IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

ANDREA HINICH,	)	
	)	No. 20 L 2020L005539
Plaintiff,	)	
vs.	)	**JURY DEMAND**
	)	
NORWOOD LIFE SOCIETY, INC. and **NORWOOD CROSSING ASSOCIATION, INC**. d/b/a **NORWOOD CROSSING**,	)	
	)	
Defendants.	)	

COMPLAINT

Plaintiff Andrea Hinich (Hinich), through her attorneys, Jeffrey R. Kulwin, KULWIN, MASCIOPINTO & KULWIN, L.L.P., states her complaint against the defendants.

Nature of the Case

1. Norwood Crossing is a nursing home and long-term care facility in Chicago. Norwood Crossing claims to be "at the forefront of senior living and healthcare."[1]

2. However, as lapses in care and a lack of transparency were "fueling the spread of COVID-19 within America's nursing homes,"[2] Norwood Crossing retaliated against Assistant Nursing Director Andrea Hinich by firing her for objecting to, reporting and refusing directives to participate in unsafe and unlawful conduct in violation of her professional nursing obligations including disregarding Illinois Department of Public Health guidance for long-term care facilities, providing inaccurate public disclosures about COVID-19 positive cases inside the facility and ignoring mandatory safety rules promulgated by the Occupational Safety & Health Administration, the Centers for Disease Control & Prevention and the Centers for Medicare & Medicaid Services.

[1] *See, e.g.,* www.norwoodcrossing.org/history.

[2] *See, e.g.*, https://www.cnn.com/2020/04/24/us/nursing-homes-coronavirus-invs/index.html.

3. In March and April 2020, as the COVID-19 pandemic gripped the Chicago area, Hinich repeatedly reported and objected to senior management that Norwood Crossing's actions and inactions needlessly jeopardized the health and safety of residents and workers.

4. Hinich refused directives from her supervisors to participate in unsafe conduct and she refused directives from her supervisors to implement practices that violated her professional nursing obligations and mandatory safety laws, rules, regulations and guidance implemented specifically for the COVID-19 pandemic.

5. Norwood Crossing's senior management repeatedly reacted in hostile and negative ways to Hinich's efforts to fulfill her professional nursing obligations and, in particular, they repeatedly resisted her warnings about unsafe and unlawful conduct.

6. On April 21, 2020, during a senior management meeting, Hinich again raised serious safety concerns and, in particular, she objected and refused directives to distribute essential personal protective equipment to the staff without giving the staff sufficient and required training on how to use it. Hinich objected and refused directives to participate in the plan because it jeopardized the health of the staff and because it violated safety laws, rules, regulations and guidance implemented specifically for the COVID-19 pandemic.

7. The next day, on April 22, 2020, without warning or notice, Hinich was terminated allegedly for "insubordination." The documents Hinich was given about her termination included false and pretextual reasons for why she was being terminated.

8. Based on these facts and others, in fact, Hinich was terminated in retaliation for engaging in protected activity in violation of state law and Illinois public policy.

9. Hinich seeks legal and equitable relief under the Nurse Practice Act (225 ILCS 65/1), the Nursing Home Care Act (210 ILCS 45/1), the Whistleblower's Act (740 ILCS 174/1) and the common law prohibiting retaliatory discharge in violation of Illinois public policy.

Parties, Jurisdiction and Venue

10. From June 2019 to April 22, 2020, Hinich worked as the Assistant Director of Nursing for Norwood Crossing in Chicago, Cook County Illinois.

11. Norwood Life Society Inc. (NLSI) is an Illinois corporation that does and transacts business in Cook County, Illinois.

12. NLSI owns and operates Norwood Crossing Association, Inc. (NCAI), an Illinois corporation that does and transacts business in Cook County, Illinois.

13. NLSI and NCAI own, operate and manage long term care facilities, including Norwood Crossing, a nursing home and long-term care facility located at 6016 N. Nina Avenue in Chicago, Cook County Illinois.

14. NLSI and NCAI share a Board of Directors, board members, executive officers, resources and employees.

15. NLSI and NCAI are referred to collectively as "Norwood Crossing."

16. The Court has jurisdiction over this controversy under Illinois common law and the Illinois Code of Civil Procedure 735 ILCS 5/2-209.

17. Venue is proper in this court because most, if not all, of the acts complained of herein took place in Cook County, Illinois.

Facts Common to All Claims

Norwood Crossing's Facility on Nina Avenue in Chicago

18. Norwood Crossing operates skilled and long-term care nursing, assisted living and sheltered care facilities.

19. Norwood Crossing operates nursing home facilities subject to being licensed and regulated by public agencies at the state and federal levels, including the Illinois Department of Public Health (IDPH) and the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS).

20. The Norwood Crossing Board of Directors is responsible for, among other things, hiring qualified Executive Officers to operate Norwood Crossing's facilities and affiliates.

21. Norwood Crossing's Chief Operating Officer (COO) is responsible for developing all policies and supervising the implementation of all policies and procedures established by Norwood Crossing's staff. The COO hires the Administrators of Norwood Life Society affiliates and the Directors and Officers that serve multiple Norwood Crossing companies.

22. The Norwood Crossing facility on Nina Avenue in Chicago was founded in 1896.

23. The Norwood Crossing facility on Nina Avenue cares for over two hundred and fifty (250+) residents and has responsibility for over five hundred (500) employees, contractors, volunteers and visitors who are regularly on site at the facility.

24. The 4th floor of the Norwood Crossing facility on Nina Avenue cares for forty-four (44) long-term residents with underlying medical conditions and multiple comorbidities requiring twenty-four (24) hour nursing care seven (7) days per week and skilled nursing care provided by licensed and professional nurses and certified nurse aides (CNAs).

Plaintiff Andrea Hinich

25. Hinich received an honorable discharge from the military after serving for eight (8) years in the United States Army.

26. In 2014, Hinich graduated with an Associate Degree in Applied Science in Nursing. Hinich earned a Bachelor of Science in Nursing from Loyola University in 2017.

27. Hinich is currently pursuing a terminal nursing degree, Doctorate in Nursing Practice, Health Systems Leadership & Informatics at the University of Illinois.

28. In 2014, Hinich became a licensed registered nurse under the Nurse Practice Act.

29. Under the Nurse Practice Act (225 ILCS 65/60-35), the nursing practice involves the "protection, promotion, and optimization of health and abilities, the prevention of illness and injury, the development and implementation of the nursing plan of care, the facilitation of nursing interventions to alleviate suffering, care coordination, and advocacy in the care of individuals, families, groups, communities, and populations."

30. Under the Nurse Practice Act (225 ILCS 65/70-5), the Department of Financial and Professional Regulation may suspend or revoke a nurse's license for misconduct including, among other things, "incapacity or incompetency to practice," "dishonorable, unethical or unprofessional conduct," which includes gross negligence in the practice of nursing, "conduct of a character likely to deceive, defraud or harm the public," the "willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law," and "knowingly aiding or assisting another person in violating" the Act.

31. As a licensed registered nurse, Hinich worked in a variety of medical and surgical focused practice settings, including working for the United States Department of Defense and some of the largest hospitals in Illinois.

32. Through her education, clinical and military leadership experience, Hinich earned a unique, deep and broad set of skills as a manager of complex patient care.

Hinich is Hired for the Assistant Nursing Director Position at Norwood Crossing

33. In 2019, Hinich applied for the position of Assistant Director of Nursing for the Norwood Crossing facility on Nina Avenue.

34. Typically, an Assistant Director of Nursing serves as the second in command to oversee and manage the work and services provided by nursing staff.

35. Hinich was interviewed for the position by the Administrator for the Nina Avenue facility, Jon Ragsdale (Ragsdale).

36. The Administrator of Norwood Crossing facilities is responsible for implementing all policies regarding employees, residents and the operation of the facility.

37. The Administrator is responsible to hire qualified Department Directors who can manage the operation of their own departments.

38. All departments at the Norwood Crossing facility report to the Administrator.

39. Mary Jo Bade (Bade) and Julie Egeland (Egeland), also attended Hinich's interviews for the Assistant Director of Nursing Position.

40. During the interviews, Hinich learned that Norwood Crossing's staff had experience in long term healthcare, but it did not have managers or healthcare workers at the facility with diverse clinical experiences or skills.

41. For example, Ragsdale's background was in Finance, not Healthcare.

42. Bade's recent clinical experience was only in long-term health care settings.

43. Egeland had less nursing experience than Hinich.

44. In June 2019, Hinich was hired and began working as the Assistant Director of Nursing for the Norwood Crossing facility on Nina Avenue.

45. Hinich understood she was hired, in part, based on her diverse experience in health care and, in particular, her skills as a manager of complex patient care.

46. Hinich was led to believe that, based on the nature of the position and her skills as a manager of complex patient care, she would be assigned and have direct responsibility for ensuring the plans of care are appropriate and are implemented in a timely and efficient manner, managing the clinical team and evaluating nursing systems, rotations and methods.

47. During the relevant time period, Hinich met or exceeded the legitimate expectations Norwood Crossing had for her work.

48. During the relevant time period, Ragsdale, Bade and Egeland knew and should have known that Hinich met or exceeded the legitimate expectations for her work.

49. By January 2020, Egeland was promoted to the position of Director of Nursing. Bade was promoted to the position of Corporate Clinical Operations Nurse. As a result, starting in January 2020, Ragsdale, Bade and Egeland supervised Hinich.

Hinich's Futile Efforts to Ensure Compliance with Mandatory Safety Rules

50. On February 28, 2020, the Centers for Disease Control and Prevention (CDC) published guidelines outlining strategies for all United States healthcare facilities to prepare for and respond to SARS-CoV-2, the virus that causes coronavirus disease (COVID-19).

51. On March 11, 2020, the World Health Organization (WHO) designated COVID-19 as a pandemic.

52. On March 13, 2020, the President of the United States declared the COVID-19 pandemic a national emergency.

53. According to the CDC, Illinois (second only to New York), was among the top three states in the nation reporting widespread outbreaks with the highest number of laboratory confirmed COVID-19 positive cases.

54. The CDC advised that the geographical surveillance data, coupled with identified vulnerable population data (age 65 and older and residents of nursing homes), and associated risk factors for mortality, demonstrate the need for particularly stringent infection control policies to not only prevent spread of the virus, but minimize its potential impact on morbidity and mortality rates in the geriatric population, particularly in the long-term care setting.

55. Hinich began meeting with staff to plan and prepare for the COVID-19 pandemic.

56. Hinich was assigned to develop plans for residents on the 4th floor of nursing consistent with mandatory safety laws, rules, regulations and guidance promulgated by the Occupational Safety & Health Administration (OSHA), CMS, the CDC and the IDPH, including IDPH's specific guidance for long-term care facilities.

57. Hinich was directly responsible for the management of the 4th floor of nursing, while other nursing units, sheltered care and assisted living were the direct responsibility of other directors, managers and staff.

58. Hinich was responsible for the care of the residents on the 4th floor of nursing in accordance with occupational safety regulations and laws governing the nursing practice.

59. Hinich was assigned to work on the 4th floor of nursing based on the needs and limited cognitive and functional status of its residents and her skills in complex patient care.

60. Hinich was specifically not assigned work in other areas because Hinich had other critical exclusive job responsibilities, including management of resident and family issues, management of the facility's vaccination programs and management of all on-site clinical rotations for nursing schools and universities.

61. During the relevant time period, as the COVID-19 pandemic unfolded in Chicago, pursuant to her job responsibilities and in accordance with her professional nursing obligations, Hinich repeatedly tried to implement practices consistent with mandatory safety laws, rules, regulations and guidance implemented for the COVID-19 pandemic promulgated by OSHA, the CDC, the CMS and the IDPH.

62. For example, OSHA's General Duty Clause requires employers to furnish to each worker "employment and a place of employment, which are free from recognized hazards that are causing or are likely to cause death or serious physical harm."

63. On March 8, 2020, CMS issued updated guidance on evaluating and testing for COVID-19 which Hinich tried to implement.

64. Under the applicable CMS guidance, nursing homes like Norwood Crossing were required to immediately ensure that they are complying with all CMS and CDC guidance related to infection control. The failure to develop and document such policies violates CMS guidance.

65. During the relevant time period, Hinich's efforts to fulfill her professional nursing obligations under the Nurse Practice Act and the Nursing Home Care Act and implement mandatory safety laws, rules, regulations and guidance implemented specifically for the COVID-19 pandemic were repeatedly rejected by her supervisors.

66. During the relevant time period, the facility was experiencing unusually high rates of respiratory illness and increased rates of death rates among its resident populations.

67. During the relevant time period, Hinich witnessed, objected to and reported to her supervisors that Norwood Crossing's actions and inaction risked the health and safety of residents and workers by disregarding and violating mandatory safety laws, rules, regulations and guidance implemented for the COVID-19 pandemic for long-term care facilities including, but not limited to, the occurrences alleged below.

68. During the relevant time period, including but not limited to the occurrences alleged below, the activity, inaction, policies, and practice implemented by Norwood Crossing violated a law, rule, regulation or guidance implemented for the COVID-19 pandemic and Hinich's professional nursing obligations under the Nurse Practice Act and the Nursing Home Care Act.

69. During the relevant time period, including the occurrences alleged below, Hinich reasonably believed the activity, inaction, policies, and practice implemented by Norwood Crossing violated a law, rule, regulation or guidance implemented for the COVID-19 pandemic.

70. During the relevant time period, including but not limited to the occurrences alleged below, Hinich refused directives from her supervisors to participate in conduct that violated a law, rule, regulation or guidance implemented for the COVID-19 pandemic and her professional nursing obligations under the Nurse Practice Act and the Nursing Home Care Act.

71. During the relevant time period, including but not limited to the occurrences alleged below, Hinich's efforts to raise serious safety issues were repeatedly disregarded and ignored by her supervisors.

72. During the relevant time period, including but not limited to the occurrences alleged below, Ragsdale, Bade and/or Egeland reacted in hostile and negative ways in response to Hinich's actions in accordance with her professional nursing obligations including her persistent reports and objections to the unsafe and unlawful conduct she observed.

73. For these and other reasons, and upon information and belief, Ragsdale, Bade and Egeland believed and anticipated that Hinich was disclosing publicly and/or would disclose publicly, including to the public bodies regulating long-term care facilities, the unsafe and unlawful conduct Hinich reasonably believed violated mandatory safety laws, rules, regulations and guidance implemented for the COVID-19 pandemic for long-term care facilities.

74. During the relevant time period, including but not limited to the occurrences alleged below, Hinich reasonably believed the state of Illinois Department of Financial and Professional Regulation could have and would have disciplined a nurse in a similar position for following the directives of her supervisors, for engaging in Norwood Crossing's conduct or knowingly aiding or assisting in Norwood Crossing's unsafe and unlawful conduct.

Ragsdale's Inaccurate Public Statements (Staffing)

75. On March 13, 2020, CMS issued specific guidance for long-term care facilities.

76. Under applicable CDC and IDPH guidelines, a facility like Norwood Crossing was required to maintain the same staffing cohorts as an infection prevention and control measure to protect health and safety of residents in long-term care facilities.

77. Under applicable CDC and IDPH guidelines, maintaining the same staffing cohorts prevents disease transmission and mitigates staffing shortages and the resulting inability to provide quality care and the potential burnout of staff.

78. Under applicable CDC and IDPH guidelines, the failure to maintain the same staffing cohorts jeopardizes the health and safety of residents, staff and their families.

79. On March 16, 2020, Ragsdale emailed the Norwood Crossing community stating the facility was "keeping the same staffing."

80. Ragsdale knew his statements in the email about maintaining the "same staffing" were important, but not accurate.

81. Contrary to Ragsdale's statements, Norwood Crossing did not keep the same staffing as Ragsdale stated in the email.

82. In response to seeing the inaccurate statements in Ragsdale's email, Hinich objected and reported to Egeland that Ragsdale violated mandatory safety laws, rules, regulations and guidance implemented for the COVID-19 pandemic by (a) not maintaining the same staffing cohorts and (b) making inaccurate and misleading statements in the email.

83. In response to Hinich's report, Egeland reacted negatively and in a hostile manner.

84. Egeland told Hinich she should "not worry about it."

Lack of Required Staff Training

85. On March 19, 2020, Ragsdale emailed the Norwood Crossing community stating that "Our care team are experienced in infection control and proper treatment."

86. Ragsdale knew his statements were important, but not accurate.

87. Contrary to Ragsdale's statements, there was no specific treatment for COVID-19 at the time, only supportive care for symptoms.

88. Further, contrary to Ragsdale's statements, most of the Norwood Crossing staff had experience only in long-term health care settings and did not have sufficient experience in "infection control" as he had suggested.

89. Further, contrary to Ragsdale's statements, many members of the nursing staff were recently hired with no prior clinical experience.

90. Further, contrary to Ragsdale's statements, no COVID-19 education or training was provided to the nursing staff, leaving them ill-equipped to identify symptoms or manage the virus.

91. The failure to train the staff sufficiently violated mandatory safety laws, rules, regulations and guidance implemented for the COVID-19 pandemic.

92. During the relevant time period, Hinich objected and reported to Ragsdale, Bade and Egeland that the staff lacked sufficient COVID-19 training and that there was an urgent need to train the staff promptly to respond effectively to COVID-19 threats.

93. Ragsdale reacted negatively and in a hostile manner.

94. Ragsdale told Hinich this was no time to be "punitive" towards the staff.

95. Due to the extreme seriousness of the issue, consistent with her professional nursing obligations, Hinich developed COVID-19 training and testing materials for the staff. Hinich sent the COVID-19 training and testing materials she developed to Ragsdale, Bade and Egeland by email asking for permission to start training the staff.

96. Neither Ragsdale, nor Bade nor Egeland replied or responded to Hinich's email.

97. As a result, Hinich's request for permission to train the staff was denied.

98. As a result, the staff never received the training.

Ragsdale's Inaccurate Public Statements (Supplies)

99. In the March 19, 2020 email, Ragsdale also stated, "[w]e have adequate supplies and practice universal precautions and advanced isolation precautions on a regular basis."

100. Ragsdale knew the statements he made were important, but not accurate.

101. Contrary to Ragsdale's statements, Norwood Crossing did not have adequate supplies and, in particular, had no N95 respirators or eye protection available to staff for use while caring for symptomatic isolated residents contrary to OSHA regulations and IDPH guidelines.

102. Further, contrary to Ragsdale's statements, there is no such thing as "advanced isolation precautions" and, as a result, they were not being practiced at Norwood Crossing.

Egeland's Improper Directive to Sanitize Medical Records

103. During the relevant time period, Hinich refused to participate in unsafe and unlawful directives from her supervisors to sanitize residents' progress notes.

104. For example, after a CNA tested positive for COVID-19, in violation of the Nurse Practice Act, Egeland hand-wrote a note to direct Hinich on "what I need you to enter into the progress notes [for residents], just copy and paste it, that's all you need to say." Egeland's note stated words to the effect of: "Family notified of positive CNA. Physician notified. DON updated on condition. Resident not showing any symptoms."

105. Based on Egeland's statements, Egeland's conduct and the context in which these events occurred, Hinich understood that Egeland was impeding the proper provision of nursing care and inducing her to record false and misleading statements in the medical record.

106. Based on Egeland's statements, Egeland's conduct and the context in which these events occurred, Egeland knew and should have known that her conduct violated state law, impeded the proper provision of nursing care and would induce Hinich to record false and misleading statements in the medical record.

107. Hinich refused Egeland's directive and, instead, she prepared her progress notes in accordance with professional nursing obligations.

108. Upon information and belief, and based on Norwood Crossing's practices, Egeland knew and should have known that Hinich refused her unlawful directive to enter false and misleading information into residents' progress notes.

109. For example, Norwood Crossing's assistant administrator reviewed all of Hinich's notes to verify communications were made and, at the time, Hinich's progress notes were available to Norwood Crossing management, including Egeland.

Ragsdale's Inaccurate Public Statements (Positive Nurse)

110. On April 18, 2020, a nurse reported testing positive for COVID-19.

111. The nurse worked as a float nurse. In the weeks prior to testing positive, she worked on each of the three skilled nursing units, including the 4th floor and the sheltered care unit.

112. On April 18, 2020, Ragsdale emailed the Norwood Crossing community stating the float nurse worked on the 4th floor.

113. Ragsdale knew the statements he made were important, but not accurate.

114. Ragsdale failed to disclose that, prior to testing positive, the float nurse recently worked on each of the three skilled nursing units, including the 4th floor and the sheltered care unit. As a result, Ragsdale failed to disclose numerous potential contacts with the float nurse.

115. Ragsdale's inaccurate, misleading and incomplete disclosure violated mandatory safety regulations to control communicable diseases and was potentially criminal.

116. For example, Ragsdale's inaccurate and incomplete disclosure violated the applicable CMS guidance which required Ragsdale to notify individuals who were in contact with the float nurse, "immediately" screen the individuals of reported contact and take all necessary actions based on findings.

117. Contrary to the applicable CMS guidance, none of the residents or staff who interacted directly with the float nurse were individually notified.

118. Consistent with her professional nursing obligations, Hinich immediately objected and reported to Ragsdale the problems raised by his email message.

119. Ragsdale ignored Hinich's email and never responded.

120. Ragsdale never corrected the error in his email.

121. As a result, Ragsdale failed to provide truthful and proper disclosure regarding the COVID-19 positive case inside the facility.

Hinich Raises Safety and PPE Issues at the April 21, 2020 Management Meeting

122. On April 21, 2020, Norwood Crossing held a safety meeting with senior management about plans for dealing with the COVID-19 pandemic.

123. The meeting was attended by, among others, Norwood Crossing's Chief Executive Officer, Michael Toohey, Norwood Crossing's Chief Operating Officer Silvia Morici, Ragsdale, Bade and Egeland.

124. Hinich was excluded from the meeting and was not informed it was taking place.

125. On April 21, 2020, when Hinich arrived at work, she was told by a staff member the meeting was taking place.

126. Ultimately, Hinich was able to attend a portion of the meeting.

127. When she arrived at the meeting, Hinich learned Norwood Crossing was planning to distribute to the staff and use essential personal protective equipment (PPE) in violation of mandatory safety laws, rules, regulations and guidance implemented for the COVID-19 pandemic.

128. For example, Ragsdale stated that essential PPE, such as N95 respirators, would be distributed to the staff.

129. However, Norwood Crossing's staff did not have the required mandatory training necessary to use N95 respirators effectively.

130. Ragsdale did not state that the staff would receive the mandatory training necessary to use N95 respirators correctly and effectively.

131. OSHA standards require using PPE when job hazards warrant it, such as gloves, eye and face protection and respiratory protection.

132. Under applicable OSHA regulations, when respirators are necessary to protect workers, employers must implement a comprehensive respiratory protection program in accordance with the Respiratory Protection standard.

133. Under applicable OSHA regulations, proper fit testing and training for the use of N95 respirators is mandatory and requires special procedures, including a medical evaluation, education and a written facility policy.

134. The Respiratory Protection standard has specific requirements for the use of N95 respirators, including a written program, medical evaluation, fit-testing and training.

135. Under OSHA, employers must follow these standards for the use of N95 respirators to ensure workers are provided with and are properly using appropriate respiratory protection when necessary to protect their health.

136. According to the CDC, healthcare professionals must receive job-specific training on PPE and demonstrated competency with selection and proper use (*e.g.*, putting on and removing PPE without self-contamination).

137. In March 2020, IDPH issued specific recommendation for N95 respirators that included requirements for appropriate training and use.

138. Ragsdale's ill-conceived plan to provide the staff with N95 respirators without the required training or fit testing violated federal and state safety regulations and poses serious safety risks because respirators cannot protect healthcare workers if they do not know how to use them correctly or if they do not fit properly.

139. During the meeting, Hinich reported to her supervisors that distributing N95 respirators without the required training and fit testing would violate mandatory safety rules.

140. Hinich objected and refused directives to participate in the plan to distribute N95 respirators to the staff without the required fit testing and training.

141. Hinich explained that, absent the required fit testing and training, N95 respirators are no more effective than standard loop masks.

142. Hinich's statements were disregarded and ignored.

143. Ragsdale and Egeland reacted negatively and in a hostile manner when Hinich raised the issue at the meeting.

144. Bade told Hinich "we don't have to do the fit testing" and "we are giving them the respirators to make them feel better."

145. During the meeting, Hinich raised and reported the on-going concerns she had about, among other things, insufficient staffing, training, inaccurate disclosures and safety violations including the occurrences alleged above.

Hinich is Terminated the Day After the Senior Management Safety Meeting

146. On April 22, 2020, when Hinich arrived at work the day after the management meeting, the receptionist told Hinich that Norwood Crossing's HR Director Jerry Granger (Granger) needed her to report to HR right away.

147. Hinich reported to HR where she was met by Granger who instructed Hinich to take a seat in the HR conference room. Hinich took a seat in the conference room as instructed.

148. Shortly afterward Granger, Ragsdale and Egeland arrived. Ragsdale sat down and placed papers on the table. Granger then passed papers to Hinich entitled Corrective Action Report.

149. Ragsdale began reading the Corrective Action Report aloud and stated Hinich was being terminated purportedly for cause for alleged "insubordination / failure to perform a task as directed by the supervisor."

150. Hinich was terminated without receiving a prior warning.

151. The Corrective Action Report was dated two days earlier on April 20, 2020.

152. The Corrective Action Report stated Hinich allegedly committed offenses on April 20, 2020 that warranted immediate termination.

153. The descriptions in the Corrective Action Report were apparently written to make Hinich the scapegoat for the same safety concerns she had been raising over recent weeks with her supervisors and the same issues they ignored when Hinich raised them.

154. For example, the Corrective Action Report stated in vague terms that Hinich did not follow directions in maintaining sufficient emergency supplies, failed to follow reporting requirements for confirmed COVID-19 cases and committed insubordination by not following directions in making notifications regarding confirmed COVID-19 cases.

155. The reasons given for terminating Hinich stated in the Corrective Action Report were false and pretextual.

156. Ragsdale and Egeland did not honestly believe the reasons given for Hinich's termination.

157. Ragsdale and Egeland did not explain the reasons why Hinich was terminated on April 22, 2020 and not two days earlier on April 20, 2020 for the offenses referenced in the Corrective Action Report that allegedly were sufficient to end her employment immediately.

158. Ragsdale and Egeland did not explain the reasons why Hinich was permitted to continue working, and not terminated immediately, after she committed the alleged offenses referenced in the Corrective Action Report that warranted immediate termination.

159. In fact, Hinich was terminated in retaliation for opposing, reporting and refusing directives to participate or work in unsafe conditions that violated her professional nursing obligations and mandatory safety laws, rules and regulations, including safety guidance implemented specifically for the COVID-19 pandemic.

160. In addition, or alternatively, Hinich was terminated in retaliation for refusing to violate the law, or refusing directives to participate in violating the law, through the fraudulent fulfillment of her professional nursing obligations and the fraudulent implementation of mandatory safety laws, rules and regulations, including guidance implemented for the COVID-19 pandemic.

161. In addition, or alternatively, Hinich was terminated in retaliation for (a) reporting, or in anticipation of her reporting, that Norwood Crossing was fraudulently and dangerously disregarding mandatory safety laws, rules and regulations, including safety guidance implemented for the COVID-19 pandemic; (b) for her efforts to ensure Norwood Crossing's management's compliance with mandatory safety rules; and/or (c) for her refusal to sanction or aid in the concealment of Norwood Crossing's wrongdoing.

162. In addition, or alternatively, Hinich was terminated in retaliation for objecting to, reporting and opposing unsafe, unlawful and potentially criminal conduct.

163. Hinich's termination was intentional, malicious, willful and oppressive.

Norwood Crossing's Conduct Violated Illinois Public Policy

164. Norwood Crossing's actions in terminating Hinich for retaliatory reasons as alleged herein violates the clearly stated and mandated public policy of Illinois.

165. For example, OSHA's purpose is to provide all workers "safe and healthful working conditions."

166. OSHA prohibits employers from retaliating against workers for raising concerns about safety and health conditions.

167. The well-defined and dominant public policy in Illinois favoring safe nursing care is evidenced by Section 2 of the Nurse Practice Act which states in relevant part:

> The practice of professional and practical nursing in the State of Illinois is hereby declared to affect the public health, safety, and welfare and to be subject to regulation and control in the public interest.

168. The Nurse Practice Act prohibits retaliation against any nurse who reports unsafe unethical, or illegal health care practices or conditions.

169. The Nursing Home Care Act was enacted to protect nursing home residents.

170. Section 3-810 of the Nursing Home Care Act provides for a private right of action for nursing home employees who face retaliation after reporting or threatening to report to a supervisor or a public body any action or incident they believe to be a violation of the law, a rule, or a regulation regarding care and treatment of nursing home residents.

171. The Whistleblower Act protects employees from retaliation.

172. The Whistleblower Act protects employees for certain disclosures and refusals if an employee reasonably believes an employer is violating a law, rule, or regulation.

173. Section 20 of the Whistleblower Act provides that employers may not retaliate against employees for refusing to participate in an activity that would result in a violation of a federal, state or local law, rule, or regulation.

174. Illinois common law prohibits retaliatory discharge in violation of public policy.

COUNT I – VIOLATION OF ILLINOIS NURSING HOME CARE ACT

175. For paragraph 175, Hinich re-alleges the allegations in paragraphs 1-174.

176. Under Section 3-810 of the Nursing Home Care Act (210 ILCS 45/3-810), a facility shall not take any retaliatory action against an employee of the facility because the employee "discloses or threatens to disclose to a supervisor or to a public body an activity, inaction, policy, or practice implemented by a facility" the employee reasonably believes "is in violation of a law, rule, or regulation."

177. Hinich is an "employee" under the Nursing Home Care Act.

178. Norwood Crossing is a "facility" under the Nursing Home Care Act.

179. During her employment, Hinich engaged in protected activity under Section 3-810 of the Nursing Home Care Act by disclosing or threating to disclose to a supervisor or to a public body "an activity, inaction, policy, or practice implemented by a facility" she reasonably believed was "in violation of a law, rule, or regulation."

180. Hinich was terminated for engaging in protected activity under Section 3-810 of the Nursing Home Care Act.

181. Hinich's protected activity was a contributing factor in her termination under the Nursing Home Care Act.

182. Hinich's termination is a "retaliatory action" under the Nursing Home Care Act.

183. Hinich suffered actual damages of a personal and pecuniary nature which are continuing to accrue at this time, which cannot be calculated with precision, but, in any event, exceed $100,000.00.

184. Pursuant to Section 3-810 of the Nursing Home Care Act (210 ILCS 45/1), Hinich seeks an award of any and all relief necessary to make her whole, including but not limited to the following, as appropriate: (a) reinstatement to either the same position held before the retaliatory action or to an equivalent position; (b) double back pay; (c) interest on back pay; (d) reinstatement of full fringe benefits and seniority rights; and (e) payment of reasonable costs and attorney's fees.

WHEREFORE, plaintiff, Andrea Hinich, respectfully requests that judgment be entered in her favor and against defendants Norwood Life Society, Inc. and Norwood Crossing Association, Inc. d/b/a Norwood Crossing and award any relief permitted under the law which may include actual damages, punitive damages, attorneys' fees and costs.

COUNT II – VIOLATION OF ILLINOIS WHISTLEBLOWER ACT

185. For paragraph 185, Hinich re-alleges the allegations in paragraphs 1-184.

186. Section 20 of the Whistleblower Act (740 ILCS 174/20), which provides "[a]n employer may not retaliate against an employee for refusing to participate in an activity that would result in a violation of a State or federal law, rule, or regulation."

187. During her employment, Hinich engaged in protected activity under Section 20 of the Whistleblower Act by opposing and refusing to participate in activities that would result in a violation of a law, rule, or regulation.

188. Hinich was terminated for engaging in protected activity under Section 20 of the Whistleblower Act (740 ILCS 174/20) by refusing to participate in activities that would result in the violation of a law, rule, or regulation.

189. Hinich suffered actual damages of a personal and pecuniary nature which are continuing to accrue at this time, which cannot be calculated with precision, but, in any event, exceed $100,000.00.

190. Section 30 of the Whistleblower Act (740 ILCS 174/30), entitles Hinich to an award of any and all relief necessary to make her whole, including but not limited to the following, as appropriate: (1) reinstatement with the same seniority status that she would have had, but for the violation; (2) back pay, with interest; and (3) compensation for any damages sustained as a result of the violation, including litigation costs, expert fees, and reasonable attorney's fees.

WHEREFORE, plaintiff, Andrea Hinich, respectfully requests that judgment be entered in her favor and against defendants Norwood Life Society, Inc. and Norwood Crossing Association, Inc. d/b/a Norwood Crossing and award any relief permitted under the law which may include actual damages, punitive damages, attorneys' fees and costs.

COUNT III - RETALIATORY DISCHARGE

191. For paragraph 191, Hinich re-alleges the allegations in paragraphs 1-190.

192. Norwood Crossing terminated Hinich.

193. Based upon the foregoing facts and others, Hinich was terminated in retaliation for reporting and opposing unsafe and unlawful conduct and/or for refusing to work under conditions which contravened government-mandated safety guidance.

194. Hinich's discharge violates a clear mandate of Illinois public policy, including the effective protection of the health and safety of Illinois citizens and in long-term care facilities.

195. Hinich's discharge violates a clear mandate of Illinois public policy as reflected in the Nurse Practice Act and the Nursing Home Care Act.

196. Illinois public policy favors the effective protection of the lives and property of citizens and providing remedies for the termination of an employee who reports and refuses demands to violate the law, or participate in violating the law, by disregarding legally required safety regulations designed to protect the lives of Illinois citizens.

197. Hinich suffered actual damages of a personal and pecuniary nature which are continuing to accrue at this time which cannot be calculated with precision, but, in any event, exceed $100,000.00.

WHEREFORE, plaintiff Andrea Hinich respectfully requests that judgment be entered in her favor and against defendants Norwood Life Society, Inc. and Norwood Crossing Association, Inc. d/b/a Norwood Crossing in an amount in excess of $100,000.00 in actual damages plus punitive damages, attorneys' fees and costs.

PLAINTIFF DEMANDS A TRIAL BY JURY ON ALL CLAIMS

Respectfully submitted,

/s/ Jeffrey R. Kulwin

One of Plaintiff's attorneys

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