Direct Dial: 804.420.6932
wpace@williamsmullen.com

December 21, 2016

BY EMAIL & HAND DELIVERY

Michael E. Harman, Esquire
Harman, Claytor, Corrigan & Wellman
4951 Lake Brook Drive, Suite 100
Glen Allen, VA 23060

Re: Jacqueline Carney, as Executrix of the Estate of Diane Franklin, deceased v. Osprey/Pantops Place, LLC, etc., et al.
McCammon Group Case No. 2106000286

Dear Mr. Harman:

Please find enclosed Defendants' Motion for Summary Judgment and Memorandum in Support of same in the above case.

Thank you for your attention to this matter and please contact me with any questions.

Very truly yours,

W. Benjamin Pace

WBP/smm

Enclosures

cc: Charles A. Gavin, Esquire (w/encls.) (by e-mail and first class mail)

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ARBITRATION PURSUANT TO AGREEMENT OF PARTIES

JACQUELINE CARNEY, as executrix of the estate of Diane Franklin, deceased, Plaintiff, v. OSPREY/PANTOPS PLACE, LLC, T/A COMMONWEALTH SENIOR LIVING AT CHARLOTTESVILLE, et al., Defendants.	)	McCammon Group Case No. 2016000286 Michael E. Harman, Esquire, Arbitrator

MOTION FOR SUMMARY JUDGMENT

Defendants, Osprey/Pantops Place, LLC, t/a Commonwealth Senior Living at Charlottesville and Commonwealth Assisted Living, LLC (collectively, "Defendants"), by counsel and pursuant to Rule 56 of the Federal Rules of Civil Procedure, move the Arbitrator for entry of an Order dismissing Count III (Punitive Damages) of Plaintiff's Complaint on the grounds that there is no genuine dispute as to any material fact and Defendants are entitled to judgment as a matter of law as to Count III. The further grounds and bases for this Motion are set forth in the accompanying Memorandum in Support of Defendants' Motion for Summary Judgment filed contemporaneously herewith.

WHEREFORE, Defendants respectfully request that the Arbitrator grant their Motion and Dismiss Count III of Plaintiff's Complaint with prejudice.

OSPREY/PANTOPS PLACE, LLC, T/A
COMMONWEALTH SENIOR LIVING AT
CHARLOTTESVILLE and
COMMONWEALTH ASSISTED LIVING, LLC

By: _____
Of Counsel

W. Benjamin Pace (VSB No. 48633)
Erica Mitchell (VSB No. 89420)
WILLIAMS MULLEN
200 South 10th Street, Suite 1600 (23219)
Post Office Box 1320
Richmond, Virginia 23218-1320
Tel: 804.420.6932
Fax: 804.420.6507
wpace@williamsmullen.com
Counsel for Defendants

CERTIFICATE

I certify that on this 21st day of December, 2016, a copy of the foregoing was sent by email and first-class mail, postage prepaid to:

Charles A. Gavin, Esquire
Cawthorn, Desekvich & Gavin, P.C.
1409 Eastridge Road
Richmond, Virginia 23229
Counsel for Plaintiff

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ARBITRATION PURSUANT TO AGREEMENT OF PARTIES

JACQUELINE CARNEY, as executrix of the estate of Diane Franklin, deceased,	)	
Plaintiff,	)	
v.	)	McCammon Group Case No. 2016000286 Michael E. Harman, Esquire, Arbitrator
OSPREY/PANTOPS PLACE, LLC, T/A COMMONWEALTH SENIOR LIVING AT CHARLOTTESVILLE, et al.,	)	
Defendants.	)	

MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Defendants, Osprey/Pantops Place, LLC, t/a Commonwealth Senior Living at Charlottesville ("CSL") and Commonwealth Assisted Living, LLC ("CAL") (collectively referred to as "Defendants" or "Commonwealth"), by counsel, and pursuant to Fed. R. Civ. P. 56, state as follows for their Memorandum in Support of Defendants' Motion for Summary Judgment:

I. Introduction

Commonwealth has admitted that its Daily Check-in procedure failed Ms. Franklin in this case, despite Commonwealth's good faith efforts to provide an additional layer of security for its independent living residents. Commonwealth does not dispute that it agreed to check on Ms. Franklin to confirm her well-being on a daily basis. Indeed, Commonwealth has accepted liability for its employees' failure to confirm Ms. Franklin's status from December 10-13, 2015 when she required assistance due to a broken clavicle. Commonwealth, however, did not intentionally fail to do so, and the evidence adduced through discovery in this case has established that Commonwealth did not act with a conscious disregard for Ms. Franklin's safety.

Rather, the undisputed facts of this case establish that while Commonwealth's staff committed acts of simple negligence amounting to inattention and inadvertence, the Defendants certainly did not act with a purpose or design to cause Ms. Franklin injury. As such, Commonwealth's conduct does not rise to the level of the "most egregious conduct" that would subject it to punitive damages under Virginia law.

Although not legally required to do so, Commonwealth implemented the Daily Check-in procedure to provide an additional safety measure for its independent living residents. While the facts of this case reflect Commonwealth's failure to execute its procedure appropriately during Ms. Franklin's incident, Commonwealth cannot be said to have acted with reckless indifference to Ms. Franklin's rights with knowledge that its conduct was likely to cause her injury. In seeking punitive damages, Plaintiff confuses the severity of this unfortunate incident's consequences to Ms. Franklin with Commonwealth's conduct related to the incident.

Accordingly, Plaintiff's claim for punitive damages (Count III) must be dismissed because she has failed to show that Defendants' conduct was willful and wanton. In sum, the undisputed facts of this case establish that Commonwealth's actions were not intentional; thus, Plaintiff's claims seeking exemplary damages for intentional conduct must be dismissed.

II. Summary Judgment Standard

Pursuant to the Federal Rules of Civil Procedure, "summary judgment is appropriate only where, on the basis of undisputed material facts, the moving party is entitled to judgment as a matter of law." *Bohreer v. Erie Ins. Grp.*, 475 F. Supp. 2d 578, 583 (E.D. Va. 2007); *citing Celotex Corp. v. Catrett,* 477 U.S. 317, 322 (1986). Moreover, the "entry of summary judgment is mandated 'against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at

trial.'" *Superformance Int'l, Inc. v. Hartford Cas. Ins. Co.*, 203 F. Supp. 2d 587, 592 (E.D. Va. 2002), *aff'd on other grounds sub nom.*, *Superperformance Int'l Inc. v. Hartford Cas. Ins. Co.*, 332 F.3d 215 (4th Cir. 2003), (citing *Celotex Corp.*, *supra*, 477 U.S. at 322).

III. Statement of Undisputed Material Facts

Pursuant to Federal Rule of Civil Procedure 56, Defendants respectfully submit this Statement of Undisputed Material Facts in support of their Motion for Summary Judgment:

1. In early 2015 after its purchase and renovation of the former Jefferson Heights building, Commonwealth began implementing its independent living policies in the community, including use of its new Resident Handbook. (**Exhibit 1**, Defs.' Ans. to Pl.'s Interrogs., Ans. to Interrog. Nos. 1 and 6.)

2. To ensure the safety of its independent living residents, Commonwealth replaced the building's emergency pull-cord system, added 24-hour receptionist coverage, and installed a new emergency pendant system and a new video surveillance system. (*Id.*, Ans. to Interrog. No. 1.)

3. In order to provide an additional safety measure, Commonwealth also implemented the Daily Check-in Program. (*Id.*) While CSL was to be CAL's first community with an independent living wing, CAL's management team had extensive experience in managing such communities while working for a previous company, and they adopted the Daily Check-in because they had used the system in the past and felt it was a best practice. (*See id.* at 6, Ans. to Interrog. No. 6.) Thus, the Daily Check-in Program was set forth in CAL's Policy and Procedure Manual (the "Manual") and its new independent living Resident Handbook based on the policies CAL's management team had used in the past. (*Id.*)

4. The Daily Check-in was described in CAL's Policy and Procedure Manual (the "Manual") as follows:

> In order to determine the safety and well-being of our Independent Living residents, it is the policy of all CAL communities to implement and maintain a system that assures residents are checked on at least once per 24-hour period. The intent of this policy is to subtly check on each resident to be sure they are not in need of emergency attention.

(**Exhibit 2**, CAL Manual at CSL00143.)

5. The Manual provided four options for completing the "Daily Resident Check," depending on the building's age and available technology, and CSL elected to implement the "Phone Check In" system, in which:

> . . . the residents are requested to phone . . . the front desk by a certain time to "check in." At the designated time, the front desk associate will compare the list of those that have checked in to the current unit roster and resident out of the building lists and then call the residents that have not checked in. If a resident does not answer each apartment will be physically checked.

(*Id.*)

6. The Manual also required that any staff involved in the process receive training, be able to demonstrate understanding of the process, and receive periodic refreshers to assure their competency in the process. (*Id.* at CSL00144.)

7. Additionally, the Manual stated that "every step of the check-in process must be documented clearly." (*Id.*)

8. Per the CAL Policy Manual, CSL's new Resident Handbook included the Daily Check-in procedure and described it as follows:

> To ensure the well-being of all residents we ask that you call the Front Desk no later than 10:30 a.m. each day. In the event you do not call we will call your apartment phone; if you do not answer an employee will then come to your apartment to ensure that you are okay and not in need of assistance.

(**Exhibit 3**, Resident Handbook at CSL00055.)

9. As reflected in the Resident Handbook, the Daily Check-in was part of an overall system of safety measures provided by Commonwealth, which included 24-hour front desk coverage, the emergency pull cord system, staff monitoring of the common areas, and surveillance cameras in the common areas. (*Id.* at CSL00056, 58, 63, 64.)

10. After consulting with CAL's regional manager, CSL's Executive Director Monica Adcock was responsible for implementing the Daily Check-in procedure. (**Exhibit 1**, Defs.' Ans. to Pl.'s Interrog. No. 1; **Exhibit 4**, M. Adcock Dep. Tr. at p. 29, lines 3-18.)

11. Ms. Adcock reviewed the Check-in procedure with CSL's Business Office Manager, Tiffany Nichols, instructed her to prepare a call log sheet for the receptionists to use in completing the Daily Check-in, and approved the Call Log Ms. Nichols devised to document the Check-in. (**Exhibit 4**, M. Adcock Dep. Tr. at p. 29, lines 20-25, p. 30, lines 1-13; **Exhibit 5**, T. Nichols Dep. Tr. at p. 23, lines 8-18.)

12. The Daily Check-in procedure was initiated in April 2015, at which time there was only one independent living resident who had signed the new CSL Residency Agreement and was subject to the Daily Check-in. (**Exhibit 6**, Apartment Call Check-In Log at CSL00076.)

13. Ms. Nichols provided on-the-job training regarding the Daily Check-in procedure to the front desk receptionists responsible for completing the Call Log. (**Exhibit 1**, Defs.' Ans. to Pl.'s Interrog. No. 10; **Exhibit 4**, M. Adcock Dep. Tr. at p. 30, lines 1-4, p. 33, lines 1-25, p. 34, lines 1-7; **Exhibit 5**, T. Nichols Dep. Tr. at p. 37, lines 12-22, p. 38, lines 1-11, p. 44, lines 2-7.)

14. The CSL staff testimony in this case establishes that:

    a. Ms. Nichols trained the receptionists on the Daily Check-in procedure. (**Exhibit 7**, D. Gentry-Ross Dep. Tr. at p. 23, lines 13-25, p. 24, lines 1-13 (stating that Ms. Nichols reviewed the Daily Check-in with her "in detail"); **Exhibit 8**, C. Mendiola Dep. Tr. at pp. 8-10; **Exhibit 9**, A. Evans Dep. Tr. at p. 11, lines 5-18.)

    b. The staff members were aware of their responsibilities regarding the Daily Check-in and the importance of same. (**Exhibit 7**, D. Gentry-Ross Dep. Tr. at pp. 25-29; **Exhibit 8**, C. Mendiola Dep. Tr. at p. 11, lines 13-25, p. 12, lines 1-14; **Exhibit 9**, A. Evans Dep. Tr. at p. 14, lines 23-25, p. 15, lines 1-12.)

    c. The staff had carried out the Daily Check-in procedure without incident prior to December 10, 2015, including the performance of "wellness checks" where the staff physically checked on residents in their apartments when the residents had not called in or answered their calls. (*See* **Exhibit 4**, M. Adcock Dep. Tr. at p. 33, lines 22-25, p. 34, lines 1-7 (stating that she observed the receptionists carrying out the policy, including checking on residents in their rooms); **Exhibit 5**, T. Nichols Dep. Tr. at p. 37, lines 12-22; **Exhibit 7**, D. Gentry-Ross Dep. Tr. at p. 27, lines 9-12 (stating that she would check on residents in their apartments as often as five times per week); **Exhibit 8**, C. Mendiola Dep. Tr. at p. 12, lines 8-10; **Exhibit 9**, A. Evans Dep. Tr. at p. 29, lines 3-25, p. 30, lines 1-2.)

    d. Ms. Nichols and other staff would place reminders in the receptionists' "Shift Reports" to emphasize the importance of completing the Daily Check-in. (*See* **Exhibit 10**, copies of relevant Shift Reports; **Exhibit 7**, D. Gentry-Ross Dep. Tr. at p. 40, lines 6-12, p. 42, lines 17-24; **Exhibit 9**, A. Evans Dep. Tr. at p. 27, lines 24-25, p. 28, lines 1-5.)

    e. Ms. Nichols also provided ongoing "coaching" and reminders to the receptionists regarding their Daily Check-in responsibilities after the initial

training. (**Exhibit 4**, M. Adcock Dep. Tr. at p. 39, lines 2-25; **Exhibit 5**, T. Nichols Dep. Tr. at p. 75, lines 4-11.)

15. Significantly, there is no evidence whatsoever that, prior to Ms. Franklin's incident, there were any incidents related to the Daily Check-in system failing and causing injury to a resident who needed assistance.

16. While there were "blanks" present on the Call Log in the first few months of the program, as more residents signed the new CSL Residency Agreement and were added to the Daily Check-in and as the Call Log itself was revised, the Call Log's documentation improved – an improvement that continued with Ms. Gentry-Ross's employment in September 2015. (*See* **Exhibit 5**, T. Nichols Dep. Tr. at p. 48, lines 14-18, p. 97, lines 16-22, p. 98, lines 1-14 (stating that Ms. Gentry-Ross was hired specifically to provide extra support for the front desk and to help with the Daily Check-in, a procedure which she was "very thorough" in completing); **Exhibit 6**, Apartment Call Check-In Log (reflecting documentation of check-in times and out of building notes improving over time as number of residents being monitored increased to 18 in total, with blanks only rarely appearing in the log from September 2015 through December 2015).)

17. Of course, the Call Log does reflect the inherent limitations of checking on an "independent" resident population and the occasional difficulty the staff had in completing the Daily Check-in – the residents could come and go as they pleased, were not required to tell the front desk when they were leaving, and many of them drove their own vehicles. (**Exhibit 5**, T. Nichols Dep. Tr. at p. 53 (noting the residents were independent and citing example of one resident who was only 55 years old and still went to work every day); **Exhibit 7**, D. Gentry-Ross Dep. Tr. at p. 33.)

18. In May of 2015, Ms. Franklin entered into a Residency Agreement with Commonwealth for accommodations in the unlicensed independent living portion of Commonwealth's community – apartments designed for persons "capable of providing for their own health care and personal needs." (**Exhibit 11**, Residency Agreement at 6.)

19. Despite suffering from multiple sclerosis and having suffered some broken bones, Ms. Franklin had maintained her independence her entire life up to and including the time she signed the Residency Agreement. (Compl. ¶ 33; **Exhibit 12**, D. Franklin Dep. Tr. at pp. 7-8; **Exhibit 13**, J. Carney Dep. Tr. at p. 48, lines 17-22, p. 49, lines 1-2.)

20. Ms. Franklin reviewed and initialed every page of the Residency Agreement prior to signing it. As such, Ms. Franklin agreed to and acknowledged the following terms:

    - The Residential Housing portion of the Community is not licensed to offer and **does not offer assistance with medications, bathing, dressing mobility needs, supervision, monitoring of your health or safety, or other personal care activities**.

- It is **your responsibility to provide for your own health care and personal care** so long as you reside in Residential Housing.

- **You represent to us that you are capable of providing for your own health care and personal care needs** and will provide for all such needs as long as you reside in Residential Housing.

(**Exhibit 11**, Residency Agreement at 6 (emphasis and bullets added).)

21. While at CSL, Ms. Franklin could ride her motorized scooter to her nearby doctor's office and also had her own car and was able to drive until the end of November 2015. (**Exhibit 12**, D. Franklin Dep. Tr. at p. 68, lines 12-25.)

22. Indeed, Ms. Franklin was totally independent during her residency right up until her incident on December 9, 2015. (**Exhibit 12**, D. Franklin Dep. Tr. at p. 7-8; **Exhibit 13**, J. Carney Dep. Tr. at p. 48, lines 17-22, p. 49, lines 1-2.)

23. Regarding the Daily Check-in procedure, Ms. Franklin testified that she complied with the program by calling the front desk each morning, or checking in at the front desk. (**Exhibit 12**, D. Franklin Dep. Tr. at p. 23, lines 16-25, p. 24, lines 1-24, p. 64, lines 4-8.)

24. In fact, Ms. Franklin testified that there were a few occasions where a staff member would call when she failed to check in or she would go to the front desk to check in when the staff did not have her marked down as having been checked in. (*Id.*)

25. Ms. Franklin typically wore a Bay Alarm pendant, which would call 911 should she need to activate it in an emergency. (*Id.* at p. 19, lines 21-25.)

26. Ms. Franklin's contract with her Bay Alarm, was coming to an end, and she was aware of CSL's free emergency pendants. (*Id.* at pp. 64-65.) Thus, Ms. Franklin planned to return the Bay Alarm pendant and to obtain one of the free emergency pendants CSL provided. (*Id.*)

27. Ms. Franklin's son, Alvin Franklin, had purchased the one-year Bay Alarm emergency pendant contract for his mother after she had broken her hip in November 2014, and he was "insistent" that she have an emergency pendant for access to emergency care. (**Exhibit 14,** A. Franklin Dep. Tr. at p. 29, lines 3-12.) To terminate the Bay Alarm contract, the equipment had to be returned, and just days before her incident, Ms. Franklin informed her son that she would box up and return the Bay Alarm pendant concurrently with picking up the free CSL emergency pendant. (*Id.* at pp. 29-32.)

28. Thus, Ms. Franklin had boxed up her Bay Alarm pendant to return it the very day she broke her clavicle, December 9, 2015. (**Exhibit 12**, D. Franklin Dep. Tr. at p. 64,

lines 9-21.) As a result, Ms. Franklin was not wearing an emergency pendant, as she typically did, when she broke her clavicle and was unable to get out of her bed.[1]

29. At approximately 9:30 or 10:00 p.m. on December 9, 2015, Plaintiff reached across her body with her left hand to place her TV remote on a bedside table to her right and broke her clavicle. (**Exhibit 12**, D. Franklin Dep. Tr. at p. 21, lines 3-8.)

30. As a result of the broken clavicle, Plaintiff was unable to remove herself from her bed, unable to reach her telephone, which was only a few feet away, and had no emergency alert systems within reach. (Compl. ¶ 64; **Exhibit 12**, D. Franklin Dep. Tr. at p. 22, lines 5-7, p. 66, lines 11-13.)

31. CSL's staff did not check-in with Plaintiff by phone or by visiting her apartment in accordance with the Daily Check-in procedure from approximately 10:30 a.m. on December 10, 2015 until Ms. Franklin was discovered by her daughter at approximately 1:15 p.m. on December 13, 2015. (Compl. ¶¶ 66, 80–82; **Exhibit 13**, J. Carney Dep. Tr. at p. 57, lines 7-10.)

32. On December 10, 2015 CSL receptionist Shadell Hughes erroneously thought she spoke with Ms. Franklin and marked an entry of "10[a.m.]" on the Call Log. (**Exhibit 6**, Call Log at CSL00109; **Exhibit 15**, S. Hughes Dep. Tr. at p. 28, lines 3-20.)

33. While unable to get out of her bed, Ms. Franklin received several calls from her daughter and from her doctors' offices; however, she was unable to answer the phone. (**Exhibit 13**, J. Carney Dep. Tr. at p. 54, lines 15-25 through p. 62, line 11.)

34. Ms. Franklin had a doctor's appointment and an appointment for an ultrasound at Sentara Martha Jefferson Hospital's Outpatient Care Center on Friday, December 11, 2015 at 9:30 a.m. (*Id.* at pp. 51-52; *see also* Video of Apartment and Answering Machine (to be provided to Arbitrator in electronic format by email).)

35. When Ms. Franklin missed the appointment, there was no calls from her health care providers that day to follow up. (**Exhibit 13**, J. Carney Dep. Tr. at p. 52, lines 14-20.)

36. On Friday, December 11, 2015, Diane Gentry-Ross, who was serving as interim Business Office Manager while Ms. Nichols was on maternity leave, made an erroneous entry of "10:00[a.m.]" on Ms. Franklin's line of the Call Log, when she was instead trying to document her check-in of the couple whose names were listed

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[1] Defendants do not cite the emergency pendant details to suggest Ms. Franklin and her family members are in any way responsible for this incident. Rather, these details are cited (1) to reflect Commonwealth's good faith efforts to provide additional safety measures for its residents, measures Ms. Franklin was aware of and intended to avail herself of had her incident not occurred, and (2) to emphasize the numerous unfortunate events that led to this incident and which mitigate Commonwealth's ability to foresee it.

on the line just below Ms. Franklin's. (**Exhibit 7**, D. Gentry-Ross Dep. Tr. at p. 56, lines 2-13; **Exhibit 6**, Call Log at CSL00109.)

37. Unfortunately, to Ms. Hughes, who was the receptionist on duty that day, or to anyone else reviewing the Call Log, it appeared that Ms. Franklin had been checked in at 10:00 a.m. on Friday December 11, 2015. (*Id.*)

38. On Saturday December 12, 2015, Crystal Mendiola was the receptionist on duty, and she mistakenly read the Call Log as indicating that Ms. Franklin was "out" until Sunday December 13, 2015, as the resident right above Ms. Franklin had a notation on his line that he would be out until Sunday. (**Exhibit 8,** C. Mendiola Dep. Tr. at p. 30, lines 11-25, p. 31, lines 1-9; **Exhibit 6**, Call Log at CSL00109.)

39. On Sunday, December 13, 2015 at approximately 9:44 a.m., CSL's Activities Director, Ms. Hollie Drobinski left a flyer at Ms. Franklin's door and noticed several other flyers. Concerned, she went directly to the front desk to ask Ms. Mendiola whether Ms. Franklin had checked in, and Ms. Mendiola reported that Ms. Franklin was out of the building until that afternoon. (**Exhibit 16**, H. Drobinski Dep. Tr. at p. 55, lines 5-25, p. 56, lines 1-4; **Exhibit 8,** C. Mendiola Dep. Tr. at p. 32, lines 12-23.)

40. At approximately 1:15 p.m. on December 13, 2015, Ms. Franklin's daughter stopped by to check on her and discovered her trapped in her bed. (**Exhibit 13**, J. Carney Dep. Tr. at p. 57, lines 7-10.)

41. After Ms. Franklin was treated for her injuries in the hospital, various tests revealed that she had Stage 4 cancer, which had metastasized to her bones and was likely the cause of her broken clavicle. (**Exhibit 12**, D. Franklin Dep. Tr. at p. 52, lines 19-25, p. 53, lines 1-7.)

IV. Applicable Law

The parties entered into an Agreement to Arbitrate this case on February 1, 2016. Clause 5 of that agreement dictates that "the law to be applied in the arbitration shall be the substantive law of the Commonwealth of Virginia and federal procedural law, including the Federal Rules of Civil Procedure." Accordingly, Defendants file this motion for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure.

V. Analysis

Plaintiff has failed to adduce evidence in discovery sufficient to meet her burden of proving by a preponderance of evidence that Defendants are liable in this case for punitive damages (Count III). Thus, this claim should be dismissed with prejudice prior to the hearing of this matter, so that the Arbitrator may focus on the sole remaining issue in this case, the amount to award Ms. Franklin's estate for her pain and suffering related to her delay in receiving care from approximately 10:30 a.m. on December 10, 2015 until she was discovered by her daughter at approximately 1:15 p.m. on December 13, 2015.[2]

A. Plaintiff Cannot Prove Defendants Committed an Act of Willful and Wanton Negligence Amounting to the "Most Egregious Conduct."

While Plaintiff has complained that Commonwealth's Daily Check-in procedure was not properly implemented and that its staff was not properly trained, such complaints do not rise to the level of the "most egregious" conduct for which punitive damages are reserved under Virginia law. At best, Commonwealth's conduct in this case amounts only to heedlessness, inattention, or inadvertence, characteristics of simple negligence, not willful and wanton conduct.[3]

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[2] Plaintiff has asserted medical bills and expenses in this matter of $33,219.53. While Defendants do not concede that all health care and treatment Ms. Franklin received after her incident is related to injuries she suffered as a result Commonwealth's failure to check on her, Defendants are stipulating that the full amount of Ms. Franklin's claimed medical bills are to be included in the Arbitrator's ultimate award. Thus, Ms. Franklin's pain and suffering related to her delay in receiving treatment and the considerations related to same are the only remaining damages issues for the Arbitrator to resolve.

[3] While Plaintiff could recover punitive damages if she were to prove that Defendants acted with "actual malice," it is Defendants' understanding that Plaintiff will stipulate that Defendants' conduct in this case does not meet that high standard. *See* VMJI No. 9.090 (defining "actual malice" as "a sinister or corrupt motive such as hatred, personal spite, ill will, or a desire to injure the plaintiff.").

The Supreme Court of Virginia has categorically stated that the imposition of punitive damages is not favored and, because such exemplary damages are in the nature of a penalty, they should be assessed only in cases of the "most egregious conduct." *Poulston v. Rock*, 251 Va. 254, 270, 467 S.E.2d 479, 488 (1996) (citations omitted). A claim for punitive damages at common law in a personal injury action must be supported by factual allegations sufficient to establish that the defendant's conduct was willful or wanton. *Woods v. Mendez*, 265 Va. 68, 76–77, 574 S.E.2d 263, 268 (2003) (citations omitted). Willful and wanton negligence is action undertaken in conscious disregard of another's rights, or with reckless indifference to consequences with the defendant aware, from his knowledge of existing circumstances and conditions, that his conduct *probably* would cause injury to another. *Green v. Ingram*, 269 Va. 281, 292 (2005) (emphasis added) (citations omitted).

Under Virginia law, willful and wanton negligence involves conduct going *beyond* that which shocks fair-minded people. *Harris v. Harman*, 253 Va. 336, 341, 486 S.E.2d 99, 102 (1997). While negligence conveys the idea of heedlessness, inattention, and inadvertence, willful and wanton negligence conveys the idea of purpose or design, actual or constructive. *Id.* In *Cabiness v. Medical Facilities of AMVIII, Ltd*, No. CL10–005, 2010 WL 7373695, *4 (Va. Cir. Ct. June 21, 2010), the court noted that there is a "fundamental distinction separating acts or omissions of simple negligence from those of gross negligence and willful and wanton negligence." It elaborated, citing the Supreme Court of Virginia:

> Acts or omissions of simple negligence may occur routinely in the performance of the activities of any organization. Employees or volunteers, in carrying out their duties, may fail to understand or to adequately follow instructions of a supervisor, may exercise poor judgment, or may have a lapse in attention to an assigned task. Willful and wanton negligence exists when the defendant *is actually aware that his conduct would cause injury to another*.

Id. (emphasis added) (citing *Cowan v. Hospice Support Care, Inc.*, 268 Va. 482, 487, 603 S.E.2d 916, 919 (2004)). In sum, a claim for punitive damages depends entirely on the conduct of the defendant, not the result of that conduct, however severe.

Because willful and wanton negligence requires the defendant to be aware that his conduct will cause injury, the facts setting forth the "existing circumstances and conditions" of which Commonwealth was aware are of critical importance to the punitive damages analysis in this case. "[E]vidence that a defendant had prior knowledge or notice that his actions or omissions would likely cause injury to others is a significant factor in considering issues of willful and wanton negligence." *Alfonso v. Robinson*, 257 Va. 540, 546, 514 S.E.2d 615, 619 (1999). In this case, Plaintiff has failed to adduce any evidence that Commonwealth was on notice that their conduct would probably lead to injury, as there were no prior incidents of a resident needing assistance and not receiving it due to a failure of the Daily Check-in procedure. While Commonwealth's employees understood an injury *could potentially* occur if they did not carry out the Daily Check-in, the receptionists in this instance believed they *were* carrying out the procedure properly on the dates in question. Only acts amounting to "simple negligence" (mistaking another resident for Ms. Franklin on the phone, making an entry in Ms. Franklin's line of the Call Log in error, misreading the Call Log to indicate Ms. Franklin was out of the facility) are present in this case. While the staff errors committed between December 10-13, 2015 may fairly be criticized as "lapses in attention to an assigned task," or even reflective of "poor judgment," such errors do not amount to conduct that goes beyond that which would shock fair-minded people.

Plaintiff's claim for punitive damages appears to focus on the overall performance of the Daily Check-in policy, as opposed to its failure in relation to Ms. Franklin's ordeal. This result-

driven critique is misplaced in the absence of prior notice to Commonwealth that the program had failed another resident who needed assistance. While the evidence reveals "blanks" on the Call Log, many of which relate to other residents, it also reflects measures taken by CSL's staff to improve the program, such as reminders to the staff, improvements to the Call Log, and the hiring of additional staff to assist with the Daily Check-in. In fact, the evidence indicates that the staff regularly carried out the Daily Check-in, regularly competed "wellness checks" at resident's apartments, and most notably, even called Ms. Franklin previously when she was not checked in by 10:30 a.m.

Plaintiff's critiques of how CSL elected to implement the Daily Check-in and the lack of formal written training on the program amount to nothing more than additional allegations of "simple negligence." Criticisms of the design of the Call Log itself and how the receptionists were trained on the Daily Check-in policy may be characterized as staff failures to properly follow, or a lack of understanding of, CAL's policy; however, there can be no dispute that the staff implemented and carried out the policy in good faith. Obviously, Ms. Franklin's ordeal has exposed flaws in the system related to the kinds of human errors that are rightly characterized as simple negligence, but there is no evidence to suggest that Commonwealth was aware of these flaws prior to December 13, 2015.

Moreover, Commonwealth's overall conduct totally refutes any allegation of a conscious disregard for its independent living residents' safety. Commonwealth replaced the building's emergency pull-cord system and added 24-hour receptionist coverage and a new video surveillance system. Significantly, Commonwealth also installed and made available at no charge to its residents emergency pendants, as yet another safety measure to try and prevent incidents such as Ms. Franklin's. Certainly, these measures must be considered in analyzing

Commonwealth's overall conduct, and parties who implement such measures cannot be said to have acted with conscious disregard for Ms. Franklin's or any other resident's safety.

For all of these reasons, Plaintiff has failed to plead sufficient facts to support her contention that the Defendants' conduct was "most egregious."[4] Thus, Plaintiff's claim does not qualify for the penalty of punitive damages.

VI. Conclusion

Defendants respectfully request that the Arbitrator enter an order dismissing Count III of Plaintiff's Complaint seeking punitive damages and awarding any other relief the Arbitrator deems appropriate.

OSPREY/PANTOPS PLACE, LLC, T/A COMMONWEALTH SENIOR LIVING AT CHARLOTTESVILLE and COMMONWEALTH ASSISTED LIVING, LLC

By: _____
Of Counsel

W. Benjamin Pace (VSB No. 48633)
Erica Mitchell (VSB No. 89420)
WILLIAMS MULLEN
200 South 10th Street, Suite 1600 (23219)
Post Office Box 1320
Richmond, Virginia 23218-1320
Tel: 804.420.6932 / Fax: 804.420.6507
wpace@williamsmullen.com
Counsel for Defendants

[4] For a case that *does* satisfy the "most egregious conduct" standard see *Crewe v. Cote De Neige*, No. CL0801075P-03, 2008 WL 6324867 (Va. Cir. Ct. 2009). In this Newport News case, a jury awarded a 55 year-old mentally handicapped man $750,000 dollars in damages, with $250,000 of that designated as punitive damages, because the assisted living facility he lived in hired a male CNA with a criminal record, who repeatedly sodomized the resident, permanently damaging his sphincter muscle in his rectum. The CNA was the only employee for most of his shift and was the victim's direct caregiver. The owner of the facility knew the man for twenty-four years before she hired him and was on notice of his violent past. Undoubtedly, that was most egregious conduct and it stands in stark contrast to the evidence of Commonwealth's conduct in this case.

CERTIFICATE

I certify that on this 21st day of December, 2016, a copy of the foregoing was sent by email and first-class mail, postage prepaid to:

Charles A. Gavin, Esquire
Cawthorn, Desekvich & Gavin, P.C.
1409 Eastridge Road
Richmond, Virginia 23229
Counsel for Plaintiff

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