Peter J. Birnbaum
Chief Justice

STATE OF ILLINOIS
COURT OF CLAIMS
630 SOUTH COLLEGE
SPRINGFIELD, ILLINOIS 62756
217/782-7101

Jesse White
Secretary of State
and Ex Officio Clerk
of The Court of Claims

Erica L. Katava
Deputy Clerk

APRIL 05, 2021

LEVIN & PERCONI
325 N LASALLE ST STE 300
CHICAGO IL 60654-0000

RE: 21CC3392 - LAMB, LESLIE, AS INDEPENDENT EXECUTOR OF THE ESTATE OF RICH
$2,000,000.00

This letter acknowledges receipt of the claim captioned above, which has been filed with the Clerk of the Court of Claims. The Attorney General will investigate the claim and represent the State in this matter. Please refer to the captioned case number in the event you have inquiries concerning your claim.

As the Clerk's office is notified of further developments in this proceeding, you will be advised.

Sincerely,

Illinois Court of Claims

EK: CD
CC: ATTORNEY GENERAL - CHICAGO

IN THE COURT OF CLAIMS OF THE STATE OF ILLINOIS

Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., Deceased,

Claimant,

vs.

State of Illinois, Illinois Department of Veterans' Affairs, and The Adjutant Illinois Veterans Home – LaSalle a/k/a LaSalle Veterans' Home,

Respondents.

NO. 21CC3392

$2,000,000.00 amount claimed per count

COMPLAINT

The Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., Deceased, by and through her attorneys, Levin & Perconti, complains against Respondents, State of Illinois, Illinois Department of Veterans' Affairs and the Adjutant Illinois Veterans Home – LaSalle a/k/a LaSalle Veterans' Home, as follows:

COUNT I
Lamb v. LaSalle
Statutory Action – Nursing Home Care Act

1. This is an action for personal injuries arising under 705 ILCS 505/8(d).

2. This action involves tort claims arising from Respondents' negligent acts and/or omissions in the care and treatment of Richard John Cieski, Sr., while a resident at the Adjutant Illinois Veterans Home – LaSalle a/k/a LaSalle Veterans' Home (hereinafter "LaSalle Veterans' Home").

3. LaSalle Veterans' Home is a long-term care facility located at 1015 O'Conor Avenue in LaSalle, LaSalle County, Illinois.

4. The present action brought by Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., is, to her knowledge, the first claim arising out of the occurrence alleged in this Complaint and against the State of Illinois, its Departments, its Officers, the Illinois Department of Veterans' Affairs, and/or LaSalle Veterans' Home.

5. The present claim brought by Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., has not been the subject of any administrative proceedings to date.

6. The present claim brought by Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., nor any other claim arising out of the same occurrence, has been previously presented to any person, firm, Court or Administrative Tribunal other than the State of Illinois.

7. Leslie Lamb is the Independent Executor of the Estate of Richard John Cieski, Sr., Deceased, (See Order Admitting Will to Probate and Appointing Representative, attached as **Exhibit A**). No assignment or transfer of this claim, or any part thereof has been made excluding a contingency fee agreement Ms. Lamb entered into with her attorneys.

8. Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., Deceased, is justly entitled to the amount herein claimed, after allowing all just credits, from Respondents or any other appropriate state agency.

9. Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., Deceased, by and through her attorneys, Levin & Perconti, believes that the facts stated in this Complaint are true.

A. <u>The Parties</u>

10. At all times relevant to this Complaint, the Illinois Department of Veterans' Affairs owned, operated, maintained, managed and controlled the long-term care facility for veterans commonly known as LaSalle Veterans' Home.

11. At all times relevant to this Complaint, the Illinois Department of Veterans' Affairs was the licensee of the long-term care facility for veterans commonly known as LaSalle Veterans' Home.

12. At all times relevant to this Complaint, LaSalle Veterans' Home held itself out as a skilled nursing home for veterans where it provided care to its residents through its employees, agents and apparent agents including doctors, nurses and other health care professionals.

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

14. Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., Deceased, brings this action pursuant to the Act.

15. At all times relevant to this Complaint, Respondent, LaSalle Veterans' Home, was a nursing facility as defined by 210 ILCS 45/1-113 and 77 Ill. Admin. Code, Ch. I, §300.300 and was subject to the requirements of the Act and the regulations of the Illinois Department of Public Health promulgated pursuant to the Act.

16. Richard John Cieski, Sr. ("Richard") was born on December 19, 1930.

17. Richard was admitted to LaSalle Veterans' Home on May 16, 2017, for long-term care.

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

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

20. On or around November 5, 2020, Richard was diagnosed with COVID-19.

21. Richard died on November 15, 2020, with "Novel Corona COVID-19 Virus Infection Pneumonia" listed as the cause of Richard's death.

22. At all times relevant to this Complaint, the Respondent, LaSalle Veterans' Home, by and through its actual, implied, and/or apparent agents, servants and employees, was not rendering assistance to the State of Illinois in response to the COVID-19 outbreak by providing health care services consistent with any guidance issued by the Illinois Department of Public Health.

23. At all times relevant to this Complaint, the Respondent, LaSalle Veterans' Home, by and through its actual, implied, and/or apparent agents, servants and employees, was not rendering assistance to the State of Illinois in response to the COVID-19 outbreak by increasing the number of beds at is facility.

24. At all times relevant to this Complaint, the Respondent, LaSalle Veterans' Home by and through its actual, implied, and/or apparent agents, servants and employees, was not rendering assistance to the State of Illinois in response to the COVID-19 outbreak by providing, preserving and properly employing PPE.

25. At all times relevant to this Complaint, the Respondent, LaSalle Veterans' Home, by and through its actual, implied, and/or apparent agents, servants and employees, was not rendering assistance to the State of Illinois in response to the COVID-19 outbreak by taking the necessary steps to provide medical care to patients with COVID-19 and to prevent further transmission of COVID-19.

26. At all times relevant to this Complaint, the Respondent, LaSalle Veterans' Home, represented to Richard and Richard's family that Respondent, LaSalle Veterans' Home, was a facility that timely, appropriately, and accurately communicates status updates regarding any changes in Richard's condition and/or living situation, including, but not limited to, any new illness contracted, room location change and the reasons for the change, and any presence and/or outbreak of highly contagious illnesses at the LaSalle Veterans' Home.

27. At all times relevant to this Complaint, Respondent, LaSalle Veterans' Home, represented itself as facility that provides services, including, but not limited to, infection control to residents for the purpose of protecting residents from any illness and/or infectious disease/virus, and promoting a higher quality of life for the resident.

28. At all times relevant to this Complaint, Richard and Richard's family specifically and reasonably relied on Respondent, LaSalle Veterans' Home's, representations that the LaSalle Veterans' Home provides their residents high quality and competent care, including infection control.

29. At all times relevant to this Complaint, Richard and Richard's family specifically and reasonably relied on Respondent, LaSalle Veterans' Home's representations that the LaSalle Veterans' Home would provide and communicate to Richard's family and Power of Attorney, status updates regarding any changes in Richard's condition and/or living situation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility;
b. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the resident assuming:
    i. 1) the resident does not require a higher level of care; and
    ii. 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19;
c. Facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In those cases, visitors will be limited to a specific room only;
d. Facilities are expected to notify potential visitors to defer visitation until further notice (through signage, calls, letters, etc.);
e. Those with symptoms of a respiratory infection (fever, cough, shortness of breath, or sore throat) should not be permitted to enter the facility at any time (even in end-of-life situations);
f. Cancel communal dining and all group activities, such as internal and external group activities;
g. Remind residents to practice social distancing and perform frequent hand hygiene;
h. Screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home;
i. Facilities should identify staff that work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19;
j. Facilities should review and revise how they interact vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), and other non-health care providers (e.g., food delivery, etc.), and take necessary actions to prevent any potential transmission; and
k. Take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible.

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

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

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

50. On March 17, 2020, the Illinois Department of Public Health (hereinafter referred to as "IDPH") confirmed the first resident of a Chicagoland area long-term care facility had tested positive for COVID-19 over the "past weekend", and upon further testing, 17 residents and four staff members tested positive for COVID-19.[7]

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

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

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

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

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

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

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

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

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

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

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

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

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[10] https://www.nytimes.com/2020/04/17/us/coronavirus-nursing-homes.html

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

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

C. Negligent Acts, Omissions and Mismanagement Leads to COVID-19 Outbreak at LaSalle Veterans' Home and Richard's Death

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

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

63. Upon information and belief, on October 31, 2020, various employees, including but not limited to, registered nurses, licensed practical nurses, certified nursing assistants, and nurses' aides attended an off-site party.

64. On or around November 1, 2020, two residents and two employees tested positive for COVID-19, and Administrator, Angela Mehlbrech informed residents, families or responsible parties and staff of the LaSalle Veterans' Home of the suspension of all visitation.[13]

65. On or after November 1, 2020, despite having actual knowledge of its own nursing staff's COVID-19 sympatology, Respondent, LaSalle Veterans' Home, by and through its actual, implied, and/or apparent agents, servants and employees, instructed nursing staff to continue to report to work and provide care to residents, including Richard.

66. On or around November 2, 2020, the nursing home Administrator, Angela Melbrech, notified the United States Department of Veterans Affairs of the outbreak and the

for the sole purpose of preservation of Plaintiff's record.

[13] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 1, 2020.

LaSalle County Health Departent notified the Illinois Department of Public Health "within the reporting system."[14]

67. On or around November 3, 2020, Respondent, LaSalle Veterans' Home nursing staff conducted a facility wide testing for COVID-19 of its residents, and the Illinois Department of Veteran Affairs and Illinois Department of Public Health were notified of the outbreak.[15]

68. On or around November 3, 2020, 22 residents tested positive for COVID-19, as well as 7 employees.[16]

69. Upon information and belief, on or around November 4, 2020, the infection control nurse at Respondent, LaSalle Veterans' Home, contacted the Illinois Department of Public Health regarding asymptomic employees working.

70. On or around November 4, 2020, Richard's family called the LaSalle Veterans' Home to ask for an update on Richard's health but did not receive a call back.

71. Upon information and belief, On or around November 5, 2020, the State of Illinois the state accepted a federal offer for personal protective gear to be supplied at Respondent, LaSalle Veterans' Home.

72. On or around November 5, 2020, Richard's family was informed that he tested positive for COVID-19.

73. On or around November 6, 2020, 48 residents tested positive for COVID-19, as well as 12 employees.[17]

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[14] https://www.bnd.com/news/coronavirus/article247894955.html

[15] Bumsted, Angela, DNP, RN, CIC, FAPIC. "Press Release: IDVA Launches Independent Investigation of Recent LaSalle Veterans' Home COVID-19 Outbreak." Received by the general public. November 24, 2020.

[16] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 3, 2020.

[17] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 6, 2020.

74. On or around November 7, 2020, 60 residents tested positive for COVID-19, as well as 43 employees.[18]

75. On or around November 8, 2020, Senator Tom Cullteron (D-Villa Park) and Paul Schimpf (R-Waterloo) requested that the Illinois Department of Veteran Affairs provide detailed documentation regarding the outbreak and how employees responded.[19]

76. On or around November 9, 2020, 62 residents tested positive for COVID-19, as well as 69 employees.[20]

77. On or around November 10, 2020, 64 residents tested positive for COVID-19, as well as 69 employees and 4 veterans' deaths.[21] The National Guard was sent to the LaSalle Veterans' Home to provide staff additional support. [22]

78. On or around November 11, 2020, 81 residents tested positive for COVID-19, as well as 88 employees, resulting in 7 veterans' deaths.[23]

79. On or around November 12, 2020, 82 residents tested positive for COVID-19, as well as 98 employees, resulting in 10 veterans' deaths.[24]

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[18] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 7, 2020.

[19] http://senategop.state.il.us/News/10114/Cullerton-and-Schimpf-formally-request-more-information-on-COVID-outbreak-at-LaSalle-Veterans-Home/news-detail/

[20] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 9, 2020.

[21] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 10, 2020.

[22] https://www.nprillinois.org/post/national-guard-staff-sent-lasalle-quincy-veterans-homes-after-outbreaks#stream/0

[23] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 11, 2020.

[24] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 12, 2020.

80. On or around November 12, 2020, Richard's family was informed that morphine would be administered if necessary.

81. On or before November 12, 2020, Respondent, LaSalle Veterans' Home, by and through its actual, implied, and/or apparent agents, servants and employees, failed to implement the CMS guidelines which were issued in the memorandum entitled "Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes".

82. On or around November 13, 2020, a site visit was conducted by the Illinois Department of Public Health where Respondent, LaSalle Veterans' Home, by and through its actual, implied, and/or apparent agents, servants and employees, was found noncompliant with various COVID-19 protocls, including but not limited to, improper handsanitizer, improper use of PPE, improper screening protocols, improper observerance of proper social distancing protocols, and improper hand hygiene and glove use.[25] In addition, 82 residents tested positive for COVID-19, as well as 90 employees, resulting in 13 veterans' deaths.[26]

83. On or around November 14, 2020, Richard's family was informed that the facility did not have morphine.

84. On or around November 15, 2020, Richard died with novel corona COVID-19 virus infection pneumonia listed as the cause of Richard's death.

85. On or around November 15, 2020, 93 residents tested positive for COVID-19, as well as 90 employees, resulting in 15 veterans' deaths.[27]

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[25] Bumsted, Angela, DNP, RN, CIC, FAPIC. "Press Release: IDVA Launches Independent Investigation of Recent LaSalle Veterans' Home COVID-19 Outbreak." Received by the general public. November 24, 2020.
[26] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 13, 2020.
[27] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 15, 2020

86. On or around November 16, 2020, 95 residents tested positive for COVID-19, as well as 90 employees, resulting in 17 veterans' deaths.[28]

87. On or around November 17, 2020, 96 residents tested positive for COVID-19, as well as 93 employees, resulting in 21 veterans' deaths.[29]

88. On or around November 18, 2020, 98 residents tested positive for COVID-19, as well as 93 employees, resulting in 23 veterans' deaths.[30]

89. On or around November 21, 2020, 103 residents tested positive for COVID-19, as well as 94 employees, resulting in 27 veterans' deaths.[31]

90. On or around November 24, 2020, 105 residents tested positive for COVID-19, as well as 95 employees, resulting in 27 veterans' deaths.[32]

91. On or around December 1, 2020, 108 residents tested positive for COVID-19, as well as 97 employees, resulting in 29 veterans' deaths.[33]

92. On or around December 3, 2020, 108 residents tested positive for COVID-19, as well as 97 employees, resulting in 31 veterans' deaths.[34]

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[28] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 16, 2020

[29] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 17, 2020

[30] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 18, 2020

[31] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 21, 2020

[32] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. November 24, 2020.

[33] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. December 1, 2020.

[34] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. December 3, 2020.

93. On or around December 5, 2020, 108 residents tested positive for COVID-19, as well as 97 employees, resulting in 32 veterans' deaths.[35]

94. On or around December 8, 2020, 108 residents tested positive for COVID-19, as well as 97 employees, resulting in 33 veterans' deaths.[36]

95. On or around December 11, 2020, the LaSalle Veterans' Home had 209 outbreak reported cases, resulting in 33 veterans' deaths.[37]

96. On or around December 19, 2020, 108 residents tested positive for COVID-19, as well as 103 employees, resulting in 34 veterans' deaths.[38]

97. On or around December 28, 2020, 108 residents tested positive for COVID-19, as well as 105 employees, resulting in 35 veterans' deaths.[39]

98. During the month of November 2020, while a resident at Respondent, LaSalle Veterans' Home, Richard suffered injuries including, but not limited to, contraction of novel corona COVID-19 virus infection pneumonia, a poor quality of life, a deterioration of his overall physical, mental, and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which Richard suffered from up until the time of his death.

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[35] Melbrech, Angela. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. December 5, 2020.

[36] Vaughn, Anthony. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. December 8, 2020.

[37] Vaughn, Anthony. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. December 11, 2020.

[38] Vaughn, Anthony. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. December 19, 2020.

[39] Vaughn, Anthony. "State of Illinois Department of Veterans' Affairs, Illinois Veterans' Home at LaSalle." Received by residents, families, or responsible parties, and staff of the Illinois Veterans Home at LaSalle. December 28, 2020.

99. Respondents, State of Illinois, Illinois Department of Veterans' Affairs and LaSalle Veterans' Home, through their owners, officers, managers, employees and/or actual, apparent or implied agents, had statutory obligations not to violate the rights of any resident of LaSalle Veterans' Home, which included the duty not to abuse or neglect any resident, as provided by the Act as follows:

> An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in the Abused and Neglected Long Term Care Facility Residents Reporting Act. 210 ILCS 45/2-107, 210 ILCS 45/3-610, 210 ILCS 45/3-808.5(c), and Ill. Admin. Code, Ch. I, §300.3240.
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> Abuse means any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility. 210 ILCS 45/1-103 and Ill. Admin. Code, Ch. I, §300.330.
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> Neglect means a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. 210 ILCS 45/1-117.
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> Neglect means the failure to provide adequate medical or personal care or maintenance, which failure results physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. This shall include any allegation where: (1) the alleged failure causing injury or deterioration is ongoing or repetitious; or (2) a resident required medical treatment as a result of the alleged failure; or (3) the failure is alleged to have caused a noticeable negative impact on a resident's health, behavior or activities for more than 24 hours. Ill. Admin. Code, Ch. I, §300.330.
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> Personal Care means assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual, who is incapable of maintaining a private, independent residence or who is incapable of managing his person whether or not a guardian has been appointed for such individual. 210 ILCS 45/1-120 and Ill. Admin. Code, Ch. I, §300.330.

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

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

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

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

102. At all times relevant to this Complaint, Respondents, State of Illinois, Illinois Department of Veterans' Affairs and LaSalle Veterans' Home, through their actual, implied and/or apparent agents, servants and employees, had a duty not to violate the rights of any resident of LaSalle Veterans' Home including, but not limited to, Richard, as specified by the provisions of the Act and the Illinois Administrative Code including, but not limited to, the following:

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

accessible;

h. 210 ILCS 45/3-202.2a: A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs;

i. 77 Ill. Admin. Code, Ch. I, §300.1210: The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care;

j. 77 Ill. Admin. Code, Ch. I, §300.696(a): Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed;

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

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

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

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

    (2) Guideline for Hand Hygiene in Health-Care Settings;
    (5) Guideline for Prevention of Nosocomial Pneumonia;
    (6) Guideline for Isolation Precautions in Hospitals;
    (7) Guidelines for Infection Control in Health Care Personnel;

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

p. 77 Ill. Admin. Code, Ch. I, §300.690.100(a)(1)(c): Persons who identify <u>a single case of a rare or significant infectious disease</u> shall report the case to the local health authority. This may include, but is not limited to, a case of

cowpox, Reye's syndrome, glanders, amoebic meningoencephalitis, orf, monkeypox, hemorrhagic fever viruses, infection from a laboratory-acquired recombinant organism, ***or any disease non-indigenous to the United States*** (emphasis added);

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

q. 77 Ill. Admin. Code, Ch. I, §300.1020(b): A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300.620 of this Part.
r. 77 Ill. Admin. Code, Ch. I, §300.1210(c): Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan;
s. 77 Ill. Admin. Code, Ch. I, §300.1210: The facility must provide adequate and properly supervised nursing care and personal care to each resident to meet the total nursing and personal care needs of the resident;
t. 77 Ill. Admin. Code, Ch. I, §300.1230(b): The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day;
u. 77 Ill. Admin. Code, Ch. I, §300.1230(d)(1) and (2): Each facility shall provide minimum direct care staff by: (1) determining the amount of direct care staffing needed to meet the needs of its residents; and (2) meeting the minimum direct care staffing ratios set forth in §300.1230;
v. 77 Ill. Admin. Code, Ch. I, §300.1230(i): The facility shall schedule nursing personnel so that the nursing needs of all residents are met; and
w. 77 Ill. Admin. Code, Ch. I, §300.3210(a): No resident shall be deprived of any rights, benefits or privileges guaranteed by law based on their status as a resident of a facility.

103. Notwithstanding such duty, Respondents, State of Illinois, Illinois Department of Veterans' Affairs and LaSalle Veterans' Home, operating through their actual, implied and/or apparent agents, servants and employees, did not exercise reasonable and due care and the level of diligence and competence required of a long-term skilled nursing care facility, as the following general isolation and infection control and prevention procedures were required to be implemented by nursing staff:

a. Establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases and infections;
b. Establish and maintain a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing nursing services;
c. The levels and amount of nursing staff available and staffed each shift must be continually and appropriately increased in order to adequately provide care and treatment to residents in accordance to facility, state, and federal infection control and prevention regulations, policies and procedures;
d. The levels and amount of PPE available to nursing staff and other long-term care facility employees must be continually purchased, provided, maintained, and/or monitored in a manner that ensures at all times PPE will be available to the nursing staff and other long-term care facility employees;
e. Staff, at all times, must be required to utilize PPE when providing care and treatment to residents that are suspected to be positive for an infectious disease, as well as residents who verbally communicate and/or physically present with symptoms consistent with an infectious and communicable disease;
f. Staff, at all times, must be required to utilize PPE when providing care and treatment to residents when there is an outbreak of infectious and communicable disease in the facility;
g. Staff, at all times, must be required to wash their hands after each direct resident contact;
h. Prohibit any employees suspected to have contracted a communicable disease or illness, as well as employees who have tested positive for a communicable disease or illness, from entering the facility, and from having any direct contact with residents;
i. Personnel must handle, store, process, and transport linens so as to prevent the spread of any infection;
j. When residents are isolated due to the presence and/or outbreak of a highly contagious and communicable virus, any health care professionals assigned to the care and treatment of the infected resident must only be assigned to that resident and/or other residents who have been identified with the same infection;
k. Health care professionals working on an isolated care unit due to an infectious outbreak must have designated a restroom(s), break room(s), and work area(s) that are separate from other health care professionals working on non-isolated and non-infectious units;
l. Maintain and have available portable x-ray equipment in resident cohort areas to reduce the need for patient transport and acute hospitalization;

m. In the event of any infectious disease or illness outbreak in a long-term care facility, the facility must purchase, provide, and maintain sufficient facemasks and/or facial coverings for all residents in order to contain infectious secretions and the spread of respiratory droplets in any communal areas;
n. In the event of any infectious disease or illness outbreak in a long-term care facility, the facility must temporarily halt admissions to the facility until the extent of transmission can be clarified, and interventions are implemented;
o. In the event of any infectious disease or illness outbreak in a long-term care facility, the facility must encourage all residents to restrict themselves to their room to the extent possible; and
p. In the event of any infectious disease or illness outbreak in a long-term care facility, the staff must provide physical assistance to any residents who are unable to "socially distance" themselves from others due to the resident's physical, mental, and/or underlying medical condition(s).

104. Notwithstanding such duty, Respondents, State of Illinois, Illinois Department of Veterans' Affairs and LaSalle Veterans' Home, operating through their actual, implied and/or apparent agents, servants and employees, were negligent in the care and treatment of Richard by one or more of the following statutory violations and negligent acts and/or omissions:

a. Failed to develop appropriate infection control and prevention policies and procedures;
b. Failed to provide, maintain, monitor and/or employ appropriate PPE, including the failure of nursing staff donning the appropriately fitted, medical-grade N95 respirators;
c. Failed to ensure staff did not enter common areas of non-COVID-19/non-cohorted units;
d. Failed to ensure a proper screening process was done at the staff entry of The Adjutant Illinois Veterans Home – LaSalle, including temperature montioring and a form which lists all screening questions and symptoms related to COVID-19 protocol;
e. Negligently instructed one or more members of the Defendant's nursing staff to continue to come into The Adjutant Illinois Veterans Home – LaSalle and provide direct care to elderly residents, including Richard;
f. Failed to timely ensure COVID-19 test results for residents and staff suspected and/or symptomatic of COVID-19;
g. Failed to properly disinfect and/or follow the appropriate infection control policies and procedures;
h. Failed to operative negative pressure rooms in an effective manner to decrease the likelihood of transmission;

i. Failed to ensure staff practiced appropriate social distancing measursing, including maintaining a distance of six (6) feet;
j. Failed to ensure adequate levels of hand hygiene, hand washing, and/or alcohol-based hand disinfectant products/equipment;
k. Failed to ensure appropriate supplies for infection control practices;
l. Failed to provide alcohol-based hand disinfectant/hygiene products both inside and outside of residents' rooms, including Richard's, at all entrances, and throughout any and all clinical areas; and
m. Failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including Richard, in full recognition of Richard's individuality.

105. As a direct and proximate result of one or more of the above negligence acts and/or omissions of Respondents, Richard suffered injuries including but not limited, the contraction of novel corona COVID-19 virus infection pneumonia, a poor quality of life, a deterioration of his overall physical, mental, and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which Richard suffered from up until the time of his death.

106. As a direct and proximate result of the negligent acts and/or omissions of Respondents, Richard suffered injuries of a personal and pecuniary nature including, but not limited to, pain, suffering, disability and disfigurement, and medical and related expenses.

107. Attached to this Complaint as **Exhibit B** is a notice served upon the Clerk of the Court of Claims and the Attorney General of the State of Illinois as required by law.

WHEREFORE, Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., Deceased, through her attorneys, Levin & Perconti, demands judgment against Respondents, State of Illinois, Illinois Department of Veterans' Affairs and the Adjutant Illinois Veterans Home – LaSalle a/k/a LaSalle Veterans' Home in the amount of Two Million Dollars ($2,000,000.00).

COUNT II
Lamb v. LaSalle
Common Law Negligence – Survival Act

1. Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., repeats, realleges and fully incorporates by reference all facts and allegations contained in Paragraphs 1-97 as fully set forth herein.

98. During the month of November 2020, while a resident at LaSalle Veterans' Home, Richard suffered injuries including, but not limited to, contraction of novel corona COVID-19 virus infection pneumonia, a poor quality of life, a deterioration of his overall physical, mental, and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which Richard suffered from up until the time of his death

99. Respondents, State of Illinois, Illinois Department of Veterans' Affairs and LaSalle Veterans' Home, through their owners, officers, managers, employees and/or actual, apparent or implied agents, had statutory obligations not to violate the rights of any resident of LaSalle Veterans' Home, which included the duty not to abuse or neglect any resident, as provided by the Act as follows:

> An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in the Abused and Neglected Long Term Care Facility Residents Reporting Act. 210 ILCS 45/2-107, 210 ILCS 45/3-610, 210 ILCS 45/3-808.5(c), and Ill. Admin. Code, Ch. I, §300.3240.
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> Abuse means any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility. 210 ILCS 45/1-103 and Ill. Admin. Code, Ch. I, §300.330.
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> Neglect means a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. 210 ILCS 45/1-117.
>
> Neglect means the failure to provide adequate medical or personal care or maintenance, which failure results physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. This shall

include any allegation where: (1) the alleged failure causing injury or deterioration is ongoing or repetitious; or (2) a resident required medical treatment as a result of the alleged failure; or (3) the failure is alleged to have caused a noticeable negative impact on a resident's health, behavior or activities for more than 24 hours. Ill. Admin. Code, Ch. I, §300.330.

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

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

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

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

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

102. At all times relevant to this Complaint, Respondents, State of Illinois, Illinois Department of Veterans' Affairs and LaSalle Veterans' Home, through their actual, implied and/or apparent agents, servants and employees, had a duty not to violate the rights of any resident of LaSalle Veterans' Home including, but not limited to, Richard, as specified by the provisions of the Act and the Illinois Administrative Code including, but not limited to, the following:

a. 210 ILCS 45/2-212: The facility shall ensure that its staff is familiar with and observes the rights and responsibilities enumerated in this Article;
b. 210 ILCS 45/3-202(2): Number and qualifications of all personnel, including management and nursing personnel, having responsibility for any part of the care given to residents; specifically, the Department shall establish staffing ratios for facilities which shall specify the number of staff hours per resident of care that are needed for professional nursing care for various types of facilities or areas within facilities;
c. 210 ILCS 45/3-202(5): Equipment essential to the health and welfare of the

residents;

d. 210 ILCS 45/3-202.05(b)(3): Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment;
e. 210 ILCS 45/2-213(c): A skilled nursing facility shall designate a person or persons as Infection Prevention and Control Professionals to develop and implement policies governing control of infections and communicable diseases. The Infection Prevention and Control Professionals shall be qualified through education, training, experience, or certification or a combination of such qualifications. The Infection Prevention and Control Professional's qualifications shall be documented and shall be made available for inspection by the Department;
f. 210 ILCS 45/2-108: Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation;
g. 210 ILCS 45/2-108(a): The administrator shall ensure that correspondence is conveniently received and mailed, and that telephones are reasonably accessible;
h. 210 ILCS 45/3-202.2a: A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs;
i. 77 Ill. Admin. Code, Ch. I, §300.1210: The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care;
j. 77 Ill. Admin. Code, Ch. I, §300.696(a): Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed;
k. 77 Ill. Admin. Code, Ch. I, §300.696(b): A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections;
l. 77 Ill. Admin. Code, Ch. I, §300.1020(a): The facility shall comply with the
m. Control of Communicable Diseases Code (77 Ill. Adm. Code 690).
n. 77 Ill. Admin. Code, Ch. I, §300.696(c): Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for

Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):

(2) Guideline for Hand Hygiene in Health-Care Settings;
(5) Guideline for Prevention of Nosocomial Pneumonia;
(6) Guideline for Isolation Precautions in Hospitals;
(7) Guidelines for Infection Control in Health Care Personnel;

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

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

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

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

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

s. 77 Ill. Admin. Code, Ch. I, §300.1210: The facility must provide adequate and properly supervised nursing care and personal care to each resident to meet the total nursing and personal care needs of the resident;

t. 77 Ill. Admin. Code, Ch. I, §300.1230(b): The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day;

u. 77 Ill. Admin. Code, Ch. I, §300.1230(d)(1) and (2): Each facility shall provide minimum direct care staff by: (1) determining the amount of direct care staffing needed to meet the needs of its residents; and (2) meeting the minimum direct care staffing ratios set forth in §300.1230;

v. 77 Ill. Admin. Code, Ch. I, §300.1230(i): The facility shall schedule nursing

personnel so that the nursing needs of all residents are met; and

w. 77 Ill. Admin. Code, Ch. I, §300.3210(a): No resident shall be deprived of any rights, benefits or privileges guaranteed by law based on their status as a resident of a facility.

103. Notwithstanding such duty, Respondents, State of Illinois, Illinois Department of Veterans' Affairs and LaSalle Veterans' Home, operating through their actual, implied and/or apparent agents, servants and employees, did not exercise reasonable and due care and the level of diligence and competence required of a long-term skilled nursing care facility, as the following general isolation and infection control and prevention procedures were required to be implemented by nursing staff:

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

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

104. Notwithstanding such duty, Respondents, State of Illinois, Illinois Department of Veterans' Affairs and LaSalle Veterans' Home, operating through their actual, implied and/or apparent agents, servants and employees, were negligent in the care and treatment of Richard by one or more of the following statutory violations and negligent acts and/or omissions:

a. Failed to develop appropriate infection control and prevention policies and procedures;
b. Failed to provide, maintain, monitor and/or employ appropriate PPE, including the failure of nursing staff donning the appropriately fitted, medical-grade N95 respirators;
c. Failed to ensure staff did not enter common areas of non-COVID-19/non-cohorted units;
d. Failed to ensure a proper screening process was done at the staff entry of The Adjutant Illinois Veterans Home – LaSalle, including temperature montioring and a form which lists all screening questions and symptoms related to COVID-19 protocol;
e. Negligently instructed one or more members of the Defendant's nursing staff to continue to come into The Adjutant Illinois Veterans Home – LaSalle and provide direct care to elderly residents, including Richard;
f. Failed to timely ensure COVID-19 test results for residents and staff suspected and/or symptomatic of COVID-19;
g. Failed to properly disinfect and/or follow the appropriate infection control policies and procedures;
h. Failed to operative negative pressure rooms in an effective manner to decrease the likelihood of transmission;
i. Failed to ensure staff practiced appropriate social distancing measursing, including maintaining a distance of six (6) feet;
j. Failed to ensure adequate levels of hand hygiene, hand washing, and/or alcohol-based hand disinfectant products/equipment;
k. Failed to ensure appropriate supplies for infection control practices;
l. Failed to provide alcohol-based hand disinfectant/hygiene products both inside and outside of residents' rooms, including Richard's, at all entrances, and throughout any and all clinical areas; and
m. Failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including Richard, in full recognition of Richard's individuality.

105. As a direct and proximate result of one or more of the above negligence acts and/or omissions of Respondents, Richard suffered injuries including but not limited, the contraction of novel corona COVID-19 virus infection pneumonia, a poor quality of life, a deterioration of his overall physical, mental, and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which Richard suffered from up until the time of his death

106. As a direct and proximate result of the negligent acts and/or omissions of Respondents, Richard suffered injuries of a personal and pecuniary nature including, but not

limited to, pain, suffering, disability and disfigurement, and medical and related expenses.

107. Attached to this Complaint as **Exhibit B** is a notice served upon the Clerk of the Court of Claims and the Attorney General of the State of Illinois as required by law.

108. Attached to this Complaint as **Exhibit C** is the Attorney Affidavit and Health Professional's Report filed pursuant to 735 ILCS 5/2-622(a)(1).

109. The Leslie Lamb, as Independent Executor of the Estate of Richard Cieski, Sr., Deceased, brings this action pursuant to the provisions of 755 ILCS 5/27-6, commonly known as the Illinois Survival Act.

WHEREFORE, Leslie Lamb, as Independent Executor of the Estate of Richard Cieski, Sr., Deceased, through her attorneys, Levin & Perconti, demands judgment against Respondents, State of Illinois, Illinois Department of Veterans' Affairs and the Adjutant Illinois Veterans Home – LaSalle a/k/a LaSalle Veterans' Home in the amount of Two Million Dollars ($2,000,000.00).

COUNT III
Lamb v. LaSalle
Common Law Negligence – Wrongful Death

1-104. The Claimant re-alleges paragraphs 1 through 104 of Count II as paragraphs 1 through 104 of Count III.

105. As a direct and proximate result of one or more of the above negligence acts and/or omissions of Respondents, Richard suffered injuries including but not limited, the contraction of novel corona COVID-19 virus infection pneumonia, a poor quality of life, a deterioration of his overall physical, mental, and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which Richard suffered from up until the time of his death.

106. The Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., Deceased, brings this action pursuant to the provisions of 740 ILCS 180/1 et seq., commonly

known as the Illinois Wrongful Death Act.

107. Richard left surviving his various person who were Richard's next-of-kin including, but not limited to:

a. **Bernadine Cieski (wife);**
b. **Leslie Lamb (daughter);**
c. **Debra Hadlock (daughter); and**
d. **Richard Cieski, Jr. (son).**

108. All of Richard's next-of-kin suffered injuries as a result of Richard's death, including loss of companionship, loss of society, grief, sorrow and mental suffering.

109. Attached to this Complaint as **Exhibit C** is the Attorney Affidavit and the Health Professional's Report filed pursuant to 735 ILCS 5/2-622(a)(1).

WHEREFORE, Leslie Lamb, as Independent Executor of the Estate of Richard Cieski, Sr., Deceased, through her attorneys, Levin & Perconti, demands judgment against Respondents, State of Illinois, Illinois Department of Veterans' Affairs and the Adjutant Illinois Veterans Home – LaSalle a/k/a LaSalle Veterans' Home, in the amount of Two Million Dollars ($2,000,000.00).

Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that he verily believes the same to be true.

Respectfully submitted,
LEVIN & PERCONTI

BY: 

Michael F. Bonamarte (mfb@levinperconti.com)
Margaret P. Battersby Black (mpb@levinperconti.com)
Isabela Bacidore (irb@levinperconti.com)
LEVIN & PERCONTI (Attorney No. 55019)
325 North LaSalle Street, Suite 300
Chicago, IL 60654
312 332-2872
312-332-3112 – fax

300

UNITED STATES OF AMERICA
STATE OF ILLINOIS COUNTY OF LASALLE
IN THE CIRCUIT COURT OF THE THIRTEENTH JUDICIAL CIRCUIT

EFILED
2/18/2021
KQ
Greg Vaccaro
13th Judicial Circuit
La Salle County, IL

ESTATE OF

Richard John Cieski, Sr.
Deceased

Case No. 2021P000034

ORDER ADMITING WILL TO PROBATE AND APPOINTING REPRESENTATIVE

Onthe verified petition of Leslie Lamb

for admission to probate of the will of Richard John Cieski, Sr. and for issuance of letters of office, the will having been proved as provided by law,

It is ordered that:

1. The will of Richard John Cieski, Sr. dated December 26 2000,

(and codicil dated November 13, 20 13) be admitted to probate;
(Complete or delete)

2. Letters of office as independent executor
(executor) (independent executor)

(administrator with will annexed) (independent administrator with will annexed)

issue to Leslie Lamb

3. This matter is continued to February 10, 2022 at 9:00AM for status.

Dated: _____, 20___

Entered: _____
Judge

Name SJ Chapman chapman@bc-lawyers.com
Attorney for Leslie Lamb
Address 123 N Wacker Dr. Suite 2300
Chicago, IL 60606
Telephone 312-583-9430

2/18/2021

EXHIBIT A

PETER J. BIRNBAUM, CHIEF JUSTICE

STATE OF ILLINOIS

COURT OF CLAIMS

630 SOUTH COLLEGE
SPRINGFIELD, ILLINOIS 62756

217/782-7101

JESSE WHITE

SECRETARY OF STATE
AND EX OFFICIO CLERK
OF THE COURT OF CLAIMS

ERICA L. KATAVA
DIRECTOR AND DEPUTY CLERK

March 9, 2021

Levin & Perconti
Attn: Isabela Bacidore
325 N LaSalle St Ste 300
Chicago, IL 60654

RE: Notice of Intent- Richard John Cieski, Sr.

Dear Sir:

We are in receipt of your Notice of Intent. Please find applicable procedures for submitting your complaint in Sec. 790.40 (Procedure) and Sec. 790.50 (Complaint-Required Provisions) in the *Illinois Court of Claims Rules and Statutes*.

To obtain a copy of the *Illinois Court of Claims Rules and Statutes*, please go to http://www.cyberdriveillinois.com.

Sincerely,

Erica Katava
Director & Deputy Clerk

EK:cd

Printed by authority of the State of Illinois. September 2019 — 1.5M — CC 74.5

EXHIBIT B

Notice of Intent of Claim for Personal Injury

IN THE COURT OF CLAIMS - STATE OF ILLINOIS

TO: DATE: 3/5/21

Attorney General Kwame Raoul
100 West Randolph Street
Chicago, Illinois 60602

and

Clerk of the Court of Claims
100 West Randolph Street
Chicago, Illinois 60602

Each Of You Are Hereby Notified that the following CLAIMANT, **Richard John Cieski, Sr., by his wife, Bernadine Cieski,** will bring a civil action against the State of Illinois for Damages for personal injuries suffered by **Richard John Cieski, Sr.**

Each Of You Are Further Notified that this Notice is given in accordance with the Illinois Statutes, Chapter 37, Section 439.22-1, and Rules of the Court of Claims. In complaint thereof, this Notice is being filed with each of you in your office, together with the following Statement of Information.

1. **Name of the person to whom the cause of action has accrued:**

   Richard John Cieski, Sr.

2. **Name and residence of the injured person:**

   Richard John Cieski, Sr.
   The Adjutant Illinois Veterans Home – LaSalle
   1015 O'Conor Avenue
   LaSalle, Illinois 61031

3. **Date and time of the injuries:**

   In November 2020, during his residency at The Adjutant Illinois Veterans Home – LaSalle, **Richard John Cieski, Sr.**, suffered injuries including the contraction of the novel corona COVID-19 virus infection pneumonia, severe acute respiratory syndrome, a poor quality of life, a deterioration of his overall physical, mental and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which caused or contributed to his death.

4. **Location where the injuries occurred:**

The Adjutant Illinois Veterans Home - LaSalle
1015 O'Conor Avenue
LaSalle, Illinois 61301

5. **Brief description of how the injuries occurred:**

Richard John Cieski, Sr., was admitted to The Adjutant Illinois Veterans Home – LaSalle for nursing care on May 15, 2017.

On or around November 1, 2020, nursing staff and residents at The Adjutant Illinois Veterans Home – LaSalle, tested positive for COVID-19. On or around November 2, 2020, all residents at The Adjutant Illinois Veterans Home – LaSalle were tested for COVID-19. On or around November 5, 2020, **Richard John Cieski, Sr.**, tested positive for COVID-19.

Richard John Cieski, Sr., eventually passed away on November 15, 2020, The Adjutant Illinois Veterans Home - LaSalle with novel corona COVID-19 virus infection pneumonia listed as the immediate cause of death. (See Death Certificate, attached as Exhibit 1).

Claimant alleges that the State of Illinois (The Adjutant Illinois Veterans Home – LaSalle), by and through its servants, employees, and/or agents, was negligent in the care and treatment of **Richard John Cieski, Sr.** Said negligence includes, but is not limited to:

a. Failed to develop appropriate infection control and prevention policies and procedures;
b. Failed to provide, maintain, monitor and/or employ appropriate PPE, including the failure of nursing staff donning the appropriately fitted, medical-grade N95 respirators;
c. Failed to ensure staff did not enter common areas of non-COVID-19/non-cohorted units;
d. Failed to ensure a proper screening process was done at the staff entry of The Adjutant Illinois Veterans Home – LaSalle, including temperature montioring and a form which lists all screening questions and symptoms related to COVID-19 protocol;
e. Negligently instructed one or more members of the Defendant's nursing staff to continue to come into The Adjutant Illinois Veterans Home – LaSalle and provide direct care to elderly residents, including Richard;
f. Failed to timely ensure COVID-19 test results for residents and staff suspected and/or symptomatic of COVID-19;
g. Failed to properly disinfect and/or follow the appropriate infection control policies and procedures;
h. Failed to operative negative pressure rooms in an effective manner to decrease the likelihood of transmission;
i. Failed to ensure staff practiced appropriate social distancing measursing, including maintaining a distance of six (6) feet;
j. Failed to ensure adequate levels of hand hygiene, hand washing, and/or alcohol-based hand disinfectant products/equipment;

k. Failed to ensure appropriate supplies for infection control practices;
l. Failed to provide alcohol-based hand disinfectant/hygiene products both inside and outside of residents' rooms, including Richard's, at all entrances, and throughout any and all clinical areas; and
m. Failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including Richard, in full recognition of Richard's individuality.

At all times relevant to this claim, **Richard John Cieski, Sr.**, suffered injuries including, but not limited to, the contraction of the novel corona COVID-19 virus infection pneumonia, severe acute respiratory syndrome, a poor quality of life, a deterioration of his overall physical, mental, and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which **Richard John Cieski, Sr.**, suffered from up until the time of his death.

6. **Name and address of the primary care physicians:**

Ramon B. Inciong, MD
402 W. Walnut Street
Oglesby, Illinois 61348

7. **Nature of injury:**

As a result of the negligence of the State of Illinois, **Richard John Cieski, Sr.**, suffered injuries including, but not limited to, the contraction of the novel corona COVID-19 virus infection pneumonia, severe acute respiratory syndrome, a poor quality of life, a deterioration of his overall physical, mental, and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which **Richard John Cieski, Sr.**, suffered from up until the time of his death.

BY: Isabela R Bacidore
ISABELA BACIDORE

RECEIVED A COPY OF ABOVE NOTICE ON _____, 2021.

STATE OF ILLINOIS

ILLINOIS ATTORNEY GENERAL

STATE OF ILLINOIS

CLERK OF THE COURT OF CLAIMS

IN THE COURT OF CLAIMS OF THE STATE OF ILLINOIS

Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., Deceased, **Claimant,** **vs.** **State of Illinois, Illinois Department of Veterans' Affairs, and The Adjutant Illinois Veterans Home – LaSalle a/k/a LaSalle Veterans' Home,** **Respondents.**	**NO:** **$2,000,000.00 amount claimed per count**

ATTORNEY'S AFFIDAVIT PURSUANT TO 2-622 OF THE ILLINOIS CODE OF CIVIL PROCEDURE

YOUR AFFIANT, **ISABELA BACIDORE**, attorney for the Plaintiff, **Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., Deceased** being first duly sworn, deposes and states that:

1. I am one of the attorneys for the Plaintiff, **Leslie Lamb, as Independent Executor of the Estate of Richard John Cieski, Sr., Deceased.**

2. I have consulted and reviewed the facts surrounding the treatment of **Richard John Cieski, Sr.,** with a physician licensed to practice medicine in all its branches, whom I reasonably believe is (i) knowledgeable in the relevant issues involved in this particular action, (ii) practices or has practiced within the last 6 years or teaches or has taught within the last 6 years in the same area of health care or medicine that is at issue in this particular action, and (iii) meets the expert witness standards set forth in paragraphs (a) through (d) of Section 8-2501.

3. The said reviewing physician is qualified by experience or has demonstrated competence in the subject of this case and has determined written reports with specific allegations as to Defendants, **State of Illinois, Illinois Department of Veterans' Affairs, and The Adjutant**

EXHIBIT C

Illinois Veterans Home – LaSalle a/k/a LaSalle Veterans' Home (copies of which are attached hereto), after a review of **Richard John Cieski, Sr.'s** medical records and other relevant material, that there is a reasonable and meritorious cause for the filing of this action as to these Defendants.

4. I have concluded, on the basis of said review and consultation of the reviewing physician, that there is a reasonable and meritorious cause for the filing of this action.

5. True and correct copies of the reports of the reviewing physician are attached hereto.

Respectfully submitted,
LEVIN & PERCONTI

By: Isabela R Bacidore
ISABELA BACIDORE

SUBSCRIBED and SWORN TO before me
this 24th day of March, 2021

Maria V. Witvliet
NOTARY PUBLIC

"OFFICIAL SEAL"
MARIA V WITVLIET
Notary Public, State of Illinois
My Commission Expires 12/1/2021

LEVIN & PERCONTI (#55019)
325 North LaSalle St., Suite 300
Chicago, IL 60654
312/332-2872 - 312/332-3112 (fax)

Richard Cieski v. LaSalle Veterans' Home

HEALTH PROFESSIONAL'S REPORT

1. I am a physician licensed to practice medicine in all its branches and practice or teach in the area of medicine applicable in this case.

2. I am knowledgeable in the relevant issues involved in this particular action.

3. I have practiced within the last 6 years in the same area of health care or medicine that is at issue in this particular action and/or have taught within the last 6 years in the same area of health care or medicine that is at issue in this particular action.

4. I am qualified by experience and have demonstrated competence in the subject of this cause.

5. I am familiar with the standard of care for long-term care facilities, like LaSalle Veterans' Home, nurses and certified nursing assistants, as these standards relate to issues of care and treatment of long-term care residents, like Richard Cieski ("Richard").

6. I have read and reviewed documents, including but not limited to, the following documents regarding COVID-19 outbreak at the Lasalle Veterans' Home:

NAME	DATE
COVID Statistics	**3/17/20-12/28/2020**
Illinois Department of Public Health Survey	**11/23/2020**
Illinois Department of Veterans' Affairs Press Release	**11/24/2020**
Illinois General Assembly Hearing Regarding COVID-19 Outbreak at LaSalle Veterans' Home	**12/16/2020**
Memorandum Asking for the Resignation of Director of Illinois Department of Veterans' Affairs	**1/1/2021**

7. I have read and reviewed documents including but not limited to, the following records of Richard Cieski in this case:

HEALTH PROVIDER	DATE OF TREATMENT
Illinois Veterans Home – LaSalle	**5/16/17-11/15/20**
City of LaSalle Fire Department	**10/20/2020**
St. Margaret's Hospital	**10/20/20-10/26/20**
IDPH Complaint Form	**1/13/2021**
IDPH Complaint Number IL 0130169	**1/20/2021**
Death Certificate	**11/15/20**

8. Richard was at high risk for COVID-19, and LaSalle Veterans' Home through its nursing staff was required to promptly diagnose and treat Richard for COVID-19 after Richard and other residents and staff of LaSalle Veterans' Home began exhibiting symptoms of COVID-19 such as fever, coughing, and shallow breathing.

9. Richard's only exposure to COVID-19 would have been by LaSalle Veterans' Home staff and employees who provided care and treatment to Richard while not being properly protected.

10. Based upon my experience, training, and knowledge, and my review of the above records, it is my opinion, to a reasonable degree of medical certainty, that the care provided to Richard by LaSalle Veterans' Home and its nursing staff fell below the minimum standard of care and constituted negligence as the staff LaSalle Veterans' Home:

    a. Failed to develop appropriate infection control and prevention policies and procedures;
    b. Failed to provide, maintain, monitor and/or employ appropriate PPE, including the failure of nursing staff donning the appropriately fitted, medical-grade N95 respirators;
    c. Failed to ensure staff did not enter common areas of non-COVID-19/non-cohorted units;
    d. Failed to ensure a proper screening process was done at the staff entry of The Adjutant Illinois Veterans Home – LaSalle, including temperature montioring and a form which lists all screening questions and symptoms related to COVID-19 protocol;
    e. Negligently instructed one or more members of the Defendant's nursing staff to continue to come into The Adjutant Illinois Veterans Home – LaSalle and provide direct care to elderly residents, including Richard;
    f. Failed to timely ensure COVID-19 test results for residents and staff suspected and/or symptomatic of COVID-19;
    g. Failed to properly disinfect and/or follow the appropriate infection control policies and procedures;
    h. Failed to operative negative pressure rooms in an effective manner to decrease the likelihood of transmission;
    i. Failed to ensure staff practiced appropriate social distancing measursing, including maintaining a distance of six (6) feet;
    j. Failed to ensure adequate levels of hand hygiene, hand washing, and/or alcohol-based hand disinfectant products/equipment;
    k. Failed to ensure appropriate supplies for infection control practices;
    l. Failed to provide alcohol-based hand disinfectant/hygiene products both inside and outside of residents' rooms, including Richard's, at all entrances, and throughout any and all clinical areas; and
    m. Failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including Richard, in full recognition of Richard's individuality.

11. As a result of the foregoing failures by LaSalle Veterans' Home and its nursing staff, Richard suffered injuries including but not limited, the contraction of novel corona COVID-19 virus infection pneumonia, a poor quality of life, a deterioration of his overall physical, mental, and psychosocial condition, a loss of dignity and self-respect, and unnecessary pain and suffering, all of which Richard suffered from up until the time of his death.

12. In my opinion, there is a reasonable and meritorious basis for filing a cause of action against LaSalle Veterans' Home and its nursing staff.

_____
Signature

_____
Date

Medical Doctor
Profession