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

ANN JACKSON, as Administrator and Representative of the Estate of PAULINE PURIFOY, Deceased,

Plaintiff,

v.

CAHOKIA NURSING AND REHABILITATION CENTER, INC.,
Serve Registered Agent:
Mr. Sheldon Wolfe
7434 N. Skokie Blvd.
Skokie, IL 60077

BENJAMIN M. KLEIN,
Serve at:
212 Oak Knoll Terrace
Highland Park, IL 60035

MIRIAM E. KLEIN,
Serve at:
1380 North Ave, Apt 316
Elizabeth, NJ 07208

ALBERT MILSTEIN,
Serve at:
6119 N Drake Ave
Chicago, IL 60659

SHELDON WOLFE,
Serve at:
6651 N. Drake
Lincolnwood, IL 60712

SW FINANCIAL SERVICES COMPANY, f/k/a SW MANAGEMENT COMPANY,
Serve Registered Agent:
Mr. Sheldon Wolfe
6651 N. Drake
Lincolnwood, IL 60712

Case No. 17L176

JURY TRIAL DEMANDED

FILED
ST. CLAIR COUNTY
APR 04 2017
CIRCUIT CLERK
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JANICE KALZ,
Serve at:
1942 Masthead Ct
Worden, IL 62097

MARY JOHNSON, and
Serve at:
2 Annable Cir
Cahokia, IL 62206

JAYE GILLELAND,
Serve at:
15 Mimosa Drive
Granite City, IL 62040

Defendants.

COMPLAINT

COMES NOW Plaintiff Ann Jackson, as Administrator and Representative of the Estate of Pauline Purifoy, and for her Complaint against Defendants pursuant to 740 ILCS 180/1 et seq., 755 ILCS 5/27-6 and 210 ILCS 45/1-101 et seq. and states as follows:

1. Plaintiff Ann Jackson is the duly appointed Administrator and Representative for the Estate of Pauline Purifoy, per St. Clair County Probate Court Order dated September 18, 2015, Estate #15-P-570. Ann Jackson currently resides in Cahokia, Illinois.

2. Defendant Cahokia Nursing and Rehabilitation Center, Inc., is an Illinois corporation licensed to do business and doing business in the State of Illinois. Defendant Cahokia Nursing and Rehabilitation Center, Inc., operates a nursing home, licensed in Illinois as a Skilled Nursing Facility at 2 Annable Cir, Cahokia, IL 62206 in St. Clair County, Illinois.

3. Defendant Benjamin Klein is an Illinois resident and was at all times relevant an agent, servant, owner and member of the board of directors of Defendant Cahokia Nursing and Rehabilitation Center, Inc.

4. Defendant Miriam Klein is a New Jersey resident and was at all times relevant an

agent, servant, owner and member of the board of directors of Defendant Cahokia Nursing and Rehabilitation Center, Inc.

5. Defendant Albert Milstein is an Illinois resident and was at all times relevant an agent, servant, owner and member of the board of directors of Defendant Cahokia Nursing and Rehabilitation Center, Inc.

6. Defendant SW Financial Services Company, f/k/a SW Management Company (herein after "SW Financial") is an Illinois corporation licensed to do business and doing business in the State of Illinois. Defendant SW Financial owned, operated, managed, controlled and/or was the parent corporation of Defendant Cahokia Nursing and Rehabilitation Center, Inc. located in St. Clair County, Illinois.

7. Defendant Janice Kalz is an Illinois resident and as the Administrator at Cahokia Nursing and Rehabilitation Center at all times relevant hereto was an agent, servant, employee of Defendant Cahokia Nursing and Rehabilitation Center, Inc. and Defendant SW Financial Services Company.

8. Defendant Mary Johnson is an Illinois resident and as the Director of Nursing at Cahokia Nursing and Rehabilitation Center at all times relevant hereto was an agent, servant, employee of Defendant Cahokia Nursing and Rehabilitation Center, Inc. and Defendant SW Financial Services Company.

9. Defendant Jaye Gilleland is an Illinois resident and as the Assistant Director of Nursing at Cahokia Nursing and Rehabilitation Center at all times relevant hereto was an agent, servant and employee of Defendant Cahokia Nursing and Rehabilitation Center, Inc. and Defendant SW Financial Services Company.

10. Jurisdiction and venue are proper in this Court pursuant to 735 ILCS 5/2-103 because Defendant Cahokia Nursing and Rehabilitation Center, Inc.'s county of residence and

the cause of action arose in St. Clair County, Illinois.

STATEMENT OF FACTS

11. Including prior hospital admissions, on or about March 27, 2015, Pauline Purifoy was readmitted to Defendant Cahokia Nursing and Rehabilitation Center, Inc.'s facility from St. Elizabeth's Hospital where she was treated for another urinary tract infection.

12. Ms. Purifoy was dependent on Defendants and their agents, employees and servants for all of her activities of daily living (ADL's), including: bathing, turning and repositioning, incontinence care, transfers in and out of bed, oral care, nutrition and hydration via her feeding tube. She relied on Defendants' agents, employees and servants for twenty-four hour skilled nursing care to assess, monitor and report to the physician changes in her physical condition.

13. On April 13, 2015, Defendant Cahokia Nursing and Rehabilitation Center, Inc.'s Pain Management Monthly Flow Record rated Ms. Purifoy's pain as an "8" with non-verbal signs of pain listed as (1) eyes tightly closed, wide open, blinking eyes, (2) crying and moaning and (3) guarding an area of the body. The non-drug intervention of repositioning was attempted and charted as ineffective. An assessment was not performed and her primary care physician was not contacted.

14. On April 14, 2015 at 1:00 a.m. according to the PRN Medication form, Ms. Purifoy received Ativan through her the feeding tube for constant yelling/agitation. The outcome was not documented. According to Defendants' own records, her primary care physician was again not contacted.

15. On April 15, 2015, the day shift employee documented a pain level of "6" with non-verbal signs of pain listed as (1) irritability and (2) facial wrinkling/grimacing. Interventions

were listed as turning and repositioning. According to Defendants' own records, her primary care physician was again not contacted.

16. On April 14, 2015, at 1:10 a.m. Vicodin was administered for symptoms of pain and hollering. The results/effectiveness of the medication intervention were not documented. According to Defendants' own records, her primary care physician was again not contacted. Ms. Purifoy was given not further pain medications after this administration.

17. On April 16, 2015, the Illinois Department of Public Health ("IDPH") directly observed Ms. Purifoy at Cahokia Nursing and Rehabilitation Center from 11:04 a.m. until 1:30 p.m. The following are excerpts from the IDPH report:

(a) Lying crumpled down in her bed and moaning on and off. Throughout this time she had green pasty material, which appeared to be vomitus, crusted around her mouth, down her chin and neck and on the front of her gown. There was green vomitus on her bed linens extending from her shoulder to her hip. She smelled of feces.

(b) At 12:15 p.m. she remained in bed with the dried vomitus on her face/neck and a small hand towel had been placed over the vomitus on her gown. She continued to smell of urine and stool.

(c) At 1:30 p.m., a Certified Nurse's Aide was in her room and had just rolled her over and placed a mechanical lift sling under her for a shower. The sheet was soaked with brown urine and smelled strongly of bowel movement.

(d) At 1:30 p.m. a bottle of Glucerna 1.2 was attached to Ms. Purifoy's feeding tube that was labeled hung at 2:30 a.m. "The feeding tube pump was turned off until 5:05 p.m. with 850 cc remaining in the bottle." Physician orders were for 50 cc/hour for 23 hours. Calculation of the flow rate indicated there should have only been 300 cc remaining in the bottle. The Assistant Director of Nursing documented the discrepancy in the nurse's notes. According to the Interdisciplinary Progress Notes, the ADON documented that the MAR, physician orders and pump reflect 75 cc/hourly, for the tube feeding rate. However, admission orders reflect the rate had decreased to 50 cc/hourly. Dr. Khan was informed the resident's weight was stable, no nausea or vomiting noted. Orders were received to resume the tube feeding rate as prior to hospitalization.

(e) According to the IDPH report the feeding pump was resumed at 5:05 p.m. by at a rate of 75 cc/hour [in light of a possible ileus and without physician consult].

18. Telephone interviews were also conducted by the IDPH, which included the following statements:

(a) The CNA caring for Ms. Purifoy stated Mr. Purifoy had several (2-3) emesis of large amounts on April 16, 2015. The CAN informed the LPN about the emesis and was told to keep the head of Ms. Purifoy's bed elevated.

(b) The LPN caring for Ms. Purifoy stated the Ms. Purifoy did have two emesis on April 16, 2015. The LPN stated that he/she gave Ms. Purifoy the as needed medication as ordered on the MAR but did not chart it as "it was a busy day and I did not do it." The MAR does not reflect the administration of medication for emesis. The LPN also stated that he/she "I did not tell anyone that [Ms. Purifoy] had vomited that day."

(c) The Assistant Director of Nursing, (ADON), stated that no nausea and vomiting had been reported from either day or evening shift on April 16, 2015.

(d) On the night of April 16, 2015, the RN stated that she was the nurse caring for Ms. Purifoy on the night shift. It was reported to her at 5:00-5:15 a.m., by a different CNA that Ms. Purifoy had two emesis that were documented at 6:25 a.m. The nurse noted the vomitus was brown and assessed Ms. Purifoy's bowel sounds and skin. Ms. Purifoy was not making eye contact as usual. The RN felt her abdomen "it was firm and that is enough to call the doctor."

19. Between 6:25 a.m. and 7:08 a.m., the nurse documented 2 bouts of emesis, the exchange was called. Dr. Kahn ordered that Ms. Purifoy be sent to St. Elizabeth's for evaluation.

20. On April 17, 2015 at 8:07 am, Ms. Purifoy arrived at St. Elizabeth's Hospital's ER. She vomited large amounts of dark green/brown gastric contents multiple times upon arrival. In the ER, she suffered a cardiac arrest, suspected secondary to hypoxia and bradycardia from aspiration of gastric contents. She was revived and intubated. A surgical consultation was called for a possible ileus. The physician found that she appeared to be dehydrated and that a CT scan

of her abdomen and pelvis shows a possible ileus. He also found that her urinary analysis was consistent with a urinary tract infection, which would be consistent with ileus and urosepsis.

21. Pauline Purifoy died from septic shock and multiorgan failure on April 18, 2015.

A. DEFENDANTS' VIOLATIONS OF THE ILLINOIS ADMINISTRATIVE CODE

22. Ill. Admin. Code tit. 77, § 300.610(a) requires that:

> The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

23. Ill. Admin. Code tit. 77, § 300.1010(h) requires that:

> The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)

24. Ill. Admin. Code tit. 77, § 300.1210(b) requires in part that:

> The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. ...

25. Ill. Admin. Code tit. 77, § 300.1210 (c) requires that:

> Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

26. Ill. Admin. Code tit. 77, § 300.1210(d) requires that:

> Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

(1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
(2) All treatments and procedures shall be administered as ordered by the physician.
(3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

27. Ill. Admin. Code tit. 77, § 300.3240(a) requires that:

An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

28. A "Level A violation" or "Type A violation" like that set forth in Ill. Admin. Code tit. 77, § 300.3240(a) is a violation which creates "a condition or occurrence relating to the operation and maintenance of a facility that creates a substantial probability that the risk of death or serious mental or physical harm will result therefrom or has resulted in actual physical or mental harm to a resident." See Ill. Admin. Code tit. 77, § 300.274 (b).

29. A "level B violation" or "Type B violation" such as those set forth in Ill. Admin. Code tit. 77, § 300.1010(h) and Ill. Admin. Code tit. 77, § 300.3240(a) are violations which create "a condition or occurrence relating to the operation and maintenance of a facility that is more likely than not to cause more than minimal physical or mental harm to a resident." See Ill. Admin. Code tit. 77, § 300.274 (b).

30. Defendant Cahokia Nursing was found by the Illinois Department of Public Health to have multiple violations of Ill. Admin. Code tit. 77, §§ 300.610(a), § 300.1010(h), 300.1210(b), 300.1210(c), 300.1210(d) and 300.3240(a) with respect to the care and treatment of Ms. Purifoy.

31. First, the Illinois Department of Public Health found a level A violation of Ill. Admin. Code tit. 77, §§ 300.610(a), § 300.1010(h), 300.1210(b), 300.1210(c), 300.1210(d), 300.1210(d) and 300.3240(a) as follows:

> Based on observation, interview, and record review, the Facility failed to provide timely assessment and monitor for changes in condition for one resident (R10) [Pauline Purifoy] reviewed for possible aspiration and pain. This failure resulted (R10) [Pauline Purifoy] having a delay in hospitalization and treatment. R10 [Pauline Purifoy] was admitted to a local emergency and subsequently to the Intensive Care Unit, with diagnoses of Hypotension, Sepsis, Hyperkalemia, Illeus, Vomiting, and Dehydration.

32. This violation was based on the following factual findings by the Illinois Department of Public Health:

(a) R10 [Pauline Purifoy]'s Admission Sheet documents diagnoses in part of: History of Urinary Tract Infections, Hematuria, Encephalopathy, Vascular Accident with Aphasia, and Adult Feeding Disorder.

(b) R10 [Pauline Purifoy]'s Care Plan, dated 2/9/15, documents a Problem of "at risk for altered nutrition and dehydration, related to a diagnosis of Aphasia." Approaches/ Interventions, in part, included: "Tube feeding as ordered, Monitor for signs and symptoms of aspiration or choking, notify Nurse/MD stat. Diet as ordered, Water flushes, monitor for signs of dehydration, R10 [Pauline Purifoy] is at risk for nutrition and dehydration, diagnosis aphasia as evidenced by the use of feeding tube to have nutritional needs met."

(c) The Care Plan - Pain, dated 2/9/15, documents R10 [Pauline Purifoy] is at risk for pain. Signs/ Symptoms of pain will be identified and pain interventions will be implemented immediately.

(d) The Facility's Pain Management Monthly Flow Record documents on 4/13/2015 Day shift Pain Intensity = 8, Very Severe. Non Verbal signs are #2, Tightly Closed, wide open, blinking eyes, #3, crying moaning, and #6, guarding an area of the body. Interventions included giving Vicodin 5/325, at 1:44AM for "complaints of pain". Other interventions of turning and repositioning were documented as ineffective. For the day shift when pain was documented to be Very Severe, no other interventions drug or non-drug were documented. There is no documentation the Z3, (Physician) was notified of R10 [Pauline Purifoy]'s pain.

(e) On 4/14/2015 the Facility's Pain Management Monthly Flow Record documents Score = 6, Severe Pain. Non verbal signs of pain are #9, Irritability and #1, facial wrinkling, grimacing. Interventions included Ativan 0.5mg (milligrams) given for "constant yelling out/increased agitation." Non-drug interventions included

turning and repositioning. There is no documentation of interventions on the day shift where it is documented R10 [Pauline Purifoy] is in pain. There is no documentation Z3, (Physician), was notified of R10 [Pauline Purifoy]'s pain.

(f) On 4/16/2015, during multiple observations from 11:04 AM through 1:30 PM, R10 [Pauline Purifoy] was observed lying crumpled down in her bed and moaning off and on. Throughout this time R10 [Pauline Purifoy] had dried green pasty material, which appeared to be vomitus, crusted around her mouth, down her chin and neck, and on the front of R10 [Pauline Purifoy];s gown. The green vomitus was on her bed linens, extending from R10 [Pauline Purifoy]'s shoulder to her hip. During this time R10 [Pauline Purifoy] smelled of feces. At 12:15pm, R10 [Pauline Purifoy] remained in bed with the dried vomitus on her face/neck and a small hand towel had been placed over the vomitus on her gown and she continued to smell of urine and stool. At 1:30pm, E6 (Certified Nurses Aide) was in her room and had just rolled her over and placed a mechanical lift sling under her for a shower. The sheet was soaked with brown urine and smelled strongly of bowel movement.

(g) On 4/16/15 the Medication Administration record documents that R10 [Pauline Purifoy] received Hydrocod/Acetaminophen 5/325 mg tablet at 1:10 PM for "complaints/ hollering- "hurts". The pain management record does not document R10 [Pauline Purifoy]'s having pain or the interventions. Pain Management record and Nurse's notes for the day shift failed to document any information on R10 [Pauline Purifoy]'s moaning/ pain, or vomiting. The 4/16/15 Medication Administration Record has no documentation of medication given for R10 [Pauline Purifoy]'s nausea and vomiting on this day.

(h) On 4/16/15, at 1:30 PM, a 1000 cubic centimeter (cc) bottle of Glucerna 1.2 was attached to R10 [Pauline Purifoy]'s feeding tube. The bottle was labeled "4/16/15, 2:30AM, amount 5." R10 [Pauline Purifoy]'s tube feeding pump was turned off until 5:05 PM with 850 cc remained in the bottle. Physicians orders dated 3/27/15 documented rate of 50 cc's per hour for 23 hours. Calculation of the flow rate from time of hanging at 2:30AM, indicates there should have only been 300 cc's remaining in the bottle at 5:05 PM. At 5:05PM, E18 turned on R10 [Pauline Purifoy]'s tube feeding pump at a rate of 75 cc's per hour.

(i) On 4/16/15 at 18:25 (6:25 PM), E3 (Assistant Director of Nursing) documented the discrepancy in the G-tube rates in her Nurses Notes. At this time she called Z3, to clarify orders, and documented "informed Z3, resident weight stable, no Nausea and Vomiting", orders received to resume tube feeding at rate prior to hospitalization, "that there is no harm done," will continue to monitor resident."

(j) In a telephone interview on 4/28/15 at 3:22PM, E36, Certified Nurses Assistant (CNA) stated "I did work with R10 [Pauline Purifoy] on 4/16/15. R10 [Pauline Purifoy] did have several, 2-3 emesis of large amounts. I told E32, (Licensed

Practical Nurse, LPN), about R10 [Pauline Purifoy]'s emesis. I was told to keep the head of her bed elevated. At 1:30 I took R10 [Pauline Purifoy] to the shower and cleaned her up.

(k) In a telephone interview on 4/28/15 at 3:50 PM, E32, (LPN), stated " I worked on day shift (6:30AM to 2:30PM) on 4/16/15, R10 [Pauline Purifoy] did have 2 emesis. R10 [Pauline Purifoy] has a history of vomiting (previously when she ate), and sometimes now with her G-Tube. I gave her the PRN (as needed) medication as ordered on her Medication Administration Record. No, I did not chart on this, as it was a busy day and I did not do it." A review of R10 [Pauline Purifoy]'s PRN-Medication sign off record found no documentation that E32 on 4/16/15, had given any medication to R10 [Pauline Purifoy] for her 2 episodes of vomiting. E32 also stated, "I did not tell anyone that R10 [Pauline Purifoy] had vomited that day."

(l) In a previous interview on 4/24/2015 at 11 :00 AM, E3, Assistant Director of Nursing (ADON) stated R10 [Pauline Purifoy]'s typical demeanor is she usually chats a sort of singing sound but no moaning nor groaning. E3 stated that on 4/16/15, she had not been told by E32 that R10 [Pauline Purifoy] had vomited earlier on the day shift. Also, she (E3) had not assessed R10 [Pauline Purifoy] when she wrote her Nurses Note that R10 [Pauline Purifoy] "had not" vomited that day. E3, did not know if E18, (LPN/evening shift), had assessed R10 [Pauline Purifoy], prior to her (E3's) calling Z3 on 4/16/15 and telling him E3 was "stable with no nausea/vomiting." E3, stated she would have expected the staff nurse to complete a physical assessment of the resident before calling the doctor, especially if vomiting was reported, but no nausea and vomiting had been reported from either day or evening shift.

(m) On 4/24/2015 at 2:12 PM, E34, (RN) stated "I was the RN caring for R10 [Pauline Purifoy] the night of 4/16/2015 - 4/17/15. E34 stated it had been reported to her at 5:00-5:15 AM, by E35, (CNA) that R10 [Pauline Purifoy] had two emesis. I documented it at "06:25AM, two emesis". E34, (RN), said she noticed the vomitus was brown and had assessed R10 [Pauline Purifoy]'s bowel sounds and skin. E34, (RN) stated R10 [Pauline Purifoy] didn't respond or make eye contact, which R10 [Pauline Purifoy] usually did respond to others and did make eye contact. E34, RN then felt her abdomen "it was firm and that is enough to call the doctor." The tube feeding had been running throughout the night at the same rate set by the second shift. E34 could not recall the rate.

(n) On 4/29/15 at 2:45 PM, Z3, (Physician on Call), stated: on 4/6/15, stated that he had been called for orders for R10 [Pauline Purifoy]'s G-Tube feeding. At that time he had not been told R10 [Pauline Purifoy] had vomited during the day. He stated that although she does have a history of periodic vomiting, he feels the staff should have told him, he would want to know. Z3, stated if he does not know if sending R10 [Pauline Purifoy] to the hospital sooner would have changed her outcome, due to her multiple medical problems, but had he known of the nausea and vomiting, he would have admitted R10 [Pauline Purifoy] to the hospital for

fluids and evaluation, earlier that day. As it was, Z3 stated he was not called until 4/17/14 and told R10 [Pauline Purifoy] had vomited.

(o) On 4/29/15 at 3:35 PM, a telephone interview was conducted with E1- (Administrator), E2- (Director of Nursing), and E30, (Regional Nurse). E30 stated, "it was normal for R10 [Pauline Purifoy] to have emesis, and staff would not have called the physician as it was not seen as a change in R10 [Pauline Purifoy]'s condition. E1 stated, Z5 (Primary Physician}, "would not" have wanted to be called for vomiting as it was normal for her to vomit at times. When informed of R10 [Pauline Purifoy]'s observed condition on 4/16/15 of moaning, and laying in vomit, E1, E2 and E30 stated they were not aware of this, and would check with their staff. E1, E2, and E30 stated they were not aware of R10 [Pauline Purifoy] having documented pain for 2 days prior to 4/16/15. E1, E2, E30 stated they were not aware E32 had not documented R10 [Pauline Purifoy]'s episodes of vomiting or that she had given R10 [Pauline Purifoy] PRN medications for vomiting. They stated that they were also not aware that on 4/16/15, E32 had not told any staff either verbally or in writing of R10 [Pauline Purifoy]'s vomiting and moaning multiple times that day. E2 stated "we will have to address that internally." E1, E2, and E3 stated "they would review R10 [Pauline Purifoy]'s record and talk to staff to find out why, (if R10 [Pauline Purifoy] routinely vomited), there was no record of nursing staff giving PRN-anti-nausea medications documented in the Medication Administration Record of R10 [Pauline Purifoy] for the months of March 2015 and April 2015."

(p) On 4/29/15 at 4:20 PM, Z5, (Primary Physician of R10 [Pauline Purifoy]), stated " R10 [Pauline Purifoy] did have a history of Nausea and Vomiting, but R10 [Pauline Purifoy] also has a history of vomiting when she has a UTI (urinary tract infection) that is becoming septic. Z5, stated, the facility should have been aware of the history of R10 [Pauline Purifoy] 's UTI's and vomiting. As R10 [Pauline Purifoy] does have PRN (as needed) medications for vomiting, but it would only be normal if it was a one time spontaneous event. However, if she had vomited two or three times already I (Z5) would want to know she had vomited to rule out possible issues of being septic or other problems due to her history of gastroparesis." Z5, stated, "because R10 [Pauline Purifoy] had multiple medical issues, it is better if staff called the physician and informed them of the nausea, vomiting, and pain, and let the physician determine if this was something that needed to be addressed or not. If R10 [Pauline Purifoy] was having nausea, vomiting, and pain, it would indicated something was wrong and probably needed to be seen by the physician. In the case of R10 [Pauline Purifoy] on 4/16/15, she could have been sent to the hospital sooner, and treatments, surgical options or Hospice could have been discussed and offered to the family."

(q) The Facility policy Change in Condition/Notification dated 2/23/09, documented; It is the responsibility of licensed staff to contact the physician and resident's responsible party whenever there is a change in the resident's physical, mental, or psychosocial status. Definition: 1. A change in condition is any assessment finding, observance, or event that deviates or has the potential to cause a deviation

in the resident's usual or expected physical, mental or psychosocial status. Policy: Upon identification of a change in condition licensed nursing personnel will contact the resident's physician to notify him/her of the change. All notifications should be preceded by an appropriate physical, mental or psychosocial assessment to enable the physician to make adequate and appropriate treatment and/or transfer decisions. Examples of Changes in Condition: (include but not limited to) Emesis or Diarrhea, Symptoms of an Infectious Process with or without fever, Abnormal reports of Pain, Subjective reports made by the resident "I don't feel good, something is wrong", contact physician after thorough physical and mental assessment.

33. Second, the Illinois Department of Public Health found a level B violation of Ill. Admin. Code tit. 77, §§ 300.610(a), § 300.1010(h), 300.1210(b), 300.1210(d), and 300.3240(a) as follows:

> Based on observation, interview, and record review, the Facility failed to provide timely monitoring and ensure food intake met the required amount as ordered by the physician for 4 residents (R3, R10 [Pauline Purifoy], R12, & R19) with Gastrostomy Tubes (G-Tubes) observed for adequate hydration, nutrition and weight loss. This failure resulted in significant weight losses for R3, R19, and R10 [Pauline Purifoy] and R19 being admitted to the hospital with a diagnoses in part of dehydration.

34. This violation was based on the following factual findings by the Illinois Department of Public Health:

(a) R10 [Pauline Purifoy]'s Admission Sheet documents diagnoses in part of : History of Urinary Tract Infections, Hematuria, Encephalopathy, Vascular Accident with Aphasia, and Adult Feeding Disorder.

(b) R10 [Pauline Purifoy]'s Care Plan, dated 2/9/15, documents a Problem of "at risk or altered nutrition and dehydration, related to a diagnosis of Aphasia." Approaches /Interventions, in part, included: "Tube feeding as ordered, Monitor for signs and symptoms of aspiration or choking, notify Nurse/MD stat. Diet as ordered, Water flushes, monitor for signs of dehydration, R10 [Pauline Purifoy] is at risk for nutrition and dehydration diagnosis aphasia as evidenced by the use of feeding tube to have nutritional needs met." Monitor for incontinence frequently. Monitor and document bowel movements (BM), report diarrhea, constipation or no BM in 3 days. G-Tube Flushes and care as ordered. Diet as ordered water flushes.

(c) R10 [Pauline Purifoy]'s Physician Order Sheet, dated 3/27/15, documents an order for Giucerna 1.2 at 50 cubic centimeters (cc) per hour for 23 hours continuously, via infusion kit and pump with IV (intravenous) Pole. Flush PEG (Percutaneous

Endoscopic Gastrostomy) tube with 150 cc's Q-4 hours (every) via enteral syringe. Flush 150 cc every 4 hours '(with water)."

(d) From 3/27/15 through 4/7/15 the Interdisciplinary Progress notes indicate R10 [Pauline Purifoy] received Glucerna 1.2 at 50cc/hr X 23 hours. However, on 4/8/15 the nurses notes document G-tube patent infusing at 75 cc per hour flushed without difficulty.

(e) Per Physician's order of 3/27/15, at a rate of 50cc/ hour X 23 hours, R10 [Pauline Purifoy] should receive 1150cc/day of feeding. Review of R10 [Pauline Purifoy]'s Fluid Intake and Output record from 4/1/15 to 4/16/15, documented multiple inconsistencies in the amount of G-tube feeding R10 [Pauline Purifoy] was given. Nursing staff failed to calculate and document the 24 hour total intake for R10 [Pauline Purifoy] during this time. R10 [Pauline Purifoy]'s intake per shift was totaled by the surveyor and found for 24 hours the following amounts infused: 4/1/15- 1236cc, 4/3/15 -790cc, 4/4/15-1390cc, 4/5/15 - 1662cc, 4/7/15 - 960cc, 4/9/15 - 1511 cc, 4/10/15 - 1632cc, 4/11/15 - 1660cc, 4/12/15 - 1700cc, 4/14/15 - 904cc, and 4/15/15 – 1872cc.

(f) On 4/2/15, 4/6/15, 4/8/15, and 4/13/15, no amounts were recorded. During this time for three days R10 [Pauline Purifoy] received 200cc to 400cc less feeding than required. And the rest of the days received between 100cc and 900cc more per day than ordered by the physician. No information was given for these discrepancies in R10 [Pauline Purifoy]'s intake.

(g) On 4/16/2015, during multiple observations from 11:04 AM through 1:30 PM, R10 [Pauline Purifoy] was observed lying crumpled down in her bed and moaning off and on. Throughout this time R10 [Pauline Purifoy] had dried green pasty material, which appeared to be vomitus, crusted around her mouth, down her chin and neck, and on the front of R10 [Pauline Purifoy]'s gown. The green vomitus was on her bed linens, extending from R10 [Pauline Purifoy]'s shoulder to her hip. R10 [Pauline Purifoy] smelled strongly of feces.

(h) On 4/16/15, at 1:30 PM, a 1000 cubic centimeter (cc) bottle of Glucerna 1.2 was attached to R10 [Pauline Purifoy]'s feeding tube. The bottle was labeled "4/16/15, 2:30 AM, amount 5 (?)."R10 [Pauline Purifoy]'s tube feeding pump was turned off from 1:30 PM until 5:05 PM with 850 cc remained in the bottle. Calculation of the flow rate from time of hanging at 2:30 AM to 5:05 PM, indicates there should have only been 275 cc's remaining in the bottle (not 850cc).

(i) On 4/16/15 at 5:05PM, E18, Licensed Practical Nurse (LPN), stated "she checked for R10 [Pauline Purifoy]'s tube feeding order on the current monthly Medication Administration Record (MAR) dated 4/2015 which documents "Glucerna 1.2 at 75 cc's per hour from 7:00PM to 7:00AM ."(order is inconsistent with current MD order of 50cc/hour for 23 hours.) E18 stated she then turned on R10 [Pauline Purifoy]'s tube feeding pump at a rate of 75 cc's per hour.

(j) On 4/22/15 at 11 am, E20, (RD), stated she does not routinely look at the intake records when she evaluates residents on G-tubes, but asks the nurses how the residents are doing. E20 stated she would expect the nurses to follow physician's orders for tube feedings and flushes. E20 stated she thinks the nurses are doing the feedings and flushes but has not considered that a factor. ... E20 when asked if she expected the nurses to follow orders and administer the amount prescribed stated "you and I both know orders are orders and everyone should follow them." E2 stated that she though R10 [Pauline Purifoy] was doing fine, but was not aware R10 [Pauline Purifoy] had been hospitalized.

(k) On 4/24/2015 at 11 :00 AM, E3, Assistant Director of Nursing (ADON) stated "On 4/16/15 I spoke to Z3, (Physician on call). He told me to write for the Glucerna to be given per the previous admission order. I wrote the order on 4/16/15 for R10 [Pauline Purifoy]'s Glucerna to run 75cc I hour for 23 hours. I was not aware the G-Tube feeding should be from 7:00PM to 7:00AM only. I did not verify the order against the original in the chart." Additionally, E3 stated she had not been told by E37 that R10 [Pauline Purifoy] had vomited earlier on the day shift.

(l) On 4/24/2015 at 2:12 PM, E34, (RN) stated "I was the RN caring for R10 [Pauline Purifoy] the night of 4/16/2015". She stated she had documented at "06:25 two emesis". The emesis had been reported to her at 5:00-5:15 AM when the E35, (CNA) showed her the linens with emesis. E34, (RN) noticed the vomitus was brown and had assessed R10 [Pauline Purifoy]'s bowel sounds and skin. E34, (RN) stated R10 [Pauline Purifoy] didn't respond or make eye contact, which R10 [Pauline Purifoy] usually did respond to others and make eye contact. E34, (RN) then felt her abdomen "it was firm and that is enough to call the doctor." The tube feeding had been running throughout the night at the same rate set by the second shift. E34 could not recall the rate.

(m) R10 [Pauline Purifoy] was transferred from the Facility to the local hospital Emergency Room (ER) on 04/17/15. The local hospital ER report documents R10 [Pauline Purifoy] diagnoses Primary Impression: Hypotension, Additional Impressions: UTI (lower urinary tract infection), Sepsis, Illeus, Vomiting, Hyperkalemia, and Dehydration·. R10 [Pauline Purifoy] was treated with bolus fluids and admitted to the hospital.

(n) On 4/29/15 at 2:45 PM, Z3, (Physician on Call), during interview stated: on 4/16/15, stated that he had been called for orders for R10 [Pauline Purifoy]'s G-Tube feeding. At that time he had not been told R10 [Pauline Purifoy] had vomited during the day. He stated that although she does have a history of periodic vomiting, he feels the staff should have told him, he would want to know and had he known of the nausea and vomiting, he would have admitted R10 [Pauline Purifoy] to the hospital for fluids and evaluation, earlier that day.

B. DEFENDANTS' VIOLATIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES' REQUIREMENTS FOR LONG TERM CARE FACILITIES

35. Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities 42 C.F.R 483.10(b)(11) (effective October 7, 2005 to November 27, 2016) requires that:

> (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is—
> (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
> (B) A significant change in the resident's physical, mental, or psychosocial status i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
> (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
> (D) A decision to transfer or discharge the resident from the facility as specified in § 483.12(a).
> (ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is—
> (A) A change in room or roommate assignment as specified in § 483.15(e)(2); or
> (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.
> (iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

36. Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities 42 C.F.R 483.25 (effective October 7, 2005 to November 27, 2016) requires that:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

37. Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities 42 C.F.R 483.25(a)(3) (effective October 7, 2005 to November 27, 2016) requires that:

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

38. Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities 42 C.F.R 483.25(g)(2) (effective October 7, 2005 to November 27, 2016) requires that:

> Based on the comprehensive assessment of a resident, the facility must ensure that –
> (1) A resident who has been able to eat enough alone or with assistance is not fed by nasa gastric tube unless the resident ' s clinical condition demonstrates that use of a nasa gastric tube was unavoidable; and
> (2) A resident who is fed by a nasa-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

39. Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities 42 C.F.R 483.75(l)(1) (effective October 7, 2005 to November 27, 2016) requires that:

> The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

40. First, the Illinois Department of Public Health found a violation of the Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities 42 C.F.R 483.10(b)(11) as follows:

> Based on observation, interview and record review the Facility failed to notify the physician promptly of a change in condition for 1 of 5 residents (R10) [Pauline Purifoy], reviewed for recent hospitalizations in the sample of 28.

41. This violation was based on the following factual findings by the Illinois Department of Public Health:

(a) The Facility's Pain Management Monthly Flow Record documents on 4/13/2015, on Day shift Pain Intensity= 8, Very Severe. Non –Verbal signs are #2, Tightly

Closed, wide open, blinking eyes, #3, crying, moaning, and #6, guarding an area of the body. On 4/14/2015 the Facility's Pain Management Monthly Flow Record documents Score = 6, Severe Pain. Non verbal signs of pain are #9, Irritability and #1, facial wrinkling, grimacing.

(b) On 4/16/2015, during multiple observations from 11:04 AM through 1:30PM, R10 [Pauline Purifoy] was observed lying crumpled down in her bed and moaning off and on. Throughout this time R10 had dried green pasty material, which appeared to be vomitus, crusted around her mouth, down her chin and neck, and on the front of R10 [Pauline Purifoy]'s gown. The green vomitus was on her bed linens, extending from R10 [Pauline Purifoy]'s shoulder to her hip. R10 [Pauline Purifoy] smelled of feces.

(c) On 4/16/15 the Pain Management record and Nurse's notes failed to document any information on R10 [Pauline Purifoy]'s ongoing pain, moaning, or vomiting or that Z3, Physician of R10 [Pauline Purifoy], had been notified of R10 [Pauline Purifoy]'s symptoms.

(d) In a telephone interview on 4/28/15 at 3:50 PM, E32, Licensed Practical Nurse,(LPN) stated " I worked on day shift (6:30 AM to 2:30 PM) on 4/16/15, R10 [Pauline Purifoy] did have 2 emesis. R10 [Pauline Purifoy] has a history of vomiting (previously when she ate), and now at times vomits with her G-Tube. E32 stated, "I did not tell anyone that R10 [Pauline Purifoy] had vomited that day, as it was not uncommon for her to sometimes vomit. I did not notify Z3, R10 [Pauline Purifoy]'s doctor."

(e) On 4/24/2015 at 11:00 AM, E3, Assistant Director of Nursing (ADON) stated R10 [Pauline Purifoy]'s typical demeanor is she usually chats a sort of singing sound but no moaning nor groaning. E3 stated that on 4/16/15, she had not been told by E32 that R10 [Pauline Purifoy]had vomited earlier on the day shift. Also, she (E3) had not assessed R10 [Pauline Purifoy] when she wrote her Nurses Note that R10 [Pauline Purifoy] had not vomited that day. E3, did not know if E18, (LPN/evening shift), had assessed R10 [Pauline Purifoy] prior to E3's calling Z3 on 4/16/15 at telling him E3 was "stable with no nausea/vomiting." E3 stated she would have expected the staff nurse to complete a physical assessment of the resident before calling the doctor, especially if vomiting was reported, but no nausea and vomiting had been reported from either shift that day.

(f) On 4/29/15 at 2:45 PM, Z3, (Physician on Call), stated during interview; on 4/16/15, that he had been called for orders for R10 [Pauline Purifoy]'s G-Tube feeding. At that time he had not been told R10 [Pauline Purifoy] had vomited during the day. He stated that although she does have a history of periodic vomiting, he feels the staff should have told him, he would want to know. Z3, stated if he had known of the nausea and vomiting, he would have admitted R10 [Pauline Purifoy] to the hospital for fluids and evaluation, earlier that day.

(g) On 4/29/15 at 4:20 PM, Z5, (Primary Physician of R10 [Pauline Purifoy]), stated R10 [Pauline Purifoy] did have a history of Nausea and Vomiting, but R10 [Pauline Purifoy] also has a history of vomiting when she has a urinary tract infection that Is becoming septic. Z5, stated, because R10 [Pauline Purifoy] multiple medical Issues, Staff should have called the physician and Informed them of the nausea, vomiting, and pain, and let the physician determine If this was something that needed to be addressed or not. In this case R10 [Pauline Purifoy] could have been sent to the hospital sooner, and treatments, surgical options or Hospice could have been discussed and offered to the family. If R10 [Pauline Purifoy] was having nausea, vomiting, and pain It would Indicated something was wrong and R10 [Pauline Purifoy] probably needed to be seen by the physician.

(h) The Facility policy Change In Condition; Notification dated 2/23/09, documented; It is the responsibility of licensed staff to contact the physician and resident's responsible party whenever there Is a change in the resident's physical, mental, or psychosocial status. Definition: 1. A change In condition is any assessment finding, observance, or event that deviates or has the potential to cause a deviation In the resident's usual or expected physical, mental or psychosocial status. Policy: Upon Identification of a change in condition licensed nursing personnel will contact the resident's physician to notify him/her of the change. All notifications should be preceded by an appropriate physical, mental or psychosocial assessment to enable the physician to make adequate and appropriate treatment and/or transfer decisions.

42. Second, the Illinois Department of Public Health also found a violation of the Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities 42 C.F.R 483.25 as follows:

> Based on observation, interview, and record review, the Facility failed to provide timely assessment and monitor for changes in condition for one of 4 residents (R1 0) reviewed for possible aspiration and pain in the sample of 28. This failure resulted (R10) having a delay in hospitalization and treatment. R10 was admitted to a local emergency and subsequently to the Intensive Care Unit, with diagnoses of Hypotension, Sepsis, Hyperkalemia, Illeus, Vomiting, and Dehydration.

43. This violation was based on the same factual findings by the Illinois Department of Public Health already sent out in paragraph 32, subparts (a) through (q) above and incorporated herein by reference.

44. Third, the Illinois Department of Public Health also found a violation of the Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities § 483.25(a)(3) as follows:

> Based on interviews, observations and record review, the facility failed to provide assistance for timely toileting and hygiene for 8 of 14 residents (R3, R6, R9, R10 [Pauline Purifoy], R14, R15, R16 and R18) reviewed for incontinent needs and hygiene in the sample of 28.

45. This violation was based on the following factual findings by the Illinois Department of Public Health:

(a) The MDS dated 2/9/15 identifies R10 [Pauline Purifoy] to be dependent on staff for all activities of daily living including bathing/hygiene and toileting.

(b) On 4/16/15 at 11:04am, R10 [Pauline Purifoy] was in bed with the head of her bed elevated. She had green-brown dried vomitus on her face/neck and on the front of her hospital gown. At 12:15pm, she remained in bed with the dried vomitus on her face/neck and a small hand towel had been placed over the vomitus on her gown and she smelled of urine and stool. At 1:30pm, E6 (Certified Nurses Aide) was in her room and have just rolled her over and placed a mechanical lift sling under her for a shower. The sheet was soaked with brown urine and smelled strongly of bowel movement. No information was given by staff as to why R10 [Pauline Purifoy] was allowed to lay in vomit, and not given timely needed care for nearly 2.5 hours.

46. Fourth, the Illinois Department of Public Health also found a violation of the Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities § 483.25(g)(2) as follows:

> Based on observation, interview, and record review, the Facility failed to provide timely monitoring and ensure food intake met the required amount as ordered by the physician for 4 of 4 residents (R3, R10 [Pauline Purifoy], R12, & R19) with Gastrostomy Tubes (G-Tubes) observed for adequate hydration, nutrition and weight loss in the sample of 28. This failure resulted in significant weight losses for R3, R19, and R10 [Pauline Purifoy] and R19 being admitted to the hospital with a diagnoses in part of dehydration.

47. This violation was based on the following factual findings by the Illinois Department of Public Health:

(a) R10 [Pauline Purifoy]'s Admission Sheet documents diagnoses in part of: History of Urinary Tract Infections, Hematuria, Encephalopathy, Vascular Accident with Aphasia, and Adult Feeding Disorder.

(b) R10 [Pauline Purifoy]'s Care Plan, dated 2/9/15, documents a Problem of "at risk or altered nutrition and dehydration, related to a diagnosis of Aphasia." Approaches /Interventions, in part, included: "Tube feeding as ordered, Monitor for signs and symptoms of aspiration or choking, notify Nurse/MD stat. Diet as ordered, Water flushes, monitor for signs of dehydration, R10 [Pauline Purifoy] is at risk for nutrition and dehydration diagnosis aphasia as evidenced by the use of feeding tube to have nutritional needs met." Monitor for incontinence frequently. Monitor and document bowel movements (BM), report diarrhea, constipation or no BM in 3 days. G-Tube Flushes and care as ordered. Diet as ordered water flushes. R10 [Pauline Purifoy]'s Physician Order Sheet, dated 3/27/15, documents an order for "Glucerna 1.2 at 50 cubic centimeters (cc) per hour for 23 hours continuously, via infusion kit and pump with IV (intravenous) Pole. Flush PEG (Percutaneous Endoscopic Gastrostomy) tube with 150 cc's Q-4 hours (every) via enteral syringe. Flush 150 cc every 4 hours (with water)."

(c) From 3/27/15 through 4/7/15 the Interdisciplinary Progress notes indicate R10 [Pauline Purifoy] received Glucerna 1.2 at 50cc/hr X 23 hours. However, on 4/8/15 the nurses notes document G-tube patent infusing at 75 cc per hour flushed without difficulty.

(d) Per Physician's order of 3/27/15, at a rate of 50cc/ hour X 23 hours, R10 [Pauline Purifoy] should receive 1150cc/day of feeding. Review of R1 O's Fluid Intake and Output record from 4/1/15 to 4/16/15, documented multiple inconsistencies in the amount of G-tube feeding R10 [Pauline Purifoy] was given. Nursing staff failed to calculate and document the 24 hour total intake for R10 [Pauline Purifoy] during this time. R10 [Pauline Purifoy]'s intake per shift was totaled by the surveyor and found for 24 hours the following amounts infused: 4/1/15 - 1236cc, 4/3/15 -790cc, 4/4/15 - 1390cc, 4/5/15 - 1662cc, 4/7/15 - 960cc, 4/9/15 - 1511 cc, 4/10/15 - 1632cc, 4/11/15 - 1660cc, 4/12/15 - 1700cc, 4/14/15 - 904cc, and 4/15/15 - 1872cc. On 4/2/15, 4/6/15, 4/8/15, and 4/13/15, no amounts were recorded. During this time for three days R10 [Pauline Purifoy] received 200cc to 400cc less feeding than required. And the rest of the days received between 100 cc and 900cc more per day than ordered by the physician. No information was given for these discrepancies in R10 [Pauline Purifoy]'s intake.

(e) On 4/16/2015, during multiple observations from 11:04 AM through 1:30 PM, R10 [Pauline Purifoy] was observed lying crumpled down in her bed and moaning off and on. Throughout this time R10 [Pauline Purifoy] had dried green pasty material, which appeared to be vomitus, crusted around her mouth, down her chin and neck, and on the front of R10 [Pauline Purifoy]'s gown. The green vomitus was on her bed linens, extending from R10 [Pauline Purifoy]'s shoulder to her hip. R10 [Pauline Purifoy] smelled strongly of feces.

(f) On 4/16/15, at 1:30 PM, a 1000 cubic centimeter (cc) bottle of Glucerna 1.2 was attached to R10 [Pauline Purifoy]'s feeding tube. The bottle was labeled "4/16/15, 2:30AM, amount 5 (?)."R10 [Pauline Purifoy]'s tube feeding pump was turned off from 1:30 PM until 5:05 PM with 850 cc remained in the bottle. Calculation of the flow rate from time of hanging at 2:30 AM to 5:05 PM, indicates there should have only been 275 cc's remaining in the bottle (not 850cc).

(g) On 4/16/15 at 5:05PM, E18, Licensed Practical Nurse (LPN), stated "she checked for R10 [Pauline Purifoy]'s tube feeding order on the current monthly Medication Administration Record (MAR) dated 4/2015 which documents "Glucerna 1.2 at 75 cc's per hour from 7:00PM to 7:00AM ."(order is inconsistent with current MD order of 50cc/hour for 23 hours.) E18 stated she then turned on R10 [Pauline Purifoy]'s tube feeding pump at a rate of 75 cc's per hour.

(h) On 4/22/15 at 11 am, E20, (RD), stated she does not routinely look at the intake records when she evaluates residents on G-tubes, but asks the nurses how the residents are doing. E20 stated she would expect the nurses to follow physician's orders for tube feedings and flushes. E20 stated she thinks the nurses are doing the feedings and flushes but has not considered that a factor. ... E20 when asked if she expected the nurses to follow orders and administer the amount prescribed stated "you and I both know orders are orders and everyone should follow them." E2 stated that she though R10 [Pauline Purifoy]was doing fine, but was not aware R10 [Pauline Purifoy]had been hospitalized.

(i) On 4/24/2015 at 11:00 AM, E3, Assistant Director of Nursing (ADON) stated "On 4/16/15 I spoke to 23, (Physician on call). He told me to write for the Glucerna to be given per the previous admission order. I wrote the order on 4/16/15 for R10 [Pauline Purifoy]'s Glucerna to run 75cc / hour for 23 hours. I was not aware the G-Tube feeding should be from 7:00 PM to 7:00AM only. I did not verify the order against the original in the chart." Additionally, E3 stated she had not been told by E37 that R10 [Pauline Purifoy]had vomited earlier on the day shift. .

(j) On 4/24/2015 at 2:12 PM, E34, (RN) stated "I was the RN caring for R10 [Pauline Purifoy] the night of 4/16/2015". She stated she had documented at "06:25 two emesis". The emesis had been reported to her at 5:00-5:15 AM when the E35, (CNA) showed her the linens with emesis. E34, (RN) noticed the vomitus was brown and had assessed R10 [Pauline Purifoy]'s bowel sounds and skin. E34, (RN) stated R1 0 didn't respond or make eye contact, which R10 [Pauline Purifoy] usually did respond to others and make eye contact. E34, (RN) then felt her abdomen "it was firm and that is enough to call the doctor." The tube feeding had been running throughout the night at the same rate set by the second shift. E34 could not recall the rate.

(k) R10 [Pauline Purifoy]was transferred from the Facility to the local hospital Emergency Room (ER) on 04/17/15. The local hospital ER report documents R10 [Pauline Purifoy] diagnoses Primary Impression: Hypotension, Additional

Impression?: UTI (lower urinary tract infection), Sepsis, Illeus, Vomiting, Hyperkalemia, and Dehydration. R10 [Pauline Purifoy]was treated with bolus fluids and admitted to the hospital.

(l) On 4/29/15 at 2:45 PM, 23, (Physician on Call), during interview stated; on 4/16/15, stated that he had been called for orders for R10 [Pauline Purifoy]'s G-Tube feeding. At that time he had not been told R10 [Pauline Purifoy] had vomited during the day. He stated that although she does have a history of periodic vomiting, he feels the staff should have told him, he would want to know and had he known of the nausea and vomiting, he would have admitted R10 [Pauline Purifoy] to the hospital for fluids and evaluation, earlier that day.

48. Fifth, the Illinois Department of Public Health also found a violation of the Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities § § 483.75(l)(1) as follows:

Based on record review and interview, the facility failed to maintain complete and accurate Intake and Output Records for Gastrostomy Tube feedings, Abuse Investigations and Fall Reports for 5 of 5 residents (R10 [Pauline Purifoy], R19, R12, R3 and R20) in a sample of 28.

49. This violation was based on the following factual findings by the Illinois Department of Public Health:

(a) Physician's order of 3/27/15, at a rate of 50cc / hour X 23 hours, R1 0 should receive 1150cc/day of feeding.

(b) Review of R10 [Pauline Purifoy]'s Fluid Intake and Output record from 4/1/15 to 4/16/15, documented multiple inconsistencies in the amount of G-tube feeding R10 [Pauline Purifoy] was given. Nursing staff failed to calculate and document the 24 hour total intake for R10 [Pauline Purifoy] during this time.

(c) R10 [Pauline Purifoy]'s intake per shift was totaled by the surveyor and found for 24 hours the following amounts infused: 4/1/15- 1236cc, 4/3/15 -790cc, 4/4/15-1390cc, 4/5/15 - 1662cc, 4/7/15 - 960cc, 4/9/15 -1511cc, 4/10/15 -1632cc, 4/11/15 -1660cc, 4/12/15 - 1700cc, 4/14/15 - 904cc, and 4/15/15 -1872cc. On 4/2/15, 4/6/15, 4/8/15, and 4/13/15, no amounts were recorded. During this time for three days R10 [Pauline Purifoy] received 200cc to 400cc less feeding than required. And the rest of the days received between 100cc - 900cc more per day than ordered by the physician. No information was given for these discrepancies and missing information in R10 [Pauline Purifoy]'s intake.

COUNT I

MEDICAL NEGLIGENCE – SURVIVAL ACT

COMES NOW Plaintiff Ann Jackson, as Administrator and Representative of the Estate of Pauline Purifoy, deceased, and for Count I of her claims against Defendant Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland states as follows:

50. Plaintiff hereby incorporates by reference Paragraphs 1 through 49 above as if fully set forth herein.

51. Plaintiff bring this claim pursuant to the Illinois Survival Statute, 755 Ill. Comp. Stat. Ann. 5/27-6.

52. From 2008 until April 17, 2015, Pauline Purifoy was a resident of Defendant Cahokia Nursing and Rehabilitation Center, Inc.'s facility for residence and care and was lawfully on Defendants' premises as an invitee of the Defendants in that there was a business benefit to Defendants as a function of Pauline Purifoy's presence on Defendants' property and a resident of Defendants' facility.

53. Defendant Cahokia Nursing and Rehabilitation Center, Inc., by and through its board of directors, owners, employees, agents and servants including but not limited to Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland, and Defendants' facility management, RNs, LPNs, CNAs and other staff, were responsible for the care, custody and control of Pauline Purifoy during her residency there.

54. Defendants owed Plaintiff a duty to use that degree of skill and learning ordinarily used under the same or similar circumstance by members of Defendants' professions.

Furthermore, the individual Defendants owed a legal duty to remedy unsafe practices or conditions at the nursing home.

55. Defendants failed to provide Pauline Purifoy with appropriate medical care that was reasonable and necessary to maintain the physical and mental health of Pauline Purifoy, failed to inform her primary care physician of her change in status and failed to transfer her to the emergency room until the morning of April 17, 2015.

56. Defendants' failure to provide such services presented a substantial probability that serious physical harm would result.

57. Defendants also owed Pauline Purifoy a duty to treat her with consideration, respect, and full recognition of her dignity and individuality.

58. Defendants deprived Plaintiff of her rights, abused her, neglected her, and violated their duties in one or more of the following ways:

(a) By failing to have a tracking method to assure Mrs. Purifoy's bowel movements were monitored upon her readmission to Cahokia Nursing and Rehabilitation Center to assure she was passing through her bowels;

(b) By failing to prevent or treat Pauline Purifoy for urinary tract infections while under the care of Defendants, despite knowing that Pauline Purifoy was a high risk for these types of infections;

(c) By failing to properly document and describe Pauline Purifoy's symptoms and treatment;

(d) By failing to properly supervise and monitor Pauline Purifoy's care and condition;

(e) By failing to adjust and monitor Pauline Purifoy's treatment for her infections;

(f) By failing to provide a referral for consultation with an appropriate specialist or otherwise seek medical treatment for Pauline Purifoy's infections and illnesses outlined above;

(g) By failing to inform her primary care physician that she was vomiting on April 16, 2015 as vomiting is a sign that she has a urinary tract infection that was becoming septic;

(h) By failing to supervise the staff of Defendant Cahokia Nursing and Rehabilitation Center, Inc.;

(i) By failing to ensure Cahokia Nursing and Rehabilitation Center was sufficiently staffed with qualified medical professionals and nurses to provide adequate care to the residents; and

(j) By failing to check that all policies and procedures were being properly implemented at Cahokia Nursing and Rehabilitation.

59. As a direct and proximate result of the negligence of Defendants, Pauline Purifoy incurred the following injuries and damages:

(a) Severe urinary tract infection and dehydration leading to sepsis and death;

(b) Extreme pain, mental anguish and suffering from the time of injury until the time of her death, including fear and depression and loss of enjoyment of life;

(c) Medical expenses incurred prior to her death.

60. On information and belief, Defendant SW Financial Service Company's Regional Director of Nursing Erika Forrestt, Regional Director Robin Suydam, Regional Compliance Officer/Nurse Consultant Jeff Davis and Defendant Cahokia Nursing and Rehabilitation Center, Inc.'s Administrator Jan Kalz and Director of Nursing Mary Johnson were directly informed of

many incidents of abuse, neglect, and improper care that were occurring at Cahokia Nursing and Rehabilitation by Cahokia Nursing and Rehabilitation's then Social Service Director, beginning in September of 2014 and continuing until May of 2015. Defendants failed to take corrective action to protect the nursing home residents, including Pauline Purifoy, from abuse, neglect and improper care which ultimately lead to the death of Pauline Purifoy and another resident of Cahokia Nursing and Rehabilitation. The Social Service Director was then subjected to retaliation, harassment and a hostile work environment and was ultimately terminated in May of 2015.

61. Defendants' conduct as described above prior to and after the injuries to and death of Pauline Purifoy manifested a gross and indifference to and a conscious disregard for the safety and rights of others, including Pauline Purifoy and Ann Jackson, thereby entitling Ann Jackson to punitive or exemplary damages to punish and deter Defendants and others similarly situated from like conduct in the future.

WHEREFORE, Plaintiff prays judgment against Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland in an amount in excess of $50,000.00 in actual and pecuniary damages, including medical expenses, punitive or exemplary damages, together with her costs, pre- and post-judgment interest in the maximum amount allowed by law, and any other relief to which Plaintiff may be entitled.

COUNT II

MEDICAL NEGLIGENCE - WRONGFUL DEATH

COMES NOW Plaintiff Ann Jackson, as Administrator and Representative of the Estate of Pauline Purifoy, deceased, and for Count II of her claims against Defendants Cahokia Nursing

and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland states as follows:

62. Plaintiff hereby incorporates by reference Paragraphs 1 through 61 above as if fully set forth herein.

63. Pursuant to § 740 ILCS 180/1 et seq., Plaintiff brings this claim against Defendants for the wrongful death of Pauline Purifoy.

64. Defendants owed Pauline Purifoy a duty to keep her free from mental and/or physical abuse and neglect while she was a resident and to employ the proper standard of care in providing medical treatment to Pauline Purifoy.

65. As set forth in the Statement of Facts and Count I, *supra*, Defendants deprived Pauline Purifoy of her rights, abused her, neglected her, violated the applicable standard of care in the medical treatment provided to Pauline Purifoy.

66. As a direct and proximate result of this negligent and reckless misconduct of Defendants as more fully set forth above, Pauline Purifoy suffered serious and permanent injuries, including a severe urinary tract infection and dehydration leading to sepsis, and such injuries directly caused or contributed to cause Pauline Purifoy's death on April 18, 2015.

67. As a direct and proximate result of Defendant's conduct, the next of kin of Pauline Purifoy have suffered the following losses:

(a) The death of Pauline Purifoy on April 18, 2015;

(b) Grief, sorrow and mental suffering of Decedent's Survivors;

(c) Cost of funeral and burial services; and

(d) Loss of money, benefits, goods, services, guidance, companionship and loss of society by Decedent's Survivors after the death of decedent.

68. In addition to compensatory damages, the plaintiff seeks punitive damages, based on the defendants' indifference to or conscious disregard for the safety and well-being of others, including Pauline Purifoy. The amount of punitive damages to be awarded is within the discretion of the jury but plaintiffs seek an amount which will punish Defendants and deter Defendants and others similarly situated from like conduct in the future.

WHEREFORE, Plaintiff prays judgment against Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland in an amount in excess of $50,000.00 in actual and pecuniary damages recoverable under the Wrongful Death Act, funeral and burial services, medical expenses past and future, together with Plaintiff's costs, and for such other and further relief as the Court may deem proper, the premises considered.

COUNT III

STATUTORY VIOLATION OF THE ILLINOIS NURSING HOME CARE ACT
(210 ILCS 45/1-101, et seq.)

COMES NOW Plaintiff Ann Jackson, as Administrator and Representative of the Estate of Pauline Purifoy, deceased, and for Count III of her claims against Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland states as follows:

69. Plaintiff hereby incorporates by reference Paragraphs 1 through 68 above as if fully set forth herein.

70. Plaintiff brings this claim pursuant to the Illinois Nursing Home Care Act, 210 ILCS 45/1-101, et seq. and the Illinois Survival Statute, 755 Ill. Comp. Stat. Ann. 5/27-6.

71. As set forth more fully in paragraphs 22 through 34, Defendants were found by

the Illinois Department of Public Health to have multiple violations of Ill. Admin. Code tit. 77, §§ 300.610(a), 300.1010(h), 300.1210(b), 300.1210(c), 300.1210(d) and 300.3240(a) with respect to the care and treatment of Ms. Purifoy.

72. As set forth more fully in paragraphs 35 through 49, Defendants were found by the Illinois Department of Public Health to have multiple violations of Centers for Medicare & Medicaid Services, Department of Health and Human Services' Requirements for Long Term Care Facilities 42 C.F.R §§483.10(b)(11), 483.25, 483.25(a)(3), 483.25(g)(2), and 483.75(l)(1) with respect to the care and treatment of Ms. Purifoy.

73. The above violations by the Defendants of their duties presented a substantial risk of death or serious mental or physical harm to Pauline Purifoy or were more likely than not to cause more than minimal physical or mental harm to Pauline Purifoy and Defendants' violation caused or contributed to cause injury and damage to Pauline Purifoy.

74. Pursuant to Ill. Admin. Code tit. 77, § 300.3290, the owner and licensee of a facility are liable to a resident for any intentional or negligent act or omission of their agents or employees which injures the resident.

75. As a direct and proximate result of Defendants' violation of the statutory codes as set forth herein, Decedent sustained the following damages:

(a) Severe urinary tract infection and dehydration leading to sepsis and death;

(b) Extreme pain, mental anguish and suffering from the time of injury until the time of her death, including fear and depression and loss of enjoyment of life;

(c) Medical expenses incurred prior to her death.

76. The deprivation Pauline Purifoy suffered was the result of negligent acts or omissions which caused serious and permanent physical and emotional injuries to Pauline

Purifoy and were the result of willful and wanton conduct or were in reckless or conscious disregard of the rights of Pauline Purifoy. Such conduct justifies exemplary or punitive damages.

WHEREFORE, Plaintiff prays judgment against Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland in an amount in excess of $50,000.00 in actual and pecuniary damages, including medical expenses, punitive or exemplary damages, together with her costs, pre- and post-judgment interest in the maximum amount allowed by law, and any other relief to which Plaintiff may be entitled.

COUNT IV

RES IPSA LOQUITUR – SURVIVAL ACT

COMES NOW Plaintiff Ann Jackson, as Administrator and Representative of the Estate of Pauline Purifoy, deceased, and for Count IV of her claims against Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland states as follows:

77. Plaintiff hereby incorporates by reference Paragraphs 1 through 76 above as if fully set forth herein.

78. Plaintiff bring this claim pursuant to the Illinois Survival Statute, 755 Ill. Comp. Stat. Ann. 5/27-6.

79. At all relevant times, Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director

of Nursing Jaye Gilleland controlled and had the right to control Pauline Purifoy and her medical care.

80. The occurrences described above, including those in which Pauline Purifoy was unmonitored and left unattended and in which Pauline Purifoy developed an untreated severe infection and sepsis are the types of occurrence that do not ordinarily occur in the absence of negligence.

81. The instrumentalities that caused Pauline Purifoy's other injuries and the rapid worsening of Pauline Purifoy's condition were under the care and management of the Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland.

82. Defendants possess superior knowledge of or means of obtaining information about the cause of Pauline Purifoy's infections and other injuries.

83. From the fact of such occurrences and the reasonable inferences therefrom, such occurrences were directly caused by Defendants' negligence.

84. As a direct and proximate result of the negligence of Defendants, Pauline Purifoy suffered the following damages and injuries:

(a) Severe urinary tract infection and dehydration leading to sepsis and death;

(b) Extreme pain, mental anguish and suffering from the time of injury until the time of her death, including fear and depression and loss of enjoyment of life;

(c) Medical expenses incurred prior to her death.

85. Defendants' actions which injured or caused or contributed to cause Pauline Purifoy's untreated urinary infection, sepsis, and resulting death were the result of willful,

wanton or malicious conduct by Defendants. Such conduct justifies exemplary or punitive damages.

WHEREFORE, Plaintiff prays judgment against Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland in an amount in excess of $50,000.00 in actual and pecuniary damages, including medical expenses, punitive or exemplary damages, together with her costs, pre- and post-judgment interest in the maximum amount allowed by law, and any other relief to which Plaintiff may be entitled.

COUNT V

RES IPSA LOQUITUR – WRONGFUL DEATH ACT

COMES NOW Plaintiff Ann Jackson, as Administrator and Representative of the Estate of Pauline Purifoy, deceased, and for Count V of her claims against Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland states as follows:

86. Plaintiff hereby incorporates by reference Paragraphs 1 through 85 above as if fully set forth herein.

87. Pursuant to § 740 ILCS 180/1 et seq., Plaintiff brings this claim against Defendants for the wrongful death of Pauline Purifoy.

88. Defendants owed Pauline Purifoy a duty to keep her free from mental and/or physical abuse and neglect while she was a resident and to employ the proper standard of care in providing medical treatment to Pauline Purifoy.

89. As set forth in the Statement of Facts and Count I, *supra*, Defendants deprived Pauline Purifoy of her rights, abused her, neglected her, violated the applicable standard of care in the medical treatment provided to Pauline Purifoy. Furthermore, as set forth in Count IV, *supra*, the occurrences in which Pauline Purifoy was unmonitored and left unattended and in which Pauline Purifoy developed an untreated severe infection and sepsis are the types of occurrence that do not ordinarily occur in the absence of negligence.

90. The instrumentalities that caused Pauline Purifoy's other injuries and the rapid worsening of Pauline Purifoy's condition were under the care and management of the Defendants and Defendants possess superior knowledge of or means of obtaining information about the cause of Pauline Purifoy's infections and other injuries

91. As a direct and proximate result of this negligent and reckless misconduct of Defendants as more fully set forth above, Pauline Purifoy suffered serious and permanent injuries, including a severe urinary tract infection and dehydration leading to sepsis, and such injuries directly caused or contributed to cause Pauline Purifoy's death on April 18, 2015.

92. As a direct and proximate result of Defendant's conduct, the next of kin of Pauline Purifoy have suffered the following losses:

(a) The death of Pauline Purifoy on April 18, 2015;

(b) Grief, sorrow and mental suffering of Decedent's Survivors;

(c) Cost of funeral and burial services; and

(d) Loss of money, benefits, goods, services, guidance, companionship and loss of society by Decedent's Survivors after the death of decedent.

93. In addition to compensatory damages, the plaintiff seeks punitive damages, based on the defendants' indifference to or conscious disregard for the safety and well-being of others, including Pauline Purifoy. The amount of punitive damages to be awarded is within the

discretion of the jury but plaintiffs seek an amount which will punish defendant and deter defendant and others similarly situated from like conduct in the future.

WHEREFORE, Plaintiff prays judgment against Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland in an amount in excess of $50,000.00 in actual and pecuniary damages recoverable under the Wrongful Death Act, funeral and burial services, medical expenses past and future, together with Plaintiff's costs, and for such other and further relief as the Court may deem proper, the premises considered.

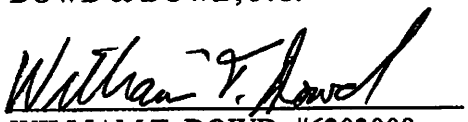
JURY DEMAND

94. Plaintiff hereby demands a trial by jury as to all issues so triable.

PRAYER

WHEREFORE, Plaintiff asks that Defendants Cahokia Nursing and Rehabilitation Center, Inc., Benjamin Klein, Miriam Klein, Albert Milstein, Sheldon Wolfe, SW Financial Services Company, Administrator Janice Kalz, Director of Nursing Mary Johnson, and Assistant Director of Nursing Jaye Gilleland be cited to appear and answer herein. That upon final trial, Plaintiff has judgment against Defendants for all damages available under applicable law, pre- and post-judgment interest in the maximum amount allowed by law, costs of court, and any other relief to which Plaintiff may be entitled.

DOWD & DOWD, P.C.

BY: 

WILLIAM T. DOWD, #6203008
RICHARD K. DOWD, MO Bar #33383
Attorneys for Plaintiff
211 North Broadway, Suite 4050
St. Louis, Missouri 63102

Phone 314-621-2500
Fax 314-621-2503