IN THE COURT OF COMMON PLEAS OF BEAVER COUNTY, PENNSYLVANIA

Civil Division

JODI GILL as Attorney-in-Fact of GLENN OSCAR GILL;

KENNETH WRIGHT;

SHELBY GALTON;

JUDITH MARIE as Guardian *Ad Litem* of DOROTHY UMSTEAD;

JAMAL WILLIAMS as Guardian *Ad Litem* of LUCILLE WILLIAMS;

JAMIE WORTHY-SMITH, Individually and as Administratrix of the Estate of KIM L. McCOY-WARFORD;

MARK J. LANTON, Individually and as Administrator of the Estate of GLORIA LANTON;

JACQUELINE YOUNG, Individually and as Administratrix of the Estate of MARION YOUNG;

BRANDY HEDGER Individually and as Administratrix of the Estate of REBECCA JOY VANKIRK;

KERI BOYER Individually and as Administratrix of the Estate of EARL DENBOW, JR.;

DENISE ELDRIDGE Individually and as Administratrix of the Estate of VIRGINIA ELDRIDGE;

TRACY MINEO and SUSAN FRAGOMENI, Individually and as Co-Administratrixes of the Estate of NANCY KEMERER;

Case No.

PATRICIA MAZZOCCA and BARBARA MACURAK, Individually and as Co-Executrixes of the Estate of ALA MAZZOCCA;

CHRISTINA CLAVELLI, Individually and as Administratrix of the Estate of JOSEPH "RANDY" CLAVELLI; and,

BOBBIE JOHNSON, Individually and as Administratrix of the Estate of SHIRLEY M. MIKE,

Plaintiffs,

vs.

COMPREHENSIVE HEALTHCARE MANAGEMENT SERVICES, LLC d/b/a BRIGHTON REHABILITATION & WELLNESS CENTER and DAVID G. THIMONS, D.O.,

Defendants.

PLAINTIFFS' COMPLAINT

AND NOW, come the Plaintiffs, by counsel, Robert F. Daley, Esquire and the law firm of Robert Peirce & Associates, P.C.; Peter D. Giglione, Esquire and the law firm of Massa Butler Giglione; and Kelly M. Tocci, Esquire and the law firm of McMillen Urick Tocci & Jones, and claim damages of Defendants Comprehensive HealthCare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center (hereinafter "Brighton" or "Brighton Rehab") and David G. Thimons D.O., and allege the following in support:

PARTIES

LIVING PLAINTIFFS

I. Glenn Oscar Gill

1. Plaintiff Jodi Gill is an adult individual with an address of 909 11th Street, Ambridge, Beaver County, PA 15003.

2. Jodi Gill is the daughter and Attorney-in Fact-of Plaintiff Glenn Oscar Gill.

3. Glen Oscar Gill is 82 years old, and has been a resident at Brighton Rehabilitation and Wellness Center since September 25, 2019.

4. Jodi Gill was appointed the Power-of-Attorney of Glenn Oscar Gill on July 4, 2016.

5. As Power of Attorney, Jodi Gill, is authorized to act on behalf of her father, Glenn Oscar Gill.

II. Kenneth Wright

6. Plaintiff Kenneth Wright is an adult individual with an address of P.O. Box 522, Mariana, Washington County, PA 15345.

7. Kenneth Wright is 57 years old, and has been a resident at Brighton Rehabilitation and Wellness Center since June 3, 2019.

III. Shelby Galton

8. Plaintiff, Shelby Galton is an adult individual with an address of 246 Friendship Circle, Beaver, Beaver County, PA 15009.

9. Shelby Galton is 41 years old, and has been a resident at Brighton Rehabilitation and Wellness Center since March 2019.

IV. Dorothy Umstead

10. Plaintiff Judith Marie is an adult individual with an address of 136 Centennial Avenue, Unit 303, Sewickley, Allegheny County, PA 15143.

11. Judith Marie is the daughter of Dorothy Umstead.

12. Dorothy Umstead is 79 years old, and has been a resident at Brighton Rehabilitation and Wellness Center since March 2019.

13. Judith Marie currently has a Petition pending to be appointed the Guardian *Ad Litem* for her mother, Dorothy Umstead.

V. Lucille Williams

14. Plaintiff Jamal Williams is an adult individual with an address of 128 Victory Lane, Leetsdale, Allegheny County, PA 15056.

15. Jamal Williams is the son of Lucille Williams.

16. Lucille Williams is 74 years old, and has been a resident at Brighton Rehabilitation and Wellness Center since April 2019.

17. Jamal Williams currently has a Petition pending to be appointed the Guardian *Ad Litem* for his mother, Lucille Williams.

PARTIES

DECEASED PLAINTIFFS

I. Kim L. McCoy-Warford

18. Plaintiff Jamie Worthy-Smith is an adult individual with an address of 1036 Knoll Street, Aliquippa, Beaver County, PA 15001.

19. Jamie Worthy-Smith is the sister of deceased Kim L. McCoy-Warford.

20. Kim L. McCoy-Warford died on April 18, 2020 at the age of 64.

21. Jamie Worthy-Smith was appointed the Administratrix of the Estate of Kim L. McCoy Warford by the Director of the Department of Court Records of Allegheny County, PA on June 29, 2020.

22. As Administratrix of the Estate of Kim L. McCoy-Warford, Jamie Worthy-Smith brings this action under 42 Pa Cons. Stat. § 8302 (Survival) on behalf of the Estate of Kim L. McCoy-Warford.

23. As the "personal representative" of the Estate of Kim L. McCoy-Warford, Jamie Worthy-Smith brings this action under 42 Pa Cons. Stat. § 8301 (Wrongful Death) and Pa. R. Civ. P. 2202(a) on her own behalf and on behalf of all wrongful death beneficiaries.

24. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Kim L. McCoy-Warford, and their relationships to her, are as follows:

Name	Address	Relationship
Michael Warford	425 Babbling Brook Drive Virginia Beach, VA 23462	Son

25. At no time during her life did Kim L. McCoy-Warford bring an action to recover damages for her personal injuries related to COVID-19 exposure and infection, and no other action has been filed to recover damages for the wrongful death of Kim L. McCoy-Warford.

II. Gloria Lanton

26. Plaintiff Mark J. Lanton is an adult individual with an address of 920 Maplewood Avenue, Ambridge, Beaver County, PA 15003.

27. Mark J. Lanton is the son of deceased Gloria F. Lanton.

28. Gloria Lanton died on April 23, 2020 at the age of 93.

29. Mark J. Lanton was appointed the Administrator of the Estate of Gloria Lanton by the Register for the Probate of Wills in Beaver, PA County on May 28, 2020.

30. As Administrator of the Estate of Gloria Lanton, Mark J. Lanton brings this action under 42 Pa Cons. Stat. § 8302 (Survival) on behalf of the Estate of Gloria Lanton

31. As the "personal representative" of the Estate of Gloria Lanton, Mark J. Lanton brings this action under 42 Pa Cons. Stat. § 8301 (Wrongful Death) and Pa. R. Civ. P. 2202(a) on her own behalf and on behalf of all wrongful death beneficiaries.

32. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Gloria Lanton, and their relationships to her, are as follows:

Name	Address	Relationship
Mark J. Lanton	920 Maplewood Avenue, Ambridge PA 15003	Son

33. At no time during her life did Gloria Lanton bring an action to recover damages for her personal injuries, and no other action has been filed to recover damages for the wrongful death of Gloria Lanton.

III. Marion Young

34. Plaintiff Jacqueline Young is an adult individual with an address of 104 Aspen Drive, Beaver, Beaver County, PA 15009.

35. Jacqueline Young is the daughter of deceased Marion Young.

36. Marion Young died on April 22, 2020 at the age of 85.

37. Jacqueline Young was appointed the Administratrix of the Estate of Marion Young by the Register for the Probate of Wills in Beaver Count, PA on September 30, 2020.

38. As Administratrix of the Estate of Marion Young, Jacqueline Young brings this action under 42 Pa Cons. Stat. § 8302 (Survival) on behalf of the Estate of Marion Young.

39. As the "personal representative" of the Estate of Marion Young, Jacqueline Young brings this action under 42 Pa Cons. Stat. § 8301 (Wrongful Death) and Pa. R. Civ. P. 2202(a) on her own behalf and on behalf of all wrongful death beneficiaries.

40. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Marion Young, and their relationships to her, are as follows:

Name	Address	Relationship
Jacqueline Young	104 Aspen Drive Beaver, PA 15009	Daughter

41. At no time during her life did Marion Young bring an action to recover damages for her personal injuries, and no other action has been filed to recover damages for the wrongful death of Marion Young.

IV. Rebecca Joy VanKirk

42. Plaintiff Brandy Hedger is an adult individual with an address of 519 Lincoln Street, Rochester, Beaver County, PA 15074.

43. Brandy Hedger is the daughter of deceased Rebecca Joy VanKirk.

44. Rebecca Joy VanKirk died on May 9, 2020 at the age of 68.

45. Brandy Hedger was appointed the Administratrix of the Estate of Rebecca Joy VanKirk by the Register for the Probate of Wills in Beaver County on September 8, 2020

46. As Administratrix of the Estate of Rebecca Joy VanKirk, Brandy Hedger brings this action under 42 Pa Cons. Stat. § 8302 (Survival) on behalf of the Estate of Rebecca Joy VanKirk.

47. As the "personal representative" of the Estate of Rebecca Joy VanKirk, Brandy Hedger brings this action under 42 Pa Cons. Stat. § 8301 (Wrongful Death) and Pa. R. Civ. P. 2202(a) on her own behalf and on behalf of all wrongful death beneficiaries.

48. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Rebecca Joy VanKirk, and their relationships to her, are as follows:

Name	Address	Relationship
Brandy Hedger	519 Lincoln Street, Rochester, PA 15074	Daughter

49. At no time during her life did Rebecca Joy VanKirk bring an action to recover damages for her personal injuries, and no other action has been filed to recover damages for the wrongful death of Rebecca Joy VanKirk.

V. Earl Denbow, Jr.

50. Plaintiff Keri Boyer is an adult individual with an address of 363 Cherokee Drive, Beaver Falls, Beaver County, PA 15010.

51. Keri Boyer is the daughter of deceased Earl Denbow, Jr.

52. Early Denbow, Jr. died on April 1, 2020 at the age of 73.

53. Keri Boyer was appointed the Administratrix of the Estate of Earl Denbow, Jr. by the Register of Wills of Beaver County, PA on September 18, 2020.

54. As Administratrix of the Estate of Earl Denbow, Jr., Keri Boyer brings this action under 42 Pa Cons. Stat. § 8302 (Survival) on behalf of the Estate of Earl Denbow, Jr.

55. As the "personal representative" of the Estate of Earl Denbow, Jr., Keri Boyer brings this action under 42 Pa Cons. Stat. § 8301 (Wrongful Death) and Pa. R. Civ. P. 2202(a) on her own behalf and on behalf of all wrongful death beneficiaries.

56. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Earl Denbow, Jr., and their relationships to him, are as follows:

Name	Address	Relationship
Keri Boyer	363 Cherokee Drive Beaver Falls, PA 15010	Daughter

57. At no time during his life did Earl Denbow, Jr. bring an action to recover damages for his personal injuries, and no other action has been filed to recover damages for the wrongful death of Earl Denbow, Jr.

VI. Virginia Eldridge

58. Plaintiff Denise Eldridge is an adult individual with an address of 4283 Upview Terrace, Pittsburgh, PA 15201.

59. Denise Eldridge is the daughter of deceased Virginia Eldridge.

60. Virginia Eldridge died on April 17, 2020 at the age of 79.

61. Denise Eldridge was appointed the Administratrix of the Estate of Virginia Eldridge by the Director of the Department of Court Records of Allegheny County, PA on September 28, 2020.

62. As Administratrix of the Estate of Virginia Eldridge, Denise Eldridge brings this action under 42 Pa Cons. Stat. § 8302 (Survival) on behalf of the Estate of Virginia Eldridge.

63. As the "personal representative" of the Estate of Virginia Eldridge, Virginia Eldridge brings this action under 42 Pa Cons. Stat. § 8301 (Wrongful Death) and Pa. R. Civ. P. 2202(a) on her own behalf and on behalf of all wrongful death beneficiaries.

64. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Virginia Eldridge, and their relationships to her, are as follows:

Name	Address	Relationship
Virginia Eldridge	4283 Upview Terrace Pittsburgh, PA 15201	Daughter
Beth Jaimison	944 Brintell Street Pittsburgh, PA 15201	Daughter
Fred Eldridge	222 East Warrington Avenue Pittsburgh, PA 15210	Son

65. At no time during her life did Virginia Eldridge bring an action to recover damages for her personal injuries, and no other action has been filed to recover damages for the wrongful death of Virginia Eldridge.

VII. Nancy Kemerer

66. Plaintiff Tracey Mineo is an adult individual with an address of 1331 Perry Highway, Porterville, PA 16051.

67. Plaintiff Susan Fragomeni is an adult individual with an address of 120 Haas Drive, Darlington, PA 16615.

68. Tracey Mineo and Susan Fragomeni are the daughters of deceased Nancy Kemerer.

69. Nancy Kemerer died on May 15, 2020, at the age of 70.

70. Tracey Mineo and Susan Fragomeni were appointed the Co-Administratrixes of the Estate of Nancy Kemerer by the Register or the Probate of Wills of Beaver County, PA on September 25, 2020.

71. As Co-Administratrixes of the Estate of Nancy Kemerer, Tracey Mineo and Susan Fragomeni bring this action under 42 Pa Cons. Stat. § 8302 (Survival) on behalf of the Estate of Nancy Kemerer.

72. As the "personal representatives" of the Estate of Nancy Kemerer, Tracey Mineo and Susan Fragomeni bring this action under 42 Pa Cons. Stat. § 8301 (Wrongful Death) and Pa. R. Civ. P. 2202(a) on their own behalf and on behalf of all wrongful death beneficiaries.

73. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Nancy Kemerer, and their relationships to her, are as follows:

Name	Address	Relationship
Tracey Mineo	1331 Perry Highway Porterville, PA 16051	Daughter
Susan Fragomeni	120 Haas Drive Darlington, PA 16615	Daughter

74. At no time during her life did Nancy Kemerer bring an action to recover damages for her personal injuries, and no other action has been filed to recover damages for the wrongful death of Nancy Kemerer.

VIII. Ala Mazzocca

75. Plaintiff, Patricia Mazzocca, is an adult individual with an address of 148 Winter Street, Aliquippa, Beaver County, PA 15001.

76. Plaintiff, Barbara Macurak, is an adult individual with an address of 152 Winter Street, Aliquippa, Beaver County, PA 15001.

77. Patricia Mazzocca and Barbara Macurak are the daughters of Ala Mazzocca.

78. Ala Mazzocca died on April 13, 2020 at the age of 91.

79. Ms. Mazzocca and Ms. Macurak were appointed as co-executrixes of the Estate of Ala Mazzocca by the Register for the Probate of Wills in Beaver County, PA on September 30, 2020.

80. As "personal representatives" of the Estate of Ala Mazzocca, Patricia Mazzocca and Barbara Macurak bring this action under 42 Pa Cons. Stat. § 8302 (Survival) on behalf of the Estate of Ala Mazzocca.

81. As "personal representatives" of the Estate of Ala Mazzocca, Patricia Mazzocca and Barbara Macurak bring this action under 42 Pa Cons. Stat. § 8301 (Wrongful Death) and Pa. R. Civ. P. 2202(a) on their own behalf and on behalf of all wrongful death beneficiaries.

82. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Ala Mazzocca, and their relationships to her, are as follows:

Name	Address	Relationship
Patricia Mazzocca	148 Winter Street Aliquippa, PA 15001	Daughter
Barbara Macurak	152 Winter Street Aliquippa, PA 15001	Daughter

83. At no time during her life did Ala Mazzocca bring an action to recover damages for her personal injuries, and no other action has been filed to recover damages for the wrongful death of Ala Mazzocca.

IX. Joseph "Randy" Clavelli

84. Plaintiff, Christina Clavelli, is an adult individual, with an address of 427 Boyle's Avenue, New Castle, Lawrence County, PA 16101.

85. Christina Clavelli is the daughter of deceased Joseph "Randy" Clavelli,

86. Joseph "Randy" Clavelli died on April 15, 2020, at the age of 66.

87. Ms. Clavelli was appointed as Administratrix of the Estate of Joseph "Randy" Clavelli by the Register for the Probate of Wills in Beaver County, PA on October 20, 2020.

88. As Administratrix of the Estate of Joseph "Randy" Clavelli, Christina Clavelli brings this action under 42 Pa Cons. Stat. § 8302 (Survival) on behalf of the Estate of Joseph "Randy" Clavelli.

89. As "personal representative" of the Estate of Joseph "Randy" Clavelli, Christina Clavelli brings this action under 42 Pa Cons. Stat. § 8301 (Wrongful Death) and Pa. R. Civ. P. 2202(a) on her own behalf and on behalf of all wrongful death beneficiaries.

90. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Joseph "Randy" Clavelli, and their relationships to her, are as follows:

Name	**Address**	**Relationship**
Christina Clavelli	427 Boyle's Avenue New Castle, PA 16101	Daughter
Marissa Clavelli	1 East Garfield Avenue New Castle, PA 16101	Daughter
Matthew Clavelli	1 East Garfield Avenue New Castle, PA 16101	Son

91. At no time during his life did Joseph "Randy" Clavelli bring an action to recover damages for his personal injuries, and no other action has been filed to recover damages for the wrongful death of Joseph "Randy" Clavelli.

X. Shirley M. Mike

92. Plaintiff Bobbie Johnson is an adult individual with an address of 1125 Greiner Street, Monaca, Beaver County, PA 15061.

93. Bobbie Johnson is the daughter of deceased Shirley M. Mike.

94. Shirley M. Mike died on April 15, 2020, at the age of 95.

95. Bobbie Johnson was appointed the Administratrix of the Estate of Shirley M. Mike by the Register of Wills of Beaver County, PA on October 1, 2020.

96. As Administratrix of the Estate of Shirley M. Mike, Bobbie Johnson brings this action under 42 Pa Cons. Stat § 8302 (Survival) on behalf of the Estate of Shirley M. Mike.

97. As the "personal representative of the Estate of Shirley M. Mike, Bobbie Johnson brings this action under 42 Pa Cons. Stat. § 8301 (Wrongful Death) and Pa. R. Civ. P. 2202(a) on her own behalf and on behalf of all wrongful death beneficiaries.

98. The names and addresses of all persons legally entitled to recover damages for the wrongful death of Shirley M. Mike, and their relationships to her, are as follows:

Name	**Address**	**Relationship**
Bobbie Johnson	1125 Greiner Street Monaca, PA 15061	Daughter
Robert Douds, Jr.	4060 Tuscawaras Road Beaver, PA 15009	Son
Rick Douds	821 Howe Avenue Monaca, PA 15061	Son

99. At no time during her life did Shirley M. Mike bring an action to recover damages for her personal injuries, and no other action has been filed to recover damages for the wrongful death of Shirley M. Mike.

PARTIES

DEFENDANTS

I. Comprehensive HealthCare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center

100. Defendant Comprehensive HealthCare Management Services, LLC is a Pennsylvania limited liability corporation that operates a skilled nursing facility at 246 Friendship Circle, Beaver, Beaver County, Pennsylvania 15009.

101. Defendant Comprehensive HealthCare Management Services, LLC operates its nursing facility under the fictitious name Brighton Rehabilitation and Wellness Center ("Brighton" or "Brighton Rehab").

102. Brighton Rehab is a nursing facility in Beaver County that has a maximum capacity of 589 residents. In March 2020, when COVID-19 began to spread to Western Pennsylvania, Brighton Rehab was home to 460, mostly elderly and/or sick citizens of Beaver County. These vulnerable individuals relied on Brighton Rehab to use its considerable resources[1] to protect them from COVID-19 to the best of its ability.

103. At all relevant times, Brighton operated as a "long-term care nursing facility" as that term is defined by Pennsylvania's Health Care Facilities Act, 35 P.S. §448.802(a) *et. seq.*, which "promote[s] the public health and welfare through the establishment and enforcement of regulations setting minimum standards in the construction, maintenance and operation of health care facilities."

104. At all relevant times, Brighton operated as a "skilled nursing facility" as that term is defined by Title XVIII of the Social Security Act, 42 U.S.C. §1395i-3 (Medicare) and as a

[1] Brighton's net profits from 2016 to 2018 totaled $10,897,508.00.

"nursing facility" as that term is defined in Title XIX of the Social Security Act, 42 U.S.C. §1396r (Medicaid).

105. Accordingly, Brighton Rehabilitation and Wellness Center was a "health care provider" as that term is defined in the Medical Care Availability and Reduction of Error Act (MCARE), 40 P.S. § 1303.503.

106. As a "health care provider" under the MCARE Act, Brighton is a "licensed professional" as defined by Pennsylvania Rule of Civil Procedure 1042.1, and Plaintiffs are asserting professional liability claims against this Defendant.

107. As to Defendant Brighton Rehab, this Complaint is brought directly against Brighton for its managerial and operational negligence, carelessness, recklessness, and willful and wanton conduct. It is not brought against Brighton's "frontline" staff who provided direct care to residents. These resident caregivers (including but not limited to staff nurses, nursing aides, care technicians, therapists, and custodial staff) were placed in the untenable position of having to care for hundreds of residents through a pandemic while being untrained, unsupervised, understaffed, and unsupported by Brighton. Brighton failed to provide these caregivers with appropriate personal protective equipment (PPE), and left them to do the best they could in the dangerous environment Brighton's administration created.

II. David G. Thimons, D.O.

108. Defendant David G. Thimons, D.O. is an adult individual employed and/or contracted by Brighton Rehabilitation and Wellness Center as the facility's Medical Director.

109. Dr. Thimons was hired to work as the Medical Director at Brighton starting in or around 2012.

110. At all relevant times, Dr. Thimons acted within the course and scope of his employment/contract as an agent and/or ostensible agent, and in his professional capacity as the Medical Director of Brighton Rehabilitation and Wellness Center.

111. As the Medical Director of the Brighton facility, Dr. Thimons was responsible for overseeing the facility in providing care to residents and ensuring the quality of care provided met all applicable standards.

112. Dr. Thimons is licensed as a Doctor of Osteopathic Medicine in the Commonwealth of Pennsylvania.

113. Dr. Thimons was a "health care provider" as that term is defined in the Medical Care Availability and Reduction of Error Act (MCARE), 40 P.S. § 1303.503.

114. As a "health care provider" under the MCARE Act, Dr. Thimons is a "licensed professional" as defined by Pennsylvania Rule of Civil Procedure 1042.1, and Plaintiffs are asserting professional liability claims against this Defendant.

FACTUAL ALLEGATIONS

I. Kim L. McCoy-Warford, Deceased

115. Kim L. McCoy-Warford ("Ms. Warford") was admitted to Brighton on June 5, 2013 for nursing and rehabilitation services following a hospital stay for altered mental state.

116. While at Brighton, Ms. Warford shared a room with three other women.

117. At some point in early March 2020, one of Ms. Warford's roommates tested positive for COVID-19.

118. The roommate who had tested positive was not moved into isolation, and instead remained in a shared room with three COVID-19 negative roommates, including Ms. Warford.

119. On or around March 23, 2020, Brighton contacted Ms. Warford's family to inform them that Ms. Warford had an elevated fever of 104 degrees.

120. A chest x-ray was ordered, which showed that Ms. Warford had lung abnormalities.

121. Ms. Warford was sent to Heritage Valley Beaver in Beaver, PA and was diagnosed with bacterial pneumonia.

122. Ms. Warford stayed overnight at Heritage Valley Beaver and was discharged back to Brighton the next morning.

123. Upon readmission, Brighton placed Ms. Warford back in her shared room with three roommates, at least one of whom was COVID-positive.

124. Brighton continued to give Ms. Warford Tylenol to treat her fever, but the next day Ms. Warford's fever spiked again.

125. Brighton transferred Ms. Warford and all three of her roommates to Heritage Valley Beaver.

126. Ms. Warford was admitted to Heritage Valley Beaver, where she stayed for several days with a persistent fever and cough.

127. Heritage Valley Beaver alerted Ms. Warford's family that she had tested positive for COVID-19.

128. On March 30, 2020, Heritage Valley Beaver again discharged Ms. Warford to Brighton.

129. Upon readmission, Brighton placed Ms. Warford in her original room, which was part of what was now being used as a COVID-19 wing of the Brighton facility.

130. At Brighton, Ms. Warford's condition deteriorated.

131. On April 16, 2020 Ms. Warford became unresponsive.

132. Ms. Warford died on April 18, 2020 at Brighton Rehab.

133. Ms. Warford's Death Certificate reflects that her cause of death was COVID-19.

II. Gloria Lanton, Deceased

134. Gloria Lanton ("Ms. Lanton") was admitted to Brighton in or around May of 2017 for rehabilitation services after suffering injuries from a fall.

135. While at Brighton, Ms. Lanton's financial affairs were handled by Eric O'Connor of River Communities Fiduciaries Services.

136. Ms. Lanton's son, Mark Lanton ("Mark"), frequently called to check in on his mother, and spoke with staff of Brighton all the while Ms. Lanton was living at Brighton.

137. Despite the fact that he frequently checked on his mother, Mark was not called or updated when his mother developed symptoms of COVID-19.

138. Mark was not called when his mother was tested for COVID-19. In fact, Mark is unaware of whether or not his mother was ever tested for COVID while she was at Brighton.

139. On April 23, 2020, Mark received a call from Eric O'Connor, his mother's fiduciary, who called to extend his condolences on the passing of Ms. Lanton.

140. Mark had not known until Mr. O'Connor's call that his mother had died. In fact, Mark did not even know that his mother had ever been sick or that she had had COVID-19.

141. Mark responded by calling Brighton and asking staff how his mother was doing. Staff responded that she was doing well, but that they weren't sure where the floor's cordless phone was at the moment. Brighton staff said they would have Mrs. Lanton call Mark back when they located it.

142. Mark called back and asked how his mother was doing another three or four times. The response from staff was always the same. "Ms. Lanton is doing well." "She will call you when we locate the phone."

143. Gloria Lanton died on April 23, 2020 at Brighton Rehab.

144. To this day, no one from Brighton has called to inform Mark of his mother's death.

145. Ms. Lanton's Death Certificate reflects that her cause of death was COVID-19.

III. Marion Young, Deceased

146. Marion Young ("Marion" or "Ms. Young") was admitted to Brighton in December 2018 for therapy services.

147. In or around late March 2020, Ms. Young's daughter Jacqueline Young was told by Brighton staff that a resident in the facility had tested positive for COVID-19, but that that person was in another unit and that Marion had not been exposed.

148. Two weeks later, in or around the second week of April 2020, Jacqueline was told by Brighton staff that Marion had pneumonia and was being treated with four different types of antibiotics.

149. At the same time, Brighton tested Ms. Young for COVID-19, and informed Jacqueline Young that it would take a few days for the results to come back.

150. About four days later, Brighton informed Jacqueline that Ms. Young had tested positive for COVID-19.

151. Brighton would not send Ms. Young to the hospital, and they informed Jacqueline that without more specific symptoms, the hospital would just send Ms. Young back to Brighton.

152. Shortly after Ms. Young's COVID-19 diagnosis, Brighton staff called Jacqueline again to tell her that they were sending Marion to the hospital because of concerning vital signs.

153. Marion was admitted to Heritage Valley Beaver.

154. Marion's condition deteriorated over the next day, and she was placed on a ventilator.

155. Marion Young died on April 22, 2020.

156. Ms. Young's Death Certificate reflects that her cause of death was COVID-19.

IV. Rebecca Joy VanKirk, Deceased

157. Rebecca Joy VanKirk ("Rebecca" or "Ms. VanKirk") was admitted to Brighton in June of 2018 for rehabilitation reservices following hip replacement surgery.

158. Like most family members of Brighton residents, Ms. VanKirk's daughter, Brandy Hedger ("Brandy") was told in early March that she could no longer enter the facility to visit her mother because of COVID-19.

159. After visitation ended, it became very difficult for Brandy to communicate with her mother, and Brandy was frequently unable to speak with staff at Brighton regarding her mother's care.

160. During the first week of April, Ms. VanKirk was sent to Heritage Valley Beaver because Brighton staff noticed her mental state had changed.

161. While in the hospital, Ms. VanKirk was tested for COVID-19 and her test came back positive.

162. A nurse from the hospital called to inform Brandy that Ms. VanKirk had contracted the virus, and also informed her that her mother had pressure ulcers on the bottoms of her feet and back, which were not there when Brandy had last seen her mother in March at Brighton.

163. Ms. VanKirk was sent back to Brighton from the hospital, but her health deteriorated quickly.

164. By the end of April, Ms. VanKirk was again sent to Heritage Valley Beaver.

165. At that time, Brandy made the decision to place her mother in hospice care, so Ms. VanKirk was returned to Brighton for that care.

166. Rebecca Joy VanKirk died on May 9, 2020 at Brighton Rehab.

167. Ms. VanKirk's Death Certificate reflects that her cause of death was COVID-19.

V. Earl Denbow, Jr., Deceased

168. Earl Denbow, Jr. ("Mr. Denbow") was admitted to Brighton in January of 2018 for long term care for his Parkinson's Disease and associated delusions.

169. Like most family members of Brighton residents, Mr. Denbow's daughter, Keri Boyer ("Keri") was told in early March that she could no longer enter the facility to visit her father because of COVID-19.

170. However, Keri was able to Facetime her father frequently with assistance from a nurse on her father's floor.

171. On March 23, 2020, Keri received a call from Brighton explaining that her father wasn't feeling well. She was informed that he had a fever and was dehydrated, so they were going to be giving him IV fluids.

172. On March 27, 2020, Keri received a call from Brighton stating that there was a positive COVID-19 case in the facility.

173. Again on March 27, 2020, less than one hour after the first phone call, Keri received another call from Brighton informing her that her father had tested positive for COVID-19.

174. Once Mr. Denbow had tested positive, staff told Keri that her father was being quarantined away from other residents at the facility.

175. However, Keri Facetimed her father, as she frequently did, and saw that Mr. Denbow was still in his original room with his roommate.

176. Mr. Denbow was not quarantined way from his roommate, despite testing positive for COVID-19.

177. On or around March 28, 2020, staff at Brighton told Keri that her father was responding well to treatment.

178. However, on March 29, 2020, Mr. Denbow was placed in hospice care.

179. Earl Denbow Jr. died on April 1, 2020 at Brighton Rehab.

180. Mr. Denbow's Death Certificate reflects that his cause of death was COVID-19.

VI. Virginia Eldridge, Deceased

181. Virginia Eldridge ("Ms. Eldridge") was admitted to Brighton in August of 2019 for long term care for her dementia and management of her medications.

182. Ms. Eldridge's family last visited her on March 10, 2020.

183. On March 12, 2020, Ms. Eldridge's family was told that Brighton was on lockdown an visitors were no longer allowed in the facility.

184. Brighton informed Denise Eldridge ("Denise"), Ms. Eldridge's daughter, that her mother was tested for COVID-19 numerous times in both March and April and her results were always negative.

185. However, On April 6, 2020, Ms. Eldridge tested positive for COVID.

186. Shortly after testing positive, Denise believed her mother was recovering. She was told by Brighton staff that her fever dropped, and she began eating again.

187. Ms. Eldridge was given oxygen intermittently, but otherwise was never placed on a ventilator, and her family was never informed that she was declining or needed to be taken to the hospital.

188. On April 17, 2020, Virginia Eldridge died at Brighton Rehab.

189. Ms. Eldridge's family was never permitted to speak with a doctor at the facility regarding her condition, and to this day, her family has not received answers as to why or how their mother declined so quickly when staff led them to believe she was recovering.

190. Ms. Eldridge's Death Certificate reflects that her cause of death was COVID-19.

VII. Nancy Kemerer, Deceased

191. Nancy Kemerer ("Ms. Kemerer") was admitted to Brighton in December of 2018 for long term care for her dementia.

192. During her residency at Brighton, Ms. Kemerer was in a private room on the rehabilitation floor of Grove 1.

193. Ms. Kemerer's daughter, Tracey Mineo ("Tracey") was informed in early April 2020 that there were a few residents at Brighton who had tested positive for COVID. However, Tracey was told all positive residents were isolated on the dementia floor.

194. Starting at the end of April, Ms. Kemerer began experiencing symptoms of COVID-19, namely severe diarrhea.

195. Almost a week after Ms. Kemerer's symptoms started, she was tested for COVID-19 and her results came back positive.

196. At some point, Ms. Kemerer was moved to Floor 3, though neither of her daughters were informed of this. Upon learning of the move, Tracey was told her mother was moved to a COVID positive floor to isolate her from other residents.

197. However, Tracey learned after her mother was moved that residents on Floor 3 were not actually being isolated, but that numerous residents were left to wander around the floor and in the sitting room areas as they pleased, with no masks on.

198. Tracey requested that her mother be taken to the hospital for treatment, but she was told by Brighton staff that the hospital was not accepting COVID-19 patients.

199. Tracey then called Heritage Valley Beaver and staff there told her that the hospital was in fact accepting COVID-19 patients.

200. Tracey then called Brighton Rehab again to give them of the information she had received from the hospital.

201. She was told by both a PA and a doctor who were treating her mother that the hospital would not be able to do anything for her mother that Brighton wasn't already doing, and refused to send Ms. Kemerer mother to the hospital.

202. After this refusal, Tracey was connected with Brighton's Medical Director, Defendant Dr. David Thimons, via Facetime.

203. Defendant Dr. Thimons told Tracey that he wanted to try to continue treating her mother before sending her to the hospital.

204. Defendant Dr. Thimons started Ms. Kemerer on IV fluids and started breathing treatments.

205. The following day, Ms. Kemerer's original Doctor stopped all treatments and told Tracey that her mother was dying and she needed to accept it, as her mother had a DNR.

206. Nancy Kemerer died on May 15, 2020 at Brighton Rehab.

207. Ms. Kemerer's Death Certificate reflects that her cause of death was COVID-19.

VIII. Glenn Oscar Gill

208. Glenn Oscar Gill ("Mr. Gill") was admitted to Brighton on September 25, 2019 for long term care for his advanced dementia.

209. Jodi Gill, Mr. Gill's daughter, received a call from a social worker at Brighton's facility on March 12, 2020, informing her that she could no longer come to visit her father, as the facility was on lockdown due to COVID-19.

210. Over the next few days, Jodi attempted to call and speak with her father on the phone multiple times, but was unable to get him on the phone. There is one cordless phone for the entire floor, and there was never any guarantee that it could be located.

211. At the end of March 2020, Jodi received a call from staff informing her that Brighton had its first positive COVID-19 case. Jodi was told the case was in "Four East", not her father's wing, and that precautions were being taken to isolate the other wings.

212. On April 8, 2020, Jodi received a call from Brighton that her father had a slight fever of 99.4 degrees, and that they were going to test him for COVID-19.

213. On April 9, 2020, Jodi received a follow-up call from Brighton informing her that her father's COVID-19 test had come back negative.

214. On May 12, 2020 new protocols were enacted by Brighton to separate positive and negative patients. Mr. Gill was moved to Grove 1, which was meant to house negative patients.

215. However, on May 28, 2020, Jodi received a call from Brighton staff saying her father had tested positive for COVID-19. Staff told Jodi her father had not exhibited symptoms and they were hoping the test was a false positive and as such, he was going to be tested again.

216. However, until he could be tested again, due to new protocols, Mr. Gill had to be moved to the COVID positive floor.

217. Despite not initially showing symptoms, Mr. Gill's second COVID-19 test also came back positive and it was confirmed that he had in fact been infected with the virus.

218. Though Mr. Gill has since recovered from COVID-19, the infection and the drastic changes within Brighton have had a severe impact on his everyday life, namely worsening his dementia.

219. Since contracting the virus, Mr. Gill has experienced increased confusion and anxiety, which has led to outbreaks of agitation on his part. In order to calm him, he is prescribed three daily doses of Seroquel, which have a dulling effect and make Mr. Gill socially withdrawn.

220. Mr. Gill's ability to communicate with his daughter Jodi has declined.

IX. Kenneth Wright

221. Kenneth Wright was admitted to Brighton on June 3, 2019 for therapy services after fracturing his humerus.

222. On April 6, 2020, Mr. Wright had a dry cough and a sore throat.

223. Because of these symptoms, Mr. Wright was tested for COVID and his test results came back as positive on April 9, 2020.

224. Since testing positive, Mr. Wright has noticed he is extremely tired, has trouble breathing, and requires oxygen to be able to breathe.

225. Mr. Wright still has trouble breathing and feels tired, even months after contracting the virus.

226. Mr. Wright fears that he may contract the virus again, given that a resident who resides on the same floor as him, Grove 3, tested positive for COVID-19 on September 24, 2020.

227. Brighton has not removed the COVID positive patient from the floor, but has instead bagged the door of the patient's room.

228. Mr. Wright is currently recovering from the virus, but he and his loved ones' fear that he may contract the virus again, given that a resident on his floor just tested positive and given the uncertainty of retransmission.

229. Mr. Wright and his loved ones also fear the long-term side effects he may suffer from contracting COVID-19.

X. Dorothy Umstead

230. Dorothy Umstead ("Ms. Umstead") was admitted to Brighton in March of 2019 for nursing and rehabilitation services following a change in her mental state.

231. In April 2019, Ms. Umstead's daughter, Judith Marie ("Judith") received the following text messages from an anonymous staff member at Brighton:

> **Anonymous:** Hi Covid is in your moms room. I won't identify myself
>
> **Anonymous:** The truth is the whole building was infected and they were moving all the infected people to one side of the building. So they were able to say it's on one side of the building. But now that those sides are all full with Covid patients there is nowhere else to go.

Anonymous: Just to let you know that it's really hush hush but it's literally one person over from her. Nobody is safe.

Anonymous: Yeah. Diagonal from her is +

Anonymous: They are in their rooms. But in your moms room there is someone that's positive and everyone else is pending. They normally move them but they didn't today. In the beginning.

Anonymous: They lied and said it was all on one side of the building. That wasn't the truth.

Anonymous: It's everywhere. It would get her out of here.

Anonymous: I'm sorry. Just wanted you to know the truth. They are not going to share everything with you because you went to the media.

Anonymous: Your mom will likely come back positive. Just a heads up. Advocate and advocate loudly.

Anonymous: When this is all over I will tell you who I am. I think you'll be pleasantly surprised, But I will take care of your mom.

232. On April 19, 2020 Dorothy Umstead was diagnosed with COVID-19.

233. Ms. Umstead is currently recovering from the virus, but she and her loved ones fear that she may contract the virus again, given the uncertainty of retransmission.

234. Ms. Umstead and her loved ones also fear the long-term side effects she may suffer from contracting COVID-19.

XI. Lucille Williams

235. Lucille Williams was admitted to Brighton in April 2019 for nursing and rehabilitation services and for daily help caring for herself.

236. On or around April 20, 2020, Ms. Williams tested positive for COVID-19.

237. Even after testing positive, Brighton did not move Ms. Williams to a different part of the facility to be isolated or quarantined from other residents who did not have COVID-19.

238. Brighton never transferred Ms. Williams to the hospital for evaluation or treatment.

239. Ms. Williams is currently recovering from the virus; but she and her loved ones fear that she may contract the virus again, given the uncertainty of retransmission.

240. Ms. Williams and her loved ones also fear the long-term side effects she may suffer from contracting COVID-19.

XII. Shelby Galton

241. Shelby Galton was admitted to Brighton in March 2019 for nursing and rehabilitation services due to intellectual and physical disabilities.

242. Kristine Skal, Ms. Galton's close friend, was Brighton's contact person for Shelby Galton.

243. In early March, Ms. Galton's roommate tested positive for COVID.

244. Brighton did not remove Ms. Galton or her roommate from their shared room.

245. On March 22, 2020 Kristine called and asked Brighton staff if residents and staff were being restricted to certain floors to prevent the spread of COVID-19. Brighton staff told Kristine that they did not know whether or not floors were being isolated.

246. On April 15, 2020 Brighton staff informed Kristine that because the facility had more than 100 residents with COVID-19 Brighton would no longer be testing residents. Instead, floors were "sheltering in place" and it would be assumed that all residents had been exposed to the virus.

247. At this point, Ms. Galton was presumed to have COVID-19, though she still had not received a COVID test.

248. On May 8, 2020 Ms. Galton was admitted to Heritage Valley Beaver because of low oxygen levels.

249. Dr. Martinez of Heritage Valley Beaver was concerned about sending Ms. Galton back to Brighton when she did not yet have a COVID test result. Dr. Martinez asked Brighton staff where Ms. Galton would be placed upon readmission at Brighton. Brighton staff told Dr. Martinez that Brighton would "sort it out."

250. On May 11, 2020 Ms. Galton was readmitted to Brighton Rehab. Brighton placed Ms. Galton in her usual room and did not isolate or quarantine Ms. Galton from other residents.

251. On May 13, 2020 Ms. Galton received the results of her COVID test—she had tested positive for COVID-19.

252. By this point, members of the Pennsylvania National Guard were stationed in the facility.

253. By recommendation of the National Guard, Ms. Galton and her roommate were moved to a four-person bedroom to be isolated from other residents who did not have COVID-19.

254. Ms. Galton is currently recovering from the virus; but fears that she may contract the virus again, given the uncertainty of retransmission.

255. Ms. Galton and her loved ones also fear the long-term side effects she may suffer from contracting the virus.

XIII. Ala Mazzocca, Deceased

256. Ala Mazzocca was admitted to Brighton Rehab in June 2015 for long term care for her advanced dementia.

257. On March 10, 2020, Barbara Macurak, Ms. Mazzocca's daughter, went to Brighton to visit her mother.

258. On March 12, 2020, Barbara Macurak returned to the facility to see her mother and was informed on arrival at Brighton that the facility was on lockdown and she was not allowed in. There was no warning nor communication prior to this.

259. Barbara Macurak called Brighton numerous times to receive updates on her mother, but all calls went without answer.

260. Ms. Macurak was eventually able to speak with the administrator which led to a call from the facility informing her that everyone was sick, and the staff was overwhelmed.

261. On April 8, 2020 Patricia Mazzocca received a call from Defendant Dr. Thimons, informing her that the facility is no longer testing anyone for COVID as they are assuming all residents and all staff have contracted the virus and the facility is treating everyone.

262. Dr. Thimons also informed Patricia that her mother wasn't acting like herself.

263. A nurse later called Patricia Mazzocca and told her "mom is totally fine, just fine."

264. The next communication either Barbara or Patricia had with the facility was on April 13, 2020. During this call, a nurse informed Barbara that Ala Mazzocca has died of pneumonia.

265. Tremella Celestin, a nurse who worked at Brighton from January 2020 to May 24, 2020, identified that the facility maintained a list of COVID positive patients and identified that Ala Mazzocca was one of the residents on that list.[2]

XIV. Joseph "Randy" Clavelli, Deceased

266. Joseph "Randy" Clavelli was admitted to Brighton Rehab on November 6, 2019 for long term care due to life-long mental health issues.

267. Mr. Clavelli was regularly visited by his daughter, Christina Clavelli, and his sister, Kim Clavelli.

268. On March 31, 2020, Mr. Clavelli was tested for COVID and the test was returned positive. Staff at Brighton did call Christina Clavelli to inform her of the positive test.

269. On April 1, 2020, the Clavelli family was contacted by Brighton and told that Mr. Clavelli had been quarantined in a COVID unit.

270. Kim Clavelli was called by Brighton and informed that her brother was ill, but not sick enough to require hospitalization.

271. On April 2, 2020, Christina received a call that Mr. Clavelli was being transferred to Heritage Valley Beaver after he was found unresponsive in bed.

272. Christina Clavelli spoke with a nurse at Heritage Valley Beaver while her father was admitted to the hospital and was informed that her father was not on a ventilator and was resting.

273. Mr. Clavelli was transferred back to Brighton Rehab on April 5, 2020.

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[2] See Declaration of Tremella Celestin attached hereto as Exhibit 1.

274. Christina Clavelli spoke with an employee at Brighton who reported that Mr. Clavelli's oxygen saturation level was low and that he was in pain.

275. On or about April 9, 2020, staff at Brighton Rehab called Christina Clavelli to discuss hospice and comfort measures for Mr. Clavelli.

276. Mr. Clavelli was admitted to Gallagher Hospice on April 10, 2020. He died days later, on April 15, 2020.

277. Mr. Clavelli's Death Certificate reflects that his cause of death was COVID-19.

XV. Shirley M. Mike, Deceased

278. Shirley M. Mike ("Ms. Mike") was admitted to Brighton on June 21, 2016 for long term care for her dementia, following a diagnosis of sepsis.

279. During her admission at Brighton, and prior to the pandemic, Ms. Mike's family spoke with her by phone and visited regularly.

280. In or around mid-March 2020, Ms. Mike's daughter, Bobbie Johnson, received a phone call from Brighton informing her that there had been an outbreak of COVID-9 at the facility and visitors were no longer allowed. Ms. Johnson was told that her mother was doing well and that she had not been diagnosed with or tested for tested for COVID-19. Johnson was further told that individuals at the facility who had COVID-19 were being quarantined in another ward, not the ward where Ms. Mike's room was located.

281. Throughout the remainder of March and early April 2020, Ms. Johnson made multiple phone calls to Brighton to check on her mother's condition. Often no one answered the phone at the facility and when someone did answer, they did not relay specific information as to Ms. Mike's condition or the outbreak at the facility.

282. On or about April 2 or 3, 2020, Ms. Johnson received a phone call from Brighton informing her that her mother had fallen, that she had some bleeding in the facial area, and that she was being taken to Heritage Valley Beaver for assessment for a possible nose fracture.

283. On or about April 3, 2020, Ms. Mike was taken to Heritage Valley Beaver for assessment following a ground level fall. She was discharged later that day and returned to Brighton.

284. Throughout April 3, 2020 Ms. Johnson made phone calls to Brighton but no one at the facility answered the phone, and she was unable to obtain information about her mother's condition.

285. On or about April 4, 2020, Ms. Johnson received a phone call from Brighton informing her that her mother had not sustained serious injury in her fall, she had elevated blood pressure, but was being administered morphine for pain and was resting comfortably.

286. On or about April 11, 2020, Ms. Mike was tested for COVID-19, with a positive result reported on April 14, 2019.

287. According to records, on or about April 13, 2020, Ms. Johnson received a phone call from Brighton informing her that her mother was having difficulty breathing. At or around this time an employee of Brighton took a photograph of Ms. Mike and forwarded it to Ms. Johnson.

288. Ms. Mike died at Brighton on April 15, 2020.

289. Brighton did not inform Ms. Johnson that her mother had been tested for COVID-19 or that her results were reported as positive for COVID-19 until they informed Ms. Johnson of her mother's death on April 15, 2020.

290. Ms. Mike's Death Certificate reflects that her cause of death was COVID-19.

Facts Common to All Causes of Action

I. Brighton's COVID Outbreak

291. On March 6, 2020 Pennsylvania Governor Tom Wolf issued an Emergency Order which required Pennsylvania residents to stay at home unless they were essential workers.

292. At the same time, the Pennsylvania Department of Health ("DOH"), issued new guidelines for its inspection of nursing facilities.[3]

293. First, the DOH suspended all "regular" on-site inspections of health care facilities, even for facilities that had previously been cited for violating infection-control regulations.

294. Next, the DOH limited its complaint-based inspections to only those situations where a facility was putting a resident in "immediate jeopardy."[4] "Immediate jeopardy" was defined as when a nursing home's "noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death."[5]

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[3] The Pennsylvania Department of Health licenses skilled nursing facilities and long-term care facilities located in the Commonwealth of Pennsylvania. The DOH is also responsible for conducting regular and complaint-based inspections of the facilities it licenses to ensure that these facilities are complying with the mandatory requirements for operation. These mandatory requirements come from state and federal regulations that provide minimum standards for patient care. If the DOH finds that a nursing facility has violated a regulation, the DOH can issue a citation. A monetary fine may accompany this citation. The DOH will also require the nursing facility to submit a written plan to correct its deficiencies. The DOH will monitor the facility to ensure that deficiency is corrected.

[4] Candy Woodall, *As coronavirus deaths increase, Pa. nursing homes have less state and federal oversight*, YORK DAILY RECORD (Apr. 24, 2020), https://www.ydr.com/story/news/2020/04/24/coronavirus-leads-pa-stop-routine-safety-inspections-nursing-homes/3016487001/

[5] CENTERS FOR MEDICARE AND MEDICAID SERVICES, *State Operations Manuel Appendix Q – Core Guidelines for Determining Immediate Jeopardy* (March 6, 2019) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf

295. On March 12, 2020, Brighton placed its facility on "lockdown" and visitors were no longer allowed inside the building to see residents.

296. By March 28, 2020, fourteen Brighton residents had tested positive for COVID-19.

297. By March 30, 2020, two female residents had died from the virus.

298. On March 31, 2020, the Service Employees International Union (SEIU) Healthcare Pennsylvania (the union representing healthcare workers at Brighton) reported that six employees of the facility had tested positive for COVID-19.

299. By this date, nineteen residents were positive for COVID-19.

300. Defendant David Thimons, D.O., Brighton's Medical Director, repeatedly released statements claiming that he and other medical staff were properly handling the COVID virus at Brighton. Among Thimons's statements were, "Is our staff stretched? Yes. Absolutely. But, we are doing physicians rounds with every patient seven days a week. From a medical standpoint we are doing everything everyone is doing to care for [COVID-19] patients around the country."[6]

301. Positive COVID-19 case numbers at Brighton rose quickly, and by April 2, 2020, Brighton reported that 38 residents had tested positive for COVID-19, and that a third resident had died from the virus.

302. However, Brighton was not reporting accurate numbers. Brighton admitted that it was omitting residents from its total COVID count by excluding those residents that it had transferred to the hospital and those residents who had died.[7]

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[6] Sean D. Hamill, *With COVID-19 cases rising, Beaver County nursing home asks for help 'from everyone'*, PITTSBURGH POST-GAZETTE (Apr. 1, 2020), https://www.post-gazette.com/local/west/2020/04/01/With-COVID-19-cases-rising-Beaver-County-nursing-home-asks-for-help-from-everyone/stories/202004010121.

[7] Hamill, *supra*, note 4.

303. On or around April 2, 2020, six Brighton employees walked off the job. They cited unsafe working conditions, including inadequate personal protective equipment (PPE) and resources, as their reason for leaving.

304. After more employees began to leave Brighton, residents' families also began to remove their loved ones from Brighton, if possible. One such family member, identified in a KDKA news report as "Connie S.," stated, "Well the nurse basically said that to me with 100% certainty, everybody is going to get it. How she knew that, I don't know, but that was the final straw."[8]

305. By April 3, 2020, five Brighton residents had died from COVID-19.

306. By April 4, 2020, forty-two Brighton residents and ten employees had tested positive for COVID-19.

307. By April 6, 2020, Brighton began operating under the presumption that everyone in their facility, including staff and all residents, would be assumed to be positive for COVID-19. Brighton issued a press release, stating, "Upon consultation with the Department of Health, and consistent with practices of facilities on the cutting edge of prevention and treatment, we are beginning to shift away from counting test results, and presuming all staff and residents may be positive."[9]

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[8] CBS PITTSBURGH, *Coronavirus In Beaver County: Healthcare Workers Who Walked Off The Job Citing Unsafe Conditions Reach Deal With Owners* (Apr. 2, 2020) https://pittsburgh.cbslocal.com/2020/04/02/brighton-rehab-and-wellness-center-union-workers-owners-deal/.

[9] Sean D. Hamill, *Beaver County nursing home now presumes everyone in building may have COVID-19*, PITTSBURGH POST-GAZETTE (Apr. 6, 2020), https://www.post-gazette.com/local/west/2020/04/06/Brighton-Rehab-and-Wellness-Beaver-PA-nursing-home-coronavirus-positive-cases/stories/202004060124.

308. By April 8, 2020, eleven residents of Brighton were confirmed dead of COVID-19 and it was estimated that at least fifty residents and ten staff members were COVID-positive.

309. Brighton's reporting of COVID numbers was so unreliable that Beaver County Commissioners began to express concern about the facility's handling of COVID-19, and could not get anyone from the facility to respond to their questions. Commissioner Tony Amadio stated, "We're having our own pandemic in Beaver County at one facility... Most of this – probably 80% is coming from one facility."[10] Commissioner Daniel Camp stated "Today [April 16, 2020] we asked the management at Brighton Rehab to be transparent –as it is important to the families of loved ones who are living there, the local medical facilities, and the medical community at large to understand the situation in their facility."[11]

310. Despite these calls to action, Brighton did not publish its numbers of COVID cases and deaths transparently. In early April, Brighton stopped releasing numbers to the public, and families were forced to estimate the numbers by cross-checking data published by the Pennsylvania Department of Health (categorized by county) with the data reported by the only other two nursing facilities in the county.[12]

311. In April, two of the other nursing facilities in Beaver County (Concordia at Villa St. Joseph and Rochester Manor and Villa) each had only one resident with COVID-19.[13]

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[10] Amy Hudak, WPXI-TV, *Beaver Co. officials express concern about coronavirus in nursing home* (Apr. 16, 2020) https://www.wpxi.com/news/local/beaver-county/beaver-co-officials-express-concern-about-coronavirus-nursing-home/L3UDGZL23VC2VFPPVRVF4V55VU/.
[11] Hudak, *supra* note 8.
[12] Daveen Rae Kurutz, THE TIMES, *State data indicates 20 new cases at Brighton Rehab, total surpasses 260* (Apr. 27, 2020) https://www.timesonline.com/news/20200427/state-data-indicates-20-new-cases-at-brighton-rehab-total-surpasses-260.
[13] Kurutz, *supra* note 10.

312. On April 16, 2020, it was suspected that Brighton had over 100 residents with COVID-19. The Pennsylvania Emergency Management Agency reported at least 104 positive cases, but the DOH suspected that the actual number was much higher.[14]

313. On April 20, 2020, the DOH released data based on ZIP-code which revealed that Brighton likely had around 161 COVID-19 cases, which accounted for approximately 54% of Beaver County's 298 cases. Brighton was suspected to have had 30 residents die of COVID, which was nearly 85% of Beaver County's total deaths.[15]

II. The Pennsylvania Department of Health's April 17, 2020 Investigation

314. Following numerous complaints about Brighton's handling of COVID-19, the Pennsylvania Department of Health conducted an on-site inspection of Brighton on April 17, 2020, evidently believing that Brighton was placing its residents in "immediate jeopardy."

315. The DOH's inspection included reviewing Brighton's written policies and procedures, observing staff providing care to residents, and interviewing staff.

316. From this inspection, the DOH cited Brighton for numerous infractions and deficiencies, including Brighton's non-compliance with federal requirements for infection control.

317. The DOH concluded that "[Brighton] failed to make certain social distancing was maintained by staff, properly store clean linens and soiled laundry, provide proper supplies to perform hand washing, properly store biohazardous waste, ensure sinks are accessible to perform handwashing, properly wear gloves and perform hand hygiene and create a clean and sanitary

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[14] Chrissy Suttles, ELLWOOD CITY LEDGER, *County families mourn, celebrate loved ones lost at Brighton Rehab* (Apr. 21, 2020), https://www.ellwoodcityledger.com/news/20200421/county-families-mourn-celebrate-loved-ones-lost-at-brighton-rehab/1

[15] Suttles, *supra* note 12.

environment which created the potential for the cross-contamination and the spread of diseases and infections for seven of eleven nursing units."[16]

318. The DOH reported the following from its interview of Brighton employees:

a. "During an interview on 4/17/20, at 3:15 p.m. the Nursing Home Administrator (NHA) confirmed the facility failed to practice proper social distancing which caused the potential of cross contamination and the spread of diseases and infections."

b. "During an interview on 4/17/20 at 4:34 p.m. the Assistant Director of Nursing (ADON) Employee E25 confirmed that the facility failed to properly store clean linens and soiled laundry and provide soap for hand washing which created the potential for cross-contamination and the spread of diseases and infections."

c. During an interview on 4/17/20, at 4:44 p.m. the ADON Employee E25 confirmed that the facility failed to provide proper supplies to perform hand washing which created the potential for cross-contamination and the spread of diseases and infections.

319. This was not Brighton's first time being cited by the Department of Health.

320. In the past 30 months, Brighton received 110 total citations from the Department of Health in the following general categories:

a. Nine citations for violations regarding "resident rights";

b. Three citations for violations regarding "staff treatment of residents";

c. One citation for a violation regarding "quality of life";

d. Two citations for violations regarding "resident assessment";

[16] DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION, Statement of Deficiencies and Plan of Correction (POC) (Apr. 17, 2020), https://sais.health.pa.gov/CommonPOC/Content/PublicWeb/PDF/1QKJ1191789051800L.PDF (Attached as Exhibit 2).

e. Seven citations for violations regarding "quality of care";

f. Seven citations for violations regarding "nursing and physician services";

g. Five citations for violations regarding "dietary services";

h. Five citations for violations regarding "ancillary services";

i. Two citations for violations regarding "physical environment";

j. Six citations for violations regarding "administration"; and

k. Sixty-three citations for violations regarding "building safety deficiencies."[17]

321. This is 74 more citations than the average skilled nursing facility in Pennsylvania received in the past 30 months, and 55 more citations than the average Pennsylvania facility of similar size.[18]

322. Additionally, Brighton had been cited three times in the past year alone (before the COVID-19 pandemic began) for infection-control infractions.

323. On October 30, 2019, Brighton was cited by the DOH for violating federal requirements for infection prevention and control.[19]

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[17] PENNSYLVANIA DEPARTMENT OF HEALTH, *Nursing Care Facility Performance Profile – 30 Month Period*, https://sais.health.pa.gov/commonpoc/Content/PublicWeb/PerformanceProfile.asp (Last accessed Sept. 8, 2020) (attached as Exhibit 3).

[18] PENNSYLVANIA DEPARTMENT OF HEALTH, *Nursing Care Facility Performance Profile – 30 Month Period, supra* note 17.

[19] DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION, *Statement of Deficiencies and Plan of Correction (POC)* (Oct. 30, 2019), https://sais.health.pa.gov/CommonPOC/Content/PublicWeb/PDF/1QKJ1191789051800L.PDF (Attached as Exhibit 4).

324. In this inspection, Brighton received a "below average" grade for a pattern of conditions that the DOH believed could lead to the "spread of infection and diseases."[20]

325. The DOH ordered Brighton to implement a plan to address and remedy its infection control deficiencies.

326. However, COVID numbers and deaths at Brighton continued to rise, evidencing that Brighton did not implement an adequate plan to get their COVID outbreaks under control.

327. On Tuesday April 28, 2020, 13 Brighton residents died from COVID in one day, increasing the total death toll from 39 to 52 residents.

328. By April 29, 2020, another six Brighton residents died from COVID, bringing the facility's total deaths to 58 residents. At this point, approximately 10% of Brighton's residents had died from COVID-19. [21]

329. On this date, there were 248 Brighton residents with COVID.[22]

330. Brighton was now responsible for 68% of Beaver County's total cases and 88% of the County's COVID-19 related deaths.[23]

331. In response to Brighton's mismanagement of its COVID outbreak, on April 15, 2020, the Department of Health appointed Long Hill Company to take over as the temporary

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[20] DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION, *Statement of Deficiencies and Plan of Correction (POC)* (Oct. 30, 2019), Exhibit 4 *supra* note 19.
[21] Daveen Rae Kurutz, ELLWOOD CITY LEDGER, *Nursing home COVID deaths rise by 13 in Beaver County at Brighton Rehab* (Apr. 28, 2020), https://www.ellwoodcityledger.com/news/20200428/nursing-home-covid-deaths-rise-by-13-in-beaver-county-at-brighton-rehab.
[22] PENNSYLVANIA DEPARTMENT OF HEALTH, PENNSYLVANIA NATIONAL ELECTRONIC DISEASE SURVEILLANCE SYSTEM, *PA Coronavirus (COVID-19) Update Archive April 2020* (Apr. 30, 2020), https://www.health.pa.gov/topics/disease/coronavirus/Pages/April-Archive.aspx.
[23] Kurutz, *supra* note 21.

manager of Brighton Rehab; though Brighton and Long Hill Company said that Long Hill's role was only to "consult."[24]

332. The DOH also contracted with a local health care consulting company, Emergency Care Research Institute (ECRI), to aid with infection control at Brighton. ECRI began holding daily calls with Brighton staff.[25]

333. These appointments at Brighton were announced to the public on April 30, 2020.

334. U.S. Representative Conor Lamb publicly called for an investigation into Brighton on April 30, 2020, stating "I believe that our government owes these families a long, detailed and thorough investigation."[26]

III. The Department of Health's May 5, 2020 Investigation

335. By May 1, 2020, the death toll at Brighton had reached 60 residents, and there were 272 residents with COVID in the facility.

336. Beginning on May 1, 2020, the Department of Health conducted a 4-day on-site investigation at Brighton Rehab.

337. Issuing its report on May 5, 2020, the DOH found that Brighton was violating various state and federal regulations for long term care facilities, thereby failing to prevent the potential for cross-contamination of disease. Out of eleven total nursing units at Brighton, the DOH

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[24] Sean D. Hamill, PITTSBURGH POST-GAZETTE, *State will impose a temporary manager at troubled Beaver County nursing home* (May 8, 2020), https://www.post-gazette.com/local/west/2020/05/08/State-will-impose-a-temporary-manager-at-troubled-Beaver-County-nursing-home-again/stories/202005080110.

[25] Patrick Varine, TRIB LIVE, *State appoints 'temporary manager' for covid-stricken Beaver nursing home* (Apr. 30, 2020), https://triblive.com/local/regional/state-appoints-temporary-manager-for-covid-stricken-beaver-nursing-home/.

[26] J.D. Prose, THE TIMES, *Lamb calls for 'thorough investigation' of Brighton Rehab COVID-19 outbreak* (Apr. 30, 2020), https://www.timesonline.com/news/20200430/lamb-calls-for-thorough-investigation-of-brighton-rehab-covid-19-outbreak.

found that Brighton had placed the residents of nine units in "Immediate Jeopardy" (risk for serious injury, serious harm, serious impairment or death).[27]

338. In its report, the DOH also found that Brighton's Nursing Home Administrator (NHA) and Director of Nursing ("DON") failed to "effectively manage the facility to make certain that proper infection control procedures were followed to protect residents from cross-contamination, infections, virus and disease in the facility. [...] The NHA and the DON failed to fulfill their essential job duties to ensure that the federal and state guidelines and regulations were followed."[28]

339. The Department of Health's May 5, 2020 Report details that in just 90 minutes of the very first day of its inspection, the DOH witnessed more than two dozen regulatory violations, including:

a. Staff failed to wear proper Personal Protective Equipment (PPE) while in the building, creating the potential for cross-contamination and the spread of disease and infections;

b. Staff failed to follow proper hand hygiene procedures after glove removal;

c. There were no soap or paper towels at handwashing sinks;

d. Employees walked through the hallways with masks down around their chins;

e. Staff left clean linen carts open to the air, creating the potential for cross-contamination;

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[27] DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION, *Statement of Deficiencies and Plan of Correction (POC)* (May 5, 2020), https://sais.health.pa.gov/CommonPOC/Content/PublicWeb/PDF/OTFS1191789051800L.PDF, (Attached as Exhibit 5).

[28] DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION, *Statement of Deficiencies and Plan of Correction (POC)* (May 5, 2020), *supra* note 27.

f. Staff failed to maintain the proper 6-feet social distance between other employees who were eating in common areas without masks on;

g. An employee obtained multiple residents' blood sugar levels using the same glucometer without changing gloves or practicing proper hand hygiene between residents;

h. Staff allowed residents' waste baskets to overflow onto the floor, and left used gloves on the floor;

i. An employee pushed a medical cart down the hall, touched and sorted through the drawers on the cart, and then locked the cart, all without taking off or changing gloves that they had worn while treating a resident; and,

j. An employee emptied resident urinals while wearing gloves; that employee then used a temporal thermometer and pulse-oximeter on multiple patients without sanitizing the devices between uses or changing their gloves that they had worn to handle residents' urine. The employee never removed her gloves, performed hand hygiene, or cleaned the equipment between residents.

340. The DOH issued Brighton a $58,260.00 fine, which would accrue an additional $110.00 each day until all violations were rectified.[29]

IV. National Guard, Federal Agencies Intervene

341. On May 11, 2020, the Pennsylvania National Guard stationed 38 guard members at Brighton to "get residents who are non-COVID and those who have recovered from the disease and separate them from those who have it, and save lives."[30]

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[29] Sean D. Hamill, PITTSBURGH POST-GAZETTE, *Inspection at Beaver County nursing home found residents were in 'Immediate Jeopardy'* (June 21, 2020), https://www.post-gazette.com/local/west/2020/06/21/Inspection-at-Beaver-County-nursing-home-found-residents-were-in-Immediate-Jeopardy/stories/202006180171.

[30] Sean D. Hamill, PITTSBURGH POST-GAZETTE, *National Guard, temporary manager move in to troubled nursing home*, https://www.post-gazette.com/local/west/2020/05/11/Brighton-Rehabilitation-and-Wellness-Center-Beaver-PA-National-Guard-temporary-manager/stories/202005110109.

342. The same day the National Guard was deployed to Brighton, the Department of Health hired another temporary manager for the facility. Allaire Health Services of Freehold, NJ, was hired to remain until Brighton achieved compliance with the recommendations of the DOH and the rate of infection was substantially reduced.[31]

343. On May 12, 2020, United States Secretary of Health and Human Services, Alex Azar, announced that Brighton Rehab would be subject to a federal investigation. Federal investigators from the Department of Health and Human Services were at the facility collecting data and observing from May 12 until May 14, 2020.[32] Investigators from the Federal Centers for Medicare and Medicaid Services (hereinafter "CMS") were still reviewing medical records from Brighton as late as mid-June.[33]

344. Azar stated that the number of lives lost at the facility, totaling 71 residents as of May 12, 2020, was the reason for the investigation.[34]

345. Following the federal investigation at Brighton Rehab, CMS Administrator Seema Verma announced that Brighton would be fined $62,580.00 for deficiencies with basic infection-

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[31] PITTSBURGH'S ACTION NEWS 4, *PA Department of Health puts temporary manager at Brighton Rehabilitation and Wellness Center* (May 11, 2020), https://www.wtae.com/article/pa-department-of-health-puts-temporary-manager-at-brighton-rehabilitation-and-wellness-center/32437776.

[32] Nicole Ford, KDKA 2 CBS PITTSBURGH, *HHS Secretary Alex Azar: Federal Investigation Underway Into Brighton Rehab And Wellness Center, Where More Than 70 Residents Have Died* (May 29, 2020), https://pittsburgh.cbslocal.com/2020/05/29/federal-investigation-brighton-rehab-and-wellness-center/.

[33] Sean D. Hamill, PITTSBURGH POST-GAZETTE, *Feds fine Beaver County nursing home for COVID-19-related deficiencies* (June 11, 2020), https://www.post-gazette.com/local/west/2020/06/11/Brighton-Rehabilitation-and-Wellness-Center-Beaver-County-nursing-home-CMS-fine/stories/202006110148.

[34] Ford, *supra* note 32.

prevention protocols. Additional fines would continue to accrue until corrective action was taken to ensure compliance.[35]

346. The deficiencies CMS found were similar to those found by the Pennsylvania Department of Health, including: inadequate or non-existent PPE, the use of medical equipment that was not properly cleaned, and improper medical record documentation.[36]

347. At the end of May 2020, the Pennsylvania Department of Health released data reporting COVID numbers for each long-term care facility in the Commonwealth. Brighton was reported to have 368 residents and 31 employees with COVID-19. The number of COVID deaths at Brighton reached 76 residents, the most deaths of any facility in the Commonwealth.[37]

348. On June 10, 2020, Brighton reported to the DOH that it was home to 334 residents, 126 fewer residents than the 460 residents Brighton reported having when the outbreak began in early March.[38]

349. By June 11, 2020, Brighton reported that 332 of its residents and 104 employees were COVID-positive. Brighton's death toll was up to 80 residents.[39]

V. Brighton's Reckless Response to the COVID-19 Outbreak

350. Tremella Celestin worked at Brighton as a Certified Nursing Assistant ("CNA") from January 2020 until May 24, 2020.[40]

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[35] Hamill, *supra* note 33.
[36] Hamill, *supra* note 33.
[37] PENNSYLVANIA DEPARTMENT OF HEALTH, *COVID-19 LTCF Data* (May 26, 2020), https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/COVID-19%20LTCF%20Data_5-26-20.pdf (Attached as Exhibit 6).
[38] Hamill, *supra* note 33.
[39] Hamill, *supra* note 33.
[40] See Declaration of Tremella Celestin, attached hereto as Exhibit 1.

351. According to Ms. Celestin, beginning sometime in March of 2020, Brighton management kept a list of all COVID-positive residents, which could be accessed by staff members.[41]

352. However, there was no widespread testing of residents for COVID-19; only residents who displayed symptoms were tested.[42]

353. At the same time, Brighton's documentation of which residents were positive was wholly inaccurate. Some residents who were considered positive were never even tested for COVID-19.

354. Even after residents at Brighton received COVID-19 positive diagnoses in March of 2020, management did not isolate or separate COVID-positive and COVID-negative residents until around May 21, 2020.[43]

355. Worse, same staff members were assigned to care for COVID-positive and COVID-negative residents at the same time, before Personal Protective Equipment ("PPE") was issued.[44]

356. Neither staff nor residents were consistently provided with PPE until the Pennsylvania National Guard arrived at Brighton.[45]

357. At no point was Ms. Celestin provided with any type of in-service training related to infection prevention, precautions, or facility protocols, even though she and other nurse aides

[41] Celestin Declaration, *supra* note 40.
[42] Celestin Declaration, *supra* note 40.
[43] Celestin Declaration, *supra* note 40.
[44] Celestin Declaration, *supra* note 40.
[45] Celestin Declaration, *supra* note 40.

were provided with paperwork indicating that they had received training related to infections and other topics.[46]

VI. Brighton's Profit from Understaffing

358. Brighton Rehab gains much of its revenue and profit from taxpayer dollars by participating in federal and state funded Medicare and Medicaid programs.

359. In the Medicare/Medicaid system, every nursing home resident is assigned an "acuity" level which reflects the number and severity of their medical conditions and illnesses.

360. An individual resident's acuity level is determined by their Resource Utilization Group or "RUG" score, which is calculated as a part of a resident's Minimum Data Set ("MDS").

361. A resident with a higher acuity level places a greater demand for care and services on a nursing home and its staff.

362. A skilled nursing facility uses acuity levels to bill Medicare/Medicaid for reimbursement for daily care and services.

363. Medicare/Medicaid reimburses nursing facilities at a higher rate for care and services based on the resident's acuity rate and number of therapy minutes provided.

364. Accordingly, the higher the facility's acuity levels, the more revenue the facility generates from Medicare and Medicaid.

365. This creates a financial incentive for nursing homes, such as Brighton Rehab, to admit and keep residents with greater mental, physical, and psychosocial needs.

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[46] Celestin Declaration, *supra* note 40.

366. Each year, skilled nursing facilities like Brighton must submit a Medicare Cost Report to The Centers Medicare and Medicaid Services ("CMS"), in which the facility must account for each dollar received and spent. Part of this report is each resident's daily RUG score.

367. Medicare/ Medicaid labels its highest and second-highest rates of reimbursement as "Ultra High" and "Very High" respectively.

368. The Cost Report submitted by Comprehensive Healthcare Management Services, LLC for Brighton Rehabilitation and Wellness Center for 2016 stated that 92.12% of all Brighton residents had been assigned RUG scores within these top two rates of reimbursement. Of all Brighton residents, 82.02% were assigned "Ultra High" RUG scores, providing Brighton with the highest rate of Medicare reimbursement for these residents. An additional 10.1% of Brighton residents were assessed to have "Very High" RUG scores, providing Brighton with the second-highest rate of Medicare reimbursement for these residents.[47]

369. In 2017, Brighton's Cost Report showed that 92.43% of all residents residing in the facility were assigned "Ultra High" or "Very High" RUG score. This year, Brighton's "Ultra High" RUG scores increased to 84.44% of all residents, with 7.99% of residents assigned "Very High" RUG scores.[48]

370. Brighton's 2018 Cost Report showed that 91.19% of all residents residing in the facility were assigned "Ultra High" (78.3%) or "Very High" (12.89%) RUG scores.[49]

371. Because Brighton reported acuity levels this high, CMS expects that more care and resources will be necessary to meet the needs of Brighton's residents.

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[47] See 2017 Cost Report, attached hereto as Exhibit 7.
[48] 2017 Cost Report, *supra* note 47.
[49] See 2018 Cost Report, attached hereto as Exhibit 8.

372. Therefore, CMS reimburses Brighton at a high rate so that Brighton can provide adequate care to its residents.

373. A resident's acuity level is also used for CMS to determine the number of hours it expects the nursing home will have to provide each day to meet each resident's needs.

374. CMS then pays the facility according to the hourly rate of reimbursement for the expected number of nursing hours required for each resident.

375. At the end of each quarter, the nursing home must provide CMS with an accounting of the hours it actually spent providing nursing care to residents.

376. To calculate nursing hours, facilities like Brighton calculate the hours spent providing care to residents by their Registered Nurses (RN), Licensed Practical Nurses ("LPN"), and Aides.

377. In 2016, Brighton failed to provide sufficient and expected licensed care to its residents and failed to supply expected aide care to its residents.

378. In 2016, Brighton provided an average of 1.49 nursing hours (LPN hours plus RN hours) to each resident each day,[50] though Brighton was paid by CMS to provide 2.07 nursing hours to each resident each day.[51]

379. In 2016, Brighton provided the majority of its nursing care using LPNs. And, while Brighton did provide sufficient LPN hours, Brighton failed to provide sufficient RN hours. In particular, Brighton was paid by CMS, based on Brighton's reported acuity, to provide 1.33 RN

[50] See Quarterly Report on CMS Expected Staffing, attached as Exhibit 9. See also RUGs, attached as Exhibit 10.
[51] CMS Expected Staffing and RUGs, *supra* note 50.

hours to each resident each day.[52] However, Brighton actually provided only 0.587 hours of RN care to each resident each day.[53]

380. Similarly, Brighton failed to provide sufficient Certified Nurse Assistant (CNA) care to its residents. In 2016, Brighton provided an average (based on Brighton's quarterly reporting) of 2.09 hours of aide care to its residents each day, though Brighton was paid by CMS to provide 2.42 hours of aide care to its residents each day.

381. In 2017, Brighton again failed to provide sufficient and expected licensed care to its residents and failed to supply expected aide care to its residents.

382. In 2017, Brighton provided an average (based on Brighton's quarterly reporting) of 1.46 nursing hours (LPN plus RN) to each resident each day.

383. However, in 2017, Brighton was required to provide (based on its reported resident acuity) 2.20 nursing hours (LPN plus RN) to each resident each day.

384. In 2017, Brighton provided the majority of its nursing care using LPNs. And, while Brighton did provide sufficient LPN hours, Brighton failed to provide sufficient RN hours. In particular, Brighton was required to provide 1.43 RN hours to each resident each day.[54] However, Brighton actually only reported 0.554 hours or RN care to each resident each day.[55]

385. Similarly, in 2017 Brighton failed to provide sufficient Certified Nurse Assistant (CNA) care to its residents.

386. In 2017, Brighton provided on average (based on Brighton's quarterly reporting) an average of 2.15 hours of aide care to its residents each day.[56]

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[52] CMS Expected Staffing and RUGs, *supra* note 50.
[53] CMS Expected Staffing and RUGs, *supra* note 50.
[54] CMS Expected Staffing and RUGs, *supra* note 50.
[55] CMS Expected Staffing and RUGs, *supra* note 50.
[56] CMS Expected Staffing and RUGs, *supra* note 50.

387. However, in 2017, Brighton was required to provide (based on its reported resident acuity) 2.50 hours of aide care to its residents each day.[57]

388. In 2017, Brighton provided an average of 2.76 nursing hours to each resident each day.[58]

389. In calendar year 2017, Brighton's Quarterly reporting for CNA, LPN, and RN hours were identical across all 4 quarters of that year.[59]

390. In the first quarter of 2018, Brighton failed to provide sufficient and expected licensed care to its residents and failed to supply expected aide care to its residents.[60]

391. In the first quarter of 2018, Brighton provided an average of 1.52 nursing hours (LPN plus RN) to each resident each day.[61]

392. However, in the first quarter of 2018, Brighton was required to provide (based on its reported resident acuity) 2.27 nursing hours (LPN plus RN) to each resident each day.[62]

393. In the first quarter of 2018, Brighton provided the majority of its nursing care using LPNs. And, while Brighton did provide sufficient LPN hours during that quarter, Brighton failed to provide sufficient RN hours. In particular, Brighton was required (based on its reported acuity) to provide 1.50 RN hours to each resident each day.[63] However, Brighton actually only reported 0.729 hours or RN care to each resident each day.[64]

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[57] CMS Expected Staffing and RUGs, *supra* note 50.
[58] CMS Expected Staffing and RUGs, *supra* note 50.
[59] CMS Expected Staffing and RUGs, *supra* note 50.
[60] CMS Expected Staffing and RUGs, *supra* note 50.
[61] CMS Expected Staffing and RUGs, *supra* note 50.
[62] CMS Expected Staffing and RUGs, *supra* note 50.
[63] CMS Expected Staffing and RUGs, *supra* note 50.
[64] CMS Expected Staffing and RUGs, *supra* note 50.

394. In sum, for 2016, 2017 and 2018, Brighton failed to provide the requisite total hours of average daily care for its residents:

a. In 2016, Brighton provided average total care per day per resident of 3.59 hours when, based on its own self-reported acuity, it should have provided at least 4.50 hours of total care per day per resident.[65]

b. In 2017, Brighton provided average total care per day per resident of 3.61 hours when, based on its own self-reported acuity, it should have provided at least 4.71 hours of total care per day per resident.[66]

c. In the first quarter of 2018, Brighton average total care per day per resident of 4.16 hours when, based on its own self-reported acuity, it should have provided at least 4.73 hours of total care per day per resident.[67]

395. While data from CMS is not presently available beyond the first quarter of 2018, upon information and belief, when that data does become available, it will show similar results, and it will show that Brighton continued to systemically understaff up to and including the COVID-19 pandemic and continuing through the present.

396. Frequently, staffing numbers at Brighton were low enough that one nurse would be left to care for up to 55 residents at a time.

397. When CMS pays facilities like Brighton at the highest acuity levels, CMS assumes that facilities will use that funding to meet residents' needs, primarily by hiring appropriate staff to provide care. Facilities primarily show that they have done this by meeting CMS's expected nursing hours.

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[65] CMS Expected Staffing and RUGs, *supra* note 50.
[66] CMS Expected Staffing and RUGs, *supra* note 50.
[67] CMS Expected Staffing and RUGs, *supra* note 50.

398. But instead of using CMS's funding to hire additional nursing staff, Brighton continually staffed below the hours CMS paid it for and pocketed the additional CMS money as profit.

399. In 2016, Brighton saved $5,647,800.00 as a result of staffing below the hours CMS paid for.[68]

400. In 2017, Brighton saved $16,981,605.00 as a result of staffing below the hours CMS paid for.[69]

401. In 2018, Brighton saved $8,775,360.00 as a result of staffing below the hours CMS paid for.[70]

402. Despite receiving this funding from Medicare and Medicaid, Brighton and its administration failed to ensure, through its operational, budgetary, and managerial decisions, that Brighton was sufficiently staffed to meet the individual needs of all residents, including the needs of the Plaintiffs and Plaintiffs' Decedents.

403. With Brighton failing to provide the number of hours of nursing care that CMS expected and paid for, it must in order to provide adequate care to its residents, Brighton was quite literally "understaffed."

404. It is no surprise then that as the Department of Health observed, Brighton's nursing staff cut corners while struggling to care for hundreds of residents during the pandemic.

405. Ms. Celestin also confirms that Brighton operated while understaffed.[71]

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[68] See Nursing Care Costs Sheet, attached as Exhibit 11.
[69] Nursing Care Costs Sheet, *supra* note 68.
[70] Nursing Care Costs Sheet, *supra* note 68.
[71] Celestin Declaration, *supra* note 40.

406. According to her Declaration, Ms. Celestin was normally required to care for forty or more residents during the 3:00 p.m. to 11:00 p.m. shift; she was unable to properly do her job because of the low staffing levels.[72]

407. For example, residents who required assistance with mobility (including turning and repositioning in their beds and chairs to prevent pressure wounds) were not timely provided it; Ms. Celestin could not assist residents to the bathroom in a timely manner; and could not timely respond to call lights.[73]

408. Even though care was not properly provided to the residents, someone at Brighton would regularly and daily falsify and complete the "Activities of Daily Living" records indicating that care was in fact properly provided to each and every resident.[74]

409. In this way, Brighton's understaffing caused cross-contamination among residents and staff and allowed the facility to become a breeding ground for the Coronavirus spread until most residents had contracted the virus and more than 70 residents had died.

410. Per the PA DOH, as of October 14, 2020, Brighton had a census of 346 residents, a total of 334 resident cases, a total of 73 resident deaths and 117 staff cases.

COUNT I

CORPORATE NEGLIGENCE – SURVIVAL

Deceased Plaintiffs v. Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation & Wellness Center

411. Plaintiffs incorporate all preceding paragraphs as if set forth more fully herein.

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[72] Celestin Declaration, *supra* note 40.
[73] Celestin Declaration, *supra* note 40.
[74] Celestin Declaration, *supra* note 40.

412. Comprehensive Healthcare Management Services, LLC exercised complete control over all aspects of the operation and management of the Brighton Rehab facility prior to and during the COVID outbreak at Brighton, including, but not limited to: creating, setting, funding, and/or implementing budgets; creating and maintaining business relationships with related parties as defined by the Centers for Medicare and Medicaid Services ("CMS") that resulted in an undercapitalized and understaffed nursing home; hiring and training caregiving staff; monitoring resident acuity levels and staffing sufficiently to meet each resident's needs; admitting and discharging residents to and from the facility; and creating and enforcing written policies and procedures to provide for the safety and well-being of all residents.

413. Each of these managerial and operational functions had a direct impact on the quality of care provided to the Plaintiff's Decedents and other residents in the Brighton facility.

414. Comprehensive Healthcare Management Services, LLC had a duty to act prudently, and had a duty to provide reasonable and ordinary care and care services to the Plaintiff's Decedents.

415. Comprehensive Healthcare Management Services, LLC had a duty to provide caregiving staff with sufficient personal protective equipment, sanitation and hygiene products, and medical tools to prevent cross-contamination and the spread of infection to residents and other staff.

416. Comprehensive Healthcare Management Services, LLC had a duty to ensure that all persons providing care within the Brighton facility were competent to provide that care.

417. Comprehensive Healthcare Management Services, LLC had a duty to oversee all persons who practice medicine in the Brighton facility.

418. Comprehensive Healthcare Management Services, LLC had a duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for residents of the Brighton facility, such as the Plaintiff's Decedents.

419. Comprehensive Healthcare Management Services, LLC had a duty to ensure that the Brighton facility was sufficiently staffed to meet the needs of its residents.

420. Comprehensive Healthcare Management Services, LLC negligently, recklessly, willfully and wantonly breached its duties owed to the Plaintiff's Decedents in the following ways:

a. By failing to establish and maintain an infection prevention and control program ("IPCP") that provided a safe, sanitary and comfortable environment which prevented the development and transmission of communicable diseases and infections, namely the transmission of COVID-19; as pled herein,

b. By failing to establish adequate written standards, policies, and procedures to identify possible communicable diseases in the Brighton facility before the infection could spread to other persons in the facility, as pled herein;

c. By failing to follow written standards, policies, and procedures to identify possible communicable diseases in the Brighton facility which were in place before the infection could spread to other persons in the facility, as pled herein;

d. By failing to establish adequate written standards, policies, and procedures that enumerate when possible incidents of communicable disease or infections should be reported, and who they should be reported to, as pled herein;

e. By failing to follow written standards, policies, and procedures that were in place that enumerate when possible incidents of communicable disease or infections should be reported, and who they should be reported to, as pled herein;

f. By failing to establish adequate written standards, policies, and procedures for precautions and safeguards to prevent the spread of infection within the Brighton facility, as pled herein;

g. By failing to follow written standards, policies, and procedures that were in place for precautions and safeguards to prevent the spread of infection within the Brighton facility, as pled herein;

h. By failing to establish adequate written standards, policies, and procedures for when and how a resident with a communicable infection should be isolated from residents and other staff, as pled herein;

i. By failing to follow standards, policies, and procedures that were in place for when and how a resident with a communicable infection should be isolated from residents and other staff, as pled herein;

j. By failing to establish adequate written standards, policies, and procedures for when and how a staff member with exposure to a communicable infection should be prevented from exposing residents and other staff, as pled herein;

k. By failing to follow written standards, policies, and procedures that were in place for when and how a staff member with exposure to a communicable infection should be prevented from exposing residents and other staff, as pled herein;

l. By failing to provide adequate training and education to caregiving staff on infection prevention and control, as pled herein;

m. By failing to ensure all caregiving staff members attended appropriate trainings and were properly trained on infection prevention and control, and by failing to ensure all staff were properly re-educated as required; as pled herein,

n. By failing to ensure that Defendant Dr. David Thimons was properly overseeing the facility in providing care to residents;

o. By failing to ensure that Defendant Dr. David Thimons was properly safeguarding that the quality of care provided met all applicable standards;

p. By failing to ensure that Dr. David Thimons, was properly auditing infection control procedures in the Brighton facility, as required;

q. By failing to accurately and/or truthfully communicate information to residents and their families about the spread of COVID-19 within the Brighton facility, so as to allow them to make informed decisions for the wellbeing of their loved ones in the Brighton facility, as pled herein;

r. By failing to accurately and/or truthfully communicate with other medical providers and the Pennsylvania Department of Health about the spread of COVID-19 within the Brighton facility, as pled herein;

s. By failing to request assistance from the proper authorities when it became apparent that COVID-19 was quickly spreading throughout the Brighton facility, as pled herein;

t. By failing to test Brighton's residents and staff for COVID-19 so as to properly separate and isolate COVID-positive individuals from those who had not been exposed to the virus, as pled herein;

u. By allowing COVID infected staff to care for residents, as pled herein;

v. By failing to provide clean linens, as pled herein;

w. By failing to communicate with residents' family members and physicians, as pled herein;

x. By stopping testing and presuming that all residents and all staff were COVID-positive instead of taking proper precautions to identify and isolate those residents and staff who had not yet contracted the virus, as pled herein;

y. By failing to ensure that proper social distancing was maintained by Brighton's residents and staff, as pled herein;

z. By failing to provide adequate supplies for residents and staff to wash their hands to prevent the spread of infection, as pled herein;

aa. By failing to ensure that sinks were accessible for residents and staff to wash their hands, as pled herein;

bb. By failing to ensure that all employees washed their hands regularly, as pled herein;

cc. By failing to properly store biohazardous waste, as pled herein;

dd. By failing to ensure that all employees wore gloves and changed their gloves when appropriate, as pled herein;

ee. By failing to ensure that all employees had access to sufficient Personal Protective Equipment (PPE), as pled herein;

ff. By failing to ensure that all staff was trained in the proper use of PPE, as pled herein;

gg. By failing to ensure that all staff used PPE properly, as pled herein;

hh. By failing to ensure all employees were trained on, and followed, guidelines for sanitizing medical equipment between uses with different residents, as pled herein;

ii. By failing to create a clean and sanitary environment, the lack of which created the potential for cross-contamination and the spread of diseases and infections, as pled herein;

jj. By failing to recognize and appreciate the extreme risk that COVID-19 posed to Brighton's residents, who—due to age, pre-existing conditions, and living arrangements—were already some of the most vulnerable individuals in our communities, as pled herein;

kk. By failing to create and implement a plan to house COVID-positive residents in an isolated unit of the Brighton facility to avoid exposing residents who were not COVID-positive, as pled herein;

ll. By intentionally understaffing the Brighton facility in order to keep the surplus Medicare and Medicaid funding as revenue, which resulted in Brighton's nursing staff being unable to meet the needs of the facility's residents, as pled herein.

421. At all relevant times, Comprehensive Healthcare Management Services, LLC had a duty to not violate the legal rights of any resident, and had a duty to comply with all provisions

of Title 28, Pa. Administrative Code, Chapters 201 (General Operation of Long-Term Care Nursing Facilities) and 211 (Program Standards for Long-Term Care Nursing Facilities) and 42 C.F.R. §483 et seq. (Centers for Medicare & Medicaid Services, Department of Health and Human Services Requirements for Long Term Care Facilities).

422. These regulations comprise part of the standard of care that facilities like Brighton must provide to its residents.

423. These regulations are designed and intended to protect the interests of skilled nursing and long-term care residents such as the Plaintiffs' Decedents.

424. These regulations are designed and intended to protect the interests of skilled nursing and long-term care residents against the hazards the Plaintiffs' Decedents encountered at Brighton and the type of harm and death they suffered – specifically, contracting viral infections from other residents and/or staff.

425. Comprehensive Healthcare Management Services, LLC negligently, recklessly, willfully and wantonly violated these regulations in the following ways:

a. By the failure of an effective governing body to adopt and enforce rules for the health care and safety of the residents, as required by 28 Pa. Code § 201.18, as pled herein;

b. By failing to conduct ongoing coordinated educational programs for the development and improvement of skills of the facility's personnel, including training related to problems, needs, and rights of the residents, as required by 28 Pa. Code § 201.20(a), as pled herein;

c. By failing to conduct in-service training at least annually which includes infection prevention and control, as required by 28 Pa. Code §201.20(c), as pled herein;

d. By admitting or re-admitting residents to the Brighton facility with disease in the communicable stage when the facility did not have the capability to care for the needs of

the residents, as prohibited by 28 Pa. Code §201.24(d), as pled herein;

e. By failing to adequately train staff in proper implementation of policies and procedures, as required by 28 Pa. Code § 201.29(d), as pled herein;

f. By failing to treat Plaintiffs with consideration, respect, and full recognition of dignity and individuality, as required by 28 Pa. Code § 201.29(j), as pled herein;

g. By failing to report to the appropriate health agencies and appropriate Division of Nursing Care Facilities filed office when a resident developed a reportable disease, as required by 28 Pa. Code § 211.1(a), as pled herein;

h. By failing to design and implement resident care policies to ensure the Plaintiffs' Decedents' total medical needs were met and that they were protected from infection, as required by 28 Pa. Code § 211.10(d), as pled herein;

i. By failing to update the facility's resident care policies as necessary to meet the total medical and psychosocial needs of Brighton's residents, as required by 28 Pa. Code §211.10, as pled herein;

j. By failing to provide services by a sufficient number of nursing personnel on a 24-hour basis to provide nursing care to meet the needs of all residents, as required by 28 Pa. Code § 211.12, as pled herein;

k. By failing to protect and promote Plaintiffs' Decedents' resident rights, as required by 42 C.F.R. § 483.10, as pled herein;

l. By failing to treat each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, as required by 42 C.F.R. § 483.10(a)(1), as pled herein;

m. By failing to treat each resident with respect and dignity, as required by 42 C.F.R. § 483.10(e), as pled herein;

n. By failing to immediately notify residents' representatives when there were significant changes in residents' physical statuses, as required by 42 C.F.R. § 483.10(g)(14), as pled herein;

o. By failing to provide residents with a safe, clean, comfortable, and homelike environment, as required by 42 C.F.R. § 483.10(i), as pled herein;

p. By failing to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, as require by 42 C.F.R. § 483.10(i)(2), as pled herein;

q. By discouraging residents from communicating with federal, state, or local officials, as prohibited by 42 C.F.R. § 483.10(k), as pled herein;

r. By failing to conduct a comprehensive assessment for the Plaintiffs' Decedents after significant changes in their condition, as required by 42 C.F.R. § 483.20, as pled herein;

s. By failing to ensure all residents, including the Plaintiffs' Decedents, received the necessary care and services to attain or maintain the highest practicable qualify of life, including physical, mental, and psychosocial well-being, as required by 42 C.F.R. § 483.24, as pled herein;

t. By failing to ensure all residents, including Plaintiffs' Decedents, received treatment and care in accordance with professional standards of practice, as required by 42 C.F.R. § 483.25, as pled herein;

u. By failing to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population, as required by 42 C.F.R. § 483.35, as pled herein;

v. By failing to provide nursing services by sufficient registered nurses on a 24-hour basis to the Plaintiffs'

Decedents in accordance with their care plans, as required by 42 C.F.R. § 483.35(b), as pled herein;

w. By failing to obtain diagnostic services to meet the needs of its residents, as required by 42 C.F.R. § 483.50(b), as pled herein;

x. By failing to administer the Brighton facility in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as required by 42 C.F.R. § 483.70, as pled herein;

y. By failing to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles, as required by 42 C.F.R. § 483.70, as pled herein;

z. By failing to conduct and document a facility-wide assessment to determine what resources were necessary to care for the facility's residents competently during both day-to-day operations and emergencies; to review and update this assessment whenever there was any change that would require a substantial modification to any part of this assessment; and for this assessment to include the care required by the resident population considering the types of diseases and overall acuity present within that population, as required by 42 C.F.R. § 483.70(e), as pled herein;

aa. By failing to establish and maintain an emergency preparedness plan that meets the requirements of 42 C.F.R. § 483.73, as pled herein;

bb. By failing to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection, as required 42 C.F.R. § 483.80, as pled herein;

cc. By failing to establish a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, and visitors, as required by 42 C.F.R. § 483.80(a)(1), as pled herein;

dd. By failing to establish a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, as required by 42 C.F.R. § 483.80(a)(2)(i), as pled herein;

ee. By failing to establish a system which specified standard and transmission-based precautions to be followed to prevent spread of infections, as required by 42 C.F.R. § 483.80(a)(2)(iii), as pled herein;

ff. By failing to establish a system which specified when and how isolation should be used for a resident, including the type and duration of the isolation, as required by 42 C.F.R. § 483.80(a)(2)(iv), as pled herein; and,

gg. By failing to establish a system which specified the circumstances under which the facility must prohibit employees with a communicable disease from direct contact with residents, if direct contract will transmit the disease, as required by 42 C.F.R. § 483.80(a)(2)(v), as pled herein;

hh. By failing to inform residents and their families of COVID-19 occurrences in the facility, as required by 42 C.F.R. § 483.80(g)(3) as pled herein;

ii. By failing to provide a safe, functional, sanitary, and comfortable environment to residents, staff, and the public, as required by 42 C.F.R. § 483.90, as pled herein;

jj. By failing to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, as required by 42 C.F.R. § 483.95, as pled herein; and,

kk. By failing to include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program, as required by 42 C.F.R. § 483.95(e), as pled herein.

426. As a direct and proximate result of the negligent acts and omissions of Comprehensive Healthcare Management Services, LLC, as set forth above, Brighton's caregiving staff was less able to contain and control the spread of COVID within Brighton's walls.

427. As a direct and proximate result of the negligent acts and omissions of Comprehensive Healthcare Management Services, LLC, as set forth above, the Plaintiffs' Decedents were exposed to and contracted COVID-19 and died.

428. As a direct and proximate result of the negligent acts and omissions of Comprehensive Healthcare Management Services, LLC, as set forth above, the Plaintiffs' Decedents suffered the following damages:

a. The Plaintiffs' Decedents experienced pain, suffering, infirmity, deterioration, debilitation, loss of enjoyment of life, anxiety, and isolation/confinement from contracting and being treated for COVID-19; and,

b. The Plaintiffs' Decedents incurred hospital, medical, and nursing expenses to be treated for the COVID-19 virus and its sequelae and effects.

429. Furthermore, because the negligence of Comprehensive Healthcare Management Services, LLC went beyond ordinary negligence into gross negligence, recklessness, and willful and wanton conduct, Plaintiffs are entitled to recover punitive damages.

WHEREFORE, Plaintiffs Jamie Worthy-Smith, Individually and as Administratrix of the Estate of Kim L. McCoy-Warford; Mark J. Lanton, Individually and as Administrator of the Estate of Gloria Lanton; Jacqueline Young, Individually and as Administratrix of the Estate of Marion Young; Brandy Hedger Individually and as Administratrix of the Estate of Rebecca Joy VanKirk; Keri Boyer Individually and as Administratrix of the Estate of Earl Denbow, Jr.; Denise Eldridge Individually and as Administratrix of the Estate of Virginia Eldridge; Tracy Mineo and Susan Fragomeni, Individually and as Co-Administratrixes of the Estate of Nancy Kemerer; Patricia Mazzocca and Barbara Macurak, Individually and as Co-Executrixes of the Estate of Ala Mazzocca; Christina Clavelli, Individually and as Administratrix of the Estate of Joseph "Randy" Clavelli; and Bobbie Johnson, Individually and as Administratrix of the Estate of Shirley M. Mike,

claim damages of Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center, and demand compensatory and punitive damages from Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center in an amount in excess of the jurisdictional arbitration limits, together with interest, and any other relief this Honorable Court deems appropriate.

COUNT II

VICARIOUS NEGLIGENCE – SURVIVAL

Deceased Plaintiffs v. Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation & Wellness Center

430. Plaintiffs incorporate all preceding paragraphs as if set forth more fully herein.

431. Brighton Rehab employs individuals who work solely in a managerial and supervisory capacity, and who generally do not provide hands-on care to residents. These managerial and supervisory employees include (but are not limited to) positions such as the Administrator, Assistant Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Infection Preventionist and Environmental Services Director.

432. At all relevant times, Brighton Rehab acted by and through these managerial and supervisory agents, servants, and/or employees, who were then and there acting within the course and scope of their employment. Accordingly, Brighton Rehab is vicariously liable for any negligence of these managerial and supervisory agents, servants, and/or employees.

433. This cause of action is limited to Brighton's vicarious liability for the negligence of only these managerial/supervisory employees who generally did not provide hands-on care to residents—including but not limited to the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, and Environmental Services

Director. Plaintiffs do not seek to hold Brighton vicariously liable for the actions or inactions of Brighton's front-line caregiving nursing staff, whose members did the best they could to provide care in the dangerous environment created by Brighton and Brighton's management.

434. Brighton's managerial and supervisory employees had the responsibility and authority to make decisions for the facility in areas such as: creating, setting, funding, and/or implementing budgets; creating and maintaining business relationships with related parties as defined by the Centers for Medicare and Medicaid Services ("CMS") that resulted in an undercapitalized and understaffed nursing home; hiring and training staff; monitoring resident acuity levels and staffing sufficiency to meet each resident's needs; admitting and discharging residents to and from the facility; and creating and enforcing Brighton's policies and procedures.

435. Brighton's managerial and supervisory employees– such as the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, and Environmental Services Director– had a duty to make these decisions and carry out these functions with reasonable and ordinary care.

436. These types of managerial decisions had a direct impact on the quality of care Brighton provided to its residents.

437. Brighton's managerial and supervisory staff had a duty to ensure that all persons providing resident care within Brighton were competent and adequately trained to provide reasonable care to Brighton's residents.

438. Brighton's managerial and supervisory staff had a duty to formulate, adopt, and enforce rules and policies to ensure reasonable care for Brighton's residents.

439. Brighton's managerial and supervisory staff had a duty to supervise the nursing and caregiving staff to ensure that Brighton's policies and procedures, and basic infection protocol, were being followed.

440. Brighton's managerial and supervisory staff negligently, recklessly, carelessly, willfully, and wantonly breached their duties owed to the Deceased Plaintiffs in the following particulars:

a. By failing to establish and maintain an infection prevention and control program ("IPCP") that provided a safe, sanitary and comfortable environment which prevented the development and transmission of communicable diseases and infections, namely the transmission of COVID-19, as pled herein;

b. By failing to follow an infection prevention and control program ("IPCP") that provided a safe, sanitary and comfortable environment which prevented the development and transmission of communicable diseases and infections, namely the transmission of COVID-19, as pled herein;

c. By failing to establish written standards, policies, and procedures for the above-mentioned IPCP, which should have specified a system of surveillance designed to identify possible communicable diseases before they can spread to other persons in the facility, to whom and when possible incidents of communicable disease or infections should be reported, precautions to be followed to prevent the spread of infections, when and how isolation should be used for a resident, and circumstances under which the facility must prohibit and prevent employees with communicable disease or infections from having direct contact with residents, as pled herein;

d. By failing to follow standards, policies, and procedures for the above-mentioned IPCP, which should have specified a system of surveillance designed to identify possible communicable diseases before they can spread to other persons in the facility, to whom and when possible incidents of communicable disease or infections should be reported, precautions to be followed to prevent the spread of infections, when and how isolation should be used for a

resident, and circumstances under which the facility must prohibit and prevent employees with communicable disease or infections from having direct contact with residents, as pled herein;

e. By failing to provide adequate training and education to caregiving staff on infection prevention and control, as pled herein;

f. By failing to ensure all caregiving staff members attended proper training sessions and were properly trained on infection prevention and control, and by failing to ensure all staff were properly re-educated as required; as pled herein;

g. By failing to truthfully communicate information to residents and their families about the spread of COVID-19 within the Brighton facility, so as to allow them to make informed decisions for the wellbeing of themselves and their loved ones in the Brighton facility, as pled herein;

h. By failing to make certain social distancing was maintained by staff, as pled herein;

i. By failing to properly store clean linens and soiled laundry, as pled herein;

j. By failing to ensure all employees properly wore gloves and performed hand hygiene, as pled herein;

k. By failing to ensure all employees properly used PPE and were trained on proper use of PPE, as pled herein;

l. By failing to ensure all employees knew of and properly followed guidelines for sanitizing medical equipment in between uses on different residents, as pled herein;

m. By choosing to keep Medicare and Medicaid funding as profit instead of staffing to meet CMS's expected nursing hours, as pled herein; and,

n. By intentionally understaffing the facility, as pled herein.

441. At all relevant times, Brighton's managerial and supervisory personnel had a duty to not violate the legal rights of any resident and to comply with all provisions of Title 28, Pa.

Administrative Code, Chapters 201 (General Operation of Long-Term Care Nursing Facilities) and 211 (Program Standards for Long-Term Care Nursing Facilities) and 42 C.F.R. §483 et seq. (Centers for Medicare & Medicaid Services, Department of Health and Human Services Requirements for Long Term Care Facilities).

442. These state and federal regulations comprise part of the standard of care that facilities like Brighton must provide to its residents.

443. These state and federal regulations are designed and intended to protect the interests of skilled nursing and long-term care residents such as the Plaintiffs' Decedents.

444. These state and federal regulations are designed and intended to protect the interests of skilled nursing and long-term care residents against the hazards the Plaintiffs' Decedents encountered at Brighton and the type of harm they suffered – specifically, contracting viral infections from other residents and/or staff.

445. Brighton's managerial and supervisory personnel negligently, recklessly, willfully, and wantonly violated these state and federal regulations in the following ways:

a. By the failure of Brighton's administrator to enforce regulations relative to the level of health care and safety of residents, as required by 28 Pa. Code § 201.18(e)(1), as pled herein;

b. By the failure of Brighton's administrator to develop and enforce adherence to policies and procedures to protect residents' rights, as required by 28 Pa. Code § 201.29(a), as pled herein;

c. By failing to adequately train staff in proper implementation of policies and procedures, as required by 28 Pa. Code § 201.29(d), as pled herein;

d. By failing to treat Plaintiffs' Decedents with consideration, respect, and full recognition of dignity and individuality, as required by 28 Pa. Code § 201.29(j), as pled herein;

e. By failing to report to the appropriate health agencies and appropriate Division of Nursing Care Facilities filed office when a resident developed a reportable disease, as required by 28 Pa. Code § 211.1(a), as pled herein;

f. By failing to design and implement resident care policies to ensure the Plaintiffs' Decedents total medical needs were met and that they were protected from infection, as required by 28 Pa. Code § 211.10(d), as pled herein;

g. By failing to update the facility's resident care policies as necessary to meet the total medical and psychosocial needs of Brighton's residents, as required by 28 Pa. Code §211.10, as pled herein;

h. By the director of nursing's failure to maintain standards of accepted nursing practice, as required by 28 Pa. Code §211.12(d)(1), as pled herein;

i. By the director of nursing's failure to ensure the adequacy of the facility's nursing policy and procedure manuals, as required by 28 Pa. Code §211.12(d)(2), as pled herein;

j. By the director of nursing's failure to ensure the adequacy of methods for coordination of nursing services with other resident services, as required by 28 Pa. Code §211.12(d)(3), as pled herein;

k. By the director of nursing's failure to make proper recommendations for the number and levels of nursing personnel to be employed, as required by 28 Pa. Code §211.12(d)(4), as pled herein;

l. By the director of nursing's failure to provide adequate general supervision, guidance, and assistance in implementing residents' personal health programs to assure that preventative measures, treatments, and other health services were properly carried out, as required by 28 Pa. Code §211.12(d)(5), as pled herein;

m. By failing to protect and promote Plaintiffs' Decedents rights as residents, as required by 42 C.F.R. § 483.10, as pled herein;

n. By failing to ensure that every resident, including Plaintiffs' Decedents and their representatives, could exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility, as required by 42 C.F.R. § 483.10(b)(1), as pled herein;

o. By failing to treat each resident with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, as required by 42 C.F.R. § 483.10(a)(1), as pled herein;

p. By failing to ensure all residents, including the Plaintiffs' Decedents, received the necessary care and services to attain or maintain the highest practicable qualify of life, including physical, mental, and psychosocial well-being, as required by 42 C.F.R. § 483.24, as pled herein;

q. By failing to ensure all residents, including the Plaintiffs' Decedents, received treatment and care in accordance with professional standards of practice, as required by 42 C.F.R. § 483.25, as pled herein;

r. By failing to establish and maintain an emergency preparedness plan that meets the minimum requirements, as set forth by 42 C.F.R. § 483.73, as pled herein;

s. By failing to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection, as required 42 C.F.R. § 483.80, as pled herein;

t. By failing to establish a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, as required by 42 C.F.R. § 483.80(a)(1), as pled herein;

u. By failing to establish a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, as required by 42 C.F.R. § 483.80(a)(2)(i), as pled herein;

v. By failing to establish a system which specified standard and transmission-based precautions to be followed to prevent

spread of infections, as required by 42 C.F.R. § 483.80(a)(2)(iii), as pled herein;

w. By failing to establish a system which specified when and how isolation should be used for a resident, including the type and duration of the isolation, as required by 42 C.F.R. § 483.80(a)(2)(iv), as pled herein; and,

x. By failing to establish a system which specified the circumstances under which the facility must prohibit employees with a communicable disease from direct contact with residents, if direct contract will transmit the disease, as required by 42 C.F.R. § 483.80(a)(2)(v), as pled herein; and,

y. By the failure of any designated Infection Preventionist(s) to administer the facility's IPCP in accordance with the requirements of 42 C.F.R. § 483.80, as pled herein.

446. As a direct and proximate result of the negligent acts and omissions of Brighton's managerial and supervisory personnel, as set forth above, Brighton's caregiving staff was less able to contain and control the spread of COVID-19 within Brighton's walls.

447. As a direct and proximate result of the negligent acts and omissions of Brighton's managerial and supervisory personnel, as set forth above, the Plaintiffs' Decedents were exposed to and contracted COVID-19.

448. As a direct and proximate result of the negligent acts and omissions of Brighton's managerial and supervisory personnel, as set forth above, the Plaintiffs' Decedents suffered the following damages:

a. Plaintiffs' Decedents experienced pain, suffering, infirmity, deterioration, debilitation, loss of enjoyment of life, anxiety, and isolation/confinement from contracting and being treated for COVID-19; and,

b. Plaintiffs' Decedents incurred hospital, medical, and nursing expenses to be treated for the COVID-19 virus and its sequelae and effects.

449. Furthermore, because the negligence of Brighton's managerial and supervisory staff went beyond ordinary negligence into gross negligence, recklessness, and willful and wanton conduct, Plaintiffs are entitled to recover punitive damages.

450. Defendant Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center is vicariously liable for the negligent acts and omissions of its managerial and supervisory staff, as set forth above, and therefore for the damages claimed herein.

WHEREFORE, Plaintiffs Jamie Worthy-Smith, Individually and as Administratrix of the Estate of Kim L. McCoy-Warford; Mark J. Lanton, Individually and as Administrator of the Estate of Gloria Lanton; Jacqueline Young, Individually and as Administratrix of the Estate of Marion Young; Brandy Hedger Individually and as Administratrix of the Estate of Rebecca Joy VanKirk; Keri Boyer Individually and as Administratrix of the Estate of Earl Denbow, Jr.; Denise Eldridge Individually and as Administratrix of the Estate of Virginia Eldridge; Tracy Mineo and Susan Fragomeni, Individually and as Co-Administratrixes of the Estate of Nancy Kemerer; Patricia Mazzocca and Barbara Macurak, Individually and as Co-Executrixes of the Estate of Ala Mazzocca; Christina Clavelli, Individually and as Administratrix of the Estate of Joseph "Randy" Clavelli; and Bobbie Johnson, Individually and as Administratrix of the Estate of Shirley M. Mike, claim damages of Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center, and demand compensatory and punitive damages from Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center in an amount in excess of the jurisdictional arbitration limits, together with interest, and any other relief this Honorable Court deems appropriate.

COUNT III

DR. THIMONS' NEGLIGENCE – SURVIVAL

Deceased Plaintiffs v. Dr. David G Thimons, D.O.

451. Plaintiffs incorporate all preceding paragraphs as if set forth more fully herein.

452. At all relevant times, David G Thimons, D.O. acted within the course and scope of his employment or agency as the Medical Director of Brighton Rehabilitation and Wellness Center.

453. Defendant Dr. Thimons had a duty to act prudently and to provide reasonable and ordinary care and care services to Plaintiffs' Decedents and all other Brighton Residents.

454. Defendant Dr. Thimons had a duty to coordinate all medical care provided in the facility and to ensure the adequacy and appropriateness of the medical services provided to the residents.

455. Defendant Dr. Thimons had a duty to formulate, implement, and enforce adequate rules and policies to ensure quality care for Brighton's residents.

456. Defendant Dr. Thimons negligently, recklessly, willfully, and wantonly breached his duties owed to Plaintiffs in the following ways:

a. By failing to provide adequate training and education to caregiving staff on infection prevention and control, as pled herein;

b. By failing to ensure all caregiving staff members attended appropriate trainings and were properly trained on infection prevention and control, and by failing to ensure all staff were properly re-educated as required, as pled herein;

c. By failing to truthfully communicate information to residents and their families about the spread of COVID-19 within the Brighton facility, so as to allow them to make informed decisions for the wellbeing of their loved ones in the Brighton facility, as pled herein;

d. By failing to make certain social distancing was maintained by staff, as pled herein;

e. By failing to properly store clean linens and soiled laundry, as pled herein;

f. By failing to ensure all employees properly wear gloves and perform hand hygiene, as pled herein;

g. By failing to ensure all employees properly used PPE and were trained on proper use of PPE, as pled herein; and,

h. By failing to ensure all employees knew of and properly followed guidelines for sanitizing medical equipment in between uses on different residents, as pled herein.

457. At all relevant times, Dr. Thimons, as the Medical Director of the Brighton facility had a duty to not violate the legal rights of any resident and to comply with all provisions of Title 28, Pa. Administrative Code, Chapters 201 (General Operation of Long-Term Care Nursing Facilities) and 211 (Program Standards for Long-Term Care Nursing Facilities) and 42 C.F.R. §483 et seq. (Centers for Medicare & Medicaid Services, Department of Health and Human Services Requirements for Long Term Care Facilities).

458. These state and federal regulations comprise part of the standard of care that facilities like Brighton must provide to its residents.

459. These state and federal regulations are designed and intended to protect the interests of skilled nursing and long-term care residents such as the Plaintiffs' Decedents.

460. These state and federal regulations are designed and intended to protect the interests of skilled nursing and long-term care residents against the hazards the Plaintiffs' Decedents encountered at Brighton and the type of harm and death they suffered – specifically, contracting viral infections from other residents and/or staff.

461. Defendant Dr. Thimons negligently, recklessly, willfully, and wantonly violated these state and federal regulations in the following ways:

a. By failing to ensure the adequacy and appropriateness of the medical services provided to Brighton's residents, as required by 28 Pa. Code § 211.2(c), as pled herein;

b. By failing to review incidents occurring in the Brighton facility and address the health and safety hazards of the facility, as required by 28 Pa. Code § 211.2(d)(1), as pled herein;

c. By failing to provide appropriate information to Brighton's Administrator to help ensure a safe and sanitary environment for residents and personnel, as required by 28 Pa. Code § 211.2(d)(1), as pled herein;

d. By failing to properly implement resident care policies, as required by 42 C.F.R. 483.70(h), as pled herein; and,

e. By failing to coordinate medical care in the Brighton facility, as required by 42 C.F.R. § 483.70(h), as pled herein.

462. As a direct and proximate result of the negligent, reckless, willful and wanton actions and inactions of Dr. Thimons, as set forth above, the Plaintiffs' Decedents suffered the following damages:

a. Plaintiffs' Decedents experienced pain, suffering, infirmity, deterioration, debilitation, loss of enjoyment of life, anxiety, and isolation/confinement from contracting and being treated for COVID-19; and,

b. They incurred hospital, medical, and nursing expenses to be treated for the COVID-19 virus and its sequelae and effects.

463. Furthermore, because the negligence of Dr. Thimons went beyond ordinary negligence into gross negligence, recklessness, and willful and wanton conduct, Plaintiffs are entitled to recover punitive damages.

464. Defendant Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center is vicariously liable for the acts and omissions of Dr. Thimons,

as set forth in this Count, and are therefore jointly and severally liable for the damages claimed herein.

WHEREFORE, Plaintiffs Jamie Worthy-Smith, Individually and as Administratrix of the Estate of Kim L. McCoy-Warford; Mark J. Lanton, Individually and as Administrator of the Estate of Gloria Lanton; Jacqueline Young, Individually and as Administratrix of the Estate of Marion Young; Brandy Hedger Individually and as Administratrix of the Estate of Rebecca Joy VanKirk; Keri Boyer Individually and as Administratrix of the Estate of Earl Denbow, Jr.; Denise Eldridge Individually and as Administratrix of the Estate of Virginia Eldridge; Tracy Mineo and Susan Fragomeni, Individually and as Co-Administratrixes of the Estate of Nancy Kemerer; Patricia Mazzocca and Barbara Macurak, Individually and as Co-Executrixes of the Estate of Ala Mazzocca; Christina Clavelli, Individually and as Administratrix of the Estate of Joseph "Randy" Clavelli; and Bobbie Johnson, Individually and as Administratrix of the Estate of Shirley M. Mike, claim damages of Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center, and demand compensatory and punitive damages from David G. Thimons, D.O. in an amount in excess of the jurisdictional arbitration limits, together with interest, and any other relief this Honorable Court deems appropriate.

COUNT IV

WRONGFUL DEATH

Deceased Plaintiffs v. Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center and David G. Thimons, D.O.

465. Plaintiffs incorporate all preceding paragraphs as if set forth more fully herein.

466. As a direct and proximate result of the negligent, reckless, willful and wanton conduct of Comprehensive Healthcare Management Services, LLC; its managerial and

supervisory staff; and David G. Thimons, D.O., as set forth more fully in Counts I-III, Plaintiffs Kim L. McCoy-Warford; Gloria Lanton; Marion Young; Rebecca Joy VanKirk; Earl Denbow, Jr.; Virginia Eldridge; Nancy Kemerer; Ala Mazzocca; Joseph "Randy" Clavelli and Shirley M. Mike died due to complications caused by the COVID-19 virus.

467. As a direct and proximate result of the negligent, reckless, willful and wanton conduct of Comprehensive Healthcare Management Services, LLC; its managerial and supervisory staff; and David G. Thimons, D.O., as set forth more fully in Counts I-III, Plaintiffs' Decedents' Wrongful Death Beneficiaries have suffered the following injuries and damages:

a. They have incurred expenses for the funeral and burial/internment/cremation of the decedents;

b. They have incurred expenses for the hospital, medical, and nursing treatment of the decedents; and,

c. They have lost and forever been denied the companionship, comfort, assistance, protection, guidance, counseling, society, support, and services of their loved ones Kim L. McCoy-Warford; Gloria Lanton; Marion Young; Rebecca Joy VanKirk; Earl Denbow, Jr.; Virginia Eldridge; Nancy Kemerer; Ala Mazzocca; Joseph "Randy" Clavelli and Shirley M. Mike.

WHEREFORE, Plaintiffs Jamie Worthy-Smith, Individually and as Administratrix of the Estate of Kim L. McCoy-Warford; Mark J. Lanton, Individually and as Administrator of the Estate of Gloria Lanton; Jacqueline Young, Individually and as Administratrix of the Estate of Marion Young; Brandy Hedger Individually and as Administratrix of the Estate of Rebecca Joy VanKirk; Keri Boyer Individually and as Administratrix of the Estate of Earl Denbow, Jr.; Denise Eldridge Individually and as Administratrix of the Estate of Virginia Eldridge; Tracy Mineo and Susan Fragomeni, Individually and as Co-Administratrixes of the Estate of Nancy Kemerer; Patricia Mazzocca and Barbara Macurak, Individually and as Co-Executrixes of the Estate of Ala

Mazzocca; Christina Clavelli, Individually and as Administratrix of the Estate of Joseph "Randy" Clavelli; and Bobbie Johnson, Individually and as Administratrix of the Estate of Shirley M. Mike, claim damages of Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center, and demand compensatory and punitive damages from Defendants in an amount in excess of the jurisdictional arbitration limits, together with interest, costs of suit, and any other relief this Honorable Court deems appropriate.

COUNT V

CORPORATE NEGLIGENCE

Living Plaintiffs v. Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center

468. Plaintiffs incorporate all preceding paragraphs as if set forth more fully herein.

469. Comprehensive Healthcare Management Services, LLC exercised complete control over all aspects of the operation and management of the Brighton Rehab facility prior to and during the COVID outbreak at Brighton, including, but not limited to: creating, setting, funding, and/or implementing budgets; creating and maintaining business relationships with related parties as defined by the Centers for Medicare Services ("CMS") that resulted in an undercapitalized and understaffed nursing home; hiring and training caregiving staff; monitoring resident acuity levels and staffing sufficiently to meet each resident's needs; admitting and discharging residents to and from the facility; and creating and enforcing written policies and procedures to provide for the safety and well-being of all residents.

470. Each of these managerial and operational functions had a direct impact on the quality of care provided to the Plaintiff Residents and other residents in the Brighton facility.

471. Comprehensive Healthcare Management Services, LLC had a duty to act prudently, and had a duty to provide reasonable and ordinary care and care services to the Plaintiff Residents.

472. Comprehensive Healthcare Management Services, LLC had a duty to provide caregiving staff with sufficient personal protective equipment, sanitation and hygiene products, and medical tools to prevent cross-contamination and the spread of infection to residents and other staff.

473. Comprehensive Healthcare Management Services, LLC had a duty to ensure that all persons providing care within the Brighton facility were competent to provide that care.

474. Comprehensive Healthcare Management Services, LLC had a duty to oversee all persons who practice medicine in the Brighton facility.

475. Comprehensive Healthcare Management Services, LLC had a duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for residents of the Brighton facility, such as the Plaintiffs.

476. Comprehensive Healthcare Management Services, LLC had a duty to ensure that the Brighton facility was sufficiently staffed to meet the needs of its residents.

477. Comprehensive Healthcare Management Services, LLC negligently, recklessly, willfully and wantonly breached its duties owed to the Living Plaintiffs in the following ways:

a. By failing to establish and maintain an infection prevention and control program ("IPCP") that provided a safe, sanitary and comfortable environment which prevented the development and transmission of communicable diseases and infections, namely the transmission of COVID-19, as pled herein,

b. By failing to follow an infection prevention and control program ("IPCP") that provided a safe, sanitary and comfortable environment which prevented the development and transmission of communicable diseases and infections, namely the transmission of COVID-19, as pled herein,

c. By failing to establish adequate written standards, policies, and procedures to identify possible communicable diseases in the Brighton facility before the infection could spread to other persons in the facility, as pled herein;

d. By failing to follow written standards, policies, and procedures to identify possible communicable diseases in the Brighton facility before the infection could spread to other persons in the facility, as pled herein;

e. By failing to establish adequate written standards, policies, and procedures that enumerate when possible incidents of communicable disease or infections should be reported, and who they should be reported to, as pled herein;

f. By failing to follow written standards, policies, and procedures that enumerate when possible incidents of communicable disease or infections should be reported, and who they should be reported to, as pled herein

g. By failing to establish adequate written standards, policies, and procedures for precautions and safeguards to prevent the spread of infection within the Brighton facility, as pled herein;

h. By failing to follow written standards, policies, and procedures for precautions and safeguards to prevent the spread of infection within the Brighton facility, as pled herein;

i. By failing to establish adequate written standards, policies, and procedures for when and how a resident with a communicable infection should be isolated from residents and other staff, as pled herein;

j. By failing to follow written standards, policies, and procedures for when and how a resident with a communicable infection should be isolated from residents and other staff, as pled herein;

k. By failing to establish adequate written standards, policies, and procedures for when and how a staff member with exposure to a communicable infection should be prevented from exposing residents and other staff, as pled herein;

l. By failing to follow written standards, policies, and procedures for when and how a staff member with exposure to a communicable infection should be prevented from exposing residents and other staff, as pled herein;

m. By failing to provide adequate training and education to caregiving staff on infection prevention and control, as pled herein;

n. By failing to ensure all caregiving staff members attended and were properly trained on infection prevention and control, and by failing to ensure all staff were properly re-educated as required; as pled herein,

o. By failing to ensure that Dr. David Thimons was properly overseeing the facility in providing care to residents, as pled herein;

p. By failing to ensure that Dr. David Thimons was properly safeguarding that the quality of care provided met all applicable standards, as pled herein;

q. By failing to ensure that Dr. David Thimons, was properly auditing infection control procedures in the Brighton facility, as required, as pled herein;

r. By failing to accurately and/or truthfully communicate information to residents and their families about the spread of COVID-19 within the Brighton facility, so as to allow them to make informed decisions for the wellbeing of their loved ones in the Brighton facility, as pled herein;

s. By failing to accurately and/or truthfully communicate with other medical providers and the Pennsylvania Department of Health about the spread of COVID-19 within the Brighton facility, as pled herein;

t. By failing to request assistance from the proper authorities when it became apparent that COVID-19 was quickly spreading throughout the Brighton facility, as pled herein;

u. By failing to test Brighton's residents and staff for COVID-19 so as to properly separate and isolate COVID-positive individuals from those who had not been exposed to the virus, as pled herein;

v. By stopping testing and presuming that all residents and all staff were COVID-positive, instead of taking proper precautions to identify and isolate those residents and staff who had not yet contracted the virus, as pled herein;

w. By failing to ensure that proper social distancing was maintained by Brighton's residents and staff, as pled herein;

x. By failing to provide adequate supplies for residents and staff to wash their hands to prevent the spread of infection, as pled herein;

y. By failing to ensure that sinks were accessible for residents and staff to wash their hands, as pled herein;

z. By failing to ensure that all employees washed their hands regularly, as pled herein;

aa. By failing to properly store biohazardous waste, as pled herein;

bb. By failing to ensure that all employees wore gloves and changed their gloves when appropriate, as pled herein;

cc. By failing to ensure that all employees had access to sufficient Personal Protective Equipment (PPE), as pled herein;

dd. By failing to ensure that all staff was trained in the proper use of PPE, as pled herein;

ee. By failing to ensure that all staff used PPE properly, as pled herein;

ff. By failing to ensure all employees were trained on, and followed, guidelines for sanitizing medical equipment between uses with different residents, as pled herein;

gg. By failing to create a clean and sanitary environment, the lack of which created the potential for cross-contamination and the spread of diseases and infections, as pled herein;

hh. By failing to recognize and appreciate the extreme risk that COVID-19 posed to Brighton's residents, who—due to age, pre-existing conditions, and living arrangements—were

already some of the most vulnerable individuals in our communities, as pled herein;

ii. By failing to create and implement a plan to house COVID-positive residents in an isolated unit of the Brighton facility to avoid exposing residents who were not COVID-positive, as pled herein;

jj. By intentionally understaffing the Brighton facility in order to keep the surplus Medicare and Medicaid funding as revenue, which resulted in Brighton's nursing staff being unable to meet the needs of the facility's residents, as pled herein.

478. At all relevant times, Comprehensive Healthcare Management Services, LLC had a duty to not violate the legal rights of any resident, and had a duty to comply with all provisions of Title 28, Pa. Administrative Code, Chapters 201 (General Operation of Long-Term Care Nursing Facilities) and 211 (Program Standards for Long-Term Care Nursing Facilities) and 42 C.F.R. §483 et seq. (Centers for Medicare & Medicaid Services, Department of Health and Human Services Requirements for Long Term Care Facilities).

479. These regulations comprise part of the standard of care that facilities like Brighton must provide to its residents.

480. These regulations are designed and intended to protect the interests of skilled nursing and long-term care residents such as the Plaintiff Residents.

481. These regulations are designed and intended to protect the interests of skilled nursing and long-term care residents against the hazards the Plaintiff Residents encountered at Brighton and the type of harm they suffered – specifically, contracting viral infections from other residents and/or staff.

482. Comprehensive Healthcare Management Services, LLC negligently, recklessly, willfully and wantonly violated these regulations in the following ways:

a. By the failure of an effective governing body to adopt and enforce rules for the health care and safety of the residents, as required by 28 Pa. Code § 201.18, as pled herein;

b. By failing to conduct ongoing coordinated educational programs for the development and improvement of skills of the facility's personnel, including training related to problems, needs, and rights of the residents, as required by 28 Pa. Code § 201.20(a), as pled herein;

c. By failing to conduct in-service training at least annually which includes infection prevention and control, as required by 28 Pa. Code §201.20(c), as pled herein;

d. By admitting or re-admitting residents to the Brighton facility with disease in the communicable stage when the facility did not have the capability to care for the needs of the resident, as prohibited by 28 Pa. Code §201.24(d), as pled herein;

e. By failing to adequately train staff in proper implementation of policies and procedures, as required by 28 Pa. Code § 201.29(d), as pled herein;

f. By failing to treat Plaintiffs with consideration, respect, and full recognition of dignity and individuality, as required by 28 Pa. Code § 201.29(j), as pled herein;

g. By failing to report to the appropriate health agencies and appropriate Division of Nursing Care Facilities filed office when a resident developed a reportable disease, as required by 28 Pa. Code § 211.1(a), as pled herein;

h. By failing to design and implement resident care policies to ensure the Plaintiffs' total medical needs were met and that they were protected from infection, as required by 28 Pa. Code § 211.10(d), as pled herein;

i. By failing to update the facility's resident care policies as necessary to meet the total medical and psychosocial needs of Brighton's residents, as required by 28 Pa. Code §211.10, as pled herein;

j. By failing to provide nursing services by a sufficient number of nursing personnel on a 24-hour basis to meet the needs of all residents, as required by 28 Pa. Code § 211.12, as pled herein;

k. By failing to protect and promote Plaintiffs' resident rights, as required by 42 C.F.R. § 483.10, as pled herein;

l. By failing to treat each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, as required by 42 C.F.R. § 483.10(a)(1), as pled herein;

m. By failing to treat each resident with respect and dignity, as required by 42 C.F.R. § 483.10(e), as pled herein;

n. By failing to immediately notify residents' representatives when there were significant changes in residents' physical statuses, as required by 42 C.F.R. § 483.10(g)(14), as pled herein;

o. By failing to provide residents with a safe, clean, comfortable, and homelike environment, as required by 42 C.F.R. § 483.10(i), as pled herein;

p. By failing to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, as require by 42 C.F.R. § 483.10(i)(2), as pled herein;

q. By discouraging residents from communicating with federal, state, or local officials, as prohibited by 42 C.F.R. § 483.10(k), as pled herein;

r. By failing to conduct a comprehensive assessment for the Plaintiff residents after significant changes in their condition, as required by 42 C.F.R. § 483.20, as pled herein;

s. By failing to ensure all residents, including the Plaintiff residents, received the necessary care and services to attain or maintain the highest practicable qualify of life, including physical, mental, and psychosocial well-being, as required by 42 C.F.R. § 483.24, as pled herein;

t. By failing to ensure all residents, including Plaintiffs, received treatment and care in accordance with professional

standards of practice, as required by 42 C.F.R. § 483.25, as pled herein;

u. By failing to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population, as required by 42 C.F.R. § 483.35, as pled herein;

v. By failing to provide nursing services by sufficient registered nurses on a 24-hour basis to the plaintiff residents in accordance with their care plans, as required by 42 C.F.R. § 483.35(b), as pled herein;

w. By failing to obtain diagnostic services to meet the needs of its residents, as required by 42 C.F.R. § 483.50(b), as pled herein;

x. By failing to administer the Brighton facility in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as required by 42 C.F.R. § 483.70, as pled herein;

y. By failing to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles, as required by 42 C.F.R. § 483.70, as pled herein;

z. By failing to conduct and document a facility-wide assessment to determine what resources were necessary to care for the facility's residents competently during both day-to-day operations and emergencies and to review and update this assessment whenever there was any change that would require a substantial modification to any part of this assessment, and for this assessment to include the care required by the resident population considering the types of diseases and overall acuity present within that population, as required by 42 C.F.R. § 483.70(e), as pled herein;

aa. By failing to establish and maintain an emergency preparedness plan that meets the requirements of 42 C.F.R. § 483.73, as pled herein;

bb. By failing to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection, as required by 42 C.F.R. § 483.80, as pled herein;

cc. By failing to establish a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, as required by 42 C.F.R. § 483.80(a)(1), as pled herein;

dd. By failing to establish a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, as required by 42 C.F.R. § 483.80(a)(2)(i), as pled herein;

ee. By failing to establish a system which specified standard and transmission-based precautions to be followed to prevent spread of infections, as required by 42 C.F.R. § 483.80(a)(2)(iii), as pled herein;

ff. By failing to establish a system which specified when and how isolation should be used for a resident, including the type and duration of the isolation, as required by 42 C.F.R. § 483.80(a)(2)(iv), as pled herein; and,

gg. By failing to establish a system which specified the circumstances under which the facility must prohibit employees with a communicable disease from direct contact with residents, if direct contract will transmit the disease, as required by 42 C.F.R. § 483.80(a)(2)(v), as pled herein;

hh. By failing to inform residents and their families of COVID-19 occurrences in the facility, as required by 42 C.F.R. § 483.80(g)(3), as pled herein;

ii. By failing to provide a safe, functional, sanitary, and comfortable environment to residents, staff, and the public, as required by 42 C.F.R. § 483.90, as pled herein;

jj. By failing to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, as required by 42 C.F.R. § 483.95, as pled herein; and,

kk. By failing to include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program, as required by 42 C.F.R. § 483.95(e), as pled herein.

483. As a direct and proximate result of the negligent acts and omissions of Comprehensive Healthcare Management Services, LLC, as set forth above, Brighton's caregiving staff was less able to contain and control the spread of COVID-19 within Brighton's walls.

484. As a direct and proximate result of the negligent acts and omissions of Comprehensive Healthcare Management Services, LLC, as set forth above, the Plaintiff Residents were exposed to and contracted COVID-19.

485. As a direct and proximate result of the negligent acts and omissions of Comprehensive Healthcare Management Services, LLC, as set forth above, the Plaintiff Residents suffered the following damages:

a. The Plaintiff Residents have experienced and may continue to experience pain, suffering, infirmity, deterioration, debilitation, loss of enjoyment of life, anxiety, and isolation/confinement from contracting and being treated for COVID-19; and,

b. The Plaintiff Residents have incurred and may continue to occur hospital, medical, and nursing expenses to be treated for the COVID-19 virus and its sequelae and effects.

486. Furthermore, because the negligence of Comprehensive Healthcare Management Services, LLC went beyond ordinary negligence into gross negligence, recklessness, and willful and wanton conduct, Plaintiffs are entitled to recover punitive damages.

WHEREFORE, Plaintiffs Jodi Gill as Attorney-in-Fact of Glenn Oscar Gill; Kenneth Wright; Shelby Galton; Judith Marie as Guardian *Ad Litem* of Dorothy Umstead; and, Jamal Williams as Guardian *Ad Litem* of Lucille Williams claim damages of Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center, and demand compensatory and punitive damages from the Defendant in an amount in excess of the jurisdictional arbitration limits, together with interest, and any other relief this Honorable Court deems appropriate.

COUNT VI

VICARIOUS NEGLIGENCE

Living Plaintiffs v. Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center

487. Plaintiffs incorporates all preceding paragraphs herein as if set forth at length.

488. Brighton Rehab employs individuals who work solely in a managerial and supervisory capacity, and who do not provide hands-on care to residents. These managerial and supervisory employees include positions such as the Administrator, Assistant Administrator, Medical Director, Director of Nursing, Infection Preventionist and Assistant Director of Nursing.

489. At all relevant times, Brighton Rehab acted by and through these managerial and supervisory agents, servants, and/or employees, who were then and there acting within the course and scope of their employment. Accordingly, Brighton Rehab is vicariously liable for any negligence of these managerial and supervisory agents, servants, and/or employees.

490. This cause of action is limited to Brighton's vicarious liability for the negligence of only these managerial/supervisory employees who did not provide hands-on care to residents—

such as the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, and Environmental Services Director. Plaintiffs do not seek to hold Brighton vicariously liable for the actions or inactions of Brighton's front-line caregiving nursing staff, whose members did the best they could to provide care in the dangerous environment created by Brighton and Brighton's management.

491. Brighton's managerial and supervisory employees had the responsibility and authority to make decisions for the facility in areas such as: creating, setting, funding, and/or implementing budgets; creating and maintaining business relationships with related parties as defined by the Centers for Medicare and Medicaid Services ("CMS") that resulted in an undercapitalized and understaffed nursing home; hiring and training staff; monitoring resident acuity levels and staffing sufficiency to meet each resident's needs; admitting and discharging residents to and from the facility; and creating and enforcing Brighton's policies and procedures.

492. Brighton's managerial and supervisory employees – such as the Administrator, Assistant Administrator, Director of Nursing, Infection Preventionist, and Assistant Director of Nursing – had a duty to make these decisions and carry out these functions with reasonable and ordinary care.

493. These types of managerial decisions had a direct impact on the quality of care Brighton provided to its residents.

494. Brighton's managerial and supervisory staff had a duty to ensure that all persons providing resident care within Brighton were competent and adequately trained to provide reasonable care to Brighton's residents.

495. Brighton's managerial and supervisory staff had a duty to formulate, adopt, and enforce rules and policies to ensure reasonable care for Brighton's residents.

496. Brighton's managerial and supervisory staff had a duty to supervise the nursing and caregiving staff to ensure that Brighton's policies and procedures, and basic infection protocol, were being followed.

497. Brighton's managerial and supervisory staff negligently, recklessly, carelessly, and willfully and wantonly breached their duties owed to the Plaintiffs in the following particulars:

a. By failing to establish and maintain an infection prevention and control program ("IPCP") that provided a safe, sanitary and comfortable environment which prevented the development and transmission of communicable diseases and infections, namely the transmission of COVID-19, as pled herein;

b. By failing to establish written standards, policies, and procedures for the above-mentioned IPCP, which should have specified a system of surveillance designed to identify possible communicable diseases before they can spread to other persons in the facility, to whom and when possible incidents of communicable disease or infections should be reported, precautions to be followed to prevent the spread of infections, when and how isolation should be used for a resident, and circumstances under which the facility must prohibit and prevent employees with communicable disease or infections from having direct contact with residents, as pled herein;

c. By failing to provide adequate training and education to caregiving staff on infection prevention and control, as pled herein;

d. By failing to ensure all caregiving staff members attended and were properly trained on infection prevention and control, and by failing to ensure all staff were properly re-educated as required, as pled herein;

e. By failing to truthfully communicate information to residents and their families about the spread of COVID-19 within the Brighton facility, so as to allow them to make informed decisions for the wellbeing of their loved ones in the Brighton facility, as pled herein;

f. By failing to make certain social distancing was maintained by staff, as pled herein;

g. By failing to properly store clean linens and soiled laundry, as pled herein;

h. By failing to ensure all employees properly wore gloves and performed hand hygiene, as pled herein;

i. By failing to ensure all employees properly used PPE and were trained on proper use of PPE, as pled herein;

j. By failing to ensure all employees knew of and properly followed guidelines for sanitizing medical equipment in between uses on different residents, as pled herein;

k. By choosing to keep Medicare and Medicaid funding as profit instead of staffing to meet CMS's expected nursing hours, as pled herein; and,

l. By intentionally understaffing the facility, as pled herein.

498. At all relevant times, Brighton's managerial and supervisory personnel had a duty to not violate the legal rights of any resident and to comply with all provisions of Title 28, Pa. Administrative Code, Chapters 201 (General Operation of Long-Term Care Nursing Facilities) and 211 (Program Standards for Long-Term Care Nursing Facilities), and 42 C.F.R. §483 et seq. (Centers for Medicare & Medicaid Services, Department of Health and Human Services Requirements for Long Term Care Facilities).

499. These state and federal regulations comprise part of the standard of care that facilities like Brighton must provide to its residents.

500. These state and federal regulations are designed and intended to protect the interests of skilled nursing and long-term care residents such as the Plaintiff Residents.

501. These state and federal regulations are designed and intended to protect the interests of skilled nursing and long-term care residents against the hazards the Plaintiff Residents

encountered at Brighton and the type of harm they suffered – specifically, contracting viral infections from other residents and/or staff.

502. Brighton's managerial and supervisory personnel negligently, recklessly, carelessly, and willfully and wantonly violated these state and federal regulations in the following ways:

a. By the failure of Brighton's administrator to enforce regulations relative to the level of health care and safety of residents, as required by 28 Pa. Code § 201.18(e)(1), as pled herein;

b. By the failure of Brighton's administrator to develop and enforce adherence to policies and procedures to protect residents' rights, as required by 28 Pa. Code § 201.29(a), as pled herein;

c. By failing to adequately train staff in proper implementation of policies and procedures, as required by 28 Pa. Code § 201.29(d), as pled herein;

d. By failing to treat Plaintiffs with consideration, respect, and full recognition of dignity and individuality, as required by 28 Pa. Code § 201.29(j), as pled herein;

e. By failing to report to the appropriate health agencies and appropriate Division of Nursing Care Facilities filed office when a resident developed a reportable disease, as required by 28 Pa. Code § 211.1(a), as pled herein;

f. By failing to design and implement resident care policies to ensure the Plaintiffs' total medical needs were met and that they were protected from infection, as required by 28 Pa. Code § 211.10(d), as pled herein;

g. By failing to update the facility's resident care policies as necessary to meet the total medical and psychosocial needs of Brighton's residents, as required by 28 Pa. Code §211.10, as pled herein;

h. By the director of nursing's failure to maintain standards of accepted nursing practice, as required by 28 Pa. Code §211.12(d)(1), as pled herein;

i. By the director of nursing's failure to ensure the adequacy of the facility's nursing policy and procedure manuals, as required by 28 Pa. Code §211.12(d)(2), as pled herein;

j. By the director of nursing's failure to ensure the adequacy of methods for coordination of nursing services with other resident services, as required by 28 Pa. Code §211.12(d)(3), as pled herein;

k. By the director of nursing's failure to make proper recommendations for the number and levels of nursing personnel to be employed, as required by 28 Pa. Code §211.12(d)(4), as pled herein;

l. By the director of nursing's failing to provide adequate general supervision, guidance, and assistance in implementing residents' personal health programs to assure that preventative measures, treatments, and other health services were properly carried out, as required by 28 Pa. Code §211.12(d)(5), as pled herein;

m. By failing to protect and promote Plaintiffs' rights as residents, as required by 42 C.F.R. § 483.10, as pled herein;

n. By failing to ensure that every resident, including Plaintiffs and their representatives, could exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility, as required by 42 C.F.R. § 483.10(b)(1), as pled herein;

o. By failing to treat each resident with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, as required by 42 C.F.R. § 483.10(a)(1), as pled herein;

p. By failing to ensure all residents, including the Living Plaintiffs, received the necessary care and services to attain or maintain the highest practicable qualify of life, including physical, mental, and psychosocial well-being, as required by 42 C.F.R. § 483.24, as pled herein;

q. By failing to ensure all residents, including the Living Plaintiffs, received treatment and care in accordance with professional standards of practice, as required by 42 C.F.R. § 483.25, as pled herein;

r. By failing to establish and maintain an emergency preparedness plan that meets the minimum requirements, as set forth by 42 C.F.R. § 483.73, as pled herein;

s. By failing to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection, as required by 42 C.F.R. § 483.80, as pled herein;

t. By failing to establish a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, as required by 42 C.F.R. § 483.80(a)(1), as pled herein;

u. By failing to establish a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, as required by 42 C.F.R. § 483.80(a)(2)(i), as pled herein;

v. By failing to establish a system which specified standard and transmission-based precautions to be followed to prevent spread of infections, as required by 42 C.F.R. § 483.80(a)(2)(iii), as pled herein;

w. By failing to establish a system which specified when and how isolation should be used for a resident, including the type and duration of the isolation, as required by 42 C.F.R. § 483.80(a)(2)(iv), as pled herein;

x. By failing to establish a system which specified the circumstances under which the facility must prohibit employees with a communicable disease from direct contact with residents, if direct contract will transmit the disease, as required by 42 C.F.R. § 483.80(a)(2)(v), as pled herein; and,

y. By the failure of any designated Infection Preventionist(s) to administer the facility's IPCP in accordance with the requirements of 42 C.F.R. § 483.80, as pled herein.

503. As a direct and proximate result of the negligent acts and omissions of Brighton's managerial and supervisory personnel, as set forth above, Brighton's caregiving staff was less able to contain and control the spread of COVID within Brighton's walls.

504. As a direct and proximate result of the negligent acts and omissions of Brighton's managerial and supervisory personnel, as set forth above, the Plaintiff Residents were exposed to and contracted COVID-19.

505. As a direct and proximate result of the negligent acts and omissions of Brighton's managerial and supervisory personnel, as set forth above, the Plaintiff Residents suffered the following damages:

a. The Plaintiffs experienced and may continue to experience pain, suffering, infirmity, deterioration, debilitation, loss of enjoyment of life, anxiety, and isolation/confinement from contracting and being treated for COVID-19; and,

b. The Plaintiffs incurred and may continue to incur hospital, medical, and nursing expenses to be treated for the COVID-19 virus and its sequelae and effects.

506. Furthermore, because the negligence of Brighton's managerial and supervisory staff went beyond ordinary negligence into gross negligence, recklessness, and willful and wanton conduct, Plaintiffs are entitled to recover punitive damages.

507. Defendant Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center is vicariously liable for the negligent acts and omissions of its managerial and supervisory staff, as set forth above, and therefore for the damages claimed herein.

WHEREFORE, Living Plaintiffs Jodi Gill as Attorney-in-Fact of Glenn Oscar Gill; Kenneth Wright; Shelby Galton; Judith Marie as Guardian *Ad Litem* of Dorothy Umstead; and, Jamal Williams as Guardian *Ad Litem* of Lucille Williams claim damages of Comprehensive

Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center, and demand compensatory and punitive damages from the Defendant in an amount in excess of the jurisdictional arbitration limits, together with interest, and any other relief this Honorable Court deems appropriate.

COUNT VII

DR. THIMONS' NEGLIGENCE

Living Plaintiffs v. Dr. David G. Thimons, D.O. and Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center

508. Plaintiffs incorporate all preceding paragraphs as if more fully set forth herein.

509. At all relevant times, David G Thimons, D.O. acted within the course and scope of his employment or agency as the Medical Director of Brighton Rehabilitation and Wellness Center.

510. Defendant Dr. Thimons had a duty to act prudently and to provide reasonable and ordinary care and care services to Plaintiffs and all other Brighton Residents.

511. Defendant Dr. Thimons had a duty to oversee all persons who practice medicine within Brighton's facility.

512. Defendant Dr. Thimons had a duty to formulate, adopt, and enforce adequate rules and policies to ensure quality care for Brighton's residents.

513. Defendant Dr. Thimons negligently, recklessly, willfully and wantonly breached his duties owed to Plaintiffs in the following ways:

a. By failing to provide adequate training and education to caregiving staff on infection prevention and control, as pled herein;

b. By failing to ensure all caregiving staff members attended and were properly trained on infection prevention and control, and by failing to ensure all staff were properly re-educated as required, as pled herein;

c. By failing to truthfully communicate information to residents and their families about the spread of COVID-19 within the Brighton facility, so as to allow them to make informed decisions for the wellbeing of themselves and their loved ones in the Brighton facility, as pled herein;

d. By failing to make certain social distancing was maintained by staff, as pled herein;

e. By failing to properly store clean linens and soiled laundry, as pled herein;

f. By failing to ensure all employees properly wear gloves and perform hand hygiene, as pled herein;

g. By failing to ensure all employees properly used PPE and were trained on proper use of PPE, as pled herein; and,

h. By failing to ensure all employees knew of and properly followed guidelines for sanitizing medical equipment in between uses on different residents, as pled herein.

514. At all relevant times, Dr. Thimons, as the Medical Director of the Brighton facility had a duty to not violate the legal rights of any resident and to comply with all provisions of Title 28, Pa. Administrative Code, Chapters 201 (General Operation of Long-Term Care Nursing Facilities) and 211 (Program Standards for Long-Term Care Nursing Facilities) and 42 C.F.R. §483 et seq. (Centers for Medicare & Medicaid Services, Department of Health and Human Services Requirements for Long Term Care Facilities).

515. These state and federal regulations comprise part of the standard of care that facilities like Brighton must provide to its residents.

516. These state and federal regulations are designed and intended to protect the interests of skilled nursing and long-term care residents such as the Plaintiff Residents.

517. These state and federal regulations are designed and intended to protect the interests of skilled nursing and long-term care residents against the hazards the Plaintiff Residents encountered at Brighton and the type of harm they suffered – specifically, contracting viral infections from other residents and/or staff.

518. Defendant Dr. Thimons negligently, recklessly, and willfully and wantonly violated these state and federal regulations in the following ways:

a. By failing to ensure the adequacy and appropriateness of the medical services provided to Brighton's residents, as required by 28 Pa. Code § 211.2(c), as pled herein;

b. By failing to review incidents occurring in the Brighton facility and address the health and safety hazards of the facility, as required by 28 Pa. Code § 211.2(d)(1), as pled herein;

c. By failing to provide appropriate information to Brighton's Administrator to help ensure a safe and sanitary environment for residents and personnel, as required by 28 Pa. Code § 211.2(d)(1), as pled herein;

d. By failing to properly implement resident care policies, as required by 42 C.F.R. 483.70(h), as pled herein; and,

e. By failing to coordinate medical care in the Brighton facility, as required by 42 C.F.R. § 483.70(h), as pled herein.

519. As a direct and proximate result of the negligent, reckless, willful and wanton actions and inactions of Dr. Thimons, as set forth above, the Plaintiff Residents suffered the following damages:

a. The Plaintiffs experienced and may continue to experience pain, suffering, infirmity, deterioration, debilitation, loss of enjoyment of life, anxiety, and isolation/confinement from contracting and being treated for COVID-19; and,

b. The Plaintiffs incurred and may continue to incur hospital, medical, and nursing expenses to be treated for the COVID-19 virus and its sequelae and effects.

520. Furthermore, because the negligence of Dr. Thimons went beyond ordinary negligence into gross negligence, recklessness, and willful and wanton conduct, Plaintiffs are entitled to recover punitive damages.

521. Defendant Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center is vicariously liable for the acts and omissions of Dr. Thimons, as set forth in this Count, and are therefore jointly and severally liable for the damages claimed herein.

WHEREFORE, Living Plaintiffs Jodi Gill as Attorney-in-Fact of Glenn Oscar Gill; Kenneth Wright; Shelby Galton; Judith Marie as Guardian *Ad Litem* of Dorothy Umstead; and, Jamal Williams as Guardian *Ad Litem* of Lucille Williams claim damages of Comprehensive Healthcare Management Services, LLC d/b/a Brighton Rehabilitation and Wellness Center, and demand compensatory and punitive damages from the Defendant in an amount in excess of the jurisdictional arbitration limits, together with interest, and any other relief this Honorable Court deems appropriate.

A JURY TRIAL IS DEMANDED.

Respectfully submitted,

ROBERT PEIRCE & ASSOCIATES, P.C.

By:_____
ROBERT F. DALEY, ESQUIRE

By:_____
ELIZABETH CHIAPPETTA, ESQUIRE

MASSA BUTLER GIGLIONE

By:_____
PETER D. GIGLIONE, ESQUIRE

McMILLEN URICK TOCCI & JONES

By:_____
KELLY M. TOCCI, ESQUIRE