IN THE IOWA DISTRICT COURT IN AND FOR POLK COUNTY

KAYLYNNE VAN ROOY, as Executor of the ESTATE OF LYNNE HARRIET STEWART, Deceased, **and** **KAYLYNNE VAN ROOY, as Administrator of the ESTATE OF SARA J. GWINN, Deceased,** Plaintiffs vs. **ABILIT HOLDINGS (HAWTHORNE CROSSING) LLC d/b/a COURTYARD ESTATES AT HAWTHORNE CROSSING** **and** **JAYBIRD SENIOR LIVING, INC.** Defendants.	CASE NO. _____ **PETITION AT LAW** **AND** **JURY DEMAND**

COME NOW Plaintiffs, Kaylynne Van Rooy, as Executor of the Estate of Lynne Harriet Stewart (hereinafter the "Estate of Lynne Stewart"), and Kaylynne Van Rooy, as Administrator of the Estate of Sara Gwinn (hereinafter the "Estate of Sara Gwinn), and for their causes of action against Defendants, AbiliT Holdings (Hawthorne Crossing) LLC d/b/a Courtyard Estates at Hawthorne Crossing (hereinafter "Courtyard Estates") and Jaybird Senior Living, Inc. (hereinafter "Jaybird") state to the Court as follows:

PARTIES, VENUE, AND JURISDICTION

1. Lynne Stewart died testate a resident of Bondurant, Polk County, Iowa, on January 21, 2022.

2. Lynne Stewart was 77 years old at the time of her death.

3. The Estate of Lynne Stewart has been opened in Polk County, Iowa, Probate Case No. ESPR081103.

4. Kaylynne Van Rooy is the duly appointed Executor of the Estate of Lynne Stewart.

5. Sara Gwinn was at all times relevant hereto a resident of Polk County, Iowa.

6. Sara Gwinn was the daughter of Lynne Stewart.

7. Sara Gwinn died intestate a resident of Des Moines, Polk County, Iowa, on November 28, 2023.

8. The Estate of Sara Gwinn has been opened in Polk County, Iowa, Probate Case No. ESPR082422.

9. Kaylynne Van Rooy is the duly appointed Administrator of the Estate of Sara Gwinn.

10. Defendant AbiliT Holdings (Hawthorne Crossing) LLC, d/b/a Courtyard Estates at Hawthorne Crossing, is a limited liability company organized under the laws of the State of Delaware, holding a certificate of authority from the Iowa Secretary of State to transact business in Iowa, and doing business in the State of Iowa at all times relevant to this action.

11. Defendant Jaybird Senior Living, Inc. is an Iowa corporation doing business in the State of Iowa at all times relevant to this action.

12. At all times material to this action, Defendants owned, operated, and managed an assisted living facility located at 601 Hawthorne Crossing Drive SE, Bondurant, Polk County, Iowa (hereinafter the "Facility").

13. At all times material to this action, Defendant Courtyard Estates owned and operated the Facility.

14. At all times material to this action, Defendant Jaybird operated and/or managed the Facility.

15. As alleged herein, all acts and omissions of employees and agents were committed in the scope of and during the course of an employment, employment contract, or agency relationship with Defendant Courtyard Estates and/or Defendant Jaybird.

16. At all times material to this action, all acts and omissions of employees and agents were committed while those employees and agents were under Defendants' direct supervision, employ, and control.

17. Defendants are liable for the wrongful conduct of their employees under the law of vicarious liability, including the doctrine of respondeat superior.

18. Facts, all or in part, giving rise to this cause of action and acts and omissions, of which Plaintiffs complain occurred in Polk County, Iowa.

19. Pursuant to Iowa Code § 616.18, Polk County is the appropriate venue as the county where Plaintiffs sustained injuries and damage.

20. The amount in controversy exceeds this Court's jurisdictional minimums.

BACKGROUND AND FACTS

21. Defendants marketed and held themselves out as experts in providing assisted living and the attendant care and supervision to residents through specifically designed programs of personalized assisted living services for residents with declining cognitive abilities, including in a memory care setting for residents with Alzheimer's disease and dementia.

22. At all times material to this action, Defendants' webpage for the Facility advertised the following about its memory care unit on its website:

> *"The Gardens Community at Courtyard Estates at Hawthorne Crossing is our Memory Care program. It provides specialized Alzheimer's and dementia care*

programming as well as assistance with the activities of daily living. Our Courtyard Estates at Hawthorne Crossing Memory Care community offers a caring staff of experts who are on hand 24 hours a day to offer your loved one the care and support they need to thrive. The community is secured for our residents' safety and features a private, enclosed courtyard, allowing them to take part in regular outdoor activities. In addition to sharing all the services and amenities provided to our Assisted Living residents, members of our Memory Care community receive regular reminders, close supervision, and safety monitoring. They also receive specialized coaching focused on helping them maintain everyday living skills, so they can remain independent longer."

23. Jaybird currently owns, operates, and/or manages approximately 40 assisted living facilities, and has at times relevant to this action owned, operated, and/or managed, as many as approximately 75 assisted living facilities throughout Iowa, Illinois, Minnesota, Wisconsin, and other states, with the most being in Iowa.

24. Defendants represented to Lynne Stewart and her family they had all requisite skill and care necessary to provide her with safe care and housing and an organized continuous twenty-four program of supervision and care commensurate with the needs of Lynne Stewart, under the direction of qualified personnel.

25. In reliance upon Defendants' representations, Lynne Stewart became a resident of the Facility.

26. Lynne Stewart became a resident of the Facility on or about March 30, 2018, and remained a resident at the Facility until her death on January 21, 2022.

27. At the time Lynne Stewart moved into the Facility she had been diagnosed with existing mental health and cognitive decline conditions including Alzheimer's disease, major depressive disorder, and anxiety disorder, and Defendants were aware of such diagnoses.

28. The Facility has two units within its building—assisted living and memory care.

29. Lynne Stewart was initially a resident of the Facility's assisted living unit, until moving to the memory care unit on or about August 23, 2019.

30. Lynne Stewart relied, required, and was dependent upon Defendants to provide her with assisted living and memory care services and protection.

31. Lynne Stewart's personal apartment door included an alarm that would trigger upon her apartment door being opened, with alerts being sent to iPads (if charged and operating properly) which were supposed to be carried by staff, and alerts also being sent to the mobile devices of the on-call registered nurse and the executive director of the Facility.

32. Lynne Stewart's personal door alarm was installed with double-sided tape rather than secured with hardware, which resulted in multiple false alarms, an issue which was known to Defendants but not remedied while Lynne Stewart was alive.

33. Defendants became desensitized to Lynne Stewart's apartment door alarm due to the multiple false alarms and the door alarm being triggered often.

34. An exterior door in Lynne Stewart's memory care unit hallway leading to a fenced-in outdoor garden area, known as the "East Garden Door," had an audible alarm which sounded upon it being opened and caused text alerts to be sent to iPads (if charged and operating properly) which were supposed to be carried by staff, and alerts also sent to the mobile devices of the on-call registered nurse and the executive director of the Facility.

The Night of Lynne Stewart's Elopement and Death

35. On January 20, 2022, Lynne Stewart wandered from her room in the memory care unit, first triggering her apartment door alarm at or about 4:23 p.m.

36. Defendants did not respond to Lynne Stewart's apartment door alarm or reset it once it was triggered until almost 15 hours later at approximately 7:15 a.m. the following morning.

37. During the extended time she was wandering unsupervised in the memory care unit, Lynne Stewart moved some of her belongings including clothing and bags from her room and placed those personal belongings near the exterior East Garden Door.

38. Lynne Stewart eventually made her way outside of the Facility at or about 9:34 p.m., at night, triggering the East Garden Door alarm.

39. It was Winter and extremely cold outside when Lynne Stewart left the building.

40. The East Garden Door locks automatically, so Lynne Stewart was unable to re-enter the Facility once she had exited and the door closed behind her.

41. The outside garden area that Lynne Stewart exited into is a fenced-in area that she could not escape.

42. Lynne Stewart, having exited the Facility at or about 9:34 p.m., remained outside the East Garden Door in well-below freezing winter temperatures until she was found over 8 hours later at or about 6:10 a.m. the next morning in an extreme state of hypothermia.

43. Lynne Stewart was exposed for over 8 hours to Winter temperatures dropping to as low as negative thirteen degrees Fahrenheit (-13°F), without proper clothing or cold weather protection.

44. Lynne Stewart was found with her bags packed, containing some of her clothing and other personal belongings, and some of her personal belongings were frozen to her body.

45. Lynne Stewart was found with abrasions on her hands and above her left eyebrow and suffered a sternal fracture.

46. The on-duty Resident Assistants pulled Lynne Stewart's body back inside shortly after she was found at or about 6:10 a.m. and called the on-call registered nurse who directed them to call 911.

47. Emergency responders provided life saving measures to Lynne Stewart and, after finding a pulse and determining she was still alive, though barely, they transferred her to the hospital by ambulance.

48. Lynne Stewart attempted to speak to emergency responders while she was being transported to the hospital.

49. Lynne Stewart died after being transferred to the hospital.

50. Lynne Stewart's body temperature before she died was found to be approximately seventy-seven degrees Fahrenheit (77°F).

Defendants Knew of Lynne Stewart's Predispositions to Wander and Exit-Seek

51. Defendants knew Lynne Stewart's predispositions as a wanderer and active exit seeker and had documented the same in her assessments and service plans.

52. Lynne Stewart was known to Defendants to have issues with memory, episodes of depression and anxiety, "sundowning," and a routine of packing up the belongings in her room and attempting to leave the facility in the evenings.

53. Lynne Stewart's documented exit seeking included occasions of Lynne Stewart making her way outside by exiting through Facility doors and throwing items over the fence in an attempt to get out.

54. As reported by Defendants' employees, Lynne Stewart had exited the Facility on recent occasion(s) in the month prior to the elopement resulting in her death, but stated to staff it was "too cold" outside and willingly came back into the Facility.

55. Defendants' service plan for Lynne Stewart required 24-hour supervision in the memory care unit, an ankle monitor/alarm, a personal apartment door alarm, and hourly visual safety checks.

Defendants Failed to Protect Against the Known Elopment Risk and Failed to Respond to Lynne Stewart's Elopement for Over Eight Hours

56. Despite the service plan and the known elopement risks specific to Lynne Stewart, no employee of Defendants made a visual check on Lynne Stewart for at least over eight (8) consecutive hours during the evening of January 20, 2022 and into the morning of January 21, 2022.

57. When Lynne Stewart exited the Facility, the audible alarm for the East Garden Door sounded but was not loud enough to be heard in the community common area where on-duty staff was working.

58. When Lynne Stewart exited the Facility, alerts should have been sent to iPads used by on-site staff, if the iPads were charged and functioning property, but the alerts did not appear on the iPads due to malfunctioning which was previously and repeatedly known to Defendants.

59. When Lynne Stewart exited the Facility, alerts appeared on the Facility office computers, but Defendants failed to have any staff monitoring the office computers during the 10:00 p.m. to 6:00 a.m. shift, and only one Resident Assistant on-duty in each of the assisted living and memory care units.

60. When Lynne Stewart exited her apartment (at or about 4:23 p.m.) and then later that night exited the Facility (at or about 9:34 p.m.), alerts were sent to the mobile devices of at least two on-call supervisor employees of Defendants.

61. Despite the multiple notifications to multiple employees, neither the on-call registered nurse nor the executive director responded to the apartment door or exterior door alarm alerts they received on their mobile devices repeatedly every five minutes for over eight hours.

62. For the over 8-hour duration that both Lynne Stewart's apartment door alarm and the exterior East Garden Door alarm were triggered and sending alerts to the facility computers, malfunctioning iPads, and *every five minutes* to the Facility's on-call registered nurse and the executive director, Lynne Stewart was left unsupervised and unaccounted for.

63. Defendants' employee Catherine Forkpa ("Ms. Forkpa") was the Resident Assistant on duty in the memory care unit from 10:00 p.m. to 6:00 a.m. on January 20, 2022 into January 21, 2022.

64. Iowa law requires staff working in a memory care unit to receive at least (i.e. a bare minimum) 8 hours of dementia training in the first 30 days on the job. Iowa Admin. Code Rule 481-69.30(1).

65. Ms. Forkpa, who was the only employee on duty in the memory care unit at the time of the incident, had received no more than 4.75 hours of dementia training.

66. Defendants' employee Sally Daniels ("Ms. Daniels") was the only Resident Assistant on duty in the assisted living unit from 10:00 p.m. to 6:00 a.m. on January 20, 2022 into January 21, 2022.

67. Resident Assistants at the Facility used iPads during their shifts to track the needs of residents and watch for alarms.

68. Upon information and belief, on-duty Resident Assistants were supposed to respond to any alarms they notice in any part of the Facility, regardless of which unit—assisted living or memory care—they are assigned to work during a shift.

69. Defendants knew the iPads relied upon to inform on-duty Resident Assistants of alarm alerts had been malfunctioning prior to Lynne Stewart's death.

70. The iPads would usually hold battery charge for approximately one full shift but the batteries would be depleted for the next shift, so the devices had to be connected to a charging station rather than be available for use by staff.

71. Alerts had failed to appear on the iPads even when charged, and the executive director had been informed by staff and was aware of this issue.

72. Near the end of Ms. Daniel's shift on January 20-21, her iPad battery died and Ms. Daniels went to the Facility office to get a replacement iPad when she noticed a computer screen showing alarms triggered on a couple doors in the memory care unit, which set off the search for the source of the alarms and ultimately finding Lynne Stewart's body outside the East Garden Door.

73. The iPad that Ms. Daniels had carried for her shift, before the battery died, did not display alerts of the alarms triggered in the memory care unit.

74. Defendants consciously disregarded substantial and unjustifiable risks of injury and death of Lynne Stewart.

75. Defendants were negligent in their supervision and care of Lynne Stewart and violated numerous regulations, laws, rights, and industry standards, causing Lynne Stewart personal injury and death.

76. Lynne Stewart suffered immense physical pain and mental anguish before she died on January 21, 2022.

77. The above allegations are not exhaustive and there may be additional acts or omissions of Defendants which support Plaintiffs claims.

78. Defendants are responsible for all relevant acts and omissions that resulted in Lynne Stewart's injuries, death, and damages.

COUNT I

WRONGFUL DEATH – NEGLIGENCE, GROSS NEGLIGENCE, AND RECKLESS DISREGARD FOR THE SAFETY OF LYNNE STEWART

Against all Defendants

79. Plaintiffs hereby reallege the previous paragraphs as if fully set forth herein.

80. Defendants owed a duty to Lynne Stewart to exercise reasonable care in their operation of the Facility and in compliance with applicable Iowa law, statutes, and regulations.

81. Defendants were under a duty to draft, adopt, formulate, institute, and promulgate policies, plans, measures, and steps to provide for proper care, treatment, monitoring, and supervision of its residents, including Lynne Stewart, and to enforce, implement, and effectuate such policies, plans, measures, and steps through Defendants' employees and agents.

82. Defendants owed duties of care to Lynne Stewart to exercise reasonable care and to ensure her health, safety, and security.

83. Defendants owed duties of custodial care to Lynne Stewart.

84. Defendants owed duties to Lynne Stewart to keep her safe from harm and to protect her from known risks.

85. There is a special relationship between an assisted living facility and a resident, especially in a memory care unit, to protect and keep safe vulnerable individuals who are unable to protect themselves.

86. There is a special relationship between an assisted living facility and a resident, especially in cases of residents who have a known history of elopement or exit-seeking.

87. Defendants are directly and vicariously liable, including through the doctrine of respondeat superior, for the wrongful conduct and negligence of their employees, agents, and

others who may have been involved in the care or supervision of Lynne Stewart or the management of the Facility.

88. Defendants' employees and agents failed to perform the essential functions of their jobs, which had the purpose of caring for and keeping Lynne Stewart safe.

89. Defendants breached their duties of care to Lynne Stewart.

90. Notwithstanding the responsibilities of Defendants to provide Lynne with reasonable care, Defendants were generally negligent and also specifically negligent, grossly negligent, and recklessly disregarded the life and safety of Lynne Stewart, including but not limited to, one or more of the following particulars:

a. Defendants' failure to monitor and perform hourly visual checks of Lynne Stewart, a known wanderer and exit seeker, for over 8 hours, including no on-duty staff so much as walking down the memory care unit hallway where Lynne Stewart's room was located for over 8 hours, despite her known predispositions to wander and exist seek and the extreme degree of risk considering the magnitude of the potential harm;

b. Defendants' executive director's and on-call registered nurse's failure to monitor and respond to repeated alarm alerts received every 5 minutes for over 8 hours for a known wanderer and exit seeker despite the extreme degree of risk considering the magnitude of the potential harm;

c. Defendants installing Lynne Stewart's door alarm with double-sided tape instead of proper hardware to secure the alarm and not remedying the issue or adding a safeguard despite becoming aware of the faulty installation;

d. Defendants ignoring and becoming desensitized to Lynne Stewart's apartment door alarm;

e. Defendants' failure to remedy known alarm defects;

f. Defendants' failure to have audible alarms for exit doors with sufficient volume that on-duty staff are able to hear the alarm from all other locations in the unit where the door is located;

g. Defendants' failure to remedy known iPad shortages and malfunctions;

h. Defendants' failure to provide sufficient or appropriate facility administration, care, and staffing to meet the needs of Lynne Stewart;

i. Defendants' failure to possess or negligent failure to exercise that degree of skill, training, and care as is possessed and exercised by average qualified members of the profession practicing their specialties;

j. Defendants' failure to ensure proper attention and supervision of its residents;

k. Defendants' failure to prevent elopement from the facility;

l. Defendants' failure to notice and/or respond to alarms;

m. Defendants' failure to search outside within a reasonable time after alarms went off in the facility, given the severe winter cold;

n. Defendants' failure to specifically check on Lynne Stewart after the alarms were triggered for her apartment door and the exterior door in the memory care unit as required in her care plan;

o. Defendants' failure to keep Lynne Stewart safe and secure;

p. Defendants' failure to follow Lynne Stewart's service/care plan;

q. Defendants' failure to abide by all relevant state and federal regulations, administrative codes, regulations, and laws;

r. Defendants' failure to establish adequate policies and procedures;

s. Defendants' failure to follow and enforce policies and procedures;

t. Defendants' failure to respect and protect Lynne Stewart's rights;

u. Defendants' violation of Lynne Stewart's dignity;

v. Defendants' false advertising;

w. Defendants' failure to properly staff an assisted living facility and its memory care unit;

x. Defendants' inadequate training of staff;

y. Defendants' negligent hiring, retaining, and supervising personnel; and

z. Such other acts and omissions as may be developed through the course of discovery.

91. Defendants knew or had reason to know of facts which would have led a reasonable person to realize that their conduct created not only an unreasonable risk of physical harm to another, but also that such risk was substantially greater than that which is necessary to make their conduct negligent.

92. Defendants' breach of the duties owed to Lynne Stewart, negligence, gross negligence, and/or reckless disregard for her life and safety were the cause of Lynne Stewart's injuries, suffering, and death.

93. Defendants' acts and omissions were willful, wanton, and in reckless disregard of Lynne Stewart's safety.

94. Lynne Stewart's death and resulting damages are within the scope of Defendants' liability and said injuries and damages arose from the same general types of danger that Defendants should have taken reasonable steps to avoid.

95. The provisions of comparative fault do not apply to Lynne Stewart, as she was an assisted living resident, residing in a memory care unit, without the ability to care for herself.

96. As a direct and proximate result of Defendants' negligent and grossly negligent acts and omissions and reckless disregard for her life and safety, Lynne Stewart suffered bodily injury, severe conscious mental anguish, mental and physical pain and suffering, and death, for which the Estate of Lynne Stewart seeks recovery for damages.

97. Plaintiff Kaylynne Van Rooy, as the Executor of the Estate of Lynne Stewart, is entitled to recover damages, including but not limited to, as follows:

a. The present worth or value of the Estate that would reasonably be expected to have been saved and accumulated as a result of her efforts between the time of her premature death and the end of her natural life, had she lived;

b. Past medical expenses;

c. Past pain and suffering;

d. Past loss of mental and physical function;

e. Past emotional impairment and mental anguish;

f. Funeral and burial expenses as well as interest on the cost of the funeral and burial of Lynne Stewart for the period between the date of her premature death and the date on which she could have been expected to die; and

g. Other such damages as may arise through the course of discovery.

WHEREFORE, Plaintiff Kaylynne Van Rooy, as Executor of the Estate of Lynne Stewart, prays the Court enter judgment against Defendants in an amount that will fully, fairly and adequately compensate Plaintiff for its injuries and damages sustained, the costs of this action, attorney fees, exemplary and punitive damages in an amount which will deter Defendants and others similarly situated from the same or similar conduct in the future, and all other damages and relief the Court deems just and reasonable, together with interest as provided for by law.

COUNT II

WRONGFUL DEATH – RES IPSA LOQUITUR

Against All Defendants

98. Plaintiffs hereby reallege the former paragraphs as if fully set forth herein.

99. Due to her physical and mental conditions that required assistance from others, Lynne Stewart was under the exclusive care and control of Defendants.

100. The Facility was under the exclusive control of Defendants.

101. A resident of a memory care unit within an assisted living facility is unable to elope and freeze to death within a fenced-in area outside the facility, under the circumstances as described throughout this Petition, if the facility is properly operated and managed.

102. Lynne Stewart would not have become locked outside the Facility for over 8 hours in the severe cold of Winter and suffered and died of hypothermia had Defendants used reasonable care.

103. The negligence of the Defendants was the cause of injuries Lynne Stewart suffered and her subsequent death, and said injuries, death, and damages would not have occurred except for the negligence of the Defendants.

104. Lynne Stewart's suffering and death are within the scope of Defendants' liability, and said injuries and damages arose from the same general types of danger that said Defendants should have taken reasonable steps to avoid.

WHEREFORE, Plaintiff Kaylynne Van Rooy, as Executor of the Estate of Lynne Stewart, prays the Court enter judgment against Defendants in an amount that will fully, fairly and adequately compensate Plaintiff for its injuries and damages sustained, the costs of this action, attorney fees, exemplary and punitive damages in an amount which will deter Defendants and others similarly situated from the same or similar conduct in the future, and all other damages and relief the Court deems just and reasonable, together with interest as provided for by law.

COUNT III

WRONGFUL DEATH – NEGLIGENCE PER SE

Against All Defendants

105. Plaintiffs replead and incorporate the former paragraphs as if fully set forth herein.

106. Following Lynne Stewart's death resulting from cold exposure outside the Facility, investigations were completed by the Polk County Sheriff's Office and the Iowa Department of Inspections and Appeals ("DIA").

107. The Defendants are negligent per se for having violated Iowa law, including multiple State regulations promulgated for the safety of residents of assisted living facilities.

108. DIA found that Defendants had committed the following violations of laws and regulations in relation to Lynne Stewart's death:

a. Failure to follow the policies and procedures established by the program. Iowa Admin. Code Rule 481-67.2(3);

b. Failure to provide care, treatment and services which are adequate and appropriate. Iowa Admin. Code Rule 481-67.3(2);

c. Failure to provide and follow the individualized service plan for Lynne Stewart. Iowa Admin. Code Rule 481-69.26(4)a;

d. Failure to, in a dementia-specific assisted living program, have one or more staff persons who monitor tenants as indicated in the tenant's service plan, be awake and on duty 24 hours a day on site and in the proximate area, and check on tenants as indicated in the tenant's service plan. Iowa Admin. Code Rule 481-69.29(4);

e. Failure to have personnel in a dementia-specific program properly trained with the minimum number of hours of dementia-specific education and training within 30 days of employment. Iowa Admin. Code Rule 481-69.30(1);

f. Failure to have an operating alarm system connected to each exit door in a dementia-specific program. Iowa Admin. Code Rule 481-69.32(2); and

g. Failure to meet structural requirements of a program designed and operated to meet the needs of the tenants. Iowa Admin. Code Rule 481-69.35(1)a.

WHEREFORE, Plaintiff Kaylynne Van Rooy, as Executor of the Estate of Lynne Stewart, prays the Court enter judgment against Defendants in an amount that will fully, fairly and adequately compensate Plaintiff for its injuries and damages sustained, the costs of this action, attorney fees, exemplary and punitive damages in an amount which will deter Defendants and others similarly situated from the same or similar conduct in the future, and all other damages and relief the Court deems just and reasonable, together with interest as provided for by law.

COUNT IV

WRONGFUL DEATH – NEGLIGENT HIRING, RETENTION, AND SUPERVISION OF EMPLOYEES

Against All Defendants

109. Plaintiffs replead and incorporate the former paragraphs as if fully set forth herein.

110. One or both Defendants employed Catherine Forkpa.

111. As the employer of Ms. Forkpa, Defendants had a duty to exercise reasonable care in the hiring, training, retention, and supervision of Ms. Forkpa because, as a result of her employment, she posed a threat of injury to members of the public and specifically Lynne Stewart and other residents of the Facility.

112. Defendants breached their duty in the negligent and reckless hiring, training, retention, and supervision of Ms. Forkpa.

113. Defendants knew, or in the exercise of ordinary care should have known, of the incompetence, unfitness, and dangerous characteristics of Ms. Forkpa.

114. The incompetence, unfitness, and dangerous characteristics of Ms. Forkpa were a cause of damages to Plaintiffs.

WHEREFORE, Plaintiff Kaylynne Van Rooy, as Executor of the Estate of Lynne Stewart, prays the Court enter judgment against Defendants in an amount that will fully, fairly and adequately compensate Plaintiff for its injuries and damages sustained, the costs of this action, attorney fees, exemplary and punitive damages in an amount which will deter Defendants and others similarly situated from the same or similar conduct in the future, and all other damages and relief the Court deems just and reasonable, together with interest as provided for by law.

COUNT V

PUNITIVE DAMAGES

Against All Defendants

115. Plaintiffs replead and incorporate the former paragraphs as if fully set forth herein.

116. Defendants knew or in the exercise of reasonable care should have known that Defendants' conduct constituted a willful and wanton disregard for the rights or safety of another and caused actual damage to Plaintiffs.

117. Defendant Jaybird has engaged in similar conduct in the case of another assisted living facility in Iowa managed by Jaybird, resulting in a similarly situated resident of that facility becoming locked outside overnight and dying of hypothermia on December 8, 2021, just 43 days before Lynne Stewart becoming locked outside Defendants' Facility and freezing to death in severe Winter weather. See *William Creasey, Individually and as Executor of the Estate of Elaine Creasey, and Stephen Creasey v. Spirit Lake Senior Operator, LLC, d/b/a Keelson*

Harbour Senior Living, Jaybird Senior Living, Inc., and Grapetree Medical Staffing, LLC (Case No. LACV031377, Iowa District Court, Dickinson County).

118. Defendants took no corrective action following that prior elopement/hypothermia death, and, along with other acts of willful and wanton disregard, the lack of corrective action to address known serious risks of harm and to prevent Lynne Stewart from eloping and dying by hypothermia just 43 days later in another Jaybird-managed assisted living facility constitutes willful and wanton disregard of Lynne Stewart's life and safety.

119. Defendants' intentional, illegal, grossly negligent, and reckless acts and omissions were malicious and done with willful and wanton disregard for the rights of Lynne Stewart, so as to entitle Plaintiff to an award of exemplary and punitive damages.

120. Punitive damages should be awarded to deter the Defendants and those similarly situated from similar conduct that could lead to these types of injuries and deaths of other individuals similar to Lynne Stewart.

WHEREFORE, Plaintiff Kaylynne Van Rooy, as Executor of the Estate of Lynne Stewart, prays the Court enter judgment against Defendants in an amount that will fully, fairly and adequately compensate Plaintiff for its injuries and damages sustained, the costs of this action, attorney fees, exemplary and punitive damages in an amount which will deter Defendants and others similarly situated from the same or similar conduct in the future, and all other damages and relief the Court deems just and reasonable, together with interest as provided for by law.

COUNT VI

LOSS OF CONSORTIUM

On Behalf of Sara Gwinn, now deceased, Against All Defendants

121. Plaintiffs replead and incorporate the former paragraphs as if fully set forth herein.

122. Sara Gwinn was the adult child of Lynne Stewart, at the time of Lynne Stewart's death.

123. As a result of Defendants' actions or failure to act, Sara Gwinn was deprived of the consortium, companionship, services, society, and support of her mother, Lynne Stewart.

WHEREFORE, Plaintiffs, Kaylynne Van Rooy, as Executor of the Estate of Lynne Harriet Stewart, and Kaylynne Van Rooy, as Administrator of the Estate of Sara Gwinn, pray the Court enter judgment against Defendants for fair and reasonable compensation for injuries and damages sustained by Lynne Stewart's surviving child, Sara Gwinn (now deceased), for her loss of consortium, including love, affection, services, society, and companionship, as a result of the injuries and premature death of Lynne Stewart.

DEMAND FOR JURY TRIAL

COME NOW, Plaintiffs, Kaylynne Van Rooy, as Executor of the Estate of Lynne Harriet Stewart, and Kaylynne Van Rooy, as Administrator of the Estate of Sara Gwinn, by and through their undersigned attorneys, and demand a jury trial of all the fact issues and claims set forth in this Petition pursuant to Iowa Rules of Civil Procedure, Rule 1.902.

Dated January 15, 2024.

Respectfully submitted,

/s/ Michael S. Eganhouse
Michael S. Eganhouse, AT0010631

/s/ Gary R. Fischer
Gary R. Fischer, AT0002469

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