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

Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased,	)	20-L-000244
Plaintiff,	)	**CASE NO.:**
vs.	)	
Geneva Nursing and Rehabilitation Center, LLC d/b/a Bria Health Services of Geneva,	)	**JURY DEMANDED**
Defendant.	)	

Thomas M. Hartwell
Clerk of the Circuit Court
Kane County, Illinois
5/18/2020 8:50 AM
FILED/IMAGED

COMPLAINT AT LAW

NOW COMES Plaintiff, Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, by and through her attorneys, Meyers & Flowers, LLC and for her Complaint at Law against Defendant, Geneva Nursing and Rehabilitation Center, LLC d/b/a Bria Health Services of Geneva, alleges as follows:

COMMON ALLEGATIONS

1. Plaintiff Pamela Colwell is the duly appointed Administrator for the estate of her mother, Helen A. Osucha ("Helen"), who died on April 26, 2020 from complications associated with a viral COVID-19 outbreak at the skilled nursing care facility known as the Geneva Nursing and Rehabilitation Center, LLC, d/b/a Bria Health Services of Geneva.

2. Geneva Nursing and Rehabilitation Center, LLC, d/b/a Bria Health Services of Geneva is an Illinois limited liability company with its corporate office located at 5151 Church Street, Skokie, Illinois that for all times material hereto operated a skilled nursing care facility at 1101 East State Street, Geneva, Illinois (hereinafter "Bria-Geneva").

3. On or about March 8, 2019 and continuing and through April 26, 2020, Defendant, Bria-Geneva, was a licensed facility with the Illinois Department of Public Health.

4. At all times material herein, there was in full force and effect, a statute in the State of Illinois commonly known as the *Nursing Home Care Act* (hereinafter the "Act"), as amended, 210 ILCS 45/1-101, et seq.

5. At all times material herein, Bria-Geneva was a "facility" as defined by §1-113 of the Act and was subject to the requirements of the Act and the regulations of the Illinois Department of Public Health promulgated pursuant to the Act.

6. At all times material herein, Bria-Geneva was a skilled nursing and intermediate care facility as defined by 77 Ill. Admin. Code, Ch. I, §300.330 and 210 ILCS 45/1-113, and was subject to the

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requirements of the Act and the regulations of the Illinois Department of Public Health promulgated pursuant to the Act.

7. At all times material herein, Bria-Geneva was the owner, operator, and/or licensee of the skilled nursing and intermediate care facility doing business as Bria Health Services of Geneva.

8. At all times material herein, as the owner, operator and/or licensee, Bria-Geneva exercised control over the day-to-day operations of its facility.

9. At all times material herein, Defendant, Bria-Geneva, employed individuals, including, but not limited to registered nurses, licensed practical nurses, certified nursing assistants, and other medically trained individuals for the purpose of providing care to its residents, including Helen.

10. At all times material herein, Defendant, Bria-Geneva, held itself out to the public as a provider of rehabilitation, skilled nursing, memory care, and long-term care.

11. To induce Helen's admission and continued residency in its facility, Bria-Geneva assured Helen and her family that it would provide high quality health care that met and exceeded all government mandates and directives applicable to a licensed skilled nursing facility.

12. To induce Helen's admission and continued residency in its facility, Bria-Geneva assured Helen and her family that it had in effect and would maintain policies, procedures, protocols, and guidelines regarding the standard precautions to prevent the transmission of viruses and other infectious agents among its residents and staff, including the implementation of hand hygiene, use of personal protective equipment and facemasks, active screening of residents and staff, and the isolation of symptomatic residents.

13. To induce Helen's admission and continued residency in its facility, Bria-Geneva assured Helen and her family that it was committed to providing opportunities for its "team members" to learn, master, and maintain the skills necessary to be excellent as well as empowering its team members to continually improve the outcomes of its care and services.

14. At all times materially relevant hereto, all of Bria-Geneva's agents, representatives, and employees providing care and treatment to Helen were doing so within the scope of their employment and as agents or acting ostensible agents of Defendant, Bria-Geneva.

15. By December 31, 2019, Chinese authorities confirmed to the World Health Organization ("WHO") that they were treating dozens of cases of pneumonia of an unknown cause in the city of Wuhan, China.

16. Chinese state media reported its first known death from the novel coronavirus "COVID-19" on January 11, 2020; Japan, South Korea, and Thailand reported confirmed cases by January 20, 2020; and the United States reported its first case in the State of Washington on January 21, 2020.

17. On January 20, 2020, the WHO announced that human-to-human spread (a/k/a "community spread") of the COVID-19 virus was rampant in the region encompassing Wuhan, China.

18. On or about January 30, 2020, the WHO declared a "public health emergency of international concern."

19. By March 3, 2020, the WHO reported more than 90,000 infections globally and about 3,000 deaths, and by March 11, 2020, the WHO had deemed COVID-19 a global "pandemic."

20. On March 9, 2020, Governor Pritzker declared all counties in the State of Illinois as a disaster area in response to a state-wide outbreak of COVID-19.

21. As COVID-19 infections are particularly lethal to elderly populations, on March 13, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a memorandum providing additional guidance to long-term care facilities, including Bria-Geneva, to help control the spread of COVID-19 based upon the recommendations of the Centers for Disease Control and Prevention ("CDC").

22. In addition to its general recommended measures for infection control and prevention, CMS announced that long-term care facilities were to immediately take additional measures which included: implementing active screening of residents and staff for fever and respiratory symptoms; contacting local or state health department(s) for guidance in the event of an increase in number of respiratory illnesses (regardless of suspected etiology); restricting all visitors, volunteers, and other non-essential health care personnel from entering the facility; canceling all group activities and communal dining; placing alcohol-based hand sanitizer with 60-95 percent alcohol in every resident room- both inside and outside the room if possible- and in every common area; ensuring sinks are well-stocked with soap and paper towels for hand washing; making tissues and facemasks available for people who are coughing; making necessary personal protective equipment ("PPE") available in areas where resident care is provided; and ensuring hospital grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident equipment.

23. Beginning on March 20, 2020 and continuing through April 20, 2020, the Illinois Department of Public Health ("IDPH") issued its "Interim Guidance" which was aimed at helping prevent the transmission of COVID-19 in long-term care facilities, including Geneva Nursing Rehabilitation Center. The additional measures recommended by the IDPH included: the isolation of any resident with signs or symptoms of a respiratory viral infection; ensuring adequate supplies of PPE are easily accessible to residents and staff; continuous screening of residents and staff, including temperature checks and the use of checklists to identify symptomatic individuals; and immediately informing the local health department and IDPH of symptomatic residents to determine if COVID-19 testing is indicated.

24. At all times material herein, including through April 26, 2020, Bria-Geneva chose not to undertake reasonable measures to ensure its employees and staff members complied with the COVID-19 preventative directives of the IDPH, CDC, and CMS.

25. Bria-Geneva's non-compliance with the COVID-19 preventative directives included its failure to ensure adequate supplies of PPE were easily accessible to residents and staff; failure to continuously screen residents and staff, including temperature checks and use of checklists to identify symptomatic patients; failure to enforce social distancing; failure to isolate any resident with signs and symptoms of a respiratory viral infection; and failure to immediately contact the

Kane County Health Department and IDPH of symptomatic residents to determine if COVID-19 testing was indicated.

26. In response to the COVID-19 health crisis, Governor Pritzker issued Executive Order 2020-19 (the "Governor's Directive"), amended by Executed Order 2020-37 on May 13, 2020, extending qualified lawsuit immunity to hospitals and nursing homes that complied with the preventative directives of the IDPH, CDC, and CMS and implemented extraordinary measures to combat the spread of the COVID-19 virus in their facilities, including increasing the number of beds, preserving and properly employing personal protective equipment, conducting widespread testing, and taking necessary steps to provide medical care to patients with COVID-19 and to prevent further transmission of COVID-19.

27. At all times material herein, Bria-Geneva failed to render assistance in support of the State's response to the COVID-19 outbreak, failed to comply with the preventative directives of the IDPH, CDC, and CMS, and failed to take the extraordinary measures set forth in the Governor's Directive.

28. Upon information and belief, despite the fact that numerous residents began exhibiting symptoms of upper respiratory infections in March 2020, Geneva Nursing and Rehabilitation failed to isolate those residents from asymptomatic residents, failed to ensure adequate supplies of PPE were easily accessible to residents and staff, failed to implement continuous screening of residents and staff, including temperature checks and the use of checklists to identify symptomatic individuals, and failed to notify either the Kane County Health Department or the IDPH of symptomatic residents to determine if COVID-19 testing was indicated.

29. Geneva Nursing and Rehabilitation ignored the Interim Guidance of the IDPH and the Governor's Directive leaving its vulnerable residents defenseless against the community spread of the virus.

30. On April 1, 2020, a nurse practitioner of Bria-Geneva emailed a resident's daughter and confirmed that the resident had a cough and a chest x-ray that "showed some mild infiltrates (pneumonia)." Despite these symptoms, the resident was not isolated nor was the resident tested for COVID-19. That resident was confirmed to have died from COVID-19 on May 1, 2020.

31. In another case, the daughter of a resident claims when she visited her mother at the facility on April 23, 2020, she was shocked to see the roof of her mother's mouth covered in sores as well as food and debris caked in her mouth, her mother's eyes sunken, and the appearance that her mother was very dehydrated. When she asked a nurse to provide her mother with water, she was told by the nurse that her mother was not being provided water because she might aspirate into her lungs. Despite her mother's symptoms and the facility's assumption she was COVID-positive, she was not isolated nor was she tested for COVID-19. This resident was confirmed to have died from COVID-19 on April 25, 2020.

32. In a recent interview with numerous local reporters, Dr. Philip Branshaw, who has served as the Medical Director of Bria-Geneva for the past five years, confirmed that until mid-April, 2020, residents exhibiting COVID-19 symptoms were not presumed by the facility to be COVID-positive—triggering rampant community spread of the virus amongst the facility's residents and staff.

33. In the same interview, Dr. Branshaw stated, "Once we got that first (coronavirus) patient, then it was a landslide of patients who started becoming ill. It was pretty obvious we had a severe outbreak in the facility."

34. On April 17, 2020, Bria-Geneva reported its first confirmed COVID-19 case.

35. According to Dr. Branshaw, Bria-Geneva did not procure sufficient COVID-19 testing kits for its residents until April 23, 2020 or April 24, 2020.

36. By April 24, 2020, Bria-Geneva had reported 55 outbreak cases and 1 death among its residents and staff.

37. By May 1, 2020, Bria-Geneva had reported 113 COVID-19 outbreak cases and 16 deaths, representing more than 80% of its residents and staff.

38. On May 8, 2020, Bria-Geneva had reported 114 Covid-19 outbreak cases and 21 deaths among its residents and staff.

39. Upon information and belief, the community spread of the COVID-19 virus infected Helen in late March or early April 2020.

40. From on or around April 15, 2020 through April 26, 2020, Helen's overall health deteriorated rapidly and she was bedridden and unable to eat or toilet on her own. Despite Helen's symptoms and the facility's assumption she was COVID-positive, she was not isolated nor was she tested for COVID-19 prior to her passing.

41. At all relevant times material hereto, Bria-Geneva failed to notify and inform Helen's daughter that her mother was gravely ill due to a COVID-19 infection contracted at the facility.

42. At all relevant times material hereto, Bria-Geneva failed to inform Helen's daughter that the facility had chosen to ignore the Interim Guidelines of the IDPH, CDC, and CMS and had determined instead to facilitate the rapid spread of the COVID-19 amongst its residents and staff.

43. On April 26, 2020, Helen died without the comfort of her family from the complications of a COVID-19 infection which she contracted as a resident of Bria-Geneva.

44. Pursuant to 77 Ill. Admin. Code, Ch. I, §300.3290(b) and 210 ILCS 45/3-601, Bria-Geneva, as the owner and/or licensee, is liable for any intentional or negligent act and/or omission of their actual, implied and/or apparent agents, servants and employees.

45. At all times material herein, Bria-Geneva was obligated to follow the IDPH's minimum standards for facilities. 210 ILCS 45/3-202.

COUNT I

Survival – Violation of the Nursing Home Care Act

46. Plaintiff hereby repeats and re-alleges the Common Allegations as Paragraphs 1-45 of this Count I as though fully set forth herein.

47. At all times material herein, Bria-Geneva, through its actual, implied, or apparent agents, servants, and employees had a statutory duty not to violate the rights of any resident of the facility, including 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.
>
> 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.
>
> 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.

48. At all times material herein, in derogation of its aforementioned duties, Defendant, Geneva Nursing and Rehabilitation, LLC, by and through its actual, implied, or apparent agents, servants, and employees violated the Act and Illinois Administrative Code in one or more of the following ways:

(a) in violation of 77 Ill. Admin. Code §300.1210(a), failed to provide Helen the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the Helen's comprehensive assessment and plan of care;

(b) in violation of 77 Ill. Admin. Code §300.1020(a), failed to comply with the Control of Communicable Diseases Code;

(c) in violation of 77 Ill. Amin. Code §300.1020(b), failed to place its residents suspected of or diagnosed as having any communicable, contagious, or infectious diseases, as defined in the Control of Communicable Code, in isolation, or initiate an involuntary transfer and discharge of those residents if it believed it could not provide the appropriate infection control measures;

(d) in violation of 77 Ill.Admin. Code §300.1210(b)(3), failed to objectively observe, assess, and evaluate changes in Helen's condition as well as the condition of its other residents;

(e) in violation of 77 Ill.Admin. Code §300.1220(b)(3), failed to develop an up-to-date care plan for Helen based upon her comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs;

(f) in violation of 77 Ill.Admin. Code §300.1810(b), failed to maintain an active medical record for Helen;

(g) in violation of 77 Ill.Admin. Code §§300.3210(n) and 300.3210(o), failed to notify Helen's family and physicians of changes in Helen's condition;

(h) in violation of 77 Ill.Admin. Code §300.3240, failed to protect Helen from neglect;

(i) failed to develop, implement, and alter, where necessary, a care plan to meet Helen's needs and to protect her from contracting COVID-19;

(j) failed to implement a care plan which identified Helen as being at high risk for contracting COVID-19;

(k) failed to properly train individuals who provided care and treatment to Helen and its other residents on infection control and prevention;

(l) failed to develop and implement appropriate infection control and prevention policies, procedures, and protocols to prevent an outbreak of COVID-19;

(m) failed to ensure adequate supplies of PPE were easily accessible to residents and staff;

(n) failed to continuously screen residents and staff, including temperature checks and use of checklists to identify symptomatic patients;

(o) failed to enforce social distancing;

(p) failed isolate any resident with signs and symptoms of a respiratory viral infection;

(q) failed to immediately contact the Kane County Health Department and IDPH of symptomatic residents to determine if COVID-19 testing was indicated;

(r) failed to otherwise undertake reasonable measures to ensure its employees and staff members complied with the COVID-19 preventative directives of the IDPH, CDC, and CMS; and

(s) otherwise failed to provide adequate medical care, personal care, maintenance and treatment to Helen.

49. That Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, brings this action pursuant to the Survival Act of the State of Illinois, 755 ILCS 5/17-6.

50. The *Nursing Home Care Act* (the "Act") 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 2 of this Act, are violated. 210 ILCS 45/3-602.

51. The Act further provides:

> The owner and licensee are liable to a resident for any intentional or negligent act or omission of their agents or employees which injures the resident. 210 ILCS 45/3-601.

52. As a direct and proximate result of one or more of Bria-Geneva's aforementioned violations of the Act, Helen sustained severe and debilitating injuries of a personal and pecuniary nature, including, but not limited to, physical and emotional trauma, disability and disfigurement, pain and suffering, and expenses for medical care.

WHEREFORE, Plaintiff, Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, prays that judgment be entered against Defendant, Bria-Geneva, LLC, in an amount in excess of $50,000.00, plus attorney's fees and costs, and for such other and further relief as this court deems equitable and just.

COUNT II
Survival – Negligence

53. Plaintiff hereby repeats and re-alleges the Common Allegations as Paragraphs 1-45 of this Count II as though fully set forth herein.

54. At all times material herein, Bria-Geneva, through its actual, implied, or apparent agents, servants, and employees, had a duty to provide care and treatment to all of its residents, including Helen, that was in accordance with accepted standards of prevailing nursing and medical practice and opinion prevailing in the greater Geneva area in the year 2020, and to exercise that degree of care and caution commonly exercised by other members of their profession in the community.

55. At all times material herein, in derogation of its aforementioned duties, Defendant, Geneva Nursing and Rehabilitation, LLC, by and through its actual, implied, or apparent agents, servants, and employees, was guilty of one or more of the following wrongful acts and/or omissions:

    (a) in violation of 77 Ill. Admin. Code §300.1210(a), failed to provide Helen the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the Helen's comprehensive assessment and plan of care;

    (b) in violation of 77 Ill. Admin. Code §300.1020(a), failed to comply with the Control of Communicable Diseases Code;

(c) in violation of 77 Ill. Amin. Code §300.1020(b), failed to place its residents suspected of or diagnosed as having any communicable, contagious, or infectious diseases, as defined in the Control of Communicable Code, in isolation, or initiate an involuntary transfer and discharge of those residents if it believed it could not provide the appropriate infection control measures;

(d) in violation of 77 Ill.Admin. Code §300.1210(b)(3), failed to objectively observe, assess, and evaluate changes in Helen's condition as well as the condition of its other residents;

(e) in violation of 77 Ill.Admin. Code §300.1220(b)(3), failed to develop an up-to-date care plan for Helen based upon her comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs;

(f) in violation of 77 Ill.Admin. Code §300.1810(b), failed to maintain an active medical record for Helen;

(g) in violation of 77 Ill.Admin. Code §§300.3210(n) and 300.3210(o), failed to notify Helen's family and physicians of changes in Helen's condition;

(h) in violation of 77 Ill.Admin. Code §300.3240, failed to protect Helen from neglect;

(i) failed to develop, implement, and alter, where necessary, a care plan to meet Helen's needs and to protect her from contracting COVID-19;

(j) failed to implement a care plan which identified Helen as being at high risk for contracting COVID-19;

(k) failed to properly train individuals who provided care and treatment to Helen and its other residents on infection control and prevention;

(l) failed to develop and implement appropriate infection control and prevention policies, procedures, and protocols to prevent an outbreak of COVID-19;

(m) failed to ensure adequate supplies of PPE were easily accessible to residents and staff;

(n) failed to continuously screen residents and staff, including temperature checks and use of checklists to identify symptomatic patients;

(o) failed to enforce social distancing;

(p) failed isolate any resident with signs and symptoms of a respiratory viral infection;

(q) failed to immediately contact the Kane County Health Department and IDPH of symptomatic residents to determine if COVID-19 testing was indicated;

(r) failed to otherwise undertake reasonable measures to ensure its employees and staff members complied with the COVID-19 preventative directives of the IDPH, CDC, and CMS; and

(s) otherwise failed to provide adequate medical care, personal care, maintenance and treatment to Helen.

56. That Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, brings this action pursuant to the Survival Act of the State of Illinois, 755 ILCS 5/17-6.

57. As a direct and proximate result of one or more of Bria-Geneva's aforementioned negligent acts and/or omissions, Helen sustained severe and debilitating injuries of a personal and pecuniary nature, including, but not limited to, physical and emotional trauma, disability and disfigurement, pain and suffering, and expenses for medical care.

WHEREFORE, Plaintiff, Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, prays that judgment be entered against Defendant, Bria-Geneva, LLC, in an amount in excess of $50,000.00, plus costs, and for such other and further relief as this court deems equitable and just.

COUNT III
Survival – Willful and Wanton

58. Plaintiff hereby repeats and re-alleges the Common Allegations as Paragraphs 1-45 of this Count III as though fully set forth herein.

59. At all times material herein, Bria-Geneva, through its actual, implied, or apparent agents, servants, and employees, had a duty to provide care and treatment to all of its residents, including Helen, that was free from willful and wanton misconduct and that was otherwise in accordance with accepted standards of prevailing nursing and medical practice and opinion prevailing in the greater Geneva area in the year 2020, and to exercise that degree of care and caution commonly exercised by other members of their profession in the community.

60. At all times material herein, in derogation of its aforementioned duties, Defendant, Geneva Nursing and Rehabilitation, LLC, by and through its actual, implied, or apparent agents, servants, and employees, with an utter indifference to or conscious disregard for the safety of Helen and its other residents, was guilty of willful and wanton misconduct in one or more of the following ways:

(a) in violation of 77 Ill. Admin. Code §300.1210(a), failed to provide Helen the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the Helen's comprehensive assessment and plan of care;

(b) in violation of 77 Ill. Admin. Code §300.1020(a), failed to comply with the Control of Communicable Diseases Code;

(c) in violation of 77 Ill. Amin. Code §300.1020(b), failed to place its residents suspected of or diagnosed as having any communicable, contagious, or infectious diseases, as defined in the Control of Communicable Code, in isolation, or initiate an involuntary transfer and discharge of those residents if it believed it could not provide the appropriate infection control measures;

(d) in violation of 77 Ill.Admin. Code §300.1210(b)(3), failed to objectively observe, assess, and evaluate changes in Helen's condition as well as the condition of its other residents;

(e) in violation of 77 Ill.Admin. Code §300.1220(b)(3), failed to develop an up-to-date care plan for Helen based upon her comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs;

(f) in violation of 77 Ill.Admin. Code §300.1810(b), failed to maintain an active medical record for Helen;

(g) in violation of 77 Ill.Admin. Code §§300.3210(n) and 300.3210(o), failed to notify Helen's family and physicians of changes in Helen's condition;

(h) in violation of 77 Ill.Admin. Code §300.3240, failed to protect Helen from neglect;

(i) failed to develop, implement, and alter, where necessary, a care plan to meet Helen's needs and to protect her from contracting COVID-19;

(j) failed to implement a care plan which identified Helen as being at high risk for contracting COVID-19;

(k) failed to properly train individuals who provided care and treatment to Helen and its other residents on infection control and prevention;

(l) failed to develop and implement appropriate infection control and prevention policies, procedures, and protocols to prevent an outbreak of COVID-19;

(m) failed to ensure adequate supplies of PPE were easily accessible to residents and staff;

(n) failed to continuously screen residents and staff, including temperature checks and use of checklists to identify symptomatic patients;

(o) failed to enforce social distancing;

(p) failed isolate any resident with signs and symptoms of a respiratory viral infection;

(q) failed to immediately contact the Kane County Health Department and IDPH of symptomatic residents to determine if COVID-19 testing was indicated;

(r) failed to otherwise undertake reasonable measures to ensure its employees and staff members complied with the COVID-19 preventative directives of the IDPH, CDC, and CMS; and

(s) otherwise failed to provide adequate medical care, personal care, maintenance and treatment to Helen.

61. That Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, brings this action pursuant to the Survival Act of the State of Illinois, 755 ILCS 5/17-6.

62. As a direct and proximate result of one or more of Bria-Geneva's aforementioned willful and wanton acts of misconduct, Helen sustained severe and debilitating injuries of a personal and pecuniary nature, including, but not limited to, physical and emotional trauma, disability and disfigurement, pain and suffering, and expenses for medical care.

WHEREFORE, Plaintiff, Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, prays that judgment be entered against Defendant, Bria-Geneva, LLC, in an amount in excess of $50,000.00, plus costs, and for such other and further relief as this court deems equitable and just.

COUNT IV
Wrongful Death – Willful and Wanton

63. Plaintiff hereby repeats and re-alleges the Common Allegations as Paragraphs 1-45 of this Count IV as though fully set forth herein.

64. At all times material herein, Bria-Geneva, through its actual, implied, or apparent agents, servants, and employees, had a duty to provide care and treatment to all of its residents, including Helen, that was in accordance with accepted standards of prevailing nursing and medical practice and opinion prevailing in the greater Geneva area in the year 2020, and to exercise that degree of care and caution commonly exercised by other members of their profession in the community.

65. At all times material herein, in derogation of its aforementioned duties, Defendant, Geneva Nursing and Rehabilitation, LLC, by and through its actual, implied, or apparent agents, servants, and employees, was guilty of one or more of the following wrongful acts and/or omissions:

(a) in violation of 77 Ill. Admin. Code §300.1210(a), failed to provide Helen the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the Helen's comprehensive assessment and plan of care;

(b) in violation of 77 Ill. Admin. Code §300.1020(a), failed to comply with the Control of Communicable Diseases Code;

(c) in violation of 77 Ill. Amin. Code §300.1020(b), failed to place its residents suspected of or diagnosed as having any communicable, contagious, or infectious diseases, as defined in the Control of Communicable Code, in isolation, or initiate an involuntary transfer and

discharge of those residents if it believed it could not provide the appropriate infection control measures;

(d) in violation of 77 Ill.Admin. Code §300.1210(b)(3), failed to objectively observe, assess, and evaluate changes in Helen's condition as well as the condition of its other residents;

(e) in violation of 77 Ill.Admin. Code §300.1220(b)(3), failed to develop an up-to-date care plan for Helen based upon her comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs;

(f) in violation of 77 Ill.Admin. Code §300.1810(b), failed to maintain an active medical record for Helen;

(g) in violation of 77 Ill.Admin. Code §§300.3210(n) and 300.3210(o), failed to notify Helen's family and physicians of changes in Helen's condition;

(h) in violation of 77 Ill.Admin. Code §300.3240, failed to protect Helen from neglect;

(i) failed to develop, implement, and alter, where necessary, a care plan to meet Helen's needs and to protect her from contracting COVID-19;

(j) failed to implement a care plan which identified Helen as being at high risk for contracting COVID-19;

(k) failed to properly train individuals who provided care and treatment to Helen and its other residents on infection control and prevention;

(l) failed to develop and implement appropriate infection control and prevention policies, procedures, and protocols to prevent an outbreak of COVID-19;

(m) failed to ensure adequate supplies of PPE were easily accessible to residents and staff;

(n) failed to continuously screen residents and staff, including temperature checks and use of checklists to identify symptomatic patients;

(o) failed to enforce social distancing;

(p) failed isolate any resident with signs and symptoms of a respiratory viral infection;

(q) failed to immediately contact the Kane County Health Department and IDPH of symptomatic residents to determine if COVID-19 testing was indicated;

(r) failed to otherwise undertake reasonable measures to ensure its employees and staff members complied with the COVID-19 preventative directives of the IDPH, CDC, and CMS; and

(s) otherwise failed to provide adequate medical care, personal care, maintenance, and treatment to Helen.

66. That Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, brings this action pursuant to the pursuant to the Wrongful Death Act of the State of Illinois, 740 ILCS 180/2.1.

67. As a direct and proximate result of one or more of Bria-Geneva's aforementioned negligent acts and/or omissions, Helen sustained severe and debilitating injuries which led to her death on April 26, 2020.

68. Pamela Colwell has sustained substantial pecuniary losses as a result of Helen's death, including the loss of his society, services, companionship, love, and affection.

WHEREFORE, Plaintiff, Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, prays that judgment be entered against Defendant, Bria-Geneva, LLC, in an amount in excess of $50,000.00, plus costs, and for such other and further relief as this court deems equitable and just.
just.

COUNT V
Wrongful Death – Willful and Wanton

69. Plaintiff hereby repeats and re-alleges the Common Allegations as Paragraphs 1-45 of this Count V as though fully set forth herein.

70. At all times material herein, Bria-Geneva, through its actual, implied, or apparent agents, servants, and employees, had a duty to provide care and treatment to all of its residents, including Helen, that was free from willful and wanton misconduct and that was otherwise in accordance with accepted standards of prevailing nursing and medical practice and opinion prevailing in the greater Geneva area in the year 2020, and to exercise that degree of care and caution commonly exercised by other members of their profession in the community.

71. At all times material herein, in derogation of its aforementioned duties, Defendant, Geneva Nursing and Rehabilitation, LLC, by and through its actual, implied, or apparent agents, servants, and employees, with an utter indifference to or conscious disregard for the safety of Helen and its other residents, was guilty of willful and wanton misconduct in one or more of the following ways:

(a) in violation of 77 Ill. Admin. Code §300.1210(a), failed to provide Helen the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the Helen's comprehensive assessment and plan of care;

(b) in violation of 77 Ill. Admin. Code §300.1020(a), failed to comply with the Control of Communicable Diseases Code;

(c) in violation of 77 Ill. Amin. Code §300.1020(b), failed to place its residents suspected of or diagnosed as having any communicable, contagious, or infectious diseases, as defined in the Control of Communicable Code, in isolation, or initiate an involuntary transfer and discharge of those residents if it believed it could not provide the appropriate infection control measures;

(d) in violation of 77 Ill.Admin. Code §300.1210(b)(3), failed to objectively observe, assess, and evaluate changes in Helen's condition as well as the condition of its other residents;

(e) in violation of 77 Ill.Admin. Code §300.1220(b)(3), failed to develop an up-to-date care plan for Helen based upon her comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs;

(f) in violation of 77 Ill.Admin. Code §300.1810(b), failed to maintain an active medical record for Helen;

(g) in violation of 77 Ill.Admin. Code §§300.3210(n) and 300.3210(o), failed to notify Helen's family and physicians of changes in Helen's condition;

(h) in violation of 77 Ill.Admin. Code §300.3240, failed to protect Helen from neglect;

(i) failed to develop, implement, and alter, where necessary, a care plan to meet Helen's needs and to protect her from contracting COVID-19;

(j) failed to implement a care plan which identified Helen as being at high risk for contracting COVID-19;

(k) failed to properly train individuals who provided care and treatment to Helen and its other residents on infection control and prevention;

(l) failed to develop and implement appropriate infection control and prevention policies, procedures, and protocols to prevent an outbreak of COVID-19;

(m) failed to ensure adequate supplies of PPE were easily accessible to residents and staff;

(n) failed to continuously screen residents and staff, including temperature checks and use of checklists to identify symptomatic patients;

(o) failed to enforce social distancing;

(p) failed isolate any resident with signs and symptoms of a respiratory viral infection;

(q) failed to immediately contact the Kane County Health Department and IDPH of symptomatic residents to determine if COVID-19 testing was indicated;

(r) failed to otherwise undertake reasonable measures to ensure its employees and staff members complied with the COVID-19 preventative directives of the IDPH, CDC, and CMS; and

(s) otherwise failed to provide adequate medical care, personal care, maintenance, and treatment to Helen.

72. That Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, brings this action pursuant to the pursuant to the Wrongful Death Act of the State of Illinois, 740 ILCS 180/2.1.

73. As a direct and proximate result of one or more of Bria-Geneva's aforementioned willful and wanton acts of misconduct, Helen sustained severe and debilitating injuries which led to her death on April 26, 2020.

74. Pamela Colwell has sustained substantial pecuniary losses as a result of Helen's death, including the loss of his society, services, companionship, love, and affection.

WHEREFORE, Plaintiff, Pamela Colwell, as Administrator of the Estate of Helen A. Osucha, deceased, prays that judgment be entered against Defendant, Bria-Geneva, LLC, in an amount in excess of $50,000.00, plus costs, and for such other and further relief as this court deems equitable and just. just.

PLAINTIFF HEREBY DEMANDS TRIAL BY A JURY OF TWELVE.

PAMELA COLWELL, AS ADMINISTRATOR OF THE ESTATE OF HELEN A. OSUCHA, DECEASED

MEYERS & FLOWERS, LLC

One of Its Attorneys

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NOTICE
BY ORDER OF THE COURT THIS CASE IS HEREBY SET FOR CASE MANAGEMENT CONFERENCE ON THE DATE BELOW. FAILURE TO APPEAR MAY RESULT IN THE CASE BEING DISMISSED OR AN ORDER OF DEFAULT BEING ENTERED.
Judge: Busch, Kevin T
8/3/2020 9:00 AM