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Attorney for Plaintiffs
NOAH BENNETT-DRAYER and
DANIEL BENNETT-DRAYER



IN THE CIRCUIT COURT OF THE THIRD CIRCUIT
HILO DIVISION

STATE OF HAWAI`I

NOAH BENNETT-DRAYER, Individually as Statutory Beneficiary;
DANIEL BENNETT-DRAYER; Individually as Statutory Beneficiary.

Plaintiffs,

vs.

AVALON CARE CENTER – VA HILO, LLC, a foreign for-profit limited liability company;

AVALON OF HAWAII, L.L.C., d/b/a AVALON CARE OF HAWAII, a foreign for-profit limited liability company;

AVALON CARE, LLC, a foreign for-profit limited liability company;

AVALON HOLDING INC., a foreign for-profit corporation;

AVALON HEALTH CARE INC., d/b/a AVALON HEALTH CARE GROUP, a foreign for-profit corporation;

Civil No.
(Other Non-Vehicle Tort; Wrongful Death)

COMPLAINT; DEMAND FOR JURY TRIAL; SUMMONS

TINA IRWIN, Individually.

DOES 1-5; and DOE ENTITIES 1-5; DOE GOVERNMENTAL ENTITIES 1-5,

Defendants.

**COMPLAINT**

COME NOW Plaintiffs NOAH BENNETT-DRAYER and DANIEL BENNETT-DRAYER, individually, and for a COMPLAINT against Defendants AVALON CARE CENTER- VA HILO, LLC; AVALON OF HAWAII, L.L.C., d/b/a AVALON CARE OF HAWAII; AVALON HEALTH CARE INC., d/b/a AVALON HEALTH CARE GROUP; and TINA IRWIN, in her individual capacity, DOES 1-5; DOE ENTITIES 1-5, and DOE GOVERNMENTAL ENTITIES 1-5, allege and aver as follows:

**PARTIES**

1. Plaintiff NOAH BENNETT-DRAYER is the son of deceased veteran, Chris Drayer, and at all times relevant herein, was a resident of Hawai'i County, State of Hawai`i.

2. Plaintiff DANIEL BENNETT-DRAYER is the son of deceased veteran, Chris Drayer, and at all times relevant herein, was a resident of Hawai'i County, State of Hawai'i.

3. Upon information and belief, Defendant AVALON CARE CENTER- VA HILO, LLC ("AVALON 1"), at all relevant times herein, was a foreign, for-profit limited liability company organized under the laws of the State of Utah. Upon information and belief, AVALON 1 was the contract operator of the Yukio Okutsu Veterans Home located in Hilo, Hawai'i.

4. Upon information and belief, Defendant AVALON OF HAWAII L.L.C. d/b/a AVALON CARE OF HAWAII ("AVALON 2") is a Utah for-profit limited liability company and the managing member of AVALON 1. Upon further information and belief, the

MANAGING MEMBER also serves as the managing member for four other care facilities including: Avalon Care Center – Hale Nani, LLC; Avalon Care Center- Honolulu, LLC; Avalon Care Center Kaneohe, LLC; Avalon Care Center – St. Francis LLC.

5. Upon information and belief, AVALON CARE, LLC ("AVALON 3") is a Utah for-profit limited liability company and managing member of AVALON 2.

6. Upon information and belief, AVALON HOLDING INC. is a Utah for-profit corporation and managing member of AVALON 3.

7. Upon information AVALON HEALTH CARE INC., d/b/a AVALON HEALTH CARE GROUP ("AVALON 4") is a Utah for-profit corporation and the parent company of AVALON 1, AVALON 2, and AVALON 3. Upon further information and belief, AVALON 4 and AVALON 3 are governed by largely the same Board of Directors.

8. Upon information and belief, TINA IRWIN is a Hawai'i resident and Regional Vice President for Hawai'i for AVALON 4. Upon further information and belief, DEFENDANT IRWIN is responsible for overseeing Hawai'i's VA facility operations, including but not limited to the operations at AVALON 1.

9. Defendants Doe 1-5, Doe Entities 1-5, and Doe Governmental Entities 1-5 are sued herein under fictitious names for the reason that, despite diligent and good faith efforts to ascertain their names and identities, through the review of applicable records and interviews, their true names and identities are presently unknown to Plaintiffs, except that they are connected in some manner with the named Defendants and/or were agents, servants, employees, employers, representative, co-venturers, associates, vendors, suppliers, manufacturers, subcontractors, contractors, owners, lessees, assignees and/or licensees of the named Defendants and/or were in some manner presently unknown to Plaintiffs engaged in the activities alleged herein and/or

were in some manner responsible for the injuries or damages to Plaintiffs described herein and/or proximately caused injuries or damages to Plaintiffs and Plaintiffs prays for leave to insert herein their true names, identities, capacities, activities and/or responsibilities when the same are ascertained.

## JURISDICTION AND VENUE

10. The Court has jurisdiction over this matter under Hawai'i Revised Statutes ("HRS") § 603-21.5.

11. Venue is proper under HRS § 603-36 because Defendants reside, conduct business in, and/or are domiciled in the County of Hawai'i, State of Hawai'i and the acts giving rise to the cause(s) of action set forth herein occurred in Hilo, Hawai'i.

12. Plaintiffs have complied with the requirements of HRS Chapter 663.

## FACTS

13. This lawsuit concerns the wrongful death of 70-year-old Volcano, Hawai'i veteran resident Chris Drayer on September 2, 2020 at the Yukio Okutsu Veterans Home ("Yukio") in Hilo, Hawai'i.

14. Mr. Drayer is a decorated honorably discharged veteran of the United States Army. He served two tours in Vietnam and was awarded numerous medals and commendations for his heroic service, including: (1) the Bronze Star; (2) the National Defense Service Medal; (3) Vietnam Service Medal; (4) Vietnam Campaign Medal; and (5) Army Commendation Medal as well as Meritorious Unit Citations.

15. As of the date of this lawsuit, there have been 26 COVID-19 deaths at this 95-bed, 87-resident, in-patient VA rehabilitation facility.[1] The COVID-19 infection rate for residents at Yukio currently stands at nearly 80%.[2]

16. Upon information and belief, Avalon administered a COVID-19 test to Mr. Drayer on August 28, 2020. He tested positive. However, the results of the August 28th COVID-19 test were not communicated to Plaintiff Noah Bennett-Drayer until August 31, 2020. Mr. Drayer passed away on September 2, 2020, due to the COVID-19 infection he contracted at Yukio.

17. Mr. Drayer's family had been planning on bringing him home from Yukio on the week of his passing. Plaintiff Noah Bennett-Drayer had installed an access ramp, handrails and various other modifications to his home in preparation of his father's return home.

18. On or about September 12, 2020, the Veteran's Affairs (VA) issued its findings from an emergency investigation into Avalon's COVID-19 practices, policies and procedures.[3] The findings of the VA investigation include, but are not limited to the following:

- There was very little evidence of proactive preparation/planning for COVID. Many practices observed seemed as if they were a result of recent changes. Even though these are improvements, these are things that should have been in place from the pandemic onset and a major contributing factor towards the rapid spread. A basic understanding of

[1] KOHN2 Web Staff, *Avalon Health Care replaced as managing company of Yukio State Veterans Home,* Sept. 25, 2020, https://www.khon2.com/coronavirus/avalon-health-care-replaced-as-managing-company-of-yukio-okutsu-state-veterans-home/.
[2] *Id.*
[3] *Yukio Okutsu State Veterans Home Onsite Assessment Team Briefing*, Department of Veteran Affairs, Sept. 2020.

segregation and workflow seemed to be lacking even approximately three weeks after first positive case.

- Hand sanitizers not readily accessible in all areas throughout.
- Disinfecting high touch surfaces—unable to define exact surfaces expected, unable to verify completion, no visual cues that cleaned every 2 hours as verbalized.
- Paper copies of information attached to high touch items making impossible to clean correctly (resident room doors, time clocks, walls).
- Scrubs currently worn home after working an entire shift.
- Isolation gowns are plastic and do not fit over face shields.
- Gowns donned upon entrance to unit and worn until staff have a break. (Example, one gown worn for all resident care and then continued in same gown while working at nurse's station.)
- Staff crossing from wing to wing wearing the same PPE (except gloves).
- Signage on bedroom doors not clear, not consistent with practice or no sign designating isolation status.
- Cloth chairs in the hallways of PUI or positive areas (unable to properly clean).
- Resident room curtains—DON unable to articulate how often or if process for cleaning.
- Refreshment cart with juice and coffee in large containers. CNA pours, enters rooms, coming back out and prepares for next room. Creates possible cross-contamination.

- Corrugated boxes on floor and sink in medication room. Large stacks of paper on shelf in medication room.
- Staff not consistently caring for residents only on one hall. Floating among two or more halls.
- Residents not cohorted based on COVID status.
- Some residents wandering throughout unit/floor into other hallways.
- Residents wearing masks outside of bedrooms not consistent.
- Fire doors were closed between the main nursing station and the halls of the unit, but resident bedroom doors were open.
- Fit test kit was available for N95 respirator fit testing. N95 respirators were available in various models but sizes were limited. Select staff were trained in July 2020 by National Guard Medical Task Force to conduct fit tests. Most of the records reviewed for staff respirator program were dated in May and June of 2020. Medical clearance documents were not reviewed.
- Powered Air Purifying Respirator (PAPRs) are not used and have not been requested.
- Ultraviolet sanitation boxes for handheld items not available in the facility.
- HVAC system (Petra system) contains two main Air Handling Units (AHU). One AHU services each floor. Individual rooms on each floor would “share” some of the recirculated air by design. Each dual occupancy room has two supply ducts and one exhaust/return air vent.

Each single occupancy room has one supply duct and one exhaust/return air vent.

- Random air flow readings were taken. At the time of readings, the resident rooms were positive pressure in relation to the adjoining hallway.
- There were no anterooms, negative pressure rooms or isolations rooms present (as designed nor temporary/make-shift).
- The AHU filter minimum efficiency reporting value (MERV) ratings could not be visually confirmed and no maintenance personnel was present. Two new filters XTREME +Plus 24x24x24x2 Self Supported Pleated Filters were seen, however, no marking of actual MERV rating was discovered. SVH Administrator provided information stating that the filters were MERV 8. That brand of filters in that size comes in MERV 6, 8, 11, and 13.
- Administrator not aware of specific housekeeping procedures (especially for terminal cleaning).
- Administrator stated there were no current processes in place to limit housekeeping staff or maintenance personnel from intermixing from the COVID unit to other units.
- Social Worker expressed exhaustion with working extended hours and covering for maintenance, feeding, and other duties due to shortage of staff. Stated the shortage was not only due to staff being out due to being positive, but also due to staff "quitting." The leadership did not appear to share the same feeling of staff shortage or need for additional staffing.

19. On or about September 11, 2020, the Hawai'i Emergency Management Agency ("HIEMA") issued its findings resulting from an investigation into Avalon's COVID-19 practices, policies and procedures.[4] The findings of the HIEMA investigation include, but may not be limited to the following:

- Biggest concern is why are staff still turning positive with each mass testing?
- Question lack of transparency with community [skilled nursing facilities] as to COVID+ patients and staff in the past as dialysis appears to be one of the origins of COVID outbreak.
- Staff with known COVID contacts, gathering in break room without masks.
- The time clock is a high touch item. No signs warning staff nor is there a hand washing station or alcohol dispenser in the area.
- Central nursing station with resident rooms in hallways designed like spokes on a wheel make it difficult for nursing staff to maintain distance and separate clean from dirty work stations on the second floor where one wing is a [Patient Under Investigation ("PUI")] unit and other units are clean units.
- Separate PUI unit not created on 8/25 when first cluster of 7 positive cases were identified on Ohana 1 [hall]. Creation of a PUI unit or cohorting PUI patients, may have helped to stop the spread.

[4] K. Albert Yazawa, MD, CMD, *RE: Yukio Okutsu State Veterans Home (YOSVH) Hilo, Hawaii,* HI EMA ESF 8 Report, Sept. 11, 2020.

- Probably closing doors on COVID+ and PUI rooms should be considered or creation of some sort of physical barrier like a plastic curtain to help maintain droplet precautions.
- Staff at [Yukio] are doing all their own testing of staff and patients.
- Staff ratio for COVID unit same as other units, but probably deserve a higher ratio of staff due to complexity of working in a COVID unit.
- More than one demented known wandering residents remained wandering on Ohana 1, lived next to HD patients and probably also facilitated spread in Ohana 1.
- Several wanderers existed on Ohana 1. No use of physical barriers or dementia designed stop signs to discourage wandering.
- Several patients still use nebulizers, including one who uses both nebulizers and inhalers, although no evidence of spread via these residents. Nebulizer use should not be an option.
- Some furniture being used is of a fabric that is not easy to clean.

20. On September 12, 2020, Hawai'i County Mayor Harry Kim held a news conference where he asked that Avalon be suspended as the manager of the Okustu facility. Then, on September 21, 2020, Mayor Kim demanded that Governor David Ige remove Avalon from the veterans' home and issued the following statement regarding Avalon's failure to protect Yukio residents:

"I have no confidence and trust in Avalon…In only a short period of time, approximately a one (1) month period, twenty-four (24) veterans from the Yukio Okutsu

State Veterans Home died with positive test results from COVID-19. This is tragic, and unacceptable."[5]

21. On September 20, 2020, United States Senator Brian Schatz issued the following statement regarding the findings of the VA/HIEMA investigations:

> "This report makes clear that Avalon did not take the steps necessary to protect its residents and staff. We have known all along that nursing homes and their residents were particularly vulnerable to COVID-19, so it is infuriating to see that basic infection control practices were not in place months after the pandemic began. Avalon must take immediate action to address the recommendations of this report to ensure the safety of the veterans and staff at the State Veterans Home. My staff and I will continue to closely monitor this outbreak and help provide any additional federal resources that are available."[6]

20. On September 25, 2020, an announcement was made that Avalon would be removed as the contract operator at Yukio.[7]

21. On September 25, 2020, United States Senator Brian Schatz issued the following statement in response to the removal of Avalon: "The recent reports have shown that Avalon is ill-equipped to operate the veterans' home and contain this outbreak. Avalon has also been unwilling to take responsibility for their mismanagement, so this was the right decision."[8]

22. On September 26, 2020, United States House Representative Tulsi Gabbard issued the following statement on the findings of the VA/HIEMA investigations:

> "These veterans and their families sacrificed for our nation and deserved the honor and care that Avalon failed to provide. I joined Mayor Harry Kim in his demand for this change and we will continue to work with the VA and all agencies involved to ensure

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[5] Kevin Dayton, *Mayor Kim Demands Ige Remove Avalon From Okutsu Veterans Home*, Honolulu Civil Beat, Sept. 22, 2020, https://www.civilbeat.org/beat/mayor-kim-demands-ige-remove-avalon-from-okutsu-veterans-home/.
[6] Sen. Brian Schatz, *Schatz Statement on VA Review of COVID-19 Outbreak at Yukio Okutsu State Veterans Home in Hilo,* Sept. 20, 2020, https://www.schatz.senate.gov/press-releases/schatz-statement-on-va-review-of-covid-19-outbreak-at-yukio-okutsu-state-veterans-home-in-hilo.
[7] KHON2 Web Staff, *supra* note 1.
[8] Kevin Dayton, *Avalon Health Care Will No Longer Manage Hawaii Veterans Home,* Honolulu Civil Beat, Sept. 25, 2020, https://www.civilbeat.org/2020/09/avalon-health-care-will-no-longer-manage-hawaii-veterans-home/.

necessary action is taken to improve the conditions at the veterans home, contain the spread of the virus, and get our veterans the treatment they need."[9]

23. On September 26, 2020, 24 days after Mr. Drayer's death, Avalon sent an email to Plaintiff Noah Bennett-Drayer stating as follows: "Hi Noah, I am so very sorry about your dad. If you could please call @ 808-961-1500. Regarding his Medicaid application. Sincerely, Alofa Ching, Private Biller."

**COUNT I**
(Wrongful Death – HRS 663-3 against all Defendants)

24. Plaintiffs re-allege and reincorporate by reference the paragraphs above as if the same were set forth in their entirety and further alleges as follows:

25. At all relevant times herein, Defendants owed a duty of care to the decedent Chris Drayer and Plaintiffs.

26. Defendants breached their duty of care owed to Chris Drayer and Plaintiffs that resulted in the wrongful death of Mr. Drayer.

27. As a direct and proximate result of these breaches, Plaintiffs have suffered pecuniary injury and loss of society, companionship, comfort and/or protection, in an amount to be proven at trial.

**WHEREFORE**, Plaintiffs pray for relief as follows:

A. Judgment in favor of Plaintiffs and against Defendants, as set forth above;

B. Special damages in an amount to be proven at trial;

C. General damages in an amount to be proven at trial;

[9] Rep. Tulsi Gabbard, *Rep. Tulsi Gabbard's Statement on the Management Change at the Yukio Okutsu State Veterans Home,* Sept. 26, 2020, https://gabbard.house.gov/news/press-releases/rep-tulsi-gabbard-s-statement-management-change-yukio-okutsu-state-veterans-home.

D. Pre-judgment interest;

E. Post judgment interest;

F. Costs of suit;

G. Leave to include a Survival Action under HRS 663-7 on behalf of Mr. Drayer's Estate that shall be created upon issuance of the death certificate and establishment of Mr. Drayer's estate; and,

H. Such other relief as this Court deem proper and just.

**JURY DEMAND**

Plaintiffs respectfully pray for a trial by jury of all claims.

DATED: Kailua-Kona, Hawai`i, September 30, 2020.

/s/Jeffrey E. Foster

JEFFREY E. FOSTER
Attorney for Plaintiffs
NOAH BENNETT-DRAYER and
DANIEL BENNETT-DRAYER

| STATE OF HAWAI'I<br>CIRCUIT COURT OF THE<br>THIRD CIRCUIT | **SUMMONS**<br>TO ANSWER CIVIL COMPLAINT | CASE NUMBER |
|---|---|---|

| PLAINTIFF | VS. | DEFENDANT(S) |
|---|---|---|
| NOAH BENNETT-DRAYER, Individually as Statutory Beneficiary; DANIEL BENNETT-DRAYER; Individually as Statutory Beneficiary. | | AVALON CARE CENTER – VA HILO, LLC, a foreign for-profit limited liability company; AVALON OF HAWAII, L.L.C., d/b/a AVALON CARE OF HAWAII, a foreign for-profit limited liability company; AVALON CARE, LLC, a foreign for-profit limited liability company; AVALON HOLDING INC., a foreign for-profit corporation; AVALON HEALTH CARE INC., d/b/a AVALON HEALTH CARE GROUP, a foreign for-profit corporation; TINA IRWIN, Individually. DOES 1-5; and DOE ENTITIES 1-5; DOE GOVERNMENTAL ENTITIES 1-5. |

PLAINTIFF'S NAME & ADDRESS, TEL. NO.

NOAH BENNETT-DRAYER, Individually as Statutory Beneficiary; DANIEL BENNETT-DRAYER; Individually as Statutory Beneficiary.
c/o Jeffrey E. Foster, Esq.
FOSTER LAW OFFICES, LLC
P.O. Box 127
Captain Cook, HI 96704
p. (808) 348-7800

**TO THE ABOVE-NAMED DEFENDANT(S)**

You are hereby summoned and required to file with the court and serve upon

Jeffrey E. Foster, Esq., FOSTER LAW OFFICES, LLC, P.O. Box 127, Captain Cook, HI 96704

_____ ,

plaintiff's attorney, whose address is stated above, an answer to the complaint which is herewith served upon you, within 20 days after service of this summons upon you, exclusive of the date of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.

**THIS SUMMONS SHALL NOT BE PERSONALLY DELIVERED BETWEEN 10:00 P.M. AND 6:00 A.M. ON PREMISES NOT OPEN TO THE GENERAL PUBLIC, UNLESS A JUDGE OF THE ABOVE-ENTITLED COURT PERMITS, IN WRITING ON THIS SUMMONS, PERSONAL DELIVERY DURING THOSE HOURS.**

**A FAILURE TO OBEY THIS SUMMONS MAY RESULT IN AN ENTRY OF DEFAULT AND DEFAULT JUDGMENT AGAINST THE DISOBEYING PERSON OR PARTY.**

The original document is filed in the Judiciary's electronic case management system which is accessible via eCourt Kokua at: http:/www.courts.state.hi.us

**Effective Date of 28-Oct-2019**
**Signed by: /s/ Cheryl Salmo**
**Clerk, 3rd Circuit, State of Hawai'i**

In accordance with the Americans with Disabilities Act, and other applicable state and federal laws, if you require a reasonable accommodation for a disability, please contact the ADA Coordinator at the Circuit Court Administration Office on HAWAII- Phone No. 808-961-7424, TTY 808-961-7422, FAX 808-961-7411, at least ten (10) working days prior to your hearing or appointment date.