VIRGINIA: IN THE CIRCUIT COURT OF FAIRFAX COUNTY

Sara A. McCorlde, by and through her Next Friend, Allen D. McCorkle Plaintiff v. **Erickson Senior Living LLC** and **Greenspring Village Inc**	)))))))))))))))	Law No. CL22-4439

MOTION TO AMEND THE COMPLAINT
TO CONFORM THE PEADINGS TO THE EVIDENCE
DISCLOSED DURING DISCOVERY

COMES NOW Plaintiff, by counsel, and files this, his Motion to Amend the Compliant to Conform the Pleadings to Evidence Disclosed During Discovery, and in support thereof, states as follows:

I. Background

After suffering neglect at her assisted living facility resulting in severe bum injuries, Plaintiff's family removed Ms. McCorkle from Greenspring Assisted Living. Plaintiff has asserted viable claims based on negligence, breach of contract, violations of the Virginia Consumer Protection Act, along with punitive damages. Defendants demurred only to the Consumer Protection claim, which was overruled by this Court on June 24, 2022.

Discovery has revealed additional facts supporting Plaintiff's claims. Given the complexity of Plaintiff's various claims, Plaintiff also seeks to clean up the pleadings by

dismissing one party that was not directly involved the care of Ms. McCorkle, specifically, National Senior Campuses Inc. Based on Defendants' admission to various regulatory violations involving Ms. McCorkle, Plaintiff has also pled negligence per se, as part of his negligence claim. This should come as no surprise to the Defendants, as Plaintiff previously pled the same regulatory violations in the original complaint, but at the time was not aware of Defendant's response to these regulatory violations. In discovery Plaintiff learned that Defendants did not contest the regulatory findings involving Plaintiff, but rather came up with a plan of correction. (Exh. No. 1, survey violations involving Ms. McCorkle with Defendants' plan of correction).'

I. ARGUMENT

A. Leave to Amend Shall be Liberally Granted

This is Plaintiff's first attempt to amend the pleadings after discovery has revealed additional facts that support Plaintiff's negligence, consumer protection and punitive damage claims. The parties are still engaging in discovery and the trial of this matter is set for March 6, 2023. As such, Defendants suffer no prejudice in responding to this amended pleading.

Pursuant to Supreme Court Rule 1:8, leave to amend should be liberally granted in furtherance of the ends of justice. Unless Defendants can show prejudice, it would be an abuse of discretion not to allow this amendment. See, *Martarino v. Consulting Eng'g Service,* 251 Va. 289, 467 S.E.2d 778 (1996)(Where the record showed no prejudice to Defendant, the trial court abused its discretion in not allowing Plaintiff to file his first amended complaint).

'Plaintiff previously issued a corporate designee notice to fully explore Defendants' responses to these alleged regulatory violations. While this deposition has yet to take place, Plaintiff did obtain Defendants' written plan of correction providing relevant evidence regarding Defendants' initial response to their adverse licensing surveys.

B. **Defendants Are Not Prejudiced by this Amendment**

Aside from dismissing a Defendant, this proposed amendment does not change Plaintiff's claims, which are premised on the same underlying conduct as set forth in the original complaint. The amount of claimed damages remains the same.

As discovery has revealed that Defendants did not contest the various regulatory violations the Department of Social Services issued against them for the alleged neglect of Ms. McCorkle, Plaintiff added language in the negligence count to clarify that she will be seeking negligence per se jury instructions at the time of trial.

The *negligence per se* allegations do not add a new claim; they simply set forth an additional basis for holding Defendants liable under Plaintiff's common law negligence claim. Where a standard of care is set by statute, an act which violates the statute is per se a violation of the standard of care. *Schlimmer v. Poverty Club,* 268 Va. 74, 78, 567 S.E.2d 43, 46 (2004). Where a Plaintiff shows that a particular harm resulted from a violation of statute or regulation, it would constitute reversible error not to instruct the jury on the doctrine of negligence per se. *McClung v. Commonwealth,* 215 Va. 654, 657, 212 S.E.2d 290, 293 (1975).

At trial this Court is obligated to properly instruct the jury on Plaintiff's negligence claims, including negligence per se doctrine, if supported by the facts. Plaintiff is pursuing this amendment now, so Defendants cannot argue surprise at trial. However, simply alleging a violation of regulations *(as* Plaintiff did in her first complaint) presents the Court with a claim of negligence per se. *MaCoy v. Colongy House Builders, Inc.,* 239 Va. 64, 69, 387 S.E.2d 760, 763 (1990).

In *White v. Robert Claude Gore and Merchants Grocery Company,* 201 Va. 239, 110 S.E.2d 228 (1959) Plaintiff filed a negligence action arising out of an automobile accident with a

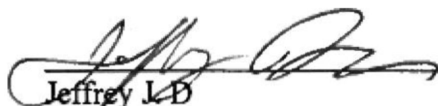
truck operated by Defendant. During deliberations, the Foreman asked the court whether, if a person violated the letter of the law, negligence would be presumed. The Judge replied that negligence is never presumed but must be proven. Counsel for Plaintiff then requested the Judge instruct the jury that a violation of a traffic regulation is negligence per se, if it was a contributing cause to the accident. The trial judge refused and the Supreme Court reversed, noting that based on the evidence and the Defendant's alleged violation of the applicable traffic regulation, the jury should have been instructed on negligence per se.

To the extent that Defendants argue that negligence per se must be pled in a separate count, apart from the negligence claim in Count I, they are wrong. Negligence per se does not create a duty of care, but merely sets the standard of care by which the Defendant may be judged in the underlying common-law action. *Tingler v. Graystone Homes Inc,* 834 S.E.2d 244, footnote 18. (2019); *Williamson v. Old Brogue Inc,* 232 Va. 350, 355, 350 S.E.621 (1986). (The doctrine of negligence per se does not create a cause of action where none otherwise exists).

Even if this Court concluded that the negligence per se allegations constitute a new, additional claim, Plaintiff would still be entitled to amend this complaint under Va. Code § 8.01-6.1. The allegations arise out of the same operative facts as alleged in the first complaint, Plaintiff has been reasonably diligent in pursuing the amendment and Defendants will not be prejudiced by the amendment. See, *Stanley v. Storck,* 61 Va. Cir. 515 (Norfolk 2003)(Amended counterclaim which added alleged defamatory statements that were not included in the original counterclaim, related back to the original filing, as they arose out of the same conduct stated in the original complaint).

Wherefore, these and other premises considered, Plaintiff moves this Court for an order granting Plaintiff's Motion to file the attached Amended Complaint. (Exh. No. 2).

Respectfully submitted, Plaintiff, by counsel,



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Counsel for Plaintiff

CERTIFICATE OF MAILING

I hereby certify that a true copy of the foregoing Plaintiffs Motion to Amend, with attachments, was served upon Defendants, by sending a copy of this Motion, with attachments, via e-mail, this 14th day of December 2022, to the following:

Ryan Furguson
Kiernan Trebach, LLC 1108
E. Main St, Suite 801
Richmond, VA 23219
Email: rfurguson@kiemantrebach.com
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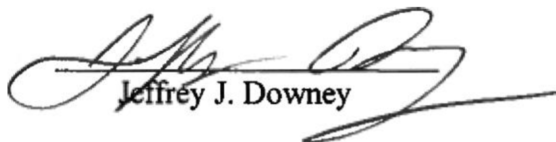
Counsel for Defendants



Exh. No. 1

Search for an Assisted Living Facility

'Return to Search Results I New Search I

GreenspAng Village
7470 Spring Village Dr
Springfield, VA 22150
(703) 923-4663

Current Inspector: Jeannette Zaykowski (703) 895-5627

Inspection Date: Feb. 22, 2021

Complaint Related: Ye

Areas Reviewed:

22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES
22VAC40-73 PERSONNEL
22VAC40-73 ADMISSION, RETENTION, AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES

Comments:

This inspection was conducted by licensing staff using an alternate remote protocol, necessary due to a state of emergency health pandemic declared by the Governor of Virginia.

A complaint inspection was initiated on 02/22/2021 and concluded on 01/21/2022. A complaint was received by the department regarding allegations in the areas of Resident Care and Related Services, and Personnel, . The Assistant. Administrator of Continuing Care was contacted by telephone to conduct the investigation. The licensing inspector emailed the Assistant Administrator of Continuing Care a list of documentation required to complete the investigation.

The evidence gathered during the investigation supported the allegations of non-compliance with standards or law, and violations were issued. Any violations not related to the complaints but identified during the course of the investigation can be found on the violation notice.

Areas of non-compliance are identified on the violation notice. Please complete the "plan of correction" and "date to be corrected" for each violation cited on the violation notice and return to the licensing office within 10 calendar days.

Please specify how the deficient practice will be or has been corrected. Just writing the word "corrected" is not acceptable. The plan of correction must contain: 1) steps to correct the non-compliance with the standard(s), 2) measures to prevent the non-compliance from occurring again; 3) person(s) responsible for implementing each step and/or monitoring any preventative measure(s); and 4) date that that plan of correction will be completed.

Thank you for your cooperation and if you have any questions please call (703) 895-5627 or contact me via e-mail at jeannette.zaykowski@dss.virginia.gov.

Violations:

Standard #: **22VAC40-73-40-A**

Complaint related: **No**

Description: **Based on documentation review, the facility failed to ensure that the licensee shall ensure compliance with all regulations for licensed assisted living facilities and**

with the facility's own policies and procedures.

EVIDENCE:

1. **Facility Policy 8614.12 Unusual Occurrences: Notification of Regulatory Agencies states "All unusual occurrences are reported as soon as possible to the State Licensing Agency" and includes "any condition or event which has or may compromise(d) the health or safety of the residents".**
2. **Facility Policy (not numbered) Call Bell System Response states "Nursing staff will manually clear all nurse calls within 15 minutes to prevent an overload of calls within the system, which in turn will prevent a delay in response time to the phone handsets".**

Plan of Correction: **Not available online. Contact Inspector for more information.**

Standard #: **22VAC40-73-70-A**

Complaint related: **Yes**

Description: **Based on interview and documentation, the facility failed to ensure that each facility shall report to the regional licensing office within 24 hours any major incident that has negatively affected or that threatens the life, health, safety, or welfare of any resident.**

EVIDENCE:

Clinical notes on 12/21/2020 at 11:05 a.m. document that Resident I was found "lying in the shower on the floor" and "writer called and on call...to inform about fall and abrasion" and "with AM nurse noted redness on resident abdominal region , facial cheeks and breast"; and Clinical notes on 12/21/2020 at 12:21 p.m. document "Resident (1) was reassessed and redness has increased...and blisters *were* observed...". The facility did not report the incident within 24 hours to the regional licensing office.

Plan of Correction: **Not available online. Contact Inspector for more information.**

Standard #: **22VAC40-73-70-C**

Complaint related: **Yes**

Description: **Based on interview and documentation review, the facility failed to ensure that the facility shall submit a complete written report of each incident specified in subsection A of this section to the regional licensing office within seven days from the date of the incident and the report shall be signed and dated by the administrator and shall include the following information: Name and address of the facility; Name of the resident involved in the incident; Date and time of the incident; Description of the incident, the circumstances under which it happened, and the extent of injury; Location of the incident; Actions taken in response to the incident; Actions to prevent recurrence of the incident, if applicable; Name of staff person in charge at the time of the incident; Names, telephone numbers, and addresses of witnesses to the incident, if any; and Name, title, and signature of the person making the report, if other than the administrator, and date of the completion of the report.**

EVIDENCE:

As specified in subsection A of this section, the facility did not submit a complete report on Resident I's incident that occurred on 12/21/2020 to the regional licensing office within seven days.

Plan of Correction: Not available online. Contact Inspector for more information.

Standard #: 22VAC40-73-450-C
Complaint related: Yes
Description: Based on record review, the facility failed to ensure that the comprehensive Individualized Service Plan (1sp) shall include description of identified needs and date identified based upon the Uniform Assessment Instrument (UAJ), admission physical examination and other sources.

EVIDENCE:
Resident l's JSP differs from other sources in the following areas:
I. Wheeling: Resident 1's Physical Examination Report dated 11/23/2020 documents that the resident "ambulatory via WC" (wheelchair) and "uses WC"; the UAI dated 11/24/2020 documents a need for help wheeling "human help only, supervision" and does not document the need for physical assistance and mechanical help; Staff 5 reported in Clinical Notes dated 11/25/2020 at 9:00 PM that the resident "came in a W/C" upon admission"; Resident l's ISP dated 11/25/2020 documents Resident 1 "will use her transport chair for mobility and will need staff assistance to push her."

2. Bathing and Toileting: Resident 1's UAI dated 11/24/2020 documents resident needs help with Bathing and Toileting as "human help only, physical assistance" and does not document a need for mechanical help; Resident l's I E dated 11/25/2020 documents a "shower chair / stool" and a "safety handrail frame for toilet" as needed mechanical devices in addition to "standby or hands-on assistance" in bathing and bathroom.

3. Walking: Resident l's UAI dated 11/24/2020 documents resident needs help Walking as "human help only, supervision" and does not document a need for mechanical help; Staff 6 reported on Clinical Notes dated 11/26/2020 at 7:28 AM that "resident ambulated on hall way with walker with private aid" and Staff 7 reported on Clinical Notes on 11/26/2020 at 12:23 PM "Has a private sitter with her...Noted using her walker to the bathroom and within her room." Resident l's ISP dated 11/25/2020 documents a needed device "wheelchair (manual) walker" and staff will need to provide stand-by supervision when (resident) is using her walker for mobility" and assistance from private aid is not documented in addition to the staff for walking.

Plan of Correction: Not available online. Contact Inspector for more information.

Standard #: 22VAC40-73-460-B
Complaint related: Yes
Description: Based on record review, the facility failed to ensure that care provision and service delivery shall be resident-centered to the maximum extent possible and shall include prompt response by staff to resident needs as reasonable to the circumstances.

EVIDENCE:
Facility's call history dated between 11/25/2020 and 12/21/2020 for Resident I's floor EV-1 documented 72 calls logged and:
1. 5/72 calls were cancelled between 1-3 hours,
2. 11/72 calls were cancelled between 31-59 minutes,

3. 14/72 calls were cancelled between 16-30 minutes,
4. and 42/72 calls were cancelled between 1-15 minutes.

Plan of Correction: Not available online. Contact Inspector for more information.

Standard #: 22VAC40-73-460-D
Complaint related: No
Description: Based on record review and interview, facility failed to ensure that the facility shall provide supervision of resident schedules, care, and activities, including attention to specialized needs, such as prevention of falls.

EVIDENCE:
1. On 12/21/2020 Resident I was found alone and unsupervised on the resident's bathroom shower floor.

2. Clinical Notes e-signed by Staff 4 on 12/21/2020 at 11:05 AM documented "Writer noted water on hallway floor went into resident's room noted her in sidelying position with her head facing shower nozzle and her feet facing side wall with water running inside shower."; and also "AM nurse noted redness on resident abdominal region , facial cheeks and breast." On 12/21/2021 at 12:21 PM, Staff 4 documented "Resident was reassessed and redness has increased to lower extremities and blisters were observed on her back, and chest" and it was decided to send resident to hospital.

3. Resident l's Uniform Assessment Instrument dated 11/24/2020 shows Resident 1 needs help for bathing with "Human Help Only, Physical Assistance".

4. Resident l's Individualized Service Plan signed by staff and family on 11/25/2020 documents "Staff will need to provide hands on assistance throughout her entire bathing routine."

Plan of Correction: Not available online. Contact Inspector for more information.

Standard #: 22VAC40-73-580-E
Complaint related: No
Description: Based on interview and documentation, the facility failed to ensure that the facility shall implement a policy to monitor each resident for compliance with any needs determined by the resident's Individualized Service Plan Oa

EVIDENCE:
Resident l's Individualized Service Plan dated 11/25/20220 documents that resident requires "assistance with bathing, hands-on" at a frequency of "1-2 times per week"; and Staff 1 informed Licensing Inspector that residents are offered showers on specific days however the facility does "not keep records of the date/time offered and if it was given."

Plan of Correction: Not available online. Contact Inspector for more information.

Disclaimer:
A compliance history is in no way a rating for a facility++.

The online compliance history includes only information after July 1, 2003. In addition, the online compliance history includes information regarding adverse actions that may be the subject of a pending