sick, sore, lame, and disabled and causing each of them to endure

CLASS ACTION ALLEGATIONS

78. This action is brought on behalf of the Plaintiffs identified above and all similarly situated persons pursuant to Civil Practice Law and Rules 901, *et seq.* The Class is defined as:

> All persons who reside, or resided, at the Facility from August 25, 2014 to June 13, 2018 or their survivors.

79. On June 13, 2018 Justice Paris certified this class as to the PHL-2801-d claim and denied certification on the negligence claim without prejudice pending additional discovery.

80. Plaintiffs reserve the right to amend the above definitions, or to propose other or additional classes, in subsequent pleadings and/or motions for class certification.

81. Plaintiffs are members of the Class.

82. Excluded from the Class are: (i) Defendants; any entity in which Defendants have a controlling interest; the officers, directors, and employees of Defendants; and the legal representatives, heirs, successors, and assigns of Defendants; (ii) any judge assigned to hear this case (or any spouse or family member of any assigned judge); (iii) any juror selected to hear this case; (iv) claims for personal injury and wrongful death; and (v) any and all legal representatives of the parties and their employees.

83. This action seeks to enjoin defendant Clinton Square from understaffing, failing to disclose its understaffing, and making misleading promises about staffing. In addition, this action seeks recovery from the Defendants for economic damages or restitution arising from Defendants' understaffing, such as recovery of statutory damages and/or monies paid by Plaintiffs and the Class as a result of Defendants' failure to disclose and its misleading promises.

84. Plaintiffs and the Class satisfy the requirements for class certification as provided by Civil Practice Law and Rules 901, *et seq.*, for the following reasons:

85. **Numerosity of the Class.** Members of the Class are so numerous that their individual joinder is impracticable. The Class consists of thousands, of persons and is therefore so numerous that joinder of all members, whether required or permitted, is impracticable. The precise number of persons in the Class and their identities and addresses may be ascertained from Defendants' records. If deemed necessary by the Court, members of the Class may be notified of the pendency of this action.

86. **Common Questions of Fact and Law.** Common questions of law and fact exist as to all members of the Class. These common legal and factual questions include, without limitation:

a. Whether Defendants negligently violated or violate New York laws, including, but not limited to, PHL 2801-d, by depriving any patient of the Facility of any

right or benefit created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule, or regulation, or by any applicable federal statute, code, rule, or regulation during the Class Period;

b. Whether Defendants negligently violated or violate New York laws, including, but not limited to, PHL 2803-c, by failing to provide any patient of the Facility with adequate and appropriate medical care, failing to provide courteous, fair and respectful care and treatment, and failing to ensure every patient was free from mental and physical abuse during the Class Period;

c. Whether Defendants failed or fail to employ an adequate number of qualified personnel to carry out all of the functions of its Facility in violation of PHL 2801-d and 2803-c;

d. Whether Defendants' decision to understaff the Facility violated or violates any right(s) of residents as set forth in PHL 2801-d and 2803-c;

e. Whether Defendants' decision to understaff its Facility and failure to provide adequate and appropriate medical care violated or violates any right(s) of residents as set forth in the Patients' Bill of Rights pursuant to PHL 2803-c;

f. Whether Defendants' conduct violated or violates sections 31.19(a) and 16.19(a) of the New York Mental Hygiene Law;

g. Whether Defendants' conduct violated or violates section 415 of the New York Code Rules and Regulations, including but not limited to subsections 415.3, 415.5, 415.12, 415.13, 415.14, and 415.15; and

h. Whether Defendants' conduct violated or violates the federal Nursing Home Reform Act, codified at 42 U.S.C. §§ 1395i-3(a)-(h) & 1396r(a)-(h) and at 42 C.F.R. §§ 483.15, 483.20, 483.25, 483.30, 483.40, 483.60, & 483.75.

87. **Typicality.** The claims of Plaintiffs are typical of the claims of the proposed Class because Plaintiffs' claims are based upon the same legal theories and same violations of New York State law. Plaintiffs' grievances, like the proposed Class members' grievances, all arise out of the same business practices and course of conduct by Defendants. Further, Plaintiffs' damages arise out of a pattern of uniform and repetitive business practices conducted by Defendants.

88. **Adequacy.** Plaintiffs will fairly and adequately represent the Class on whose behalf this action is prosecuted. Their interests do not conflict with the interests of the Class.

89. The representatives and their chosen attorneys, Finkelstein, Blankinship, Frei-Pearson & Garber, LLP ("FBFG"), are familiar with the subject matter of the lawsuit and have full knowledge of the allegations contained in this Complaint so as to be able to assist in its prosecution. Indeed, FBFG has been appointed as lead counsel in several complex class actions across the country and has secured numerous favorable judgments in favor of its clients. FBFG's attorneys are competent in the relevant areas of the law and have sufficient experience to vigorously represent the Class members. Finally, FBFG possesses the financial resources necessary to ensure that the litigation will not be hampered by a lack of financial capacity and is willing to absorb the costs of the litigation.

90. **Superiority.** A class action is superior to any other available methods for adjudicating this controversy. The proposed class action is the surest way to fairly and expeditiously compensate so large a number of injured persons, to keep the courts from becoming paralyzed by hundreds -- if not thousands -- of repetitive cases, and to reduce transaction costs so that the injured Class members can obtain the most compensation possible.

91. Class treatment presents a superior mechanism for fairly resolving similar issues and claims without repetitious and wasteful litigation for many reasons, including the following:

a. Absent a class action, Class members will suffer continuing, ever-increasing damages; violations of Class members' rights will continue without remedy; and the Facility will continue to remain understaffed, resulting in the mistreatment and improper care of its Patients.

b. It would be a substantial hardship for most individual members of the Class if they were forced to prosecute individual actions. Many members of the Class are not in the position to incur the expense and hardship of retaining their own counsel to prosecute individual actions, which in any event might cause inconsistent results.

c. When the liability of Defendants has been adjudicated, the Court will be able to determine the claims of all members of the Class. This will promote global relief and judicial efficiency in that the liability of Defendants to all Class members, in terms of money damages due and in terms of equitable relief, can be determined

in this single proceeding rather than in multiple, individual proceedings where there will be a risk of inconsistent and varying results.

d. A class action will permit an orderly and expeditious administration of the Class claims, foster economies of time, effort, and expense, and ensure uniformity of decisions. If Class members are forced to bring individual suits, the transactional costs, including those incurred by Defendants, will increase dramatically, and the courts of New York will be clogged with a multiplicity of lawsuits concerning the very same subject matter, with the identical fact patterns and the same legal issues. A class action will promote a global resolution, and will promote uniformity of relief as to the Class members and as to Defendants.

e. This lawsuit presents no difficulties that would impede its management by the Court as a class action. The class certification issues can be easily determined because the Class includes only the residents of the Facility, the legal and factual issues are narrow and easily defined, and the Class membership is limited. The Class does not contain so many persons that would make the Class notice procedures unworkable or overly expensive. The identity of the Class members can be identified from Defendants' records, such that direct notice to the Class members would be appropriate.

FIRST CAUSE OF ACTION

NEGLIGENCE

92. Plaintiffs repeat, reiterate, and re-allege each and every allegation contained above with the same force and effect as if the same were set forth at full length herein.

93. Defendants owed a duty to Plaintiffs and the Class to provide reasonable, diligent care under the circumstances pursuant to PHL § 2801-d, PHL § 2803-c, and the common-law.

94. Defendants acted negligently, recklessly, and/or in an otherwise wrongful manner in that they:

a. failed to conduct initial and periodic assessments of each resident's functional capacity;

b. failed to provide care by qualified persons according to each resident's functional capacity;

c. failed to provide food that was nutritional, appetizing, tasty, attractive, well-cooked, and at the proper temperature;

d. failed to provide necessary care and services to maintain or improve the highest well-being of each resident;

e. failed to move Plaintiffs and Class members on a regular basis;

f. failed to change the position of Plaintiffs and Class members at least every two hours in order to relieve pressure;

g. failed to provide daily range of motion exercises for Plaintiffs and Class members;

h. failed to wash Plaintiffs and Class members on a regular basis;

i. failed to follow protocols regarding skin care, including inspecting the skin every day, keeping the skin clean, keeping the skin dry, and relieving areas of moisture near the skin;

j. failed to undertake timely and proper tests, examinations, procedures, studies, surgery, pre- and post-surgical care, and, in general, render medical care, attention, treatment and/or care to the Plaintiffs and Class members;

k. failed to understand the clinical analysis, laboratory analysis, history, physical examination, complaints, pains, signs, and/or symptoms so that a proper and timely diagnosis could be made and/or a proper course of treatment could have been provided;

l. failed to conform to the accepted standards of care and skill in giving advice, treatment, prescriptions, examination, information, services, surgery, pre- and post-surgical care, attentions, studies, laboratory and/or radiological examinations and/or facts to Plaintiffs and Class members and/or their families;

m. failed to comply with section 31.19(a) of the New York Mental Hygiene Law, which mandates that no individual who is or appears to be mentally disabled shall be detained, deprived of her liberty, or otherwise confined without lawful authority, or inadequately, unskillfully, cruelly, or unsafely cared for or supervised by any person;

n. failed to comply with section 16.19(a) of the New York Mental Hygiene Law, which mandates that no individual who is or appears to have a developmental disability shall be detained, deprived of liberty or otherwise confined without lawful authority, or inadequately, unskillfully, cruelly or unsafely cared for or supervised by any person;

o. failed to comply with 10 NYCRR 415.3(a), which mandates that a resident has a right to a dignified existence with respect, consideration and privacy in treatment and care for personal needs, and communication with and access to persons and services inside and outside the Facility;

p. failed to comply with 10 NYCRR 415.5, which mandates that the Facility shall: care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life; promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality; provide for an ongoing program of activities designed to meet, in accordance with the comprehensive resident assessment, the interests and the physical, mental, and psychosocial well-being of each resident; provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible; provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior; provide clean bed and bath linens that are in good condition; provide comfortable and safe temperature levels and for the maintenance of comfortable sound levels;

q. failed to comply with 10 NYCRR 415.12, which mandates that each resident shall receive and the Facility shall provide the necessary care and service to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care subject to the resident's right of self-determination;

r. failed to comply with 10 NYCRR 415.12(a)(1,) which provides that a Facility must ensure that a resident's abilities in activities of daily living (including the resident's ability to bathe; dress and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems) do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable;

s. failed to comply with 10 NYCRR 415.13, which mandates that each resident shall receive and the Facility shall provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and that the Facility shall assure that each resident receives treatments, medications, diets, and other health services in accordance with individual care plans;

t. failed to comply with 10 NYCRR 415.14 which mandates that each resident shall receive and the Facility shall provide each resident with a nourishing, palatable, and well-balanced diet that meets the daily nutritional and special dietary needs of each resident;

u. failed to comply with 10 NYCRR 415.15, which mandates that each resident shall receive and the Facility shall provide medical services to meet the needs of its residents that assures that each resident's responsible physician attends to the resident's medical needs, participates in care planning, follows the schedule of visits maintained in accordance with 10 NYCRR 415.15(b), and complies with Facility policies; and

v. failed to conform to the accepted standards of care and skill in providing nursing, geriatric, nursing home, and health aide care to Plaintiffs and Class members.

95. Plaintiffs and Class members are not seeking to recover any damages for which they have been reimbursed and/or are covered by insurance or collateral sources.

96. As a result of Defendants' acts and/or omissions, Plaintiffs and the Class suffered and sustained -- and continue to sustain -- severe, serious, and permanent personal injuries and severe and serious pain and suffering, mental anguish, and loss of enjoyment of life. Plaintiffs and Class members also incurred -- and continue to incur -- expenses for medical services and related expenses, and have thereby been injured and damaged in a sum which exceeds the jurisdictional limitations of all lower courts which would otherwise have jurisdiction.

97. Defendants' conduct involved willful malfeasance, gross neglect and negligence, and gross abuse.

98. As a result of Defendants' conduct, Plaintiffs and the Class have sustained great pain, agony, injury, suffering, disability, and hospitalization, as well as mental anguish and emotional distress.

99. Consequently, Plaintiffs and the Class demand punitive damages.

SECOND CAUSE OF ACTION

PUBLIC HEALTH LAW § 2801-d

100. Plaintiffs repeat, reiterate, and re-allege each and every allegation contained above with the same force and effect as if the same were set forth at full length herein.

101. At all relevant times, Defendants conducted business as a licensed nursing home as defined under PHL § 2801(2).

102. At all relevant times, Defendants had possession and control of the Facility's building(s), the nursing home located at 918 James Square, Syracuse, New York.

103. The Facility is a geriatric center, adult living facility, and/or a nursing home, which provides nursing care to sick, invalid, infirmed, disabled, or convalescent persons in addition to lodging and board or health related services pursuant to PHL § 2801(2).

104. The Facility is a residential health care facility as defined in PHL § 2801(3).

105. Defendants are subject to the provisions of PHL § 2801-d and 2803-c, as well as the rules and regulations set forth in sections 31.19(a) and 16.19 (a) of the New York Mental Hygiene Law, section 415 of the New York Code Rules and Regulations, and the federal Nursing Home Reform Act.

106. Plaintiffs and the Class entered the Facility for care, treatment, supervision, management, and/or rehabilitation.

107. Plaintiffs and the Class were under the exclusive care, custody, control, treatment, rehabilitation, supervision, and management of Defendants.

108. During the period of the Plaintiffs and the Class' residency in the Facility, Defendants, through their officers, employees, agents, and staff, violated PHL § 2801-d by depriving Plaintiffs and the Class of rights or benefits created or established for their well-being by the terms of a contract(s) and/or by the terms of state and federal statutes, rules, and regulations.

109. During Plaintiffs' residency, they sustained severe and permanent personal injuries; became sick, sore, lame and disabled; and suffered mental anguish as a result of Defendants' negligence in their care and treatment.

110. Plaintiffs and their families complained and continue to complain to the Facility's staff regarding the neglectful, improper, and/or inadequate care and treatment of Plaintiffs.

111. In addition, during Plaintiffs' residency at the Facility, they were and are subjected to indignities and other harms that directly resulted and result from inadequate nurse staffing levels at the Facility, including but not limited to: infrequent and inadequate turning and repositioning; no response or long response times to a call light; failure to provide adequate showers; lack of assistance with grooming and bathing; inadequate attention to toileting needs requiring Plaintiffs and the Class to remain in their own urine and fecal matter for extended periods of time; lack of assistance with eating; failure to provide fluids as needed; lack of assistance with dressing; and being confined to their bed without removal for long periods. Indeed, Plaintiffs and their families have often found no nurses or doctors present on the floor for hours at a time or indeed for an entire evening.

112. Defendants' acts and/or omissions substantially contributed to, created, and/or caused Plaintiffs' injuries.

113. Defendants' violation of Plaintiffs' rights afforded by PHL § 2801-d and enumerated in § PHL 2803-c substantially contributed to, created, and/or caused Plaintiffs' injuries.

114. Defendants' responsibilities and obligations to Plaintiffs, as outlined in PHL § 2803-c, are non-delegable, and thus Defendants have direct and/or vicarious liability for violations, deprivations, and infringements of such responsibilities and obligations by any person or entity under Defendants' control, direct or indirect, including their employees, agents, consultants, and independent contractors, whether in-house or outside entities, individuals, agencies, or pools, or caused by Defendants' policies, whether written or unwritten, or its common practices.

115. Defendants deprived Plaintiffs of their protective rights pursuant to PHL § 2801-d, enumerated in PHL § 2803-c.

116. All acts, and omissions, committed by employees and agents of Defendants were pervasive, omnipresent events that occurred, and continued, throughout Plaintiffs' residency at the Facility, and were such that supervisors, administrators, and managing agents of Defendants knew, or should have been aware, of them.

117. As a result of Defendants' acts and/or omissions, Plaintiffs have been forced to undergo medical treatment; incur medical expense; suffer disfigurement, disability, mental anguish, and pain; and suffer loss of enjoyment of life. These injuries sustained by Plaintiffs and the Class were preventable with adequate care, nourishment, and hydration.

118. As a result of the foregoing acts and/or omissions, Plaintiffs and the proposed Class were denied their rights under PHL § 2801-c.

119. Pursuant to PHL § 2801-d(2), Plaintiffs and the Class seek compensatory damages in an amount sufficient to compensate each Patient for their injury, but in no event less than twenty-five percent of the daily per-patient rate of payment established for the Facility under PHL § 2807, or, in the event the Facility does not have an established rate, the average daily total charges per patient for the Facility, for each day that such injury existed.

120. In addition to damages suffered by Plaintiffs and as the result of Defendants' deprivation of Plaintiffs' rights as nursing home residents, justice requires that Plaintiffs and the Class be entitled to recover attorney's fees pursuant to PHL § 2801-d(6), and punitive damages pursuant to PHL § 2801-d(2), and costs.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, on behalf of themselves and the Class, respectfully request that the Court grant relief against Defendants as follows:

a. For a Court Order certifying that the action may be maintained as a class action;

b. For injunctive relief prohibiting Defendants' violations of PHL §§ 2801-d and 2801-c in the future;

c. On the First Cause of Action for negligence, damages in an amount to be determined at trial and punitive damages, together with costs, disbursements, and attorney's fees in this action;

d. On the Second Cause of Action for violation of PHL § 2801-d, damages in an amount to be determined at trial and punitive damages, together with costs, disbursements, and attorney's fees in this action;

e. For restitution and any other monetary relief permitted by law;

f. For attorney's fees and costs; and

g. For such other and further relief as the Court may deem just and proper.

DEMAND FOR TRIAL BY JURY

Plaintiffs, individually and on behalf of the Class, demand a trial by jury as to all issues triable of right.

Dated: White Plains, New York
January 11, 2019

Respectfully Submitted,

FINKELSTEIN, BLANKINSHIP, FREI-PEARSON & GARBER, LLP

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Attorneys for Plaintiffs and the Proposed Class

VERIFICATION

STATE OF NEW YORK)
) ss:
COUNTY OF WESTCHESTER)

I, the undersigned, am an attorney admitted to practice in the Courts of the State of New York and say that:

I am the attorney of record for the Plaintiffs and Class. I have read the annexed Third Amended Summons and Third Amended Class Action Complaint and know the contents thereof, and the same are true to my knowledge, except those matters therein which are based on information and belief, and as to those matters I believe them to be true. My belief, as to those matters therein not stated upon knowledge, is based on the contents of the file. The reason I make this affirmation instead of Plaintiffs is because Plaintiffs reside outside the county in which deponent has his office.

Dated: White Plains, New York
January 11, 2019

/s/Jeremiah Frei-Pearson
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