VIRGINIA: IN THE CIRCUIT COURT OF NOTTOWAY COUNTY

Matthew Charles Henderson, Administrator of the Estate of Charles L Henderson Plaintiff v. Hickory Hill Retirement Community LLC d/b/a Hickory Hill Retirement Community 900 Cary Shop Road Burkeville, VA 23922 Serve: Registered Agent Dolores Mullens 900 Cary Shop Road Burkeville, VA 23922 and Dolores V. Mullens 900 Cary Shop Road Burkeville, VA 23922 and Countryside Estates, LLC 4119 Lunenburg County Rd Keysville, VA 23947 Serve: Registered Agent Dolores Mullens 900 Cary Shop Road Burkeville, VA 23922 Defendants	)	Law No. _____

COMPLAINT

COME NOW Plaintiff, Matthew Charles Henderson, as Administrator of the Estate of Charles L Henderson and files this Complaint against the above-named Defendants, Hickory Hill Retirement Community LLC, Countryside Estates LLC and Dolores V. Mullens, jointly and

severally, and in support thereof, states the following:

1. Plaintiff brings this action through the Administrator of his Estate and on behalf of the Estate and Statutory beneficiaries who suffered damages and losses. Matthew Charles Henderson was lawfully appointed as Administrator of the Estate of Charles L. Henderson on about August 14, 2018, in Nottoway County, Virginia.

2. Defendant Hickory Hill Retirement Community LLC (HHRC) is a provider of assisted living and elder care services in Virginia operating under the trade name Hickory Hill Retirement Community. Their facility license allowed up to 90 residents and offered specialized dementia care services to their residents.

3. Defendant Dolores V. Mullens was at all pertinent times herein partial owner and Administrator of HHRC.

4. Defendant Countryside Estates LLC is the owner of Hickory Hill Retirement Community LLC. Neither Countryside Estates LLC nor HHRC is a licensed health care provider under Virginia law.

5. The staff who cared for Plaintiff at HHRC were employed by Hickory Hill Retirement Community LLC and/or Dolores Mullens.

6. Venue is proper in this Court as Defendants regularly operate an assisted living facility in Nottoway County, Virginia and through various acts and/or omissions described below, caused injury to Plaintiff in Nottoway County, Virginia.

7. At all times relevant herein Defendants Hickory Hill Retirement Community LLC, Countryside Estates LLC and Dolores Mullens were involved in a joint venture under Virginia law relating to the ownership and operation of HHRC. By virtue of express and/or implied agreements,

each entity/person had a voice in the operation and/or control of the HHRC and each shared in the profits and/or losses of this facility.

8. Prior to filing this case Plaintiff, through his attorney, had highly qualified experts review the records in this case. They certified in writing that Defendants, through their staff, violated assisted living standards causing injury, harm and death to Charles Henderson, as more fully alleged herein.

Count I – Negligence/Survivorship

9. Plaintiff incorporates paragraphs one through eight as if fully set forth herein and further alleges the following:

10. On or about July 24, 2017, Charles Henderson was admitted to HHRC. The staff evaluated Mr. Henderson as pleasant and cooperative, but he had significant dementia and confusion. His son Matthew was the designated decision maker for his father. Upon admission, Matthew Henderson explained that he father was vulnerable to dehydration if he was not given regular fluids. The staff had evaluated Mr. Henderson's hydration level on the first day and noted that his skin was not "tenting."

11. On or about July 26, 2017, Mr. Henderson was noted to be combative with the staff. He was refusing resident care. The facility failed to inform either the treating doctor of family about these care issues.

12. On or about July 27, 2017, the staff of HHRC continued to note that Mr. Henderson was being combative and resistant to care. No physician or family member was notified.

13. On July 28, 2017, the staff notes that Mr. Henderson became combative with the staff – he was incontinent of feces. The staff contacted the son and left a message on his phone.

No physician was notified. The son called back that same day and according to the records, "was unable to offer much insight into these behaviors." No physician was notified.

14. On August 9, 2017, the HHCR staff documents that Mr. Henderson had not eaten or drank fluids "all day." Although this failure to receive fluids put Mr. Henderson at significant risk for complications from dehydration, the HHRC staff failed to notify a physician or contact a responsible family member.

15. On August 10, 2017, Matthew Henderson picked up his father from HHRC and took him to the VA hospital. The HHRC staff had not informed Mr. Henderson of any recent change in his father's condition. At that time, Mr. Henderson noted his father was lethargic and nonresponsive. Upon presentation to the VA hospital, Mr. Henderson learned that his father was in renal failure due, in large part, to his dehydrated status. He was also suffering from Rhabdomyolysis.

16. Defendants, through their staff, operating within the course and scope of their employment, made material misrepresentations to Plaintiff and his family in an effort to induce Mr. Henderson into HHRC. They misrepresented that HHRC had sufficient staff to be able to provide ADL care to Mr. Henderson, including frequent hydration and monitoring of Mr. Henderson's hydration status, as had been done on the first day of his admission.

17. Per their sales brochure, Hickory Hill promised "special amenities and the finest in social, recreational and personal care, as well as specialized care for dementia and Alzheimer's in our Memory Care unit." Hickory described their services to include "RN and LPNs, . . . a full complement of personal care services," including "medication management and health oversight – 24 hours." Their website explains that "our specialized team of trained nurses provides joy and happiness, while providing professionalism in personal care, health care, activities and

stimulation in an environment of beautiful surroundings." As Mr. Henderson required assistance with all his ADL services, the family materially relied on these representations in deciding to admit Mr. Henderson to HHRC.

18. At all times relevant herein, Defendants and their direct care staff who were responsible for the care of Mr. Henderson were aware of his medical condition and history as reflected in his records. Defendants, through their agents/employees, represented to Mr. Henderson and his family, and to the Commonwealth of Virginia, that they could adequately care for Mr. Henderson and that they could meet his needs in an assisted living setting. Defendants agreed to provide various forms of care and monitoring, including assistance with fluid intake, meal consumption, grooming, bathing, incontinence care and monitoring of any changes in his condition. As Mr. Henderson had prior issues with dehydration, he was at high risk for both malnutrition and dehydration if not properly monitored.

19. Under Virginia's "Standards for Licensed Assisted Living Facilities" HHRC was required to provide a program of care that met Mr. Henderson's "physical, mental and psychosocial needs" and "the objectives of the service plan." 22 VAC 40-72-40, *Program of Care.* HHRC was required to provide "staff adequate in knowledge, skills and abilities and sufficient in numbers to provide services to attain and maintain the physical, mental and psychosocial well-being of each resident as determined by resident assessments and individualized service plans." Under Virginia regulations, facilities are prohibited from admitting patients "whose physical or mental health care needs cannot be met in the specific assisted living facility. . ." 22 VAC 40-72-340(G)(12).

20. Based on regulatory and community standards, Defendants were required to deny admission to any resident whose needs they could not meet.

21. Defendant's staff at HHRC negligently failed to properly assess, monitor and address Plaintiff's health, including his need for regular hydration. Defendants negligently admitted Mr. Henderson into their care when they knew or should have known that they did not have the staffing levels necessary to meet his care needs. Defendants and their staff, operating in the course and scope of their employment and in breach of applicable standards, failed to provide the necessary care that Mr. Henderson required. They further breached the standard of care by failing to alert a physician about his declining mental and physical health and resistance to care.

22. Defendants' staff at HHRC, contrary to representations made during the admissions process, never made appropriate care services available to Mr. Henderson. In breach of applicable standards, the facility failed to put in place an individualized service plan for Mr. Henderson. As a result, Defendants' staff failed to undertake a proper assessment of Plaintiff's declining health status and failed to put in place a service plan of care that would have addressed his frequent need for monitoring and hydration.

23. Defendants were investigated by their licensing authority for the events involving Mr. Henderson. Inspections undertaken on or about August 30, 2017 and October 10, 2017, resulted in various assessed deficiencies and breaches in regulatory standards, including, *inter alia*,

a. Failing to have an individualized service plan to meet Mr. Henderson's needs;

b. Failing to assume general responsibility health, safety and welfare of Mr. Henderson, by failing to notify a physician about his combative behaviors and resistance to care, by failing to reassess the resident for alternative placement, by failing to implement a plan for increased supervision and by failing to implement a plan that ensured his aggressive behaviors would not negatively impact his health; and

c. Failing to keep a written plan for medication management, with facility records showing inconsistent medication documentation and lack of staff supervision in medication administration.

24. Defendant Dolores V. Mullens independently breached applicable standards of care by failing to property train her staff, by failing to provide proper instructions and protocols for staff when she was absent from the building and by failing to assure that Mr. Henderson received the care and treatment he needed while at HHRC. Ms. Mullens also left for vacation without assuring that the staff was properly equipped to deal with a resident like Mr. Henderson, who had a high acuity level for an assisted living facility and at times, was resistant to care. Ms. Mullens also failed to properly assess and respond to the dehydrated condition of Mr. Henderson upon her return from vacation.

25. Defendants, through their staff operating within the course and scope of their employment, negligently allowed Mr. Henderson to decline both physically and mentally, without proper care or medical interventions. Defendants' negligence includes, but is not limited to, the following:

a. Failing to adequately assess Mr. Henderson during the admission process and admitting a patient whose needs could not be met in an assisted living setting;
b. Failing to provide daily monitoring of his condition and timely reporting changes in condition to family members and a treating physician;
c. Failing to seek a psychiatric or other referral when Mr. Henderson became combative and resistant to care;
d. Using improper methods and techniques to address Mr. Henderson's agitated behaviors. For example, the staff sought to physically restrain Mr. Henderson by

holding down his arms and feet to provide care. This was a form of physical abuse that caused Mr. Henderson to become further agitated;

e. Failing to follow regulatory standards in place for assisted living facilities, including standards for assessment, documentation, service planning and physician notification;

f. Failing to provide activities and exercises to avoid adverse outcomes. Based on lack of physical activity, Mr. Henderson likely developed Rhabdomyolysis, which further compromised his physical health;

g. Failing to timely reassess the level of care that Mr. Henderson required and failing to provide the necessary discharge recommendations for a higher level of care; and

h. Failing to staff their facility with sufficient staff, properly trained, to meet the care needs of their high acuity residents, including Mr. Henderson.

26. As a direct and proximate result of Defendants' negligence as outlined above, Plaintiff sustained pain, suffering, muscle deterioration and a significant decline in his physical and mental condition. Plaintiff also suffered from inconvenience, indignity and general neglect, which adversely impacted his quality of life and caused suffering separate from his physical injuries. Finally, Plaintiff incurred medical bills in an effort to treat his condition

Count II – Consumer Protection Claims

27. Plaintiff incorporates paragraphs one through twenty-six as if fully set forth herein and further alleges the following:

28. At all pertinent times herein Plaintiff, through his lawful agents, engaged in a consumer transaction as defined under Va. Code § 59.1-198. Plaintiff was a consumer and

Defendants were engaged in the business of providing personal services to their residents, including Charles Henderson.

29. In an effort to recruit patients into their facilities, HHRC had pursued an active marketing program to recruit higher acuity patients, despite not being able to provide effective or consistent care.

30. Defendants, through their staff operating within the course and scope of their employment, intentionally misrepresented various material facts to Plaintiff and his family in an effort to induce them into the HHRC. As part of the admissions process, which constituted a consumer transaction, Defendants' staff stated that they could meet Mr. Henderson's needs for hydration, which they assessed upon the day of admission.

31. As part of the admissions process, Defendants also misrepresented that their facility was equipped to provide "specialized care for dementia and Alzheimer's patients in their Memory Care unit." Such services anticipated that Defendant's staff, if properly trained, would be able to manage combative behaviors that were commonly associated with demented patients who were subject to a change in environment. However, contrary to Defendant's representations, the staff was not equipped to handle combative and aggressive resident like Mr. Henderson. To the contrary, at times the staff would physically hold down Mr. Henderson's arms and legs in an effort to force care upon him. This abusive conduct reflected a staff that, contrary to marking representations, was simply not trained to meet the care needs of cognitively impaired or demented residents like Mr. Henderson.

32. HHRC described their services to include "Rn and LPNs, . . . a full complement of personal care services," including "medication management and health oversight – 24 hours." Their website explains that "our specialized team of trained nurses provides joy and happiness,

while providing professionalism in personal care, health care, activities and stimulation in an environment of beautiful surroundings." In fact, HHRC did not provide health oversight on a 24-hour basis and the staff that cared for Mr. Henderson (after Administrator Mullens went on vacation) lacked the ability to provide meaningful health oversight, as evidenced by the neglect of Mr. Henderson and failure to contact a physician as his condition deteriorated.

33. At the time Defendants made these misrepresentations, they knew or should have known that their staffing at was inadequate to provide such care. Even after it became apparent that Mr. Henderson's needs could not be met in an assisted living setting, Defendants failed to secure discharge or obtain referral to a medical provider. By the time Mr. Henderson's son took him to the VA hospital on August 10, 2017, he was in renal failure in large part because severe dehydration. Soon thereafter he was placed in hospice care and died four days later.

34. Defendants' misrepresentations, as set forth above, constitute material violations of Virginia's Consumer Protection Act, Va. Code § 59.1-200, *et seq.* Defendants, through their staff, engaged in various prohibited practices in connection with the consumer transaction at issue including, misrepresenting that the services had certain characteristics, uses or benefits, such as misrepresenting that HHRC had the ability to provide frequent monitoring and hydration for Mr. Henderson. Defendants also misrepresented that their services were a particular standard or quality when they wrongfully claimed that their staff had specialized training, including nurse supervision, to meet the needs of demented patient. Defendants engaged in such deception, false promises and misrepresentations knowing that Mr. Henderson and his family would likely rely on such information in making their admission decision.

35. Plaintiff and his family reasonably relied upon such material factual misrepresentations and placed their trust in HHRC when they agreed to admit Mr. Henderson.

36. As a direct and proximate result of Defendants' material, factual misrepresentations as noted above, Plaintiff sustained both economic and non-economic damages. The non-economic damages include personal injury, dehydration, muscle deterioration, pain, suffering and debility. The economic damages include medical expenses incurred for the treatment of Plaintiff's injuries and declining physical condition, along with contractual sums paid to HHRC for Mr. Henderson's daily care.

37. Defendant's conduct was willful within the meaning of the Virginia Consumer Protection Act, entitling Plaintiff to treble damages, attorney's fees, costs and other damages.

Count III – Wrongful Death

38. Plaintiff repeats and realleges paragraphs one through twenty-five as if fully set forth herein and further avers as follows:

39. As a direct and proximate result of Defendants' negligence as outlined above, Charles L. Henderson expired on or about August 14, 2017. The primary cause of death as reflected on the death certificate, was renal failure. However, an autopsy performed after death also confirmed that bilateral pneumonia and ischemic necrosis were contributing causes.

40. At the time of his death Charles Henderson was survived by Statutory Beneficiaries including his son Matthew Henderson and daughter Sally Henderson.

41. As a direct and proximate result of Mr. Henderson's death through the negligence of Defendants and their staff, the statutory beneficiaries suffered damages including, *inter alia*, sorrow, mental anguish, loss of solace, loss of society, loss of comfort along with medical and funeral expenses.

Count IV – Punitive Damages

42. Plaintiff incorporates paragraphs one through forty-one as if fully set forth herein and further alleges as follows:

43. As Plaintiff suffered from dementia and confusion which affected his ability to understand, he was completely vulnerable and trusted Defendants to take care of his total care needs. Defendants intentionally mispresented the nature of available services to Plaintiff and his family in an effort to recruit Plaintiff into the facility. Once Plaintiff's admission was achieved, Defendants failed to provide those services despite knowing that such failures would put Plaintiff at increased risk of harm and/or death. Defendant's staff also physically abused Mr. Henderson when they held him down to perform certain acts of "care."

44. Defendants and their agents/employees, who were operating within the course and scope of their employment, took advantage of Mr. Henderson inability to advocate for himself by failing to provide him with the services, assistance and care necessary for his well-being. Defendants failed to timely inform Plaintiff's responsible party of problems with his care, including his agitated and aggressive behaviors, which put him at risk.

45. Defendants also knew that their failure to report changes in condition to a treating physician, would put Mr. Henderson at further risk of injury or death. Despite not consuming fluids and food for extended periods (at one point an entire day), the staff recklessly disregarded Mr. Henderson's rights to be evaluated and treated by other healthcare providers. By the time he was finally removed to the VA hospital by his son on August 10, 2017, he was terminal because of his extensive kidney damage.

46. Defendants knew that the failure to provide sufficient staffing, including a staff with necessary training to care of a high acuity patient, would likely cause injury to residents like Mr. Henderson, who required significant ALD assistance and ongoing incontinence care.

47. Defendants were on notice, through Virginia Department of Social Service Investigations, that the needs of their residents at HHRC were being neglected.

48. Prior to Plaintiff's residency at HHRC, Defendants had been cited by their licensing agency for, *inter alia*, the following violations: failing to assure that staff received proper training, failing to submit verification that a qualified health professional is willing and able to assume responsibility for assisting with the development of the facility's protocols, failing to develop an individualized service plan within 72 hours of admission, failing to submit evidence that an ISP had been updated, failing to provide documentation showing annual staff evaluations, failing to label medications, failing to correct a strong odor of urine, and failing to secure a hazardous area. Many of these failures, especially those related to staff training and lack of proper service planning, are substantially similar to the neglect experienced by Mr. Henderson.

49. Given Defendants' history of non-compliance with basic regulatory standards, Defendants' management staff knew or should have known that HHRC was not suited for residents with high acuity or who had potential behavioral problems. Defendants' management, in an effort to generate increased revenues and profits, intentionally admitted high acuity residents who were beyond the care abilities of their staff. Such admission practices, designed to increase census and revenue, recklessly sacrificed the resident's safety rights for increased profits.

50. Defendants recklessly disregarded Plaintiff's rights when they admitted Mr. Henderson despite their knowledge that they lacked a sufficient staffing to monitor him and keep him hydrated on a daily basis. Defendant Mullens knew or should have known that leaving the staff without proper supervision and training would put her high acuity residents like Mr. Henderson at risk. The supervising staff also lacked proper training to determine when to contact a physician. Defendants intentionally, and/or with reckless indifference, mispresented their

abilities to care for a patient like Mr. Henderson when they informed Matthew Henderson that they could monitor his hydration status with a nursing staff that could assess his condition.

51. Even after Defendant's staff became aware of the progression of Mr. Henderson's condition, they continued to neglect his needs despite their knowledge that such failures would lead to the further decline of Mr. Henderson. The staff even documented that Ms. Henderson had gone for extended periods (at least an entire day) without food or water, yet the staff failed to timely notify a physician or seek a higher level of care. Defendants' staff, recklessly disregarded the rights of Mr. Henderson by failing to recommend examination by a doctor and/or discharge him to a higher level of care.

52. Defendants ratified their employees/agents' conduct by condoning it and by failing to correct repeated prior incidences of neglect of their residents in ways that were substantially similar to the neglect experienced by Mr. Henderson. Defendants also ratified the conduct of their staff by intentionally and/or recklessly staffing its facility without a sufficient number of properly trained staff. As Defendant's management staff, including Ms. Mullens, was aware of the regulatory violations and inability of their staff to meet the needs of their residents, including Mr. Henderson and directly participated in the neglect and willful conduct described above, the management staff ratified the acts of its agents and employees rendering the corporate Defendants liable for punitive damages. Finally, management also ratified the conduct of their staff by condoning it and concealing it by not initially reporting these violations to their licensing authority.

53. As a direct and proximate result of the aforesaid willful and wanton negligence, Mr. Henderson sustained personal injuries including a serious decline in his physical and mental health, muscle deterioration, severe dehydration and renal failure, suffered great pain of body and

mind, suffered emotional distress, and incurred medical and out-of-pocket expenses, costs, and attorney's fees.

Wherefore, these and other premises considered, Plaintiff moves this Court for judgment against Defendants, Hickory Hill Retirement Community LLC, Countryside Estates, LLC and Dolores Mullens, jointly and severally, as follows:

a. An award of compensatory damages of $2.5 million, plus costs and interest from August 10, 2017;

b. An award of punitive damages of $400,000, plus costs, interest and fees;

c. Attorney's fees and treble damages under the Consumer Protection Act;

d. Prejudgment interest to be determined by the trier of fact; and

e. Any other relief that this Court determines is appropriate.

Jury Demand

Plaintiff requests that a jury resolve all issues of liability and damages in this case.

Date: April 18, 2019

Respectfully submitted, Plaintiff, by counsel

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