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STATE OF MINNESOTA **DISTRICT COURT**

COUNTY OF OLMSTED **THIRD JUDICIAL DISTRICT**

Case No. _____

Benjamin Glubka, Type: Employment

Plaintiffs,

v.

SUMMONS

Cornerstone Management Services, LLC

Defendants.

THIS SUMMONS IS DIRECTED TO EACH ABOVE-LISTED DEFENDANT.

1. **YOU ARE BEING SUED.** The Plaintiffs have started a lawsuit against you. The Plaintiffs' Complaint against you is attached to this Summons. Do not throw these papers away. They are official papers that affect your rights. You must respond to this lawsuit even though it may not yet be filed with the Court and there may be no court file number on this Summons.

2. **YOU MUST REPLY WITHIN 21 DAYS TO PROTECT YOUR RIGHTS.** You must give or mail to the person who signed this summons a **written response**, called an Answer, within 20 days of the date on which you receive this Summons. You must send a copy of your Answer to the person who signed this summons located at:

Joshua Newville
Pamela Johnson
HALUNEN LAW
80 S. 8th St., Suite 1650
Minneapolis, MN 55402

3. **YOU MUST RESPOND TO EACH CLAIM.** The Answer is your written response the Plaintiffs' Complaint. In your Answer you must state whether you agree or disagree with each paragraph of the Complaint. If you believe the

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

Plaintiffs should not be given everything asked for in the Complaint, you must say so in your Answer.

4. **YOU WILL LOSE YOUR CASE IF YOU DO NOT SEND A WRITTEN RESPONSE TO THE COMPLAINT TO THE PERSON WHO SIGNED THIS SUMMONS.** If you do not provide a written Answer in response to this Complaint to the person who signed this Summons within 20 days, you will lose this case. You will not get to tell your side of the story, and the Court may decide against you and award the Plaintiffs everything asked for in the Complaint. If you do not want to contest the claims stated in the Complaint, you do not need to respond. A default judgment can then be entered against you for the relief requested in the Complaint.

5. **LEGAL ASSISTANCE.** You may wish to get legal help from a lawyer. If you do not have one, the Court Administrator may have information about places where you can get legal assistance. **Even if you cannot get legal help, you must still provide a written Answer to protect your rights or you may lose this case.**

6. **ALTERNATIVE DISPUTE RESOLUTION.** The parties may agree or be ordered to participate in an alternative dispute resolution process under Rule 114 of the Minnesota General Rules of Practice. You must still send your written response to the Complaint even if you expect to use alternative means of resolving this dispute.

Dated: May 20, 2024

HALUNEN LAW

/s/ Joshua Newville

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ATTORNEYS FOR PLAINTIFF

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

STATE OF MINNESOTA DISTRICT COURT

COUNTY OF OLMSTED THIRD JUDICIAL DISTRICT

Benjamin Glubka,

Plaintiff,

v.

Cornerstone Management Services LLC

Defendant

Case Type: Employment
Court File No.:_____
Judge:_____

COMPLAINT AND JURY DEMAND

COMES NOW Plaintiff Benjamin Glubka, through counsel, for his Complaint against his former employer Cornerstone Management Services LLC ("Cornerstone"), and states and alleges as follows:

INTRODUCTION

1. This is a whistleblower retaliation case in which Cornerstone, a Minnesota-based senior community living management company, fired Mr. Glubka, the Director of Nursing (DON) of Cornerstone's Lino Lakes facility, because he repeatedly reported and complained about violations of law—including Cornerstone's refusal to report the circumstances of a resident's massive hemorrhage and death.

2. On January 22, 2024, a Lino Lakes resident was found unconscious in a large pool of blood. The resident died at the hospital the following day. At the time, the resident was on a blood thinner and had recently complained of unexplained bleeding.

3. Nonetheless, Cornerstone, under pressure from an insurer and recent allegations of neglect from other residents' families, declined to file a Minnesota Adult Abuse Reporting Center (MAARC) report, as required by Minn. Stat. § 626.557 whenever a vulnerable adult suffers suspected neglect or sustains "a physical injury which is not easily explained."

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

4. Between January 23 and February 12, 2024, Mr. Glubka repeatedly told Cornerstone management that he believed the refusal to report was unlawful.

5. During this same period, Mr. Glubka also reported concerns about Cornerstone's unlawfully dangerous nurse-to-resident ratio as well as dangerous defects in Cornerstone's recordkeeping process, which prevented staff from documenting resident health information.

6. Throughout his employment with Cornerstone, Mr. Glubka was the only Registered Nurse employed at a facility with over 90 residents.

7. As of mid-January 2024, Mr. Glubka had received praise from Cornerstone's Corporate Director of Clinical" for his performance and leadership.

8. On February 13, 2024—after his reports regarding the January 22 resident death and related violations—Cornerstone placed Mr. Glubka on a Performance Improvement Plan (PIP), blaming him for backlogs and other deficiencies which predated his employment and for which upper-management had refused to provide support despite his reports and requests.

9. On March 5, 2024, Cornerstone terminated Mr. Glubka, citing non-specific "performance" issues and "code of conduct" violations as pretextual reasons.

10. Based on the foregoing and as more fully alleged herein, Plaintiff brings this action for unlawful retaliation in violation of the Minnesota Whistleblowers Act (MWA), Minn. Stat. § 181.932; and the Minnesota Vulnerable Adults Act (MVAA), Minn. Stat. § 626.557, subd. 17.

PARTIES

11. Plaintiff Benjamin Glubka is a resident of Rush City, Minnesota.

12. Defendant Cornerstone Management Services, LLC is a Minnesota company with its principal place of business located at 3520 E River Rd NE, Rochester, MN 55906.

JURISDICTION AND VENUE

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

13. Plaintiff invokes the jurisdiction of this Court as the acts giving rise to this Complaint occurred in the State of Minnesota and involve Minnesota law.

14. Venue is appropriate, pursuant to Minn. Stat. § 542.09, as facts giving rise to this Complaint occurred within the borders of Olmsted County, where Cornerstone is headquartered.

FACTS

Background

15. Mr. Glubka has been a Registered Nurse (RN) since 1994, holds a master's degree in nursing administration from the University of Minnesota, and has over two decades of experience in long-term care and assisted living.

16. In late November 2023, Mr. Glubka commenced employment with Cornerstone as the DON of Cornerstone's Lino Lakes facility, a Minnesota-licensed provider of Assisted Living and Memory Care services.

17. Within his first couple of weeks as DON, Mr. Glubka quickly ascertained that Lino Lakes—a facility with over 90 residents, no RNs on staff other than himself, and a history of high staffing turnover—was stretched impossibly thin, with significant need for improvement in multiple areas, including staff training and supervision; general morale; and timely completion of required documentation, such as incident reports, supervisory visits, and resident assessments.

18. To make matters worse, many of Lino Lakes residents were relatively "high acuity," i.e., they needed nursing home-level care but had chosen Assisted Living.

19. Cornerstone, through Regional Director of Operations Hannah Pryor, targeted such higher acuity residents for admission to Lino Lakes, because they qualified for payment through Minnesota's taxpayer funded "Elderly Waiver" program.

20. Nonetheless, Mr. Glubka took on these challenges and hit the ground running.

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

21. Throughout his first few weeks, Mr. Glubka worked feverishly, completing paperwork as quickly as possible while also spending the majority of his time out on the floor, attending to residents and supervising staff.

22. In an effort to curb turnover, Mr. Glubka established a positive rapport with multiple team members and even provided staff incentives out of his own pocket.

23. At the same time, Mr. Glubka implemented an innovative system to track and hold staff accountable when services were not provided, which succeeded in reducing the number of "missing services" from about 1500 to less than 307 in a matter of weeks.

24. In recognition of his efforts, one of Mr. Glubka's superiors, Cornerstone's "Corporate Director of Clinical," Nina Flannery, praised Mr. Glubka and his team, stating on January 4, 2024: "You all make me proud!" and "Thank you for your leadership on this, Ben!"

Mr. Glubka's Initial Protected Activity and Cornerstone's Pattern, Practice, and Corporate Culture of Neglect

25. While Mr. Glubka appreciated the praise, what he really needed from Ms. Flannery and other senior executives was sufficient resources and support—or, at the very least, responses to his emails.

26. Throughout December 2023 and into January 2024, Mr. Glubka reported concerns to Ms. Flannery regarding Lino Lakes' unsustainable staffing levels and 1:93 RN-to-resident ratio. He received no substantive responses, and often no responses at all.

27. On January 5, 2024, for example, Mr. Glubka followed up with Ms. Flannery regarding a January 2, 2024 email to which he had received no reply.

28. In the January 2 email, Mr. Glubka had raised concerns about Cornerstone's Resident Aide (RA) staffing levels, noting the recent increase in "care needs"; highlighting a

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

beyond-capacity "med cart" as an example, stating his desire "to try to get ahead of things" in light of new admissions, and asking if Ms. Flannery could "could carve out a little time" to discuss the current RA staffing model.

29. Mr. Glubka received no reply to his January 2 or 5 emails.

30. On January 8, 2024, Regional Director Hannah Pryor asked Ms. Flannery if she would be willing to help by conducting a training for Lino Lakes staff members, which was legally required for them to be able to help pass out medication.

31. In reply to Ms. Pryor, Ms. Flannery brusquely refused, stating: "Medication delegation is a responsibility for Ben as the community RN."

32. Around the same time, Mr. Glubka discovered serious deficiencies in Cornerstone's recordkeeping policies and practices. Specifically, staff including Resident Aides were not able to access or enter electronic progress notes into residents' medical records.

33. Instead, Cornerstone often relied on after-the-fact documentation.

34. For example, on or about January 19, 2024, after the State of Minnesota requested records related to a resident's fall, Nina Flannery directed Mr. Glubka to "come up with some" notes pre-dating the State investigator's request to "show that we did something."

35. While Mr. Glubka entered an appropriate note of a conversation he had with staff after the fall and focused on a detailed care plan, assessment, and incident report, this was insufficient for Ms. Flannery, who sent Mr. Glubka an email seeming to blame him for the lack of additional notes.

36. Nonetheless, Mr. Glubka refused to fabricate or backdate notes.

37. At one point during Mr. Glubka's employment with Cornerstone, Ms. Pryor's fellow executive, Vice President of Clinical Operations Dawn Rand, announced that Mr. Glubka

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

and other facility directors were prohibited from calling her and even went as far as to change her phone number to make such communication impossible.

38. Thus, while executives like Rand and Flannery demanded immediate attention to their emails and various matters deemed important to corporate, they ignored, minimized, and washed their hands almost completely of concerns raised by on-site providers like Mr. Glubka regarding the quality of the care, services, safety to which the residents were legally entitled.

39. Illustrating this practice and culture of corporate neglect is an April 2023 finding by the Minnesota Department of Health that a Lino Lakes had "neglected" a resident when Cornerstone failed to complete wound monitoring and clinical assessments, and the resident subsequently suffered a life-threatening medical emergency.

40. Similarly, a March 2023 survey by the State of Minnesota found that Cornerstone had failed to develop a required staffing plan based on the individual needs of Lino Lakes' residents, and also failed to provide the required level of nursing coverage.

41. According to the state, these violations had the potential to affect the health and safety of each of the more than 90 Lino Lakes residents.

42. In addition to these staffing violations, the March 2023 survey found that Cornerstone had failed to report an incident in which a resident was found lying naked in bed with blood all over them, which led to the resident being sent to the ER and examined for sexual assault.

43. When interviewed by State investigators, Mr. Glubka's predecessor, the former Lino Lakes DON, said she was "not sure" why the incident had not been reported.

44. Ultimately, the state issued Lino Lakes a "Level 3" violation for Cornerstone's "failure to develop to implement an individual abuse prevention plan (IAPP) for each vulnerable adult" as required by law.

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

45. As a result of these and/or other findings, the Minnesota Department of Health temporarily restricted Cornerstone's ability to accept new admissions at Lino Lakes.

46. This restriction was in place when Mr. Glubka commenced employment with Cornerstone, and it was explained to him by Renae Witschen, Cornerstone's "Corporate Director of Compliance."

47. As soon as the restriction was lifted or expired, Cornerstone immediately began pressuring Lino Lakes to admit new residents, despite having taken no meaningful steps to address the deficiencies that caused the need for the restriction in the first place.

48. Mr. Glubka vocally resisted this pressure on multiple occasions, but his clinical judgment regarding the appropriateness of proposed new admissions was overridden by corporate executives, including Vice President of Clinical Operations Dawn Rand.

49. Indeed, Dawn Rand overrode Mr. Glubka with respect to a resident who required colostomy bag services and another who required chemotherapy treatment—services which Cornerstone was not properly equipped to provide, and which Cornerstone had thus omitted from the Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) form it had prepared and submitted to the State of Minnesota as required by Minn. Stat. § 144G.40 Subd. 2.

The January 22, 2024 Resident Death

50. On January 21, 2024, one of Cornerstone's residents called for assistance because they had bled through their undergarments.

51. Despite the resident having a documented recent history of similar bleeding, Cornerstone's "triage" nurse—a remote provider contracted by Cornerstone as a cheaper alternative to hiring its own nurses—suggested that the Lino Lakes staff merely monitor the resident's blood pressure, with no further direction. Mr. Glubka was off that day and was not

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

consulted about the situation.

52. The following morning, January 22, the resident was found unresponsive in a massive pool of blood.

53. Shortly thereafter, Mr. Glubka found that there was no record of the resident's pulse or blood pressure having been taken since the call to the triage nurse.

54. The resident was then transferred to the ER and hospital and died the next day, having reportedly lost nearly 2/3 of their blood.

55. The resident's room was unlike anything Mr. Glubka had seen in his career: the bed, floor, and chair were so thickly coated in congealed blood that the Lino Lakes housekeeping staff did not know how to clean it up, ultimately resorting to using dustpans as shovels.

56. Mr. Glubka reported all he knew about the incident to Lino Lakes Executive Director Jake Chernugal, who investigated the incident at the direction of Cornerstone executives.

Mr. Glubka Reports His Concern About the Death and Corresponding Failure to Report

57. Over the course of the two weeks following the resident's death, Mr. Glubka reported and explained to multiple Cornerstone managers that he believed Cornerstone was in violation of state law by declining to report the death and circumstances thereof to the State of Minnesota, i.e. to file a MAARC report.

58. For example, on January 26, 2024, Mr. Glubka spoke with Lino Lakes' Executive Director Jake Chernugal, who told Mr. Glubka that Cornerstone would not be filing a MAARC report.

59. Incredulous, Mr. Glubka explained why he believed the incident needed to be reported, but Mr. Chernugal reiterated that Cornerstone's position was that "***there really isn't anything to report***" and that a report is only necessary "***if they die on premises."***

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

60. Pressed by Mr. Glubka, who expressed concern that it sounded like Cornerstone was "**trying to cover it up**," Mr. Chernugal conceded that Cornerstone's practice of not enabling all staff to enter contemporaneous progress notes had resulted in the incident being improperly documented.

61. Following his discussion with Chernugal, Mr. Glubka, based on his knowledge of the applicable regulations and the circumstances that led to the resident's death, became increasingly concerned that Cornerstone's refusal to report the death was blatantly unlawful.

62. Around that time, Mr. Cherngual admitted to Mr. Glubka that Cornerstone was facing multiple allegations of resident neglect and abuse as well as difficult negotiations involving an insurance provider's desire to raise Cornerstone's premiums.

63. On January 31, Mr. Glubka spoke again with Mr. Chernugal regarding Mr. Glubka's belief that Cornerstone was required to MAARC report.

64. Mr. Glubka's reports fell on deaf ears, as Cornerstone made no changes and filed no MAARC report related to the resident's death.

65. Indeed, Ms. Pryor had asserted that the question of whether to report events like the January incident fell into a "gray area."

66. Ms. Pryor's assertion was knowingly false. She fully understood that, as a mandatory reporter, Cornerstone was required to report the January 22 incident given the circumstances, but she was attempting to dissuade Mr. Glubka from continuing to raise concerns.

The Retaliatory Performance Improvement Plan & Administrative Leave

67. On February 12, 2024, Mr. Chernugal and Ms. Pryor informed Mr. Glubka that Cornerstone was placing him on a "Performance Improvement Plan" (PIP).

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

68. During this conversation, Mr. Glubka was told that the PIP concerned the backlog of incident reports, patient assessments, and supervisory visits—the very same issues which preexisted Mr. Glubka's hiring and which he had been reporting, working towards fixing, and seeking assistance for since December.

69. Although Ms. Pryor said he would be issued the PIP that day, the day ended without Mr. Glubka receiving the PIP.

70. Thus, in an email sent later in the day, Mr. Glubka requested a copy of the PIP and defended himself against the performance allegations, reminding Chernugal that a ratio of 1 RN to 93 patients was not sustainable and noting how his documented reports and requests for assistance from the corporate office had gone unanswered.

71. In the same February 12 email, Mr. Glubka reported that he believed he was being retaliated against with the PIP because he reported concerns regarding the circumstances of the January resident death and the decision not to file a MAARC report.

72. Finally, Mr. Glubka sent a second, follow-up email, also on February 12, with Cornerstone's COO and CEO copied, reiterating his retaliation concerns and further reporting that he had spoken with local law enforcement officers who had agreed with him that the circumstances of the January death were suspicious and should be reported.

73. On February 13, 2024, Cornerstone issued Mr. Glubka a written PIP, which Mr. Glubka signed.

74. The duration of the PIP was 60 days, with periodic progress reviews to be conducted and documented every 15 days.

75. Cornerstone never provided Mr. Glubka with any periodic PIP progress reviews.

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

76. After reporting his concern that the PIP was retaliatory, over the course of the next two weeks Mr. Glubka nonetheless continued to work hard, fulfilling his responsibilities as DON and working towards completion of the PIP.

77. Shortly after being placed on the PIP, Mr. Glubka noticed that a note had been entered by a staff member into the pre-January 22, 2024 progress notes regarding the deceased resident. Mr. Glubka was surprised by this because the note was entered several weeks *after* the date of the note, and that the new note seemed to contradict the prior, contemporaneous notes with respect to the resident's recent history of bleeding by including the observation of "no blood."

78. When Mr. Glubka asked the staff member about the note, the staff member exclaimed and confessed "***Oh my God, Dawn [Rand] made me do it***."

79. A few days later, Cornerstone fired the staff member, allegedly for improper handling of medication.

80. On February 21, Mr. Glubka learned that his aunt, who raised him as his mother and was sick in the hospital, was being taken off life support. When Mr. Glubka asked Ms. Flannery if he she could provide or find coverage for the last part of his shift, she refused.

81. When Mr. Glubka explained his situation to Ms. Rand later in the afternoon of February 21 and expressed his disappointment and surprise at Ms. Flannery's response, Ms. Rand replied, "It is not policy that Corporate employees cover call for front line staff" and "maybe we need to discuss your position."

82. However, a week later, on February 27, Ms. Rand went out of her way to offer to Mr. Glubka that he take the rest of the day, and the entire following day, off to "take some much-needed time" for himself and that she appreciated all the hard work he was doing for Lino Lakes during such a difficult time.

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

83. In truth, Ms. Rand just wanted Mr. Glubka out of the facility.

84. On February 28, 2024, Mr. Chernugal called Mr. Glubka and informed him that he was being placed on administrative leave pending an investigation of an unspecified "complaint."

85. During the call, Mr. Chernugal said Cornerstone was "just starting the investigative process."

86. On February 29, 2024, in response to an inquiry from Mr. Glubka, Cornerstone's HR Representative informed Mr. Glubka that he would not be allowed to have legal representation at an investigative meeting scheduled for March 1.

Mr. Glubka's Termination

87. Later on February 29, Mr. Glubka received a call from Cornerstone's CEO, Mark Dickson.

88. During the call, Mr. Glubka reported the staff member's allegation that Dawn Rand had directed them to falsify medical documentation related to the January death and implored Mr. Dickson to "just listen."

89. In reply, Mr. Dickson cut off Mr. Glubka, told him "no"; said that he did not want to have a "dispute" with Mr. Glubka; and said, "I just called because I like you."

90. Mr. Dickson then immediately referenced Mr. Glubka's concerns about the January 22 incident and Mr. Glubka's related February 12 email, telling Mr. Glubka that "sometimes we get ahead of ourselves" and "think something is something that it isn't."

91. During the call, Mr. Dickson told Mr. Glubka to "trust the process" and not to "jump to conclusions."

92. During the call, Mr. Dickson told Mr. Glubka "you're not being terminated."

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

93. During the call, Mr. Dickson said that Mr. Glubka was free to bring a lawyer to the March 1 meeting but also told him it would be like bringing a "steak knife to a hamburger" and that he did not think there was a need to "bring an attorney to have an HR discussion."

94. On March 5, 2024, Cornerstone's COO, Ryan Ravallette, informed Mr. Glubka that Cornerstone was terminating Mr. Glubka's employment effective immediately and offered him a "severance agreement" of 2 weeks of pay in exchange for Mr. Glubka signing a release of his right to bring legal claims against Cornerstone and a non-disclosure provision.

95. Mr. Glubka declined to sign the severance agreement.

96. During the meeting, Mr. Ravallette told Mr. Glubka that he was being terminated based on Cornerstone's "Code of Conduct" and "general assessments" of Mr. Glubka's "ultimate performance."

97. During the meeting, Mr. Glubka twice asked the HR Director present, Kaspar Cochran, which part of the Code of Conduct Cornerstone he was found to have violated.

98. Neither Ms. Conchran nor anyone else present during the meeting ever told Mr. Glubka which part of the Code of Conduct he was found to have violated.

99. Ms. Cochran, in response to Mr. Glubka's request for specification of the policy violation at issue, stated that she would provide a response to Mr. Glubka in writing.

100. During the meeting, when Mr. Glubka continued to ask which allegations against him were found to be violations, Ms. Cochran said that in fact "performance reasons" were the ultimate reason for this decision but did not give any examples.

101. As of March 5, Mr. Glubka was only 21 days into his 60-day PIP.

102. Toward the end of the meeting, Mr. Glubka expressed his belief that his PIP and termination were retaliation for the concerns he had raised regarding the circumstances of the

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

January 22, 2024 resident death and Cornerstone's decision not to file a MAARC report, which Mr. Glubka described as involving gross negligence as well as potential criminal conduct.

103. After the March 5 meeting, Cornerstone prepared and sent Mr. Glubka a termination letter stating that the reason for his termination was "job performance" and "multiple confirmed allegations of harassment and other behaviors that violated the company's code of conduct policy."

104. The termination letter did not provide any other information regarding the purported performance deficiencies or harassment allegations.

105. Prior to January 22, Mr. Glubka had not received any disciplinary action or any negative performance reviews.

106. Shortly after his termination, Mr. Glubka filed a MAARC report on his own regarding the January 22 incident.

CAUSES OF ACTION

COUNT I

RETALIATION
IN VIOLATION OF THE MWA

107. Plaintiff repeats and realleges each allegation made in Paragraphs 1-106 above.

108. The Minnesota Whistleblower Act (MWA) prohibits employers from engaging in retaliation against employees for making good-faith reports of violations of law. In particular:

> An employer shall not discharge, discipline, threaten, otherwise discriminate against, or penalize an employee regarding the employee's compensation, terms, conditions, locations, or privileges of employment because: The employee … in good faith, reports a violation or suspected violation, or planned violation to any federal or state law or common law or rule adopted pursuant to law to an employer or to any governmental body or law enforcement official. …

Minn. Stat. § 181.932, subd. 1.

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

109. The MWA applies to good-faith safety reports of violations or suspected violations of the laws, regulations, and standards of care governing operation of Assisted Living facilities, including the safety and rights of, and services owed to, the residents of such facilities, including but not limited to the reporting requirements of Minn. Stat. § 626.557.

110. The MWA defines "report" as "a verbal, written, or electronic communication by an employer about an actual, suspected, or planned violation of a statute, regulation, or common law, whether committed by an employer or a third party." Minn. Stat. § 181.932, subd. 6

111. As detailed above, Plaintiff engaged in MWA-protected activity when he reported dangerously low staffing levels, including a 1:93 nurse-to-resident ratio; defective recordkeeping processes; suspicious circumstances and neglect regarding a January 22 incident in which a resident was found in a pool of blood; unlawful failure to report the January 22 incident to state regulators; falsification of medical records; and retaliation.

112. Plaintiff's reports were made in good faith, that is, Plaintiff's reports were neither knowingly false nor made in reckless disregard for the truth.

113. Defendant Cornerstone, through its agents, retaliated against Plaintiff because of his MWA-protected activity by placing him on a PIP, subjecting him to a sham harassment investigation; and terminating his employment.

114. The unlawful employment practices complained above were engaged in by Defendant with malice and/or reckless indifference for Plaintiff's rights, as well as the rights and safety of the facility's residents.

115. As a direct and proximate result of Defendant's illegal conduct, Plaintiff has suffered, and continues to suffer, emotional distress, humiliation, embarrassment, pain and

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

suffering, loss of reputation, loss of enjoyment of life, lost wages, and benefits, and has incurred attorneys' fees and expenses and other damages.

COUNT II

RETALIATION IN VIOLATION OF THE MVAA

116. Plaintiff repeats and re-alleges each allegation made in Paragraphs 1-115.

117. The Minnesota Vulnerable Adults Act (MVAA) prohibits assisted living facility operators from retaliating against any person, including any employee, who makes a good faith report that a vulnerable adult "has sustained a physical injury which is not reasonable explained" or who reports potential maltreatment. Minn. Stat. § 626.557, subds. 3, 4, 4a, and 17.

118. A "vulnerable adult" includes any resident of a licensed Assisted Living facility as well as any person who "possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction." Minn. Stat. § 626.5572, subd. 21.

119. "Maltreatment" includes potential "neglect," which is defined to include, inter alia, (1) the failure to provide the amount of monitoring or supervision "reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety" as well as (2) an "error" by facility staff that results in injury or harm that is not "immediately reported." Minn. Stat. § 626.5572, subds. 15, 17(b),(d)(5).

120. The Lino Lakes resident who was discovered unconscious and bleeding in her room on January 22, 2024 was a vulnerable adult under the MVAA, and Mr. Glubka's multiple internal reports regarding resident's unexplained injury, and the potential neglect that caused it, constitute protected reports under the MVAA.

121. Defendant, through its managers and officials acting on its behalf and within the scope of their employments, subjected Mr. Glubka to retaliatory adverse actions prohibited under

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

the MVAA when they issued him a PIP, subjected him to sham investigation, and terminated his employment.

122. Because each of the Defendant's retaliatory adverse actions against Mr. Glubka occurred within 90 days of one or more of his protected reports, the adverse actions are presumed to be retaliatory under the MVAA. Minn. Stat. § 626.557, subd. 17(c).

123. Defendant engaged in unlawful, retaliatory employment practices with malice and/or reckless indifference to the MVAA's protection of Plaintiff and the residents of Lino Lake.

124. As a direct and proximate result of Defendant's illegal conduct described above, Plaintiff has suffered, and continues to suffer, emotional distress, humiliation, embarrassment, pain and suffering, loss of reputation, loss of enjoyment of life, lost wages and benefits, and has incurred attorneys' fees and expenses and other damages.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully prays for judgment against Defendant for the following relief:

A. That the practices of Defendant complained of herein be adjudged, decreed, and declared to be violations of the rights secured to Plaintiff;

B. That Plaintiff be awarded front and back pay and the monetary value of any employment benefits to which he would have been entitled in his position with Defendant but for Defendant's conduct;

D. That Plaintiff be awarded compensatory damages, including damages for lost past and future income and benefits, emotional distress, damage to reputation, punitive damages, and all other damages arising from or related to Defendant's conduct in an amount to be established at trial;

Filed in District Court
State of Minnesota
5/23/2024 3:49 PM

E. That the Court award Plaintiff pre- and post-judgment interest in accordance with Minnesota law.

F. That the Court award Plaintiff his reasonable attorneys' fees, costs, and disbursements pursuant to state law; and

G. That the Court grant such other and further relief as it deems fair and equitable.

Plaintiff demands a trial by jury on all counts.

Dated: May 20, 2024

HALUNEN LAW

/s/ Pamela Johnson

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