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

REPLY MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND IN OPPOSITION TO PLAINTIFF'S 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, state as follows for their Reply Memorandum in Support of Defendants' Motion for Summary Judgment and in Opposition to Plaintiff's Motion for Summary Judgment:

I. Introduction

From the outset of this case, Commonwealth has acknowledged its liability for Ms. Franklin's ordeal and has asked the Arbitrator to award a fair and reasonable amount to her estate. At the hearing of this matter on January 12, 2017, the parties submitted their stipulations and evidence on damages and await the Arbitrator's award. Regarding Plaintiff's claim for punitive damages, the parties have submitted the issue to the Arbitrator via competing motions for summary judgment. At this stage, the Arbitrator need answer only one question: whether Commonwealth's conduct in this case, taken as a whole, amounts to "the most egregious conduct" under Virginia law – conduct that goes *beyond* that which would shock fair-minded people.

The undisputed facts of this case establish that Commonwealth's conduct, taken as a whole, does not evince a "conscious disregard" for Ms. Franklin's safety. Commonwealth adopted the Daily Check-in as an *additional* safety measure, in concert with 24-hour receptionist coverage, emergency pull-cords, emergency pendants and video surveillance of the common areas. The mere fact that Commonwealth made free emergency pendants available to every resident establishes that Commonwealth did not act in reckless disregard of its residents' safety. Moreover, because there were no prior incidents related to a failure of the Daily Check-in, Commonwealth was not on notice that an incident such as Ms. Franklin's might occur. In short, while Commonwealth's good faith efforts to provide additional safety failed Ms. Franklin in this instance, it cannot be said that Commonwealth acted intentionally with knowledge that Ms. Franklin's incident would likely occur.

In her summary judgment pleadings, Plaintiff focuses her argument on nonexistent standards and facts irrelevant to the circumstances of Ms. Franklin's incident – belittling the staff's qualifications, parsing staff testimony on training, and suggesting a standard of care for carrying out a daily check-in program based on hindsight. None of Plaintiff's post hoc analysis changes the fact that every receptionist on duty during Ms. Franklin's incident understood her role in the Daily Check-in process and was complying with the system, albeit while committing acts of simple negligence, during the incident.

Plaintiff spends a great deal of time critiquing the Call Log's design, bemoaning the lack of written training materials on the Daily Check-in system, and extrapolating system "failure rates" based on check-in times after 10:30 a.m. for residents other than Ms. Franklin and on dates not in question. These exercises ignore the fact that the only aspect of the Daily Check-in at issue in this case is the staff's obligation to check on Ms. Franklin by phone or by a visit to her

room in the event she did not call to check in on a given day. The unquestioned testimony of the receptionists establishes that they were at the front desk taking check-in calls on the dates in question and due to acts of 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), they failed to realize Ms. Franklin had not checked in and was in need of assistance.

Finally, Plaintiff argues that because independent living is not regulated by the state, "there are limited ways that an independent living resident can enjoy protection from negligence." (Pl.'s Mot. S.J. at 2.) Thus, Plaintiff encourages the Arbitrator to award punitive damages in this case to send a "clear message" to independent living facilities that implementation of safety programs must be taken seriously. (*Id.*) Plaintiff's offered rationale for imposing punitive damages on Commonwealth ignores the fact that Ms. Franklin is protected from negligence in this case the same way any of us are protected from negligence – whether on the roads, in the common areas of businesses, or otherwise – through the law of negligence. Commonwealth's self-imposed duty to check in with Ms. Franklin daily and its willingness to admit liability despite opportunities to assert contractual and contributory negligence defenses establishes that there is no need for "punishment" of Commonwealth to send a message to other providers. In fact, because Commonwealth has not violated a professional standard of care, regulatory requirement or common law duty in this case, imposing punitive damages would only *discourage* other independent living providers from implementing additional safety measures for fear of potential liability for *self-imposed* duties.

In sum, Plaintiff's claim for punitive damages (Count III) must be dismissed because she has failed to show that Defendants' conduct was willful and wanton.

II. Restated and Supplemented Statement of Undisputed Material Facts

Plaintiff failed to provide a numbered Statement of Undisputed Material Facts pursuant to Federal Rule of Civil Procedure 56; rather, she engaged in a twenty-one page characterization of the evidence reflecting her argument as to how the facts should be interpreted. Plaintiff then attempted to summarize her discussion in an additional three and a half pages of bulleted "facts" by category. Commonwealth will not attempt to parse through Plaintiff's 25-pages of unnumbered facts; however, it will stipulate that the referenced deposition testimony and exhibits speak for themselves. Otherwise, Plaintiff's characterization of facts contrary to the testimony and exhibits cited, and any alleged facts stated but not supported by evidence properly in the record are denied. Additionally, Commonwealth offers the following restatement and supplementation of its original Statement of Facts, which is incorporated herein by reference:[1]

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

2. To provide an additional safety measure, Commonwealth also implemented the Daily Check-in Program. (*Id.*)

3. The Daily Check-in was set forth 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.)

[1] Any citations to exhibits reference the exhibits attached to Commonwealth's opening Memorandum in Support of Motion for Summary Judgment, unless otherwise noted.

4. 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.*)

5. 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.)

6. Commonwealth assigned the implementation of all of its policies and procedures at CSL, including the Daily Check-in, to CSL's Executive Director Monica Adcock, who was a Licensed Assisted Living Facility Administrator and Licensed Practical Nurse in Virginia. (**Exhibit 1**, Defs.' Ans. to Pl.'s Interrog. No. 1; **Exhibit 4**, M. Adcock Dep. Tr. at p. 29, lines 3-18; p. 11, Lines 3-5.)

7. 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.)

8. 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.)

9. 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.)

10. 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; **Exhibit 15**, S. Hughes Dep. Tr. at pp. 31-32, 38-42.)

    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.)

11. Ms. Adcock observed the staff carrying out the Daily Check-in appropriately, taking the keys to physically check on residents several times a week, and checking the log book herself at least once a week. (**Exhibit 4**, M. Adcock Dep. Tr. at p. 34, lines 1-4; p. 45, lines 13-17; p. 46, lines 5-8.)

12. Based on Ms. Adcock's observations, the Daily Check-in was "being done appropriately," and she "didn't see a problem" with the program. (*Id.* at p. 47, lines 1-5.)

13. 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.

14. 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).)

15. 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.)[2]

16. Regarding the receptionists' comprehension of the Daily Check-in's requirements, they testified as follows:

    a. **Diane Gentry-Ross**:

    > The understanding of the process of every day I would come in at 9 a.m. . . . If they [the residents] walk by walking their dog we would say good morning, we would check them in. If we physically laid eyes on them at breakfast, we would check them in. We knew they were okay. If they called, say this is such-and-such apartment, just wanted to check in this morning, we would check them off.

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[2] Plaintiff cites Daily Check-in "failure rates" calculated based on any check-in times noted on the Call Log after the 10:30 a.m. deadline for residents to call the front desk. (Pl.'s Mot. S.J. at 20, Ex. C.) Such a calculation is not just irrelevant, but also totally inaccurate because it assumes the system has "failed" if the staff did not check on any resident (by phone or by a visit to their apartment) *immediately* after the 10:30 a.m. deadline. Such a premise fails to account for residents who have instructed the staff not to call them until later in the day and/or residents who have left the facility without checking in, which occurred regularly. (**Exhibit 5**, T. Nichols Dep. Tr. at pp. 53, 95-98); **Exhibit 7**, D. Gentry-Ross Dep. Tr. at p. 33.)

At around 10:30-ish or so, I would start – well, I would say around maybe 10:15 or so I would start calling people that I had not seen. The numbers were right beside their name and their apartment.

(**Exhibit 7**, D. Gentry-Ross Dep. Tr. at p. 25, lines 16-25, p. 26, lines 1-5.)

Q. What would happen, in your mind, if somebody did not call and by 10:30?

A. I would place a phone call to them. If they did not answer, I would physically get up out of my seat, go to the key box, look at the key log that we have, . . . take keys, go to their apartment, knock three times, say, "wellness check." And if I don't hear anything, or if they say come in or whatnot, I would put the key in, go in, and check on them.

(**Exhibit 7**, D. Gentry-Ross Dep. Tr. at p. 26, lines 22-25, p. 27, lines 1-6.)

b. **Crystal Mendiola**:

We were required to go through the daily log, and by 10:00 you have to get it done. As far as whoever was on the list or in the log, we would have to – if we didn't see them physically, then we would have to contact them over the phone.

(**Exhibit 8**, C. Mendiola Dep. Tr. at p. 11, lines 18-22.)

Q. . . . what happened if they don't call in?

A. I would call them. If they don't answer, then you go up to their apartment.

Q. And what happens if they don't answer at the apartment?

A. If they don't answer at the apartment, you come back and you get the keys and you go in the apartment.

(**Exhibit 8**, C. Mendiola Dep. Tr. at p. 13, lines 1-8.)

c. **Ashley Evans**:

Q. What was your understanding on the requirements of the program?

A. That the residents on the list would have to check in once a day by – I believe it was by 12:00

(**Exhibit 9**, Evans Dep. Tr. at p. 12, lines 22-25, p. 13, line 1.)

A. . . . I was mistaken. It's 10:30.

Q. Okay. So if a resident did not call in by 10:30, what was your understanding of what you would be required to do?

A. I would first call them. And if they didn't answer the phone, I would go to their apartment to complete a wellness check.

(**Exhibit 9**, Evans Dep. Tr. at p. 14, lines 21-25, p. 15, lines 1-3.)

d. **Shadell Hughes**:

Q. . . . would you say you worked almost all night shifts, meaning after 5:00 p.m.?

A. I worked more night shifts definitely than day shifts.

Q. Would you say you only maybe worked a few day shifts a month?

A. Probably so.

Q. – in September, October, November?

A. Yeah, only a few a month.

Q. Okay. And primarily you worked the overnight shift, from 1:00 a.m. to 9:00 a.m.?

A. Correct.

(**Exhibit 15**, Hughes Dep. Tr. at p. 38, lines 2-13.)

Q. But when you did work the – during the daytime hours, you were aware of the daily check-in system?

A. Correct.

Q. And you knew that the residents were supposed to call in; is that right?

A. Yeah. They were –

Q. And if they didn't call in and you saw them in the lobby or in the dining room, and you could check them in visually?

A. Correct.

Q. And so you would write down times based on when they called and when you saw them?

A. Correct.

(**Exhibit 15**, Hughes Dep. Tr. at p. 39, lines 4-17.)

Q. Did you think it was important that I've got my call log and I need to see all the highlighted people, not everybody, but all the highlighted people, by the end of the day I need to have seen them?

A. It was important to me to make sure my residents were okay –

(**Exhibit 15**, Hughes Dep. Tr. at p. 40, lines 13-19.)

Q. So you cared about the residents, right?

A. Yes.

Q. And you wanted to know how they were doing, right?

A. Correct.

Q. And the call log was something that you were told was a duty and you would put the times down when you saw them, right?

A. Correct.

(**Exhibit 15**, Hughes Dep. Tr. at p. 41, lines 15-22, p. 42, line 1.)

Q. So there was never somebody that you didn't know where they were during a day and had to raise an alarm?

A. Correct.

(**Exhibit 15**, Hughes Dep. Tr. at p. 42, lines 19-22.)

Q. . . . what was your instruction if someone went to an apartment because a resident had not checked in and allowed themselves to enter . . . the apartment to check on the resident? . . . . What was your understanding and training on what you would do next?

A. We would go in and announce ourself, say, hey, I'm here, I'm just checking on you, loud enough so they could hear us. And then we were told that if . . . we didn't hear anyone say anything, we would then just walk to . . . the kitchen, look around the corner, see if they're there, the same for the living

room, bathroom area, if the door was closed to knock and say, so and so, I'm here to check on you, same with the bedrooms.

(**Exhibit 15**, Hughes Dep. Tr. at p. 31, lines 16-22, p. 32, lines 1-10.)

17. After Ms. Franklin's incident, Ms. Nichols terminated Shadell Hughes for leaving the front desk for 45 minutes without notice to her supervisor, a decision Ms. Hughes disagreed with. Ms. Hughes holds a negative opinion of Ms. Nichols, whom she felt was "rude." (**Exhibit 15**, Hughes Dep. Tr. at p. 36, lines 12-22, p. 37, lines 1-7, p. 44, lines 13-22, p. 45, lines 1-9.)

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. There was no additional charge for the Daily Check-in procedure, which was part of the Resident Handbook and free to all residents who agreed to participate under the CSL Residency Agreement. (*See* **Exhibit 17**, Schedule of Fees for Optional Services (containing Plaintiff's handwritten notes that there was "no charge" for Daily Check-in, which was "free"). This exhibit was admitted into evidence at the Jan. 12, 2017 Hearing and is attached hereto as Exhibit 17 to Defs.' Mot. for S.J.)

20. 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.)

21. 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.)

22. 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.)

23. 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.)

24. 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 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.)

25. 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.*)

26. 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.)

27. 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.)

28. 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.)

III. Argument

In considering the material facts of this case, Commonwealth's conduct was admittedly negligent in regards to Ms. Franklin's incident. The errors made by CSL's staff may fairly be characterized as reflecting a lack of attention to detail, a failure to follow fully Commonwealth's instructions set forth in the Daily Check-in policy, and poor judgment. Plaintiff's criticisms of the Daily Check-in system; however, do not fall outside the above acts of simple negligence because there are absolutely no facts even suggesting that Commonwealth *intentionally* took actions it knew would result in injury. In short, Plaintiff has failed to prove that Commonwealth's conduct amounts to the "most egregious conduct" that is *beyond* that which would shock fair-minded people.

A. The Facts Establish that Commonwealth Did Not Act Intentionally with Knowledge that Injury Would Probably Occur.

The parties appear to agree on the basic law of punitive damages in Virginia. 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).

In addressing Plaintiff's punitive damages claim, the Arbitrator must focus on the "fundamental distinction separating acts or omissions of simple negligence from those of gross negligence and willful and wanton negligence":

> 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.*

Cabiness v. Medical Facilities of AMVIII, Ltd, No. CL10–005, 2010 WL 7373695, *4 (Va. Cir. Ct. June 21, 2010) (emphasis added) (citing *Cowan v. Hospice Support Care, Inc.*, 268 Va. 482,

487, 603 S.E.2d 916, 919 (2004)). Here, Plaintiff's claim fails, as there is no evidence to support the argument that Commonwealth was "actually aware" that any conduct at issue in this case would cause injury.

To establish an entitlement to punitive damages, Plaintiff must prove that Commonwealth acted willfully and wantonly. Willful and wanton conduct requires: (1) action undertaken, (2) with reckless indifference to consequences, (3) with the defendant aware, from his knowledge of existing circumstances and conditions, (4) that his conduct would probably cause injury to another. *Green v. Ingram*, 269 Va. 281, 292, 608 S.E.2d 917, 923 (2005). Negligence conveys the idea of heedlessness, inattention, inadvertence, whereas willfulness and wantonness convey the idea of purpose or design, actual or constructive. *Id.* What separates simple negligence from willful and wanton negligence is the presence of an *intentional* act carried out with knowledge the act itself is *likely* to cause injury. The arguments Plaintiff has forwarded as to the facts of this case fail to meet such a high standard, and can be summarized as follows:

- The Call Log was improperly designed by Ms. Nichols.
- Ms. Nichols was not qualified to oversee the Daily Check-in.
- The staff training on the Daily Check-in was insufficient.
- The staff compliance issues related to the Daily Check-in should have placed Defendants on notice of a risk to the residents.[3]

First, as Plaintiff acknowledges in her motion, there is no "standard of care" derived from regulations, the common law, or established professional canons applicable to the implementation and carrying out of a Daily Check-in program. This was a duty Commonwealth

[3] While Plaintiff also criticizes the Daily Check-in system for a failure to address various scenarios (e.g., what the staff should do when a resident does not check in and is then not found in her apartment), these "what if" scenarios do not relate to Ms. Franklin's incident and are thus irrelevant. There is no evidence that these aspects of the Daily Check-in played any role in the errors that lead to Ms. Franklin's incident. In other words, because the questioned conduct is not at issue in this case, it is not subject to punitive damages.

imposed upon itself. While it is fair to say that, in hindsight, the CSL staff could have created a better Call Log or could have "charted" more information on the Call Log, such failures amount to no more than a failure to sufficiently understand and/or to follow Commonwealth's instructions set forth in the Daily Check-in policy. These are, at best, acts of simple negligence.

Similarly, there is no "standard of care" regarding the qualifications of an employee to oversee a Daily Check-in program. While Ms. Nichols was not a licensed health care provider, Plaintiff can point to no requirement that certain qualifications are necessary to manage a staff of receptionists responsible for taking phone calls to check on residents. In this regard, it must be remembered that, while certainly frustrating in the context of this case, the duties making up the Daily Check-in were very simple in nature – using a telephone and/or observing residents coming and going to check them in, writing down check-in times, reviewing the Call Log for any resident who had not checked in, and if necessary visiting the resident's apartment to confirm her status if she had not been seen or could not be reached on the phone. These are administrative tasks suitable for a receptionist and there is no evidence of any required standard for the qualifications necessary to manage such receptionists.

In this regard, Plaintiff's complaint about the lack of written training materials also fails to establish willful and wanton conduct. The tasks the receptionists had to complete were extremely simple. Significantly, despite the lack of any written training materials or more formal training program, each receptionist's testimony reflects that she knew her duties and how to carry them out. Here, the receptionists could demonstrate their understanding of their duties, and their managers (Ms. Nichols and Ms. Adcock) observed the staff carrying out those duties on a regular basis. Again, Plaintiff can cite no "standard" for the level of training required for such simple tasks. Even if the Arbitrator concludes more training could have been done, such a

failure would only amount to simple negligence, especially where, as is the case here, there is no evidence that Commonwealth knew more training was necessary to avoid injuries.

Finally, although the evidence does reflect issues related to staff compliance with the Daily Check-in, the evidence as a whole establishes that CSL took action to address those issues prior to Ms. Franklin's incident. It is uncontested that when Ms. Nichols, and other staff, noticed blanks on the Call Log, reminders of the policy were noted in the Shift Reports, additional coaching of staff was conducted, and CSL even hired an additional staff person (Ms. Gentry-Ross) to improve the Daily Check-in. In fact, the evidence in this case reflects that compliance with the Daily Check-in and documentation in the Call Log vastly improved after CSL hired Ms. Gentry-Ross, in part, to handle the Daily Check-in. Moreover, it cannot be forgotten that there were no prior incidents where a resident did not receive assistance due to a failure of the Daily Check-in.

In sum, Plaintiff is unable to establish that Commonwealth took any affirmative action with knowledge that it would likely injure Ms. Franklin, or any other resident. Moreover, as Plaintiff concedes, Commonwealth's conduct *as a whole* must be considered. It is uncontested that Commonwealth offered free emergency pendants to every CSL resident, including Ms. Franklin. This act alone establishes that Commonwealth did not intentionally act in conscious disregard of Ms. Franklin's safety.

The Virginia cases Plaintiff cites as upholding punitive damages awards are easily distinguishable from the facts of this case. First, *Cabiness v. Medical Facilities of AMVIII, Ltd*, No. CL10–005, 2010 WL 7373695, *4 (Va. Cir. Ct. June 21, 2010), is a case dealing with a nursing standard of care in a health care facility that had prior knowledge of similar incidents related to the same conduct. In *Cabiness*, the defendant was actually aware that its nursing staff

was not adequately trained to perform a specialized medical procedure (reinsertion of a feeding tube). Also, there was evidence that similar feeding tube injuries and deaths had previously occurred in the defendant's medical facilities, putting the defendant on notice of the potential for injury. The Daily Check-in in this case is not comparable to an advanced medical procedure. Moreover, there is no evidence in this case that Commonwealth was on notice that previous injuries had occurred as a result of flaws in the Daily Check-in.

In the other case Plaintiff cites, *Crouse v. Prosperous Medical Facilities of America XLVIII*, No. CL09002319–00, 2013 WL 8019583 at *11 (Va. Cir. Ct. January 22, 2013), the decision turned on the defendants' awareness that their training materials improperly instructed their nursing staff in how to use bed alarms. Again, this case involved a nursing standard of care and knowledge of prior incidents causing injury. The evidence established that the defendant medical facility was on notice that the bed alarms were not being used properly and that such improper use was causing injuries, yet the facility failed to revise the training materials to train its staff on the proper use of the alarms. Specifically, the plaintiff cited regulatory survey results that reflected numerous prior incidents related to improper use of bed alarms causing injury. Here again, it is uncontested that there were no prior incidents at any Commonwealth communities in which a resident was injured as a result of a failure of the Daily Check-in procedure. This lack of prior knowledge of a failure causing harm to another independent living resident distinguishes this case from those Plaintiff cites and exposes the flaw in Plaintiff's punitive damages claim.

For all of these reasons, Plaintiff has failed to establish that the Defendants committed intentional acts with knowledge that an injury was likely to occur. Thus, Plaintiff's claim does not qualify for the penalty of punitive damages and should be dismissed.

IV. Conclusion

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

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

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CERTIFICATE

I certify that on this 21st day of January, 2017, 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

_____

32737331_1

SCHEDULE OF FEES FOR OPTIONAL SERVICES

(as of 03/27/15)

***We may change these fees upon 30 days' written notice.**

Additional Services - Available but not included in the Monthly Rate; will be added to monthly bills as supplied:

- Additional Housekeeping @ $20.00 per hour.
- Special Purchases for Special Diet will be charged at cost for any required specialty food purchases. Tray Service to room @ $4.00 per each delivery.
- Personal Transport @ $1.00 per mile $40.00 minimum/trip (Complimentary transportation is available on specific days as scheduled on the Activities Calendar.
- Guest Meals @ $10.00 each.
- Additional Resident Meals @ $8.00 each.
- Apartment Transfer Fee - $500.00 (only applies to residents who have not paid a Community Fee).
- Internal Apartment Moving Assistance-$500.00
- Storage Area Rental $40.00 month (Limited availability)
- Parking Garage Use @ $30.00 per month (Limited availability)
- Pet Fee $500 non-refundable
- Hair Care, Beauty Care and Nail Care are available, with prices varying per treatment.

Other services will be considered and priced upon request.

* daily check yes - by 10 am call or front desk visit if ø resident sighting. staff check

no charge → part of above for free

resident handbook

Terri

Apt 111

back building view

same layout as previous apt (kitchen to left of front door)

- tubs need cut out & handrails
- cable install to be done after move by maint.
- deposit to hold apt
- can take lease to mom to sign
  I sign as guarantor

DEFENDANT'S EXHIBIT 17