VIRGINIA:

IN THE CIRCUIT COURT FOR LOUDOUN COUNTY

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| Plaintiff, (name redacted) by her next friend, Plaintiff's Guardian (name redacted and Power of Attorney | ) | |
| Plaintiff, | ) | |
| v. | ) | Law No. _____ |
| CCSP NOVA LLC<br>a/k/a Nova Care LLC<br>d/b/a Cameron Glen Health and Rehab Center<br>46531 Harry Byrd Hwy, Sterling, VA 20164<br>Serve: Registered Agent: Jeannie Adams<br>5372 Fallowater Lane, #200<br>Roanoke, VA 24018 | ) | |
| INOVA HEALTH SYSTEMS SERVICES<br>8100 Gatehouse Road, Suite #200E<br>Falls Church, VA 22042<br>Serve: James Kim<br>8110 Gatehouse Rd, East Tower#200<br>Falls Church, VA 22042 | ) | |
| POTOMAC FALLS HEALTH AND REHAB CENTER<br>a/k/a Cameron Glen Health and Rehab Center<br>1800 Cameron Glen Drive<br>Reston, VA 20170<br>Serve: Registered Agent: Jeannie Adams<br>5372 Fallowater Lane, #200<br>Roanoke, VA 24018 | ) | |
| COMMONWEALTH CARE OF ROANOKE INC.<br>a/k/a Commonwealth Care or Roanoke<br>5372 Fallowater Lane, #200<br>Roanoke, VA 24018<br>Serve: Registered Agent: Jeannie Adams<br>5372 Fallowater Lane, #200<br>Roanoke, VA 24018 | ) | |

)
)
Defendants. )

**COMPLAINT**

COMES NOW Plaintiff, by her next friend and Power of Attorney and moves this Court for judgment against Defendants CCSP Nova LLC, a/k/a Nova Care LLC, Inova Health Systems Services, Potomac Falls Health and Rehab Center and Commonwealth Care of Roanoke, Inc. ("Defendants"), jointly and severally, on the grounds and in the amounts hereafter set forth:

1. At all times herein, the Defendants transacted business in the County of Loudoun by owning and operating the long-term care facility known as Cameron Glen Health and Rehab Center ("Cameron Glen"), 6531 Harry Byrd Hwy, Sterling, Virginia.

2. At all pertinent times herein, Defendant Commonwealth Care of Roanoke, Inc. was the management company operating Cameron Glen.

3. As of January 1, 2013, up through the time that Plaintiff was a patient at Cameron Glen, CCSP NOVA LLC a/k/a Nova Care LLC was the licensed operator of Cameron Glen pursuant to license No. NH2776. In 2014, the trade name of the nursing home was changed from Potomac Falls Health and Rehab Center to Cameron Glen Health and Rehab Center.

4. At all relevant times alleged herein, Defendant Inova Health System Services had an ownerships interests in Cameron Glen and provided related services, including lease and management services.

5. At all times alleged herein, Defendants CCSP Nova LLC, a/k/a Nova Care LLC, Inova Health Systems Services, Potomac Falls Health and Rehab Center and Commonwealth Care of Roanoke, Inc., were engaged in a joint venture as defined under Virginia law. By virtue of agreements between them, these Defendants participated in the control and/or operation of

Cameron Glen for their mutual benefits and shared in the profits and/or losses of their joint venture. Each Defendant had a voice in the nursing home's operation, control, and/or management.

6. From the time of her initial admission through her discharge, Plaintiff had a continuous and substantially interrupted course of treatment from Defendants and their agents for the same conditions which prompted her admission.

7. On or about April 14, 2016, Plaintiff''s daughter was appointed as Power of Attorney for her mother with full legal authority to handle all financial matters including the pursuit of her legal rights and remedies.

8. Prior to filing this action, the Plaintiff, through her counsel, obtained the required Certificate of Merit from a highly-qualified expert supporting the allegations in this case that Defendants, through their staff, breached applicable standards of care in the care and treatment of Plaintiff, leading to personal injuries as described herein, including a left hip fracture.

**COUNT ONE**
**(Negligence/Survivorship)**

Plaintiff repeats and realleges each allegation set forth in paragraphs one through eight as if fully set forth herein and further states as follows:

9. At all times relevant herein, Defendants and their direct care staff who were responsible for the care of Plaintiff were aware of her medical condition and history as reflected in her records. Defendants, through their agents/employees, represented to Plaintiff, her family, and to the Commonwealth of Virginia that they could adequately care for Plaintiff and provide nursing, rehabilitative and necessary related care. They also represented that they would provide staff with sufficient numbers and sufficient training to meet the total care needs of their nursing home residents, including the needs of Plaintiff.

10. Defendants and their agents/employees owed Plaintiff a duty to provide reasonable care and to properly monitor, assess, treat, maintain, and rehabilitate her. Furthermore, the duty to provide Plaintiff's care was a non-delegable duty; hence, Defendants are responsible for the conduct of those to whom they delegated such duties.

11. Defendants, as operators of a skilled nursing facility, had a duty to provide sufficient staffing including nurses, nurse aides, and other staff in sufficient numbers and with sufficient training to meet the needs of Plaintiff. Defendants, before and during Plaintiff's residency were aware of significant deficiencies in the care of their residents, including Plaintiff, yet persistently and in violation of applicable standards of care, provided staffing which was insufficient in numbers and training to meet the needs of their nursing home residents, including the needs of Plaintiff. This proximately caused and/or contributed to substandard care which was provided to Plaintiff in various healthcare areas, as described below.

12. Plaintiff was admitted to Cameron Glen on or about February 18, 2016. She was known to the facility from prior admissions. Her history on admission included a history of falling, prior rib fracture, arthritis, confusion, lack of coordination and difficultly walking. She was on medications that increased her risk of falling and impaired her judgment, including narcotics. Defendants' staff knew that Plaintiff was a high fall risk requiring active supervision and assistance. In fact, she had fallen during a prior admission.

13. As of March 1, 2016, Plaintiff required extensive assistance with activities of daily living (ALDs), including toileting. Based on these fall risk factors and Plaintiff's need to void in the evening, Plaintiff's daughter had asked for a bedside commode and requested the staff put mats down to reduce her mother's risk of injury. She had also requested that alarms be used because Plaintiff had sustained a prior similar fall to her March 1, 2016 fall. The staff

failed to accommodate these requests or put other required interventions in place to address Plaintiff's high fall risk.

14. In the 10 days leading up to the March 1, 2016 fall, Defendants' staff had repeatedly failed to address Plaintiff's requests for assistance to the toilet, including the early morning of March 1, 2016, when Plaintiff was found on the ground, having suffered a fall and resulting injuries. Defendants and their staff, including nurses and nurse aides, breached applicable standards of care in failing to provide Plaintiff with the assistance and supervision she needed to prevent falls, including her fall of March 1, 2016.

15. In addition to the acts described above, Defendants through their agents and employees, during a continued patient relationship and acting within the course and scope of their employment, subjected Plaintiff to additional forms of substandard care in violation of accepted standards, as follows:

a. Defendants and their agents/employees failed to undertake adequate fall assessments of Plaintiff's condition and/or document the results of such assessments in her record;

b. Defendants and their employees negligently failed to provide adequate care planning, including care planning for fall prevention;

c. Defendants and their agents and employees negligently failed to provide adequate assistance with ADL activities including hygiene and related care. Defendants' staff either ignored or delayed their response to Plaintiff's request of assistance through her call lights. At times, Plaintiff would be forced to void urine or feces upon herself, given the staff's failure to timely toilet her;

d. Defendants and their management staff failed to provide adequate supervision of the staff, who would watch TV and use their phone while patient call lights went unanswered;

e. Defendants and their staff failed to provide Plaintiff with adequate assistance in consuming food and water. She required assistance with her meals that was not provided on a consistent basis, causing weight loss; and

f. Defendants and their management staff failed to provide appropriate staffing, including appropriately trained staff to meet Plaintiff's needs and keep her safe in a skilled care environment.

As a direct and proximate result of the aforesaid negligence and breaches in applicable standards of care, Plaintiff sustained personal injuries including a hip fracture. She also suffered from humiliation, embarrassment, inconvenience and a corresponding decline in her physical and mental condition, as well as pain and suffering. Finally, she further incurred medical and related costs to treat her injuries.

**COUNT TWO**
**(Punitive Damages)**

Plaintiff incorporates by reference paragraphs one through fifteen as if fully set forth herein and further alleges as follows:

16. As of her February 18, 2016 admission, Plaintiff required extensive assistance with activities of daily living. Because she was a high fall risk, she required vigilant monitoring and staff assistance with all transfers, including transfers in and out of bed and to the toilet.

17. At all relevant times herein, Defendants knew or should have known that the failure to provide appropriate fall prevention for Plaintiff would place her at a high risk of injury or death. In disregard of Plaintiff's rights to live in a safe environment, Defendants failed to

provide basic safety measures including increased supervision, timely call light responses, and protective floor mats.

18. Defendants also knew that the failure to answer Plaintiff's call lights on time would result in her seeking to go to the bathroom on her own, which put her at high risk for injury. Defendants, in conscious disregard of this risk, consistently failed to timely respond to Plaintiff's call bell requests, including on the morning of March 1, 2016 (when she sustained a hip fracture), despite their knowledge that such failure would likely cause injury to Plaintiff.

19. Based on Defendants' regulatory history with the Department of Health, Defendants' management staff should have known that their direct care staff was placing their residents, including high acuity residents, in significant jeopardy. Such failures flowed from lack of proper staff training for high acuity patients and lack of adequate staffing.

20. In the three years leading up to Plaintiff's February 2016 admission, Defendants were cited by their licensing authority for, *inter alia*, the following violations:

a. failing to develop comprehensive care plans;

b. failing to provide a sanitary environment;

c. failing to follow physician orders regarding patient care;

d. failing to meet proper professional standards;

e. failing to recognize, monitor and report a change in the resident's condition to his/her treating physician;

f. failing to treat residents with dignity and respect;

g. failing to assure accurate resident assessments;

h. failing to assure the accuracy of documentation;

i. failing to provide a safe environment and proper resident supervision; and

j. failing to notify family members of a resident's change in medical status and admission to hospital prior to the resident's death;

21. Many of the assessed violations were similar to the deficiencies experienced by Plaintiff, yet Defendants, in reckless disregard of Plaintiff's rights, failed to address and/or correct known deficiencies in care which put their residents and Plaintiff, at increased risk of harm.

22. Defendants and their staff operating within the course and scope of their employment attempted to conceal their neglect of Plaintiff by failing to document the true circumstances of her March 1, 2016 fall in the record and by failing to make timely and/or accurate mandatory reporting of this incident to their licensing authority.

23. Defendants' management staff, because they were aware of the circumstances surrounding Plaintiff's fall and the serious nature of her injuries, directly participated in the conduct described above, and as such, ratified the actions of their staff members. Defendants also directly participated in the conduct which caused Plaintiff's injuries by failing to staff their facility with sufficient staffing, including a properly trained staff, which was necessary to meet the needs of their high acuity patients like Plaintiff. Defendants also ratified their employees conduct by condoning it and failing to correct prior incidences of resident neglect, including prior problems with Plaintiff's care, which were voiced by her daughter. This ratification conduct and direct corporate action render the Defendant corporations and limited liability companies directly liable for punitive damages.

24. As a direct and proximate result of Defendants' willful, wanton and reckless conduct as described above, Plaintiff sustained significant personal injuries including a hip

fracture, physical pain and suffering, a decline in her health status, and further incurred medical and other expenses to treat her injuries.

Wherefore these and other premises considered, Plaintiff, by and through her next friend moves this Court for judgment against Defendants, CCSP Nova LLC, a/k/a Nova Care LLC, Inova Health Systems Services, Potomac Falls Health and Rehab Center and Commonwealth Care of Roanoke, Inc., jointly and severally, for the following relief:

a. $1,250,000.00 in compensatory damages for injuries and damages sustained plus costs and prejudgment interest from March 1, 2016;

b. $700,000.00 in punitive damages with interest from March 1, 2006;

c. post-judgment interest and costs;

d. and any additional relief this Court deems appropriate.

**JURY DEMAND**

Plaintiff demands a jury by jury as to all issues involved.

Plaintiff , by and through her Next Friend, and though her Counsel,

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