DISTRICT COURT, ELBERT COUNTY, COLORADO Court Address: 751 Ute Ave. Kiowa, CO 80117	DATE FILED: February 26, 2020 11:45 AM FILING ID: 5674F3C1BE112 CASE NUMBER: 2020CV30011
Plaintiff(s): CHARLES SHLLING, individually and as Personal Representative of the Estate of Bonnie Shilling, deceased, v. **Defendant(s):** THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY d/b/a/ GOOD SAMARITAN SOCIETY - SIMLA; and BRENDA ATWELL, in her capacity as Administrator of Good Samaritan Society-Simla	▲ **COURT USE ONLY** ▲
Plaintiff's Counsel: Brent L. Moss, #42215 Brian D. Reddick, #46386 Robert Francis, #47007 John V. O'Grady, #49703 Ian T. Norris, #49757 Michael McNally, #16107 Reddick Moss, PLLC One Information Way, Suite 105 Little Rock, Arkansas 72202 (501) 907-7790 (501) 907-7793 (Fax) brent@reddickmoss.com brian@reddickmoss.com rob@reddickmoss.com john@reddickmoss.com ian@reddickmoss.com mmcnally@reddickmoss.com	Case Number: Div: Ctrm:
COMPLAINT AND JURY DEMAND	

Plaintiff, Charles Shilling, individually and as Personal Representative of the Estate of Bonnie Shilling, deceased, for her Complaint and Jury Demand against the Defendants The Evangelical Lutheran Good Samaritan Society d/b/a Good Samaritan Society – Simla; and Brenda Atwell, in her capacity as Administrator of Good Samaritan Society-Simla, states as follows:

STATEMENT OF PARTIES & JURISDICTION

1. Charles Shilling was the husband of Bonnie Shilling and is the duly appointed Personal Representative of her estate pursuant to the Letters of Administration issued July 25, 2019, attached hereto as **Exhibit A**.

2. Bonnie Shilling was a resident of Good Samaritan Society - Simla (sometimes referred to herein as the "Facility"), a nursing home located at 320 Pueblo Ave., Simla, Colorado 80835, from approximately March 15, 2013, through April 20, 2018.

3. Good Samaritan Society - Simla is a skilled nursing facility owned, operated, controlled, and managed by Defendants The Evangelical Lutheran Good Samaritan Society d/b/a Good Samaritan Society - Simla and Brenda Atwell, in her capacity as Administrator of Good Samaritan Society - Simla (hereinafter the "Defendants").

4. Defendant The Evangelical Lutheran Good Samaritan Society d/b/a Good Samaritan Society – Simla, is a foreign nonprofit corporation with its principal office located at 4800 West 57th Street P.O. Box 5038, Sioux Falls, South Dakota 57117 and owned, operated, controlled, managed, and held the license to operate Good Samaritan Society - Simla. Defendant The Evangelical Lutheran Good Samaritan Society d/b/a Good Samaritan Society - Simla, may be served with process via its registered agent: CT Corporation System, 7700 E. Arapahoe Rd. Suite 220, Centennial, Colorado 80112.

5. Upon information and belief, Defendant Brenda Atwell was the Administrator of Good Samaritan Society - Simla during the residency of Bonnie Shilling and is a resident and citizen of Colorado.

6. The Defendants collectively controlled the operation, planning, management, budget, and quality control of Good Samaritan Society - Simla. The authority exercised by the Defendants over the Facility included, but was not limited to, control of marketing, human

resources management, training, staffing, creation, and implementation of all policy and procedures, federal and state reimbursement, quality care assessment and compliance, licensure and certification, legal services, and financial, tax, and accounting control through fiscal and managerial policies established by the Defendants.

7. At all relevant times mentioned herein, Defendants owned, operated, managed, and/or controlled Good Samaritan Society - Simla, either directly or through a joint enterprise, partnership, and/or through the agency of each other and/or other diverse subalterns, subsidiaries, governing bodies, agents, servants, or employees.

8. Venue is proper in the Elbert County District Court as the acts and omissions complained of herein occurred within Elbert County.

9. The Court has jurisdiction over the subject matter at issue because this is a civil action for damages and/or equitable relief. Colo. Const. Art. VI, § 9(1).

FACTUAL BACKGROUND

10. Bonnie Shilling was a resident of Good Samaritan Society - Simla from approximately March 15, 2013, through April 20, 2019. Defendants were aware of Bonnie Shilling's medical conditions and the care that she required when they represented that they could adequately care for her needs.

11. Bonnie Shilling was approximately 68 years old when she was admitted to Good Samaritan Society – Simla following a cerebral vascular event (stroke) affecting her right dominant side.

12. As a result of the stroke, Ms. Shilling had some difficulty communicating and could no longer ambulate independently. She used an electric wheelchair for locomotion, and she was totally dependent on staff for bathing, toileting, and transferring.

13. Ms. Shilling's medical history included hemiplegia and hemiparesis resulting from the stroke, atherosclerotic heart disease, sleep apnea, heart failure, gastro-esophageal reflux disease, hypertension, gout, atrial fibrillation, diabetes mellitus type 2, myocardial infarction, previous deep vein thrombosis, and depression.

14. Ms. Shilling's care plan from November 27, 2013 recognized and acknowledged her tendency for mood and behavioral issues arising from her stroke, including intermittent outburst, refusing to acknowledge staff members and frustrations with her verbal and physical limitations.

15. In early 2016, Ms. Shilling had an altercation in which she struck out at an aid during a change and transfer. Ms. Shilling's care plan was then revised to note her tendency to be resistive to care and to add an intervention for staff to spend one on one time with Ms. Shilling and take an interest in her to "butter her up."

16. Ms. Shilling's care plan also noted that she "can be resistive to care…if resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again."

17. At all times in her residency, Ms. Shilling used a motorized or electric wheelchair for mobility.

18. The Facility had a policy and procedure for the use and monitoring of motorized mobility devices that stated, "The use of motorized mobility devices can assist residents to achieve their highest practical level of functioning. While these devices assist in increasing independence, safety concerns need to be considered on an individualized basis."

19. The Facility also had a policy and procedure regarding Behavioral Causes and Interventions which provided, "Cognitively intact residents who leave, or have the potential to leave the location without the knowledge of the employees, may benefit from documentation to identify any trend or pattern to the behavior…"

20. The Facility performed a motorized wheelchair assessment for Ms. Shilling on March 19, 2015, which assessed Ms. Shilling for use of the motorized wheelchair inside the facility only. The assessment was never updated.

21. Ms. Shilling was not assessed for use of the wheelchair outside the facility, even though Facility employees reported that Ms. Shilling frequently took the wheelchair outside and would let the staff know by saying "outside" as she was going down the hall. The terrain outside the Facility was substantially different and more challenging than inside, including gravel, uneven sidewalks and asphalt.

22. As early as November 7, 2016, the Facility documented Ms. Shilling's tendency to "wander," noting that she exhibited such behaviors 1-3 days a week.

23. Ms. Shilling's tendency to wander was noted again on February 7, 2017 with the same frequency.

24. In May, 2017, the Facility noted that Ms. Shilling's tendency to wander had increased, reporting that she now exhibited the behavior 4 to 6 days a week.

25. Documentation Survey Reports completed monthly for the Facility all consistently document Ms. Shilling's regular wandering behavior. Every report for 2017 through her death in April, 2019 documented wandering by Ms. Shilling.

26. On the evening of April 20, 2019, Facility notes indicate that around 7:25 p.m., Facility staff members Riley Blomquist and Cynthia Tyler were assisting Ms. Shilling in getting ready for bed. During the process, Ms. Shilling became upset and struck Ms. Blomquist. The employees left Ms. Shilling's room and went to assist other residents, telling Ms. Shilling that they would come back later.

27. A few minutes later, Ms. Shilling approached Ms. Melinda Petty, the charge nurse on duty, and indicated that she was ready to go to bed. Ms. Shilling was notably upset, with "a red face and down turned facial expression."

28. Ms. Petty told her that she had heard that Ms. Shilling hit the CNA that was helping her get ready for bed. She stated that the CNAs were now assisting another resident and they would come help get her into bed as soon as they could.

29. But in fact, Ms. Blomquist had finished with the resident and moved onto assisting another resident, and Ms. Tyler had taken a lunch break.

30. Around 7:45 p.m., Ms. Petty went to Ms. Shilling's room, but she was not there. Ms. Petty did not locate her in the Facility's common areas, so she went out the front door and down the front walk. A girl from the neighborhood approached her and told her that someone had fallen in the ditch.

31. A video taken from a building across the street from the Facility indicates that at approximately 7:41 p.m., Ms. Shilling eloped from the Facility in her wheelchair. She traveled down the highway next to the Facility and eventually hit the edge of a drainage ditch. Ms. Shilling was ejected from her wheelchair and landed in the bottom of the drainage ditch. According to Ms. Blomquist, Ms. Shilling had been wearing a safety belt on her wheelchair when Ms. Blomquist left the room, but she stated that Ms. Shilling was able to unbuckle her safety belt independently.

32. The police report for the incident indicated that at around 7:44pm, a 911 call was placed by an unknown male stating that he had found an elderly lady (later identified as Bonnie Shilling) face down in the bottom of a drainage ditch. The caller stated that the ditch contained water, and that he had been able to pull Ms. Shilling out of the water, and that she was conscious and breathing.

33. Ms. Shilling was transported by ambulance to St. Francis Hospital in Colorado Springs. Hospital notes indicate that she "appear[ed] to have some pain with manipulation of the pelvic area" and it was determined that she had suffered bilateral femur fractures. Medical documentation noted that the femur fractures "were comminuted and displaced [and] would be a good explanation of her pain or discomfort with leg manipulation."

34. While in the hospital, Ms. Shilling's blood pressure and O2 saturation began decreasing, and she became more lethargic. She went into acute respiratory failure, with a PH of 6.83 and a pCO2 of 125.

35. Although she was listed as DNR, her husband decided to allow the hospital to intubate her to monitor for any improvement. The intubation was successful, but her condition continued to deteriorate.

36. Within twenty minutes of intubation, Ms. Shilling suffered respiratory arrest and died at 1:17 a.m. on the morning of April 21, 2019. Hospital documentation identifies Ms. Shilling's cause of death as septic shock, and her death certificate notes that she received injury when she "went off the edge of road and was thrown from wheelchair." Her final diagnosis was notated as hypercapnic respiratory failure, septic shock, alveolar pulmonary edema and bilateral femoral fractures.

37. Following Ms. Shilling's death, the Colorado Department of Public Health and Environment inspected the Facility and issued citations for:

- Failing to ensure that all staff had received a required in-service training related to handling aggressive behaviors
- Failing to ensure Ms. Shilling was assessed for outdoor use of her motorized wheelchair;
- Failing to have a system in place to monitor residents when they left the facility alone;

38. Regarding the lack of training, the Department found that almost half of the Facility residents had behavioral health needs, but less than half of the staff had received the mandatory training on handling aggressive behaviors.

39. Ms. Shilling's nurse on April 20, 2019 had not received the mandatory training.

40. The Facility's Director of Nursing stated that the mandatory training would have been important for Ms. Shilling's nurse to have received.

41. The Facility also provided a mandatory handout entitled Predicting Abusive Behaviors and Behavioral Causes and Interventions, but that handout was also only provided to less than half of the Facility staff.

42. Regarding the failure of the Facility to appropriately monitor Ms. Shilling's use of the motorized wheelchair, the Department found that Ms. Shilling had not been assessed for outdoor operation of her motorized wheelchair, and that the outdoor terrain was substantially different than the terrain on which the wheelchair operated within the facility. The Department also found that the most recent motorized wheelchair assessment had been completed over four years earlier, in March 2015. The Department also noted that the sign-out book located at the nurses' station was "used primarily when someone went to the doctor or out with family" rather than when a resident left the Facility alone.

43. Finally, the Department noted that although the incident resulted in serious bodily injury to Ms. Shilling, the Facility failed to report it to the state regulatory agency until six days after the date of the incident.

44. Defendant Brenda Atwell, Administrator for the Facility, stated, "I wasn't going to report this but then after hearing the news my company felt that since we had an allegation of neglect (related to the media coverage) we needed to report it to the state."

45. Defendants were fully aware of Bonnie Shilling's medical history, medical conditions and co-morbidities and the level of nursing care she would require while a resident at the Facility.

46. Defendants, through advertising and marketing of the Facility to local hospitals and other providers, held themselves out as capable of providing the level of care required by sick, elderly and frail individuals, including Bonnie Shilling, through many services, including medical, skilled nursing, occupational therapy, physical therapy, speech therapy, and daily custodial care.

47. When Defendants agreed to admit Bonnie Shilling, they assumed the obligation of providing for her total healthcare, including the provision of nutrition, hydration, activities of daily living, medical, skilled nursing, occupational therapy, speech therapy, physical therapy and daily custodial care.

48. Defendants exercised complete and total control over the healthcare of all the residents of the Facility, including Bonnie Shilling.

49. Defendants exercised control over the Facility, including cash management; cost control; setting staffing levels; budgeting; marketing; maintaining and increasing census; supervision of the Facility Administrator and Director of Nursing; supervision and oversight of the staff; credentialing of physicians who saw patients in the Facility; development and implementation of nursing staff in-services; development and implementation of all pertinent policies and procedures; monitoring customer satisfaction via surveys; performing mock surveys through use of regional and local employees; risk management; corporate and regulatory compliance; quality of care assessment; licensure and certification; controlling accounts payable and receivable; setting guidelines in place that controlled whether or not residents were discharged based on certain clinical condition criteria; development and implementation of reimbursement strategies; retaining contract management, physician therapy and dietary services; dictating census

and payor source quotas for admission to the Facility; and employing Facility-level, regional and corporate staff who together operated the Facility.

50. Defendant The Evangelical Lutheran Good Samaritan Society monitored the care being provided at the Facility, through its members, managers, regional personnel, board of directors and corporate officers, who did so by utilizing Department of Health Survey Results, Customer Satisfaction Surveys, Mock Surveys, internal quality indicator reports, and CMS Quality Indicator Reports.

51. Defendant The Evangelical Lutheran Good Samaritan Society exercised ultimate authority over all budgets and had final approval over the allocation of resources for staffing, supplies, capital expenditures, and operations of its nursing homes, including the Facility.

52. Defendants had the duty and responsibility to establish policies and procedures that addressed the clinical and daily needs of the residents of the Facility, including Bonnie Shilling. Defendants had the duty and responsibility to ensure that those policies and procedures were implemented.

53. Defendants had the duty and responsibility to ensure those policies and procedures addressed the individualized needs of the residents of the Facility, which included Bonnie Shilling. This included policies and procedures addressing the recognition and/or treatment of Bonnie Shilling, to ensure that she received timely and appropriate care.

54. Defendant The Evangelical Lutheran Good Samaritan Society, acting through its administrators, members, managers, board of directors and corporate offices, had the duty and responsibility to oversee the standard of professional practice by the members of its staff at the Facility, including regarding the conduct at issue herein.

55. Defendants had a duty to employ competent, qualified, and trained staff to ensure that proper care, treatment and services were provided to all residents of the Facility, including Bonnie Shilling.

56. Defendants had a duty and responsibility to ensure that the Facility and its residents, including Bonnie Shilling, were provided with sufficient staff and resources to guarantee the timely recognition and appropriate treatment of their medical, nursing and/or custodial needs whether within the Facility or from other medical care providers.

57. Knowing that staffing costs were the largest part of the Facility's budget, Defendants chose to operate and manage the Facility to maximize their profits at expense of the care provided to their residents, including Bonnie Shilling, by negligently, intentionally, or recklessly mismanaging or reducing staffing levels at the Facility below the levels needed to sufficiently meet the needs of the residents, including Bonnie Shilling.

58. Despite their knowledge of the likelihood of harm due to these insufficient staffing levels, and despite complaints of insufficient staffing from staff members, residents and their families, Defendants recklessly and/or negligently disregarded the consequences of their actions, and/or negligently caused staffing levels at the Facility to be set at a level that did not allow staff to sufficiently meet the needs of the residents, including Bonnie Shilling.

59. Defendants knew that residents with greater health problems and higher acuity are a source of higher reimbursement rates, from governmental programs including Medicare, because of their complex medical needs. Upon present information and belief, such reimbursements from governmental programs, including Medicaid and Medicare, are the primary source of income for Defendant The Evangelical Lutheran Good Samaritan Society.

60. Defendants intentionally maintained census levels comprised of residents with higher acuity and complex medical needs which outpaced the Facility's capacity to provide adequate care in light of the budget-driven restrictions on staffing imposed by the Defendants

61. Defendants knew, or should have known, that this increase in the acuity and care needs for the residents would significantly increase the need for additional staff, services, resources and supplies necessary to provide these residents with adequate care and meet their needs, including Bonnie Shilling.

62. Despite the knowledge of the increased needs for additional staff because of the increased acuity levels of the Facility residents, including Bonnie Shilling, Defendants knowingly disregarded those acuity levels and knowingly established staffing levels that created recklessly high resident to nurse ratios and recklessly high resident to certified nurse aide ratios.

63. Defendants knowingly disregarded the increased resident acuity levels and the increased time required by the staff to provide activities of daily living, medications, and treatments.

64. The acts and omissions of the Defendants were motivated by a desire to decrease the costs and increase the profits of the Facility.

65. Defendants accomplished these goals by knowingly and recklessly reducing the expenditures for needed staffing, training, care and supplies, at the expense of the healthcare of the residents and despite the knowledge that this cost-cutting would inevitably lead to severe injuries, such as those suffered by Bonnie Shilling.

66. The aforementioned acts and omissions directly caused injury to Bonnie Shilling and were known to Defendants.

67. Defendants knowingly sacrificed the quality of care received by all residents, including Bonnie Shilling, by failing to manage, care, monitor, document, chart, prevent, diagnose

and/or treat the injuries and illnesses suffered by Bonnie Shilling, as described herein, including failing to properly instruct staff on handling residents with behavioral health needs, failing to monitor and assess Ms. Shilling's use of her motorized wheelchair outside the facility, and failing to appreciate and reduce the risk of Ms. Shilling eloping from the Facility.

68. At all times material, Defendants were operating personally or through their agent, servants, workers, employees, contractors, subcontractors, staff, and principals, who acted with actual, apparent and/or ostensible authority, and all of whom were acting within the course and scope of their employment and under the direct and exclusive control of Defendants.

69. The aforementioned incidents were caused solely and exclusively because of the negligence, carelessness and recklessness of Defendants, their agents, servants, contractors, subcontractors, staff and employees and was due in no part to any act or failure to act on the part of Bonnie Shilling.

70. Defendants, their agents, servants, contractors, subcontractors, staff and employees were, at all times material hereto, licensed professionals, professional corporations, or businesses, and Plaintiff is asserting professional liability claims against them.

71. In addition to all other claims and demands for damages set forth herein, Plaintiff is asserting claims for ordinary negligence, custodial neglect, and corporate negligence against Defendants herein, as each of the Defendants herein are directly and vicariously liable for their independent acts of negligence, for their acts of general negligence, and for their acts of general corporate negligence.

72. Defendants were fully aware of Bonnie Shilling's medical history, medical conditions and co-morbidities and the level of nursing care she would require while a resident at the Facility.

73. The medical record for Bonnie Shilling while she was a resident at Defendants' Facility includes and evidences missing and incomplete documentation including but not limited to nursing assessments and nursing notes.

74. Defendants negligently caused severe injury to Bonnie Shilling when they: mismanaged the Facility; placed unreasonable budgetary restraints on the Facility; understaffed the Facility; failed to train or supervise the Facility's employees; failed to provide adequate and appropriate healthcare as described herein; engaged in incomplete, inconsistent documentation; failed to develop an appropriate care plan for Bonnie Shilling; failed to ensure the highest level of physical, mental and psychosocial well-being for Bonnie Shilling; failed to notify her physician of significant changes in condition or behaviors; failed to care plan for her individualized needs; failed to properly monitor and assess her use of the motorized wheelchair; failed to properly monitor her when she left the Facility alone; and failed to properly follow her care plan; which, together, caused Bonnie Shilling's injuries.

75. As a result of the negligence, carelessness and recklessness of the Defendants herein described, Bonnie Shilling suffered serious and permanent injuries as described herein, to, in and about her body and possible aggravation or activation of any pre-existing conditions, illnesses, ailments, or diseases she had, and the accelerated deterioration of her health, physical and mental condition, and a loss of the ordinary pleasures of life, a loss of dignity, humiliation, and more particularly, broken bones, septic shock, malnutrition, dehydration, poor hygiene, severe pain, hypercapnic respiratory failure, alveolar pulmonary edema, and death.

76. The Defendants knew or should have known about their problems with resident care at the Facility because they were placed on actual or constructive notice through the Colorado Department of Public Health & Environment surveys that were conducted just prior to, during, and just after Bonnie Shilling's residency.

77. The survey citations identified the Facility's quality of care issues and many of the deficiencies were like those experienced by Bonnie Shilling during her residency.

78. For instance, in a survey completed May 31, 2018, the Facility was cited for violations related to the provision of nursing and medical care, including:

- Failing to properly monitor and apply interventions regarding behavioral health needs; and
- Failing to comprehensively assess and care plan the continued use of personal alarms and wander guards as potential restraints.

COUNT ONE: NEGLIGENCE

79. Plaintiff hereby incorporates herein by reference all allegations contained in the preceding paragraphs. Plaintiff brings this negligence claim in his capacity as personal representative of the Estate of Bonnie Shilling.

80. Defendants were under a continuing duty, both under the common law of the State of Colorado and by the terms of Bonnie Shilling's admissions agreement, to exercise reasonable care in the monitoring, supervision, and treatment of Bonnie Shilling considering her known condition.

81. Upon accepting Bonnie Shilling as a resident at the Facility, Defendants individually and jointly assumed direct, non-delegable duties to Bonnie Shilling to provide her with adequate and appropriate healthcare, as well as basic custodial and hygiene services, as set forth herein.

82. If Defendants were unable or unwilling to meet the needs of Bonnie Shilling, they had an affirmative duty and legal obligation to discharge her from the Facility.

83. Defendants owed a non-delegable duty to provide adequate and appropriate medical, skilled nursing, rehabilitation, physical therapy, occupational therapy, speech therapy,

activities of daily living and other custodial care service and supervision to Bonnie Shilling and other residents at the Facility, such as reasonable caregivers would provide under similar circumstances.

84. Defendants each owed a non-delegable duty to the Facility's residents, including Bonnie Shilling, to hire, train and supervise their employees to ensure that the Facility was operated and services were provided to Defendants' residents in a safe and reasonable manner.

85. Defendants, by and through their agents, employees, and/or servants each owed a duty of care to Bonnie Shilling to exercise the appropriate skill and care of licensed physicians, nurses, certified nurse aides, therapy providers, rehabilitation providers, dietary personnel, Directors of Nursing, and Nursing Home Administrators.

86. Each Defendant owed the following duties to Bonnie Shilling:

a. to use reasonable care in the maintenance of safe and adequate facilities and equipment;

b. to select, train and retain only competent staff;

c. to oversee and supervise all persons who practiced medicine, nursing, rehabilitation and/or therapy within the Facility;

d. to staff the Facility with personnel at sufficient numbers and training to provide care and services to meet the needs of the residents;

e. to ensure the respect and dignity of the residents;

f. to adequately fund the facility and not to under-budget for staffing and resources;

g. to formulate, implement, update and enforce policies and procedures to ensure that all residents receive quality care as required by the applicable standards of care and in accordance with each resident's comprehensive plan of care;

h. to take adequate measures to remedy known problems in the delivery of hygiene and custodial care as well as in the provision of medical, skilled nursing, rehabilitation, occupation therapy and speech therapy;

i. to notify residents, their families and/or representatives of the fact that Defendants were unable to provide adequate care and services when Defendants

knew, or should have known, of their deficiencies in providing such care and services;

j. to refuse to admit residents that Defendants knew or should have known they were unable to provide the necessary care and services required by the residents;

k. to not admit more residents than they could safely provide the necessary care and services for that the residents required; and, among others,

l. to keep the Facility's residents free from abuse and neglect, including Bonnie Shilling.

87. Defendants failed to uphold and fulfill the aforementioned duties, which failures proximately caused severe injuries to Bonnie Shilling as detailed herein.

88. In addition to the direct acts and omissions of the corporate Defendant, the Defendants also acted through their agents, servants and employees, who were in turn acting within their course and scope of their employment under the direct supervision and control of Defendants.

89. Upon information and belief, at all times material hereto, Defendants authored, produced and/or received multiple and frequent reports detailing the number, frequency, factual circumstance and types of injuries, illnesses, and infections sustained by Bonnie Shilling and the other residents of the Facility.

90. Despite being made aware of this information, including those specific to Bonnie Shilling, Defendants failed to take actions to prevent the occurrence of these types of injuries, illnesses, and infections.

91. Defendants knew, or should have known, of the aforementioned issues that were occurring with the care of Bonnie Shilling, as they were placed on actual and/or constructive notice of the same, through their own reports, CMS Quality Indicator Reports and Federal and CDPHE Health Surveys.

92. Defendant The Evangelical Lutheran Good Samaritan Society, as the corporate members, managers, owners, and/or directors of the Facility, breached its duties and was, therefore, negligent, careless and reckless in its obligations to Bonnie Shilling.

93. Defendant The Evangelical Lutheran Good Samaritan Society's corporate conduct was independent of the negligent conduct of the employees of the Facility, and was outrageous, willful and wanton and exhibited a reckless indifference to the health and well-being of the residents, including Bonnie Shilling.

94. Defendants' breaches of duties, negligence, professional negligence, corporate negligence, carelessness and recklessness, individually, vicariously and/or acting by and through their officers, directors, members, managers, physicians, physicians' assistants, nurses, certified nurse aides, rehabilitation personnel, therapy personnel, dietary personnel, regional and corporate staff, who examined, treated and/or communicated the condition of Bonnie Shilling, and through the administrative personnel responsible for hiring, retaining and/or dismissing staff, staff supervision and policy making and enforcement, as well as any agents servants, employees, contractors, subcontractors and/or consultants of Defendants where exhibited in the following acts and omissions in the care and treatment of Bonnie Shilling.

95. Defendants failed to hire, utilize, train and retain sufficient staff to meet the needs of the residents, including Bonnie Shilling, which caused Bonnie Shilling to suffer broken bones, septic shock, poor hygiene, severe pain, hypercapnic respiratory failure, alveolar pulmonary edema, and death.

96. Defendants failed to ensure that each resident, including Bonnie Shilling, received, and that the Facility provided, the necessary care and services in accordance with the comprehensive assessment and plans of care, which included care plans for behavior health needs, assessments for use of motorized mobility devices, and elopement risks, among others.

97. Defendants failed to ensure that Bonnie Shilling did not needlessly suffer from preventable and treatable pain.

98. Defendants failed to timely and appropriately notify Bonnie Shilling's physician(s) and consulting specialists when she experienced significant changes in her condition and behaviors.

99. Defendants failed to obtain new or modified physician orders when Bonnie Shilling's changes in condition and behaviors required the same.

100. Defendants failed to accurately and consistently document Bonnie Shilling's needs and the care and services provided to her in response to such needs.

101. Defendants failed to ensure that Bonnie Shilling did not develop serious and permanent injuries to, in and about her body and possible aggravation and/or activation of any pre-existing conditions, illnesses, ailments, or disease she had, and/or accelerated the deterioration of her health, physical and mental condition.

102. Defendants failed to ensure Bonnie Shilling's comprehensive care plans were developed, reviewed and updated as required by the standard of care, including with significant changes in condition and behavior.

103. Defendants failed to develop and implement an appropriate, comprehensive and individualized care plan for Bonnie Shilling that included measurable objectives and timetables to meet her medical, nursing, custodial, mental and psychosocial needs as identified in the comprehensive assessment.

104. Defendants failed to administer the Facility in a manner that enabled it to use its resources effectively and efficiently.

105. Defendants failed to have the governing body of the Facility to discharge their legal and lawful obligation of:

a. ensuring compliance with the rules and regulations designed to protect the health and safety of Bonnie Shilling;

b. ensuring compliance with the resident care policies at the Facility such as policies concerning accurate and complete documentation, infections, use of assistive devices and equipment, and resident supervision and elopement; and

c. ensuring that appropriate corrective measures were implemented to correct problems concerning staffing, infections, care plans, documentation, and inadequate resident care.

106. The failure to maintain medical records on Bonnie Shilling in accordance with accepted professional standards and practices for skilled nursing facilities with respect to:

a. Nursing assessments and nursing progress notes relating to Bonnie Shilling;

b. the treatment of Bonnie Shilling's injuries; and

c. the assessment and establishment of appropriate plans of care and treatment;

107. Defendants failed to oversee and supervise all persons who practiced medicine, skilled nursing, rehabilitation, occupation therapy, speech therapy, dietary services and custodial care in the Facility who failed to provide adequate and appropriate healthcare to prevent Bonnie Shilling from suffering from injuries, broken bones, septic shock, poor hygiene, severe pain, and death.

108. Defendants failed to formulate, implement and enforce adequate policies and procedures to prevent Bonnie Shilling from suffering injuries, broken bones, septic shock, poor hygiene, severe pain, and death.

109. Defendants failed to implement a budget that properly funded the Facility's staffing and supply needs and allowed the Facility to provide adequate and appropriate healthcare to Bonnie Shilling.

110. Defendants failed to take necessary and appropriate steps to remedy the continuing problems at the Facility that Defendants knew, or should have known, were occurring with Bonnie Shilling's care, which included the need to increase the number of employees, hiring skilled and/or

trained employees, providing adequate training to the employees, monitoring the conduct of the employees, and/or changing policies and procedures to improve resident care.

111. Defendants failed to maintain compliance with the governmental regulations, including 42 C.F.R. § 483.101 *et seq.* and 6 CCR 1011-1 Chap 05 *et seq.*, to which Defendants are required to adhere and to which their delivery of care is compared during Federal and CDPHE Health Annual and Complaint-based surveys, including 42 C.F.R. §483.10(i)(2), §483.24(b), §483.25, §483.25(b), §483.25(d), §483.45(e), §483.45(d), and §483.45(f).

112. Defendants failed to adequately monitor and assess Ms. Shilling for use of her motorized vehicle, failed to appreciate and guard against elopement from the Facility, and failed to properly respond to her behavioral health needs, culminating in Ms. Shilling's ultimate injuries and death.

113. In committing the acts and omissions herein, Defendants acted in a negligent manner, with reckless indifference to the rights and safety of Bonnie Shilling.

114. Upon information and belief, Defendant The Evangelical Lutheran Good Samaritan Society's owners, officers, directors, partners, members and managers were made aware of Federal and CDPHE survey results and placed on notice of the care issues and/or physical/environmental issues of the Facility.

115. Upon information and belief, Defendants, including The Evangelical Lutheran Good Samaritan Society's owners, officers, directors, partners, members, managers and employees, knew the Facility had been cited by Federal and CDPHE surveyors for deficiencies regarding the Facility prior to, during and after the residency of Bonnie Shilling, and were placed on notice as to care issues and/or physical/environmental issues at the Facility.

116. As a direct and proximate result of Defendants' acts and/or omissions, and their breach of their duty of care, negligence, carelessness and recklessness, Bonnie Shilling suffered

(a) severe permanent physical injuries resulting in severe pain, suffering and disfigurement (b) mental anguish, embarrassment, humiliation, degradation, emotional distress, and loss of personal dignity, (c) loss of capacity for enjoyment of life, (d) expense of otherwise unnecessary hospitalizations, medical expenses and residency at the Facility, (e) aggravation of her pre-existing medical conditions, and (f) severe pain.

117. In causing the aforementioned injuries, Defendants knew, or should have known, that Bonnie Shilling would suffer such harm.

118. The Defendants' multiple breaches of the duties owed to Bonnie Shilling as set forth above caused her to suffer economic loss, non-economic loss, and personal injury. Damages include pain and suffering, severe emotional distress, grief, upset, hospital bills, and doctor bills in an amount to be determined by the jury at trial.

COUNT TWO: VIOLATION OF THE COLORADO CONSUMER PROTECTION ACT

119. Plaintiff hereby incorporates each and every averment set forth herein as if each and every averment were set forth verbatim herein. Plaintiff brings this Colorado Consumer Protection Act claim in his capacity as personal representative of the Estate of Bonnie Shilling as a successor in interest pursuant to C.R.S. § 6-1-101 et seq.

120. At all times relevant to this complaint, the Defendants had in effect a massive marketing campaign designed to lure actual and prospective consumers of their services into to the Facility.

121. The Defendants' marketing and advertising campaign significantly impacted the market for long-term care services locally and nationally. Specifically, the marketing and advertising campaign was designed to influence residents of Colorado such as the Plaintiff, who was looking for a skilled nursing facility for his loved one, into selecting the Good Samaritan Society – Simla rather than another facility

122. In addition to print and internet marketing and advertising media, the Facility had admissions and marketing personnel responsible for filling the Facility's beds with residents by representing that the Facility could adequately meet the needs of residents.

123. Yet the Defendants knew that the Facility was incapable of providing the level of care and treatment necessary to ensure the health, safety, and well-being of the residents, including Ms. Shilling, due to chronic and pervasive understaffing and lack of training at the Facility.

124. The Defendants' promises and representations about the quality of care and the level of services provided at Good Samaritan Society - Simla were unfair and deceptive.

125. As noted above, in a survey completed May 31, 2018, the Facility was cited for its failure to properly monitor and apply necessary interventions for behavioral health needs as well as failing to comprehensively assess and care plan the continued use of personal alarms and wander guards as potential restraints.

126. The Defendants' regulatory violations are indicative of understaffing, lack of training, and lack of care at the Facility and evidence that the Defendants knew, or should have known, that they were unable to provide the kind of care and treatment and services necessary to promote the health, safety, and well-being of their residents, including Bonnie Shilling.

127. The Defendants' deceptive and fraudulent representations about the level and quality of care offered at Good Samaritan Society - Simla constitute deceptive trade practices actionable under the Colorado Consumer Protection Act. C.R.S. § 6-1-101, *et seq*.

128. These deceptive and fraudulent practices also constitute a pattern of deceptive trade practices.

129. As a result of the Defendants' deceptive trade practices and violations of the Colorado Consumer Protection Act, the Plaintiff has suffered actual damages in an amount to be determined by the jury at trial.

COUNT THREE: WRONGFUL DEATH

130. Plaintiff hereby incorporates each and every averment set forth herein as if each and every averment were set forth verbatim herein. Plaintiff brings this wrongful death claim in his individual capacity.

131. Charles Shilling, the Plaintiff, is the widower of Bonnie Shilling, deceased and brings this wrongful death action on behalf of all the surviving heirs of Bonnie Shilling.

132. By understaffing Good Samaritan Society - Simla, failing to train its employees, failing to monitor and assess Bonnie Shilling, and failing to follow care plan directives regarding behavioral health needs, the Defendants caused injuries to Bonnie Shilling. Understaffing led to a lack of adequate care, treatment, and supervision, which resulted in Bonnie Shilling's severe injuries and ultimate death.

133. As a result of the injuries to Bonnie Shilling, medical expenses and funeral expenses were incurred and are claimed together with all damages permitted under the Colorado Wrongful Death Act.

134. The injuries Bonnie Shilling sustained at the hands of the Defendants, and as a result of Defendants purposeful understaffing of the facility, directly led to Bonnie Shilling's death.

135. As a result of the Defendants' negligence and wrongful acts or inaction, Bonnie Shilling suffered fatal injuries as more fully set forth herein, and Plaintiff claims for all medical and burial expenses, non-economic damages, and all damages permitted under the Colorado Wrongful Death Act.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays that this Court enter judgment in his favor and against the Defendants in an amount to be determined by the jury at trial, and for the following relief and damages:

a. Economic loss;

b. Non-economic loss;

c. Actual damages under the Colorado Consumer Protection Act;

d. All damages permitted by the Colorado Wrongful Death Act;

e. Attorney's fees;

f. Court costs and witness fees;

g. Pre-judgment and post judgment interest on any award of damages to the extent permitted by law;

h. Treble damages and actual damages under the Colorado Consumer Protection Act; and

i. Such other and further relief as this court may deem proper.

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

This matter is exempt from C.R.C.P. 16.1 as the damages claimed herein exceed $100,000.

Respectfully submitted February 26, 2020,

/s/ Brent L. Moss
Brent L. Moss, #42215
Brian D. Reddick, #46386
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District Court El Paso County, Colorado 270 South Tejon St. Colorado Springs, CO 80903	DATE FILED: July 25, 2019 10:42 AM CASE NUMBER: 2019PR30743
In the Matter of the Estate of: **BONNIE LEA SHILLING, aka BONNIE L. SHILLING, aka BONNIE SHILLING,** **Deceased.**	**COURT USE ONLY** Case Number: **2019PR30743** Division: **W** Courtroom: **W150**

LETTERS OF ADMINISTRATION

Charles Thomas Shilling was appointed or qualified by this court or its registrar on July 25, 2019 as Personal Representative.

The decedent died on April 21, 2019.

These Letters are proof of the Personal Representative's authority to act pursuant to § 15-12-701, et.seq., C.R.S.

☑The Personal Representative's authority is unrestricted; or
❑The Personal Representatives authority is restricted as follows:

Date: July 25, 2019

Probate Registrar

Sarah L. Ortiz
Registrar

CERTIFICATION

Certified to be a true copy of the original in my custody and to be in full force and effect as of _____ (date).

Probate Registrar/(Deputy)Clerk of Court

EXHIBIT A