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IN THE CIRCUIT COURT
FOR THE TWENTIETH JUDICIAL CIRCUIT
ST. CLAIR COUNTY, ILLINOIS

PATRICIA PENROD, as Administrator to Collect for the Estate of JOHN D. PENROD, Deceased,	)	
Plaintiff,	)	No. 19L0504
v.	)	
BELLEVILLE HEALTHCARE & REHABILITATION CENTER, INC., d/b/a BRIA HEALTH SERVICES OF BELLEVILLE; WEISS MANAGEMENT GROUP, INC.; BRIA HEALTH SERVICES, L.L.C.; SUZANNE R. SCHNARRE, R.N.; and AMANDA R. SCHOTT, L.P.N.,	)	
Defendants.	)	

COMPLAINT AT LAW

Plaintiff, Patricia Penrod, as Independent Administrator of the Estate of John D. Penrod, deceased, through her attorneys, Kralovec, Jambois & Schwartz, states the following in complaint of the defendants, Belleville Healthcare & Rehabilitation Center, Inc., d/b/a Bria Health Services of Belleville, Weiss Management Group, Inc., Bria Health Services, L.L.C., Suzanne R. Schnarre, R.N., and Amanda R. Schott, L.P.N.:

General Allegations

1. John D. Penrod was a resident of the long-term care facility known as Belleville Healthcare & Rehabilitation Center, Inc., d/b/a Bria Health Services of Belleville ("Bria") from on or about June 30, 2017 to July 15, 2018, with many hospitalizations during this time period.

2. Belleville Healthcare & Rehabilitation Center, Inc., d/b/a Bria Health Services of Belleville is an Illinois corporation licensed to do business in the State of Illinois.

3. During all times relevant to this Complaint, Belleville Healthcare & Rehabilitation Center, Inc., d/b/a Bria Health Services of Belleville was the licensee and/or owner of Bria.

4. During all times relevant to this Complaint, Belleville Healthcare & Rehabilitation Center, Inc., d/b/a Bria Health Services of Belleville, owned, operated, managed, maintained and/or controlled Bria.

5. Weiss Management Group, Inc., is a corporation licensed to do business in the State of Illinois.

6. During all times relevant to this Complaint, Weiss Management Group, Inc., was the management company of Bria.

7. During all times relevant to this Complaint, Weiss Management Group, Inc., operated, managed, maintained and/or controlled Bria.

8. Bria Health Services, L.L.C., is a corporation licensed to do business in the State of Illinois.

9. During all times relevant to this Complaint, Bria Health Services, L.L.C., was the management company of Bria.

10. During all times relevant to this Complaint, Bria Health Services, L.L.C., operated, managed, maintained and/or controlled Bria.

11. During all times relevant to this Complaint, Suzanne R. Schnarre, R.N., was a registered nurse licensed by the State of Illinois.

12. During all times relevant to this Complaint, Suzanne R. Schnarre, R.N., was employed as a registered nurse by the defendant, Bria, and at all times acted within the scope of her agency, service, and/or employment.

13. During all times relevant to this Complaint, Amanda R. Schott, L.P.N., was a licensed practical nurse, licensed by the State of Illinois.

14. During all times relevant to this Complaint, Amanda R. Schott, L.P.N., was employed as a licensed practical nurse by the defendant, Bria, and at all times acted within the scope of her agency, service, and/or employment.

15. Bria located in St. Clair County, Illinois and the causes of action set forth in this Complaint arose in St. Clair County, making venue proper pursuant to §5/2-101(2) of the Illinois Code of Civil Procedure.

16. During all times relevant to this Complaint, John D. Penrod was not decisional secondary to his significant dementia.

17. On June 30, 2017, John D. Penrod began his residency at Bria.

18. On admission to Bria, John D. Penrod to be confused, primarily bed and wheelchair bound and requiring extensive staff assistance with all ADLs. His admission weight was 150 lbs.

19. On July 12, 2017, the nursing staff prepared a care plan for functional joint mobility of his extremities, however no interventions were provided to identify and prevent contractures.

20. On August 11, 2017, the nursing staff first documented that John D. Penrod was not eating or drinking.

21. On August 11, 2017, John D. Penrod was treated in the ED at Memorial Hospital of Belleville where it was reported that John D. Penrod had urinary retention for three days.

22. John D. Penrod was transferred back to Bria with an order to follow up with Urology, and the nursing staff failed to notify the physician of his need for follow up with Urology.

23. On August 21, 2017, a urine culture returned positive for a UTI.

24. The nursing staff at Bria waited until August 24, 2017 to obtain orders for antibiotics to treat the UTI.

25. On August 25, 2017, the physician ordered a foley catheter change every two weeks.

26. On August 31, 2017, a urine culture was positive for Proteus mirabilis, and his antibiotics were changed.

27. On September 5, 2017, John D. Penrod was transferred to Memorial Hospital of Belleville for a scheduled removal of his left ureteral stent. Upon transfer to the floor, the staff documented that he had skin breakdown to his buttock and scabbed areas to his right lateral foot, 3rd toe and left shin.

28. On September 9, 2017, John D. Penrod was transferred back to Bria with a documented high risk for skin breakdown.

29. Despite this high risk for skin breakdown and actual open areas, the nursing staff failed to implement interventions such as a low air loss mattress, wheelchair cushion, and a turning and repositioning schedule.

30. Further upon his readmission, the nursing staff failed to obtain orders regarding his foley catheter care in order to prevent the development of UTIs.

31. On September 14, 2017, John D. Penrod weighed 136.7 lbs.

32. On September 27, 2017, John D. Penrod had a DTI to his right buttock with 25% slough.

33. On October 3, 2017, the right buttock wound was documented as a Stage III wound with 100% slough.

34. On October 11, 2017, John D. Penrod sustained a fall to the floor with a small skin tear to his left knee. He was evaluated in the ED at Memorial Hospital of Belleville.

35. On October 17, 2017, John D. Penrod was found kneeling on the mat next to his bed with no apparent injuries. No fall prevention interventions were initiated and the physician and family were not notified.

36. On October 25, 2017, John D. Penrod was found on the floor with a large lump to his head.

37. At Memorial Hospital of Belleville, the CT of the head and c-spine were negative for acute findings, but he was diagnosed with a UTI and treated for head trauma, a left frontal scalp hematoma and the UTI.

38. On October 27, 2017, Dr. Mohsin ordered Megace to improve his appetite. However, the nursing staff never started him on the appetite stimulant.

39. On November 13, 2017, John D. Penrod developed a new wound to the right hip.

40. On November 15, 2017, John D. Penrod was transferred to Memorial Hospital of Belleville for not eating or drinking.

41. At Memorial Hospital of Belleville, John D. Penrod was admitted with a UTI and sepsis.

42. On November 16, 2017, John D. Penrod developed a new wound to the right lateral foot.

43. On November 21, 2017, John D. Penrod returned to Bria.

44. On November 27, 2017, John D. Penrod weighed 129 lbs. The physician was not notified and a calorie count was not ordered.

45. On November 28, 2017, John D. Penrod had amber colored urine, low grade temperature and decline.

46. The EMS staff documented that the staff told them that John D. Penrod had not eaten or drank for the past couple of days, and his heart rate was 126.

47. At Memorial Hospital of Belleville, John D. Penrod was treated for dehydration, UTI, acute cystitis and rhabdomyolysis.

48. On November 30, 2017, a G tube was placed for nutrition, as John D. Penrod was 119.6 lbs.

49. On December 6, 2017, John D. Penrod returned to Bria with a G tube and foley catheter. No orders were obtained for catheter care.

50. On December 19, 2017, the right hip pressure ulcer was 3.5 cm x 2 cm and 100% necrotic. A new pressure ulcer to the sacrum measured 4 cm x 6 cm.

51. On December 22, 2017, the nurses documented post fall charting although the original fall was not documented.

52. On December 26, 2017, the wound nurse documented a moderate amount of purulent drainage from the right hip wound and the nurse did not notify the physician or obtain an order for a wound culture.

53. On January 8, 2018, the wound nurse, Suzanne R. Schnarre, R.N., documented a moderate amount of purulent drainage from the right hip wound but did not notify the physician of this significant finding.

54. On January 10, 2018, a wound culture was taken which revealed heavy growth of multiple organisms.

55. On January 16, 2018, John D. Penrod was transferred to Memorial Hospital of Belleville for osteomyelitis of the right hip and a UTI. His right hip pressure ulcer measured 5.4 cm x 3.7 cm x .5 cm with tunneling.

56. On January 22, 2018, a PICC line was placed for long term IV antibiotics.

57. On March 12, 2018, a urine culture was positive for growth. The nurses did not fax these results to the physician until March 14, 2018 and did not obtain orders for treatment until March 16, 2018.

58. On March 19, 2018, John D. Penrod developed a new Stage III pressure ulcer to the left buttock which measured 3 cm x 3 cm.

59. On March 28, 2018, John D. Penrod was on follow-up monitoring post fall, although the actual fall was never documented in the record.

60. On April 5, 2018, John D. Penrod developed a new Stage II pressure ulcer to the left hip which measured 10 cm x 8 cm.

61. On April 5, 2018, John D. Penrod was transferred to Memorial Hospital of Belleville for treatment of his wound.

62. On April 8, 2018, his stool sample was positive for C. diff, and his wound culture was positive for MRSA.

63. On April 10, 2018, John D. Penrod returned to Bria with orders to change his foley catheter every two weeks. However, the nursing staff failed to change his foley catheter every two weeks to prevent UTIs.

64. On May 3, 2018, the physician ordered that John D. Penrod be turned and repositioned every hour. However, there was no evidence in the nursing documentation that this was order was carried out.

65. On May 4, 2018, the nursing staff documented the presence of malodorous drainage from the right hip wound but failed to obtain an order for a wound culture.

66. On May 19, 2018, the nursing staff documented that John D. Penrod had a large stool with blood and a temperature of 101.7.

67. On May 19, 2018, John D. Penrod was transferred to Memorial Hospital of Belleville with a UTI and mild hydroneprhosis. He underwent a cystoscopy and a left ureteral stent was placed.

68. On May 22, 2018, his stool sample was positive for C. diff and his wound culture was positive for growth.

69. On May 30, 2018, John D. Penrod returned to Bria where his wounds continued to deteriorate.

70. On June 20, 2018, John D. Penrod had a temperature of 104.1, and he also was contracted. He was transferred to the hospital.

71. On June 20, 2018, John D. Penrod was a patient at Memorial Hospital Belleville where he was admitted for UTI and sepsis. His stool sample was also positive for C diff. Wound cultures of the right hip and right lateral foot were positive for growth.

72. On June 29, 2018, John D. Penrod returned to Bria with orders for antibiotics which were not administered until July 4, 2018 at 6 am. Amanda R. Schott, L.P.N., was one of the nurses who missed a Vancomycin dose on July 3, 2018.

73. The on July 4, 2018 at 7:16 am, the nurse on duty, Amanda R. Schott, L.PN., documented that the CNA reported two episodes of vomiting. Nurse Schott also documented that he was very talkative and was able to follow commands, although John D. Penrod was non-verbal. Nurse Schott did not notify the physician of this significant change in condition.

74. On July 4, 2018 at 12:01 pm, the nursing staff documented that he was diaphoretic, restless and vomited three more times. The nurse notified the physician of this significant change in condition.

75. On July 4, 2018, John D. Penrod was transferred to the hospital where he was admitted for sepsis possibly due to the infected right hip wound, C. diff colitis and/or UTI. Upon arrival, his right hip wound was actively oozing pus.

76. On July 10, 2018, the family opted for hospice care.

77. On July 10, 2018, John D. Penrod was transferred back to Bria in hospice care.

78. On July 15, 2018, John D. Penrod died at Bria in hospice care.

79. The Circuit Court of St. Clair County, Illinois, entered an order appointing Patricia Penrod, as Administrator to Collect for the Estate of John D. Penrod, deceased, evidencing her right and standing to sue.

80. The Attorney Affidavit and Physician Report pursuant to 735 ILCS 6/2-622 is attached as Exhibit A and is incorporated by reference.

Count I – Belleville Healthcare & Rehabilitation Center, Inc.,
d/b/a Bria Health Services of Belleville
(Nursing Home Care Act)

81. Plaintiff incorporates all General Allegations by reference as if pleaded herein in full in Count I.

82. During 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.*

83. During all times relevant to this Complaint, Bria was a "facility" as defined by 45/1-113 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.

84. During all times relevant to this complaint, Defendant Bria was the licensee, owner and/or operator of this facility.

85. During all times relevant to this Complaint, Defendant Bria, by and through its owners, officers, agent, servants and/or employees, whether actual or apparent, was under a

statutory obligation not to violate the rights of any resident of Bria including the obligations not to abuse or neglect any resident.

86. During all times relevant to this Complaint, Bria, by and through its agents, servants and/or employees, whether actual or apparent, during the course of the residency of John D. Penrod at Bria, violated the provisions of the Act as follows:

a. Failure to ensure the health and safety of John D. Penrod at the nursing facility, in violation of 210 ILCS 45/2-101;

b. Failure to provide and revise/update the care plan for fall risk and interventions to prevent falls in violation of 77 Ill. Admin. Code §300.1210(b), 77 Ill. Admin. Code §300.1210(d)(6), and 210 ILCS 45/2-104;

c. Failure to follow physician orders in violation of 77 Ill. Admin. Code §300.1210(d)(2), and 210 ILCS 45/2-104;

d. Failure to perform skin assessments every shift and institute interventions to promote healing in violation of 77 Ill. Admin. Code §300.1210(b)(c), 77 Ill. Admin. Code §300.1210(d)(5), and 210 ILCS 45/2-104;

e. Failure to offload the wound and provide a turning and repositioning schedule in violation of 77 Ill.Admin Code §300.1210(b)(c), 77 Ill. Admin. Code §300.1210(d)(5), and 210 ILCS 45/2-104;

f. Failure to provide wound care treatments as per physician orders in violation of 77 Ill.Admin Code §300.1210(b), 77 Ill. Admin. Code §300.1210(d)(2) & (5), and 210 ILCS 45/2-104;

g. Failure to prevent and treat urinary tract infections in violation of 77 Ill.Admin Code §300.1210(b)(3), 77 Ill. Admin. Code §300.1210(d)(3), and 210 ILCS 45/2-104;

h. Failure to recognize a significant change in condition and timely notify the physician in violation of 77 Ill. Admin. Code §300.1210(d)(3) and 210 ILCS 45/2-104;

i. Failure to timely transfer resident to an acute care facility in violation of 77 Ill. Admin. Code §300.1210(d)(3) and 210 ILCS 45/2-104;

j. Failure to provide interventions to prevent weight loss, to ensure nutritional support and hydration in violation of 77 Ill.Admin Code §300.1210(b), 77 Ill. Admin. Code §300.1210(d)(3), and 210 ILCS 45/2-104;

k. Failure to provide a comprehensive resident care plan to prevent contractures and provide PROM and AROM in violation of 77 Ill.Admin Code §300.1210(a), 77 Ill. Admin. Code §300.1210(d), and 210 ILCS 45/2-104; and

l. Failure to timely observe, monitor, assess, evaluate, document and treat changes in the resident's condition and status in violation of 77 Ill. Admin. Code §300.1210(b); 77 Ill. Admin. Code §300.1210(d)(3), and 210 ILCS 45/2-104.

87. As a direct and proximate result of one or more of the foregoing careless and negligent acts and/or omissions on the part of this defendant, by any through its agents, servants, and/or employees, whether actual or apparent, the resident received care and treatment below the standard of care, constituting negligence, and as a result of receiving negligent treatment over a prolonged period of time, the resident sustained serious and permanent injuries; suffered from disability and disfigurement; experienced great pain and physical suffering until his death.

88. The Act, as amended, provides that "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 this Act, are violated." 210 ILCS 45/3-602.

89. The Act, as amended, provides that "the owner and licensee are liable to a resident for any intentional or negligent act or omission of their agency or employees, which injures the resident." 210 ILCS 45/3-601.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Count II – Belleville Healthcare & Rehabilitation Center, Inc.,
d/b/a Bria Health Services of Belleville
(Wrongful Death Act)

90. Plaintiff incorporates all General Allegations by reference as if pleaded here in full in Count II.

91. During all times relevant to this Complaint, any and all nurses and certified nursing assistants providing care and treatment to John D. Penrod were agents, servants and/or employees, whether actual or apparent, of this defendant and at all times relevant hereto, acted within the scope of that agency, service and/or employment.

92. During all times relevant to this Complaint, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, had a duty to possess and apply the skill and knowledge of a reasonably well-qualified healthcare staff and to treat John D. Penrod in a manner which equaled or exceeded the applicable standard of care.

93. Disregarding its duty, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, was then and there guilty of one of more of the following careless and negligent acts and/or omissions:

a. Failure to ensure the health and safety of John D. Penrod while he was a resident at the facility;

b. Failure to provide and revise/update the care plan for fall risk and interventions to prevent falls;

c. Failure to perform skin assessments every shift and institute interventions to promote healing;

d. Failure to offload the wounds and provide a turning and repositioning schedule;

e. Failure to provide wound care treatments as per physician orders;

f. Failure to prevent and treat urinary tract infections;

g. Failure to recognize and timely notify the physician of a significant change in condition;

h. Failure to timely transfer resident to an acute care facility;

i. Failure to timely observe, monitor, assess, evaluate, document, and treat changes in resident's condition and status;

j. Failure to provide interventions to prevent weight loss, to ensure nutritional support and hydration;

k. Failure to recognize and appropriately treat contractures and provide PROM and AROM to prevent contractures;

l. Failure to follow physician's orders; and

m. Failure to timely observe, monitor, assess, evaluate, document and treat changes in the resident's condition and status.

94. As a direct and proximate result of one or more of the foregoing careless and negligent acts and/or omissions on the part of this defendant, the resident sustained injuries that caused or contributed to his death on July 15, 2018.

95. Plaintiff brings this action pursuant to 740 ILCS 180/1, *et seq.*, commonly known as the Wrongful Death Act.

96. Decedent left surviving the following next-of-kin, Hae Suk Kim, his wife, Patricia Penrod, his adult daughter, and John Kim Penrod, his adult son, who suffered injuries as a result of the decedent's death, including loss of companionship and loss of society.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Count III – Belleville Healthcare & Rehabilitation Center, Inc.,
d/b/a Bria Health Services of Belleville
(Survival Act)

97. Plaintiff incorporates all General Allegations by reference as if pleaded here in full in Count III.

98. During all times relevant to this Complaint, any and all nurses and certified nursing assistants providing care and treatment to John D. Penrod were agents, servants and/or employees, whether actual or apparent, of this defendant and at all times relevant hereto, acted within the scope of that agency, service and/or employment.

99. During all times relevant to this Complaint, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, had a duty to possess and apply the skill and knowledge of a reasonably well-qualified healthcare staff and to treat John D. Penrod in a manner which equaled or exceeded the applicable standard of care.

100. Disregarding its duty, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, was then and there guilty of one of more of the following careless and negligent acts and/or omissions:

a. Failure to ensure the health and safety of John D. Penrod while he was a resident at the facility;

b. Failure to provide and revise/update the care plan for fall risk and interventions to prevent falls;

c. Failure to perform skin assessments every shift and institute interventions to promote healing;

d. Failure to offload the wounds and provide a turning and repositioning schedule;

e. Failure to provide wound care treatments as per physician orders;

f. Failure to prevent and treat urinary tract infections;

g. Failure to recognize and timely notify the physician of a significant change in condition;

h. Failure to timely transfer resident to an acute care facility;

i. Failure to timely observe, monitor, assess, evaluate, document, and treat changes in resident's condition and status;

j. Failure to provide interventions to prevent weight loss, to ensure nutritional support and hydration;

k. Failure to recognize and appropriately treat contractures and provide PROM and AROM to prevent contractures;

l. Failure to follow physician's orders; and

m. Failure to timely observe, monitor, assess, evaluate, document and treat changes in the resident's condition and status.

101. As a direct and proximate result of one or more of the foregoing careless and negligent acts and/or omissions on the part of this defendant, the decedent was injured and suffered damages of a personal and pecuniary nature, including pain and suffering, damages for which, had he survived, he would have been entitled to maintain an action; and such an action has survived him and accrued to the benefit of his heirs at law: Hae Suk Kim, his wife, Patricia Penrod, his adult daughter, and John Kim Penrod, his adult son.

102. Plaintiff brings this action in Count III under 755 ILCS 5/27-6, commonly known as the Survival Act of Illinois.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Count IV – Weiss Management Group, Inc.
(Wrongful Death)

103. Plaintiff incorporates all General Allegations by reference as if pleaded herein in full in Count IV.

104. During all times relevant to this Complaint, Weiss Management Group, Inc., was the management company for Bria.

105. During all times relevant to this Complaint, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, had a duty to possess and apply the skill and knowledge of a reasonably well-qualified nursing home management company and to treat John D. Penrod.

106. Disregarding its duty, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, was then and there guilty of one or more of the following careless and negligent acts and/or omissions:

a. Failure to ensure that the nursing facility was adequately staffed with qualified and licensed medical professionals to provide adequate care for the resident;

b. Failure to appropriately hire adequately trained staff;

c. Failure to ensure that the facility has sufficient nursing staff to provide nursing and related services to maintain the highest practicable physical, mental and psychosocial well-being of each resident; and

d. Failure to ensure the policies and procedures of the facility regarding resident care plans were implemented by the nursing staff.

107. As a direct and proximate result of one or more of the foregoing careless and negligent acts and/or omissions on the part of this defendant, the resident sustained injuries that caused or contributed to his death on July 15, 2018.

108. Plaintiff brings this action pursuant to 740 ILCS 180/1, *et seq.*, commonly known as the Wrongful Death Act.

109. Decedent left surviving the following next-of-kin, Hae Suk Kim, his wife, Patricia Penrod, his adult daughter, and John Kim Penrod, his adult son, who suffered injuries as a result of the decedent's death, including loss of companionship and loss of society.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Count V – Weiss Management Group, Inc.
(Survival Act)

110. Plaintiff incorporates all General Allegations by reference as if pleaded here in full in Count V.

111. During all times relevant to this Complaint, Weiss Management Group, Inc., was the management company for Bria.

112. During all times relevant to this Complaint, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, had a duty to possess and apply the skill and knowledge of a reasonably well-qualified nursing home management company and to treat John D. Penrod.

113. Disregarding its duty, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, was then and there guilty of one or more of the following careless and negligent acts and/or omissions:

a. Failure to ensure that the nursing facility was adequately staffed with qualified and licensed medical professionals to provide adequate care for the resident;

b. Failure to appropriately hire adequately trained staff;

c. Failure to ensure that the facility has sufficient nursing staff to provide nursing and related services to maintain the highest practicable physical, mental and psychosocial well-being of each resident; and

d. Failure to ensure the policies and procedures of the facility regarding resident care plans were implemented by the nursing staff.

114. As a direct and proximate result of one or more of the foregoing careless and negligent acts and/or omissions on the part of this defendant, the decedent was injured and suffered damages of a personal and pecuniary nature, including pain and suffering, damages for which, had he survived, he would have been entitled to maintain an action; and such an action has survived him and accrued to the benefit of his heirs at law: Hae Suk Kim, his wife, Patricia Penrod, his adult daughter, and John Kim Penrod, his adult son.

115. Plaintiff brings this action in Count V under 755 ILCS 5/27-6, commonly known as the Survival Act of Illinois.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Count VI – Bria Health Services, L.L.C.
(Wrongful Death)

116. Plaintiff incorporates all General Allegations by reference as if pleaded herein in full in Count VI.

117. During all times relevant to this Complaint, Bria Health Services, L.L.C., was the management company for Bria.

118. During all times relevant to this Complaint, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, had a duty to possess and apply the skill and knowledge of a reasonably well-qualified nursing home management company and to treat John D. Penrod.

119. Disregarding its duty, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, was then and there guilty of one or more of the following careless and negligent acts and/or omissions:

a. Failure to ensure that the nursing facility was adequately staffed with qualified and licensed medical professionals to provide adequate care for the resident;

b. Failure to appropriately hire adequately trained staff;

c. Failure to ensure that the facility has sufficient nursing staff to provide nursing and related services to maintain the highest practicable physical, mental and psychosocial well-being of each resident; and

d. Failure to ensure the policies and procedures of the facility regarding resident care plans were implemented by the nursing staff.

120. As a direct and proximate result of one or more of the foregoing careless and negligent acts and/or omissions on the part of this defendant, the resident sustained injuries that caused or contributed to his death on July 15, 2018.

121. Plaintiff brings this action pursuant to 740 ILCS 180/1, *et seq.*, commonly known as the Wrongful Death Act.

122. Decedent left surviving the following next-of-kin, Hae Suk Kim, his wife, Patricia Penrod, his adult daughter, and John Kim Penrod, his adult son, who suffered injuries as a result of the decedent's death, including loss of companionship and loss of society.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Count VII – Bria Health Services, L.L.C.
(Survival Act)

123. Plaintiff incorporates all General Allegations by reference as if pleaded here in full in Count VII.

124. During all times relevant to this Complaint, Bria Health Services, L.L.C., was the management company for Bria.

125. During all times relevant to this Complaint, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, had a duty to possess and apply the skill and knowledge of a reasonably well-qualified nursing home management company and to treat John D. Penrod.

126. Disregarding its duty, this defendant, by and through its agents, servants and/or employees, whether actual or apparent, was then and there guilty of one or more of the following careless and negligent acts and/or omissions:

a. Failure to ensure that the nursing facility was adequately staffed with qualified and licensed medical professionals to provide adequate care for the resident;

b. Failure to appropriately hire adequately trained staff;

c. Failure to ensure that the facility has sufficient nursing staff to provide nursing and related services to maintain the highest practicable physical, mental and psychosocial well-being of each resident; and

d. Failure to ensure the policies and procedures of the facility regarding resident care plans were implemented by the nursing staff.

127. As a direct and proximate result of one or more of the foregoing careless and negligent acts and/or omissions on the part of this defendant, the decedent was injured and suffered damages of a personal and pecuniary nature, including pain and suffering, damages for which, had he survived, he would have been entitled to maintain an action; and such an action has survived him and accrued to the benefit of his heirs at law: Hae Suk Kim, his wife, Patricia Penrod, his adult daughter, and John Kim Penrod, his adult son.

128. Plaintiff brings this action in Count VII under 755 ILCS 5/27-6, commonly known as the Survival Act of Illinois.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Count VIII – Suzanne R. Schnarre, R.N.
(Wrongful Death Act)

129. Plaintiff incorporates all General Allegations by reference as if pleaded here in full in Count VIII.

130. During all times relevant to this Complaint, this defendant was an agent, servant and/or employee, whether actual or apparent, of Bria, and at all times relevant hereto, acted within the scope of that agency, service and/or employment.

131. During all times relevant to this Complaint, this defendant was a registered nurse at Bria.

132. During all times relevant to this Complaint, this defendant accepted the decedent as a resident of Bria and undertook to provide him care and treatment.

133. During all times relevant to this Complaint, there existed a duty on the part of this defendant to possess and apply the skill and knowledge of a reasonably well-qualified registered nurse, and to plan, organize, direct and supervise the operation, treatment and care of the residents of Bria in a manner which equaled or exceeded the applicable standard of care.

134. Disregarding her duty, this defendant as an agent and/or employee, whether actual or apparent, of Bria, was guilty of one or more of the following careless and negligent acts and/or omissions:

a. Failure to ensure the health and safety of John D. Penrod while he was a resident at the facility;

b. Failure to perform skin assessments every shift and institute interventions to promote healing;

c. Failure to offload the wounds and provide a turning and repositioning schedule;

d. Failure to provide wound care treatments as per physician orders;

e. Failure to recognize and timely notify the physician of a significant change in condition;

f. Failure to timely transfer resident to an acute care facility;

g. Failure to timely observe, monitor, assess, evaluate, document, and treat changes in resident's condition and status;

h. Failure to provide interventions to prevent weight loss, to ensure nutritional support and hydration;

i. Failure to follow physician's orders; and

j. Failure to timely observe, monitor, assess, evaluate, document and treat changes in the resident's condition and status.

135. As a direct and proximate result of one or more of this defendant's foregoing careless and negligent acts and/or omissions, the decedent sustained injuries that caused or contributed to his death on July 15, 2018.

136. Plaintiff brings this action pursuant to 740 ILCS 180/1, *et seq.*, commonly known as the Wrongful Death Act.

137. Decedent left surviving the following next-of-kin, Hae Suk Kim, his wife, Patricia Penrod, his adult daughter, and John Kim Penrod, his adult son, who suffered injuries as a result of the decedent's death, including loss of companionship and loss of society.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Count IX – Suzanne R. Schnarre, R.N.
(Survival Act)

138. Plaintiff incorporates all General Allegations by reference as if pleaded here in full in Count IX.

139. During all times relevant to this Complaint, this defendant was an agent and/or employee of the defendant, Bria, and at all times hereto, acted within the scope of that agency and/or employment.

140. During all times relevant to this Complaint, this defendant had a duty to possess and apply the skill and knowledge of a reasonably well-qualified registered nurse and to treat John D. Penrod in a manner which equaled or exceeded the applicable standard of care.

141. Disregarding its duty, this defendant was then and there guilty of one of more of the following careless and negligent acts and/or omissions:

a. Failure to ensure the health and safety of John D. Penrod while he was a resident at the facility;

b. Failure to perform skin assessments every shift and institute interventions to promote healing;

c. Failure to offload the wounds and provide a turning and repositioning schedule;

d. Failure to provide wound care treatments as per physician orders;

e. Failure to recognize and timely notify the physician of a significant change in condition;

f. Failure to timely transfer resident to an acute care facility;

g. Failure to timely observe, monitor, assess, evaluate, document, and treat changes in resident's condition and status;

h. Failure to provide interventions to prevent weight loss, to ensure nutritional support and hydration;

i. Failure to follow physician's orders; and

j. Failure to timely observe, monitor, assess, evaluate, document and treat changes in the resident's condition and status.

142. As a direct and proximate result of one or more of the foregoing careless and negligent acts and/or omissions on the part of this defendant, the decedent was injured and suffered damages of a personal and pecuniary nature, including pain and suffering, damages for which, had he survived, he would have been entitled to maintain an action; and such an action has survived him and accrued to the benefit of his heirs at law: Hae Suk Kim, his wife, Patricia Penrod, his adult daughter, and John Kim Penrod, his adult son.

143. Plaintiff brings this action in Count IX under 755 ILCS 5/27-6, commonly known as the Survival Act of Illinois.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Count X – Amanda R. Schott, L.P.N.
(Wrongful Death Act)

144. Plaintiff incorporates all General Allegations by reference as if pleaded here in full in Count X.

145. During all times relevant to this Complaint, this defendant was an agent, servant and/or employee, whether actual or apparent, of Bria, and at all times relevant hereto, acted within the scope of that agency, service and/or employment.

146. During all times relevant to this Complaint, this defendant was a licensed practical nurse at Bria.

147. During all times relevant to this Complaint, this defendant accepted the decedent as a resident of Bria and undertook to provide him care and treatment.

148. During all times relevant to this Complaint, there existed a duty on the part of this defendant to possess and apply the skill and knowledge of a reasonably well-qualified licensed practical nurse, and to plan, organize, direct and supervise the operation, treatment and care of the residents of Bria in a manner which equaled or exceeded the applicable standard of care.

149. Disregarding her duty, this defendant as an agent and/or employee, whether actual or apparent, of Bria, was guilty of one or more of the following careless and negligent acts and/or omissions:

a. Failure to ensure the health and safety of John D. Penrod while he was a resident at the facility;

b. Failure to provide and revise/update the care plan for fall risk and interventions to prevent falls;

c. Failure to perform skin assessments every shift and institute interventions to promote healing;

d. Failure to offload the wounds and provide a turning and repositioning schedule;

e. Failure to provide wound care treatments as per physician orders;

f. Failure to prevent and treat urinary tract infections;

g. Failure to recognize and timely notify the physician of a significant change in condition;

h. Failure to timely transfer resident to an acute care facility;

i. Failure to timely observe, monitor, assess, evaluate, document, and treat changes in resident's condition and status;

j. Failure to provide interventions to prevent weight loss, to ensure nutritional support and hydration;

k. Failure to recognize and appropriately treat contractures and provide PROM and AROM to prevent contractures;

l. Failure to follow physician's orders; and

m. Failure to timely observe, monitor, assess, evaluate, document and treat changes in the resident's condition and status.

150. As a direct and proximate result of one or more of this defendant's foregoing careless and negligent acts and/or omissions, the decedent sustained injuries that caused or contributed to his death on July 15, 2018.

151. Plaintiff brings this action pursuant to 740 ILCS 180/1, *et seq.*, commonly known as the Wrongful Death Act.

152. Decedent left surviving the following next-of-kin, Hae Suk Kim, his wife, Patricia Penrod, his adult daughter, and John Kim Penrod, his adult son, who suffered injuries as a result of the decedent's death, including loss of companionship and loss of society.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Count XI – Amanda R. Schott, L.P.N.
(Survival Act)

153. Plaintiff incorporates all General Allegations by reference as if pleaded here in full in Count XI.

154. During all times relevant to this Complaint, this defendant was an agent and/or employee of the defendant, Bria, and at all times hereto, acted within the scope of that agency and/or employment.

155. During all times relevant to this Complaint, this defendant had a duty to possess and apply the skill and knowledge of a reasonably well-qualified licensed practical nurse and to treat John D. Penrod in a manner which equaled or exceeded the applicable standard of care.

156. Disregarding its duty, this defendant was then and there guilty of one of more of the following careless and negligent acts and/or omissions:

a. Failure to ensure the health and safety of John D. Penrod while he was a resident at the facility;

b. Failure to provide and revise/update the care plan for fall risk and interventions to prevent falls;

c. Failure to perform skin assessments every shift and institute interventions to promote healing;

d. Failure to offload the wounds and provide a turning and repositioning schedule;

e. Failure to provide wound care treatments as per physician orders;

f. Failure to prevent and treat urinary tract infections;

g. Failure to recognize and timely notify the physician of a significant change in condition;

h. Failure to timely transfer resident to an acute care facility;

i. Failure to timely observe, monitor, assess, evaluate, document, and treat changes in resident's condition and status;

j. Failure to provide interventions to prevent weight loss, to ensure nutritional support and hydration;

k. Failure to recognize and appropriately treat contractures and provide PROM and AROM to prevent contractures;

l. Failure to follow physician's orders; and

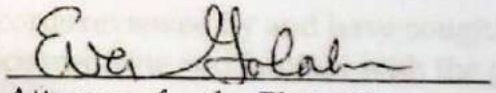
m. Failure to timely observe, monitor, assess, evaluate, document and treat changes in the resident's condition and status.

157. As a direct and proximate result of one or more of the foregoing careless and negligent acts and/or omissions on the part of this defendant, the decedent was injured and suffered damages of a personal and pecuniary nature, including pain and suffering, damages for which, had he survived, he would have been entitled to maintain an action; and such an action has survived him and accrued to the benefit of his heirs at law: Hae Suk Kim, his wife, Patricia Penrod, his adult daughter, and John Kim Penrod, his adult son.

158. Plaintiff brings this action in Count XI under 755 ILCS 5/27-6, commonly known as the Survival Act of Illinois.

WHEREFORE, the plaintiff prays for judgment against this defendant in such amount in excess of this Court's jurisdictional requisite as will fairly and adequately compensate the plaintiff for the injuries, losses, and damages alleged.

Respectfully submitted,



Attorneys for the Plaintiff

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April 16, 2019

Eva E. Golabek
Kralovec, Jambois & Schwartz
Goodman, Theatre Building, 4th Floor
60 West Randolph Street
Chicago, Illinois 60601

Re: John Penrod v. Bria of Belleville

Dear Mrs. Golabek:

As you know, I am a physician licensed to practice medicine in all of its branches and am currently practicing. I am knowledgeable of the issues presented in this case. I have reviewed the medical records of John Penrod as requested. These include the records from Bria of Belleville and Memorial Hospital.

Mr. Penrod (DOB 10/13/36) was an 81-year old man with a history of significant dementia. He was not decisional. On 6/20/17, Mr. Penrod was transferred from Swansea Rehab and Nursing to Memorial Hospital Belleville. At that time, he had a UTI. He was septic and dehydrated and ended up getting stents as well as a Foley.

On 6/30/17, Mr. Penrod was transferred to Bria of Belleville. The nursing staff allowed Mr. Penrod to develop multiple UTIs without identifying them and treating them in a timely fashion. He had UTIs on 7/27/17, 8/21/17, 8/31/17, 10/25/17, 11/15/17, 11/28/17, 1/16/18, 3/12/18, 5/19/18 and 6/20/18. Most often there was a 2- to 4-day delay in obtaining a urine culture or in obtaining antibiotics after a positive result for growth. They also failed to provide adequate hydration to prevent the development of UTIs. Further, he was treated at Belleville Hospital for UTIs which more often progressed to sepsis on 10/25/17, 11/15/17-11/21/17, 11/28/17-12/6/17, 1/16/18-1/22/18, 5/19/18-5/30/18 and 6/20/18-6/29/18 because the nursing staff failed to follow physician orders to change the Foley catheter every two weeks which resulted in these hospitalizations.

The nurses also did not provide appropriate PROM and AROM therapy which resulted in the development of contractures. He also fell several times (10/11/17, 10/17/17, 10/25/17, 12/22/17, 1/30/18) and fortunately without any significant injuries. However, the nursing staff failed to provide effective interventions to prevent his falls and he required evaluations in the ED to rule out more serious injuries.

Mr. Penrod also had significant dehydration and malnutrition issues there. The nursing staff failed to provide Mr. Penrod with adequate assistance during meals. At times, an appetite stimulant was ordered by the physician which was never administered by the nursing staff. His admission weight on 6/30/17 was 150 lbs. On 9/14/17, he was 136.7 lbs. On 11/27/17, he was 129 lbs. on 11/30/17, he was 119 lbs. As a result, he required placement of a GT for enteral feedings. His dehydration and malnutrition also led to the worsening of her pressure ulcers.

In addition, several pressure wounds developed and deteriorated during his residency at Bria. On 9/5/17, a new coccyx wound developed with progression to Stage II. On 9/27/17, a new right buttock wound developed with progression to unstageable. The worst wound was the right hip ulcer which developed on 11/13/17. On 12/26/17, the right hip wound showed signs of infection and the nursing staff failed to notify the physician. On 1/8/18, the nurses, again, to notify the physician of signs consistent with right hip wound infection which resulted in a subsequent delay in diagnosis and treatment. When he had drainage from his wounds, the nursing staff rarely documented that they notified the physician. On

Exhibit A

1/16/18, the right hip wound was with osteomyelitis and progressed to Stage IV. On 4/5/18, 5/19/18, 6/20/18 and 7/4/18, the right hip wound became infected again and diagnosis and treatment was always delayed. Additional wounds developed to the right lateral foot, sacrum, left buttock and right bunion. The nursing staff failed to obtain orders for a low air loss mattress upon his admission and failed to document that they turned and repositioned him as ordered by the physician, either every hour or every 1-2 hours. He had other complications including C. difficile infection, which is pertinent because on 7/15/18, he died of sepsis secondary to UTI, C diff colitis and a grossly infected right hip wound.

It is my opinion that the staff at Bria of Belleville was negligent in their care of Mr. Penrod. This negligence included failing to prevent UTIs, dehydration, malnutrition and contractures. The staff also failed to prevent falls, the development of significant pressure ulcers and the worsening of wound infections. He had complications from his hospitalizations, including C difficile infections which directly led to his death from sepsis secondary to UTI, C diff colitis and a grossly infected right hip wound.

It is my opinion that the staff at Bria of Belleville deviated from the standard of care in Mr. Penrod's care by its:

1) Failure to ensure the health and safety of Mr. Penrod while he was a resident at Bria of Belleville;
2) Failure to timely observe, monitor, assess, evaluate, document and treat changes in resident's condition and status;
3) Failure to provide and revise/update the care plan for fall risk and interventions to prevent falls;
4) Failure to provide and revise/update the care plan for skin breakdown and interventions to prevent the development of new wounds and deterioration/infection of existing wounds;
6) Failure to provide an appropriate mattress, implement a turning and repositioning schedule and offload the bony prominences;
7) Failure to prevent and timely treat urinary tract infections;
8) Failure to change the foley catheter every two weeks as ordered by the physician to prevent recurrent urinary tract infections;
9) Failure to provide AROM and PROM to prevent the development of contractures;
10) Failure to prevent dehydration, malnutrition and significant weight loss;
11) Failure to recognize a significant change in condition;
12) Failure to follow physician's orders; and
13) Failure to timely notify a physician regarding him significant change in condition and timely transfer him to the hospital for an acute evaluation.

These multiple deviations at Bria of Belleville directly led to hospitalization evaluation and ongoing care needs including 1) the continued residency at Bria of Belleville until his death on 7/15/18, 2) the ED visit to Memorial Hospital of Belleville on 8/11/17, 3) the hospital admission to Memorial Hospital of Belleville from 9/5/17-9/9/17, 4) the ED visit to Memorial Hospital of Belleville on 10/11/17, 5) the ED visit to Memorial Hospital of Belleville on 10/17/17, 6) the ED visit to Memorial Hospital of Belleville on 10/25/17, 7) the hospital admission to Memorial Hospital of Belleville from 11/15/17-11/21/17, 8) the hospital admission to Memorial Hospital of Belleville from 11/28/17-12/6/17, 9) the hospital admission to Memorial Hospital of Belleville from 1/16/18-1/22/18, 10) the hospital admission to Memorial Hospital of Belleville from 4/5/18-4/10/18, 11) the hospital admission to Memorial Hospital of Belleville from 5/19/18-5/30/18, 12) the hospital admission to Memorial Hospital of Belleville from 6/20/18-6/29/18, and the hospital admission to Memorial Hospital of Belleville from 7/4/18-7/15/18.

Exhibit A

It is my opinion that Suzanne Schnarre, RN, deviated from the standard of care in Mr. Penrod's care by her:

1) Failure to ensure the health and safety of Mr. Penrod while he was a resident at Bria of Belleville;
2) Failure to timely observe, monitor, assess, evaluate, document and treat changes in resident's condition and status;
3) Failure to provide and revise/update the care plan for skin breakdown and interventions to prevent the development of new wounds and deterioration/infection of existing wounds;
4) Failure to provide an appropriate mattress, implement a turning and repositioning schedule and offload the bony prominences;
5) Failure to prevent dehydration, malnutrition and significant weight loss;
6) Failure to recognize a significant change in condition;
7) Failure to follow physician's orders; and
8) Failure to timely notify a physician regarding him significant change in condition and timely transfer him to the hospital for an acute evaluation.

These multiple deviations at Bria of Belleville directly led to hospitalization evaluation and ongoing care needs including 1) the continued residency at Bria of Belleville until his death on 7/15/18, 2) the ED visit to Memorial Hospital of Belleville on 8/11/17, 3) the hospital admission to Memorial Hospital of Belleville from 9/5/17-9/9/17, 4) the ED visit to Memorial Hospital of Belleville on 10/11/17, 5) the ED visit to Memorial Hospital of Belleville on 10/17/17, 6) the ED visit to Memorial Hospital of Belleville on 10/25/17, 7) the hospital admission to Memorial Hospital of Belleville from 11/15/17-11/21/17, 8) the hospital admission to Memorial Hospital of Belleville from 11/28/17-12/6/17, 9) the hospital admission to Memorial Hospital of Belleville from 1/16/18-1/22/18, 10) the hospital admission to Memorial Hospital of Belleville from 4/5/18-4/10/18, 11) the hospital admission to Memorial Hospital of Belleville from 5/19/18-5/30/18, 12) the hospital admission to Memorial Hospital of Belleville from 6/20/18-6/29/18, and the hospital admission to Memorial Hospital of Belleville from 7/4/18-7/15/18.

It is my opinion that Amanda Schott, LPN, deviated from the standard of care in Mr. Penrod's care by her:

1) Failure to ensure the health and safety of Mr. Penrod while he was a resident at Bria of Belleville;
2) Failure to timely observe, monitor, assess, evaluate, document and treat changes in resident's condition and status;
3) Failure to provide and revise/update the care plan for fall risk and interventions to prevent falls;
4) Failure to provide and revise/update the care plan for skin breakdown and interventions to prevent the development of new wounds and deterioration/infection of existing wounds;
6) Failure to provide an appropriate mattress, implement a turning and repositioning schedule and offload the bony prominences;
7) Failure to prevent and timely treat urinary tract infections;
8) Failure to change the foley catheter every two weeks as ordered by the physician to prevent recurrent urinary tract infections;
9) Failure to provide AROM and PROM to prevent the development of contractures;
10) Failure to prevent dehydration, malnutrition and significant weight loss;
11) Failure to recognize a significant change in condition;
12) Failure to follow physician's orders; and

13) Failure to timely notify a physician regarding him significant change in condition and timely transfer him to the hospital for an acute evaluation.

These multiple deviations at Bria of Belleville directly led to hospitalization evaluation and ongoing care needs including 1) the continued residency at Bria of Belleville until his death on 7/15/18, 2) the ED visit to Memorial Hospital of Belleville on 8/11/17, 3) the hospital admission to Memorial Hospital of Belleville from 9/5/17-9/9/17, 4) the ED visit to Memorial Hospital of Belleville on 10/11/17, 5) the ED visit to Memorial Hospital of Belleville on 10/17/17, 6) the ED visit to Memorial Hospital of Belleville on 10/25/17, 7) the hospital admission to Memorial Hospital of Belleville from 11/15/17-11/21/17, 8) the hospital admission to Memorial Hospital of Belleville from 11/28/17-12/6/17, 9) the hospital admission to Memorial Hospital of Belleville from 1/16/18-1/22/18, 10) the hospital admission to Memorial Hospital of Belleville from 4/5/18-4/10/18, 11) the hospital admission to Memorial Hospital of Belleville from 5/19/18-5/30/18, 12) the hospital admission to Memorial Hospital of Belleville from 6/20/18-6/29/18, and the hospital admission to Memorial Hospital of Belleville from 7/4/18-7/15/18.

Thank you for referring this case for my review. If I can be of any further assistance in this matter, please feel free to contact me.

Sincerely,

[signature omitted]

Exhibit A

IN THE CIRCUIT COURT
FOR THE TWENTIETH JUDICIAL CIRCUIT
ST. CLAIR COUNTY, ILLINOIS

PATRICIA PENROD, as Administrator To Collect for
the Estate of JOHN D. PENROD, Deceased,
)
Plaintiff,
No.
v.
)
BELLEVILLE HEALTHCARE & REHABILITATION
CENTER, INC., d/b/a BRIA HEALTH SERVICES OF
BELLEVILLE; WEISS MANAGEMENT GROUP,
INC.; BRIA HEALTH SERVICES, L.L.C.; SUZANNE
R. SCHNARRE, R.N.; and AMANDA R. SCHOTT,
L.P.N.,
)
Defendants.

ATTORNEY AFFIDAVIT

I, Eva E. Golabek, an attorney licensed to practice law by the State of Illinois, under the penalties of perjury, do hereby state:

1. I have reviewed the medical records of John Penrod's care and treatment rendered by Bria of Belleville and Memorial Hospital of Belleville.

2. I had the abovementioned records reviewed by and have sought and received the consultation of a physician licensed to practice medicine and familiar with the practice of general medicine and who is currently practcing.

3. I reasonably believe the consulting physician to be knowledgeable in the care and treatment required by and rendered to John D. Penrod.

4. The consulting physician reviewed the aforementioned medical records and drew the conclusion therefrom that Bria Health Services of Belleville, Suzanne R. Schnarre, RN, and Amanda R. Schott, LPN, rendered negligent treatment to John D. Penrod.

5. The consulting physician advised me that there is a reasonable and meritorious cause of filing a claim for malpractice against Bria Health Services of Belleville, Suzanne R. Schnarre RN and Amanda R. Schott, LPN.

6. On the basis of the attached Physician's Report, the discussion between my colleagues, the consulting physician and my professional legal opinion, I believe there is a reasonable and meritorious cause for filing this complaint.

EXHIBIT A