Filing # 261142395 E-Filed 11/10/2026 06:26:58 PM

IN THE CIRCUIT COURT OF THE 15TH JUDICIAL CIRCUIT, IN AND FOR PALM BEACH COUNTY, FLORIDA

CASE NO.:

KIMBERLY DUKER, as Personal Representative to the Estate of MARK HEIFFERMAN,

Plaintiff,

vs.

THE ENCORE AT BOCA RATON REHABILITATION AND NURSING CENTER, LLC; CARERITE CENTERS, LLC; and FLORIDA VENTURE B LLC,

Defendants.
_____/

COMPLAINT

COMES NOW the Plaintiff, KIMBERLY DUKER, as Personal Representative to the Estate of MARK HEIFFERMAN, by and through undersigned counsel, and sues the Defendants, THE ENCORE AT BOCA RATON REHABILITATION AND NURSING CENTER, LLC (hereinafter referred to as "LICENSEE"), CARERITE CENTERS, LLC (hereinafter referred to as "MANAGEMENT"), and FLORIDA VENTURE B LLC (hereinafter referred to as "CORPORATE") and alleges:

GENERAL JURISDICTIONAL ALLEGATIONS

1. This is a cause of action for damages, which exceeds Fifty Thousand Dollars ($50,000.00), exclusive of costs, interest, and attorney's fees, and is being filed within the applicable statute of limitations.

2. All conditions precedent to the filing of this action, including compliance with the notice provisions of Chapter 400, have been met or waived.

3. This action is being brought by the Plaintiff for violations of Chapter 400 against LICENSEE, MANAGEMENT, and CORPORATE while MARK HEIFFERMAN (hereinafter referred to as "RESIDENT") was a resident at the Defendants' nursing home located in Palm Beach County, Florida (hereafter "the nursing home" or "the facility").

4. At all times material, RESIDENT was a resident of Florida.

5. At all times material, KIMBERLY DUKER is the daughter of RESIDENT.

6. At all times material, KIMBERLY DUKER is, or is in the process of being, appointed as the Personal Representative of the Estate of RESIDENT and is the proper party to bring this action. *See* ***Exhibit "A",*** *Order Appointing Personal Representative.*

7. At all times material, LICENSEE, was a company doing business in the county in which the subject nursing home is located.

8. LICENSEE committed tortious acts against RESIDENT in the State of Florida. Each tortious act is specifically alleged in the subsequent counts. Accordingly, LICENSEE is subject to the jurisdiction of the courts of the State of Florida.

9. At all times material, MANAGEMENT, was a company doing business in the county in which the subject nursing home is located.

10. MANAGEMENT committed tortious acts against RESIDENT in the State of Florida. Each tortious act is specifically alleged in the subsequent counts. Accordingly, MANAGEMENT is subject to the jurisdiction of the courts of the State of Florida.

11. At all times material, CORPORATE, was a company doing business in the county in which the subject nursing home is located.

12. CORPORATE committed tortious acts against RESIDENT in the State of Florida. Each tortious act is specifically alleged in the subsequent counts. Accordingly, CORPORATE is subject to the jurisdiction of the courts of the State of Florida.

13. Venue is appropriate in this action as the events giving rise to the cause of action occurred in the county where the subject nursing home is located, one or more of the Defendant(s) operates and does business in the county where the subject nursing home is located, and the Plaintiff resides in the county where the subject nursing home is located.

14. At all times material hereto, the Defendant facility was subject to the provisions of Chapter 400 of Florida Statutes, Titles 10 and 59 of the Florida Administrative Code, and OBRA 1987, which set the standards for operating nursing homes such as this facility.

15. This Complaint is being filed within the applicable statute of limitations period.

16. The undersigned certifies a good faith basis for bringing this action.

ALLEGATIONS AGAINST LICENSEE

17. At all times material hereto, the Defendant, LICENSEE, was the licensee of the nursing home facility, which was authorized to do business in the State of Florida and to operate the subject nursing home and is subject to the provisions of Florida Statutes Chapter 400.

18. At all times material hereto, the Defendant, LICENSEE employed the nurses and caretakers at the facility and is therefore responsible for their tortious conduct.

19. At all times material hereto, the Defendant, LICENSEE, was operating the subject facility and/or had a non-delegable duty to ensure reasonable operation of the facility and reasonable care to residents, as the licensee of the facility, licensed as a nursing home as that term is defined in Florida Statutes Chapter 400.

20. At all times material hereto, the Defendant, LICENSEE, owed a duty to its residents to exercise reasonable care in its operation of the subject nursing home according to §400.023(3), Florida Statutes.

ALLEGATIONS AGAINST MANAGEMENT

21. At all times material, MANAGEMENT, was a "management or consulting company" of the nursing home as defined under Chapter 400.023 of the Florida Statutes.

22. At all times material, MANAGEMENT, performed under a contract and/or received a fee for management / consulting services performed for LICENSEE.

23. At all times material hereto the Defendant, MANAGEMENT, was in the business of owning, managing, and/or maintaining nursing and convalescent homes and related health care facilities, including the subject facility.

24. At all times material hereto, the Defendant, MANAGEMENT, was the management company for the subject facility, which was licensed as a nursing home as that term is defined in Florida Statutes Chapter 400.

25. At all times material hereto, the Defendant, MANAGEMENT, controlled, or had the ability to control, the budget at LICENSEE.

26. At all times material hereto, the Defendant, MANAGEMENT, controlled, or had the ability to control, staffing levels at LICENSEE.

27. At all times material hereto, the Defendant, MANAGEMENT, controlled, or had the ability to control, the hiring and firing of the administrator of LICENSEE.

28. At all times material hereto, the Defendant, MANAGEMENT, controlled, or had the ability to control, the policies and procedures at LICENSEE.

29. At all times material hereto, the Defendant, MANAGEMENT, was operating the Defendants' facility and/or had a non-delegable duty to ensure reasonable operation of the facility and reasonable care to residents, as the management company for the facility, which was licensed as a nursing home as that term is defined in Florida Statutes Chapter 400.

30. At all times material hereto, MANAGEMENT owed a duty to its residents to exercise reasonable care in its operation of the subject nursing home according to §400.023(3), Florida Statutes.

ALLEGATIONS AGAINST CORPORATE

31. At all times material, CORPORATE, was a "management or consulting company" of the nursing home as defined under Chapter 400.023 of the Florida Statutes.

32. At all times material, CORPORATE, performed under a contract and/or received a fee for management / consulting services performed for LICENSEE.

33. At all times material hereto the Defendant, CORPORATE, was in the business of actively owning, managing, and/or maintaining nursing and convalescent homes and related health care facilities, including the subject facility.

34. At all times material hereto, the Defendant, CORPORATE, was actively operating the subject facility, which was licensed as a nursing home as that term is defined in Florida Statutes Chapter 400.

35. At all times material hereto, the Defendant, CORPORATE, controlled, or had the ability to control, the budget at LICENSEE.

36. At all times material hereto, the Defendant, CORPORATE, controlled, or had the ability to control, staffing levels at LICENSEE.

37. At all times material hereto, the Defendant, CORPORATE, controlled, or had the ability to control, the hiring and firing of the administrator of LICENSEE.

38. At all times material hereto, the Defendant, CORPORATE, controlled, or had the ability to control, the policies and procedures at LICENSEE.

39. At all times material hereto, the Defendant, CORPORATE, was operating the Defendants' facility and/or had a non-delegable duty to ensure reasonable operation of the facility and reasonable care to residents, as the management company for the facility, which was licensed as a nursing home as that term is defined in Florida Statutes Chapter 400.

40. At all times material hereto, CORPORATE owed a duty to its residents to exercise reasonable care in its operation of the subject nursing home according to §400.023(3), Florida Statutes.

FACTS GIVING RISE TO THIS CAUSE OF ACTION

41. RESIDENT was admitted to the Defendants' nursing home for care and supervision relating to ongoing medical conditions and cognitive changes.

42. At all times material, RESIDENT was at risk for preventable injuries including but not limited to skin breakdown, falls, wandering, infection, malnutrition, and dehydration.

43. During admission and at all times material, RESIDENT was vulnerable and unable to care for themselves and was dependent on facility staff for assistance in performing their activities of daily living.

44. RESIDENT required supervision and assistance with their day to day function from facility staff to remain safe and free from harm, abuse, and preventable injury.

45. Defendants owed a duty to provide the reasonable care, supervision, and assistance that RESIDENT needed while RESIDENT resided at their facility.

46. Despite this, Defendants by and through their staff, negligently failed to provide the required reasonable care, supervision, and assistance to RESIDENT.

47. As a result of these failures, RESIDENT suffered preventable injury.

48. Specifically, as a result of Defendants' negligence, RESIDENT suffered preventable injury, including but not limited to pressure ulcer, skin breakdown, corresponding infection, as well as facility-acquired infection, pneumonia, urinary tract infection, sepsis and other serious injury during the subject residency at the Defendants' facility.

49. The aforementioned injuries plagued RESIDENT until his death on May 12, 2026.

WRONGFUL DEATH DAMAGES

50. RESIDENT wrongfully died on or around May 12, 2026 as a direct and proximate result of the Defendant's negligence, more fully described above and below.

51. As a direct and proximate result of the negligence outlined above and below, the Estate of RESIDENT and the survivors of the Estate, is/are entitled to all damages recoverable for the wrongful death caused by the Defendant, as alleged above and below, including but not limited to:

i. Any and all damages available under the wrongful death statute;

ii. Medical bills and expenses;

iii. Funeral expenses;

iv. Loss of net accumulations;

v. The survivor(s) have suffered mental pain and suffering, past and future, which will continue for the rest of their life, and they have suffered the loss of services, consortium, society, comfort and support of the decedent, and have incurred

medical and funeral expenses as a result of the decedent's death, and have suffered the loss of the decedent's love and companionship.

SURVIVAL DAMAGES

52. Alternatively, if these injuries did not cause RESIDENT's death, the Estate of RESIDENT claims all damages recoverable under a survival action, including but not limited to the non-economic and economic damages of the decedent for bodily injury and resulting pain and suffering, disability, disfigurement, mental anguish, loss of capacity for the enjoyment of life, expense of hospitalization, medical and nursing care and treatment, and aggravation of a previously existing condition, from the time of injury of RESIDENT to the time of their death. These survival damages occurred as a direct and proximate result of the negligence of the Defendants(s) outlined above and below.

COUNT I:
RESIDENT v. LICENSEE – WRONGFUL DEATH

53. Plaintiff re-adopts and re-alleges paragraphs 1 through 51 and further alleges:

54. Defendant, LICENSEE, through its employees, agents and apparent agents were below the standard of care and thus violated the Chapter 400 rights of RESIDENT as follows:

i. Failing to prevent physical injury and abuse to the resident;
ii. Failing to properly assess skin breakdown, pressure ulcers and infection;
iii. Failing to institute appropriate preventative measures and monitoring for skin breakdown, pressure ulcers and infection;
iv. Failing to prevent skin breakdown, pressure ulcers and infection;
v. Failing to properly respond to skin breakdown, pressure ulcers and infection;
vi. Failing to properly assess risk of falls, wandering, transfer injuries and unsupervised ambulation;
vii. Failing to prevent falls, wandering, transfer injuries, and unsupervised ambulation;
viii. Failing to properly respond to falls, wandering, transfer injuries, and unsupervised ambulation;
ix. Failing to properly supervise at-risk residents;
x. Failing to keep common areas clean of fall hazards;
xi. Failing to document the resident's injuries;
xii. Failing to inform family members of serious changes in condition;

xiii. Failing to treat the resident for injuries and report abnormalities;
xiv. Failing to provide appropriate hygiene;
xv. Failing to keep the resident clean and to change diapers and linens;
xvi. Failing to report the resident's signs of injury/illness to her/her healthcare providers;
xvii. Failing to timely provide outside consultation with physicians and specialists;
xviii. Failing to timely transfer the resident to a higher care facility;
xix. Failing to inform the resident's family of the resident's unexplained injuries and/or deteriorated condition;
xx. Failing to follow physician's orders;
xxi. Failing to provide appropriate nutrition and hydration to the resident;
xxii. Failing to properly assess and prevent dehydration and malnutrition;
xxiii. Failing to uphold rights to dignity of the resident
xxiv. Failing to follow state and federal regulations to protect nursing home residents;
xxv. Failing to appropriately staff and train employees and agents;
xxvi. Failing to provide appropriate budgeting for the subject facility;
xxvii. Failing to provide appropriate policies and procedures to the subject facility;
xxviii. Failing to provide medication when required; and
xxix. Failing to provide the resident with safety, well-being, and appropriate healthcare under all the circumstances.

55. The above negligence occurred from the actions and omissions of employees, agents and apparent agents of Defendant, LICENSEE, while in the course and scope of their employment, agency and/or apparent agency.

56. As a direct and proximate result of said negligence, RESIDENT wrongfully died.

WHEREFORE, the Plaintiff, ESTATE of RESIDENT and its survivors, demand judgment for damages against Defendant, LICENSEE, and further demand a trial by jury of all issues so triable.

COUNT II:
RESIDENT v. MANAGEMENT – WRONGFUL DEATH

57. Plaintiff re-adopts and re-alleges paragraphs 1 through 51 and further alleges:

58. Defendant, MANAGEMENT, through its employees, agents and apparent agents were below the standard of care and thus violated the Chapter 400 rights of RESIDENT as follows:

i. Failing to prevent physical injury and abuse to the resident;
ii. Failing to properly assess skin breakdown, pressure ulcers and infection;

iii. Failing to institute appropriate preventative measures and monitoring for skin breakdown, pressure ulcers and infection;
iv. Failing to prevent skin breakdown, pressure ulcers and infection;
v. Failing to properly respond to skin breakdown, pressure ulcers and infection;
vi. Failing to properly assess risk of falls, wandering, transfer injuries and unsupervised ambulation;
vii. Failing to prevent falls, wandering, transfer injuries, and unsupervised ambulation;
viii. Failing to properly respond to falls, wandering, transfer injuries, and unsupervised ambulation;
ix. Failing to properly supervise at-risk residents;
x. Failing to keep common areas clean of fall hazards;
xi. Failing to document the resident's injuries;
xii. Failing to inform family members of serious changes in condition;
xiii. Failing to treat the resident for injuries and report abnormalities;
xiv. Failing to provide appropriate hygiene;
xv. Failing to keep the resident clean and to change diapers and linens;
xvi. Failing to report the resident's signs of injury/illness to her/her healthcare providers;
xvii. Failing to timely provide outside consultation with physicians and specialists;
xviii. Failing to timely transfer the resident to a higher care facility;
xix. Failing to inform the resident's family of the resident's unexplained injuries and/or deteriorated condition;
xx. Failing to follow physician's orders;
xxi. Failing to provide appropriate nutrition and hydration to the resident;
xxii. Failing to properly assess and prevent dehydration and malnutrition;
xxiii. Failing to uphold rights to dignity of the resident
xxiv. Failing to follow state and federal regulations to protect nursing home residents;
xxv. Failing to appropriately staff and train employees and agents;
xxvi. Failing to provide appropriate budgeting for the subject facility;
xxvii. Failing to provide appropriate policies and procedures to the subject facility;
xxviii. Failing to provide medication when required; and
xxix. Failing to provide the resident with safety, well-being, and appropriate healthcare under all the circumstances.

59. The above negligence occurred from the actions and omissions of employees, agents and apparent agents of Defendant, MANAGEMENT, while in the course and scope of their employment, agency and/or apparent agency.

60. As a direct and proximate result of said negligence, RESIDENT wrongfully died.

WHEREFORE, the Plaintiff, ESTATE of RESIDENT and its survivors, demand judgment for damages against Defendant, MANAGEMENT, and further demand a trial by jury of all issues so triable.

COUNT III:
RESIDENT v. CORPORATE – WRONGFUL DEATH

61. Plaintiff re-adopts and re-alleged paragraphs 1 though 51 and further alleges:

62. Defendant, CORPORATE, through its employees, agents and apparent agents were below the standard of care and thus violated the Chapter 400 rights of RESIDENT as follows:

i. Failing to prevent physical injury and abuse to the resident;
ii. Failing to properly assess skin breakdown, pressure ulcers and infection;
iii. Failing to institute appropriate preventative measures and monitoring for skin breakdown, pressure ulcers and infection;
iv. Failing to prevent skin breakdown, pressure ulcers and infection;
v. Failing to properly respond to skin breakdown, pressure ulcers and infection;
vi. Failing to properly assess risk of falls, wandering, transfer injuries and unsupervised ambulation;
vii. Failing to prevent falls, wandering, transfer injuries, and unsupervised ambulation;
viii. Failing to properly respond to falls, wandering, transfer injuries, and unsupervised ambulation;
ix. Failing to properly supervise at-risk residents;
x. Failing to keep common areas clean of fall hazards;
xi. Failing to document the resident's injuries;
xii. Failing to inform family members of serious changes in condition;
xiii. Failing to treat the resident for injuries and report abnormalities;
xiv. Failing to provide appropriate hygiene;
xv. Failing to keep the resident clean and to change diapers and linens;
xvi. Failing to report the resident's signs of injury/illness to her/her healthcare providers;
xvii. Failing to timely provide outside consultation with physicians and specialists;
xviii. Failing to timely transfer the resident to a higher care facility;
xix. Failing to inform the resident's family of the resident's unexplained injuries and/or deteriorated condition;
xx. Failing to follow physician's orders;
xxi. Failing to provide appropriate nutrition and hydration to the resident;
xxii. Failing to properly assess and prevent dehydration and malnutrition;
xxiii. Failing to uphold rights to dignity of the resident
xxiv. Failing to follow state and federal regulations to protect nursing home residents;
xxv. Failing to appropriately staff and train employees and agents;
xxvi. Failing to provide appropriate budgeting for the subject facility;

xxvii. Failing to provide appropriate policies and procedures to the subject facility;
xxviii. Failing to provide medication when required; and
xxix. Failing to provide the resident with safety, well-being, and appropriate healthcare under all the circumstances.

63. The above negligence occurred from the actions and omissions of employees, agents and apparent agents of Defendant, CORPORATE, while in the course and scope of their employment, agency and/or apparent agency.

64. As a direct and proximate result of said negligence, RESIDENT wrongfully died.

WHEREFORE, the Plaintiff, ESTATE of RESIDENT and its survivors, demand judgment for damages against Defendant, CORPORATE, and further demand a trial by jury of all issues so triable.

COUNT IV:
RESIDENT v. LICENSEE – SURVIVAL CLAIM

65. Plaintiff re-adopts and re-alleges paragraphs 1 through 49 and 52 and further alleges:

66. Defendant, LICENSEE, through its employees, agents and apparent agents were below the standard of care and thus violated the Chapter 400 rights of RESIDENT as follows:

i. Failing to prevent physical injury and abuse to the resident;
ii. Failing to properly assess skin breakdown, pressure ulcers and infection;
iii. Failing to institute appropriate preventative measures and monitoring for skin breakdown, pressure ulcers and infection;
iv. Failing to prevent skin breakdown, pressure ulcers and infection;
v. Failing to properly respond to skin breakdown, pressure ulcers and infection;
vi. Failing to properly assess risk of falls, wandering, transfer injuries and unsupervised ambulation;
vii. Failing to prevent falls, wandering, transfer injuries, and unsupervised ambulation;
viii. Failing to properly respond to falls, wandering, transfer injuries, and unsupervised ambulation;
ix. Failing to properly supervise at-risk residents;
x. Failing to keep common areas clean of fall hazards;
xi. Failing to document the resident's injuries;
xii. Failing to inform family members of serious changes in condition;
xiii. Failing to treat the resident for injuries and report abnormalities;

xiv. Failing to provide appropriate hygiene;
xv. Failing to keep the resident clean and to change diapers and linens;
xvi. Failing to report the resident's signs of injury/illness to her/her healthcare providers;
xvii. Failing to timely provide outside consultation with physicians and specialists;
xviii. Failing to timely transfer the resident to a higher care facility;
xix. Failing to inform the resident's family of the resident's unexplained injuries and/or deteriorated condition;
xx. Failing to follow physician's orders;
xxi. Failing to provide appropriate nutrition and hydration to the resident;
xxii. Failing to properly assess and prevent dehydration and malnutrition;
xxiii. Failing to uphold rights to dignity of the resident
xxiv. Failing to follow state and federal regulations to protect nursing home residents;
xxv. Failing to appropriately staff and train employees and agents;
xxvi. Failing to provide appropriate budgeting for the subject facility;
xxvii. Failing to provide appropriate policies and procedures to the subject facility;
xxviii. Failing to provide medication when required; and
xxix. Failing to provide the resident with safety, well-being, and appropriate healthcare under all the circumstances.

67. The above negligence occurred from the actions and omissions of employees, agents and apparent agents of Defendant, LICENSEE, while in the course and scope of their employment, agency and/or apparent agency.

68. As a direct and proximate result of the Defendant's deprivation of and infringement upon RESIDENT's Chapter 400 rights as alleged in this Complaint, which includes the above alleged negligence, RESIDENT suffered bodily injury and resulting pain and suffering, disability disfigurement, mental anguish, loss of capacity for the enjoyment of life, expense of hospitalization, medical and nursing care and treatment, and aggravation of a previously existing condition.

WHEREFORE, the Plaintiff, ESTATE of RESIDENT, demands judgment for damages against Defendant, LICENSEE, and further demands a trial by jury of all issues so triable.

COUNT V:
RESIDENT v. MANAGEMENT – SURVIVAL CLAIM

69. Plaintiff re-adopts and re-alleges paragraphs 1 through 49 and 52 and further alleges:

70. Defendant, MANAGEMENT, through its employees, agents and apparent agents were below the standard of care and thus violated the Chapter 400 rights of RESIDENT as follows:

i. Failing to prevent physical injury and abuse to the resident;
ii. Failing to properly assess skin breakdown, pressure ulcers and infection;
iii. Failing to institute appropriate preventative measures and monitoring for skin breakdown, pressure ulcers and infection;
iv. Failing to prevent skin breakdown, pressure ulcers and infection;
v. Failing to properly respond to skin breakdown, pressure ulcers and infection;
vi. Failing to properly assess risk of falls, wandering, transfer injuries and unsupervised ambulation;
vii. Failing to prevent falls, wandering, transfer injuries, and unsupervised ambulation;
viii. Failing to properly respond to falls, wandering, transfer injuries, and unsupervised ambulation;
ix. Failing to properly supervise at-risk residents;
x. Failing to keep common areas clean of fall hazards;
xi. Failing to document the resident's injuries;
xii. Failing to inform family members of serious changes in condition;
xiii. Failing to treat the resident for injuries and report abnormalities;
xiv. Failing to provide appropriate hygiene;
xv. Failing to keep the resident clean and to change diapers and linens;
xvi. Failing to report the resident's signs of injury/illness to her/her healthcare providers;
xvii. Failing to timely provide outside consultation with physicians and specialists;
xviii. Failing to timely transfer the resident to a higher care facility;
xix. Failing to inform the resident's family of the resident's unexplained injuries and/or deteriorated condition;
xx. Failing to follow physician's orders;
xxi. Failing to provide appropriate nutrition and hydration to the resident;
xxii. Failing to properly assess and prevent dehydration and malnutrition;
xxiii. Failing to uphold rights to dignity of the resident
xxiv. Failing to follow state and federal regulations to protect nursing home residents;
xxv. Failing to appropriately staff and train employees and agents;
xxvi. Failing to provide appropriate budgeting for the subject facility;
xxvii. Failing to provide appropriate policies and procedures to the subject facility;
xxviii. Failing to provide medication when required; and
xxix. Failing to provide the resident with safety, well-being, and appropriate healthcare under all the circumstances.

71. The above negligence occurred from the actions and omissions of employees, agents and apparent agents of Defendant, MANAGEMENT, while in the course and scope of their employment, agency and/or apparent agency.

72. As a direct and proximate result of the Defendant's deprivation of and infringement upon RESIDENT's Chapter 400 rights as alleged in this Complaint, which includes the above alleged negligence, RESIDENT suffered bodily injury and resulting pain and suffering, disability disfigurement, mental anguish, loss of capacity for the enjoyment of life, expense of hospitalization, medical and nursing care and treatment, and aggravation of a previously existing condition.

WHEREFORE, the Plaintiff, ESTATE of RESIDENT, demands judgment for damages against Defendant, MANAGEMENT, and further demands a trial by jury of all issues so triable.

COUNT VI:
RESIDENT v. CORPORATE – SURVIVAL CLAIM

73. Plaintiff re-adopts and re-alleges paragraphs 1 through 49 and 52 and further alleges:

74. Defendant, CORPORATE, through its employees, agents and apparent agents were below the standard of care and thus violated the Chapter 400 rights of RESIDENT as follows:

i. Failing to prevent physical injury and abuse to the resident;
ii. Failing to properly assess skin breakdown, pressure ulcers and infection;
iii. Failing to institute appropriate preventative measures and monitoring for skin breakdown, pressure ulcers and infection;
iv. Failing to prevent skin breakdown, pressure ulcers and infection;
v. Failing to properly respond to skin breakdown, pressure ulcers and infection;
vi. Failing to properly assess risk of falls, wandering, transfer injuries and unsupervised ambulation;
vii. Failing to prevent falls, wandering, transfer injuries, and unsupervised ambulation;
viii. Failing to properly respond to falls, wandering, transfer injuries, and unsupervised ambulation;
ix. Failing to properly supervise at-risk residents;
x. Failing to keep common areas clean of fall hazards;

xi. Failing to document the resident's injuries;
xii. Failing to inform family members of serious changes in condition;
xiii. Failing to treat the resident for injuries and report abnormalities;
xiv. Failing to provide appropriate hygiene;
xv. Failing to keep the resident clean and to change diapers and linens;
xvi. Failing to report the resident's signs of injury/illness to her/her healthcare providers;
xvii. Failing to timely provide outside consultation with physicians and specialists;
xviii. Failing to timely transfer the resident to a higher care facility;
xix. Failing to inform the resident's family of the resident's unexplained injuries and/or deteriorated condition;
xx. Failing to follow physician's orders;
xxi. Failing to provide appropriate nutrition and hydration to the resident;
xxii. Failing to properly assess and prevent dehydration and malnutrition;
xxiii. Failing to uphold rights to dignity of the resident
xxiv. Failing to follow state and federal regulations to protect nursing home residents;
xxv. Failing to appropriately staff and train employees and agents;
xxvi. Failing to provide appropriate budgeting for the subject facility;
xxvii. Failing to provide appropriate policies and procedures to the subject facility;
xxviii. Failing to provide medication when required; and
xxix. Failing to provide the resident with safety, well-being, and appropriate healthcare under all the circumstances.

75. The above negligence occurred from the actions and omissions of employees, agents and apparent agents of Defendant, CORPORATE, while in the course and scope of their employment, agency and/or apparent agency.

76. As a direct and proximate result of the Defendant's deprivation of and infringement upon RESIDENT's Chapter 400 rights as alleged in this Complaint, which includes the above alleged negligence, RESIDENT suffered bodily injury and resulting pain and suffering, disability disfigurement, mental anguish, loss of capacity for the enjoyment of life, expense of hospitalization, medical and nursing care and treatment, and aggravation of a previously existing condition.

WHEREFORE, the Plaintiff, ESTATE of RESIDENT, demands judgment for damages against Defendant, CORPORATE, and further demands a trial by jury of all issues so triable.

DATED this 10th day of November 2026.

/s./ *William J. Sarubbi, II*

William J. Sarubbi, II, Esq.
Florida Bar No.: 113401
SENIOR JUSTICE LAW FIRM
6001 Broken Sound Parkway
Suite 600
Boca Raton, FL 33487
Phone: 561.717.0813
Fax: 561.708.6781
Email: Eservice@SeniorJustice.com
Attorneys for Plaintiff

Exhibit A

IN THE CIRCUIT COURT OF THE 15TH JUDICIAL CIRCUIT
IN AND FOR PALM BEACH COUNTY, FLORIDA

IN RE: ESTATE OF PROBATE DIVISION

MARK STEPHEN HEIFFERMAN, File No. 502026CP003499XXXANB
Deceased.
_____/

ORDER ADMITTING WILL TO PROBATE
AND APPOINTING PERSONAL REPRESENTATIVE
(self-proved)

The instrument presented to this court as the last will of MARK STEPHEN HEIFFERMAN, deceased, having been executed in conformity with law, and made self-proved by the acknowledgment of the decedent and the affidavits of the witnesses, made before an officer authorized to administer oaths and evidenced by the officer's certificate attached to or following the will in the form required by law, and no objection having been made to its probate, and the court finding that the decedent died on May 12, 2026, and that KIMBERLY DUKER is entitled and qualified to be personal representative, it is

ADJUDGED that the will dated November 28, 2022 a self-proved will with two (2) witnesses, named Kasey Connick and Theresa J. Boutwell is admitted to probate according to law as the last will of the decedent, and it is further

ADJUDGED that KIMBERLY DUKER is appointed personal representative of the estate of the decedent, and that upon taking the prescribed oath, filing designation and acceptance of resident agent, and entering into bond in the sum of $___0_____, letters of administration shall be issued.

DONE AND ORDERED in Palm Beach County, Florida.

502026CP003499XXXANB 08/21/2026
Charles E. Burton Circuit Judge

This estate shall be closed within 12 months of this order, pursuant to Florida Probate Rule 5.400.

502026CP003499XXXANB 08/21/2026
Charles E. Burton
Circuit Judge

Copy to:
Scott R. Bugay, PA
2501 Hollywood Blvd. Suite 206
Hollywood, FL 33020

IN THE CIRCUIT COURT OF THE 15TH JUDICIAL CIRCUIT
IN AND FOR PALM BEACH COUNTY, FLORIDA

IN RE: ESTATE OF

MARK STEPHEN HEIFFERMAN,
Deceased.
_____/

PROBATE DIVISION

File No. 502026CP003499XXXANB

LETTERS OF ADMINISTRATION
(Single personal representative)

TO ALL WHOM IT MAY CONCERN

WHEREAS, MARK STEPHEN HEIFFERMAN, a resident of PALM BEACH County, died on May 12, 2026, owning assets in the State of Florida, and

WHEREAS, KIMBERLY DUKER has been appointed personal representative of the estate of the decedent and have performed all acts prerequisite to issuance of Letters of Administration in the estate.

NOW, THEREFORE, I, the undersigned circuit judge, declare KIMBERLY DUKER duly qualified under the laws of the State of Florida to act as personal representatives of the estate of MARK STEPHEN HEIFFERMAN, deceased, with full power to administer the estate according to law; to ask, demand, sue for, recover and receive the property of the decedent; to pay the debts of the decedent as far as the assets of the estate will permit and the law directs; and to make distribution of the estate according to law.

DONE AND ORDERED in Palm Beach County, Florida.

502026CP003499XXXANB 08/21/2026
Charles E. Burton Circuit Judge

This estate shall be closed within 12 months of this order, pursuant to Florida Probate Rule 5.400.

502026CP003499XXXANB 08/21/2026
Charles E. Burton
Circuit Judge

Copy to:
Scott R. Bugay, PA
2501 Hollywood Blvd. Suite 206
Hollywood, FL 33020