VIRGINIA: IN THE CIRCUIT COURT OF FAIRFAX COUNTY

Sara A. McCorkle, by and through her Next Friend, Allen D. McCorkle Plaintiff v. **Erickson Senior Living LLC** a/k/a Erickson Senior Living 701 Maiden Choice Lane Baltimore, MD Registered Agent: Corporation Service Company 100 Shockoe Slip, 2nd floor Richmond, VA 23219-4100 **Greenspring Village Inc** a/k/a Greenspring Village 7410 Spring Village Drive Springfield, Virginia 22150 Registered Agent: Corporation Service Company 100 Shockoe Slip, 2nd floor Richmond, VA 23219-4100 Defendants	)	Law No. CC-22-0004439

First Amended Complaint

COMES NOW Plaintiff, Sara A. McCorkle, through her Next Friend Allen D. McCorkle, and moves this Court for judgment against Defendants Erickson Senior Living LLC and Greenspring Village Inc., jointly and severally, and in support thereof, states as follows:

1. At all times relevant herein Defendants transacted business in Fairfax County by owning and operating an assisted living facility known as Garden Ridge Assisted living ("Garden Ridge"), at 7470 Spring Village Drive, Springfield Virginia, 22150.

2. Defendant Erickson Senior Living LLC ("Erickson") manages long term care communities, employing some 14,000 people and providing services to over 25,000 seniors across the United States. There are now over 30 companies within the Erickson corporate family, including Defendants National Senior Communities and Greenspring Village Inc. Erickson also employed the direct care staff who cared for Plaintiff and provided the staff with guidelines and protocols designed to meet both regulatory and community practice standards.

3. Defendant Greenspring Village Inc. ("Greenspring Village") is the licensed operator of an assisted living facility within the Erickson community known as Garden Ridge, located at 7470 Spring Village Drive, Springfield, Virginia 22150.

4. Plaintiff Sara McCorkle had been long-term resident at Greenspring Village since 2002. From her initial admission until her injuries on December 21, 2020, Ms. McCorkle had a continuous and substantially uninterrupted course of treatment from Defendants and their staff, for the same conditions which prompted her admission. Her son Allen D. McCorkle is her lawful Power of Attorney, which arrangement was formalized on July 26, 2011.

5. At all times alleged herein Defendants Erickson Senior Living LLC and Greenspring Village Inc. were engaged in a joint venture under Virginia law. By virtue of agreements between them, these Defendants participated in the control and operation of Garden Ridge for their mutual benefit and shared in the profits and/or losses of their joint venture. Each Defendant had a voice in the facility's operation, control and/or management.

COUNT I
(Negligence/Survivorship – All Defendants)

Plaintiff repeats and realleges each allegation set forth in paragraphs one through five and further alleges as follows:

6. At all times relevant herein, Defendants and their direct care staff who were

responsible for the care of Ms. McCorkle were aware of her history and medical condition, which included dementia, confusion, unsupervised toileting attempts and falls. Defendants, through their agents/employees, represented to Ms. McCorkle and the Commonwealth of Virginia that they were licensed to meet the needs of their residents, including Plaintiff. They also represented that they had staff in sufficient numbers and with sufficient training to meet the needs of demented and confused residents, like Sara McCorkle.

7. As Ms. McCorkle lost her independence, she transitioned to the assisted living unit, Garden Ridge, on or about November 25, 2020. At the time of transfer, she had a history of falls as noted below, which put the Defendants on notice of her need for hands on care for all ADLs, especially toileting and bathing. Ms. McCorkle also had dementia and confusion, rendering her incapable of making informed judgments about her own safety.

8. Sara fell on July 31, 2019, because she attempted to walk without support.

9. Sara fell January 4, 2020, and suffered a thoracic spine fracture. After this injury her cognition continued to decline, and she could not be relied upon to remember staff directives.

10. As part of Sara's admission, Garden Ridge undertook a Uniform Assessment on November 24, 2020 to determine an appropriate plan of care. The stated goal was to provide Sara with an environment and systems in place to prevent falls and receive prompt attention from the staff. She required staff assistance for dressing, walking and transferring. She required hands on assistance while bathing.

11. In an effort to address Ms. McCorkle's safety issues, the staff developed a service plan, which became part of Ms. McCorkle's plan of care. The plan required hands-on assistance while in the bathroom and noted that her routine included a shower in the morning. She enjoyed

the hot water but was not able to get water in her ears. She was also incontinent of urine, prompting frequent visits to the bathroom.

12. On November 25, 2020, the staff assessed Sara as being alert with intermittent confusion. She was unable to hear in her left hear, was unsteady on her feet, had syncope and could collapse. She used a walker and had ongoing shoulder pain.

13. That same day Plaintiff's daughter met with the Don Wright, Manager, who stated the family would not need private duty aides as the staff would be able to provide all of her ADL and related care. This misrepresentation was consistent with what the family was told when they were evaluating the transition from independent to assisted living, namely that the assisted living staff could provide for all her daily care needs, including the need for supervision, fall prevention and bathing/toileting assistance. During the admissions process, Defendants' staff , including Donald Wright, was informed that Ms. McCorkle liked to take hot showers and would sometimes get up in the evening or early morning hours to self-bathe or toilet. They were also told that because Ms. McCorkle had a missing ear drum, she could not get water in her ear.

14. Ms. McCorkle's family had used the services of a private duty nursing when Ms. McCorkle was in the independent living unit. As the family transitioned from independent to assisted living at increased cost, they were told that the Garden Ride nurse aides would be able to meet all of Ms. McCorkle's ADL needs, including toileting, changing, feeding and bathing.

15. After being admitted to Garden Ridge the family discovered that the facility did not have sufficient staff to keep their mother safe. They continued to retain private duty staff as they were concerned about Sara's safety. The family had received conflicting information and recommendations from the staff. The direct care nurse aides acknowledged that the facility was understaffed and encouraged the family to get private duty aides. The management staff,

including the manager Don Wright, told the family that the Greenspring's staff would be performing all the daily ADL care, and that to the extent the family retained private during nursing, the private duty aides should simply use the call bell to summon the staff.

16. Prior to December 21, 2020, Defendants' staff, including but not limited to Don Wright, was informed through McCorkle family members and private duty aides that Ms. McCorkle was repeatedly getting up in the evening and early morning hours to self-bathe and/or toilet.

17. The private duty staff reported that the facility was understaffed and slow to respond to Sara's call bell. During the initial weeks of her residency, her call bell system was not even functioning. The nurse aide on the floor would repeatedly complain that there was only one nurse aide on the unit. During discovery, Defendants produced a staffing schedule (BS 000044) showing that on the evening of December 20, 2020, there was only one staff member on duty on the unit (ALF-EV1) where Ms. McCorkle resided, which covered 3 wings and some 27 residents.

18. In the month of December, the private duty aide observed that the Erickson staff was not attending to Ms. McCorkle's morning bathroom needs. The aide repeatedly arrived to find Ms. McCorkle dirty or with water on the floor, reflecting that she had bathed earlier in the morning. The private duty nurse addressed with issue with the direct care staff, management and the McCorkle family. She explained that Sara was not safe to bath by herself as she was a fall risk and could not get water in her ears.

19. On December 8, 2020, Sara's daughter wrote an email to Donald Wright noting that there was only one nurse for three hallways. Sara had been recently found naked, in a soiled bed and disheveled room. The daughter also informed the direct care staff about her concerns that her

mother was not safe in the facility with the lack of staff. The staff apologized and asked to be given another chance.

20. On December 21, 2020, at around 7:00 am, a nurse aide named Priscilla called Ms. McCorkle's daughter to explain that her mother had been found in the shower, but had not been injured. She was being put back to bed.

21. On December 21, 2020, at 11:05 am, the staff documents that Ms. McCorkle was found on the shower floor, with water running. She was assisted back to bed and no injuries were documented by the staff.

22. On December 21, 2020, at 12:17 p.m., NP Kauser evaluates Sara and starts her on Bacitracin for "rashes." At 12:21 pm, the staff documents redness to her lower extremities with blisters on her back and chest. The family was updated on her status, but not told of any burn injuries. They requested that Sara be taken to the hospital. Neither the nursing notes nor the discharge papers make any reference to Sara being found under hot water in the shower.

23. Defendants' service plan required the staff to anticipate Ms. McCorkle's needs based on "her individual daily routine and preferences." On the morning of December 21, 2020, the staff breached applicable standards of care in failing to assist Sara with toileting and showering. In fact, it was not until the water had flowed out into the hallway that a staff member even responded to her cries for help.

24. Defendants breached the standard of care by failing to follow their own service plan, which required that Sara be toileted and assisted with showering in the morning, as was her routine. Despite being aware of Ms. McCorkle's attempt to self-bathe or toilet, Defendant's staff, including Donald Wright, failed to update her written plan of care to reflect this dangerous behavior. As a result of this failure, Plaintiff's attending nurse on the evening of December 20,

2020 was unaware of this dangerous behavior and failed to provide the level of care and attention that Ms. McCorkle required

25. On or about February 22, 2021, Defendant Greenspring Village Inc. was investigated by their licensing authority, the Department of Social Services, for events involving Ms. McCorkle. Defendants were cited for various regulatory violations for their failures in the care of Ms. McCorkle, as set forth below.

26. The February 22, 2021, licensing investigation found that Defendants had failed to follow regulations for reporting unusual events, in violation of regulations and their own policy on reporting unusual events. The facility had failed to report the unusual event involving Ms. McCorkle being found unattended in the shower on December 21, 2020.

27. The February 22, 2021, licensing investigation found that Defendants failed to create an appropriate comprehensive individualized service plan ("UAI") that accurately described the needs of the patients, specifically Ms. McCorkle. More specifically, the resident's UAI documented the need for help with bathing and toileting as "human health only, physical assistance," but did not document the need for mechanical help.

28. The February 22, 2021, licensing investigation found that Defendants failed to ensure that they provided "supervision of residents schedules, care and activities, including attention to specialized needs, such as fall prevention." This finding related to Ms. McCorkle being found unattended in the shower on December 21, 2020, having fallen and sustained burn injuries after being exposed to hot, running water for an extended period of time.

29. Defendants did not dispute the underlying factual findings of the February 22, 2021 survey. On the contrary, they came up with a plan of correction that involved, inter alia, record audits and staff retraining.

30. The February 22, 2021, survey findings were based on assisted living regulations set forth at 22 VAC 40-73-10 *et. seq*. These regulations, including, but not limited to provisions for staffing (22 VAC 40-73-280), service planning (22 VAC 40-73-450), event/incident reporting (22 VAC 40-73-70) and resident supervision (22 VAC 40-73-460) and assistance with ADL activities (22 VAC 40-73-460) (including showering and bathing) were enacted for the care, safety and benefit of assisted living residents, including Ms. McCorkle. Sara McCorkle was, at all times herein, a member of the class of people sought to be protected by these regulations. Her fall and injuries suffered in the shower incident were the type of harm that the assisted living regulations were designed to protect against. For example, assisted living facilities are required to update written service plan to reflect any significant change in condition which endangers the resident's health or wellbeing, so that the dangerous behavior can be addressed and prevented.

31. Defendants' response to the February 22, 2021, licensure findings constitute an admission of their culpability for the regulatory violations stated therein. Defendants' violation of the above regulatory provisions constitutes negligence per se, as such negligence, as outlined herein, was a proximate cause of Plaintiff's injuries and damages.

32. Defendants, through their staff and operating within the course and scope of their employment, breached additional standards of care, including the following:

a. Failing to properly supervise and attend to the toileting and bathroom needs of Plaintiff, including the failure to provide required assistance with bathing on December 21, 2020;

b. Failing to adequately assess Ms. McCorkle's care needs and failing to implement a service plan that would address her need for early morning assistance with toileting and bathing;

c. Failing to provide increased rounding and offering early morning bathing opportunities to conform with Ms. McCorkle's behaviors and preferences;

d. Failing to make use of a shower safety device or shower stopper, that would prevent Ms. McCorkle from accessing the shower or running water;

e. Failing to provide adequate fall prevention, resulting in multiple falls during her residency;

f. Failing to properly evaluate Ms. McCorkle's prior falls/incidents and document information in the record as to the specific circumstances giving rise to such incidents;

g. Failing to accurately document the circumstances of Ms. McCorkle's December 21, 2020 shower incident, along with failing to pass on critical information to the treating hospital about how the blisters were created;

h. Failing to send Ms. McCorkle to the hospital with her hearing aide;

i. Failing to follow regulatory standards in place for assisted living facilities, including standards for assessment, documentation, incident reporting, record preservation and service planning; and

j. Failing to staff their facility with sufficient staff, properly trained, to meet the care needs of their high-acuity residents, including Ms. McCorkle.

33. After being admitted to Inova Fairfax Hospital on December 21, 2020, Sara McCorkle tested positive for Covid and was placed in isolation. Defendants negligently failed to

inform the Hospital that Sara had tested positive at the facility in October, and was not symptomatic when she was discharged. Due to her isolation, Sara was unable to be seen by dermatologist until after discharge.

34. On December 27, 2020, Ms. McCorkle sought follow up treatment at Augusta Health, Urgent Care of Waynesboro, where burn blisters were noted to be present on her left hip and back. The staff prescribed medications and referred her to a dermatologist.

35. On or about January 5, 2021, she sought treatment at Mid Atlantic Plastic Surgeons, where they recorded a history of second degree burns caused by exposure to hot water in the shower. Her skin was described as bright red erythema with edema and vesicles (blisters) located on her left thigh and upper back.

36. After experiencing ongoing neglect at Garden Ridge, the McCorkle family decided to remove Sara from the community where she had spent over 17 years as the staff proved unable to meet her needs.

As a direct and proximate result of Defendants' negligence, as outlined above, Sara McCorkle sustained physical injuries, including severe burn injuries, physical pain and mental suffering, medical expenses and increased costs of care. Plaintiff also suffered from inconvenience, indignity and general neglect, which adversely impacted her quality of life and caused suffering separate from her physical injuries. Finally, Plaintiff's damages, including her financial damages, continue into the future.

Count II
(Consumer Protection Claims – All Defendants)

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

37. At all pertinent times herein Plaintiff, through her lawful agents, engaged in a consumer transaction as defined under Va. Code § 59.1-198. Sara McCorkle was a consumer and Defendants were engaged in the business of providing personal services to their residents, including the Plaintiff.

38. In an effort to recruit patients into their facilities, Defendants had pursued an active marketing program to recruit high acuity, demented patients into their assisted living section, despite not being able to provide effective or consistent staffing. Erickson recruited patients by factually misrepresenting that all residents, upon paying the $335,000 entrance fee, could age in place within the community. As the resident's medical conditions deteriorated, Erickson represented that they would be able to provide a correspondingly higher level of care to suit the resident's increasing needs. If the resident ran out of money, Erickson would not seek discharge and would accept whatever compensation the resident could provide, i.e., social security and/or Medicaid. Upon being transferred from independent to assisted living, Defendants failed to meet Ms. McCorkle's care need as represented and further put her in danger of physical harm.

39. Defendants, through their staff operating within the course and scope of their employment, intentionally misrepresented various material facts to Plaintiff and her family in an effort to induce them into transferring to the assisted living section and remaining within Erickson's community. As part of the admissions process, which constituted a consumer transaction, Defendants' staff claimed that their trained staff could meet Sara's needs to providing all ADL care including the assistance she required to safely bathe and toilet. In fact, Defendants were unable to meet Sara's basic needs, being even unable to properly respond to her call bell inquiries or her need for bathing and hygiene assistance.

40. As part of the admissions process, and consistent with their admission agreement,

Defendants misrepresented that their facility was equipped to provide supervision, physical assistance in all ADL activities and an individualized plan of care to meet the resident's needs. Upon entering into the agreement, Ms. McCorkle paid the initial sum of $335,000, which did not cover her monthly fees or expenses.

41. As part of the admissions process, Defendant provided an Assisted Living Facility Disclosure statement that set forth the contractual care obligations of Defendant with corresponding fees. In this disclosure agreement, Defendant misrepresented that the number of direct care staff after January 2020, would be as follows: 26 direct care staff per shift from 7 am to 3 pm, 24 staff from 3 pm to 11 pm and 16 from 11 pm to 7 a.m.

42. The Assisted Living Disclosure statement factually represented that the following services would be available to Ms. McCorkle: licensed nurse on duty, licensed nurse management of chronic conditions on a regular basis, staff assistance for activities of daily living, roam alert system, incontinence care, local hospital visits by a Greenspring Nurse, regularly scheduled licensed nurse reviews and assessments, pullcord and 24 hour emergency response services with nursing staff, intervention from the nurse, nurse practitioner or physician (more than 1x week), and staff involvement for issues relating to cognition and behavior and other supportive services.

43. At the time Defendants made these misrepresentations, they knew or should have known that their staffing was inadequate to provide such care. For example, the call bell system did not work in Sara's room for some two weeks. The manager of Garden Ridge misrepresented to the McCorkle family that Sara's daily ADL care needs (including toileting and bathing) would be met by the direct care staff. The direct care staff would complain that the facility was understaffed and suggest that the family retain private duty nurses to assure that Sara got the care she needed. Private duty nurse hired by the family often found that Sara was not being provided

timely toileting, bathing or incontinence care, especially in the morning. The family learned that Defendant had far less direct care staff, then had been factually represented in their disclosure statements. At times there would only be one staff member on the 11 pm to 7 am shift, which meant there was inadequate staff to provide Sara's morning care, as she was an early riser.

44. At no time during Ms. McCorkle's residency did any member of the Erickson management team suggest that the facility was unable to meet Sara's needs or that she should be transferred to another facility. Even after the family advised management of the neglect Sara was experiencing, they took no action to address her ongoing care problems.

45. 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 Defendants had the ability to provide assistance with all ADL activities, including incontinence care, toileting, bathing and fall prevention. Defendants also misrepresented that their services were a particular standard or quality when they wrongfully claimed that they had sufficient staff to allow demented residents to age in place. Defendants engaged in such deception, false promises and misrepresentations knowing that Ms. McCorkle and her family would likely rely on such information in making their admission and transfer decisions.

46. Plaintiff and her family reasonably relied upon such material factual misrepresentations and placed their trust in Defendants when they agreed to admit Ms. McCorkle into their assisted living wing at Garden Ridge. 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

47. 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, severe burns, deconditioning, pain, mental suffering and debility. The economic damages include medical expenses incurred for the treatment of Plaintiff's injuries and declining physical condition, along with increased costs associated with her new care. Her economic damages also include the lost interest income on $ 335,000, which was paid to Defendants based on their misrepresentation that Ms. McCorkle could age in place within the community, when in reality the facility was unable to meet her needs after her transfer from independent living to assisted living.

Count III
(Punitive Damage – Defendants Erickson Senior Living LLC and Greenspring Village Inc)

Plaintiff incorporates paragraphs one through forty-seven as if fully set forth herein and further alleges the following:

48. Upon her transfer to Garden Ridge Ms. McCorkle had significant dementia, confusion and memory problems. She could not be relied upon to exercise good judgment for her own safety. As such, she was completely reliant upon the care and services provided by Defendants' staff.

49. Before and during the transfer process Defendants intentionally mispresented the nature of available services to Plaintiff and her family in an effort to convince them to remain within the Erickson community. Given her history, Defendants knew or should have known that they could not meet Ms. McCorkle's needs. Rather than lose a paying resident, Defendants

recklessly disregarded their obligations to Sara McCorkle and placed her in an environment where she would likely be neglected and injured due to a lack of adequate staff.

50. Sara McCorkle had previously made use of private duty aides when she was at Erickson's independent living community. When Sara transitioned into Garden Ridge at a higher cost, the family inquired whether they should continue with private duty aides given her worsening dementia and history of falls. The management staff engaged in the reckless and wanton disregard of Plaintiff's rights by misinforming the family and Ms. McCorkle that there was sufficient staffing at Garden Ridge to meet all her ADL needs, when in fact the facility lacked adequate staffing to keep high acuity residents, like Ms. McCorkle, safe. In fact, when they transferred Sara to Garden Ridge, they recklessly placed her in a unit that did not have a working call bell system.

51. Once Plaintiff's admission to Garden Ridge was achieved, Defendants learned that Sara was getting up to toilet and bath herself without staff assistance. The Defendants came up with a service plan that anticipated that the staff would provide hands-on assistance with all her bathing and toileting needs. However, in breach of applicable standards of care, Defendants failed to update her service plan to address her dangerous behaviors in getting up in the early morning hours to self-bathe or toilet.

52. Defendants' staff recklessly disregarded Plaintiff's rights by failing to follow their own care plan, despite the known risk that Sara presented when she would bath or shower on her own. Prior to Ms. McCorkle's December 21, 2020 bathroom injury, the staff and management team were repeatedly warned that Sarah was getting up in the early morning and self-bathing and toileting. Rather than properly address this significant safety hazard, Defendant's staff, including

their direct staff and manager, recklessly ignored this risk as well as the family's complaints of neglect, as outlined above.

53. Defendant's staff, in an effort to cover-up their misconduct, intentionally sought to document incriminating information in the incident report, which was not part of the chart produced to Plaintiff in this case. As explained by the Nurse Small, who completed the incident report, the purpose of the incident report is to record what actually happened to the resident. Nurse Small left out the actual time she found Ms. McCorkle in the nursing records (4:30 am) and recorded that information in the incident report. She also included in the incident report the fact that her son Allen informed the staff that Ms. McCorkle had showered herself without assistance from the private duty aides or nursing staff.

54. Defendant's staff also sought to intentionally conceal how Sara developed burn injuries on December 21, 2020, and purposely failed to pass on this critical information to the treating hospital and family about how her "blisters" actually developed. Sara was previously assessed as liking to linger in the shower and enjoy the hot water. She did not have blisters before the incident, so it should have been apparent to anyone that she developed burn blisters from heat exposure. Fairfax hospital staff reached out to inquire whether Sara had been exposed to a heat source. Rather than document this potentially incriminating information in the chart as established standards of care required, the staff intentionally concealed this information from the family and subsequent treating hospital, to the detriment of Ms. McCorkle.

55. Defendants also intentionally disregarded their reporting obligations to their licensing agency, the Department of Social Services. A February 22, 2021, licensing investigation found that Defendants had failed to follow regulations for reporting unusual events, in violation of regulations and their own policy on reporting unusual events. The facility had failed to report the

unusual event involving Ms. McCorkle being found, unattended in the shower on December 21, 2020. When the event was reported to their licensing agency by the McCorkle family, Defendants were cited for multiple failures in care relating to Ms. McCorkle.

56. Defendants tracked information about their residents through 24-hour reports. Defendants' staff acknowledged that information regarding Ms. McCorkle would have been recorded in their 24-hour reports. Defendants intentionally spoliated their 24-hour reports despite receiving an evidence preservation letter with a Notice of Claim on April 13, 2021. Defendants also destroyed their as-worked staffing schedules, that would have shown the actual staffing levels on December 20 and December 21, 2020.

57. Defendants knew that the failure to provide sufficient staffing, including a staff with necessary training to care for a high acuity patient, would likely cause injury to residents like Ms. McCorkle, who required extensive hands-on assistance with all her ADL activities. During Ms. McCorkle's residence, Defendants also received complaints from other families and residents that their needs were not being met. Defendants should have known from these complaints and from their extreme delays in responding to call bells, including call bells from the room of Ms. McCorkle, that the staff was not meeting the needs of their residents, including Ms. McCorkle.

58. Based on their substandard regulatory performance as revealed through their licensing surveys, Defendants knew or should have known that the needs of high acuity residents were not being met at Garden Ridge. On May 1, 2017, Defendants were cited for failing to protect the physical and mental well-being of a resident who was injured and found to have bruising and a hematoma on her face and had failed to timely update the same resident's service plan.

59. On November 28, 29 and 30, 2018, Defendants were cited for failing to ensure that care provide and service delivery was resident-centered to the maximum extent possible, failing to assure that residents participated in their service planning, failing to personalize care to the resident's circumstances and failing to provide prompt response to the resident's needs. The specific failure in this inspection involved the facility's failure to timely toilet a resident who needed physical assistance with toileting. In response to this survey, the Defendants reeducated staff members on, *inter alia*, abuse, resident's rights and infection control.

60. On August 19, 2019, Defendants were cited by their licensing authority for failing to assure that major incidents that negatively affected or threatened the life, health or safety of the resident were reported. Defendant had failed to report an outbreak of respiratory illnesses within the facility.

61. On October 22 and 23, 2019, Defendants were cited for the administrator's failure to assess and properly document whether the admission of a resident with serious cognitive impairment was appropriate. Defendant was also cited for failing to engage in proper service planning, as the service plans had not been reviewed or signed by the administrator, his/her designee the resident or his legal representative.

62. On November 19, 2020, Defendants were cited for failing to assure that a resident with dementia was evaluated by a psychologist or independent physician before being admitted to the assisted living facility. During this same survey, the facility was cited for the administrator's failure to assess whether the resident was an appropriate placement.

63. Given Defendants' history of non-compliance with basic regulatory standards and the numerous complaints of neglect involving Ms. McCorkle and other residents, Defendants' management staff knew or should have known that Garden Ridge was not suited for demented

residents with high acuity who had the propensity to get up and bath or toilet without supervision. Defendants' management, in an effort to generate increased revenues and profits, intentionally admitted high acuity residents like Sara, 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.

64. Even after Defendant's staff became aware of the increased danger that Ms. McCorkle represented (because the staff was unable to meet her needs for supervision and ADL toileting/bathing assistance), they recklessly failed to implement additional safety measures, despite knowing that she would likely suffer injury, as she had in the past.

65. 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 Ms. McCorkle. Defendants also ratified the conduct of their staff by intentionally and/or recklessly staffing its facility without a sufficient number of properly trained staff. Defendants ratified the acts of their employees by participating in the cover up, by failing to report this incident to their licensing authority, and by destroying relevant documents including staffing records and 24 hour reports. Defendants ratified this conduct by condoning corporate practices in which incriminating information is buried in incident reports and not put in the patient chart. As Defendant's management staff was aware of the regulatory violations and family complaints regarding the neglect of Ms. McCorkle 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 attempting to conceal Plaintiff's injuries

by not documenting the manner in which such injuries were caused and by failing to report this unusual event to their licensing authority.

66. As a direct and proximate result of Defendants' willful wanton and reckless conduct, as outlined above, Sara McCorkle sustained physical injuries, including severe burn injuries, physical pain and mental suffering, medical expenses and increased costs of care. Plaintiff also suffered from inconvenience, indignity and general neglect, which adversely impacted her quality of life and caused suffering separate from her physical injuries. Finally, Plaintiff's damages, including her financial damages, continue into the future.

Count IV
(Breach of Contract – Defendant Greenspring Village Inc.)

Plaintiff incorporates paragraphs one through sixty-six as if fully set forth herein, and further states as follows:

67. For valuable consideration exchanged between the parties, on May 24, 2002, Sara McCorkle entered into a contract with Greenspring Village Inc., known as the Greenspring Village and Residence and Care Agreement. (Exh. A). On or about November 25, 2020, she also signed a transfer addendum to move into the ALF memory care assisted living section, increasing her monthly fee to $8,659.00 a month. (Exh. B). This document, which modified the original admission agreement, set forth the contractual obligations for Level D services, which Defendant was contractually obligated to provide. *Id*.

68. Level D services included, *inter alia*, the following: licensed nurse on duty, licensed nurse management of chronic conditions on a regular basis, staff assistance for activities of daily living, roam alert system, incontinence care, three meals a day, local hospital visits by a Greenspring Nurse, regularly scheduled licensed nurse reviews and assessments, care plans designed by a care team (including assisted living manager, wellness manager, resident and

family), pullcord and 24 hour emergency response services with nursing staff, intervention from the nurse, nurse practitioner or physician (more than 1x week), staff involvement for issues relating to cognition and behavior and other supportive services, spiritual and religious services and staff encouragement to participate in daily events. *Id.* The contract also stated that the resident may be discharged or transferred to a higher level of care where she, *inter alia*, requires 24 hour nursing supervision, has a cognitive decline severe enough to prevent the making of simply decisions regarding activities such as bathing, dressing and eating and cannot respond appropriately to cuing and simple directions, the resident requires more than assistance with transfer, the resident is a danger to self or others or the resident's health and safety would be endangered if not discharged. Section 5, 5.1 – 5.11.

69. As part of their contractual obligations, Defendant provided an Assisted Living Facility Disclosure statement that restated the contractual obligations of Defendant with corresponding fees. (Exh. C). In this disclosure agreement, Defendant represented that the number of direct care staff after January 2020, would be as follows: 26 direct care staff per shift from 7 am to 3 pm, 24 staff from 3 pm to 11 pm and 16 from 11 pm to 7 a.m. *Id*.

70. By virtue of Defendant Greenspring Village Inc's conduct, as outlined herein, Defendant materially breached their contractual agreement with Ms. McCorkle after she was transferred to the assisted living wing on or about November 25, 2020.

71. After being admitted to the Garden Ridge assisted living facility, the family discovered that there was insufficient staff to provide Plaintiff with her much needed assistance with ADL care. During the initial weeks of her residency, her call bell system was not even functioning. Even after the call bell system was repaired, the staff still failed to timely respond to call bells, in breach of their contractual obligations.

72. As Sara was incontinent, she required frequent toileting, bathing and change of clothes or depends. During late November and throughout December, the family repeatedly learned that Sara's ADL needs were not being met, in violation of Defendant's contractual obligations. Nurse aides on the unit complained about lack of staffing and informed the family that they needed to hire separate private duty care to keep Ms. McCorkle safe.

73. The private duty staff hired by the McCorkle family reported that when they would visit Sara, they would find Sara dirty with her room not cleaned. They would also find that the staff was not assisting her with bathing, toileting and incontinence care, as required by the agreement.

74. On December 8, 2020, Sara's daughter wrote an email to Donald Wright noting that there was only one nurse for three hallways. Sara had been recently found naked, in a soiled bed and disheveled room. The daughter also informed the direct care staff about her concerns that her mother was not safe in the facility with the lack of staff. Failures to provide adequate staffing to meet Ms. McCorkle's daily care needs was a material breach of the contract that necessitated the family's removal of Sara from the facility to keep her safe.

75. As a direct result of Defendant's material breaches of the contract at issue, Plaintiff sustained various types of financial damages. She lost of time value of some $335,000 in income that she had provided to Defendant as a condition of admission. While that money was returned after her discharge from Greenspring Village, she lost the investment and income potential that these funds would have generated over the course of some 18 years. As a proximate result of the contractual breach, Plaintiff had to hire private duty nurses at increased costs and incurred further damages to pay for nursing care services since she is no longer able to receive the benefit of aging in place at a fixed cost, as promised by Defendants.

Wherefore, these and other premises considered, Plaintiff moves this Court for judgment against Defendants, Erickson Senior Living LLC and Greenspring Village Inc., Inc, jointly and severally (with the exception of the contract claim, which is against Greenspring Village Inc. only), as follows:

a. An award of compensatory damages of $2.5 million, plus costs and interest from December 21, 2020;

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

c. An award of Punitive damages of $400,000

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: December 14, 2022

Respectfully submitted, Plaintiff, by counsel

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Exh. A

Exh. B

Exh. C