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3
4 IN THE CIRCUIT COURT OF THE STATE OF OREGON
5 FOR THE COUNTY OF MULTNOMAH

6 JUDITH JOY JONES, THROUGH ANGELA) Case No.
7 BROWN AS PERSONAL REPRESENTATIVE)
8 OF THE ESTATE OF JUDITH JOY JONES,) COMPLAINT
9) (Negligence, Negligence *per se*,
10 Plaintiff,) Statutory Elder Abuse)
11 v.) Amount of Prayer: \$1,800,000
12 ST. JUDE OPERATING COMPANY, LLC, dba) Filing Fee: \$834
13 HEALTHCARE AT FOSTER CREEK, and) ORS 21.160(d)
14 BENICIA SENIOR LIVING, LLC) CLAIMS NOT SUBJECT TO
15) MANDATORY ARBITRATION
16 Defendants.) JURY TRIAL DEMANDED

17 COMES NOW the plaintiff, Judith Joy Jones (“Ms. Jones”), appearing through Angela
18 Brown as the Personal Representative of the Estate of Judith Joy Jones, who brings this action
19 against the above-named defendants St. Jude Operating Company, LLC (“St. Jude Operating
20 Company”) dba Healthcare at Foster Creek (“Foster Creek”) and Benicia Senior Living, LLC
21 (“Benicia Senior Living”) for negligence and Elder Abuse leading to plaintiff’s wrongful death.

22 **INTRODUCTION**

23 1.

24 Healthcare at Foster Creek, a nursing home facility owned by St. Jude Operating
25 Company and managed by Benicia Senior Living, has had by far the least competent and
26 deadliest response to the COVID-19 virus of any Oregon nursing home. To date, roughly 120
cases and nearly 30 deaths resulting from COVID-19 have been linked to this facility. Foster
Creek’s negligence and failure to follow basic infection control procedures to stop the spread of

1 COVID-19 led the State of Oregon (“the State”) to take the extraordinary step of suspending the
2 facility’s operations on May 4, 2020. The State’s decision was based upon investigative efforts
3 that had been ongoing since April of 2020, and a finding that Foster Creek’s “continued
4 operation poses a serious danger to the public health and safety.” Unfortunately, Foster Creek’s
5 shut-down came too late for Ms. Jones.

6 2.

7 On April 18, 2020 – roughly two weeks before the facility was finally shut down, and in
8 the midst of what State investigators would later identify as Foster Creek’s deadly failures – Ms.
9 Jones was transported from Foster Creek to a local hospital emergency room where she tested
10 positive for COVID-19. Ms. Jones remained hospitalized and died on April 25, 2020, from
11 complications of the COVID-19 virus that she contracted due to Foster Creek’s gross negligence.

12 **PARTIES**

13 3.

14 At the time of her death Ms. Jones was a 75-year-old female. She suffered from physical
15 and mental health conditions, including cancer and dementia. Ms. Jones was an elderly person, a
16 person with a disability, and a vulnerable person as defined by the Elder Persons and Persons
17 with Disabilities Abuse Prevention Act (the “Elder Abuse Law”). As an elderly and disabled
18 person living in a nursing home with serious underlying medical conditions, Ms. Jones met all
19 criteria for being at high risk from COVID-19.

20 4.

21 Plaintiff Angela Brown (“Ms. Brown”) is Ms. Jones’s daughter. Ms. Brown served as her
22 mother’s medical guardian, and is the personal representative of her mother’s estate.

23 5.

24 Defendant St. Jude Operating Company is a domestic limited liability company
25 incorporated in Oregon. St. Jude Operating Company does business as, and operated a 114-

26

1 resident capacity nursing facility known as, Healthcare at Foster Creek. Healthcare at Foster
2 Creek is located at 6003 SE 136th Ave, Portland, Multnomah County, Oregon.

3 6.

4 Defendant Benicia Senior Living is a limited liability company authorized to do business
5 in Oregon. On information and belief, Benicia Senior Living managed Foster Creek’s operations,
6 including hiring, training, and management of staff, and has had or shared managerial and
7 operational control of Foster Creek since July 1, 2011. Benicia’s principal place of business is in
8 West Linn, Oregon, and at least one of its members is a natural person with an Oregon address
9 according to records on file with the Oregon Secretary of State.

10 7.

11 St. Jude Operating Company has been the licensed owner of the Foster Creek facility
12 since 2003. Benicia Senior Living has helped manage and operate Foster Creek since 2011.
13 Defendants operate under Oregon DHS license (license #1600506066) pursuant to ORS 441.015
14 *et seq.* and Oregon Administrative Rules (“OAR”) Chapter 411.

15 8.

16 The Foster Creek facility is divided into four separate units: Columbia Unit, Sandy Unit,
17 Wilson Unit, and Mt. Hood Unit, a secured Enhanced Care Unit (“ECU”) for residents with
18 mental health conditions. At all times relevant to this Complaint, Ms. Jones resided in the
19 secured Mt. Hood ECU.

20 **VENUE**

21 9.

22 The venue for this action is properly in Multnomah County where the cause of action
23 arose, and where defendants conducted regular, sustained business activity.

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1 **BACKGROUND FACTS**

2 **A. Authorities Sound the COVID-19 Alarm**

3 COVID-19 is a viral respiratory illness which the World Health Organization (“WHO”)
4 declared a Public Health Emergency of International Concern on January 30, 2020.

5 10.

6 On February 21, 2020, the Centers for Disease Control (“CDC”) issued COVID-19
7 recommendations for health care professionals, which included review of infection prevention
8 and control policies, and CDC recommendations for implementation of precautions.

9 11.

10 On March 8, 2020, Oregon Governor Kate Brown issued Executive Order 20-03 finding
11 COVID-19 a threat to public health and safety. The Executive Order declared a state of
12 emergency and empowered the Oregon Health Authority (“OHA”) and state agencies to respond
13 and develop procedures to control COVID-19.

14 12.

15 On March 10, 2020, the Oregon Department of Human Services (“DHS”) sent an
16 Executive Letter to all licensed nursing and residential care facilities specifying immediate
17 policies to limit exposure to COVID-19.

18 13.

19 On March 11, 2020, the WHO declared COVID-19 a global pandemic.

20 14.

21 The CDC warned that persons at high risk for severe illness or death from COVID-19
22 include people 65 years and older, people who live in a nursing home or long-term care facility,
23 and people who have a serious underlying medical condition.

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1 OAR 411-086-0100(3) Nursing Services: Staffing: for failing to provide sufficient
2 staff to prevent staff from going between units in order to prevent the spread of
COVID-19;

3 OAR 411-086-0120(1) Nursing Services: Changes of Condition: for failing to
4 notify residents' physician(s) of change in resident condition that warranted
medical or nursing intervention;

5 OAR 411-086-0140(1)(a)(E) Nursing Services: Problem Resolution and
6 Preventative Care: for failing to prevent the spread of COVID-19; and

7 OAR 411-086-0330(1) Infection Control and Universal Precautions: for failing to
8 appropriately use personal protective equipment to prevent the spread of COVID-
19.

9
10 20.

11 The State went on to find that based upon the above violations, "...Respondent failed to
12 ensure appropriate measures are in place to prevent the spread of COVID-19. This failure
13 presents an immediate risk to the health and safety of all residents in Respondent's facility."

14 21.

15 The State went so far as to mandate an immediate infection control training to facility
16 staff in an effort to correct Foster Creek's many deficiencies. The State also placed a condition
17 on defendants' license, such that the facility could not admit any new residents.

18 22.

19 Defendants never informed Ms. Jones or her family about the grossly deficient care they
20 were providing to residents, that Ms. Jones's life was in immediate jeopardy based upon those
21 deficient practices, or that the situation was so dire that the facility could no longer admit new
22 residents.

23 23.

24 To the contrary, defendants continued to represent to Ms. Jones's daughter a positive yet
25 false picture of defendants' compliance with proper infection control at Foster Creek. They
26 emphasized that Ms. Jones was in the separate and highly secure Mt. Hood ECU within the
facility, which afforded Ms. Jones additional protection and safety. By doing so, defendants

1 failed to provide accurate or sufficient information about COVID-19 conditions at Foster Creek
2 to allow Ms. Jones’s daughter to make informed decisions regarding her care, including whether
3 to remove or transfer Ms. Jones from Foster Creek.

4 24.

5 When Ms. Jones’s daughter asked Foster Creek administrators and staff questions about
6 safety precautions and her mother’s safety in the ECU, and was reassured that all was well. For
7 example, on April 13, 2020, she asked Foster Creek’s administrator if Foster Creek was sharing
8 employees between units, and was told “No. We’re isolating employees.” That was a false
9 statement, as proven by the State’s investigations.

10 25.

11 On April 18, 2020, a Foster Creek nurse discovered Ms. Jones had a 101.5 degree fever.
12 Ms. Jones was transferred to the Adventist Medical Center Emergency Room in Portland. There,
13 Ms. Jones was diagnosed with COVID-19. Ms. Jones never left Adventist Medical Center and
14 never returned to Foster Creek.

15 **D. Despite State Assistance, Foster Creek’s Failures Persisted**

16 26.

17 In the wake of its April 15, 2020 report, DHS provided Personal Protective Equipment
18 (“PPE”) and technical assistance to Foster Creek. DHS and OHA continued investigating and
19 monitoring defendants, including continuing site observations and infection control assessments.
20 DHS became alarmed by Foster Creek’s inability to follow required practices and continued
21 failures including staff cohorting residents, staff working across units, improper training, and not
22 meeting required staffing levels.

23 27.

24 On April 18, 2020 – the same day Ms. Jones was transferred to the hospital – the State
25 declared an emergency at the facility and issued a partial evacuation order.

26 ///

1 28.

2 Over the next week, DHS and OHA continued infection control assessments, surveys,
3 and other information gathering.

4 29.

5 On April 24, DHS imposed a finding of immediate jeopardy under federal law.

6 30.

7 On April 28, the Centers for Medicare and Medicaid Services issued a notice of
8 involuntary termination of Foster Creek’s Medicare provider agreement.

9 31.

10 COVID-19 continued to spread at Foster Creek, and the death toll mounted. Foster Creek
11 was unable to comply with the conditions imposed by the Notice and Order.

12 **E. The State Shuts Down Foster Creek**

13 32.

14 On May 4, 2020, DHS issued an Order of Emergency Suspension (“Emergency Order”)
15 against St. Jude Operating Company, LLC d.b.a. Healthcare at Foster Creek (“Respondent” in
16 the Emergency Order).

17 33.

18 The Emergency Order’s Statement of Violations concluded, “Based on observations,
19 interviews and record review it was determined Respondent failed to implement adequate
20 infection control practices to prevent the spread of COVID-19 (Coronavirus).”

21 34.

22 The Emergency Order stated “Respondent failed to ensure appropriate measures are in
23 place to prevent the spread of COVID-19. This failure presents an immediate risk to the health
24 and safety of all residents in Respondent facility.”

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26 ///

1 35.

2 The Emergency Order further found that the facility’s failures constituted violations of
3 the following State rules:

4 OAR 411-086-0060(2)(a) Comprehensive Assessment and Care Plan: for failing
5 to assess respiratory changes, for failing to update COVID-19 diagnosis, and
6 failing to update resident care plans;

7 OAR 411-086-0100(3) Nursing Services: Staffing: for failing to provide sufficient
8 staff to prevent staff from going between units in order to prevent the spread of
9 COVID-19

10 OAR 411-086-0120(1) Nursing Services: Changes of Condition: for failing to
11 notify residents’ physician(s) of change in resident condition that warranted
12 medical or nursing intervention;

13 OAR 411-086-0140(1)(a)(E) Nursing Services: Problem Resolution and
14 Preventative Care: for failing to prevent the spread of COVID-19; and

15 OAR 411-086-0330(1) Infection Control and Universal Precautions: for failing to
16 appropriately use personal protective equipment to prevent the spread of COVID-
17 19.”

18 36.

19 Tragically, these were the exact same violations the State had found in April. Nothing
20 had been remedied by defendants despite the warning in April that residents’ lives were in
21 immediate jeopardy due to defendants’ failures.

22 37.

23 The State’s Emergency Order also addressed cross-unit COVID-19 infection control
24 failure with respect to the Mt. Hood ECU:

25 “Based on observations and interviews the facility failed to maintain adequate
26 certified and licensed nursing staffing to ensure dedicated staff worked in the four
separate and distinct units, failed to ensure staff did not cross units within the
facility and failed to ensure staff were in each of the units at all times, resulting in
residents being exposed to the COVID-19 virus. This staffing practice resulted in
the potential for all residents to be infected with COVID-19 virus with the
likelihood of serious illness and death.

1 On 4/17/20, it was determined a resident tested positive for COVID19 in a unit
2 that previously had no residents with COVID-19. **Due to this being a locked**
3 **unit, and the fact that residents do not leave the unit, the spread of COVID-**
4 **19 was more likely that (sic) not to have been caused by staff working across**
5 **units.**

6 Staff was observed on at least one occasion to have no facility staff in on (sic) the
7 locked Enhanced Care Unit, leaving residents at risk for serious injury or harm.
8 (emphasis added)”

9 38.

10 Upon information and belief, the “locked unit” referenced above is Mt. Hood ECU,
11 where Ms. Jones resided. April 17, 2020 was one day before Ms. Jones developed a fever, was
12 transported to the hospital, and was diagnosed with COVID-19.

13 39.

14 The effect of the Emergency Order was to suspend St. Jude Operating Company’s
15 nursing facility operating license and completely halt defendants’ operations at Foster Creek. All
16 remaining Foster Creek residents were released to family members and caretakers, or transferred
17 to other facilities.

18 40.

19 In its Emergency Order, DHS found

20 “Based on the violations outlined above, DHS finds that Respondent’s actions
21 create a serious danger to the public health and safety. That is because, despite
22 numerous enforcement actions, infection control guidance and oversight, and
23 facility support, Respondent has demonstrated a consistent inability to adhere to
24 basic infection control standards and Oregon Administrative Rules. This has
25 resulted in, and continues to result in, a persistent source and spread of COVID-
26 19 in a facility with extremely vulnerable residents, and in the community at
27 large.”

28 41.

29 The May 4, 2020 Order of Emergency Suspension went into immediate effect.

30 ///

31 ///

1 42.

2 Nine days earlier, on April 25, 2020, Ms. Jones had died from COVID-19 she contracted
3 at defendants' facility while under defendants' care.

4 **FIRST CLAIM FOR RELIEF**
5 **(Count 1 – Negligence, Against All Defendants)**

6 43.

7 Plaintiff realleges all of the paragraphs above as if fully set forth herein.

8 44.

9 Defendants owed a duty of care to Ms. Jones, who was under defendants' care.

10 45.

11 Defendants exposed Ms. Jones to a risk of foreseeable harm and breached their duty of
12 care to Ms. Jones, as described above.

13 46.

14 Such breach resulted in harm to Ms. Jones, including injury, damage, or death to Ms.
15 Jones by COVID-19.

16 47.

17 The negligence of defendants as outlined above was a proximate cause of Ms. Jones's
18 injuries and death.

19 48.

20 As a result of defendants' negligence and fault, plaintiff has been damaged in the amount
21 of \$100,000 for economic damages and \$500,000 for non-economic damages for pain, suffering,
22 emotional distress, anguish, and mental distress. Plaintiff is entitled to pre-judgment interest on
23 her economic damages at the statutory rate of 9% from April 25, 2020 through entry of
24 judgment.

25 **(Count 2 – Negligence *per se*, Against All Defendants)**

26 49.

Plaintiff realleges all of the paragraphs above as if fully set forth herein.

1 50.

2 As described above, defendants were negligent *per se* in violating:

3 OAR 411-086-0060(2)(a) Comprehensive Assessment and Care Plan: for failing to
4 assess respiratory changes, for failing to update COVID-19 diagnosis, and failing to
update resident care plans;

5 OAR 411-086-0100(3) Nursing Services: Staffing: for failing to provide sufficient staff
6 to prevent staff from going between units in order to prevent the spread of COVID-19;

7 OAR 411-086-0120(1) Nursing Services: Changes of Condition: for failing to notify
8 residents' physician(s) of change in resident condition that warranted medical or nursing
intervention;

9 OAR 411-086-0140(1)(a)(E) Nursing Services: Problem Resolution and Preventative
10 Care: for failing to prevent the spread of COVID-19; and

11 OAR 411-086-0330(1) Infection Control and Universal Precautions: for failing to
12 appropriately use personal protective equipment to prevent the spread of COVID-19.

13 51.

14 The *per se* negligence of defendants as outlined above was a proximate cause of Ms.
15 Jones's injuries and death.

16 52.

17 As a result of defendants' negligence and fault, plaintiff has been damaged in the amount
18 \$100,000 for economic damages and \$500,000 for non-economic damages for pain, suffering,
19 emotional distress, anguish, and mental distress. Plaintiff is entitled to pre-judgment interest on
20 her economic damages at the statutory rate of 9% from April 25, 2020 through entry of
judgment.

21 **SECOND CLAIM FOR RELIEF**

22 **(Elder Abuse Law – ORS 124.100 and ORS 124.105, Against Benicia Senior Living)**

23 53.

24 Plaintiff realleges all of the paragraphs above as if fully set forth herein.

25 54.

26 Ms. Jones is an elderly person and a vulnerable person.

1 55.

2 Defendant, as described above, recklessly engaged in conduct which recklessly
3 endangered Ms. Jones by creating a substantial risk of serious physical injury to her.

4 56.

5 Ms. Jones suffered injury, damage, or death by reason of physical abuse which defendant
6 caused or permitted its agents to cause.

7 57.

8 As a result of defendant's abuse, plaintiff has been damaged in the amount of \$100,000
9 for economic damages and \$500,000 for non-economic damages for pain, suffering, emotional
10 distress, anguish, and mental distress. Plaintiff is entitled the treble damages pursuant to ORS
11 124.100(2)(a) and (b).

12 58.

13 Plaintiff is entitled to pre-judgment interest on her economic damages at the statutory rate
14 of 9% from April 25, 2020 through entry of judgment.

15 **ATTORNEYS FEES**

16 59.

17 Pursuant to ORS 124.100(2)(c), plaintiff is entitled to recover reasonable attorney fees,
18 costs, and disbursements.

19 **PUNITIVE DAMAGES**

20 60.

21 Defendants have shown a reckless and outrageous indifference to a highly unreasonable
22 risk of harm and acted with conscious indifference to the health, safety, and welfare of Ms.
23 Jones. Pursuant to 31.730(1), plaintiff reserves her right to move for punitive damages.

24 **PRAYER FOR RELIEF**

25 WHEREFORE, plaintiff demands judgment against defendants and each of them for the
26 following relief:

- 1 1. A judgment in favor of plaintiff and against defendants in the amount of \$600,000 on
2 Plaintiff's first claim for relief.
- 3 2. A judgment in favor of plaintiff and against Benicia Senior Living in the amount of
4 \$1,800,000 on plaintiff's second claim for relief.
- 5 3. Plaintiff's reasonable attorney fees, costs, disbursements, and prevailing party fees.
- 6 4. Such other relief as the Court deems appropriate.

7
8 DATED this 14th day of May 2020.

9 RICHARDSON WRIGHT LLP

10
11 By s/Bonnie Richardson

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