UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

JENNIFER WALDRON, as guardian of S.B.

Plaintiff,

-against-

INDEPENDENT LIVING ASSOCIATION, INC.

Defendant.

No. 24 Civ. 834

COMPLAINT AND JURY DEMAND

Plaintiff Jennifer Waldron, as guardian of S.B., by and through her attorneys Kaufman Lieb Lebowitz & Frick LLP, alleges as follows:

INTRODUCTION

1. As the operator of residential programs for people with intellectual and developmental disabilities, Defendant Independent Living Association, Inc. ("ILA") is tasked with the care and protection of some of our most vulnerable and defenseless neighbors. ILA assumes total control over the safety and well-being of people with disabilities, whose families and loved ones depend on ILA and its staff not to abuse that control.

2. This case is about an appalling betrayal of that trust.

3. S.B. is a non-verbal, severely developmentally disabled woman who resides in an Individual Residential Alternative ("IRA") group home operated by ILA in Queens, called the 226th Street Residence.

4. While under ILA's care, S.B. endured staggering violence and cruelty at the hands of those who were supposed to protect and care for her.

5. The horrific abuse S.B. endured came to light on February 7, 2022, when a whistleblower anonymously texted four videos to S.B.'s sister and legal guardian, Plaintiff Jennifer Waldron.

6. These videos show S.B.'s supposed caregivers choking her with a sex toy, beating her with a cable box, throwing a boot at her, and standing idly by while another resident slapped her.

7. Tragically, the physical abuse depicted in these videos was just the tip of the iceberg. S.B. has been abused and neglected since she entered ILA's care in 2017.

8. S.B.'s outrageous mistreatment was the direct result of a culture of impunity that permeated the 226th Street Residence. Much of S.B.'s abuse occurred openly, with the full knowledge, approval, and participation of supervisors and managers. ILA's culture actively discouraged reporting of abuse and misconduct.

9. Perhaps most astonishingly, although S.B. herself repeatedly reported that she was being abused, ILA continuously dismissed her as malingering and manipulative.

10. S.B., whose verbal skills are limited because of her disability, cried for help in the limited ways she could—but she could not get through to anyone who would listen.

11. For too long, S.B. has suffered in silence. The time has now come for that silence to be broken, and for her tormentors to be held accountable. This action seeks redress for violations of S.B.'s rights under federal, state, and local law—and of her fundamental human dignity.

JURISDICTION AND VENUE

12. The Court has subject-matter jurisdiction over Plaintiff's federal claims under 28 U.S.C. §§ 1331 and 1343(a). The Court has supplemental jurisdiction over Plaintiff's state law claims under 28 U.S.C. § 1367(a).

13. Venue lies in the Eastern District of New York under 28 U.S.C. § 1391(b)(2) because a substantial part of the events or omissions giving rise to the claim occurred in Queens County, New York.

PARTIES

14. S.B. is a 29-year-old woman and appears in this action by and through her legal guardian, Plaintiff Jennifer Waldron. S.B. has resided at the 226th Street Residence since 2017.

15. Defendant ILA is a 501(c)(3) organization organized under the laws of New York with its principal place of business in Brooklyn, New York. At all relevant times, ILA has operated the 226th Street Residence under Operating Certificate number 7645482, issued by the New York State Office for People with Developmental Disabilities ("OPWDD").

JURY DEMAND

16. Plaintiff demands a jury trial.

FACTUAL ALLEGATIONS

S.B.'s Disabilities and Transfer to ILA's Care

17. S.B. has a primary diagnosis of moderate intellectual developmental disability. Her secondary diagnoses include bipolar disorder, ADHD, and impulse control disorder. S.B. has an I.Q. of approximately 41 and extremely limited communication, socialization, daily living, and adaptive behavior skills.

18. S.B. enjoys listening to music, dancing, getting manicures, doing arts and crafts, exploring the community, and visiting with her sister.

19. In summer 2017, S.B. was transferred to the ILA group home on 226th Street in Laurelton, Queens. At that time ILA staff noted in a services plan prepared for S.B. that while she "needs assistance in controlling her impulses," S.B. "is responsive to re-direction" and "is a very sweet girl and with patience she can be re-directed" using "a variety of coping strategies."

20. Unfortunately, ILA's staff has proved utterly incapable of using any "coping strategies" to "redirect" S.B.

21. Instead, for years, ILA staff have perpetuated a disturbing pattern: Rather than redirecting her when S.B. engages in what ILA staff termed "a behavior," staff simply call the police and/or transport her to the emergency room, often multiple times in a single week.

22. During her time in ILA's care, S.B. has been taken to the emergency room *hundreds* of times, and staff have called the police to respond to S.B. *dozens* of times.

23. Predictably, S.B.'s pain and frustration grew, and her "behaviors" were met with increasing belligerence and cruelty on the part of residence staff.

24. The result was a marked decline in S.B.'s physical and mental health.

An Anonymous Leak Reveals Shocking Physical and Sexual Abuse

25. On or about February 7, 2022, an anonymous whistleblower sent Ms. Waldron four videos showing S.B.'s horrific mistreatment in ILA's care.

26. The first video depicts an unimaginably humiliating and demeaning act: Latisha Woodall, a Direct Support Professional ("DSP") employed by ILA, shoves a large dildo down S.B.'s throat.

27. Although this assault was videotaped, the unidentified videographer, who worked at the 226th Street Residence, did not intervene to stop the attack or help S.B.

28. In the two-second video clip, Woodall is straddling S.B. from behind, holding S.B.'s head back to gain better access to S.B.'s throat. With her right hand, on which she is wearing a blue medical glove, Woodall forcibly inserts the large sex toy into S.B.'s mouth. S.B. is clearly agitated; she struggles and shoves Woodall away before collapsing on the floor.

29. Under state law, individuals who work in residential programs for people with developmental disabilities are mandated reporters, and must report all allegations of abuse, neglect, or mistreatment to the Vulnerable Persons' Central Register ("VPCR"), operated by the New York State Justice Center for the Protection of People with Special Needs ("Justice Center"). These reports trigger immediate protections and the launch of an official investigation.

30. Although several ILA employees witnessed S.B.'s abuse, none reported it to anyone.

31. Because no one contemporaneously reported the assault to the Justice Center or the police (as the law requires), Woodall was not removed from the home and

separated from contact with disabled residents until February 2022, after Ms. Waldron received the video,

32. A second video, also texted to Ms. Waldron, shows DSP Amelia Parcells repeatedly striking S.B. with a cable box, while Woodall sits on a nearby couch and fails to intervene.

33. Since S.B. is wearing the same clothes and Woodall the same sandals as in the first clip, it is plausible that this video was taken the same day as Woodall's sexual assault with the dildo.

34. The anonymous videographer again failed to intervene.

35. In the three-second video, S.B. cowers in the corner of the room behind a couch, trying to turn her body away from Parcells and shield herself from the blows. The clip—which clearly begins midway through the assault—shows Parcells strike S.B. twice on her rear with the large object.

36. Once again, Parcells's attack was not reported to the Justice Center or to the police until after this clip was leaked to Ms. Waldron in February 2022. As such, corrective action was taken only when the abuse was exposed to people outside the home, even though multiple members of ILA's staff witnessed it and had an obligation to report.

37. A third video shows another resident, I.P., slapping S.B. in the face while DSP Marjorie Cadesty and another staff member, plus the unknown videographer, fail to intervene.

38. Before she is struck, S.B. appears to jerk her head to the side, as if she expects a blow. A moment later, after she is slapped, S.B. visibly yelps with pain.

39. As discussed further below, ILA has continuously failed to protect S.B. from I.P., despite being well aware of I.P.'s aggressive and violent tendencies.

40. The last video shows Cadesty throwing a boot across the room at S.B. DSP Erlande Orelus is shown sitting on a nearby couch for the entire exchange but does nothing to intervene.

41. Astoundingly, Orelus not only failed to report the incident as required when it happened; indeed, she persisted in denying that she had witnessed any staff abuse even when interviewed by the Justice Center in February 2022, *after* the videos were leaked.

42. Perhaps Orelus knowingly lied to investigators, or perhaps she did not consider throwing a boot at a resident to constitute abuse. Either possibility reveals a shocking failure of training and supervision on the part of ILA.

43. According to the anonymous person who ultimately reported this final incident to the Justice Center, Cadesty was also "hitting S.B. . . . aggressively with an open hand" before striking her with the boot. That abuse is what led the anonymous reporter to take out their cell phone and start recording. S.B. "asked [Cadesty] to stop." When Cadesty did not stop, the reporter "went to get the medical coordinator and was told not to say anything" because the medical coordinator "like[d] the way that [Cadesty] worked."

44. Thus, not only did ILA staff repeatedly abuse S.B.; they did so with the explicit blessing of more senior staff who actively thwarted the residence's mandatory reporting obligations.

45. After these incidents were belatedly reported to the VPCR, the Justice Center conducted an extensive investigation and substantiated a slew of allegations arising from the incidents depicted in the recordings.

46. Under Section 493 of the New York Social Services Law, instances of abuse or neglect of a vulnerable person are classified into one of three categories. Category 1 involves the most serious conduct, such as physical or sexual abuse with the potential to kill or injure the victim or to cause sustained psychological harm. Category 2 includes any other abuse and neglect that seriously endangers the health, safety, or welfare of the victim. Category 3 comprises all abuse and neglect that does not rise to the level of Category 1 or 2.

47. In its investigation of the videotaped incidents, the Justice Center found that Woodall committed Category 1 Sexual Abuse, Category 1 Physical Abuse, and Category 2 Neglect; Parcells committed Category 1 Physical Abuse and Category 2 Neglect; Cadesty committed Category 1 Physical Abuse and Category 2 Neglect; and Orelus committed Category 3 Neglect and Category 3 Obstruction.

48. Woodall, Parcells, and Cadesty were also criminally charged.

49. Tragically, however, these videotaped incidents from 2021 were far from the first or only instances in which ILA staff physically abused S.B.

Additional Instances of Physical Abuse by Staff

February 2020: DSP Christina Vieux Repeatedly Body-Slams S.B.; ILA Covers it Up

50. On February 3, 2020, a resident at the 226th Street Residence reported to the Justice Center that DSP Christina Vieux had physically and verbally abused S.B. the previous afternoon.

51. The resident witnessed Vieux "use her whole body to 'body slam' S.B. [] to the ground," and reported that "it was not an accident."

52. The resident said she did not know why Vieux had body slammed S.B., but "S.B. fell very hard" and "[began] crying after she was slammed to the ground."

53. The resident further reported that Vieux "[was] verbally abusive" towards the residents as a matter of course, and that Vieux "needs to be moved from 226th Street because she [the resident] [was] afraid that [Vieux] will hurt of them [sic]."

54. After the Justice Center informed ILA of the incident on February 3, ILA conducted an internal investigation.

55. In the course of the investigation, S.B. stated that Vieux pushed her to the ground *twice on February 2 alone*.

56. Further, S.B.'s clinical records from February 5 reflect that, in the immediate aftermath of these assaults, her "mood and behavior have gotten worst [sic]" and that her maladaptive and self-harming behaviors had increased, including biting herself, banging her head against the wall, and "trying to get objects to hurt herself."

57. Despite this evidence, at the conclusion of its half-hearted, whitewash investigation, ILA deemed the allegation of physical abuse against Vieux to be unsubstantiated, primarily because Vieux denied abusing S.B. and no other staff witnessed the incident.

58. As a result, ILA took no meaningful corrective action in response to the incident.

59. What is more, ILA staff appear to have conspired to cover up the incident. In the first instance, Vieux—according to both S.B. and the reporting resident—tried to make it impossible to immediately report her abuse by hiding the telephone.

60. Then, a few days later, the Justice Center received a report from a concerned family member of a resident, who said that S.B.—in tears—had told her that, on February 3, the very same day the Justice Center informed ILA of the body-slamming investigation, an ILA employee "was verbally abusing [S.B.] and talking to her roughly," including by "yelling at [her] and telling her to get away from her."

61. The unavoidable implication is that someone was yelling at S.B. in retribution for the Justice Center report concerning Vieux's assault the previous day.

62. ILA also appears to have lied about and omitted the body-slamming incident in S.B.'s clinical records. For example, a monthly nursing review form completed in March 2020 by ILA RN Kerryann Perry falsely states that S.B.'s visit to the ER on February 3 was in response to disruptive behavior by S.B. In fact, as reflected in ILA's own contemporaneous reports to the Justice Center, S.B. was brought to the ER on February 3 for evaluation after ILA received a call from OPWDD about the body-slamming allegation.

63. ILA staff appear to have stuck to this strategy of selective omission when dealing with outside physicians. S.B.'s ER records for her February 3 visit reflect that the attending physician understood the reason for the visit to be "[a]gitation" due to S.B.'s pre-diabetic condition, making no mention of any evaluation for bruises or other physical injuries.

64. ILA's own investigative report then relied on the fact there were no physical findings from S.B.'s ER visit and concluded that her allegation could not be substantiated.

October 2020: ILA Staff Throw a Remote Control at S.B.'s Head

65. On October 3, 2020, S.B. was taken to the ER by ambulance (one of over 20 times she was rushed to the ER in an ambulance in 2020 alone), ostensibly for a "behavioral outburst."

66. There, S.B. repeatedly told medical staff that "[ILA] staff had hit her in the head," specifying that staff threw a remote control at her that hit her on the "right side of her head diagonally above her ear." *Id.*

67. Medical staff then called the residence and spoke with staff, who appear to have denied S.B.'s allegations, saying that S.B. had been "aggressive towards staff" and pulled a peer's hair. *Id.*

68. As it did with so many of S.B.'s allegations, ILA promptly discounted S.B.'s story as unworthy of any serious consideration: S.B.'s clinical records categorize her statement at the hospital "that staff beat her up" as an "inappropriate statement."

February 2022: S.B. Reports Additional Physical Abuse by ILA Staff

69. Just a week after the video clips were leaked, the Justice Center received another disturbing report concerning physical abuse by an ILA employee.

70. ILA's Director of Vacancy Management Velma Bishop Leacock was on the phone with Ms. Waldron arranging transportation, as S.B. had been staying with Ms. Waldron since the videos came to light. When Bishop Leacock mentioned that DSP Belina Dey-Glanville would pick up S.B., S.B. chimed in and said she did not want Dey-Glanville. S.B. reported that Dey-Glanville had hit her and threatened to beat her up.

71. ILA had long been aware of Dey-Glenville's aggressive tendencies toward. S.B. In 2018, another staff member became distressed at witnessing Dey-Glanville screaming at S.B. about lipstick that Dey-Glanville wrongly believed S.B. had stolen. The

other staff member separated Dey-Glanville and S.B. into different rooms and reported the incident to the Justice Center. ILA's subsequent investigation found that Dey-Glanville had mistreated S.B., but it does not appear that ILA took any meaningful corrective action. What is more, ILA subsequently assigned Dey-Glanville to work with S.B. on a one-on-one basis.

72. When Justice Center investigators interviewed S.B. about her report of abuse by Dey-Glanville in February 2022, she said that Dey-Glanville hit her repeatedly in various locations throughout the 226th Street Residence, including "using her fist."

73. Meanwhile, an ILA supervisor failed to appear for a scheduled interview, reflecting a troubling nonchalance toward the investigative process.

74. For her part, DSP Dey-Glanville claimed to investigators that she "d[id] not recall" hitting S.B. and insisted that S.B. "would not say that"—even though, of course, she did. DSP Dey-Glanville also said that S.B. "is like the boy that cries wolf."

75. Other abuse by ILA staff members surfaced in late February 2022 during S.B.'s interview with the Justice Center. S,B. alleged that DSP Woodall and DSP Andrea Williams "would hit her on her chest, kick her in the leg and slap her."

76. In addition, S.B. reported that Cadesty "put her in a headlock," which allowed S.B. to breathe only "a little bit."

77. She also reported that DSP Orelus "started to hit [S.B.] on her arm," and "pushed her down on the floor."

June 2023: An ILA Staff Member Punch S.B. in the Face

78. On June 6, 2023, S.B. reported that an ILA staff member had punched her in the face that morning.

79. S.B. was taken to an Urgent Care office, where medical staff noted that their findings were consistent with a trauma injury to the left side of her face.

ILA Failed to Protect S.B. from Physical Assaults by Other Residents and from Self-Injury

80. S.B. was not only directly victimized by ILA staff. She also suffered at the hands of her housemates because ILA utterly failed to provide proper supervision and care.

February 2018: I.P. Strikes and Cuts S.B. with a Glass Bottle While S.B. Showers Unsupervised

81. On February 3, 2018, S.B. was attacked by a fellow resident as a result of negligence by ILA staff.

82. S.B.'s 2017-2018 Individualized Protective Oversight Plan ("IPOP") explicitly provided that S.B. must be supervised by staff when completing activities of daily living, including showering.

83. On February 3, 2018, ILA staff ignored these mandatory safeguards and permitted S.B. to shower alone.

84. I.P., the same resident seen slapping S.B. in one of the 2021 video clips, took ILA staff's negligence as an opportunity to attack S.B.

85. While S.B. showered on the second floor of the residence, I.P., also evidently unsupervised, ambushed her. I.P. struck S.B. on the back with a glass bottle, opening up three gashes on S.B.'s left upper back.

86. A staff member who was downstairs—there appear not to have been any staff on the second floor—heard S.B. "crying out for staff" and "went upstairs to see what happened."

87. S.B. had to be rushed to the E.R. and required a follow-up doctor's visit three days later.

88. As Arthur Palevsky, ILA's then-CEO, affirmed under oath, I.P. has a long history of "aggressive and risky behaviors" and "physical aggression towards her housemates and ILA staff," including by making "homicidal threats using objects as weapons," "throwing hot coffee in a housemate's face," and "throwing a brick at another housemate while threatening to kill her."

89. ILA staff knew from the moment S.B. came into their care that she and I.P. had interpersonal issues that often escalated to violence, requiring them to stay in separate areas of the residence and to be "closely supervised" whenever they had to be together.

90. Despite their awareness of I.P.'s violent propensities, and the fact that she often targeted S.B. specifically, ILA staff appear to have given I.P. free rein to physically attack S.B. on February 3, 2018. This early pattern would be repeated multiple times, including the 2021 slap and additional incidents discussed below.

2018-2019: ILA Repeatedly Fails to Protect S.B. from Being Scalded with Boiling Hot Liquids

91. On August 12, 2018, I.P. threw hot coffee on S.B.'s back, requiring S.B. to be rushed to the emergency room.

92. Notwithstanding that this incident clearly constitutes a reportable instance of neglect, ILA staff appear not to have deemed this incident reportable to the Justice Center or even to have recorded the incident internally.

93. Moreover, after ILA staff failed to implement safeguards sufficient to ensure a similar event would not re-occur, I.P threw boiling water on S.B. again the following year.

94. On December 3, 2019, I.P. threw "boiling hot" tea on S.B.'s back after ILA staff failed to adequately protect S.B. from I.P., despite I.P.'s previous identical behavior.

95. S.B. sustained second-degree burns on her scapula and upper and lower back. She also required multiple doctor's appointments for pain management over the following month.

96. Though I.P.'s attack was as predictable as it was preventable, ILA staff appear to have promptly cleared themselves of any wrongdoing: ILA classified the incident solely as one between individuals receiving services and appears not to have investigated staff for neglect. *Id.*

97. There is no sign that ILA implemented additional protective measures for S.B. after any of the incidents involving I.P., ensuring that they would repeat themselves. Indeed, during the February 2022 Justice Center investigation, S.B. claimed that I.P. "would hit her," a troubling albeit general accusation suggesting that the abuse described above was a constant feature of S.B.'s life.

May 2019: Another Resident, L.S., Punches S.B. in the Forehead While ILA Staff Fail to Intervene or Report the Incident

98. On the morning of May 4, 2019, S.B. was scheduled to visit Ms. Waldron at the latter's home.

99. However, at the direction of Shakia Thomas, a supervisor at the residence, staff told S.B. that she could not go home. There was no one to bring her home because relief staff failed to arrive for their morning shift without explanation.

100. According to a contemporaneous investigation report, staff gave S.B. "no explanation" for why she could not go home and were "very hostile towards S.B. when telling her she could not go home," despite knowing that doing so "would trigger a big behavior."

101. Predictably, S.B. began engaging in self-harming behaviors, including biting herself and banging her head against the wall—a well-established behavior documented in her IPOP. S.B.'s agitation was compounded by the fact that other ILA staff were simultaneously taking two other residents, I.P. and L.S., to the movies, and her visible agitation upset the other residents.

102. As the situation escalated, staff repeatedly called their supervisor, Thomas, who, according to the investigation report, had "no compassion for the situation" and was so "upset" by the calls that she took 40 minutes to arrive at the residence.

103. Before Thomas arrived, L.S. punched S.B. in the forehead with a closed fist hard enough to sprain L.S.'s wrist; S.B. slammed her own head against a glass door so hard that staff worried her head "would go through the glass door"; and staff called the police, who placed S.B. in handcuffs until Thomas arrived.

104. S.B. was subsequently brought to the ER in an ambulance.

105. Once again, ILA appears to have cleared itself of any wrongdoing in this instance, deeming the corresponding neglect allegation to be unsubstantiated.

2019-2021: ILA Fails to Protect S.B. from Self-Injurious Behavior

106. The harm S.B. has suffered while living at the 226th Street Residence is not limited to physical abuse at the hands of staff and other residents.

107. For at least two years, ILA staff watched S.B. bang her head against a wall constantly and continuously and develop near-daily headaches from doing so—yet failed to implement even the most obvious of protective measures.

108. Evidently frustrated by the constant stream of abuse meted out by her caregivers and housemates, S.B. expressed herself in one of the few ways she could: by hitting her head on the wall. This pattern of behavior appears to have increased in frequency over the course of her time in ILA's care. Not surprisingly, by the summer of 2019, S.B. began to complain of headaches four or five times a week, accompanied by light and sound sensitivity as well as nausea.

109. S.B.'s doctors made the connection between the head-banging and the headaches by 2019, if not earlier. During an August 2019 appointment for which an ILA staff member was present throughout, a doctor noted that S.B. "often complains of a headache after willfully banging her head."

110. Yet according to ILA's own clinical records, the use of a protective helmet had not even been "tried" as of early 2021. A helmet was finally purchased only in April 2021.

111. Thus, at least 20 months, if not much longer, evidently elapsed between when the problem was identified and when ILA started to try a helmet.

CLAIMS FOR RELIEF

FIRST CAUSE OF ACTION
Negligence – New York Common Law

112. Plaintiff repeats and realleges the foregoing paragraphs as if the same were fully set forth at length herein.

113. Defendant owed a duty of care to S.B. as a resident of its 226th Street IRA.

114. Defendant breached the duty of care that it owed to S.B. by allowing her to be abused and neglected, failing to provide her with necessary and proper care and supervision, and failing to detect and remedy the abuse and neglect of S.B.

115. Defendant additionally breached the duty of care that it owed to S.B. through its negligent supervision of S.B., its repeated violation of mandatory reporting requirements, and its negligent hiring, supervision, training, discipline, and retention of staff at the 226th Street Residence.

116. Defendant is vicariously liable for the negligent care, supervision, and protection its employees provided to S.B.

117. Defendant's breaches of the duty of care were the proximate cause of S.B.'s serious and unnecessary injuries as herein described.

SECOND CAUSE OF ACTION
New York State Human Rights Law – N.Y. Executive Law § 296

118. Plaintiff repeats and realleges the foregoing paragraphs as if the same were fully set forth at length herein.

119. At all times relevant hereto, the 226th Street Residence was a "housing accommodation" as defined by N.Y. Executive Law § 292(10) and a "publicly-assisted housing accommodation" as defined by N.Y. Executive Law § 292(11).

120. At all times relevant hereto, Defendant acted as the 226th Street Residence's owner, lessee, sub-lessee, assignee, and/or managing agent.

121. S.B. is disabled within the meaning of the New York State Human Rights Law.

122. Defendant's acts and omissions as herein described, including without limitation failing to provide S.B. with necessary and proper care and supervision, abusing and neglecting S.B., and failing to detect and remedy the abuse and neglect of S.B., constituted discrimination against S.B. because of disability in the furnishing of facilities or services in connection with S.B.'s occupancy at the 226th Street Residence, and/or aided, abetted, incited, compelled, and/or coerced said discrimination.

123. As a direct and proximate result of this discrimination, S.B. sustained the damages herein alleged.

124. Defendant is vicariously liable for the unlawful discriminatory practices of its employees.

THIRD CAUSE OF ACTION
Fair Housing Act – 42 U.S.C. § 3604

125. Plaintiff repeats and realleges the foregoing paragraphs as if the same were fully set forth at length herein.

126. Defendant's conduct and omissions as herein described constitute discrimination in the provision of services or facilities in connection with a dwelling because of disability, in violation of the Fair Housing Act, 42 U.S.C. § 3604(f)(2).

127. The conduct and omissions of Defendant and its employees and agents as herein described subjected S.B. to harassment and abuse so pervasive and severe as to create a hostile housing environment.

128. Plaintiff is an aggrieved person as defined by 42 U.S.C. § 3602(i).

129. The unlawful discrimination carried out by Defendant was intentional, willful, and done in reckless disregard for the rights of others, entitling Plaintiff to actual and punitive damages.

130. Defendant is vicariously liable for the discriminatory housing practices of its employees pursuant to 24 C.F.R. § 100.7(b).

FOURTH CAUSE OF ACTION
Section 504 of the Rehabilitation Act – 29 U.S.C. § 794

131. Plaintiff repeats and realleges the foregoing paragraphs as if the same were fully set forth at length herein.

132. At all times material to this action, Defendant received federal financial assistance to operate programs and activities through and at the 226th Street Residence.

133. S.B. is an otherwise qualified individual with a disability.

134. Defendant is required, including without limitation pursuant to 28 C.F.R. § 42.504, to make assurances to the federal government that programs and activities conducted by, through, and at the 226th Street Residence are conducted in compliance with Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, and for remedying any non-compliance with such assurances or with Section 504.

135. Defendant discriminated against S.B. by reason of her disability in violation of the Rehabilitation Act and failed to ensure that the services, programs, and activities of the 226th Street Residence complied with the Rehabilitation Act by failing to ensure that S.B. was provided with the necessary and proper care and supervision; failing to properly supervise its employees; and failing to detect and remedy abuse and neglect of S.B. that targeted her on the basis of his disability.

136. As a direct and proximate result of this unlawful discrimination, S.B. sustained damages.

FIFTH CAUSE OF ACTION
New York City Human Rights Law – N.Y.C. Admin. Code § 8-107

137. Plaintiff repeats and realleges the foregoing paragraphs as if the same were fully set forth at length herein.

138. At all times relevant hereto, the 226th Street Residence was a "housing accommodation" as defined by Section 8-102 of the New York City Administrative Code.

139. At all times relevant hereto, Defendant acted as the 226th Street Residence's owner, lessor, lessee, sublessee, assignee, or managing agent.

140. S.B. is a person with a "disability" as that term is defined by Section 8-102 of the New York City Administrative Code.

141. Defendant's acts and omissions as herein described, including without limitation failing to provide S.B. with necessary and proper care and supervision, abusing and neglecting S.B., and failing to detect and remedy the abuse and neglect of S.B. constituted discrimination against S.B. because of disability in the furnishing of facilities or services in connection with S.B.'s occupancy at the 226th Street Residence.

142. As a direct and proximate result of this discrimination, S.B. sustained the damages herein alleged.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests judgment against Defendant as follows:

A. Compensatory damages in an amount to be determined at trial;

B. Punitive damages in an amount to be determined at trial;

C. Reasonable costs and attorneys' fees;

D. Pre- and post-judgment interest to the fullest extent permitted by law; and

E. Any additional relief the Court deems just and proper.

Dated: February 5, 2024
New York, New York

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