STATE OF ILLINOIS)
) SS
COUNTY OF KANE)

Firm ID # 55019

IN THE CIRCUIT COURT OF THE SIXTEENTH JUDICIAL CIRCUIT
KANE COUNTY, ILLINOIS

FAITH HEIMBRODT, as Independent Administrator of the Estate of CAROL ORLANDO, Deceased, **Plaintiff,** ***versus*** **GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company d/b/a BRIA HEALTH SERVICES OF GENEVA,** **Defendant.**	**Court No:** **12-PERSON JURY DEMAND**

PLAINTIFF'S COMPLAINT AT LAW

The Plaintiff, **FAITH HEIMBRODT, as Independent Administrator of the Estate of CAROL ORLANDO, Deceased,** through her attorneys, **LEVIN & PERCONTI**, complains against the Defendant, **GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company d/b/a BRIA HEALTH SERVICES OF GENEVA**, and alleges as follows:

INTRODUCTION

This case is about Carol Orlando, a 79-year-old resident of the nursing home commonly known as Bria Health Services of Geneva, who died from COVID-19 as a result of the Defendant's gross negligence. Carol's early and wrongful death was a byproduct of years of the nursing home's mismanagement, misallocation of resources and staffing, and repeated violations and cited deficiencies of infection control and prevention requirements. Airborne and communicable diseases and pathogens have always had profoundly lethal impact on nursing home residents, and in light of the COVID-19 pandemic, and despite having both actual and constructive notice of COVID-19's

highly contagious, transmittable, and deadly course of illness, the Defendant nursing home consciously disregarded the health and safety of its residents.

As will be set forth in greater detail below, the Defendant continuously reassured Carol's family that Carol was safe, provided adequate protection from COVID-19, and not on the list of potential COVID-19 positive residents. Yet, after dying at the facility, Bria Health Services of Geneva placed her in a body bag and labeled it COVID-19 Positive. Carol's symptoms of COVID-19 in early April fell on the deaf ears of a nursing home corporation that put profits over the health and safety of its residents and staff. This lawsuit is brought by the Plaintiff for express violations of the Illinois Nursing Home Care Act, and seeks money damages to compensate Carol and her loved ones for the shocking and utterly reckless conduct of the Defendant nursing home.

COMMON ALLEGATIONS OF FACT

A. The Parties

1. **CAROL ORLANDO** (hereinafter referred to as "**CAROL**") was born on October 25, 1940.

2. **CAROL** died on April 25, 2020, with "COVID 19" and "Acute Respiratory Failure" listed as the causes of **CAROL's** death.

3. At all times relevant to this Complaint, **CAROL** was at high risk for suffering serious medical complications as a result of contracting COVID-19.

4. At all times relevant to this Complaint, **CAROL** was at high risk for death as a result of contracting COVID-19.

5. **FAITH HEIMBRODT** is the daughter and **Independent Administrator of the Estate of CAROL, Deceased**. (See Letters of Office, attached as Exhibit 1).

6. **CAROL** was a resident of the long-term care facility commonly known as **BRIA HEALTH SERVICES OF GENEVA**, and located at 1101 E. State Street, in Kane County, Illinois, from approximately October 15, 2018, through April 25, 2020, excluding intermittent hospitalization.

7. At all times relevant to this Complaint, there was in full force and effect, a statute known as the Nursing Home Care Act, as amended (the "Act"), 210 ILCS 45/1-101 et seq.

8. Pursuant to 210 ILCS 45/3-714, the remedies provided by The Illinois Nursing Home Care Act are cumulative and shall not be construed as restricting any party from seeking any remedy, provisional or otherwise, provided by law for the benefit of the party, and from obtaining additional relief based upon the same facts.

9. At all times relevant to this Complaint, Defendant, **GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company,** owned, operated, managed, controlled, and/or was the licensee of the long-term skilled nursing care and rehabilitation facility commonly known as **BRIA HEALTH SERVICES OF GENEVA**.

10. At all times relevant to this Complaint, the Defendant, **GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company,** (hereinafter referred to as "**BRIA HEALTH SERVICES OF GENEVA**"), was obligated to follow all regulations applicable to nursing facilities under the Nursing Home Care Act.

11. On and before March 28, 2020, Defendant **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, implied, and/or apparent agents, servants and employees, was not rendering assistance to the State of Illinois in response to the COVID-19 outbreak by providing health care services consistent with any guidance issued by the Illinois Department of Public Health.

12. On and before March 28, 2020, Defendant **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, implied, and/or apparent agents, servants and employees, was not rendering assistance to the State of Illinois in response to the COVID-19 outbreak by increasing the number of beds at is facility.

13. On and before March 28, 2020, Defendant **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, implied, and/or apparent agents, servants and employees, was

not rendering assistance to the State of Illinois in response to the COVID-19 outbreak by providing, preserving and properly employing PPE.

14. On and before March 28, 2020, Defendant **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, implied, and/or apparent agents, servants and employees, was not rendering assistance to the State of Illinois in response to the COVID-19 outbreak by conducting widespread testing of residents, including **CAROL**, for COVID-19.

15. On and before March 28, 2020, Defendant **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, implied, and/or apparent agents, servants and employees, was not rendering assistance to the State of Illinois in response to the COVID-19 outbreak by conducting widespread and regular testing of staff, including the staff providing care and services to **CAROL**, for COVID-19.

16. On and before March 28, 2020, **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, implied, and/or apparent agents, servants and employees, was not rendering assistance to the State of Illinois in response to the COVID-19 outbreak by taking the necessary steps to provide medical care to patients with COVID-19 and to prevent further transmission of COVID-19.

17. At all times relevant to this Complaint, the Defendant, **BRIA HEALTH SERVICES OF GENEVA,** was a nursing facility as defined by 210 ILCS 45/1-113 and 77 Ill. Admin. Code, Ch. I, §300.330 and was subject to the requirements of the Act and the regulations of the Illinois Department of Public Health promulgated pursuant to the Act.

18. Pursuant to 77 Ill. Admin. Code, Ch. I, §300.3290(b) and 210 ILCS 45/3-601, the Defendant, **GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company**, as owner and/or licensee of **BRIA HEALTH SERVICES OF GENEVA**, is liable for any intentional and/or negligent act or omission of their actual, implied and/or apparent agents, servants and employees.

19. At all times relevant to this Complaint, Bria Health Services, LLC, an Illinois Limited

Liability Company (hereinafter referred to as "Bria Health Services") was the management company and provided management and/or professional services to **BRIA HEALTH SERVICES OF GENEVA**.

20. At all times relevant to this Complaint, Patti Long was the Administrator of **BRIA HEALTH SERVICES OF GENEVA**.

21. Alternatively, at all times relevant to this Complaint, Patti Long was an actual, implied and/or apparent agent, servant, and/or authorized representative of **BRIA HEALTH SERVICES OF GENEVA**.

22. At all times relevant to this Complaint, Patti Long**,** was acting within the scope of her employment, agency, servitude, and/or authorized representation with the long-term care facility commonly known as **BRIA HEALTH SERVICES OF GENEVA**.

23. As an agent, servant and/or employee of Defendant, **BRIA HEALTH SERVICES OF GENEVA** is vicariously liable for any and all negligent acts and omissions of Patti Long.

24. Under 210 ILCS §45/1-105, as Administrator of the Defendant facility, **BRIA HEALTH SERVICES OF GENEVA**, Patti Long was charged with the general administration and supervision of the defendant facility.

25. Under 77 IL Adm. Code, Ch. I §300.330, as administrator of the Defendant facility, **BRIA HEALTH SERVICES OF GENEVA**, Patti Long was directly responsible for the operation and administration of the facility.

26. At all times relevant to this Complaint, Bria Health Services was a related party to **BRIA HEALTH SERVICES OF GENEVA** as defined by the Centers for Medicare Services.

27. At all times relevant to this Complaint, the Defendant **BRIA HEALTH SERVICES OF GENEVA**, was a recipient of Medicare and Medicaid reimbursement funds.

28. As a recipient of Medicare and Medicaid reimbursement funds, the Defendant **BRIA HEALTH SERVICES OF GENEVA**, was required to submit annual data to both Medicaid and/or

Medicare.

29. At all times relevant to this Complaint, the Defendant, **BRIA HEALTH SERVICES OF GENEVA**, received reimbursement for services and treatment rendered from Medicaid and/or Medicare based on the level of acuity of the residents in the facility.

30. At all times relevant to this Complaint, the Defendant, **BRIA HEALTH SERVICES OF GENEVA**, was incentivized to maintain the highest possible occupancy level while minimizing patient care expenses such as hiring adequate levels of nursing staff, including, but not limited to RNs, LPNs, and CNAs, as well as purchasing patient protective equipment ("hereinafter referred to as "PPE").

31. At all times relevant to this Complaint, Defendant **BRIA HEALTH SERVICES OF GENEVA**, held itself out to the community as a long-term care facility that develops a skilled nursing program for each of its residents, 24-hour skilled nursing care, and evidence-based treatment programs.

32. At all times relevant to this Complaint, Defendant **BRIA HEALTH SERVICES OF GENEVA** represented itself as a facility that hires and retains an adequate level of competent and qualified nursing staff to provide residents, like **CAROL,** with quality and skilled care, including, but not limited to, infection control.

33. At all times relevant to this Complaint, Defendant **BRIA HEALTH SERVICES OF GENEVA** represented to **CAROL** and **CAROL's** family that **BRIA HEALTH SERVICES OF GENEVA** was a facility that timely, appropriately, and accurately communicates status updates regarding any changes in **CAROL's** condition and/or living situation, including, but not limited to, any new illness contracted, room location change and the reasons for the change, and any presence and/or outbreak of highly contagious illnesses at the **BRIA HEALTH SERVICES OF GENEVA**.

34. At all times relevant to this Complaint, **BRIA HEALTH SERVICES OF GENEVA** represented itself as facility that provides services, including, but not limited to, infection control to

residents for the purpose of protecting residents from any illness and/or infectious disease/virus, and promoting a higher quality of life for the resident.

35. At all times relevant to this Complaint, **CAROL** and **CAROL's** family specifically and reasonably relied on **BRIA HEALTH SERVICES OF GENEVA's** representations that **BRIA HEALTH SERVICES OF GENEVA** provides their residents high quality and competent care, including infection control.

36. At all times relevant to this Complaint, **CAROL** and **CAROL's** family specifically and reasonably relied on **BRIA HEALTH SERVICES OF GENEVA's** representations that **BRIA HEALTH SERVICES OF GENEVA** would provide and communicate to **CAROL's** family, status updates regarding any changes in **CAROL's** condition and/or living situation.

37. **CAROL** and **CAROL's** family's reliance on the veracity of each and every representation made by **BRIA HEALTH SERVICES OF GENEVA,** by and through its actual, implied and/or apparent agents, servants and employees, was the reason why **BRIA HEALTH SERVICES OF GENEVA** was selected as the skilled nursing facility to care for **CAROL**.

B. Timeline of Novel Coronavirus 2019, a/k/a COVID-19[1]

38. On December 31, 2019, the World Health Organization (herein after referred to as "WHO") China County Office was informed of dozens of cases of pneumonia of unknown etiology detected in Wuhan City, Hubei Province of China.

39. On January 7, 2020, the viral outbreak in Wuhan, China was identified as a new type/strain of coronavirus, 2019-nCoV (hereinafter referred to as "novel coronavirus").

40. On January 11, 2020, Chinese state media reported its first known death from the novel coronavirus.

[1] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

41. On January 12, 2020, China shared the genetic sequence of the novel coronavirus for countries to use in developing specific diagnostic kits.

42. On January 20, 2020, Japan, South Korea and Thailand reported their first confirmed cases of the novel coronavirus. On that same day, the head of a Chinese government coronavirus team confirmed that the novel coronavirus outbreak was transmitted by human-to-human contact, which was a development that put medical facilities, institutions, and long-term skilled nursing facilities on notice of the possibility that the novel corona virus could spread quickly and widely.

43. On January 23, 2020, the United States and WHO confirmed its first case of the novel coronavirus in the State of Washington.

44. On information and belief, on January 24, 2020, a Chicago woman in her 60s, who in December of 2019 traveled to Wuhan, China, was the second confirmed case of the novel coronavirus in the United States after she returned to Chicago, Illinois on January 13, 2020.[2]

45. On January 30, 2020, the WHO declared the outbreak of the novel coronavirus a "public health emergency of international concern." On that same day, and upon information and belief, the first person-to-person transmission of the novel coronavirus in the United States was discovered in Chicago, Illinois.[3]

46. On February 11, 2020, the WHO announced "COVID-19" as the shortened name of the novel "coronavirus disease 2019".

47. On February 13, 2020, the U.S. Director of The Centers for Disease Control and Prevention (hereinafter referred to as "CDC") announced that COVID-19 will likely become a community virus and remain beyond this current season.

[2] https://www.chicagotribune.com/coronavirus/ct-viz-coronavirus-timeline-20200507-uvrzs32nljabrpn6vkzq7m2fpq-story.html

[3] https://www.chicagotribune.com/business/ct-biz-illinois-spread-person-to-person-coronavirus-20200130-yqbxfhqotvagdmvc5ibgvvwugy-story.html

48. On February 25, 2020, the CDC issued a CDC warning that spread to the United States is likely and that people should prepare; U.S. senators receive a classified briefing on the Trump administration's coronavirus response

49. On February 28, 2020, a case of the novel coronavirus disease was identified and confirmed in a woman resident of a long-term care skilled nursing facility in King County, Washington. A subsequent epidemiologic investigation identified 129 cases of COVID-19, including 81 residents (over 62% of the resident population), 34 staff members, and 14 visitors. [4]

50. On February 29, 2020, the United States instituted "do not travel warnings" for affected areas including Italy and South Korea.

51. On March 3, 2020, the WHO reported more than 90,000 infections of COVID-19 globally and about 3,000 deaths.

52. On March 9, 2020, Governor J.B. Pritzker declared a First Gubernatorial Disaster Proclimation and Executive Order regarding COVID-19 in Illinois[5].

53. On March 11, 2020, President Donald J. Trump suspended travel from Europe, with the exception of the United Kingdom, and the WHO deemed COVID-19 a global "pandemic."

54. On March 13, 2020, President Donald J. Trump declared a "national emergency".

55. On March 13, 2020, the Center for Medicare & Medicaid Services ("CMS") a issued a memorandum entitled: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes[6], which stated, in part:

> i. Prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility;

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[4] https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm

[5] Plaintiff specifically and expressly maintains that the March 9, 2020, and May 13, 2020 Executive Gubernatorial Orders, individually and/or in any combination, are not applicable to Plaintiff's causes of action stated herein, are categorically unconstitutional exercises of power that restricts fundamental liberties and statutory rights, and are Orders that are neither narrowly tailored nor the least restrictive means possible. Plaintiff further and explicitly takes exception to the aforementioned Executive Orders, and only alleges facts that acknowledge the existence of the Orders for the sole purpose of preservation of Plaintiff's record.

[6] https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf

ii. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the resident assuming:
   a) 1) the resident does not require a higher level of care; and
   b) 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19;

iii. Facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In those cases, visitors will be limited to a specific room only;

iv. Facilities are expected to notify potential visitors to defer visitation until further notice (through signage, calls, letters, etc.);

v. Those with symptoms of a respiratory infection (fever, cough, shortness of breath, or sore throat) should not be permitted to enter the facility at any time (even in end-of-life situations);

vi. Cancel communal dining and all group activities, such as internal and external group activities;

vii. Remind residents to practice social distancing and perform frequent hand hygiene;

viii. Screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home;

ix. Facilities should identify staff that work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19;

x. Facilities should review and revise how they interact vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), and other non-health care providers (e.g., food delivery, etc.), and take necessary actions to prevent any potential transmission; and

xi. Take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible.

56. On March 15, 2020 the CDC issued guidance and advised that no gatherings of 50 or more people take place until further notice.

57. On March 16, 2020, President Trump advised citizens to avoid groups of more than 10 individuals.

58. On March 17, 2020, the Illinois Department of Public Health (hereinafter referred to as "IDPH") confirmed the first resident of a Chicagoland area long-term care facility had tested positive

for COVID-19 over the "past weekend", and upon further testing, 17 residents and four staff members tested positive for COVID-19.[7]

59. On On March 17, 2020, the IDPH updated guidance for nursing homes in Illinois, and recommended the following measures be put into place relating to the COVID-19 outbreak:[8]

i. Restrict all visitation except for certain compassionate care situations, such as end of life residents;
ii. Restrict all volunteers and non-essential health care personnel (e.g., barbers);
iii. Cancel all group activities and communal dining; and
iv. Implement active screening of residents and health care personnel for fever and respiratory symptoms.

60. On March 19, 2020, the U.S. Department of States issued a level-four "Do Not Travel" advisory.

61. On or before March 19, 2020, Pat Comstock of the Health Care Council of Illinois, a professional healthcare association representing nearly 200 long-term care facilities in Illinois, admitted during an interview with the Chicago Tribune that "[i]t is true the coronavirus has ***put additional stress on existing workforce shortages***[9]…" (emphasis added).

62. On March 20, 2020, Governor Pritzker issued a "Stay at Home" Order, which took effect March 21, 2020, and ordered citizens of Illinois to stay at their residence except for essential activities, prohibited non-essential travel, and recognized a practice deemed as "social distancing."

63. On March 29, 2020, the United States accounted for the highest number of infections in the world, recording more than 140,000 cases and 2,000 deaths. On that same day President Donald J. Trump announced an extension of "social distancing" guidelines.

64. On April 17, 2020, the New York Times reported that approximately one fifth (or 20%) of all COVID-19 deaths were related nursing homes[10].

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[7] http://www.dph.illinois.gov/news/public-health-officials-announce-first-illinois-coronavirus-disease-death
[8] http://www.dph.illinois.gov/news/public-health-officials-announce-first-illinois-coronavirus-disease-death
[9] https://www.chicagotribune.com/coronavirus/ct-nursing-homes-infection-control-covid-20200319-jq6s2xgusnfw3obhwy2h5yyc6e-story.html?
[10] https://www.nytimes.com/2020/04/17/us/coronavirus-nursing-homes.html

65. Just two days later, on April 19, 2020, CMS mandated new regulations that require all nursing homes in the United States to inform residents, their families, and representatives of any and all COVID-19 cases identified in the facility.

66. On April 19, 2020, Illinois Department of Public Health Director Dr. Ngozi Ezike, in response to a press conference question regarding the high number of COVID-19 cases and deaths in Illinois nursing homes, stated, "We knew even before we got into having the large numbers of long-term care facilities with cases, that that would be one of our hardest areas.[11]"

67. On May 1, 2020, Governor Pritzker required all residents in the State of Illinois to wear face masks and/or coverings in public.

68. On May 13, 2020, Governor J.B. Pritzker declared a Second Gubernatorial Disaster Proclamation and Executive Order regarding COVID-19 in Illinois[12].

69. Based on data collected from long-term care facilities across the country, as of May 22, 2020, 43% of all COVID-19 deaths in the United States were residents of long-term care failities, despite only comprising 0.62% of the nation's population.[13]

70. On May 27, 2020, over 100,000 Americans died from COVID-19.

71. As of May 27, 2020, there have been 114,306 confirmed positive COVID-19 cases in Illinois, and at least 5,083 people have died, including **CAROL**.[14]

72. As of May 27, 2020, at least 2,402 long-term care residents have died from COVID-19, which totals around 47% of all COVID-19 deaths in Illinois.[15]

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[11] https://www.wbez.org/stories/new-data-show-covid-19s-deadly-reach-at-illinois-nursing-homes/20a1ff9d-571d-496e-b3e2-8c94915a44f0

[12] Plaintiff specifically and expressly maintains that the March 9, 2020, and May 13, 2020 Executive Gubernatorial Orders, individually and/or in any combination, are not applicable to Plaintiff's causes of action stated herein, are categorically unconstitutional exercises of power that restricts fundamental liberties and statutory rights, and are Orders that are neither narrowly tailored nor the least restrictive means possible. Plaintiff further and explicitly takes exception to the aforementioned Executive Orders, and only alleges facts that acknowledge the existence of the Orders for the sole purpose of preservation of Plaintiff's record.

[13] https://www.forbes.com/sites/theapothecary/2020/05/26/nursing-homes-assisted-living-facilities-0-6-of-the-u-s-population-43-of-u-s-covid-19-deaths/#593e28af74cd

[14] https://blockclubchicago.org/2020/05/28/coronavirus-in-chicago-nursing-homes-cant-reopen-to-visitors-anytime-soon/

[15] https://blockclubchicago.org/2020/05/28/coronavirus-in-chicago-nursing-homes-cant-reopen-to-visitors-anytime-soon/

C. Regulatory History Shows Systemically Negligent and Reckless Conduct

73. On or about April 18, 2013, the Illinois Department of Public Health cited **BRIA HEALTH SERVICES OF GENEVA** for violations of Section 483.65: Infection Control, Prevent Spread, Linens, as **BRIA HEALTH SERVICES OF GENEVA** failed to ensure the nursing staff knew guidelines on when to discontinue contact isolation and the staff did not contaminate the environment of a resident in contact isolation..

74. On or about May 14, 2014, the Illinois Department of Public Health cited **BRIA HEALTH SERVICES OF GENEVA** for violations of Section 483.65: Infection Control, Prevent Spread, Linens, as **BRIA HEALTH SERVICES OF GENEVA** failed to ensure the staff washed their hands after coughing and also failed to wear gloves and wash hands before and after performing blood glucose/sugar monitoring tests.

75. In a Plan of Correction for the May 14, 2014 violation, **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, implied, and/or apparent agent, servants and employees, stated "all staff was in-serviced on following the policy and procedure of infection control"

76. However, on or about June 24, 2015, the Illinois Department of Public Health cited **BRIA HEALTH SERVICES OF GENEVA** for violations of Section 483.65: Infection Control, Prevent Spread, Linens, as **BRIA HEALTH SERVICES OF GENEVA** failed to ensure that staff wash their hands during bowel and bladder incontinence care, when measuring blood glucose, when administering medications including the administration of insulin, and when giving a nebulizer treatment and eyedrops. Further, the facility also failed to cover the equipment (machines and the mask) used for administering nebulizer treatments.

77. On or about July 21, 2016, the Illinois Department of Public Health cited **BRIA HEALTH SERVICES OF GENEVA** for violations of Section 483.65: Infection Control, Prevent Spread, Linens, as **BRIA HEALTH SERVICES OF GENEVA** failed to maintain sanitary conditions by handwashing after removing gloves during incontinence and personal hygiene care.

78. In 2019, Defendant **BRIA HEALTH SERVICES OF GENEVA's** nursing staff continued to engage in a pattern of conduct exhibiting reckless indifference for the health and safety of its resident; on July 11, 2019, the Illinois Department of Public Health cited **BRIA HEALTH SERVICES OF GENEVA** for violations of Section 483.80: Infection Control, Prevent Spread, Linens, as **BRIA HEALTH SERVICES OF GENEVA** again failed to wash hands and change gloves to prevent the spread of infection. Moreover, on July 11, 2019, the Illinois Department of Public Health cited **BRIA HEALTH SERVICES OF GENEVA** for violations of Section 483.35(a)(1)(2): Nursing Services, as **BRIA HEALTH SERVICES OF GENEVA** failed to provide sufficient staff to meet the needs of residents.

79. Of significant importance, Defendant **BRIA HEALTH SERVICES OF GENEVA's** Plan of Correction for the July 11, 2019 Section 483.80 violation stated, "All staff have been in-serviced on when to wash hands and proper handwashing technique."

80. However, on or about August 14, 2019, the Illinois Department of Public Health cited **BRIA HEALTH SERVICES OF GENEVA** for violations of Section 483.80: Infection Control, Prevent Spread, Linens, as **BRIA HEALTH SERVICES OF GENEVA** again failed to ensure staff perform hand hygiene after glove changes, during and after incontinence care, as well as failed to ensure staff offer handwashing for residents after assisting with toileting.

81. Defendant, **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, implied, and/or apparent agents, servants and employees failed to timely, appropriately, and consistently implement the Plans of Correction related to the July 11, 2019 IDPH violation.

82. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF**

GENEVA, was on notice that its nursing staff continued to engage in pattern of conduct that exhibits a reckless indifference for the health and safety of its residents, as the nursing staff did not provide care and treatment to residents in compliance with Defendant's own Infection Control and Prevention policies and procedures, and the standards of practice per the Illinois Department of Public Health.

83. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF GENEVA,** did not act in a reasonably careful manner when the nursing home and failed to hire additional staff members, and failed to implement additional facility-wide infection control and prevention protocols so that **BRIA HEALTH SERVICES OF GENEVA** had capacity to provide care in compliance with its own written policies and procedures, as well as the appropriate standards of practice per the Illinois Department of Public Health.

84. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF GENEVA,** consciously disregarded the health and safety of residents, including **CAROL**, by both failing to hire additional staff members, and failing to implement additional facility-wide infection control and prevention protocols so that **BRIA HEALTH SERVICES OF GENEVA** had capacity to provide care in compliance with its own written policies and procedures, as well as the appropriate standards of practice per the Illinois Department of Public Health.

85. When a skilled nursing facility does not adequately and/or timely implement infection control procedures and prevention safeguards, it is foreseeable that residents of the facility will suffer from serious medical complications and death when there is an outbreak of a highly contagious and communicable respiratory illness.

86. When a skilled nursing facility has received multiple and repeated citations from the Illinois Department of Health for failure to comply with infection control and prevention regulations and procedures, it is foreseeable that residents of that facility will suffer from serious medical complications and death when there is an outbreak of a highly contagious and communicable respiratory illness.

D. Careless and Reckless Acts, Omissions and Mismanagement Leads to COVID-19 Outbreak at Bria Health Services of Geneva, and Carol's Death

87. At all times relevant to this Complaint, the extent and magnitude of serious medical complications and death to nursing home residents, like **CAROL**, resulting from the outbreak of a highly contagious and communicable respiratory illness was foreseeable.

88. At all times relevant to this Complaint, the vulnerable nature of the nursing home population combined with the inherent risks of congregate living in a healthcare setting, required aggressive efforts, procedures, and safeguards to limit exposure to prevent the spread of highly communicable respiratory illnesses, like COVID-19, within nursing homes.

89. At all times relevant to this Complaint, **CAROL's** physical, mental, and underlying medical conditions made her dependent on the nursing staff for assistance with activities of daily living, as well as the employ of "social distancing" measures.

90. On or around July 11, 2019, **BRIA HEALTH SERVICES OF GENEVA** was cited for having insufficient staff to meet residents' needs and for some workers not using proper hygiene or following protocol to prevent the spread of infection.[16]

91. Per the July 11, 2019 Inspection Report, one resident told the inspector that "We just don't have enough staff" and another resident told the inspector that "I get it that we don't have enough staff but I feel like I'm being punished because I ask them for help. It makes me nervous because I'm afraid I'm going to get hurt. We either don't have enough staff or they are in too much of a hurry."[17]

92. Upon information and belief, in March of 2020, residents at **BRIA HEALTH SERVICES OF GENEVA** began to show signs and symptoms of COVID-19.[18]

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[16] https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=146067&SURVEYDATE=07/11/2019&INSPTYPE=STD

[17] https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=146067&SURVEYDATE=07/11/2019&INSPTYPE=STD

[18] https://www.kcchronicle.com/2020/05/19/2nd-covid-related-wrongful-death-lawsuit-filed-against-bria-of-geneva/a6apedq/

93. Upon information and belief, on or around April 1, 2020, **BRIA HEALTH SERVICES OF GENEVA's** nursing staff, including a nurse practitioner, reported and communicated to at least one resident's family, that a resident had a cough and underwent a chest x-ray which indicated the presence of pneumonia.[19]

94. On and after April 1, 2020, Defendant **BRIA HEALTH SERVICES OF GENEVA,** failed to implement the CMS guidelines which were issued in the memorandum entitled "Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes."

95. On and before April 1, 2020, no members of the nursing staff, including, but not limited to, registered nurses, licensed practical nurses, certified nursing assistances, and registered dieticians, utilized, employed, or otherwise engaged in the use of PPE while providing direct care to resients in the general population (i.e. not in isolation), including **CAROL**.

96. In April of 2020, **CAROL's** family was informed that **CAROL** was suffering from a fever, shallow breathing, and a decline in her functional abilities.

97. Despite these symptoms, **BRIA HEALTH SERVICES OF GENEVA** staff assured **CAROL's** family that they were not related to COVID-19 and that **CAROL** was not exposed to anyone at the facility who had tested positive for COVID-19.

98. Defendant, **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, implied and/or apparent agents, servants and employees, expressly told **CAROL's** family that **CAROL** did not have COVID-19, yet **BRIA HEALTH SERVICES OF GENEVA** had not tested **CAROL**.

99. On or around April 17, 2020, **BRIA HEALTH SERVICES OF GENEVA** reported its first COVID-19 case.[20]

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[19] https://www.kcchronicle.com/2020/05/19/2nd-covid-related-wrongful-death-lawsuit-filed-against-bria-of-geneva/a6apedq/

[20] https://www.dailyherald.com/news/20200514/a-quarter-of-the-residents-at-bria-of-geneva-died-from-covid-19-families-want-answers

100. Per Dr. Phillip Branshaw, the medical director at **BRIA HEALTH SERVICES OF GENEVA,** "Once we [Bria Health Services of Geneva] got our first patient, it was a landslide" and "We were still trying to figure out the scope of the issue."[21]

101. On or around April 23, 2020 and April 24, 2020, for the first time, **BRIA HEALTH SERVICES OF GENEVA** began administering tests to residents exhibiting COVID-19 symptoms.[22]

102. On or around April 23, 2020, and April 24, 2020, for the first time, **BRIA HEALTH SERVICES OF GENEVA** began administering tests to staff members exhibiting COVID-19 symptoms.

103. On or around April 24, 2020, **BRIA HEALTH SERVICES OF GENEVA** reported to the State of Illinois 35 COVID-19 cases and 1 death as a result of COVID-19.[23]

104. On or around April 24, 2020, Patti Long, the Administrator of **BRIA HEALTH SERVICES OF GENEVA** reported to **CAROL's** family that as of April 24, 2020, the facility had confirmed 19 residents and 24 staff members had tested positive for COVID-19.

105. At no point throughout **CAROL's** admission at **BRIA HEALTH SERVICES OF GENEVA** was she isolated from other residents.

106. At no point throughout **CAROL's** admission at **BRIA HEALTH SERVICES OF GENEVA** was she tested for COVID-19.

107. Throughout March and April 2020 of **CAROL's** admission at **BRIA HEALTH SERVICES OF GENEVA,** she was placed in a room with a roommate, and neither were provided with personal protective equipment.

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[21] https://www.propublica.org/article/a-quarter-of-the-residents-at-this-nursing-home-died-from-covid-19-families-want-answers
[22] https://www.propublica.org/article/a-quarter-of-the-residents-at-this-nursing-home-died-from-covid-19-families-want-answers
[23] https://www.usatoday.com/story/news/investigations/2020/05/01/coronavirus-nursing-homes-more-states-pressured-name-facilities/3062537001/

108. **CAROL** died on April 25, 2020, yet neither **BRIA HEALTH SERVICES OF GENEVA** nor **CAROL's** family knew her cause of death.

109. On or around April 25, 2020, **CAROL's** family arranged for the Cremation Society of Illinois to procure **CAROL's** body.

110. Upon arrival to **BRIA HEALTH SERVICES OF GENEVA** the Cremation Society of Illinois found **CAROL's** body in a bag labeled "COVID-19 Positive", yet to **CAROL's** family's knowledge, **CAROL** had never even been tested for COVID-19.

111. After hearing **CAROL's** name and "COVID-19 Positive" in the same sentence for the first time, **CAROL**'**s** family requested an autopsy.

112. On or around April 29, 2020, the Kane County Coroner, Rob Russel, took possession of **CAROL's** body and performed a nasal swab to test for COVID-19.[24]

113. On or around May 1, 2020, the Kane County Coroner, Rob Russel, confirmed the test results of the nasal swab which showed that **CAROL** died of COVID-19 while living at **BRIA HEALTH SERVICES OF GENEVA**.[25]

114. Following **CAROL's** death, Patti Long, the Administrator of **BRIA HEALTH SERVICES OF GENEVA** reported that as of May 1, 2020, the facility had confirmed 75 residents and 36 staff members had tested positive for COVID-19, and 18 deaths as a result of COVID-19.

115. On or around May 5, 2020, **BRIA HEALTH SERVICES OF GENEVA** reported 20 deaths as a result of COVID-19.[26]

116. During the months of March and April of 2020, **BRIA HEALTH SERVICES OF GENEVA** did not provide to its nursing staff and employees essential PPE, including, but not limited to, appropriate masks, gowns, and/or face shields.

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[24] https://www.nwherald.com/2020/04/30/daughter-questions-mothers-death-at-bria-of-geneva/anfadjy/
[25] https://www.nwherald.com/2020/05/05/test-confirms-mom-died-of-covid-19-at-bria-of-geneva/avfkd6g/
[26] https://www.nwherald.com/2020/05/05/test-confirms-mom-died-of-covid-19-at-bria-of-geneva/avfkd6g/

117. As of May 29, 2020, there have been 132 confirmed positive COVID-19 cases at **BRIA HEALTH SERVICES OF GENEVA**, and 26 people have died, including **CAROL**.

COUNT I
FAITH HEIMBRODT for CAROL ORLANDO, Deceased v. GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company
(Illinois Nursing Home Care Act – Negligence)

The Plaintiff, **FAITH HEIMBRODT, as Independent Administrator for the Estate of CAROL ORLANDO, Deceased**, by her attorneys, **LEVIN & PERCONTI**, complains against the Defendant, **GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company d/b/a BRIA HEALTH SERVICES OF GENEVA** as follows:

1. Plaintiff, **FAITH HEIMBRODT, as Independent Administrator for the Estate of CAROL ORLANDO, Deceased,** repeats, realleges and fully incorporates by reference all facts and allegations contained in Paragraphs 1 through 117 as fully set forth herein.

118. At all times relevant to this Complaint, **BRIA HEALTH SERVICES OF GENEVA** was required to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

119. At all times relevant to this Complaint, and irrespective of any guidance issued by any governmental agency, regulatory commission, or any other entity overseeing long-term care facility operation and regulation, **BRIA HEALTH SERVICES OF GENEVA** knew or should have known that residents, like **CAROL**, who comprise an elderly patient population in a nursing home, and who are known to have documented underlying medical conditions, were at high risk for the contraction and transmission of respiratory illnesses and other viruses by means of respiratory droplets, including, but not limited to, different types of coronaviruses.

120. On or before January 24, 2020, when the first case of COVID-19 was identified in both Illinois and Chicago, and irrespective of any guidance issued by any governmental agency, regulatory

commission, or any other entity overseeing long-term care facility operation and regulation, Defendant **BRIA HEALTH SERVICES OF GENEVA** knew or should have known that residents, like **CAROL**, who comprise an elderly patient population in a nursing home, and who are known to have documented underlying medical conditions, were at high risk for the contraction and transmission of COVID-19, and at high risk to the susceptibility of COVID-19's deadly course of illness.

121. At all times relevant, long-term skilled nursing facilities, like **BRIA HEALTH SERVICES OF GENEVA**, did not have any luxury to treat and respond to the COVID-19 pandemic and specific outbreaks of the virus casually, as any failures in responses to COVID-19 in long-term care facilities have cascading, downstream and deadly consequences for elderly patient populations with known and documented underlying medical conditions, like **CAROL**.

122. Employers, like Defendant **BRIA HEALTH SERVICES OF GENEVA**, have a duty to act reasonably in both hiring and retaining its employees.

123. A master, like Defendant **BRIA HEALTH SERVICES OF GENEVA**, has the duty to supervise its servants.

124. The initiation and existence of an employment relationship imposes a duty upon an employer, like Defendant **BRIA HEALTH SERVICES OF GENEVA** to exercise reasonable care in employing competent individuals.

125. It is foreseeable that a resident of a long-term skilled nursing facility, like **CAROL**, could be harmed by a facility, like **BRIA HEALTH SERVICES OF GENEVA**'s failures to hire, supervise and retain adequate levels of nursing staff in order to provide adequate care and protect residents from harm.

126. The harm which can be caused to a nursing home resident, like **CAROL,** by a long-term care facility, like **BRIA HEALTH SERVICES OF GENEVA**'s failures to hire, supervise and retain adequate levels of nursing staff in order to provide adequate care and protect residents is significant.

127. At all times relevant to this Complaint, Defendant **BRIA HEALTH SERVICES OF GENEVA**, had the ability and resources to hire, supervise, and retain adequate levels of nursing staff in order to protect and provide care to its residents, including **CAROL**, with ages and underlying medical conditions that place them at high risk for the contraction and transmission of respiratory illnesses and other viruses by means of respiratory droplets, including, but not limited to, COVID-19.

128. Despite the Defendant's abilities, and at all times relevant to this Complaint, **BRIA HEALTH SERVICES OF GENEVA** did not exercise reasonable care and failed to utilize its resources, and failed to hire, supervise, and retain adequate levels of nursing staff in order to provide care to residents and protect them.

129. At all times relevant to this Complaint, Defendants, **BRIA HEALTH SERVICES OF GENEVA** failed to exercise reasonable care in both allowing and encouraging the nursing staff to care for an inappropriately large number of different patients in a single given day and/or shift, including **CAROL**, which increases the risk for the contraction and transmission of respiratory illnesses and other viruses by means of respiratory droplets, including, but not limited to, COVID-19.

130. It is foreseeable that a resident of a long-term skilled nursing facility, like **CAROL**, could be harmed by a facility, like **BRIA HEALTH SERVICES OF GENEVA**'s failures in purchasing, providing, maintaining, and/or monitoring the numbers of PPE available to its employees and staff, as the nursing staff is assigned to care for a number of different patients in a single given day and/or shift.

131. The harm which can be caused to a nursing home resident, like **CAROL,** by a long-term care facility, like **BRIA HEALTH SERVICES OF GENEVA**'s failures to purchase, provide, maintain, and/or monitor the numbers of PPE available to staff is significant.

132. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF GENEVA,** had the ability and resources to purchase, provide, maintain, and/or monitor the numbers

of PPE available to its employees and staff, as the nursing staff is assigned to care for a number of different patients in a given day and/or shift.

133. Despite the Defendant's abilities, at all times relevant to this Complaint, Defendant **BRIA HEALTH SERVICES OF GENEVA** did not exercise reasonable and due care as Defendant failed to utilize their resources, and failed to purchase, provide, and/or monitor the numbers of PPE available to its employees and staff, which increased risk of contraction and transmission of respiratory illnesses and other viruses by means of respiratory droplets, including, but not limited to, COVID-19.

134. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF GENEVA,** did not exercise reasonable and due care as the Defendant both allowed and encouraged the nursing staff to provide care to a number of different residents, including **CAROL**, without adequate numbers, qualities, and/or sanitized PPE.

135. At all times relevant to this Complaint, **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, apparent, and/or implied agents, servants, and employees, were fundamentally responsible, and had a statutory duty under the Illinois Nursing Home Care Act, to develop and implement policies governing control of infections and communicable diseases so that nursing homes, like **BRIA HEALTH SERVICES OF GENEVA,** can continually be on guard to detect any rapidly and easily transmittable virus, disease, and illness, including, but not limited to, respiratory illnesses and other viruses by means of respiratory droplets.

135. At all times relevant to this Complaint, the Defendant, **BRIA HEALTH SERVICES OF GENEVA**, through its nursing staff who were actual, implied, and/or apparent agents, servants, and employees, had a statutory duty not to violate the rights of any resident of the facility, including **CAROL**, which included the duty not to abuse or neglect any resident, as provided by the Act as follows:

> An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in the Abused

and Neglected Long-term Care Facility Residents Reporting Act. 210 ILCS 45/2-107, 210 ILCS 45/3-610, 210 ILCS 45/3-808.5(c), and Ill. Admin. Code, Ch. I, §300.3240.

Abuse means any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility. 210 ILCS 45/1-103 and Ill. Admin. Code, Ch. I, §300.330.

Neglect means a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. 210 ILCS 45/1-117.

Neglect means the failure to provide adequate medical or personal care or maintenance, which failure results physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. This shall include any allegation where: (1) the alleged failure causing injury or deterioration is ongoing or repetitious; or (2) a resident required medical treatment as a result of the alleged failure; or (3) the failure is alleged to have caused a noticeable negative impact on a resident's health, behavior or activities for more than 24 hours. Ill. Admin. Code, Ch. I, §300.330.

Personal Care means assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual, who is incapable of maintaining a private, independent residence or who is incapable of managing his person whether or not a guardian has been appointed for such individual. 210 ILCS 45/1-120 and Ill. Admin. Code, Ch. I, §300.330.

136. The Illinois Nursing Home Care Act, as amended, provides as follows:

The licensee shall pay the actual damages and costs and attorney's fees to a facility resident whose rights, as specified in Part 1 of Article II of the Nursing Home Care Act, are violated. 210 ILCS 45/3-602.

137. The Illinois Nursing Home Care Act, as amended, provides as follows:

The owner and licensee are liable to a resident for any intentional or negligent acts or omissions of their agents or employees, which injures the residents. 210 ILCS 45/3-601 and Ill. Admin. Code, Ch. I. §300.3290(b).

138. At all times relevant to this Complaint, the Defendant, **BRIA HEALTH SERVICES**

OF GENEVA, through its nursing staff who were actual, implied, and/or apparent agents, servants, and employees, had a duty not to violate the rights of any resident of **BRIA HEALTH SERVICES OF GENEVA**, including, but not limited to, **CAROL**, as specified by provisions of the Act and the Illinois Administrative Code including, but not limited to, the following:

a. 210 ILCS 45/2-212: The facility shall ensure that its staff is familiar with and observes the rights and responsibilities enumerated in this Article;
b. 210 ILCS 45/3-202(2): Number and qualifications of all personnel, including management and nursing personnel, having responsibility for any part of the care given to residents; specifically, the Department shall establish staffing ratios for facilities which shall specify the number of staff hours per resident of care that are needed for professional nursing care for various types of facilities or areas within facilities;
c. 210 ILCS 45/3-202(5): Equipment essential to the health and welfare of the residents;
d. 210 ILCS 45/3-202.05(b)(3): Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment;
e. 210 ILCS 45/2-213(c): A skilled nursing facility shall designate a person or persons as Infection Prevention and Control Professionals to develop and implement policies governing control of infections and communicable diseases. The Infection Prevention and Control Professionals shall be qualified through education, training, experience, or certification or a combination of such qualifications. The Infection Prevention and Control Professional's qualifications shall be documented and shall be made available for inspection by the Department;
f. 210 ILCS 45/2-108: Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation;
g. 210 ILCS 45/2-108(a): The administrator shall ensure that correspondence is conveniently received and mailed, and that telephones are reasonably accessible;
h. 210 ILCS 45/3-202.2a: A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs;
i. 77 Ill. Admin. Code, Ch. I, §300.1210: The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care;
j. 77 Ill. Admin. Code, Ch. I, §300.696(a): Policies and procedures for investigating, controlling, and preventing infections in the facility shall be

established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed;

k. 77 Ill. Admin. Code, Ch. I, §300.696(b): A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections;

l. 77 Ill. Admin. Code, Ch. I, §300.1020(a): The facility shall comply with the

m. Control of Communicable Diseases Code (77 Ill. Adm. Code 690).

n. 77 Ill. Admin. Code, Ch. I, §300.696(c): Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):

    (2) Guideline for Hand Hygiene in Health-Care Settings;

    (5) Guideline for Prevention of Nosocomial Pneumonia;

    (6) Guideline for Isolation Precautions in Hospitals;

    (7) Guidelines for Infection Control in Health Care Personnel;

o. 77 Ill. Admin. Code, Ch. I, §300.690.100-(a)-(1): The following diseases and conditions are declared to be contagious, infectious or communicable and may be dangerous to the public health. Any <u>unusual case of a disease or condition caused by an infectious agent</u> not listed in this Part that is of urgent public health significance and shall be reported immediately (within three hours) by telephone, upon initial clinical suspicion of the disease, to the local health authority, which shall then report to the Department immediately (within three hours). (emphasis added);

p. 77 Ill. Admin. Code, Ch. I, §300.690.100(a)(1)(c): Persons who identify <u>a single case of a rare or significant infectious disease</u> shall report the case to the local health authority. This may include, but is not limited to, a case of cowpox, Reye's syndrome, glanders, amoebic meningoencephalitis, or, monkeypox, hemorrhagic fever viruses, infection from a laboratory-acquired recombinant organism, ***or any disease non-indigenous to the United States*** (emphasis added);

    i. Influenza A, Novel Virus, (690.469);

    ii. Severe Acute Respiratory Syndrome, (690.635);

q. 77 Ill. Admin. Code, Ch. I, §300.1020(b): A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300.620 of this Part.

a. discharge is necessary, the burden of proof rests on the facility.

b. 77 Ill. Admin. Code, Ch. I, §300.1210(c): Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan;

c. 77 Ill. Admin. Code, Ch. I, §300.1210: The facility must provide adequate and

properly supervised nursing care and personal care to each resident to meet the total nursing and personal care needs of the resident;

d. 77 Ill. Admin. Code, Ch. I, §300.1230(b): The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day;
e. 77 Ill. Admin. Code, Ch. I, §300.1230(d)(1) and (2): Each facility shall provide minimum direct care staff by: (1) determining the amount of direct care staffing needed to meet the needs of its residents; and (2) meeting the minimum direct care staffing ratios set forth in §300.1230;
f. 77 Ill. Admin. Code, Ch. I, §300.1230(i): The facility shall schedule nursing personnel so that the nursing needs of all residents are met; and
g. 77 Ill. Admin. Code, Ch. I, §300.3210(a): No resident shall be deprived of any rights, benefits or privileges guaranteed by law based on their status as a resident of a facility.

139. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF GENEVA,** did not exercise reasonable and due care and the level of diligence and competence required of a long-term skilled nursing care facility, as the following general isolation and infection control and prevention procedures were required to be implemented by nursing staff:

a. Establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases and infections;
b. Establish and maintain a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing nursing services;
c. The levels and amount of nursing staff available and staffed each shift must be continually and appropriately increased in order to adequately provide care and treatment to residents in accordance to facility, state, and federal infection control and prevention regulations, policies and procedures;
d. The levels and amount of PPE available to nursing staff and other long-term care facility employees must be continually purchased, provided, maintained, and/or monitored in a manner that ensures at all times PPE will be available to the nursing staff and other long-term care facility employees;
e. Staff, at all times, must be required to utilize PPE when providing care and treatment to residents that are suspected to be positive for an infectious disease, as well as residents who verbally communicate and/or physically present with symptoms consistent with an infectious and communicable disease;
f. Staff, at all times, must be required to utilize PPE when providing care and treatment to residents when there is an outbreak of infectious and communicable disease in the facility;

g. Staff, at all times, must be required to wash their hands after each direct resident contact;
h. Prohibit any employees suspected to have contracted a communicable disease or illness, as well as employees who have tested positive for a communicable disease or illness, from entering the facility, and from having any direct contact with residents;
i. Personnel must handle, store, process, and transport linens so as to prevent the spread of any infection;
j. When residents are isolated due to the presence and/or outbreak of a highly contagious and communicable virus, any health care professionals assigned to the care and treatment of the infected resident must only be assigned to that resident and/or other residents who have been identified with the same infection;
k. Health care professionals working on an isolated care unit due to an infectious outbreak must have designated a restroom(s), break room(s), and work area(s) that are separate from other health care professionals working on non-isolated and non-infectious units;
l. Maintain and have available portable x-ray equipment in resident cohort areas to reduce the need for patient transport and acute hospitalization;
m. In the event of any infectious disease or illness outbreak in a long-term care facility, the facility must purchase, provide, and maintain sufficient facemasks and/or facial coverings for all residents in order to contain infectious secretions and the spread of respiratory droplets in any communal areas;
n. In the event of any infectious disease or illness outbreak in a long-term care facility, the facility must temporarily halt admissions to the facility until the extent of transmission can be clarified, and interventions are implemented;
o. In the event of any infectious disease or illness outbreak in a long-term care facility, the facility must encourage all residents to restrict themselves to their room to the extent possible; and
p. In the event of any infectious disease or illness outbreak in a long-term care facility, the staff must provide physical assistance to any residents who are unable to "socially distance" themselves from others due to the resident's physical, mental, and/or underlying medical condition(s).

140. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF GENEVA,** did not exercise reasonable and due care and the level of diligence and competence required of a long-term skilled nursing care facility, as the following COVID-19 isolation and infection control and prevention procedures, in addition to the general isolation and infection control and prevention procedures aforementioned, were required to be implemented by nursing staff:

a. Establish and maintain a specific COVID-19 infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of COVID-19;
b. Establish and maintain a system to identify, investigate, and control COVID-19 infections, which includes, but is not limited to, screening all residents of a long-term care facility for COVID-19 symptoms and elevated temperature, heart rate, respirations, and pulse oximetry;
c. As a measure to limit long-term care resident's exposure to COVID-19, the facility must designate entire units within the facility to care for residents with known cases and/or suspected cases of COVID-19;
d. As a measure to conserve PPE for professional health care workers and other staff in caring for residents of long-term care facilities, the facility must designate entire units within the facility for residents with known cases and/or suspected cases of COVID-19;
e. As a measure to limit long-term care resident's exposure to COVID-19, the facility must assign specific and consistent members of the nursing staff to residents with known cases and/or suspected cases of COVID-19, and further limit the designated staff from providing care to negative or asymptomatic residents;
f. As a measure to conserve PPE for professional health care workers and other staff in caring for residents of long-term care facilities, the facility must assign specific and consistent members of the nursing staff to residents with known cases and/or suspected cases of COVID-19, and further limit the designated staff from providing care to negative or asymptomatic residents;
g. Ensure the levels and amount of nursing staff available and staffed each shift is increased as necessary, and in accordance to facility, state, and federal infection control and prevention regulations, policies and procedures, in order to adequately provide care and treatment to residents with and without COVID-19;
h. Residents with confirmed COVID-19 or displaying any respiratory symptoms should receive all services in room with door closed (meals, physical and occupational therapy, activities, and personal hygiene, etc.)
i. Restrict visitation of all visitors and non-essential health care personnel into the facility, but encourage other forms visitation and communication such as telephone calls or electronic video conferencing;
j. Facilities must screen any and all persons that enter a long-term care facility, including all staff at the beginning of each shift, which includes, but is limited to, temperature checks, requiring and/or providing masks or face covering prior to entering the facility, issuance of a questionnaire regarding symptoms and potential exposure, and physical observation of any signs or symptoms;
k. All group activities and communal dining must be canceled until further guidance provides for their continuation;
l. Long-term care facilities must disinfect frequently touched surfaces at a minimum of every two hours with EPA registered and approved products;
m. Residents in a long-term care facility who develop symptoms consistent with COVID-19 must be removed from the general resident population and

isolated in quarantine until a COVID-19 test is administered and results are received;

n. Residents in a long-term care facility who develop symptoms consistent with COVID-19 must not be placed or reside in a room with a new admission, nor should they be moved to the designated COVID-19 care unit unless the symptomatic resident is confirmed to be positive for COVID-19 by testing;
o. If a long-term care resident tests positive for COVID-19 and/or if the resident displays or reports signs and symptoms of a respiratory viral infection, staff must frequently and accurately obtain and then immediately document resident vital signs, including temperature, respirations, heart rate, and pulse oximetry;
p. Any resident identified with symptoms of fever and lower respiratory illness (cough, shortness of breath, sore throat) should be immediately placed in both contact and droplet transmission-based precautions;
q. Roommates of residents who are positive for COVID-19 should be considered exposed and potentially infected and, should not be allowed to share rooms with other residents unless they remain asymptomatic and/or have tested negative for COVID-19 for a minimum of 14 days after their last exposure;
r. Positive COVID-19 residents of a long-term care facility should reside in the same room/location for the entire duration and course of illness so as to reduce the chance of transmission to others;
s. Positive and/or symptomatic COVID-19 residents should be given a surgical mask encouraged to wear at all times, especially when in close contact with others;
t. Positive and/or symptomatic COVID-19 residents should be provided with all nursing, rehabilitative, medication, and treatment services in their designated room/space;
u. Residents confirmed to be positive for COVID-19, regardless of the presentation of their symptoms, should be transferred to a designated COVID-19 care unit;
v. Long-term care facilities must have a plan and specific protocols in place for managing new admissions and readmissions of residents whose COVID-19 status is unknown;
w. If a resident of a long-term care facility is positive and/or displaying symptomology of COVID-19 and is discharged from the facility, all staff, including nursing personnel and environmental/janitorial personnel must refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles;
x. If a resident of a long-term care facility is positive and/or displaying symptomology of COVID-19 and is discharged from the facility, the vacated room must undergo appropriate cleaning and surface disinfection before it is returned to routine use;
y. Long-term care facility must not cohort residents on the same unit based on COVID-19 symptoms alone, as that practice increases the risk of transmission between infected and non-infected residents;

z. Residents being re-admitted to a long-term care facility who is known or suspected to be positive for COVID-19 must be admitted to a single-person room and/or be designated to a room without a roommate;
aa. Screen all staff at the beginning of their shift for fever and respiratory symptoms by actively taking staff members' temperatures, and document any absence of fever, shortness of breath, new or change in cough, and sore throat before the staff is allowed into the facility;
bb. Identify any staff that work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.), and actively screen and restrict those individuals' access to the facility and/or to residents if they have been exposed to COVID-19 and/or show signs and symptoms of the same; and
cc. Provide alcohol-based hand disinfectant/hygiene products both inside and outside of residents' rooms, at all entrances, and throughout any and all clinical areas.

141. Any failures of a long-term care facility to implement the foregoing COVID-19 isolation and infection control and prevention procedures constitutes a failure to exercise reasonable and due care.

142. The Defendant, **BRIA HEALTH SERVICES OF GENEVA**, through its actual, implied, and/or apparent agents, servants, and employees, violated the provisions of the Nursing Home Care Act in that Defendant engaged in the following acts and/or omissions:

a. Failed to develop appropriate infection control and prevention policies and procedures;
b. Failed to develop and implement COVID-19 isolation and infection control and prevention procedures that were specifically tailored to **BRIA HEALTH SERVICES OF GENEVA**;
c. Failed to implement appropriate interventions related to infection control and prevention;
d. Failed screen all residents, including **CAROL,** for COVID-19 symptoms and elevated temperature, heart rate, respirations, and pulse oximetry;
e. Negligently instructed one or more members of the Defendant's nursing staff to continue to come into **BRIA HEALTH SERVICES OF GENEVA** and provide direct care to elderly residents, including **CAROL**;
f. Failed to frequently obtain vitals for all residents, including **CAROL**, for signs/symptoms of a respiratory distress, fever, cough, all of which are known signs/symptoms of COVID-19;
g. Failed to timely isolate residents suspected and/or symptomatic of COVID-19 from the general resident population;
h. Failed to provide, maintain, monitor and/or employ standard contact and droplet precautions and PPE;
i. Failed to ensure sufficient levels of staff to provide skilled nursing care and treatment to all residents, including **CAROL**, in accordance with their care plans;

j. Failed to ensure sufficient levels of staff to limit the nursing staff caring and/or assigned to positive or symptomatic residents from providing any care to negative or asymptomatic residents;
k. Failed to provide positive or symptomatic patients with surgical masks and other protective interventions to help reduce transmission;
l. Failed to immediately isolate residents identified with symptoms of fever and lower respiratory illness, including, but not limited to cough, shortness of breath, and sore throat;
m. Failed to maintain isolation protocols for residents identified with symptoms of fever and lower respiratory illness up to and until staff obtained a physician order that discontinued isolation protocol;
n. Failed to provide all resident services, including, but not limited to meals, physical and occupational therapy, social service activities, and personal hygiene in residents' designated rooms with the door closed for both suspected and confirmed COVID-19 residents, and/or any resident displaying acute respiratory symptoms;
o. Failed to disinfect frequently touched surfaces at a minimum of every two hours with EPA registered and approved products;
p. Failed to adhere to, and/or have in place, cleaning and disinfection policies and procedures;
q. Failed to purchase, provide, maintain, monitor and/or employ adequate PPE;
r. Failed to limit access to the **BRIA HEALTH SERVICES OF GENEVA** facility to any and all individuals that were not essential employees and/or nursing staff personnel;
s. Failed to ensure adequate levels of hand hygiene, hand washing, and/or alcohol-based hand disinfectant products/equipment;
t. Failed to provide alcohol-based hand disinfectant/hygiene products both inside and outside of residents' rooms, including **CAROL's**, at all entrances, and throughout any and all clinical areas;
u. Failed to provide appropriate and sufficient levels of nursing staff to meet the daily needs of its' residents, including **CAROL**;
v. Failed to take appropriate action after residents, including **CAROL**, displayed and/or complained of symptoms of fever and lower respiratory illness, including, but not limited to cough, shortness of breath, and sore throat;
w. Negligently accepted new admissions and/or re-admissions of residents that were symptomatic and/or tested positive for COVID-19;
x. Negligently cohorted suspected and/or positive COVID-19 residents with (at the time) non-COVID-19 residents;
y. Failed to test **CAROL** for COVID-19 despite **CAROL**'s presentation and complaints of COVID-19 symptoms, including, but not limited to, fever, cough, general but articulable malaise, and shortness of breath, intentionally, recklessly and/or repeatedly failed to test **CAROL** for COVID-19;
z. Failed to communicate to **CAROL's** physician the need to test **CAROL** for COVID-19 after she presented with, and complained of, COVID-19 symptoms, including, but not limited to, fever, cough, general but articulable malaise, and shortness of breath;
aa. Failed to maintain sufficient nursing staff to provide nursing and related services to attain or maintain **CAROL**'s highest practicable physical, mental, and psychosocial wellbeing as determined by **CAROL**'s assessments and individual plans of care;

bb. Failed to operate and provide services in compliance with all applicable professional standards in ways including, but not limited to, maintaining adequate documentation in **CAROL**'s clinical record; and

cc. Failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including **CAROL**, in full recognition of **CAROL's** individuality.

143. In light of a COVID-19 outbreak, and after having both constructive and actual notice of COVID-19's highly contagious, transmittable, and deadly course of illness, Defendant, **BRIA HEALTH SERVICES OF GENEVA**'s failures to implement any of the foregoing isolation and infection control and prevention procedures constituted a violation of the Illinois Nursing Home Care Act.

144. As a direct and proximate result of one or more of the Defendant, **BRIA HEALTH SERVICES OF GENEVA's** statutory violations and negligent acts and/or omissions, **CAROL** suffered injuries including, but not limited to, the contraction of COVID-19, a poor quality of life, a deterioration of her overall physical, mental, and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which **CAROL** suffered from up until the time of her death.

145. As a direct and proximate result of one or more of the Defendant, **BRIA HEALTH SERVICES OF GENEVA's** statutory violations and negligent acts and/or omissions, **CAROL** suffered injuries of a personal and pecuniary nature including, but not limited to, pain, suffering, disability and disfigurement, and medical and related expenses, all of which **CAROL** would have been entitled to receive compensation from the Defendant, had she survived.

146. The Plaintiff, **FAITH HEIMBRODT, as Independent Administrator for the Estate of CAROL ORLANDO, Deceased** brings this action pursuant to the provisions of 755 ILCS 5/27-6, commonly known as the Illinois Survival Act.

147. The Plaintiff**, FAITH HEIMBRODT, as Independent Administrator for the Estate of CAROL ORLANDO, Deceased**, brings this action pursuant to the provisions of 210 ILCS 45/1-

101 <u>et seq.</u>, commonly known as the Illinois Nursing Home Care Act.

WHEREFORE, the Plaintiff, **FAITH HEIMBRODT, as Independent Administrator for the Estate of CAROL ORLANDO, Deceased**, through her attorneys, **LEVIN & PERCONTI**, asks that a judgment be entered against the Defendant, **GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company d/b/a BRIA HEALTH SERVICES OF GENEVA** in a fair and just amount in excess of Fifty-Thousand Dollars ($50,000.00), plus attorney's fees and costs as provided for by statute.

COUNT II
FAITH HEIMBRODT for CAROL ORLANDO, Deceased v. GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company
(Illinois Nursing Home Care Act – Willful and Wanton)

The Plaintiff, **FAITH HEIMBRODT, as Independent Administrator for the Estate of CAROL ORLANDO, Deceased**, by her attorneys, **LEVIN & PERCONTI**, complains against the Defendant, **GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company d/b/a BRIA HEALTH SERVICES OF GENEVA** as follows:

1. Plaintiff, **FAITH HEIMBRODT, as Independent Administrator for the Estate of CAROL ORLANDO, Deceased,** repeats, realleges and fully incorporates by reference all facts and allegations contained in Paragraphs 1 through 117 as fully set forth herein.

118. At all times relevant to this Complaint, **BRIA HEALTH SERVICES OF GENEVA** was required to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

119. At all times relevant to this Complaint, and irrespective of any guidance issued by any governmental agency, regulatory commission, or any other entity overseeing long-term care facility operation and regulation, **BRIA HEALTH SERVICES OF GENEVA** knew or should have known that residents, like **CAROL**, who comprise an elderly patient population in a nursing home, and who

are known to have documented underlying medical conditions, were at high risk for the contraction and transmission of respiratory illnesses and other viruses by means of respiratory droplets, including, but not limited to, different types of coronaviruses.

120. On or before January 24, 2020, when the first case of COVID-19 was identified in both Illinois and Chicago, and irrespective of any guidance issued by any governmental agency, regulatory commission, or any other entity overseeing long-term care facility operation and regulation, Defendant **BRIA HEALTH SERVICES OF GENEVA** knew or should have known that residents, like **CAROL**, who comprise an elderly patient population in a nursing home, and who are known to have documented underlying medical conditions, were at high risk for the contraction and transmission of COVID-19, and at high risk to the susceptibility of COVID-19's deadly course of illness.

121. At all times relevant, long-term skilled nursing facilities, like **BRIA HEALTH SERVICES OF GENEVA**, did not have any luxury to treat and respond to the COVID-19 pandemic and specific outbreaks of the virus casually, as any failures in responses to COVID-19 in long-term care facilities have cascading, downstream and deadly consequences for elderly patient populations with known and documented underlying medical conditions, like **CAROL**.

122. Employers, like Defendant **BRIA HEALTH SERVICES OF GENEVA**, have a duty to act reasonably in both hiring and retaining its employees.

123. A master, like Defendant **BRIA HEALTH SERVICES OF GENEVA**, has the duty to supervise its servants.

124. The initiation and existence of an employment relationship imposes a duty upon an employer, like Defendant **BRIA HEALTH SERVICES OF GENEVA** to exercise reasonable care in employing competent individuals.

125. It is foreseeable that a resident of a long-term skilled nursing facility, like **CAROL**, could be harmed by a facility, like **BRIA HEALTH SERVICES OF GENEVA**'s willful and/or

reckless failures to hire, supervise and retain adequate levels of nursing staff in order to provide adequate care and protect residents from harm.

126. The harm which can be caused to a nursing home resident, like **CAROL,** by a long-term care facility, like **BRIA HEALTH SERVICES OF GENEVA**'s willful and/or reckless failures to hire, supervise and retain adequate levels of nursing staff in order to provide adequate care and protect residents, is great, and such failures rise to the level of a conscious disregard for a the health and safety of others.

127. At all times relevant to this Complaint, Defendant **BRIA HEALTH SERVICES OF GENEVA**, had the ability and resources to hire, supervise, and retain adequate levels of nursing staff in order to protect and provide care to its residents, including **CAROL**, with ages and underlying medical conditions that place them at high risk for the contraction and transmission of respiratory illnesses and other viruses by means of respiratory droplets, including, but not limited to, COVID-19.

128. Despite the Defendant's abilities, and at all times relevant to this Complaint, **BRIA HEALTH SERVICES OF GENEVA** willfully and/or recklessly failed to utilize its resources, and consciously chose not to hire, supervise, and retain adequate levels of nursing staff in order to provide care to residents and protect them.

129. At all times relevant to this Complaint, Defendants, **BRIA HEALTH SERVICES OF GENEVA** was willful and/or reckless in both allowing and encouraging the nursing staff to care for an inappropriately large number of different patients in a single given day and/or shift, including **CAROL**, which increases the risk for the contraction and transmission of respiratory illnesses and other viruses by means of respiratory droplets, including, but not limited to, COVID-19.

130. It is foreseeable that a resident of a long-term skilled nursing facility, like **CAROL**, could be harmed by a facility, like **BRIA HEALTH SERVICES OF GENEVA**'s willful and/or reckless failures in purchasing, providing, maintaining, and/or monitoring the numbers of PPE

available to its employees and staff, as the nursing staff is assigned to care for a number of different patients in a single given day and/or shift.

131. The harm which can be caused to a nursing home resident, like **CAROL,** by a long-term care facility, like **BRIA HEALTH SERVICES OF GENEVA**'s willful and/or reckless failures to purchase, provide, maintain, and/or monitor the numbers of PPE available to staff, is great, and such failures rise to the level of a conscious disregard for a the health and safety of others.

132. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF GENEVA,** had the ability and resources to purchase, provide, maintain, and/or monitor the numbers of PPE available to its employees and staff, as the nursing staff is assigned to care for a number of different patients in a given day and/or shift.

133. Despite the Defendant's abilities, at all times relevant to this Complaint, Defendant **BRIA HEALTH SERVICES OF GENEVA** willfully failed to utilize their resources and consciously chose not to purchase, provide, and/or monitor the numbers of PPE available to its employees and staff, which recklessly increased risk of contraction and transmission of respiratory illnesses and other viruses by means of respiratory droplets, including, but not limited to, COVID-19.

134. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF GENEVA,** was reckless, willful, and consciously disregarded residents' health by both allowing and encouraging the nursing staff to provide care to a number of different residents, including **CAROL**, without adequate numbers, qualities, and/or sanitized PPE.

148. At all times relevant to this Complaint, **BRIA HEALTH SERVICES OF GENEVA**, by and through its actual, apparent, and/or implied agents, servants, and employees, were fundamentally responsible, and had a statutory duty under the Illinois Nursing Home Care Act, to develop and implement policies governing control of infections and communicable diseases so that nursing homes, like **BRIA HEALTH SERVICES OF GENEVA,** can continually be on guard to

detect any rapidly and easily transmittable virus, disease, and illness, including, but not limited to, respiratory illnesses and other viruses by means of respiratory droplets.

149. At all times relevant to this Complaint, the Defendant, **BRIA HEALTH SERVICES OF GENEVA**, through its nursing staff who were actual, implied, and/or apparent agents, servants, and employees, had a statutory duty not to willfully and/or recklessly violate the rights of any resident of the facility, including **CAROL**, which included the duty not to abuse or neglect any resident, as provided by the Act as follows:

> An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in the Abused and Neglected Long-term Care Facility Residents Reporting Act. 210 ILCS 45/2-107, 210 ILCS 45/3-610, 210 ILCS 45/3-808.5(c), and Ill. Admin. Code, Ch. I, §300.3240.
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> Abuse means any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility. 210 ILCS 45/1-103 and Ill. Admin. Code, Ch. I, §300.330.
>
> Neglect means a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. 210 ILCS 45/1-117.
>
> Neglect means the failure to provide adequate medical or personal care or maintenance, which failure results physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. This shall include any allegation where: (1) the alleged failure causing injury or deterioration is ongoing or repetitious; or (2) a resident required medical treatment as a result of the alleged failure; or (3) the failure is alleged to have caused a noticeable negative impact on a resident's health, behavior or activities for more than 24 hours. Ill. Admin. Code, Ch. I, §300.330.
>
> Personal Care means assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual, who is incapable of maintaining a private, independent residence or who is incapable of managing

his person whether or not a guardian has been appointed for such individual. 210 ILCS 45/1-120 and Ill. Admin. Code, Ch. I, §300.330.

150. The Illinois Nursing Home Care Act, as amended, provides as follows:

> The licensee shall pay the actual damages and costs and attorney's fees to a facility resident whose rights, as specified in Part 1 of Article II of the Nursing Home Care Act, are violated. 210 ILCS 45/3-602.

151. The Illinois Nursing Home Care Act, as amended, provides as follows:

> The owner and licensee are liable to a resident for any intentional or negligent acts or omissions of their agents or employees, which injures the residents. 210 ILCS 45/3-601 and Ill. Admin. Code, Ch. I. §300.3290(b).

152. At all times relevant to this Complaint, the Defendant, **BRIA HEALTH SERVICES OF GENEVA,** through its nursing staff who were actual, implied, and/or apparent agents, servants, and employees, had a duty not to willfully and/or recklessly violate the rights of any resident of **BRIA HEALTH SERVICES OF GENEVA**, including, but not limited to, **CAROL**, as specified by provisions of the Act and the Illinois Administrative Code including, but not limited to, the following:

a. 210 ILCS 45/2-212: The facility shall ensure that its staff is familiar with and observes the rights and responsibilities enumerated in this Article;
b. 210 ILCS 45/3-202(2): Number and qualifications of all personnel, including management and nursing personnel, having responsibility for any part of the care given to residents; specifically, the Department shall establish staffing ratios for facilities which shall specify the number of staff hours per resident of care that are needed for professional nursing care for various types of facilities or areas within facilities;
c. 210 ILCS 45/3-202(5): Equipment essential to the health and welfare of the residents;
d. 210 ILCS 45/3-202.05(b)(3): Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment;
e. 210 ILCS 45/2-213(c): A skilled nursing facility shall designate a person or persons as Infection Prevention and Control Professionals to develop and implement policies governing control of infections and communicable diseases. The Infection Prevention and Control Professionals shall be qualified through education, training, experience, or certification or a combination of such qualifications. The Infection Prevention and Control Professional's qualifications shall be documented and shall be made available for inspection by the Department;
f. 210 ILCS 45/2-108: Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or

visitation;

g. 210 ILCS 45/2-108(a): The administrator shall ensure that correspondence is conveniently received and mailed, and that telephones are reasonably accessible;
h. 210 ILCS 45/3-202.2a: A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs;
i. 77 Ill. Admin. Code, Ch. I, §300.1210: The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care;
j. 77 Ill. Admin. Code, Ch. I, §300.696(a): Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed;
k. 77 Ill. Admin. Code, Ch. I, §300.696(b): A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections;
l. 77 Ill. Admin. Code, Ch. I, §300.1020(a): The facility shall comply with the
m. Control of Communicable Diseases Code (77 Ill. Adm. Code 690).
n. 77 Ill. Admin. Code, Ch. I, §300.696(c): Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):
   (2) Guideline for Hand Hygiene in Health-Care Settings;
   (5) Guideline for Prevention of Nosocomial Pneumonia;
   (6) Guideline for Isolation Precautions in Hospitals;
   (7) Guidelines for Infection Control in Health Care Personnel;
o. 77 Ill. Admin. Code, Ch. I, §300.690.100-(a)-(1): The following diseases and conditions are declared to be contagious, infectious or communicable and may be dangerous to the public health. Any <u>unusual case of a disease or condition caused by an infectious agent</u> not listed in this Part that is of urgent public health significance and shall be reported immediately (within three hours) by telephone, upon initial clinical suspicion of the disease, to the local health authority, which shall then report to the Department immediately (within three hours). (emphasis added);
p. 77 Ill. Admin. Code, Ch. I, §300.690.100(a)(1)(c): Persons who identify <u>a single case of a rare or significant infectious disease</u> shall report the case to

the local health authority. This may include, but is not limited to, a case of cowpox, Reye's syndrome, glanders, amoebic meningoencephalitis, or, monkeypox, hemorrhagic fever viruses, infection from a laboratory-acquired recombinant organism, ***or any disease non-indigenous to the United States*** (emphasis added);

  i. Influenza A, Novel Virus, (690.469);
  ii. Severe Acute Respiratory Syndrome, (690.635);

q. 77 Ill. Admin. Code, Ch. I, §300.1020(b): A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300.620 of this Part.

h. discharge is necessary, the burden of proof rests on the facility.
i. 77 Ill. Admin. Code, Ch. I, §300.1210(c): Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan;
j. 77 Ill. Admin. Code, Ch. I, §300.1210: The facility must provide adequate and properly supervised nursing care and personal care to each resident to meet the total nursing and personal care needs of the resident;
k. 77 Ill. Admin. Code, Ch. I, §300.1230(b): The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day;
l. 77 Ill. Admin. Code, Ch. I, §300.1230(d)(1) and (2): Each facility shall provide minimum direct care staff by: (1) determining the amount of direct care staffing needed to meet the needs of its residents; and (2) meeting the minimum direct care staffing ratios set forth in §300.1230;
m. 77 Ill. Admin. Code, Ch. I, §300.1230(i): The facility shall schedule nursing personnel so that the nursing needs of all residents are met; and
n. 77 Ill. Admin. Code, Ch. I, §300.3210(a): No resident shall be deprived of any rights, benefits or privileges guaranteed by law based on their status as a resident of a facility.

153. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF GENEVA,** willfully and/or recklessly failed to exercise the level of diligence and competence required of a long-term skilled nursing care facility, as the following general isolation and infection control and prevention procedures were required to be implemented by nursing staff:

a. Establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases and infections;
b. Establish and maintain a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all

residents, staff, volunteers, visitors, and other individuals providing nursing services;

c. The levels and amount of nursing staff available and staffed each shift must be continually and appropriately increased in order to adequately provide care and treatment to residents in accordance to facility, state, and federal infection control and prevention regulations, policies and procedures;
d. The levels and amount of PPE available to nursing staff and other long-term care facility employees must be continually purchased, provided, maintained, and/or monitored in a manner that ensures at all times PPE will be available to the nursing staff and other long-term care facility employees;
e. Staff, at all times, must be required to utilize PPE when providing care and treatment to residents that are suspected to be positive for an infectious disease, as well as residents who verbally communicate and/or physically present with symptoms consistent with an infectious and communicable disease;
f. Staff, at all times, must be required to utilize PPE when providing care and treatment to residents when there is an outbreak of infectious and communicable disease in the facility;
g. Staff, at all times, must be required to wash their hands after each direct resident contact;
h. Prohibit any employees suspected to have contracted a communicable disease or illness, as well as employees who have tested positive for a communicable disease or illness, from entering the facility, and from having any direct contact with residents;
i. Personnel must handle, store, process, and transport linens so as to prevent the spread of any infection;
j. When residents are isolated due to the presence and/or outbreak of a highly contagious and communicable virus, any health care professionals assigned to the care and treatment of the infected resident must only be assigned to that resident and/or other residents who have been identified with the same infection;
k. Health care professionals working on an isolated care unit due to an infectious outbreak must have designated a restroom(s), break room(s), and work area(s) that are separate from other health care professionals working on non-isolated and non-infectious units;
l. Maintain and have available portable x-ray equipment in resident cohort areas to reduce the need for patient transport and acute hospitalization;
m. In the event of any infectious disease or illness outbreak in a long-term care facility, the facility must purchase, provide, and maintain sufficient facemasks and/or facial coverings for all residents in order to contain infectious secretions and the spread of respiratory droplets in any communal areas;
n. In the event of any infectious disease or illness outbreak in a long-term care facility, the facility must temporarily halt admissions to the facility until the extent of transmission can be clarified, and interventions are implemented;

o. In the event of any infectious disease or illness outbreak in a long-term care facility, the facility must encourage all residents to restrict themselves to their room to the extent possible; and
p. In the event of any infectious disease or illness outbreak in a long-term care facility, the staff must provide physical assistance to any residents who are unable to "socially distance" themselves from others due to the resident's physical, mental, and/or underlying medical condition(s).

154. At all times relevant to this Complaint, Defendant, **BRIA HEALTH SERVICES OF GENEVA,** willfully and/or recklessly failed to exercise the level of diligence and competence required of a long-term skilled nursing care facility, and in addition to the general isolation and infection control and prevention procedures aforementioned, the following COVID-19 isolation and infection control and prevention procedures were required to be implemented by nursing staff:

a. Establish and maintain a specific COVID-19 infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of COVID-19;
b. Establish and maintain a system to identify, investigate, and control COVID-19 infections, which includes, but is not limited to, screening all residents of a long-term care facility for COVID-19 symptoms and elevated temperature, heart rate, respirations, and pulse oximetry;
c. As a measure to limit long-term care resident's exposure to COVID-19, the facility must designate entire units within the facility to care for residents with known cases and/or suspected cases of COVID-19;
d. As a measure to conserve PPE for professional health care workers and other staff in caring for residents of long-term care facilities, the facility must designate entire units within the facility for residents with known cases and/or suspected cases of COVID-19;
e. As a measure to limit long-term care resident's exposure to COVID-19, the facility must assign specific and consistent members of the nursing staff to residents with known cases and/or suspected cases of COVID-19, and further limit the designated staff from providing care to negative or asymptomatic residents;
f. As a measure to conserve PPE for professional health care workers and other staff in caring for residents of long-term care facilities, the facility must assign specific and consistent members of the nursing staff to residents with known cases and/or suspected cases of COVID-19, and further limit the designated staff from providing care to negative or asymptomatic residents;
g. Ensure the levels and amount of nursing staff available and staffed each shift is increased as necessary, and in accordance to facility, state, and federal infection control and prevention regulations, policies and procedures, in order

to adequately provide care and treatment to residents with and without COVID-19;

h. Residents with confirmed COVID-19 or displaying any respiratory symptoms should receive all services in room with door closed (meals, physical and occupational therapy, activities, and personal hygiene, etc.)
i. Restrict visitation of all visitors and non-essential health care personnel into the facility, but encourage other forms visitation and communication such as telephone calls or electronic video conferencing;
j. Facilities must screen any and all persons that enter a long-term care facility, including all staff at the beginning of each shift, which includes, but is limited to, temperature checks, requiring and/or providing masks or face covering prior to entering the facility, issuance of a questionnaire regarding symptoms and potential exposure, and physical observation of any signs or symptoms;
k. All group activities and communal dining must be canceled until further guidance provides for their continuation;
l. Long-term care facilities must disinfect frequently touched surfaces at a minimum of every two hours with EPA registered and approved products;
m. Residents in a long-term care facility who develop symptoms consistent with COVID-19 must be removed from the general resident population and isolated in quarantine until a COVID-19 test is administered and results are received;
n. Residents in a long-term care facility who develop symptoms consistent with COVID-19 must not be placed or reside in a room with a new admission, nor should they be moved to the designated COVID-19 care unit unless the symptomatic resident is confirmed to be positive for COVID-19 by testing;
o. If a long-term care resident tests positive for COVID-19 and/or if the resident displays or reports signs and symptoms of a respiratory viral infection, staff must frequently and accurately obtain and then immediately document resident vital signs, including temperature, respirations, heart rate, and pulse oximetry;
p. Any resident identified with symptoms of fever and lower respiratory illness (cough, shortness of breath, sore throat) should be immediately placed in both contact and droplet transmission-based precautions;
q. Roommates of residents who are positive for COVID-19 should be considered exposed and potentially infected and, should not be allowed to share rooms with other residents unless they remain asymptomatic and/or have tested negative for COVID-19 for a minimum of 14 days after their last exposure;
r. Positive COVID-19 residents of a long-term care facility should reside in the same room/location for the entire duration and course of illness so as to reduce the chance of transmission to others;
s. Positive and/or symptomatic COVID-19 residents should be given a surgical mask encouraged to wear at all times, especially when in close contact with others;

t. Positive and/or symptomatic COVID-19 residents should be provided with all nursing, rehabilitative, medication, and treatment services in their designated room/space;
u. Residents confirmed to be positive for COVID-19, regardless of the presentation of their symptoms, should be transferred to a designated COVID-19 care unit;
v. Long-term care facilities must have a plan and specific protocols in place for managing new admissions and readmissions of residents whose COVID-19 status is unknown;
w. If a resident of a long-term care facility is positive and/or displaying symptomology of COVID-19 and is discharged from the facility, all staff, including nursing personnel and environmental/janitorial personnel must refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles;
x. If a resident of a long-term care facility is positive and/or displaying symptomology of COVID-19 and is discharged from the facility, the vacated room must undergo appropriate cleaning and surface disinfection before it is returned to routine use;
y. Long-term care facility must not cohort residents on the same unit based on COVID-19 symptoms alone, as that practice increases the risk of transmission between infected and non-infected residents;
z. Residents being re-admitted to a long-term care facility who is known or suspected to be positive for COVID-19 must be admitted to a single-person room and/or be designated to a room without a roommate;
aa. Screen all staff at the beginning of their shift for fever and respiratory symptoms by actively taking staff members' temperatures, and document any absence of fever, shortness of breath, new or change in cough, and sore throat before the staff is allowed into the facility;
bb. Identify any staff that work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.), and actively screen and restrict those individuals' access to the facility and/or to residents if they have been exposed to COVID-19 and/or show signs and symptoms of the same; and
cc. Provide alcohol-based hand disinfectant/hygiene products both inside and outside of residents' rooms, at all entrances, and throughout any and all clinical areas.

155. Any failures of a long-term care facility to implement the foregoing isolation and infection control and prevention procedures constitutes a failure to exercise the level of diligence and competence required of a long-term skilled nursing care facility.

156. The Defendant, **BRIA HEALTH SERVICES OF GENEVA**, through its actual, implied, and/or apparent agents, servants, and employees, willfully, and with conscious disregard for the safety of its residents, including **CAROL**, repeatedly violated the provisions of the Nursing Home

Care Act in that Defendant engaged in the following acts and/or omissions:

a. Intentionally, recklessly and/or repeatedly failed to develop appropriate infection control and prevention policies and procedures;
b. Intentionally, recklessly and/or repeatedly failed to develop and implement COVID-19 isolation and infection control and prevention procedures that were specifically tailored to **BRIA HEALTH SERVICES OF GENEVA**;
c. Intentionally, recklessly and/or repeatedly failed to implement appropriate interventions related to infection control and prevention;
d. Intentionally, recklessly and/or repeatedly failed screen all residents, including **CAROL,** for COVID-19 symptoms and elevated temperature, heart rate, respirations, and pulse oximetry;
e. Intentionally, recklessly and/or consciously disregarded **CAROL's** health and safety after instructing one or more members of the Defendant's nursing staff to continue to come into **BRIA HEALTH SERVICES OF GENEVA** and provide direct care to elderly residents, including **CAROL**;
f. Intentionally, recklessly and/or repeatedly failed to frequently obtain vitals for all residents, including **CAROL**, for signs/symptoms of a respiratory distress, fever, cough, all of which are known signs/symptoms of COVID-19;
g. Consciously disregarded the health of residents, including **CAROL**, by failing to timely isolate residents suspected and/or symptomatic of COVID-19 from the general resident population;
h. Intentionally, recklessly and/or repeatedly failed to provide, maintain, monitor and/or employ standard contact and droplet precautions and PPE;
i. Intentionally, recklessly and/or repeatedly failed to ensure sufficient levels of staff to provide skilled nursing care and treatment to all residents, including **CAROL**, in accordance with their care plans;
j. Intentionally, recklessly and/or repeatedly failed to ensure sufficient levels of staff to limit the nursing staff caring and/or assigned to positive or symptomatic residents from providing any care to negative or asymptomatic residents;
k. Intentionally, recklessly and/or repeatedly failed to provide positive or symptomatic patients with surgical masks and other protective interventions to help reduce transmission;
l. Intentionally, recklessly and/or repeatedly failed to immediately isolate residents identified with symptoms of fever and lower respiratory illness, including, but not limited to cough, shortness of breath, and sore throat;
m. Intentionally, recklessly and/or repeatedly failed to maintain isolation protocols for residents identified with symptoms of fever and lower respiratory illness up to and until staff obtained a physician order that discontinued isolation protocol;
n. Intentionally, recklessly and/or repeatedly failed to provide all resident services, including, but not limited to meals, physical and occupational therapy, social service activities, and personal hygiene in residents' designated rooms with the door closed for both suspected and confirmed COVID-19 residents, and/or any resident displaying acute respiratory symptoms;
o. Intentionally, recklessly and/or repeatedly failed to disinfect frequently touched surfaces at a minimum of every two hours with EPA registered and approved products;
p. Intentionally, recklessly and/or repeatedly failed to adhere to, and/or have in place, cleaning and disinfection policies and procedures;

q. Intentionally, recklessly and/or repeatedly failed to purchase, provide, maintain, monitor and/or employ adequate PPE;
r. Intentionally, recklessly and/or repeatedly failed to limit access to the **BRIA HEALTH SERVICES OF GENEVA** facility to any and all individuals that were not essential employees and/or nursing staff personnel;
s. Intentionally, recklessly and/or repeatedly failed to ensure adequate levels of hand hygiene, hand washing, and/or alcohol-based hand disinfectant products/equipment;
t. Intentionally, recklessly and/or repeatedly failed to provide alcohol-based hand disinfectant/hygiene products both inside and outside of residents' rooms, including **CAROL's**, at all entrances, and throughout any and all clinical areas;
u. Engaged in a pattern of conduct exhibiting an intentional and reckless disregard for **CAROL's** health and safety by failing to provide appropriate and sufficient levels of nursing staff;
v. Engaged in a pattern of conduct exhibiting an intentional and reckless disregard for **CAROL's** health and safety by failing to take appropriate action after residents, including **CAROL**, displayed and/or complained of symptoms of fever and lower respiratory illness, including, but not limited to cough, shortness of breath, and sore throat;
w. Engaged in a pattern of conduct exhibiting an intentional and reckless disregard for **CAROL's** health and safety by accepting new admissions and/or re-admissions of residents that tested positive for COVID-19;
x. Engaged in a pattern of conduct exhibiting an intentional and reckless disregard for **CAROL's** health and safety by cohorting suspected and/or positive COVID-19 residents with (at the time) non-COVID-19 residents;
y. Intentionally, recklessly and/or consciously disregarded the health of **CAROL** by failing to test **CAROL** for COVID-19 despite **CAROL**'s presentation and complaints of COVID-19 symptoms, including, but not limited to, fever, cough, general but articulable malaise, and shortness of breath, intentionally, recklessly and/or repeatedly failed to test **CAROL** for COVID-19;
z. Intentionally, recklessly and/or consciously disregarded the health of **CAROL** by failing to communicate to her physician the need to test **CAROL** for COVID-19 after **CAROL** presented and complained of COVID-19 symptoms, including, but not limited to, fever, cough, general but articulable malaise, and shortness of breath, intentionally, recklessly and/or repeatedly failed to test **CAROL** for COVID-19;
aa. Intentionally, recklessly and/or repeatedly failed to maintain sufficient nursing staff to provide nursing and related services to attain or maintain **CAROL**'s highest practicable physical, mental, and psychosocial wellbeing as determined by **CAROL**'s assessments and individual plans of care;
bb. Intentionally, recklessly and/or repeatedly failed to operate and provide services in compliance with all applicable professional standards in ways including, but not limited to, maintaining adequate documentation in **CAROL**'s clinical record; and
cc. Intentionally, recklessly and/or repeatedly failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including **CAROL**, in full recognition of **CAROL's** individuality.

157. In light of a COVID-19 outbreak, and after having both constructive and actual notice of COVID-19's highly contagious, transmittable, and deadly course of illness, Defendant, **BRIA HEALTH SERVICES OF GENEVA**'s failures to implement any of the foregoing isolation and infection control and prevention procedures constituted a reckless and conscious disregard for health and safety of its residents, including **CAROL**.

158. As a direct and proximate result of one or more of the Defendant, **BRIA HEALTH SERVICES OF GENEVA's** reckless and willful acts and/or omissions in violation of statute, and conscious disregard for **CAROL's** health and safety, **CAROL** suffered injuries including, but not limited to, the contraction of COVID-19, a poor quality of life, a deterioration of her overall physical, mental, and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which **CAROL** suffered from up until the time of her death.

159. As a direct and proximate result of one or more of the Defendant, **BRIA HEALTH SERVICES OF GENEVA's** reckless and willful acts and/or omissions in violation of statute, and conscious disregard for **CAROL's** health and safety, **CAROL** suffered injuries of a personal and pecuniary nature including, but not limited to, pain, suffering, disability and disfigurement, and medical and related expenses, all of which **CAROL** would have been entitled to receive compensation from the Defendant, had she survived.

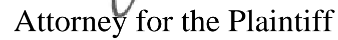
160. The Plaintiff, **FAITH HEIMBRODT, as Independent Administrator for the Estate of CAROL ORLANDO, Deceased** brings this action pursuant to the provisions of 755 ILCS 5/27-6, commonly known as the Illinois Survival Act.

161. The Plaintiff**, FAITH HEIMBRODT, as Independent Administrator for the Estate of CAROL ORLANDO, Deceased**, brings this action pursuant to the provisions of 210 ILCS 45/1-101 et seq., commonly known as the Illinois Nursing Home Care Act.

WHEREFORE, the Plaintiff, **FAITH HEIMBRODT, as Independent Administrator for**

the Estate of CAROL ORLANDO, Deceased, through her attorneys, **LEVIN & PERCONTI**, asks that a judgment be entered against the Defendant, **GENEVA NURSING AND REHABILITATION CENTER, LLC, an Illinois Limited Liability Company d/b/a BRIA HEALTH SERVICES OF GENEVA** in a fair and just amount in excess of Fifty-Thousand Dollars ($50,000.00), plus attorney's fees and costs as provided for by statute.

Respectfully submitted,
LEVIN & PERCONTI



By: ______________________
Attorney for the Plaintiff

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IN THE CIRCUIT COURT OF THE SIXTEENTH JUDICIAL CIRCUIT
KANE COUNTY, ILLINOIS

Case No. 20-P-000258

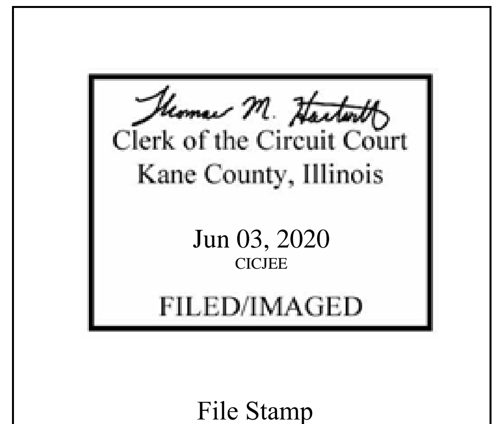
IN THE MATTER OF THE ESTATE OF (DECEDENT):

Name: Carol Jean Orlando

Address: 1101 East State State

City, State, Zip: Geneva, IL 60134

Date of Death: April 25, 2020



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ORDER APPOINTING ADMINISTRATION

☒ **No Will** ☐ **With Will Annexed** ☐ **De Bonis Non** ☐ **De Bonis Non With Will Annexed**

☒ **Independent Administration** ☐ **Supervised Administration**

The verified petition of Faith Heimbrodt for appointment of an administrator and the admission to probate of the will (and codicils(s) if shown and attached) if requested, being presented for hearing;

THE COURT FINDS due notice has been given to all parties according to law and that it has jurisdiction of the subject matter of the petition.

After having considered said petition and having proof in accordance with the Probate Act, and the Court having determined that the petitioner's nominee is qualified to act as such Administrator;

IT IS THEREFORE ORDERED THAT:

1. The will, and codicil(s) if shown and attached, is/are admitted to probate as the last Will of said decedent.
2. (Administrator's Name and complete address Faith Heimbrodt, 11140 Fitzgerald Ln., Huntley, IL 60142 ______ is hereby appointed Administrator of the estate of decedent in this cause.
3. Appropriate Letters of Administration shall issue in accordance with the provisions of this Order.
4. A ☒ Corporate Bond ☐ Individuals as Surety required of Administration is ordered in the amount of $1,000 .

Date Entered: ______________

____
Judge

Prepared By: Bielski Chapman, Ltd

Attorney/Pro Se: SJ Chapman

Address: 123 North Wacker Drive, Ste. 2300

City, State, Zip: Chicago, IL 60606

Telephone No.: (312) 583-9430

Atty. Registration No.: 6312516

Attorney E-mail: chapman@bc-lawyers.com

P1-PR-004 (11/12)

EXHIBIT 1